Ebola Virus Disease

POLICY STATEMENT
This policy provides guidelines for the recognition, control, prevention, and transmission of Ebola Virus Disease (EVD).

This policy was written to provide guidelines for the recognition, control, and prevent transmission of Ebola Virus Disease (EVD) within healthcare due to the recent, largest documented, EVD outbreak in West Africa and the increasing likelihood of patients traveling from impacted countries to the United States.

The policy will:

1) Provide guidance on identification of EVD;
2) Outline infection prevention management of patients with suspected EVD;
3) Provide guidance on internal and external notification; and
4) Clarify which specimens should be obtained and how to submit for diagnostic testing.

AFFECTED STAKEHOLDERS
Indicate all entities and persons within the Enterprise that are affected by this policy:

☒ Administrative Services
☒ Hired Staff
☒ Housestaff/Residents & Clinical Fellows
☒ Leased staff
☒ Medical Staff (includes Physicians, PAs, APNs)
☒ Patient Care Services (Nursing, PCT’s, Unit Clerks)
☒ Professional Services (Laboratory, Radiology, Respiratory, Pharmacy; etc.)
☒ Vendors/Contractors
☒ Other: Visitors

DEFINITIONS

| Aerosol Generating Procedures (AGP) | Procedures that stimulate coughing and/or promote the generation of aerosols which increase the risk of infection, especially for healthcare personnel. Such procedures include intubation, manual ventilation, non-invasive ventilation, tracheostomy insertion, and suctioning. These procedures require additional precautions to include placement in a negative pressure room, limitation of only necessary healthcare |

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**Process & Procedures**

A. **Identification of a Patient with Suspected EVD:**

1. Healthcare personnel (HCP) should evaluate all patients to identify those with symptoms or risk factors for Ebola virus infection as follows:
   1. Clinical criteria, which includes:
      1. Fever greater than 38.0° Celsius or 100.4° Fahrenheit, **AND**
2. Additional symptoms such as severe headache, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; **AND**

3. Epidemiologic risk factors within the past 21 days before the onset of symptoms, such as:

<table>
<thead>
<tr>
<th>No Known Exposure</th>
<th>Low-Risk Exposure</th>
<th>High-Risk Exposure</th>
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| ▪ Residence in or travel to affected area without LOW or HIGH risk exposure  
  ▪ Review up-to-date travel notices¹ and outbreak map² for affected areas |
| ▪ Household members of an EVD patient and others who had brief direct contact (eg, shaking hands) with an EVD patient without appropriate PPE |
| ▪ Healthcare personnel in facilities with confirmed or probable EVD patients who have been in the care area for a prolonged period of time while not wearing recommended PPE |
| ▪ Percutaneous (e.g. needle stick) or mucous membrane exposure with body fluids from an EVD patient |
| ▪ Direct skin contact with, or exposure to blood or body fluids from an EVD patient |
| ▪ Processing blood or body fluids from an EVD patient without appropriate PPE or standard biosafety precautions |
| ▪ Direct contact with a dead body (including during funeral rites) in an Ebola affected area without appropriate PPE |
| ▪ Direct handling of bats, rodents, or primates from disease affected areas |
| ▪ Consumption or handling bush meat or were involvement with animal rituals in affected areas |

4. **Note:** Malaria diagnostics should also be a part of initial testing, because it is a common cause of febrile illness in persons with a travel history to the affected countries
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5. For persons with a high-risk exposure but without a fever, testing is recommended only if there are other compatible clinical symptoms present and blood work findings are abnormal (i.e., thrombocytopenia <150,000 cells/µL and/or elevated transaminases) or unknown.

6. Refer to the link for additional information on the EVD case definition.³

   ii. Testing is recommended for all persons with onset of fever within 21 days of having a high-risk exposure.

1. Contact Hospital Epidemiology to assist with case management; see section “Notification of a Suspected EVD Case” for additional information.

