

EMORY HEALTHCARE VIRAL HEMORRHAGIC FEVER (VHF) PLAYBOOK



EMORY
UNIVERSITY

**Serious Communicable
Diseases Program**

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CONTENTS

Plan Activation	5
Identification.....	6
Screening & Registration	7
ED triage	7
Isolate	8
Transmission.....	8
Isolation	9
Transmission-Based Precautions	9
VHF PPE Supply Cart Location	10
PPE: Trained Observer	10
Donning.....	11
Doffing.....	11
PPE Breach	11
Inform/ Notification	12
Triage or Registration	12
Charge Nurse	12
Infection Prevention	12
Hospital Epidemiologist	13
Nursing Supervisor	13
Emergency Management.....	13
Administrator On-Call (AOC)	13
Communication.....	13
Response.....	14
Hospital Safety.....	14
Facility Visitors	15
Specimen Collection & Transport.....	15
VHF Testing	15
Specimen Collection and Labeling	15
Routine Labs*	15
Specimen Transport.....	15

Imaging.....	15
Waste Management	16
Cleaning & Disinfection	17
Definitions of Cleaning Types:	18
Responsibilities for Select Departments.....	19
Charge Nurse	19
Environmental Services (EVS)	19
Epidemiologist.....	20
Facilities	20
Food & Nutrition	20
Infection Prevention.....	20
Laboratory.....	20
Materials management	21
Primary Physician or APP.....	21
Registration	21
Respiratory Therapy	21
Security / Public Safety	21
Trained Observer	22
Additional Considerations	22
Appendix A: Checklist for Room Preparation.....	24
Appendix B: Route for Patient Transport In ED.....	28
Appendix C: PPE Donning and Doffing Checklists	29
Assessment – Level PPE	29
PAPR – Level PPE	33
Appendix D: Specimen Collection and Transport for Suspected Special Pathogens.....	37
Appendix E: Waste Management	39
Appendix F: Containment Wrap for Patient Transport.....	44
Appendix G: Operating Unit Details	45
References	46

PLAN ACTIVATION

This plan is not relevant to outpatient settings.

The Emergency Department (ED) and Labor and Delivery (L&D) Departments are likely to first identify or report a potential Viral Hemorrhagic Fever (VHF) case. Any suspicion of VHF should immediately be reported to Infection Prevention (IP) for further investigation.

The IP will monitor current information regarding the emergence of epidemics or new infections by utilizing emergency notification systems such as:

- Gwinnett Newton Rockdale Health Department
- CDC's Health Alert Network
- Georgia Department of Public Health (GADPH)
- Fulton County Board of Health
- Dekalb Public Health
- Association of Practitioners in Infection Prevention (APIC) email and social media
- Emory Healthcare Serious Communicable Diseases Committee
- Emory Healthcare Special Pathogens Oversight Committee (SPOC)
- World Health Organization

If a potential VHF case is identified, the Administrator on call (AOC), IP, Epidemiologist, ED Director, or the ED Medical Director will determine if VHF Playbook should be implemented.

IDENTIFICATION

This guidance refers only to the following VHF:

Pathogen & Illness	1. Symptoms (in addition to fever, headache, N/V/D) 2. Epidemiological Risks (in addition to ill contacts)	Dry/Suspect/Stable PPE: For a suspect case with stable vital signs and NO vomiting or diarrhea.	Wet/Confirmed/Unstable PPE: For a suspect case with unstable vitals or vomiting or diarrhea, and ALL confirmed patients.
Ebola Virus Disease (EVD) 4 species cause disease in humans: EBOV (Zaire), SUDV (Sudan), BDBV (Bundibugyo), TAFV (Tai Forest) Incubation period: 2-21 days	1. Myalgia, hiccups 2. Travel to central or sub-Saharan Africa; exposure to bats, bushmeat, funeral care *Vaccine currently available for EBOV only		
Marburg Virus Disease (MVD) Incubation period: 2-21 days	1. Altered mental status, rash 2. Travel to central or sub-Saharan Africa; exposure to caves, fruit bats, funeral care		
Lassa fever Incubation period: 2-21 days	1. Sore throat, facial swelling w/o peripheral edema 2. Travel to West Africa; exposure to rodents, rodent droppings, cleaning, farms, food stores; endemic in Nigeria, Sierra Leone, Liberia, Guinea		
Crimean-Congo Hemorrhagic Fever (CCHF) Incubation period: 1-14 days	1. Sudden onset of fever, joint pain, photophobia, petechial rash 2. Travel to Europe, Mediterranean, Middle East, Africa, India, China; exposure to ticks, livestock, farms, slaughterhouses		
South American Hemorrhagic Fevers (SAHF) Incubation periods: Junin (6-14 days), Sabia (6-21 days), Machupo (3-16 days), Guanarito (3-19 days)	1. Malaise 2. Travel to South America; exposure to rodents, rodent droppings, cleaning, farms, food stores		
Andes Hantavirus (ANDV) is currently the only Hantavirus with known PTP spread Incubation period: 9-40 days	1. Rapid progression to high fever, respiratory distress 2. Travel to South America, especially Argentina, Chile; exposure to rodents, rodent droppings *Dry VHF PPE with respiratory protection sufficient for Suspect and Confirmed patients		
Nipah virus (NIV) Incubation period: 5-14 days	1. May rapidly progress to respiratory distress or encephalitis 2. Travel to Asia, Bangladesh, India, Malaysia; exposure to fruit bats, pigs, date palm sap, or juice		
Hendra virus (HeV) Incubation period: 9-16 days	1. Sore throat, cough 2. Extremely rare. Travel to Australia; exposure to flying fox (bats), horses		
Langya (LayV) Incubation period: 2 days-2 months, very limited data	1. Anorexia 2. Extremely rare. Travel to China; exposure to animal market, shrews		
Severe Fever with Thrombocytopenia Syndrome (SFTS) Incubation period: 5-14 days	1. Altered mental status, low platelets/WBCs 2. Travel to China, Japan, South Korea; exposure to ticks, farms, rural areas, animal bites		

Transmission Risks:
Body fluid exposure, either direct or indirect, as from contaminated materials, fomites. Risk of infectious aerosols when wet. Strict isolation, AIIR when available.

PPE Recommendations:
Dry, Suspect, and Stable = Fluid-resistant gown, mask, eye protection, shoe covers, double gloves (extended cuff outer glove).
Wet, Confirmed, or Unstable = Total body coverage with fluid-impervious outer layer, respiratory protection, and double gloves (extended cuff outer glove).

Precautions:
All waste is Category A waste. For lab, many are Select Agents.

The following VHF's do not have person-to-person transmission and require standard precautions:

- Dengue
- Kyasanur
- Omsk
- Rift Valley Fever
- Yellow Fever

SCREENING & REGISTRATION

All patients presenting to admissions, the ED, and L&D should be evaluated for the following using the Epic travel screen. If patients have any of the symptoms listed below AND a history of international travel within the last 30 days, they should alert the ED / L&D triage RN for further assessment.

- Fever
- Rash
- Cough
- International travel in the past 30 days

ED triage

ED triage should take place in a designated private triage area. In the triage area, the RN will verify symptoms and confirm travel history. If the travel screen has not been completed, the RN will complete the travel history and document in the patient's chart.

If a patient is identified to have traveled to a region known to have VHF and has at least one symptom concerning for VHF, immediately notify the charge nurse and inform the Infection Prevention team. The patient should be given a mask to put on (if not already completed).

Follow [Appendix A](#) for room preparation prior to moving patient to AIIR room. **Once the room has been prepared, the patient should be immediately isolated in an AIIR with droplet plus, airborne, and contact precautions applied.** If an AIIR or a private room are not available, the patient can be held in the waiting room with a mask on at a 6 feet distance from others until one is available.

Travel-related Diseases by Country

The GADPH website below is updated regularly to provide information on recent outbreaks and diseases relevant to travelers.

https://sendss.state.ga.us/ords/sendss/!world_ob.search

ISOLATE

TRANSMISSION

VHF comprises several associated infections and diseases. The table below identifies key vectors and modes of transmission.

For other specific VHFs not listed below, [CDC Yellow Book](#) can be referenced.

