Interim Guidance

Infection Prevention and Control for the Management of Mpox in People in Situations of Vulnerability such as Prisons and Other Custodial Facilities

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Contents

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Scope – Infection prevention and control recommendations for the management of persons suspected or confirmed to have mpox in prisons and other custodial facilities. This guidance does not seek to replace surveillance, case investigation, and contract-tracing or clinical management guidance or recommendations from other sources.[1]

Intended audience – national health authorities, healthcare workers in prisons, prison staff, prison administration

Note: This document is based on the most current recommendations available and will be updated if or when new evidence becomes available.

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[1] Additional international guidance may be found in two World Health Organization (WHO) documents: (1) World Health Organization. Surveillance, case investigation and contact tracing for monkeypox. Interim guidance. 25 August 2022. Geneva: WHO; 2022. Available from: https://www.who.int/publications/i/item/WHO-MPX-Surveillance-2022.3; and (2) World Health Organization. Clinical management and infection prevention and control for monkeypox. Interim rapid response guidance. 10 June 2022 Geneva: WHO; 2022. Available from: https://www.who.int/publications/i/item/WHO-MPX-Clinical-and-IPC-2022.1.

1. Background

Mpox spreads from person to person through close contact with someone who has an mpox[1] rash. Close contact can mean being face to face (such as talking, breathing, or singing close to one another, which can generate droplets or short-range aerosols); skin-to-skin contact (such as touching or vaginal/anal sex); mouth-to-mouth contact (such as kissing); or mouth-to-skin contact (such as oral sex or kissing the skin) *(1)*. Prisons and other custodial facilities (jails, detention centers, etc.) provide a unique setting where the convergence of external populations interface with facility employees in often overcrowded [2] and precarious settings *(2)* and sometimes with lack of access to health care. Communicable disease outbreaks in prisons have been documented previously *(3–6)* and most recently during the COVID-19 pandemic *(7)*.

The introduction of mpox into prisons and other custodial facilities has been documented in the Region of the Americas *(8, 9)*, and limiting the risk of transmission and considering the possibility of additional cases due to transmission in this setting should remain among the priorities for public health authorities, healthcare providers, and facility staff within these settings.

2. Infection prevention and control recommendations for healthcare workers

Standard precautions and transmission-based precautions

Health workers should always follow standard precautions and perform a risk assessment to evaluate the need to use additional precautions *(10)*.

In addition to standard precautions, contact and droplet precautions should be implemented for any suspect or confirmed patient with mpox *(11)*.

Due to the transmission through close contact and droplets, suspected and confirmed patients with mpox should be managed in a well-ventilated single room with dedicated bathroom or toilet, with limited contact with others in order to interrupt transmission of pathogens, while providing health services and humanitarian support. If a well-ventilated single room is not available, then group patients with a confirmed mpox diagnosis should be managed with adequate spatial separation (at least 1 m between patients). The room/area should have signage

[1] In line with the recent change by WHO, this guidance document uses the term mpox rather than monkeypox: World Health Organization. WHO recommends new name for monkeypox disease. Geneva: WHO; 2022 [cited 16 December 2022]. Available from: https://www.who.int/news/item/28-11-2022-who-recommends-new-name-for-monkeypox-disease.

[2] Overcrowding in prisons, correctional institutions, and other imposed congregate settings often leads to individuals living in close proximity to one another, which may result in the inability to maintain adequate separation to prevent disease transmission.

posted at the entrance indicating that patient is under contact/droplet precautions and the required personal protective equipment (PPE) in the correct order for healthcare workers.

Patients should cover exposed lesions (if they are not being clinically evaluated) when others are in the room and if they can tolerate.

Precautions should remain in place until lesions have crusted, scabs have fallen off, and a fresh layer of skin has formed underneath.

Personal protective equipment

Staff should receive appropriate training and be competent in the required PPE donning and doffing procedures and hand hygiene. Staff should know their local procedures for reporting any PPE breach or other risk contact with a suspected, probable, or confirmed case so that they can be assessed for follow-up and possible restrictions.

For suspected, probable, and confirmed cases, the minimum recommended PPE *(12)* are:

- Gloves (nonsterile);
- Gown;
- Respirator[3] or surgical masks (if respirators are not available);
- Eye protection such as goggles (required if there is a risk of splashing to the face and eyes, for example, when conducting diagnostic tests).

