Appendix 3 (as supplied by the authors): Critical Care Response to Suspected/Confirmed Ebola patient in Emergency Department Requiring Intensive Care Unit Admission

For all transport – need to contact security and housekeeping as well
While preparing for transport security will ensure route is clutter free
Patient suspected with Ebola needs ICU

1. Emergency Department (ED) Care Facilitator (CF) calls Intensive Care Unit (ICU) CF and ED physician call ICU physician
2. ICU CF
    a. Checks ICU room is ready, red board is brought in
    b. Activates staff - 2 nurses, porter, +/- RT
3. 2 ICU nurses go to ED and bring: MMS, portable monitor, portable vent if needed
4. **Risk Assessment performed** – completed with team - ICU nurse and physician
    a. Determine minimum number of staff required to transfer and stabilize safely
    b. Do they need to transferred on monitor or can they be safely transported off of the monitor (there are many small spaces on the monitor that could be difficult to decontaminate, if monitor used remove all pressure modules if not needed)
    c. Patient stability for transport and body fluid management
        1. Respiratory distress – assess need for intubation prior to transfer or use a mask
        2. Nausea/vomiting- assess need for nasogastric (NG) tube
        3. Diarrhea- insert fecal management system
        4. Incontinent of urine - Foley catheter
        5. Open wounds covered and dressed
5. Patient ready for transport- Two ICU nurses don personal protective equipment (PPE), remain outside the door
    a. Note – if ICU nurses or physicians were in the room with the patient to assess or assist with stabilization they will need to follow doffing procedures and then don clean PPE to accept the patient outside of the room door
6. MMS, monitor, vent handed in to the room ED staff hook patient up, patient masked if non vented
7. Patient moved on stretcher out of the resus room
    a. **Security** - leads ensures that route is clutter free and to open door (Note: security must be careful not to be too far ahead as they press the automatic door open disks – otherwise risk that the doors will automatically close on the transport team and get contaminated)
    b. **ICU Nurse 1** - and ICU MD/RT transfer patient to the ICU
    c. **ICU Nurse 2** – follows behind and remains clean and observes the team transport actions to identify any contamination
    d. **Housekeeping** – follow behind prepared to clean any contaminated surfaces
8. Patient transferred to ICU bed with the red board
9. ICU Nurse 2 pushing the bed and the ICU MD/RT will get the patient settled in bed
10. ICU Nurse 1 does not go in the room and becomes the observation nurse for everyone on the room

Appendix to: Sarti SJ, Sutherland D, Robillard N, et al. Ebola preparedness: a rapid needs assessment of critical care in a tertiary hospital. *CMAJ Open* 2015. DOI: 10.1503/cmajo.20150025.
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Note:
A. If Nurse 1 remains clean then on arrival to the ICU room, Nurse 1 can stay outside of the room and remove PPE without full doffing procedures, Nurse 1 will continue to serve as the observer monitoring the team.
B. If Nurse 1 comes in contact with the patient or equipment during transport OR if Nurse 1 is required to stabilize the patient in the room, Nurse 1 will enter the room with the team and complete full doffing procedure. In this case a trained observer must still be in place outside of the room – team suggested the CF
Need to decide what to do with the stretcher – this will require further exploration. Numerous suggestions have been made to cover in plastic prior to transferring patient onto stretcher.