

Occupational Health

Occupational Health.

- Occupational Health will provide:
 - Non-emergent diagnosis and treatment for job related injuries/illnesses for active duty members and civilian employees.
 - Periodic surveillance examinations for military and civilian staff with exposure to potential hazards in occupational assignments.
 - Evaluations of employees returning to work after a prolonged absence because of illness or injury.
 - Resources to coordinate the NAVOSH Program with current OSHA requirements and DOD directives.
 - Occupational health and safety/walk through.
 - Identification of common risk factors among exposed workers with relation to specific work environments.
 - Pre-employment physical exams on civilians seeking employment at the Naval Medical Center and related commands.

Infection Control.

Occupational Health

- Occupational Health personnel provide a health monitoring program for staff active duty and civil service employees with access to the military healthcare system for job-related illnesses or injuries. This department is generally staffed with an RN who provides primary screening for routine, as well as, acute healthcare needs. Audiology Clinic provides services associated with the hearing conservation programs. Strict attention to all infection control policies is essential in their patient contact and in cleaning procedures associated with audiology and respiratory equipment. Special guidelines include the following measures:
 - Disposable speculums only are used for ear exams.
 - Headset earphones are cleaned with an alcohol pad at the end of each week.
 - Handwashing is done after each patient contact.
 - Patients presenting with ear pain and/or drainage will not be tested until medical evaluation and treatment is rendered.
 - Patients with symptoms of an upper respiratory infection will not be given pulmonary function tests.
 - Disposable mouthpieces used in pulmonary function testing are discarded after each patient's use. The connector piece between the mouth piece and spirometer hose is wiped with alcohol on inner and outer surfaces after each patient use. The spirometer hose is decontaminated after each testing session by soaking in germicidal solution according to manufacturer's instructions for time and dilution. The hose is thoroughly rinsed and air-dried prior to the next testing session.

Protocols for Specific Occupationally-related Diseases

Occupational Health Programs and Infection Control.

The Occupational Health Division monitors a variety of Occupational Health Programs required by the Navy's Occupational Safety and Health Program (OPNAV 5300.23 series). These occupational health programs assist in control of infections throughout the hospital.

General Policy.

The Occupational Health Department follows specific protocol when staff personnel receive a potential exposure to an infectious agent. The following sections identify the protocol for each agent.

Bloodborne Pathogen Exposure Evaluation.

See Post-exposure Management for Bloodborne Pathogens

Hepatitis B Vaccine Policy.

Ref:(a) 29 CFR 1910.1030; Occupational Exposure to Bloodborne Pathogens

(b) NAVMEDCENPTSVAINST 6260.5 Series. Bloodborne Pathogens Exposure Control Plan.

- Hospital staff with reasonably anticipated exposure to blood and other potentially infectious material shall receive the hepatitis B vaccine in accordance with references (a) and (b). This shall include hospital volunteers and students attached to the command.
- Hepatitis B vaccine shall be administered in a 3-dose series via the intramuscular route in the deltoid muscle. The second dose is given one month after the first and the third dose will be given 5 months after the second. Either plasma-derived hepatitis B vaccine or recombinant DNA vaccine may be used. If necessary, the vaccine may be interchanged during the 3-dose series. Testing for antibody to hepatitis B surface antigen (anti-HBs) is done 30-60 days after completing the primary 3-dose vaccination series.
- Those healthcare workers not responding to the primary series (i.e., serum anti-HBs < 10 IU/ml) shall receive a second three dose series. One to two months after completion of the second three dose series, they will be tested again for anti-HBs. If the titer is inadequate, they will be checked for HBsAg.
 - If they are HBsAg positive, they will be referred to an occupational medicine or infectious disease specialist for further evaluation.
 - Primary non-responders who are HBsAg negative are considered susceptible to HBV and will be counseled by an occupational medicine specialist regarding precautions to prevent HBV infection and the need to receive hepatitis B immune globulin in the event of a known or probable parenteral exposure to HBsAg positive blood.
- Booster doses of hepatitis B vaccine are not necessary and anti-HBs will not be checked periodically.
- HCWs who have never had serologic testing for anti-HBs should not be tested unless it is during a post-exposure evaluation. When a HCW is found to have had an anti-HBs level drawn (usually several years after the primary series) that is negative and there are no prior levels in his/her record, then administer one booster dose and recheck the titer one to two months later. If the titer is inadequate after this booster dose, complete a second three dose series and then recheck the titer one to two months after this is completed. If the titer is still inadequate, occupational health will counsel the HCW on risks as above.