Hand hygiene

Handwashing is considered the single most important means of preventing the spread of infection. Alcohol-based hand sanitizer can be used as an alternative to soap and water for visibly clean, dry hands.

Healthcare workers should regularly clean their hands with soap and water (for 40–60 seconds) or use an alcohol-based rub (at least 60% alcohol for 20–30 seconds), if available.

When products containing alcohol (e.g., alcohol-based hand rubs) are stored in locked areas, access to running water, soap, and disposable towels must be prioritized to ensure adequate hand hygiene.

Health workers should perform hand hygiene according to the WHO guidance My 5 Moments for Hand Hygiene (before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings), including prior to putting on and after removing PPE *(13)*.

[3] WHO has noted that due to the current uncertainty related to the potential for aerosol transmission and risks to health workers providing direct care to confirmed patients with mpox, the guidance panel voted for the use of respirators as additional respiratory protection, in the context of a well-ventilated room as a precautionary measure at this time. This recommendation does not extend outside of the healthcare context.

Cleaning and disinfection

Areas within the prison healthcare facility frequently used by the patient or where patient care activities occur, such as the patient environment, and patient care equipment should be cleaned and disinfected as per national or facility guidelines.

PPE (reusable rubber gloves, gown, respirator, and eye protection) should be worn by health workers while cleaning and disinfecting patient care equipment and patient care areas or rooms where patients were suspected or confirmed to have mpox. Clean surfaces first with detergent and water, followed by disinfection with an approved disinfectant with virucidal activities (follow national or facility guidelines). Particular attention should be paid to toilets and frequently touched surfaces.

Areas where mpox patients were assessed should be terminally cleaned once the patient is discharged from the room wearing appropriate PPE as described above. Terminal cleaning consists of using the standard cleaning detergent and disinfection products:

- Remove all disposable items and dispose of them in waste bags.
- Bag laundry packs and remove as described for contaminated laundry.
- Clean all hard surfaces and touch points including walls, floors, chairs, bed frame, mattress, and attached bathroom facilities adhering to national or facility guidelines including for management of mops and cloths used for cleaning.
- Clean or vacuum clean any soft furnishings should be steam. If using a vacuum cleaner, use only a machine with high-efficiency particulate air (HEPA) filtration – PPE as recommended for contact and droplet precautions to be worn when emptying the vacuum cleaner into a waste bag.

Waste management

All waste produced by the case in isolation should be bagged in the room. Waste generated by health care should be disposed of as healthcare waste according to the national legal framework.

PPE (reusable rubber gloves, gowns, respirators masks, and eye protection) should be worn by people handling waste, and hands washed immediately after removal and disposal of PPE.

Contaminated linen

Mpox can be spread via contact with clothing or linens (such as bedding or towels) used by an infected person. Therefore, such clothing and linens should be considered contaminated, and handling should be minimized. Linens and bedding should be carefully lifted and rolled by the healthcare worker to prevent dispersion of infectious particles from lesions and body fluids. Any such linen should be bagged in the room. This bag should be placed into a plastic bag outside the room and transported to the laundry *(11)*.

Where a prison has off-site laundry facilities, each premise should discuss the requirements for safe prelaundering storage, transfer, and processing of contaminated laundry. Where possible, wash laundry items from patients suspected or confirmed to have mpox separately from the rest of the prison's laundry using the normal detergent, following the manufacturer's instructions.

Appropriate PPE (gown, heavy duty gloves, respirator, and eye protection) should be worn by people handling used laundry, and hands washed after disposing of PPE. This includes prison staff if they perform some or all of these activities. Laundry should be washed at temperatures above 65 °C and dried.

Where laundry is processed in the facility or off-site, no additional decontamination steps are required for disinfected linens to be returned for reuse.

Monitoring exposed health workers or facility staff

Any health worker or facility staff member who has cared for a person with probable or confirmed mpox and experienced an unprotected exposure should be alert to the development of symptoms that could suggest mpox virus infection, especially within the 21-day period after the last date of unprotected exposure. Health workers or facility staff with occupational exposure to mpox should notify the appropriate facility authorities and public health authorities to receive an assessment and management plan of the potential infection *(14)*.

Health workers and facility staff who have occupational exposures (i.e., needlestick injuries or contact exposure with an mpox case while not wearing appropriate PPE) or exposure to possibly contaminated materials should follow international and national infection control guidance. The health workers or facility staff do not need to be excluded from work duty if asymptomatic, but should actively monitor for symptoms, which includes measurement of temperature at least twice daily for 21 days following the exposure; and they should be instructed not to work with vulnerable persons during this period. Prior to reporting for work each day, the health worker or facility staff should be interviewed regarding evidence of any relevant signs or symptoms.[4] If symptoms develop, the healthcare worker or staff member should abstain from work and seek medical care.

