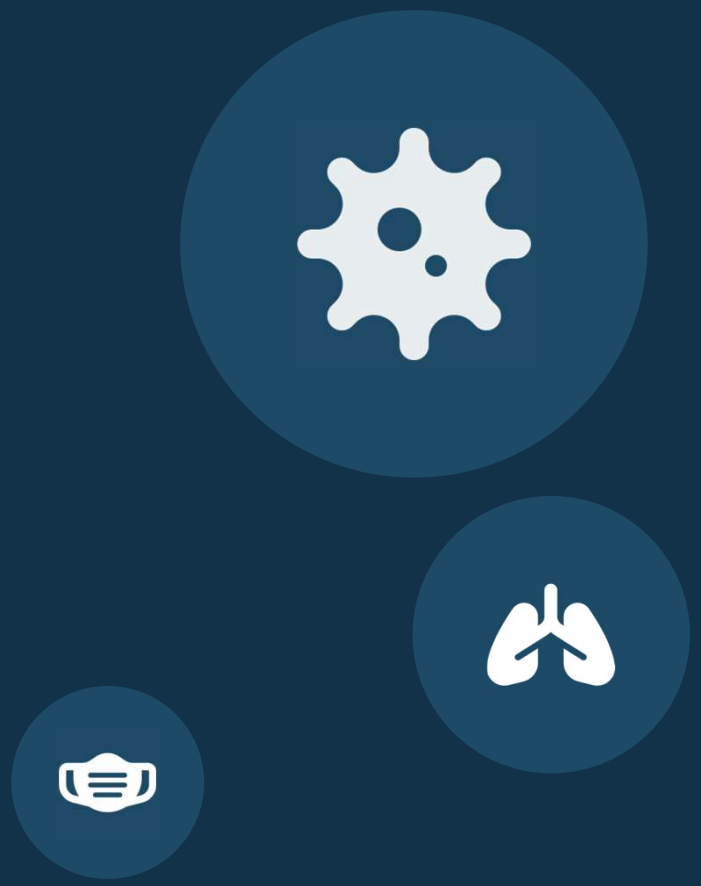
2026–2027 SEASON

NC SPICE

Viral Respiratory Guidance 2026

New CDC updates & toolkits for hospitals and long-term care, plus what's new from NC DHHS



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Today’s game plan

Healthcare personnel

CDC’s new exposure & return-to-work rules

Day 0 to Day 8

The timeline everyone should know

Long-term care toolkit

Prepare • Respond • Control

Hospitals & all settings

Core practices & broader masking

North Carolina updates

NC DHHS data, memos & vaccines

Myth or Fact?

Quick quiz, takeaways & Q&A

Why this season matters in North Carolina

335

flu-related deaths in NC last season, including 10 children

3rd

highest NC flu death count since broad reporting began in 2009

Oct 8

NCDHHS announced the first flu death of the 2026–27 season

Flu, COVID-19 and RSV can all co-circulate, and our residents and patients are the people most at risk.

Source: NCDHHS press release, Oct 8, 2026

01

CDC healthcare personnel guidance

Released September 11, 2026: one approach for COVID-19, flu, RSV and more



What’s new: one rule set for respiratory viruses

Replaces the COVID-only rules

Retires the Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure.

Covers many viruses

COVID-19, flu, RSV, parainfluenza, rhinovirus, hMPV, adenovirus, enterovirus and others.

Testing not required to return

Return-to-work is based on symptoms and time, not a negative test.

Rooted in HICPAC

Based on recommendations HICPAC approved in November 2024.

Not covered: measles, mumps, rubella, varicella, CMV, parvovirus B19, viral conjunctivitis, MERS. Those keep their own guidance.

