Guideline: Communicable Disease - Guidelines for Exposure

Department: Caregiver Health Services
Date: 2/10/2023

Scope: All workforce members

Purpose: In keeping with our mission and values, we have established guidelines to support the Communicable Disease Management policy in the prevention of exposure and transmission of communicable diseases.

Terms:

CDC: Centers for Disease Control and Prevention

Communicable diseases: For purposes of this policy, those diseases referenced on the CDC Guidelines and Recommendations: Guidelines for Infection Control in Health Care Personnel, 1998 will be monitored.

Core leader: Any person in a management or supervisory role is considered a core leader.

Direct patient care: Refers to physical contact or interaction with a patient

Healthcare personnel: All personnel working in an environment/building where patient or clinical services are performed.

High risk patients: Are considered NICU infants, neonates, patients with burns, immune compromised patients (includes Leukemia, Lymphomas, patients with WBC<500, patients on chemo or radiation therapy, transplant patients) and others on a case-by-case basis.

Proof of immunity: Documented history of immunization or proof by laboratory testing of immunity acquired by actual disease or immunization

Workforce member means caregivers, volunteers, trainees, interns, medical staff, students, independent contractors, vendors and other individuals working for us, whether or not they are paid by or under our direct control.

Guidelines:

1. **Caregiver Health Services (CHS)**
    A. Core leaders should report to CHS and Infection Prevention (IP) if any of their workforce members are ill with the symptoms of an infectious disease. Core leaders should also report to CHS and IP any workforce members or their family members being diagnosed with those diseases that are easily transmitted, such as Chickenpox, Measles, Tuberculosis, Conjunctivitis, Rashes, Lice, Scabies, etc.
    B. Core leaders should watch for and report when 3 or more workforce members in same work group develop or present with cough, diarrhea, fever or flu.
    C. All workforce members with these symptoms should report them to their core leader and CHS.
    D. Unless specified as applying to healthcare personnel, guidelines apply to all workforce members.
        1. A fever of equal to or greater than 100.4° F (or 38° C) without fever reducing medications, by itself or with any of the following symptoms: cough, runny nose, or sneezing; sore throat; swollen glands in the neck or an undiagnosed rash.
        2. Any draining skin lesions which cannot be contained by an occlusive dressing.
        3. Redness and/or discharge from either eye, see Viral Conjunctivitis in Table #1.
        4. Acute vomiting and/or diarrhea (3 or more loose stools in 24 hr.) such as gastroenteritis lasting longer than 24 hours, or which is accompanied by other

symptoms (e.g., fever, abdominal cramps) must be evaluated by their healthcare provider before returning to work.

5. New, undiagnosed rash with itching (+/-fever) must be evaluated by the workforce member's primary care provider (PCP) and cleared through CHS before returning to work.

E. Infection Prevention will notify the County Health Department as appropriate.

F. Post-exposure guidelines are noted in Table #1.

2. **Preventative measures for communicable diseases**

A. **Post-offer screenings and immunizations**

1. Offers of employment are conditioned upon satisfactory completion of a designated health screening evaluation.
2. Tuberculosis (TB) screening will be conducted on all new hires and testing will be performed by Interferon-Gamma Release Assay (IGRA) blood test along with TB questionnaire.
3. OSHA Respiratory Questionnaire and training for Powered Air Purifying Respirator (PAPR) or fit testing for N-95 respirator is performed prior to use, if use is required.
4. Verification of immunity to vaccine-preventable diseases will be managed by CHS and the following are required:

Disease	Requirements
Hepatitis B	• Documentation of completed vaccination series with a positive titer ~30 days after final dose • Laboratory evidence of immunity • Written declination (where applicable)
Influenza	• Documentation of annual influenza vaccination OR • Written declination (where applicable)
Measles, Mumps, Rubella (MMR)	• Documentation of 2 doses of MMR at least 28 days apart after the age of one • Laboratory evidence of immunity • Written declination (where applicable)
Varicella (chickenpox)	• Documentation of 2 doses of varicella vaccine, at least 28 days apart • Laboratory evidence of immunity • Written declination (where applicable)
Tetanus, Diphtheria, Pertussis (Tdap)	• Documentation of Tdap vaccination • Written declination (where applicable)
COVID-19	• See COVID-19 Vaccination policy.

