

# Public *Accommodation* Facilities *Regulations*

Effective April 2006

## Appendix M: *Recommendations for Precautions*

*Serving Boulder City, Clark County, Henderson,  
Las Vegas, Mesquite and North Las Vegas*



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## Section 1 of 4

### RECOMMENDATIONS FOR PRECAUTIONS Amended for use in Public Accommodation Facilities

#### Infection Control Practices Rationale for Precautions in Public Accommodation Facilities

Transmission of infection within a public accommodation facility requires three elements: a source of infecting microorganisms, a susceptible host, and a means of transmission for the microorganism.

#### Source

Human sources of the infecting microorganisms in public accommodation facilities may be guests or personnel and may include persons with acute disease, persons in the incubation period of a disease, persons who are colonized by an infectious agent but have no apparent disease, or persons who are chronic carriers of an infectious agent. Other sources of infecting microorganisms can be the guest's own endogenous flora, which may be difficult to control, and inanimate environmental objects that have become contaminated.

#### Host

Resistance among persons to pathogenic microorganisms varies greatly. Some persons may be immune to infection or may be able to resist colonization by an infectious agent; others exposed to the same agent may establish a commensal relationship with the infecting microorganism and become asymptomatic carriers; still others may develop clinical disease. Host factors such as age; underlying diseases; certain treatments with antimicrobials, corticosteroids, or other immunosuppressive agents; irradiation; and breaks in the first line of defense mechanisms caused by other factors may render some guests more susceptible to infection.

#### Transmission

Microorganisms are transmitted in public accommodation facilities by several routes, and the same microorganism may be transmitted by more than one route. There are five main routes of transmission -- contact, droplet, airborne, common vehicle, and vectorborne. For the purpose of this guideline, common vehicle and vectorborne transmission will be discussed only briefly, because neither play the main role in typical acquired infections at this time. However, they may play an increasing role in the future.

- (1) Contact transmission, the most important and frequent mode of transmission of infections, is divided into two subgroups: direct-contact transmission and indirect-contact transmission.
  - (a) Direct-contact transmission involves a direct body surface-to-body surface contact and physical transfer of microorganisms between a susceptible host and an infected or colonized person, such as occurs when a guest has contact with service personnel or when service personnel perform activities that require direct personal contact. Direct-contact transmission also can occur between two guests, with one serving as the source of the infectious microorganisms and the other as a susceptible host.

- (b) Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, such as contaminated dishes, bathroom surfaces, used needles, clothing, uniforms, or bedding, or contaminated hands that are not washed between contact with guests, moving from guest room to guest room or between tear-down and cleaning and make-up of the clean guest room. Common items in public accommodation facilities such as ticket validation stamps, hand rails, escalators, elevators, playing cards, casino chips, slot machine handles, and coin cups can play a large role in indirect contact transmission, especially with viruses.
- (2) Droplet transmission, theoretically, is a form of contact transmission. However, the mechanism of transfer of the pathogen to the host is quite distinct from either direct- or indirect-contact transmission. Therefore, droplet transmission will be considered a separate route of transmission in this guideline. Droplets are generated from the source person primarily during coughing, sneezing, talking and, spitting (such as with chewing tobacco). Transmission occurs when droplets containing microorganisms generated from the infected person are propelled a short distance through the air and deposited on the host's conjunctivae, nasal mucosa, or mouth. Because droplets do not remain suspended in the air, droplet transmission must not be confused with airborne transmission.
- (3) Airborne Transmission occurs by dissemination of either airborne droplet nuclei (small-particle residue {5  $\mu$ m or smaller in size} of evaporated droplets containing microorganisms that remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Microorganisms carried in this manner can be dispersed widely by air currents and may become inhaled by a susceptible host within the same room or over a longer distance from the source guest, depending on environmental factors; therefore, special air handling and ventilation are required to prevent airborne transmission. Most public accommodation facilities are not equipped to address airborne transmission of illness. Microorganisms transmitted by airborne transmission include *Mycobacterium tuberculosis* and the rubeola and varicella viruses.
- (4) Common Vehicle Transmission applies to microorganisms transmitted by contaminated items such as food, water, and equipment. This can be a large factor when considering whether or not an illness outbreak is foodborne or waterborne within a public accommodation facility. When a large outbreak begins to emerge and is associated with a public accommodation facility, one of the first things investigators look for is an associated banquet or other common meal source. Once that is ruled out, observations relating to the general environment within the facility should be the focus of the investigation.
- (5) Vectorborne Transmission occurs when vectors such as mosquitoes, flies, rats, and other vermin transmit microorganisms. This route of transmission is of less significance in public accommodation facilities in the United States than in other regions of the world, but does still need to be addressed. Integrated pest management plans are a must to control potential vectors. In addition, emerging vectorborne illnesses such as West Nile Virus may take a more prominent role in the future.

Precautions are designed to prevent transmission of microorganisms by these routes in public accommodation facilities. Because agent and host factors are more difficult to control, interruption of transfer of microorganisms is directed primarily at transmission. The recommendations presented in this guideline are based on this concept.

## **Fundamentals of Isolation Precautions**

A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in public accommodation facilities. These measures make up the fundamentals of isolation precautions. Identifying and transporting ill guests to medical treatment as quickly as possible or asking ill guests to stay in their rooms are both examples of isolation precautions as they apply to public accommodation facilities.

### **Handwashing and Gloving**

Proper handwashing frequently is the single most important measure to reduce the risks of transmitting microorganisms from one person to another or from one location to another within the public accommodation facility. Washing hands as promptly and thoroughly as possible between physical guest contacts; after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them; after tearing down guest rooms; and after handling dirty tableware and laundry is an important component of infection control. In addition to handwashing, gloves play an important role in reducing the risks of transmission of microorganisms.

