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PROVINCIAL INFECTION CONTROL NETWORK OF BRITISH COLUMBIA
A program of the Provincial Health Services Authority

BRITISH COLUMBIA | Office of the Provincial Health Officer

Provincial Infection Prevention and Control Guidance for the Management of a High Threat Pathogen in Community-based Clinic Settings

Updated: October 30, 2024

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- Provincial Infection Prevention and Control/Workplace Health & Safety COVID-19 Working Group
- BC Biocontainment Unit
- Communicable Disease Medical Health Officer group
- Primary Care Reference Group
- Public Health Response, BC Centre for Disease Control
- Office of the Provincial Health Officer

A patient partner also reviewed and provided input from a patient, family, and visitor perspective.

Abbreviations

AGMP	aerosol generating medical procedure
BCCDC	BC Centre for Disease Control
DIN	drug identification number
HCW	health care worker
HTP	high threat pathogen
IPC	infection prevention and control
MHO	medical health officer
ORA	organizational risk assessment
PCRA	point-of-care risk assessment
PHAC	Public Health Agency of Canada
PPE	personal protective equipment
SOP	standard operating procedure
UPCC	urgent and primary care center
VHFs	viral hemorrhagic fevers
WHO	World Health Organization

Introduction

This document provides guidance on high threat pathogen (HTP) preparedness for primary care practitioners, including clinicians and nurse practitioners, community-based physicians, and office staff in primary care centers/clinics, walk-in clinics, specialist offices or non-health authority operated urgent and primary care centers (UPCCs). This includes guidance for the safe assessment and management of individuals who call or present with a suspected or confirmed HTP. Due to the broad range of primary care settings in British Columbia, this guideline should be adapted to each specific setting.

For health authority operated UPCCs, refer to the Infection Prevention and Control Guidance for the Management of a High Threat Pathogen in Acute Care Settings.

For the purpose of this guidance and in the context of British Columbia (BC), a HTP is defined as:

- Viral hemorrhagic fevers (VHFs) [these include Ebola, Lassa, Marburg, and Crimean Congo Hemorrhagic Fever]; or
- Unknown/newly emerging pathogens that are transmissible from human to human.

The following are factors to consider when determining whether a pathogen is high threat:

i) Disease-related factors:

- Significant risk/consequence to humans and is associated with a high morbidity and/or mortality.
- High transmissibility and likelihood of secondary cases.
- There may not be an effective vaccine, prophylaxis, or treatment.

ii) Practice-related factors:

- Specific infection prevention and control (IPC) measures are required in addition to implementation of airborne, droplet and contact precautions, depending on disease progression.
- Absence of existing guidance.
- Potential use of a biocontainment unit due to clinical or public health concerns.

Note: pathogens known to transmit from animals to humans may evolve in the future to transmit from human-to-human. Therefore, the pathogens included in the scope of this guidance could change as new information becomes available.

While the probability of a HTP occurring in BC is low, preparedness is essential to ensure those working in these settings can safely and effectively care for patients who may present with associated symptoms and risk-factors and implement pre-exposure measures (if available) to prevent infection or disease in others (e.g., vaccines, pre-exposure prophylaxis).

Effective preparedness requires administrative and engineering controls, clear guidance, tools (e.g.,

algorithms, checklists) and clinical processes, appropriate personal protective equipment (PPE) supply and deployment, and appropriate awareness training for staff in both the processes and equipment.

All facilities are responsible for implementing the recommended practices described below to ensure readiness for managing patients with suspected or confirmed HTPs.

The recommendations and information contained in this document are subject to change as new evidence emerges. For supplementary information, see the BCCDC High Threat Pathogens website and Key Resources section below.

High Threat Pathogens

Viral Hemorrhagic Fevers

Transmission

Transmission of viruses causing VHFs generally occur via zoonotic transmission through direct contact with infected animals (e.g., rodents) and/or ticks, or person to person via direct or indirect contact through broken or non-intact skin or mucous membranes with blood, body fluids, respiratory secretions, or tissues of an infected person or medical equipment that is contaminated with infected body fluids. For some VHFs, nosocomial transmission through percutaneous contact/injury or aerosol exposure (through aerosol generating medical procedures (AGMPs)) has been documented.[1,2]

The infectious dose for some VHFs is very low.[3–5] Severe illness is strongly associated with high levels of virus production. The risk of exposure to blood or other body fluids and the opportunity for transmission increases as the patient's condition deteriorates requiring invasive medical care. VHFs are not generally transmissible before the individual develops symptoms.