3. Infection prevention and control recommendations for prison staff

Staff should receive clear guidance about mpox including the potential for spread through close, sustained physical contact, and prevention by appropriate donning and doffing of PPE and hand hygiene.

[4] Signs and symptoms of mpox include, but are not limited to: fever, headache, back pain, muscle aches, lack of energy, lymphadenopathy, and a rash that presents in sequential stages – macules, papules, vesicles, pustules, umbilication. Presentation with oral ulcers is common.

If staff must enter the isolation area, they should maintain a distance of at least 1 m from the patient whenever possible.

Overcrowding may facilitate the transmission of mpox, and measures should be taken to facilitate physical distancing, if possible.

Personal protective equipment

Staff entering the isolation areas should wear a gown, nonsterile gloves, eye protection, and a well-fitting medical mask. They should clean their hands with either soap and water or an alcohol-based hand sanitizer before and after contact with the patient or surrounding environment, and before putting on and after removing their gown and gloves, and before and after removing their mask and eye protection.

4. Infection prevention and control recommendations for people in prison and prison transfers suspected or confirmed to have mpox

Management of suspected or confirmed cases in prisons and other custodial settings

Identifying cases may be done at intake, following presentation within the facility itself, or via contact-tracing.

Intake screening / new admission and prison transfer assessment

Upon intake or admission to the facility, implement a screening process by a trained health worker to rapidly identify possible cases of mpox.

Mpox screening should assess for suspected, probable, or confirmed cases, based on the most current case definitions by WHO *(14)*. The case definitions for use in this outbreak may be reviewed as more evidence becomes available.

Suspected case:

- A person who is a contact of a probable or confirmed mpox case in the 21 days before the onset of signs or symptoms, and who presents with any of the following: acute onset of fever (>38.5 °C), headache, myalgia (muscle pain/body aches), back pain, and profound weakness or fatigue.

OR

- A person presenting since 1 January 2022 with an unexplained acute skin rash, mucosal lesions, or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the anogenital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Anorectal lesions can also manifest as anorectal inflammation (proctitis), pain, and/or bleeding.

AND

- For which the following common causes of acute rash or skin lesions do not fully explain the clinical picture: varicella zoster, herpes zoster, measles, herpes simplex, bacterial skin infections, disseminated gonococcus infection, primary or secondary syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, molluscum contagiosum, allergic reaction (e.g., to plants), and any other locally relevant common causes of papular or vesicular rash.

Probable case:

- A person presenting with an unexplained acute skin rash, mucosal lesions, or lymphadenopathy (swollen lymph nodes). The skin rash may include single or multiple lesions in the anogenital region or elsewhere on the body. Mucosal lesions may include single or multiple oral, conjunctival, urethral, penile, vaginal, or anorectal lesions. Anorectal lesions can also manifest as anorectal inflammation (proctitis), pain, and/or bleeding.

AND

- One or more of the following:
- has an epidemiological link[5] to a probable or confirmed case of mpox in the 21 days before symptom onset;
- identifies as a gay, bisexual, or other man who has sex with men and has had multiple and/or casual sexual partners in the 21 days before symptom onset;
- has detectable levels of anti-orthopoxvirus (OPXV) IgM antibody2 (during the period of 4–56 days after rash onset); or a fourfold rise in IgG antibody titer based on acute (up to day 5–7) and convalescent (day 21 onward) samples; in the absence of a recent smallpox/mpox vaccination or other known exposure to OPXV;
- has a positive test result for orthopoxviral infection (e.g. OPXV-specific polymerase chain reaction [PCR] without MPXV-specific PCR or sequencing).

Confirmed case:

- A person with laboratory confirmed mpox virus infection by detection of unique sequences of viral DNA by real-time (PCR)c and/or sequencing.

The above case definitions have been developed with a view to balancing the importance of detecting cases and interrupting chains of transmission while avoiding an overly sensitive definition that would overburden public health, diagnostic, and treatment resources. Public health authorities may adapt these case definitions to suit local circumstances.

[5] The person has been exposed to a probable or confirmed monkeypox case.

