

California Department of Public Health Healthcare-Associated Infections Program

Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in California Skilled Nursing Facilities – 2024-25

Introduction

Skilled nursing facility (SNF) residents are at increased risk for severe disease, hospitalization, death, and outbreaks caused by SARS-CoV-2 (the virus that causes COVID-19), influenza, respiratory syncytial virus (RSV), and other respiratory viruses. This California Department of Public Health (CDPH) guidance document provides streamlined recommendations and strategies that can be broadly applied for the prevention and control of COVID-19, influenza, RSV, and other common respiratory viruses (e.g., adenovirus, parainfluenza virus, etc.) in California SNFs. This guidance aligns with the Centers for Disease Control and Prevention (CDC) [Viral Respiratory Pathogens Toolkit for Nursing Homes](https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/) (www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/).

Key Messages

- **Encourage residents and healthcare personnel (HCP) to stay up to date on recommended vaccinations** to prevent morbidity and mortality from respiratory infections in SNFs.
- **Maintain policies for source control masking** with well-fitting facemasks or respirators that cover a person's mouth and nose to reduce respiratory virus transmission in healthcare settings.
- **Initiate prompt testing and treatment** of COVID-19 and influenza to reduce the risk of severe illness, hospitalization, and death.

Guidance

Develop and implement a **respiratory virus prevention and control plan** year-round, as respiratory viruses occur throughout the year with heightened activity in the winter months. The SNF infection preventionist (IP) leads and monitors implementation with the assistance and support of facility leadership. Maintain **awareness of respiratory virus circulation** throughout the year in the local community to guide prevention efforts, prepare to care for residents with infections, and manage outbreaks. Refer to:

- [California Weekly Respiratory Virus Report](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/RespiratoryVirusReport.aspx)
(www.cdph.ca.gov/Programs/CID/DCDC/Pages/RespiratoryVirusReport.aspx)
- CDC [RESP-NET](https://www.cdc.gov/surveillance/resp-net/dashboard.html)
(www.cdc.gov/surveillance/resp-net/dashboard.html)
- CDC [Respiratory Illnesses Data Channel](https://www.cdc.gov/respiratory-illnesses/data/index.html)
(www.cdc.gov/respiratory-illnesses/data/index.html)

Elements of a SNF respiratory virus prevention and control plan include:

Vaccination

- **Vaccines are the most effective tools for preventing infection, hospitalization, serious complications, and deaths from respiratory infections.** Available vaccines for prevention of respiratory infections in adults include COVID-19, influenza, pneumococcal, and RSV vaccines.
 - Refer to [CDC Adult Immunization Schedule by Age](https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html) (www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html).
 - For links to current respiratory infection vaccine guidance, education, and promotion tools, refer to [CDPH Resources for Long-Term Care Facilities](https://eziz.org/resources-for-longterm-care-facilities/) (eziz.org/resources-for-longterm-care-facilities/).
- The Center for Medicare and Medicaid Services (CMS) requires SNFs to **educate and offer** COVID-19, influenza, and pneumococcal vaccines to residents, and to educate and offer COVID-19 vaccines to HCP. Refer to [eCFR :: 42 CFR 483.80 -- Infection control](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.80#p-483.80(d)(3)) ([www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.80#p-483.80\(d\)\(3\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.80#p-483.80(d)(3))).
- During outbreaks, continue to offer vaccines that protect against respiratory diseases to residents and HCP according to CDC recommendations.

Source Control Masking

- HCP use of masks or respirators for source control of respiratory infections in healthcare settings **prevents HCP from infecting residents and other HCP with respiratory viruses.** Implement source control masking:
 - During periods of increased community transmission of respiratory viruses
 - If there are elevated resident or HCP respiratory infections or HCP absenteeism
 - In the event of a facility outbreak
- During an outbreak, consider source control masking for residents while in common areas.
- For additional considerations, see [CDPH Guidance for Face Coverings as Source Control in Healthcare Settings](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-for-Face-Coverings-as-Source-Control-in-Healthcare-Settings.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-for-Face-Coverings-as-Source-Control-in-Healthcare-Settings.aspx).