Hospital Staff with Hepatitis B, Hepatitis C, and HIV.

Hospital staff that are determined to be infected by HIV, HBV, or HCV shall be evaluated by occupational health regarding any potential restriction in clinical activity. In general, staff that are HCV or HBV carriers (HBeAg negative) will not have restriction in clinical activity. They will be counseled regarding “Universal/Standard Precautions”, adequate handwashing techniques, and potential for double gloving in certain situations. HIV and HBeAg positive HCWs shall be evaluated by an occupational medicine specialist with consultation from ID. Per CDC guidelines, an expert panel comprised of occupational medicine, infectious disease, and medical staff from the provider’s specialty will convene to determine whether there should be any restriction in clinical activity.

Measles, Mumps, and Rubella in Healthcare Workers.

- Rubella/Rubeola screening
 - All military personnel and civilian employees, including volunteers, engaged in delivery of healthcare and having patient contact must be immunized against measles, mumps, and rubella, or they must have documented serological evidence of immunity to these agents.
- Policy
 - All employees working in patient contact areas shall be screened for immunity to Rubella/Rubeola.
- Procedure
 - Occupational Health Nurse
 - Obtain Rubella/Rubeola documentation or titer on all staff working in patient contact areas. This usually is done on pre-placement for civil service personnel. Persons who have had this test done prior to their pre-employment may present a copy of lab results or written verification, from a local medical doctor, for inclusion in their medical record.
 - Notify staff member if in non-immune status with copy of lab results.
 - Document Immune/Non-Immune status on Problem Summary List.
 - Employee
 - Responsible for submitting, to Occupational Health Department, written documentation of immunization or that immunization is not recommended by medical doctor.
 - Supervisor
 - Responsible for ensuring that staff report to Occupational Health Department for screening or follow-up on Non-Immune titers.

Methicillin-resistant *Staphylococcus aureus* (MRSA) colonization

MRSA colonization in a healthcare worker (HCW) can result in colonization and infection to patients. In the event of an outbreak of MRSA, it may become necessary to culture staff members in certain areas to ascertain if they could possibly be colonized with the bacteria. This is done to aid in halting the outbreak. The MRSA decolonization regimen is considered safe; however, HCW’s must be assessed for contraindications (including allergies and renal failure) to the medications used. The Infection Control staff will alert Occupational Health as to when this protocol must be activated. The decolonization protocol is completed without any expense to the employee for medications

Decolonization Procedure:

. For five (5) days, the employee will:

- Take Sulfa-trimethoprim, two single-strength tablets or one double-strength tablet, PO BID.
- Take Rifampin 300 mg PO BID.
- Apply Bacitracin or Mupirocin ointment to anterior nose, BID.
- Bathe daily (bath or shower) with Chlorhexidine gluconate scrub or 3% Hexachlorophene or Povidone iodine by: a) wetting skin; b) apply 2 ounces of antimicrobial scrub, full strength, to the skin and scrub for five minutes; c) do not get in eyes or ears; d) rinse off thoroughly and dry with a clean towel; e) put on clean clothes; f) bedding and linens must be changed/cleaned daily until the end of the decolonization protocol.
- Reculture the HCW (nares and original MRSA-positive site, if applicable) a minimum of 24 hours after completion of above 5 day decolonization protocol.
- If reculture is negative, repeat in one week.
- Treatment failures are treated individually after conferring with Infection Control, Occupational Medicine, and Infectious Disease and may result in an assignment change.

Tuberculin Screening of Hospital Employees.

