Screening and Management of Patients with Suspected or Confirmed Ebola Virus Disease

The current outbreak of Ebola Virus Disease (EVD) is in West Africa. There have never been any cases of Ebola in Canada. The World Health Organization (WHO) continues to monitor the evolution of the EVD outbreak in Sierra Leone, Liberia, Guinea,

What do health care workers need to know about Ebola?

Health care workers in Canada are advised to be vigilant for the recognition, reporting and prompt investigation of patients with symptoms of Ebola and other similar diseases that can cause viral hemorrhagic fevers.

Ebola virus can only be transmitted through contact with infected blood or bodily fluids from humans or animals. Person-to-person transmission occurs primarily through direct contact (e.g. through broken skin or mucous membranes) with the blood or bodily fluids of someone who is sick or deceased, or contact with contaminated materials. The virus has been isolated in blood, saliva, semen, urine, stool, vomit, nasal secretions, and tears. Cases are not considered to be communicable before the onset of symptoms. A person with EVD is communicable as long as the virus remains in the bodily fluids. **EVD is not transmitted through the air;** therefore brief interactions such as walking by a person pose no risk.

There is no effective antiviral treatment for EVD. Treatment is supportive, and is directed at maintaining renal function and electrolyte balance, and at combatting haemorrhage and shock.

Health care workers caring for patients with suspected or confirmed Ebola virus disease must carefully and consistently apply the recommended infection prevention and control precautions.

Clinical symptoms

Clinical symptoms of Ebola typically appear **within three weeks (the incubation period) of exposure to the virus.** In most situations in Canada, this exposure would have been through travel in a country where Ebola is occurring. Symptoms include:

- sudden onset of fever
- malaise
- myalgia
- headache
- conjunctival injection
- pharyngitis
- impaired kidney and liver function
- vomiting, diarrhea that can be bloody

It is often accompanied by a maculopapular or petechial rash that may progress to purpura. Bleeding from gums, nose, injection sites and gastrointestinal tract occurs in about 50% of patients. Dehydration and significant wasting occur as the disease progresses. In severe cases, the haemorrhagic phase may be accompanied by leucopenia; thrombocytopenia; hepatic, renal and central nervous system involvement; or shock with multi-organ dysfunction.

People are contagious once they begin to show symptoms.

Reporting

Canadian health care workers are advised to be on the lookout for illnesses compatible with EVD in recent travellers (within past 21 days), including health care workers, to affected areas. All suspected and confirmed cases of EVD must be **immediately** reported to:

- The Medical Officer of Health (MOH) at 902-481-5800 (or after hours through locating at 902-473-2220, asking for the MOH on call).
- Delegated department person to make internal CDHA notification as per EVD Communications protocol.

Infection Control Precautions in Hospital

The recommended infection prevention and control practices (see below) should be implemented immediately for any suspected or confirmed case of EVD. Please refer to the Department of Health and Wellness' *Ebola Virus Disease: Standardized Triage Screening Tool.*

Carefully apply Routine Practices when providing care to ALL patients regardless of the signs and symptoms they present with. The initial manifestation of VHF may be non-specific. Routine Practices include the use of hand hygiene according to the *Four Moments of Hand Hygiene (*www.handhygiene.ca), cleaning and disinfection of all shared equipment, regular environmental cleaning using an effective hospital-approved general veridical disinfectant, meticulous attention to safety around the use of needles and sharps, and a complete and careful point of care risk assessment performed prior to any patient encounter.

Perform hand hygiene and change gloves before and after patient care or contact with patient environment, after any contact with potentially contaminated surfaces, before performing aseptic procedures, and before and after removal of PPE. Hand hygiene can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled and after removal of PPE, use soap and water, not alcohol-based hand rubs.

1. Identification

i) Screening will be done in all patients presenting to the Emergency Departments and the Collaborative Care Centres; using the Nova Scotia Screening Tool in Appendix 1. Patients must be asked about illness compatible with EVD in recent travellers (within 21 days), including health care workers, to affected areas.

ii) ***The recommended infection prevention and control practices should be implemented immediately for any suspected or confirmed case of EVD.***

2 Notifications

2.1 All suspected and confirmed cases of EVD must be **immediately** reported to:

- The Medical Officer of Health (MOH) at 902-481-5800 (or after hours through locating at 902-473-2220, asking for the MOH on call).
- Delegated department person to make internal CDHA notification as per the site based EVD Communications protocol.

