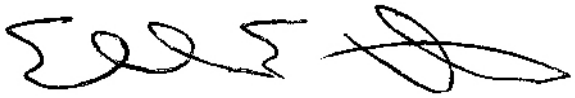
Central Whidbey Island Fire & Rescue
General Orders

UPDATED

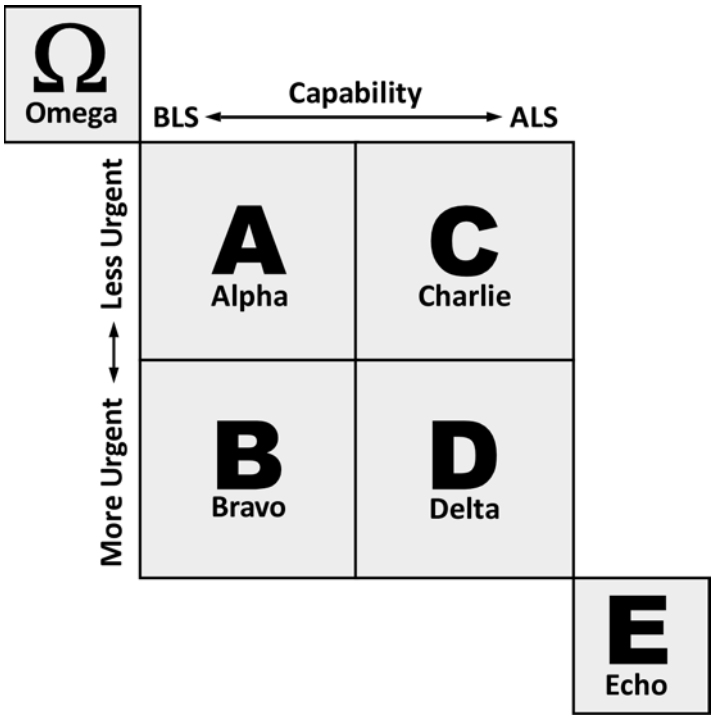
Title	GO #
EMS Response-Corona Virus/COVID-19	20-1
Authorization	**Effective Date**
	3/17/2020

The COVID-19 situation continues to evolve. The World Health Organization (WHO) has declared a pandemic due to significant world wide spread. General Order (GO) 20-1 has been updated to reflect currently available information and recommendations to protect our members, their families, and the community.

Criteria Based Dispatch

In order to maximize effective use of limited system resources, the following criteria-based dispatch procedures have been implemented by Central Whidbey Island Fire & Rescue, North Whidbey Fire and Rescue, and WhidbeyHealth EMS. The Island County Emergency communications Center (ICOM) assigns emergency medical responses to a series of non-linear response levels based on the capability required (ALS or BLS) and the urgency of the response given patient acuity as illustrated in Figure 1.

Figure 1. Non-Linear Response Levels



Note: Clawson, J. & Dernocoeur, K. (2001). Adapted from Determinant Codes Versus Response Understanding How It Is Done. https://www.emergencydispatch.org/articles/princdocpull03.pdf.

AID503 will be dispatched on Alpha medical incidents without response of a medic unit. Depending on the time required to establish the response level, a medic unit may be dispatched initially and then cancel enroute once an Alpha response level is determined by ICOM.

AID503 will be dispatched on Bravo and Omega medical incidents with a medic unit. The lead paramedic will triage Bravo responses and may cancel the medic unit response based on details provided in the computer aided dispatch (CAD).

CWIFR will be dispatched together with WhidbeyHealth EMS medic units for all Charlie, Delta, and Echo medical responses.

A simple flow chart outlining Criteria Based Dispatch and PPE requirements is provided in Appendix A.

Personal Protective Equipment

Personal protective equipment referred to in this GO is designated as Level II (Medium Precautions) or Level III (High Precautions) as illustrated in Table 1. A simple flow chart outlining Criteria Based Dispatch and PPE requirements is provided in Appendix A.

Figure 2. PPE Levels

Level II PPE	Level III PPE
Gloves Safety Glasses N95 Respirator	Gloves Goggles (or Face Shield) N95 Respirator Gown

Level II PPE shall be worn for all EMS responses (inclusive of vehicle accidents) until further notice. Providers should have a low threshold to upgrade eye protection to goggles or face shield. See GO 20-2 for PPE requirements for other types of response and public contact activity.

