- A patient who is admitted for **active TB** determined to be **smear and culture positive** will remain on airborne precautions until:
  - Completion of minimum 14 days of daily anti-tuberculosis therapy by DOT; **and**
  - Three successive sputum specimens (spontaneous or induced) are negative on smear; **and**
  - There is clinical evidence of improvement **and**
  - Drug susceptibilities are known and drug resistance is ruled out
  - After 14 days of daily treatment if sputum specimens are still smear positive, the patient must remain in airborne isolation until three successive sputum specimens (spontaneous or induced) are negative on smear on three separate days
  - Patients known to have active multidrug-resistant TB or mono-resistance to rifampin: These patients should be kept under airborne precautions for the duration of their hospital stay or until three consecutive sputum cultures (not smears) are negative after 6 weeks of incubation.

Discontinuation of isolation precautions should NEVER be based on a fixed interval of treatment (e.g. 2 weeks) but, rather, on evidence of clinical and bacteriologic improvement and evidence of the adequacy of the treatment regimes. In summary, **isolation precautions should be continued until patients are highly likely to be non-infectious.**

See **Section 8, Treatment for Tuberculosis**, for further details.

Direct Observed Treatment (DOT)

Nursing staff are responsible for Directly Observed Treatment (DOT) of the patient's anti-TB medications, which includes:

- documentation of directly observing ingestion of the medications; **OR**
- documentation and reporting of any refused doses. Refused or missed doses must be reported immediately to the OCPHO and IM specialist.

- See **Section 8, Treatment for Tuberculosis**, for more details on DOT.

Discharge Planning

Prior to discharging a patient back to his or her home community, it is imperative to assess for any social issues that may limit adherence to the long-term TB treatment. Referrals for alcohol or drug rehabilitation programs or social incentives such as food vouchers or taxi tickets needed to assist with adherence, may need consideration.

Discharge planning should include a referral to social services if indicated.

It is also imperative that there is sufficient capacity at the local health clinic to provide DOT on a daily or thrice weekly basis depending on the recommendation of treatment. Failure to deal with these issues at the initial admission may at times necessitate repeat admissions under Public Health Order requiring 24/7 security. This is a costly endeavor especially to the health care facility which incurs the costs. Regional Health and Social Services Authorities may need to consider added staffing for management of the TB Program and DOT in situations of outbreak or where numerous patients are on DOT.

Clinical Monitoring

All patients going on treatment should be fully informed of the benefits and side effects of their medication and specific, personalized case management and follow-up MUST be done on all patients.

Clinical monitoring is necessary for all patients receiving treatment for active TB disease (at least monthly) until treatment has been discontinued or completed. The Internal Medicine Specialist and OCPHO should be advised immediately of any patient that, during the course of treatment:

- Experiences recurrence or worsening of symptoms of active TB disease (including unexpected weight loss)
- Develops symptoms/signs suggestive of drug toxicity or other adverse reaction to anti-tuberculosis medications
- Becomes pregnant
- Misses more than two consecutive doses of TB meds
- Any other significant changes to their health status
- See **Section 8, Treatment for Tuberculosis,** for more details on clinical monitoring of the patient on TB treatment