



III. Precautions to Prevent Transmission of Infectious Agents

ISOLATION PRECAUTIONS GUIDELINE
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Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)

AT A GLANCE

Precautions to prevent transmission of infectious agents from the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007).

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Overview

See also [Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings](#).

There are two tiers of HICPAC/CDC precautions to prevent transmission of infectious agents, Standard Precautions and Transmission-Based Precautions. Standard Precautions are intended to be applied to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. **Implementation of *Standard Precautions* constitutes the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel.** Transmission-Based Precautions are for patients who are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. Since the infecting agent often is not known at the time of admission to a healthcare facility, Transmission-Based Precautions are used empirically, according to the clinical syndrome and the likely etiologic agents at the time, and then modified when the pathogen is identified or a transmissible infectious etiology is ruled out. Examples of this syndromic approach are presented in [Table 2](#). The HICPAC/CDC Guidelines also include recommendations for creating a Protective Environment for allogeneic HSCT patients.

The specific elements of Standard and Transmission-Based Precautions are discussed in Part II of this guideline. In Part III, the circumstances in which Standard Precautions, Transmission-Based Precautions, and a Protective Environment are applied are discussed. See [Tables 4](#) and [5](#) for summaries of the key elements of these sets of precautions.

III.A. Standard Precautions

Standard Precautions combine the major features of Universal Precautions (UP) ^{780, 896} and Body Substance Isolation (BSI) ⁶⁴⁰ and are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered ([Table 4](#)). These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious

agents (e.g., wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

The application of Standard Precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. For some interactions (e.g., performing venipuncture), only gloves may be needed; during other interactions (e.g., intubation), use of gloves, gown, and face shield or mask and goggles is necessary. Education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions because they facilitate appropriate decision-making and promote adherence when HCWs are faced with new circumstances.^{655, 681-686} An example of the importance of the use of Standard Precautions is intubation, especially under emergency circumstances when infectious agents may not be suspected, but later are identified (e.g., SARS-CoV, *N. meningitidis*). The application of Standard Precautions is described below and summarized in [Table 4](#). Guidance on donning and removing gloves, gowns and other PPE is presented in the [Figure](#).

Standard Precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or via equipment used during patient care.

III.A.1. New elements of standard precautions.

Infection control problems that are identified in the course of outbreak investigations often indicate the need for new recommendations or reinforcement of existing infection control recommendations to protect patients. Because such recommendations are considered a standard of care and may not be included in other guidelines, they are added here to Standard Precautions. Three such areas of practice that have been added are: Respiratory Hygiene/Cough Etiquette, safe injection practices, and use of masks for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia). While most elements of Standard Precautions evolved from Universal Precautions that were developed for protection of healthcare personnel, these new elements of Standard Precautions focus on protection of patients.

III.A.1.a. Respiratory hygiene/cough etiquette.

The transmission of SARS-CoV in emergency departments by patients and their family members during the widespread SARS outbreaks in 2003 highlighted the need for vigilance and prompt implementation of infection control measures at the first point of encounter within a healthcare setting (e.g., reception and triage areas in emergency departments, outpatient clinics, and physician offices).^{21, 254, 897} The strategy proposed has been termed Respiratory Hygiene/Cough Etiquette^{9, 828} and is intended to be incorporated into infection control practices as a new component of Standard Precautions. The strategy is targeted at patients and accompanying family members and friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering a healthcare facility.^{40, 41, 43} The term *cough etiquette* is derived from recommended source control measures for *M. tuberculosis*.^{12, 126}

The elements of Respiratory Hygiene/Cough Etiquette include

1. education of healthcare facility staff, patients, and visitors;
2. posted signs, in language(s) appropriate to the population served, with instructions to patients and accompanying family members or friends;
3. source control measures (e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate);
4. hand hygiene after contact with respiratory secretions; and
5. spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible.

