Coastal Bend Regional Advisory Council TSA-U

Regional High Consequence Infectious Disease (HCID) Transportation Guidelines

Update 11-1-2018

CBRAC TSA-U
Regional HCID
Transportation Guidelines

Purpose

This document is designed to serve as a guideline to a response of suspected HCID patients in TSA-U. The Centers for Disease Control and Prevention as reference to the creation of this guideline. In TSA-U there is one designated Emergency Medical Service Provider that has committed to the responsibility of transporting suspected HCID patients, Corpus Christi Fire Department (CCFD).

Through the TSA-U Health Care Coalition, CCFD will be issued equipment that includes, personal protective equipment, education, and training. This equipment and training with will be uniform with the EMTF-IDRU equipment.

CCFD will follow their Medical Protocols for the treatment of suspected HCID patients.

Through the TSA-U Health Care Coalition, there will be equipment issued to local hospitals that includes, personal protective equipment, education, and training. This equipment and training with will be uniform with the EMTF-IDRU equipment.

This document will include

- Guidelines for Patient Handoff between a Healthcare Facility and a Transporting Ambulance
- Guidelines for Decontamination of an Ambulance that has Transported a PUI or Patient with Confirmed Ebola
- Diagram of Activation of CCFD and Transportation to Designated HCID Receiving Facilities

Contacts for training and questions on response:

Hilary Watt, Executive Director
CBRAC
361-939-7177
Hilary.watt@cbrac.org

Billy Belyeu, Battalion Chief
CCFD
361-826-3941
BillyBe@cctexas.com

John Phillips, EMTF-11 Coordinator
CBRAC
956-367-3683
john.phillips@cbrac.org

TSA-U HCID Destination Hospital HAI Contact information:

CCMC Northwest Hospital:	Manager-Infection Control	361-761-1824
Driscoll Children's Hospital:	Director of Infection Prevention	361-694-5490
CHRISTUS Spohn Hospital Memorial:	Director of Infection Prevention	361-881-3417

TSA- Corpus Christi Nueces County Public Health Department Contact Information:

Public Health Emergency Preparedness Manager:	361-826-7251
Public Health Administrator - Protection Division	361-826-7323

TSA-U San Patricio Public Health Department Contact Information:

Public Health Emergency Preparedness Manager	361-587-3530
Public Health San Patricio County after hours	210-846-7502

Guidelines for Patient Handoff between a Healthcare Facility and a Transporting Ambulance

Purpose

This document provides guidance to facilitate planning for and execution of patient handoff between personnel at a fixed facility (hospital or clinic) and CCFD. Information is presented in a chronological format and is provided at a level of detail that will afford local planners and operators the flexibility to develop procedures that are suitable for their environment.

The following key assumptions are being made:

- All healthcare workers (hospital and out-of-hospital) who are involved will have received education and training and demonstrated the necessary competencies for management of patients with serious communicable diseases.
- Healthcare facilities and CCFD have procedures and protocols for the management of patients with serious communicable diseases.
- Facilities and CCFD are conducting tabletop and operational exercises that test and refine procedures for the transfer of patients.
- This guidance complements other CDC guidance for management of patients with serious communicable diseases.

Mobilizing for patient transport

- Notify responsible parties, including sending facility, receiving facility, CCFD, local public health authority, Texas Department of State Health Services, local emergency management agency, Texas Division of Emergency Management, CBRAC, law enforcement, and (if applicable) aviation and CCFD hazardous materials.
- Establish a communications plan that identifies all points of contact and distribute it to all parties to facilitate communication (ICS 205).
- All parties should consider notifying their public affairs official.
- Discuss methods of notification, as radio and other non-secure methods of communication may be monitored by the media or the public.
- Communicate to all parties the patient's risk of exposure to HCID and clinical condition.
- Communicate whether the patient will be ambulatory or non-ambulatory.

- Confirm that CCFD personnel and receiving facility personnel have appropriate personal protective equipment (PPE) ensembles (they may be different depending on mission requirements and patient condition).
- Confirm and communicate with the designated point of contact at each facility the location for transition of patient care at point of origin and destination – this location will likely be pre-determined by facilities and chosen in order to minimize environmental exposure at the facility and prevent exposure of unprotected staff, patients, and visitors.
- Confirm and communicate location for donning and doffing of PPE for CCFD personnel and ambulance decontamination and disinfection.
- Affirm appropriate supervision for the doffing of CCFD personnel. Hospital PPE and doffing protocols may be different and therefore supervision may need to be specific to the CCFD crews involved.
- Personnel doffing and ambulance decontamination locations must be prepared to manage regulated waste.
- Determine the need for additional security with sending and receiving facility security, as well as local, county, state public safety and law enforcement personnel both during transport and at the healthcare facilities.