Ref:(a) BUMEDINST 6224.8, BUMED-24, 8 FEB 93

(b) CDC Guidelines

(c) Command TB Exposure Control Plan

Baseline PPD testing of all personnel (including personnel with a history of bacille Calmette-Guerin [BCG] vaccination) during their pre-employment physical examination or their application for hospital privileges will identify personnel who have been previously infected. For baseline testing, a two-step procedure for personnel without a PPD test in the past 12 months can be used to minimize the likelihood of confusing reactivity from an old infection (boosting) with reactivity from a recent infection (conversion). Hospital staff in patient care areas will be tested at least annually during their birthmonth. Areas determined to be intermediate or high-risk for exposure to TB shall have testing on a more frequent basis as outline in reference (c).

- Procedures
 - Occupational Health Nurse/Immunization Clinic
 - Do intradermal PPD skin test (Mantoux) on healthcare patient workers, unless hypersensitivity exists and read results in 48-72 hours. Those with negative reaction (0-10mm) are skin tested annually. Positive reactions (10mm or greater) are interpreted in accordance with references (a) through (c).
 - Arrangements for employees who convert from a negative to positive PPD reaction to have a chest X-ray taken immediately to rule out active communicable disease.
 - The results of the tests are to be documented on the staff member's health record.
 - Any current employee with a positive finding is to be sent to Occupational Health for investigation or treatment.

- Those wishing to get medical investigation from civilian MD must return written verification of such for inclusion in health record.
- Prospective employees or contract workers are to be sent to a civilian MD or health department for medical care and return with written documentation of treatment or non-treatment.
- Tracking of follow-up care on PPD converters will be done by Preventive Medicine.
- Submit name of TB converters to the Preventive Medicine Department and Safety Department.
- Report any employee who refuses TB surveillance after sufficient notification with written memo to the appropriate department head.
- Employee
 - Employees will be required to report to Occupational Health for TB screening annually during their birth month. Persons hypersensitive to the skin checks are to have annual questionnaire. Documented PPD reactors will complete an annual questionnaire.
- Supervisor
 - Shall be responsible for ensuring his/her staff report to the Occupational Health Department for TB screening at the appropriate time.
 - TB screening is mandatory for Naval Medical Center civil service personnel on check-in and on an annual basis for healthcare workers. Those civilian personnel in clerical or non-patient care areas will be offered TB on a voluntary basis.
- Chemoprophylaxis
 - All tuberculin reactors must be evaluated and considered for preventive therapy with isoniazid (INH) by Occupational Health following the guidelines in references (a) through (c) and the following table for details on INH prophylaxis.

Age	Risk Factor	Tuberculin Skin Test Induration			
		0-4 mm	5-9 mm	10-14 mm	≥15mm
All ages	Recruit	No	No	Yes	Yes
	Close Contact of newly diagnosed infectious tuberculosis case	No	Yes	Yes	Yes
	Known/suspected HIV infection	No	Yes	Yes	Yes
	Chest radiograph showing fibrotic lesions compatible with old healed tuberculosis	No	Yes	Yes	Yes
	Intravenous drug user	No	No	Yes	Yes

	Medical condition which increases risk of tuberculosis	No	No	Yes	Yes
< 35 years old	Born in high prevalence country	No	No	Yes	Yes
	Resident of correctional facility	No	No	Yes	Yes
	Recent tuberculin skin test converter	No	No	Yes	Yes
	No risk factor	No	No	No	Yes
> 35 years old	Born in high prevalence country	No	No	No	No
	Resident of correctional facility	No	No	No	No
	Recent tuberculin skin test converter	No	No	No	Yes
	No risk factor	No	No	No	No

Infection Control Issues for Healthcare Workers

Pregnant Healthcare Workers Work Recommendations.

Ref:(a) Guidelines for Infection Control in Healthcare Personnel; American Journal of Infection Control, 1998, 26:289-354.

- Cytomegalovirus infections – CMV
 - Personnel may be exposed to patients with CMV infections, but the risk of acquiring CMV infection from patients appears to be small. Pregnant HCW's are not known to be at greater risk of contracting CMV infections than HCW's who are not pregnant. The precise mechanism of CMV transmission is unknown, however, infection appears to be acquired only through intimate direct contact with contaminated secretions.

