Legal Issues Connected to EBOLA in the United States

Milling Benson Woodward L.L.P. (Andrew R. Capitelli, Esq., Thomas S. Schneidau, Esq., Normand F. Pizza, Esq., Lisa Dutruch, RN, BSN)

A twenty-five year old female patient arrives at the emergency department ("ED") with a 101 degree fever, abdominal pain, dizziness, nausea and headaches. During an initial screening, the patient indicates that she recently returned from a two week mission trip to Sierra Leone. After the initial evaluation, the patient's fever remains constant. The emergency room physician reviews the patient's chart, orders administration of Tylenol, and discharges the patient with instructions to rest, drink fluids, and follow-up with the patient's primary care physician. Two days later, the patient returns to the ED in an ambulance with a 103 degree fever and symptoms consistent with Ebola. The hospital admits and isolates the patient for a blood test and treatment, but the patient does not survive. Did the hospital comply with its screening obligations under the Emergency Medical Treatment and Active Labor Act ("EMTALA")?

A woman arrives at the ED with her two year old child. The child presents with a 100 degree fever, headaches, and nausea. During the initial examination, the woman states that her husband recently returned from a work trip in West Africa. The emergency room physician orders admission and isolates the child until an Ebola blood test can be performed. The negative blood test results return twelve hours later. The physician then performs a full examination, orders tests, and diagnoses the child with bacterial meningitis. Before treatment begins, the child succumbs to the illness. Did the physician and the hospital meet their EMTALA stabilization and treatment requirements?

EMTALA ISSUES

Under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), a hospital with an ED must provide an appropriate medical screening evaluation ("MSE") to an individual that comes to the ED to determine whether an emergency medical condition exists. If the MSE indicates that the individual has an emergency medical condition, EMTALA further requires that the hospital provide necessary stabilizing treatment, or an appropriate transfer.

During a health crisis, EMTALA remains in effect unless the requirements are suspended by the issuance of an EMTALA waiver. When a waiver is issued, "sanctions . . . for an inappropriate transfer or for the direction or relocation of an individual to receive a medical screening at an alternate location do not apply to a hospital with a dedicated emergency department." The Centers for Medicare & Medicaid Services ("CMS") also notes that an EMTALA waiver allows hospitals to "direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a State emergency or pandemic preparedness plan, for the MSE."

Triggering an EMTALA waiver requires an emergency or disaster declaration by the President of the United States and a public health emergency declaration by the Secretary of the United States Department of Health and Human Services ("DHH Secretary"). The DHH Secretary must properly notify Congress, and the waiver must extend to the hospital at issue. Additionally, the hospital must activate its disaster protocol, the State must activate its emergency preparedness plan or pandemic preparedness plan, and any redirection of individuals must be consistent with such plan. The EMTALA regulations further require that:

1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

2. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

3. The hospital is located in an emergency area during an emergency period, as defined in the Social Security Act, and

4. There has been a determination that a waiver of sanctions is necessary.

CMS notes that "[e]ven when a waiver is in effect there is still the expectation that everyone who comes to the ED will receive an appropriate MSE, if not in the ED, then at the alternate care site." In the event of an emergency, CMS may elect to advise hospitals in a geographic area that they are covered by the waiver without requiring each hospital to apply individually. Hospitals that receive the CMS notice must still notify their State Survey Agency at the time they activate their disaster protocol. In the absence of a CMS notification, hospitals must contact CMS and request that the waiver be applied to their facility.

An EMTALA waiver does not begin until the waiver's effective date, and the waiver is generally effective for seventy-two (72) hours after the hospital activated its disaster plan. In the case of a pandemic infectious disease, however, the waiver is effective until the termination of the public health emergency declaration. Additionally, if the State emergency or pandemic preparedness plan is deactivated, or if the hospital deactivates its disaster protocol, the hospital no longer falls within the EMTALA waiver.

If a waiver is not in effect, CMS has identified several options available for managing a surge in ED demand. CMS notes that the required MSE does not have to take place in the ED. Instead, a hospital may set up an alternative site on its campus to perform the MSE. Individuals may be logged in and redirected to the alternative site; however, the individual performing the redirection must be qualified to recognize individuals in need of immediate treatment in the ED.

Alternatively, hospitals may set up screening at off-site, hospital-controlled locations. The hospital may encourage individuals to go to the off-site location for screening, and, unless the off-site location is already a dedicated ED, the EMTALA regulations do not apply. The hospital may not, however, redirect individuals that arrive at the ED to the off-site location, and the hospital cannot hold the site out as a place that provides care for emergency medical conditions. Further, the hospital is required to staff the site with medical personnel trained to evaluate the pandemic symptoms, and to arrange a transfer if an individual needs medical attention on an emergent basis.