2.2 Throughout the patients hospital stay, Infection Control will provide regular status reports on inpatients to Public Health. Infection Control will also assist in Contact Tracing, information gathering, and discharge teaching of inpatients.

3 Patient Placement / Accommodation / Signage

3.1 Patients with suspected or confirmed Ebola must be **placed in a private room with its own washroom** (or dedicated commode with use of Hygie waste management bags).

3.2 **There must be restricted access to the room.** (Door to room to remain closed.) A room with an ante room or dedicated change room is required.

3.3 **Only essential hospital personnel should enter the patient's room.** Restrict non-essential staff from the patient care area.

3.4 **Maintain a log of persons entering the patient's room. See Appendix 2. This log must be faxed daily at 0800h to Employee Health at and Public Health at .**

3.5 **Determine the location of PPE donning and removal space ensuring clear separation of "clean" and "dirty" processes.** Each facility will have different physical layouts for an isolation/single room and anteroom (if available). Area designated for donning PPE must include optimum designation of areas for storage and donning of clean PPE and then the area to be designated for removal of PPE and collection of waste.

3.6 The **anteroom** can be designated as a **"clean area"** for the storage and donning of PPE as there may be additional supplies required than are normally stocked in a PPE caddy or mobile cabinet. For removing of PPE, an area just within the doorway of the patient room will then be designated for that purpose. There will need to be access to hand hygiene sinks and products along with a waste receptacle to collect the used PPE. If space within the patient room is limited and safe removal of PPE would be difficult due to proximity to the patient or other equipment, the hospital can designate the anteroom for removing purposes. The anteroom would then be considered a **"dirty area".** Space in the outside corridor would then be dedicated to the storage and donning of PPE.

3.7 Ensure access to hand hygiene sinks and products along with a waste receptacle to collect the used PPE.

3.8 Patients suspect or confirmed EVD and/or with symptoms compatible with **airborne infections e.g. tuberculosis, measles, etc. or who require an aerosol generating procedure**, should be placed in an **airborne (negative air) isolation room.**

14 Administrative Controls

i) Clinical and non-clinical personnel must be assigned exclusively to the patient care and members of this staff cohort must not move freely between isolation area and other clinical areas.

ii) Staffing must take into consideration coverage for rest breaks and staff absences as well as anticipated increase to workload. Staff may require more breaks to manage heat from the enhanced PPE.

iii) Clinical care must be provided by experienced and highly skilled staff, proficient in the tasks or procedures required for patient care.

iv) Health care providers must be trained in the use of PPE for EVD. Untrained HCWs must not care for a patient with EVD. Staff who have not been fitted for an N-95 mask or who are unable to be fitted for N 95, must not care for patient.

v) **As per section 5 iv, additional personnel must be posted at the patient's door** to ensure appropriate and consistent use of PPE by all persons entering the patient room. Trained individuals or a "buddy-system" must be implemented. The second observer **must observe the application and removal of PPE** to ensure that inadvertent contamination of eyes, mucous membranes, skin or clothing does not occur.

vi) A manager or supervisor must be available and liase with Occupational Health and Safety and Infection Control.

vii) Health Services Manager must ensure adequately trained staff are available on a 24 hour basis, to provide care to suspect or confirmed Ebola patient.

viii) Patient care models and tasks must minimize the number of staff exposed to the patient with suspect or confirmed EVD. Students, volunteers, and any personnel who are not essential must not enter patient care area.

ix) Health Services Manager must ensure staff receive rigorous and repeated training and education. Training must be documented and ongoing.

4 Droplet and Contact Precautions

In Addition to Routine Practices**, immediately initiate Contact <u>and</u> Droplet Precautions on a patient with suspect EVD.** Do not wait for etiology to be confirmed.

4.1 Document the initiation and removal of precautions.

4.2 Never take health record or chart into the room or bedspace of the patient

4.3 Ensure signage is posted on entry to room.

4.4 Airborne Precautions must be used for aerosol generating procedures (in addition to droplet and contact precautions). See below.

5 Aerosol Generating Medical Procedures (AGMP's)

Avoid AGMP's (e.g.: bronchoscopy, sputum induction, intubation, endotracheal suctioning, and open suctioning of airways). If AGMPs are absolutely necessary, implement the following strategies to reduce aerosol generation include the following:

5.1 AGMPs should be anticipated and planned for.

5.2 Appropriate patient sedation should be used.

5.3 The procedure should be performed by the most highly experienced staff member available.

5.4 The number of staff in the room must be limited to those required to perform AGMP.

5.5 AGMP's should be performed in an airborne (negative air) isolation room. Ensure appropriate ventilation of the room.

5.6 **All staff who enter the room should wear Enhanced PPE, with the addition of an N95 respirator instead of a facemask**.