2. Refer to the section “Laboratory Testing” before obtaining specimens.

   iii. Asymptomatic persons with high- or low-risk exposures should be monitored daily for fever and symptoms for 21 days from the last known exposure and evaluated medically at the first indication of illness.

B. AMBULATORY CARE SERVICES:

1. Ambulatory services personnel should assess the patient’s travel history when scheduling a visit for a patient with a fever using Attachment A.

2. If the patient has a significant travel history (refer to the provided web link¹² for areas with ongoing transmission) within 21 days and a fever, the patient should be instructed to stay home and wait for a call from a Licensed Independent Practitioner (LIP).

3. The patient’s information should be provided to a LIP assigned to the clinic that day, and the LIP should call the patient to obtain additional information regarding their illness, using Attachment B.

4. If symptoms are consistent with Ebola and the patient traveled to an area with diagnosed Ebola cases, the LIP will:

   i. Contact Hospital Epidemiology to assist with case management; see section “Notification of a Suspected EVD Case” for additional information).
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5. Patients presenting to the ambulatory setting should be asked whether or not they have had a fever or travel within the last 3 weeks.
   i. If the patient answers yes to fever and the patient screens positive for a travel history upon review of up-to-date travel notices and outbreak map for affected areas, Ebola should be suspected. The patient should be instructed to wear a surgical mask and placed in an exam room adjacent to a bathroom with the door closed.
   ii. If the patient answers no to fever, but yes to travel history for an affected area, obtain a temperature in intake and if the patient’s temperature is elevated, Ebola should be suspected. The patient should be instructed to wear a surgical mask and placed in an exam room adjacent to a bathroom with the door closed.
   iii. If the patient answers yes to fever or has an elevated fever on intake and no to a travel history to an affected area for Ebola, the patient should be handled according to otherwise normal precautions for the situation.
   iv. Ambulatory Care personnel should:
      1. Demonstrate the patient’s proper use of the surgical mask.
      2. Minimize the number of HCP who interact with the patient and maintain a log of all such interactions (see attachment D).
      3. Place the patient on Standard, Contact and Droplet Precautions.
      4. Wear the appropriate PPE upon entry to the patient’s room which includes gloves, a fluid resistant or impermeable gown, eye protection (goggles or face shield), and a facemask.
         a. Additional protective equipment might be required in certain situations (e.g., copious amounts of blood, other body fluids, vomit, or feces present in the environment), including but not limited to double gloving, disposable shoe covers, leg coverings and a N-95 mask.
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5. Prohibit use of the adjacent bathroom by others until it has been appropriately disinfected after the patient is either removed from precautions or moved to another setting.
6. Move the patient only if essential.
7. Coordinate transportation to an alternative level of care with Hospital Epidemiology.
8. Review additional guidelines as outlined in section “MANAGEMENT OF PATIENTS WITH SUSPECTED OR CONFIRMED EVD”.

C. EMS PERSONNEL:

1. EMS personnel should assess the patient upon pick up for travel to endemic areas and symptoms of infection. Patients with a significant travel history and symptoms consistent with Ebola should be placed into isolation immediately upon arrival to the facility.
   **Note:** When the patient is categorized as suspect Ebola, the patient should remain within the ambulance until the patient’s room is ready for immediate occupancy.
2. Suspected EVD patients should only be received into the Emergency Department or an Airborne Infection Isolation Room if an interfacility transport. Suspected EVD patients arriving via EMS should not be transported to ambulatory care sites.
3. The pertinent travel history or suspected EVD should be communicated to the Emergency Communications Center in advance of the EMS unit arrival to allow for the availability of an Airborne Infection Isolation Room.
4. The ECC will advise the EMS personnel to remain in the ambulance until an Airborne Infection Isolation Room (AIIR) is confirmed to be available. The ECC will then coordinate the movement of the patient directly to the AIIR and in conjunction with the ED Charge nurse.
5. The patient is placed in the AIIR to allow for appropriate donning and doffing of PPE and in the possibility that aerosol generating procedures may become necessary. This approach will limit any unnecessary movement.
6. All other precautions will be taken as outlined below. Please refer to the following link for additional training: [https://www.youtube.com/watch?v=9IK59Hjw-GA&feature=youtu.be](https://www.youtube.com/watch?v=9IK59Hjw-GA&feature=youtu.be)
D. EMERGENCY DEPARTMENT:

1. Emergency Department personnel should assess the patient’s travel history when triaging a patient with a fever or complaint of fever.