As a final option, communities may set up screening clinics at sites that are not under the control of a hospital. EMTALA does not apply to community screening clinics, and hospitals may encourage the public to go to the screening clinic for screening. Hospitals may not, however, direct an individual that arrives at its ED to the off-site location for an MSE.

Hospitals and healthcare providers should ensure compliance with EMTALA, or with the demand surge options outlined by CMS, until an EMTALA waiver takes effect. Failure to satisfy the EMTALA MSE, stabilization, or transfer requirements may result in monetary penalties for the hospital and termination of its provider agreement. Additionally, a physician responsible for the insufficient examination, treatment, or transfer of the individual, including an on-call physician, risks monetary penalties and exclusion from Federal and State healthcare programs. Further, an individual that suffers harm or a medical facility that incurs a financial loss as a result of an EMTALA violation may pursue a civil action against the hospital.

In the case of the twenty-five year old female mentioned above, assuming an EMTALA waiver had not been issued, a plaintiff would have a strong argument that the physician failed to perform an adequate MSE during the patient's initial visit to the ED. The plaintiff would likely assert that the patient's symptoms, coupled with the indication that she recently visited an Ebola hot zone, required the physician to further evaluate the patient for an Ebola diagnosis and to consider isolating the patient for treatment.

Similarly, in the case involving the two year old patient, again assuming an EMTALA waiver had not been issued, a plaintiff would persuasively assert that the physician and hospital did not meet their stabilization and treatment obligations. While isolation was appropriate, the plaintiff would argue that failure to further evaluate a child exhibiting symptoms consistent with bacterial meningitis for a twelve hour period while awaiting blood test results did not meet the EMTALA treatment and stabilization requirements.

TORT ISSUES

Many health care providers are asking themselves the same question these days: am I prepared to treat an Ebola patient? A similar question follows: is my facility prepared? These questions have primary importance, of course, for the patient seeking care. Needless to say, they are equally important to the provider himself who then thinks: Will I be infected? Will I risk infecting the staff? My family?

Secondary to these musings, but of significant consequence, is the legally minded question: will I be sued if my facility and I are not prepared? To answer that question, we look to tort law, which, generally speaking, is a product of state law (the most significant exception being the Federal Tort Claims Act). More particularly, in matters of patient care, state malpractice law is likely to govern. In Louisiana, medical malpractice is defined in pertinent part as:

> ...any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient, including failure to render services timely and the handling of a patient, including loading and unloading of a patient, and also includes all legal responsibility of a health care provider arising . . . in the training or supervision of health care providers....

To prevail in a medical malpractice action against a physician, a plaintiff must prove: (1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised by

physicians (i.e. the standard of care); (2) that there was a breach of the standard of care; and (3) that the breach was a proximate cause of plaintiff's injuries. Significantly, the standard of care for physicians practicing in a specialty like emergency medicine is a national one, as opposed to the standard for general practitioners, which is community standard. A hospital, for its part, must exercise the requisite standard of care required by a patient's condition, and it must shield the patient from external circumstances peculiarly within its control.

But what is the standard of care for the treatment of Ebola? The CDC gives some guidance:

> No FDA-approved vaccine or medicine (e.g., antiviral drug) is available for Ebola.
>
> Symptoms of Ebola are treated as they appear. The following basic interventions, when used early, can significantly improve the chances of survival:

- Providing intravenous fluids (IV)and balancing electrolytes (body salts)
- Maintaining oxygen status and blood pressure
- Treating other infections if they occur

> Experimental vaccines and treatments for Ebola are under development, but they have not yet been fully tested for safety or effectiveness.

The CDC's statement echoes that of Doctors Without Borders, the well known provider organization battling Ebola in the international community:

> Standard treatment for Ebola is limited to supportive therapy. This consists of hydrating the patient, maintaining their oxygen status and blood pressure, and treating him or her for any complicating infections.

The difficulty with these rather general statements on care is that many health care providers legitimately fear exposing themselves, their co-workers and families to Ebola, and the infection of two health care workers in Texas certainly has done nothing to calm such fear. Significantly, it is no secret that the CDC guidelines related to the use of personal protective equipment (PPE) have changed since Ebola first appeared in the United States. Compounding the problem, many providers feel they have inadequate training or equipment to conform to the changing guidelines. Hospitals, for their part, are in a hurry to establish and/or implement protocols related to training, triage and patient care. That process in itself arguably creates "standards of care" the hospital and its staff must meet. On the opposite side of the coin, patients naturally want and need competent care, and the general public wants reassurance they are safe, or to receive adequate warning they may be at risk.