Gloves are worn for important reasons in public accommodation facilities. First, gloves are worn to provide a protective barrier and to prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, or items that may be contaminated by them such as sheets, pillowcases, towels, toilets, bathtubs, or any other place in the room where they are common. Wearing gloves in specified circumstances to reduce the risk of exposures to bloodborne pathogens is mandated by OSHA, “Bloodborne Pathogens final rule.” In other words, glove use can reduce the employee’s risk of picking up microorganisms from guests and making themselves ill. It also reduces the chance of spreading them to other guests or clean surfaces, causing guest illness. Wearing gloves does not replace the need for handwashing, because gloves may have small, inapparent defects or may be torn during use, and hands can become contaminated during removal of gloves. Failure to use gloves appropriately is a health hazard.

### **Transport of Infected Guests**

Limiting the movement and transport of guests infected with virulent microorganisms reduces opportunities for transmission of microorganisms in public accommodation facilities. Once a guest is identified as having a contagious disease, they should be referred to medical treatment as soon as possible. When guest transport is necessary, it is important that appropriate barriers such as masks or impervious dressings are worn or used by the guest and any personnel, including emergency response personnel, to reduce the opportunity for transmission of pertinent microorganisms to other guests, and employees and to reduce contamination of the environment. Guests should be informed of ways by which they can assist in preventing the transmission of their illness to others. If the guest should return to the public accommodation facility while still in a communicable state, employees who will be serving that guest should be notified to take appropriate precautions. Guests who are still ill or in a carrier state should be asked to cooperate by staying in their rooms. The guest may need to stay in the hospital and not return to the public accommodation facility if the pathogen is particularly virulent.

### **Masks, Respiratory Protection, Eye Protection, Face Shields**

Various types of masks, goggles, and face shields are worn alone or in combination to provide barrier protection. A mask that covers both the nose and the mouth, and goggles or a face shield can be worn by public accommodation facility staff during clean up procedures and guest first aid activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions to provide protection of the mucous membranes of the eyes, nose, and mouth from contact transmission of pathogens. If something more serious is emerging at the public accommodation facility, management may decide to provide higher-end respiratory protection for employees who must deal with the hazard. If that happens, the staff who must use the respirators will be required to get an OSHA physical, be fit tested for their respirator, and receive training on how to use it.

### **Protective Apparel**

Various types of protective apparel are worn to provide barrier protection and to reduce opportunities for transmission of microorganisms in public accommodation facilities. Protective apparel is worn to prevent contamination of clothing and to protect the skin of employees from blood and body fluid exposures. Protective apparel especially treated to make them impermeable to liquids, leg coverings, boots, or shoe covers provide greater protection to the skin when splashes or large quantities of potentially infective material are present or anticipated.

### **Linen and Laundry**

Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is significantly reduced if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to guests, staff, and the surrounding environment. Hygienic and common sense storage and processing of clean and soiled linen are recommended. The methods for handling, transporting, and laundering of soiled linen are determined by the public accommodation facility's procedures and any applicable regulations.

### **Dishes, Glasses, Cups, and Eating Utensils**

No special precautions are needed for dishes, glasses, cups, or eating utensils. Either disposable/single-use or reusable dishes and utensils can be used by guests. The combination of hot water, detergents, and heat or chemical sanitizing used in public accommodation facility dishwashers or three-compartment sinks is sufficient to decontaminate dishes, glasses, cups, and eating utensils. It is important to ensure that reusable items are stored in room such as coffee carafes and ice buckets are also washed, rinsed, and sanitized between guests or whenever they visibly soiled. These items must also be protected from contamination by storing them on housekeeping carts and in storage areas that are clean and sanitary.

### **Routine and Check-out Cleaning**

The guest room and furniture in the guest room should be cleaned using Standard Precautions, unless there is reason to believe that infecting microorganism(s) and the amount of environmental contamination indicate special cleaning, such as in the case of an emetic event or release of other bodily fluids in the room or when a guest known to have had a communicable disease stayed in the room. Guests checking in to public accommodation facility guest rooms that previously were occupied by guests infected or colonized with environmentally hardy pathogens are at increased risk of infection from contaminated environmental surfaces if they have not been cleaned and disinfected

adequately. The methods, thoroughness, and frequency of cleaning and the products used are determined by the public accommodation facility's procedures and Health Authority regulations.

Housekeeping and Security staff must also be aware of the risk of needle sticks while servicing guest rooms. Diabetic guests who use legitimate injectables may have been careless with the disposal of their needles. Also, users of illicit drugs have been known to leave behind their needles carelessly in trash cans, under mattresses, in cut-open box springs, and on top of closet shelves. Staff must never stick their hands in places they cannot see. Any needle stick must be taken seriously and must be evaluated by a medical professional. Report them to management immediately so that treatment and appropriate testing for bloodborne pathogens can begin.

## **Precautions**

There are two tiers of precautions. In the first, and most important, tier are those precautions designed for the care of all guests and handling of all guest rooms and public areas in public accommodation facilities, regardless of the health status of the guest. Implementation of these "Standard Precautions" is the primary strategy to control the spread of infectious microorganisms within the facility. In the second tier are precautions designed only for the care of sick guests. These additional "Transmission-Based Precautions" are for guests known or suspected to be infected by contagious pathogens spread by airborne or droplet transmission or by contact with dry skin or contaminated surfaces.

## **Standard Precautions**

Standard Precautions join the major features of Universal Precautions, which are blood and body fluid precautions designed to reduce the risk of transmission of bloodborne pathogens and Body Substance Isolation designed to reduce the risk of transmission of pathogens from moist body substances and applies them to all guests, guest rooms, and public areas in public accommodation facilities. These Standard Precautions are used at all times whether or not the guest is sick or the area is known to be contaminated with an infectious substance. Standard Precautions apply to blood; all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood; broken skin; and, mucous membranes. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection.

