



Infection prevention and control guidelines for Ebola disease in Australian healthcare settings



Citation page

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1. Introduction

1.1 Using these guidelines

These guidelines outline the national approach for the prevention and control of Ebola disease in Australian acute healthcare settings. These guidelines are informed by available evidence at the time of publication, a pragmatic approach to issues for which evidence is evolving, consultation with a range of experts and jurisdictional guidance.

Jurisdictional guidance and advice from local public health infection prevention and control (IPC) and infectious disease specialists take precedence over these guidelines if it is necessary to provide care to a patient with suspected, probable or confirmed Ebola disease.

1.2 Scope

These guidelines relate primarily to IPC strategies for the care of individuals with suspected, probable or confirmed Ebola disease in Australian acute healthcare settings. Information is included on IPC practices to minimise the risk of transmission of Ebola disease including standard and transmission-based precautions, use of personal protective equipment (PPE), environmental cleaning and disinfection, linen handling, waste management, work health and safety and care of the deceased.

The guidelines may also be relevant for non-acute, primary and community settings.

1.3 Definition

Ebola disease refers to the disease caused by infection of any orthoebolavirus which can cause disease in humans. Previously this was referred to as Ebola virus disease. However, in 2023 a review of the nomenclature of *Filoviridae* resulted in changing the term “Zaire virus” to “Ebola virus” in recognition of Zaire being an outdated term. Ebola virus disease now refers specifically to disease caused by Ebola virus (*Orthoebolavirus zairense*).¹

More information about Ebola disease is available in [Section 2 Ebola disease overview](#).

1.4 Acronyms and abbreviations

Acronyms	Descriptions
ABHR	alcohol-based hand rub
ACSQHC	Australian Commission on Safety and Quality in Health Care
ADG Code	Australian Dangerous Goods Code
AHPPC	Australian Health Protection Principal Committee
AICGs	Australian Guidelines for the Prevention and Control of Infection in Healthcare

Acronyms	Descriptions
Australian CDC	Australian Centre for Disease Control
CDC	US Centers for Disease Control and Prevention
CDNA	Communicable Disease Network Australia
HCID	high consequence infectious disease
HCW	healthcare worker
IPC	infection prevention and control
PAPR	powered air-purifying respirator
PFR	particulate filter respirator
PHU	public health unit
PPE	personal protective equipment.

1.5 Revision history and context

The previous version of this document, titled ‘Infection prevention and control principles and recommendations for Ebola virus disease: including information about PPE for clinical care of patients with suspected or confirmed Ebola virus disease in the Australian healthcare setting’ was developed by the Infection Prevention and Control Expert Advisory Group for the Australian Health Protection Principal Committee (AHPPC) following the 2014 Ebola outbreak.

When the World Health Organization declared the 2026 Ebola disease outbreak a Public Health Emergency of International Concern in May 2026, the Australian Centre for Disease Control (Australian CDC) requested the Australian Commission on Safety and Quality in Health Care (ACSQHC) undertake an interim and urgent update of Ebola disease IPC guidance for healthcare settings to:

- update terminology from Ebola virus disease to Ebola disease;
- include a current Ebola disease definition;
- update information on Ebola disease in humans;
- include guidance on IPC risk assessment;
- update PPE advice including the promotion of eye protection and guidance on double-glove use;
- include suitable environmental cleaning products;
- remove references to previous Ebola disease outbreaks;
- update links;
- reformat the document;

- update the reference and resource list.

The work of the ACSQHC was informed by a rapid literature review and targeted consultation with members of its Infection Prevention and Control Advisory Committee. This update was funded by the Australian Government.

Version	Date	Changes
1.0	5 December 2014	Executive summary endorsed by AHPPC
1.0	6 February 2015	Rationale document and revised executive summary endorsed by AHPPC
1.1	19 March 2015	Technical editing of combined documents
2.0	31 July 2026	Update by the ACSQHC, in consultation with the Australian CDC and jurisdictional and national experts on infection prevention and control and public health, under a Memorandum of Understanding with the Department of Health, Disability and Ageing.

2. Ebola disease overview

2.1 Ebola disease

Ebola disease is a High Consequence Infectious Disease (HCID). A HCID is an acute human infectious disease with severe symptoms which require a high level of care.

Ebola disease can spread from person to person and therefore healthcare workers (HCWs) are required to take precautions to prevent transmission.

There have been no cases of Ebola disease in Australia. Cases have been reported in several African countries.²

2.1.1 Disease pathogen and its reservoir

Ebola disease is caused by infection with an orthoebolavirus, which belongs to the family *Filoviridae*. Four types of ortheobolaviruses cause illness in people:

- Ebola virus (*Orthoebolavirus zairense*, previously “Zaire virus”)¹
- Sudan virus (*Orthoebolavirus sudanense*)
- Bundibugyo virus (*Orthoebolavirus bundibugyoense*)
- Taï Forest virus (*Orthoebolavirus taiense*).

Forest dwelling fruit bats are believed to be the reservoir for orthoebolaviruses. Wild animals such as chimpanzees, gorillas and monkeys are likely incidental hosts.^{3,4}

2.1.2 Incubation and clinical features

Ebola disease has an incubation period of 2–21 (usually 8–10) days.

Symptoms start suddenly and worsen over time.^{2,3} Early symptoms, sometimes referred to as 'dry' symptoms, include:

- fever
- severe headache
- muscle pains
- weakness
- sore throat.

This is followed by:

- vomiting
- diarrhoea
- abdominal pain
- rash
- internal and external bleeding.

These are often called 'wet' symptoms.

Death results primarily from fluid and electrolyte loss, but early treatment and optimal supportive care can improve outcomes.⁵ The case fatality rate is high and varies by virus type, geographical context, availability of resources and healthcare infrastructure but the average is around 50%.^{5,6}

2.1.3 Infectivity and transmission

Ebola disease can be transmitted through multiple routes including:

- person-to-person transmission through direct contact with symptomatic patients or through laboratory exposure (through broken skin, including micro abrasions or mucous membranes) with:
 - blood or body fluids (urine, saliva, sweat, faeces, vomit, breast milk, and amniotic fluid) of a person who is sick with or has died from Ebola disease; and
 - objects that have been contaminated with body fluids (like blood, faeces, vomit) of a person who is sick or has died from Ebola disease
- healthcare-associated transmission due to inadequate IPC practices including self-inoculation from contaminated hands
- burial ceremonies involving direct contact with deceased individuals
- zoonotic transmission, for example:
 - consumption of raw or undercooked meat from infected animals
 - exposure to blood from infected animals.

Sexual transmission cannot be ruled out as virus can persist in semen for months after recovery; however, few suspected cases of sexual transmission have been documented.^{5,7}

People are infectious from the onset of symptoms. Infectivity increases as symptoms progress and is highest at the point of death and after death. Blood is the most infectious body fluid due to high viral loads.⁵ There is no evidence of respiratory transmission however there is uncertainty about the risks to HCWs from aerosol generating procedures and a precautionary approach is taken.^{5,8}

2.2 Public health and legal classification

In Australia, Ebola disease (as a viral haemorrhagic fever) is a Listed Human Disease under the national [Biosecurity Act 2015](#)⁹ and is a nationally notifiable disease under the [National Health Security Act 2007](#).¹⁰ Health authorities in each state and territory must report cases through to the National Notifiable Diseases Surveillance System as per their state and territory legislation. Suspected, probable and confirmed cases of Ebola disease must be urgently notified to the National Incident Centre and the National Focal Point (via Health.Ops@health.gov.au). Public health units (PHU) should notify their Chief Health Officer and Chief Human Biosecurity Officer. Communicable Disease Network Australia (CDNA) representatives should notify the CDNA Chair and secretariat.

The [Ebola Disease CDNA National Guidelines for Public Health Units](#)⁴ outlines the national approach to public health management of Ebola disease. The public health response aims to ensure prompt identification, isolation and treatment of suspected, probable and confirmed cases of Ebola disease to prevent the exposure of other people and identify and manage contacts of people with Ebola disease.

The [Ebola disease CDNA National Guidelines for Public Health Units](#)⁴ include definitions of suspected, probable and confirmed Ebola disease.