Consequently, the streams of potential tort liability resulting from the Ebola response are diverse: (1) patient v. provider and facility; (2) provider v. facility; and (3) third party v. provider and facility. Is it easy for a patient to question whether he is receiving adequate supportive therapy when he has a sense his providers would rather be a thousand miles away? Certainly.

What if the patient shows up at the emergency department with symptoms and a story consistent with Ebola and is sent home and subsequently dies after returning, as in the first example cited above in the discussion of EMTALA? Providers and facilities should be prepared for a wrongful death and survival action. Further, the experience of Texas tells us such an occurrence is not mere speculation. As to the example cited above of the child who was appropriately isolated but received delayed treatment and later died, no doubt child's parents would argue the providers breached a duty to conduct a full and proper medical screening to discern other medical conditions. Note, too, that EMTALA itself contemplates a private right of action against a hospital for any individual experiencing "personal harm" as a result of a hospital's EMTALA violation.

Similarly, it is easy to envision a suit by a health care provider against the hospital where the provider worked should that provider become infected with Ebola. Perhaps the hospital did not provide the appropriate PPE to the provider or failed to utilize a trained observer in the donning and doffing of PPE. Perhaps it failed to properly disinfect work surfaces or failed to follow the protocols it established. To the extent such errors were "based on" services rendered to a patient, it is arguable the provider has a malpractice claim against the hospital. If not, general tort liability likely will attach. There may be contractual liability, too, depending on the working relationship between the hospital and the provider.

Additionally, what of family or community members who want to sue because a provider or facility did not warn them of a potential risk of infection? Any plaintiff would have to establish the provider or facility had a duty to disclose the risk of infection from the patient to he or she as a third party. That may prove a tall task. For instance, Louisiana's Sanitary Code explicitly states it does not impose or create any general duty upon health care providers to warn third parties if the provider has complied with state disease reporting requirements (i.e. to the office of public health). Of course, that provision begs the question, what if the provider has not complied with state disease reporting requirements?

The truth is, there are only limited provisions in Louisiana statutory law creating or even suggesting a provider duty to warn third parties (outside disclosure powers granted to the state health officer). Psychiatrists and certain other mental health workers, for one, have a duty to warn potential victims and law enforcement officials of a significant threat of physical violence by a patient (or the provider must otherwise take reasonable precautions to provide protection from violent behavior). Notably, the Louisiana Supreme Court has found such failure to warn claims do not fall under Louisiana's Medical Malpractice Act, but under general tort law. Additionally, under certain circumstances, HIV test results may be disclosed by physicians to contacts of the patient when there is significant risk of infection, but such physician disclosure is not statutorily required (though there is case law in Louisiana apparently recognizing a hospital owes a general duty to an employee to warn him of HIV exposure in dealing with a patient). In fact, Louisiana statutory law provides that unless there is applicable state or federal law to the contrary, the intentional disclosure of protected health information to a third person subjects the disclosing party to civil penalties. Moreover, the HIPAA rules also serve to restrict disclosure, though Louisiana law is arguably more protective of a patient's protected health information. Regardless, it is likely third party "failure to warn" claims will at least be tested in court should a

disease like Ebola spread among the general populace. That real possibility can be a headache enough, particularly when it is unclear whether providers are insured against such claims.

HIPAA ISSUES

The federal rules governing the privacy and security of patient protected health information ("PHI"), as well as the breach notification and enforcement related to such PHI, are commonly known as the HIPAA Rules. Health care providers conducting certain electronic transactions, along with health plans and health care clearinghouses, each called a covered entity, are no doubt aware (or at least should be) of their general rights and obligations under the HIPAA Rules. Similarly, business associates -- persons or entities outside the covered entity performing work for that entity which involves access to PHI (and subcontractors with such tasks and access) -- should, by now, have an appreciation for their own rights and obligations under the HIPAA Rules. Beyond the rules themselves, those obligations are outlined in business associate agreements. Of course, the rights of a business associate to use or disclose PHI are, generally speaking, never broader than the rights of the covered entity with whom it is associated.

While awareness of the rights and obligations applicable to covered entities and business associates under the HIPAA Rules has grown over the last few years (due in large part to the issuance of the March 2013 final omnibus rule), burgeoning health care events, like the appearance of and concern over Ebola in the United States, provide an appropriate framework for continued training.