- When hygienic practices such as good handwashing are used, the risk of acquiring infection through patient contact is low. Patients known to be shedding CMV should be placed on appropriate isolation precautions. “Universal/Standard Precautions” are to be followed on all patients, regardless of their diagnosis.
- Pregnant HCW’s are not routinely restricted from caring for patients with CMV infections.
- Acquired Immunodeficiency Syndrome – AIDS – HIV
 - Pregnant HCW’s are not known to be at greater risk of contracting HIV infections than HCW’s who are not pregnant. All HCW’s (including pregnant HCW’s) should be familiar with and follow “Universal/Standard Precautions” for all patients, regardless of their diagnosis.
 - Pregnant HCW’s are not routinely restricted from caring for patients with AIDS or HIV infections.
- Hepatitis B Infections
 - Pregnant HCW’s are at no greater risk of contracting HBV than other HCW’s. All HCW’s (including pregnant HCW’s) should follow standard infection control procedures which consist of “Universal/Standard Precautions” for all patients, regardless of their diagnosis.
 - Pregnant HCW’s are not routinely restricted from caring for patients with hepatitis B.
 - Refer to the following table regarding management of pregnant healthcare personnel.

Management of Occupational Exposures to infectious agents for pregnant healthcare workers

Agent	Potential effect on fetus	Rate of perinatal transmission	Maternal screening	Prevention
Cytomegalovirus	Hearing loss; congenital syndrome	15% after primary maternal infection; symptomatic 5%	Antibody provides some but not complete protection against clinical disease; routine screening not recommended	Standard precautions
Hepatitis B	Hepatitis; development of chronic infection in infant	HBeAg seropositive 90%; HBeAg negative 0-25%	HBeAg routine screening recommended	Vaccine and HBIG to infant; standard precautions
Hepatitis C	Hepatitis	2%-5%	Anti-HCV; HCV RNA in reference labs; routine screening not recommended	Standard precautions
Herpes simplex	Mucutaneous lesions, sepsis, encephalitis; congenital malformations (rare)	Unlikely from nosocomail exposure; primary 33%-50%, recurrent 4%	Antibody testing not useful; inspection for lesions at delivery	Standard precautions
Human immuno-deficiency virus	AIDS by 2-3 yr	8%-30%	Antibody by enzyme immunoassay, Western blot	Avoid high-risk behaviors; consider post-exposure prophylaxis after high-risk needlestick exposure; intrapartum and postnatal zidovudine for HIV-seropositive mothers and their babies; standard precautions
Influenza	Inconsistent	Rare	None	Vaccine (safe during pregnancy); droplet precautions
Measles	Prematurity; abortion	Rare	History, antibody	Vaccine; airborne precautions
Parvovirus B19	Hydrops, stillbirth	Rare, 3%-9% maximum adverse outcome	IgM and IgG antibody prepregnancy; antibody protective	Droplet precautions
Rubella	Congenital syndrome	45%-50% overall; 90% in 1 st 12 wk	Antibody	Vaccine; droplet precautions for acute infection; contact precautions for congenital rubella
Tuberculosis	Hepatomegaly, pulmonary, CNS	Rare	Skin test	Isoniazid ± ethambutol for disease; airborne precautions
Varicella-zoster	Malformations (skin, limb, CNS, eye); chickenpox	Total 25%; congenital syndrome (0%-4%)	Antibody	Vaccine; VZIG within 96 hours of exposure if susceptible; airborne and contact precautions

Immunobiologics and Schedules for Healthcare Personnel (modified from ACIP recommendations)

Immunizing agents strongly recommended for healthcare personnel.

