



System Infection Prevention

POLICY/GUIDELINE TITLE: Patients on Precautions	CLINICAL POLICY AND PROCEDURE MANUAL
POLICY #: INF.1129	CATEGORY: Infection Prevention
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GENERAL STATEMENT OF PURPOSE

The purpose of this policy is to outline a process for placing patients on precautions to minimize transmission of pathogens that cause infection and/or disease.

POLICY

It is the responsibility of health care personnel (HCP) to minimize the risk of spread of facility-acquired infection. Attachment A, “Patient Isolation Precaution Guidelines” outlines guidelines to minimize the transmission of diseases and other potentially harmful pathogens.

When hospital admissions exceed bed capacity, and it is challenging to place patients with select resistant organisms on precautions, a risk assessment should be conducted by Infection Prevention and Infectious Disease. Once the risk assessment is completed, a determination will be made to modify the current precaution and isolation guidelines to assist with hospital admissions, the increased demand to beds, and the demand for precautions.

SCOPE

This policy applies to all Northwell Health employees, as well as medical staff, volunteers, students, trainees, physician office staff, contractors, trustees and other persons performing work for or at Northwell Health; faculty and students of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell conducting research on behalf of the Zucker School of Medicine on or at any Northwell Health facility; and the faculty and students of the Hofstra Northwell School of Graduate Nursing and Physician Assistant Studies.

DEFINITIONS

Three elements must be present in every case in order for an infection to spread within the hospital: A source of an infecting agent, a means of transmission for that agent, and a susceptible host.

A. SOURCE OF INFECTION:

An infectious agent can be transmitted by a patient, visitor, or a hospital employee with an illness, or who carries an infectious agent. Infection can also be transmitted by inanimate objects in the environment that have become contaminated, such as food and equipment, furniture, or by inadequately cleaned air.

B. MEANS OF TRANSMISSION:

There are four main routes for the transmission of microorganisms. They are contact, vehicle, airborne and vector-borne. It is important to note that some organisms can spread by more than one route. The differences of infectivity and the mode of transmission of various agents form the basis for the categories of isolation and precautions that are explained later in this policy.

- I. The **CONTACT ROUTE** can be divided into three subgroups:
 - A. Direct contact (the physical transfer of the organism directly from an infected person to a susceptible host), may occur between patient and hospital personnel during such procedures as giving baths, rubs, changing dressings or other duties requiring physical contact. Direct contact can also take place between two patients. Finally, the patient's own endogenous bacterial flora (auto-infection) can be directly infectious.
 - B. Indirect contact can occur when the susceptible host interacts with contaminated inanimate articles in the environment such as equipment, furniture, bed linens, clothing, instruments, dressings, etc.
 - C. Airborne spread occurs by transmitting an infectious agent in the form of droplets from an infected person who coughs, sneezes, or talks to the susceptible host. These droplets may then come in contact with the conjunctiva, nose or mouth. This is considered a contact infection because of the close physical proximity necessary - droplets usually travel no more than three feet.
- II. The **VEHICLE ROUTE** applies to diseases transmitted through:
 - A. Contaminated food; (salmonellosis)
 - B. Contaminated water; (shigellosis)
 - C. Contaminated drugs; (pseudomonas infections resulting from contaminated ophthalmologic ointment)
 - D. Contaminated blood; (hepatitis)
- III. **AIRBORNE** - Transmission occurs through the dissemination of either droplet nuclei: (the residue of evaporated droplets that may remain suspended in the air for a long period of time) or dust particles containing the infectious agent. Organisms carried in this manner may be inhaled or deposited upon the susceptible host.

- IV. **VECTORBORNE** - Transmission is of considerably less significance in the United States than in other countries; one example is Malaria transmitted by mosquito.

C. HOST:

In order for infection to occur there must be a susceptible host. Individual resistance to pathogenic microorganism varies markedly. Persons with diabetes mellitus, lymphomas, leukemia, neoplasia, agranulocytosis, and uremia, and those being treated with certain antibiotics, corticosteroids, irradiation or immunosuppressive agents, are particularly prone to infection. Age, debilitating disease, shock, coma and accidental or surgical trauma also increase susceptibility to infection. Host factors explain why some individuals are resistant to colonization by infectious agents while others exposed to the same agent may establish a commensal relationship and become healthy carriers and still others may develop clinical disease.

The procedures set forth in this policy, attempt to balance the disadvantages of isolation against the hazards posed by the various communicable diseases, and to prevent the spread of infections among our patients, visitors, and personnel.

PROCEDURE/GUIDELINES:

Attachment A “Patient Isolation Precaution Guidelines” should be utilized to minimize the risk for transmission of communicable diseases and/or harmful pathogens.

CLINICAL REFERENCES/PROFESSIONAL SOCIETY GUIDELINES

N/A

REFERENCES TO REGULATIONS and/or OTHER RELATED POLICIES

1. Joint Commission Surveillance, Prevention and Control of Infections
2. New York State Department of Health 405.11
3. CDC HIC PAC: Guideline for Isolation Precautions in Hospitals, 2007. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, **June 2007** <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>.

FORMS

N/A

ATTACHMENTS

[Attachment A](#) – Patient Precaution Guidelines

[Attachment A-1](#) - Patient Precaution Guidelines: Clinical Syndrome or Condition

[Attachment A-2](#)- Patient Precaution Guidelines: Disease Specific Isolation Precautions

[Attachment A-3](#) – Contact Precaution Guidelines for Multi-Drug Resistant Organisms (MDRO) and *Clostridium Difficile*

[Attachment A-4](#) - Patient Isolation Precaution Guidelines for Respiratory Viral Illnesses in Adult Patients

APPROVAL:	
System Clinical P&P Committee	10/28/15
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Standardized Versioning History:

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Patient Precaution Guidelines

A. PRINCIPLES OF ISOLATION:

Isolation precautions are designed to prevent the spread of microorganisms among patients, personnel, and visitors. Since agent and host factors are difficult to control, interruption of the chain of infection in the hospital is directed primarily at transmission. The isolation precautions recommended in this guideline are based on this concept.