Incubation Period

The incubation period (time from exposure to onset of symptoms) varies for each VHF and ranges from 2 to 21 days. For asymptomatic individuals, who may have been exposed more than 21 days ago, VHFs generally do not need to be considered in the differential diagnosis.

Clinical course

VHFs can cause a severe, often fatal, acute viral infection that causes hemorrhagic fever in humans and animals. The case-fatality rate for VHFs varies depending on the specific pathogen (Crimean Congo Hemorrhagic Fever (CCHF): between 4-60%[6–9];Ebola: between 25-100% depending on species[3,10]; Lassa: 1-2% in endemic areas, higher in pregnant women (30%) and hospitalized individuals (generally 15-20%, can reach 50% during epidemics)[4,11]; and Marburg: between 23-90%.[5,12]

For more information on VHFs, see disease-specific information on the US Centre for Disease

Control Viral Hemorrhagic Fevers website and Key Resources section below.

Unknown/Newly Emerging Pathogens

Once a health threat from an unknown or newly emerging pathogen(s) has been identified, the World Health Organization (WHO), the Public Health Agency of Canada (PHAC) and other organizations will communicate specific details to appropriate health care providers to safely manage potential patients and ensure staff and patient safety. These details will outline what is known regarding transmission and symptoms. ***All must be aware that the situation may evolve as more is learned***.

BC's Tiered System

The provincial strategy for providing care for patients with a suspected or confirmed HTP is based on a three tier model, with specific roles for facilities at each type. Briefly,

- Type One facilities will assess, stabilize and transfer patient with suspected HTP.
- Type Two facilities will provide confirmatory testing, short term treatment and transfer patients to a provincial designated facility.
- Type Three facilities will accept patients with suspected or confirmed HTP and provide ongoing care.

All primary care settings are Type One facilities that will assess, stabilize and refer patients with suspected HTP to Type Two sites for further assessment. For more information, see Roles of Provincial Facilities for Care of Persons Under Investigation or Confirmed Ebola Virus Disease Patients.

Planning and Preparedness

An organizational risk assessment (ORA) is done by organizations/institutions to identify and evaluate the risk of exposure to infectious agents in the healthcare environment and to implement appropriate control measures (e.g., communicable disease safety plan) according to the hierarchy of controls to minimize the risk of exposure to and transmission of microorganisms within healthcare settings.

- Conducting an ORA will help the facility identify the effectiveness of present control measures and the breadth of the hierarchy of controls to prevent transmission of HTPs. It also helps identify transmission risks related to health care workers (HCWs) to establish specific job tasks that have a potential for occupational exposure.

Office/reception staff are often the first point of contact and, in some clinics, play a critical role in the initial assessment and triage of patients who contact a health care provider.

- Develop a plan for your clinic/center on how a patient presenting with a suspected or confirmed HTP would be managed until they can be transported to appropriate facility for further assessment/care.
- Determine and assign responsibility for conducting preliminary assessment and triage of patients

for your setting. If office/reception staff are involved in initial assessment, ensure a process to alert medical staff is established.

- Consider developing a setting-specific standard operating procedure (SOP) that includes processes and established roles and responsibilities.
- Consider which designated examination room/assessment area the patient can be placed in, if needed, that is separated from other patients.
- Identify HCWs who will have a lead role in HTP response and who may come into contact with patients with a HTP and/or their environment.
- Ensure you have the appropriate PPE supplies available in your clinic.

Training of personnel

Prior to providing care for a patient with known or suspected HTP, HCWs must be trained in necessary IPC procedures to ensure care can be provided safely.

- Ensure office/reception staff are trained to recognize that anyone with symptoms or visible body fluid soiled clothing needs to be separated and assessed by the health team more immediately. Ensure an alert process is established.
- Ensure HCWs are trained on selection and specific donning and doffing procedures for personal protective equipment (PPE). See Key Resources section for resources on donning and doffing PPE.
- Ensure staff responsible for cleaning and disinfection of medical equipment, surfaces and handling waste are aware and trained on appropriate protocols. See section on Room Cleaning and Disinfection below for more information.
- Where feasible, ensure there are regular opportunities for training and practice, such as simulation exercises, to maintain proficiency and readiness among care teams.
    - Readiness can also be achieved by having an HTP kit labelled and available at key points of entry decided at the site level. Every year when seasonal readiness for VRIs is completed the HTP kit and overall PPE requirements can be reviewed and distinguished as different from IPC measures for VRIs.
- Online training is available the LearningHub
    - Infection Control Precautions for High Threat Pathogens
    - Infection Control Precautions for High Threat Pathogens (PAPR)
    - Biocontainment Cleaning for High Threat Pathogens (EVS/Housekeeping)
    - Biocontainment Cleaning of Medical Equipment for High Threat Pathogens
- Maintain records of training.

