**Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients Who Present With Possible Ebola Virus Disease in the United States**

December 2, 2014
**Special note: The likelihood of contracting Ebola in the United States is extremely low unless a person has direct contact with the blood or body fluids (like urine, saliva, vomit, sweat, and diarrhea) of a person who is infected with Ebola virus. The majority of patients with fever and other non-specific signs and symptoms**[**\***](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftnA)**in the U.S. do not have Ebola Virus Disease (Ebola), and the transmission risk posed to those in direct contact by patients with Ebola and early symptoms is lower than the risk from a patient hospitalized with severe Ebola. Nevertheless, because early Ebola symptoms are similar to those seen with other febrile illnesses, providers should consider and assess patients for the possibility of Ebola. The guidance provided in this document reflects lessons learned from the recent experience caring for patients with Ebola in U.S. healthcare settings. Although inpatient hospital settings generally present a higher risk of Ebola virus transmission to healthcare personnel, transports by emergency medical services (EMS) present unique challenges because of the uncontrolled nature of the work, the potential for resuscitation procedures being needed, enclosed space during transport, and a varying range of patient acuity. Close coordination and frequent communications are important among 9-1-1 Public Safety Answering Points (PSAPs) (commonly known as “9-1-1 call centers”), the EMS system, healthcare facilities, and the public health system when preparing for and responding to patients with suspected Ebola.**

\*Signs and symptoms of Ebola include: Fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal (stomach) pain, unexplained hemorrhage (bleeding or bruising). Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola, but the average is 8 to 10 days.

**What’s New:** This version of the guidance has been updated to clarify the minimum PPE levels for EMS personnel and first responders.  The updated information reflects the PPE guidance described in other CDC guidance documents such as “[Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease](http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html)” and “[Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)” to keep workers safe when responding to patients with suspected Ebola.

**Who this is for**: Emergency medical services providers (including emergency medical technicians (EMTs), paramedics, and medical first responders who could be providing patient care in the field-- such as law enforcement and fire service personnel) as well as managers of 9-1-1 PSAPS, EMS agencies, EMS systems, and agencies with medical first responders.

**What this is for:** Guidance to assure EMS and first responders are safe and patients are appropriately managed while handling inquiries and responding to patients with possible Ebola infection.

**How to use**: Employers and supervisors should use this information to understand and explain to staff how to respond and stay safe. Supervisors can use this information to prepare and train EMS personnel. Individual providers can use this information to respond to patients who are suspected to have Ebola and to stay safe.

Key Points:

* The likelihood of contracting Ebola in the United States is extremely low unless a person has direct contact with the blood or body fluids (like urine, saliva, vomit, sweat, and diarrhea) of a person who is infected with Ebola virus.
* It is important for PSAPs to question callers about:
	+ Residence in, or travel to, a [country or area with widespread Ebola virus transmission](http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html) or uncertain control measures or having had contact with an individual with confirmed Ebola Virus Disease within the previous 21 days; AND
	+ Signs and symptoms of Ebola (such as fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal pain, and unexplained hemorrhage.)
* Managers of 9-1-1 PSAPs, EMS Agencies, EMS systems, agencies with medical first responders (such as fire and law enforcement) should collaborate with local public health authorities to develop coordinated plans for responding to a person with possible Ebola in a given jurisdiction, including the possibility of designating certain teams for this response.
* All personnel should be trained regarding Ebola response protocols. Those who may respond to a person with possible Ebola should also be trained in the use of the appropriate personal protective equipment (PPE) consistent with their response role.
* If PSAP call takers have information alerting them to a person with possible Ebola, they should make sure any first responders and EMS providers are made aware of the potential for a patient with possible exposure/signs and symptoms of Ebola **before the responders arrive on scene**. This will enable EMS providers to select and correctly put on PPE following the principles described in CDC’s guidance documents: “[Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease](http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html)” and [“Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)](http://www.cdc.gov/vhf/ebola/hcp/procuring-ppe.html)”. The fundamental principle of standard and transmission based precautions is to prevent contact with blood or potentially infectious body fluid. However, as pre-hospital patient care is frequently provided in an uncontrolled environment with unique operational challenges, EMS systems must design their procedures to accommodate their local operational challenges. For PPE use, responders may also wish to review the Interagency Board’s (IAB) “[Recommendations on Selection and Use of Personal Protective Equipment for First Responders against Ebola Exposure Hazards[PDF - 11 pages]](https://iab.gov/Uploads/IAB%20Ebola%20PPE%20Recommendations_10%2024%2014.pdf%22%20%5Co%20%22Link%20to%20External%20Web%20Site%22%20%5Ct%20%22_blank) .”
* Prior to working with patients with suspected Ebola, providers should have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning/doffing proper PPE.
* When EMS providers arrive at the scene, they should immediately check for symptoms and risk factors for Ebola and should don PPE appropriate to the situation. EMS providers should notify the receiving healthcare facility in advance when they are bringing a patient with suspected Ebola, so that proper infection control precautions are prepared at the healthcare facility before EMS arrives with the patient.  Medical directors and EMS agencies should collaborate with healthcare and public health agencies to define local or regional protocols for the transport of patients with suspected Ebola to an appropriate facility for Ebola triage and care.
* Local protocols should be developed for cleaning and disinfection of the ambulance and equipment as well as [disposing of medical waste](http://www.cdc.gov/vhf/ebola/hcp/medical-waste-management.html) consistent with this guidance.