Preparing for transfer of patient and patient care

Sending facility

- Maintain appropriate infection control posture while managing patient.
- Determine appropriate level of personnel to accompany patient during transfer.
- Provide management of volume depletion and nausea/vomiting as much as possible to facilitate event-free transport.
- Be prepared to communicate with CCFD directly to provide up-to-date patient status and facilitate patient transfer.
- Advise CCFD about any patient belongings that may accompany patient.
- Determine and communicate whether patient is ambulatory or will require a stretcher transport.
- Obtain vital signs immediately before transfer of care to share with CCFD team.
- As mutually agreed upon with CCFD and just prior to their arrival, have patient apply barrier garments with the goal of limiting exposure of transport team or vehicle (e.g., as tolerated), including footed impermeable suit, surgical mask, and gloves for ambulatory patient, or impervious sheets and surgical mask for non-ambulatory patient, and adult undergarment, as needed.
- Communicate transport plan to family and friends of patient, as appropriate.
- Provide written patient care report (PCR) that includes signs and symptoms and care rendered. Provide PCR to CCFD in a manner that assures it is contamination-free.
- Ensure patient's property is secured and documented appropriately (assume property is contaminated).
- Transfer patient care and any belongings to transport team.
- Follow facility SOPs for mission completion, which may include disinfection of exposed environmental surfaces, etc.

Corpus Christi Fire Department (Transport Agency)

Before transport

- Ensure transportation readiness:
    - Confirm that receiving facility is ready for patient arrival.
    - Confirm patient's condition and level of personnel required to accompany patient during transfer.
    - Confirm whether additional passengers are being transported (family, etc.).
    - Confirm location for decontamination and disinfection of ambulance and doffing of ambulance transport personnel PPE. Confirm hospital (or contracted service) is prepared to handle contaminated waste (CCFD Haz-Mat).

    - Communicate with designated emergency management officials and coordinate with the agency that will be providing security as required for the mission.
    - Confirm that all agencies involved in patient transport have access to secure communications.
    - Ensure procedures have been implemented to limit contamination of ambulance environmental surfaces (isolation of driver compartment, draping, etc.).
- Ensure adequate inventory of supplies and appropriately-sized PPE for the personnel who are assigned to the transport mission.
    - Barrier drapes and tape for transport vehicle as indicated
    - PPE ensemble – correct size suits, back-up PPE for possible breach, charged batteries if using powered air-purifying respirator (PAPR), etc.
    - Supplies for decontamination and disinfection – U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant wipes effective against the known or suspected pathogen, hand disinfectant, a "spill kit" (household bleach, absorbent towels and appropriate water-tight container to secure gross contamination), etc.
    - Supplies for waste collection – biohazard bags, autoclave bags
- Ensure appropriate medical director (or appropriate person providing medical oversight) is immediately available throughout the transport.
- Hold mission briefing for transport team to review:
    - Purpose and team primary contacts
    - Transport provider health check
    - Patient history and condition
    - Infection control posture – ambulance configuration and personnel PPE
    - Team member (paramedic, EMT, driver, supervisor/safety officer, EMS physician, etc.) roles and responsibilities, including supervision of donning and doffing procedures, etc.
    - Relevant clinical care guidelines including appropriateness of interventions or invasive procedures
    - Transportation of patient samples and medication, if applicable
    - Transfer of paper or electronic ambulance patient care records in a way that avoids contaminating the receiving facility
    - Decontamination and disinfection procedure
    - Waste collection and mission recovery
    - Post-mission surveillance
    - Special considerations – transfer of patient across state borders, deterioration of patient condition in transit, vehicle malfunction and other contingencies, etc.
    - Media discipline

During transport

- Communicate with sending facility for patient updates and to confirm patient transfer location.
- Contact sending facility to verify patient management steps have been taken to facilitate event-free transport and reduce risk of exposure.
- Depart for patient location and provide estimated time of arrival (ETA) for ambulance at sending facility.
- Communicate with designated point of contact at each facility the arrival of transporting ambulance at sending and receiving facilities.
- Observe donning of PPE and when ready, proceed to make patient contact (only the minimum number of providers necessary to manage the patient should be present).
- Conduct brief patient assessment to determine patient's stability, "dry" or "wet" symptoms, and need for intervention before and/or during patient transport. Clearly define appropriate interventions for patient deterioration/decompensation. Consider minimizing patient contact. For example, consider not obtaining vital signs if patient is "dry," has no visual evidence of distress or shock, and transport time is not prolonged.
- Transport patient in impervious suit if ambulatory, or in impervious sheets if non-ambulatory and stretcher-bound, as tolerated.
- Consider any patient belongings to be contaminated, which are typically bagged, labeled, and transported with the patient in the patient compartment.