Routine Practices

Routine Practices are fundamental to prevent transmission of microorganisms among patients and HCW in all health care settings.

- The basic elements of Routine Practice that are especially important include conducting a point of care risk assessment (PCRA), appropriate use of personal protective equipment (PPE), hand hygiene, respiratory hygiene, cleaning and disinfection, risk reduction strategies, and education of HCWs, patients, family and visitors.
- An assessment should be conducted prior to every interaction to determine the infectious risk posed to oneself and others.

Screening and Triage Assessment

While obtaining a travel history is an important part of clinical care, this guideline *does not suggest* that every patient calling or presenting should be queried about potential exposure to a HTP. In the event there is imminent risk of a HTP presenting in BC, a directive will be communicated from the Office of the Provincial Health Officer to inform health system partners/organizations of this risk and to provide guidance, including the requirement to implement the IPC measures outlined in this guidance document on a broader scale.

Initial Assessment

This guideline covers **two possible scenarios** for individuals with concerns related to HTPs: **individuals who call** a primary health care provider and **individuals who arrive** at a primary health care center without an appointment or as a walk-in patient. For both scenarios, assess risk for exposure to a HTP, such as a VHF, in conjunction with the presence of signs and symptoms.

- The factors included below are relevant to VHFs and may need to be adapted for unknown or newly emerging pathogens as new information becomes available. Indication of potential exposure, signs, and symptoms may include the following:
    - History of travel to region with active transmission,
    - Contact with blood, and body fluids or human remains of a person with a suspected or confirmed HTP (e.g., household, community or occupational contact);
    - Contact with live or deceased animals known or suspected to have HTP;
    - Notification to self-monitor for HTP by public health or other authorities;
    - Presence of signs and symptoms of HTP, such as fever of greater than 38 degrees Celsius, malaise, myalgia, headache, arthralgia, fatigue, loss of appetite, conjunctival redness, sore throat, chest pain, abdominal pain, nausea, vomiting, diarrhea that can be bloody, hemorrhage, or erythematous maculopapular rash on the trunk.
- If there is uncertainty around potential exposures, consult with Public Health for assistance with the risk assessment.
- Refer to the High Threat Pathogen Risk Assessment Algorithms for Community-based Clinic Settings for a reference guide on triage and screening by phone and in-person.
- Contact information for MHOs is also included at the end of this guideline.

Patient Management

The information provided in this section is relevant to VHFs and may need to be adapted for unknown or newly emerging pathogens as new information becomes available.

Patient management is based on findings from the initial risk assessment, which determines whether the patient was exposed and their presenting signs and symptoms. Based on these factors, patients will be managed in the following way:

Scenario A – People who call a health care provider

1. Patient had NO exposure within past 21 days, AND:
    a. The patient does not have any signs or symptoms consistent with VHF, they can be reassured that they are not at risk of a HTP and reminded that they can contact the office again if they continue to be concerned or have other health concerns.

    b. The patient has signs or symptoms consistent with VHF, routine telephone protocols should be followed to determine whether the patient should be seen in the clinic regarding the possibility of another illness or infectious diseases such as malaria, meningitis, dysentery, typhoid fever, tuberculosis, measles, and gastroenteritis.
2. Patient had known exposure within the past 21 days, AND:
    a) The patient does not have signs or symptoms consistent with VHF, determine if the patient needs to be seen in person. Consult Public Health and provide them with patient contact information (name, phone numbers, email, street address, and emergency contact).

    b) The patient has signs or symptoms consistent with VHF (i.e., fever 38^0C or higher; or reports feeling generally unwell, with muscle aches, headache, red eyes, sore throat, stomachache, vomiting, diarrhea, unusual bleeding or bruising, rash on the trunk), **advise them not to come to the clinic**.

