Pulmonary Tuberculosis Nursing Care Plan Sample

Sample 1

Nursing Diagnosis: **Ineffective Airway Clearance related to presence of bronchial infection and secretion.**

Assessment	Nursing Diagnosis	Expected Outcomes	Nursing Interventions	Rationale	Evaluation
Subjective: • "I have had this recurrent cough for almost a month now, and it seems to be getting worse. I feel short of breath at times and get tired easily. I have lost my appetite and some weight. At night, I wake up sweating and often feel chills." **Objective:** • RR = 24 breaths/min • PR = 98 beats/min • T = 37.8°C • BP = 110/70 mmHg • SpO_2 = 94% on room air	Ineffective Airway Clearance related to excessive mucus production	After 8 hours of nursing care, the patient will demonstrate effective airway clearance, as evidenced by readily expectorating secretions.	1. Implement strict airborne precautions, including N95 mask use, hand hygiene, negative-pressure isolation (if hospitalized), and patient masking when in shared spaces. 2. Position the patient in High-Fowler's position (head elevated 45–90 degrees) and	1. TB is transmitted via airborne droplets; strict precautions prevent nosocomial transmission and protect healthcare workers and other patients (WHO, 2024). 2. Enhances lung expansion, improves ventilation-perfusion matching, reduces work of breathing, and	After 8 hours of nursing care, the goal is partially met, as the patient effectively expectorated secretions but continues to experience intermittent dyspnea, requiring ongoing management.

Assessment	Nursing Diagnosis	Expected Outcomes	Nursing Interventions	Rationale	Evaluation
• Easy fatigability • Productive cough (>3 weeks) • Hemoptysis • Shortness of breath • Night sweats and chills • Loss of appetite and weight loss (~5 kg in two months) • Chest X-ray: Right upper lobe infiltrates and cavitation • Sputum AFB Smear: Positive • GeneXpert MTB/RIF: Positive for *M. tuberculosis* • CBC: Mild leukocytosis, low hemoglobin (10.5 g/dL) • TST: >15 mm induration • IGRA: Positive			encourage frequent repositioning. 3. Encourage deep breathing exercises, pursed-lip breathing, and use of an incentive spirometer every 2 hours. 4. Promote adequate hydration (≥2.5 L/day), unless contraindicated, and encourage warm fluids. 5. Administer prescribed bronchodilators (e.g., salbutamol) and mucolytics (e.g.,	prevents mucus stasis, which may lead to secondary infections (UpToDate, 2024). 3. Increases alveolar ventilation, prevents atelectasis, and mobilizes mucus for easier expectoration (CDC, 2024). 4. Liquefies thick mucus, making it easier to clear secretions and reducing airway obstruction. Warm fluids have been shown to soothe the respiratory tract and aid in mucus mobilization (WHO, 2024). 5. Bronchodilators reduce airway resistance, while mucolytics break down tenacious secretions,	

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			acetylcysteine) as indicated.	improving airflow and secretion clearance (UpToDate, 2024).	
			6. Perform chest physiotherapy (e.g., percussion, vibration, postural drainage) twice daily if not contraindicated.	6. Enhances secretion mobilization using gravity and mechanical stimulation, reducing risk of airway obstruction (CDC, 2024).	
			7. Initiate Directly Observed Therapy (DOT) to ensure adherence to the full TB treatment regimen (6–9 months) and assess for medication side effects.	7. Strict adherence to anti-TB therapy prevents treatment failure, drug resistance (MDR-TB, XDR-TB), and relapse (WHO, 2024).	
			8. Monitor respiratory status closely, including breath sounds, respiratory rate, oxygen saturation (SpO_2), and use of accessory muscles.	8. Early identification of respiratory distress, worsening hypoxia, or signs of treatment failure allows for timely interventions (UpToDate, 2024).	