Table 1

Infectious Agent	Incubation	Period of communicability	Infectious exposure/transmission	Work restriction/precautions
AIDS/HIV	3-12 weeks	Indefinite	Infected blood and designated body fluids Direct contact with non-intact skin, mucous membranes	To be handled on a case-by-case basis. Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures as well as skill and technique of the worker; standard precautions should always be observed; refer to state regulations. Suggestions for panel members include but are not limited to: infection preventionist (IP), IP Provider, caregiver health, respiratory therapy, quality/risk director, DOH provider, medical director, human resources representative.
Amebiasis (Ova/parasites) such as Giardia	Variable, ranging from a few days to months or years but commonly is 1 to 4 weeks		Infected feces Contact with contaminated food, water, feces and enema equipment	No patient contact or handling of food stuff until stools return to normal, no blood in stool and 2 stool samples test negative for parasites. Treatment with antibiotics started. Employees with acute vomiting and/or diarrhea (three or more loose stool per day) lasting longer than 24 hours, or which is accompanied by other symptoms (e.g., fever, abdominal cramps must be evaluated by their health care provider before returning to work). Notification to CHS to verify guidelines followed.
Campylobacter	1-10 days, usually 2-5 days	While experiencing diarrhea, usually a few days to a few weeks	Feces Oral/fecal Person to person transmission is rare	Return to work after diarrhea ceases. Notification to CHS to verify guidelines followed.
Clostridium Difficile (C-Diff)	Variable	Usually limited to the duration of excretion of the pathogen	Feces Direct contact with infectious material; oral/fecal route	**Initial diagnosis:** Exclude from duty until half of the recommended treatment has been taken and until symptoms have resolved for >48 hours. Notification to CHS to determine if all guidelines were followed. **Recurrence:** Exclude from duty until full course of recommended treatment has been taken and until symptoms have resolved for >48 hours. Notification to CHS to determine if all guidelines were followed.
Chicken Pox			See **Varicella**	See **Varicella**
Cholera	Usually 1 to 3 days with a range of a few hours to 5 days		Infected food or water Ingestion of contaminated food or water Not usually contagious from human to human	Restricted from food handling positions until disease resolved. Employees with acute vomiting and/or diarrhea (3 of more loose stools a day) lasting longer than 24 hours, or which is accompanied by other symptoms (e.g., fever, abdominal cramps) must be evaluated by their health care provider before returning to work. Notification to CHS to verify guidelines followed.

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
CMV-Cytomegalovirus	No known	N/A	Saliva, urine, or other body fluids Direct contact with secretions	**No restrictions with standard precautions**
Conjunctivitis-Bacterial or viral (Pink Eye) Ref: CDC	1-14 days based upon agent • Bacterial: usually 24-72 hrs • Viral: varies but usually 5-12 days	During course of active infection and can be infectious up to 14 days	Discharge from eye, respiratory secretions Direct or indirect contact with infectious material	All workforce members: Until discharge ceases/stops and all other symptoms have cleared. Hand washing is stressed after touching eye.
COVID-19				COVID-19 guidance is rapidly changing. Follow current recommendations from CDC, ID-CDT, RIPL, and local health authorities, and reference COVID-19 Vaccination policy in the portal.
Dermatitis (weeping) Does not include poison ivy or poison oak, which are not infectious diseases	Depends on causative agent	Depends on causative agent	Secretions Direct contact with potentially infectious secretions	**Exclude from duty if draining skin lesions cannot be contained by an occlusive dressing.**
Diarrhea Also see **Gastrointestinal** (acute stage with other symptoms) Acute bacterial gastrointestinal illnesses with diarrhea, unless physician-certified as noninfectious vomiting, diarrhea, jaundice	Depends on causative agent	Depends on causative agent but usually limited to the duration of excretion of the pathogen	Feces Direct contact with infectious material; oral/fecal route	**All workforce members:** Restricted from work until symptoms resolve. No patient or food handling. Notification to CHS to determine if all guidelines followed. Remain off work if three or more loose stools in 24 hours.