There are two (2) tiers of precautions:

I. Standard Precautions:

- A. Designed for the care of all patients regardless of their diagnosis or presumed infection status
- B. The use of Standard Precautions combines the major elements of Universal 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).

II. Transmission - Based Precautions:

- A. Used for patients known or suspected to be infected or colonized with epidemiologically important pathogens that can be transmitted by airborne or droplet transmission or by contact with dry skin or contaminated surfaces.
- B. There are three (3) types of transmission - based Precautions:
 - 1. Airborne Precautions
 - 2. Droplet Precautions
 - 3. Contact Precautions

They may be combined for diseases that have multiple routes of transmission. When used singularly or in combination, they are to be used in addition to Standard Precautions.

In general, it is safer to over-isolate than to under-isolate, particularly when the diagnosis is uncertain and several diseases are being considered. For the patients who appear to have a disease requiring isolation precaution, it is important to institute appropriate precautions immediately rather than wait for confirmation of the diagnosis.

Isolation precautions also may have to be modified for a patient who needs constant care or whose clinical condition may require emergency intervention such as those in intensive care units or nurseries. When such modifications are made, it is essential that the risk to other patients or hospital personnel of acquiring nosocomial infection be minimized.

B. RESPONSIBILITIES FOR CARRYING OUT PRECAUTIONS

The facility is responsible for ensuring that patients are placed on appropriate precautions. All personnel including physicians, nurses, technicians, students, and others are responsible

for complying with precautions. The physician or nurse providing care for the patient shall explain the appropriate precautions to the patient and document accordingly. Epidemiology/Infection Prevention can be contacted to assist with education.

C. STANDARD PRECAUTIONS

- I. Standard Precautions apply to:
 - A. Blood
 - B. All body fluids, secretions and excretions, except sweat, whether or not they contain visible blood
 - C. non-intact skin
 - D. mucous membranes

- II. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

A. Key components of Standard Infection Control Precautions:

I. Hand Hygiene - the single most important measure to reduce the risks of transmitting microorganisms from one person to another. 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 patient contact and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. Wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites. Use a plain, non-antimicrobial soap for routine hand washing. **Alcohol gel is appropriate for hand antisepsis before and after patient care, except when hands are visibly soiled.**

1. **Gloves:**

- a. Wear clean, non-sterile gloves when touching blood, body fluids, secretions, excretions, and contaminated items, before touching mucous membranes and non-intact skin.
- b. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.
- c. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another patient. **WASH HANDS** immediately to avoid transfer of microorganisms to other patients and environments.

2. **Masks, Eye Protection, Face Shields:**

Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes nose and mouth during procedures and patient care activities that are likely to

generate splashes or sprays of blood, body fluids, secretions and excretions.

3. **Gowns:**

Wear a clean impervious gown to protect skin and to prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood. Remove soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments.

4. **Patient Care Equipment:**

Handle used patient care 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 patients and environments. Reusable equipment should be cleaned and reprocessed appropriately prior to use on another patient. Single use items should be discarded.

5. **Environmental Control:**

The hospital has adequate procedures to ensure cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces, and insures that these procedures are being followed.

- a. Cleaning shall primarily be directed toward those items that have been in direct contact with the patient or in contact with the patient's infective material.
- b. Disinfectant solution used for terminal cleaning shall be made according to manufacturer guidelines.
- c. Housekeeping personnel shall use the same precautions to protect themselves during cleaning that they would use if the patient were still in the room.
- d. All non-disposable critical items shall be returned to Sterile Processing for decontamination and reprocessing.
- e. All disposable items shall be discarded.
- f. All equipment that is not sent to Sterile Processing or discarded shall be cleaned with a disinfectant solution in-between patient use.
- g. All horizontal and vertical surfaces of furniture and mattress covers shall be cleaned with a disinfectant solution.
- h. Routine washing of blinds and curtains is not indicated; however, these shall be washed whenever they are visibly soiled. Cubicle curtains should be washed with terminal cleaning.

6. **Linen:**
 - a. Handle, transport and process soiled or used linen soiled with blood, body fluids secretions and excretions in a manner that prevents exposures and contamination of clothing and that avoids transfer of microorganisms to other patients and environments. Soiled linen must be placed in a covered receptacle (hamper). Clean linen must be kept separate and covered.
7. **Occupational Health & Bloodborne Pathogens:**
 - a. Never recap used needles, or manipulate them using both hands, or use any other technique that involves directing the point of a needle toward any part of a body. Instead use a one-handed scoop technique or a mechanical device designed for holding the needle sheath.
 - b. Do not remove used needles from disposable syringes by hand and do not bend, break or otherwise manipulate used needles by hand.
 - c. Place used disposable syringes and needles, scalpel blades and other sharp items in appropriate puncture - resistant container.
 - d. Use mouthpieces, resuscitation bags or other ventilation devices as an alternate to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable.
8. **Patient Placement - applies to patients that are hospitalized.**
 - a. Private Room:
 - (i) Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is unavailable, consult with infection control professionals regarding patient placement.
 - (ii) A private room is indicated for patients with infections that are highly infectious or are caused by microorganisms that are likely to be virulent when transmitted.
 - (iii) A private room may be indicated for patients colonized with microorganisms of special clinical or epidemiologic significance. , for example, multi-resistant bacteria such as methicillin resistant Staphylococcus aureus (MRSA), highly resistant organisms,

and select resistant gram negative organisms.

