

City of Fairfax Fire Department
Interim Medical Directive - Ebola Treatment Guidelines (Released: 11/04/2014)

This document shall serve to provide guidelines for the assessment and treatment of a patient with suspected presentation of Ebola Virus Disease (EVD).

Primary goals are:

- Protect all providers, responders and healthcare workers by utilizing the most up-to-date personal protection equipment (PPE) guidelines.
- Limiting exposure of personnel and equipment to a patient (person) under investigation (PUI).
- Allow for limitation of unnecessary medical procedures during the pre-hospital treatment and transport of potential or known Ebola patients.
- Provide skilled, compassionate, humanistic care to patients.

BLS Providers:

- Don proper PPE. This will be determined by the officer in charge (OIC) utilizing the CDC guidelines and Fairfax County guidance.
- Make verbal contact. Per the CDC guidelines, utilize the 6 foot rule of distance between the providers and the PUI. (Stand-off assessment)
- Establish general impression of patient through during the initial stand-off assessment
 - Age
 - General appearance
 - Infectious scene hazards such as blood, stool, or vomit
- Based on the initial stand-off assessment, escalate or deescalate PPE as needed. Do not initiate hand-on care without proper PPE.
 - If patient is in cardiac or respiratory arrest:
 - WITH bystander CPR on-going: provide verbal instructions while providers are donning PPE. Contact on-line medical control. Consider termination of resuscitation.
 - WITHOUT bystander CPR: Establish down time. Contact on-line medical control. Consider termination of resuscitation.
 - If CPR is started/assumed by EMS, LUCAS2 device shall be utilized

- Obtain a set of vital signs to include temperature, pulse, respirations, and blood pressure.
- Based on the above, determine if the patient is stable or unstable.
 - Unstable
 - Altered mental status
 - SBP <90mmHg or <70 =(2xage) for pediatrics
 - Hypoxia with impending respiratory failure (elevated RR,SP02 <90% with accessory muscle use)
- All PUI will be transported with the medic unit OIC as the attendant-in-charge

For Stable Patients:

- Place a **surgical** mask on patient. Do not use N95 mask on patient.
- Assist patient to stretcher if needed. Allow patient to move under his or her own power as much as possible.
- If patient is vomiting or has diarrhea, transport the patient in supplied body bag.
 - Bag should be wrapped in sheets and blankets
 - Bag should be concealed to best of ability
 - Do not zip bag past patient's shoulders
 - Head of bed can be raised to semi-fowlers position if needed.
 - Use emesis basin with Chux pad or other absorbent device contain the vomitus.
- Do not initiate IV.
- Do not use nebulizer.
- No monitoring is required during transport. Obtain repeat vitals on arrival to hospital.
- If patient is complaining of both viral symptoms AND cardiac chest pain, obtain baseline 12 lead EKG. If no evidence of AMI is present, no further EKG monitoring is required.
- Medications
 - Ondansetron
 - Adult: 4-8 milligrams PO/ODT
 - Pediatric:
 - >4yo 4 to 8 milligrams PO/ODT
 - 2-4yo 2 to 4 milligrams PO/ODT
 - Acetaminophen (Tylenol) 15 milligram/killogram PO for headache, muscle pain, fevers OR

- Ibuprofen (Motrin, Advil) 10 milligram/kilogram PO for headache, muscle pain, fever.
- Supplemental oxygen via nasal cannula as needed.
- Priority 2 transport

For Unstable Patients:

- Place **surgical** mask on patient if it will not compromise the airway. Do not use N95 mask on patient
- Transport the patient in supplied body bag.
 - Bag should be wrapped in sheets and blankets
 - Bag should be concealed to best of ability
 - Do not zip bag past patient's shoulders
 - Head of bed can be raised to semi-fowlers position if needed.
- Use emesis basin with Chux pad or other absorbent device contain the vomitus.
- Any invasive procedure should be done in a controlled environment by the most experienced provider. Do not perform interventions in a moving vehicle.
 - Consider IO over IV as PPE will limit manual dexterity. Multiple attempts at venous access increase risk of provider exposure to needle sticks.
 - Isolate sharps in separate container (e.g.: Sharp Shuttle)
- Avoid nebulizer therapy – utilize inhaled multi-dose medications instead
- For respiratory failure:
 - Place supplemental oxygen up to an including 100% NRB as needed
 - Use RSI for intubation to limit gagging
 - Strongly consider use of McGrath and bougie if placing endotracheal tube
 - King LT airway is acceptable alternative to ETT to secure airway
 - Bag-valve-mask should be done with 2 providers to ensure tight seal of mask against face
 - Use CPAP only if absolutely necessary for respiratory support
- For hypotension:
 - 1 liter NS bolus or 20cc/kg for pediatrics. May repeat x1.
- Monitor respiratory status using SpO2 and EtCO2 as needed
- Cardiac monitoring is not required.

- Obtain repeat vital signs on arrival at hospital
- For cardiac arrest witnessed by Fire/EMS providers, secure airway and initiate mechanical CPR only. Contact on-line medical control. Consider termination of resuscitation.
- There are no changes from existing protocols for medications for the PUI.