



supplement 4 infection control

TABLE OF CONTENTS

S4-I. RATIONALE	S4-3
S4-II. INFLUENZA TRANSMISSION	S4-3
A. Modes of transmission.....	S4-3
1. Droplet transmission.....	S4-3
2. Contact transmission.....	S4-4
3. Airborne transmission	S4-4
B. Pathogenesis of influenza and implications for infection control	S4-5
C. Control of transmission in healthcare settings.....	S4-5
S4-III. OVERVIEW	S4-5
S4-IV. RECOMMENDATIONS FOR INFECTION CONTROL IN HEALTHCARE SETTINGS	S4-6
A. Basic infection control principles for preventing the spread of pandemic influenza in healthcare settings.....	S4-6
B. Management of infectious patients	S4-7
1. Respiratory hygiene/cough etiquette	S4-7
2. Droplet precautions and patient placement	S4-7
C. Infection control practices for healthcare personnel.....	S4-7
1. Personal protective equipment (PPE).....	S4-8
a) PPE for standard and droplet precautions	S4-8
b) PPE for special circumstances	S4-9
c) Caring for patients with pandemic influenza	S4-9
2. Hand hygiene.....	S4-9
3. Disposal of solid waste.....	S4-10
4. Linen and laundry	S4-10
5. Dishes and eating utensils.....	S4-10
6. Patient-care equipment.....	S4-10
7. Environmental cleaning and disinfection.....	S4-11
a) Cleaning and disinfection of patient-occupied rooms.....	S4-11
b) Cleaning and disinfection after patient discharge or transfer	S4-11
8. Postmortem care.....	S4-11
9. Laboratory specimens and practices.....	S4-11
D. Occupational health issues.....	S4-11
E. Reducing exposure of persons at risk for complications of pandemic influenza.....	S4-12
F. Healthcare setting-specific guidance	S4-12
1. Hospitals	S4-12
a) Detection of persons entering the facility who may have pandemic influenza	S4-12
b) "Source control" measures to limit dissemination of influenza virus from respiratory secretions.....	S4-13

c) Hospitalization of pandemic influenza patients.....	S4-13
d) Control of nosocomial pandemic influenza transmission.....	S4-14
2. Nursing homes and other residential facilities.....	S4-14
a) Prevention or delay of pandemic influenza virus entry into the facility	S4-15
b) Monitoring patients for pandemic influenza and instituting appropriate control measures.....	S4-15
3. Prehospital care (emergency medical services).....	S4-15
4. Home healthcare services.....	S4-16
5. Outpatient medical offices.....	S4-16
a) Detection of patients with possible pandemic influenza	S4-16
b) "Source control" measures	S4-16
c) Patient placement.....	S4-17
6. Other ambulatory settings	S4-17
G. Care of pandemic influenza patients in the home.....	S4-17
1. Management of influenza patients.....	S4-17
2. Management of other persons in the home.....	S4-18
3. Infection control measures in the home.....	S4-18
H. Care of pandemic influenza patients at alternative sites	S4-18

S4-V. RECOMMENDATIONS FOR INFECTION CONTROL IN SCHOOLS AND WORKPLACES....S4-18

S4-VI. RECOMMENDATIONS FOR INFECTION CONTROL IN COMMUNITY SETTINGSS4-19

Box 1. Summary of Infection Control Recommendations for Care of Patients with Pandemic Influenza	S4-20
Box 2. Respiratory Hygiene/Cough Etiquette.....	S4-22

S4-I. RATIONALE

The primary strategies for preventing pandemic influenza are the same as those for seasonal influenza: vaccination, early detection and treatment with antiviral medications (as discussed elsewhere in this plan), and the use of infection control measures to prevent transmission during patient care. However, when a pandemic begins, a vaccine may not yet be widely available, and the supply of antiviral drugs may be limited. The ability to limit transmission in healthcare settings will, therefore, rely heavily on the appropriate and thorough application of infection control measures. While it is commonly accepted that influenza transmission requires close contact—via exposure to large droplets (droplet transmission), direct contact (contact transmission), or near-range exposure to aerosols (airborne transmission)—the relative clinical importance of each of these modes of transmission is not known.

The infection control guidance provided in this supplement is based on our knowledge of routes of influenza transmission (S4-II.A), the pathogenesis of influenza (S4-II.B), and the effects of influenza control measures used during past pandemics and interpandemic periods (S4-II.C) (see also supporting references in the Appendix). Given some uncertainty about the characteristics of a new pandemic strain, all aspects of preparedness planning for pandemic influenza must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds. The specific characteristics of a new pandemic virus—virulence, transmissibility, initial geographic distribution, clinical manifestation, risk to different age groups and subpopulations, and drug susceptibility—will remain unknown until the pandemic gets underway. If the new virus is unusual in any of these respects, HHS and its partners will provide updated infection control guidance.

S4-II. INFLUENZA TRANSMISSION

A. Modes of transmission

Despite the prevalence of influenza year after year, most information on the modes of influenza transmission from person to person is indirect and largely obtained through observations during outbreaks in healthcare facilities and other settings (e.g., cruise ships, airplanes, schools, and colleges); the amount of direct scientific information is very limited. However, the epidemiologic pattern observed is generally consistent with spread through close contact (i.e., exposure to large respiratory droplets, direct contact, or near-range exposure to aerosols). While some observational and animal studies support airborne transmission through small particle aerosols, there is little evidence of airborne transmission over long distances or prolonged periods of time (as is seen with *M. tuberculosis*). The relative contributions and clinical importance of the different modes of influenza transmission are currently unknown.

1. Droplet transmission (www.cdc.gov/ncidod/hip/ISOLAT/std_prec_excerpt.htm)

Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated from the source person primarily during coughing, sneezing, or talking and during the performance of certain procedures such as suctioning and bronchoscopy. Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances (about 3 feet) through the air. Because droplets do not remain suspended in the air, special air handling and ventilation are not required to prevent droplet transmission.

