COVID-19 PROCEDURE

The agency has crafted numerous inter-related procedures for the purpose of minimizing employee exposure risks. These procedures continue to be developed through thoughtful collaborations with medical direction, robust guidance by PCFR Infection Control Officer, Dr. Christine McGuire-Wolfe, CDC recommendations, state health organizations, other internal subject matter experts and national industry best practices.

The best way to protect yourself from exposure is to do the following:

1. Thoroughly wash your hands with soap and water, keeping your hands away from your face, eyes and mouth.
2. Use the proper PPE as described in the following pages.
3. Keep a safe distance (> 6 feet) with all patients until you determine their risk factors for exposing you to a viral disease.
4. Follow all associated administrative orders.

DISPATCH

Dispatch will utilize the Emerging Infectious Disease Surveillance (EIDS) tool for the following chief complaints: Sick Person, SOB & Flu type Symptoms. If patient meets the EIDS criteria, Dispatch will advise responding crew, Dispatch will utilize a UDTS code, that will reflect ***Use Respiratory Universal Precautions*** in the CAD notes to alert the crew of potential risk. If through call takers screening, utilizing the EIDS tool, the patient is a "Respiratory Universal Precautions" alert, every attempt will be made to confirm crew acknowledgement.

The donning of proper PPE must be adhered too when a patient is presenting with shortness of breath, cough, rhinorrhea, fever, nausea/vomiting, diarrhea, etc.

- A single pair of disposable patient examination gloves. Change gloves if they become torn or heavily contaminated,
- Disposable isolation gown or coveralls
- Respiratory protection (N-95) or acceptable alternative (simple facemask)
- Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face).

CORONAVIRUS (COVID-19) SCREENING TOOL

SCREENING CRITERIA	√

1. Patient has laboratory confirmed COVID-19 or respiratory infection (i.e. pneumonia) _____

OR

2. Patient presents with Fever / Temperature of >100.3 °F
   (If the patient has taken Motrin or Tylenol in the last <6 hours assume the patient is febrile) _____

AND

3. Any two (2) of the following symptoms activate a "***Viral Alert***" _____

- Oxygen Saturation of <94% w/ Good Waveform
- Presence of Cough
- Sore Throat
- Body aches
- Pulse Rate >100
- Shortness of Breath with a Respiratory Rate >20 or <8

A "Viral Alert" shall be called regardless of a complaint of diarrhea if the above criteria is met.

*The **Viral Alert** will be issued to the receiving hospital and dispatch as soon as possible.

All **Viral Alert patients will be transported to the closest, most appropriate facility.

ARRIVAL ON SCENE

If dispatched to a ***Respiratory Universal Precautions***, respiratory related, unresponsive, sick person or any call the responder believes could be of higher risk – Prior to entering the building or residence:

One rescuer will don appropriate PPE unless otherwise required to effectively render patient care

PPE	MINIMUM	TIER-1	TIER -2 "VIRAL ALERT"
	YES	YES	YES
	NO[1]	NO[1]	YES
	NO[2]	NO[2]	YES
	NO	YES[3] RESCUER[4]/PATIENT	PATIENT
	NO	NO	YES

[1] A gown should be utilized anytime there is a risk of splash of any bodily fluids.[2] An N-95, or greater mask will be used anytime there is a risk for aerosol, airborne pathogen exposure, and/or any airway management procedures are being conducted (i.e. artificial ventilation, suctioning, and endotracheal intubation) [3] Any provider in the back of the ambulance while a patient is being artificially ventilated is to wear an N95 mask. [4] A surgical mask (simple mask) is sufficient when there is no risk for aerosol exposure and/or not conducting any airway maintenance/management procedure.

A "Viral Alert" should be announced once screening procedure as recognized criteria has been met.

ON-SCENE PROCEDURES

- Dispatch will instruct patient and family to not approach responders
- Dispatch to request patient to exit occupancy (if possible) and wait outside
- Once the rescuer has donned the appropriate PPE, he/she will enter the scene, contact the patient, and complete a patient assessment/interview.
- Rescuer will immediately place a surgical mask (simple) mask on the patient when

required. In the event the patient requires oxygen therapy, place the mask over delivery device.