*The guidance provided in this document is based on current knowledge of Ebola. Updates will be posted as needed on the* [*CDC Ebola webpage*](http://www.cdc.gov/vhf/ebola/index.html)*.The information contained in this document is intended to complement existing guidance for healthcare personnel, “*[*Identify, Isolate, Inform: Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease*](http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html)*” and “*[*Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in U.S. Hospitals*](http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html)*”.*

Background

The current Ebola outbreak in West Africa has increased the possibility of patients with Ebola traveling from the affected countries to the United States.[1](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftn1) The likelihood of contracting Ebola is extremely low unless a person has had direct unprotected contact with blood or body fluids (like urine, saliva, vomit, sweat, and diarrhea) of a person infected with Ebola virus.  Initial signs and symptoms of Ebola include fever, chills, fatigue, weakness, and muscle aches, followed approximately 4-6 days after illness onset by diarrhea, nausea, vomiting, and abdominal pain. Other symptoms such as chest pain, shortness of breath, headache, or confusion, may also develop. Signs and symptoms may become increasingly severe and may include jaundice (yellow skin), severe weight loss, mental confusion, bleeding inside and outside the body, and complications such as shock, and multi-organ failure.[2](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftn2)

Ebola virus infection can cause severe illness and extra care is needed when coming into direct contact with a recent traveler who has signs and symptoms of Ebola and has travelled from a country with an Ebola outbreak. The initial signs and symptoms of Ebola are similar to many other more common diseases found in West Africa (such as malaria and typhoid). Ebola should be considered in anyone with a fever who has traveled to, or lived in, an area where Ebola is present.[3](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftn3) In general, the majority of febrile patients presenting to first responders and EMS in the U.S. do not have Ebola, and the risk posed by patients with early, limited symptoms is lower than that from a patient hospitalized with severe Ebola.

The incubation period for Ebola, from exposure to when signs or symptoms appear, ranges from 2 to 21 days (most commonly 8-10 days). Any Ebola patient with signs or symptoms should be considered infectious.

Key safe work practices include avoiding:

* Unprotected exposure to blood or body fluids of infected patients through contact with skin, mucous membranes of the eyes, nose, or mouth
* Injuries with contaminated needles or other sharp objects
* Aerosol-generating procedures when possible

Coordination among 9-1-1 PSAPs and the EMS system is important. Training and exercising with healthcare facilities and the public health system is critical when preparing to respond to patients with suspected Ebola. Each 9-1-1 and EMS system should include an EMS medical director to provide appropriate medical oversight.