Sources: CDC Viral Respiratory Infections, Infection Control in HCP (Sept 11, 2026); LeadingAge (Sept 16, 2026)

One guidance for all viral respiratory illnesses

Now covered by the same rules

- **COVID-19 (SARS-CoV-2)**
- **Influenza**
- **RSV**
- **Parainfluenza**
- **Rhinovirus**
- **Human metapneumovirus**
- **Adenoviruses**
- **Seasonal coronaviruses**
- **Enteroviruses**
- **…and others**

Not included: own guidance

- Measles
- Mumps
- Rubella
- Varicella (chickenpox)
- CMV
- Parvovirus B19
- Viral conjunctivitis
- MERS

Source: CDC Viral Respiratory Infections, Infection Control in HCP (Sept 11, 2026)

Exposed but feeling fine? Keep working, mask up



No work restriction

Asymptomatic staff with a known or suspected exposure do not need to stay home.



Source control

Wear a mask from the day of first exposure through at least day 5 after the last exposure.



Watch for symptoms

Self-monitor for at least 5 days. New symptoms? Stop working and follow the sick-staff rules.

What counts as an exposure? Close, unprotected contact (e.g., in the room without recommended PPE) or mucous membrane contact with secretions. Walking past someone in the hall usually doesn't count.

Source: CDC Viral Respiratory Infections, Infection Control in HCP (Sept 11, 2026)

Spotting a respiratory virus in staff

Common symptoms (acute onset of any)

Fever	**Chills**	**Fatigue**
Cough	**Runny/stuffy nose**	**Sore throat**
Headache/aches	**Weakness**	**Low appetite**
Vomiting	**Diarrhea**	**Loss of taste/smell**

No test? Use ARI criteria

Acute respiratory illness = 2 or more of: fever, cough, runny nose or congestion, sore throat.

Know your tests

Antigen: faster results
NAAT/PCR: more reliable, but can stay positive after someone is no longer contagious

Source: CDC Viral Respiratory Infections, Infection Control in HCP (Sept 11, 2026)

Sick with a respiratory virus? Check all four boxes

At least 3 days
since symptoms began (or first positive test)

Fever-free 24 hours
without fever-reducing medicine

Symptoms improving
getting better, not worse

Feels well enough
to safely do the job

Back at work?

Wear source control through the end of day 7. Day 8 is the first possible day without it.

Day of symptom onset = Day 0

Source: CDC Viral Respiratory Infections, Infection Control in HCP (Sept 11, 2026)

The Day 0 to Day 8 roadmap



Stay home (Days 0–3)

Rest, recover, don't come in "just for a few hours."

Return + source control (Days 4–7)

Only when all four criteria are met. Mask around everyone.

**Day 4 return only if fever-free 24h, improving, and feeling well. Severely ill or immunocompromised staff: case-by-case with Occupational Health.*

Then vs. now: COVID-19 work exclusion

BEFORE

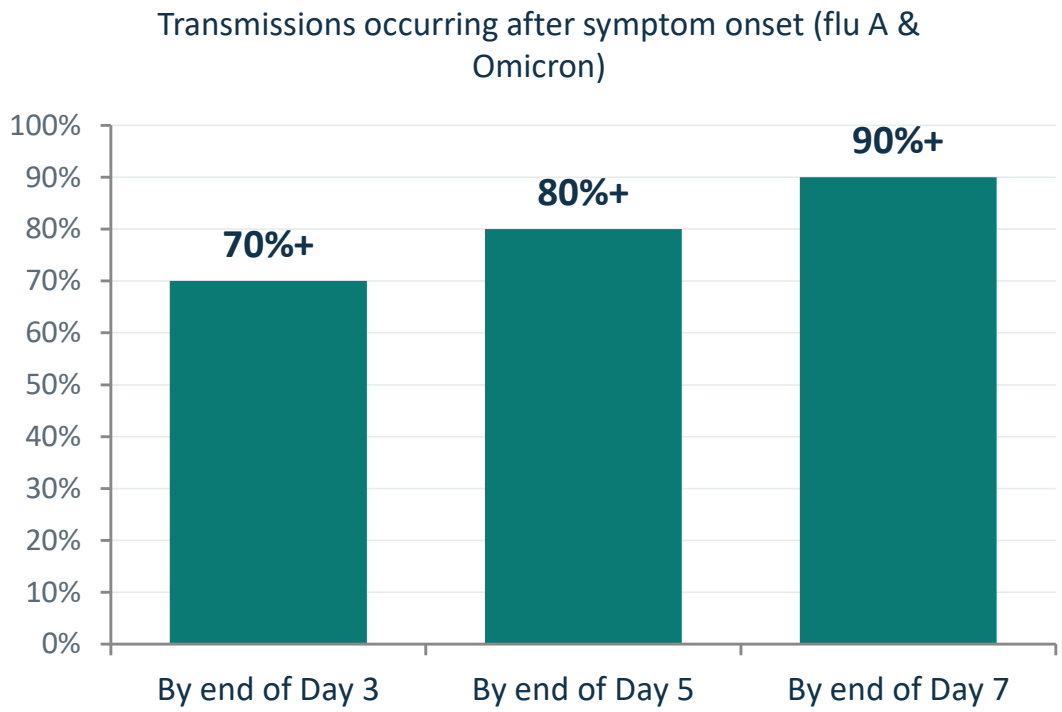
- At least 7 days out with negative testing, or 10 days without testing
- Separate COVID-specific rules for staff
- Testing built into return decisions

