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Owner:	*Yvonne Strader: CNO St Mary Med Ctr*
Policy Area:	*Patient Care Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Isolation Precautions, 8720.5404

Purpose:

To establish a consistent process which decreases the risks associated with the cross transmission of potentially infectious agents between patients, healthcare workers and visitors.

Responsibilities

A. Physicians, staff and visitors entering patient rooms must follow standard precautions and additional isolation measures as posted.

B. Nursing staff is to convey isolation related information at change of shift and before transferring patient to another department.

C. Nursing staff is to provide and document patient isolation education.

D. Department managers are to ensure employee compliance with isolation policy.

E. Environmental Services is to complete room cleaning as directed for each isolation precaution category and remove the precautions sign after discharge cleaning has been completed.

F. Engineering to daily monitor airflow when Airborne Contact and Airborne Respirator Precautions are in use.

G. Supply Chain Management is to distribute and maintain PPE supplies as needed on the units.

H. Supply Chain Management to clean stock and return isolation carts to appropriate units.

I. Nursing staff to maintain supply of PPE in nurse servers and isolation carts.

Policy

Patient care requires the use of Standard Precautions which considers all body fluids potentially infectious and does not depend on diagnostic or culture reports. This consistent approach is essential to prevent transmission of infectious agents from unknown and/or undiagnosed sources.

Staff education pertaining to isolation measures occurs during new employee orientation and reinforced as indicated thru monitoring of the isolation process.

Patient education is provided by nursing staff and visitor instructions are posted on door.

Procedure

Standard Precautions

Table 1

Standard Precautions applies to blood and all body fluids, secretions and excretions regardless of whether they contain visible blood, non-intact skin and mucous membranes.

The choice of personal protective equipment during patient care is determined by the nature of the healthcare worker-patient interaction and the extent of anticipated contact with blood or other body fluids.

Room Selection – Patient rooms are single occupancy.

Cohorting

(grouping patients with the same infection or colonization together).

a. Confer with Infection Prevention prior to cohorting patients.
b. Cohorting is to be based on clinical diagnosis, microbiologic confirmation when available and mode of transmission of the conditions.
c. Criteria for cohorting:
    - The patient is not infected with other potentially transmissible microorganisms.
    - The likelihood of reinfection with the same organism is minimal.
    - The patient is not immunocompromised.

Hand Hygiene

a. When hands are visibly dirty or contaminated, wash hands with water and antimicrobial soap.
b. If hands are not visibly soiled, use an alcohol-based hand rub.
c. Wash hands with soap and water if caring for suspected **C. difficile** cases or Diarrhea and when Contact Enteric Precautions are in use .
d. Practice hand hygiene after gloves are removed. (Hand Hygiene #8720.5044).

Gloves

a. Clean gloves are to be worn when touching any moist body substance, mucus membranes, or non-intact skin.
b. When selecting gloves, consider the level of risk of exposure, the duration of the task and concerns of sensitivity to latex.
c. Nitrile gloves are preferred for procedures and tasks considered moderate to high risk for exposure to blood.
    - Latex use in not recommended for individuals with known or suspected allergy to latex or for prolonged contact with high-level disinfectants or chemotherapy agents.
    - Employees with latex sensitivities are to contact Employee Health.
d. Vinyl gloves are appropriate for short term tasks that involve minimal stress on the glove and low risk of exposure to blood or body fluids.
    - Changing linens, suctioning, emptying urinals and emesis basins or discontinuing an IV line.
    - Not recommended for moderate to high risk of exposure to blood or body fluids, when handling chemotherapy agents, when handling caustic agents or disinfectants.
e. Gloves are to be worn for all phlebotomy (blood draws, IV sticks, ABG sticks) and removal of IV devices.
f. Gloves are to be kept in every patient room.
g. Disposable, single use gloves are to be used and changed if torn or punctured.
h. Change gloves between contacts with different body substances of same patient and between patients.
i. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before leaving the patient room.
j. Dispose of gloves in lined waste receptacle.
k. Practice hand hygiene after removing gloves.
l. Gloves are not to be washed for reused.

m. When gloves are worn in combination with other personal protective equipment, they are put on last and removed first.

Gowns

a. Wear a disposable gown (clothes cover) when clothing is likely to be soiled with blood or other moist body substances. Gowns are usually the first PPE to be donned.
    - Fluid resistant gowns are available for procedures likely to cause clothing to become wet, i.e., bronchoscopy, delivery, OR, some wound irrigations, endoscopy.

b. Gowns are to be donned prior to entering the precautions room and removed before leaving the patient room or work area.

c. The outside of the gown is contaminated and should be turned inward and rolled into a ball prior to being discarded into the waste container or soiled linen

d. Gowns are to be worn once and not reused even for repeated contacts with the same patient.

Masks-Respiratory Protection

a. Wear masks with eye protection during aerosolizing procedures: e.g.; coughing, patient who does not cover mouth or nose, suctioning patient, wound irrigation.

b. Protective masks are worn once and discarded.

c. Remove masks touching only the clean elastic or string holders.

d. N-95 masks are to be used for care of patients with suspected or proven airborne conditions (Airborne Respirator Precautions) and require fit testing prior to use.

e. Masks may not protect susceptible persons from certain airborne diseases. Healthcare workers and visitors susceptible to measles, mumps, rubella or chicken pox are not to enter the rooms of patients with these conditions.

Eye Protection and Face Shields:

a. Protective eyewear or face shields are to be used in situations in which splatter with blood or other body substances is anticipated, i.e., bronchoscopy, delivery, suction procedures, massive trauma in ER, endoscopy procedures, and O.R.

b. Protective eyewear is available at the nursing stations, may be ordered from Supply Chain Management and is available attached to face masks.

Airway Resuscitation

a. To minimize the need for emergency mouth to mouth resuscitation, pocket masks are available in the nurse's station and in each patient room.

Laboratory specimens from all patients are handled with equal care. All are considered potentially infectious.

a. All specimens will be placed in a well-constructed container with a secure lid to prevent leaking during transport.

b. The outside of all specimen containers is to be kept clean, using caution when collecting the specimen to avoid contaminating the outside of the container.

c. The specimen container is to be placed in a sealed plastic bag labeled with the biohazard symbol for transport.

d. Specimens may be placed in the vacuum tube system using the transport tubes indicated for specimen.