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Diphtheria, Pharyngeal Ref: CDC	Usually 2-5 days (range 1-10 days)	2 weeks to several months	Respiratory droplets/secretions, skin lesions Contact with patient or carrier, soiled articles, discharge from lesions of infected person	1. Administer postexposure prophylaxis in accordance with CDC recommendations. A. Exclude from work and obtain nasal and pharyngeal swabs for diphtheria culture. 1. If nasal AND pharyngeal cultures are negative for toxin-producing C. diphtheriae, healthcare personnel may return to work while completing postexposure antibiotic therapy. 2. If nasal OR pharyngeal cultures are positive for toxin-producing C. diphtheriae. B. Complete postexposure antibiotic therapy. 1. Healthcare personnel may return to work when: postexposure antibiotic therapy is completed AND at least 24 hours after completion of postexposure antibiotic therapy, two consecutive pairs of nasal AND pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing C. diphtheriae. C. Implement daily monitoring for the development of signs and symptoms of diphtheria for 7 days after the last exposure. 2. For healthcare personnel with respiratory diphtheria infection, exclude from work until: A. Antibiotic and antitoxin (if needed) therapy are completed AND at least 24 hours after completion of antibiotic therapy, two consecutive pairs of nasal AND pharyngeal cultures, obtained at least 24 hours apart, are negative for toxin-producing C. diphtheriae. 3. For healthcare personnel with cutaneous diphtheria infection or other diphtheria infection manifestations, determine the duration of exclusion from work in consultation with federal, state, and local public health authorities. Ref: Epidemiology and Control of Selected Infections | Infection Control | CDC

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Ebola CDC	Usually 2-21 days	The virus can remain in areas of the body that are immunologically privileged sites after acute infection. These are sites where viruses and pathogens, like the Ebola virus, are shielded from the survivor's immune system, even after being cleared elsewhere in the body. These areas include the testes, interior of the eyes, placenta, and central nervous system, particularly the cerebrospinal fluid. Whether the virus is present in these body parts and for how long varies by survivor. Scientists are now studying how long the virus stays in these body fluids among Ebola survivors. Ebola virus can survive on dry surfaces, like doorknobs and countertops for several hours; in body fluids like blood, the virus can survive up to several days at room temperature.	The virus spreads through direct contact (such as through broken skin or mucous membranes in the eyes, nose, or mouth) with: 1. Blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, amniotic fluid, and semen) of a person who is sick with or has died from Ebola virus disease (EVD). 2. Objects (such as clothes, bedding, needles, and medical equipment) contaminated with body fluids from a person who is sick with or has died from EVD. 3. Infected fruit bats or nonhuman primates (such as apes and monkeys). 4. Semen from a man who recovered from EVD (through oral, vaginal, or anal sex). The virus can remain in certain body fluids (including semen) of a patient who has recovered from EVD, even if they no longer have symptoms of severe illness. There is no evidence that Ebola can be spread through sex or other contact with vaginal fluids from a woman who has had Ebola.	People with percutaneous or mucocutaneous exposures to blood, body fluids, secretions, or excretions from a PUI should: • Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (conjunctiva) should be irrigated with copious amounts of water or eyewash solution. • Immediately contact occupational health/supervisor for assessment and access to postexposure management services for all appropriate pathogens (Human Immunodeficiency Virus, Hepatitis C, etc.). • HCP who develop sudden onset of fever, fatigue, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage should not report to work or should immediately stop working. • Notify their supervisor. • Seek prompt medical evaluation and testing. • Notify local and state health departments. • Comply with work exclusion until they are deemed no longer infectious to others (decision made by Infectious Disease provider or Public Health. For asymptomatic HCP who had an unprotected exposure (not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD should receive medical evaluation and follow-up care including fever monitoring twice daily for 21 days after the last known exposure. Hospitals should consider policies ensuring twice daily contact with exposed personnel to discuss potential symptoms and document fever checks.
E. Coli O157 (Escherichia coli)	Usually 3 to 4 days after exposure but may be as short as 1 day or as long as 10 days Ref: CDC		Bacteria transmitted through contaminated water or food, or through contact with animals or persons	Consult with local or state health department for restrictions.