- Rescuer should identify, and request the resources needed to move the patient, limiting unnecessary exposures. Rescuers who are assisting with patient care must don proper PPE prior to entering the residence
- Active airway assistance, artificial ventilation, suctioning, or those procedures identified as being high risk for airborne pathogen exposure will require the rescuer utilization of an N-95 mask, goggles, gown, gloves, etc.
- When no risk of airborne pathogen exposure a surgical mask (simple mask) is sufficient.
- When dispatched to any call that does not fall within the listed categories above the rescuers should follow:
    - One rescuer will make contact with the patient keeping a distance of >6 feet and perform the primary assessment and patient interview.
    - If the patient relates any respiratory issues or signs and symptoms associated with a viral event, the responder will retreat to don the proper PPE, advise other responders and mitigate the call to completion.

PRECAUTION FOR AEROSOL—GENERATING PROCEDURES

Certain procedures may aerosolize COVID-19, and therefore are considered higher risk and should be avoided unless necessary. These procedures include the following: bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, CPCP, or resuscitation involving emergency intubation or cardiopulmonary resuscitation. When necessary, personnel must follow the below guidelines:

- If proper PPE is being worn, this significantly reduces possible exposure
- N-95 or appropriate alternative respirators must be worn by person responsible for airway and breathing procedures
- Gowns or splash resistant suits should be worn when biological droplet is expected (cough, sneeze, etc.)
- Utilize King Tube over endotracheal tube in these patients, minimizing exposure to personnel. Endotracheal tube is the desired method of securing the pediatric airway.
- RSI with King Tube placement may be preferable to CPAP in patients in severe respiratory distress; Solumedrol should be utilized instead of the traditional Albuterol and/or Atroven Nebulizers
- Full respiratory PPE (N95 mask, Gown, Eye protection with face shield) must be used if performing any aerosolizing procedure. During these procedures, when the vehicle is not in motion and whenever possible, the rear doors of the vehicle should be open with the HVAC system activated
- Maintain safe distance (>6 feet) from patients when possible

BEFORE TRANSPORT

- Use only the EMS personnel that are needed for patient care and loading. Cancel any unnecessary units or engines.
- If the driver of the ambulance was not in contact with the patient, they are to remain in the driver compartment.
- After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE, except mask, and perform hand hygiene prior to entering the cab to avoid soiling the compartment.
- All personnel should avoid touching their face while working.
- All personnel should wash hands when available for >20 seconds prior to and after every patient contact with soap and water with the understanding that hand washing is a high-priority prevention activity.

TRANSPORTING

- Issue "Viral Alert" to the receiving facility as soon as possible. This will give the hospital time to prepare for your patient. Provide them with all pertinent information.
- Family members and other contacts of patients with possible COVID-19 are not allowed to ride in the ambulance except a parent of a child patient. Parent / guardian will ride in the patient compartment and wear a simple facemask.
- Isolate the ambulance driver from the patient compartment. Utilize Installed plexi-glass isolation when possible and in older spare rescues that have the sliding pass-thru window, this must remain closed to the patient compartment area.
- During transport, vehicle ventilation in both compartments should be on **non-recirculated** mode to maximize air changes that reduce potentially infectious particles in the vehicle.
- If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.

AFTER DELIVERY OF PATIENT- DECONTAMINATION (APPARATUS/CREW)

- After the transfer of patient care at the receiving facility, the EMS supervisor will be notified of the crew's need for the disinfectant sprayer (so the EMS Supervisor can arrange transfer of the disinfecting sprayer to the station).
- Dispatch will be notified that the Rescue is out of service.
- The crew will perform gross decontamination of the Rescue (using Clorox Hydrogen Peroxide wipes.)
- The crew will remove their gowns and gloves and discard immediately.
- The crew will use the same mask they were wearing during the transport, don a new gown and gloves, and return to their assigned station.
- During this time period, the EMS Supervisor will have either transported or arranged for transport of the Disinfectant sprayer to the crews' assigned station.
- While still in PPE, the crew will disinfectant both the patient compartment and the cab of the Rescue, then doff PPE.
- Discarded PPE should be double knotted in a biohazard bag for disposal.
- The crew will remain out of service while they shower and change.
- Clothing should immediately be laundered.
- Vehicle is back in service

