CHARLES COUNTY EMERGENCY SERVICES

SPECIAL ORDER 2020-01

Transport of Infectious Disease Patients Under Investigation for Coronavirus Disease 2019 (COVID-19)

EMERGENCY MEDICAL SERVICES

Issue Date: 03/03/2020 **Revised:** 10/13/2020

Expiration Date: N/A

1. OVERVIEW

With the annual occurrence of influenza season, and with the recent developments regarding the Coronavirus, we are all reminded that the manner in which we approach infection control incidents is of the utmost importance. Many within the Charles County Department of Emergency Services (CCDES), Charles County Association of Emergency Medical Services (CCAEMS) and the Office of the Medical Director are remaining vigilant to emerging issues related to infection control. Of concern is the Coronavirus outbreak which originated in the Wuhan Province of China, and the subsequent cases that have occurred here in the United States and elsewhere throughout the world. This policy and procedure outline the preparation, mobilization, and demobilization required for care and transport of suspected and known Coronavirus 2019 patients.

2. DEFINTIONS

- **Close Contact** - Close contact is defined as being within six (6) feet of a COVID-19 patient or being within the patient's care area or room for a prolonged period of time. Brief interactions such as walking by a person or moving past their room do not constitute close contact.

- **Coronavirus 2019** - A novel coronavirus is a new coronavirus that has not been previously identified. The virus causing coronavirus disease 2019 (COVID-19), is not the same as the coronaviruses that commonly circulate among humans and cause mild illness, like the common cold. On February 11, 2020 the World Health Organization announced an official name for the disease that is causing the 2019 novel coronavirus outbreak, first identified in Wuhan China. The new name of this disease is coronavirus disease 2019, abbreviated as COVID-19. In COVID-19, 'CO' stands for 'corona,' 'VI' for 'virus,' and 'D' for disease. Formerly, his disease was referred to as "2019 novel coronavirus" or "2019-nCoV". There are many types off human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease, caused be a novel (or new) coronavirus that has not previously been seen in humans.

- **Infectious Period -** The time period during which a person can transmit a virus. The infectious period for COVID-19 is considered to be forty-eight (48) hours before symptom onset (if symptomatic) or before specimen collection date (if asymptomatic) until the infected individual completes their isolation period. Determining the infectious period for an asymptomatic case is challenging due to the absence of an illness onset. The period beginning forty-eight (48) hours prior to specimen collection should be considered an estimate instead of a precise timeframe.

- **Non-exposure** – The following individuals are NOT considered "exposed" to COVID-19:

    - EMS clinicians who are farther than six (6) feet from the patient or,
    - EMS clinicians who are within six (6) feet of the patient for less than five (5) minutes and not performing respiratory procedures,
    - EMS clinicians who are wearing appropriate PPE when interacting with a PUI patient.

- **Person Under Investigation (PUI)** – A person who meets the CDC established criteria for COVID-19 symptoms and epidemiological risk factors. Symptoms include a fever and/or symptoms of acute respiratory illness (e. g. cough, difficulty breathing).

- **Personal Protection Equipment (PPE) –** For the purpose of this Special Order, PPE is considered those items in accordance with the recommendations of the Maryland Institute for Emergency Medical Services Systems – Infection Control and PPE Guidance (attachment). Such items included are gloves, respiratory protection masks, eye protection and gowns.

- **Seasonal Flu -** Influenza is spread by cough, sneeze, or by common contact with virus-contaminated surfaces.

- **Suspected Low Risk Exposure** – This event is defined when an EMS Clinician comes in contact with a known COVID-19 patient and the following are place:

    - The patient is wearing a mask, and
    - The EMS Clinician is wearing all appropriate PPE.

- **Suspected Moderate to High Risk Exposure** – This event is defined when an EMS Clinician comes in contact with a PUI and/or known COVID-19 patient, and the following are true:

    - There is a prolonged (greater than 15 minutes) close contact within six (6) feet of a suspected PUI and/or known COVID-19 patient without appropriate PPE,
    - An EMS clinician performs any respiratory procedures (intubation, nebulizer treatments, CPAP, oxygen) without wearing appropriate PPE.
    - An EMS clinician comes in direct exposure to respiratory secretions.

