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Fundamental elements needed to prevent transmission of infectious agents in healthcare settings. Healthcare organizations can demonstrate a commitment to preventing transmission of infectious agents by incorporating infection control into the objectives of the organization's patient and occupational safety programs.⁵⁴³⁻⁵⁴⁷ An infrastructure to guide, support, and monitor adherence to Standard and Transmission-Based Precautions ^{434, 548, 549} will facilitate fulfillment of the organization's mission and achievement of the Joint Commission on Accreditation of Healthcare Organization's patient safety goal to decrease HAIs.⁵⁵⁰ Policies and procedures that explain how Standard and Transmission-Based Precautions are applied, including systems used to identify and communicate information about patients with potentially transmissible infectious agents, are essential to ensure the success of these measures and may vary according to the characteristics of the organization. A key administrative measure is provision of fiscal and human resources for maintaining infection control and occupational health programs that are responsive to emerging needs. Specific components include bedside nurse ⁵⁵¹ and infection prevention and control professional (ICP) staffing levels,⁵⁵² inclusion of ICPs in facility construction and design decisions,¹¹ clinical microbiology laboratory support,^{553, 554} adequate supplies and equipment including facility ventilation systems,¹¹ adherence monitoring,⁵⁵⁵ assessment and correction of system failures that contribute to transmission,^{556, 557} and provision of feedback to healthcare personnel and senior administrators.^{434, 548, 549, 558} The positive influence of institutional leadership has been demonstrated repeatedly in studies of HCW adherence to recommended hand hygiene practices.^{176, 177, 434, 548, 549, 559-564} Healthcare administrator involvement in infection control processes can improve administrators' awareness of the rationale and resource requirements for following recommended infection control

practices. Several administrative factors may affect the transmission of infectious agents in healthcare settings: institutional culture, individual worker behavior, and the work environment. Each of these areas is suitable for performance improvement monitoring and incorporation into the organization's patient safety goals.^{543, 544, 546, 565} The effectiveness of infection surveillance and control programs in preventing nosocomial infections in United States hospitals was assessed by the CDC through the Study on the Efficacy of Nosocomial Infection Control (SENIC Project) conducted 1970-76.⁵⁶⁶ In a representative sample of US general hospitals, those with a trained infection control physician or microbiologist involved in an infection control program, and at least one infection control nurse per 250 beds, were associated with a 32% lower rate of four infections studied (CVC-associated bloodstream infections, ventilator-associated pneumonias, catheter-related urinary tract infections, and surgical site infections). Since that landmark study was published, responsibilities of ICPs have expanded commensurate with the growing complexity of the healthcare system, the patient populations served, and the increasing numbers of medical procedures and devices used in all types of healthcare settings. The scope of work of ICPs was first assessed in 1982 ⁵⁶⁷⁻⁵⁶⁹ by the Certification Board of Infection Control (CBIC), and has been re-assessed every five years since that time.^{558, 570-572} The findings of these task analyses have been used to develop and update the Infection Control Certification Examination, offered for the first time in 1983. With each survey, it is apparent that the role of the ICP is growing in complexity and scope, beyond traditional infection control activities in acute care hospitals. Activities currently assigned to ICPs in response to emerging challenges include: None of the CBIC job analyses addressed specific staffing requirements for the identified tasks, although the surveys did include information about hours worked; the 2001 survey included the number of ICPs assigned to the responding facilities.⁵⁵⁸ There is agreement in the literature that 1 ICP per 250 acute care beds is no longer adequate to meet current infection control needs; a Delphi

project that assessed staffing needs of infection control programs in the 21st century concluded that a ratio of 0.8 to 1.0 ICP per 100 occupied acute care beds is an appropriate level of staffing.⁵⁵² A survey of participants in the National Nosocomial Infections Surveillance (NNIS) system found the average daily census per ICP was 115.3.¹⁶ Results of other studies have been similar: 3 per 500 beds for large acute care hospitals, 1 per 150-250 beds in long term care facilities, and 1.56 per 250 in small rural hospitals.^{573, 575} The foregoing demonstrates that infection control staffing can no longer be based on patient census alone, but rather must be determined by the scope of the program, characteristics of the patient population, complexity of the healthcare system, tools available to assist personnel to perform essential tasks (e.g., electronic tracking and laboratory support for surveillance), and unique or urgent needs of the institution and community.⁵⁵² Furthermore, appropriate training is required to optimize the quality of work performed.^{558, 572, 576}

II.A.1.A.I. INFECTION CONTROL NURSE LIAISON.

Designating a bedside nurse on a patient care unit as an infection control liaison or "link nurse" is reported to be an effective adjunct to enhance infection control at the unit level.⁵⁷⁷⁻⁵⁸² Such individuals receive training in basic infection control and have frequent communication with the ICPs, but maintain their primary role as bedside caregiver on their units. The infection control nurse liaison increases the awareness of infection control at the unit level. He or she is especially effective in implementation of new policies or control interventions because of the rapport with individuals on the unit, an understanding of unit-specific challenges, and ability to promote strategies that are most likely to be successful in that unit. This position is an adjunct to, not a replacement for, fully trained ICPs. Furthermore, the infection control liaison nurses should not be counted when considering ICP staffing. There is increasing evidence that the level of bedside nurse-staffing influences the quality of patient care.^{583, 584} If there are adequate nursing staff, it is more likely that infection control practices, including hand hygiene and Standard and Transmission-Based Precautions,

will be given appropriate attention and applied correctly and consistently.⁵⁵² A national multicenter study reported strong and consistent inverse relationships between nurse staffing and five adverse outcomes in medical patients, two of which were HAIs: urinary tract infections and pneumonia.⁵⁸³ The association of nursing staff shortages with increased rates of HAIs has been demonstrated in several outbreaks in hospitals and long term care settings, and with increased transmission of hepatitis C virus in dialysis units.^{22, 418, 551, 585-597} In most cases, when staffing improved as part of a comprehensive control intervention, the outbreak ended or the HAI rate declined. In two studies,^{590, 596} the composition of the nursing staff ("pool" or "float" vs. regular staff nurses) influenced the rate of primary bloodstream infections, with an increased infection rate occurring when the proportion of regular nurses decreased and pool nurses increased. The critical role of the clinical microbiology laboratory in infection control and healthcare epidemiology is described well ^{553, 554, 598-600} and is supported by the Infectious Disease Society of America policy statement on consolidation of clinical microbiology laboratories published in 2001.⁵⁵³ The clinical microbiology laboratory contributes to preventing transmission of infectious diseases in healthcare settings by promptly detecting and reporting epidemiologically important organisms, identifying emerging patterns of antimicrobial resistance, and assisting in assessment of the effectiveness of recommended precautions to limit transmission during outbreaks.⁵⁹⁸ Outbreaks of infections may be recognized first by laboratorians.¹⁶² Healthcare organizations need to ensure the availability of the recommended scope and quality of laboratory services, a sufficient number of appropriately trained laboratory staff members, and systems to promptly communicate epidemiologically important results to those who will take action (e.g., providers of clinical care, infection control staff, healthcare epidemiologists, and infectious disease consultants).⁶⁰¹ As concerns about emerging pathogens and bioterrorism grow, the role of the clinical microbiology laboratory takes on even greater importance. For