NOW (Sept 2026)

- At least 3 days out, plus fever-free, improving, and feeling well
- Same approach for COVID-19, flu, RSV and more
- No test needed to return; mask through Day 7

Sources: AHCA/NCAL (Sept 2026); CDC Viral Respiratory Infections (Sept 11, 2026)

Why Day 3, 5 and 7? Follow the science



The takeaway

Most spread happens early. Staying home Days 0–3 and masking through Day 7 covers the window when more than 90% of transmissions occur, while keeping staff on the floor.

Source: CDC rapid review cited in Viral Respiratory Infections guidance (Sept 11, 2026); previously healthy, mildly ill adults

Special situations & masking done right

Case-by-case with Occupational Health

Severely ill or immunocompromised staff may be contagious longer; consult an ID expert and consider pathogen-specific testing.

Antiviral post-exposure prophylaxis is not routine, but may be considered for high-risk staff or outbreak units.

Vaccines and antivirals may reduce spread but don’t change return-to-work timing.

Source control that works

- Comfortable enough to wear for a full shift
- Worn around patients, residents, coworkers and visitors
- Take mask breaks (eating, drinking) away from others
- Does not replace PPE for Standard and Transmission-Based Precautions

Source: CDC Viral Respiratory Infections, Infection Control in HCP (Sept 11, 2026)

02

Long-term care toolkit

CDC Viral Respiratory Pathogens Toolkit for Nursing Homes, updated Sept 24, 2026

Three moves: Prepare, Respond, Control

PREPARE

- Vaccinate residents & staff
- Stock PPE and hand sanitizer
- Watch community levels; mask more when high
- Educate, ventilate, line up rapid testing & pharmacy

RESPOND

- Act fast on the first case
- Transmission-Based Precautions
- Test for COVID-19 and flu at minimum
- Treat early; non-punitive sick leave

CONTROL

- Notify the health department
- Universal masking on affected units
- Active surveillance every shift
- Escalate if spread continues

Source: CDC Viral Respiratory Pathogens Toolkit for Nursing Homes (updated Sept 24, 2026)

First signs in a resident: act fast



Think atypical

Older adults may have no fever. Watch for malaise, dizziness, GI symptoms, loss of taste/smell, or behavior changes.



Test smart

At minimum, SARS-CoV-2 and influenza. Multiplex tests are ideal; consider RSV.

Unknown respiratory virus that could be COVID-19?



N95 respirator



Gown



Gloves



Eye protection

Adjust PPE once the cause is known. Don't place a symptomatic resident with a new roommate.

Source: CDC Viral Respiratory Pathogens Toolkit for Nursing Homes (updated Sept 24, 2026)

Flu in the building: know your numbers

2 in 72

At least 2 ill residents within 72 hours, with 1 or more lab-confirmed flu, triggers prophylaxis on the affected unit

48 hrs

Antiviral treatment works best started within 2 days, but still treat very sick or high-risk residents after that

2 weeks

Minimum chemoprophylaxis, continuing up to 1 week after the last known case

Treat suspected flu right away, even before results return. Prophylaxis goes to non-ill residents regardless of vaccination status.