2. If the patient has a significant travel history (refer to the web link for areas with ongoing transmission) within 21 days plus signs and symptoms consistent with Ebola the following should be initiated:
   i. **Provide the patient with a surgical mask and demonstrate its proper use.**
   ii. Place in a single room (preferably negative pressure) and place the patient on Standard, Droplet, and Contact Precautions.
   iii. The HCP should wear gloves, a gown (fluid resistant or impermeable), eye protection (goggles or face shield), and a facemask when there is contact with the patient.
   iv. Additional guidelines are outlined in section “MANAGEMENT OF PATIENTS WITH SUSPECTED OR CONFIRMED EVD”.
   v. **Refer to Attachment A for the Guidance for Initial Triage/Screening for MERS/Ebola.**

E. NOTIFICATION OF A SUSPECTED/CONFIRMED EVD CASE:

1. Internal Notification:
   **Notify the Hospital Epidemiology:**
   Monday – Friday, 8:00 am – 5:00 pm at Office number:    706-721-2224
   After Hours  Department Director:                 Pager 1486
   GRMC Medical Epidemiologist:     Pager 5324
   CHOG Medical Epidemiologist:     Pager 8011

2. External Communication:
   i. If the case meets the definition for suspected Ebola, the Georgia Department of Public Health or South Carolina Department of Health and Environmental Control (DHEC) will be called by Hospital Epidemiology for consultation.
      1. These health departments will assist with case management and approval for testing at the Centers for Disease Control and Prevention (CDC).
   3. When you call the Hospital Epidemiology, be prepared to:
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ii. State you have a suspected Ebola case, and provide your name plus contact telephone number.

iii. Describe the patient’s risk factors and travel history, including dates and locations of travel and any contact with sick patients, healthcare facilities, or animals in areas with ongoing EVD transmission.

iv. Describe the patient’s presenting symptoms, signs, and duration of illness.

4. Refer to Attachment B “Ebola Virus Disease (EVD) Evaluation Tool” to gather needed information as listed above.

F. LABORATORY TESTING:
1. Laboratory specimen collection and testing should be minimized to what is necessary for supportive care in suspected and confirmed cases of EVD.
2. If testing is indicated, obtaining and submission of specimens should be coordinated with Hospital Epidemiology who will assist with appropriate management of specimens.
   i. **Note:** Do NOT send any specimens to a reference laboratory.
3. All laboratory specimens should be labeled “Suspected Ebola” or “Confirmed Ebola” and placed in plastic collection containers when possible and then placed within a double-bagged biohazard bag. The double bagged specimen should be placed in a transport container at the patient’s doorway. Specimens should be hand delivered to the Core Laboratory (BI-2120), and the transport container should be discarded. **Specimens should NOT be sent by pneumatic tube.**
4. The specimen within the laboratory should be handled under a hood and the staff member should wear a gown, gloves, and full face protection or goggles, masks to cover all of the nose and mouth, when manipulating the specimen, i.e. splitting of specimens. The hood should be a certified class II Biosafety cabinet or Plexiglas splash guard. Use of splash guards does not negate the necessity to wear adequate face protection. Instruments used to process specimens should include manufacturer-installed safety features.
5. Refer to Attachment C for guidance on specimen testing.
6. Employees within the laboratory should wear the following:
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i. Impermeable gown with back closure (front button or front snap closing laboratory coats are not acceptable)  

ii. Double gloves  

iii. Mask to cover nose and mouth (an N95 respiratory is not recommended as specimens will be handled under a hood)  

iv. Eye protection such as safety goggles  

7. Upon completion of the testing, the testing area should be decontaminated with a 10% bleach solution that is EPA approved.  