## **Transmission-Based Precautions**

Transmission-Based Precautions are designed for guests who have or are suspected to be infected with highly transmissible pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission to other guests or staff. There are three types of Transmission-Based Precautions: Airborne Precautions, Droplet Precautions, and Contact Precautions. They may be combined for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

Airborne Precautions are designed to reduce the risk of airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei (small-particle residue {5  $\mu$ m or smaller in size} of evaporated droplets that may remain suspended in the air for long periods of time) or dust particles containing the infectious agent. Microorganisms carried in this manner can be dispersed widely by air currents and may become inhaled by or deposited on a

susceptible host within the same room or over a longer distance from the source guest, depending on environmental factors; therefore, special air handling and ventilation are required to prevent airborne transmission. Most public accommodation facilities are not equipped to address airborne transmission of illness. Airborne Precautions apply to guests known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

Droplet Precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5  $\mu\text{m}$  in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of CPR or other life-saving measures. Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 3 feet or less, through the air. Because droplets do not remain suspended in the air, special air handling and ventilation, which are not practical in public accommodation facilities, are not required to prevent droplet transmission. Droplet Precautions apply to any guest known or suspected to be infected with pathogens that can be transmitted by infectious droplets.

Contact Precautions are designed to reduce the risk of transmission of pathogenic microorganisms by direct or indirect contact. Direct-contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when staff have personal contact, such as shaking hands, with guests. Direct-contact transmission also can occur between two guests when they shake hands or hug, with one serving as the source of infectious microorganisms and the other as a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated object, usually inanimate, in the guest's environment. If a guest or staff member who is ill or in a carrier state with an infectious agent touches an item in the environment and then the susceptible person touches the item later, the infectious organism can be transmitted to the receiving person and cause illness. Contact Precautions apply to people known or suspected to be infected or colonized (presence of microorganism in or on guest but without clinical signs and symptoms of infection) with microorganisms that can be transmitted by direct or indirect contact. Acutely ill guests should be asked to stay in their rooms or be sent for medical care. Ill or recently ill employees must be excluded from work until they are cleared by a medical professional.

A synopsis of the types of precautions and the guests requiring the precautions is listed in Table 1.

### **Empiric Use of Airborne, Droplet, or Contact Precautions**

In many instances, the risk of transmission of infection may be highest before an illness within the public accommodation facility is identified and before precautions based on that information can be implemented. The routine use of Standard Precautions for all guests and employees should reduce greatly this risk for conditions other than those requiring Airborne, Droplet, or Contact Precautions. While it is not possible to identify all people needing these enhanced precautions, certain conditions carry a sufficiently high risk to warrant the addition of enhanced precautions while a more information is gathered. A listing of such conditions and the recommended precautions beyond Standard Precautions is presented in Table 2.

The organisms listed under the column "Potential Pathogens" are not intended to represent the complete or even most likely diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out. Infection control professionals are encouraged to modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, public accommodation facilities must have systems in place to observe guests routinely according to these criteria and offer assistance to the guest in seeking professional medical care.

## Recommendations

The recommendations presented below are categorized as follows:

**Strongly Recommended and Supported**-Strongly recommended for all public accommodation facilities and strongly supported by well-designed experimental or epidemiologic studies.

**Strongly Recommended**-Strongly recommended for all public accommodation facilities and reviewed as effective by experts in the field and a consensus of HICPAC based on strong rationale and suggestive evidence, even though definitive scientific studies have not been done.

**Suggested**-Suggested for implementation in many public accommodation facilities. Recommendations may be supported by suggestive clinical or epidemiologic studies, a strong theoretical rationale, or definitive studies applicable to some, but not all, public accommodation facilities.

**No recommendation**; unresolved issue. Practices for which insufficient evidence or consensus regarding efficacy exists.

The recommendations are limited to the topic of precautions. Therefore, they must be supplemented by public accommodation facility policies and procedures for other aspects of infection and environmental control, occupational health, administrative and legal issues, and other issues beyond the scope of this guideline.

### I. Administrative Controls

#### 1. Education

Develop a system to ensure that public accommodation facility guests, staff, and contractors are educated about use of precautions and their responsibility for adherence to them.

**Strongly Recommended**

#### 2. Adherence to Precautions

Periodically evaluate adherence to precautions, and use findings to direct improvements.

**Strongly Recommended**

### II. Standard Precautions

Use Standard Precautions, or the equivalent, for all staff and give applicable information to all guests. **Strongly Recommended**

#### 1. Handwashing

### Part 1 of 2 Narrative

Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between activities and when otherwise indicated to avoid transfer of microorganisms to other staff, guests, or cross-contamination of environments. **Strongly Recommended**

2. Gloves

Wear clean gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before cleaning up any vomit or feces in a guest room or public area, before touching mucous membranes and nonintact skin, such as when rendering first aid, or when conducting any work where the hands may become contaminated. Change gloves between tasks after contact with material that may contain a high concentration of microorganisms such as dirty sheets and towels or following cleaning bathroom surfaces. Remove gloves promptly after use, before touching clean items and environmental surfaces, and before going to another task. Wash hands immediately to avoid transfer of microorganisms to other guests or environments. **Strongly Recommended**

3. Mask, Eye Protection, Face Shield

Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during clean up or first aid activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. **Strongly Recommended**

4. Protective apparel

Wear clean protective apparel to protect skin and to prevent soiling of clothing during clean up or first aid activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Select protective clothing that is appropriate for the activity and amount of fluid likely to be encountered. Remove soiled apparel and clothing as promptly as possible, but a minimum before returning to any other work. Wash hands to avoid transfer of microorganisms to other people or environments. **Strongly Recommended**

5. Equipment

Handle used equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other people and environments. Ensure that reusable equipment is not used until it has been cleaned and sanitized properly. Ensure that disposable/single-use items are discarded properly. **Strongly Recommended**

6. Environmental Control

Ensure that the public accommodation facility has adequate procedures for the routine maintenance, cleaning, and disinfection of environmental surfaces, bathrooms, restrooms, beds, furniture, bedside equipment, and other frequently touched surfaces such as hand rails, escalator rails, validation machines, and slot machines. Ensure that these procedures are being followed. Institute additional procedures for cleaning and sanitizing the public

accommodation facility when there is a known or suspected outbreak of a communicable disease. **Strongly Recommended**