Case Definition for Ebola

CDC’s most current case definition for Ebola may be accessed here: [Case Definition for Ebola Virus Disease (EVD)](http://www.cdc.gov/vhf/ebola/hcp/case-definition.html)

Recommendations for 9-1-1 PSAPs

State and local EMS authorities should coordinate with state and local public health, PSAPs, and other emergency call centers to use modified caller queries about Ebola, outlined below,  when they consider the risk of Ebola to be higher in their community. This should be decided from information provided by local, state, and federal public health authorities, including the city or county health department(s), state health department(s), and CDC.

Modified Caller Queries

It will be important for PSAPs to question callers and determine the possibility of anyone having Ebola. This information should be communicated immediately to EMS providers before arrival in order to assign the appropriate EMS resources. Local or state public health officials should also be notified. PSAPs should utilize medical dispatch procedures that are coordinated with their EMS medical director and with the local public health department.

* If PSAP call-takers suspect a caller is reporting symptoms of Ebola, they should screen callers for risk factors within the past 3 weeks (21 days):
	+ Residence in, or travel to, a country or area [with widespread Ebola transmission](http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/index.html) or uncertain control measures; (a list of countries can be accessed at the following link: [2014 Ebola Outbreak in West Africa - Outbreak Distribution Map](http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html)).
	+ Contact with blood or body fluids (including but not limited to urine, saliva, vomit, sweat, and diarrhea) of a patient known to have or suspected to have Ebola.
* If PSAP call takers have information alerting them to a person with possible Ebola, they should make sure any first responders and EMS providers are made aware of the potential for a patient with possible exposure/signs and symptoms of Ebola **before the responders arrive on scene**.
* If responding to a report of an ill traveler at an airport or other port of entry to the United States, the PSAP or EMS unit should notify the CDC Quarantine Station for the port of entry. Click here for contact information for CDC [Quarantine Station](http://www.cdc.gov/quarantine/quarantinestationcontactlistfull.html) or the PSAP or EMS unit can call the CDC’s Emergency Operations Center at 770-488-7100 to be connected with the appropriate quarantine station.

Recommendations for EMS and Medical First Responders

For the purposes of this section, “EMS provider” means pre-hospital EMS and medical first responders. These EMS provider practices should be based on the most up-to-date Ebola clinical recommendations and information from appropriate public health authorities and EMS medical direction.

When state and local EMS authorities determine there is an increased risk (based on information provided by local, state, and federal public health authorities, including the city or county health department(s), state health department(s), and the CDC), they may direct EMS providers to modify their practices as described below.

**Patient assessment**

* To minimize potential exposure, only one EMS provider should approach the patient and perform the initial screening from at least 3 feet away from the patient. If, based on the initial screening, the EMS provider suspects the patient could have Ebola then PPE should be put on before coming into close contact with the patient. Keep the other emergency responders further away, while assuring they are still able to support the provider with primary assessment duties.
* No one should have direct contact with a patient who may have Ebola without wearing appropriate personal protective equipment (PPE) described below.
* During patient assessment and management, EMS personnel should consider the signs and symptoms and risk factors of Ebola. A relevant exposure history should be taken including:
	+ Residence in, or travel to, a [country or area with widespread Ebola virus transmission](http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html) or uncertain control measures.
	+ Contact with blood or body fluids (including but not limited to urine, saliva, vomit, sweat, and diarrhea) of a patient known to have or suspected to have Ebola.
* Patients who meet the criteria should be further questioned regarding the presence of signs or symptoms of Ebola such as fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal pain, diarrhea, and unexplained hemorrhage.

Safety and Personal Protective Equipment (PPE)

* If PSAP call takers advise that the patient is suspected of having Ebola, EMS personnel should put on the PPE appropriate for suspected cases of Ebola before entering the scene. PPE options are described in detail below.
* To minimize potential exposure, only one EMS provider should approach the patient and perform the initial screening from at least 3 feet away from the patient. If, based on the initial screening, the EMS provider suspects the patient might have Ebola then PPE should be put on before coming into close contact with the patient. Keep the other emergency responders further away, while assuring they are still able to support the provider with primary assessment duties.
* No one should have direct contact with a patient who may have Ebola without wearing appropriate personal protective equipment (PPE).