Patient Care Equipment

Ensure that non critical, reusable equipment is cleaned/low level disinfected or reprocessed appropriately between uses on different patients.

a. Reusable patient care equipment must be cleaned and maintained according to the manufacturers instructions.

b. Wear appropriate PPE for handling used patient-care equipment soiled with blood, body fluids, secretions, and

excretions in a manner that prevents skin and mucous membranes exposures, contamination of clothing, and transfer of microorganism to other patients and environments.

c. Use the hospital approved cleaner/disinfectant following manufacture's recommendations for contact times.

d. Once cleaned, items need to be stored in such a manner to prevent contamination.

e. Ensure that single use items are not reused and are discarded.

f. Non critical items such as commodes, IV pumps, bladder scanners, etc must be cleaned between uses with the approved environmental detergent/disinfectant.

   - A prepared bleach/detergent wipe will be used for equipment used in Contact Enteric Precautions.
   - Environmental services clean these items during room discharge.
   - Nursing staff clean the devices if they are removed from the rooms prior to discharge for use with another patient.

g. Reusable equipment requiring high level disinfection or sterilization will be returned to Central Processing.

h. Used instruments to be transported to Central Processing are to be placed in a secured soiled instrument container labeled with the biohazard symbol located in soiled hold areas.

i. Non sharp items contaminated with body fluids will be bagged prior to transport. The purpose of bagging reusable soiled articles is to prevent leakage and exposures to potentially infectious body fluids.

   - Place soiled reusable items onto the soiled hold cart.
   - Body fluid contaminated articles are to be placed in red bags labeled with a biohazard symbol.

Disposable Patient Care Articles and Trash:

a. Disposable items or trash contaminated with body substances may be placed in a plastic lined garbage receptacle unless blood or other potentially infectious body fluid is free flowing or compressible from the item.

b. Items saturated with body fluids and those which are unable to be emptied (i.e., drainage systems) are handled as an infectious waste and placed in a red bag for transport to the Biohazard barrel in soiled hold (Infectious Waste policy #7050.5404).

Linen

All used linen is considered contaminated and handled in the same manner. Soiled linen is to be handled as little as possible and with a minimum of agitation.

a. Soiled linen from all patient rooms is to be bagged inside the patient room into a single, clear plastic bag.

b. Clear plastic bags are placed in the bottom section of nurse servers. Do not fill bags more than 2/3 full.

c. Environmental Services collects soiled linen on a scheduled basis and when called.

Room Cleaning

Cleaning of the patient room is performed in a standard and consistent manner for all patient rooms and as required by isolation precautions.

a. Rooms are cleaned at least daily. Frequency and intensity of cleaning may change based on the patients level of hygiene and the degree of environmental contamination.

b. Cleaning procedures use a hospital approved disinfectant and focus on frequently touched surfaces and those most likely to be contaminated with blood and body fluids (e.g., bedrails, bedside tables, commodes, doorknobs, sinks, surfaces and equipment in close proximity to the patient.

   - Bleach/detergent wipes will be used to clean high touch surfaces in rooms using Contact Enteric Precautions.

Cleaning of Body Fluid Spills:

a. Body fluid spills are to be immediately cleaned by personnel wearing appropriate protective equipment.

b. Gloves are to be worn and gowns if soiling of clothes is likely.

c. Remove as much of the body fluid with paper towels as possible.
   - Apply the hospital-approved germicide according to label.

d. Wipe clean with clean cloth, do not rinse.

e. Dispose of cleaning cloths into laundry and gloves into regular waste stream unless saturated with blood or other potentially infectious body substance.
   - Cleaning cloths saturated with blood are placed into red biohazard bags.
   - Wash hands with soap and water after removing gloves.

Respiratory Hygiene/Cough Etiquette

A component of Standard Precautions is Respiratory Hygiene/Cough Etiquette which reduces the risk of exposures to conditions transmitted by respiratory secretions.

a. Instruct patients, visitors and other persons with symptoms of a respiratory infection to cover their mouth/noses when coughing or sneezing, to use tissues, and perform hand hygiene after hands have been in contact with respiratory secretions

b. Respiratory Hygiene Cough Etiquette signs, hand hygiene resources, masks, tissues, and no-touch waste receptacles will be placed in public entrances and waiting areas.

c. Cover face and nose with a tissue or sleeve when coughing.

d. Practice hand hygiene after coughing or handling tissues.

e. Provide special separation, ideally >6 feet, for persons with respiratory infections in common waiting areas.

   NOTE: Neutropenic Precautions do not reduce the incidence of infection in compromised patients and are not recommended. Visitors who are ill should not visit and hand hygiene should be practiced before entering the patient room.
   - Physicians may order protective patient care regimens with the necessary requirements defined.
   - Consultation with the Infection Control Practitioner is encouraged.

Transmission Based Precautions

Table 2

In addition to Standard Precautions, transmission based precautions for specific conditions are required for patients known or suspected to be infected or colonized with pathogens that can be transmitted by contact with dry skin, contaminated surfaces, airborne or droplets. Transmission based precautions focus on the sources of infection for specific conditions and their modes of transmission.

a. More than one category of isolation may be used at a time. The highest level of protection will apply at all times.

Transmission based precautions are put into use at the time a communicable condition is suspected and do not rely on a confirmed diagnoses for implementation.

a. Transmission based precautions should be used until either the diagnosis is established or pathogen is excluded.

The categories of transmission based precautions are:

- Contact Precautions

1. Contact Enteric Precautions

- Droplet Precautions
- Airborne Contact Precautions
- Airborne Respirator Precautions

Duration of precautions differs by condition- Table 3.

Isolation supplies and personal protective equipment are kept in the top portion of the Nurse Servers (gowns, gloves, and masks).

a. Isolation supplies are accessed from the outside of the patient room only.
    - Practice hand hygiene before using the Nurse Server.
b. Isolation supplies are kept stocked by unit staff from the clean supply carts.

Areas without Nurse Servers will utilize the Isolation Cart System (Pediatrics).

a. Yellow isolation carts are stored on the units using them.
b. Unit staffs stock the isolation carts while in use.
c. When isolation is discontinued, call Supply Chain Management who will retrieve the cart, clean, restock and return the cart to the appropriate unit.

In addition to Standard Precautions procedures, transmission based precautions require:

Patient Care Equipment:

a. Leave patient-care equipment in the room-dedicate the use of non-critical items (such as stethoscope, B/P cuff, commode, walker, oximeter and thermometer) to the isolation room.
b. Leave hospital cell phones, patient chart/clipboards outside the room.
c. If it is necessary to use common equipment clean and disinfect between patients.
    - Use bleach wipes for Contact Enteric Precautions.

Precaution Signs/Labels:

a. Precautions signs are used to alert health care workers and visitors when additional isolation measures are required.
b. Isolation signs and associated patient education sheets are kept on the units in designated areas and are available electronically.
c. Isolation signs and education sheets may be ordered from Print Shop.
d. Isolation signs and associated patient/visitor education sheets are stocked in the isolation carts.
e. Display isolation signs on the top portion of the nurse server AND on the patient door.
f. Upon transfer, discharge or/or discontinuation of isolation, leave isolation sign on the door until room in cleaned-Environmental Services will remove the sign after cleaning has been completed.
g. Hand off information includes isolation categories that may be in use.