3. GENERAL

The information contained in this procedure is intended to be consistent with the EMS and PSAP interim guidance given by the Centers for Disease Control (CDC) and Prevention and by MIEMSS for management of patients with known or suspected COVID-19. In some cases, our local implementation of infection control procedures will exceed those recommended by the CDC. In addition, as this is a rapidly emerging situation, the policy is subject to frequent changes. It is our goal to update this plan in accordance with changes recommended by MIEMSS and/or the CDC as they develop.

4. PROCEDURES

A. PATIENT SCREENING

1. Utilizing the State's Emergency Infectious Diseases Surveillance Tool, the Charles County 911 Communications Center will begin to screen callers requesting emergency medical services for possible COVID-19 symptoms to include the presence of respiratory illness, cough or fever. Additional factors may include travel to a COVID-19 outbreak country, travel to a state where COVID positive cases exceed ten (10%) percent of the population, or travel on a cruise ship porting at areas with COVID-19 outbreaks within fourteen (14) days as well as close contact with someone who has laboratory confirmed COVID-19 within the previous fourteen (14) days as well.

2. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Per the CDC, as of 03-24-2020.

3. An incident involving a patient that has complaints of respiratory illness, sore throat, cough and/or fever shall be considered a PUI incident.

4. 911 Communications Center shall communicate to field personnel the aforementioned findings of a respiratory illness, sore throat, cough and/or fever so that proper PPE selection and procedures can be made prior to patient contact.

5. The same indicators of a suspected PUI should be used in field screenings of patients. Field screening questions should be asked at a distance of six (6) feet or more if possible, prior to implementing direct patient contact.

B. RESPONSE

1. When the Charles County 911 Communications Center determines there is a patient that conforms to the COVID-19 PUI criteria, the closest appropriate EMS units will be dispatched.

2. All personnel who are dispatched to the scene of a known or suspected COVID-19 PUI must don the appropriate PPE prior to entering the scene. This PPE is defined in the Maryland Institute for Emergency Medical Services Systems – Infection Control and PPE Guidance (attachment).

3. For patient encounters in which a potential PUI patient Incident has not been identified at the time of dispatch, yet on-scene providers suspect the patient may be a PUI candidate, prior to establishing close contact; personnel should remotely interview and assess the patient from outside of a six (6) feet perimeter to determine whether the patient meets the criteria for being a COVID-19 PUI. If the patient meets the established criteria; immediately back out of the scene and don the appropriate level of PPE.

4. If however, a crew establishes close contact with a PUI patient prior to donning the appropriate PPE personnel should, in a professional and compassionate manner, explain to the patient that additional PPE precautions will need to be taken given the patient's situation, that there will be a slight delay to their care and remove themselves from the patient's room.

5. The number of EMS clinicians and other first responders encountering patient contact should be limited to the minimum number of personnel necessary to treat and safely care for the patient.

    a. If possible, only a single EMS clinician should make contact with the patient.
    b. Once the patient is assessed, the single lead EMS clinician can call in additional resources as required.

6. Once a clinical assessment has determined that the patient is ambulatory, have them come to you or even meet you outside as to limit contact and additional exposure potential.

7. Personnel who are pregnant or immunocompromised should not provide care for known or suspected COVID-19 patients.

C. TREATMENT AND TRANSPORT

1. Place a surgical mask on the patient. If an oxygen mask or nasal canula is clinically indicated, a surgical mask should be placed over the device.

2. Have patient utilize alcohol-based hand cleaner if feasible.

3. All persons in the patient compartment shall use the appropriate level of PPE.

4. Isolate the driver's compartment from the patient treatment compartment by either shutting the door or window. If the ambulance is not equipped with a mechanical way to isolate the two compartments, a piece of plastic may be affixed to the opening.

    a. Ensure good ventilation at all times.
    b. Increase ventilation by operating the ventilation system in non-recirculation mode and bringing in as much outdoor air as possible by opening windows.
    c. In the rear compartment, activate the ventilation fan.

5. Contact the receiving hospital via EMRC prior to initiating transport. You must notify the ED staff that the patient is complaining of respiratory illness and/or fever.

6. Family members and other contacts of patients (outside of parents or legal guardians) should not ride in the transport vehicle, if possible. If it is necessary for a family member, parent or guardian to ride in the transport vehicle, they too should wear a facemask.

7. Transport to the closest appropriate hospital-based emergency department.

8. Drivers, if providing direct patient care (e.g., moving patients onto stretchers), should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.