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Enteroviral Infections (Coxsackie virus including Hand, Foot, and Mouth disease) Ref: CDC	Usually 3-5 days	Most contagious during the first week of illness People can sometimes be contagious for days or weeks after symptoms go away	Saliva, sputum, or nasal mucus, blister fluid, or stool of infected persons close personal contact, the air (through coughing or sneezing), contact with feces, contaminated objects and surfaces	Exclude from duties in high-risk patient areas until symptoms resolve. Contain oral and nasal secretions and wash hands with soap and water. Notification to CHS to verify guidelines followed.
Epstein Barr Virus (Infectious Mononucleosis)	Usually 4-6 weeks		Oropharyngeal route via saliva and blood	No restrictions with standard precautions
Epiglottitis due to Haemophilus influenza	1-5 days	3-5 days, up to 7 in children	Respiratory secretions Direct contact through droplet spread	Restricted from work for 24 hours after start of antibiotic therapy
Fifth Disease			See **Parvovirus B19**	
Gastro-Intestinal Diseases Acute bacterial gastrointestinal illnesses with vomiting or diarrhea unless physician- certified as noninfectious WAC 218-251 vomiting, diarrhea, jaundice	N/A	N/A	N/A	**Workforce members:** Restricted from work until symptoms resolve 24 hours or more. No patient or food handling. Notification to CHS to verify guidelines followed.
Hepatitis A	Usually 25-30 days with a range of 14-50 days (average 28-30)	Highest viral titers are found in stool 1-2 weeks before onset of symptoms Risk of transmission is minimal 1 week after onset of symptoms	Fecal-oral route Feces contamination such as: • Contact with stool of infected patient without wearing gloves • Not washing hands after handling an infected infant/patient	**Exposed:** No work restrictions. **Confirmed diagnosis:** Restrict until one week (7 days) following onset of jaundice or other clinical symptoms. Provider release – documentation of diagnosis. Notification to CHS to determine if all guidelines were followed.