5.7 Closed endotracheal suction systems should be used wherever possible.

5.8 Following the procedure, the room should be cleaned. Depending on the air exchanges in the room, cleaning should take place at a time interval after the AGMP has been performed that ensures 99.9% removal of the microorganisms.

6 Personal Protective Equipment

6.1 **Point of care Risk assessment** must be conducted by HCWs with each patient to evaluate their potential exposure to blood and/or body fluids. This should be used to determine the required level of PPE. The need for additional PPE such as the use of double gloves, foot/leg coverings, head/neck coverings, waterproof gowns or specific biohazard suits depends on the potential for fluid contact as determined by the procedure being performed and the presence of clinical symptoms that increase the likelihood of contact with body fluids. As the patient's condition changes, the risk to HCPs may also change.

6.2 **Personal Protective Equipment (PPE)**

6.2.1 In addition to wearing hospital scrubs; **all persons entering the patient room must wear** at least:

- ✓ Extended Cuff Gloves (double gloving with outer layer being nitrile)
- ✓ Gown (disposable fluid resistant or impermeable)

- ✓ Eye protection (goggles or face shield)
- ✓ Surgical Facemask

Note: Masks with visors are not suitable; face shields should be long enough to prevent splashing underneath; eyeglasses are not suitable eye protection.

6.2.2 The need for **additional PPE** depends on the potential for fluid contact determined by your **Point of Care Risk Assessment**. **Additional PPE** is required for exposure to blood, other body fluids, vomit, or feces, including but not limited to:

- ✓ Extended cuff Impervious gloves (double gloving with outer layer being nitrile))
- ✓ Impermeable Boot and leg coverings
- ✓ Impermeable head/neck covering

The Additional PPE must be work over hospital supplied scrubs.

The following table has been developed to assist you in the selection of appropriate PPE based on your Point of Care Risk Assessment. Select the appropriate PPE to minimize your risk of exposure to an infectious agent from blood and/or body fluids.

Table 1

	Suspect or Confirmed Case EVD	**Suspect or Confirmed Case EVD: Exposure to copious drainage of blood &/or Body Fluids**	**Suspect or Confirmed Case EVD: Aerosol Generating Procedure (AGMP)**
Additional Precautions	*Droplet and Contact Precautions for EVD*	*Droplet and Contact Precautions With* ***Additional PPE*** *for EVD*	*Droplet and Contact Precautions with Additional PPE for EVD*
Based on PCRA of Exposure to Blood and/or Body Fluids	▫ Early stages EVD when patient minimally symptomatic ie. Without diarrhea and vomiting or patients body fluids are contained ▫ convalescing stage of EVD	▫ Progressing and later stages of EVD when patient experiences significant vomiting, diarrhea, hemorrhagic symptoms ie. With copious amounts of body fluids	Examples of AGMP's: ▫ Intubation ▫ Bronchoscopy ▫ Sputum Induction ▫ open suctioning of airways
PPE for any contact with patient/ patient environment	▫ Impermeable Gown ▫ Surgical Facemask ▫ Extended Cuff Nitrile Gloves ▫ Face Shield ▫ Head/neck Cover	▫ Impermeable Gown ▫ Surgical Facemask ▫ Double Gloves: Extended Cuff Nitrile Gloves ▫ Face Shield ▫ Impermeable Head/neck Cover	▫ PPE same as same as EVD with exposure to copious amounts of secretions/excretions EXCEPT ▫ **N-95 Surgical Respirator instead of Facemask Mask** ▫ **Perform in Negative**

		▫ Impermeable Boot Covers ▫ Optional impermeable apron	**Pressure Room**

If any item of PPE becomes compromised, the HCW must change the affected item.
***foot wear as per hospital Dress Code Policy CH 08-095**

6.3 **Extra care should be taken when removing PPE**; to avoid any contact between soiled (e.g. gowns and gloves) and any area of the face, skin, or openings in the skin. Hands must be cleaned before contact with the face. If there is any doubt, clean hands again to ensure mucous membranes (eyes, nose, mouth) are not contaminated. PPE should be removed at the doorway upon exiting the room and discarded in the biohazard waste container in the patient room. Exception: N-95 Facemask removed and discarded in anteroom. Always wash hands with soap and water immediately after the removal of protective equipment.