Generic name	Primary booster dose schedule	Indications	Major precautions and contraindications	Special considerations
Hepatitis B recombinant vaccine	Two doses IM in the deltoid muscle 4 wk apart; 3 rd dose 5 mo after 2 nd ; booster doses not necessary	Healthcare personnel at risk of exposure to blood and body fluids	No apparent adverse effects to developing fetuses, not contraindicated in pregnancy; history of anaphylactic reaction to common baker's yeast	No therapeutic or adverse effects on HBV-infected persons; cost-effectiveness of prevaccination screening for susceptibility to HBV depends on costs of vaccination and antibody testing and prevalence of immunity in the group of potential vaccinees; healthcare personnel who have ongoing contact with patients or blood should be tested 1-2 mo after completing the vaccination series to determine serologic response
Influenza vaccine (inactivated whole or split virus)	Annual single-dose vaccination IM with current (either whole- or split-virus vaccine)	Healthcare personnel with contact with high-risk patients or working in chronic care facilities; personnel with high-risk medical conditions and/or ³ 65 yr	History of anaphylactic hypersensitivity after egg ingestion	No evidence of maternal or fetal risk when vaccine was given to pregnant women with underlying conditions that render them at high-risk for serious influenza complications.
Measles live-virus vaccine	One dose SC; 2 nd dose at least 1 mo later	Healthcare personnel born in or after 1957 without documentation of (a) receipt of two doses of live vaccine on or after their 1 st birthday, (b) physician-diagnosed measles, or (c) laboratory evidence of immunity; vaccine should be considered for all personnel, including those born before 1957, who have no proof of immunity	Pregnancy; immuno-compromised state; (including HIV-infected persons with severe immunosuppression) history of anaphylactic reactions after gelatin ingestion or receipt of neomycin; or recent receipt of immune globulin	MMR is the vaccine of choice if recipients are also likely to be susceptible to rubella and/or mumps; persons vaccinated between 1963 and 1967 with (a) a killed measles vaccine alone, (b) killed vaccine followed by a live vaccine, or (c) a vaccine of unknown type should be revaccinated with two doses of live measles vaccine
Mumps live-virus vaccine	One dose SC; no booster	Healthcare personnel believed to be susceptible can be vaccinated; adults born before 1957 can be considered immune	Pregnancy; immuno-compromised state; history of anaphylactic reaction after gelatin ingestion or receipt of neomycin	MMR is the vaccine of choice if recipients are also likely to be susceptible to measles and rubella
Rubella live-virus vaccine	One dose SC; no booster	Healthcare personnel, both male and female, who lack documentation of receipt of live vaccine on or after their 1 st birthday, or of laboratory evidence of immunity; adults born before 1957 can be considered immune, except women of childbearing age	Pregnancy; immuno-compromised state; history of anaphylactic reaction after receipt of neomycin	Women pregnant when vaccinated or who become pregnant within 3 mo of vaccination should be counseled on the theoretic risks to the fetus, the risk of rubella vaccine-associated malformations in these women is negligible; MMR is the vaccine of choice if recipients are also likely to be susceptible to measles or mumps
Varicella zoster live-virus vaccine	Two 0.5ml doses SC, 4-8 wk apart if ³ 13 yr	Healthcare personnel without reliable history of varicella or laboratory evidence of varicella immunity	Pregnancy; immuno-compromised state; history of anaphylactic reaction after receipt of neomycin or gelatin; salicylate use should be avoided for 6 wk after vaccination	Because 71%-93% of persons without a history of varicella are immune, serologic testing before vaccination may be cost-effective
Tetanus and diphtheria (Td)	Two doses IM 4 wk apart; 3 rd dose 6-12 mo after 2 nd dose; booster every 10 yr	All adults; tetanus prophylaxis in wound management		First trimester of pregnancy; history of a neurologic reaction or immediate hypersensitivity reaction; individuals with severe local (Arthus-type) reaction after previous dose of Td vaccine should not be given further routine or emergency doses of Td for 10 yr