Pathogen & Illness	1. Symptoms (in addition to fever, headache, N/V/D) 2. Epidemiological Risks (in addition to ill contacts)	Dry AND SUSPECT Suspect (Suspected Case) Wet/Confirmed/Unstable PPE: For a suspect case with unstable vitals or vomiting or diarrhea, and ALL confirmed patients. WET OR CONFIRMED Confirmed (Confirmed Case)
Ebola Virus Disease (EVD) 4 species cause disease in humans: EBOV (Zaire), SUDV (Sudan), BOBV (Bundibugyo), TAFV (Tai Forest) Incubation period: 2-21 days	1. Myalgia, hiccups 2. Travel to central or sub-Saharan Africa; exposure to bats, bushmeat, funeral care *Vaccine currently available for EBOV only	
Marburg Virus Disease (MVD) Incubation period: 2-21 days	1. Altered mental status, rash 2. Travel to central or sub-Saharan Africa; exposure to caves, fruit bats, funeral care	
Lassa fever Incubation period: 2-21 days	1. Sore throat, facial swelling w/o peripheral edema 2. Travel to West Africa; exposure to rodents, rodent droppings, cleaning, farms, food stores; endemic in Nigeria, Sierra Leone, Liberia, Guinea	
Crimean-Congo Hemorrhagic Fever (CCHF) Incubation period: 1-14 days	1. Sudden onset of fever, joint pain, photophobia, petechial rash 2. Travel to Europe, Mediterranean, Middle East, Africa, India, China; exposure to ticks, livestock, farms, slaughterhouses	
South American Hemorrhagic Fevers (SAHF) Incubation periods: Junin (6-14 days), Sabia (6-21 days), Machupo (3-16 days), Guanarito (3-19 days)	1. Malaise 2. Travel to South America; exposure to rodents, rodent droppings, cleaning, farms, food stores	
Andes Hantavirus (ANDV) is currently the only Hantavirus with known PTP spread Incubation period: 9-40 days	1. Rapid progression to high fever, respiratory distress 2. Travel to South America, especially Argentina, Chile; exposure to rodents, rodent droppings *Dry VHF PPE with respiratory protection sufficient for Suspect and Confirmed patients	
Nipah virus (NiV) Incubation period: 5-14 days	1. May rapidly progress to respiratory distress or encephalitis 2. Travel to Asia, Bangladesh, India, Malaysia; exposure to fruit bats, pigs, date palm sap, or juice	
Hendra virus (HeV) Incubation period: 9-16 days	1. Sore throat, cough 2. Extremely rare. Travel to Australia; exposure to flying fox (bats), horses	
Langya (LayV) Incubation period: 2 days-2 months, very limited data	1. Anorexia 2. Extremely rare. Travel to China; exposure to animal market, shrews	
Severe Fever with Thrombocytopenia Syndrome (SFTS) Incubation period: 5-14 days	1. Altered mental status, low platelets/WBCs 2. Travel to China, Japan, South Korea; exposure to ticks, farms, rural areas, animal bites	
Transmission Risks: Body fluid exposure, either direct or indirect, as from contaminated materials, fomites. Risk of infectious aerosols when wet. Strict isolation, AIIR when available. PPE Recommendations: Dry, Suspect, and Stable = Fluid-resistant gown, mask, eye protection, shoe covers, double gloves (extended cuff outer glove). Wet, Confirmed, or Unstable = Total body coverage with fluid-impervious outer layer, respiratory protection, and double gloves (extended cuff outer glove). Precautions: All waste is Category A waste. For lab, many are Select Agents.		

PPE Matrix for High-Consequence Infectious Diseases

Page 2/3

<http://www.netec.org>

Updated May 5, 2026

ISOLATION

Where possible, infection prevention measures will be established to contain the infection at the point of entry into the facility.

If the patient meets criteria for VHF (symptoms and positive travel history), they should be isolated in an AIIR with the door closed.

Follow [Appendix A](#) for room preparation prior to moving patient to an AIIR.

For appropriate patient transport to AIIR room, follow [Appendix B](#). Ensure the patient wears a surgical mask and maintains a 6 feet distance from other patients, visitors, and staff members not directly involved in the patient's care during transport to AIIR.

- Reference [Appendix G](#) for predetermined AIIR location

Doors to patient rooms on the route to AIIR room should be closed. Public safety / security or designee should ensure the path is clear and route is secure from other patients, staff, or visitors. See security section for more details on methods for securing the area.

If an AIIR room is unavailable, the patient should be placed in a private room with the door closed and facilities should be contacted for a high efficiency particulate air (HEPA) filter if available. Facilities should be able to assist with identifying rooms without shared ventilation with other patient rooms or staff work areas.

Patients should receive dedicated medical equipment, preferably disposable. If disposable is not available, the equipment should be quarantined until appropriately disinfected (see [Cleaning and Disinfection](#) section).

Ensure that the patient wears a surgical mask to reduce the risk of droplet or aerosol transmission. If family members or visitors are present, they should also be screened, instructed to wear a mask, and placed in a separate room.

TRANSMISSION-BASED PRECAUTIONS

Until VHF is ruled out, ensure the patient is on droplet plus, airborne, and contact precautions.

When VHF is suspected, follow the guidance below for appropriate personal protective equipment (PPE).

All PPE used during any provision of care for patients with suspected or confirmed VHF should be single use and disposable.

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		Transmission Risks: Body fluid exposure, either direct or indirect, as from contaminated materials, fomites. Risk of infectious aerosols when wet. Strict isolation, AIIR when available. PPE Recommendations: Dry, Suspect, and Stable = Fluid-resistant gown, mask, eye protection, shoe covers, double gloves (extended cuff outer glove). Wet, Confirmed, or Unstable = Total body coverage with fluid-impervious outer layer, respiratory protection, and double gloves (extended cuff outer glove). Precautions: All waste is Category A waste. For lab, many are Select Agents.	

PPE Matrix for High-Consequence Infectious Diseases

Page 2/3

<http://www.netec.org>

Updated May 5, 2026

VHF PPE Supply Cart Location

- Reference [Appendix G](#) for VHF PPE Supply Cart Location

PPE: Trained Observer

Trained observers must be present for all procedures. The observer(s) will:

- Verbally guide healthcare workers (HCWs) through the donning and doffing process, utilizing the PPE donning and doffing checklist in [Appendix C](#).
- Confirm each step has been completed correctly.

Trained observers should wear the following PPE in circumstances listed below:

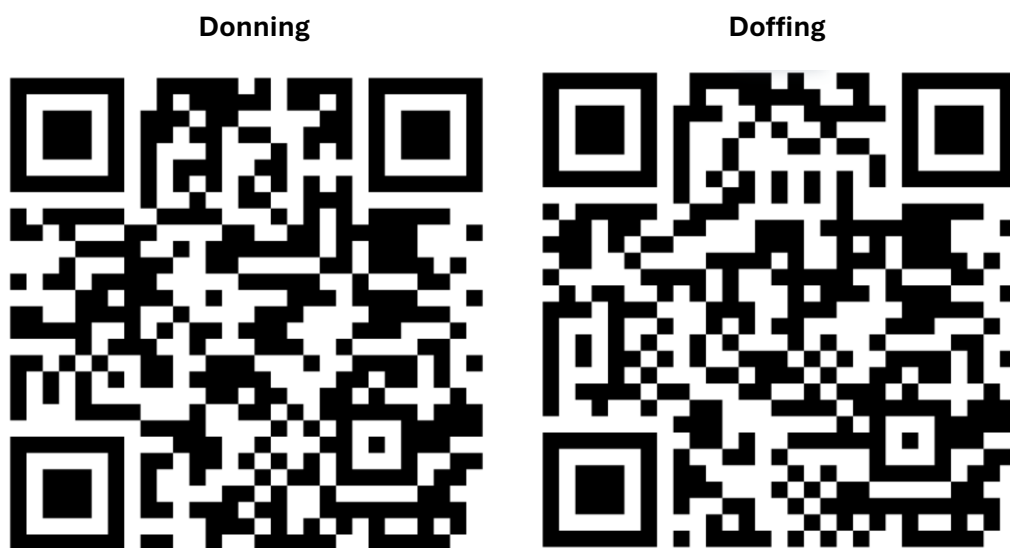
- Fluid resistant gown or coveralls
- Full face shield
- N-95 respirator
- 2 pairs of gloves (outer gloves should be extended cuff)
- Fluid resistant boot covers

Circumstances when the trained observer is required to wear PPE:

- When handing supplies and equipment into the patient room

- Guiding doffing from inside the ante room or inside the patient room
- Receiving specimens
- Cleaning the doffing space outside the patient room
- And in case emergency assistance is needed by in-room staff to protect the safety of a HCW at risk of imminent harm

PPE should be donned and doffed in a designated area to minimize the risk for contamination. The videos below can be used as a reference to appropriate donning and doffing methods for patients with wet symptoms or those who are clinically unstable.