Consider the reported case of two employees at Nebraska Medical Center who were fired by the facility in late September 2014 after it was discovered they had accessed the electronic medical records of Ebola patient Dr. Rick Sacra. In a written statement, the hospital said it had "zero tolerance" for the unauthorized access, which it admitted was a HIPAA violation. The hospital also said it notified the patient of the event in person and in writing before his departure.

Those employees were reminded the hard way about their legal obligations. But their experience raises an important question in the rising fears over Ebola: absent patient authorization, what uses and disclosures *can* a covered entity (and by delegation, a business associate) make concerning a patient with a serious disease like Ebola *without* violating the HIPAA Rules?

First, the HIPAA Rules state a disclosure of PHI may be made by a covered entity to an authorized public health authority to prevent or control diseases. The Centers for Disease Control and Prevention ("CDC"), an agency of the United States charged with protecting public health and safety, is one such public health authority. State health departments, which frequently serve as the recipients of disease reports from providers as required by state laws, act as another type of public health authority. State laws often specifically prescribe the disease information to be reported to such health departments.

Second, a disclosure may be made by a covered entity to someone exposed to a communicable disease or who is at risk of contracting or spreading a disease or condition, but

only if the law otherwise authorizes such a disclosure by the covered entity or public health authority for public health interventions or investigations. A Louisiana state regulation does allow the state's health officer (a public official) "to disclose unreported cases and to reveal susceptible contacts if such information is required to prevent a serious health threat to the community." This power flows from the recognition that the state health officer and the office of public health have the authority to take any action necessary to bring about the subsidence and suppression of diseases to prevent their spread.

Third, the HIPAA Rules allow use or disclosure of PHI by a covered entity when the entity has a good faith belief that: (1) the use or disclosure is required to prevent or reduce a serious and imminent threat to a person's or the public's health or safety; and (2) the use or disclosure is made to the person(s) reasonably able to prevent or lessen the threat. While this provision seemingly is intended to help prevent criminal acts, it also appears applicable to address serious concerns related to the spread of diseases like Ebola.

In each of the above instances, unless a particular use or disclosure is *required* by law, the HIPAA Rules require that reasonable efforts be taken to limit the PHI to the minimum necessary to achieve the intended purpose of the use or disclosure. Nonetheless, a covered entity may reasonably rely on a public official's representation that the requested information is the minimum necessary for the public health need.

It is noteworthy that, according to guidance issued by the CDC and the U.S. Department of Health and Human Services, public health authorities are not the business associates of covered entities when receiving PHI from them as required or authorized by law. Thus, a business associate agreement would not be required to facilitate such disclosures. Still, the public health authority may be a covered entity subject to the HIPAA Rules in its own right if, for instance, it provides health care services and conducts certain electronic transactions. Alternatively, a public health authority may be a "hybrid" entity (having both covered an non-covered functions under the HIPAA Rules) or simply a non-covered entity. Consequently, the public health authority must be aware of its status under the law to determine what restrictions may exist on its own use and disclosure of the information it has received.

The fear, the uncertainty and the novelty associated with a disease like Ebola simply are not grounds to set aside the restrictions of the HIPAA Rules; they are grounds to remember them. Covered entities and business associates would do well to remind their employees that PHI remains as such, even in a time of crisis. In fact, even if the President of the United States were to declare an emergency or disaster, accompanied by a declaration of a public health emergency by the Secretary for the Department of Health and Human Services, only an extremely limited waiver of HIPAA Rule restrictions is possible, and then only for hospitals. Further, the HIPAA Rules themselves make it clear that any contrary state law on PHI that is more stringent will govern, perhaps providing even greater PHI protection. Make sure you and your business understand how the HIPAA Rules and similar laws apply by consulting competent legal counsel. You will be thankful you did. Though HIPAA does not expressly create a private right of action against providers and facilities, some will argue it establishes a standard of care in a negligence action. Further, covered entities and business associates who violate HIPAA are

subject to civil monetary penalties of up to $50,000 for each violation, with a maximum of $1,500,000 per year for identical violations.