8. Specimens for Ebola Testing:  

i. Hospital Epidemiology will coordinate specimen collection and submission to the Centers for Disease Control and Prevention (CDC) upon confirmation by the CDC that the patient meets the EVD case definition and specimen submission is approved.  

ii. HCPs should collect serum, plasma, or whole blood. A minimum sample volume of 4 mL is required to be shipped refrigerated or frozen on ice pack or dry ice (no glass tubes), in accordance with International Air Transporters Association (IATA) guidelines as a Category B diagnostic specimen. Refer to [http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html) for detailed instructions and a link to the specimen submission form for Centers for Disease Control and prevention laboratory testing.  

G. MANAGEMENT OF PATIENTS WITH SUSPECTED OR CONFIRMED EVD:  

1. Patient Placement and Management:  

i. Place the patient in a single patient room, preferably with an ante-room (containing a private bathroom) with the door closed. Special consideration should be given when selecting an appropriate room to provide a large enough ante-room for appropriate removal of PPE so as not to contaminate one’s self or the environment.  

ii. Maintain a log all persons entering the patient's room; refer to Attachment D.  

iii. Limit the number of people entering the room.  

iv. Ensure that all persons entering the room wear the recommended personal protective equipment (PPE).
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2. **Precautions:**
   i. Place a Droplet and Contact Precaution sign in visual locations (above the bed, at the door and on the medical record).
   ii. Place the patient on Airborne and Contact Precautions if any AGPs are anticipated; see the definition of AGPs at the beginning of the policy and section 6 below. The patient should remain on Airborne and Contact until Hospital Epidemiology with consultation with the local health department and/or the CDC change the Airborne to Droplet Precautions.

3. **Personal Protective Equipment (PPE):**
   i. All persons entering the patient room should wear at least:
      1. Gloves
      2. Gown (fluid resistant or impermeable which covers both the front and back torso completely)
      3. Eye protection (goggles or face shield)
      4. Facemask
   ii. Additional PPE might be required in certain situations (e.g., copious amounts of blood, other body fluids, vomit, or feces present in the environment), including but not limited to:
      1. Double gloving
      2. Impermeable disposable shoe covers
      3. Leg coverings
      4. **Note:** A hazmat suite is not required.
      5. Donning and doffing of PPE should be as outlined by the CDC. Refer to the following information at http://www.cdc.gov/HAI/pdfs/ppe/ppeposter148.pdf.
      6. See Attachment F for a list of approved PPE that may be obtained from Central Distribution.
   iii. **PPE utilization should include:**
      1. Donning PPEs when entering the room/area.
      2. Upon exiting the patient room/area, care should be taken not to contaminate the eyes, mucous membranes, or clothing with potentially infectious materials when removing PPE.
3. After removing PPEs perform hand hygiene upon exiting the patient’s room/area.

4. **Transport:**
   i. Limit the movement and transport of the patient from the room to essential purposes only. Minimize patient dispersal of droplets by masking the patient if possible and if not already masked.
   ii. Anticipate the need for AGPs and the need for an AIIR prior to patient placement to limit moving the patient.
   iii. If a patient requires a test or procedure that cannot be performed within the room, contact Hospital Epidemiology to outline a plan for safe transport.

5. **Hand Hygiene:**
   i. Strict adherence to hand hygiene prior to entering and exiting the patient’s room/area. Refer to the Hand Hygiene policy within the Infection Control Manual.
   ii. Prior to donning gloves, hands should be decontaminated with alcohol sanitizer.
   iii. If hands are visibly soiled prior to gloving, hands must be washed with soap and water.
   iv. When leaving the room, gloves should be removed and hand hygiene performed.