Source: CDC Viral Respiratory Pathogens Toolkit for Nursing Homes (updated Sept 24, 2026)

Outbreak extras: staff prophylaxis & COVID-19 care

Flu antiviral prophylaxis for staff



Offer it to unvaccinated staff who care for residents at higher risk of flu complications.



Consider it for all staff, vaccinated or not, if the strain is poorly matched to the vaccine or staffing is tight.



Newly vaccinated staff: consider it for up to 2 weeks while immunity builds.



COVID-19 in residents

Treat mild-to-moderate illness; check contraindications and drug interactions.



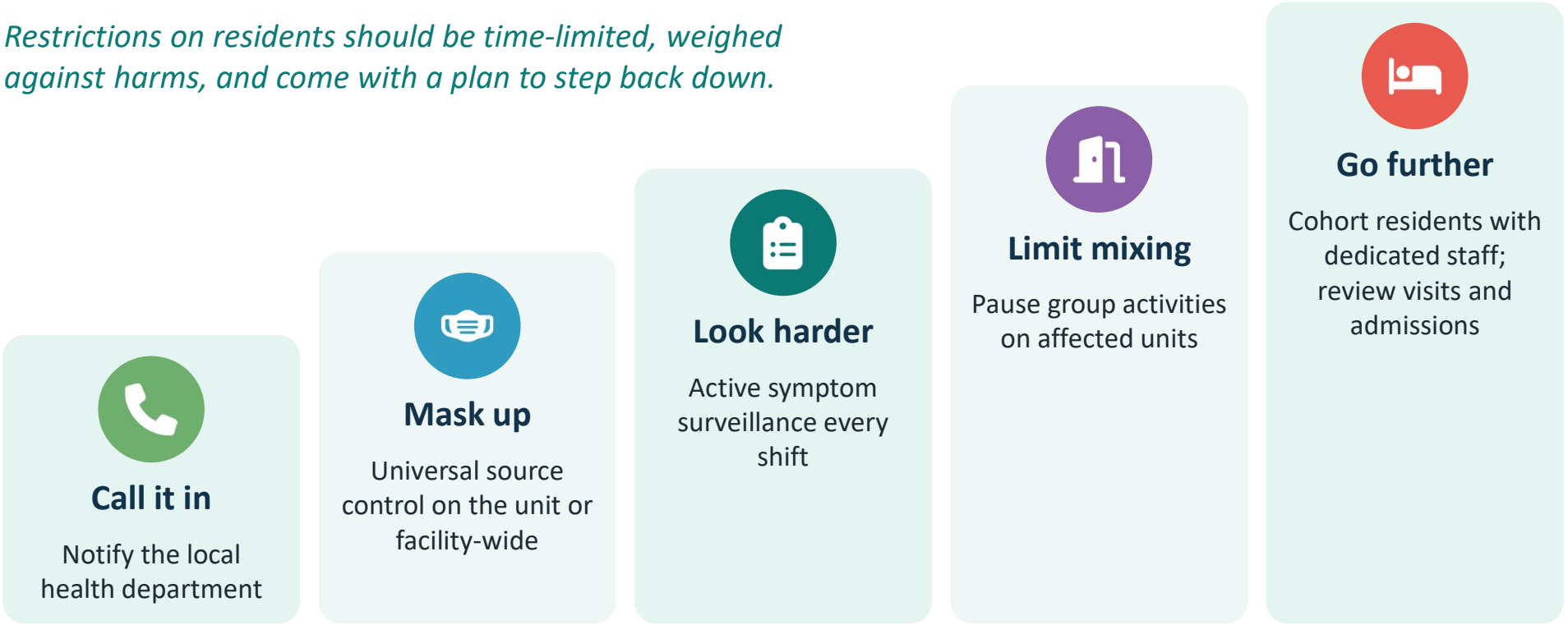
Watch for resistance

Sick while on prophylaxis? Switch to treatment dosing and call public health.

Source: CDC Viral Respiratory Pathogens Toolkit for Nursing Homes (updated Sept 24, 2026)

Control spread: climb the ladder

Restrictions on residents should be time-limited, weighed against harms, and come with a plan to step back down.