3. Ebola disease infection prevention and control

[The Australian Guidelines for the Prevention and Control of Infection in Healthcare](#)¹¹ (AICGs) provide the overarching principles and guidance for IPC and support the development of tailored jurisdictional and, where appropriate, local protocols and processes to reduce their risk of transmission of infections for HCWs and to provide safe care to patients.

The AICGs support health services to meet the requirements of the [National Safety and Quality Health Service Standards](#)¹², particularly the [Preventing and Controlling Infections Standard](#).¹²

3.1 Principles of infection prevention and control for Ebola disease

The following principles apply for the prevention and control of Ebola disease.

- Healthcare facilities must be prepared to manage unexpected presentations of a suspected Ebola disease case and have protocols in place for early identification, isolation and prompt notification (see [3.2 Early detection and preparedness](#)).
- A combination of standard and transmission-based precautions (see [4. Personal protective equipment for managing patients with suspected, probable or confirmed Ebola disease](#)).
- A risk assessment approach using the hierarchy of controls should guide management strategies, taking into consideration planned activities, level of risk, and work environment.¹¹
- Workplace health and safety teams, IPC experts and/or relevant decision-making bodies should oversee PPE selection, training and competency assessment, with adherence to manufacturers' instructions.
- HCWs who are most likely to care for patients with suspected, probable or confirmed Ebola disease must receive comprehensive training and demonstrate competency in the correct use of PPE. This includes regular practice in putting on and taking off PPE to minimise the risk of self-contamination.
- Environmental cleaning and disinfection must follow established protocols, including routine cleaning, spill management and discharge cleaning. Disinfectants must be listed in the Australian Register of Therapeutic Goods (ARTG) and proven to be effective against Ebola disease (see [6.7 Disinfectant solutions](#)).
- Linen and waste should be managed as potentially infectious and disposed of in accordance with relevant legislation and organisational procedures (see [6. Environmental hygiene and waste management controls](#)).
- Contact with a patient with Ebola disease must be limited to essential clinical interactions. A record of all HCWs having contact with the patient must be maintained for contact tracing purposes.
- HCWs who are unable to adhere to IPC and PPE use procedures should not care for patients with Ebola disease.

- Patient care should be overseen by experienced clinicians with an understanding of Ebola disease and expertise in IPC and PPE practices.

3.2 Early detection and preparedness

Health services should establish IPC processes to ensure early detection, containment, and safe management of suspected, probable or confirmed Ebola disease cases.

A foundational approach to managing a patient with suspected Ebola disease is the 'Identify, Isolate, Inform' protocol which can be adapted for use in all healthcare settings. Digital tools to support remote triage and communication for patients in isolation should be utilised where possible to reduce transmission risk and support patient care.

Essential patient care, including diagnostic tests and treatment, should not be delayed while waiting for Ebola disease test results.

3.2.1 Identify

Screen for symptoms and travel history that may indicate exposure to Ebola disease. Obtain a full travel and exposure history, including symptoms, illness onset, travel dates and travel activities/locations. Early recognition is critical to prevent transmission.

3.2.2 Isolate

Place the patient in a single room with their own bathroom and provide the patient with a surgical mask if they can tolerate it. Limit entry into the room.

A negative pressure room is preferable due to its larger size and space for storage outside the patient area. If a negative pressure room or isolation room with anteroom is unavailable, interim isolation should be implemented using:

- a single room with ensuite and closed door, or
- a single-occupancy or isolated space with a multi-bedroom that can be enclosed, use of commode and a clearly designated restricted area outside the room.

Transmission-based precautions must be used in addition to standard precautions for patients with suspected Ebola disease. HCWs providing direct care must:

- Wear enclosed footwear that is resistant to fluids and sharps, long pants or scrubs and PPE as per Level 1 or Level 2 PPE (see [4.3 Levels of personal protective equipment](#)).
- Follow strict protocols for putting on and taking off PPE to prevent contamination (see [4.4 Putting on and taking off personal protective equipment](#)).
- Ensure environmental cleaning includes disinfectants effective against the viruses that cause Ebola disease, with discharge cleaning after the patient has left the facility (see [6. Environmental hygiene and waste management controls](#)).
- Treat all linen and waste as potentially infectious and dispose of it according to state and territory legislation and protocols.

Consider methods to provide clinical care while limiting entry into the room if patient acuity enables this (e.g. remote monitoring tools, oral treatments including fluids, antiemetics, paracetamol).

3.2.3 Inform

Notify relevant staff and teams as per local protocols including:

- senior clinical staff in the department where the patient is located to ensure appropriate staff are allocated to patient (seniority, training in PPE)
- infection control
- infectious diseases
- public health and
- hospital executive.

4. Personal protective equipment for managing patients with suspected, probable or confirmed Ebola disease

4.1 General principles for the selection and use of personal protective equipment

PPE should be selected and worn based on a clinical risk assessment, the patient's symptoms, the clinical environment, planned activities and the patient's ability to follow instructions (for example a young child).

The following points should be considered when selecting and using PPE.

- PPE should protect the mucous membranes of the eyes, mouth and nose to prevent exposure to splashes of body fluids and potential self-contamination.
- PPE should provide maximum protection with minimal discomfort for the wearer.
- PPE should be appropriately sized and fit correctly.
- PPE should be of suitable quality to provide the required level of protection for the tasks to be undertaken.
- Putting on and taking off PPE must be undertaken slowly and methodically, according to an agreed sequence (see [4.4 Putting on and taking off personal protective equipment](#)).
- The use of a PPE buddy is recommended to enhance the safety and effectiveness of putting on and taking off PPE (see [4.5 Buddy system for safely putting on and taking off personal protective equipment](#)).

4.2 Personal protective equipment items

4.2.1 Particulate filter respirators (PFR)

A single use fluid-resistant PFR is recommended for the care of symptomatic patients with suspected, probable or confirmed Ebola disease because of its fluid-resistant rigid structure and the possibility that an aerosol-generating procedure may be required. Respirators should be fit tested according to local respiratory protection programs and fit checked when putting on PPE. PFRs should be changed when wet, once an episode of care is completed or after exiting the room. HCWs should leave the patient room and remove PPE if the PFR becomes wet and needs to be changed.

4.2.2 Face shield or protective eyewear

While protective eyewear protects the conjunctivae, a face shield allows full skin and conjunctival protection and should be used instead of protective eyewear.

4.2.3 Head cover

Various types of head covers are available, including a balaclava-type cover, or a surgical hood with a flange to cover the neck and upper chest. All head covers should be fluid resistant. Depending on the design, the head cover may be worn outside or beneath the gown. Head covers with a full flange that covers the shoulders should be worn outside the gown. The hood incorporated into a powered air-purifying respirator (PAPR) is also suitable; see below.

4.2.4 Powered air-purifying respirator (PAPR)

PAPRs may be required in place of a fluid-resistant PFR, based on a risk assessment. Use of a PAPR removes the requirement for a face shield, PFR and headcover. Reusable PAPRs should only be used where a governance and training program is in place. Proper use relies on HCW competency, maintenance protocols including correct storage, cleaning and adherence to IPC standards.

4.2.5 Body covering

In most Australian healthcare settings, a fluid-resistant gown will be the preferred body covering. The gown should be sufficiently fluid resistant to prevent clothes becoming wet if splashed, be large enough to allow free movement, cover the wrists, reach to mid-calf and overlap at the back so that no underlying clothing is exposed. Note that gowns have [different levels of fluid resistance](#).¹³ The level should be checked before use to ensure that it is adequate to prevent the underlying clothes or skin from getting wet.

In some settings (e.g. pre-hospital/ambulance), coveralls are used routinely and preferred. They provide equivalent protection but are more difficult to remove, especially if hooded, and are more likely to cause heat stress. They are not recommended for routine use as the risk of self-contamination during removing PPE is higher than for gowns. If staff have been specifically trained and are competent in their use, they are a reasonable alternative.

4.2.6 Gloves

Two pairs of gloves must be worn.^{5,15,16} The outer glove should reach the mid-forearm⁵ and remain in place without a gap and without the need for taping. Fabric cuffs of gowns are not fluid resistant and must be covered by the inner long cuffed glove. Gloves must be the correct size for the user. Nitrile gloves are preferred to latex gloves, as they are more resistant to the effects of alcohol and less likely to cause an allergic reaction. Sterile gloves are not required, except during invasive procedures, but are preferred by some because they provide a better fit. Taping gloves is discouraged because, during removal, the glove may be torn and hands could become contaminated.