7. Linen

Handle, transport, and process with extra care used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures and contamination of clothing, and that avoids transfer of microorganisms to other guests and environments. Routinely handle used linen and towels as if there is the potential for these items to be contaminated with microorganisms. Keep used linen segregated from clean linen on housekeeping carts and in laundry and storage areas. Develop methods of room make up that allow dirty jobs to be done first, followed by glove removal, handwashing, and clean glove change before moving to clean linen handling and room make up. **Strongly Recommended**

8. Occupational Health and Bloodborne Pathogens

Take care to prevent injuries when using box cutters, knives, and other sharp instruments or devices; when handling sharp tools after procedures; when cleaning used instruments; and when disposing of used needles left by guests. Never recap used needles, or otherwise manipulate them using both hands, or use any other technique that involves directing the point of a needle toward any part of the body; rather, use either a one-handed "scoop" technique or a mechanical device designed for holding the needle sheath. Do not remove used needles from disposable syringes by hand, and do not bend, break, or otherwise manipulate used needles by hand. Place used disposable syringes and needles, cutting blades, and other sharp items in appropriate puncture-resistant containers, which are located as close as practical to the area in which the items were used. Many public restrooms within the public accommodation facility possess sharps containers for self-disposal of needles used by diabetics and other guests required to self-inject medications. Be careful during guest room servicing not to stick one's hand into any area that cannot be seen. This way, a hidden needle would not be given an opportunity to cause a needle stick. **Strongly Recommended**

Keep mouthpieces, resuscitation bags, or other ventilation devices available in areas where the need for resuscitation is possible. Avoid using direct mouth-to-mouth resuscitation methods, if possible. Only those on staff trained in CPR should attempt to use any of these devices until professional paramedical help arrives for the guest or staff member. Once the decision is made to administer resuscitation, whether with or without an appropriate barrier, it cannot be abandoned until professional help arrives or the rescuer becomes exhausted. **Strongly Recommended**

### III. Airborne Precautions

In addition to Standard Precautions, use Airborne Precautions, or the equivalent, for guests known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue {5  $\mu$ m or smaller in size} of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance). Category IB

1. Guest Placement

Place the guest in a private guest room. Keep the guest room door closed and the guest in the room until transport to medical treatment arrives. Make the guest as comfortable as possible and limit as much as practical anyone coming and going in the vicinity of the ill guest. Staff that must have contact or be in the room with the ill guest should have, at a minimum, a mask, eye protection, and gloves. **Strongly Recommended**

2. Guest Transport

Take a path when moving the guest for transport through areas of the public accommodation facility that are the least populated. When transport or movement is necessary, minimize dispersal of droplet nuclei by placing a mask on the guest, if possible. **Strongly Recommended**

IV. Droplet Precautions

In addition to Standard Precautions, use Droplet Precautions, or the equivalent for a guest known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets {larger than 5  $\mu\text{m}$  in size} that can be generated by the guest during coughing, sneezing, talking, or spitting). **Strongly Recommended**

1. Guest Placement

Place the guest in a private guest room. Special ventilation is not necessary, and the door may remain open. **Strongly Recommended**

2. Mask

In addition to Standard Precautions, wear a mask when working within 3 ft of the guest. (Logistically, some public accommodation facilities may want to implement the wearing of a mask to enter the room of an ill guest.) **Strongly Recommended**

3. Guest Transport

Acutely ill guests should be transported to professional medical care facilities. If a guest refuses transport, limit the movement of the guest from the guest room to essential purposes only by asking the guest to remain in the room while he or she is experiencing respiratory or other symptoms of acute illness. If transport is accepted, minimize guest dispersal of droplets by masking the guest, if possible, while they are moved through the public areas of the facility. **Strongly Recommended**

V. Contact Precautions

In addition to Standard Precautions, use Contact Precautions, or the equivalent, for specified guests known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the guest (hand or skin-to-skin contact that occurs when providing services that require touching the guest's dry skin) or indirect contact (touching) with environmental surfaces or items in the ill or recovering guest's environment. This becomes more important if the infectious

agent is identified as Norovirus because it is environmentally hardy and causes infection in low numbers of organisms. **Strongly Recommended**

1. Guest Placement

Place the guest in a private guest room. Ask the guest to remain in his or her room until no longer ill and during any subsequent period where he or she might be contagious. Acutely ill guests should be transported to appropriate professional medical care. Recovering guests may feel better and decide to be noncompliant about remaining in their rooms, but the request to restrict their movements must still be attempted. **Strongly Recommended**

2. Gloves and Handwashing

In addition to wearing gloves as outlined under Standard Precautions, wear gloves when entering the room. Even the most careful staff member may touch a surface or one of the guest's items without realizing it. During the course of providing service for a guest, change gloves after having contact with potentially infective material or surfaces that may contain microorganisms. Remove gloves before leaving the guest's environment and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the guest's room to avoid transfer of microorganisms to oneself, other people or environments. **Strongly Recommended**

3. Protective apparel

If you anticipate that your clothing will have substantial contact with contaminated environmental surfaces or items in the guest's room or in public areas where clean up is necessary, or if the guest is vomiting or has diarrhea, you may want to wear protective clothing to keep your uniform or clothing from becoming contaminated. Remove the protective clothing before leaving the contaminated area. After removal of the protective apparel, ensure that your uniform or clothing does not contact potentially contaminated environmental surfaces or clean up waste to avoid transfer of microorganisms to other people or environments. **Strongly Recommended**

4. Guest Transport

Ask the guest to limit movement from the room to essential purposes only. If the guest is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of microorganisms to other guests and contamination of environmental surfaces or equipment. **Strongly Recommended**

## Section 2 of 4

### REFERENCES

1. Garner JS. The CDC Hospital Infection Control Practices Advisory Committee. *Am J Infect Control* 1993;21:160-162.
2. National Communicable Disease Center. *Isolation Techniques for Use in Hospitals*. 1st ed. Washington, DC: US Government Printing Office; 1970. PHS publication no. 2054.
3. Centers for Disease Control. *Isolation Techniques for Use in Hospitals*. 2nd ed. Washington, DC: US Government Printing Office; 1975. HHS publication no. (CDC) 80-8314.
4. Garner JS, Simmons BP. CDC Guideline for Isolation Precautions in Hospitals. Atlanta, GA: US Department of Health and Human Services, Public Health Service, Centers for Disease Control; 1983. HHS publication no. (CDC) 83-8314; *Infect Control* 1983;4:245-325, and *Am J Infect Control* 1984;12:103-163.