Patient Education

a. Provide the patient with education specific to the type of isolation in use. Each category has an accompanying patient education sheet.
b. Leave the education sheet in the patient room for visitors and discard when isolation is discontinued.
c. Document education in patient record.

Visitors

a. Visitors and correctional officers are to observe the same precautions as staff.
b. Practice hand hygiene upon entering and leaving the patient room.
c. Should **not** eat in rooms of patients in Contract Enteric Precautions.
d. Should wear a mask when patient is in Droplet Precautions and they are within 6 feet of the patient.

e. Should only enter the room of patients on Airborne Contact Precautions if they are immune to the communicable condition present.

f. Must wear an N-95 during visits with patients on Airborne Respirator Precautions. No fit test is required.

g. Exceptions may to be discussed with Infection Prevention.

h. Visitor non compliance is addressed by unit managers and Infection Prevention.

- If family/visitors demonstrate non-compliance with required practices, unit personnel will make a second attempt to educate those involved about the reason for precautions and the specific practices that are necessary.
- If family/visitors continue to be non-compliant with required elements of isolation, notify the unit director, Hospital Administrative Coordinator and/or Infection Prevention.
- Additional attempts to determine the reason(s) for non-compliance and to requrest family/visitor compliance will be made.
- In the event that efforts to gain family/visitor compliance have failed [after three attempts], discuss next steps and limit-setting, which may include the involvement of the patient, Security and/or local Public Health.
- Call Security for assistance.
- Document the event in Quantros.

Documentation

a. Document the date/time and types of isolation precautions started.

- Enter type of isolation precautions on worklist and add isolation problem to the care plan.

b. Document the patient education.

Transportation of patients in precautions:

a. Both patients and staff must clean their hands on leaving the room and returning.

b. Patients who leave their rooms for other than essential purposes must be:

- Competent to understand directions
- Cooperative and willing to follow directions
- Continent of urine and stool
- Contained wounds and drainage
- Clean-clean clothes cover (robe or gown) and clean hands

FIVE Cs

c. Staffs are to wear the appropriate PPE when entering the room to prepare the patient.

d. Appropriate PPE must be worn by the patient when leaving their room for any reason: masks and clean gown/robe as directed by the type of isolation precaution in use.

- Patients don clean PPE prior to leaving their room.
- Patients on Droplet Precautions, Airborne Contact Precautions and Airborne Respirator Precautions are to wear a mask while out of their room.

e. After the patient PPE has been donned in the patient room, staffs remove their PPE and practice hand hygiene prior to leaving the room.

f. Protect wheelchairs and stretcher patient contact surfaces with linens and clean/disinfect patient contact surfaces with disinfectant wipes after use.

g. Notify other departments who will be providing services about the type of isolation category in use (Hand off information).

No special precautions are needed for dishes, glasses, cups or eating utensils. Disposable meal trays are not necessary. The combination of hot water and detergents used in hospital dishwashers is sufficient to decontaminate.

Contact Precautions

Prevents the spread of infection transmitted by directly touching the patient or something they have touched.

Conditions requiring Contact Precautions:

- RSV
- Scabies
- Draining wounds that cannot be covered.
- Fecal incontinence or other discharges from the body that are not contained and suggest an increased transmission risk and/or environmental contamination.
- Multidrug resistant organisms (MDROs):

  MRSA (Methicillin Resistant **Staph aureus**) Oxacillin
  VRE (Vancomycin Resistant **Entercoccus**)
  PRSP (Penicillin Resistant **Strep pneumoniae**)
  ESBL (Extended spectrum Beta Lactamase)
  Carbepenem resistant gram negatives (CREs)
  Others as identified by Microbiology

  a. Lab will place an Infection Prevention Alert on microbiology report and notify the nursing unit by telephone.
  b. Medical records of patients with a history of a MDRO will be flagged by Infection Prevention with MDRO-Contact Precautions Required. Contact Precautions are required for subsequent admissions.
  c. Patients whose history indicates a MDRO will be placed in Contract Precautions during inpatient admissions.
  d. Outpatient Procedure Center, Clinic Settings, Cancer Center and ED will use Standard Precautions to care for patients with a history of MRSA and who have no active infections. Contact Precautions will be used for patients with a history of MDRO other than MRSA and/or a current MRSA infection (Contact Precautions will not be used for history of MRSA without a current infection).
  e. Should the physician want to re-culture to determine continued presence of an MDRO:
     - Culture after patient has been off antibiotics for at least a week.
     - Obtain 2 cultures of previously positive site 24 hours apart.
     - Include rectal cultures for VRE and other resistant gram negative organism.
     - A physicians order is required for cultures.

There are no evidence based recommendations for how/when to determine continued presence of an MRDO. It is assumed that once infected or colonized, persons remain colonized with the MDRO.

Follow standard precautions and instructions on the Contact Precautions isolation sign for requirements:

Gowns required each entry.
Gloves required for each entry.
Use patient dedicated equipment

Contact Enteric Precautions

Contact enteric precautions are designed to prevent transmission of gastrointestinal infectious agents which are spread from (direct) contact from a patient to healthcare worker and to prevent transmission from a contaminated item to healthcare worker or other patient.

Conditions requiring Contact Enteric Precautions:

- Acute uncontained diarrhea,
- **Clostridium difficile** (C. Difficile, C. Diff.)-start precautions when the test is ordered.
- Norovirus,
- Rotavirus

Contact Enteric Precautions to be continued until treatment has been completed and symptoms resolved for a minimum of 48 hours.

Follow Standard Precautions and the instruction on the isolation sign. Specific requirements of Contact Enteric Precautions-

Hand Hygiene: Cleanse hands with Alcohol hand sanitizer before donning gown and gloves to enter the patient's room.

Wash with antimicrobial soap and after removing gowns and/or gloves and before leaving the room.

Dietary: Family and Visitors should not eat in the room.

Room Cleaning: Through cleaning for enteric precautions with the addition of cubicle curtain changes at discharge or transfer. Following routine cleaning, clean and disinfect with **chlorine-based disinfectant wipe**.

Droplet Precautions

Prevents the spread of infection transmitted during coughing, sneezing and talking or during the certain aerosolizing procedures.

Conditions requiring Droplet Precautions:

- Influenza
- Meningitis (until Neisseria meningitidis ruled out)
    - Droplet Precautions for **N. meningitidis** may be discontinued after the patient has been on appropriate antibiotics 24 hours.
- Pertussis
- Respiratory viruses.
- **MRSA** in the sputum or pneumonia requires Contact and Droplet Precautions.