4.2.7 Shoes/boots and shoe coverings

Footwear should be enclosed, and resistant to fluids and sharps. Some facilities provide rubber boots for staff; however, personal footwear can be adequately protected with fluid-resistant, disposable boot covers that reach mid-calf and are overlapped by the gown. In the unlikely event that shoes become contaminated (e.g. by fluid leaking into the boot cover, or the boot cover splitting), they must be discarded as contaminated waste. Removal of boot covers requires particular attention during PPE removal to avoid staff contamination.

4.3 Levels of personal protective equipment

Level 1 PPE is appropriate when caring for patients:

- suspected of having Ebola disease:
 - who are clinically stable and symptoms are limited to fever, muscle pain and fatigue ('dry' symptoms).¹⁵

Level 2 PPE is appropriate when caring for patients:

- suspected of having Ebola disease:
 - who are clinically unstable or have diarrhoea, vomiting or bleeding ('wet' symptoms)
 - when performing invasive/aerosol-generating procedures (e.g. intubation, suctioning)¹⁶
- confirmed to have Ebola disease.

The level of PPE should always be selected and worn based on a clinical risk assessment, the patient's symptoms, the clinical environment, planned activities and the patient's ability to follow instructions (for example a young child).

Table 1 Personal protective equipment levels for the care of patients with suspected, probable or confirmed Ebola disease*

Personal protective equipment item	Level 1	Level 2
Single use fit-tested fluid-resistant disposable PFR. Level 2 only – a PAPR can be worn based on availability and preference. If a PAPR worn then the use of PFR, headcover, and face shield is not required.	✓	✓
Single use long-sleeved fluid-resistant disposable gown that extends to at least mid-calf.	✓	✓
Single use full face shield (preferred) or protective eyewear.	✓	✓
Single use gloves with extended cuffs. Two pairs of gloves should be worn with the outer glove reaching mid-forearm.	✓	✓
Single use below-knee fluid-resistant disposable booties to cover impervious shoes or rubber boots.		✓
Single use impervious surgical hood that provides full head coverage (skin and hair).		✓

*Jurisdictional guidance on PPE may differ due to local policies providing guidance on all viral haemorrhagic fevers and/or high consequence infectious diseases

4.4 Putting on and taking off personal protective equipment

- Each healthcare facility should determine and document an appropriate sequence for putting on and taking off PPE, and train staff accordingly.
- The general principle is that the outermost items (which are most likely to be contaminated because they may have been in contact with the patient or their blood or body fluids) are removed first and in such a way as to avoid contact between these items and unprotected skin.
- Dedicated separate areas with adequate space should be set aside for putting on and taking off PPE. PPE should be put on in a clean area away from the patient's room to protect the HCW from contamination. PPE should be taken off immediately adjacent to the patient's room to prevent the risk of contamination in other areas.
- Signage should be used to clearly identify the patient care area, and the areas for putting on and taking off PPE.
- Staff should tie up long hair and remove any personal items that may become contaminated (staff ID cards, watches, jewellery (including wedding rings) and stethoscopes) before putting on PPE.
- While wearing PPE, HCWs must not touch their face protection (face shield, PFR) after touching the patient environment.
- Equipment to support the safe removal of PPE should be available including mirror, disinfectant wipes, alcohol-based hand rub (ABHR), gloves and stool.
- Footwear or personal clothing (e.g. socks or underwear) that becomes contaminated by a patient's blood or other body fluids, should be carefully removed and discarded with the used PPE.
- A plan should be in place for a location for a HCW to shower if they are splashed with blood or body fluids.

[Appendix 1](#) provides an example of a step-by-step checklist of actions to take when level 1 PPE is required. [Appendix 2](#) provides an example of a step-by-step checklist of actions to take when level 2 PPE is required.

4.5 Buddy system for safely putting on and taking off personal protective equipment

The 'buddy' is a trained, experienced HCW who observes, guides and documents activities of HCWs caring for patients with Ebola disease. This includes alerting the HCW to any potential breaches of IPC, while supervising them putting on and taking off PPE. The buddy should have access to communication systems within the anteroom.

A risk assessment should determine the level of PPE a buddy should wear.

The role of the buddy includes the following:

- check and record that the PPE is put on properly, in the correct order according to the checklist, and before the HCW enters the patient room; specifically, check that the PPE covers all body surfaces and remains in place during bending or stretching
- remind and assist the HCW to fit-check the PFR
- assist if required with tying the apron or gown
- observe the HCW at all times while in the patient room (via window or video monitor), checking for any breaches in PPE (e.g. HCW touches their own face, dislodges PPE)
- record all people entering the patient room including date and time
- check and record that the PPE is removed slowly and methodically, to avoid contamination; specifically check for visible contamination or damage to the PPE before starting removal
- read out and check off each item to be removed in the correct order
- if necessary, assist with untying of apron or gown ties, or taking off boot covers – perform hand hygiene after this has been done
- wipe down surfaces (e.g. chair used by the HCW while taking off PPE)
- ensure that the HCW – who is likely to be tired, hot and, possibly, distressed at the end of a shift – remains calm and focused while taking off PPE
- identify (and record, if appropriate) any potential breach of procedure during patient care or PPE removal, and advise on further action, such as showering or clinical follow-up
- ensure that correct hand hygiene technique is followed while taking off PPE; the buddy should dispense the ABHR onto the HCW's hands (to prevent contamination of the dispenser)
- ensure that the removed PPE items are discarded into a clinical waste bag and do not come in contact with any environmental surface.

4.6 Hand hygiene requirements

Hand hygiene should be performed using either an ABHR or soap and running water, applying the technique as per the [5 moments of hand hygiene](#).¹⁷ Soap and water should be used for visibly soiled hands.

4.7 Glove decontamination

Glove decontamination should be performed as per below.

- Between clean and dirty tasks within the patient care area
- As a component of PPE doffing sequences
- Using Therapeutic Goods Administration (TGA)-approved hospital-grade disinfectant wipes to remove gross contamination, especially when visible contamination is present, to reduce the risk of cross-contamination.

Gloves should be changed if there is decreased glove integrity or unusual changes (e.g. they become sticky) that would affect work-related tasks.^{5,18}

4.8 Disposal or decontamination of personal protective equipment

Following removal, disposable PPE must be double bagged and placed into suitable rigid, lockable waste bins for disposal as per state and territory legislation and protocols.

If parts of the PPE are reusable (e.g. motorised power packs for PAPRs), they should be protected from contamination as much as practicable and decontaminated using an appropriate method before reuse.

5. Care of patients with suspected, probable or confirmed Ebola disease

5.1 General patient management

All HCWs should follow these general patient management principles.

- Prompt patient care and treatment is essential.
- Clinicians should provide clear, consistent, and timely information to any patient undergoing assessment for Ebola disease. They should ensure that communication promotes understanding, reduces anxiety and encourages shared decision making through the assessment process.
- The patient should have a device for communication (e.g. iPad or phone).
- Use caution when approaching a patient with suspected Ebola disease. On rare occasions, Ebola disease can cause delirium and erratic behaviour (e.g. flailing or staggering), which can place HCWs at an increased risk of exposure.
- Keep the patient separated from other people as much as possible.
- Limit the number of providers who provide care for a patient with suspected, probable or confirmed Ebola disease.
- Limit the use of needles and other sharps as much as possible. Any needles and sharps should be handled with extreme care and disposed of in puncture-proof, sealed containers designated for the care of this patient.
- Retractable safety devices significantly reduce the risk of needlestick injury. If available, they should be used for essential invasive procedures by HCWs familiar with their use, unless technical issues make their use difficult (e.g. in small children). All HCWs being trained to care for patients with Ebola disease should be trained in using retractable safety devices.
- If the patient is vomiting, give them a large biohazard or emesis bag.
- If the patient has profuse diarrhoea, consider wrapping them in an impermeable sheet to reduce contamination of other surfaces.

5.2 Visitors

Visitors should be excluded from any direct patient visits while the patient is in isolation. Non-contact style visits, such as virtual visits, should be arranged. Children should not visit because of difficulty in ensuring adherence to PPE. If a visit from someone other than immediate healthcare staff is required, they must be trained and supervised during the visit in the correct use and safe removal of the same PPE as used by healthcare staff.