These definitions are for surveillance purposes and should not be used to guide clinical management. WHO interim guidance for clinical management and infection prevention and control for mpox has been published separately *(12)*.

> *Note:* At all times measures should be taken to comply with proper procedures to ensure privacy, confidentiality, and informed consent during examinations *(15, 16)* (See Annex 1) and as set out in national regulations and individual institutional policies. Even if their mpox status information is needed for epidemiological surveillance and preventive public health measures such as medically based isolation, individuals should be informed of any circumstances in which information obtained may be disclosed, for example, for purposes of contact-tracing. This information should only be considered an exception to overall confidentiality and protected to the maximum extent possible. All efforts should be made to avoid unnecessary stigmatization of individuals and communities potentially affected by mpox. No punitive measures must be taken when suspected or confirmed cases in prisons and other custodial settings are identified.

Persons with symptoms that meet the case definition for suspected, probable, or confirmed mpox should enter an mpox clinical care pathway *(12)*, immediately be given a well-fitting medical mask, be managed in a well-ventilated single room, and be placed on contact and droplet precautions. If a well-ventilated single room is not available, then group patients with similar clinical diagnosis and based on epidemiological risk factors, with a spatial separation (at least 1 m between patients), that is: suspected cases should not be cohorted together with confirmed cases (see the section Managing Cohorting below).

Reporting suspected, probable, or confirmed mpox cases

When suspected, probable, or confirmed cases are identified, the relevant authorities should be informed and relevant case management guidance followed according to national guidelines and regulations for clinical case management related to mpox.

Isolation of cases

Can they remain on-site to isolate?

Suspected, probable, or confirmed cases as per the mpox case definitions should be managed in medically based isolation in single-cell accommodation if possible and according to facility policies or while awaiting national health authorities' advice and until further clinical assessment is arranged. The objective of this measure is to contain the spread of the virus, while providing health services and humanitarian support.

Arrangements for individual patients should be considered on a case-by-case basis. Isolation within the prison or custodial facility can be used for clinically well, ambulatory, suspected or confirmed cases for whom it is judged safe and clinically appropriate.[6]

If patients with suspected or confirmed mpox need to be transported to hospital, lesions should be covered, and a face mask should be worn by the patient. If a suspect or confirmed case has extensive lesions that cannot be readily covered, then ambulance transport will be required, and the case may need to be isolated in a health facility.

How to medically isolate – single room, dedicated toilet?

Patients with suspected or confirmed mpox should be managed in single-cell accommodation with separate toilet facilities. If this cannot be arranged, this must be discussed with the appropriate national health authorities. The isolation area should have good ventilation and natural light, and the conditions should allow communication with others, including the family. Additional environmental cleaning should be arranged that should minimize possible transmission via surfaces.

Patients with mpox should frequently clean their hands with soap and water or an alcohol-based hand sanitizer.

The patient with mpox should wear a well-fitting medical mask and cover lesions when in close proximity to others, and when it is necessary to move outside of the designated isolation area. Where applicable, conjugal visits should be postponed until all lesions have crusted, scabs have fallen off, and a fresh layer of skin has formed underneath to prevent transmission of mpox. Based on the precautionary principle, WHO suggests the use of condoms consistently during sexual activity (receptive and insertive oral/anal/vaginal) for 12 weeks after recovery to prevent the potential transmission of mpox *(14)*.

Items such as eating utensils, linens, towels, or beds should be dedicated to the person with mpox. The patient with mpox should avoid sharing personal items. If using reusable crockery and cutlery, use reusable rubber gloves and a disposable gown to collect crockery and cutlery, transport to a dishwasher, and then wash hands thoroughly after removing and disposing of the PPE.

Managing cohorting

Suspected and probable cases should be managed in a single cell. Confirmed cases may be cohorted in a shared room with other confirmed cases[7] while maintaining >1 m separation

[6] A clinically well, ambulatory person with mpox is capable of walking and not bedridden, has good food and water intake, is able to feed, bathe and dress themselves, and requires minimal to no assistance from a caregiver.

[7] WHO recommends, if single rooms are not available, considering cohorting confirmed cases, maintaining a distance of at least 1 m between patients. Contacts of cases who have not developed signs or symptoms should not be placed with confirmed cases or with other nonconfirmed, suspected cases of mpox.

between persons. Suspected cases should not be cohorted with confirmed cases to prevent transmission.

How long to isolate?

Precautions should remain in place until lesions have crusted, scabs have fallen off, and a fresh layer of skin has formed underneath *(12)*.