Based on epidemiologic patterns of disease transmission, large droplet transmission has been considered a major route of influenza transmission. However, data directly demonstrating large droplet transmission of influenza in human outbreaks is indirect and limited.

2. Contact transmission (www.cdc.gov/ncidod/hip/ISOLAT/contact_prec_excerpt.htm)

Direct-contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient-care activities that require physical contact. Direct-contact transmission also can occur between two patients (e.g., by hand contact), with one serving as the source of infectious microorganisms and the other as a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment.

Contact transmission of influenza may occur through either direct skin-to-skin contact or through indirect contact with virus in the environment. Transmission via contaminated hands and fomites has been suggested as a contributing factor in some studies. However, there is insufficient data to determine the proportion of influenza transmission that is attributable to direct or indirect contact.

3. Airborne transmission (www.cdc.gov/ncidod/hip/ISOLAT/airborne_prec_excerpt.htm)

Airborne transmission occurs by dissemination of either airborne droplet nuclei or small particles in the respirable size range containing the infectious agent. Microorganisms carried in this manner—such as *M. tuberculosis*—may be dispersed over long distances by air currents and may be inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual. Organisms transmitted in this manner must be capable of sustaining infectivity, despite desiccation and environmental variation that generally limit survival in the airborne state. Preventing the spread of agents that are transmitted by the airborne route requires the use of special air handling and ventilation systems (e.g., negative pressure rooms).

The relative contribution of airborne transmission to influenza outbreaks is uncertain. Evidence is limited and is principally derived from laboratory studies in animals and some observational studies of influenza outbreaks in humans, particularly on cruise ships and airplanes, where other mechanisms of transmission were also present. Additional information suggesting airborne transmission was reported in a Veterans Administration Hospital study that found lower rates of influenza in wards exposed to ultraviolet radiation (which inactivates influenza viruses) than in wards without UV radiation. Another study indicated that humidity can play a role in the infectivity of aerosolized influenza, although the influence of humidity on the formation of droplet nuclei was not evaluated.

Small-particle aerosols. There is no evidence that influenza transmission can occur across long distances (e.g., through ventilation systems) or through prolonged residence in air, as seen with airborne diseases such as tuberculosis. However, transmission may occur at shorter distances through inhalation of small-particle aerosols (droplet nuclei), particularly in shared air spaces with poor air circulation. An experimental study involving human volunteers found that illness could be induced with substantially lower virus titers when influenza virus was administered as a small droplet aerosol rather than as nasal droplets, suggesting that infection is most efficiently induced when virus is deposited in the lower rather than the upper respiratory tract. While this study supports the possibility of droplet nuclei transmission of influenza, the proportion of infections acquired through droplet nuclei—as compared with large droplet or contact spread—is unknown.

It is likely that some aerosol-generating procedures (e.g., endotracheal intubation, suctioning, nebulizer treatment, bronchoscopy) could increase the potential for dissemination of droplet nuclei in the immediate vicinity of the patient. (Although transmission of SARS-CoV was reported in a Canadian hospital during an aerosol-generating procedure [intubation], it occurred in a situation involving environmental contamination with respiratory secretions.) Although this mode of transmission has not been evaluated for influenza, additional precautions for healthcare personnel who perform aerosol-generating procedures on influenza patients may be warranted.

B. Pathogenesis of influenza and implications for infection control

The cellular pathogenesis of human influenza indicates that infection principally takes place within the respiratory tract. While conjunctivitis is a common manifestation of systemic influenza infection, the ocular route of inoculation and infection has not been demonstrated for human influenza viruses. This may not be true with certain avian species of influenza (e.g., H7N7) that have been associated primarily with conjunctivitis in humans.¹ This information suggests that preventing direct and indirect inoculation of the respiratory tract is of utmost importance for preventing person-to-person transmission when caring for infectious patients.

C. Control of transmission in healthcare facilities

Outbreaks of influenza have been prevented or controlled through a set of well established strategies that include vaccination of patients and healthcare personnel; early detection of influenza cases in a facility; use of antivirals to treat ill persons and, if recommended, as prophylaxis; isolation of infectious patients in private rooms or cohort units; use of appropriate barrier precautions during patient care, as recommended for Standard and Droplet Precautions (Box 1); and administrative measures, such as restricting visitors, educating patients and staff, and cohorting healthcare workers assigned to an outbreak unit.

These are the primary infection control measures recommended in this plan. They will be updated, as necessary, based on the observed characteristics of the pandemic influenza virus.

S4-III. OVERVIEW

Supplement 4 provides guidance to healthcare and public health partners on basic principles of infection control for limiting the spread of pandemic influenza. These principles (summarized in Box 1) are common to the prevention of other infectious agents spread by respiratory droplets. **Supplement 4** also includes guidance on the selection and use of personal protective equipment (PPE); hand hygiene and safe work practices; cleaning and disinfection of environmental surfaces; handling of laboratory specimens; and post-mortem care. The guidance also covers infection control practices related to the management of infectious patients, the protection of persons at high-risk for severe influenza or its complications, and issues concerning occupational health.

Supplement 4 also provides guidance on how to adapt infection control practices in specific healthcare settings, including hospitals, nursing homes and other long-term care facilities, pre-hospital care (emergency medical services [EMS]), medical offices and other ambulatory care settings, and during the provision of professional home healthcare services. The section on hospital care covers detection of entering patients who may be infected with pandemic influenza; implementation of source-control measures to limit virus dissemination from respiratory secretions; hospitalization of pandemic influenza patients; and detection and control of nosocomial transmission.

In addition, **Supplement 4** includes guidance on infection control procedures for pandemic influenza patients in the home or in alternative care sites that may be established if local hospital capacity is overwhelmed by a pandemic. Finally, it includes recommendations on infection control in schools, workplaces, and community settings.