6.4 **Additional personnel must be posted at the patient's door** to ensure appropriate and consistent use of PPE by all persons entering the patient room. Trained individuals or a "buddy-system" must be implemented. The second observer **must observe the application and removal of PPE** to ensure that inadvertent contamination of eyes, mucous membranes, skin or clothing does not occur. If unfamiliar PPE is being worn, just in time refresher training is recommended prior to application and during removal until the HCP is comfortable with the PPE. They must monitor and ensure that HCWs appropriately select and apply, remove and dispose of PPE appropriately, to ensure HCWs are not self-contaminating and to monitor/log entry into room (i.e. limit entry to only essential HCWs).

6.5 Refer to Appendix for the correct sequence for applying and removing PPE. The buddy must use the checklist in Appendix to provide feedback and document the PPE donning and removal process.

6.6 PPE should not be adjusted during patient care. If any breach in PPE occurs during patient care, the health care worker should move to the doffing area to investigate the breach, and follow the Employee Health's exposure process.

6.7 If PPE become grossly contaminated during the provision of care, the health care worker should exit the room, follow the correct PPE doffing procedure and don clean PPE before continuing care.

6.8 Disposable PPE should be used. In cases where disposable materials are not available, equipment should be cleaned in compliance with the manufacturer's recommendation, or discarded after one use.

6.9 The Ebola Cart must remain stocked and supplies brought to isolation room. A HCW must be tasked with ensuring it is always stocked

6.10 **Perform hand hygiene** and change gloves before and after patient care or contact with patient environment, after any contact with potentially contaminated surfaces, before performing aseptic procedures, and before and after removal of PPE. Hand hygiene can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled and after removal of PPE, use soap and water, not alcohol-based hand rubs.

7 Environment Cleaning

7.1 **Personal Protective Equipment:** Environmental Services personnel performing environmental cleaning and disinfection must wear recommended PPE (described above) including the use of additional barriers (shoe and leg coverings, etc.)

7.2 Experienced Environmental Services Staff must be assigned to cleaning and they must also participate in the 'buddy system' as outlined earlier to ensure staff appropriately select and apply, remove and dispose of PPE appropriately, to ensure ES staff do not self-contaminate. Training with PPE and cleaning practices must be provided.

7.3 **Standard hospital disinfectants** may be used to clean the environment of suspect or confirmed EVD patients. Clorox wipes will be used. Diligent environmental cleaning and disinfection and safe handling of potentially contaminated materials is paramount, as blood, sweat, emesis, feces and other body secretions represent potentially infectious materials.

7.4 **All horizontal and frequently touched surfaces should be cleaned at least twice daily and when soiled**. Surfaces that are likely to be touched and/or used frequently should be cleaned and disinfected on a more frequent schedule. This includes surfaces that are in close proximity to the patient (e.g., bedrails, bedside/over-bed tables, call bells) and frequently touched surfaces in the patient care environment, such as door knobs, surfaces in the patient's bathroom.

7.5 **Follow established Environmental Services Policy for procedures used for cleaning EVD rooms**.

7.6 Daily and Discharge/Terminal Clean must be completed as per Housekeeping Policy: Cleaning for Ebola

8 Patient Care Equipment and Supplies

8.1 **Only essential medical equipment should be taken into the patient's room.**

8.1.1 Cover any equipment that cannot be removed from the room with large plastic covers, if possible.

8.2 **Use single use or disposable medical equipment and supplies** when possible**.**

8.3 **Dedicate any reusable medical equipment** for the provision of this patient care. Single use disposable devices should be used and discarded in no-touch waste receptacles immediately after use.

8.4 **Manufacturer's instruction for cleaning and reprocessing reusable equipment used on an patient with Ebola must be obtained from the manufacturer;to ensure the device can be reprocessed in the specific situation. Provide Infection Prevention and Control with a copy of correspondence.**

8.5 **Reusable items** and equipment are to be cleaned and disinfected according to hospital policy and manufacturer's recommendations **following a risk assessment by Infection Prevention and Control.**

8.6 Discard any items that cannot be safely transported, cleaned and reprocessed. Reprocessing of reusable medical equipment must be done with a disinfectant with a broad spectrum viricide claim.