Based on the clinical presentation of the patient, there are two PPE options:

* If the patient is **not** exhibiting obvious bleeding, vomiting, or diarrhea and there is no concern for bleeding, vomiting, or diarrhea, [then EMS personnel should at a minimum wear the following PPE](http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html):
	1. Face shield and surgical face mask
	2. Impermeable gown, and
	3. Two pairs of gloves
* If the patient is exhibiting obvious bleeding, vomiting, or diarrhea or there is concern for potential bleeding, vomiting, or diarrhea then EMS personnel should wear PPE described in the "[Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)."
* PPE should be put on before entering a scene with a suspected Ebola patient and continued to be worn until providers are no longer in contact with the patient. PPE should be carefully put on and taken off under the supervision of a trained observer as described in the “[Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html).”
* If the patient exhibits obvious bleeding, vomiting , copious diarrhea or a clinical condition that warrants invasive or aerosol-generating procedures (e.g., intubation, suctioning, active resuscitation), then use [PPE designated for the care of hospitalized patients](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html).
* If blood, body fluids, secretions, or excretions from a patient with suspected Ebola come into direct contact with the EMS provider’s unprotected skin or mucous membranes, then the EMS provider should immediately stop working. They should wash the affected skin surfaces with a cleansing or antiseptic solution and mucous membranes (e.g., conjunctiva) should be irrigated with a large amount of water or eyewash solution, as per usual protocols. All waste should be placed in a biohazard bag. EMS providers should report exposure to an occupational health provider, supervisor or designated infection control officer for immediate care.

Patient management

* No one should have direct contact with a patient who could have Ebola without wearing appropriate personal protective equipment (PPE).
* Use caution when approaching a patient with suspected Ebola. On rare occasions, illness can cause delirium, with erratic behavior (e.g., flailing or staggering) that can place EMS providers at additional risk of exposure.
* Keep the patient separated from other persons as much as possible.
* Limit the number of providers who provide care for a patient with suspected Ebola.  All EMS personnel having direct contact with a suspected Ebola patient must wear PPE.
* Limit the use of needles and other sharps as much as possible. Any needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers that are specific to the care of this patient, in accordance with OSHA’s Bloodborne Pathogens Standard, 29 CFR 1910.1030[6](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftn6). Do not dispose of used needles and sharps in containers that have sharps from other patients in them.
* Consider giving the patient oral medicine to reduce nausea, per your medical director’s protocols and consistent with your scope of practice.
* If patient is vomiting, give them a large red biohazard bag to contain any emesis.
* If patient has profuse diarrhea, consider wrapping the patient in an impermeable sheet to reduce contamination of other surfaces.
* Pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation frequently result in a large amount of body fluids, such as saliva and vomit. Performing these procedures in a less controlled environment (e.g., moving vehicle) increases risk of exposure to infectious pathogens for EMS providers. If conducted, perform these procedures under safer circumstances (e.g., stopped vehicle, hospital destination) and wear the [PPE recommended by CDC to use during aerosol-generating procedures](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html).

Pre-Hospital Care Considerations

Pre-hospital patient care is frequently provided in an uncontrolled environment with unique operational challenges. EMS systems must design their procedures to accommodate their local operational challenges while still following the principles of the CDC PPE guidance.

* It may be as simple as having one provider put on PPE and manage the patient while the other provider does not engage in patient care but serves in the role of trained observer.
* There may be situations where a patient must be carried and multiple providers are required to put on PPE. EMS providers wearing PPE who have cared for the patient must remain in the back of the ambulance and should not serve as the driver.
* EMS agencies may consider sending additional resources (for example, a dedicated driver for the EMS unit who may not need to wear PPE if the patient compartment is isolated from the cab) to eliminate the need for putting on PPE (field-donning) by additional providers.
* Doffing of PPE must be performed with meticulous care to prevent self-contamination. See[guidance on PPE doffing](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html) and ensure that training emphasizes adherence to a standardized protocol.