        - If assessment indicates patient is ***medically stable***, advise the patient to go to the nearest acute care hospital. Determine how the patient will get to the facility, e.g., if able to drive or requiring transport. Notify the receiving health care facility of the patient's arrival.
        - If assessment indicates patient is ***medically unstable*** and needs immediate referral for Emergency Department assessment, **advise the patient to call 911 and let the ambulance dispatch know that they are suspected of having a HTP and need immediate care**, so they can take appropriate precautions.
        - **Contact your local MHO urgently** to assist with the risk assessment. Provide them with the patient contact information (name, personal health number/PHN, phone numbers, email, street address, and emergency contact).

Scenario B – People who arrive at a primary health care center

1. Patient had no exposure within past 21 days, AND:
    a. The patient does not have any signs or symptoms consistent with VHF, continue with routine triage process and patient care. Remind patient them that they can contact the office again if they continue to be concerned or have additional health concerns.

    b. The patient has signs or symptoms consistent with VHF, routine triage and assessment protocols should be followed to evaluate their symptoms for another illness or infectious diseases such as malaria, meningitis, dysentery, typhoid fever, tuberculosis, measles, and gastroenteritis.

2. Patient had known exposure within the past 21 days, AND:

a) The patient does not have signs or symptoms consistent with VHF, continue with routine triage process and patient care.
    - Advise the patient that Public Health staff will contact them to evaluate their risk and provide advice about monitoring their health and steps to take if symptoms develop. Release the patient and advise them to contact the clinic again if they have additional questions or concerns.
    - Call the MHO to arrange for patient follow up and provide them with the patient contact information (name, phone number, email, street address, and emergency contact).

b) If the patient has signs or symptoms consistent with VHF, implement the following:

- Health care provider to immediately follow **droplet and contact precautions** and put on PPE.
- Support patient to perform hand hygiene and wear medical mask, if tolerated.
- If the clinical assessment suggests they have contaminated clothing (i.e., vomiting, diarrhea, visible soiling), provide them with a gown to cover their clothing. Assist patient with containing bodily fluids, if necessary (e.g., provide emesis basin).
- ***Patient placement:*** patient(s) and their support person/visitor (if present) should not sit in the general waiting room/area.
    - Ask the patient(s) and their support person/visitor to return to their own vehicle, if applicable and they are well enough to do so, to await further instruction.
    - If patient is unwell and not able to leave, immediately place the patient in a private examination room (with a private bathroom, if available) or designated assessment area separated from other patients.
    - Allow accompanying support person/visitor to remain with the patient until assessment is completed. See section on Management of Essential Visitors or Support Persons for more information.

    - Clear the room of removable items prior to patient entering room to reduce cleaning requirements later (e.g., records, instruments, etc.).
- If patient had contact with desk area or chair at triage, clean and disinfect using products that have a Health Canada Drug Identification Number (DIN) with broad spectrum virucidal and/or specific HTP (if pathogen is known) claims.
- **Call the MHO on an urgent basis** to assist with further risk assessment and care plan.
    - Ensure patients with symptoms are also assessed in a timely manner for HTPs and for other alternative or co-existing potential infections (e.g., malaria, meningitis, dysentery, typhoid fever, tuberculosis, measles, gastroenteritis, or other VHFs).
    - Based on direction from the MHO, prepare the patient for transfer to provincial designated facility for ongoing care. See section below on Patient Transfer for more information.
- Ensure there is continued communication with patient and support person/visitor of procedures being implemented to ensure provision of safe care (e.g., use of PPE, need for transfer, etc.), to prevent additional stress and stigmatization.

Additional Precautions and Key Personal Protective Equipment Recommendations

Appropriate infection control precautions, in addition to routine practices, must be instituted based on the clinical presentation and a point-of-care risk assessment (PCRA), for all direct patient care activities, once HTP risk has been identified at triage. Focus clinical management and assessment on essential activities as directed by the MHO.