Level III PPE will be worn for all EMS responses under the following conditions:

- **Critical patient requiring immediate intervention (e.g., CPR)**
- **Fever, cough or respiratory distress (patient or any other occupant)?**
- **Patient or facility suspected to have COVID-19**
- **Patient had previous contact with a COVID-19 patient?**
- **Chohorted community (care home, nursing home, etc.)?**
- **Aerosol generating procedures may be necessary?**

Source capture using a surgical mask on the patient will be used whenever Level III PPE is required.

Place a surgical mask placed on the patient or any other individual(s) experiencing the respiratory symptoms (this is a major factor in reducing your risk of exposure). Even better is to have them place the

mask themselves if they are capable. Minimize patient contact until a mask has been placed on the patient.

PPE Reuse

Supplies of N95 respirators can become depleted during an influenza pandemic. NIOSH has provided several recommendations to conserve supplies while safeguarding health care workers under these circumstances (NIOSH, 2018). The district will use two of these recommendations to manage limited supplies of N95 respirators:

- Minimize the number of individuals who need to use respiratory protection by limiting the number of providers having patient contact to the minimum necessary.
- Using alternatives to N95 respirators when necessary. The district is in the process of procuring air purifying respirator adapters for Scott self-contained breathing apparatus (SCBA) facepieces and associated P100 cartridges to use in the event that N95 respirators are not available in sufficient quantity.
- Limited reuse of N95 respirators is permitted under specific circumstances such as If a N95 respirator is worn, but the provider has no contact with a patient suspected of having COVID-19 or other respiratory illness, and has not been contaminated by blood or other body fluids, the respirator may be placed in a paper bag labeled with the member's name and reused for another EMS response.

Patient Assessment/Risk Management

ICOM askes callers requesting emergency medical services to ask a series of screening questions. However, do not rely solely on dispatch for alerts regarding respiratory illness of potential for a patient with COVID-19.

- Is the patient suspected to have COVID-19?
- Does the facility have COVID-19 patients?
- Is this a cohorted (high risk) community such as a nursing home, care home, jail, etc.?

Conduct doorway triage, asking the following series of questions on all EMS responses:

- Does anyone here have a fever, cough, shortness of breath, or respiratory distress?
- Has anyone here had previous contact with a COVID-19 patient?

If the answer to any of these five questions is yes, Level III PPE is required.

One provider should assess patients and other occupants for COVID-19. Initial assessment should begin from a distance of at least 6 feet. This does not apply to critical patients (e.g., CPR) in which case providers shall default to Level III PPE.

Limit the number of EMS providers entering the area where the patient is located. If the Whidbey Unit is on-scene prior to CWIFR arrival, advise them you are on-scene and provide assistance with close patient contact only on request. If CWIFR arrives first, one member should assess the patient (as noted above with other crew member(s) keeping their distance) and provide information to the Whidbey Unit on their arrival. This approach is used to minimize individual and collective potential for exposure.

Reported illnesses have ranged from mild symptoms to severe illness and death for confirmed coronavirus disease 2019 (COVID-19) cases. The following symptoms may appear 2-14 days after exposure:

- Fever
- Cough
- Shortness of breath

Patients may not be symptomatic before 14 days after exposure, but may still be contagious. Ask if the patient or others have potentially been exposed to COVID-19. **Maintain a high index of suspicion!**

Limit the number of providers to those necessary for providing patient care (all others stay outside). The WhidbeyHealth paramedic on the call will make transport decisions in consultation with the lead paramedic and medical program director (MPD).

Precautions for Aerosol-Generating Procedures

If possible, consult with medical control before performing aerosol-generating procedures for specific guidance.

In addition to wearing the required personal protective equipment, EMTs should exercise caution if an aerosol-generating procedure (e.g., bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, continuous positive airway pressure (CPAP), bi-phasic positive airway pressure (biPAP), or resuscitation involving emergency intubation (including placement of a King LTS-D airway) or cardiopulmonary resuscitation (CPR) is necessary.

If aerosol generating procedures will be performed in an ambulance, the rear doors of the transport vehicle should be opened and the HVAC system should be activated during the procedures if possible. This should be done away from pedestrian traffic.

Patient Transport

If the potential COVID-19 patient is transported in AID503, take the following precautions:

- Do not allow family member or patient contacts to ride in AID503.
- Whenever possible, the individual who performed patient assessment and treatment will be the attendant in the patient compartment of the ambulance to minimize potential for exposure.