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Hepatitis B **Hepatitis C**	Hepatitis B: 45-180 days (usually 60-90) Hepatitis C: Exposure to onset of symptoms is 4-12 weeks (usually 2 weeks to 6 months)	While HBsAg positive Hepatitis C potentially always contagious and can span from one or more weeks before onset of first symptoms and may persist in some persons indefinitely.	Blood, semen, vaginal secretions and certain other body fluids Direct contact with infectious material	**Standard precautions should always be used. If Workforce member is positive for Hep B or Hep C:** • **Workforce members who do not perform exposure-prone procedures:** no restriction unless epidemiologically linked to transmission of infection. • **Workforce members who perform exposure-prone procedures:** should not perform these until they have sought counsel from an expert review panel, which should review and recommend the procedures the worker can perform, taking into account the specific procedure as well as the skill and technique of the worker. Gloves are worn for procedures that involve trauma to tissues or direct contact with mucus membranes or non-intact skin. Those workforce members who perform exposure-prone procedures are handled on a case-by-case basis. **If exposed:** report to Caregiver Health Services immediately for immunity status and source testing. If susceptible for Hep B, administer HBIG and initiate vaccination series.
Herpes Simplex	Usually 2-12 days.	Genital: 7-12 days Orofacial: Secretion of virus in saliva has been reported for as long as 7 weeks	Unprotected contact with: • Either primary or recurrent lesions • From virus containing secretions such as saliva, vaginal secretions, or amniotic fluid	Genital: none Hand washing stressed **Herpetic Whitlow:** Exclude from patient contact until lesions healed. **Orofacial:** Personnel should wear a mask and be on medication if providing care to high-risk patients (see definition section on page 1). Personnel should not provide care to patients with large open areas/rash/burns.
Influenza Virus Ref: CDC Prevention Strategies for seasonal influenza in healthcare settings | CDC	Usually 1-4 days (average 2 days)	Most infectious 24 hours before onset of symptoms and up to 5 to 7 days **after** becoming sick	Respiratory droplets. Direct contact with infections material within 3 feet (sneezes, cough, contaminated surfaces)	Workforce members with signs and symptoms, and temperature equal to or greater than 38 C or 100.4 F without fever reducing medications should not work. Workforce members with fever equal to or greater than 38 C or 100.4 F, and any of the following symptoms: cough, sore throat, body aches, nausea/vomiting, should not work. Workforce members who develop a febrile respiratory illness should be excluded from work until 24 hours after fever has resolved without the aid of fever reducing drugs and symptoms have improved. Consider temporary reassignment if returning to care for severely immunocompromised patients for seven days from onset or until resolution of non-cough symptoms, whichever is longer.

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Lice (Pediculosis)	7-14 days	As long as lice or eggs remain alive on person or clothing Survival time away from the host: • 10 days for head lice • 10 days for body lice • 2 days for pubic lice Nits that are >10mm from the scalp and have been present >2 weeks may not be viable.	Arthropod host Direct contact with person or via shared clothing Sexual contact for crab lice **Head lice:** hair to hair contact with • Infested person • Hats, combs, brushes **Body lice:** skin contact with linen or clothes of infected person without wearing gloves **Pubic lice:** intimate or sexual contact	**Active infection**: No patient contact. Contact with patient environment until 24 hours after treatment has been initiated for lice and has been observed to be free of adult and immature lice. Notification to CHS to verify guidelines followed. **If exposed:** Report to CHS immediately for assessment of extent of exposure and need for treatment.
Measles (Rubeola)	7-18 days (average 10 days)	4 days before rash to 4 days after appearance of rash 8 days total May be longer in immuno-compromised persons.	Direct Contact with Respiratory secretions: Eye or mucous membrane contact with nasal or oral secretions from an infected person or items contaminated with these secretions. Airborne exposure: exposure to patient within 3 feet or time spent with patient is greater than 10 minutes without use of PPE or Negative Airflow. Highly contagious	**Confirmed diagnosis:** Restricted from work until after day 4 of rash. Notification to CHS to determine when all guidelines have been met. **If exposed:** Report immediately to your core leader and CHS. CHS will determine immune status. Susceptible workforce members will be restricted from work from the 5th through 21st day after exposure and/or 4 days after rash appears Notification to CHS to verify guidelines followed.
Mumps	A range of 12-25 days (usually 16-18) Ref: CDC	Most communicable 48 hours before onset of illness but may begin as early as 7 days before onset of overt parotitis (swelling) and continue as long as 9 days thereafter	Contact within 3 feet of infected person without wearing a mask Respiratory secretions or saliva Droplets and direct contact	**Confirmed diagnosis:** Exclude until 5 days after onset of parotitis (swelling). Provider release – documentation of diagnosis. **Non-immune exposed:** Exclude from the 12th day after the first exposure through the 25th day of the last exposure, or until 5 days after onset of parotitis Ref: CDC and CDC Mumps All workforce members to notify CHS if signs and symptoms occur.