Based on the probability of an individual presenting to a primary care setting with severe symptoms of a HTP, such as VHF, being low, and the level of clinical care provided in these settings, implement the following measures:

- **Droplet and contact precautions for direct care of a patient(s) with suspected or confirmed HTP.** This includes wearing a medical mask, eye protection (face shield or goggles), gloves and fluid resistant/impermeable gown.
    - Additional PPE (e.g., N95 respirator) may be needed if the patient has other conditions or illnesses caused by specific infectious diseases, such as tuberculosis. Conduct a PCRA to determine if additional PPE or IPC measures are required.
- Only essential personnel with appropriate PPE should enter the examination room.
- If patient is clinically unstable or presents with uncontrolled body fluids – immediately call 911 and the MHO.
- Where possible, avoid performing AGMPs for patients with suspected or confirmed HTP, unless. If an AGMP is medically necessary, use an N95 respirator or equivalent and eye protection (e.g., goggles or face shield), gloves and gown.
    - AGMPs should be performed in an airborne infection isolation room (also referred

to as a negative pressure room). If unavailable, a single/private room located furthest away from other patients, visitors and health care workers should be used. The door must be kept closed when not being used to enter or exit.

- Only essential personnel wearing appropriate PPE should be present during the AGMP.

- For information on donning (putting on) and doffing (taking off) PPE, including checklists and posters, please refer to the Key Resources section.
- Ensure you have the appropriate PPE supplies available in your clinic.
- Monitor and maintain a log of all persons entering and exiting the patient room, including time and date.
- Ensure there is a clearly demarcated area near the patient's room where HCWs can remove and discard their PPE.
    - Removal of PPE presents a high risk for self-contamination if not done properly and requires a structured and monitored process that must be done slowly and deliberately.
    - If a breach in PPE occurs, the HCW should stop patient care, initiate PPE removal process, and then leave the patient room. See section on Exposures or Breaches (Potential or Known) & Reporting below for more information.
- Advise and support patients to perform hand hygiene frequently, particularly after toileting and vomiting, and adhere to respiratory hygiene.

Patient Transfer

If the MHO advises to transfer the patient to the emergency department, the patient may take their own vehicle if well enough to drive themselves or be driven by someone who has already had contact with them.

Otherwise, the patient should be transferred via ambulance by calling 911. **Notify the receiving emergency department and the ambulance dispatch service that a"patient with suspected HTP" is being transferred**, so they can take appropriate measures.

- Prior to transfer from the primary care setting, the most direct route to exit the clinic should be chosen and closed off to avoid exposure of other individuals (e.g., HCWs, visitors, etc.).
- Provide the patient with a clean mask and gown, if needed, and ensure any drainage is contained.
- Support the patient to perform hand hygiene before leaving the room.

Management of Visitors or Support Persons

- For visitors/support persons accompanying the patient, establish procedures for monitoring

and managing them including screening for symptoms upon arrival to the facility and their ability to comply with additional precautions.

- Liaise with MHO as needed for visitors/support persons who are under self-isolation related to close contact exposure with the patient.
- Refer to B.C.'s HTP Ethical Decision Making Framework to assist with decision making around essential visitors/support persons.

- Movement of visitors and support persons within the facility should be restricted to the patient/examination room and an immediately adjacent vacant waiting area.
- Provide education for accompanying visitors/support persons on the IPC precautions in place, as well as the prevention of transmission of disease to others (e.g., limiting surfaces touched), with a particular focus on hand hygiene, respiratory hygiene, and use of PPE while in the patient room. Ensure they are aware of the risk of self-contamination when using their PPE.

Room Cleaning and Disinfection

- Do not use the examination room, including patient care equipment used in the room, in which a patient with suspected or confirmed HTP was examined and/or placed in, until it has been cleaned and disinfected.
- Public areas where the patient has passed through or spent minimal time in (such as corridors) and which are not visibly contaminated with blood or bodily fluids do not need to be specially cleaned and disinfected.
- Ensure personnel responsible for environmental cleaning have received adequate training on processes and procedures required for rooms with patients with a suspected or confirmed HTP.
- For more information and recommendations on environmental cleaning and disinfection and waste management, see Provincial Recommendations for Environmental Services, Biohazardous Waste Management, and Food and Linen Management for HTP.

Equipment Cleaning and Disinfection

- For information on cleaning and disinfection of medical equipment used in the care of patients with a suspected or confirmed HTP, see Provincial Recommendations for Cleaning and Disinfection of Medical Equipment for High Threat Pathogens.

Staff Management

- All HCWs involved in providing care to patient(s) with a suspected or confirmed HTP must:
  - Routinely self-monitor for symptoms and perform daily health checks for 21 days following last contact with the patient, depending on the HTP of concern.
  - Be aware of signs and symptoms of the HTP of concern.
- Establish a process for recording daily health checks.