healthcare organizations that outsource microbiology laboratory services (e.g., ambulatory care, home care, LTCFs, smaller acute care hospitals), it is important to specify by contract the types of services (e.g., periodic institution-specific aggregate susceptibility reports) required to support infection control. Several key functions of the clinical microbiology laboratory are relevant to this guideline: Safety culture (or safety climate) refers to a work environment where a shared commitment to safety on the part of management and the workforce is understood and followed.^{557, 620, 621} The authors of the Institute of Medicine Report, *To Err is Human*,⁵⁴³ acknowledge that causes of medical error are multifaceted but emphasize repeatedly the pivotal role of system failures and the benefits of a safety culture. A safety culture is created through Safety and patient outcomes can be enhanced by improving or creating organizational characteristics within patient care units as demonstrated by studies of surgical ICUs.^{622, 623} Each of these factors has a direct bearing on adherence to transmission prevention recommendations.²⁵⁷ Measurement of an institutional culture of safety is useful for designing improvements in healthcare.^{624, 625} Several hospital-based studies have linked measures of safety culture with both employee adherence to safe practices and reduced exposures to blood and body fluids.⁶²⁶⁻⁶³² One study of hand hygiene practices concluded that improved adherence requires integration of infection control into the organization's safety culture.⁵⁶¹ Several hospitals that are part of the Veterans Administration Healthcare System have taken specific steps toward improving the safety culture, including error reporting mechanisms, performing root cause analysis on problems identified, providing safety incentives, and employee education.⁶³³⁻⁶³⁵ Adherence to recommended infection control practices decreases transmission of infectious agents in healthcare settings.^{116, 562, 636-640} However, several observational studies have shown limited adherence to recommended practices by healthcare personnel.^{559, 640-657} Observed adherence to universal precautions ranged from 43% to 89%.^{641, 642, 649, 651, 652} However, the degree of adherence

depended frequently on the practice that was assessed and, for glove use, the circumstance in which they were used. Appropriate glove use has ranged from a low of 15%⁶⁴⁵ to a high of 82%.⁶⁵⁰ However, 92% and 98% adherence with glove use have been reported during arterial blood gas collection and resuscitation, respectively, procedures where there may be considerable blood contact.^{643, 656} Differences in observed adherence have been reported among occupational groups in the same healthcare facility⁶⁴¹ and between experienced and nonexperienced professionals.⁶⁴⁵ In surveys of healthcare personnel, self-reported adherence was generally higher than that reported in observational studies. Furthermore, where an observational component was included with a self-reported survey, self-perceived adherence was often greater than observed adherence.⁶⁵⁷ Among nurses and physicians, increasing years of experience is a negative predictor of adherence.^{645, 651} Education to improve adherence is the primary intervention that has been studied. While positive changes in knowledge and attitude have been demonstrated,^{640, 658} there often has been limited or no accompanying change in behavior.^{642, 644} Self-reported adherence is higher in groups that have received an educational intervention.^{630, 659} Educational interventions that incorporated videotaping and performance feedback were successful in improving adherence during the period of study; the long-term effect of these interventions is not known.⁶⁵⁴ The use of videotape also served to identify system problems (e.g., communication and access to personal protective equipment) that otherwise may not have been recognized. Use of engineering controls and facility design concepts for improving adherence is gaining interest. While introduction of automated sinks had a negative impact on consistent adherence to hand washing,⁶⁶⁰ use of electronic monitoring and voice prompts to remind healthcare workers to perform hand hygiene, and improving accessibility to hand hygiene products, increased adherence and contributed to a decrease in HAIs in one study.⁶⁶¹ More information is needed regarding how technology might improve adherence. Improving adherence to

infection control practices requires a multifaceted approach that incorporates continuous assessment of both the individual and the work environment.^{559, 561} Using several behavioral theories, Kretzer and Larson concluded that a single intervention (e.g., a handwashing campaign or putting up new posters about transmission precautions) would likely be ineffective in improving healthcare personnel adherence.⁶⁶² Improvement requires that the organizational leadership make prevention an institutional priority and integrate infection control practices into the organization's safety culture.⁵⁶¹ A recent review of the literature concluded that variations in organizational factors (e.g., safety climate, policies and procedures, education and training) and individual factors (e.g., knowledge, perceptions of risk, past experience) were determinants of adherence to infection control guidelines for protection against SARS and other respiratory pathogens.²⁵⁷ Surveillance is an essential tool for case-finding of single patients or clusters of patients who are infected or colonized with epidemiologically important organisms (e.g., susceptible bacteria such as *S. aureus*, *S. pyogenes* [Group A streptococcus] or *Enterobacter-Klebsiella* spp; MRSA, VRE, and other MDROs; *C. difficile*; RSV; influenza virus) for which transmission-based precautions may be required. Surveillance is defined as the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health.⁶⁶³ The work of Ignaz Semmelweis that described the role of person-to-person transmission in puerperal sepsis is the earliest example of the use of surveillance data to reduce transmission of infectious agents.⁶⁶⁴ Surveillance of both process measures and the infection rates to which they are linked are important for evaluating the effectiveness of infection prevention efforts and identifying indications for change.^{555, 665-668} The Study on the Efficacy of Nosocomial Infection Control (SENIC) found that different combinations of infection control practices resulted in reduced rates of nosocomial surgical site infections, pneumonia, urinary tract

infections, and bacteremia in acute care hospitals;⁵⁶⁶ however, surveillance was the only component essential for reducing all four types of HAIs. Although a similar study has not been conducted in other healthcare settings, a role for surveillance and the need for novel strategies have been described in LTCFs ^{398, 434, 669, 670} and in home care.⁴⁷⁰⁻⁴⁷³ The essential elements of a surveillance system are: Data gathered through surveillance of high-risk populations, device use, procedures, and/or facility locations (e.g., ICUs) are useful for detecting transmission trends.⁶⁷¹⁻⁶⁷³ Identification of clusters of infections should be followed by a systematic epidemiologic investigation to determine commonalities in persons, places, and time; and guide implementation of interventions and evaluation of the effectiveness of those interventions. Targeted surveillance based on the highest risk areas or patients has been preferred over facility-wide surveillance for the most effective use of resources.^{673, 676} However, surveillance for certain epidemiologically important organisms may need to be facility-wide. Surveillance methods will continue to evolve as healthcare delivery systems change ^{392, 677} and user-friendly electronic tools become more widely available for electronic tracking and trend analysis.^{674, 678, 679} Individuals with experience in healthcare epidemiology and infection control should be involved in selecting software packages for data aggregation and analysis to assure that the need for efficient and accurate HAI surveillance will be met. Effective surveillance is increasingly important as legislation requiring public reporting of HAI rates is passed and states work to develop effective systems to support such legislation.⁶⁸⁰ Education and training of healthcare personnel are a prerequisite for ensuring that policies and procedures for Standard and Transmission-Based Precautions are understood and practiced. Understanding the scientific rationale for the precautions will allow HCWs to apply procedures correctly, as well as safely modify precautions based on changing requirements, resources, or healthcare settings.^{14, 655, 681-688} In one study, the likelihood of HCWs developing SARS was strongly associated with less than 2 hours of