Source: CDC Viral Respiratory Pathogens Toolkit for Nursing Homes (updated Sept 24, 2026)

Grab-and-go tools inside the toolkit

Resident handout

Customizable color or grayscale illness-prevention handout

Vaccine counseling

“Why Get Vaccinated?” for residents & families: English, Spanish, Chinese

PPE job aid

Donning and doffing sequence poster

Masking signage

Ready-to-post mask graphics and signs

Fact sheet

Respiratory viruses fact sheet for staff

Webinar

CDC & AMA recording on LTC respiratory outbreaks

All linked from the Resources section of the CDC Viral Respiratory Pathogens Toolkit for Nursing Homes

03

Hospitals & all healthcare settings

CDC core practices for preventing viral respiratory transmission



Six core practices for every setting

Controls & air

Limit crowding, separate symptomatic patients, improve ventilation

Communicate

Signs at entrances: report symptoms, mask if sick, clean hands

Respiratory hygiene

Masks, tissues, no-touch bins and sanitizer at entries and triage

Broader source control

Mask on outbreak units and during high community spread

Empiric precautions

TBP based on suspected cause; COVID precautions until ruled out

Manage ill staff

Vaccinate, follow work restrictions, non-punitive sick leave

Source: CDC Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings

When should everyone mask?



Outbreak on a unit

Source control for everyone living or working on that unit until the outbreak is over.

Recommended



High community spread

Consider masking on entry, facility-wide or targeted to EDs, urgent care, or immunocompromised patients.

Consider



Any time

Even without a requirement, let anyone wear a mask or respirator by personal preference.

Always allow

Source: CDC Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings

04

North Carolina updates

NC DHHS & Division of Public Health, 2026–2027 season



What's new from NC DHHS

Sept 30, 2026

2026–27 respiratory season memos for clinicians: Immunization, Infection Prevention & Control, and Surveillance

Every week

NC Respiratory Virus Summary Dashboard tracks flu, COVID-19 and RSV statewide

Weekly too

NC Respiratory Immunization Dashboards for flu, COVID-19 and RSV coverage

Oct 8, 2026

First flu death of the 2026–27 season announced; vaccinate now

Heads up: state guidance can differ from CDC. Check flu.nc.gov for current NC recommendations.

Sources: NC DPH 2026–27 respiratory season memos (Sept 30, 2026); NCDHHS press release (Oct 8, 2026)

2026–27 vaccines: who gets what

FLU

Everyone 6 months and older, every season. 2026–27 vaccines are trivalent.

COVID-19

CDC: ages 6 months+ through individual-based (shared clinical) decision-making. AAP, AMA and AAFP recommend annual vaccine for all adults.

RSV

One-time dose for all adults 75+ and adults 50–74 at increased risk. Infant protection under 8 months.

Pro tips

- Flu, COVID-19 and RSV can be given at the same visit
- Fall is the best time to vaccinate
- Vaccinated staff protect residents and patients

Sources: NCDHHS press release (Oct 8, 2026); NC Immunization Branch memos (Aug 11 & Sept 28, 2026)

Myth or Fact? Let's play!

1. Staff need a negative test before returning to work after COVID-19.

2. An exposed staff member without symptoms can keep working.

3. Once back at work on Day 4, a mask is optional.

4. Nursing home residents always run a fever with flu.

Shout it out, or hold up a thumbs up for Fact and a thumbs down for Myth!

And the answers are…

1. MYTH

No test is needed. Return is based on time, fever, symptoms and feeling well.

2. FACT

No work restriction; mask through Day 5 after last exposure and watch for symptoms.

3. MYTH

Keep wearing source control through the end of Day 7.

4. MYTH

Residents often present atypically, without fever. Look for behavior changes, GI symptoms and malaise.

Five things to take back to your unit

3 + 4 = return	At least 3 days out and all four criteria met before coming back
Mask through Day 7	Source control after return; through Day 5 after an exposure
Test & treat early	COVID-19 and flu testing; start flu antivirals right away
Use the toolkit	Prepare, Respond, Control in long-term care
Vaccinate & report	Get vaccinated; report outbreaks to your local health department

NC DPH COVID-19 PPE memo for hospitals

HOSPITAL-SPECIFIC. This memo does NOT apply to long-term care settings.