Supplement 4 does not address the use of vaccines and antivirals in the control of influenza transmission in healthcare settings and the community. These issues are addressed in **Supplements 6 and 7**, respectively.

¹ Eye protection is recommended when working with conjunctivitis-inducing avian influenza viruses

S4-IV. RECOMMENDATIONS FOR INFECTION CONTROL IN HEALTHCARE SETTINGS

The recommendations for infection control described below are generally applicable throughout the different pandemic phases. In some cases, as indicated, recommendations may be modified as the situation progresses from limited cases to widespread community illness.

A. Basic infection control principles for preventing the spread of pandemic influenza in healthcare settings

The following infection control principles apply in any setting where persons with pandemic influenza might seek and receive healthcare services (e.g. hospitals, emergency departments, out-patient facilities, residential care facilities, homes). Details of how these principles may be applied in each healthcare setting follow.

- Limit contact between infected and non-infected persons²
 - Isolate infected persons (i.e., confine patients to a defined area as appropriate for the healthcare setting).
 - Limit contact between nonessential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
 - Promote spatial separation in common areas (i.e., sit or stand as far away as possible—at least 3 feet—from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
- Protect persons caring for influenza patients in healthcare settings from contact with the pandemic influenza virus. Persons who must be in contact should:
 - Wear a surgical or procedure mask³ for close contact with infectious patients.
 - Use contact and airborne precautions, including the use of N95 respirators, when appropriate [S4-IV.C].
 - Wear gloves (gown if necessary) for contact with respiratory secretions.
 - Perform hand hygiene after contact with infectious patients.
- Contain infectious respiratory secretions:
 - Instruct persons who have “flu-like” symptoms (see below) to use respiratory hygiene/cough etiquette (See Box 2).
 - Promote use of masks⁴ by symptomatic persons in common areas (e.g., waiting rooms in physician offices or emergency departments) or when being transported (e.g., in emergency vehicles).

Symptoms of influenza include fever, headache, myalgia, prostration, coryza, sore throat, and cough. Otitis media, nausea, and vomiting are also commonly reported among children. Typical influenza (or “flu-like”) symptoms, such as fever, may not always be present in elderly patients, young children, patients in long-term care facilities, or persons with underlying chronic illnesses (see **Supplement 5, Box 2**).

² During the early stages of a pandemic, laboratory-confirmation of influenza infection is recommended when possible.

³ Surgical masks come in two basic types: one type is affixed to the head with two ties, conforms to the face with the aid of a flexible adjustment for the nose bridge, and may be flat/pleated or duck-billed in shape; the second type of surgical mask is pre-molded, adheres to the head with a single elastic and has a flexible adjustment for the nose bridge. Procedure masks are flat/pleated and affix to the head with ear loops. All masks have some degree of fluid resistance but those approved as surgical masks must meet specified standards for protection from penetration of blood and body fluids.

⁴ Coughing persons may wear either a surgical or procedure mask. However, only procedure masks come in both adult and pediatric sizes.

B. Management of infectious patients

1. Respiratory hygiene/cough etiquette

Respiratory hygiene/cough etiquette has been promoted as a strategy to contain respiratory viruses at the source and to limit their spread in areas where infectious patients might be awaiting medical care (e.g., physician offices, emergency departments) (see S4-IV.B.2).

The impact of covering sneezes and coughs and/or placing a mask on a coughing patient on the containment of respiratory secretions or on the transmission of respiratory infections has not been systematically studied. In theory, however, any measure that limits the dispersal of respiratory droplets should reduce the opportunity for transmission. Masking may be difficult in some settings, e.g., pediatrics, in which case the emphasis will be on cough hygiene.

The elements of respiratory hygiene/cough etiquette include:

- Education of healthcare facility staff, patients, and visitors on the importance of containing respiratory secretions to help prevent the transmission of influenza and other respiratory viruses
- Posted signs in languages appropriate to the populations served with instructions to patients and accompanying family members or friends to immediately report symptoms of a respiratory infection as directed
- Source control measures (e.g., covering the mouth/nose with a tissue when coughing and disposing of used tissues; using masks on the coughing person when they can be tolerated and are appropriate)
- Hand hygiene after contact with respiratory secretions, and
- Spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible.

2. Droplet precautions and patient placement

Patients with known or suspected pandemic influenza should be placed on droplet precautions for a minimum of 5 days from the onset of symptoms. Because immunocompromised patients may shed virus for longer periods, they may be placed on droplet precautions for the duration of their illness. Healthcare personnel should wear appropriate PPE (see S4-IV.C). The placement of patients will vary depending on the healthcare setting (see setting-specific guidance).

If the pandemic virus is associated with diarrhea, contact precautions (i.e., gowns and gloves for all patient contact) should be added.

CDC will update these recommendations if changes occur in the anticipated pattern of transmission (www.cdc.gov/flu).

C. Infection control practices for healthcare personnel

Infection control practices for pandemic influenza are the same as for other human influenza viruses and primarily involve the application of standard and droplet precautions (Box 1) during patient care in healthcare settings (e.g., hospitals, nursing homes, outpatient offices, emergency transport vehicles). This guidance also applies to healthcare personnel going into the homes of patients. During a pandemic, conditions that could affect infection control may include shortages of antiviral drugs, decreased efficacy of the vaccine, increased virulence of the influenza strain, shortages of single-patient rooms, and shortages of personal protective equipment. These issues may necessitate changes in the standard recommended infection control practices for influenza. CDC will provide updated infection control guidance as circumstances dictate. Additional guidance is provided for family members providing home care (S4-IV.G) and for use in public settings (e.g., schools, workplace) where people with pandemic influenza may be encountered (S4-V and S4-VI).

1. Personal protective equipment

a) PPE for standard and droplet precautions

PPE is used to prevent direct contact with the pandemic influenza virus. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures (see below). Information on the selection and use of PPE is provided at www.cdc.gov/ncidod/hip/isolat/isolat.htm/.