PPE Breach

Should PPE be compromised at any point, ensure both the HCW caring for the patient and the trained observer are informed. In general, the strategy should be to contain the exposed area and remove the affected PPE. If there is another layer of PPE under the affected layer (e.g., in the case of outer gloves, shoe covers, and gown/aprons), ensure the innermost layer of PPE is intact and that skin is intact. Together, the trained observer and HCW should determine:

- Can the HCW stop what they were doing safely? (E.g., the patient is not perched at the edge of the bed)
- If the skin is NOT intact: expose and wash with soap and water. Trained observer should be preparing someone to relieve the caregiver

Steps to resolve PPE contamination:

1. Sanitize gloved hands or change outer gloves after touching the patient, patient clothing, or anything known or suspected of being contaminated

2. Visible contamination should be cleaned with a sanitizing wipe using the “1-wipe, 1-swipe” method down and away from yourself
3. Mitigation steps can include:
 - a. changing the cover gown, outer gloves, or shoe covers in the patient room
 - b. cleaning and repairing a coverall or cover gown tear to make immediate doffing safer
 - c. exposing and washing a hand if both layers of gloves tear to assess for injury (then replacing a glove to doff)

Other Considerations for Transmission-Based Precautions

Air Handling: Efforts should be taken to avoid aerosol-generating procedures (AGP) if possible. If an AGP is necessary, it should be conducted in a room that is also an AIIR, with the doors kept closed and limited entry/exit.

Limit procedures involving needles and sharps and follow safe injection practices.

INFORM/ NOTIFICATION

TRIAGE OR REGISTRATION

If a patient is identified to have traveled to a region known to have VHF and has symptoms concerning for VHF, immediately notify the charge nurse and inform the Infection Prevention team. The patient should be given a mask to put on and immediately isolated in a private room if an AIIR room is not readily available.

CHARGE NURSE

The charge nurse should notify the provider and then Infection Prevention through the EHConnect paging system (refer to [Appendix G](#) for PIC #). If Infection Prevention does not return the page within 15 minutes, the Hospital Epidemiologist should be paged using the EHConnect paging system refer to [Appendix G](#) for PIC #). The charge nurse should also notify the house supervisor of a potential VHF patient.

INFECTION PREVENTION (PIC #: REFER TO [APPENDIX G](#))

The Infection Preventionist will notify the Hospital Epidemiologist and if the patient is deemed to be a suspect case, the Infection Preventionist will advise:

- the charge nurse
- nursing supervisor
- EVS leadership (to initiate conversations with Stericycle and to terminally clean the areas in which the suspect patient has been waiting)

- AOC
- Employee / Occupational Health (as needed)

HOSPITAL EPIDEMIOLOGIST (PIC #: REFER TO [APPENDIX G](#))

The Hospital Epidemiologist will contact Emory Healthcare's Serious Communicable Disease Unit (SCDU) (PIC 50498) and the Georgia Department of Public Health (1-866-782-4584). The Hospital Epidemiologist will work with SCDU to determine appropriate testing and transport. The Hospital Epidemiologist will notify EHC Hospital Epidemiologist, Infection Prevention Director, and Chief Quality Officer if testing is being pursued.

NURSING SUPERVISOR

If the patient is deemed to be a suspected case by Infection Prevention and Hospital Epidemiology, the nursing supervisor will notify Emergency Management and Security / Public Safety Lead to facilitate barrier placement and lock doors (see Security / Public Safety section for details). Infection Prevention and Hospital Epidemiology are available to consult as needed.

EMERGENCY MANAGEMENT

Emergency Management will oversee duties related to security and hospital safety.

ADMINISTRATOR ON-CALL (AOC)

The AOC will implement the incident command center (ICC) to help coordinate patient care and resources. The AOC will designate a person responsible for communicating with news sources and other organizations not directly involved in the patient's care.

COMMUNICATION

Communication in and out of the patient room should take place while maintaining isolation precautions (NETEC, 2024).

In-room staff members will use a designated form of communication ([Appendix G](#)) to communicate with other staff members outside of the patient room as needed. If limitations to communication methods occur, EPIC SecureChat will be used to facilitate communication with other members of the healthcare team.

Patients can communicate with others outside of the healthcare team using their personal devices or the phone attached to the call bell in the room. The HCW may elect to allow the patient to use another form of communication ([Appendix G](#)) with others outside of the room.

Designate staff members for keeping families informed without compromising patient isolation.

RESPONSE

Response activities include, but are not limited to the following:

- Estimate possible number of patients that may present to EHC for treatment of the emerging infection
- Establish the number of staff necessary to properly care for patients and fulfill the mission of EHC
- Assign appropriate number of staff to patient care areas
 - Consider limiting to essential staff only
- Establish additional triage or treatment areas
- Organize the necessary supplies, including Personal Protective Equipment (PPE) as appropriate
- Plan containment of known or suspected infected patients
- Develop a means to assess incoming patients, staff, and currently admitted patients
- Staff or patient exposure management
- Refer to Operation Unit's Emergency Operations Plan for:
 - Expanded bed capacity
 - Additional staffing
 - Consumables and durables

HOSPITAL SAFETY

During activation of this plan, a triage nurse and security guard may be stationed outside of the facility or just inside the facility's doors to provide triage and wayfinding.

The entrance and exit to the patient care room should be monitored when in use. Every effort should be made to support patient privacy (e.g., use of mobile barriers, ensuring window shades are closed as appropriate, etc.) and maintain empathy and patient-centered care.

The ultimate responsibility of site safety falls to the Public Safety Officers and/or the AOC. All staff are encouraged to identify and report hazards or unsafe conditions. This may include, but is not limited to:

- Vehicle traffic congestion
- Pedestrian traffic
- Increase panic or reactive patients
- Depletion of supplies
- Contamination of facility property/building
- Systems failure

FACILITY VISITORS

As a general rule, visitors should not be allowed and signage should be posted on the patient's door to indicate this. The ICC and AOC, in collaboration with IP and the Hospital Epidemiologist, will determine if exceptions can be made.

SPECIMEN COLLECTION & TRANSPORT

VHF TESTING

If the case is deemed to be a suspect case by the Hospital Epidemiologist, the Hospital Epidemiologist will review the case with the on-call provider for the SCDU and Georgia DPH and determine if testing is necessary. If testing is necessary, it will be coordinated through the SCDU; depending on the type of VHF will depend on where and how testing is performed.

SPECIMEN COLLECTION AND LABELING

Coordinate with Georgia DPH and inform healthcare providers on appropriate methods for specimen collection and labeling. Refer to [Appendix D](#) for further guidance.

ROUTINE LABS*

- CBC
- CMP
- INR/PTT
- LDH
- Collect and label additional tubes preemptively to prevent multiple sticks

**Routine labs should not go to the core lab*

SPECIMEN TRANSPORT

As needed, SCDU Laboratory personnel can assist with providing support for packaging and sending Category A specimens. Refer to [Appendix D](#) for further guidance.

IMAGING

Use single-use products where possible. If single-use is not an option, equipment should be covered with plastic and taped completely sealed where possible, with an additional plastic covering on top. Cleaning and disinfection methods should be followed per the manufacturer's instructions for use (IFU).

For plain film radiography, refer to Emory Healthcare's procedure titled "[Performing X-Rays in the Serious Communicable Disease Unit.](#)"

For any other imaging needs, contact Infection Prevention to determine the most appropriate method for completion.