infection control training and lack of understanding of infection control procedures.⁶⁸⁹ Education about the important role of vaccines (e.g., influenza, measles, varicella, pertussis, pneumococcal) in protecting healthcare personnel, their patients, and family members can help improve vaccination rates.⁶⁹⁰⁻⁶⁹³ Education on the principles and practices for preventing transmission of infectious agents should begin during training in the health professions and be provided to anyone who has an opportunity for contact with patients or medical equipment (e.g., nursing and medical staff; therapists and technicians, including respiratory, physical, occupational, radiology, and cardiology personnel; phlebotomists; housekeeping and maintenance staff; and students). In healthcare facilities, education and training on Standard and Transmission-Based Precautions are typically provided at the time of orientation and should be repeated as necessary to maintain competency; updated education and training are necessary when policies and procedures are revised or when there is a special circumstance, such as an outbreak that requires modification of current practice or adoption of new recommendations. Education and training materials and methods appropriate to the HCW's level of responsibility, individual learning habits, and language needs, can improve the learning experience.^{658, 694-702} Education programs for healthcare personnel have been associated with sustained improvement in adherence to best practices and a related decrease in device-associated HAIs in teaching and non-teaching settings ^{639, 703} and in medical and surgical ICUs {Coopersmith, 2002 #2149; Babcock, 2004 #2126; Berenholtz, 2004 #2289; [This link is no longer active: www.ihl.org/IHI/Programs/Campaign], #2563} Several studies have shown that, in addition to targeted education to improve specific practices, periodic assessment and feedback of the HCWs knowledge, and adherence to recommended practices are necessary to achieve the desired changes and to identify continuing education needs.^{562, 704-708} Effectiveness of this approach for isolation practices has been demonstrated for control of RSV.^{116, 684} Patients, family members, and visitors can be

partners in preventing transmission of infections in healthcare settings.^{9, 42, 709-711} Information about Standard Precautions, especially hand hygiene, Respiratory Hygiene/Cough Etiquette, vaccination (especially against influenza) and other routine infection prevention strategies may be incorporated into patient information materials that are provided upon admission to the healthcare facility. Additional information about Transmission-Based Precautions is best provided at the time they are initiated. Fact sheets, pamphlets, and other printed material may include information on the rationale for the additional precautions, risks to household members, room assignment for Transmission-Based Precautions purposes, explanation about the use of personal protective equipment by HCWs, and directions for use of such equipment by family members and visitors. Such information may be particularly helpful in the home environment where household members often have primary responsibility for adherence to recommended infection control practices. Healthcare personnel must be available and prepared to explain this material and answer questions as needed. Hand hygiene has been cited frequently as the single most important practice to reduce the transmission of infectious agents in healthcare settings ^{559, 712, 713} and is an essential element of Standard Precautions. The term "hand hygiene" includes both handwashing with either plain or antiseptic-containing soap and water, and use of alcohol-based products (gels, rinses, foams) that do not require the use of water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbiocidal activity, reduced drying of the skin, and convenience.⁵⁵⁹ Improved hand hygiene practices have been associated with a sustained decrease in the incidence of MRSA and VRE infections primarily in the ICU.^{561, 562, 714-717} The scientific rationale, indications, methods, and products for hand hygiene are summarized in other publications.^{559, 717} The effectiveness of hand hygiene can be reduced by the type and length of fingernails.^{559, 718, 719} Individuals wearing

artificial nails have been shown to harbor more pathogenic organisms, especially gram negative bacilli and yeasts, on the nails and in the subungual area than those with native nails.^{720, 721} In 2002, CDC/HICPAC recommended (Category IA) that artificial fingernails and extenders not be worn by healthcare personnel who have contact with high-risk patients (e.g., those in ICUs, ORs) due to the association with outbreaks of gram-negative bacillus and candidal infections as confirmed by molecular typing of isolates.^{30, 31, 559, 722-725} The need to restrict the wearing of artificial fingernails by all healthcare personnel who provide direct patient care or by healthcare personnel who have contact with other high risk groups (e.g., oncology, cystic fibrosis patients), has not been studied, but has been recommended by some experts.²⁰ At this time such decisions are at the discretion of an individual facility's infection control program. There is less evidence that jewelry affects the quality of hand hygiene. Although hand contamination with potential pathogens is increased with ring-wearing,^{559, 726} no studies have related this practice to HCW-to-patient transmission of pathogens. PPE refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission. Guidance on the use of PPE is discussed in Part III. A suggested procedure for donning and removing PPE that will prevent skin or clothing contamination is presented in the Figure. Designated containers for used disposable or reusable PPE should be placed in a location that is convenient to the site of removal to facilitate disposal and containment of contaminated materials. Hand hygiene is always the final step after removing and disposing of PPE. The following sections highlight the primary uses and methods for selecting this equipment. Gloves are used to prevent contamination of healthcare personnel hands when Gloves can protect both patients and healthcare personnel from exposure to infectious material that may be carried on hands.⁷³ The extent to which gloves will protect healthcare personnel from

transmission of bloodborne pathogens (e.g., HIV, HBV, HCV) following a needlestick or other puncture that penetrates the glove barrier has not been determined. Although gloves may reduce the volume of blood on the external surface of a sharp by 46-86%,⁷²⁹ the residual blood in the lumen of a hollowbore needle would not be affected; therefore, the effect on transmission risk is unknown. Gloves manufactured for healthcare purposes are subject to FDA evaluation and clearance.⁷³⁰ Nonsterile disposable medical gloves made of a variety of materials (e.g., latex, vinyl, nitrile) are available for routine patient care. ⁷³¹ The selection of glove type for non-surgical use is based on a number of factors, including the task that is to be performed, anticipated contact with chemicals and chemotherapeutic agents, latex sensitivity, sizing, and facility policies for creating a latex-free environment.^{17, 732-734} For contact with blood and body fluids during non-surgical patient care, a single pair of gloves generally provides adequate barrier protection.⁷³⁴ However, there is considerable variability among gloves; both the quality of the manufacturing process and type of material influence their barrier effectiveness.⁷³⁵ While there is little difference in the barrier properties of unused intact gloves,⁷³⁶ studies have shown repeatedly that vinyl gloves have higher failure rates than latex or nitrile gloves when tested under simulated and actual clinical conditions.^{731, 735-738} For this reason either latex or nitrile gloves are preferable for clinical procedures that require manual dexterity and/or will involve more than brief patient contact. It may be necessary to stock gloves in several sizes. Heavier, reusable utility gloves are indicated for non-patient care activities, such as handling or cleaning contaminated equipment or surfaces.^{11, 14, 739} During patient care, transmission of infectious organisms can be reduced by adhering to the principles of working from "clean" to "dirty", and confining or limiting contamination to surfaces that are directly needed for patient care. It may be necessary to change gloves during the care of a single patient to prevent cross-contamination of body sites.^{559, 740} It also may be necessary to change gloves if the patient interaction also involves touching