6. **Aerosol Generating Procedures (AGPs):**
   i. Avoid AGPs for a suspected and confirmed case.
   ii. Visitors should not be present during aerosol-generating procedures.
   iii. Limit the number of HCP present during the procedure to only those essential for patient-care and support.
   iv. Conduct the procedures in a private room and ideally in an Airborne Infection Isolation Room (AIIR) when feasible. Room doors should be kept closed during the procedure except when entering or leaving the room. Entry and exit should be minimized during and shortly (1 hour) after the procedure.
      1. An Airborne Precaution sign should be posted on the outside of the door through one hour post procedure.
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v. HCP should wear gloves, a gown, disposable shoe covers, and either a face shield that fully covers the front and sides of the face or goggles, and respiratory protection that are at least as protective as a NIOSH certified fit-tested N95 filtering face piece respirator during aerosol generating procedures.

vi. Conduct environmental surface cleaning following procedures (see section below on environmental infection control).

7. Management of respiratory therapy:

i. Inhaled Medications: Metered Dose Inhalers (MDI) with an attached holding chamber is the first choice to reduce exposure from contaminated aerosol. If appropriate MDI and holding chamber is not available secondary options include small volume nebulizers incorporating both an inspiratory reservoir and expiratory filter or a breath actuated nebulizer.

ii. Manual Resuscitation: Resuscitation bags must be disposable and include an appropriately rated filter.

iii. Oxygen Therapy: For patients requiring > 40% a mask with a good seal and appropriately rated expiratory filter must be used.

iv. Tracheostomy Humidification: Use heat and moisture exchanger in spontaneously breathing patients. Aerosol therapy must be avoided to prevent environmental contamination.

v. Suctioning Artificial Airways: Only use closed system suctioning. Open system suctioning must be avoided.

vi. Non-invasive ventilation: Use circuit with expiratory port filter and closed (non-ported) face mask.

vii. Invasive Ventilation: The ventilator circuit must include inspiratory/expiratory lines to prevent condensate or use a heat and moisture exchanger. An appropriately rated expiratory filter must be used.

viii. High Frequency Oscillatory Ventilation (HFOV): To prevent environmental contamination of unfiltered aerosolized gas only use filtered HFOV circuits.

ix. Visitors should not be present during aerosol-generating procedures.
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x. Limit the number of health care personnel present during the procedure to only those essential for patient-care and support.  

8. Patient Care Equipment:  
   i. Use disposable patient care items whenever possible.  
   ii. Dedicate the use of non-critical items, such as a stethoscope, thermometer, blood pressure cuff, an IV pole, etc. Remove temporary medical devices as soon as they are no longer needed, disinfecting before putting back into service.  
   iii. Limit use of reusable equipment that cannot be dedicated to prevent cross contamination; disinfect such equipment (e.g. EKG machines, x-ray machines, ultrasound machines, etc.) with a hospital-approved disinfectant as they are removed from the room.  
   iv. Disinfect all personal and non-dedicated stethoscopes with a hospital-approved disinfectant before it is used on another patient.  