Follow Standard Precautions and the instructions on the isolation sign. Specific requirements of Droplet Precautions-

Visitors: Preferably limit visitors to those already exposed.

Masks: Wear a mask upon entry into the room.

Gown/ Gloves: wear gown and gloves on entry to patient's room *if contact with secretions or excretions are likely*. Remove gown/gloves before leaving the room and ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to other patient's environments.

Patient Transport: patient is to wear a surgical mask.

Airborne Contact Precautions

Airborne isolation precautions are designed to reduce the risk of airborne transmission of infectious agents. This isolation is used for patients with known or suspected to be infected with microorganisms transmitted by droplets containing microorganisms that remain suspended in the air or that can be dispersed widely by air currents within a room or over a long distance). These conditions also have the capacity to be spread by contact when vesicles are present.

Conditions Requiring Airborne Contact Precautions:

- Chickenpox
- Disseminated herpes zoster (shingles)
- Localized zoster in immuncompromised individuals
- Measles.

Follow Standard Precautions and the directions on the isolation sign. Specific requirements of Airborne Contact Precautions-

PRIOR TO PLACEMENT: Reference Facilities Policy: Management of Ventilation Components in Critial Area Environements

Doctors, Staff, Families and Visitors enter room only if immune (By history, titer or immunization)

a. Visitors who are not immune should not visit – parents and siblings who have not had the disease or immunization may by incubating the disease and be contagious for two days prior to the onset of rash or other symptoms, putting other

patients and staff at risk.

Patient Placement:

a. Place the patient in a negative airflow rooms 315, 316, 449, 462 or designated ED rooms 11 & 12 and PACU Bed 5.

b. Nursing to activate the negative air pressure switch where applicable (all NAF rooms except Rooms 315 and 316 which are continuously in negative pressurization), and **close the door**. It takes approximately 10 minutes for the negative pressurization to be achieved within establisted parameters.

c. Nursing to notify Engineering and Infection Preventionist immediately that the NAF room is in use.

d. Monitoring of NAF will be done daily by Engineering.

e. Engineering to perform validation testing at the room (tissue test) when patient to be placed in room requiring airborne precautions. For outpatient rooms this will be a one time test. Engineering will document this in their "Isolation Room Log" in Facilities.

f. Nursing to verify and document each shift in the EMR that the patient remains in airborne precautions with an environmental surveillance check of pressure monitor outside of NAF room. Green light on pressure sensor means that negative air pressurization is within established parameters. If red light is on, engineering should be contacted as the pressurization is outside of the set parameters.

g. Daily validation testing (tissue test) will be conducted by engineering during the time that patients remains in air-borne precautions. Engineering will document this in their daily “Isolation Room Log” in facilities.

h. Patient should not leave their room unless absolutely necessary and they must wear a surgical mask and clean clothes.

i. Nursing will notify engineering when the patient no longer requires airborne precautions or is discharged and will document the discontinuance of airborne precautions in the EMR.

Communication Between Engineering and Clinical Staff:

A. All negative air flow rooms are continuously monitored by the Building Automated System (BAS) with alarm parameters established and automated alarm notification to Engineering

B. Engineering will communicate with clinical staff in the impacted area when alarm parameters have been exceeded if patient present in the impacted room. Engineering will take action to restore the ventilation component to the correct relationship.

C. If engineering is unable to restore the air pressure relationships to the defined ranges within 30 minutes after alarm activation they will notify the Unit Manager and Infection Prevention Practitioner to assist clinical staff with a plan of care for the patient while more prolonged efforts are made by engineering to troubleshoot and correct the pressure relationships.

D. Clinical Staff can monitor the pressurization of the NAF room via the pressure monitor outside of each NAF room. If red light appears on pressure monitor clinical staff will notify engineering (if engineering has not already responded to the alarm).

Respiratory Protection:

a. Susceptible persons should not enter the room of patients with suspected or confirmed measles (rubeola), rubella or varicella (chickenpox).

b. Persons immune to measles or varicella need not wear respiratory protection.

c. Only staff who have been identified and fit tested by Employee Health in the use of a TB respirator mask (N95) may enter the room or provide care/services to the patient.

d. Primary choice of respiratory protection for all other staff is the PAPR- Powered Air Purifying Respirator

e. Visitors are to wear the N-95 mask while in the patient room. They are not fit tested.

Airborne Respirator Precautions

Airborne Respirator Precautions is designed to reduce the risk of airborne transmission of tuberculosis. This isolation is used for patients suspected or known to be infected with tuberculosis, which is transmitted by airborne droplet nuclei (small particle residue 5*u*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).

(Refer to TB Exposure Control Plan #8720.5406)

Follow Standard Precautions and the directions on the isolation sign. Specific requirements of Airborne Respirator Precautions:

PRIOR TO PLACEMENT: Reference Facilities Policy: Management of Ventilation Components in Critial Area Environements

Patient Placement:

A. Place the patient in a negative airflow rooms 315, 316, 449, 462 or designated ED rooms 11 & 12 and PACU Bed 5.

B. Nursing to activate the negative air pressure switch where applicable (all NAF rooms except Rooms 315 and 316 which are continuously in negative pressurization), and close the door. It takes approximately 10 minutes for the negative pressurization to be achieved within establisted parameters.

C. .Nursing to notify Engineering and Infection Preventionist immediately that the NAF room is in use.

D. Monitoring of NAF will be done daily by Engineering.

E. Engineering to perform validation testing at the room (tissue test) when patient to be placed in room requiring airborne precautions. For outpatient rooms this will be a one time test. Engineering will document this in their "Isolation Room Log" in Facilities.

F. Nursing to verify and document each shift in the EMR that the patient remains in airborne precautions with an environmental surveillance check of pressure monitor outside of NAF room. Green light on pressure sensor means that negative air pressurization is within established parameters. If red light is on, engineering should be contacted as the pressurization is outside of the set parameters.

G. Daily validation testing (tissue test) will be conducted by engineering during the time that patients remains in air-borne precautions. Engineering will document this in their daily “Isolation Room Log” in facilities.

H. Patient should not leave their room unless absolutely necessary and they must wear a surgical mask and clean clothes.

I. Nursing will notify engineering when the patient no longer requires airborne precautions or is discharged and will document the discontinuance of airborne precautions in the EMR.

Communication Between Engineering and Clinical Staff:

A. All negative air flow rooms are continuously monitored by the Building Automated System (BAS) with alarm parameters established and automated alarm notification to Engineering

B. Engineering will communicate with clinical staff in the impacted area when alarm parameters have been exceeded if patient present in the impacted room. Engineering will take action to restore the ventilation component to the correct relationship.