Ventilation and Filtration of Indoor Air and Isolation Areas

- Proper **ventilation and filtration of indoor air** helps reduce the accumulation of infectious virus particles and reduce the risk of transmission of SARS-CoV-2 and other respiratory viruses in SNFs.
 - For strategies to improve general indoor air quality, refer to CDPH's guidance on [Improving Ventilation Practices to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities](https://www.cdph.ca.gov/Programs/CCDC/DEODC/OHB/Pages/ventilationFAQ.aspx) (www.cdph.ca.gov/Programs/CCDC/DEODC/OHB/Pages/ventilationFAQ.aspx).
- For additional strategies to improve ventilation and filtration and create directional airflow from clean to less-clean isolation areas, refer to CDPH's [Best Practices for Ventilation of Isolation Areas to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities, Long-Term Care Facilities, Hospices, Drug Treatment Facilities, and Homeless Shelters](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Best-Practices-for-Ventilation-of-Isolation-Areas-to-Reduce-COVID-19-Transmission-Risk.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Best-Practices-for-Ventilation-of-Isolation-Areas-to-Reduce-COVID-19-Transmission-Risk.aspx).

Monitoring for Respiratory Illness

- During periods of increased community transmission of respiratory viruses and in the event of an outbreak, conduct **active daily monitoring of residents** to identify signs or symptoms of respiratory illness and quickly manage any ill residents.
 - Track residents with respiratory illness using a line list.
- Educate HCP on routine self-screening for signs and symptoms of respiratory illness before reporting to work. During periods of increased community transmission of respiratory viruses and in the event of an outbreak, institute **active symptom screening of HCP** upon reporting to work. This could include establishing a process for HCP to self-attest if they have a positive test for COVID-19, respiratory symptoms or fever, or close contact with someone with COVID-19.

Management of Healthcare Personnel with Respiratory Symptoms or COVID-19 Exposures

- If HCP develop symptoms while at work, instruct them to put on a mask (if they are not already wearing a mask), notify their supervisor, leave promptly, and obtain testing for SARS-CoV-2 and influenza.
- If HCP test positive for SARS-CoV-2, follow return-to-work guidance outlined in [AFL 21-08.9](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx) (www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx); otherwise, follow routine return-to-work guidance for ill HCP (i.e., HCP should not return to work until afebrile >24 hours without antipyretic treatment and with improvement in respiratory symptoms).
- In the setting of an outbreak, it's essential that the facility has instituted source control masking broadly. This would apply to all HCP, including those returning to work after a suspected or confirmed respiratory infection.
- Ensure that the facility has a transparent, non-punitive sick leave policy for HCP to allow them to stay home when they are sick.
- HCP who have had close contact with someone with COVID-19 are not restricted from work but should follow the testing and masking guidance specified in [AFL 21-08.9](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx) (www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx).

Testing

- Testing to identify the etiology of acute respiratory illness is necessary to inform:
 - Treatment of COVID-19 and influenza
 - Chemoprophylaxis during an influenza outbreak
 - Transmission-Based Precautions and cohorting decisions

- In advance of each winter respiratory virus season and especially during periods of increased community transmission of respiratory viruses:
 - Determine the point-of-care SARS-CoV-2 and influenza test supplies that will be needed and how the SNF will obtain and re-stock them as needed.
 - Identify a laboratory that performs molecular testing for SARS-CoV-2, influenza, and complete respiratory panels and provides results within 24-48 hours.
- **Immediately test residents and HCP with signs or symptoms of respiratory illness:**
 - Test for SARS-CoV-2, and for influenza when influenza is circulating.
 - If a rapid antigen (point-of-care) test for SARS-CoV-2 or influenza is used to test a symptomatic individual and is negative, obtain confirmatory testing with a molecular test.
 - If RSV is circulating, consider preferential use of a molecular test that includes RSV in addition to SARS-CoV-2 and influenza; this could include a full respiratory panel or other multiplex assay.
 - If initial testing is negative and >1 resident is ill, obtain a full respiratory panel to evaluate for other respiratory infections.
 - See CDC guidance on [Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating](https://www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html) (www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html).
 - See CDPH [quicksheet](https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/FluAndRespiratoryIllnessOutbreakQuicksheet.pdf) (PDF) for additional information on specimen collection (www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/FluAndRespiratoryIllnessOutbreakQuicksheet.pdf).
- For asymptomatic SARS-CoV-2-exposed residents or HCP:
 - Test for SARS-CoV-2 immediately (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and if negative, again at 5 days after the exposure.
 - Quarantine is not necessary for asymptomatic exposed residents. However, all asymptomatic residents who have had close contact with someone with COVID-19 should continue to wear a mask when outside their room for 10 days after their exposure even if tests are negative in that time period.
- The approach to a COVID-19 outbreak investigation in a SNF could involve either contact tracing or a broad-based approach; for specific guidance on testing in response to a COVID-19 outbreak, consult with your local health department and see [CDC Infection Control Guidance: SARS-CoV-2](https://www.cdc.gov/covid/hcp/infection-control/index.html) (www.cdc.gov/covid/hcp/infection-control/index.html).
- In general, **testing asymptomatic individuals for influenza, RSV, or other non-SARS-CoV-2 respiratory viruses is not recommended**. Reserve combined SARS-CoV-2/influenza rapid tests for residents with respiratory symptoms; do not use combined SARS-CoV-2/influenza rapid tests for asymptomatic testing.
- In certain circumstances (e.g., unusual severity of illness or higher-than-expected attack rate), public health might recommend additional testing of respiratory specimens for whole genome sequencing.