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Meningitis (Haemophilus influenzae) (Neisseria meningitidis) (Meningococcal pneumonia) Ref: CDC Pinkbook CDC Meningococcal	A range of 2-10 days	Persons with disease are infectious until they have taken 24 hours of effective antibiotic therapy	Respiratory droplets Exchanging respiratory and throat secretions during close or lengthy contact, e.g., suctioning, intubation or CPR lab workers	Administer antimicrobial prophylaxis to healthcare personnel, regardless of vaccination status, who have an exposure to N. meningitidis. Exclude healthcare personnel with invasive N. meningitidis disease from work until 24 hours after the start of effective antimicrobial therapy. Work restrictions are not necessary for healthcare personnel who only have nasopharyngeal carriage of N. meningitidis. Ref: CDC Epidemiology and Control of Selected Infections | Infection Control | CDC
Norovirus	12-48 hours		Feces/emesis Direct contact with infectious material oral/fecal route	**Confirmed diagnosis for all workforce members:** Exclude from duty for 48 hours after symptoms resolve. Notification to CHS to determine if all guidelines followed. Ref: CDC
Parvovirus B19 (Slapped cheek, Fifth Disease)	Usually 4-14 days with a range up to 20 days Rash and joint symptoms occur 2-3 weeks after acquisition	No risk of transmission after rash appears Immuno-compromised persons can have chronic infections and can shed virus for prolonged periods	Respiratory secretions, droplets, blood Ref: CDC	No restrictions; pregnant personnel should be aware of risks If respiratory secretions present without a rash, use respiratory etiquette and cover your mouth with a mask.

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Pertussis (Whooping Cough)	Usually 7-10 days (with a range of 4-21 days)	Most contagious during catarrhal stage Communicability diminishes rapidly after onset of cough but can persist as long as 3 weeks	Face-to-face contact with an infected person within 3 feet or spending 1 hour in a room without wearing a mask Mucous secretions of infected person(s) Direct droplet contact with discharge of upper respiratory mucous membranes, droplets or inhalation	1. For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and are likely to interact with persons at increased risk for severe pertussis: A. Administer postexposure prophylaxis. B. If not receiving postexposure prophylaxis, restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis for 21 days after the last exposure. 2. For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and are not likely to interact with persons at increased risk for severe pertussis: A. Administer postexposure prophylaxis; OR B. Implement daily monitoring for 21 days after the last exposure for development of signs and symptoms of pertussis. 3. For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and who have preexisting health conditions that may be exacerbated by a pertussis infection: A. Administer postexposure prophylaxis. 4. Exclude symptomatic healthcare personnel with known or suspected pertussis from work for 21 days from the onset of cough, or until 5 days after the start of effective antimicrobial therapy. 5. Work restrictions are not necessary for asymptomatic healthcare personnel who have an exposure to pertussis and receive postexposure prophylaxis, regardless of their risk for interaction with persons at increased risk for severe pertussis. Ref: Epidemiology and Control of Selected Infections | Infection Control | CDC
Rabies CDC	Weeks to months		Direct contact (such as through broken skin or mucous membranes in the eyes, nose, or mouth) with saliva or brain/nervous system tissue from an infected animal. Other modes of transmission are uncommon.	1. For healthcare personnel who have an exposure to rabies virus, administer postexposure prophylaxis in accordance with CDC and ACIP recommendations and in consultation with federal, state, and local public health authorities. 2. Work restrictions are not necessary for asymptomatic healthcare personnel who have an exposure to rabies virus. 3. For healthcare personnel who have a suspected or confirmed rabies virus infection, exclude from work in consultation with federal, state, and local public health authorities.