- b. Roommates for Patients on Precautions:
 - (i) Infected patients shall not share a room with a patient who is likely to become infected or in whom consequences of infection are likely to be severe, such as a neutropenic patient.
 - (ii) When an infected patient shares a room with non-infected patients, it is assumed that patients and personnel will take measures to prevent the spread of infection. For example, a patient whose fecal material is infective may be in a room with others as long as he or she is cooperative, washes hands carefully, and does not have such severe diarrhea or fecal incontinence that either roommates or objects used by them become contaminated. When these conditions cannot be met, a private room is indicated.
 - (iii) Patients infected by the same microorganisms may share a room. Cohorting of patients is especially useful during outbreaks when there is a shortage of private rooms.

D. RESPIRATORY ETIQUETTE

To prevent the transmission of **all** respiratory infections in healthcare settings, including influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person. They should be incorporated into infection control practices as one component of Standard Precautions.

- I. **Visual Alerts:**
Post a visual alert (in appropriate languages) at the entrance of the outpatient facility (e.g., emergency departments, physician offices, outpatient clinics) instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection at the time of registration. Patients with symptoms should practice Respiratory Hygiene/Cough Etiquette.
- II. **Respiratory Hygiene/Cough Etiquette:**
The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection.
 - A. Cover the nose/mouth when coughing or sneezing;
 - B. Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
 - C. Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic hand solution)

after having contact with respiratory secretions and contaminated objects/materials.

- D. Healthcare facilities should have available materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.
- E. Provide tissues and no-touch receptacles for used tissue disposal.
- F. Provide conveniently located dispensers of alcohol-based hand rub; where sinks are available, supplies for hand washing (i.e., soap, disposable towels) are consistently available.
- G. Encourage coughing into the elbow or crook of the arm rather than the hands

III. **Masking and Separation of Persons with Respiratory Symptoms:**

During periods of increased respiratory infection activity in the community (e.g., when there is increased absenteeism in schools and work settings and increased medical office visits by persons complaining of respiratory illness), offer masks to persons who are coughing. Either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions (respirators such as N-95 or above are not necessary for this purpose). The patient should be placed in a single exam room or area or when space and chair availability permit, encourage coughing persons to sit at least three feet away from others in common waiting areas. Some facilities may find it logistically easier to institute this recommendation year-round.

E. AIRBORNE PRECAUTIONS:

In addition to Standard Precautions, use Airborne Precautions, for patients known or suspected to be infected with tuberculosis or known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue [5 µm or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air current within a room or over a long distance).

- I. Patients Placement - applies to hospitalized patients.
Place the patient in a private room that has;
 - A. Daily monitoring with a visual indicator to assure negative air pressure in relation to the surrounding areas.
 - B. 6 to 12 air changes per hour.
 - C. Appropriate discharge of air outdoors or monitored high-efficiency filtration of room air before the air is circulated to other areas in the hospital.
 - D. Keep the room door closed at all times. For rule/out Tuberculosis: patient must be housed in private negative pressure room.
 - E. For other cases: When a private room is not available, place the patient in a room with a patient who has active infection with the same microorganism, unless otherwise recommended, but with no other infection.

- II. Respiratory Protection:
Wear respirator mask when entering room. Patient visitors will be offered a respirator mask and receive instructions for proper use.
Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or varicella (chickenpox) if other immune caregivers are available. If susceptible persons must enter the room of a patient known or suspected to have measles (rubeola) or varicella, they should wear a mask. Persons immune to measles (rubeola) or varicella need not wear a mask.
- III. Patient Transport:
Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize patient dispersal of droplet nuclei by placing a surgical mask on the patient, notify area ahead and go directly to the designated area.

F. DROPLET PRECAUTION:

In addition to Standard Precautions, use Droplet Precautions for patients known or suspected to be infected with microorganisms transmitted by droplets (larger particle droplets [larger than 5 μm in size] that can be generated by the patient during coughing, sneezing, talking or the performance of procedures).

- I. Patients Placement- applies to hospitalized patients.
 - A. Private room
 - B. When a private room is not available, place the patient in a room with a patients(s) who has active infection with the same microorganisms, but with no other infection (cohorting).
 - C. When a private room is not available and cohorting is not achievable, maintain spatial separation of at least 6 feet between the infected patient and other patients.
 - D. Special air handling and ventilation are not necessary and the door may remain open.
- II. Mask:
In addition to standard precautions wear a surgical mask when working within 6 feet of the patient.
- III. Patient Transport:
Limit the movement and transport of the patient from the room to essential purposes only. Minimize patient dispersal of droplets by masking the patient if possible.

G. CONTACT PRECAUTIONS:

In addition to Standard Precautions, use Contact Precautions for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient's skin to skin contact that occurs when performing patient -care activities that require touching the patient's skin or indirect contact (touching) with environmental surfaces or patient - care items in the patient's environment.

- I. Patients Placement - applies to hospitalized patients. Patients certain settings, i.e. ambulatory settings, do not require Contact Precautions, Standard Precaution are adequate. Contact Precautions in the psychiatric and ambulatory settings shall be used as directed by Infection Prevention.
 - A. Private room.
 - B. When a private room is not available, place the patient in a room with a patient(s) with the same microorganisms.
 - C. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. Consultation with infection prevention professionals is advised before patient placement.

- II. Gloves and Hand Washing:
 - A. In addition to wearing gloves as outlined under standard precautions, wear gloves when contact with the patient or environment is expected.
 - B. During the course of providing care for a patient, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage).
 - C. Remove gloves before leaving the patients environment and perform hand hygiene either with soap and water or a waterless antiseptic agent.
 - D. After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items in the patients' room to avoid transfer of microorganisms to other patients or environments.

- III. Gown:
 - A. In addition to wearing a gown as outlined under standard precautions, wear a gown (clean, non-sterile) if close contact with the patient or environment is anticipated. Remove the gown before leaving the patients environment.