- **Masks (surgical or procedure)**
 - Wear a mask when entering a patient's room. A mask should be worn once and then discarded. If pandemic influenza patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
 - Change masks when they become moist.
 - Do not leave masks dangling around the neck.
 - Upon touching or discarding a used mask, perform hand hygiene.
- **Gloves**
 - A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers who have latex allergy.
 - Gloves should fit comfortably on the wearer's hands.
 - Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
 - Perform hand hygiene after glove removal.
 - If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.
 - Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.
- **Gowns**
 - Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. **Most patient interactions do not necessitate the use of gowns.** However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are examples of when a gown may be needed when caring for pandemic influenza patients.
 - A disposable gown made of synthetic fiber or a washable cloth gown may be used.
 - Ensure that gowns are of the appropriate size to fully cover the area to be protected.
 - Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
 - If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. It is doubtful that disposable aprons would provide the desired protection in the circumstances where gowns are needed to prevent contact with

influenza virus, and therefore should be avoided. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

- **Goggles or face shield**

In general, wearing goggles or a face shield for routine contact with patients with pandemic influenza is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn as recommended for standard precautions. Additional information related to the use of eye protection for infection control can be found at <http://www.cdc.gov/niosh/topics/eye/eye-infectious.html>.

b) PPE for special circumstances

- **PPE for aerosol-generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a N95 respirator or other appropriate particulate respirator. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and training. If possible, and when practical, use of an airborne isolation room may be considered when conducting aerosol-generating procedures.

- **PPE for managing pandemic influenza with increased transmissibility**

The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of influenza exhibiting increased transmissibility, during initial stages of an outbreak of an emerging or novel strain of influenza, and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.

- **Precautions for early stages of a pandemic**

Early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic influenza. Therefore precautions consistent with all possible etiologies, including a newly emerging infectious agent, should be implemented. This may involve the combined use of airborne and contact precautions, in addition to standard precautions, until a diagnosis is established.

c) Caring for patients with pandemic influenza

Healthcare personnel should be particularly vigilant to avoid:

- Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important. (See also: <http://www.cdc.gov/ncidod/hip/ppe/default.htm>)
- Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

2. Hand hygiene

Hand hygiene has frequently been cited as the single most important practice to reduce the transmission of infectious agents in healthcare settings (see <http://www.cdc.gov/handhygiene/pressrelease.htm>) and is an essential element of standard precautions. The term "hand hygiene" includes both handwashing with either plain or antimicrobial soap and water and use of alcohol-based products (gels, rinses, foams) containing an emollient that do not require the use of water.

- If hands are visibly soiled or contaminated with respiratory secretions, wash hands with soap (either non-antimicrobial or antimicrobial) and water.

- In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbiocidal activity, reduced drying of the skin, and convenience.
- Always perform hand hygiene between patient contacts and after removing PPE.
- Ensure that resources to facilitate handwashing (i.e., sinks with warm and cold running water, plain or antimicrobial soap, disposable paper towels) and hand disinfection (i.e., alcohol-based products) are readily accessible in areas in which patient care is provided. For additional guidance on hand hygiene see <http://www.cdc.gov/handhygiene/>.

3. Disposal of solid waste

Standard precautions are recommended for disposal of solid waste (medical and non-medical) that might be contaminated with a pandemic influenza virus:

- Contain and dispose of contaminated medical waste in accordance with facility-specific procedures and/or local or state regulations for handling and disposal of medical waste, including used needles and other sharps, and non-medical waste.
- Discard as routine waste used patient-care supplies that are not likely to be contaminated (e.g., paper wrappers).
- Wear disposable gloves when handling waste. Perform hand hygiene after removal of gloves.

4. Linen and laundry

Standard precautions are recommended for linen and laundry that might be contaminated with respiratory secretions from patients with pandemic influenza:

- Place soiled linen directly into a laundry bag in the patient's room. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
- Wear gloves and gown when directly handling soiled linen and laundry (e.g., bedding, towels, personal clothing) as per standard precautions. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
- Wear gloves for transporting bagged linen and laundry.
- Perform hand hygiene after removing gloves that have been in contact with soiled linen and laundry.
- Wash and dry linen according to routine standards and procedures (www.cdc.gov/ncidod/hip/enviro/guide.htm).

5. Dishes and eating utensils

Standard precautions are recommended for handling dishes and eating utensils used by a patient with known or possible pandemic influenza:

- Wash reusable dishes and utensils in a dishwasher with recommended water temperature (www.cdc.gov/ncidod/hip/enviro/guide.htm).
- Disposable dishes and utensils (e.g., used in an alternative care site set-up for large numbers of patients) should be discarded with other general waste.
- Wear gloves when handling patient trays, dishes, and utensils.

6. Patient-care equipment

Follow standard practices for handling and reprocessing used patient-care equipment, including medical devices:

- Wear gloves when handling and transporting used patient-care equipment.

- Wipe heavily soiled equipment with an EPA-approved hospital disinfectant before removing it from the patient's room. Follow current recommendations for cleaning and disinfection or sterilization of reusable patient-care equipment.
- Wipe external surfaces of portable equipment for performing x-rays and other procedures in the patient's room with an EPA-approved hospital disinfectant upon removal from the patient's room.