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Plague (Pneumonic)	2-6 days	Fleas may remain infective for months under suitable conditions	Contaminated respiratory droplets, highly contagious Airborne	Restricted from work for 3 days after start of effective antibiotic therapy
Respiratory Infections and/or Sore Throat **Acute, when accompanied by fever. Without fever: don a mask.**				**Workforce members** restricted from work if fever over 100.4 F or 38 C and may return after 24 hours fever free without fever reducing medications. If the workforce member is at work and has a productive cough and/or sore throat; workforce member must wear a mask and leave work as soon as possible.
Rubella (German Measles)	A range of 12-23 days (average 14 days) Ref: CDC	7 days before rash and 5-7 days after appears Maculopapular rash 14 to 17 days after exposure Up to 1 year for infants with congenital rubella	Droplet spread or direct contact with infected patients Nasopharyngeal secretions Respiratory secretions Eye or mucous membrane contact within 3 feet of infected person without wearing a mask and eye protection Direct contact with urine from infant with congenital rubella without wearing gloves.	**Confirmed diagnosis:** Exclude until 7 days after rash appears. Provider documentation of diagnosis. **Exposed:** Susceptible workforce members restricted from work beginning 7 days after exposure and continuing through either 23 days after last exposure or 7 days after rash appears. Notification to CHS to verify guidelines followed.
Salmonella (including Typhoid Fever)	6 hours-5 days (usually 1-3 days up to 16 days)	As long as organisms are excreted in the feces from days to months	Oral/fecal route Feces	Assessment of returning to work will be made with the recommendation of the Health Department. **In general:** Food handler: Restricted from work until 2 negative stool samples at least 24 hours apart are obtained. Notification to CHS to verify guidelines followed. **Workforce members:** Restricted from work if symptomatic. If asymptomatic, may work using strict hand washing before patient contact and after personal use of toilet. Employee Health & Well-being notification required. **Office worker:** No restrictions. Notification to CHS to verify guidelines followed. ****Typhi* has a longer communicability and restrictions may be longer. Food service workers with a history of disease within the last 3 months need to be released with clearance note from their provider.**
Scabies	4-5 weeks if no previous infestation 1-4 days if previous infestation	Person remains contagious until treatment, may sometimes require multiple treatments with scabicidal agent	Mites Direct contact skin to skin with infected person	**Exposed:** Asymptomatic, no work restriction. **Confirmed diagnosis:** No patient care; may return to work 24 hours after scabicide treatment.
Shingles			See Varicella Zoster	

Infectious Agent	Incubation	Period of Communicability	Infectious Exposure/Transmission	Work Restrictions/Precautions
Shigella **Shiga toxin-producing Escherichia coli**	1-4 days, rarely as short as 12 hours or as long as 7 days	While experiencing diarrhea and 1-2 weeks after	Feces Oral/fecal	**Food handler:** Restricted from work until 2 negative stool samples at least 24 hours apart are obtained. Notification to CHS to verify guidelines followed. **Workforce member:** Restricted from work if symptomatic. If asymptomatic, may work using strict hand washing before patient contact and after personal use of toilet. CHS notification required. **Office worker:** No restrictions. Notification to CHS to verify guidelines followed. WAC 246-215-251
Staphylococcus Aureus (including MRSA) **(Impetigo)**	Variable & indefinite	As long as purulent lesions continue to drain or carrier state persists	Draining lesion or purulent discharge Contact with carrier	**All workforce members:** Those with wound drainage (pus) and cannot properly cover and contain with a clean dry bandage should be restricted from work. Those with active infections should be excluded from activities where skin to skin contact with the affected skin area is likely to occur and until their infections are healed. Those workforce members in high-risk areas check with local IP and CHS for restrictions. Ref: CDC **Carrier state:** No restriction unless shown to be epidemiologically disseminating the organism.
Streptococcus Group A	1-10 days Varies based on site of infection	Until 24 hours after start of adequate antibiotic therapy	Droplets of saliva, secretions from nose, eye or from a colonized wound Ref: CDC Direct or intimate contact with carriers	1. Postexposure prophylaxis and work restrictions are not necessary for healthcare personnel who have an exposure to group A Streptococcus. 2. For healthcare personnel with known or suspected group A Streptococcus infection, obtain a sample from the infected site, if possible, for group A Streptococcus and exclude from work until group A Streptococcus infection is ruled out, or until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered. A. For draining skin lesions that cannot be adequately contained or covered (e.g., on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining. 3. Work restrictions are not necessary for healthcare personnel with known or suspected group A Streptococcus colonization, unless they are epidemiologically linked to transmission of the organism in the healthcare setting. 4. For healthcare personnel with group A Streptococcus colonization who are epidemiologically linked to transmission of the organism in the healthcare setting, A. Administer chemoprophylaxis in accordance with CDC recommendations AND B. Exclude from work until 24 hours after the start of effective antimicrobial therapy AND C. Obtain a sample from the affected site for group A Streptococcus testing 7 to 10 days after completion of chemoprophylaxis; if positive, repeat administration of chemoprophylaxis and again exclude from work until 24 hours after the start of effective antimicrobial therapy. Ref: Epidemiology and Control of Selected Infections | Infection Control | CDC