9. Potential limitation of procedures:

    a. Patients should be provided the care they need, and the procedures that are indicated.
    b. Aerosolized (nebulizer) treatments and CPAP should be avoided except for patients experiencing severe distress.
    c. The State has authorized the use of intra-muscular terbutaline sulfate as a treatment for asthma and reversible airway obstruction associated with bronchitis or emphysema in lieu of aerosolized medical treatments. Protocol attached.
    d. Minimize intranasal administration of medications.
    e. Minimize endotracheal intubation, instead utilize supraglottic airways (LMA's or King LT) whenever possible.
    f. Non-essential (lifesaving) interventions, such as elective IVs or elective advanced airway procedures should be deferred to the hospital setting when treatment indications are such that deferral of those procedures is appropriate.
    g. Life-saving procedures that are indicated by protocol shall be instituted by providers using the appropriate PPE.
    h. Aeromedical transport is not recommended.

10. Prior to arrival at Charles Regional Medical Center, consult with the 911 Communications Center when you are three (3) to five (5) minutes out. The 911 Communications Center will notify the ED staff. Priority One (1) and Two (2) patients should have a medical consult performed via the EMRC radio.

    a. Inform ED staff if the patient cannot wear a mask or is on CPAP.
    b. Upon arrival at the ED, the patient may be unloaded at the ED entrance and brought by stretcher or wheelchair into the ED.
    c. The lead EMS Clinician will give triage information to the EMS RN or Resource RN who will direct them to a designated patient room.
    d. Transfer of patient care will be conducted in the patient's room.
    e. Equipment decon processes should be performed outside of the ED.

11. If a family member or the patient's legal guardian accompanied the patient to the ED, they are not to follow the patient into the ED. Instead, instruct them to report to the waiting area and await further instruction from ED staff.

12. If the patient is receiving a nebulized medication treatment or CPAP, that treatment should be suspended while transferring the patient through public areas. Example: Hallways, patient care areas, and waiting areas.

D. DECONTAMINATION OF PERSONNEL:

1. On arrival, after the patient is released to the facility, EMS clinicians should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures.

2. If effective PPE was not in place for a portion of the incident, and a provider was in close contact with a COVID-19 PUI, decontamination measures for that provider will be commensurate with the level of contamination.

    a. Any known areas of contamination should be washed with soap and water. Do not use bleach or hospital disinfectant on skin. An alcohol-based gel or foam can be used following washing with soap and water. Shower as required.
    b. Clothing should be removed and placed in double red biohazardous waste bags.
    c. Once decontaminated, a person cannot spread the virus unless they actually contract the virus (develop an infection). If infection occurs, symptoms can develop in two (2) to fourteen (14) days from exposure.

E. DECON OF APPARATUS AND EQUIPMENT:

1. After transporting the patient, leave the rear doors of the transport vehicle open to allow for sufficient air exchange to remove potentially infectious particles. The time to complete the transfer of patient to the receiving facility and complete all documentation should provide sufficient air exchange.

2. When cleaning the vehicle, EMS clinicians should wear a disposable gown and gloves. A face shield or facemask and goggles should also be worn if splashes or sprays during cleaning are anticipated.

3. A stocked decontamination station is available at CRMC for personnel to use when performing decon procedures. The decon station will be stocked with:

    a. An Environmental Protection Agency (EPA) registered hospital disinfectant,
    b. Hand and pump sprayers,
    c. Paper towels,
    d. Waste disposal bin,
    e. And the Material Data Safety Sheet for the disinfectants being provided.

4. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle.

    a. Carefully bag any linens used in red biohazardous waste bags.
    b. All high contact surfaces should be decontaminated, including the interior of any cabinets or compartments opened and any equipment that was present in the patient compartment area.
    c. Use an appropriate cleaning solution:

        - An EPA registered hospital disinfectant with the label claim for disinfection of non-enveloped organisms (e.g. norovirus, rotavirus, adenovirus, poliovirus). If a commercial disinfectant is used, follow the direction set forth by the manufacturer.
        - A freshly mixed 1:10 bleach solution, made by using 5-6% (household) bleach that is less than one (1) year old mixed with cold water in a spray bottle. This solution will remain effective as a disinfectant for twenty-four (24) hours, then discard.

    d. Clean up any visible body fluids.
    e. Spray all surfaces with an appropriate cleaning solution, allow to sit for at least ten (10) minutes.
    f. Wipe remaining solution as necessary.
    g. If available, wipe all surfaces with hospital disinfectant cloths. This provides a further level of decontamination.
    h. Double bag any red biohazardous waste bags generated.
    i. If sharps were generated, seal sharps container and process as biohazardous medical waste.

5. Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.

F. REPORTING PROCEDURES

1. Personnel that have a suspected moderate to high risk exposure, should complete an Incident Report and First Report of Injury paperwork.

2. In the patient care report submitted to the Elite reporting system, the provider should complete the COVID-19 Panel and the Crew Exposures/Injury tab found on the Narrative panel. The following fields should be completed:

    a. Crew Member
    b. PPE Used
    c. Type of Exposure – Other = "COVID-19"

3. In order to maximize the protection of our first responders, a new signature option was created in Elite which no longer requires the signature of a patient if cross-contamination is a concern. EMS clinicians may now select "Not Signed – Patient Contamination Concern" in the Elite drop down of the patient signature section.

G. EXPOSURES

1. Patients who test positive for COVID-19 will be tracked through the State-designated Health information exchange, the Chesapeake Regional Information System for Our Patients, Inc. (CRISP).

2. CRISP shall notify the Infection Control Officer of the EMS Operational Program who in turn will process appropriate notifications to all affected providers.

3. Personnel who are deemed to have a confirmed low risk exposure will be instructed to self-monitor and report the onset of fever, cough, or other respiratory symptomology.

4. Personnel who are deemed to have a confirmed moderate to high risk exposure should be instructed to stay at home and self-isolate for fourteen (14) days. During quarantine, personnel will be expected to measure their temperature daily and report this information along with any signs or symptoms to their designated healthcare provider.

5. Personnel who complete the fourteen (14) days of self-isolation without fever or respiratory illness for at least seventy-two (72) hours, should be cleared to return to full duty.
6. Personnel who develop fever or respiratory illness during quarantine must contact their primary care physician for further guidance and/or treatment.

7. Personnel under quarantine who experience the aforementioned symptoms must be cleared by a physician prior to return to full duty.

H. FIRST RESPONDER PERSONAL PREPARATION:

1. Personnel should familiarize themselves with some of the many reputable resources regarding COVID-19 and infectious diseases, especially the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/index.html. As with all things that can be dangerous to us while on-duty, learn about COVID-19 and infectious disease, and how the risks they present can be minimized.

2. Ensure your issued infection control PPE is in ready condition.

3. Ensure your assigned unit has adequate supplies of PPE and decontamination supplies.

4. Ensure the contents of your issued PPE bag are in ready condition. It is a good idea to have a simple change of clothes stowed in it. This is useful practice for a host of possibilities that might occur during a duty shift.

5. Ensure the information contained in your personal communications devices is frequently backed up. If you choose to carry your phone (or other belongings) on your person while on-duty, anticipate the potential need to have them be quarantined or for them to be possibly damaged during decontamination.

6. Plan for the possibility that you might be called upon to care for an COVID-19 PUI. Familiarize yourself with equipment available to you to manage this situation.

I. STANDARDS & BEST PRACTICES:

1. If you are sick, stay home.

2. Wellness checks must be performed and documented at the beginning of each shift. A wellness check should consist of the following basic monitoring areas:

    a. Presence of cough, sore throat or trouble breathing,
    b. Temperature,
    c. Blood Pressure,
    d. Pulse,
    e. Pulsoximetry.

    Anomalies should be reported to your supervisor. Personnel will be excluded from work/volunteering if they have exhibited the following:

    a. Temperatures greater than or equal to 100.4 F or,
    b. Any of the following symptoms: cough, sore throat, trouble breathing.

    Personnel should be without a fever or other aforementioned symptoms for at least seventy-two (72) hours before they are cleared to return to duty.

3. County employees are required to document their daily health screening by using the provided station log. If no station log is available, county personnel should use the COVID-19 Health Screening Authentication Application located on the County's ICG. https://www.charlescounty.org/encrypt/loginCOVID.jsp?redURL=http://www.charlescounty.org/apps/covidscreen/servlet/MainServlet&refAPP=COVID-19%20Health%20Screening&secureServer=https://www.charlescounty.org/

    a. Noted anomalies within the County's Health Screening App will be immediately reported to the County's contact tracers.
    b. Contact tracing and notification will be conducted for all noted anomalies.