Infectious Diseases Encountered by Hospital Employees

Infectious Agent	Incubation Period	Period of communicability	General Precautions	Diagnostic Tests
Hepatitis B	6-24 weeks	While HBsAg positive. HBcAg positive is associated with high infectivity.	Universal/Standard Precautions for patients HBsAg positive. Personnel are evaluated and informed, counseled to wear gloves, but not usually removed from work unless clinically ill.	HBsAg = acute or chronic infection or carrier. HBeAg = positive increased infectivity. Anti-HBs = immunity; Anti-HBc = acute, chronic, or previous infection
Hepatitis C	2 weeks – 6 months	For one or more weeks before onset of symptoms through the acute clinical course and indefinitely in the chronic carrier stages.	Same as for hepatitis B. Universal/Standard Precautions to be followed.	Anti-HCV
Hepatitis A	2 – 7 weeks	2 – 3 weeks before jaundice; until 7 days after onset of jaundice.	Enteric/stool precautions for patients. Good handwashing by employees; remove from work for 7 days after onset of jaundice.	Anti-HAV; IgM (acute); IgM (immune)
Rubella (German Measles)	14 – 21 days	7 days before to 5 days after onset of rash.	Employee history is unreliable. Respiratory isolation for patients. Remove infected employee from work for period of communicability.	HA to screen, HAI (fourfold rise) to diagnose acute disease.
Rubella (measles)	Adults 8 – 15 days from the onset of the catarrhal stage to 4 days after the onset of the rash.	5 – 21 days after exposure.	Respiratory isolation for patients. Employee history is reliable. Exposed susceptible employees should be removed from 5 –21 days after exposure.	Usually not necessary.
Mumps	12 – 26 days	7 days before to 9 days after perotitis.	Respiratory isolation for patients. Positive history is reliable; if negative, may still be immune. Employee usually removed from work for period of communicability.	Usually not necessary.
Influenza	1 – 3 days	1 day before to 5 days after clinical onset.	Respiratory isolation for patients. Remove employees from work for period of communicability.	CF and HAI antibody test available. Viral isolation possible

Infectious Agent	Incubation Period	Period of communicability	General Precautions	Diagnostic Tests
Varicella Zoster (chickenpox)	Usually 14 – 21 days after exposure.	10 – 21 days after exposure	Patients with chickenpox require strict isolation; patients with localized herpes zoster are placed on contact precautions. History of chickenpox is reliable. Exposed susceptible employees should not work. Infectious employees should not work. Infectious employees are removed until lesions are dry and crusted. Employees with localized herpes zoster should cover lesions and not care for high-risk patients.	FAMA most sensitive test; false negative tests occur with CF.
Herpes simplex (herpetic whitlow)	Variable.	Until lesions crust over.	Employee history is suggestive. Employees should use gloves when caring for infected patients. Infected employees should avoid contact with immunosuppressed patients or neonates.	Not helpful. Viral culture available.
Acquired Immuno-deficiency Syndrome (AIDS)	6 months – 2 years	Unknown.	Universal/Standard Precautions are standard. Use of protective barriers and care in the use and disposal of needles and other sharps. Additional precautions depend on the patient's illness.	HIV or LAV antibody tests are available.
Tuberculosis	Usually 3 – 5 weeks. Range 2 – 8 weeks.	Until 3 consecutive sputum are free of tubercle bacilli or the patient is on adequate therapy for 2 weeks.	Evaluate contacts and monitor employees with PPD skin test. AFB isolation for patients. Negative pressure ventilation. UV lights in high-risk areas.	Tuberculin skin tests. Acid fast smears. Cultures.
Meningococcal meningitis	Variable. 1 – 10 days.	Variable.	Close prolonged exposure required for transmission (mouth to mouth resuscitation or prolonged exposure to infected secretions). Respiratory precau..	Culture on selected agar or broth.

Infectious Agent	Incubation Period	Period of communicability	General Precautions	Diagnostic Tests
Salmonella, Shigella, Campylobacter	Variable. 1 – 5 days	While organism is present to stool (days to weeks).	Enteric precautions for patients. Employees should be removed while they are symptomatic. Employees with salmonella should not have contact with high-risk patients.	Culture on blood agar.
Staphylococcus aureus	Variable. 4 – 10 days.	During skin infection or as a nasal “disseminator”.	Patients placed on contact precautions. Infected personnel should be evaluated by employee health service and may be removed from work.	None.
Scabies	Days to weeks.	Until mites or eggs are destroyed.	Patients should be isolated until treated. Infected personnel should be excluded from work until the day after treatment.	