9. Environment:  
   i. Clean all environmental surfaces routinely with a hospital-approved disinfectant daily (1:10 bleach or quaternary ammonium) and when the patient is discharged. This includes bedrails, charts, carts, doorknobs, bed controls, call bells, telephones, faucet handles, commodes, curtains, etc. Focus on areas potentially contaminated with infectious materials such as blood, sweat, emesis, feces and other body secretions.  
   ii. Clean grossly soiled surfaces (e.g. vomitus or stool) with 1:10 dilution of household bleach solution.  
   iii. HCP performing environmental cleaning and disinfection should wear recommended PPE and consider use of additional barriers (shoe and leg coverings, etc.) if needed.  
   iv. Liquid medical waste such as feces and vomitus can be disposed of in the sanitary sewer following local sewage disposal requirements. Care should be taken to avoid splashing when disposing of these materials. Wear protective garments (gloves, gown, eye and face protection) to avoid contamination of clothing, skin, or portal of entry such as eyes and mouth.  
   v. **All waste should be discarded as regulated medical waste** (using red, biohazardous bags).
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10. Patient Belongings:
   i. Discard clothing in a red biohazard bag.
   ii. Double bag and itemize other personal belongings e.g. wallet and purse. When possible, these should be sent home with family after instructing on how to appropriately disinfect. If unable to take home, these items should stay in the patient room until discharge.
   iii. Instruct the patient’s family to provide clean clothing upon discharge.
   iv. Return any bagged wallets and purses to the patient upon discharge with instructions for appropriate disinfection or disposal.

11. Utensils and Food Trays:
   i. Use disposable trays and dishes.

12. Linen:
   i. Immediately discard soiled linen into an impervious (leak proof) linen hamper (lined with a red, biohazardous bag) at the site of use. Promptly remove and transport to a designated area for pick up as regulated medical waste. Use disposable linen if available and discard as regulated medical waste (red biohazardous bag). Do NOT place soiled linen in the laundry chutes.

13. Patient Care Considerations with Needles and Sharps:
   i. Limit phlebotomy, procedures, and laboratory testing to the minimum necessary for essential diagnostic evaluation and medical care.
   ii. Handle all needles and sharps with extreme care and dispose in designated, puncture-proof, sealed containers.

14. Instruments requiring sterilization:
   i. When possible, utilize disposable instruments.
   ii. Reprocess instruments separately within the decontamination area to minimize contamination.

15. Patients receiving mechanical ventilation:
   i. Place mechanically ventilated patients in an AIIR on Airborne and Contact Precautions.
   ii. Consults with Hospital Epidemiology and Respiratory Therapy regarding the management of the respirator and reusable components of the ventilator prior to use on another patient. The
ventilator should remain within the patient’s room until it is decontaminated.

16. **Patients receiving dialysis:**
   i. Clean and disinfect the dialysis machine as outlined for hepatitis B patients, ensuring that dialysis are performed in the patient’s room.

H. **DISCONTINUING PRECAUTIONS:**
   1. Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities through collaboration with Hospital Epidemiology. Precautions for EVD may be discontinued if an alternative diagnosis for the patient’s symptoms is established.
   
   **Note:** For cases in which the diagnosis of EVD is confirmed, the recommendation is to isolate until the patient is no longer viremic. Guidance may be provided by external agencies.

I. **DISCHARGE INSTRUCTIONS FOR PATIENTS WITH CONFIRMED EBOLA:**
   1. Male patients should be informed that their sperm may still be contagious for a period of three months after clinical recovery, and that the Ebola virus is transmitted during sexual intercourse. During this period, the patient must either abstain from sex or use condoms.

2. Female patients that are breast feeding must be informed that breast milk is contagious for three months. Breastfeeding should be avoided during this time. Should the female choose to pump, the breast milk should be discarded during the first three months from disease recovery; safe handling should be advised to prevent cross acquisition.

J. **MONITORING, MANAGEMENT, AND TRAINING OF VISITORS:**
   1. Visitors should not be allowed within the patient care room/area.
      Exception may be considered on a case by case basis for those who are essential for the patient’s wellbeing, e.g., parent of a child. Those allowed to visit must be documented on the log as with healthcare personnel (Attachment D).
2. Visitors should wear PPE while in the patient’s room/area and wash their hands or use hand sanitizer after patient contact and upon exiting the patient’s room.
3. Instruct visitors on how to appropriately apply and remove PPE.
4. Visitors should be screened for signs and symptoms of Ebola and evaluated and reported to the local health department (LHD) if infection is suspected.
   a. Visitors accompanying the patient should not be allowed to be checked in with the patient unless visitors are symptomatic. If symptomatic, follow the above guidelines and isolate.
   b. Visitors that are not symptomatic should be informed to stay home. Contact information should be obtained from the visitors/family for the medical team or LHD to contact them for further information and to update on the patient’s status.