Isolation, Transmission-Based Precautions, and Cohorting

- Symptomatic residents and residents with respiratory virus exposures should generally remain in their current room and wear a mask for source control when outside their room. **Avoid movement of residents that could lead to new exposures** (e.g., roommates of symptomatic residents, who have already been potentially exposed, should not be placed with new roommates, if possible).

- **While awaiting test results on symptomatic residents, implement empiric Transmission-Based Precautions for COVID-19**, including HCP use of a fit-tested N95 or higher-level respirator, eye protection, gloves and gown.
 - **If SARS-CoV-2 test results are negative, HCP may downgrade their N95 to a surgical mask while awaiting test results for influenza and other respiratory viruses**; ongoing Transmission-Based Precautions will depend on the determined etiology.
- Refer to Table 1 for guidance on recommended Transmission-Based Precautions and personal protective equipment (PPE) for HCP caring for residents with COVID-19, influenza, and RSV infection. Table 1 also includes guidance on recommended duration of isolation for residents with these infections.
- Residents with confirmed COVID-19 should be placed in a single room, if available, or a designated COVID-19 isolation area or cohort. This area may be a designated floor, unit, or wing, or a group of rooms at the end of a unit that is physically separate and ideally includes ventilation measures to prevent transmission to other residents outside the isolation area.
- If single rooms are unavailable, multiple residents with confirmed influenza or other respiratory viruses (e.g., RSV) may be cohorted together in shared rooms or a designated area of the facility for residents with the *same confirmed virus infection*. Otherwise, residents should remain in their original rooms.
- Restrict residents with respiratory infections from communal dining or other group activities while in isolation (e.g., serve meals in room, bring activities into room, use electronic devices to connect with others outside of the room virtually).

Additional Infection Prevention and Control Measures

- During periods of increased community transmission of respiratory viruses and in the event of an outbreak:
 - Implement active screening of visitors for signs and symptoms of respiratory virus infection.
 - In general, SNFs should not restrict visitation for residents; however, symptomatic visitors should be asked to defer their visit and offered a remote visit or other alternative.
 - Increase the frequency of environmental cleaning and disinfection with focus on high-touch surfaces and common areas.
 - Display signage promoting **respiratory hygiene and cough etiquette for residents, HCP, and visitors**.
 - Provide supplies including masks for source control, tissues, and no-touch receptacles for tissue disposal.
 - For signage that facilities can download and print, refer to [Print Materials, Graphics and More from Project Firstline](https://www.cdc.gov/project-firstline/hcp/communication-resources/index.html) (www.cdc.gov/project-firstline/hcp/communication-resources/index.html).
- In the event of an outbreak, consider temporarily pausing communal dining and other group activities until control measures have been instituted.
- Consult with the local health department (LHD) to determine if the facility should limit new admissions during an outbreak.
 - Develop plans for managing new admissions and readmissions of residents with COVID-19 or influenza who require Transmission-Based Precautions, while still maintaining capacity to provide care safely for other residents.
 - Facility-wide and prolonged closures are not necessary if transmission is controlled and there is an unaffected location available where new admissions can be placed.