HBsAg: hepatitis B surface antigen
 HBIG: hepatitis B immune globulin
 Anti-HBs: antibody to HBsAg
 Anti-HBc: antibody to HBcAg
 ISG: immune serum globulin
 HAV: hepatitis A
 HAI: hemagglutination inhibition antibody
 CF: complement fixation
 FAMA: fluorescent antibody membrane antigen
 VZIG: varicella-zoster immune globulin
 HTLV-III: human T-cell lymphotropic virus type III
 LAV: lymphadenopathy-associated virus
 PPD: purified protein derivative
 BCG: bacille Calmette-Guerin
 UV: ultraviolet
 HIV: Human Immunodeficiency Virus

Summary of Important Recommendations and Work Restriction for Personnel with Other Infectious Diseases

Disease / Problem	Relieve from Direct Patient Contact	Partial Work Restriction	Duration	Category
Conjunctivitis, infectious	Yes		Until discharge ceases.	II
Cytomegalovirus infections	No			II
Diarrhea				
Acute stage (diarrhea with other symptoms)	Yes		Until symptoms resolve and infection with Salmonella is ruled out.	
Convalescent stage Salmonella (non-typhoidal)	No	Personnel should not take care of high-risk patients.	Until stool is free of infection organism on 2 consecutive cultures not less than 24 hours apart	II
Other enteric pathogens	No			II
Enteroviral infections	No	Personnel should not take care of infants and newborns.	Until symptoms resolve.	II
Group A streptococcal disease	Yes		Until 24 hours after adequate treatment is started.	I
HIV Disease		Consult HIV Division.		
Hepatitis, viral Hepatitis A	Yes		Until 7 days after onset of jaundice.	III
Hepatitis B, Acute and Chronic		Personnel will be evaluated individually to determine work restriction. Personnel must be counseled to adhere to Universal/Standard Precautions, handwashing, protective barriers, and care in the use and disposal of needles and other sharp instruments. Healthcare Workers who have exudative lesions or weeping dermatitis should refrain from direct patient care and from handling patient care equipment and devices used in performing invasive procedures.	Until antigenemia resolves.	II
Hepatitis C	No	Same as acute hepatitis B.	Period of infectivity has not been determined.	II
Herpes simplex				
Genital	No			II
Hands (herpetic whitlow)	Yes	Note: It is not known whether gloves prevent transmission.	Until lesions heal.	I
Orofacial	No	Personnel should not take care of high-risk patients.	Until lesions heal.	II
Measles, active	Yes		Until 7 days after the rash appears.	I
Post-exposure (Susceptible Personnel)	Yes		From the 5 th through the 21 st day after exposure and/or 7 days after rash appears.	II
Mumps, active	Yes		Until 9 days after onset of parotitis.	I
Post-exposure	Yes		From the 12 th through the 26 th day after exposure or until 9 days after onset parotitis.	III
Pertussis, active	Yes		From the beginning of the catarrhal stage through the 3 rd week after onset paroxysms or until 7 days after the start of effective therapy.	I
Post-exposure (Asymptomatic Personnel)	No			II

Disease / Problem	Relieve from Direct Patient Contact	Partial Work Restriction	Duration	Category
Post-exposure (Symptomatic Personnel)	Yes		Same as active pertussis.	I
Rubella, active	Yes		Until 5 days after the rash appears.	
Post-exposure (Susceptible Personnel)	Yes		From the 7 th through the 21 st day after exposure and/or 5 days after rash appears.	II
Scabies	Yes		Until treated.	I
Staphylococcus Aureus (skin lesions)	Yes		Until lesions have resolved.	II
Upper respiratory infections (high-risk patients)	Yes	Personnel with upper respiratory infections should not take care of high-risk patients.	Until acute symptoms resolve.	II
Zoster (Shingles), active	No	Appropriate barrier desirable; personnel should not take care of high-risk patients.	Until lesions dry and crust.	II
Post-exposure (Susceptible Personnel)	Yes		From the 10 th through the 21 st day after exposure or if varicella occurs until lesions dry and crust.	I
Varicella (Chickenpox)				
Active	Yes		Until all lesions dry and crust.	I
Post-exposure	Yes		From the 10 th through the 21 st day after exposure or if varicella occurs until all lesions dry and crust.	I

Mumps vaccine may be offered to susceptible personnel. When given after exposure, mumps vaccine may not provide protection. However, if exposure did not result in infections, immunizing personnel should protect against subsequent infection. Neither mumps immune globulin nor immune serum globulin (ISG) is of established value in post-exposure prophylaxis. Transmission of mumps among personnel and patients has not been a major problem in hospitals in the United States, probably due to multiple factors, including high-levels of natural and vaccine-induced immunity.