- Immediately report new onset symptoms (e.g., fever) to the manager/supervisor and Public Health/MHO.
    - Staff should not report to work if experiencing any new symptoms during the period of self-monitoring.
    - If symptom onset occurs at work, staff should stop working immediately and report symptoms (see next section).
    - Staff should be prepared to isolate themselves if experiencing new symptoms during the self-monitoring period, and to follow any further instructions from Public Health/ the MHO.

Exposures or Breaches (Potential or Known) & Reporting

- Report exposures to HTP (e.g., direct exposure without appropriate PPE or through percutaneous injury) immediately to the manager/supervisor and to Public Health/the MHO.
- Perform first aid immediately if there has been exposure to blood or other body fluids, as per routine practice for blood or body fluid exposure. Refer to BCCDC Blood and Body Fluid Exposure Management guidance for more information.
- Staff who have had direct contact with a patient with HTP **AND** a breach in PPE or infection control practices should:
    - Contact manager/supervisor.
    - Report to Public Health.
    - Self-isolate (duration will be based on pathogen incubation period and on communicable period if symptoms develop).
    - Self-monitor twice daily for symptoms (record temperature and health check daily).
- Decision for HCW to return to work will be made in consultation with the MHO.
- All HTP staff breach events must be documented in the facility's documentation system.

Staff Psychological Health and Resilience

The mental and emotional impacts of caring for patient(s) with HTP can be significant.

Support the psychological well-being and resilience of HCWs and staff involved caring for patients with HTP through the following:

- Include psychosocial considerations in planning and decision-making to ensure timely and effective support is communicated and provided to staff.
- Promote awareness of and access to available program and services.
- Debrief after the event is over/once patient(s) has been discharged, focusing on things that went well, areas of opportunity and recommendations for improvement.

See Key Resources section for more information.

Management of Close Contacts

- Report any potential or known exposures among visitors and/or patients to a person with suspected or confirmed HTP to local Public Health for follow up.

- For more information on management of asymptomatic contacts of Ebola virus disease (EVD), see BCCDC's British Columbia EVD Case and Contact Investigation and Management Guidelines.

Calling the Medical Health Officer

When you call, be explicit that you are a calling about an **urgent** matter related to a HTP.

The MHO for your region can be reached at the following numbers:

Fraser Health:	Business hours: 1-866-990-9941 After business hours: 604-527-4806
Interior Health:	1 866 457-5648 (24/7)
Island Health:	Business hours: see Medical Health Officers - www.islandhealth.ca/about-us/medical-health-officers After business hours: 1-800-204-6166
Northern Health:	Business hours: 250-645-3794 After business hours: 250-565-2000, press 7, ask for the MHO on call
Vancouver Coastal Health:	604 675-3900 (M-F, 8:30-5:00) **OR** 604-527-4893 (after hours)

Reportable disease requirements:

By consulting the local MHO you have met your responsibility for reporting.

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Key Resources

Disease-specific information:

- BC Centre for Disease Control (BC CDC):
  - Ebola
  - EVD Case and Contact Investigation and Management Guidelines
- US Centre for Disease Control Viral Hemorrhagic Fevers:
  - Crimean-Congo hemorrhagic fever
  - Ebola (Ebola Virus Disease)
  - Lassa Fever
  - Marburg hemorrhagic fever
- For up-to-date information on disease outbreaks globally, see World Health Organization (WHO) Disease Outbreak News (DONs)
- Public Health Agency of Canada (PHAC):
  - Infection prevention and control measures for Ebola disease in acute care settings
  - Biosafety guidelines for laboratories handling specimens from patients under investigation for Ebola disease

Other HTP resources:

- **Clinical management**
  - High Risk Communicable Disease Protocol for Interpreter Usage
  - B.C.'s HTP Ethical Decision Making Framework
- **IPC resources:**
  - Point of care risk assessment tool
  - PPE Donning and Doffing materials:
    - How to don PPE
    - How to doff PPE
    - Respirator donning and doffing instructions
    - Eye and Facial Protection Selection Fit Tool
    - Prescription Eye Protection Selection Requirements

Psychological health and wellness resources:

- Occupational Exposure to Ebola Virus Disease (PDF, 316KB)
- Psychosocial Considerations for Responding Health Care Providers (PDF, 102KB)
- BCCDC Health Care Provider Support page