7. Environmental cleaning and disinfection

Cleaning and disinfection of environmental surfaces are important components of routine infection control in healthcare facilities. Environmental cleaning and disinfection for pandemic influenza follow the same general principles used in healthcare settings.

a) Cleaning and disinfection of patient-occupied rooms

(See: www.cdc.gov/ncidod/hip/enviro/Enviro_guide_03.pdf)

- Wear gloves in accordance with facility policies for environmental cleaning and wear a surgical or procedure mask in accordance with droplet precautions. Gowns are not necessary for routine cleaning of an influenza patient's room.
- Keep areas around the patient free of unnecessary supplies and equipment to facilitate daily cleaning.
- Use any EPA-registered hospital detergent-disinfectant. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.
- Follow facility procedures for regular cleaning of patient-occupied rooms. Give special attention to frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, lavatory surfaces including safety/pull-up bars, doorknobs, commodes, ventilator surfaces) in addition to floors and other horizontal surfaces.
- Clean and disinfect spills of blood and body fluids in accordance with current recommendations for Isolation Precautions (www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm).

b) Cleaning and disinfection after patient discharge or transfer

- Follow standard facility procedures for post-discharge cleaning of an isolation room.
- Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.
- Do not spray (i.e., fog) occupied or unoccupied rooms with disinfectant. This is a potentially dangerous practice that has no proven disease control benefit.

8. Postmortem care

Follow standard facility practices for care of the deceased. Practices should include standard precautions for contact with blood and body fluids.

9. Laboratory specimens and practices

Follow standard facility and laboratory practices for the collection, handling, and processing of laboratory specimens.

D. Occupational health issues

Healthcare personnel are at risk for pandemic influenza through community and healthcare-related exposures. Once pandemic influenza has reached a community, healthcare facilities must implement systems to monitor for illness in the facility workforce and manage those who are symptomatic or ill.

- Implement a system to educate personnel about occupational health issues related to pandemic influenza.
- Screen all personnel for influenza-like symptoms before they come on duty. Symptomatic personnel should be sent home until they are physically ready to return to duty.
- Healthcare personnel who have recovered from pandemic influenza, and should develop antibody against future infection with the same virus, and therefore should be prioritized for the care of patients with active pandemic influenza and its complications. These workers would also be well suited to care for patients who are at risk for serious complications from influenza (e.g., transplant patients and neonates).
- Personnel who are at high risk for complications of pandemic influenza (e.g., pregnant women, immunocompromised persons) should be informed about their medical risk and offered an alternate work assignment, away from influenza-patient care, or considered for administrative leave until pandemic influenza has abated in the community.

E. Reducing exposure of persons at high risk for complications of influenza

Persons who are well, but at high risk for influenza or its complications (e.g., persons with underlying diseases), should be instructed to avoid unnecessary contact with healthcare facilities caring for pandemic influenza patients (i.e., do not visit patients, postpone nonessential medical care).

F. Healthcare setting-specific guidance

All healthcare facilities should follow the infection control guidance in S4-IV.A-E above. The following guidance is intended to address setting-specific infection control issues that should also be considered.

1. Hospitals

a) Detection of persons entering the facility who may have pandemic influenza

- Post visual alerts (in appropriate languages) at the entrance to hospital outpatient facilities (e.g., emergency departments, outpatient clinics) instructing persons with respiratory symptoms (e.g., patients, persons who accompany them) to:
 - Inform reception and healthcare personnel when they first register for care, and
 - Practice respiratory hygiene/cough etiquette (see www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm).
 Sample visual alerts are available on CDC's SARS website: <http://www.cdc.gov/ncidod/hip/INFECT/RespiratoryPoster.pdf>
- Triage patients calling for medical appointments for influenza symptoms:
 - Discourage unnecessary visits to medical facilities.
 - Instruct symptomatic patients on infection control measures to limit transmission in the home and when traveling to necessary medical appointments.

As the scope of the pandemic escalates locally, consider setting up a separate triage area for persons presenting with symptoms of respiratory infection. Because not every patient presenting with symptoms will have pandemic influenza, infection control measures will be important in preventing further spread.

- During the peak of a pandemic, emergency departments and outpatient offices may be overwhelmed with patients seeking care. A "triage officer" may be useful for managing patient flow, including deferral of patients who do not require emergency care.
- Designate separate waiting areas for patients with influenza-like symptoms. If this is not feasible, the waiting area should be set up to enable patients with respiratory symptoms to sit as far away as possible (at least 3 feet) from other patients.

b) "Source control" measures to limit dissemination of influenza virus from respiratory secretions

- Post signs that promote respiratory hygiene/cough etiquette in common areas (e.g., elevators, waiting areas, cafeterias, lavatories) where they can serve as reminders to all persons in the healthcare facility. Signs should instruct persons to:
 - Cover the nose/mouth when coughing or sneezing.
 - Use tissues to contain respiratory secretions.
 - Dispose of tissues in the nearest waste receptacle after use.
 - Perform hand hygiene after contact with respiratory secretions.
Samples of visual alerts are available on CDC's SARS website: <http://www.cdc.gov/ncidod/hip/INFECT/RespiratoryPoster.pdf>
- Facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of materials in waiting areas for patients and visitors.
 - Provide tissues and no-touch receptacles (e.g., waste containers with pedal-operated lid or uncovered waste container) for used tissue disposal.
 - Provide conveniently located dispensers of alcohol-based hand rub.
 - Provide soap and disposable towels for handwashing where sinks are available.
- Promote the use of masks and spatial separation by persons with symptoms of influenza.
 - Offer and encourage the use of either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties or elastic) by symptomatic persons to limit dispersal of respiratory droplets.
 - Encourage coughing persons to sit as far away as possible (at least 3 feet) from other persons in common waiting areas.

c) Hospitalization of pandemic influenza patients

- Patient placement
 - Limit admission of influenza patients to those with severe complications of influenza who cannot be cared for outside the hospital setting.
 - Admit patients to either a single-patient room or an area designated for cohorting of patients with influenza.
- Cohorting
 - Designated units or areas of a facility should be used for cohorting patients with pandemic influenza.⁶ During a pandemic, other respiratory viruses (e.g., non-pandemic influenza, respiratory syncytial virus, parainfluenza virus) may be circulating concurrently in a community. Therefore, to prevent cross-transmission of respiratory viruses, whenever possible assign only patients with confirmed pandemic influenza to the same room. At the height of a pandemic, laboratory testing to confirm pandemic influenza is likely to be limited, in which case cohorting should be based on having symptoms consistent with pandemic influenza.
 - Personnel (clinical and non-clinical) assigned to cohorted patient care units for pandemic influenza patients should not "float" or otherwise be assigned to other patient care areas. The number of personnel entering the cohorted area should be limited to those necessary for patient care and support.
 - Personnel assigned to cohorted patient care units should be aware that patients with pandemic influenza may be concurrently infected or colonized with other pathogenic organisms (e.g., *Staphylococcus aureus*, *Clostridium*

⁶ During the early stages of a pandemic, laboratory-confirmation of influenza infection is recommended when possible before cohorting patients.

difficile) and should adhere to infection control practices (e.g., hand hygiene, changing gloves between patient contact) used routinely, and as part of standard precautions, to prevent nosocomial transmission.