WASTE MANAGEMENT

- As early as possible of suspect case identification, the Director of EVS, or designee, should notify Stericycle or similar contractor of the potential need for Category A waste removal. These contractors are responsible for obtaining appropriate permits (e.g., through the Department of Transportation) to transport Category A waste. It is recommended that the contractor is contacted once patient is identified as a suspect case. The Director of EVS, or designee should collaborate with Infection Prevention prior to confirming waste pickup with Stericycle or similar contractor.
- Waste from a patient with a Viral Hemorrhagic Fever is considered Category A waste.
- To the extent possible, all waste should be held in the patient's room (e.g., not sent for autoclaving, not sent to waste contractor) until lab tests confirm disease and/or the patient is transferred.
- If confirmatory testing results positive or the patient is transferred, waste can be moved to a pre-identified location for sequestering ([Appendix G](#)). If possible, prior to waste placement in this room, clear the room of all mobile supplies and equipment not necessary for waste handling. This room should remain locked while waste is being held. Waste should be held until confirmatory testing has been completed.
- Primary and secondary packaging of waste should be conducted by the primary HCWs (e.g., physicians and nurses) wearing PPE in affected patient room(s) as close as possible to the point of generation. [Follow Appendix E](#) for specific waste packaging instructions. This should take place while the patient is a suspect case and should continue if the patient becomes a confirmed case.
- Transport of waste to holding room can be completed by trained staff who are part of the primary healthcare team, EVS, or a trained designee.
- During waste handling, including collection and transportation, appropriate PPE should be worn at all times.
- Solid waste: Any solid waste generated during VHF patient care is considered Category A waste. This includes linens, sharps, cleaning byproducts, PPE, and medical equipment that cannot be safely and effectively decontaminated.
- Liquid waste: Liquid waste includes bodily fluids and feces.
 - If a patient is using a bedpan, urinal, section canister, or bedside commode, a solidifier or absorbent material should be used to contain fluids and reduce the risk of spilling.
 - Liquid waste collected with absorbent material should be double-bagged in leakproof bags, securely closed, and stored in a designated waste container at the periphery of the room.
 - All other liquid waste should be poured carefully to avoid splashing in the designated toilet for the patient. **The toilet lid should be closed prior to the toilet being flushed. Once the toilet is flushed, the handles, toilet seat, and lid**

surfaces should be cleaned and disinfected with an approved disinfectant/cleaner for Ebola (see [List Q](#) and [List L](#)) (NETEC, 2024).

- Waste containment:
 - When possible, a 55-gallon rigid waste container/ barrel with a lid should be used to hold waste bags (U.S. Department of Transportation, Pipeline and Hazardous Materials Safety Administration, 2025). Bags should be large enough to overlap the waste barrel and should be put into the barrel without creating an air pocket under the bag. Waste barrels picked up by contracting companies, such as SteriCycle, cannot enter the patient room and should be stored in a designated location.
 - The Director of EVS, or designee should collaborate with Infection Prevention to determine need for contacting SCDP to obtain 55-gallon waste bins if none are available on-site at the time of need.
 - Waste barrels should not be filled more than $\frac{3}{4}$ full and waste should never be compressed to make more room in the bag. Waste should be placed gently into the bag to prevent aerosolization of contents.
 - **Waste should be double-bagged in leakproof bags, securely closed using a gooseneck or balloon knot, and stored in a designated waste container at the periphery of the room** (e.g., in or near the patient bathroom). Avoid manipulating waste once placed in the barrel.
- Refer to [Appendix E](#) for additional waste management considerations, including primary and secondary bag removal and packaging.
- To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, nonfluid-impermeable pillows or mattresses, and textile privacy curtains into the waste stream and dispose of appropriately.

CLEANING & DISINFECTION

The level of PPE required for cleaning and disinfection will be determined by the patient's clinical status and risk. Prior to cleaning and disinfecting, please contact Infection Prevention. The cleaning and disinfection matrix below should be utilized.

		Suspect Case		Confirmed Case	
		Dry/Stable Patient	Wet/ Unstable Patient	Dry/Stable Patient OR Wet/ Unstable Patient	
		Assessment Level PPE	PAPR Level PPE	Assessment Level PPE	PAPR Level PPE
Patient Room	Daily Clean	HCW	HCW	N/A	HCW
	Primary Clean	HCW	HCW	N/A	HCW
	Secondary Clean	HCW	HCW	N/A	HCW

	Terminal Clean	EVS Staff (Assessment Level PPE)			
		Once terminal clean is complete, EVS staff to contact Infection Prevention to determine need to UV disinfect the patient room. Should UV disinfection not be available, EHSO has ability to disinfect using vaporized hydrogen peroxide.			
All Other Spaces (e.g., Imaging)	Primary Clean	HCW	HCW	N/A	HCW
	Secondary Clean	HCW	HCW	N/A	HCW
	Terminal Clean	EVS Staff (Assessment Level PPE)			
		Once terminal clean is complete, EVS staff to contact Infection Prevention to determine need to UV disinfect the patient room. Should UV disinfection not be available, EHSO has ability to disinfect using vaporized hydrogen peroxide.			
		*Non-patient care areas may only require one round of cleaning and disinfection, depending on the patient's clinical scenario (e.g., a dry/stable patient transported through hallway via wheelchair). In these instances, please consult Infection Prevention.			

DEFINITIONS OF CLEANING TYPES:

- **Daily clean:** Regular, ongoing cleaning and disinfection of high-touch surfaces and patient care areas performed at least once every 24 hours, or more frequently as needed. The goal is to remove visible soil and reduce the microbial load on frequently touched surfaces like bedrails, call buttons, doorknobs, light switches, and bedside tables.
- **Primary clean:** Synonymous with daily clean, although takes place initially once a patient has been discharged, transferred, or has passed away.
- **Secondary clean:** Synonymous with daily clean, although takes place after the primary clean once a patient has been discharged, transferred, or has passed away.
- **Terminal clean:** This is the most comprehensive and thorough cleaning and disinfection performed in a patient room or area after a patient has been discharged, transferred, or has passed away, and before a new patient is admitted. The objective is to eliminate all potential pathogens, including spores, from every surface within the room. This involves cleaning and disinfecting all horizontal and vertical surfaces, fixtures, equipment, and often includes stripping and disinfecting floors, cleaning walls, windows, and vents.
- Environmental surfaces should be disinfected with a US Environmental Protection Agency (EPA) registered hospital disinfectant from [List Q](#) or [List L](#).
- Patients should receive dedicated medical equipment, preferably disposable. If single-use is not an option, equipment should be covered with plastic and taped completely sealed where possible, with an additional plastic covering on top. All non-dedicated and non-disposable medical equipment should be cleaned and disinfected according to the manufacturer's recommendations / IFUs. Smooth, non-permeable surfaces are able to be disinfected.

- Surfaces in the patient care area should be regularly cleaned and disinfected even in the absence of visible contamination. Disposable cleaning cloths/wipes should be used and disposed of in leakproof bags.
- In the case of a spill, remove bulk spill matter, clean the site, then disinfect the site. Refer to List Q and List L for appropriate cleaning disinfectants.

RESPONSIBILITIES FOR SELECT DEPARTMENTS

CHARGE NURSE

1. Ensure patient is correctly placed in AIIR room
2. Identify staff members to prepare room and obtain PPE cart (refer to [Appendix A](#) for room preparation details)
3. Appoint patient care tech to document all actions taken by charge nurse (use activity log located in [Appendix A](#))
4. Appoint trained observers and coach/monitor donning and doffing, providing immediate corrective action as needed
5. Identify 2 RNs to care for the patient and have one begin the donning process with a trained observer
6. Notify the ED Director if additional staff are needed to continue taking care of other patients in the ED
7. Close the areas the patient was in prior to rooming (ED visitor bathroom, triage, consult room, etc.)
8. Ensure VHF PPE supply cart and designated items or form of communication are available outside of patient room
9. Collaborate with Infection Prevention to determine need for obtaining a list of patients waiting in the waiting room if the patient was waiting prior to being isolated
10. Collaborate with Infection Prevention to determine need for obtaining a list of all staff that had contact with the patient prior to isolating (including EMS)
11. Place staff log (found in [Appendix A](#)) to the quarantined area and ensure all active members of the care team complete at least once after every shift

ENVIRONMENTAL SERVICES (EVS)

- As early as possible of suspect case identification, the Director of EVS, or designee, should notify Stericycle of the potential need for Category A waste removal. The Director of EVS, or designee should collaborate with Infection Prevention prior to confirming waste pickup with Stericycle.
- The Director of EVS, or designee should collaborate with Infection Prevention to determine need for contacting SCDP to obtain 55-gallon waste bins if none are available on-site at the time of need.
- All waste bags should be double bagged, sealed using a balloon knot or goosenecked, and boxed prior to waste pickup. Please refer to the Waste Management and Cleaning & Disinfection sections of the playbook for additional guidance.

EPIDEMIOLOGIST

- Provide subject matter support for the Infection Prevention team
- Ensure required clinical and social information is collected by patient care team
- Assess the likelihood of VHF based on patient symptoms and travel history as relayed by direct care staff*
 - [CDC Yellow Book](#)
 - [Georgia DPH Travel Clinical Assistant](#)
- Provide assistance to primary physician in discussions with Georgia Health Department of Public Health (DPH) at 1-866-PUB-HLTH (1-866-782-4584) to discuss with state epidemiologist
- Contact Serious Communicable Diseases Unit (SCDU)
 - SCDU On-call PIC 50498
 - SCDU Lab Director PIC 52002

**Hospital Epidemiologist may choose to discuss case with SCDU provider to understand the likelihood of VHF prior to involving DPH.*

FACILITIES

- Ensure AIIR rooms are functioning appropriately, including appropriate number of air exchanges
- At the direction of infection prevention or ICC, install barrier from floor to ceiling to control patient / staff flow (see floor plan)

FOOD & NUTRITION

Patient food should be brought to the unit on a disposable tray. When the tray is on the unit, the Food & Nutrition staff member should communicate that the tray is ready to be delivered to the patient's room to either the charge nurse or the registered nurse. The registered nurse caring for the patient will be responsible for bringing the tray into the patient's room.