5. Lynch T. Communicable Disease Nursing. St. Louis, MO: Mosby; 1949.
6. Gage ND, Landon JF, Sider MT. Communicable Disease. Philadelphia, PA: FA Davis; 1959.
7. Haley RW, Shachtman RH. The emergence of infection surveillance and control programs in US hospitals; an assessment, 1976. *Am J Epidemiol* 1980;111:574-591.
8. Schaffner W. Infection control: old myths and new realities. *Infect Control* 1980;1:330-334.
9. Garner JS, Comments on CDC guideline for isolation precautions in hospitals, 1984. *Am J Infect Control* 1984;12:163-164.
10. Haley RW, Garner JS, Simmons BP. A new approach to the isolation of patients with infectious diseases: alternative systems. *J Hosp Infect* 1985;6:128-139.
11. Nauseef WM, Maki DG. A study of the value of simple protective isolation in patients with granulocytopenia. *N Engl J Med* 1981;304:448-453.
12. Pizzo PA. The value of protective isolation in preventing nosocomial infections in high risk patients. *Am J Med* 1981;70:631-637.
13. Jacobson JT, Johnson DS, Ross CA, Conti MT, Evans RS, Burke JP. Adapting disease-specific isolation guidelines to a hospital information system. *Infect Control* 1986;7:411-418.
14. Goldmann DA. The role of barrier precautions in infection control. *J Hosp Infect* 1991;18:515-523.
15. Goldmann DA, Platt R, Hopkins C. Control of hospital-acquired infections. In: Gorbach SL, Bartlett JG, Blacklow NR, eds. *Infectious Diseases*. Philadelphia, PA: WB Saunders; 1992:378-390.
16. Centers for Disease Control. Management of patients with suspected viral hemorrhagic fever. *MMWR* 1988;37(3S):1-16.
17. Centers for Disease Control. Risks associated with human parvovirus B19 infection. *MMWR* 1989;38:81-88,93-97.
18. Centers for Disease Control. Guidelines for preventing the transmission of tuberculosis in health-care settings, with special focus on HIV-related issues. *MMWR* 1990;39(RR-17):1-29.
19. Centers for Disease Control. Nosocomial transmission of multidrug-resistant tuberculosis to health-care workers and HIV-infected patients in an urban hospital -- Florida. *MMWR* 1990;39:718-722.
20. Centers for Disease Control. Nosocomial transmission of multidrug-resistant tuberculosis among HIV-infected persons -- Florida and New York, 1988-91. *MMWR* 1991;40:585-591.
21. Centers for Disease Control and Prevention. Initial therapy for tuberculosis in the era of multidrug resistance: recommendations of the Advisory Council for the Elimination of Tuberculosis. *MMWR* 1993; 42(RR-7):1-8.
22. Centers for Disease Control and Prevention. Draft guidelines for preventing the transmission of tuberculosis in health-care facilities, second edition. *Federal Register* 1993;58(195):52810-52850.
23. Centers for Disease Control and Prevention. Guidelines for preventing the transmission of tuberculosis in health-care facilities, 1994. *MMWR* 1994;43(RR-13):1-132, and *Federal Register* 1994;59(208):54242-54303.
24. Centers for Disease Control. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. *MMWR* 1985;34: 681-686,691-695.
25. Centers for Disease Control. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus during invasive procedures. *MMWR* 1986;35:221-223.
26. Centers for Disease Control. Update: human immunodeficiency virus infections in health-care workers exposed to blood of infected patients. *MMWR* 1987;36:285-289.
27. Center for Disease Control. Recommendations for prevention of HIV transmission in health-care settings. *MMWR* 1987;36(2S):1S-18S.
28. Centers for Disease Control. Update: universal precautions for prevention of transmission of human immunodeficiency virus, hepatitis B virus, and other bloodborne pathogens in health-care settings. *MMWR* 1988;37:377-382,387-388.
29. Lynch P, Jackson MM, Cummings MJ, Stamm WE. Rethinking the role of isolation practices in the prevention of nosocomial infections. *Ann Intern Med* 1987;107:245-246.
30. Lynch P, Cummings MJ, Roberts PL, Herriott MJ, Yates B, Stamm WE. Implementing and evaluating a system of generic infection precautions: body substance isolation. *Am J Infect Control* 1990;18:1-12.
31. McPherson DC, Jackson MM, Rogers JC. Evaluating the cost of the body substance isolation system. *J Healthcare Material Mgmt* 1988;6:20-28.
32. Patterson JE, Vecchio J, Pantelick EL, et al. Association of contaminated gloves with transmission of *Acinetobacter calcoaceticus* var. *anitratum* in an intensive care unit. *Am J Med* 1991;91:479-483.
33. Klein BS, Perloff WH, Maki DG. Reduction of nosocomial infection during pediatric intensive care by protective isolation. *N Engl J Med* 1989; 320:1714-1721.
34. Leclair JM, Freeman J, Sullivan BF, Crowley CM, Goldmann DA. Prevention of nosocomial respiratory syncytial virus infections through compliance with gown and glove isolation precautions. *N Engl J Med* 1987;317: 329-334.
35. Weinstein RA, Kabins SA. Strategies for prevention and control of multiple drug-resistant nosocomial infection. *Am J Med* 1981;70:449-454.
36. Garner JS, Hierholzer WJ. Controversies in isolation policies and practices. In: Wenzel RP, ed. *Prevention and Control of Nosocomial Infections*. 2nd ed. Baltimore, MD: Williams & Wilkins, 1993:70-81.
37. Garner JS, Hughes JM. Options for isolation precautions. *Ann Intern Med* 1987;107:248-250.
38. Weinstein RA, Kabins SA. Isolation practices in hospitals. *Ann Intern Med* 1987;107:781-782. Letter.
39. Doebbeling BN, Pfaller MA, Houston AK, Wenzel RP. Removal of nosocomial pathogens from the contaminated glove: implications for glove reuse and handwashing. *Ann Intern Med* 1988;109:394-398.
40. Sussman GL, Tarlo S, Dolovich J. The spectrum of IgE-mediated response to latex. *JAMA* 1991;255:2844-2847.
41. Bubak ME, Reed CE, Fransway AF, et al. Allergic reactions to latex among health-care workers. *Mayo Clin Proc* 1992;67:1075-1079.
42. Albert RK, Condie F. Hand-washing patterns in medical intensive care units. *N Engl J Med* 1981;304:1465-1466.
43. Preston GA, Larson EL, Stamm WE. The effect of private isolation rooms on patient care practices, colonization, and infection in an intensive care unit. *AM J Med* 1981;70:641-645.
44. Larson E, Leyden JJ, McGinley KJ, Grove GL, Talbot GH. Physiologic and microbiologic changes in skin related to frequent handwashing. *Infect Control* 1986;7:59-63.
45. Department of Labor, Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens; proposed rule and notice of hearings. *Federal Register* 1989;54(102):23042-23139.
46. Doebbeling BN, Wenzel RP. The direct costs of universal precautions in a teaching hospital. *JAMA* 1990;264:2083-2087.
47. Eickhoff TC. The cost of prevention. *Infect Dis News* 1991;4:6.
48. Fahey BJ, Koziol DE, Banks SM, Henderson DK. Frequency of nonparenteral occupational exposures to blood and body fluids before and after universal precautions training. *Am J Med* 1991;90:145-153.

