

**III.A. Standard Precautions** Standard Precautions combine the major features of Universal Precautions (UP)<sup>780, 896</sup> and Body Substance Isolation (BSI)<sup>640</sup> and are based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered (Table 4). These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient). The application of Standard Precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. For some interactions (e.g., performing venipuncture), only gloves may be needed; during other interactions (e.g., intubation), use of gloves, gown, and face shield or mask and goggles is necessary. Education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions because they facilitate appropriate decision-making and promote adherence when HCWs are faced with new circumstances<sup>655, 681-686</sup>. An example of the importance of the use of Standard Precautions is intubation, especially under emergency circumstances when infectious agents may not be suspected, but later are identified (e.g., SARS-CoV, *N. meningitidis*). The application of Standard Precautions is described below and summarized in Table 4. Guidance on donning and removing gloves, gowns and other PPE is presented in the Figure. Standard Precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or via equipment used during patient care.

**III.A.1. New Elements of Standard Precautions** Infection control problems that are identified in the course of outbreak investigations often indicate the need for new recommendations or reinforcement of existing infection control recommendations to protect patients. Because such recommendations are considered a standard of care and may not be included in other guidelines, they are added here to Standard Precautions. Three such areas of practice that have been added are: Respiratory Hygiene/Cough Etiquette, safe injection practices, and use of masks for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia). While most elements of Standard Precautions evolved from Universal Precautions that were developed for protection of healthcare personnel, these new elements of Standard Precautions focus on protection of patients.

**III.A.1.a. Respiratory Hygiene/Cough Etiquette** The transmission of SARS-CoV in emergency departments by patients and their family members during the widespread SARS outbreaks in 2003 highlighted the need for vigilance and prompt implementation of infection control measures at the first point of encounter within a healthcare setting

(e.g., reception and triage areas in emergency departments, outpatient clinics, and physician offices)<sup>21, 254, 897</sup>. The strategy proposed has been termed Respiratory Hygiene/Cough Etiquette<sup>9, 828</sup> and is intended to be incorporated into infection control practices as a new component of Standard Precautions. The strategy is targeted at patients and accompanying family members and friends with undiagnosed transmissible respiratory infections, and applies to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering a healthcare facility<sup>40, 41, 43</sup>. The term *cough etiquette* is derived from recommended source control measures for *M. tuberculosis*<sup>12, 126</sup>. The elements of Respiratory Hygiene/Cough Etiquette include 1) education of healthcare facility staff, patients, and visitors; 2) posted signs, in language(s) appropriate to the population served, with instructions to patients and accompanying family members or friends; 3) source control measures (e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate); 4) hand hygiene after contact with respiratory secretions; and 5) spatial separation, ideally >3 feet, of persons with respiratory infections in common waiting areas when possible. Covering sneezes and coughs and placing masks on coughing patients are proven means of source containment that prevent infected persons from dispersing respiratory secretions into the air<sup>107, 145, 898, 899</sup>.

Masking may be difficult in some settings, (e.g., pediatrics, in which case, the emphasis by necessity may be on cough etiquette<sup>900</sup>). Physical proximity of <3 feet has been associated with an increased risk for transmission of infections via the droplet route (e.g., *N. meningitidis*<sup>103</sup> and group A streptococcus<sup>114</sup> and therefore supports the practice of distancing infected persons from others who are not infected. The effectiveness of good hygiene practices, especially hand hygiene, in preventing transmission of viruses and reducing the incidence of respiratory infections both within and outside<sup>901-903</sup> healthcare settings is summarized in several reviews<sup>559, 717, 904</sup>. These measures should be effective in decreasing the risk of transmission of pathogens contained in large respiratory droplets (e.g., influenza virus<sup>23</sup>, adenovirus<sup>111</sup>, *B. pertussis*<sup>827</sup> and *Mycoplasma pneumoniae*<sup>112</sup>). Although fever will be present in many respiratory infections, patients with pertussis and mild upper respiratory tract infections are often afebrile. Therefore, the absence of fever does not always exclude a respiratory infection. Patients who have asthma, allergic rhinitis, or chronic obstructive lung disease also may be coughing and sneezing. While these patients often are not infectious, cough etiquette measures are prudent. Healthcare personnel are advised to observe Droplet Precautions (i.e., wear a mask) and hand hygiene when examining and caring for patients with signs and symptoms of a respiratory infection. Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a mask should be worn while providing patient care.

**III.A.1.b. Safe Injection Practices** The investigation of four large outbreaks of HBV and HCV among patients in ambulatory care facilities in the United States identified a need to define and reinforce safe injection practices<sup>453</sup>. The four outbreaks occurred in a private medical practice, a pain clinic, an endoscopy clinic, and a hematology/oncology clinic. The primary breaches in infection control practice that contributed to these outbreaks were 1) reinsertion of used needles into a multiple-dose vial or solution container (e.g., saline bag) and 2) use of a single needle/syringe to administer intravenous medication to multiple patients. In one of these outbreaks, preparation of medications in the same workspace where used needle/syringes were dismantled also may have been a contributing factor. These and other outbreaks of viral hepatitis could have been prevented by adherence to basic principles of aseptic technique for the preparation and administration of parenteral medications<sup>453, 454</sup>. These include the use of a sterile, single-use, disposable needle and syringe for each injection given and prevention of contamination of injection equipment and medication. Whenever possible, use of single-dose vials is preferred over multiple-dose vials, especially when medications will be administered to multiple patients. Outbreaks related to unsafe injection practices indicate that some healthcare personnel are unaware of, do not understand, or do not adhere to basic principles of infection control and aseptic technique. A survey of US healthcare workers who provide medication through injection found that 1% to 3% reused the same needle and/or syringe on multiple patients<sup>905</sup>. Among the deficiencies identified in recent outbreaks were a lack of oversight of personnel and failure to follow-up on reported breaches in infection control practices in ambulatory settings. Therefore, to ensure that all healthcare workers understand and adhere to recommended practices, principles of infection control and aseptic technique need to be reinforced in training programs and incorporated into institutional policies that are monitored for adherence<sup>454</sup>.

**III.A.1.c. Infection Control Practices for Special Lumbar Puncture Procedures** In 2004, CDC investigated eight cases of post-myelography meningitis that either were reported to CDC or identified through a survey of the Emerging Infections Network of the Infectious Disease Society of America. Blood and/or cerebrospinal fluid of all eight cases yielded streptococcal species consistent with oropharyngeal flora and there were changes in the CSF indices and clinical status indicative of bacterial meningitis. Equipment and products used during these procedures (e.g., contrast media) were excluded as probable sources of contamination. Procedural details available for seven cases determined that antiseptic skin preparations and sterile gloves had been used. However, none of the clinicians wore a face mask, giving rise to the speculation that droplet transmission of oropharyngeal flora was the most likely explanation for these infections. Bacterial meningitis following myelogram and other spinal procedures (e.g., lumbar puncture, spinal and epidural anesthesia, intrathecal chemotherapy) has been reported previously<sup>906-915</sup>. As a result, the question of whether face masks should be worn to prevent droplet spread of oral flora during spinal procedures (e.g., myelogram, lumbar puncture, spinal anesthesia) has been debated<sup>916, 917</sup>. Face masks are effective in limiting the dispersal of oropharyngeal droplets<sup>918</sup> and are recommended for the

placement of central venous catheters . In October 2005, the Healthcare Infection Control Practices Advisory Committee (HICPAC) reviewed the evidence and concluded that there is sufficient experience to warrant the additional protection of a face mask for the individual placing a catheter or injecting material into the spinal or epidural space.

Source: 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  
<http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>