Covering sneezes and coughs and placing masks on coughing patients are proven means of source containment that prevent infected persons from dispersing respiratory secretions into the air.^{107, 145, 898, 899} Masking may be difficult in some settings, (e.g., pediatrics, in which case, the emphasis by necessity may be on cough etiquette.⁹⁰⁰ Physical proximity of <3 feet has been associated with an increased risk for transmission of infections via the droplet route (e.g., *N. meningitidis*¹⁰³ and group A streptococcus¹¹⁴ and therefore supports the practice of distancing infected persons from others who are not infected. The effectiveness of good hygiene practices, especially hand hygiene, in preventing transmission of viruses and reducing the incidence of respiratory infections both within and outside⁹⁰¹⁻⁹⁰³ healthcare settings is summarized in several reviews.^{559, 717, 904}

These measures should be effective in decreasing the risk of transmission of pathogens contained in large respiratory droplets (e.g., influenza virus,²³ adenovirus,¹¹¹ *B. pertussis*⁸²⁷ and *Mycoplasma pneumoniae*.¹¹² Although fever will be present in many respiratory infections, patients with pertussis and mild upper respiratory tract infections are often afebrile. Therefore, the absence of fever does not always exclude a

respiratory infection. Patients who have asthma, allergic rhinitis, or chronic obstructive lung disease also may be coughing and sneezing. While these patients often are not infectious, cough etiquette measures are prudent.

Healthcare personnel are advised to observe Droplet Precautions (i.e., wear a mask) and hand hygiene when examining and caring for patients with signs and symptoms of a respiratory infection. Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a mask should be worn while providing patient care.

III.A.1.b. Safe injection practices.

The investigation of four large outbreaks of HBV and HCV among patients in ambulatory care facilities in the United States identified a need to define and reinforce safe injection practices.⁴⁵³ The four outbreaks occurred in a private medical practice, a pain clinic, an endoscopy clinic, and a hematology/oncology clinic. The primary breaches in infection control practice that contributed to these outbreaks were

1. reinsertion of used needles into a multiple-dose vial or solution container (e.g., saline bag) and
2. use of a single needle/syringe to administer intravenous medication to multiple patients.

In one of these outbreaks, preparation of medications in the same workspace where used needle/syringes were dismantled also may have been a contributing factor. These and other outbreaks of viral hepatitis could have been prevented by adherence to basic principles of aseptic technique for the preparation and administration of parenteral medications.^{453, 454} These include the use of a sterile, single-use, disposable needle and syringe for each injection given and prevention of contamination of injection equipment and medication. Whenever possible, use of single-dose vials is preferred over multiple-dose vials, especially when medications will be administered to multiple patients.

Outbreaks related to unsafe injection practices indicate that some healthcare personnel are unaware of, do not understand, or do not adhere to basic principles of infection control and aseptic technique. A survey of US healthcare workers who provide medication through injection found that 1% to 3% reused the same needle and/or syringe on multiple patients.⁹⁰⁵ Among the deficiencies identified in recent outbreaks were a lack of oversight of personnel and failure to follow-up on reported breaches in infection control practices in ambulatory settings. Therefore, to ensure that all healthcare workers understand and adhere to recommended practices, principles of infection control and aseptic technique need to be reinforced in training programs and incorporated into institutional policies that are monitored for adherence.⁴⁵⁴

III.A.1.c. Infection Control Practices for Special Lumbar Puncture Procedures.

In 2004, CDC investigated eight cases of post-myelography meningitis that either were reported to CDC or identified through a survey of the Emerging Infections Network of the Infectious Disease Society of America. Blood and/or cerebrospinal fluid of all eight cases yielded streptococcal species consistent with oropharyngeal flora and there were changes in the CSF indices and clinical status indicative of bacterial meningitis. Equipment and products used during these procedures (e.g., contrast media) were excluded as probable sources of contamination. Procedural details available for seven cases determined that antiseptic skin preparations and sterile gloves had been used. However, none of the clinicians wore a face mask, giving rise to the speculation that droplet transmission of oropharyngeal flora was the most likely explanation for these infections. Bacterial meningitis following myelogram and other spinal procedures (e.g., lumbar puncture, spinal and epidural anesthesia, intrathecal chemotherapy) has been reported previously.⁹⁰⁶⁻⁹¹⁵ As a result, the question of whether face masks should be worn to prevent droplet spread of oral flora during spinal procedures (e.g., myelogram, lumbar puncture, spinal anesthesia) has been debated.^{916, 917} Face masks are effective in limiting the dispersal of oropharyngeal droplets⁹¹⁸ and are recommended for the placement of central venous catheters.⁹¹⁹ In October 2005, the Healthcare Infection Control Practices Advisory Committee (HICPAC) reviewed the evidence and concluded that there is sufficient experience to warrant the additional protection of a face mask for the individual placing a catheter or injecting material into the spinal or epidural space.