- IV. Patient Transport:
 - A. Limit movement and transport of the patient from the room to essential purposes only.
 - B. If the patient is transported out of the room, in accordance with guidelines precautions are maintained to minimize the risk of transmission of microorganisms to other patients and contamination of environmental surfaces or equipment.

V. Patient Care Equipment:

- A. When possible, dedicate the use of non-critical patient-care equipment to a single patient (or cohort of patients infected or colonized with the pathogen requiring precautions) to avoid sharing between patients.
- B. If use of common equipment or items is unavailable then adequately clean and disinfect them before use for another patient.

H. IMMUNOCOMPROMISED PATIENTS:

Immunocompromised patients vary in their susceptibility to nosocomial infections, depending on the severity and duration of immune-suppression. They are generally at increased risk for bacterial, fungal, parasitic, and viral infections from both endogenous and exogenous sources.

The use of Standard Precautions for all patients and Transmission - Based Precautions for specified patients, as recommended by the Centers for Disease Control and Prevention Guidelines, should reduce the acquisition by these patients of institutionally acquired bacterial from other patients and environments.

I. PRECAUTIONS PROCEDURE:

Precautions are designed to prevent the spread of microorganisms among patients, personnel, and visitors. Since agent and host factors are more difficult to control interruption of the chain of infection in the hospital is directed primarily at transmission. The hospital is responsible for ensuring that patients are placed on appropriate isolation precautions. All personnel, physicians, nurses, technicians, students, and others are responsible for complying with precautions. The precautions recommended are:

- Standard Precautions
 - Airborne Precautions
 - Droplet Precautions
 - Contact Precautions
- I. The indication for precautions is outlined in the policy in this manual. Precautions are applicable when:
 - A. The physician confirms or suspects the presence of infectious or communicable disease, the patient has a fever and cough with a significant travel history and has traveled to an endemic region with identified outbreaks (i.e. SARS, MERS, etc...), or the patient has a fever and rash that does not have a definitive diagnosis, or the patients presents with diarrhea related to an infectious etiology.
 - B. The patient is identified with a disease/condition that requires precautions as outlined by the Centers for Disease Control and Prevention and facility protocol.
 - C. The nurse, the physician and/or Epidemiology/Infection Prevention staff will place the patient on appropriate precautions on admission or when a disease or organism is suspected or known.
 - D. The nurse, physician, and/or Epidemiology/Infection Prevention staff will identify the need for or discontinuing precautions based the results of laboratory data, physician diagnosis and/or signs and symptoms. When precautions are initiated or discontinued by

Epidemiology/Infection Prevention staff, the Epidemiology/Infection Prevention staff will notify the nursing unit and/or staff involved in bed assignment. Instructions as to type of precaution necessary and/or reason for removal shall be given.

- II. The precaution sign shall be placed outside the patient's door to inform visitors and staff regarding the need for special precautions before entering the room that requires more than standard precautions. When a patient on precautions is within a multi-bedded room the precaution sign shall be placed at the entrance of the room and above the patient's bed.
- III. Precaution practices are outlined in this policy. Each patient's need for education regarding his/her precaution need shall be assessed and provided by the appropriate nursing/medical personnel. Visitors shall also be informed of necessary precautions and education provided as needed. If necessary consult with Epidemiology/Infection Prevention for supplemental education.
- IV. Precautions will be assessed and monitored by the Epidemiology/Infection Prevention staff at least weekly.
- V. The Nurse Manager shall be responsible for carrying out all functions of the precaution procedures. This includes supervision of personnel and assuring that all personnel and visitors follow all isolation procedures.
- VI. When select criteria are met precautions can be discontinued. Consult the Epidemiology/Infection Control Practitioner. Discontinuing of precautions requires documentation within the patient's medical record by the physician or nursing staff.
- VII. Environmental Services – When patients are discharged and on Contact Precautions at the time of discharge, a terminal clean shall be performed. Refer to the Environmental Service procedures for cleaning a patient's room when on contact precautions.

Patient Precaution Guidelines: Clinical Syndrome or Condition

Clinical syndromes or conditions warranting addition precautions to prevent transmission of epidemiologically important pathogens pending confirmation of diagnosis:

Clinical Syndrome or Condition	Potential Pathogen	Precautions
Diarrhea		
Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens	Contact
Diarrhea in an adult	Clostridium difficile	Contact
Meningitis		
Rash or exanthems, etiology unknown	Neisseria meningitidis	Droplet for 24 hours after initiation of antibiotic therapy. Patient then can be removed from precautions
Petechial/ecchymotic with fever	Neisseria meningitidis	Droplet (see above)
Vesicular	Varicella	Airborne & Contact
Maculopapular with coryza and fever	Rubeola (measles)	Airborne
Respiratory Infections		
Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for HIV infection	Mycobacterium tuberculosis	Airborne
Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient at high risk for HIV infection	Mycobacterium tuberculosis	Airborne
Paroxysmal or severe persistent cough during period of pertussis activity	Bordetella pertussis	Droplet
Respiratory infections, particularly bronchiolitis and croup, in infants and young children	Respiratory syncytial or Parainfluenza virus	Contact- Refer to Attachment A-3
Cough, fever, difficulty breathing with a travel history or known contact with SARS case	Severe Acute Respiratory Syndrome (SARS)	Airborne & Contact
Risk of multidrug-resistant microorganisms		
History or current infection or colonization with multidrug-resistant organisms	Resistant bacteria	Contact
Skin, wound, or urinary tract infection in a patient with a recent hospital or nursing home stay in a facility where multidrug-resistant organisms are prevalent	Resistant bacteria	Contact
Skin or Wound Infection		
Abscess or draining wound that cannot be covered	Staphylococcus aureus, Group A streptococcus	Contact