8.7 Education, including PPE use, must be provided to staff responsible for reprocessing medical equipment.

9 Handling of Sharps

9.1 **Limit use of needles**. Phlebotomy, procedures, and laboratory testing must be limited to the minimum necessary for essential diagnostic evaluation and medical care. They should only be done by trained staff who are proficient in procedures associated tasks. E.g. phlebotomy, IV initiation, etc.

9.2 All needles and sharps must be handled with extreme care and disposed immediately after use in puncture-proof, sealed containers. Safety engineered devices and used needles and sharp instruments must be handled with extreme care to avoid injuries.

9.3 **Blood specimens** must be collected using plastic (not glass) tubes. (**Note**: Exception is blood culture tubes, which are only glass.)

10 Laboratory Precautions

10.1 **Do not draw blood**

10.2 **Follow microbiology Policy for Laboratory Testing Requests, Specimen Collection and Transport for Patients with Suspected VHF policy and procedure document (CC 85-090).**

10.3 **Do not use the pneumatic system to transport blood collected.**

10.4 The decision for specimen collection and testing should be predicated on the clinical status of the patient and based on an on-going risk assessment.

10.5 Consultation with the MOH, microbiologist and an infectious disease specialist is recommended to ensure appropriate diagnostic tests are collected. Blood will not be processed on automated analyzers but rather point of care equipment used with in the virology laboratory. As such, clinicians should be aware that minimal routine testing can be

performed (including electrolytes, creatinine, urea and complete blood count).

11 Patient Transport and Flow

11.1 Movement/ transport must be restricted to essential diagnostic and therapeutic tests only.

11.2 Transport staff must be aware of the patient's status and the required PPE.

11.3 While EVD is not spread through the droplet route, patients with respiratory symptoms should wear a mask to contain respiratory droplets during transport as per routine practices.

Transport Procedures

11.4 Put here

12 Visitor Management and Education

10.1 Visitors **shall be restricted.** Exceptions will be considered on a case by case basis, in consultation with Infection Control.

10.2 Other communication modes between patient and family are encouraged e.g Skype, etc.

10.3 Any visitors must follow the recommended infection prevention and control recommendations and must not visit any other areas of the hospital.

10.4 Should visitors be approved, the nursing staff must ensure that they are taught to use PPE and perform hand hygiene. Visitors must be monitored when donning and doffing PPE by the nurses caring for the patient.

10.6 Log of persons entering room must be maintained.

10.7 HCW's must educate patients, their visitors, families about the precautions being used, the duration of precautions, as well as the prevention of transmission of disease to others, with a particular focus on hand hygiene and respiratory hygiene.

10.8 If a patient is visited by family members and visitors, trained HCWs will provide a 'buddy system' process to ensure these visitors don and remove the appropriate PPE correctly.

10.9 Discharge planning (including but not limited to continuation of infection prevention and control precautions in the home setting) should be managed on a case-by-case basis in consultation with the MOH, Public Health, infectious disease specialists, and infection prevention and control professionals. Individuals recovering from EVD should either abstain from sexual intercourse or wear condoms for a minimum of 12 weeks, ideally for 15 weeks after the date of symptom onset.

13 Handling Deceased Bodies

13.1 In the event of a patient death, contact the Nova Scotia Medical Examiner's Service (NSMES) at 902-424-2722 (24 hours) and unit manager or designate. The staff at the NSMES will provide removal service of ALL deceased with suspected or confirmed EVD, regardless of whether they are a Medical Examiner's cases or not.

13.2 Medical devices (i.e., intravenous catheters, urinary catheter, or endotracheal tubes) must be clamped and left in place. Tubing and bags shall be disconnected from machines and placed on the decedent's abdomen.

13.3 Do **NOT** wrap the decedent in a shroud. Ensure identification armband is visible for NSMES staff.

13.4 Ensure the deceased remains within the patient room with the door closed until collected by the NSMES.

13.5 Security must be notified and arrangements made for them to accompany NSMES staff.

13.6 After removal by the NSMES, environmental cleaning of the patient room will be completed by trained Environmental Services/designated staff at the facility.

14 Waste Management

14.1 Dispose of soiled linen, cleaning/disinfection cloths, disposable gloves and any other item in contact with body fluids (eating utensils) in a red **biohazard waste disposal bag.**

14.2 Collected human waste (ie. Vomit, feces, etc,) may be disposed of and flushed down a toilet in patient room.

14.3 Biomedical waste should be contained in impervious waste-holding bags and rigid biohazard container at the point of care. All outer biohazardous waste bags and containers must be wiped with Chlorox wipes (not sprayed), prior to leaving room.