- Because of the high patient volume anticipated during a pandemic, cohorting should be implemented early in the course of a local outbreak.
- Patient transport
 - Limit patient movement and transport outside the isolation area to medically necessary purposes.
 - Consider having portable x-ray equipment available in areas designated for cohorting influenza patients.
 - If transport or movement is necessary, ensure that the patient wears a surgical or procedure mask. If a mask cannot be tolerated (e.g., due to the patient's age or deteriorating respiratory status), apply the most practical measures to contain respiratory secretions. Patients should perform hand hygiene before leaving the room.
- Visitors
 - Screen visitors for signs and symptoms of influenza before entry into the facility and exclude persons who are symptomatic.
 - Family members who accompany patients with influenza-like illness to the hospital are assumed to have been exposed to influenza and should wear masks.
 - Limit visitors to persons who are necessary for the patient's emotional well-being and care.
 - Instruct visitors to wear surgical or procedure masks while in the patient's room.
 - Instruct visitors on hand-hygiene practices.

d) Control of nosocomial pandemic influenza transmission

- Once patients with pandemic influenza are admitted to the hospital, nosocomial surveillance should be heightened for evidence of transmission to other patients and healthcare personnel. (Once pandemic influenza is firmly established in a community this may not be feasible or necessary.)
- If limited nosocomial transmission is detected (e.g., has occurred on one or two patient care units), appropriate control measures should be implemented. These may include:
 - Cohorting of patients and staff on affected units
 - Restriction of new admissions (except for other pandemic influenza patients) to the affected unit(s)
 - Restriction of visitors to the affected unit(s) to those who are essential for patient care and support
- If widespread nosocomial transmission occurs, controls may need to be implemented hospital wide and might include:
 - Restricting all nonessential persons
 - Stopping admissions not related to pandemic influenza and stopping elective surgeries

2. Nursing homes and other residential facilities

Residents of nursing homes and other residential facilities will be at particular risk for transmission of pandemic influenza and disease complications. Pandemic influenza can be introduced through facility personnel and visitors; once a pandemic influenza virus enters such facilities, controlling its spread is problematic. Therefore, as soon as pandemic influenza has been detected in the region, nursing homes and other residential facilities should implement aggressive measures to prevent introduction of the virus.

a) Prevention or delay of pandemic influenza virus entry into the facility

- Control of visitors
 - Post visual alerts (in appropriate languages) at the entrance to the facility restricting entry by persons who have been exposed to or have symptoms of pandemic influenza.
 - Enforce visitor restrictions by assigning personnel to verbally and visually screen visitors for respiratory symptoms at points of entry to the facility.
 - Provide a telephone number where persons can call for information on measures used to prevent the introduction of pandemic influenza.
- Control of personnel
 - Implement a system to screen all personnel for influenza-like symptoms before they come on duty. Symptomatic personnel should be sent home until they are physically able to return to duty.

b) Monitoring patients for pandemic influenza and instituting appropriate control measures

Despite aggressive efforts to prevent the introduction of pandemic influenza virus, persons in the early stages of pandemic influenza could introduce it to the facility. Residents returning from a hospital stay, outpatient visit, or family visit could also introduce the virus. Early detection of the presence of pandemic influenza in a facility is critical for ensuring timely implementation of infection control measures.

- Early in the progress of a pandemic in the region, increase resident surveillance for influenza-like symptoms. Notify state or local health department officials if a case(s) is suspected.
- If symptoms of pandemic influenza are apparent (see Supplement 5), implement droplet precautions for the resident and roommates, pending confirmation of pandemic influenza virus infection. Patients and roommates should not be separated or moved out of their rooms unless medically necessary. Once a patient has been diagnosed with pandemic influenza, roommates should be treated as exposed cohorts.
- Cohort residents and staff *on units with known or suspected cases of pandemic influenza*.
- Limit movement within the facility (e.g., temporarily close the dining room and serve meals on nursing units, cancel social and recreational activities).

3. Prehospital care (emergency medical services)

Patients with severe pandemic influenza or disease complications are likely to require emergency transport to the hospital. The following information is designed to protect EMS personnel during transport.

- Screen patients requiring emergency transport for symptoms of influenza.
- Follow standard and droplet precautions when transporting symptomatic patients.
- Consider routine use of surgical or procedure masks for all patient transport when pandemic influenza is in the community.
- If possible, place a procedure or surgical mask on the patient to contain droplets expelled during coughing. If this is not possible (i.e., would further compromise respiratory status, difficult for the patient to wear), have the patient cover the mouth/nose with tissue when coughing, or use the most practical alternative to contain respiratory secretions.
- Oxygen delivery with a non-rebreather face mask can be used to provide oxygen support during transport. If needed, positive-pressure ventilation should be performed using a resuscitation bag-valve mask.
- Unless medically necessary to support life, aerosol-generating procedures (e.g., mechanical ventilation) should be avoided during prehospital care.

- Optimize the vehicle's ventilation to increase the volume of air exchange during transport. When possible, use vehicles that have separate driver and patient compartments that can provide separate ventilation to each area.
- Notify the receiving facility that a patient with possible pandemic influenza is being transported.
- Follow standard operating procedures for routine cleaning of the emergency vehicle and reusable patient care equipment.