Patient Precaution Guidelines: Disease Specific Isolation Precautions

Type and Duration of Precautions Needed for Selected Infections and Conditions:

Infection/Condition	Comments	Precautions	
		Type	Duration
Abscess			
Drainage, major	No dressing or containment of drainage	C	DI
Drainage, minor or limited	Dressing covers and contains drainage	S	
Acquired immunodeficiency syndrome		S	
Acitnomycosis		S	
Amebiasis		S	
Anthrax			
Cutaneous	Place on Contact if there is a large amount of uncontained drainage	S	
Pulmonary		S	
Antibiotic-associated colitis (see Clostridium difficile)			
Arthropodborne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St. Louis, California encephalitis)		S	
Arthropodborne viral fevers (dengue, yellow fever, Colorado tick fever)		S	
Ascariasis		S	
Aspergillosis	Contact & Airborne if massive soft tissue infection with drainage & irrigations.	S	
Avian Influenza (see influenza)			
Babesiosis		S	
Blastomycosis, North American, cutaneous or pulmonary		S	
Botulism		S	
Bronchiolitis (see respiratory infections in infants and young children)	Use mask according to Standard Precautions	C	DI
Brucellosis (undulant, Malta, Mediterranean fever)		S	
Campylobacter gastroenteritis (see gastroenteritis)			
Candida Auris	Environment and equipment (if not contraindicated by manufacturer guidelines) cleaning with an EPA-approved sporicidal disinfectant effective against Clostridium difficile spores. Complete Northwell Health Form #HS062 Patient on Precautions Transfer Form	C	
Candidiasis, all forms including mucocutaneous		S	
Cat-scratch fever (benign inoculation lymphoreticulosis)		S	
Cellulitis, uncontrolled drainage		S	
Chancroid (soft chancre)		S	
Chickenpox (varicella)			
Chlamydia trachomatis			

Conjunctivitis		S	
Genital		S	
Pneumonia (infant \leq 3 mos. of age) & adults		S	
Cholera (see gastroenteritis)			
Closed-cavity infection			

Infection/Condition	Comments	Precautions	
		Type	Duration
Draining, limited or minor		S	
Not draining		S	
Clostridium			
Clostridium botulinum		S	
Clostridium difficile	Refer to Attachment A-3	C	Comment
Food poisoning		S	
Gas gangrene		S	
Coccidioidomycosis (valley fever)			
Draining lesions		S	
Pneumonia		S	
Colorado tick fever		S	
Congenital rubella	Until 1 year of age	C	
Conjunctivitis			
Acute bacterial		S	
Chlamydia or Gonococcal		S	
Acute viral (acute hemorrhagic)		C	DI
Coxsackievirus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease	Refer to CJD policy	S	
Croup (see respiratory infections in infants and young children)			
Cryptococcosis		S	
Cryptosporidiosis (see gastroenteritis)			
Cystic Fibrosis (CF)	Patients should wear a procedure mask when outside their room. Private room required, do not cohort patients.	C	
Cytomegalovirus infection, neonatal or immunosuppressed		S	
Decubitus ulcer, infected			
Major	If no dressing or containment of drainage.	C	DI
Minor or limited	If dressing covers & contains drainage.	S	
Dengue		S	
Diarrhea, acute - infective etiology suspected (see gastroenteritis)			
Diphtheria			
Cutaneous	Until 2 cultures taken 24 hours apart and reported as negative	C	CN
Pharyngeal		D	
Ebola (see viral hemorrhagic fever)			
Echinococcosis (hydatidosis)		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)	Refer to Attachment A-3		

Infection/Condition	Comments	Precautions	
		Type	Duration
Enteroviral infections			
Adults	Standard; Standard and Contact <u>if</u> diapered or incontinent or part of an outbreak	S/C	DI
Infants and young children	Standard; Standard and Contact <u>if</u> diapered or incontinent or part of an outbreak	S/C	DI
RVP-positive Enterovirus /Rhinovirus(suspect D 68)	Only during time periods with increased incidence, an outbreak, or suggested by an external regulatory agency or expert source or when recommended by the Chairperson of the Infection Control Committee	D & C	DI
Epiglottitis, due to Haemophilus influenzae		D	U ^{24 hrs}
Erythema infectiosum (also see Parvovirus B19)		S	
Escherichia coli gastroenteritis (see gastroenteritis)			
Food poisoning			
Botulism		S	
Clostridium perfringens or welchii		S	
Staphylococcal		S	
Furunculosi - staphylococcal			
Infants and young children		C	DI
Gangrene (gas gangrene)		S	
Gastroenteritis			
Adenovirus	Use Contact for diapered or incontinent persons	D & C	DI- See Attachment C
Campylobacter species	Use Contact for diapered or incontinent persons	S	
Cholera		S	
Clostridium difficile	Refer to Attachment A-3	C	
Cryptosporidium species		S	
Escherichia coli			
Enterohemorrhagic O157:H7	Use Contact for diapered or incontinent persons until 2 negative stool cultures have been obtained	S	
Diapered or incontinent		C	DI
Other species		S	
Giardia lamblia		S	
Rotavirus		C	DI
Salmonella species (including S typhi)	Use Contact for diapered or incontinent persons	S	
Shigela species		S	
Vibrio parahaemolyticus		S	
Viral (if not covered elsewhere)		S	
Yersinia enterocolitica		S	
German measles (see rubella)		D	