Caring for suspected or confirmed COVID-19:

Wear: Fit-tested, NIOSH-approved N95 or higher

Wear: Eye protection: goggles or face shield covering front and sides

No longer routine: Gown & gloves: use per Standard Precautions when contact with infectious material is expected

Good to know

- N95s need NC Dept. of Labor medical clearance, training & fit testing
- Discard N95s after doffing, at breaks, or before eating/drinking
- Extra PPE is OK if it adds no hazard
- Guidance, not regulation

Source: NC DPH Interim Guidance on the Use of PPE for HCP Caring for Patients with Suspected or Confirmed SARS-CoV-2 (Sept 14, 2026)

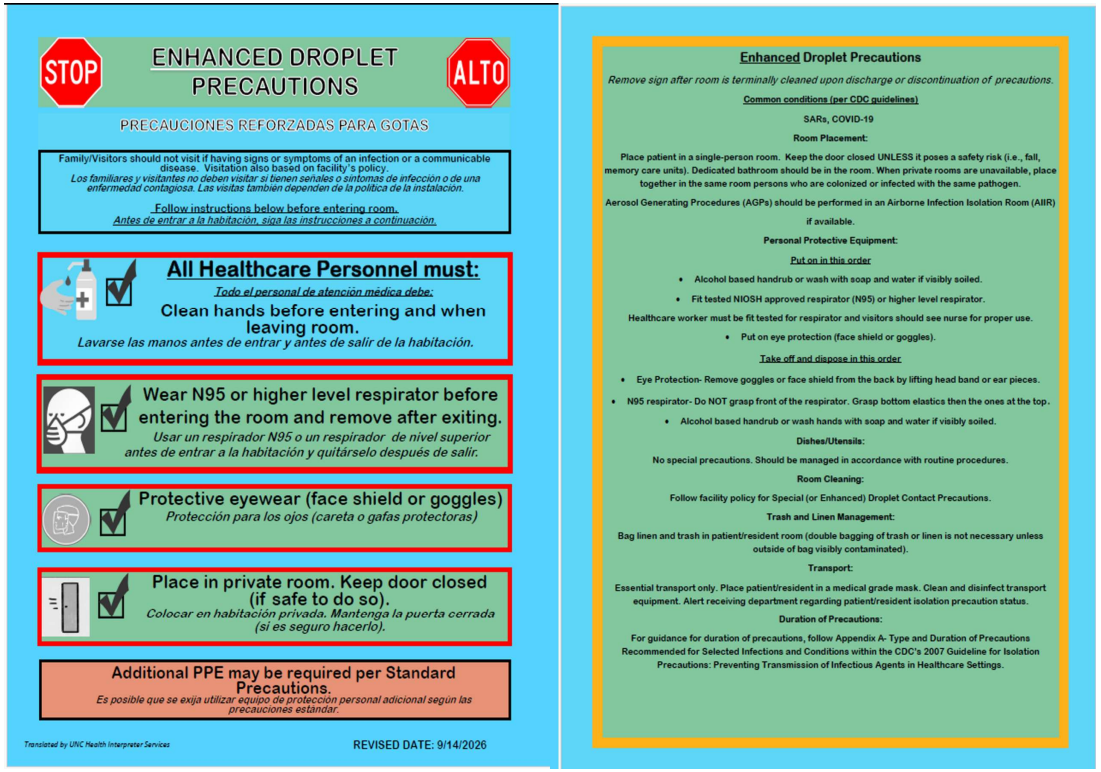
COVID-19 PPE: hospital vs. long-term care

	HOSPITALS NC DPH memo, Sept 2026	LONG-TERM CARE Follow current CDC guidance
N95 respirator	**Yes**	**Yes**
Eye protection	**Yes**	**Yes**
Gown	Only if contact expected	**Yes**
Gloves	Only if contact expected	**Yes**

Long-term care: keep using N95, gown, gloves and eye protection per CDC.