C. If engineering is unable to restore the air pressure relationships to the defined ranges within 30 minutes after alarm activation they will notify the Unit Manager and Infection Prevention Practitioner to assist clinical staff with a plan of care for the patient while more prolonged efforts are made by engineering to troubleshoot and correct the pressure relationships.

D. Clinical Staff can monitor the pressurization of the NAF room via the pressure monitor outside of each NAF room. If red light appears on pressure monitor clinical staff will notify engineering (if engineering has not already responded to the alarm).

Respiratory Protection:

A. Susceptible persons should not enter the room of patients with suspected or confirmed measles (rubeola), rubella or

varicella (chickenpox).

B. Persons immune to measles or varicella need not wear respiratory protection

C. Only staff who have been identified and fit tested by Employee Health in the use of a TB respirator mask (N95) may enter the room or provide care/services to the patient.

D. Primary choice of respiratory protection for all other staff is the PAPR- Powered Air Purifying Respirator

E. Visitors are to wear the N-95 mask while in the patient room. They are not fit tested.

Duration of Airborne Respirator Precautions:

A. Until the tuberculosis diagnosis is disproved or ruled out by another diagnosis, thechest x-ray is negative or there have been three negative AFB smears.

B. The patient has clinical improvement while on antituberculin drugs:

- Decreased cough and decreasing A.F.B. on sequential sputum smears.

C. Patients with presumptive drug resistant organisms are to remain in AFB isolation for the duration of the hospitalization.

Special Precautions

Precautions defined by Infection Prevention when an infectious agent or modes of transmission are uncertain.

Infection Prevention will create the signage by adding symbols and written special precautions on Special Precautions signs.

Outbreak Management

Infection Prevention and Control may institute Transmission Based Precautions in outbreak situations after an epidemiological assessment.

Outbreaks are defined as:

- two or more facility acquired cases of a significant organism in any unit
- situations that indicate ongoing transmission despite implementation of control measures

Outbreak strategies will be tailored to the situation by Infection Prevention and Control and the Infection Control Committee.

Infection Prevention and Control will notify Risk Management, Administration, Patient Services and Department of Health as appropriate.

REFERENCES:

APIC: **Text of Infection Control and Epidemiology,** 2005.

Washington State DOH House Bill 1123

Washington State Hospital Association- Standardized Isolation System 2008.

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. HICPAC/CDC, 2007.

Table I

STANDARD PRECAUTIONS SUMMARY

Body Fluid/Procedures	Always Requires	Sometimes Requires
SPUTUM & ORAL SECRETIONS • suctioning • coughing patients • pneumonia • bronchitis	• Glove for sputum contact • Hand hygiene after contact and glove removal. • Mask/eye protection for suctioning. • Instruct patient in hand hygiene	• Roommate restriction when patient or roommate has poor personal hygiene. • Mask/eye protection if patient is likely to cough or expectorate in

	and disposal of sputum contained in tissues. • Gown when soiling of clothing is likely.	your face. • Use Airborne Respirator Precautions if diagnosis of TB is suspected.
WOUND DRAINAGE • open skin ulcers • boils • pustular lesions • wounds • wound infections • open non-intact skin • rashes	• Mask/eye protection for irrigation and working over large wounds. • Glove for contact with drainage or open wound. • Hand Hygiene after contact and glove removal. • Gown when soiling of clothing is likely. • Bag soiled linen & dressings. • Instruct pt. in hand hygiene. • Cover draining wounds with dressings.	• Roommate restriction when drainage excessive or if patient or roommates have poor personal hygiene. • Requires Contact Precautions if drainage cannot be contained with dressings.
URINE DRAINAGE • urine incontinence • urinary fistula • catheter drainage • specimen handling	• Gloves for urine contact. • Hand hygiene after contact and glove removal. • Bag urine soaked linen & trash-regular waste stream.	• Roommate restriction when patient or roommate has poor personal hygiene. • Avoid placing patients with bladder catheters in rooms together.
FECES • fecal incontinence • stoma drainage • gallbladder drainage • diarrhea due to any cause	• Glove for fecal contact. • Wash hands with soap and water after contact and after glove removal. • Gown when soiling of clothing is likely. • Bag heavily soiled linen and trash-regular waste stream. • Instruct patient hand washing.	• Roommate restriction when fecal soiling is excessive or if either patient or roommate has poor personal hygiene. • Uncontained fecal incontinence requires Contact Precautions.
BLOOD • GI bleeding • Serosanguinous drainage • CPR • hemoptysis	• Glove for blood contact. • Wash hands after contact and glove removal • Immediately report exposures to E.H. for follow up. • Gowns when soiling of clothing is likely. • Bag bloody linen and trash. • Instruct patient in care of bloody discharge and hand washing. • Staffs to immediately change clothes contaminated with blood.	• Roommate restriction when soiling is excessive or if patient or roommate has poor personal hygiene.

Table 2
TRANSMISSION BASED PRECAUTIONS SUMMARY

Most Frequently Seen Conditions	Precautions to be Instituted
Multidrug Resistant Organisms MDROs	**Contact Precautions**

• MRSA ◦ Inpatient areas-current infection and history of MRSA. ◦ Outpatient areas and ED- use Standard Precautions areas for patient with no current infection. • Vancomycin resistant enterococci-VRE • Resistant gram negative ESBLs, CRE, KPCs Scabies Wounds or abscesses with uncontained drainage RSV in children *(**Contact** + **Droplet** Precautions)	
Acute diarrhea with unknown etiology **C.difficile** (C.diff) Norovirus	**Contact Enteric Precautions** • **Wash hands with soap and water.** • Begin CE Precautions when the test for **C. difficile** is ordered. • C. difficile-Continue CEP until treatment complete and symptoms gone for 48 hours. • Use prepared bleach cloths for cleaning/disinfection of room and equipment
Influenza Meningitis until N. Meningitidis ruled out Pertussis RSV * (**Contact** + **Droplet** Precautions)	**Droplet Precautions** • Wear a mask while in the room. • Mask patient if patient must leave their room or is transferred. • May discontinue isolation for N. meningitidis after 24 hours of appropriate antibiotic therapy.
Chickenpox *Disseminated* herpes zoster (shingles everywhere) Shingles *in immunocompromised persons* Measles (Rubeola)	**Airborne** Contact Precautions • Place patient into rooms 315, 316, 436, 449 or 463 ◦ Activate the NAF system in 436 • Call Engineering to monitor air direction • ONLY those immune can enter room
Pulmonary or laryngeal TB TB	**Airborne** Respirator Precautions • N- 95 mask staff and visitors • PAPRS for staff without a fit test • Patient wears surgical mask for transfers and when out of room**.** • Place patient into negative airflow rooms 315, 316, 436, 449 or 463.

