Virginia Beach Department of Emergency Medical Services

Operations

Infectious Respiratory Illnesses

PURPOSE: This purpose of this Standard Operating Guideline (SOG) is to establish guidelines for response to infectious respiratory illness CoVID-19. This guidance is based on information from the Virginia Department of Health (VDH) and the US Centers for Disease Control and Prevention (CDC).

APPLICABILITY: This SOG applies to all emergency responders within the Emergency Response System.

DEFINITIONS: **High Risk, Full PPE -** Don full PPE (N-95 mask/respirator, proper eye protection, non-latex gloves). Full PPE protects against CoVID-19 **and proper use of full PPE does not constitute an exposure to the provider.** It is strongly recommended that providers wear their issued, reusable, industrial-style respirator instead of paper N95's.

Aerosolized Generating Procedure (AGP) – Any actions or procedures involving the airway including nebulized medication administration process (Hand-held nebulizer, non-rebreather or simple facemask nebulizer, etc.), CPR, chest decompression, Bag Valve Mask usage (includes Endotracheal Tubes and King airway devices), intubation, King, nasal or oral airway insertion, or CPAP use.

PROCEDURES:

1. **Responder Actions**

    1. All personnel will complete the daily self-check before any shift, class, meeting, or in-person EMS activity.
        i. Volunteer providers will complete the app/link on the department website which will provide specific direction to the user based on the how the questions are answered.
        ii. Career staff will complete the city checklist.
        iii. If there are any questions, contact the EMS Supervisor.

    2. Responders will wear a surgical mask while on duty for the shift. This includes indoors (when social distancing cannot be managed), in vehicles, and outdoors (if provider has not been vaccinated).

i. A single surgical mask may be worn until it becomes soiled. Maximize the use of the surgical mask. Cleaning and re-using the surgical mask is not authorized.
ii. Member-provided non-medical, non-industrial face coverings may be used as outerwear on top of a properly worn surgical mask, and in fact may help prolong the useful life of a surgical mask. Wearing such face coverings this way is acceptable if the following conditions are met:
    1. The outer face covering is kept clean. Members should wash such face coverings between shifts.
    2. Inappropriate words, symbols, or other graphics are not displayed on the outer face mask. For instance, biohazard icons, skull-and-crossbones, faux skeleton images, etc., shall not be allowed.
    3. Face coverings should NOT be worn over N95 masks. Doing so may compromise and defeat the purpose of using the N95 mask.

3. Minimal PPE for patient contact:
    i. Any call with a known or suspected COVID patient requires crew members to don Full PPE-N95/respirator, eye protection and gloves.
    ii. If performing AGP's, all crew members involved shall wear Full PPE- N95/respirator with eye protection and gloves.
    iii. All other patient contacts require the use of a surgical mask and eye protection in addition to other required standard precautions.
    iv. A surgical mask should be applied to the patient if they can tolerate it, including one over oxygen delivery devices.

4. Response personnel should screen all patients, initially from at least six feet away, if possible, by assessing information about:
    - Fever (subjective)
    - Respiratory symptoms (i.e. cough, shortness of breath, difficulty breathing)
    - CoVID-19 exposure risk
    - Travel history
    - Residence location (skilled nursing facility, assisted living, jail, etc.)

5. The first arriving responders should limit the number of providers (1-2) for the initial assessment to determine risk and advise the rest of the crew regarding the level of PPE required. All patients should receive a surgical mask if one is available and does not add additional distress to the patient. Do not use a non-rebreather mask or simple face mask to substitute for a surgical mask.

1) If units arrive on scene simultaneously, the ambulance crew and/or zone medic provider (preferably the Attendant-In-Charge) should initiate primary patient care to minimize personnel exposure.

6. **All hospitals are prepared to receive patients.** The ambulance Attendant-in-Charge should alert the hospital of the concern about a COVID-19 infection. The hospital will provide further instructions regarding deviations to turnover.

7. For ALL providers that have been issued a full-face reusable, industrial respirator devices, these devices should be worn in lieu of other respirators since it protects the providers eyes and respiratory system. However, NO VEHICLE SHALL BE OPERATED BY THE PROVIDER WEARING A FULL-FACE MASK. Half face respirators can be worn while driving.