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			9. Encourage high-protein, high-calorie meals to support immune function and counteract weight loss associated with TB.	9. Malnutrition weakens immunity and prolongs recovery; nutritional support is crucial for TB patients who often suffer from significant weight loss (WHO, 2024).	
			10. Provide psychological support and patient education on disease stigma, treatment adherence, and lifestyle modifications (e.g., smoking cessation, stress management).	10. TB patients face social stigma, mental distress, and treatment fatigue; emotional support and education improve adherence and overall well-being (CDC, 2024).	
			11. Encourage family screening and contact tracing per public health guidelines.	11. Early identification and prophylactic treatment of household contacts help prevent further disease transmission and outbreaks (WHO, 2024).	

Sample 2

Nursing Diagnosis: **Risk for Infection Related to Airborne Transmission of TB**

Assessment	Nursing Diagnosis	Expected Outcomes	Nursing Interventions	Rationale	Evaluation
Subjective: • "I have been living with family members who have TB, and I am worried that I might have been exposed. I don't have any symptoms yet, but I want to make sure I'm not infected and that I don't spread it to others." **Objective:** • No current respiratory symptoms reported • RR = 18 breaths/min • PR = 82 beats/min • T = 37.0°C • BP = 120/80 mmHg	Risk for Infection related to airborne transmission of Mycobacterium tuberculosis due to prolonged close contact with an individual with infectious pulmonary TB.	After 24 hours of nursing care, the patient and family will demonstrate understanding of TB transmission and prevention by adhering to airborne precautions.	1. Implement strict airborne precautions, including N95 mask use, hand hygiene, patient isolation, and proper cough etiquette. 2. Educate the patient and family on TB transmission, proper use of masks, importance of ventilation, and adherence to hygiene practices. 3. Ensure household contacts undergo screening for TB exposure, referring them for tuberculin skin testing (TST),	1. TB is transmitted through airborne droplets; strict precautions reduce exposure risk to healthcare workers and household contacts (WHO, 2024). 2. Patient and family education enhances compliance with airborne precautions, reducing the risk of infection spread in the household and community (CDC, 2024). 3. Early identification and treatment of latent TB infections (LTBI) prevent progression to active TB and further transmission (CDC, 2024).	After 24 hours of nursing care, the goal is met, as the patient and family demonstrated understanding of TB prevention and adhered to airborne precautions, with household contacts referred for screening.

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Assessment	Nursing Diagnosis	Expected Outcomes	Nursing Interventions	Rationale	Evaluation
• SpO_2 = 98% on room air • Positive household TB exposure history • Tuberculin Skin Test (TST): Positive (>15 mm induration) • Interferon-Gamma Release Assay (IGRA): Positive • Chest X-ray: No visible infiltrates or cavitation			IGRA, chest X-ray, or sputum testing if indicated. 4. Promote BCG vaccination for eligible high-risk individuals per national guidelines. 5. Reinforce the importance of adherence to TB preventive therapy (e.g., isoniazid prophylaxis for latent TB) in high-risk individuals. 6. Collaborate with public health authorities for contact tracing and community education programs	4. BCG vaccination provides partial protection against severe TB forms, including miliary TB and TB meningitis, particularly in children (WHO, 2024). 5. Completion of TB preventive therapy significantly reduces the risk of latent TB progressing to active TB, especially in immunocompromised individuals (UpToDate, 2024). 6. Public health interventions reduce community transmission rates by identifying and managing TB-exposed individuals early (WHO, 2024).	

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			on TB prevention.	7. Early detection of symptom onset allows for prompt medical intervention, reducing disease progression and spread (CDC, 2024).	
			7. Monitor the patient for early signs of active TB development, including persistent cough, night sweats, weight loss, and fatigue.	8. Fear of social stigma can prevent individuals from seeking screening or adhering to infection control measures (WHO, 2024).	
			8. Provide psychological support and counseling to address TB-related stigma, anxiety, and adherence challenges.	9. A well-nourished immune system helps the body fight latent TB infection, reducing the likelihood of disease activation (UpToDate, 2024).	
			9. Encourage proper nutrition and hydration to maintain immune system strength and overall health.	10. Regular follow-ups ensure long-term prevention efforts are maintained and allow for early intervention if TB develops (CDC, 2024).	
			10. Schedule follow-up visits to monitor infection status and		

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			reinforce adherence to preventive strategies. 11. Educate on the importance of avoiding high-risk environments to minimize exposure risk.	11. Reducing exposure in high-risk settings lowers the chance of airborne TB transmission, particularly in endemic regions (WHO, 2024).	