Table 3

Type and Duration of Precautions Needed for Selected Infections and Conditions

C = Contact
D = Droplet
AC = Airborne Contact
CE = Contact Enteric
AR = Airborne Respirator

S = Standard
DI=Duration of Illness

	Precautions	
Infection/Condition/Comments	**Type**	**Duration†**
Abscess		
• Draining, major-no dressing or drainage not contained by dressing	C	DI
• Draining, minor or limited -dressing covers and contains drainage	S	
Acquired immunodeficiency syndrome Reportable to WWCHD 5242650	S	
Actinomycosis-not transmitted person to person	S	
Adenovirus infection, in infants and young children	D,C	DI
Amebiasis- Use care when handling diapered infants and mentally challenged patients.	S	
Anthrax- Reportable immediately WWCHD 5242650 Infected persons do no generally pose a transmission risk.		
• Cutaneous	C	
• Pulmonary	S	
Antibiotic-associated colitis (see *Clostridium difficile*)	CE	Until trmt.completed. S/S gone
Arthropodborne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis) Not transmitted person to person except rarely by transfusion, breast milk or transplacentally.	S	
Arthropodborne viral fevers (dengue, yellow fever, Colorado tick fever) Reportable immediately WWCHD 5242650	S	
Ascariasis –Round Worm NOT TRANSMITTED PERSON TO PERSON	S	
Aspergillosis • AC if massive soft tissue infection with copious drainage with irrigations	S or AC	DI

Babesiosis Not transmitted person to person	S	
Blastomycosis, North American, cutaneous or pulmonary Not transmitted person to person	S	
Botulism NOT TRANSMITTED PERSON TO PERSON Reportable immediately WWCHD 5242650	S	
Bronchiolitis (see respiratory infections in infants and young children)	C, D	DI
Brucellosis (undulant, Malta, Mediterranean fever) Reportable immediately WWCHD 5242650 Not transmittable person to person	S	
Campylobacter gastroenteritis (see gastroenteritis) Reportable immediately WWCHD 5242650	S	
Candidiasis, all forms including mucocutaneous	S	
Cat-scratch fever (benign inoculation lymphoreticulosis) Not transferred person to person.	S	
Cellulitis-minimal to no drainage • uncontrolled drainage requires CP	S	DI
Chancroid (soft chancre) Reportable immediately WWCHD 5242650	S	
Chickenpox (varicella) Non-immune persons should not enter the room. Exposed HCW to report to EH immediately.	AC	Until lesions crusted or 7 days from onset of fever
Chlamydia trachomatis Reportable WWCHD 5242650	S	
Conjunctivitis	S	
Genital	S	
Respiratory	S	
Cholera (see gastroenteritis)	EC	DI
Clostridium		
• *C botulinum* Reportable immediately WWCHD 5242650	S	
• *C difficile*	CE	Until 48 hours after trmt complete and s/s resolved .

• *C perfringens*		
Food poisoning	S	
Gas gangrene	C	DI
Coccidioidomycosis (valley fever) Not Transmitted person to person	S	
• Draining lesions	S	
• Pneumonia	S	
Colorado tick fever Not transmitted person to person	S	
Congenital rubella	C	Infants on precautions for 1 year of age.
Conjunctivitis		
• Acute bacterial	S	
• *Chlamydia*	S	
• Gonococcal	S	
• Acute viral (acute hemorrhagic)	C	DI
Coxsackievirus disease (see enteroviral infection)		
Creutzfeldt-Jakob disease –extra precautions are necessary for handling and decontamination of blood and body fluids.	S	
Croup (see respiratory infections in infants and young children)		
Cryptococcosis Not transmitted person to person.	S	
Cryptosporidiosis (see gastroenteritis) Reportable to WWCHD 5242650	CE	DI
Cysticercosis Not transmitted person to person.	S	
Cytomegalovirus infection (CMV), neonatal or immunosuppressed	S	
Decubitus ulcer, infected		
Major –no dressing or drainage not contained	C	Until drainage stops or can be contained.
Minor or limited-dressing contains drainage	S	
Dengue	S	
Diarrhea, acute-infective etiology suspected (see gastroenteritis)	CE	DI
Diphtheria Reportable immediately WWCHD		

5242650		
• Cutaneous	C	Until 2 cultures negative 24 hours apart
• Pharyngeal	D	Until 2 cultures negative 24 hours apart
Ebola viral hemorrhagic fever Reportable immediately WWCHD 5242650	AC	DI
Echinococcosis (hydatidosis) Not transmitted person to person.	S	
Echovirus (see enteroviral infection)		
Encephalitis or encephalomyelitis (see specific etiologic agents)		
Endometritis	S	
Enterobiasis (pinworm disease, oxyuriasis)	S	
Enterococcus species (see multidrug-resistant organisms if epidemiologically significant or vancomycin resistant)		
Enterocolitis, *Clostridium difficile*	CE	DI
Enteroviral infections		
• Adults	S	
• Infants and young children	C	DI
Epiglottitis, due to *Haemophilus influenzae*	D	Until after 24 hours of appropriate ABX therapy.
Epstein-Barr virus infection, including infectious mononucleosis	S	
Erythema infectiosum (also see Parvovirus B19)	S	
Escherichia coli gastroenteritis (see gastroenteritis) Reportable immediately WWCHD 5242650	S	
Food poisoning		
• Botulism Reportable immediately WWCHD 5242650	S	
• *Clostridium perfringens or welchii*	S	
• Staphylococcal	S	
Furunculosis-staphylococcal		
• Infants and young children	C	DI
• Gangrene (gas gangrene)	S	
Gastroenteritis- Use Contact precautions for diapered or incontinent persons or for outbreaks.		