Circumstances involving paediatric patients and end-of-life care need to be managed on a case-by-case basis in discussion with IPC, infectious disease and public health experts.

5.3 Healthcare worker vulnerabilities

HCWs who have medical or physical conditions that will interfere with safe use of the PPE described in these guidelines should not be involved in the direct care of patients with Ebola disease. HCWs must be assessed for their fitness to care for patients with Ebola disease and should be encouraged to communicate concerns about any negative effects of PPE use on underlying health conditions. There should be a system in place for staff to take appropriate breaks from the patient room.

Some conditions may preclude HCWs from providing direct care for patients with Ebola disease, including:

- underlying medical conditions that could affect the HCW's ability to exit the room quickly and safely
- underlying medical conditions that could require another HCW to enter the room to provide urgent medical assistance to the HCW (e.g. seizure disorder, hypoglycaemia)
- non-intact skin; for example, from dermatitis, abrasions or wounds
- inability to safely put on, use or remove recommended PPE, including achieving a good fit with a PFR (e.g. significant anxiety, body morphology or mobility issues)
- claustrophobia
- alteration in body temperature modulation
- problems with immune competence
- pregnancy.

5.4 Healthcare settings and infection prevention and control procedures

Different levels of assessment, treatment and care may be required, depending on the healthcare setting. For example:

- hospital settings, including Ebola disease designated and non-designated hospitals
- ambulatory and primary care settings (including allied healthcare professionals in community settings).

Table 2 Summary of healthcare settings and associated level of Ebola disease care*

Healthcare setting	Ebola disease care level	Personal protective equipment
Ebola disease treatment hospitals (designated hospitals)	Identify suspected Ebola disease patients, isolate, inform PHU (or contact point identified by jurisdiction), provide laboratory confirmation, treat for duration of illness, and manage all cleaning and waste disposal.	Maintain sufficient PPE reserves, and appropriate training and preparation of adequate staff numbers to provide care for duration of patient's illness.
Other hospitals	Identify suspected Ebola disease patients, isolate, inform PHU and provide short-term care. Follow jurisdictional protocols, including for patient transfer to a designated Ebola disease treatment hospital if appropriate or for patient care. Manage all cleaning and waste disposal.	Maintain sufficient PPE reserves, and appropriate training and preparation of HCWs to provide care for patient with suspected Ebola disease.
Primary and ambulatory care	Identify suspected Ebola disease patients, isolate, inform PHU and seek support for immediate transfer (if required). Manage cleaning and waste disposal, as directed by PHU.	Avoid unnecessary contact; PPE is required if it is essential to contact the patient directly.

*States and territories may have designated hospitals for care of Ebola disease patients and have their own detailed protocols for the response to and management of Ebola disease. These should be followed in preference to the general guidance provided in this document.

5.5 Ambulatory and primary care settings

Ambulatory and primary care settings include offices and surgeries of general practitioners, nurse practitioners, dentists and allied health professionals, and pathology collection centres in community settings.

It is unlikely that a patient with Ebola disease will present to an ambulatory or primary care setting. The local PHU should be contacted immediately if a patient with suspected Ebola disease presents to an ambulatory or primary care setting to organise transport to, and assessment and care at an appropriate hospital.

All primary healthcare providers should have a triage plan that covers the roles of all members of the practice in line with the 'identify, isolate and inform' approach (see [3.2 Early detection and preparedness](#)).

Two scenarios are provided in Table 3 for the primary care setting. One for a patient with Ebola disease who presents with advance notice, and the other for a patient who presents

without advanced notice. Note that the 'identify, isolate and inform' steps apply in the primary care setting in the same way that they apply in the acute healthcare setting.

Table 3 Example scenarios and proposed management for patients who present to the primary care setting

Scenario type	Patient management
1. Advance notice of a patient attending a primary healthcare setting	• The patient phones ahead to make an appointment. They report symptoms of Ebola disease, and a history of travel to an affected country and/or relevant exposure. • Advise the patient not to attend the primary care facility and to await further advice from the PHU. If practicable and the problem is urgent, the patient may be advised to contact the designated Ebola disease hospital. • Contact the relevant PHU for assistance with assessment and management of the patient and, if necessary, coordination of transfer to the designated Ebola disease hospital or another appropriate hospital. • If it is an emergency, contact the ambulance service on 000 and advise the operator of the patient's potential risk factors to ensure that ambulance personnel arrive wearing the correct PPE. • If, following discussion with the PHU and infectious diseases physicians, it is decided that the patient does not require further assessment or testing for Ebola disease, manage the patient as per usual practice.
2. Patient presenting in person to a primary healthcare setting	Identify • The patient reports a history of travel to an affected country and possible contact with a patient with Ebola disease. Isolate • Escort the patient to a single room and close the door to avoid unnecessary direct contact. Provide the patient with a surgical face mask if tolerated. • Do not perform any procedures unless urgently required for patient care or stabilisation. • Where practicable, remove unnecessary equipment from the room to reduce cleaning requirements. Inform • Contact the local PHU to assist in risk assessment and coordinate transfer to the designated Ebola disease hospital or another appropriate hospital. Determine PPE • Standard precautions apply to all HCWs for all patients. • If direct contact is unavoidable, assign a single HCW to put on PPE. • Perform hand hygiene with soap and water, or ABHR, and put on PPE. See 4.3 Levels of personal protective equipment.

Scenario type	Patient management
	See 4.4 Putting on and taking off personal protective equipment for specific instructions for putting on and taking off PPE.

5.6 Ambulance services and patient transport

The general IPC and PPE principles and recommendations provided in this document apply to ambulance and patient transport services.

Ambulance and patient transport services should have protocols in place for:

- identification of a suspected patient with Ebola disease
- management and transport of a suspected, probable or confirmed patient with Ebola disease which is coordinated with local/jurisdictional plans
- cleaning and disinfection of vehicles, equipment and waste disposal that are consistent with the guidance provided in this document.

5.7 Specimen collection, transport and laboratory testing

The National High Security Quarantine Laboratory is operated by the Victorian Infectious Disease Reference Laboratory (VIDRL) and undertakes testing for Ebola disease in a physical containment level 4 (PC4) facility.

When a patient with suspected Ebola disease is identified, the on-call Medical Microbiologist should be notified through the relevant State or Territory Chief Quarantine Officer. Direct contact with the VIDRL on-call Medical Microbiologist is essential to arrange receipt of specimens and for advice regarding specimen collection, safe packaging and transport.

Only essential specimens should be collected, and safety must take priority, in accordance with the [Public Health Laboratory Network National High Security Quarantine Laboratory Guideline for Management of Quarantinable Viral Haemorrhagic Fevers](#).¹⁹

6. Environmental hygiene and waste management controls

6.1 Principles of waste management for Ebola disease

- All healthcare facilities should have a policy for minimising, segregating, collecting, treating and disposing of waste.
- All waste generated from the care of a patient with suspected, probable or confirmed Ebola disease, should be treated as infectious waste. This includes clinical waste, equipment from the patient's room including linen, PPE and environmental cleaning equipment.
- Single-use equipment should be used whenever possible. Where single-use equipment is not available, equipment must be dedicated to the patient for their exclusive use.
- Reusable pieces of equipment, such as mattresses and critical medical equipment, are safe for reuse if their surfaces can be properly cleaned and decontaminated. Equipment that cannot be adequately cleaned and disinfected may require disposal and should be discussed with an IPC expert.
- Waste should be segregated at the point of generation to enable appropriate and safe handling. This may be different based on a suspected or confirmed case (see [6.4 Waste disposal, equipment and environment cleaning](#)).
- Sharp objects (e.g. needles, glass vials) used within the patient area should be disposed of by being placed inside puncture-resistant waste containers and sealed as per [Australian Standards AS 23907:2023](#).
- Incineration is the ideal method of waste elimination.
- All personnel involved in environmental hygiene and waste management should wear Level 2 PPE (see [4.3 Levels of personal protective equipment](#)) as cleaning activities have the potential to generate aerosols.