K. MANAGEMENT OF POTENTIALLY EXPOSED EMPLOYEES:
   1. Persons with percutaneous or mucocutaneous exposures to blood, body fluids, secretions, or excretions from a patient with suspected EVD should:
      i. Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) should be irrigated with copious amounts of water or eyewash solution.
      ii. Immediately notify direct supervisor and contact Employee Health and Wellness for assessment and access to post exposure management services for all appropriate pathogens (e.g., Human Immunodeficiency Virus, hepatitis B, hepatitis C, etc.).
   2. HCP who had an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD:
      iii. Should receive medical evaluation and follow-up care including fever monitoring twice daily for 21 days after the last known exposure.
      iv. Continue to work while receiving twice daily fever checks. Any temperature elevation should be evaluated through the Emergency Department and communicated to Employee Health and Wellness and Hospital Epidemiology.
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3. HCP who develop fever greater than 38.0° Celsius or 100.4° Fahrenheit, weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after exposure to an EVD patient, whether or not it was unprotected should:
   v. Immediately stop working or not report to work.
   vi. Notify their supervisor.
   vii. Seek prompt medical evaluation and testing.
   viii. Contact Hospital Epidemiology to notify the LHD.
   ix. Comply with work exclusions until they are deemed no longer infectious to others.

I. POST-MORTEM CARE:
If the patient dies, handling of the body should be minimized. The remains should NOT be embalmed. Remains should be wrapped in the approved, sealed leak-proof material. Remains should not be transported to the morgue, but left in the room until picked up for prompt cremation or burial in a sealed casket. If an autopsy is deemed necessary, Hospital Epidemiology should be notified to provide consultation with the CDC regarding appropriate precautions.

M. HEALTHCARE PERSONNEL TRAVELING TO/FROM AFFECTED AREAS:
   1. Healthcare Personnel (HCP) traveling to affected areas should receive:
      i. Counseling prior to departure.
      ii. Education on appropriate PPE use.
      iii. Information on self-monitoring 21 days post return from an affected area.
   2. HCP returning from an affected area should:
      i. Notify their immediate supervisor of anticipated return date.
      ii. Provide travel information to include travel location, departure date, and return date into the United States.
      iii. Complete risk exposure section on HCP Ebola Post-travel Evaluation Tool, Attachment E.
      iv. Complete fever monitoring twice daily for 21 days upon return to the United States from an affected area, using the designated section on the HCP Ebola Post-travel Evaluation Tool.
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v. Continue to work while performing twice daily fever checks. Employees with any temperature elevation should be stay at home or immediately stop working and report the elevation for further evaluation to Employee Health and Wellness and/or Hospital Epidemiology via telephone.
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REFERENCES, SUPPORTING DOCUMENTS, AND TOOLS

Attachment A: Guidance for Initial Triage/Screening for MERS/Ebola
Attachment B: Ebola Virus Disease (EVD) Evaluation Tool
Attachment C: Guidance for Specific Procedures
Attachment D: Patient Encounter Log
Attachment E: Healthcare Personnel Post-travel Evaluation Tool
Attachment F: Personal Protective Equipment (PPE) Product Ordering Information

REFERENCES

1 Up-to date travel notices can be viewed at http://wwwnc.cdc.gov/travel/notices
2 Outbreak map can be viewed at http://www.cdc.gov/vhf/ebola/resources/distribution-map-guinea-outbreak.html
3 Ebola Case Definition at http://www.cdc.gov/vhf/ebola/hcp/case-definition.html

RELATED POLICIES

Hand Hygiene Policy, Corporate policy # 20.7.1.3

APPROVED BY
Chief Executive Officer, Georgia Regents Medical Center  Date: 10/23/2014