• *Campylobacter* species Reportable WWCHD 5242650	S	
• Cholera Reportable immediately WWCHD 5242650	S	
• *Clostridium difficile*	CE	Until treatment completed and symptoms gone for 48 hours.
• *Cryptosporidium species*	S	
• Enterohemorrhagic O157:H7 Reportable immediately WWCHD 5242650	S	
• Diapered or incontinent	C	DI
• *Giardia lamblia* Reportable to WWCHD 524265	S	
• Norovirus • Staffs working with patients who are vomiting or persons who clean areas heavily contaminated with feces or vomitus whoud wear a mask. The virus can be aerosolized from these body substances. • Room cleaning should be followed by bleach wiping. • Alcohol hand agents are effective.	CE D	Until symptoms have gone for 48 hours.
• Rotavirus	CE	Until symptoms have gone for 48 hours.
• Diapered or incontinent	CE	
• *Salmonella* species (including *S typhi*) Reportable to WWCHD 5242650	S	
• *Shigella* species Reportable to WWCHD 5242650	S	
• Diapered or incontinent	CE	Until symptoms have gone for 48 hours.
Vibrio parahaemolyticus	S	
Viral (if not covered elsewhere)	S	
Yersinia enterocolitica Reportable to WWCHD 5242650	S	
German measles (see rubella)		
Giardiasis (see gastroenteritis) Reportable to WWCHD 5242650		
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	S	

Gonorrhea Reportable immediately WWCHD 5242650	S	
Granuloma inguinale (donovanosis, granuloma venereum)	S	
Guillain-Barré syndrome	S	
Hand, foot, and mouth disease (see enteroviral infection)		
Hantavirus pulmonary syndrome Reportable immediately WWCHD 5242650	S	
Helicobacter pylori	S	
Hemorrhagic fevers (for example, Lassa and Ebola)	C	DI
Hepatitis, viral Reportable to WWCHD 5242650		
• Type A	C	Contact Precautions 2 weeks after the onset of symptoms
• Diapered or incontinent patients	C	Entire hospitalization
• Type B-HBsAg positive	S	
• Type C and other unspecified non-A, non-B	S	
• Type E	S	
Herpangina (see enteroviral infection)		
Herpes simplex (*Herpesvirus hominis*)		
• Encephalitis	S	
• Neonatal [I] (see F [I] for neonatal exposure) Reportable to WWCHD 5242650	C	DI
• Mucocutaneous, disseminated or primary, severe	C	DI
• Mucocutaneous, recurrent (skin, oral, genital) Genital reportable to WWCHD 5242650	S	
Herpes zoster (varicella-zoster-shingles) HCW who have not had chickenpox should not provide care.		
• Localized in immunocompromised patient, or disseminated	AC	Until lesions crusted.
• Localized in patient with intact immune system	S	

Histoplasmosis Not transmitted person to person.	S	
Hookworm disease (ancylostomiasis, uncinariasis)	S	
Human immunodeficiency virus (HIV) infection Reportable to WWCHD 5242650	S	
Impetigo	C	Until 24 hours after appropriate abx.
Infectious mononucleosis	S	
Influenza • Seasonal • Pandemic	D C, D	5-7 days from onset
Kawasaki syndrome	S	
Lassa fever	C	DI
Legionnaires' disease Reportable to WWCHD 5242650	S	
Leprosy	S	
Leptospirosis Reportable to WWCHD 5242650. Not transmitted person to person	S	
Lice (pediculosis) • Head • Body-transmitted through infected clothing. Gowns/gloves when removing clothing, bag clothing. • Pubic	C C S	Until 24 hours after appropriate abx.
Listeriosis Reportable to WWCHD 5242650	S	
Lyme disease Reportable to WWCHD 5242650	S	
Lymphocytic choriomeningitis Not transmitted person to person	S	
Lymphogranuloma venereum Reportable to WWCHD 5242650	S	
Malaria Reportable to WWCHD 5242650	S	
Marburg virus disease	C	DI
Measles (rubeola), all presentations Susceptible HCW should not enter the room or provide care. Exposed HCW report immediately to EH.	AC	DI 4 days after onset of rash
Melioidosis, all forms Not transmitted person to person	S	
Meningitis –Use Droplet Precautions until **Neisseria meningitidis** ruled out		

• Aseptic (nonbacterial or viral meningitis; also see enteroviral infections)	S	
• Bacterial, gram-negative enteric, in neonates	S	
• Fungal	S	
• *Haemophilus influenzae*, known or suspected	D	Until 24 hours after appropriate abx.
• *Listeria monocytogenes*	S	
• *Neisseria meningitidis* (meningococcal) known or suspected Reportable immediately WWCHD 5242650	D	Until 24 hours after appropriate abx.
• Pneumococcal	S	
• M. tuberculosis Concurrent active pulmonary disease or draining lesions require AR Reportable to WWCHD 5242650	S	
• Other diagnosed bacterial	S	
Molluscum contagiosum	S	
Monkey Pox Reportable immediately WWCHD 5242650	AC	Until small pox ruled out or lesions crusted.
Mucormycosis	S	
Multidrug-resistant organisms, infection or colonization [p] MRSA VRE ESBL Pen resistant **S. pneumoniae** • MRSA pneumonia requires Contract and Droplet *Outpatient areas and ED use Standard Precautions for colonization and Contact Precautions for active infections.	C C,D	Precautions continue until discharge and for readmissions.
Mumps (infectious parotitis) Reportable WWCHD 5242650 Non immune HCW should not provide care to patient.	D	Until after 9 days from the onset of swelling.
Mycobacteria, **nontuberculosis** (atypical)		
• Pulmonary	S	
• Wound	S	
Mycoplasma pneumonia	D	DI

Necrotizing enterocolitis Contact Precautions if outbreak	S	
Nocardiosis, draining lesions or other presentations	S	
Norwalk agent gastroenteritis (see viral gastroenteritis)	CE	DI
Orf	S	
Parainfluenza virus infection, respiratory in infants and young children	C	DI
Parvovirus B19 Erythema infection	D	DI If patient is immunodeficient, otherwise for 7 days.
Pediculosis (lice)	C	Until 24 hours after appropriate therapy.
Pertussis (whooping cough) Reportable immediately WWCHD 5242650	D	Single pt. room. Maintain precautions for 5 days after abx.
Pinworm infection	S	
Plague		
• Bubonic	S	
• Pneumonic	D	Until 72 hours after appropriate abx.
Pleurodynia (see enteroviral infection)		
Pneumonia		
• Adenovirus	C, D	DI
• Bacterial not listed elsewhere (including gram-negative bacterial)	S	
• *Burkholderia cepacia* in cystic fibrosis (CF) patients, including respiratory tract colonization	S	
• *Chlamydia*	S	
• Fungal	S	
• *Haemophilus influenzae*		
• Adults	S	
• Infants and children (any age)	D	Until 24 hours after appropriate abx.
• *Legionella*	S	
• Meningococcal Reportable immediately WWCHD 5242650	D	Until 24 hours after appropriate abx.
• Multidrug-resistant bacterial (see multidrug-resistant organisms)	C,D	