Infection/Condition	Comments	Precautions	
		Type	Duration
Giardiasis (see gastroenteritis)			
Gonococcal ophthalmis neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)		S	
Hand, foot, and mouth disease (see enteroviral infection)			
Hantavirusi pulmonary syndrome		S	
Helicobacter pylori		S	
Hepatitis, viral			
Type A		S	
Diapered or incontinent patients	Duration of hospitalization for < 3 years and > 3 years of age for 1 week after the onset of symptoms.	C	
Type B - HBsAg positive; acute or chronic		S	
Type C and other unspecified non-A/B		S	
Type B - HBsAg positive; acute or chronic		S	
Type C and other unspecified non-A non-B		S	
Herpangina (see enteroviral infection)			
Herpes simplex (Herpevirus hominis)			
Encephalitis		S	
Mucocutaneous, disseminated or primary, severe	Until lesions crust	C	DI
Mucocutaneous, recurrent (skin, oral, genital)		S	
Neonatal	Until lesions crust	C	DI
Herpes zoster (varicella-zoster)			
Localized in Immunocompromised patient, or disseminated in immunocompetent		A, C	DI
Localized in normal patient		S	
Histoplasmosis		S	
HIV (see human immunodeficiency virus)		S	
Hookworm disease (ancylostomiasis, uncinariasis)		S	
Human Immunodeficiency virus (HIV) infection ³		S	
Impetigo		C	U ^{24 hrs}
Infectious mononucleosis		S	
Influenza			

Infection/Condition	Comments	Precautions	
		Type	Duration
Human (seasonal influenza) including H1N1 influenza	<input type="checkbox"/> Influenza A – 24 hours after resolution of fever without antipyretics and improved symptoms. <input type="checkbox"/> Immunocompromised patient duration of illness, usually 5-7 days after symptom presentation <input type="checkbox"/> Refer to Attachment A-3	D	Comment
Avian influenza	Refer to current CDC guidelines	A	
Pandemic influenza	Refer to CDC guidelines	D	Comment
Kawasaki syndrome		S	
Lassa fever		C	DI
Legionnaires' disease		S	
Leprosy		S	
Leptospirosis		S	
Lice (pediculosis) - head		C	U ²⁴
Listeriosis		S	
Lyme disease		S	
Lymphocytic choriomeningitis		S	
Lymphogranuloma venereum		S	
Malaria		S	
Marburg virus disease		C	DI
Measles (rubeola), all presentations	4 days after the onset of rash; duration of illness in immunocompromised	A	DI
Meningitis		S	
Aseptic		S	
Bacterial, gram-negative enteric, neonates		S	
Fungal		S	
Haemophilus influenza, known or suspected		D	U ^{24 hrs}
Listeria monocytogenes		S	
Neisseria meningitidis (meningococcal)	known or suspected	D	U ^{24 hrs}
Pneumococcal (Streptococcal pneumoniae)		S	
Tuberculosis		S	
Other diagnosed bacterial		S	
Meningococcal pneumonia		D	U ^{24 hrs}
Meningococemia (meningococcal sepsis)		D	U ^{24 hrs}
Metapneumovirus,	For duration of illness, usually 5 days Refer to Attachment A-3	C	DI
Methicillin Resistant Staphylococcus aureus (MRSA)	Refer to Attachment A-3	S & C	
Monkeypox	Airborne until diagnosis is confirmed and smallpox excluded, Contact until lesions are crusted	A, C	Comment

Infection/Condition	Comments	Precautions	
		Type	Duration
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., CRE, MRSA, VRE, VISA/VRSA, ESBLs, resistant <i>S. pneumoniae</i>)	Refer to Attachment A-3	S, C	
Mumps	Up to 9 days	D	Comment
Mycobacteria, nontuberculosis (atypical)	Not transmitted from person-to-person		
Pulmonary		S	
Wound		S	
<i>Mycoplasma pneumoniae</i>		D	DI
Necrotizing enterocolitis		S	
Nocardiosis, draining lesions, or other presentations		S	
Parainfluenza virus infection (Immunocompetent)		C	DI
Parainfluenza virus infection-Immunocompromised	Droplet and Contact Precautions , usually 5 days for droplet and 3 weeks for contact	D & C	Comment
Parvovirus B19 (Erythema infectiosum)	Duration of precautions for immunosuppressed patients.	D	Comment
Pediculosis (lice)		C	U ^{24 hrs}
Pertussis (whooping cough)		D	Comment
Pinworm infection		S	
Plague			
Bubonic		S	
Pneumonic		D	U ^{48 hrs}
Pleurodynia (see enteroviral infection)			
Pneumonia			
Adenovirus		D, C	DI
Bacterial not listed elsewhere (including gram – bacteria)		S	
Burholderia cepacia in cystic fibrosis (CF) patients, including respiratory tract colonization	Duration of precautions not established	C	DI
Chlamydia		S	
Fungal		S	
Haemophilus influenzae			
Adults		S	
Infants and children (any age)		D	U ^{24 hrs}
Legionella		S	
Meningococcal		D	U ^{24 hrs}
Multidrug-resistant bacterial (see multidrug-resistant)			
Mycoplasma (primary atypical pneumonia)		D	DI
Pneumococcal		S	
Multidrug-resistant organisms (MDROs), infection or colonization (e.g. CRE, MRSA, VRE, VISA/VRSA, ESBLs, resistant <i>S. pneumoniae</i>)	Refer to Attachment A-3	S, C	