- Any documents provided by sending facility should be free of contamination. When in doubt, consider them contaminated and package as appropriate for transport by ambulance personnel.
- Report patient's condition and ETA to receiving facility to facilitate their readiness to receive patient from transport agency immediately upon arrival, thus avoiding PPE-induced fatigue/dehydration for patient, ambulance crew and/or receiving staff.

Upon arrival

- Confirm arrival with receiving facility and specific route of travel within facility before debarking ambulance with patient.
- Transport patient to designated location in receiving facility – via the most direct route to isolation unit – ambulatory vs. stretcher.
- Ensure route of travel is secure, inside City of Corpus, Corpus Christi PD) outside city is still a work in progress.
- Transfer patient care to receiving facility team as arranged (and exercised).
- Return to ambulance and proceed to designated decontamination/disinfection station.
- Disinfect ambulance per SOP (CCFD Haz-Mat).
- CCFD personnel doff PPE under supervision of qualified personnel (CCFD PPE ensemble and SOP may differ from hospital).
- Have appropriately trained personnel package waste from ambulance transport.
- Transfer waste to hospital or appropriate agency as previously arranged and in accordance with applicable regulations.
- Secure mission, debrief providers, and initiate post-mission surveillance as indicated.

Receiving facility

- Ensure isolation unit is ready to receive patient.
- Prepare arrival site and route of entry to isolation unit – ambulatory vs. stretcher transport.
- Communicate with ambulance transport agency regarding readiness to receive patient, route of entry, and location of patient transfer.
- Confirm location for ambulance decontamination/disinfection and personnel doffing of PPE.
- Consider need for security on route of intra-facility patient transport (e.g., from ambulance entrance to the designated ward or unit) and/or in decontamination area (if on hospital premises).
- Prepare to receive biohazard waste from transporting ambulance agency and facilitate waste management.
- Inform appropriate public health, emergency management, and public safety authorities on arrival of patient.
- Communicate any diagnostic test results to transporting ambulance agency as appropriate to inform need for continuing post-mission surveillance of ambulance providers (EMTs, paramedics, etc.).

Guideline for Decontamination of an Ambulance That Has Transported a Suspected HCID Patient

Purpose

This guideline can serve as a model for emergency medical services (EMS) transport agencies to standardize the procedures and responsibilities for the decontamination and disinfection of an ambulance that has transported a person with suspected HCID. It is highly recommended that procedures and responsibilities for decontamination and disinfection of the ambulance be clearly defined before transporting a suspected HCID patient. **This guideline shall not replace any guidelines already in place by CCFD.** All personnel should be trained in donning and doffing (putting on and taking off) techniques for personnel protective equipment (PPE).

The following key assumptions are being made:

- All healthcare workers (hospital and out-of-hospital) who are involved will have received education and training and demonstrated the necessary competencies for management of patients with serious communicable diseases.
- Healthcare facilities and CCFD have procedures for the management of patients with serious communicable diseases.
- Facilities and CCFD are conducting tabletop and operational exercises that test and refine procedures for the transfer of patients.
- This guidance complements other CDC guidance for management of patients with serious communicable diseases.

Safety

Ebola is transmitted through contact with infected body fluids, so infection control measures must be implemented that prevent contact with blood or infectious body fluid throughout the decontamination process.

This process is designed for a 3-person team. Two people will be donned in PPE and perform the decontamination. A third person, not donned in PPE, will be available to document the decontamination and for other assistance as needed

Decontamination site setup

- Select an appropriate site for ambulance decontamination that protects the vehicle and the decontamination team from weather elements, preferably a well-ventilated large enclosed structure.
- Establish a secure perimeter for safety of the public and decontamination personnel.
- Include considerations for waste management, security plan, public perception, and media visibility when selecting decontamination site.
- Depending on the location, the ability for climate control is beneficial.
- Define and mark hot, warm, and cold zones of contamination[1] around the ambulance that require PPE to enter.