49. Klein RS. Universal precautions for preventing occupational exposures to human immunodeficiency virus type 1. *Am J Med* 1991;90:141-153.
50. Wong ES, Stotka JL, Chinchilli VM, Williams DS, Stuart CG, Markowitz SM. Are universal precautions effective in reducing the number of occupational exposures among healthcare workers? *JAMA* 1991;265: 1123-1128.
51. Department of Labor, Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens; final rule. *Federal Register* 1991;56(235):64175-64182.
52. American Hospital Association. OSHA's Final Bloodborne Pathogens Standard: A Special Briefing. 1992; item no. 155904.
53. Bruning LM. The bloodborne pathogens final rule. *AORN J* 1993;57: 439-461.
54. Jackson MM, Lynch P. An attempt to make an issue less murky: a comparison of four systems for infection precautions. *Infect Control Hosp Epidemiol* 1991;12:448-450.
55. Pugliese G, Lynch P, Jackson MM. Universal Precautions: Policies, Procedures, and Resources. Chicago, IL: American Hospital Association; 1991:7-87.
56. Birnbaum D, Schulzer M, Mathias RG, Kelly M, Chow AW. Adoption of guidelines for universal precautions and body substance isolation in Canadian acute-care hospitals. 1990;11:465-472.
57. Lynch P, Cummings MJ, Stamm WE, Jackson MM. Handwashing versus gloving. *Infect Control Hosp Epidemiol* 1991;12:139. Letter.
58. Birnbaum D, Schulzer M, Mathias RG, Kelly M, Chow AW. Handwashing versus gloving. *Infect Control Hosp Epidemiol* 1991;12:140. Letter.
59. Gurevich I. Body substance isolation. *Infect Control Hosp Epidemiol* 1992;13:191. Letter.
60. Jackson MM, Lynch P. Body substance isolation. *Infect Control Hosp Epidemiol* 1992;13:191-192. Letter.
61. Rudnick JR, Kroc K, Manangan L, Banerjee S, Pugliese G, Jarvis W. Are US hospitals prepared to control nosocomial transmission of tuberculosis? *Epidemic Intelligence Service Annual Conference, 1993*;60. Abstract.
62. Institute of Medicine. *Emerging Infections: Microbial Threats to Health in the United States*. 1st ed. Washington, DC: National Academy Press, 1992.
63. Centers for Disease Control and Prevention. Nosocomial enterococci resistant to vancomycin -- United States, 1989-1983. *MMWR* 1993;42: 597-599.
64. Lowbury EJJ, Lilly HA, Bull JP. Disinfection of hands: removal of transient organisms. *Br Med J* 1964;2:230-233.
65. Sprunt K, Redmon W, Leidy G. Antibacterial effectiveness of routine handwashing. *Pediatrics* 1973;52:264-271.
66. Steere AC, Mallison GF. Handwashing practices for the prevention of nosocomial infections. *Ann Intern Med* 1975;83:683-690.
67. Food and Drug Administration. The tentative final monograph for over-the-counter topical antimicrobial products. *Federal Register* 1978;43:1210-1249.
68. Garner JS, Favero MS. *Guidelines for Handwashing and Hospital Environmental Control*. Atlanta, GA: US Department of Health and Human Services, Public Health Service, Centers for Disease Control; 1985.
69. Larson E. APIC guideline for use of topical antimicrobial products. *Am J Infect Control* 1988;16:253-266.
70. Ehrenkranz NJ. Bland soap handwash or hand antiseptics? The pressing need for clarity. *Infect Control Hosp Epidemiol* 1992;13:299-301.
71. Larson E. Skin cleansing. In: Wenzel RP, ed. *Prevention and Control of Nosocomial Infections*. 2nd ed. Baltimore, MD: Williams & Wilkins, 1993:450-459.
72. Larson EL, 1992, 1993, and 1994 Association for Professionals in Infection Control and Epidemiology Guidelines Committee. APIC guideline for handwashing and hand antiseptics in health care settings. *Am J Infect Control* 1995;23:251-269.
73. Paulssen J, Eidem T, Kristiansen R. Perforations in surgeons' gloves. *J Hosp Infect* 1988;11:82-85.
74. DeGroot-Kosolcharoen J, Jones JM. Permeability of latex and vinyl gloves to water and blood. *Am J Infect Control* 1989;17:196-201.
75. Kotilainen HR, Brinker JP, Avato JL, Gantz NM. Latex and vinyl examination gloves: quality control procedures and implications for healthcare workers. *Arch Intern Med* 1989;149:2749-2753.
76. Olsen RJ, Lynch P, Coyle MB, Cummings MJ, Bokete T, Stamm WE. Examination gloves as barriers to hand contamination and clinical practice. *JAMA* 1993;270:350-353.
77. Health Resources and Services Administration. *Guidelines for Construction and Equipment of Hospital and Medical Facilities*. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, 1984. PHS publication no. (HSA)84-14500.
78. American Institute of Architects, Committee on Architecture for Health. *General hospital*. In: *Guidelines for Construction and Equipment of Hospital and Medical Facilities*. Washington, DC: The American Institute of Architects Press; 1993.
79. American Society of Heating, Refrigerating, and Air Conditioning Engineers. *Health facilities*. In: *1991 Application Handbook*. Atlanta, GA: American Society of Heating, Refrigerating, and Air Conditioning Engineers, Inc; 1991.
80. Jarvis WR, Bolyard EA, Bozzi CJ, et al. Respirators, recommendations, and regulations: the controversy surrounding protection of health care workers from tuberculosis. *Ann Intern Med* 1995;122:142-146.
81. Department of Health and Human Services, Department of Labor. *Respiratory protective devices: final rules and notice*. *Federal Register* 1995;60(110):30336-30402.
82. Rutula WA, Mayhall CG. The Society for Hospital Epidemiology of America position paper: medical waste. *Infect Control Hosp Epidemiol* 1992;13:38-48.
83. Rhame FS. The inanimate environment. In: Bennett JV, Brachman PS, eds. *Hospital Infections*. 3rd ed. Boston, MA: Little, Brown and Co; 1992: 299-333.
84. Rutula WA. Disinfection, sterilization, and waste disposal. In: Wenzel RP, ed. *Prevention and Control of Nosocomial Infections*. 2nd ed. Baltimore, MD: Williams & Wilkins. 1993:460-495.
85. Maki DG, Alvarado C, Hassemer C. Double-bagging of items from isolation rooms is unnecessary as an infection control measure: a comparative study of surface contamination with single and double bagging. *Infect Control* 1986;7:535-537.
86. American Society for Healthcare Central Services. *Recommended Practices for Central Service: Sterilization*. Chicago, IL: American Hospital Association; 1988.
87. American Society for Healthcare Central Services. *Recommended Practices for Central Service: Decontamination*. Chicago, IL: American Hospital Association; 1990.
88. Rutula WA. APIC guideline for selection and use of disinfectants. *Am J Infect Control* 1990;18:99-117.
89. Bond WW, Ott BJ, Franke KA, McCracken JE. Effective use of liquid chemical germicides on medical devices: instrument design problems. In: Block SS, ed. *Disinfection, Sterilization, and Preservation*. 4th ed. Philadelphia, PA: Lea and Febiger, 1991:1097-1106.
90. Favero MS, Bond WW. Sterilization, disinfection, and antiseptics. In: Ballows A, Hausler WJ, Herrmann KL, Isenberg HO, Shadomy HJ, eds. *Manual of Clinical Microbiology*. 5th ed. Washington, DC: American Society for Microbiology; 1991:183-200.
91. Favero MS, Bond WW. Chemical disinfection of medical and surgical materials. In: Block SS, ed. *Disinfection, Sterilization, and Preservation*. 4th ed. Philadelphia, PA: Lea and Febiger. 1991:617-641.