INFECTION PREVENTION

- Ensure appropriate isolation precautions are in place
- Facilitate communication with epidemiologist and charge nurse
- Communicate lab results with EVS to inform appropriate cleaning and disinfection and waste management

LABORATORY

- To limit exposure, phlebotomy does not perform venipuncture on patient. However, if assistance for a difficult draw is necessary, the phlebotomist will wear appropriate PPE during the venipuncture.
- If samples have been collected and are stored in the lab, the lab staff will retrieve the samples. They will be sent to SCDU following labeling and transport instructions.

MATERIALS MANAGEMENT

Materials management will be responsible for determining adequate par levels for assessment-level and PAPR-level PPE. They will be responsible for ensuring appropriate par levels are available and procuring additional supplies.

During a VHF response, materials management will identify thresholds to begin conservation and contingency plans for PPE.

PRIMARY PHYSICIAN OR APP

- Stabilize patient
- Assess patient travel and exposure history, symptoms, and current medical needs
- Relay important clinical information to coordinating team (Infection Prevention and / or Hospital Epidemiologist)
- Assist in communication about the patient to Department of Public Health along with hospital epidemiologist

REGISTRATION

Complete patient registration over the phone, via iPad, EPIC SecureChat, white board, or another form of communication ([Appendix G](#)) with the primary care team that is in the room.

If the armband is not already on the patient, this should be given to the observer to hand off to the primary nurse for placement on the patient.

RESPIRATORY THERAPY

- Treat patients for respiratory distress; oxygen therapy and administration of bronchodilators
- Assist with airway management and ventilatory support if necessary
- If the patient requires ventilation, respiratory therapy will be consulted to determine the most appropriate method for ventilation (bagged ventilation, ventilator, ventilator, etc.)

SECURITY / PUBLIC SAFETY

- Block off area to be barricaded as needed (see floor plan) as soon as patient is considered for highly communicable infectious disease to control patient / staff flow
- Lock doors to physically deny access to potentially contaminated or impacted areas
- Provide support for wayfinding
 - Ensure clear route for patient entry into hospital and identify designated waiting area and triage area if needed
 - Ensure Staff and EMS use predetermined entrance to ED
- Support unidirectional flow of the unit (OpenWHO Team, 2024)
- Ensure the number of personnel that enter the isolation space is limited to essential staff members actively participating in the patient's care

- Support with traffic control if/when waste is transported to predetermined space for sequestering. Ensure waste sequestering room is locked.

TRAINED OBSERVER

The trained observer can be any team member who has been trained in PAPR-level PPE donning and doffing (e.g., a member of the clinical team or Infection Prevention).

Because the sequence and actions involved in each donning and doffing step are critical to avoid exposure, a trained observer should read aloud to the HCW each step in the procedure checklist and visually confirm and document that the step has been completed correctly. The trained observer will coach, monitor, and document successful donning and doffing procedures, and provide immediate corrective instruction if the HCW is not following the recommended steps.

The observer should **NOT** provide physical assistance during doffing. If there is physical contact, the observer is considered contaminated and should have a different trained observer present during removal of their PPE.

In addition to assisting with donning and doffing, trained observer(s) should:

- Advise in-room staff on PPE breaches, spills, waste collection and sequestering, specimen collection
- Assist with supply, medication, equipment procurement to support patient care activities
- Clean and disinfect areas within the warm zone
- Assist with communication efforts
- Support with access control in warm / hot zones

ADDITIONAL CONSIDERATIONS

Patient Transport

- Infection Prevention, DPH, and SCDU should collaborate on patient transportation via EMS.
- Patients with suspected or confirmed VHF should only be transported when necessary. If patient transport to another facility is necessary, it must be coordinated with public health and transportation staff should adhere to [infection prevention protocols](#).
- Follow [Appendix F](#) for containment wrapping procedures prior to patient transport.

Patient Discharge

Patients with symptoms and suspected or confirmed VHF should remain in isolation until they have been determined not to have VHF (if suspected) or to be no longer contagious (if confirmed). Discharge will be coordinated with health department officials.

Patient Code Blue

In the case of a code blue, the nurse and provider caring for the patient should don appropriate PPE with trained observer and provide patient care inside the room. Roles such as timekeepers/recorders, supply runner, pharmacy should provide supportive care from outside of the patient room, passing equipment from the code cart into the room as needed.

Patient Post-Mortem Care

If there is death as a result of an infectious agent, adherence to Emory's "Death – Pronouncement and Notification" policy is necessary. Discussion with the health department on proper handling of the body and whether the infectious agent excludes the deceased as a candidate for the facility's designated organ donor network should be determined.

Special post-mortem procedures required ([CDC, 2024](#)):

- Do not wash, clean, nor embalm the body
- Do not perform an autopsy on the body unless absolutely necessary, and if so, then consult public health officials or the CDC for instructions
- Do not remove any inserted medical equipment
- Perform cremation when possible, or bury in a standard metal casket

Employee/Occupational Health Considerations

Blood or bodily fluid exposures should immediately be reported to Occupational Health Services (OHS). OHS policies and procedures will be followed.

For exposure management:

- The hospital epidemiologist will define exposure criteria
- Infection Prevention will perform contact tracing for staff, patients, and visitors, as needed.
- Infection Prevention will collaborate with Occupational Health Services for prophylaxis, quarantine, and additional measures as indicated for employees.
- Infection Prevention will collaborate with risk management and the department of public health for exposures involving patients and visitors

Post-Response Considerations

- Complete PPE cart inventory survey to support restocking of supplies



APPENDIX A: CHECKLIST FOR ROOM PREPARATION

- Designate who will be responsible for preparing the room
- Things that need to be done before the patient enters the room
 - Remove extra equipment
 - Remove furniture with porous surfaces
 - Remove any extra furniture
 - Remove any extra equipment
 - Disposable medical supplies (gauze, syringes, bandages)
 - IV poles, wheelchairs, IV pumps
 - Remove any extra linens
 - Empty trash
 - Remove any other equipment that is difficult to clean or decontaminate
 - Remove any durable equipment that you will need for other patients (otoscope, ECG machine)
 - Add appropriate isolation signs to the patient's doorway / anteroom (droplet plus, airborne, contact)
 - Bring in EPA approved disinfectant wipes in the room (e.g., Super SaniCloth Wipes)
 - Zero the bed for and accurate weight
 - Make sure the alcohol-based hand rub is full or a portable one is in the room
 - Ensure a working communication system between the inside and outside of the room is in place (e.g., iPad is set up and working in patient room)
 - Move crash cart out of warm zone
- Things that can be done after the patient enters the room
 - Post staff contact log near patient door (included in this appendix)
 - Handing in an IV pump
 - Handing in additional waste bins
 - Handing in a commode, red biohazard bag, solidifier, and chuck pads
 - Handing in a Swiffer-like mop



CAUTION

**ONLY TRAINED
STAFF BEYOND
THIS POINT**



STAFF CONTACT LOG

	Date	Time	Employee Name	Role
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Activity Log

[illegible]

6. Prepared by

PRINT NAME:

SIGNATURE:

DATE/TIME:

FACILITY:

APPENDIX B: ROUTE FOR PATIENT TRANSPORT IN ED

Insert floorplan of ED

APPENDIX C: PPE DONNING AND DOFFING CHECKLISTS

ASSESSMENT – LEVEL PPE

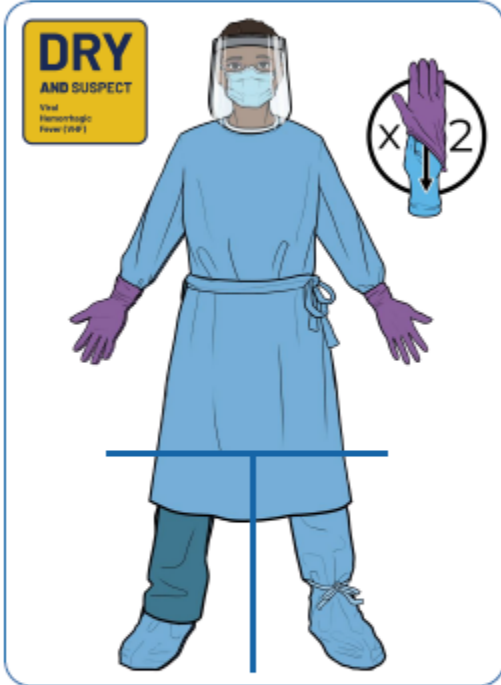
PPE Donning and Doffing: Non-PAPR Dry and Suspect Viral Hemorrhagic Fever (VHF)



Introduction
Step-by-step guidance for donning and doffing the PPE non-PAPR ensemble used in the care of clinically stable, suspect cases of viral hemorrhagic fevers (VHF) or similar pathogens who are not having vomiting or diarrhea.