Infection/Condition	Comments	Precautions	
		Type	Duration
Pneumocystis carinii		S	
Pseudomonas cepacia (see Burkholderia cepacia)		S	
Mycoplasma (primary atypical pneumonia)		D	DI
Staphylococcus aureus		S	
Streptococcus, Group A			
Adults		D	U ^{24 hrs}
Infants and young children		D	U ^{24 hrs}
Viral			
Adults		S	
Infants and young children (see respiratory infectious disease, acute)			
Poliomyelitis		C	DI
Psittacosis (ornithosis)		S	
Q fever		S	
Rabies		S	
Rat-bite fever (Streptobacillus moniliformis disease, Spirillum minus disease)		S	
Relapsing fever		S	
Respiratory infectious disease (RSV) (Immunocompromised)	Usually 5 days for Droplet and 3 weeks for Contact	D & C	DI
Respiratory infectious disease (RSV) (Immunocompetent)		C	DI
Reye's syndrome		S	
Rheumatic fever		S	
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne typhus fever)		S	
Rickettsialpox (vesicular rickettsiosis)		S	
Ringworm (dermatophytosis, dermatomycosis, tinea) - Pediatrics		C	
Ritter's disease (staphylococcal scalded skin syndrome)		C	DI
Rocky Mountain spotted fever		S	
Roseola infantum (examthem subitum)		S	
Rotavirus infection (see gastroenteritis)			
Rubella (German measles; also see congenital rubella)	Follow Department of Health guidance for precaution discontinuation of isolation	D & C	Comment
Rheumatic fever		S	
Rhinovirus in children		S	
Salmonellosis (see gastroenteritis)		S	
Severe acute respiratory syndrome (SARS)	DI, plus 10 days after resolution of fever, provided respiratory symptoms are absent	A, C	DI
Scabies		C	U ^{24 hrs}
Scalded skin syndrome, staphylococcal (Ritter's disease)		S	

Infection/Condition	Comments	Precautions	
		Type	Duration
Schistosomiasis (bilharziasis)		S	
Shigellosis (see gastroenteritis)			
Sporotrichosis		S	
Spirillum minus disease (rat-bite fever)		S	
Staphylococcal disease (<i>S aureus</i>)			
Skin, wound, or burn			
Major		C	DI
Minor or limited Scalded skin syndrome		S	
Enterocolitis		S	
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., CRE, MRSA, VRE, VISA/VRSA, ESBLs, resistant <i>S. pneumoniae</i>)	Refer to Attachment A-3	S, C	
Pneumonia		S	
Toxic shock syndrome		S	
Streptobacillus moniliformis disease (rat-bite fever)		S	
Streptococcal disease (group A streptococcus)			
Skin, wound, or burn			
Major ¹		C	U ^{24 hrs}
Minor or limited ²		S	
Endometritis (puerperal sepsis)		S	
Pharyngitis in infants and young children		D	U ^{24 hrs}
Pneumonia in infants and young children		D	U ^{24 hrs}
Scarlet fever in infants and young children		D	U ^{24 hrs}
Serious invasive disease		D	U ^{24 hrs}
Streptococcal disease (group A or B streptococcus), neonatal		S	
Streptococcal disease (not group B)		S	
Strongyloidiasis		S	
Syphilis			
Skin and mucous membrane, including congenital, primary, secondary		S	
Latent (tertiary) and seropositivity without lesions		S	
Tapeworm disease			
Hymenolepis nana & Taenia solium		S	
Tetanus		S	
Tinea (fungus infection dermatophytosis, dermatomycosis, ringworm)		S	
Toxoplasmosis		S	
Toxic shock syndrome (staphylococcal disease)		S	

Infection/Condition	Comments	Precautions	
		Type	Duration
Tuberculosis			
Extrapulmonary, draining lesion		A & C	
Extrapulmonary, no lesion, meningitis		S	
Pulmonary, confirmed or suspected or laryngeal disease	Refer to the Tuberculosis protocol for guidelines for discontinuing precautions	A	
Skin-test positive with no evidence of current pulmonary disease		S	
Tularemia		S	
Typhoid (<i>Salmonella typhi</i>) fever (see gastroenteritis)			
Typhus, endemic and epidemic		S	
Vancomycin Resistant Enterococcus (VRE)	Refer to Attachment A-3	S & C	
Vancomycin intermediate/resistant <i>Staphylococcus aureus</i> (VISA/VRSA)	Any site	C	DI
Varicella (chickenpox)	Until lesions are dry & crusted	A & C	Comment
<i>Vibrio parahaemolyticus</i> (see gastroenteritis)			
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Single-patient room preferred. Emphasize: 1) use of sharps safety devices and safe work practices, 2) hand hygiene; 3) barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4) appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected	S,D,C	
Whooping cough (see pertussis)			
<i>Yersinia enterocolitica</i> gastroenteritis (see gastro enteritis)			
Zygomycosis (phycomycosis, mucormycosis)		S	
Zoster (see varicella-zoster)			

Abbreviations: type of precautions: A, Airborne; C, Contact; D, Droplet; S, Standard; CN, until of antibiotics and culture negative; DI, duration of illness (with wound lesions, DI means until drainage stops); U, until time specified in hours (hrs)

Contact Precautions Guidelines for Multiple-drug Resistant Organisms (MDRO) and *Clostridium difficile*