4. Home healthcare services

Home healthcare includes health and rehabilitative services performed in the home by providers including home health agencies, hospices, durable medical equipment providers, home infusion therapy services, and personal care and support services staff. The scope of services ranges from assistance with activities of daily living and physical and occupational therapy to wound care, infusion therapy, and chronic ambulatory peritoneal dialysis (CAPD). Communication between home healthcare providers and patients or their family members is essential for ensuring that these personnel are appropriately protected.

When pandemic influenza is in the community, home health agencies should consider contacting patients before the home visit to determine whether persons in the household have an influenza-like illness.

- If patients with pandemic influenza are in the home, consider:
 - Postponing nonessential services
 - Assigning providers who are not at increased risk for complications of pandemic influenza to care for these patients
- Home healthcare providers who enter homes where there is a person with an influenza-like illness should follow the recommendations for standard and droplet precautions described above. Professional judgment should be used in determining whether to don a surgical or procedure mask upon entry into the home or only for patient interactions. Factors to consider include the possibility that others in the household may be infectious and the extent to which the patient is ambulating within the home.

5. Outpatient medical offices

Patients with nonemergency symptoms of an influenza-like illness may seek care from their medical provider. Implementation of infection control measures when these patients present for care will help prevent exposure among other patients and clinical and nonclinical office staff.

a) Detection of patients with possible pandemic influenza

- Post visual alerts (in appropriate languages) at the entrance to outpatient offices instructing persons with respiratory symptoms (e.g., patients, persons who accompany them) to:
 - Inform reception and healthcare personnel when they first register for care
 - Practice respiratory hygiene/cough etiquette (see www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm)
 Sample visual alerts may be found on CDC's SARS website: <http://www.cdc.gov/ncidod/hip/INFECT/RespiratoryPoster.pdf>
- Triage patients calling for medical appointments for influenza symptoms:
 - Discourage unnecessary visits to medical facilities.
 - Instruct symptomatic patients on infection control measures to limit transmission in the home and when traveling to necessary medical appointments.

b) "Source control" measures

- Post signs that promote cough etiquette in common areas (e.g., elevators, waiting areas, cafeterias, lavatories) where they can serve as reminders to all persons in the healthcare facility. Signs should instruct persons to:

- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions.
- Facilitate adherence to respiratory hygiene/cough etiquette. Ensure the availability of materials in waiting areas for patients and visitors.
 - Provide tissues and no-touch receptacles (e.g., waste containers with pedal-operated lid or uncovered waste container) for used tissue disposal.
 - Provide conveniently located dispensers of alcohol-based hand rub.
 - Provide soap and disposable towels for hand washing where sinks are available.
- Promote the use of procedure or surgical masks and spatial separation by persons with symptoms of influenza.
 - Offer and encourage the use of either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties or elastic) by symptomatic persons to limit dispersal of respiratory droplets.
 - Encourage coughing persons to sit at least 3 feet away from other persons in common waiting areas.

c) Patient placement

- Where possible, designate separate waiting areas for patients with symptoms of pandemic influenza. Place signs indicating the separate waiting areas.
- Place symptomatic patients in an evaluation room as soon as possible to limit their time in common waiting areas.

6. Other ambulatory settings

A wide variety of ambulatory settings provide chronic (e.g., hemodialysis units) and episodic (e.g., freestanding surgery centers, dental offices) healthcare services. When pandemic influenza is in the region, these facilities should implement control measures similar to those recommended for outpatient physician offices. Other infection control strategies that may be utilized include:

- Screening patients for influenza-like illness by phone or before coming into the facility and rescheduling appointments for those whose care is nonemergency
- Canceling all nonemergency services when there is pandemic influenza in the community

G. Care of pandemic influenza patients in the home

Most patients with pandemic influenza will be able to remain at home during the course of their illness and can be cared for by other family members or others who live in the household. Anyone residing in a household with an influenza patient during the incubation period and illness is at risk for developing influenza. A key objective in this setting is to limit transmission of pandemic influenza within and outside the home. When care is provided by a household member, basic infection control precautions should be emphasized (e.g., segregating the ill patient, hand hygiene). Infection within the household may be minimized if a primary caregiver is designated, ideally someone who does not have an underlying condition that places them at increased risk of severe influenza disease. Although no studies have assessed the use of masks at home to decrease the spread of infection, use of surgical or procedure masks by the patient and/or caregiver during interactions may be of benefit.

1. Management of influenza patients

- Physically separate the patient with influenza from non-ill persons living in the home as much as possible.
- Patients should not leave the home during the period when they are most likely to be infectious to others (i.e., 5 days after onset of symptoms). When movement outside the home is necessary (e.g., for medical care), the patient should

follow cough etiquette (i.e., cover the mouth and nose when coughing and sneezing) and wear procedure or surgical masks if available.

2. Management of other persons in the home

- Persons who have not been exposed to pandemic influenza and who are not essential for patient care or support should not enter the home while persons are actively ill with pandemic influenza.
- If unexposed persons must enter the home, they should avoid close contact with the patient.
- Persons living in the home with the pandemic influenza patient should limit contact with the patient to the extent possible; consider designating one person as the primary care provider.
- Household members should monitor closely for the development of influenza symptoms and contact a telephone hotline or medical care provider if symptoms occur.