PPE Selection

- Eye protection: Full face shield, integrated face shield of powered respirator, or tight-fitting goggles
- Nose and mouth coverage: Medical mask or optional respiratory protection with NIOSH-approved N95®, elastomeric, or powered air-purifying respirator (PAPR)
- Torso/Body coverage: Fluid-resistant gown (Level 3 or 4) or coverall
- Gloves: 2 pairs of gloves, outer pair with extended cuffs
- Shoe or boot covers are optional unless otherwise specified by facility or public health guidance





Page 1/4
June 10, 2025

 www.netec.org

Donning PPE for Dry / Suspect VHF

ITEMS:



Gloves x2



Gown



Mask



Eye protection



Optional boot / shoe covers

1



Batch work ahead of time and plan ahead, having items available outside patient room.

2



Put on shoe or boot covers (optional unless required in your state or at your institution).

3



Sanitize hands.

4



Put on inner gloves.

5



Put on gown outside room. Gown opens in the back. Pull gown sleeves over wrists of inner gloves. Tie the back of the gown.



6



Put on mask.

7



Put on face shield.

8



Put on outer gloves.

9



Enter room.

10



Do not touch face or re-adjust mask or face shield inside room.

Doffing PPE for Dry / Suspect VHF - INSIDE ROOM

1



Sanitize gloves and touched dispenser.

2



Untie or break the waist ties of the gown.

3



Cross your arms in an "X" to grasp gown at upper arm, close to shoulder.

4



Uncross your arms slowly. Extend them away from your body until they are straight, inverting the gown.

5



Holding gown away from body, roll in a ball by touching only the inside of the gown and discard gown and gloves.

6



Sanitize gloves and dispenser, if touched.

7 - 15

IF USING BOOT/SHOE COVERS...



EXIT room. Refer to Instructions to continue doffing: "Doffing PPE for Dry / Suspect VHF - OUTSIDE ROOM"

IF USING BOOT/SHOE COVERS...

7



Before you begin, identify clean area where you will step with uncovered foot.

8



Using a balance aid or chair, touching only the inside of shoe/boot cover, turn it inside out over head and remove.

9



Step with that foot into a clean area.

10



Place boot cover in trash.

11



Sanitize gloves and dispenser, if touched.

12



Using a balance aid or chair, touching only the inside of shoe/boot cover, turn it inside out over head and remove.

13



Step with that foot into a clean area.

14



Place boot cover in trash.

15



Sanitize gloves and dispenser, if touched.

Doffing PPE for Dry / Suspect VHF – OUTSIDE ROOM

16



Remove face shield by grasping strap at the temples. Tilt head slightly forward and allow face shield to fall forward.

17



Place face shield in trash.

18



Sanitize gloves and dispenser, if touched.

19



(OPTIONAL) Change into new gloves.

20



Remove mask, place in trash.

21



Sanitize gloves and dispenser, if touched.

22



Remove inner gloves.

23



Wash hands with soap and water.

PAPR – LEVEL PPE

putting ON PAPR

Donning Checklist 1/2



- | | | | |
|---|---|---|---|
| <p>Shoe liners + gloves</p> <ol style="list-style-type: none"> 1 Qualified monitor is present. 2 Set up cart for donning and doffing. 3 Remove personal effects (phone, keys, badges, pens, etc.). 4 Put on clear inner shoe liners over your shoes and pants. 5 Put on extended cuff inner gloves. | <p>Belt + helmet</p> <ol style="list-style-type: none"> 6 Secure belt snug around waist with clip facing up. Place excess belt into clip and loop. 7 Secure the battery on the left side of the belt. 8 Connect helmet to battery. 9 Check that 3 LED lights on helmet are green to ensure battery is fully charged. 10 Adjust temple holder (top hole for larger head, 2nd hole works for most though). 11 Put helmet on head and size to fit by turning ratchet knob to adjust the headband. 12 Bend over to ensure helmet is tight enough to stay on without slipping. 13 Ensure long hair is in a low bun or ponytail is above shoulders. 14 Adjust fan speed to comfort. 15 Disconnect the battery. | <p>Hood + cap</p> <ol style="list-style-type: none"> 16 Open the hood bag. 17 Set aside outer cap. 18 Orient the hood so markings face you and are in upward direction and flat edge is at top. 19 Hold the upper corners and shake the hood until it fully unfolds. 20 Connect the center hole of the hood to the center hook on the front of the helmet. Once you are hooked, keep pushing until you hear a snap. 21 Connect the right and left sides of the hood to the helmet in the same way until you hear a snap. 22 Grab the bottom of the hood and pull it back and over the helmet until it fits. 23 Take the cap and fit it fully over the top of the hood. 24 Set assembled PAPR hood aside. | <p>Coveralls + booties</p> <ol style="list-style-type: none"> 25 Put on coveralls outside room. Feet in first. Open-end faces your front. Do not zip up yet. 26 Ensure proper mobility of arms and legs within coveralls. 27 Tape coverall and wrist of the gloves and form a release tab at end of the loop. 28 Don booties. |
|---|---|---|---|

continued next page...

PAPR Donning Checklist 2/2

- 29** **Sanitize** gloves and touched dispenser.
- 30** **Insert** PAPR power cord connector into the battery.
- 31** **Put** the helmet on, letting the hood drape around your shoulders over the coveralls. Last chance to **adjust** the helmet!
- 32** **Tuck** the cord into your suit.
- 33** **Zip up** the front of the coveralls.
- 34** **Insert** fingers into facial liner and **tug** it around your face until it tucks under your chin.
- 35** **Find** both neck ties and bring them to the front and **tie** a shoelace knot close to neck.
- 36** **Find** both torso ties from center back of hood, bring them around and **insert** them through the front holes, then **tie** into shoelace knot.
- 37** **Unfold** and **put on** gown.
- 38** **Secure** neck of gown, making sure neck tie of hood is covered.
- 39** **Tie** gown at waist at left side.
- 40** **Put on** extended cuff outer gloves, **tuck** gown sleeves into gloves.
- 41** Safety monitor completes **360° check** of PPE.
- 42** **Sanitize** Gloves and touched dispenser.
- 43** **Enter** room. Do not enter room without proper fit of the PAPR system.
- 44** **Do not touch** or re-adjust PAPR system inside the room.