portable computer keyboards or other mobile equipment that is transported from room to room. Discarding gloves between patients is necessary to prevent transmission of infectious material. Gloves must not be washed for subsequent reuse because microorganisms cannot be removed reliably from glove surfaces and continued glove integrity cannot be ensured. Furthermore, glove reuse has been associated with transmission of MRSA and gram-negative bacilli.⁷⁴¹⁻⁷⁴³ When gloves are worn in combination with other PPE, they are put on last. Gloves that fit snugly around the wrist are preferred for use with an isolation gown because they will cover the gown cuff and provide a more reliable continuous barrier for the arms, wrists, and hands. Gloves that are removed properly will prevent hand contamination (Figure). Hand hygiene following glove removal further ensures that the hands will not carry potentially infectious material that might have penetrated through unrecognized tears or that could contaminate the hands during glove removal.^{559, 728, 741} Isolation gowns are used as specified by Standard and Transmission-Based Precautions, to protect the HCW's arms and exposed body areas and prevent contamination of clothing with blood, body fluids, and other potentially infectious material.^{24, 88, 262, 744-746} The need for and type of isolation gown selected is based on the nature of the patient interaction, including the anticipated degree of contact with infectious material and potential for blood and body fluid penetration of the barrier. The wearing of isolation gowns and other protective apparel is mandated by the OSHA Bloodborne Pathogens Standard.⁷³⁹ Clinical and laboratory coats or jackets worn over personal clothing for comfort and/or purposes of identity are not considered PPE. When applying Standard Precautions, an isolation gown is worn only if contact with blood or body fluid is anticipated. However, when Contact Precautions are used (i.e., to prevent transmission of an infectious agent that is not interrupted by Standard Precautions alone and that is associated with environmental contamination), donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces.^{54, 72, 73, 88}

The routine donning of isolation gowns upon entry into an intensive care unit or other high-risk area does not prevent or influence potential colonization or infection of patients in those areas.^{365, 747-750} Isolation gowns are always worn in combination with gloves, and with other PPE when indicated. Gowns are usually the first piece of PPE to be donned. Full coverage of the arms and body front, from neck to the mid-thigh or below will ensure that clothing and exposed upper body areas are protected. Several gown sizes should be available in a healthcare facility to ensure appropriate coverage for staff members. Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room. Isolation gowns should be removed in a manner that prevents contamination of clothing or skin (Figure). The outer, "contaminated", side of the gown is turned inward and rolled into a bundle, and then discarded into a designated container for waste or linen to contain contamination. Masks are used for three primary purposes in healthcare settings: Masks may be used in combination with goggles to protect the mouth, nose and eyes, or a face shield may be used instead of a mask and goggles, to provide more complete protection for the face, as discussed below. Masks should not be confused with particulate respirators that are used to prevent inhalation of small particles that may contain infectious agents transmitted via the airborne route as described below. The mucous membranes of the mouth, nose, and eyes are susceptible portals of entry for infectious agents, as can be other skin surfaces if skin integrity is compromised (e.g., by acne, dermatitis).^{66, 751-754} Therefore, use of PPE to protect these body sites is an important component of Standard Precautions. The protective effect of masks for exposed healthcare personnel has been demonstrated.^{93, 113, 755, 756} Procedures that generate splashes or sprays of blood, body fluids, secretions, or excretions (e.g., endotracheal suctioning, bronchoscopy, invasive vascular procedures) require either a face shield (disposable or reusable) or mask and goggles.^{93-95, 96, 113, 115, 262, 739, 757} The wearing of masks, eye protection, and face shields in specified circumstances

when blood or body fluid exposures are likely to occur is mandated by the OSHA Bloodborne Pathogens Standard.⁷³⁹ Appropriate PPE should be selected based on the anticipated level of exposure. Two mask types are available for use in healthcare settings: surgical masks that are cleared by the FDA and required to have fluid-resistant properties, and procedure or isolation masks.⁷⁵⁸ #2688 No studies have been published that compare mask types to determine whether one mask type provides better protection than another. Since procedure/isolation masks are not regulated by the FDA, there may be more variability in quality and performance than with surgical masks. Masks come in various shapes (e.g., molded and non-molded), sizes, filtration efficiency, and method of attachment (e.g., ties, elastic, ear loops). Healthcare facilities may find that different types of masks are needed to meet individual healthcare personnel needs. Guidance on eye protection for infection control has been published.⁷⁵⁹ The eye protection chosen for specific work situations (e.g., goggles or face shield) depends upon the circumstances of exposure, other PPE used, and personal vision needs. Personal eyeglasses and contact lenses are NOT considered adequate eye protection (NIOSH Eye Protection for Infection Control [Current version of this document may differ from original.]). NIOSH states that, eye protection must be comfortable, allow for sufficient peripheral vision, and must be adjustable to ensure a secure fit. It may be necessary to provide several different types, styles, and sizes of protective equipment. Indirectly-vented goggles with a manufacturer's anti-fog coating may provide the most reliable practical eye protection from splashes, sprays, and respiratory droplets from multiple angles. Newer styles of goggles may provide better indirect airflow properties to reduce fogging, as well as better peripheral vision and more size options for fitting goggles to different workers. Many styles of goggles fit adequately over prescription glasses with minimal gaps. While effective as eye protection, goggles do not provide splash or spray protection to other parts of the face. The role of goggles, in addition to a mask, in preventing exposure to infectious agents transmitted via

respiratory droplets has been studied only for RSV. Reports published in the mid-1980s demonstrated that eye protection reduced occupational transmission of RSV.^{760, 761} Whether this was due to preventing hand-eye contact or respiratory droplet-eye contact has not been determined. However, subsequent studies demonstrated that RSV transmission is effectively prevented by adherence to Standard plus Contact Precautions and that for this virus routine use of goggles is not necessary.^{24, 116, 117, 684, 762} It is important to remind healthcare personnel that even if Droplet Precautions are not recommended for a specific respiratory tract pathogen, protection for the eyes, nose and mouth by using a mask and goggles, or face shield alone, is necessary when it is likely that there will be a splash or spray of any respiratory secretions or other body fluids as defined in Standard Precautions. Disposable or non-disposable face shields may be used as an alternative to goggles.⁷⁵⁹ As compared with goggles, a face shield can provide protection to other facial areas in addition to the eyes. Face shields extending from chin to crown provide better face and eye protection from splashes and sprays; face shields that wrap around the sides may reduce splashes around the edge of the shield. Removal of a face shield, goggles and mask can be performed safely after gloves have been removed, and hand hygiene performed. The ties, ear pieces and/or headband used to secure the equipment to the head are considered "clean" and therefore safe to touch with bare hands. The front of a mask, goggles and face shield are considered contaminated (Figure). The subject of respiratory protection as it applies to preventing transmission of airborne infectious agents, including the need for and frequency of fit-testing is under scientific review and was the subject of a CDC workshop in 2004.⁷⁶³ Respiratory protection currently requires the use of a respirator with N95 or higher filtration to prevent inhalation of infectious particles. Information about respirators and respiratory protection programs is summarized in the Guideline for Preventing Transmission of *Mycobacterium tuberculosis* in Health-care Settings, 2005 (CDC.MMWR 2005; 54: RR-17 12). Respiratory protection is broadly regulated by