Transport unit decontamination

Note: All disinfection should use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (norovirus, rotavirus, adenovirus, and poliovirus) to disinfect environmental surfaces at appropriate concentration and contact time.

Before decontamination

- To limit the number of people exposed to potentially contaminated materials, the vehicle operator and patient care provider may be responsible for decontamination and disinfection of the transport unit. However, a separate team may also be used to do this.
- All waste, including PPE, drapes, and wipes, should be considered Category A infectious substance, and should be packaged appropriately for disposal.
- Two people in PPE should decontaminate and disinfect. A third person should be available to document the decontamination and be available for other assistance as needed.
- PPE should be donned and doffed according to organizational protocols.
- PPE selection should consider worker protection for biological exposures and potential chemical exposures based on the disinfectant used.

During decontamination

- Disinfect the outside of any prepositioned but unused medical equipment (still inside the protective bags they were placed in) and pass it to the warm zone. If the equipment was removed from a protective bag in transit, assess the equipment to determine if it can be properly decontaminated and disinfected, or disposed of.
- Any areas that are visibly contaminated with the patient's body fluids should be decontaminated first with an approved EPA-registered disinfectant for the appropriate contact time before soaking up the fluid with absorbent materials.
- If the interior of the ambulance was draped prior to transport, remove the draping by rolling the drapes down outside in, from the ceiling to the floor of the unit starting at the front of the compartment and moving to the rear.
- Roll flooring drapes from the front to rear of the compartment, rolling drapes outside in.
- To facilitate packaging and transport, drapes can be gently cut into segments.
    - It is important that all drape materials are in sections that are small enough to facilitate the insertion of the biohazard bags into an autoclave or pre-determined Category A infectious substance packaging for disposal.
- Two people in PPE should manually disinfect the interior of the patient care compartment with particular detail for high-touch surfaces such as door handles and steps using care to limit mechanically generated aerosols and using the surface wipe method to disinfect.
- Disinfect the interior as a team so that the team members can talk each other through the process and expedite the decontamination process.
- Once the manual interior wipe down has been completed, collect and package all waste as Category A waste.
- Manually wipe down the ambulance's exterior patient loading doors and handles, and any areas that may have been contaminated, with disinfectant. The exterior of the ambulance does not require a full disinfectant wipe down.
- Once the outside of all surfaces (including waste bags) have been wiped with disinfectant, then doffing can occur.

After decontamination

- A third person who has been in the cold zone should supervise doffing, which should be performed according to organization doffing protocols.
- Dispose of all waste according to organization protocols as well as local and federal regulations for Category A infectious substances.
- Additional cleaning methods can also be used. While not required, this may provide additional assurance to personnel and public prior returning the vehicle to service.
    - Ultraviolet germicidal irradiation, chlorine dioxide gas, or hydrogen peroxide vapor can be used for an additional disinfection step. However, these should not replace the manual disinfection, as their efficacy against organisms in body fluids has not been fully established and these methods may require specialized equipment and PPE.
- The ambulance can then be returned to service.

Materials and equipment needed to decontaminate an ambulance (for two people performing the decontamination) **Items**	#
Fluid-resistant or impermeable coveralls (appropriate sized suits)	4
Fluid-resistant or impermeable boot covers	4
Powered air-purifying respirator (PAPR)	2
PAPR batteries	6
PAPR filters	6
PAPR hoods	3
PAPR hose and clamp	
OR	
Full-face respirators with appropriate cartridges for protection against particles and EPA-registered hospital disinfectant (OV/AG/P95 organic vapor/acid gas cartridges)	2
Bio bags (Large)	30
Garbage bags (Large)	20
Nitrile gloves box (Small, Medium, Large, Extra-large)	1EA
Hand sanitizer (bottle)	10
Absorbent rags (package)	2
Caution tape (yellow 200' roll)	2
Duct tape (roll)	2
Bucket	1
Healthcare bleach (wipes) or other EPA-registered hospital disinfectant wipes	4
Scissors	1
Documentation	
Bio-safety check-off sheet, donning check-off sheet, doffing check-off sheet, contact list	

Coastal Bend Regional Advisory Council, TSA-U

Transport Protocol for the suspected HCID patient.