**Additional Considerations**

* Prepare and use safe procedures to treat and transport the patient to the hospital
* The EMS provider driving the ambulance should contact the receiving hospital and follow previously agreed upon local or regional protocols to transport the patient to the receiving hospital.
* Remove and keep nonessential equipment away from the patient, so as to minimize contamination, on the scene and in the ambulance.
* Avoid contamination of reusable porous surfaces that are not designated for single use.  Cover the stretcher with an impermeable material.
* Conduct appropriate patient assessment according to established protocols, using minimal equipment.

EMS Transport of Patient to a Healthcare Facility

Persons who may have an exposure history and signs and symptoms suggestive of Ebola should be transported to a healthcare facility prepared to further evaluate and manage the patient as instructed by EMS medical direction and local/regional protocols that are consistent with the predefined transportation/destination plan developed by public health officials, hospital, medical and EMS personnel.

* Isolate the ambulance driver from the patient compartment.
* During transport, ensure that an appropriate disinfectant (EPA Approved hospital grade disinfectant with a non-enveloped virus claim) is available (for example in spray bottles or as commercially prepared wipes).

Interfacility Transport

EMS personnel involved in the interfacility transfer of patients with suspected or confirmed Ebola should follow [donning and doffing procedures as recommended in CDC guidance](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html). Provide patient care as needed to minimize the contact with patient and follow infection control guidelines as noted below.

Infection Control

EMS providers can safely manage a patient with suspected Ebola by following the recommendations for appropriate PPE and following these CDC recommendations:

* Limit activities, especially during transport, that can increase the risk of exposure to infectious material.
* Limit the use of needles and other sharps as much as possible. Any needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers that are specific to the care of the patient, in accordance with OSHA’s Bloodborne Pathogens standard, 29 CFR 1910.1030.  Do not dispose of used needles and sharps in containers that have other sharps from other patients in them.
* Invasive procedures should be limited to those essential for patient management.
* Donning and doffing of PPE must be supervised by a trained observer to ensure proper completion of established PPE protocols. In collaboration with the receiving hospital, EMS agencies should consider how best to facilitate a supervised [doffing process](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html).

Documentation of Patient Care

* Documentation of patient care should be done after EMS providers have completed their personal cleaning and decontamination of equipment and vehicle.  Any written documentation should match the verbal communication given to the Emergency Department providers at time of patient handover.
* EMS documentation should include a listing of public safety providers involved in the response and level of contact of those providers with the patient (e.g., no contact with patient, provided direct patient care).  This documentation may need to be shared with local public health authorities.

Cleaning EMS Transport Vehicles after Transporting a Patient with Suspected Ebola

The following are general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a patient with suspected Ebola:

* EMS providers performing cleaning and disinfection where body fluids from a patient with suspected Ebola are present (vomit, diarrhea, sweat, urine or blood) should wear [PPE](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html) as recommended by the CDC. If no body fluids from an Ebola patient are present then the following minimal PPE should be worn:
	+ Face shield and surgical face mask;
	+ Impermeable gown;
	+ Two pairs of gloves.
* Use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus)[4](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftn4),[5](http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html#ftn5) [to disinfect environmental surfaces in rooms of patients with suspected or confirmed Ebola virus infection](http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html). Cleaning and decontaminating surfaces or objects soiled with blood or body fluids are addressed below. There should be the same careful attention to the safety of the EMS providers during the cleaning and disinfection of the transport vehicle as there is during the care of the patient.
* Patient-care surfaces (including stretchers, railings, door handles, medical equipment control panels, and adjacent flooring, walls and work surfaces), as well as stretcher wheels, brackets, and other areas are likely to become contaminated and should be cleaned and disinfected thoroughly after each transport.
* A blood spill or spill of other body fluid or substance (like urine, saliva, vomit, sweat, and diarrhea) should be managed by personnel wearing correct PPE, and includes removal of bulk spill matter, cleaning of the soiled site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant’s active ingredient. Follow the chemical disinfectant product’s labeled instructions and dispose of the potentially contaminated materials used during the cleaning and disinfecting process as [recommended in CDC guidance](http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html).
* Contaminated reusable patient care equipment (e.g., glucometer, blood pressure cuff) should be placed in biohazard bags and labeled for cleaning and disinfection or disposal according to agency policies and manufacturer recommendations. Reusable equipment should be cleaned and disinfected according to manufacturer's instructions by trained personnel wearing correct PPE. Avoid contamination of reusable porous surfaces that are not designated as single use.
* Use only a mattress and pillow with plastic or other covering that fluids cannot penetrate.
* To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard used linens, non-fluid-impermeable pillows or mattresses as appropriate at the receiving facility.