III.B. Transmission-Based Precautions

There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions. Transmission-Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. For some diseases that have multiple routes of transmission (e.g., SARS), more than one Transmission-Based Precautions category may be used. When used either singly or in combination, they are always used in addition to Standard Precautions. See Appendix A for recommended precautions for specific infections. When Transmission-Based Precautions are indicated, efforts must be made to counteract possible adverse effects on patients (i.e., anxiety, depression and other mood disturbances,⁹²⁰⁻⁹²² perceptions of stigma,⁹²³ reduced contact with clinical staff,⁹²⁴⁻⁹²⁶ and increases in preventable adverse events⁵⁶⁵ in order to improve acceptance by the patients and adherence by HCWs.

III.B.1. Contact precautions.

Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment as described in I.B.3.a. The specific agents and circumstance for which Contact Precautions are indicated are found in Appendix A. The application of Contact Precautions for patients infected or colonized with MDROs is described in the 2006 [HICPAC/CDC MDRO guideline](#).⁹²⁷ Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission. A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, ≥ 3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, *C. difficile*, noroviruses and other intestinal tract pathogens; RSV).^{54, 72, 73, 78, 274, 275, 740}

III.B.2. Droplet precautions.

Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions as described in I.B.3.b. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission. Infectious agents for which Droplet Precautions are indicated are found in Appendix A and include *B. pertussis*, influenza virus, adenovirus, rhinovirus, *N. meningitides*, and group A streptococcus (for the first 24 hours of antimicrobial therapy). A single patient room is preferred for patients who require Droplet Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). Spatial separation of ≥ 3 feet and drawing the curtain between patient beds is especially important for patients in multi-bed rooms with infections transmitted by the droplet route. Healthcare personnel wear a mask (a respirator is not necessary) for close contact with infectious patient; the mask is generally donned upon room entry. Patients on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene/Cough Etiquette.

III.B.3. Airborne precautions.

Interim Measles Infection Control [July 2019]

See [Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings](#)



Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], *M. tuberculosis*, and possibly SARS-CoV) as described in I.B.3.c and Appendix A. The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR). An AIIR is a single-patient room that is equipped with special air handling and ventilation capacity that meet the American Institute of Architects/Facility Guidelines Institute (AIA/FGI) standards for AIIRs (i.e., monitored negative pressure relative to the surrounding area, 12 air exchanges per hour for new construction and renovation and 6 air exchanges per hour for existing facilities, air exhausted directly to the outside or recirculated through HEPA filtration before return).^{12, 13} Some states require the availability of such rooms in hospitals, emergency departments, and nursing homes that care for patients with *M. tuberculosis*. A respiratory protection program that includes education about use of respirators, fit-testing, and user seal checks is required in any facility with AIIRs. In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned to the home environment, as deemed medically appropriate. Healthcare personnel caring for patients on Airborne Precautions wear a mask or respirator, depending on the disease-specific recommendations (Respiratory Protection II.E.4, [Table 2](#), and Appendix A), that is donned prior to room entry. Whenever possible, non-immune HCWs should not care for patients with vaccine-preventable airborne diseases (e.g., measles, chickenpox, and smallpox).

III.C. Syndromic and Empiric Applications of Transmission-Based Precautions

Diagnosis of many infections requires laboratory confirmation. Since laboratory tests, especially those that depend on culture techniques, often require two or more days for completion, Transmission-Based Precautions must be implemented while test results are pending based on the

clinical presentation and likely pathogens. Use of appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs of transmissible infection, or arrives at a healthcare facility for care, reduces transmission opportunities. While it is not possible to identify prospectively all patients needing Transmission-Based Precautions, certain clinical syndromes and conditions carry a sufficiently high risk to warrant their use empirically while confirmatory tests are pending ([Table 2](#)). Infection control professionals are encouraged to modify or adapt this table according to local conditions.