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TB – Mycobacterium	2-12 weeks Ref: CDC	Until AFB smears negative	Tubercle bacilli in airborne droplet nuclei Airborne	Restricted from work until two weeks completion of appropriate therapy, clinical improvement, and three negative AFB smears. Work with local Health Department. Notification to CHS to verify guidelines followed. Exposure: No restriction from work: Follow up with CHS required.
Varicella Zoster (Chickenpox) Active Exposure (susceptible person)	A range of 10-21 days In persons who received VZIG, the range extends up to 28 days (average 14-16 days) Ref: CDC	Chickenpox: most contagious 1-2 days before and shortly after rash appears Transmission can occur up to 5 days after rash appears Immuno-compromised persons may be contagious as long as new lesions appear	Respiratory secretions, lesions Airborne or contact with infectious materials	Active: Exclude until lesions are dry and crusted. Exposure: Restrict susceptible workforce members from work from the 8th day after the first exposure through the 21st day after the last exposure. If no proof of immunity and no titer on file, draw immediate titer to determine immunity/susceptibility Workforce members who receive VZIG should not work in patient areas for 10-28 days following exposure if no illness occurs. Monitor for symptoms. Notification to CHS to determine if all guidelines were followed. Ref: MMWR If workforce member is immunocompromised or pregnant women w/o immunity f/u with infectious disease provider within 4 business days.
Varicella Zoster (Shingles)		Usually 1 week after appearance of lesions- until blisters scab over Ref: CDC	Fluid from vesicles Direct or indirect contact with fluid from vesicles Varicella virus is shed and becomes airborne in disseminated cases	**Non-Disseminated:** **If able to cover lesions:** No restrictions but exclude from high-risk patient care. **If unable to cover lesions:** Exclude from patient contact until lesions dry and crusted. **Disseminated:** Restrict from work until provider determination made to return to patient care. Notification should be provided to CHS before returning. Ref: CDC **Exposure:** Report immediately to CHS. CHS will determine immune status. Susceptible workforce members will be restricted from work from the 8th through the 21st day after exposure or if Varicella occurs, until all lesions dry and crusted. Ref: CDC

References:

- Communicable Disease Management Policy, COVID-19 Vaccination Policy, Influenza Policy, and Tuberculosis Surveillance Policy in the portal
- Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (cdc.gov) (October 3, 2022)
- Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus and Other Bloodborne Pathogens in Health Care Settings (cdc.gov) (MMWR June 24, 1988 / 37(24); 377-82, 387-8)
- Guideline for Infection Control in Health Care Personnel (cdc.gov) (1998)
- Immunization of Healthcare Personnel (cdc.gov) (MMWR November 25, 2011 / 60(RR07);1-45)
- Infectious Disorders, Professional Care Guides (Matthew Cahill, Sr., Publisher, Springhouse Corporation – 1995)
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