Sources: NC DPH PPE memo (Sept 14, 2026); CDC Viral Respiratory Pathogens Toolkit for Nursing Homes (Sept 24, 2026)

Enhanced Droplet Precautions sign for hospitals



FOR HOSPITAL USE

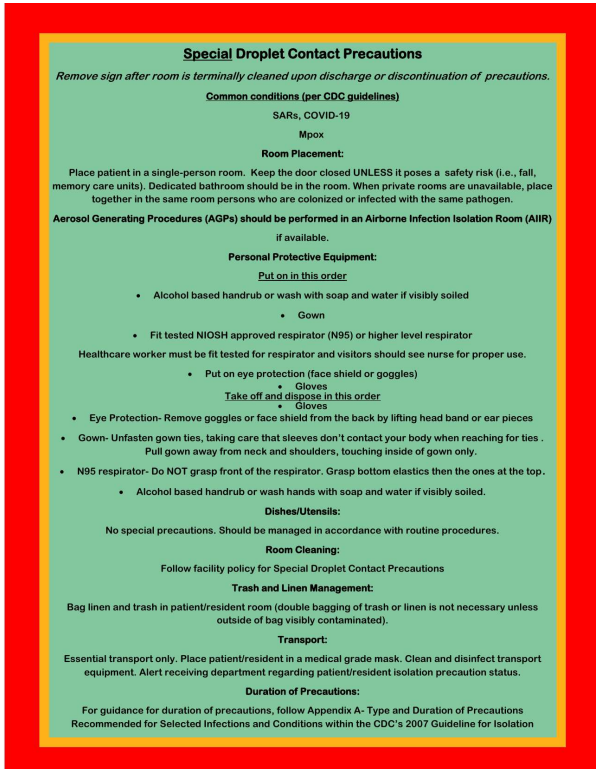
- Clean hands in and out
- N95 or higher + eye protection
- Private room; door closed if safe
- AGPs in an AIIR if available
- Gown & gloves only per Standard Precautions

Long-term care: keep using CDC precautions.

Source: NC SPICE Enhanced Droplet Precautions sign, English/Spanish (revised 9/14/2026)

Special Droplet Contact Precautions sign for LTC





LONG-TERM CARE
No changes to isolation

Used for:

COVID-19 (SARS) and mpox

Staff keep wearing all four:

- Gown
- N95 or higher
- Eye protection
- Gloves

NC DPH PPE memo & Enhanced Droplet sign: hospitals only.

Source: NC SPICE Special Droplet Contact Precautions sign, English/Spanish (revised 10/7/2024)

Staff vs. patient isolation: not the same clock

STAFF

Changed: CDC, Sept 11, 2026

- Out at least 3 days + all four criteria
- Earliest return: Day 4
- Mask through end of Day 7
- No test needed to return

PATIENTS & RESIDENTS

No change

- Transmission-Based Precautions per CDC Appendix A and pathogen-specific guidance
- COVID-19: at least 10 days (mild to moderate) or 10 to 20 days (severe), plus fever-free 24h and improving
- Immunocompromised: test-based strategy + ID consult

Example: A nurse with COVID-19 may be back, masked, on Day 4. A resident with COVID-19 is still on precautions.

Sources: CDC Viral Respiratory Infections, HCP (Sept 11, 2026); CDC Appendix A, Type and Duration of Precautions; CDC SARS-CoV-2 Infection Control Guidance

How long do patients & residents stay in isolation?

CDC Appendix A reviewed Sept 11, 2026: no changes to isolation duration

Influenza

Hospitalized patients & residents

- 7 days after illness onset, OR 24h after fever and respiratory symptoms resolve, whichever is longer
- May extend for young children or severely immunocompromised (clinical judgment)

COVID-19

Hospitalized patients & residents

- Mild to moderate: at least 10 days from symptom onset
- Severe to critical: 10 to 20 days
- No symptoms: 10 days from first positive test
- Plus 24h fever-free and improving symptoms
- Immunocompromised: 2 negative tests 48h apart

Sources: CDC Appendix A, Type and Duration of Precautions (reviewed Sept 11, 2026); CDC Influenza IPC in Healthcare Settings (Sept 29, 2026)

05

A companion tool: CDC CaseTrace

A CDC dashboard for visualizing patient overlap in time and location during outbreak investigations

Open the tool: **cdcposit.cdc.gov/CaseTrace**

Learn more: cdc.gov/healthcare-associated-infections/php/casetrace

CaseTrace: see who overlapped, where and when

Upload a de-identified linelist

Patient stays, tests and events. No patient or facility names.