14.4 Biohazard bags and containers with contaminated waste must not be carried against body.

14.5 Housekeeping must designate a plan to transport and store waste safely, until it is picked up. See Waste Management for Ebola Plan in Appendix .

Employee Health: Guidance and Monitoring for HCW's Working with EVD Patients

Any staff member who is symptomatic or has had an unprotected exposure to blood, body fluids, secretions, or excretions of a patient with suspected or confirmed EVD must immediaely stop work and report to their manager and Exposure Line at 473-4666. He/she must remain out of the workplace until

cleared for work by Employee Health. The Occupational Health Nurse will follow up with staff member and advise ill and exposed staff as per Public Health guidelines.

Health Canada Supplement - *Canadian Contingency Plan for Viral hemorrhagic Fevers and other Related Diseases in Canada Communicable Disease Report* (January 1997)

Interim Infection Prevention and Control Guidance for Care of Patients with Suspected or Confirmed Filovirus Haemorrhagic Fever WHO Guidelines: in Health-Care Settings, with Focus on Ebola (August 2014)
http://www.who.int/csr/resources/who-ipc-guidance-ebolafinal-09082014.pd

Infection Prevention and Control Guidance for Patients with Suspected or Confirmed Ebola Virus Disease (EVD) in Ontario Health Care Settings. In PIDAC, August 14, 2014.
http://www.publichealthontario.ca/en/eRepository/EVD_IPAC_Guidance.pdf

Centers for Disease Control and Prevention (CDC) (2014). Infection prevention and control recommendations for hospitalized patients with known or suspected Ebola hemorrhagic fever in U.S. hospitals. Retrieved from; http://www.cdc.gov/vhf/ebola/

Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2014). *Infection prevention and control guidance for patients with suspected or confirmed Ebola virus disease (EVD) in Ontario health care settings*. Toronto, ON: Queen's Printer for Ontario.

Health Care Provider and Visitor Log

Appendix 1

Isolation Room Number & Site_____

DATE	TIME IN	TIME OUT	NAME	DEPARTMENT	REASON FOR ENTERING

Fit Testing for N 95 Mask AppendixA

Information provided by Safety Programs.

If respirator, mask or other breathing apparatus is required to safely perform work duties, all Capital Health employees must be fitted for the piece of equipment before use

- It is important to be proactive with getting employees fitted before a high risk situation arises where a high volume of employees need to be fitted immediately (high risk patient, harmful substances in air, etc.)

- In general, Capital Health requires all employees exposed to aerosolized environments, tuberculosis patients, or negative air environments to wear an N95 respirator

FAQ

- How long does it take?
    - Process takes less than half an hour
- Is the test invasive or uncomfortable?
    - Test is not invasive, requires wearing the respirator required for job task, and completing simple movements and tasks
- Where do I go?
    - Clinics will be offered on a regular basis throughout the district and will be promoted through the following means: Intranet, on the Safety & Injury Prevention website, Capital News and Joint Occupational Health and Safety Committee Boards
- When might I need a respirator?
    - If the employee is exposed to substances that may cause discomfort, disease, irritation or other negative effects to the individual upon entry into the respiratory system, Capital Health requires the employee to use a respirator.

Contact

- Please contact Sherida Flemming or Ben Beaton with Safety & Injury Prevention at:
    - Sherida – 473-2313 or sherida.flemming@cdha.nshealth.ca
    - Ben – 473-4033 or ben.beaton@cdha.nshealth.ca

Additional Information

- Capital Health Respirator Protection Program
    - http://policy.nshealth.ca/Site_Published/dha9/document_render.aspx?

documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=49934

- Safety & Injury Prevention main site:
  - http://www.cdha.nshealth.ca/safety-injury-prevention
    - Follow the link for promotion of the clinics
- Canadian Centre for Occupational Health and Safety (CCOHS) information on respirator use
  - http://www.ccohs.ca/oshanswers/prevention/ppe/respslct.html

Guiding Principles

1. Along with the safety and care of patients, health care worker safety is of paramount importance.

2. To prevent the transmission of infection, personal protective equipment (PPE) represents one type of control, along with administrative controls and environmental/engineering controls. Each type of control is equally important and must act as complementary parts in a system.

Ebola is spread through direct contact (via broken skin or mucous membranes) with the blood/ body fluids of an Ebola-infected person, or with items contaminated with blood/body fluids containing Ebola. Every effort should be made to avoid direct contact with infectious materials.