

A.C.E. Tool

Assessment Communication Education
(for assessment of TB transmission risk)

Attach Patient Label

Assess patient risk factors:

Related to TB exposure	✓
• Known history of TB exposure or contact with someone with TB (consider occupational exposures)	
• Time spent in endemic country (foreign born, work, travel)	
• Living or working in crowded and or low income settings (DTES, incarceration, Aboriginal reserve)	

Related to developing active disease or reactivation	✓
• Known previous disease (call BC TB Control to get background info including evidence of effective treatment and share with clinical team)	
• Immunocompromised (eg: Organ transplant, HIV/AIDs, prolonged steroid use)	
• Certain co-morbidities: diabetes, cancer, kidney disease, silicosis	
• Increased age/elderly	

Related to clinical presentation	✓
• Respiratory symptoms (cough, chest pain, hemoptysis) particularly if longer than 3 weeks and/or unresolved with antibiotics	
• Constitutional symptoms (fever/night sweats, unexplained weight loss, fatigue, loss of appetite)	

Review Imaging: CXR & Chest CT

Typical findings: Triad of classic findings are seen in non-immunocompromised adults	✓
• Position – apical-posterior segments of upper lobes or superior segment of lower lobes in 90%	
• Volume loss – this is a hallmark of TB disease as a result of its destructive and fibrotic nature	
• Cavitation – this is seen at a later stage and depends upon a vigorous immune response; may not be seen in severely immunocompromised individuals	

Review Imaging: CXR & Chest CT (continued)

Atypical features: these may be seen in patients with immunocompromising conditions such as HIV infection, diabetes, renal failure, or corticosteroid use	✓
• Hilar and mediastinal lymphadenopathy, particularly in HIV infected individuals	
• Non-cavitary infiltrates and lower lobe involvement	
• Normal CXR in 10% of patients with HIV co-infection	

Review Microbiology

Monitor Microbiology Lab Results	✓
• Three AFB’s should be ordered (collected at least 1 hour apart with one specimen taken in the am prior to eating)—if only 1 AFB ordered clarify with care team directly and ask to order 2 more.	
• Consider collection of induced sputum for patients that are unable to produce good quality specimens or for whom bronchoscopy is not appropriate.	
• If patient has bronchoscopy ordered; ask to collect post-bronchoscopy specimen.	
• Specimens should be of good quality; ask to recollect if lab reports specimen of poor quality.	
• When interpreting AFB result, consider possible influence of previous/concurrent antibiotic use (e.g. Moxifloxacin)	

Review Airborne Precautions

Communicate with Patient Care Unit	✓
• Confirm time and date patient was put on airborne precautions in a negative pressure room	
• Ensure appropriate IPAC precautions sign is on door	
• Remind nurse to collect and/or communicate need for specimens at change of shift.	
• Ensure care plan indicates that consultation with IPAC is required prior to discontinuing precautions	

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Process for Discontinuation of Airborne Precautions for Pulmonary TB

- ✓ **The patient care unit must consult IPAC prior to discontinuing precautions.**
- ✓ Discontinuation of Airborne precautions requires a physicians order.

After ruling out Pulmonary TB

Patients suspected of having Pulmonary TB should remain on Airborne Precaution until they have met ALL of the following criteria:	✓
<ul style="list-style-type: none">• Minimum of 3 negative AFB	
<ul style="list-style-type: none">• Clinical improvement	
<ul style="list-style-type: none">• An alternate diagnosis (that explains the syndrome)	

When Pulmonary TB is no longer suspected

If AFBs were ordered, but after review attending physician no longer suspects PTB and doesn't feel the patient needs to be on airborne precautions, the physician needs to:	✓
<ul style="list-style-type: none">• Clearly document his/her rationale in the chart	
<ul style="list-style-type: none">• Cancel any outstanding orders for AFB	
<ul style="list-style-type: none">• Consult Medical Microbiologist if there are questions	
If a physician is looking for non-tuberculosis mycobacterium in sputum for AFB (e.g. MAC), they need to:	✓
<ul style="list-style-type: none">• Clearly document his/her rationale in the chart	
<ul style="list-style-type: none">• Cancel any outstanding orders for AFB	

After treatment of PTB

Patients undergoing treatment for PTB need to remain on precautions until:	✓
<ul style="list-style-type: none">• Two weeks of documented treatment (review notes/MAR to confirm no missed doses or obvious factors affecting drug absorption (e.g. vomiting/diarrhea)	
<ul style="list-style-type: none">• Clinical improvement	
<ul style="list-style-type: none">• Three consecutive negative AFB sputum's of good quality (with first specimen taken at 14 days post-treatment).	