Helmet + zip + hood

Gown + outer gloves

Entry

PAPR Doffing Checklist 1/2

Inside room

- | | |
|---|--|
| <p>Setup</p> <ol style="list-style-type: none"> 1 Make sure that you have everything you need to complete a successful doffing. (Trash can, hand sanitizer, balance aid). 2 Check that your partner outside of the room is aware you are preparing to doff. 3 Inspect PPE for visible signs of contamination. Have your partner inspect your back through the window on the door. 4 Wipe away contamination with SaniWipes. 5 Place a large underpad in front of the door, with trash can and sanitizer within reach. 6 Sanitize gloves and if touched, dispenser. | <p>Booties</p> <ol style="list-style-type: none"> 16 Using balance aid if appropriate, with one hand remove one bootie. As you remove it, step with that foot onto pad. Throw bootie away. 17 Remove other bootie. Step onto pad. Throw bootie away. 18 Sanitize gloves and if touched, dispenser. |
| <p>Cap + gown</p> <ol style="list-style-type: none"> 7 With one hand, reach up to the back of the helmet, pinch and remove cap from top of PAPR hood, throw into trash. 8 Sanitize gloves and if touched, dispenser. 9 Gently pull the sleeves of the gown out from under each outer glove cuff, working your way around the wrist. 10 Sanitize gloves and if touched, dispenser. 11 Grasp gown at sides over waist tie, pull forward to break tie. 12 Cross your arms in an "X" to grasp gown at upper arm, close to shoulder, avoid touching PAPR hood. 13 Uncross your arms slowly, extending them away from your body, inverting the gown. Extend your arms outward until they are straight. 14 Keeping arms extended away from your body, bundle the gown and discard. 15 Sanitize gloves and if touched, dispenser. | <p>Outer gloves + hood + tape</p> <ol style="list-style-type: none"> 19 Pinch glove cuff and pull over fingers, but do not remove glove. With covered fingers, pinch and pull opposite glove off. Using other hand, remove initial glove and discard both gloves. 20 Sanitize gloves and touched dispenser. 21 Untie torso ties, ball up and pull through one side, and discard. 22 Sanitize gloves and if touched, dispenser. 23 In a controlled manner, pull tape down and away to remove tape from both wrists. 24 Sanitize gloves and if touched, dispenser. |
| | <p>Coveralls</p> <ol style="list-style-type: none"> 25 Avoiding touching the inside of the PAPR hood, zip down coveralls with one hand. 26 Grasp the coveralls near lower back, at the hips, and pull the coveralls straight down. 27 Touching only the inside of the coveralls, push the coveralls down below the knees. 28 Step on the crotch of the suit to remove feet from coverall. Repeat step motion until feet are free. 29 Step off coveralls and leave the coveralls for the next person to pick up. 30 Sanitize gloves and touched dispenser. |
| | <p>Exit</p> <ol style="list-style-type: none"> 31 Observer opens the door. 32 Exit the patient room. |

Continue: "OUTSIDE room"

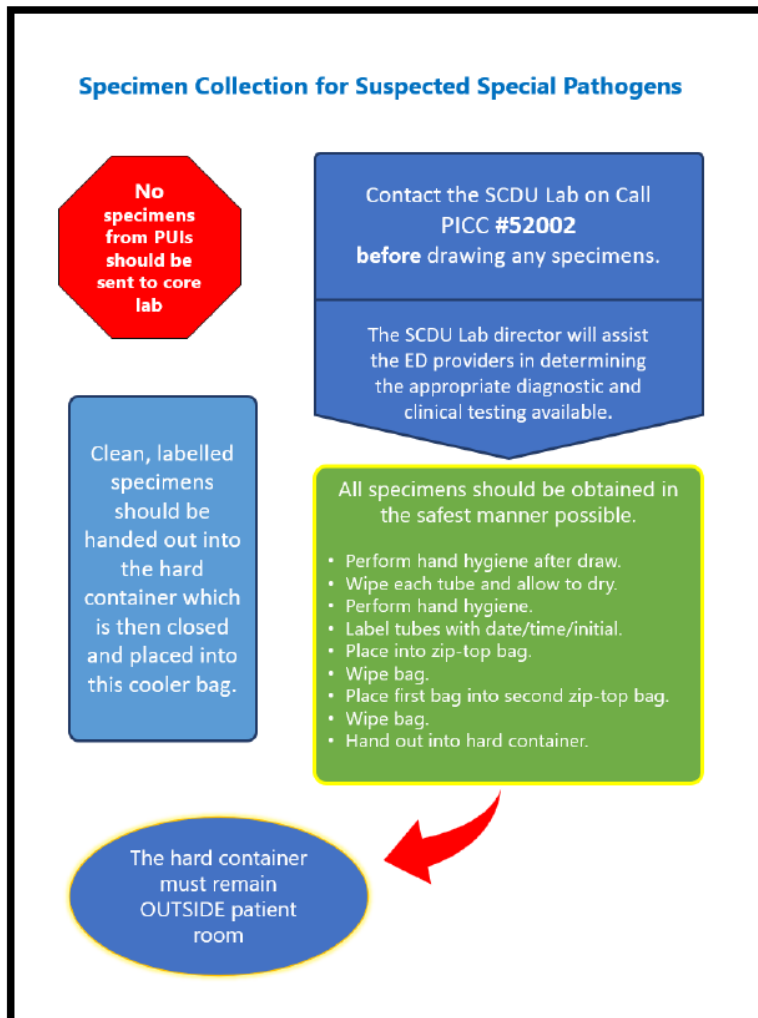
PAPR Doffing Checklist 2/2

Outside room

- Hood + inner gloves**
 - 33 Sanitize gloves and if touched, dispenser.
 - 34 Place both hands under the front of the hood, palms forward. **Do not cross arms. Reach** to the back of the helmet on each side. Fully **gather** hood material and **tightly roll** touching only the inside of the hood.
 - 35 Continue to **roll** the hood material up across the back and top of the helmet until you reach the top of the head, in line with the ears.
 - 36 Move fingers to the edge of the face shield and unsnap the temple post from the helmet and fold visor in half.
 - 37 With an upward motion, **pull** folded visor from center post.
 - 38 Remove hood.
 - 39 Sanitize gloves and if touched, dispenser.
 - 40 Pinch glove cuff and **pull** over fingers, but **do not remove** glove. With covered fingers, **pinch** and **pull** opposite glove off. Using other hand, **remove** initial glove and **discard** both gloves.
- shoe covers + belt**
 - 41 Sanitize hands and if touched, dispenser.
 - 42 Raise arms over head in "raise the roof" motion.
 - 43 Observer **holds** the battery.
 - 44 Observer **unbuckles** belt.
 - 45 Observer **removes** helmet motor from behind, **avoiding** the face.
- Clean up**
 - 46 Put on clean gloves
 - 47 Remove shoes covers
 - 48 Pinch glove cuff and **pull** over fingers, but **do not remove** glove. With covered fingers, **pinch** and **pull** opposite glove off. Using other hand, **remove** initial glove and **discard** both gloves.
 - 49 Sanitize hands and if touched, dispenser.
 - 50 Wash hands and arms thoroughly with soap and water.
 - 51 Talk with your infection prevention team about showering protocols.

APPENDIX D: SPECIMEN COLLECTION AND TRANSPORT FOR SUSPECTED SPECIAL PATHOGENS

- ▶ **Prepare a space**
 - To receive specimens
 - To receive CLEANED specimens
- ▶ **Prepare supplies**
 - In addition to phlebotomy supplies:
 - 2 lab specimen bags
 - Labels
 - Sani-wipes
 - Hand sanitizer
 - Pen
- ▶ **Steps:**
 1. Draw
 2. Hand sanitize
 3. Wipe each tube and set in clean space
 4. Hand sanitize
 5. Label specimens (date-time-initial)
 6. Place in first lab bag
 7. Wipe outside of first lab bag
 8. Place into second lab bag
 9. Wipe outside of second lab bag
 10. Drop into hard container at doorway



How to send specimens to the SCDU laboratory:

Questions? Contact SCDU pager #52002 using [EHConnect](#) Paging on EHC Intranet

Print extra labels for the specimen(s) to be used for creating packing lists and tracking the samples

Make sure the specimen cap is secure (use parafilm if you can)

Place tube(s) in a specimen bag; clean the outside of the bag with a disinfecting wipe.

Double bag the specimens and clean again with a new wipe. Change gloves.

Place the specimen bags in the hard plastic container with a secure top (screw-on top is recommended) Do not add any cooling packs.

Cover the top of the hard container with a **Do Not Open!** Label

Nestle the hard container into the courier specimen tote. (Optional: the zippers can be secured with cable ties)

Ensure the address to SCDU lab is showing on the tote. The extra labels and packing list (optional) can be placed in this side pouch as well.

Call EML Customer Service to arrange transport: 404-712-5227 option #3 Request an EML courier



**Do Not Open!
Contact SCDU
pager# 52002**

Send to:
Emory University Hospital
SCDU Laboratory, Room HG28
1364 Clifton Road
Atlanta, GA 30322

APPENDIX E: WASTE MANAGEMENT



Are you preparing suspected **Ebola-contaminated waste** for transportation?

Ebola contaminated waste is considered a Category A infectious substance and must be doubled bagged and placed in a rigid outer packaging prior to transportation.

Packaging Requirements:

You must use packaging meeting the requirements for a Division 6.2 Category A material (49 CFR 173.196) or Special Permit DOT-SP 16279.