CRITERIA:

- IF THE PATIENT DOES NOT MEET BOTH THE SYMPTOMS AND TRAVEL/CONTACT CRITERIA, THEY CAN BE TRANSPORTED TO A FACILITY OF CHOICE BY ANY LOCAL 911 EMS PROVIDER.
- IF THE PATIENT DOES MEET THE CRITERIA OF SYMPTOMS AND TRAVEL/CONTACT, BELOW IS THE ACTIVATIONS PROCESS FOR THE REGIONAL TRANSPORT TEAM AND THE THREE DESTINATION HOSPITALS.
- REGIONAL TRANSPORTATION OF SUSPECTED HCID PATIENTS IS HANDLED BY CORPUS CHRISTI FIRE DEPARTMENT (CCFD). ACTIVATION OF CCFD and EMTF SUPPORT CAN BE DONE BY CALLING THE 24/7 NUMBER AT 361-886-2600.

If the patient requests a **Corpus Christi Medical Center** facility, **Northwest Hospital** has been designated. Entrance will remain the current ER entrance.

If the patient requests a **CHRISTUS Spohn** facility, **Spohn Memorial** has been designated. Entrance will be via the building entrance located on same side of the Helo-Pad, not the normal ER entrance.

Pediatric patients (**ages 17 and younger**) should be transported to **Driscoll Children's Hospital**. Entrance will be through the current ER.

If transporting a patient that MEETS the above criteria, contact the hospital enroute preferably via landline.

Emerging Infectious Disease Surveillance Tool (SRI/MERS/EBOLA)

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This Protocol developed and approved by the IAED's CBRN Fast Track Committee of the Council of Standards.

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Emerging Infectious Disease Surveillance Tool (SRI/MERS/Ebola)

Listen carefully:

Ask only in early phases when new flu, respiratory illness, or hemorrhagic fever is emerging from specific areas:

- ☐ has s/he traveled in the last 21 days (if so, where?)
  Note: (If travel timeframe questionable) Was it roughly within the past month?
- ☐ confirmed travel from a known infected ("hot") area
- ☐ contact with a person who has traveled from a known infected ("hot") area in the past 21 days
- ☐ contact with someone with the flu or flu-like symptoms (if so, when?)

Now **tell me** if s/he has **any** of the **following symptoms:**

- ☐ measured body temperature ≥ 100.4° F (38.0° C)
- ☐ fever (hot to the touch in room temperature)
- ☐ chills
- ☐ unusual sweats
- ☐ unusual total body aches
- ☐ headache
- ☐ recent onset of any diarrhea, vomiting, or bloody discharge from the mouth or nose
- ☐ abdominal or stomach pain
- ☐ unusual (spontaneous/non-traumatic) bleeding from any area of the body
- ☐ difficulty breathing or shortness of breath
- ☐ nasal congestion (blocked nose)
- ☐ persistent cough
- ☐ sore throat
- ☐ runny or stuffy nose

Note:
Symptoms in red should be considered Ebola-essential symptoms to ask.

*Continued on reverse side

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EDS (SRI/MERS/Ebola) v5.0.1 10/20/2014

Emerging Infectious Disease Surveillance Tool (SRI/MERS/Ebola)

Medical Director-approved additional questions:

- ☐ _____
- ☐ _____
- ☐ _____

Ask only if a higher-risk exposure is suspected (close contact with sick persons, dead bodies, or exotic African animals):

- ☐ needlestick, scalpel cut, or similar injury in treating or caring for Ebola patients
- ☐ blood or body fluid exposure to eyes, nose, or mouth (mucous membranes) in treating or caring for Ebola patients
- ☐ skin contact with, or exposure to, blood or body fluids of an Ebola patient
- ☐ direct contact with a dead body without use of personal protective equipment in an area where an Ebola outbreak is occurring
- ☐ handling of bats, rodents, or non-human primates in or recently received from Africa

Infection Prevention Instructions:

- ☐ **(Keep isolated)** From now on, **don't allow** anyone to come in **close contact** with her/him.

Medical Director-approved Special Instructions:

- ☐ _____
- ☐ _____
- ☐ _____

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EDS (SRI/MERS/Ebola) v5.0.1 10/20/2014

Emerging Infectious Disease Surveillance Tool (SRI/MERS/Ebola)

EIDS (SRI/MERS/Ebola) v5.0.1 10/20/2014

Abbreviations

EVD = Ebola Viral Disease
EIDS Tool = Emerging Infectious Disease Surveillance Tool
CDC = Centers for Disease Control, US Gov't
WHO = World Health Organization, UN
SRI = Severe Respiratory Infection
MERS = Middle East Respiratory Syndrome

EIDS Tool Statement

The International Academies of Emergency Dispatch's CBRN Fast Track Committee first began issuing updates on the dispatch aspects of Ebola and the Surveillance Tool in early August 2014 and on October 10, 2014, published their Ebola-specific Emerging Infectious Disease (EIDS) Tool for anyone in the world to use.