3. Infection control measures in the home

- All persons in the household should carefully follow recommendations for hand hygiene (i.e., handwashing with soap and water or use of an alcohol-based hand rub) after contact with an influenza patient or the environment in which care is provided.
- Although no studies have assessed the use of masks at home to decrease the spread of infection, use of surgical or procedure masks by the patient and/or caregiver during interactions may be of benefit. The wearing of gloves and gowns is not recommended for household members providing care in the home.
- Soiled dishes and eating utensils should be washed either in a dishwasher or by hand with warm water and soap. Separation of eating utensils for use by a patient with influenza is not necessary.
- Laundry can be washed in a standard washing machine with warm or cold water and detergent. It is not necessary to separate soiled linen and laundry used by a patient with influenza from other household laundry. Care should be used when handling soiled laundry (i.e., avoid "hugging" the laundry) to avoid contamination. Hand hygiene should be performed after handling soiled laundry.
- Tissues used by the ill patient should be placed in a bag and disposed with other household waste. Consider placing a bag for this purpose at the bedside.
- Normal cleaning of environmental surfaces in the home should be followed.

H. Care of pandemic influenza patients at alternative sites

If an influenza pandemic results in severe illness that overwhelms the capacity of existing healthcare resources, it may become necessary to provide care at alternative sites (e.g., schools, auditoriums, conference centers, hotels). Existing "all-hazard" plans have likely identified designated sites for this purpose. The same principles of infection control apply in these settings as in other healthcare settings. Careful planning is necessary to ensure that resources are available and procedures are in place to adhere to the key principles of infection control.

S4-V. RECOMMENDATIONS FOR INFECTION CONTROL IN SCHOOLS AND WORKPLACES

- In schools and workplaces, infection control for pandemic influenza should focus on:
 - Keeping sick students, faculty, and workers away while they are infectious.
 - Promoting respiratory hygiene/cough etiquette and hand hygiene as for any respiratory infection.

The benefit of wearing masks in these settings has not been established.

- School administrators and employers should ensure that materials for respiratory hygiene/cough etiquette (i.e., tissues and receptacles for their disposal) and hand hygiene are available. Educational messages and infection control guidance for pandemic influenza are available for distribution. (CDC will develop educational materials appropriate to various audiences.)

S4-VI. RECOMMENDATIONS FOR INFECTION CONTROL IN COMMUNITY SETTINGS

Infection control in the community should focus on “social distancing” and promoting respiratory hygiene/cough etiquette and hand hygiene to decrease exposure to others. This could include the use of masks by persons with respiratory symptoms, if feasible. Although the use of masks in community settings has not been demonstrated to be a public health measure to decrease infections during a community outbreak, persons may choose to wear a mask as part of individual protection strategies that include cough etiquette, hand hygiene, and avoiding public gatherings. Mask use may also be important for persons who are at high risk for complications of influenza. Public education should be provided on how to use masks appropriately. Persons at high risk for complications of influenza should try to avoid public gatherings (e.g., movies, religious services, public meetings) when pandemic influenza is in the community. They should also avoid going to other public areas (e.g., food stores, pharmacies); the use of other persons for shopping or home delivery service is encouraged.

BOX 1. SUMMARY OF INFECTION CONTROL RECOMMENDATIONS FOR CARE OF PATIENTS WITH PANDEMIC INFLUENZA

COMPONENT	RECOMMENDATIONS
STANDARD PRECAUTIONS	See www.cdc.gov/ncidod/hip/ISOLAT/std_prec_excerpt.htm
Hand hygiene	Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.
Personal protective equipment (PPE) <ul style="list-style-type: none"> • Gloves • Gown • Face/eye protection (e.g., surgical or procedure mask and goggles or a face shield) 	<ul style="list-style-type: none"> • For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).
Patient resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.
Soiled linen and laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and other sharps	Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.

BOX 1. SUMMARY OF INFECTION CONTROL RECOMMENDATIONS FOR CARE OF PATIENTS WITH PANDEMIC INFLUENZA (CONT.)

COMPONENT	RECOMMENDATIONS
STANDARD PRECAUTIONS (cont.)	See www.cdc.gov/ncidod/hip/ISOLAT/std_prec_excerpt.htm
Environmental cleaning and disinfection	Use EPA-registered hospital detergent-disinfectant; follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).
Disposal of solid waste	Contain and dispose of solid waste (medical and non-medical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.
Respiratory hygiene/cough etiquette Source control measures for persons with symptoms of a respiratory infection; implement at first point of encounter (e.g., triage/reception areas) within a healthcare setting.	Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.
DROPLET PRECAUTIONS	www.cdc.gov/ncidod/hip/ISOLAT/droplet_prec_excerpt.htm
Patient placement	Place patients with influenza in a private room or cohort with other patients with influenza.* Keep door closed or slightly ajar; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room. *During the early stages of a pandemic, infection with influenza should be laboratory-confirmed, if possible.
Personal protective equipment	Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Other	Follow standard precautions and facility procedures for handling linen and laundry and dishes and eating utensils, and for cleaning/disinfection of environmental surfaces and patient care equipment, disposal of solid waste, and postmortem care.
AEROSOL-GENERATING PROCEDURES	During procedures that may generate small particles of respiratory secretions (e.g., endotracheal intubation, bronchoscopy, nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator or other appropriate particulate respirator.

BOX 2. RESPIRATORY HYGIENE/COUGH ETIQUETTE

To contain respiratory secretions, all persons with signs and symptoms of a respiratory infection, regardless of presumed cause, should be instructed to:

- Cover the nose/mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions.
- Dispose of tissues in the nearest waste receptacle after use.
- Perform hand hygiene after contact with respiratory secretions and contaminated objects/materials.

Healthcare facilities should ensure the availability of materials for adhering to respiratory hygiene/cough etiquette in waiting areas for patients and visitors:

- Provide tissues and no-touch receptacles for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub.
 - Provide soap and disposable towels for handwashing where sinks are available.

Masking and separation of persons with symptoms of respiratory infection

During periods of increased respiratory infection in the community, persons who are coughing should be offered either a procedure mask (i.e., with ear loops) or a surgical mask (i.e., with ties) to contain respiratory secretions. Coughing persons should be encouraged to sit as far away as possible (at least 3 feet) from others in common waiting areas. Some facilities may wish to institute this recommendation year-round.