8. Personnel who believe they have suffered an exposure to CoVID-19 should follow the standard health exposure reporting process. An exposure is defined as an event in which established processes, procedures, and protections failed to provide adequate protection to the member. Incidents involving a CoVID-19 patient in which health risks were successfully managed using FULL PPE will not be considered an exposure. If a potential provider exposure occurred, the Safety Officer will be in touch with the provider for follow-on guidance per the CDC.

3. Protocol Deviations

A. If the patient is acutely ill and requires urgent medical care, provide patient-specific care incorporating the goal to limit airborne droplet spread. You may provide airway treatment such as oxygen therapies, as clinically indicated. Additional protocol direction is provided below.

B. Full PPE must be used when working with the airway including conducting needle chest decompressions.

C. Use of video laryngoscopy is preferred over manual intubation.

D. On all calls where you are using a BVM (intubation or King LT), contact the emergency department when you arrive on the hospital campus and request the staff meet you in the ambulance to assess. Some hospitals may choose to place the patient on a portable ventilator in

the ambulance prior to moving into the ED. Other hospitals should verify that you have or will place an in-line HEPA filter on the tube.

E. Bring all the patient's personal MDIs with them to use in the ER in the event they need continued puffs from the MDI (potential shortage in the hospital).

F. Patients with a respiratory illness should have pulse oximetry and capnography. If the patient is in respiratory distress, follow TEMS protocols. If little to no relief, move to endotracheal intubation (with RSI, if needed). Use an in-line HEPA filter placed between the endotracheal tube (or King airway device), if available and the BVM (ETT>HEPA filter>ETCO2>BVM). PEEP valves have also been placed in ambulance intubation kits for use on the BVM, if needed.

    1) For patients that are in severe respiratory distress, all RSI-certified Paramedics may conduct the RSI protocol on standing order. A second ALS provider (EMT-Intermediate or above) is still required to support the intubation. Ensure your narrative documentation includes verbiage regarding the protocol deviation.
    2) Open the windows and turn on the exhaust fan in the patient compartment.

G. **Cardiac arrests** should be managed with a higher index of suspicion. ALS providers should exercise critical thinking along with sound judgement in determining whether to work a cardiac arrest.
    1) Unless the patient has a sustained return of spontaneous circulation or ROSC, after 20 minutes of working the arrest, contact on-line medical control prior to moving the patient on to a stretcher for consultation.
    2) Placement of LUCAS device will now return to standard protocol for cardiac arrest with CPR and resuscitation for 10 minutes prior to placement of the device.

H. Engage in best practices for safe transport and decontamination for equipment and transport units.

4. Documentation Guidelines for CoVID-19 Responses

A. Specific job-aids have been developed for documentation of patients with symptoms consistent with CoVID-19 and/or confirmed cases of the virus. Based on certain signs/symptoms entered in Elite the CoVID-

19 Screening Worksheet will be required. It is always available as an assessment tool, even if not required.

B. Guidelines for documentation, as recommended by the CDC, have been produced to help providers better document cases in such a way that data retrieval is more consistent.

C. PPE utilized should be documented in the ***Provider Safety*** field in Elite. It is also important, as always, to document all crew members present in the ***Crew Member*** field.

D. Record details of risk profile to include specific locations of travel, residence, and nature of known or suspected virus exposure in the patient care report. Determine course of illness – specifically onset of symptoms, onset of fever, and highest measured temperature (if available).

5. Virginia Beach EMS CoVID-19 Surveillance Activities

Virginia Beach EMS has implemented daily surveillance for COVID-19 to identify EMS responses that have treated a patient that is confirmed positive with CoVID-19.

6. Infection Control Officer – Role and Responsibilities

The Department of EMS maintains a Designated Infection Control Officer. The Infection Control Officer is critical to ensuring your agency receives the most accurate information about the dynamic situation and updates about any respiratory illness and specifically, CoVID-19.

APPROVED:

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Operational Medical Director **Date**

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