OSHA under the general industry standard for respiratory protection (29CFR1910.134)⁷⁶⁴ which requires that U.S. employers in all employment settings implement a program to protect employees from inhalation of toxic materials. OSHA program components include medical clearance to wear a respirator; provision and use of appropriate respirators, including fit-tested NIOSH-certified N95 and higher particulate filtering respirators; education on respirator use and periodic re-evaluation of the respiratory protection program. When selecting particulate respirators, models with inherently good fit characteristics (i.e., those expected to provide protection factors of 10 or more to 95% of wearers) are preferred and could theoretically relieve the need for fit testing.^{765, 766} Issues pertaining to respiratory protection remain the subject of ongoing debate. Information on various types of respirators may be found at [This link is no longer active: www.cdc.gov/niosh/npptl/respirators/respsars.html. Similar information may be found at NIOSH Respirators.] and in published studies.^{765, 767, 768} A user-seal check (formerly called a "fit check") should be performed by the wearer of a respirator each time a respirator is donned to minimize air leakage around the facepiece.⁷⁶⁹ The optimal frequency of fit-testing has not been determined; re-testing may be indicated if there is a change in facial features of the wearer, onset of a medical condition that would affect respiratory function in the wearer, or a change in the model or size of the initially assigned respirator.¹² Respiratory protection was first recommended for protection of preventing U.S. healthcare personnel from exposure to *M. tuberculosis* in 1989. That recommendation has been maintained in two successive revisions of the Guidelines for Prevention of Transmission of Tuberculosis in Hospitals and other Healthcare Settings.^{12, 126} The incremental benefit from respirator use, in addition to administrative and engineering controls (i.e., AIIRs, early recognition of patients likely to have tuberculosis and prompt placement in an AIIR, and maintenance of a patient with suspected tuberculosis in an AIIR until no longer infectious), for preventing transmission of airborne infectious agents (e.g., *M. tuberculosis*) is

undetermined. Although some studies have demonstrated effective prevention of *M. tuberculosis* transmission in hospitals where surgical masks, instead of respirators, were used in conjunction with other administrative and engineering controls,^{637, 770, 771} CDC currently recommends N95 or higher level respirators for personnel exposed to patients with suspected or confirmed tuberculosis. Currently this is also true for other diseases that could be transmitted through the airborne route, including SARS ²⁶² and smallpox,^{108, 129, 772} until inhalational transmission is better defined or healthcare-specific protective equipment more suitable for preventing infection are developed. Respirators are also currently recommended to be worn during the performance of aerosol-generating procedures (e.g., intubation, bronchoscopy, suctioning) on patients with SARS Co-V infection, avian influenza and pandemic influenza (See Appendix A). Although Airborne Precautions are recommended for preventing airborne transmission of measles and varicella-zoster viruses, there are no data upon which to base a recommendation for respiratory protection to protect susceptible personnel against these two infections; transmission of varicella-zoster virus has been prevented among pediatric patients using negative pressure isolation alone.⁷⁷³ Whether respiratory protection (i.e., wearing a particulate respirator) would enhance protection from these viruses has not been studied. Since the majority of healthcare personnel have natural or acquired immunity to these viruses, only immune personnel generally care for patients with these infections.⁷⁷⁴⁻⁷⁷⁷ Although there is no evidence to suggest that masks are not adequate to protect healthcare personnel in these settings, for purposes of consistency and simplicity, or because of difficulties in ascertaining immunity, some facilities may require the use of respirators for entry into all AIRs, regardless of the specific infectious agent. Procedures for safe removal of respirators are provided (Figure). In some healthcare settings, particulate respirators used to provide care for patients with *M. tuberculosis* are reused by the same HCW. This is an acceptable practice providing the respirator is not damaged or soiled, the fit

is not compromised by change in shape, and the respirator has not been contaminated with blood or body fluids. There are no data on which to base a recommendation for the length of time a respirator may be reused. Injuries due to needles and other sharps have been associated with transmission of HBV, HCV and HIV to healthcare personnel.^{778, 779} The prevention of sharps injuries has always been an essential element of Universal and now Standard Precautions.^{1, 780} These include measures to handle needles and other sharp devices in a manner that will prevent injury to the user and to others who may encounter the device during or after a procedure. These measures apply to routine patient care and do not address the prevention of sharps injuries and other blood exposures during surgical and other invasive procedures that are addressed elsewhere.⁷⁸¹⁻⁷⁸⁵ Since 1991, when OSHA first issued its Bloodborne Pathogens Standard to protect healthcare personnel from blood exposure, the focus of regulatory and legislative activity has been on implementing a hierarchy of control measures. This has included focusing attention on removing sharps hazards through the development and use of engineering controls. The federal Needlestick Safety and Prevention Act signed into law in November, 2000 authorized OSHA's revision of its Bloodborne Pathogens Standard to more explicitly require the use of safety-engineered sharp devices.⁷⁸⁶ CDC has provided guidance on sharps injury prevention,^{787, 788} including for the design, implementation and evaluation of a comprehensive sharps injury prevention program.⁷⁸⁹ Exposure of mucous membranes of the eyes, nose and mouth to blood and body fluids has been associated with the transmission of bloodborne viruses and other infectious agents to healthcare personnel.^{66, 752, 754, 779} The prevention of mucous membrane exposures has always been an element of Universal and now Standard Precautions for routine patient care ^{1, 753} and is subject to OSHA bloodborne pathogen regulations. Safe work practices, in addition to wearing PPE, are used to protect mucous membranes and non-intact skin from contact with potentially infectious material. These include keeping gloved and ungloved hands that

are contaminated from touching the mouth, nose, eyes, or face; and positioning patients to direct sprays and splatter away from the face of the caregiver. Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and possible face or mucous membrane contamination during use. In areas where the need for resuscitation is unpredictable, mouthpieces, pocket resuscitation masks with one-way valves, and other ventilation devices provide an alternative to mouth-to-mouth resuscitation, preventing exposure of the caregiver's nose and mouth to oral and respiratory fluids during the procedure. The performance of procedures that can generate small particle aerosols (aerosol-generating procedures), such as bronchoscopy, endotracheal intubation, and open suctioning of the respiratory tract, have been associated with transmission of infectious agents to healthcare personnel, including *M. tuberculosis*,⁷⁹⁰ SARS-CoV 93, 94, 98 and *N. meningitidis*.⁹⁵ Protection of the eyes, nose and mouth, in addition to gown and gloves, is recommended during performance of these procedures in accordance with Standard Precautions. Use of a particulate respirator is recommended during aerosol-generating procedures when the aerosol is likely to contain *M. tuberculosis*, SARS-CoV, or avian or pandemic influenza viruses. Options for patient placement include single patient rooms, two patient rooms, and multi-bed wards. Of these, single patient rooms are preferred when there is a concern about transmission of an infectious agent. Although some studies have failed to demonstrate the efficacy of single patient rooms to prevent HAIs,⁷⁹¹ other published studies, including one commissioned by the American Institute of Architects and the Facility Guidelines Institute, have documented a beneficial relationship between private rooms and reduction in infectious and noninfectious adverse patient outcomes.^{792, 793} The AIA notes that private rooms are the trend in hospital planning and design. However, most hospitals and long-term care facilities have multi-bed rooms and must consider many competing priorities when determining the appropriate room placement for patients (e.g., reason for admission;

