

Case ID number: \_\_\_\_\_



# Health care worker Ebola virus investigation questionnaire

Liberia (last edit 3 Dec 2014)

Form Approved  
OMB No. 0920-xxxx  
Exp. Date xx/xx/xxxx

## 1. Introduction

Hi, my name is \_\_<name>\_\_ and I'm working with the MOHSW. We would like to talk to you to try to find out how you may have got infected. The reason we want to know is to try to stop other health workers getting sick. Is it ok to ask you a few questions about how you may have got sick?

If you feel tired at any point please let me know and we can let you rest.

It is ok if you don't remember any details, just let us know.

The information we collect is confidential. Any analysis conducted will not contain your name.

Lastly, do you consent to us contacting your family and some of your colleagues to help answer some of these questions? Who would be the best people to talk to? \_\_\_\_\_

How do we contact them: \_\_\_\_\_

Verbal consent obtained:  Yes  No (specify reason): \_\_\_\_\_

## 2. Interview details (interviewer)

Investigator name: \_\_\_\_\_ Investigation date (dd/mm/yy): \_\_\_/\_\_\_/\_\_\_

Interviewed:  Patient

Other person1- specify name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Address of person interviewed: \_\_\_\_\_

Other person2- specify name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Address of person interviewed: \_\_\_\_\_

Other person3- specify name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Address of person interviewed: \_\_\_\_\_

## 3. HCW identity (HCW or administration)

Surname name: \_\_\_\_\_ First name: \_\_\_\_\_ Second name: \_\_\_\_\_

Nickname/alternate name: \_\_\_\_\_

Date of birth (dd/mm/yy): \_\_\_/\_\_\_/\_\_\_ Age (years): \_\_\_\_\_ Sex:  Male  Female

Permanent residence: \_\_\_\_\_ County: \_\_\_\_\_

Health District: \_\_\_\_\_ Clan/Zone: \_\_\_\_\_ Country: \_\_\_\_\_

Next of kin (last and first name): \_\_\_\_\_ Phone: \_\_\_\_\_

Full address (if known): \_\_\_\_\_

Nationality: \_\_\_\_\_ Ethnic group: \_\_\_\_\_

Religion:  Christian  Islam  Traditional  No religion  Unknown

Other (specify): \_\_\_\_\_

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#### 4. HCW status (administration)

Was HCW tested for Ebola?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
If Yes, was the Ebola test positive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
HCW classification:	<input type="checkbox"/> Suspected	<input type="checkbox"/> Probable	<input type="checkbox"/> Confirmed
Status	<input type="checkbox"/> Alive	<input type="checkbox"/> Dead	<input type="checkbox"/> Don't know
	If alive: <input type="checkbox"/> Well for interview <input type="checkbox"/> Too unwell for interview		
Date of onset: ___/___/____	Calculated incubation period (21 days prior): _____		

#### 5. Work details (HCW, colleague, family)

<input type="checkbox"/> Doctor	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Nurse	<input type="checkbox"/> Nurse Aid	<input type="checkbox"/> Lab technician
<input type="checkbox"/> Midwife	<input type="checkbox"/> Trained traditional midwife	<input type="checkbox"/> Cleaner (hygienist)	<input type="checkbox"/> Office	
<input type="checkbox"/> Mortician	<input type="checkbox"/> Security guard	<input type="checkbox"/> Vaccinator	<input type="checkbox"/> Ambulance driver	<input type="checkbox"/> Traditional healer
<input type="checkbox"/> Community health worker	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Private drug store worker		
<input type="checkbox"/> Other (specify): _____				

##### Healthcare facility (HCF) workplace 21 days prior to illness onset: *(tick all that apply)*:

<input type="checkbox"/> Ebola Treatment Unit (ETU)	<input type="checkbox"/> Community Care Center (CCC)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Health centre
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Clinic	<input type="checkbox"/> Pharmacy/medicine store	
<input type="checkbox"/> Other (specify): _____			

**Service area/s:**

<input type="checkbox"/> EVD Suspected Cases Unit	<input type="checkbox"/> EVD Confirmed Cases Unit	<input type="checkbox"/> Ebola contacts		
<input type="checkbox"/> OPD	<input type="checkbox"/> IPD	<input type="checkbox"/> Maternity	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Paediatric	<input type="checkbox"/> Surgery	<input type="checkbox"/> Emergency	<input type="checkbox"/> Triage	<input type="checkbox"/> Administration
<input type="checkbox"/> Morgue	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Other (specify): _____		

HCF name and location 1: \_\_\_\_\_  
HCF name and location 2: \_\_\_\_\_  
HCF name and location 3: \_\_\_\_\_

#### 6. IPC training (HCW)

Did HCW receive training on infection prevention and control in the context of the Ebola outbreak?