Antiviral Treatment and Chemoprophylaxis

- **Prompt antiviral treatment of SNF residents with newly diagnosed influenza and mild-moderate COVID-19 can reduce serious illness, hospitalizations, and death.**
 - All facilities should develop processes for ensuring rapid treatment per clinical guidelines.
- SNFs should evaluate all residents for any specific dose adjustments that will be needed for influenza antiviral drugs (e.g., renal dosing), and for oral COVID-19 therapeutic drug-drug interaction risk and/or renal and hepatic impairment *in advance of a diagnosis*, and indicate this information in charts to facilitate prompt access to appropriate therapeutics when an influenza or COVID-19 diagnosis is made. Refer to [AFL-23-29](http://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-29.aspx) (www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-29.aspx).
- COVID-19:
 - Provide antiviral treatment for SNF residents with mild-to-moderate COVID-19 as soon as possible.
 - See [AFL-23-29](http://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-29.aspx) (www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-29.aspx).
 - See [IDSA Guidelines on the Treatment and Management of Patients with COVID-19](http://www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/) (www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/).
 - See [CDPH COVID-19 Treatments](http://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Treatments.aspx) (www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Treatments.aspx).
- Influenza:
 - Provide antiviral treatment immediately for all residents with suspected or confirmed influenza.
 - See [CDC Influenza Antiviral Medications](http://www.cdc.gov/flu/professionals/antivirals/index.htm) (www.cdc.gov/flu/professionals/antivirals/index.htm).
 - Provide influenza antiviral chemoprophylaxis to all exposed non-ill individuals (e.g., roommates) of residents with confirmed influenza.
 - Once an influenza outbreak is determined, promptly provide influenza antiviral chemoprophylaxis with the currently recommended antiviral drug at the appropriate dose to all non-ill residents in the affected ward or facility, regardless of vaccination status, per [CDC guidance](http://www.cdc.gov/flu/hcp/infection-control/ltc-facility-guidance.html) (www.cdc.gov/flu/hcp/infection-control/ltc-facility-guidance.html).
 - If there is a limited supply of antiviral drugs, prioritize roommates and residents on the same floor or unit as residents with active influenza, and residents in the same building with shared HCP.
 - Continue influenza chemoprophylaxis for at least 2 weeks, and for at least 7 days after the last known case was identified.

Outbreak Definitions, Reporting, and Duration of Outbreak Control Measures

- COVID-19:
 - Residents: ≥ 2 cases of probable or confirmed COVID-19 among residents, with epi-linkage.
 - HCP: ≥ 2 cases of suspect, probable or confirmed COVID-19 among HCP AND ≥ 1 case of probable or confirmed COVID-19 among residents, with epi-linkage AND no other more likely sources of exposure for at least 1 of the cases.
 - Epi-linkage among SNF residents is defined as overlap on the same unit or having the potential to have been cared for by common HCP within a 7-day time period of each other; this could include residents who resided in the same facility within a 7-day time period of each other, where the possibility of exposure to common HCP cannot be excluded. See [CORHA COVID-19 guidance](http://www.corha.org/wp-content/uploads/2024/01/COVID-19-HC-Outbreak-Definition-Guidance_January-2024.pdf) (PDF)(www.corha.org/wp-content/uploads/2024/01/COVID-19-HC-Outbreak-Definition-Guidance_January-2024.pdf).

- Influenza:
 - At least one case of laboratory-confirmed influenza in the setting of a cluster (≥ 2 cases) of influenza-like illness (ILI) within a 72-hour period.
 - ILI is defined as fever ($\geq 100^{\circ}\text{F}$ or 37.8°C) plus cough and/or sore throat, in the absence of a known cause other than influenza. Persons with ILI often have fever or feverishness with cough, chills, headache, myalgia, sore throat, or runny nose. Some persons, such as older persons, may have atypical clinical presentations, including the absence of fever.
- Non-influenza and non-COVID-19, respiratory outbreak of known etiology:
 - At least one case of a laboratory-confirmed respiratory pathogen, other than influenza or COVID-19, in the setting of a cluster (≥ 2 cases) of acute respiratory illness (ARI) within a 72-hour period.
 - ARI is defined as an illness characterized by any two of the following: fever, cough, rhinorrhea (runny nose) or nasal congestion, sore, or muscle aches.
- Respiratory outbreak of unknown etiology:
 - A sudden increase of ARI cases over the normal background rate in the absence of a known etiology.
- As soon as the criteria for an outbreak are met:
 - Notify facility IP, administration, and medical director
 - Report to local health department (LHD), per Title 17 California Code of Regulations
 - Report to CDPH Licensing and Certification (L&C) district office (AFL 23-08)
 - As a best practice, notify other stakeholders (e.g., residents, family members, visitors) per the [Framework for Healthcare-Associated Infection Outbreak Notification](https://corha.org/tools/patient-notification) (corha.org/tools/patient-notification)
- In general, once no new cases have been identified for at least two median incubation periods after the last confirmed case, it is reasonable to consider the outbreak over and resume routine operations.
 - For influenza and currently circulating SARS-CoV-2, the duration of two median incubation periods is approximately 1 week. For RSV outbreaks, a 10-day duration of outbreak control measures can be used. In addition, some measures instituted during an outbreak, e.g., source control masking, influenza antiviral chemoprophylaxis, etc., may continue beyond the defined end of the outbreak.
 - For outbreaks caused by other respiratory viruses, if the respiratory virus is identified, use the approximate duration of two median incubation periods to determine how long to continue outbreak control measures. If the respiratory virus is unknown and/or mild in nature, it would be reasonable to use 7 days.
- Notify and consult the CDPH HAI Program at HAIProgram@cdph.ca.gov, in addition to your LHD, in the event of an outbreak with unusual severity (hospitalizations and/or deaths) or higher-than-expected attack rate, or if infection prevention and control guidance or an infection preventionist site visit is requested.