6.2 Codes and regulations

6.2.1 Australian Dangerous Goods Code

The [Australian Dangerous Goods \(ADG\) Code](#) contains information about transporting dangerous goods. Infectious substances are in Division 6.2 under Class 6 – Toxic and infectious substances.²⁰

Ebola disease is a Category A infectious substance. Waste material or linen that is contaminated with blood or other body fluids from a patient with Ebola disease will be classified in Category A and must be labelled and transported as UN 2814 – INFECTIOUS SUBSTANCES AFFECTING HUMANS.

Dangerous goods must be packaged, transported and disposed of correctly. The waste generator (i.e. the hospital) is responsible for safe and secure packaging in compliance with the requirements of the competent authority in the relevant jurisdiction. For UN 2814 substances, a minimum of three layers of packaging are required – that is, a leak-proof

primary receptacle, a leak-proof secondary packaging and a rigid outer packaging (drum, box or rigid bin). Medical waste rendered safe by steam sterilisation in an autoclave, incineration or high-level chemical disinfection is not regarded as dangerous and is not bound by the ADG Code.

6.2.2 Regulators

The National Transport Commission is the Australian Government agency that hosts the ADG Code, but it is not the national competent authority for the purposes of packaging, transporting and disposing of infectious substances. Within Australia, state and territory governments are responsible for the regulation of dangerous goods, and there are competent authorities in each jurisdiction. However, their roles and responsibilities vary. The appropriate authorities in each state and territory can provide exemptions to permit safe and secure packaging, transport and disposal under the ADG Code. Exemptions are important during a potentially dangerous situation when handling dangerous goods does not fit neatly within the ADG Code.

6.3 Routine environmental cleaning

Environmental surfaces (floors, bed, furniture, and other high touch surfaces) should be cleaned and disinfected daily.

Environmental cleaning includes either a:

- 2-step clean, which involves physical cleaning using a detergent solution followed by use of a chemical disinfectant; or a
- 2-in-1 clean with a combined detergent/chemical disinfectant wipe or solution (see [6.7 Disinfectant solutions](#))

It is recommended that patients with Ebola disease use disposable bed pans and urinals rather than toilets to reduce the risk of handling, transporting and flushing of body fluids. High-absorbency gel should be added to the contents of bed pans or urinals. If only reusable bedpans or urinals are available, these must be discarded after use. Human waste should be treated as clinical waste and not disposed of into sluices or macerators.

If a toilet is used by the patient, disinfectant should be left to soak in the toilet for 10–30 minutes with the lid closed before flushing, as Ebola disease has been shown to survive in wastewater for 24 hours.⁵ Check with local authorities or environmental health departments for specific requirements for sewage.

Disposable cleaning equipment and PPE worn for cleaning must be discarded immediately after use as clinical waste. For further information on routine environmental and patient care equipment cleaning and disinfection, see Section 3.1.3 Routine management of the physical environment of the AICGs.¹¹

6.4 Waste disposal, equipment and environment cleaning

6.4.1 Patient with suspected Ebola disease awaiting results

If a patient with suspected Ebola disease is awaiting laboratory results, contaminated waste should be placed in sealed bags and treated in one of the following ways:

- left in the patient room until Ebola disease has been excluded or confirmed (this should be a short-term solution)
- stored (double bagged and in a rigid, sealed container) in or adjacent to the patient room in a designated area
- discarded immediately as Category A infectious waste if there is insufficient room for storage.

6.4.2 Patient with confirmed Ebola disease

All waste generated during the care of a patient with confirmed Ebola disease should be managed as Category A infectious waste according to the ADG Code.

The equipment in the patient room must be limited to what is essential for patient care. All equipment must be dedicated for that patient's sole use and remain within the room for the duration of their hospitalisation. Disposable products should be used, if available.

Any contaminated equipment should be cleaned and disinfected or disposed of as appropriate.

6.4.3 Staff training, and allocation of environmental cleaning and waste management duties

All staff involved in environmental cleaning and waste management should be trained in appropriate use of PPE, including safe procedures for putting on and taking off PPE.

The number of staff members entering the patient room should be limited, including for the purpose of environmental cleaning. Spills should be managed by whichever member of staff is present at the time.

6.5 Handling of Ebola virus-contaminated waste

Records should be kept of staff involved in packaging, handling and transporting clinical waste, and performing environmental cleaning in rooms occupied by patients with suspected, probable or confirmed Ebola disease.

6.5.1 Double bagging

Healthcare facilities should have a system for double bagging of clinical waste. The outside of the inner bag should be inspected for visible contamination or damage before it is placed in the second bag in the designated waste space. If contaminated, an additional bag should be used (i.e. triple bagged).

Clinical waste bags should be sealed before being placed in a rigid outer container for transport. If the waste includes a liquid component, the inner and outer bag, or the space

between them, should contain absorbent powder or material to contain any spill. Bags should not be filled to capacity, because this will prevent them from being adequately sealed. Once filled, the rigid container should be cleaned prior to the waste being released for incineration or removal.

Double-bagged waste must be transferred directly to the facility's on-site sterilisation area or be placed into a dedicated clinical waste bin that carries labelling consistent with UN 2814/ADG Code Division 6.2 for transport.

Sharps containers must be certified to [Australian Standard AS 23907:2023](#) and placed in an outer bag that contains absorbent material for disposal.

6.5.2 Autoclaving

Waste for autoclaving needs to be separated from clinical waste for incineration at the point of generation. Autoclaves should be dedicated to the treatment of biohazardous waste (i.e. not used for sterilising reusable devices) and validated for that purpose. Processed waste can then be disposed of as routine clinical waste.

The receipt, treatment and disposal of each autoclaved load must be documented, including confirmation that the necessary temperature and time for complete inactivation were achieved.

6.5.3 Incineration

Double-bagged waste for transport and destruction via incineration must be placed and secured in a dedicated rigid container that is puncture resistant, able to be secured and in line with the ADG Code – that is, it is either leak-proof or contains an equally effective means of containing leakage.

Waste that needs to be temporarily stored before transport must be secured in a locked, dedicated area to prevent unauthorised access, tampering or accidental spillage.

The transfer of contaminated waste into the custody of an appropriately trained and licensed waste management company should be documented.

6.6 Management of spills

6.6.1 Management of blood and body fluid spills

Any blood or body fluid spill must be managed immediately to reduce the risk of exposure. See Section 3.1.3 Routine management of the physical environment in the AICGs¹¹ for information on the general principles used to manage blood and body fluid spills.

Management of blood and body fluid spills for Ebola disease follows the same process as for any other blood or body fluid spill regardless of the size of the spill or type of body fluid, however staff will need to include additional steps for disinfection and waste disposal. If available, staff should use a dedicated spill kit to manage the spill – these should be in the patient room and anteroom.

Table 4 Process to manage Ebola disease blood and body substance spills

Steps	Actions
1. Immediate risk control	- Restrict access and ensure the area is supervised until the spill is completely removed. The person supervising the area should wear PPE consistent with Level 1 PPE (see 4.3 Levels of personal protective equipment). - Notify IPC and or the immediate supervisor about the incident.
2. Put on appropriate PPE	Put on Level 2 PPE (see 4.3 Levels of personal protective equipment).
3. Contain and disinfect the spill	- Cover the spill with absorbent paper or clumping material. - Cover the spill (paper or clumping material) liberally with a 5,000-ppm sodium hypochlorite solution and leave to soak for 15–30* minutes before being wiped up.
4. Remove contaminated waste	After 15–30 minutes, working from the outside in, remove all material (paper towels, clumping material) into a plastic lined receptacle for disposal as contaminated waste.
5. Clean and disinfect the spill site	Clean and disinfect the spill area with a 5,000-ppm sodium hypochlorite solution and leave for 15–30 minutes before rinsing the surface with clean water.
6. Remove and dispose of PPE	- Remove all PPE under supervision, performing hand hygiene between each step to reduce the risk of self-contamination. - Dispose of PPE as clinical waste.

*Evidence and recommendations vary for length of time required for disinfection. Follow jurisdictional guidance.

6.7 Disinfectant solutions

Chlorine-based disinfectants, such as sodium hypochlorite, are effective at inactivating enveloped RNA viruses, including Ebola disease.⁵ Other disinfectants have been shown to be effective in inactivating Ebola disease and can be considered based on local protocols.^{5,8} Only disinfectants listed on the ARTG should be used.