Pathogen	Antibiotic resistance Resistant (R) or Intermediate (I)	Contact Precautions	Duration	Room Placement
Extended Spectrum Beta Lactamase (ESBL) producer <i>Klebsiella species, Proteus mirabilis, Escherichia coli, Enterobacter species</i>	Cefepime or Ceftazidime or laboratory MDRO	BASED ON SITE SPECIFIC GUIDELINES PROVIDED BY THE INFECTION CONTROL/PREVENTION COMMITTEE - All patients on any unit with this organism from any source	~72 hours post completion of appropriate therapy	Private room preferred, OR cohort with another patient with the same resistant organism(s)
Other resistant organisms	Gram-negative resistant or intermediate to ALL: Amikacin, Cefepime, and Ciprofloxacin	BASED ON SITE SPECIFIC GUIDELINES PROVIDED BY THE INFECTION CONTROL/PREVENTION COMMITTEE NICU only: Gentamicin resistant gram negative bacillus	AND 1 negative culture from the source	
<i>Candida auris</i>	Isolate all cases	*see comments under duration	OR the original source is unavailable for culture (e.g. wound is healed, no sputum production or suctioning required)	
Methicillin resistant <i>Staphylococcus</i> (MRSA)	Oxacillin	NICU: All patients with MRSA from any source Patients on any unit with MRSA from any source except: <ul style="list-style-type: none"> • Surveillance cultures or PCR • Blood cultures with no draining wound, respiratory or urine source 	OR \geq 6 months since last positive culture and the patient is not presenting with active infection from the original site. OR if patient is not treated with antibiotics, repeat 1 culture \geq 7 days later is negative.	
Vancomycin resistant <i>Enterococcus</i> (VRE)	Vancomycin	Neonatal Intensive Care Unit, Bone Marrow Transplant Unit or designated oncology unit – All patients with VRE from any <i>clinical</i> source (surveillance cultures are excluded) Other units: Contact Precautions are not needed	* Maintain isolation precautions and assure the Department of Health and receiving facility is aware of any transfers/discharges. Use sporicidal agent for disinfection, and assure any transport devices and vehicles are thoroughly disinfected with a sporicidal agent.	
Carbapenem Resistant Enterobacteriaceae (CRE) <i>Klebsiella species, Escherichia coli, Proteus species, Enterobacter species, Morganella morganni, Providencia species</i>	Resistant to any carbapenem class drug (imipenem, meropenem, ertapenem or doripenem) or have carbapenemase	All patients on any unit with CRE from any source	~72 hours post completion of appropriate therapy AND 1 repeat blood culture is negative if blood was the source OR 2 negative sequential cultures from the original sources OR the original source is unavailable for culture (e.g. wound is healed, no sputum production or suctioning required) OR \geq 1 year since the last positive culture and the patient is not presenting active infection from the original site OR if patient is not treated with antibiotics, repeat 2 sequential cultures \geq 7 days later	
<i>Clostridium difficile</i> (C. diff)	Not applicable	All <i>symptomatic</i> patients from any unit: Start precautions as soon as <i>Clostridium difficile</i> is suspected	Suspected: Until stool test(s) are confirmed negative OR patient has no diarrhea for >24 hours and does not produce specimen. Confirmed: Patient has been asymptomatic at least 48 hours AND if possible, place in a new, clean room	

*** Note:** Modification of precaution requirements based on facility census may be initiated following discussion with the Chairperson of the Infection Control Committee
For patients with history of an MDRO that cannot be verified: assess for active infection and request a culture from the site. If no active infection is present, Infection Prevention should discontinue precautions or consult with Infectious Diseases when necessary.

Patient Precaution Guidelines for Respiratory Viral Illnesses in Adult Patients

* **Note:** Modification in the management of isolation patients based on the facilities census may be initiated following discussion with the Chairperson of the facility's Infection Control Committee.

Patient management with influenza-like illness (ILI)	Emergency Department (ED)	Inpatient Setting	
<ul style="list-style-type: none"> • Patient screening (applies to any patient with fever (> 100°F or >=37.8°C) <p>AND</p> <ul style="list-style-type: none"> • cough or sore throat or rhinorrhea 	<ul style="list-style-type: none"> • Any patient with signs and symptoms of influenza-like illness should be masked at triage and placed in a single room on Droplet Precautions. 	<ul style="list-style-type: none"> • Any patient with influenza-like illness should be masked, placed on Droplet Precautions in a single room or with a patient who tested positive for the same type influenza • During periods of high influenza activity, as determined by Infection Prevention, patients with negative Rapid Influenza A/B shall be placed on Droplet and Contact precautions pending the Respiratory Viral Panel by PCR • (Exclude from cohorting: transplants, dialysis, neutropenic, active chemo/radiation, and AIDs patients) 	
<p>Send a Nasal Pharyngeal swab for:</p> <ul style="list-style-type: none"> • Rapid Respiratory Viral Panel (if available) OR • Rapid influenza A/B (if available) OR • Respiratory Viral Panel by PCR 	<p>Any patient who meets any of the following criteria should be tested for influenza:</p> <ul style="list-style-type: none"> • Fever (oral temperature > 100°F or >=37.8°C AND cough and/or sore throat or rhinorrhea) 		
<p>Confirmed laboratory results</p>	<p>Results:</p>	<p>Precautions</p>	
	<p>Adenovirus infection</p>	<p>Droplet and Contact for duration of illness, usually 5 days</p>	
	<p>Influenza A Influenza B</p>	<p>Droplet Precautions until 24 after resolution of fever without antipyretics and improved symptoms. Minimum 3 days, maximum 5 days depending on flu symptoms *Immunocompromised patient: duration of illness</p>	
	<p>Human Metapneumovirus</p>	<p>Contact Precautions for duration of illness, usually 5 days</p>	
	<p>Parainfluenza</p>	<p>Contact Precautions for duration of illness, usually 5 days *Immunocompromised: Droplet and Contact Precautions, usually 5 days for Droplet and 3 weeks for Contact</p>	
	<p>Respiratory Syncytial Virus (RSV)</p>	<p>Contact Precautions for duration of illness, usually 5 days *Immunocompromised: Droplet and Contact Precautions, usually 5 days for Droplet and 3 weeks for Contact</p>	
	<p>Pertussis (whooping cough)</p>	<p>Droplet Precautions 5 days after start of effective therapy</p>	
	<p>Coronavirus</p>	<p>No Isolation Require</p>	
	<p>Enterovirus /Rhinovirus Only during time periods with increased incidence, an outbreak, or suggested by an external regulatory agency or expert source or when recommended by the Chairperson of the Infection Control Committee</p>	<p>Droplet and Contact for duration of illness, usually 5 days</p> <ul style="list-style-type: none"> • Suspect Enterovirus D68 isolation will be discontinued as per Infectious Disease physician 	
	<p>*Immunocompromised patients are identified with provider input and may include populations with primary or acquired immune deficiencies, such as those receiving chemotherapy, immune modulating medications, anti-TNF medications, long-term high dose steroids (i.e., ≥40mg/day for at least two weeks) AIDS.</p>		