Packaging Preparation:

1 Bag the waste

- Put contaminated waste into a leakproof primary receptacle
- Use authorized container for sharps
- Wrap sharp edges to prevent puncturing of the plastic bag
- Close the packaging in accordance with closure instructions
- If following a DOT-SP, spray exterior surface with EPA-registered disinfectant that is recommended by the CDC for use against the Ebola virus

PROPERLY CLOSED
SHARPS CONTAINER



2 Double bag

- Place primary receptacle into a leakproof secondary packaging with the closure facing upward
- Include absorbent material sufficient to absorb the entire contents of all primary receptacles
- Close the packaging in accordance with closure instructions
- If following a DOT-SP, spray exterior surface with disinfectant

LINER



3 Put contaminated waste in outer packaging

- Put primary receptacle and secondary packaging in rigid outer packaging
- Close the packaging in accordance with closure instructions
- If following a DOT-SP, spray exterior surface with disinfectant



For more information on transporting infectious substances, please visit PHMSA's website:

<https://www.phmsa.dot.gov/transporting-infectious-substances/transporting-infectious-substances-overview>

or contact the Hazmat Info Center: 1-800-467-4922

PHH50-0000-0000

Image source: <https://www.phmsa.dot.gov/training/hazmat/are-you-preparing-suspected-ebola-contaminated-waste-transportation>

Tips – Primary and Secondary Bag Removal

- Remove the bag using a method that will not cause aerosolization of the contents
 - Lift the overlap by 2 diagonal corners (**wearing clean gloves**).
 - Turn the top of the bag to create a twist
 - Firmly grasp the twist before lifting the bag out of the container



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Tips – Secondary Container

Secondary Packaging

- Prepare a waste container that is larger than the primary waste container by lining it with a biohazard bag, making sure the bag is inserted all the way to the bottom of the container with the excess overlapping the top
- Pass the waste from the hot zone into the second bag in the warm zone
- Secure the bag in the same way as the primary bag



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EMORY APPROACHES

General Waste

Double autoclave bag, largest daily volume

- PPE
- Food trays
- Patient care debris, disposable supplies, packaging
- Cleaning debris, wipes



Linens

Double autoclave bag, **blue bin**

- Dry, damp, or saturated
- If heavily soiled, staff to discard



Liquids

Double autoclave bag with solidifier

- Human waste in red biohazard bags, solidified
- Suction canisters, solidified
- Bowel management bags



Sharps, Lab, & CRRT

Autoclavable sharps box with solidifier

- Lab cartridges, lab waste
- CRRT, dialysis supplies
- PleurEvac



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90

• Tips for Sequestering Medical Waste



- Use an adjacent vacant patient room as a waste holding room
- Place 2-3 large (approx. 6 ft. x 6 ft. x 3 ft.) wheeled linen carts in the waste holding room
- Line each cart with a large plastic cart liner and absorbent material
- Double-bag solid waste from care of PUI using same procedures as for confirmed Ebola patient
- Place bags in lined carts in waste holding room until definite decision on Ebola diagnosis



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Liquid Waste

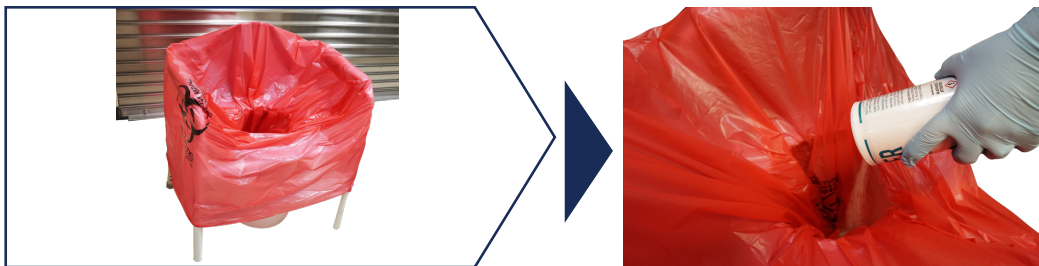
Handling Liquid Waste

- Staff should be trained to manage human waste from patients
- Ideally the patient room should have a private flushable toilet
- Protocols should be in place for the disposal of liquid waste that incorporate state and local regulations on pretreatment if required
 - If pretreatment is required, use a chemical that does not pose a respiratory risk to the patient or staff, and one that does not cause corrosion to plumbing
- CDC guidance does not require pretreatment



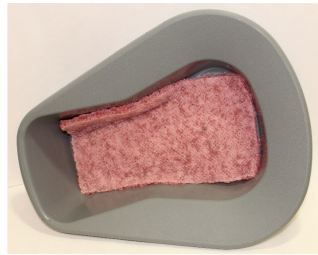
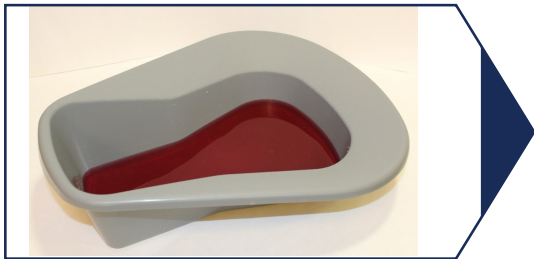
Tips: Liquid Waste Management

- If there is no toilet in the patient room, use a covered bedside commode
- Minimize the risk of spills by adding solidifier to the contents and dispose of as solid waste



Tips: Liquid Waste Management

- If using a bed pan, minimize risk of spills by adding a solidifier to the commode contents and dispose as solid waste
- Alternatively, consider use of a bowel management system for patients who are unstable, have altered mental status, or are unable to ambulate safely to the commode



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DIRECTIONS FOR THE USE
OF A SPECIAL PATHOGEN
WASTE KIT VIDEO

APPENDIX F: CONTAINMENT WRAP FOR PATIENT TRANSPORT

Containment Wrap for Patient Transport



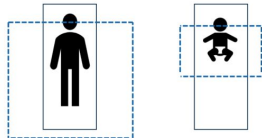
Containment Wrap Definition

A containment wrap is used to minimize the risk of contamination to personnel and the environment when a confirmed or suspected high-consequence infectious disease patient is being moved within or transported into or out of a facility.

Patient wrapping techniques are designed to keep the outside of the wrap material as clean as possible and contain any body fluids or potentially infectious materials within the wrap.

What Material Can I Use For Containment Wraps?

Fluid-impervious sheeting, AAMI Level 4 surgical drapes, plastic drop cloths, or tarp material of a sufficient size to overlap completely side-to-side after folding excess material up from the foot area.



Select drape sizes appropriate for the size of the patient.

Wheelchair Wrap



If wrapping a patient who will use a wheelchair, place the wrap material so that there is sufficient material at the foot area to fold upward toward the patient's knees once seated. Tuck this excess material out of the way until the patient is seated to avoid creating a trip hazard. Once seated, bring the material at the foot up first, then cover the patient from side to side, leaving head and face uncovered.

Supplies

1. Biohazard trash bag
2. Emesis bag
3. Source control mask for patient
4. Containment wrap material

Optional: Draw sheets, absorbent pads, patient transfer board, extra gloves

Clinical Considerations

- Keep wrap material loose enough for patient comfort.
- Consider heat retention, transport time, and the need to medicate for fever.
- Do not wrap patient's face.
- Consider the addition of absorbent pads, diapers, or towels as needed for body fluid management.
- Consider using a drawsheet or patient transfer device to avoid tearing wrap material when handling.



Page 1/2
Updated May 22, 2026

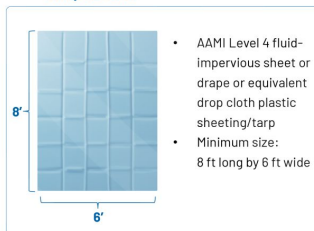
www.netec.org

Containment Wrap for Patient Transport

Equipment and Supplies for Wrap

1. Wheeled stretcher or wheelchair
2. Slide board if available
3. (2) Draw sheets
4. Extra large fluid impervious sheet or drape (containment wrap)

Wrap Material



- AAMI Level 4 fluid-impervious sheet or drape or equivalent drop cloth plastic sheeting/tarp
- Minimum size: 8 ft long by 6 ft wide

Prepare Bed

1. Prepare containment wrap on a clean bed or stretcher in a clean area.
2. Place bottom sheet on mattress.
3. Place drawsheet over bottom sheet.
4. Place containment wrap as top layer, with excess material draped at the foot and both sides.

Containment Wrap



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Page 2/2

Updated May 22, 2026

APPENDIX G: OPERATING UNIT DETAILS

- Infection Prevention PIC #:
- Hospital Epidemiology PIC #:
- ED Charge Nurse Phone #:
- Location of Designated AIIR:
- Location of VHF PPE Supply Cart:
- Location to Sequester/Hold Category A Waste:
- Preferred Communication Method with Patient (e.g., baby monitor, whiteboard, iPad):
- Map of ED: Insert in Appendix B

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