Disinfectant solutions must be prepared to the correct concentration, as per the manufacturer's instructions for use, immediately prior to use. The concentration of the solution can weaken over time if prepared too early in advance.

When using disinfectants, ensure all solutions have adequate contact time on surfaces to allow for effective disinfection. The World Health Organization suggests that the concentrations of hypochlorite solutions of 0.5% (5,000-ppm of available chlorine) listed below achieve effective disinfection⁵:

- On nonporous, contaminated surfaces without visible spills, 10 minutes of contact time is consistently effective
- For surfaces with visible spills, complete disinfection can be achieved by covering the spill with a paper towel or cloth and pouring hypochlorite solution of 0.5% on it and then allowing 15 minutes of contact time.

6.8 Linen management

Use disposable linen if available. There is no reliable evidence that linen or patient clothing soiled with blood or body fluids contaminated with Ebola disease can be safely cleaned and disinfected, therefore the World Health Organization recommends that soiled linen is incinerated rather than disinfected or decontaminated.⁵

Non-disposable linen and clothing should be managed as per clinical waste. Wet linen and clothing must be placed into a leak-proof bag before disposal.

6.9 Discharge cleaning

On discharge or transfer of a patient with Ebola disease, dispose of all single use items into clinical waste, keeping all items for disposal together. Use a 2-step clean or 2-in-1 clean (as described above) for discharge cleaning. All surfaces of the room, bathroom/ensuite and patient care equipment should be thoroughly cleaned, using firm mechanical friction, with neutral detergent, followed by disinfection. Once the room has air dried (visibly dry, you cannot see any liquid on any environmental surfaces) repeat the cleaning and disinfection process and allow the room to air dry.

Only trained personnel should undertake discharge cleaning, and appropriate PPE should be worn whilst undertaking cleaning activities.

All equipment used for discharge cleaning (buckets, mop handles, mop heads, cloths) must be disposed of into the clinical waste.

Where negative pressure air handling systems are used, negative pressure must be maintained during cleaning and for 30 minutes afterwards before the room is made available for a new patient. Where negative pressure is not available, the door must remain closed until cleaning and disinfection is complete and all surfaces are dry.

7. Safe management of the deceased

7.1 Ebola disease in deceased patients

Direct physical contact with an Ebola disease patient, including contact with body fluids from infected patients or touching deceased bodies, are associated with risk of infection. The handling of deceased patients with suspected, probable or confirmed Ebola disease should be done in a safe, culturally sensitive manner, to reduce exposure and transmission.

General precautions for handling patients who have died from Ebola disease are included below.

- Deceased individuals should be correctly identified and handled with dignity.
- Do not perform post-mortem examinations unless necessary. A post-mortem examination should only be done if directed by the coroner and following discussion with the relevant public health authority.
- HCWs handling the body should wear Level 2 PPE (see [4.3 Levels of personal protective equipment](#)). The World Health Organization recommends the outer pair of gloves should be heavy-duty and rubber boots should be worn.⁵
- Do not wash, clean or embalm the body.
- An apron should be worn over the PPE because of the increased likelihood of significant contamination with blood or other body fluids.
- Mortuary staff and others likely to have contact with the body should be trained in putting on, wearing, taking off and disposing of PPE before contact with the body. Training should be the same as that recommended for care in designated hospitals including using a buddy to ensure that PPE is applied and removed correctly.
- The number of staff involved in handling, or in the same room as, the body should be kept to a minimum.
- The body should be properly prepared at the site of death. It should only be moved after this has been completed, and the outer surface of the body bag or other outer covering has been decontaminated.
- In the unlikely event that the patient dies outside an isolation room (e.g. during transfer between facilities or rooms), the body should be taken to an isolation room for preparation.
- When a deceased person has suspected, but not confirmed, Ebola disease, any post-mortem procedures should be delayed until testing for Ebola disease is completed. The body should be handled as if Ebola disease is present until the definitive test result is available.

7.2 After-death care in hospitals

Complete any identification procedures (including those needed for cremation) before the body is prepared. Body bags should only be reopened if directed by the coroner and following discussion with the PHU. A person required to identify the body must not have direct contact with the deceased. Any viewing should be done from a separate room, either through a window or via a video link. Anyone entering the room must wear appropriate PPE.

- Do not remove intravenous lines, endotracheal tubes or other types of medical devices and tubing that are present at the time of death.
- Leave behind, in the patient room, any of the patient's personal belongings. This includes mobile phones and other equipment. A risk assessment with IPC experts should be conducted as to whether the items can be appropriately cleaned and disinfected or need to be discarded as contaminated waste.
- Before a body is handled, use a surgical mask to cover the nose and mouth of the deceased. During manipulation and handling of bodies (e.g. while they are being placed into body bags), fluids can be expelled from body cavities. A mask should reduce the risk that fluids will travel any distance from any upper body cavities.
- Place the body in a sealed, leak-proof body bag. This should be impermeable, vinyl with a minimum thickness 400 microns, able to hold 100–125 kilos and fully contain bloodborne pathogens.⁵ The body bags to be used should be selected in consultation with the receiving mortuary (as designated by the local PHU).
- Once the body is enclosed in the first bag, change the outer gloves and apron worn by the HCW handling the body. Disinfect the inner gloves with an ABHR or hospital-grade disinfectant wipe before new outer gloves are put on.
- Place the first bag sequentially into two further sealable leak-proof body bags not less than 400 microns thick.
- Decontaminate the surface of the outer body bag before transport to the mortuary. Remove any visible contamination on the bag surfaces and then apply the hypochlorite disinfectant to the entire outer body bag surface and allow to air dry.
- Take particular care to ensure that the bags are adequately protected from puncture by either any sharp objects inside the bags (e.g. medical devices left in place) or any external objects.
- Once the body bag has been decontaminated, staff should move to the area to take off PPE and follow the sequence for taking it off.
- Clearly write the name or identification of the deceased on the top surface of the outer bag.
- Clearly mark the outside of the body bag to show that the deceased is a suspected or confirmed case of Ebola disease.
- Orientate bodies in bags with the seal pointing up, and to avoid pitch and roll of the body during transport to a morgue.
- After the body is made safe for transportation (i.e. secured to prevent unauthorised access) using the procedures outlined above, continue as follows:
 - Move the body from the patient room to the mortuary or to the parked funeral vehicle via a trolley with side walls to prevent accidental penetration of the body bags during movement on the trolley. Most facilities have a trolley designed to transport deceased people, which will have sides (not dissimilar to an open-lid coffin). These will need to be appropriately cleaned and disinfected after use.
 - Ensure that the room or other site of death is cleaned and disinfected by a HCW trained in the use of PPE for Ebola disease and environmental cleaning.
 - Transport the body bag, once decontaminated, following the approval of the responsible PHU.

7.3 Handling bodies in the mortuary

Post-mortem examinations of patients with known or suspected Ebola disease should be avoided wherever possible.

Basic procedures for handling bodies in the mortuary include the following:

- Carefully check for any evidence of leakage or soiling of the outer bag. If contamination is present, again place the bag in three sealed, leak-proof body bags as per the protocol for bodies. These activities should be carried out wearing Level 2 PPE (see [4.3 Levels of personal protective equipment](#)).
- Do not perform embalming.
- Do not open the body bag or handle the remains.
- If a body bag must be opened (e.g. under instruction from the coroner's office for identification purposes), follow the PPE procedures used for performing a post-mortem examination. Do not permit direct viewing of the body. Have the identifier view the body through a window or via a remote device, such as a closed-circuit or web camera.
- In the event of leakage or where the body bag is required to be opened, clean and disinfect any equipment used and the environment. Staff members doing this must be trained in PPE and cleaning for Ebola disease.
- Place the body bag into a sealed casket or coffin for cremation or burial.
- No special precautions are required when transporting the hermetically sealed casket.

7.4 Post-mortem examinations

Non-coronial post-mortem examinations should not be performed on patients with confirmed or suspected Ebola disease who have a known alternative cause of death. A post-mortem examination should only be carried out if there is a specific instruction from the coroner's office.