ADA ISSUES

The Americans with Disabilities Act ("ADA") provides nondiscrimination protection for individuals with disabilities in employment, public services, public accommodations operated by private entities, services provided by private entities, transportation and telecommunication. As noted by the Congressional Research Service, "[a]lthough the ADA does not include provisions specifically discussing its application to disasters, its nondiscrimination provisions are applicable to emergency preparedness and responses to disasters." The Department of Justice has also interpreted the ADA regulations to prohibit discrimination in emergencies. Specifically, the Department of Justice stated:

> One of the most important roles of local government is to protect their citizenry from harm, including helping people prepare for and respond to emergencies. Making local government emergency preparedness and response programs accessible to people with disabilities is a critical part of this responsibility. Making these programs accessible is also required by the [ADA].

To assist in the application of the ADA to emergencies, the Department of Justice issued an ADA Guide for local government emergency preparedness. While the ADA Guide focuses on short term, localized disaster planning, such as a terrorist attack or natural disaster, the guide may be used for pandemic planning for disabled individuals. The ADA Guide primarily recommends involving disabled individuals in the emergency planning process, and developing adequate procedures for notification, transportation, and communication with disabled individuals.

Under the ADA, facilities and communities must provide access and accommodation for disabled individuals in the event of an emergency, such as a pandemic. ADA compliance includes assuring that disabled individuals can access temporary screening and treatment facilities, and that such facilities are equipped to transport, communicate with, and treat disabled individuals. Failure to ensure ADA compliance within emergency preparations will subject a facility to sanctions, including civil monetary penalties.

Identifying Authorities and Establishing Protocols

> The healthcare industry is rarely at a loss for sources of authority, yet the arrival of the Ebola virus in the U.S. has placed an impetus on defining who sets the standards and what those standards are. The U.S. Department of Health and Human Services' website provides linkage directly to the Center for Disease Control for Ebola information. Other national organizations including the American Medical Association, American Nurses Association, and the American Hospital Association also include links to Ebola information on the web sites of

Emory Healthcare and Nebraska Medical Center. State authorities, including the Louisiana Hospital Association, Louisiana State Board of Medical Examiners, and the Louisiana State Board of Nurses have deferred to the Center for Disease Control, and advises their licensees to monitor the CDC's site for updates and changes as they become available.

Previous information from the CDC relied upon standard-practice droplet precautions to protect healthcare providers. In the wake of two providers testing positive for the virus, public concern demanded the CDC provide more explicit guidance to protect healthcare providers and the public. In response, the CDC has outlined more robust measures to ensure quality and safety for patients, providers, and the public. The most recent guidelines from the CDC (October 20, 2014), define control measures at the administrative, environmental, and provider levels. Drawing on policies and procedures from facilities that have successfully treated patients with Ebola without incident, the CDC has set the standard for management of patients with possible/confirmed Ebola Virus Disease. The CDC standards are outlined below and drafts of specific policies and procedures are available at:
http://c.ymcdn.com/sites/www.lhaonline.org/resource/resmgr/HHS/Emory_Healthcare_Ebola_Prepa.pdf from Emory Health Care.

Recommended Administrative and Environmental Controls
(http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

ADMINISTRATIVE CONTROLS: Infection Control, in collaboration with Employee Health will:

A-1. Design and implement triage protocols to effectively identify patients who have or may have Ebola.

A-2. Designate individuals as site managers.

A-3. Identify critical patient care functions and essential healthcare workers for care of Ebola patients.

A-4. Train and ensure competency of healthcare workers on all PPE recommended protocols before they enter an Ebola patient's room.

A-5. Train PPE observers and create an isolated areas for donning/doffing PPE.

ENVIROMENTAL CONTROLS: Safe work practices include the following:

E-1. Isolate the Ebola patient in a closed door, single patient room with a private bathroom. Implement observation of patient and healthcare workers in the patient room, if possible.

E-2. Monitor the patient care area at all times, and log at a minimum entry and exit of all healthcare workers who enter the room of an Ebola patient.

E-3. Limit the number of healthcare workers who come into contact with the Ebola patient and restrict non-essential personnel and visitors from the patient care area.

E-4. Ensure that a trained observer watches and utilizes a check list to confirm that donning and doffing protocols are followed.

E-5. Ensure that healthcare workers have sufficient time to don and doff PPE correctly without disturbances.

E-6. Ensure that practical precautions are taken, such as keeping hands away from the face, limiting touch of surfaces and body fluids, preventing needlestick and sharps injuries.

E-7. Performing frequent disinfection of gloved hands using an alcohol-based hand rub (ABHR), particularly after handling body fluids.

E-8. Perform regular cleaning and disinfection of patient care area surfaces, even absent visible contamination.

E-9. Disinfect immediately any visibly contaminated PPE surfaces, equipment, or patient care area surfaces using an *EPA-registered disinfectant wipe.