<input type="checkbox"/> Yes, specify date of the training?: ___/___	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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How long did the training last?  Less than 1 day     1 day     More than 1 day

At any time in their training did HCW practice putting on and taking off all or any items of PPE?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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At any time in their training did HCW practice correct hand washing procedure?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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## 7. Contact with EVD patient/s (HCW, colleague, family)

**COMMUNITY:** Had the HCW been in known direct contact **COMMUNITY** with anyone with suspected, probable, or confirmed EVD in the 21 days prior to illness onset?  Yes  No  Don't know

Was the contact with:  Suspected  Probable  Confirmed  Don't know

Was the contact:  Protected  Unprotected

Type of exposure  Intimate contact  Sharing of utensils  Caring for sick

Other (specify): \_\_\_\_\_

Specify EVD patient's relationship with HCW (*tick all that apply*):

Patient  Household member  Friend  Relative  None

Other (specify): \_\_\_\_\_

Located:  At home (specify): \_\_\_\_\_  
(*tick all that apply*)  In the community (specify): \_\_\_\_\_

Did the HCW attend any funeral of someone who might have died of Ebola in the 3 weeks preceding the onset of the symptoms?  Yes  No  Don't know

If yes, did the HCW participate in the preparation of burials that involved touching the dead body without adequate PPE?  Yes  No  Don't know

**WORK:** Had the HCW been in known direct contact **AT WORK** with anyone with suspected, probable, or confirmed EVD in the 21 days prior to illness onset?  Yes  No  Don't know

If Yes to either: (*tick all that apply and indicate healthcare facility*)

Was the contact:  Protected  Unprotected

Type of exposure:  Needle stick  Scalpel cut  
 Body fluid splash on intact skin  Body fluid splash on non-intact skin  
 Body fluid splash on eye  Body fluid splash on mouth/lips

Other (specify): \_\_\_\_\_

Located:  Ebola Treatment Unit (ETU) (specify): \_\_\_\_\_  
(*tick all that apply*)  Community Care Center (CCC) (specify): \_\_\_\_\_  
 Another health care facility (specify): \_\_\_\_\_

Specify EVD patient's relationship with HCW (*tick all that apply*):

Patient  Other HCW (specify below)  Other (specify): \_\_\_\_\_

If "Other HCW" was contact:

At work, in a patient care area (specify facility): \_\_\_\_\_

Outside of workplace (specify facility): \_\_\_\_\_

At work, in a non-patient care area (break room, office, nursing station, etc) (specify): \_\_\_\_\_

Why did unprotected contact occur? (*tick all that apply*)

Person was not thought to be a case at the time

Person had been a suspect case, but had tested negative for Ebola on the first test

PPE were not available to wear

Other (specify): \_\_\_\_\_

Case ID number: \_\_\_\_\_

## 8. Infection prevention and control (HCW, colleague, supervisor)

### Healthcare facility workplace/s use of PPE and standard precautions: *(specify different workplaces)*

During possible time of exposure, was PPE used?

HCF 1:  Yes  No  Don't know

HCF 2:  Yes  No  Don't know

Describe what items *(tick all mentioned)*

HCF 3:  Yes  No  Don't know

- Single gloves       Double gloves       Disposable gown       Coverall (Tyvek-like)  
 Coverall (Tychem-like)       Face shield       Goggles       Facemask  
 N-95 or above respirator       Waterproof apron       Cap       Hood  
 Shoe covers       Rubber boots       Closed resistant shoes  
 Leg covers       Other (specify): \_\_\_\_\_

If different workplaces have different procedures please specify difference: \_\_\_\_\_

Did the HCW apply duct tape to secure PPE?

HCF 1:  Yes  No  Don't know

HCF 2:  Yes  No  Don't know

HCF 3:  Yes  No  Don't know

How long would HCW usually work while wearing PPE per entry in the isolation area?

HCF 1 \_\_\_\_\_ (hours)      HCF 2 \_\_\_\_\_ (hours)      HCF \_\_\_\_\_ (hours)

Was a 'buddy' system (co-worker observing) used to take off PPE?

HCF 1:  Yes  No  Don't know

HCF 2:  Yes  No  Don't know

HCF 3:  Yes  No  Don't know

At possible time of exposure, was hand hygiene performed appropriately?  Yes  No  Don't know

Were hand hygiene products available at time of exposure?

HCF 1:  Yes  No  Don't know

HCF 2:  Yes  No  Don't know

HCF 3:  Yes  No  Don't know

If Yes, which

*(specify HCF)*

- Running (tap) water       Chlorinated water from reservoir       Soap  
 Disposable towels       Alcohol antiseptic       Other (specify): \_\_\_\_\_

At possible time of exposure, were safety boxes available?

HCF 1:  Yes  No  Don't know

HCF 2:  Yes  No  Don't know

HCF 3:  Yes  No  Don't know

Could the HCW identify other deficiencies in infection prevention and control at their workplaces?

<i>(tick all that apply)</i>	HCF 1	HCF 2	HCF 3
No triage available			
Proper isolation of patients not available			
PPE not consistently available or complete			
Improper or inadequate training of staff			
Hand hygiene facilities unavailable			
Other (specify)			

**COMMUNITY:** During possible time of exposure, was PPE used during all community exposures?

Yes       No       Don't know

If Yes, describe PPE use: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_