Key Resources

[CDC Viral Respiratory Pathogens Toolkit for Nursing Homes](https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit)

(www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit)

[CDC Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating](https://www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html)

(www.cdc.gov/flu/hcp/testing-methods/nursing-homes.html)

[CDC Infection Control Guidance: SARS-CoV-2](https://www.cdc.gov/covid/hcp/infection-control/index.html)

(www.cdc.gov/covid/hcp/infection-control/index.html)

[CDC Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities](https://www.cdc.gov/flu/hcp/infection-control/ltc-facility-guidance.html)

(www.cdc.gov/flu/hcp/infection-control/ltc-facility-guidance.html)

[CDC Prevention Strategies for Seasonal Influenza in Healthcare Settings](https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html)

(www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html)

[CDPH Guidance for Face Coverings as Source Control in Healthcare Settings](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-for-Face-Coverings-as-Source-Control-in-Healthcare-Settings.aspx)

(www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-for-Face-Coverings-as-Source-Control-in-Healthcare-Settings.aspx)

[Clinical Practice Guidelines by the Infectious Diseases Society of America: 2018 Update on Diagnosis, Treatment, Chemoprophylaxis, and Institutional Outbreak Management of Seasonal Influenza](https://academic.oup.com/cid/article/68/6/e1/5251935?login=false)

(academic.oup.com/cid/article/68/6/e1/5251935?login=false)

[CDC Clinical Overview of RSV](https://www.cdc.gov/rsv/hcp/clinical-overview/index.html)

(www.cdc.gov/rsv/hcp/clinical-overview/index.html)

Table 1. Recommended Transmission-Based Precautions and Duration of Isolation for Residents with Respiratory Viral Infections

Virus	Mask or Respirator*	Eye Protection	Gown	Gloves	Duration of Isolation
SARS-CoV-2	N95 or higher-level respirator	Yes	Yes	Yes	10 days
Influenza	Surgical mask	Per Standard Precautions	Per Standard Precautions	Per Standard Precautions	≥ 7 days
RSV and other respiratory viruses	Surgical mask	Per Standard Precautions	Yes	Yes	≥ 7 days**

[Interim Infection Prevention and Control Recommendations for Healthcare Personnel During COVID-19 Pandemic](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

[Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities](https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm)

(www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm)

[CDC Isolation Precautions Guideline](https://www.cdc.gov/infection-control/hcp/isolation-precautions/index.html)

(www.cdc.gov/infection-control/hcp/isolation-precautions/index.html) Appendix A, Table 2.

*SNFs are subject to the [Cal/OSHA Aerosol Transmissible Diseases \(ATD\) Standard](#) (PDF) and should consult those regulations for applicable requirements (www.dir.ca.gov/dosh/dosh_publications/ATD-Guide.pdf).

**[CDC Clinical Overview of RSV](#) (www.cdc.gov/rsv/hcp/clinical-overview/index.html) refers to the [CDC 2007 Guideline for Isolation Precautions](#) (www.cdc.gov/infection-control/hcp/isolation-precautions/), which recommends Transmission-Based Precautions for RSV be continued for the “duration of illness.” A reasonable approach is to isolate for at least 7 days after illness onset or until 24 hours after the resolution of fever and improvement in respiratory symptoms, whichever is longer. This is based upon available information about the duration of viral shedding in adults with RSV; see [article by Walsh et al, Journal of Infectious Diseases 2013](#) (www.ncbi.nlm.nih.gov/pmc/articles/PMC3610422/).

Notes:

Don gowns and gloves after performing hand hygiene upon entry into the room or entry into a bedspace and doff gowns and gloves followed by hand hygiene upon exiting the room or leaving a bedspace. Doff the mask or respirator after leaving the room. When caring for residents with the same infection, mask or respirator does not need to be removed after exiting the room unless soiled or wet. In multi-occupancy rooms, treat each bed space as a separate room, changing PPE and performing hand hygiene between bed spaces. Consider the privacy curtain as part of the bed space.

Examples of Standard Precautions include hand hygiene, wearing gloves for any contact with potentially infectious material, wearing gowns for any patient-care activity when contact with blood, body fluids, secretions (including respiratory), or excretions is anticipated, and eye protection during procedures and patient care activities likely to generate splashes or sprays.