If a post-mortem is required, general procedures include the following:

- Try to use non-invasive procedures, such as imaging, with minimal invasive physical examination.
- If a limited or full autopsy is necessary, following specific written instruction from the coroner's office, it should be conducted by appropriately trained senior staff in a physically separate room using precautions as required for surgical procedures on a patient with Ebola disease.
- Leave the body in the body bag, if possible.
- Minimise the use of sharp instruments and the number of people in the room.
- If body incisions are needed, consider using added protection for staff, such as chainmail gloves or approved orthopaedic protective gloves, to help prevent sharp injuries from instruments or bones.
- After the examination is complete, seal the remains again in three body bags. Clean and decontaminate the outer bag before the body is moved.
- Ensure that the autopsy room or mortuary is cleaned and disinfected by a staff member trained in PPE and environmental cleaning for Ebola disease.

7.5 Staff monitoring

All staff members who have contact with the body need to be monitored and documented. The procedure should follow the same requirements as for HCWs caring for living patients with Ebola disease, after consultation with local public health authorities.

Appendix 1 Putting on Level 1 personal protective equipment – checklist

Level 1 PPE is appropriate when caring for patients:

- suspected of having Ebola disease:
 - who are clinically stable and symptoms are limited to fever, muscle pain and fatigue ('dry' symptoms).¹⁵

The level of PPE should always be selected and worn based on a clinical risk assessment, the patient's symptoms, the clinical environment, planned activities and the patient's ability to follow instructions (for example a young child). Recommended PPE includes:

- fluid-resistant PFR
- face shield (preferred) or protective eyewear
- two pairs of gloves – the outer gloves should have extended cuffs
- long-sleeved, fluid-resistant gown.

Note:

- Putting on and taking off PPE should be supervised by a trained buddy
- Head and neck coverings, and foot and leg coverings are not required.
- A high risk of exposure requires enhanced precautions see PPE level 2.

Table A1.1 Steps for putting on Level 1 personal protective equipment

Putting on personal protective equipment in a clean area	Completed
Remove all personal items, such as jewellery (including wedding rings), wrist watches and staff ID. Ensure hair is tied or pinned back, and prescription glasses are secured.	
Visually inspect PPE to check integrity of all items.	
Perform hand hygiene.	
Put on first pair of gloves.	
Put on long-sleeved gown; secure at neck and waist.	
Put on PFR (follow the manufacturer's instructions to perform a fit check).	
Put on full-face shield.	
Put on second pair of gloves; ensure that gloves extend over cuffs of gown.	
Visually inspect PPE to check integrity of all items and covers all mucous membranes.	
Enter patient room.	

Table A1.2 Steps for taking off Level 1 personal protective equipment

Taking off personal protective equipment in designated area	Completed
Visually inspect PPE to check integrity of all items.	
Leave the patient room and move to the designated PPE doffing area. The buddy is to check for contamination.	
Remove outer gloves.	
Remove the long-sleeved gown – undo the waist ties before the neck ties and roll the gown into a ball and discard into the bin.	
Perform hand hygiene by applying ABHR to the gloves.	
Remove the face shield and discard it into the bin.	
Perform hand hygiene by applying ABHR to the gloves.	
Remove the PFR and discard into the bin.	
Remove inner gloves.	
Perform hand hygiene.	
Visually inspect scrubs and: • if contaminated, remove and discard into the clinical waste bin • if not contaminated, discard them as non-infectious used linen, after taking them off in an uncontaminated area.	
If prescription glasses are worn: • put on a new pair of gloves • remove and clean the glasses with a hospital-grade disinfectant wipe and allow to dry • remove gloves and perform hand hygiene.	

Appendix 2 Putting on Level 2 personal protective equipment – checklist

Level 2 PPE is appropriate when caring for patients:

- suspected of having Ebola disease:
 - who are clinically unstable or have diarrhoea, vomiting or bleeding ('wet' symptoms)
 - when performing invasive/aerosol-generating procedures (e.g. intubation, suctioning)¹⁶
- confirmed to have Ebola disease.

The level of PPE should always be selected and worn based on a clinical risk assessment, the patient's symptoms, the clinical environment, planned activities and the patient's ability to follow instructions (for example a young child).

Recommended Level 2 PPE includes:

- fluid-resistant PFR or PAPR
- face shield (preferred) or protective eyewear
- two pairs of gloves – the outer gloves should have extended cuffs
- long-sleeved, fluid-resistant gown
- a head cover that covers all hair, ears and neck, and extends to the shoulders
- below-knee booties to cover fluid and sharps resistant footwear.

Note: Putting on and taking off PPE must be supervised by a trained buddy.

Table A2.1 Steps for putting on Level 2 personal protective equipment

Putting on personal protective equipment in a clean area	Completed
Remove all personal items, such as jewellery (including wedding rings), wrist watches and staff ID. Ensure hair is tied or pinned back, and prescription glasses are secured.	
Change into scrubs.	
Visually inspect PPE to check integrity of all items.	
Sit and don booties. Ensure booties are secure around ankles and knees and ties are tied.	
Perform hand hygiene.	
Put on first pair of gloves.	
Put on head cover.	
Put on long-sleeved gown; secure at neck and waist.	

Putting on personal protective equipment in a clean area	Completed
Put on PFR (follow the manufacturer's instructions to perform a fit check).	
Put on plastic apron (if using).	
Put on disposable full-face shield.	
Put on second pair of gloves; ensure that gloves extend over cuffs of gown.	
Visually inspect PPE to check integrity of all items and all bare skin is covered and protected.	
Enter patient room.	

Table A2.2 Steps for taking off Level 2 personal protective equipment

Taking off personal protective equipment in designated area	Completed
Before leaving patients room visually inspect PPE to check integrity of all items. Wipe away any visible contamination using a hospital-grade disinfectant wipe.	
Leave the room and move to the designated PPE doffing area.	
Remove outer gloves and discard the glove into the clinical waste bin. Check if the inner glove is soiled. If so, use a hospital-grade disinfectant wipe to remove.	
Perform hand hygiene by applying ABHR to the gloves.	
Remove the apron (if put on) and discard into the bin.	
Perform hand hygiene by applying ABHR to the gloves.	
Remove the long-sleeved gown – buddy to undo the waist ties before the neck ties. Roll gown into a ball and discard it into the bin.	
Perform hand hygiene by applying ABHR to the gloves.	
Sit on a clean stool/chair and take off booties.	
Perform hand hygiene by applying ABHR to the gloves.	
Remove the face shield and discard into the bin.	
Perform hand hygiene by applying ABHR to the gloves.	
Remove the PFR and discard into the bin.	
Perform hand hygiene by applying ABHR to the gloves.	

Taking off personal protective equipment in designated area	Completed
Remove the head cover and discard into the bin.	
Remove the inner gloves and discard gloves into the clinical waste bin.	
Perform hand hygiene.	
Visually inspect scrubs and: • if contaminated, remove and discard into the clinical waste bin • if not contaminated, discard them as non-infectious used linen, after taking them off in an uncontaminated zone.	

Appendix 3

A3.1 Administrative and facility requirements for Ebola disease infection prevention and control

Implementing enhanced IPC measures while preparing to care for a patient with an infectious disease of high consequence, such as Ebola disease, will require additional administrative arrangements.

- Ensure adequate stocks of PPE, cleaning products and supplies appropriate to the hospital's function are available, and that sufficient stock is maintained and distributed to manage patients for an appropriate length of time.
- Training a core group of staff in the competent use of PPE. Training should be done by specialists in IPC and/or infectious diseases, and/or workplace health and safety staff. Limiting the number of staff trained allows resources to be concentrated. However, sufficient staff – including emergency department and infectious diseases staff – should be trained to ensure their availability at any time and for an adequate duration. In designated hospitals, this will also include intensive care, laboratory and cleaning staff.
- Training should include procedures for putting on and taking off PPE, providing initial clinical care, collecting and transporting specimens, and placing intravenous lines.
- Jurisdictions should ensure respiratory protection programs are implemented to ensure HCWs are able to be fit-tested to the required PFR. Technique assessment is required to establish competency, but formal certification is not recommended, as training must be repeated regularly (as determined by the healthcare facility) to maintain competency.
- Training records should be kept up to date.
- Appropriate training resources should be available.
- Development and maintenance of local and jurisdictional protocols for patients with suspected Ebola disease, to guide whether the patient is managed in place (with testing at the jurisdictional reference lab) or transferred for testing and management.
- If PPE includes equipment that requires maintenance (e.g. charging batteries) or disinfection of reusable components, a schedule is required to ensure that this maintenance is performed regularly.
- Where possible, all other equipment required for patient care should be disposable and dedicated for use with an individual patient.
- Physical infrastructure must be checked regularly; for example, the air pressure and high-efficiency particulate air (HEPA) filters in isolation room(s).
- Procedures for disposing of highly infectious liquid waste (in consultation with local water or sewage authorities) and solid clinical waste (in consultation with the appropriate environment protection or waste management authority) must be reviewed.
- Rosters should be appropriate to avoid staff fatigue. HCWs can tolerate enhanced PPE for only short periods, depending on ambient temperature and intensity of activity, before developing heat exhaustion and dehydration.