Additional considerations

Visitation

Visitation should prevent direct contact with any lesions, and the person with suspected, probable, or confirmed mpox should wear a well-fitting medical mask and cover any lesions with clothing or light bandages. Conjugal visits should be suspended for suspected, probable, or confirmed cases until mpox has been ruled out or all lesions are healed, and a new layer of skin has formed. Clean and disinfect rooms for intimate visits (conjugal rooms) and wash all bedding after each use. Routine disinfectants are effective.

Environmental cleaning and disinfection

Dishes and utensils and household surfaces, such as furniture, beds, toilets, or floors, or any location where the patient has had contact should be cleaned with water and soap and disinfected regularly (e.g., with common household disinfectant or bleach products). Pay particular attention to frequently touched surfaces.

Floors should be cleaned with soap and water, followed by a disinfectant (effective against enveloped viruses) using the damp-mopping method. Avoid dry sweeping to prevent dispersion of infectious particles.

Linens, towels, and clothing

Linens and bedding should be carefully lifted and rolled to prevent dispersion of infectious particles from lesions and body fluids. They should not be shaken. Only the patient with mpox should handle and launder their bedding, clothing, etc.

Linens, towels, and clothing from the patient with mpox should be laundered separately from other prison laundry. Clothing and linens of the person with mpox can be reused after washing with soap and preferably hot water (>60 °C) or soaked in chlorine[8] if hot water is not available.

[8] Due to the lack of available research with the mpox virus, there is uncertainty about the precise concentration of chlorine or the amount of risk reduction that might be achieved. However, there is consensus based on evidence from other viruses that the addition of chlorine is likely to reduce residual contamination, and this may be particularly useful where thermal disinfection, dilution, and mechanical action are suboptimal.

Management of contacts including contact-tracing

Contact-tracing

Contact-tracing is a key public health measure to control the spread of infectious disease pathogens such as the mpox virus. It allows for the interruption of chains of transmission and can also help people at a higher risk of developing severe disease to identify their exposure more quickly, so they can monitor their health status and seek medical care quickly if they become symptomatic. Cases should be interviewed as soon as possible to elicit the names and contact information of all potential contacts and identify places visited where contact with other people may have occurred. Persons should be informed about the value of their contribution to contact-tracing efforts, that confidentiality will be protected, and that no punitive actions will be taken.

Contacts of cases should be notified within 24 hours of identification and advised to monitor their health status and seek medical care if they develop symptoms.

In the current context, as soon as a suspected case is identified, contact identification and contact-tracing should be initiated per national guidelines, while further investigation of the source case is ongoing to determine if the case can be classified as probable or confirmed; in the event that the case is discarded, contact-tracing may be stopped.

Definition of a contact

A contact is defined as a person who has been exposed to an infected person during the infectious period, i.e., the period beginning with the onset of the index case's first symptoms and ending when all scabs have fallen off, and who has one or more of the following exposures with a probable or confirmed case of mpox *(14)*:

- Direct skin-to-skin and skin-to-mucosal physical contact (such as touching, hugging, kissing, intimate or sexual contact);
- Contact with contaminated materials such as clothing or bedding, including material dislodged from bedding or surfaces during handling of laundry or cleaning of contaminated rooms;
- Prolonged face-to-face respiratory exposure in close proximity;
- Respiratory exposure (i.e., possible inhalation of) or eye mucosal exposure to lesion material (e.g., scabs/crusts) from an infected person;
- the above also applies for health workers potentially exposed in the absence of proper use of appropriate PPE *(17).*

Contact identification and monitoring

Once contacts have been identified, they should be informed of their exposure, their risk of developing infection, the symptoms of mpox, and when symptoms may appear.

Options for monitoring by public health authorities are dependent on available resources. Contacts can be monitored passively, actively, or directly *(14)*.

Contacts should be monitored, or should self-monitor, daily for the onset of signs or symptoms for a period of 21 days from the last contact with the probable or confirmed case or their contaminated materials during the infectious period. Signs and symptoms of concern include headache, fever, chills, sore throat, malaise, fatigue, rash, and lymphadenopathy (swollen lymph nodes). Contacts should monitor their temperature twice daily. Asymptomatic contacts that adequately and regularly monitor their status can continue routine daily activities (i.e., no quarantine is necessary).