92. Pugliese G, Hunstiger CA. Central services, linens, and laundry. In: Bennett JV, Brachman PS, eds. Hospital Infections. 3rd ed. Boston, MA: Little, Brown and Co; 1992:335-344.
93. Joint Committee on Healthcare Laundry Guidelines. Guidelines for Healthcare Linen Service -- 1994. Hallandale, FL: Textile Rental Services Association of America; 1994.
94. Hospital Infection Control Practices Advisory Committee. Recommendations for preventing the spread of vancomycin resistance. Am J Infect Control 1995;23:87-94, Infect Control Hosp Epidemiol 1995;16:105-113, and MMWR 1995;44(No. RR-12):1-13.
95. Tablan OC, Anderson LJ, Arden NH, Breiman RF, Butler JC, McNeil MM. Hospital Infection Control Practices Advisory Committee. Guideline for prevention of nosocomial pneumonia. Part I: issues on prevention of nosocomial pneumonia -- 1994. Am J Infect Control 1994;22:247-266, Infect Control Hosp Epidemiol 1994;15:587-604, and American Association of Respiratory Care 1994;12:1191-1209.
96. Hospital Infection Control Practices Advisory Committee. Guideline for prevention of nosocomial pneumonia. Part II: recommendations for prevention of nosocomial pneumonia. Am J Infect Control 1994;22: 266-292, Infect Control Hosp Epidemiol 1994;15:604-627, and American Association of Respiratory Care 1994;12:1209-1236.
97. Centers for Disease Control and Prevention. Update: management of patients with suspected viral hemorrhagic fever -- United States. MMWR 1995;44:475-479.

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#### TABLE 1

#### SYNOPSIS OF TYPES OF PRECAUTIONS AND PEOPLE REQUIRING THE PRECAUTIONS

##### Standard Precautions

- ❖ Use Standard Precautions for all situations.

##### Airborne Precautions

In addition to Standard Precautions, use Airborne Precautions for people known or suspected to have serious illnesses transmitted by airborne droplet nuclei. Examples of such illnesses include:

- ❖ Measles
- ❖ Varicella (including disseminated zoster)
- ❖ Tuberculosis

##### Droplet Precautions

In addition to Standard Precautions, use Droplet Precautions for people known or suspected to have serious illnesses transmitted by large particle droplets. Since it is unlikely that the guest's illness will have been identified yet, when guests are coughing or sneezing excessively or uncontrollably or exhibit other signs and symptoms that indicate the illness may be transmitted to and by the respiratory tract, then Droplet Precautions should be observed until severe illness is ruled out by a medical professional.