- Different categories of HCWs (including supervisors) have different levels of risk. Therefore, training in use of PPE, environmental cleaning and use of disinfecting equipment must be appropriate for each category.
- Adequate resources (human, material and financial) must be provided to support and maintain appropriate IPC measures.

A3.2 Patient rooms

Patient rooms must be considered when dealing with a suspected or confirmed case of Ebola disease. General requirements include the following:

- A single room is required with its own toilet and bathroom facilities (if ensuite facilities are not available in a suitable location, a commode can be used for short-term patient care).
- A negative-pressure room is preferred and is required for patients who may require aerosol-generating procedures.

A3.3 Patient-care areas

The strict procedures required for putting on and taking off PPE mean that patient-care location and environment need careful consideration. Using separate areas, based on the risk of environmental contamination, is useful to minimise risks to HCWs and others.

There should be two adjacent areas to the patient room: a 'clean' area and a 'possibly contaminated' area. The clean area should be used for storing and putting on clean PPE. The possibly contaminated area should be of adequate size to safely remove PPE and dispose of clinical waste.

If there is an anteroom that is large enough to allow PPE to be safely removed, it can be used for this purpose. Alternatively, two adjoining rooms can be used, one for patient care and the other for taking off PPE. The latter should be immediately adjacent to the patient room, preferably with direct access, to reduce the risk of environmental contamination in general access areas.

Many facilities will have isolation rooms (with anterooms) engineered to allow negative-pressure airflow. Negative-pressure airflow is not required for Ebola disease management, but such a room with its associated facilities will usually make care of the patient with Ebola disease easier.

Appendix 4 Operational planning and infection prevention and control

Effective preparedness begins before a patient presents. Health services can adopt the 'Isolate, Identify, Inform' approach (see [3.2 Early detection and preparedness](#)) as a proactive planning tool to ensure readiness for rapid response.

The operational response structures and activities below are recommended for acute healthcare settings.

- Maintain documented communication, outbreak response plans and disaster response frameworks, including links to public health, laboratories and emergency management teams. This should include a description of incident management structures, escalation pathways, state and territory reporting arrangements and interaction with PHUs.
- Conduct annual review of Ebola disease policy, procedures and protocols and include tabletop exercises and simulation exercises with relevant stakeholders.

An operations group should be established to supervise and oversee administrative tasks, as well as the management of patients with suspected or confirmed Ebola disease. The group should also define roles for key HCWs, such as:

- patient care – including triage, initial management and risk assessment, in association with a PHU
- communication between
 - internal departments (hospital executive, IPC, infectious diseases, microbiology and pathology, intensive care unit, imaging/radiology)
 - external services, including the reference laboratory, acute care hospitals for Ebola disease case management and PHU
 - other HCWs, patients and their relatives, and the media
- management and follow-up, if required (e.g. counselling, risk assessment, contact identification), of all HCWs involved in patient care, and especially of any HCWs who are potentially exposed to Ebola disease
- before the diagnosis is considered (e.g. in the emergency department)
- when a breach of PPE has occurred while caring for a patient with confirmed Ebola disease
- general oversight to ensure continuity of other hospital services.

Glossary

Alcohol-based hand rub (ABHR)

An alcohol-containing preparation registered with the Therapeutic Goods Administration that is designed to reduce the number of viable microorganisms on the hands without the use or aid of running water. It is included on the Australian Register of Therapeutic Goods as a medicinal product.

Anteroom

A small room leading from a corridor into a room.

Buddy

A trained, experienced HCW who observes, guides and documents activities of clinical staff caring for patients with Ebola disease, including warning of any breaches in IPC, and supervising putting on and taking off PPE.

Chlorine-based disinfectants (hypochlorite)

Hypochlorites are available as sodium hypochlorite (including household bleach) and as powder (e.g. calcium hypochlorite). They have a broad antimicrobial spectrum but are inactivated by organic material and rapidly lose potency when diluted. In high concentrations, they cause skin and mucous membrane irritation, metal corrosion and fabric bleaching, and release toxic chlorine gas when mixed with acid or ammonia.

Clinical waste

Waste material that consists wholly or partly of, or is contaminated with, human or animal tissue, blood or body fluids, excretions, drugs or other pharmaceutical products; includes swabs, dressings, syringes, needles and other sharp instruments.

Confirmed case

Refers to a person who is confirmed as having Ebola disease as per the [Ebola disease CDNA National Guidelines for Public Health Units](#)².

Disinfectant

A chemical product registered with the Therapeutic Goods Administration that is intended for disinfecting surfaces or medical devices.

Fit-check

A manual procedure that is used each time a respirator is used to ensure a seal is achieved. This is a user seal check or self-check.

Fit test

A validated process (either qualitatively or quantitatively) of determining the type and size of a respirator that achieves an adequate seal on an individual's face.

Fluid resistant

In this document, fluid resistant' refers to protective clothing, including PFR, tested against water as the liquid challenge.

Fomite

An object or substance capable of carrying an infectious organism. Examples of fomites in healthcare settings include patient care devices and equipment, used PPE and contaminated environmental surfaces.

Hand hygiene

A general term applying to processes that aim to reduce the number of microorganisms on hands. This includes:

- applying a waterless antimicrobial agent (e.g. alcohol-based hand rub) to the surface of the hands
- using soap or soap solution (plain or antimicrobial) and water (if hands are visibly soiled), followed by patting dry with single-use towels.

Healthcare worker (HCW)

All people delivering healthcare services, including students and trainees, who have contact with patients, or with blood or other body fluids.

Impermeable

In this document, 'impermeable' refers to materials that provide demonstrated blockage of fluids and microorganisms using a recognised standard test method.

Negative-pressure room

A single-occupancy patient-care room used to isolate people with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in negative-pressure rooms to minimise the transmission of infectious agents that are usually transmitted from person to person by droplets associated with coughing or aerosolisation of contaminated fluids.

Particulate filter respirator (PFR)

A close-fitting mask worn for airborne precautions, which is capable of filtering 0.3-µm particles. A PFR must comply with AS/NZS 1716: 2012.¹¹ The term PFR is used throughout this document. The difference between the N95 and P2 classifications for respirators is that the N95 classification indicates compliance with United States testing requirements, whereas the P2 classification indicates compliance with European testing requirements. In practical terms, these differences have virtually no impact on the level of respiratory protection provided to wearers.

Powered air-purifying respirator (PAPR)

PAPRs pass contaminated air through a HEPA filter and supply clean air to the wearer's face. PAPRs should conform with Standard AS/NZS 1715:2009 and Standard AS/NZS 1716:2012¹¹ and must only be used by HCWs who are trained in their use. The manufacturer's instructions for cleaning, decontaminating and maintenance must be followed. PAPRs may be suitable for HCWs with facial hair and those who fail fit testing for a PFR.

Probable case

Refers to a person under investigation as a probable case as per the [Ebola disease CDNA National Guidelines for Public Health Units](#)².

Sharps

Instruments used in delivering health care that can inflict a penetrating injury (e.g. needles, lancets, scalpels).

Standard precautions

Work practices that constitute the first-line approach to IPC in the healthcare setting. These are recommended for the treatment and care of all patients.

Surgical masks

Loose-fitting, single-use items that cover the nose and mouth. They include products labelled as dental, medical procedure, isolation and laser masks.

Suspected case

Refers to both a person under investigation and a suspected case as per the [Ebola disease CDNA National Guidelines for Public Health Units](#)².

Additional resources

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All information in this publication is correct as at July 2026