• *Mycoplasma* (primary atypical pneumonia)	D	DI
• Pneumococcal	S	
• *Pneumocystis carinii*	S	
• *Pseudomonas cepacia* (see *Burkholderia cepacia*)	S	
• *Staphylococcus aureus*	S	
• *Streptococcus*, group A		
• Adults- C if lesions also present.	S	
• Infants and young children	D	Until 24 hours after appropriate abx.
• Viral		
• Adults	S	
• Infants and young children (see respiratory infectious disease, acute)		
Poliomyelitis Reportable to WWCHD 5242650	C	
Psittacosis (ornithosis) Not transmitted person to person.	S	
Q fever	S	
Rabies Reportable immediately WWCHD 5242650	S	
Rat-bite fever (*Streptobacillus moniliformis* disease, *Spirillum minus* disease) Not transmitted person to person.	S	
Relapsing fever Reportable to WWCHD 5242650	S	
Resistant bacterial infection or colonization (see multidrug-resistant organisms)	C	
Respiratory infectious disease, acute (if not covered elsewhere)		
• Adults	S	
• Infants and young children	C, D	Until RSV and Influenza ruled out.
Respiratory syncytial virus (RSV) infection, in infants and young children, and immunocompromised adults	C, D	DI
Reye's syndrome	S	

Rheumatic fever	S	
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne typhus fever)	S	CP for outbreaks.
Rickettsialpox (vesicular rickettsiosis)	S	
Ringworm (dermatophytosis, dermatomycosis, tinea)	S	
Ritter's disease (staphylococcal scalded skin syndrome)	S	
Rocky Mountain spotted fever	S	
Roseola infantum (exanthem subitum)	S	
Rotavirus infection (see gastroenteritis)		
Rubella (German measles; also see congenital rubella) Reportable immediately WWCHD 5242650 Susceptible HCW should not enter room. Pregnant women who are not immune should not care for these patients. Exposed susceptible HCW should report immediately to Employee Health.	AC	Until 7 days after rash presents.
Salmonellosis (see gastroenteritis) Reportable to WWCHD 5242650	S	
SARS (Severe Acute Respiratory Syndrome)	AC, D	DI Plus 10 days after resolution of symptoms.
Scabies	C	Until 24 hours after appropriate abx.
Scalded skin syndrome, staphylococcal (Ritter's disease)	C	DI
Schistosomiasis (bilharziasis)	S	
Shigellosis (see gastroenteritis) Reportable to WWCHD 5242650 Contact for incontinent patients and infants.	S	DI
Shingles-see Varicella Zoster		
Small pox (Variola) Reportable to WWCHD 5242650 Emergency Operations Plan	AR, C	Until all scabs have crusted (3-4 weeks). N-95
Shigella-see gastroenteritis		
Sporotrichosis	S	
Spirillum minus disease (rat-bite fever)	S	
Staphylococcal disease (*S aureus*)		
• Skin, wound, or burn		
• Major	C	DI

• Minor or limited	S	
• Enterocolitis	S	
• Multidrug-resistant (see multidrug-resistant organisms)	C	
• Pneumonia	S	
• Scalded skin syndrome	C	
• Toxic shock syndrome	S	
Streptobacillus moniliformis disease (rat-bite fever)	S	
Streptococcal disease (group A streptococcus)		
• Skin, wound, or burn		
• Major No dressing or does not contain drainage	C, D	Until 24 hours after appropriate abx.
• Minor or limited	S	
• Endometritis (puerperal sepsis)	S	
• Pharyngitis in infants and young children	D	Until 24 hours after appropriate abx.
• Pneumonia in infants and young children	D	Until 24 hours after appropriate abx.
• Scarlet fever in infants and young children	D	Until 24 hours after appropriate abx.
Streptococcal disease (group B streptococcus), neonatal	S	
Streptococcal disease (not group A or B) unless covered elsewhere	S	
Syphilis Reportable to WWCHD 5242650		
• Skin and mucous membrane, including congenital, primary, secondary	S	
• Latent (tertiary) and seropositivity without lesions	S	
Tapeworm disease		
• *Hymenolepis nana*	S	
• *Taenia solium* (pork)	S	
• Other	S	

Tetanus Reportable immediately WWCHD 5242650	S	
Tinea (fungus infection dermatophytosis, dermatomycosis, ringworm)	S	
Toxoplasmosis	S	
Toxic shock syndrome (staphylococcal disease)	D	Until 24 hours after appropriate abx.
Trachoma, acute	S	
Trench mouth (Vincent's angina)	S	
Trichinosis Reportable to WWCHD 5242650	S	
Trichomoniasis Reportable to WWCHD 5242650	S	
Trichuriasis (whipworm disease)	S	
Tuberculosis Reportable to WWCHD 5242650	AR	
• Extrapulmonary, draining lesion (including scrofula) Patient should be examined for evidence of active pulmonary tuberculosis and AR precautions used if evidence exists.	C	Discontinue when pt. improving clinically draining ceases.
• Extrapulmonary, no draining lesions or meningitis	S	
• Pulmonary, confirmed or suspected or laryngeal disease • MASK PATIENT FOR TRANSPORT • PLACE PATIENT IN NEGATIVE AIRFLOW ROOM 315, 316 or 436	AR	Discontinue after 3 neg. AFBs or on therapy with improved symptoms and decreasing AFBs
• Skin-test positive with no evidence of current pulmonary disease	S	
Tularemia Reportable to WWCHD 5242650		
• Draining lesion	S	
• Pulmonary	S	
Typhoid (*Salmonella typhi*) fever (see gastroenteritis)		
Typhus, endemic and epidemic	S	
Urinary tract infection (including pyelonephritis), with or without urinary	S	

catheter		
Varicella Zoster (chickenpox) HCW who are susceptible should not enter the room.	AC	Until all lesions are dry and crusted
West Nile Virus Reportable to WWCHD 5242650	S	
Vibrio parahaemolyticus (see gastroenteritis)		
Vincent's angina (trench mouth)	S	
Viral diseases		
• Respiratory (if not covered elsewhere)		
• Adults	S	
• Infants and young children (see respiratory infectious disease, acute)		
VRE	C	Entire stay and readmits.
Whooping cough (pertussis) Reportable immediately WWCHD 5242650	D	
Wound infections		
• Major –Drainage not contained or wound cannot be covered.	C	DI
• Minor or limited	S	
Yersinia enterocolitica gastroenteritis (see gastroenteritis) Reportable to WWCHD 5242650		
Zoster (varicella-zoster-Shingles) HCW susceptible to chickenpox are also at risk for developing varicella when exposed to patients with herpes zoster lesions and should not enter the room.		
• Localized in immunocompromised patient or disseminated	AC	DI
• Localized in normal patient	S	
Zygomycosis (phycomycosis, mucormycosis)	S	

Attachments:

Isolation Precautions

Approval Signatures

Approver	Date
Yvonne Strader: VP CNO St Mary Med Center	01/2015
Elizabeth Bowen: Qual Analyst/Infectn Prevnt Rn	01/2015

Applicability

WA - Providence St. Mary MC