The Ebola virus is a Category A infectious substance regulated by the U.S. Department of Transportation’s (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes disposable medical equipment, sharps, linens, and used health care products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used PPE, [e.g., gowns or coveralls, masks, gloves, goggles, face shields, respirators, booties] or byproducts of cleaning) contaminated or suspected of being contaminated with a Category A infectious substance.7 EMS systems should work with designated receiving hospitals to dispose of waste from suspected Ebola patients.

Follow-up and/or Reporting Measures by EMS Providers after Caring for a Suspected Ebola Patient

* EMS providers should be aware of the follow-up and/or reporting measures they should take after caring for a suspected Ebola patient.
* EMS agencies should develop policies for [monitoring and management](http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html) of EMS providers potentially exposed to Ebola virus.
* EMS agencies should develop sick leave policies for EMS providers that are non-punitive, flexible and consistent with public health guidance
* Ensure that all EMS providers, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.
* EMS providers with exposure to blood, bodily fluids, secretions, or excretions from a patient with suspected Ebola should immediately:
	+ Stop working and wash the affected skin surfaces with a cleansing or antiseptic solution and mucous membranes (e.g., conjunctiva of the eye) should be irrigated with a large amount of water or eyewash solution, as per usual protocols. All wipes and solution should be placed in a biohazard bag.
	+ Contact occupational health/supervisor/designated infection control officer for immediate assessment and access to post-exposure management services.
	+ Receive medical evaluation and follow-up care, based upon EMS agency policy and consultation with local, state, and federal public health authorities.

1 [2014 Ebola Outbreak in West Africa - Outbreak Distribution Map](http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html)

2 [Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings](http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html)

3 [Case Definition for Ebola Virus Disease (EVD)](http://www.cdc.gov/vhf/ebola/hcp/case-definition.html)

4 [US Environmental Protection Agency Office of Pesticide Programs, List G: EPA Registered Hospital Disinfectants Effective Against Norovirus (Norwalk-like virus)[PDF- 3 pages]](http://www.epa.gov/oppad001/list_g_norovirus.pdf%22%20%5Co%20%22Link%20to%20External%20Web%20Site%22%20%5Ct%20%22_blank)

5 [Disinfectants for Use Against the Ebola Virus](http://www.epa.gov/oppad001/list-l-ebola-virus.html%22%20%5Co%20%22Link%20to%20External%20Web%20Site%22%20%5Ct%20%22_blank)

6 [Occupational Safety and Health Standards](https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS" \o "Link to External Web Site" \t "_blank)

7 [FAQ: Department of Transportation Guidance for Transporting Ebola Contaminated Items, a Category A Infectious Substance](http://phmsa.dot.gov/portal/site/PHMSA/menuitem.6f23687cf7b00b0f22e4c6962d9c8789/?vgnextoid=4d1800e36b978410VgnVCM100000d2c97898RCRD&vgnextchannel=d248724dd7d6c010VgnVCM10000080e8a8c0RCRD&vgnextfmt=print" \o "Link to External Web Site" \t "_blank)