III.D. Discontinuation of Transmission-Based Precautions

Transmission-Based Precautions remain in effect for limited periods of time (i.e., while the risk for transmission of the infectious agent persists or for the duration of the illness (Appendix A). For most infectious diseases, this duration reflects known patterns of persistence and shedding of infectious agents associated with the natural history of the infectious process and its treatment. For some diseases (e.g., pharyngeal or cutaneous diphtheria, RSV), Transmission-Based Precautions remain in effect until culture or antigen-detection test results document eradication of the pathogen and, for RSV, symptomatic disease is resolved. For other diseases, (e.g., *M. tuberculosis*) state laws and regulations, and healthcare facility policies, may dictate the duration of precautions¹²). In immunocompromised patients, viral shedding can persist for prolonged periods of time (many weeks to months) and transmission to others may occur during that time; therefore, the duration of contact and/or droplet precautions may be prolonged for many weeks.^{500, 928-933}

The duration of Contact Precautions for patients who are colonized or infected with MDROs remains undefined. MRSA is the only MDRO for which effective decolonization regimens are available.⁸⁶⁷ However, carriers of MRSA who have negative nasal cultures after a course of systemic or topical therapy may resume shedding MRSA in the weeks that follow therapy.^{934, 935} Although early guidelines for VRE suggested discontinuation of Contact Precautions after three stool cultures obtained at weekly intervals proved negative,⁷⁴⁰ subsequent experiences have indicated that such screening may fail to detect colonization that can persist for >1 year.^{27, 936-938} Likewise, available data indicate that colonization with VRE, MRSA,⁹³⁹ and possibly MDR-GNB, can persist for many months, especially in the presence of severe underlying disease, invasive devices, and recurrent courses of antimicrobial agents.

It may be prudent to assume that MDRO carriers are colonized permanently and manage them accordingly. Alternatively, an interval free of hospitalizations, antimicrobial therapy, and invasive devices (e.g., 6 or 12 months) before reculturing patients to document clearance of carriage may be used. Determination of the best strategy awaits the results of additional studies. See the 2006 HICPAC/CDC MDRO guideline⁹²⁷ for discussion of possible criteria to discontinue Contact Precautions for patients colonized or infected with MDROs.

III.E. Application of Transmission-Based Precautions in Ambulatory and Home Care Settings

Although Transmission-Based Precautions generally apply in all healthcare settings, exceptions exist. For example, in home care, AIIRs are not available. Furthermore, family members already exposed to diseases such as varicella and tuberculosis would not use masks or respiratory protection, but visiting HCWs would need to use such protection. Similarly, management of patients colonized or infected with MDROs may necessitate Contact Precautions in acute care hospitals and in some LTCFs when there is continued transmission, but the risk of transmission in ambulatory care and home care, has not been defined. Consistent use of Standard Precautions may suffice in these settings, but more information is needed.

III.F. Protective Environment

A Protective Environment is designed for allogeneic HSCT patients to minimize fungal spore counts in the air and reduce the risk of invasive environmental fungal infections (see [Table 5](#) for specifications).^{11, 13-15} The need for such controls has been demonstrated in studies of aspergillus outbreaks associated with construction.^{11, 14, 15, 157, 158} As defined by the American Institute of Architecture¹³ and presented in detail in the Guideline for Environmental Infection Control 2003,^{11, 861} air quality for HSCT patients is improved through a combination of environmental controls that include

1. HEPA filtration of incoming air;
2. directed room air flow;
3. positive room air pressure relative to the corridor;
4. well-sealed rooms (including sealed walls, floors, ceilings, windows, electrical outlets) to prevent flow of air from the outside;

- 5. ventilation to provide ≥12 air changes per hour;
- 6. strategies to minimize dust (e.g., scrubbable surfaces rather than upholstery⁹⁴⁰ and carpet,⁹⁴¹ and routinely cleaning crevices and sprinkler heads); and
- 7. prohibiting dried and fresh flowers and potted plants in the rooms of HSCT patients.

The latter is based on molecular typing studies that have found indistinguishable strains of *Aspergillus terreus* in patients with hematologic malignancies and in potted plants in the vicinity of the patients.⁹⁴²⁻⁹⁴⁴ The desired quality of air may be achieved without incurring the inconvenience or expense of laminar airflow.^{15, 157} To prevent inhalation of fungal spores during periods when construction, renovation, or other dust-generating activities that may be ongoing in and around the health-care facility, it has been advised that severely immunocompromised patients wear a high-efficiency respiratory-protection device (e.g., an N95 respirator) when they leave the Protective Environment^{11, 14, 945}). The use of masks or respirators by HSCT patients when they are outside of the Protective Environment for prevention of environmental fungal infections in the absence of construction has not been evaluated. A Protective Environment does not include the use of barrier precautions beyond those indicated for Standard and Transmission-Based Precautions. No published reports support the benefit of placing solid organ transplants or other immunocompromised patients in a Protective Environment.

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Part IV: Recommendations

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