Visualize patient movement

Maps stays over time and location to reveal possible exposure windows.

Nothing is saved

All data and graphs are deleted from the server when the session ends.

Runs in any browser

No installation needed.

Where it fits

- Use during the epidemiologic and lab investigation, once 2 or more cases may be linked
- Add typing or WGS results to filter by strain
- Shows who was co-located, not who infected whom

Open: cdcposit.cdc.gov/CaseTrace

About: cdc.gov/healthcare-associated-infections/php/casetrace

Source: CDC CaseTrace User Manual V1; NC SPICE GAS Outbreak Investigation Guide

Using CaseTrace: build, upload, interpret

1. Build your linelist

One row per stay, test or event. No names.

Required: patient, admission/discharge, facility/unit/location, test/test_date

Optional: wgs, event/event_date

2. Upload

Go to:

cdcposit.cdc.gov/CaseTrace

.xlsx or .csv; column names must match the CDC template.

Times out after 5 min idle or 30 min total; a 15-min extension is offered.

3. Interpret

Overlap = days two patients shared a unit or room.

Overlap is not proof of transmission.

Check data quality and pair results with epi, lab and IP judgment.

Source: CDC CaseTrace User Manual V1; NC SPICE GAS Outbreak Investigation Guide

Bookmark these resources

CDC: Viral Respiratory Infections (HCP)
cdc.gov/infection-control/hcp/healthcare-personnel-epidemiology-control/viral-respiratory-infections.html

CDC: Respiratory Pathogens Toolkit for Nursing Homes
cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit

CDC: Preventing Viral Respiratory Transmission
cdc.gov/infection-control/hcp/viral-respiratory-prevention

CDC: CaseTrace outbreak overlap dashboard
cdc.gov/healthcare-associated-infections/php/casetrace

NC DHHS Seasonal Respiratory Virus Hub & memos
flu.nc.gov

NC SPICE • Ask SPICE (send us your IP questions)
spice.unc.edu spice.unc.edu/ask-spice

NC SPICE: Viral respiratory outbreak visitor sign (printable)
spice.unc.edu/wp-content/uploads/2023/11/Viral-Resp_outbreak_11_23-1.pdf

NC Communicable Disease Branch epidemiologist on call, 24/7: (919) 733-3419

Key references for today's presentation

CDC: Viral Respiratory Infections, Infection Control in Healthcare Personnel

Updated Sept 11, 2026 • Staff exposure & return-to-work guidance

https://www.cdc.gov/infection-control/hcp/healthcare-personnel-epidemiology-control/viral-respiratory-infections.html

CDC: Viral Respiratory Pathogens Toolkit for Nursing Homes

Updated Sept 24, 2026 • Prepare, Respond, Control for long-term care

https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html

NC DPH: Interim Guidance on PPE for HCP Caring for COVID-19 Patients

Sept 14, 2026 • Hospital-specific; does not apply to long-term care

https://www.dph.ncdhhs.gov/epidemiology/communicable-disease/covid-ppe-memopdf/download?attachment

Links are clickable in slideshow mode.

NC SPICE is here to help

COMING SOON



NC SPICE Respiratory Protection Plan Toolkit

Watch spice.unc.edu for the release.

ONGOING

NC SPICE Mentorship Program for NC infection preventionists

- ICARs
- Environmental rounding
- Education
- Outbreak guidance
- All other IP needs
- Ask SPICE
  spice.unc.edu/ask-spice

ICAR = Infection Control Assessment and Response

Questions?

Thank you for keeping North Carolina's patients and residents safe!

Vicki Allen
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spice.unc.edu