During the 21-day monitoring period contacts should regularly practice hand hygiene and respiratory etiquette. Contacts should also try to avoid physical contact with children, pregnant women, immunocompromised individuals, and animals *(14)*.

Isolation of contacts

A contact who develops prodromal symptoms or lymphadenopathy without rash should be isolated to contain the possible spread of the virus and referred for further clinical assessment per national guidelines.

If the contact develops skin or mucosal lesions, they should be isolated to contain the possible spread of the virus and referred for further clinical assessment per national guidelines.

Vaccination

Some contacts may be given vaccination as post-exposure prophylaxis; this will be agreed with the national health authorities.

Testing, treatment, and human rights considerations

Human rights considerations have been incorporated throughout this document, in conformity with the applicable United Nations Treaties, and such that people in prison should enjoy quality health care that is at least equivalent to that available in the community and should have access to necessary healthcare services free of charge without discrimination on the grounds of their sexual orientation or gender identity/expression, legal status, or any status. Testing and treatment of suspected and confirmed mpox should be offered in accordance with international standards and national guidelines *(12, 14)*.

Seamless care

- Screen people for symptoms of mpox pre-release.
- Ensure linkages with health facilities when people with mpox, contacts, or symptoms are released from prison.

General information/education for persons in prisons

- Participate in information sessions on mpox, know how to prevent infection and what to do if symptoms develop in yourself or someone else.
- Do not share or reuse needles for tattooing or for injecting drugs or medication.

- If you are responsible for handling or washing other people's clothing and laundry, use disposable gloves, if available use adequate PPE.
- Notify staff immediately if you have symptoms that could be mpox or notice someone else with a rash, skin ulcers, and/or feeling unwell.

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Annex 1: Conditions of the medical examinations

Given that the mpox examination requires undressing (to detect the visible signs and symptoms of mpox), the appearance of such examination is no different from a body search,[1] which implies two points.

1. The mpox examination should go through the three criteria of legality, necessity, and proportionality.[2]
2. It is subject to human rights treaties to prevent torture and inhumane treatment.

Specifically:

- Body searches, and examinations must be carried out in two stages to avoid the detainee's humiliation and complete nudity.[1] The inmate should take off their clothes from the waist up and then put them back on before taking off their clothes from the waist down.
- These searches must be conducted in private, in a separate room, away from the eyes of inmates or others.
- There must be adequate conditions of hygiene and cleanliness.
- These searches must be conducted by staff with sufficient medical knowledge and skill to perform the search safely and respect the individual's privacy and dignity
- These searches must be conducted by staff of the same gender as the detainee and must be conducted out of sight and presence of staff of the opposite gender.

[1] Association for the Prevention of Torture. Body searches. Geneva: APT; 2022 [cited 16 December 2022]. Available from: http://www.apt.ch/en/knowledge-hub/detention-focus-database/safety-order-and-discipline/body-searches.

[2] Legality: they are provided for and defined by law; necessity: they are necessary to prevent the entry and trafficking of banned substances or objects; proportionality: they are proportional to the threat, that is to say that they are the least intrusive means to ensure safety.

Annex 2: Key definitions

Cohorting: This term applies to the practice of grouping patients infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible patients (cohorting patients). During outbreaks, healthcare personnel may be assigned to a cohort of patients to further limit opportunities for transmission (cohorting staff).

High-touch surfaces: Surfaces, often in patient care areas, that are frequently touched by healthcare workers and patients (e.g., bedrails, overbed table, IV pole, doorknobs, light switches, medication carts).

Isolation: A healthcare concept that separates sick people with a contagious disease from people who are not sick to prevent disease transmission.

Personal protective equipment (PPE). A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

Respirator. A personal protective device worn by healthcare personnel over the nose and mouth to protect them from acquiring airborne infectious diseases due to inhalation of infectious airborne particles that are <5 µm in size.

Reusable rubber gloves (also referred to as domestic gloves or household gloves): Gloves that protect the hands from liquids, including cleaning or disinfectant solutions, and chemicals. They are stronger (more durable) than disposable (single-use) latex gloves.

Surgical mask. A device worn over the mouth and nose by operating room personnel during surgical procedures to protect both surgical patients and operating room personnel from transfer of microorganisms and body fluids. Surgical masks also are used to protect healthcare personnel from contact with large infectious droplets (>5 µm in size).

Terminal (discharge) cleaning: Cleaning and disinfection after the patient is discharged or transferred. It includes the removal of organic material and significant reduction and elimination of microbial contamination.