patient characteristics, such as age, gender, mental status; staffing needs; family requests; psychosocial factors; reimbursement concerns). In the absence of obvious infectious diseases that require specified airborne infection isolation rooms (e.g., tuberculosis, SARS, chickenpox), the risk of transmission of infectious agents is not always considered when making placement decisions. When there are only a limited number of single-patient rooms, it is prudent to prioritize them for those patients who have conditions that facilitate transmission of infectious material to other patients (e.g., draining wounds, stool incontinence, uncontained secretions) and for those who are at increased risk of acquisition and adverse outcomes resulting from HAI (e.g., immunosuppression, open wounds, indwelling catheters, anticipated prolonged length of stay, total dependence on HCWs for activities of daily living).^{15, 24, 43, 430, 794, 795} Single-patient rooms are always indicated for patients placed on Airborne Precautions and in a Protective Environment and are preferred for patients who require Contact or Droplet Precautions.^{23, 24, 410, 435, 796, 797} During a suspected or proven outbreak caused by a pathogen whose reservoir is the gastrointestinal tract, use of single patient rooms with private bathrooms limits opportunities for transmission, especially when the colonized or infected patient has poor personal hygiene habits, fecal incontinence, or cannot be expected to assist in maintaining procedures that prevent transmission of microorganisms (e.g., infants, children, and patients with altered mental status or developmental delay). In the absence of continued transmission, it is not necessary to provide a private bathroom for patients colonized or infected with enteric pathogens as long as personal hygiene practices and Standard Precautions, especially hand hygiene and appropriate environmental cleaning, are maintained. Assignment of a dedicated commode to a patient, and cleaning and disinfecting fixtures and equipment that may have fecal contamination (e.g., bathrooms, commodes,⁷⁹⁸ scales used for weighing diapers) and the adjacent surfaces with appropriate agents may be especially important when a single-patient room can

not be used since environmental contamination with intestinal tract pathogens is likely from both continent and incontinent patients.^{54, 799} Results of several studies to determine the benefit of a single-patient room to prevent transmission of *Clostridium difficile* are inconclusive.^{167, 800-802} Some studies have shown that being in the same room with a colonized or infected patient is not necessarily a risk factor for transmission.^{791, 803-805} However, for children, the risk of healthcare-associated diarrhea is increased with the increased number of patients per room.⁸⁰⁶ Thus, patient factors are important determinants of infection transmission risks, and the need for a single-patient room and/or private bathroom for any patient is best determined on a case-by-case basis. Cohorting is the practice of grouping together patients who are colonized or infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent. It is generally preferred not to place severely immunosuppressed patients in rooms with other patients. Cohorting has been used extensively for managing outbreaks of MDROs including MRSA,^{22, 807} VRE,^{638, 808, 809} MDR-ESBLs;⁸¹⁰ *Pseudomonas aeruginosa*; ²⁹ methicillin-susceptible *Staphylococcus aureus*;⁸¹¹ RSV;^{812, 813} adenovirus keratoconjunctivitis;⁸¹⁴ rotavirus;⁸¹⁵ and SARS.⁸¹⁶ Modeling studies provide additional support for cohorting patients to control outbreaks Talon.⁸¹⁷⁻⁸¹⁹ However, cohorting often is implemented only after routine infection control measures have failed to control an outbreak. Assigning or cohorting healthcare personnel to care only for patients infected or colonized with a single target pathogen limits further transmission of the target pathogen to uninfected patients ^{740, 819} but is difficult to achieve in the face of current staffing shortages in hospitals ⁵⁸³ and residential healthcare sites.⁸²⁰⁻⁸²² However, when continued transmission is occurring after implementing routine infection control measures and creating patient cohorts, cohorting of healthcare personnel may be beneficial. During the seasons when

RSV, human metapneumovirus,⁸²³ parainfluenza, influenza, other respiratory viruses,⁸²⁴ and rotavirus are circulating in the community, cohorting based on the presenting clinical syndrome is often a priority in facilities that care for infants and young children.⁸²⁵ For example, during the respiratory virus season, infants may be cohorted based solely on the clinical diagnosis of bronchiolitis due to the logistical difficulties and costs associated with requiring microbiologic confirmation prior to room placement, and the predominance of RSV during most of the season. However, when available, single patient rooms are always preferred since a common clinical presentation (e.g., bronchiolitis), can be caused by more than one infectious agent.^{823, 824, 826} Furthermore, the inability of infants and children to contain body fluids, and the close physical contact that occurs during their care, increases infection transmission risks for patients and personnel in this setting.^{24, 795} Patients actively infected with or incubating transmissible infectious diseases are seen frequently in ambulatory settings (e.g., outpatient clinics, physicians' offices, emergency departments) and potentially expose healthcare personnel and other patients, family members and visitors.^{21, 34, 127, 135, 142, 827} In response to the global outbreak of SARS in 2003 and in preparation for pandemic influenza, healthcare providers working in outpatient settings are urged to implement source containment measures (e.g., asking coughing patients to wear a surgical mask or cover their coughs with tissues) to prevent transmission of respiratory infections, beginning at the point of initial patient encounter ^{9, 262, 828} as described below in section III.A.1.a. Signs can be posted at the entrance to facilities or at the reception or registration desk requesting that the patient or individuals accompanying the patient promptly inform the receptionist if there are symptoms of a respiratory infection (e.g., cough, flu-like illness, increased production of respiratory secretions). The presence of diarrhea, skin rash, or known or suspected exposure to a transmissible disease (e.g., measles, pertussis, chickenpox, tuberculosis) also could be added. Placement of potentially infectious patients without delay in an

examination room limits the number of exposed individuals, e.g., in the common waiting area. See Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings. In waiting areas, maintaining a distance between symptomatic and non-symptomatic patients (e.g., >3 feet), in addition to source control measures, may limit exposures. However, infections transmitted via the airborne route (e.g., M tuberculosis, measles, chickenpox) require additional precautions.^{12, 125, 829} Patients suspected of having such an infection can wear a surgical mask for source containment, if tolerated, and should be placed in an examination room, preferably an AIIR, as soon as possible. If this is not possible, having the patient wear a mask and segregate him/herself from other patients in the waiting area will reduce opportunities to expose others. Since the person(s) accompanying the patient also may be infectious, application of the same infection control precautions may need to be extended to these persons if they are symptomatic.^{21, 252, 830} For example, family members accompanying children admitted with suspected M. tuberculosis have been found to have unsuspected pulmonary tuberculosis with cavitary lesions, even when asymptomatic.^{42, 831} Patients with underlying conditions that increase their susceptibility to infection (e.g., those who are immunocompromised ^{43, 44} or have cystic fibrosis ²⁰) require special efforts to protect them from exposures to infected patients in common waiting areas. By informing the receptionist of their infection risk upon arrival, appropriate steps may be taken to further protect them from infection. In some cystic fibrosis clinics, in order to avoid exposure to other patients who could be colonized with B. cepacia, patients have been given beepers upon registration so that they may leave the area and receive notification to return when an examination room becomes available.⁸³² In home care, the patient placement concerns focus on protecting others in the home from exposure to an infectious household member. For individuals who are especially vulnerable to adverse outcomes associated with certain infections, it may be beneficial to either remove them from the home or segregate