E-10. Establish a facility exposure management plan (decontamination, and follow-up of unprotected exposure.

CDC Guidance: Key Principals of PPE
(http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

Key Principals regarding PPE for all healthcare workers entering a room of an Ebola patient:

 KEY-1 Employees must have received repeated training/demonstrated competency in all Ebola-related infection control practices; specifically in donning/doffing proper PPE.

 KEY-2 Care of Ebola patients must be overseen by an onsite manager at all times, and each step of every PPE donning/doffing procedure must be supervised by a trained observer.

 KEY-3 While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.

Competency Checklist for Using PPF

Donning

- *PPE is donned correctly, in proper order before entry into the patient care area.*
- *PPE is not modified/adjusted while in the patient care area. The donning activities must be directly observed by a trained observer.*

During Patient Care

- *PPE must remain in place and be worn correctly for the duration of exposure to potentially contaminated areas.*
- *Healthcare workers should perform frequent disinfection of gloved hands using an ABHR, particularly after handling body fluids.*
- *If a potential or actual breach in PPE occurs, the healthcare exposure and implement the facility exposure plan, if indicated by assessment.*

Doffing

- *Removing PPE must be observed by a trained observer, in a designated doffing area.*
- *PPE must be removed slowly and deliberately in the correct sequence.*
- *A stepwise process facilitated by a check sheet, should be developed and used during training and daily practice.*
- *Each provider has completed facility exposure management training for unprotected exposures.*

Recommended Personal Protective Equipment

- PAPR or N95 Respirator. If a NIOSH-certified PAPR and a NIOSH-certified fit-tested disposable N95 respirator is used in facility protocols, ensure compliance with all elements of the OSHA Respiratory Protection Standard, 29 CFR 1910.134, including fit testing, medical evaluation, and training of the healthcare worker.

    - o PAPR: A PAPR with a full face shield, helmet, or headpiece. Any reusable helmet or headpiece must be covered with a single-use (disposable) hood that extends to the shoulders and fully covers the neck and is compatible with the selected PAPR. The facility should follow manufacturer's instructions for decontamination of all reusable components and, based upon those instructions, develop facility protocols that include the designation of responsible personnel who assure that the equipment is appropriately reprocessed and that batteries are fully charged before reuse.

        - § A PAPR with a self-contained filter and blower unit integrated inside the helmet is preferred.

        - § A PAPR with external belt-mounted blower unit requires adjustment of the sequence for donning and doffing, as described below.

    - o N95 Respirator: Single-use (disposable) N95 respirator in combination with single-use (disposable) surgical hood extending to shoulders and single-use (disposable) full face shield.** If N95 respirators are used instead of PAPRs, careful observation is required to ensure healthcare workers are not inadvertently touching their faces under the face shield during patient care.

- Single-use (disposable) fluid-resistant or impermeable gown that extends to at least mid-calf or coverall without integrated hood. Coveralls with or without integrated socks are acceptable. Consideration should be given to selecting gowns or coveralls with thumb hooks to secure sleeves over inner glove. If gowns or coveralls with thumb hooks are not available, personnel may consider taping the sleeve of the gown or coverall over the inner glove to prevent potential skin exposure from separation between sleeve and inner glove during activity. However, if taping is used, care must be taken to remove tape gently. Experience in some facilities suggests that taping may increase risk by making the doffing process more difficult and cumbersome.
- Single-use (disposable) nitrile examination gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.
- Single-use (disposable), fluid-resistant or impermeable boot covers that extend to at least mid-calf or single-use (disposable) shoe covers. Boot and shoe covers should allow for ease of movement and not present a slip hazard to the worker.

    - o Single-use (disposable) fluid-resistant or impermeable shoe covers are acceptable only if they will be used in combination with a coverall with integrated socks.

- Single-use (disposable), fluid-resistant or impermeable apron that covers the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea. An apron provides additional protection against exposure of the front of the body to body fluids or excrement. If a PAPR will be worn, consider selecting an apron that ties behind the neck to facilitate easier removal during the doffing procedure.

External (Non-CDC) Resources on PPE

- Emory Healthcare: Ebola Preparedness Protocols
- University of Nebraska Medical Center: PPE for Ebola
- Médecins Sans Frontières (Doctors without Borders): Filovirus Haemorrhagic Fever Guideline, 2008[PDF - 134pages]
- World Health Organization (WHO): Infection prevention and control guidance for care of patients in health-care settings, with focus on Ebola

Authors:

Milling Benson Woodward L.L.P.