Academy Advice on Tool Use

With the spread of EVD outside of West Africa now appearing unpredictably in new places, the specifics of when to use this Tool and **the extent of questioning within this Tool must remain user-defined** (Medical Director–controlled wherever possible).

Where a secondary surveillance software, like FirstWatch™, is used, there may be a greater desire to collect more information using this Tool to aid in its predictability features and output. This is a local decision that must be directed by EMS and public health officials and medical control physicians.

Rules

1. This Tool **does not require a specific order or number of questions** to ask. Geographically, areas of recent travel concern can change daily or simply become irrelevant.
2. There are **three spaces** for "Medical Director–defined" **questions** for local agency use. Since ProQA cannot recognize these, you must have each question previously **defined by Medical Director–approved policy.**
3. During EVD emergence, **check the IAED's website daily** for any new updates or dispatch-related advice until the public health is again stable and assured. **Updates** to the EIDS Tool may be posted **at any time at:** www.emergencydispatch.org
4. There are **several questions related to an elevated body temperature** – one specifically asking about any **measured temperature at or above 100.4°F/38.0°C** and 3 other "surrogate" temperature questions: **fever (hot to the touch in room temperature), chills,** and **unusual sweats.** Per your agency's policy, a **positive answer** to any one of these questions can **eliminate the need to ask** the others.
5. The EIDS Tool is **not launched automatically** off any Chief Complaint Protocols at this time. IAED recommends the following as **1st Tier Protocols** to **locally consider launching** on: **1, 18, 21, and 26.** The **2nd Tier Protocols** include: **6, 10, and 32;** however, these designations **could change** at any time.

EIDS (SRI/MERS/Ebola) v5.0.1 10/20/2014

Limitations Warnings

The content, format, and/or intended use of the EIDS Tool can change at any time. It is important that you and your agency stay informed of any updates by visiting the IAED website at least once daily. **Neither the IAED nor PDC has any obligation, beyond its website postings, to individually inform licensed users, or other agencies using this Tool,** of any updates or changes, due to the rapidly evolving aspects of such diseases, outbreaks, epidemics, or a pandemic.

As North American English (NAE) is the "mother" language of the IAED, the Academy and its CBRN Fast Track Committee must make quick and difficult decisions on the release order and timeliness of translations into other languages and dialects and their ultimate availability, based on rapidly changing conditions regarding current areas of outbreak and government recommendations. This will likely affect the order and priority of such postings.

Ebola Viral Disease (EVD)

EVD is a very serious disease **residing in exotic animal populations** in several places in Africa. The **case fatality rate** in the current outbreak is **55% to 60%.**

EVD has **not been proven** to be passed in an airborne manner, **but is passed by contact** with an **infected patient's bodily fluids,** including sweat. Due to the **rapidity of viral mutations,** however, **this could change** at a future time.

As opposed to earlier viral outbreaks and pandemics, Ebola signs and symptoms appear initially to be **less respiratory-related** and **more GI-related** and, ultimately, **include spontaneous bleeding from any area of the body.**

The **incubation period** of EVD (latent period without evidence of symptoms) can range from **2 to 21 days** (average 8 to 10 days) per the CDC and WHO.

The general course of the disease appears to progress as follows:

- **1 to 3 days:** Flu-like symptoms, fever
- **4 to 7 days:** Diarrhea, vomiting, low blood pressure
- **7 to 10 days:** Profuse internal/external bleeding, organ failure, coma, death

Late stages preceding death include **swelling** of the whole body, **bleeding** under the skin, profound **fluid loss,** and **organ failure.**

Printing Instructions

To print the EIDS Tool for manual cardset use, please select pages 2 and 3 in your printer options and also select duplex or two-sided. Once printed, fold the page in half with initial Tool questions on the outside of card.

To trim the pullout tab, use another pullout card as a guide to cut the curved edges of the tab. Reinforce the tab using clear packaging tape and trim again.

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Additional Resources

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6. Lowe, J.J., Olinger, P.L., Gibbs, S.G., Rengarajan, K, Beam, E.L., Boulter, K.C., Schwedhelm, M.M., Hayes, K.A., Krotochvil, C.J., Vanairsdale, S., Frislie, B; Lewis J., Hewlett, A., Smith, P.W., Gartland, B., Ribner, B.S. Environmental infection control considerations for Ebola.