4. All other personnel should document their daily wellness checks in the designated station logbook.

5. In some instances, MIEMSS recommends the minimal level of EMS Clinician respiratory protection as a simple facemask. As a best practice in Charles County and as an effort to maximize the safety of our first responders, EMS Clinicians should use a N-95 mask for all patient encounters.

6. Maintain social distancing. If you are unable to social distance properly, don a mask.

7. The station should be cleaned at least daily (more if needed) to ensure that communal hygiene standards are maintained at the highest level.

8. Personal hygiene standards should be maintained at the highest level in an effort to combat the spread of communicable diseases.

9. Bring a change of clothes with you when you report for duty. Change into your personal clothes and bag your uniform at the end of your shift.

10. Be kind and always do the right thing. Remember that every patient you encounter is just as worried or concerned about their well-being and the well-being of their families as you are. The public is counting on you to comfort them, give them guidance and treat them as if they were part of your family. Please don't disappoint them.

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5. APPROVAL

Approved: Michelle Lilly Date: 10/19/2020

Michelle Lilly, Director

Approved: Date: 10/19/20

Dr. Kevin Seaman, Jurisdictional Medical Director

Approved: Date: 10/19/2020

Andrew Spalding, Volunteer Chief; CCAEMS

~ Maryland Institute for Emergency Medical Services Systems ~

COVID-19 EMS Guidance

Signs & Symptoms: Any patient with or without fever who has respiratory symptoms (shortness of breath, cough, sore throat), muscle aches, new loss of sense of smell or taste, or diarrhea, regardless of travel history.

Recommended PPE*: Gowns, Gloves, Eye Protection, Fit-tested N-95 Respirator**

*N-95 respirators should be used by clinicians providing direct patient care to PUI patients or personnel working within 6 feet of PUI patients.

** If the N-95 supply chain becomes compromised, use of N-95 respirators should be prioritized for clinicians caring for patients presenting in cardiac arrest, and/or performing respiratory procedures (oxygen administration, nebulized medication administration, suctioning, CPAP/BiPAP, BVM ventilation, CPR, etc.).

Arrival Patient

- ❒ Limit EMS personnel and perform an initial assessment at a minimum distance of six feet
- ❒ Don the appropriate PPE
- ❒ Place a simple facemask (NOT N-95) on the patient unless that patient is unable to do so due to a significant disability or if the patient is under 2 years of age

Assessment and Treatment

- ❒ Limit respiratory procedures to patients presenting in severe respiratory distress, such as an inability to speak between breaths, increased number of breaths per minute, diaphoresis, accessory muscle use, tripoding, cyanosis, and respiratory/cardiac arrest
- ❒ Supplemental oxygen should be titrated to an oxygen saturation between 94%-96%, and respiratory devices (NRB, nasal cannula, etc.) should be covered with a surgical mask
- ❒ Advanced airway procedures should be performed by the most experienced EMS clinician, and they should utilize video laryngoscopy whenever available
- ❒ Cardiac arrest patients should be intubated at the earliest possible opportunity after any necessary defibrillation has occurred, pausing chest compressions to intubate
- ❒ Mechanical CPR devices should be utilized whenever possible
- ❒ Intramuscular administration of 1 mg/ml epinephrine OR terbutaline can be considered per protocol (refer to memo from OMD regarding epinephrine & terbutaline, dated 4.6.2020, updated 4.9.2020)
- ❒ Patients using their own albuterol inhaler and spacer should be encouraged to continue to do so as an alternative to EMS-administered nebulizers

Transport

- ❒ Activate the patient compartment's exhaust fan in non-recirculating mode and limit the number of EMS clinicians in the patient compartment
- ❒ No individuals may accompany a patient during transport unless absolutely necessary; if someone must accompany the patient, they **must** wear a simple facemask

Arrival at ED

- ❒ Individuals accompanying the patient during transport must remain outside of the ED
- ❒ Turn off nebulizers and CPAP before entering the ED if patient condition allows
- ❒ Leave all ambulance doors open to allow for air exchange
- ❒ Transfer patient and promptly return the stretcher to the ambulance, ensuring not to contaminate any surfaces along the way

Returning to Service

- ❒ Don PPE (if removed) and decontaminate ambulance according to established policies
- ❒ Remove PPE and perform hand hygiene

This document replaces the "COVID-19 EMS Guidance" (dated 8.20.2020)

- Revised October 6, 2020 -

Proper PPE ensemble for a suspected PUI patient, for patients and clinicians.