******NOTE****** When crews return to the station and park on the apron, the rescue vehicle should not be parked within 6 feet of the apparatus bay door with rear vehicle doors open

POTENTIAL CREW EXPOSURE DOCUMENTATION

- EMS Supervisors are to call or text the ICO anytime a patient direct exposure involves personnel NOT wearing proper PPE not just filing an exposure report, which allows for the prioritization of exposures.
- The crew will complete an exposure form and submit to ICO through the EMS Supervisor. The form contains the information that I will need to follow up on the patient.
- ICO will hold these exposure forms for 30 years past the last date of the employee's employment with PCFR.
- The employee will be entered in the temperature monitoring system. If he/she is already active in the program, their monitoring date will be extended to 14 days past the date of the call. If he/she is new to the program, a number will be assigned for logging purposes.
- If the employee needs a thermometer, one will be provided to them, if available. The involved employee, Captain, or supervisor should notify ICO of this need via email message.
- If more than one employee is involved in the potential exposure, the EMS supervisor or Captain should send the exposure reports as a group email, with a list of who does and does not already have thermometers.
- If you are on temperature monitoring, but still cleared for work, please be sure that you are actively participating.
- Expectations for self – isolation is that the employee practice and maintain social distancing and follow all CDC and Department of Health guidelines

ADMINISTRATIVE

COVID-19 EMPLOYEE SCREENING & DISMISSAL FROM DUTY

All crews will complete a shift-change screening process to assess their communicable disease risk to their crew members, patients, and the community as a whole. This process should be completed for each employee *before* they relieve the personnel from the departing shift. The station Captain is responsible for completing the form, but the preceding shift's Captain may begin the screening process for the on-coming shift if crew members report for duty early. The completed form must be submitted to the Battalion Chief before 10 am each shift day. After reviewing for completeness, the Battalion Chief will forward to the Infection Control Officer and Shift Commander via e-mail.

The form includes an assessment for fever and four additional screening questions based on currently identified risk for COVID-19. If any of the questions are answered "yes", the employee must be sent home from duty unless otherwise cleared by the Infection Control Officer (ICO). These exceptions will be rare and must include a solid, alternate explanation for symptoms. Employees that are sent home from duty will receive a monitoring number and further directions from the Infection Control Officer based on the date of the exposure or onset of symptoms (typically 14 days).

Infrared thermometers will be delivered to the stations, headquarters, fire rescue supply services, and training during the week of March 30, 2020 and will be designated for the sole use of employees. The Centers for Disease Control (CDC) allows for subjective reporting of fever in these circumstances. This process will be implemented at shift change on March 17, 2020. Once infrared thermometers are available at the stations, a reading will be taken for each employee at every shift screening until this A.O. is rescinded. Station Captains will be responsible for securing the infrared thermometers after completing the shift screening – any unaccounted for thermometers will be the responsibility of the station officer.

Any employee (regardless of work assignment), who meets any of the following criteria, will be required to remain off duty until the window of risk has passed (typically 14 days, to be determined by the ICO).

- Fever (temperature defined at 100.3^{o}F or above), current or within the last 14 days. Temperature screenings over 100.3 will warrant a more in-depth health screening by the EMS Supervisor and the Infection Control Officer with the final determination of isolation to be done by the Deputy Chief of Operations
- Symptoms of respiratory infection (such as cough or fever)
- History of air travel, including train and cruise, within the past 14 days. In accordance with CDC guidelines, employees that have traveled domestically via airplane or participated in any cruise travel, will self-isolate at home for 14 days from the last date of travel.
- Close contact with a known COVID-19 case in the past 14 days.