them within the home. Persons who are not part of the household may need to be prohibited from visiting during the period of infectivity. For example, if a patient with pulmonary tuberculosis is contagious and being cared for at home, very young children (<4 years of age) ⁸³³ and immunocompromised persons who have not yet been infected should be removed or excluded from the household. During the SARS outbreak of 2003, segregation of infected persons during the communicable phase of the illness was beneficial in preventing household transmission.^{249, 834} Several principles are used to guide transport of patients requiring Transmission-Based Precautions. In the inpatient and residential settings these include For tuberculosis, additional precautions may be needed in a small shared air space such as in an ambulance.¹² Cleaning and disinfecting non-critical surfaces in patient-care areas are part of Standard Precautions. In general, these procedures do not need to be changed for patients on Transmission-Based Precautions. The cleaning and disinfection of all patient-care areas is important for frequently touched surfaces, especially those closest to the patient, that are most likely to be contaminated (e.g., bedrails, bedside tables, commodes, doorknobs, sinks, surfaces and equipment in close proximity to the patient).^{11, 72, 73, 835} The frequency or intensity of cleaning may need to change based on the patient's level of hygiene and the degree of environmental contamination and for certain for infectious agents whose reservoir is the intestinal tract.⁵⁴ This may be especially true in LTCFs and pediatric facilities where patients with stool and urine incontinence are encountered more frequently. Also, increased frequency of cleaning may be needed in a Protective Environment to minimize dust accumulation.¹¹ Special recommendations for cleaning and disinfecting environmental surfaces in dialysis centers have been published.¹⁸ In all healthcare settings, administrative, staffing and scheduling activities should prioritize the proper cleaning and disinfection of surfaces that could be implicated in transmission. During a suspected or proven outbreak where an environmental reservoir is suspected, routine cleaning procedures should be reviewed,

and the need for additional trained cleaning staff should be assessed. Adherence should be monitored and reinforced to promote consistent and correct cleaning is performed. EPA-registered disinfectants or detergents/disinfectants that best meet the overall needs of the healthcare facility for routine cleaning and disinfection should be selected.^{11, 836} In general, use of the existing facility detergent/disinfectant according to the manufacturer's recommendations for amount, dilution, and contact time is sufficient to remove pathogens from surfaces of rooms where colonized or infected individuals were housed. This includes those pathogens that are resistant to multiple classes of antimicrobial agents (e.g., *C. difficile*, VRE, MRSA, MDR-GNB ^{11, 24, 88, 435, 746, 796, 837}). Most often, environmental reservoirs of pathogens during outbreaks are related to a failure to follow recommended procedures for cleaning and disinfection rather than the specific cleaning and disinfectant agents used.⁸³⁸⁻⁸⁴¹ Certain pathogens (e.g., rotavirus, noroviruses, *C. difficile*) may be resistant to some routinely used hospital disinfectants.^{275, 292, 842-847} The role of specific disinfectants in limiting transmission of rotavirus has been demonstrated experimentally.⁸⁴² Also, since *C. difficile* may display increased levels of spore production when exposed to non-chlorine-based cleaning agents, and the spores are more resistant than vegetative cells to commonly used surface disinfectants, some investigators have recommended the use of a 1:10 dilution of 5.25% sodium hypochlorite (household bleach) and water for routine environmental disinfection of rooms of patients with *C. difficile* when there is continued transmission.^{844, 848} In one study, the use of a hypochlorite solution was associated with a decrease in rates of *C. difficile* infections.⁸⁴⁷ The need to change disinfectants based on the presence of these organisms can be determined in consultation with the infection control committee.^{11, 847, 848} Detailed recommendations for disinfection and sterilization of surfaces and medical equipment that have been in contact with prion-containing tissue or high risk body fluids, and for cleaning of blood and body substance spills, are available in the Guidelines for

Environmental Infection Control in Health-Care Facilities 11 and in the Guideline for Disinfection and Sterilization.⁸⁴⁸ Medical equipment and instruments/devices must be cleaned and maintained according to the manufacturers' instructions to prevent patient-to-patient transmission of infectious agents.^{86, 87, 325, 849} Cleaning to remove organic material must always precede high level disinfection and sterilization of critical and semi-critical instruments and devices because residual proteinaceous material reduces the effectiveness of the disinfection and sterilization processes.^{836, 848} Noncritical equipment, such as commodes, intravenous pumps, and ventilators, must be thoroughly cleaned and disinfected before use on another patient. All such equipment and devices should be handled in a manner that will prevent HCW and environmental contact with potentially infectious material. It is important to include computers and personal digital assistants (PDAs) used in patient care in policies for cleaning and disinfection of non-critical items. The literature on contamination of computers with pathogens has been summarized ⁸⁵⁰ and two reports have linked computer contamination to colonization and infections in patients.^{851, 852} Although keyboard covers and washable keyboards that can be easily disinfected are in use, the infection control benefit of those items and optimal management have not been determined. In all healthcare settings, providing patients who are on Transmission-Based Precautions with dedicated noncritical medical equipment (e.g., stethoscope, blood pressure cuff, electronic thermometer) has been beneficial for preventing transmission.^{74, 89, 740, 853, 854} When this is not possible, disinfection after use is recommended. Consult other guidelines for detailed guidance in developing specific protocols for cleaning and reprocessing medical equipment and patient care items in both routine and special circumstances.^{11, 14, 18, 20, 740, 836, 848} In home care, it is preferable to remove visible blood or body fluids from durable medical equipment before it leaves the home. Equipment can be cleaned on-site using a detergent/disinfectant and, when possible, should be placed in a single plastic bag for

transport to the reprocessing location.^{20, 739} Soiled textiles, including bedding, towels, and patient or resident clothing may be contaminated with pathogenic microorganisms. However, the risk of disease transmission is negligible if they are handled, transported, and laundered in a safe manner.^{11, 855, 856} Key principles for handling soiled laundry are The methods for handling, transporting, and laundering soiled textiles are determined by organizational policy and any applicable regulations;⁷³⁹ guidance is provided in the Guidelines for Environmental Infection Control.¹¹ Rather than rigid rules and regulations, hygienic and common sense storage and processing of clean textiles is recommended.^{11, 857} When laundering occurs outside of a healthcare facility, the clean items must be packaged or completely covered and placed in an enclosed space during transport to prevent contamination with outside air or construction dust that could contain infectious fungal spores that are a risk for immunocompromised patients.¹¹ Institutions are required to launder garments used as personal protective equipment and uniforms visibly soiled with blood or infective material.⁷³⁹ There are few data to determine the safety of home laundering of HCW uniforms, but no increase in infection rates was observed in the one published study ⁸⁵⁸ and no pathogens were recovered from home- or hospital-laundered scrubs in another study.⁸⁵⁹ In the home, textiles and laundry from patients with potentially transmissible infectious pathogens do not require special handling or separate laundering, and may be washed with warm water and detergent.^{11, 858, 859} The management of solid waste emanating from the healthcare environment is subject to federal and state regulations for medical and non-medical waste.^{860, 861} No additional precautions are needed for non-medical solid waste that is being removed from rooms of patients on Transmission-Based Precautions. Solid waste may be contained in a single bag (as compared to using two bags) of sufficient strength.⁸⁶² The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating

utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions. In the home and other communal settings, eating utensils and drinking vessels that are being used should not be shared, consistent with principles of good personal hygiene and for the purpose of preventing transmission of respiratory viruses, Herpes simplex virus, and infectious agents that infect the gastrointestinal tract and are transmitted by the fecal/oral route (e.g., hepatitis A virus, noroviruses). If adequate resources for cleaning utensils and dishes are not available, disposable products may be used. Important adjunctive measures that are not considered primary components of programs to prevent transmission of infectious agents, but improve the effectiveness of such programs, include Detailed discussion of judicious use of antimicrobial agents is beyond the scope of this document; however the topic is addressed in the Management of Multidrug-Resistant Organisms in Healthcare Settings 2006. Antimicrobial agents and topical antiseptics may be used to prevent infection and potential outbreaks of selected agents. Infections for which postexposure chemoprophylaxis is recommended under defined conditions include B. pertussis, 17, 863 N. meningitidis,⁸⁶⁴ B. anthracis after environmental exposure to aerosolizable material,⁸⁶⁵ influenza virus,⁶¹¹ HIV,⁸⁶⁶ and group A streptococcus.¹⁶⁰ Orally administered antimicrobials may also be used under defined circumstances for MRSA decolonization of patients or healthcare personnel.⁸⁶⁷ Another form of chemoprophylaxis is the use of topical antiseptic agents. For example, triple dye is used routinely on the umbilical cords of term newborns to reduce the risk of colonization, skin infections, and omphalitis caused by S. aureus, including MRSA, and group A streptococcus.^{868, 869} Extension of the use of triple dye to low birth weight infants in the NICU was one component of a program that controlled one longstanding MRSA outbreak.²² Topical antiseptics are also used for decolonization of healthcare personnel or selected patients colonized with MRSA, using mupirocin as discussed in the MDRO guideline.^{870 867, 871-873} Certain immunizations recommended for susceptible

healthcare personnel have decreased the risk of infection and the potential for transmission in healthcare facilities.^{17, 874} The OSHA mandate that requires employers to offer hepatitis B vaccination to HCWs played a substantial role in the sharp decline in incidence of occupational HBV infection.^{778, 875} The use of varicella vaccine in healthcare personnel has decreased the need to place susceptible HCWs on administrative leave following exposure to patients with varicella.⁷⁷⁵ Also, reports of healthcare-associated transmission of rubella in obstetrical clinics ^{33, 876} and measles in acute care settings ³⁴ demonstrate the importance of immunization of susceptible healthcare personnel against childhood diseases. Many states have requirements for HCW vaccination for measles and rubella in the absence of evidence of immunity. Annual influenza vaccine campaigns targeted to patients and healthcare personnel in LTCFs and acute-care settings have been instrumental in preventing or limiting institutional outbreaks and increasing attention is being directed toward improving influenza vaccination rates in healthcare personnel.^{35, 611, 690, 877, 878, 879} Transmission of *B. pertussis* in healthcare facilities has been associated with large and costly outbreaks that include both healthcare personnel and patients.^{17, 36, 41, 100, 683, 827, 880, 881} HCWs who have close contact with infants with pertussis are at particularly high risk because of waning immunity and, until 2005, the absence of a vaccine that could be used in adults. However, two acellular pertussis vaccines were licensed in the United States in 2005, one for use in individuals aged 11-18 and one for use in ages 10-64 years.⁸⁸² Provisional ACIP recommendations at the time of publication of this document include adolescents and adults, especially those with contact with infants < 12 months of age and healthcare personnel with direct patient contact.^{883 884} Immunization of children and adults will help prevent the introduction of vaccine-preventable diseases into healthcare settings. The recommended immunization schedule for children is published annually in the January issues of the Morbidity Mortality Weekly Report with interim updates as needed.^{885, 886} An adult

immunization schedule also is available for healthy adults and those with special immunization needs due to high risk medical conditions.⁸⁸⁷ Some vaccines are also used for postexposure prophylaxis of susceptible individuals, including varicella,⁸⁸⁸ influenza,⁶¹¹ hepatitis B,⁷⁷⁸ and smallpox ²²⁵ vaccines.^{17, 874} In the future, administration of a newly developed *S. aureus* conjugate vaccine (still under investigation) to selected patients may provide a novel method of preventing healthcare-associated *S. aureus*, including MRSA, infections in high-risk groups (e.g., hemodialysis patients and candidates for selected surgical procedures).^{889, 890} Visitors have been identified as the source of several types of HAIs (e.g., pertussis,^{40, 41} *M. tuberculosis*,^{42, 892} influenza, and other respiratory viruses ^{24, 43, 44, 373} and SARS ^{21, 252-254}). However, effective methods for visitor screening in healthcare settings have not been studied. Visitor screening is especially important during community outbreaks of infectious diseases and for high risk patient units. Sibling visits are often encouraged in birthing centers, post partum rooms and in pediatric inpatient units, ICUs, and in residential settings for children; in hospital settings, a child visitor should visit only his or her own sibling. Screening of visiting siblings and other children before they are allowed into clinical areas is necessary to prevent the introduction of childhood illnesses and common respiratory infections. Screening may be passive through the use of signs to alert family members and visitors with signs and symptoms of communicable diseases not to enter clinical areas. More active screening may include the completion of a screening tool or questionnaire which elicits information related to recent exposures or current symptoms. That information is reviewed by the facility staff and the visitor is either permitted to visit or is excluded.⁸³³ Family and household members visiting pediatric patients with pertussis and tuberculosis may need to be screened for a history of exposure as well as signs and symptoms of current infection. Potentially infectious visitors are excluded until they receive appropriate medical screening, diagnosis, or treatment. If exclusion is not considered to be in the

best interest of the patient or family (i.e., primary family members of critically or terminally ill patients), then the symptomatic visitor must wear a mask while in the healthcare facility and remain in the patient's room, avoiding exposure to others, especially in public waiting areas and the cafeteria. Visitor screening is used consistently on HSCT units.^{15, 43} However, considering the experience during the 2003 SARS outbreaks and the potential for pandemic influenza, developing effective visitor screening systems will be beneficial.⁹ Education concerning Respiratory Hygiene/Cough Etiquette is a useful adjunct to visitor screening. The use of gowns, gloves, or masks by visitors in healthcare settings has not been addressed specifically in the scientific literature. Some studies included the use of gowns and gloves by visitors in the control of MDRO's, but did not perform a separate analysis to determine whether their use by visitors had a measurable impact.⁸⁹³⁻⁸⁹⁵ Family members or visitors who are providing care or having very close patient contact (e.g., feeding, holding) may have contact with other patients and could contribute to transmission if barrier precautions are not used correctly. Specific recommendations may vary by facility or by unit and should be determined by the level of interaction. CDC provides information on infection control and clinical safety to help reduce the risk of infections among healthcare workers, patients, and visitors. Languages Language Assistance Languages Language Assistance