Sample 3

Nursing Diagnosis: **Imbalanced Nutrition: Less than Body Requirements Related to Increased Metabolic Demand**

Assessment	Nursing Diagnosis	Expected Outcomes	Nursing Interventions	Rationale	Evaluation
Subjective: • "I have lost my appetite and about 6 kg over the past two months. I feel weak, tired, and have little energy for daily activities."	Imbalanced Nutrition: Less than Body Requirements related to increased metabolic demands and inadequate oral intake secondary to	After two weeks of nursing care, the patient will demonstrate improved nutritional status, evidenced by a weight gain of at least 1 kg, increased oral intake, and verbalization of	1. Encourage small, frequent, high-calorie meals rich in protein, vitamins, and minerals.	1. TB increases metabolic demands, leading to weight loss and muscle wasting; small, frequent meals optimize intake and	After two weeks of nursing care, the patient demonstrated improved nutritional status, evidenced by a weight gain of 1.2 kg, increased oral intake, and verbalization of dietary requirements,

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Objective: • BMI = 16.5 (underweight) • RR = 20 breaths/min • PR = 90 beats/min • T = 37.2°C • BP = 110/70 mmHg • SpO_2 = 96% on room air • Pale appearance, easy fatigability • Reduced oral intake reported • Dry mucous membranes • Mild anemia (Hb: 10.5 g/dL) • Slightly decreased serum albumin indicating poor nutritional status	tuberculosis and its treatment.	dietary requirements.	2. Provide oral nutritional supplements as needed to meet daily caloric and protein requirements. 3. Manage medication-related side effects (e.g., administer anti-nausea drugs before meals to improve intake). 4. Educate the patient on the importance of nutrition in recovery, including the role of proteins, carbohydrates, and micronutrients in immune function and tissue repair.	prevent early satiety (WHO, 2024). 2. Nutritional supplementation helps bridge dietary gaps, supporting weight gain and immune function (UpToDate, 2024). 3. TB medications (e.g., rifampin, isoniazid) can cause nausea and gastrointestinal upset, reducing food intake (CDC, 2024). 4. Proper nutrition enhances immunity, promotes lung tissue healing, and supports overall recovery from TB (WHO, 2024).	meeting the expected outcome.

Assessment	Nursing Diagnosis	Expected Outcomes	Nursing Interventions	Rationale	Evaluation
			5. Monitor food intake and record daily caloric consumption to assess nutritional progress.	5. Tracking intake ensures that caloric goals are met and helps detect early signs of malnutrition or inadequate dietary adherence (UpToDate, 2024).	
			6. Encourage fluid intake of at least 2.5 L/day unless contraindicated to prevent dehydration and support digestion.	6. Hydration supports metabolism, digestion, and medication absorption while preventing constipation and dehydration (CDC, 2024).	
			7. Promote consumption of iron-rich foods (e.g., lean meats, beans, leafy greens) to address potential TB-related anemia.	7. Chronic infections like TB often lead to anemia due to inflammation and poor dietary intake; iron-rich foods help restore hemoglobin levels (WHO, 2024).	

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			8. Assess for signs of vitamin and mineral deficiencies and provide supplementation as indicated (e.g., vitamin D, B-complex).	8. TB treatment can deplete essential nutrients, and deficiencies (e.g., vitamin D) are linked to poor TB outcomes (UpToDate, 2024).	
			9. Coordinate with a dietitian to develop an individualized, culturally appropriate nutrition plan tailored to the patient's dietary preferences and needs.	9. Personalized meal planning increases adherence to dietary recommendations and ensures adequate nutrition (WHO, 2024).	
			10. Provide emotional and psychological support to address TB-related anxiety, depression, or social stigma that may contribute to poor appetite.	10. Mental health support is essential, as depression and social stigma associated with TB can lead to decreased motivation to eat and adhere to treatment (CDC, 2024).	