Examples of such illnesses include:

- ❖ Invasive *Haemophilus influenzae* type b disease, including meningitis, pneumonia, epiglottitis, and sepsis
- ❖ Invasive *Neisseria meningitidis* disease, including meningitis, pneumonia, and sepsis
- ❖ Other serious bacterial respiratory infections spread by droplet transmission, including:
  - Diphtheria (pharyngeal)
  - *Mycoplasma pneumoniae*
  - Pertussis
  - Pneumonic plague
  - *Streptococcal* pharyngitis, pneumonia, or scarlet fever in infants and young children
- ❖ Serious viral infections spread by droplet transmission, including:
  - Adenovirus
  - Influenza
  - Mumps

- Parvovirus B19
- Rubella

### Contact Precautions

In addition to Standard Precautions, use Contact Precautions for people known or suspected to have serious illnesses easily transmitted by direct contact or by contact with items in the person's environment. Illnesses in this category are the most likely to cause problems in a public accommodation facility. Examples of such illnesses include:

- ❖ Gastrointestinal, respiratory, skin, or wound infections or colonization with multidrug-resistant bacteria such as MRSA.
- ❖ Enteric infections with a low infectious dose or prolonged environmental survival, including:
  - *Clostridium difficile*
  - Enterohemorrhagic *Escherichia coli* O157:H7, *Shigella*, hepatitis A, Norovirus, or rotavirus
- ❖ Respiratory syncytial virus, parainfluenza virus, or enteroviral infections in infants and young children
- ❖ Skin infections that are highly contagious or that may occur on dry skin, including:
  - Diphtheria (cutaneous)
  - Herpes simplex virus (neonatal or mucocutaneous)
  - Impetigo
  - Major (noncontained) abscesses, cellulitis, or decubiti
  - Pediculosis
  - Scabies
  - Staphylococcal furunculosis in infants and young children
  - Zoster (disseminated or in the immunocompromised host)
- ❖ Viral/hemorrhagic conjunctivitis
- ❖ Viral hemorrhagic infections (Ebola, Lassa, or Marburg) \*

**Section 4 of 4**

TABLE 2

SYNDROMES OR CONDITIONS WARRANTING PRECAUTIONS TO PREVENT TRANSMISSION OF PATHOGENS PENDING CONFIRMATION OF DIAGNOSIS BY A MEDICAL PROFESSIONAL

Syndrome or Condition +	Potential Pathogens ++	Precautions
<b>Diarrhea</b>		
Acute diarrhea with likely infectious cause	Enteric Pathogens &	Contact Precautions
Diarrhea in an adult with a history of recent antibiotic use	<i>Clostridium difficile</i>	Contact Precautions
<b>Meningitis</b>	<i>Neisseria meningitidis</i>	Droplet Precautions
<b>Rash or exanthems, generalized, etiology unknown</b>		
Petechial/ecchymotic with fever	<i>Neisseria meningitidis</i>	Droplet Precautions
Vesicular	Varicella	Airborne and Contact Precautions
Maculopapular with coryza and fever	Rubeola (measles)	Airborne Precautions
<b>Respiratory Infections</b>		
Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for HIV infection	<i>Mycobacterium tuberculosis</i>	Airborne Precautions
Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection	<i>Mycobacterium tuberculosis</i>	Airborne Precautions
Paroxysmal or severe persistent cough during periods of pertussis activity	<i>Bordetella pertussis</i>	Droplet Precautions
Respiratory infections, particularly bronchiolitis and croup, in infants and young children	Respiratory syncytial or parainfluenza virus	Contact Precautions
<b>Risk of multidrug-resistant microorganisms</b>		
History of infection or colonization with multidrug-resistant organisms @	Resistant bacteria	Contact Precautions
Skin, wound, or urinary tract infection in a person with recent hospital or nursing home stay in a facility where multidrug-resistant organisms are prevalent	Resistant bacteria	Contact Precautions
<b>Skin or Wound Infection</b>		
Abscess or draining wound that cannot be covered	<i>Staphylococcus aureus</i> , Group A <i>Streptococcus</i>	Contact Precautions

+ People with the syndromes or conditions listed below may have with atypical signs or symptoms (eg, pertussis in neonates and adults may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.

++ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.

& These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella*, hepatitis A, Norovirus and rotavirus.

@ Resistant bacteria judged by current state, regional, or national recommendations to be of special significance.

		MINIMUM PERSONAL PROTECTIVE EQUIPMENT REQUIRED					
		Gloves	Gowns Tyvek suits Other protective clothing	Masks	Protective Eyewear Face Shields	Ventilation/ Isolation	Full-face respirator with HEPA filtration or supplied air
EXPOSURE TYPE	Standard Precautions	X	X if splashing is likely to occur	X if splashing is likely to occur	X if transmittable to all mucosal linings and splashing is likely to occur	X Only when practical to isolate guest	X For high-risk agents (viruses) that cause life-threatening disease
	Airborne Precautions	X	X if coughing, sneezing, or splashing is likely to occur	X for both guest and employee	X if transmittable to all mucosal linings	X routine isolation of guest before transportation to health care	X For high-risk agents (viruses) that cause life-threatening disease
	Contact Precautions	X	X if splashing is likely to occur	X if splashing is likely to occur	X if transmittable to all mucosal linings and splashing is likely to occur	X Only when practical to ask guest to restrict movement	X For high-risk agents (viruses) that cause life-threatening disease
	Droplet Precautions	X	X if coughing, sneezing, or splashing is likely to occur	X within 3 feet of guest	X if transmittable to all mucosal linings	X Only when practical to isolate guest before transport to health care	X For high-risk agents (viruses) that cause life-threatening disease
	Enteric Precautions	X	X if splashing is likely to occur	X if splashing is likely to occur	X if transmittable to all mucosal linings and splashing is likely to occur	X Only when practical to ask guest to restrict movement	X For high-risk agents (viruses) that cause life-threatening disease

Chart adapted from CDC's Part II. Recommendations for Isolation Precautions in Hospitals to fit the needs of Public Accommodation Facilities.