Alternately, the EMT performing initial patient assessment may drive and the medic continues patient care. This may require a split crew between AID503 and the medic unit.

- If the driver has been involved with patient care, the driver must remove and properly dispose of gloves, gown, and mask before entering the driver's compartment. Clean personal protective clothing must be donned before unloading the patient at the destination.
- Keep the driving compartment separated from the patient compartment (close the door). Keep HVAC on intake (non-recirculating) or open the driver's compartment windows. *The door between the patient compartment and the driver's compartment must be closed before loading the patient*.
- If driving an ambulance with no patient compartment separation, maintain respiratory protection during transport and keep driver's compartment windows open.
- Use exhaust ventilation in the patient compartment
- Contact the receiving hospital prior to initiating the transport and utilize the term, patient under investigation (PUI) for coronavirus during the consultation
- Maintain use of personal protective equipment until after decontamination of the ambulance at the destination hospital.
- After transporting the patient, leave the rear doors of the transport vehicle open to allow for adequate air change to remove potentially infectious particles for at least 30 minutes.

Decontamination

If the potential COVID-19 patient is transported in AID503 decontaminate the ambulance and change uniform clothing prior to leaving the hospital. Crew members assigned to AID503 (and potentially all members on-shift) should maintain a second set of clothing in an exterior compartment (not connected to the patient compartment).

- Wear Level III PPE when decontaminating the ambulance after transporting a potential COVID-19 patient.
- Decontaminate the ambulance and disinfect all visibly soiled and potentially contaminated surfaces (e.g., stretcher, rails, control panels, floors, walls, and work surfaces) with an EPA-registered hospital disinfectant according to directions on the label.
- Medical equipment (stethoscope, BP cuff, etc.) making patient contact should be disposable or cleaned and disinfected using appropriate disinfectants before use on another patient.
- After decontamination of the ambulance and equipment, remove personal protective equipment avoiding contact with potentially contaminated surfaces. Dispose of potentially contaminated personal protective equipment as biohazardous material.

- Wash hands with soap and water immediately and thoroughly after removal of personal protective equipment. If soap and water are not immediately available use and alcohol-based disinfectant and wash with soap and water as soon as possible.
- If transporting to WhidbeyHealth, there is a bathroom with a shower in the hallway across from the ED hallway entrance. If you do not have a clean spare uniform, have the Lead Medic get you a set of scrubs to borrow. Shower and put clean uniform or scrubs on. The Lead Medic will notify Environmental Services that that bathroom will need to be cleaned before it can be used again.
- Do not forget to decontaminate your shoes/boots!

Exposure Risk

One concern for our members, their families and the district is potential for occupational exposure and illness. The following table outlines risk factors and exposure categories provided as interim guidance from the Centers for Disease Control (CDC, 2020). **Important! These tables are not recommendations to use less than the personal protective equipment required by the general order, simply an illustration of how source capture (surgical mask on the patient) and PPE reduce your risk.**

Table 1. Prolonged close contact with a COVID-19

Epidemiologic risk factors	Exposure Category	Recommended Monitoring for COVID-19 (14 Days)	Work Restrictions for Asymptomatic EMT
PPE: None, No patient facemask.	High	Active	Exclude from work for 14 days after last exposure
PPE: Not wearing a facemask or respirator, No patient facemask.	High	Active	Exclude from work for 14 days after last exposure
PPE: None, Patient facemask used.	Medium	Active	Exclude from work for 14 days after last exposure
PPE: Not wearing a facemask or respirator, Patient facemask used.	Medium	Active	Exclude from work for 14 days after last exposure
PPE: Not wearing eye protection, No patient facemask.	Medium	Active	Exclude from work for 14 days after last exposure
PPE: Not wearing eye protection, Patient facemask used.	Low	Self with delegated supervision	None
PPE: Not wearing gown or gloves, Patient facemask used.	Low	Self with delegated supervision	None
PPE: Not wearing gown or gloves, No patient facemask.	Low	Self with delegated supervision	None
PPE: Wearing all recommended PPE, No patient facemask.	Low	Self with delegated supervision	None

The following definitions for active and self-monitoring have been excerpted from Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases (CDC, 2020).

> ***Active monitoring*** means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever, cough, or difficulty breathing. For people with high-risk exposures, CDC recommends this communication occurs at least once each day. The mode of communication can be determined by the state or local public health authority and may include telephone calls or any electronic or internet-based means of communication.
>
> ***Self-monitoring*** with public health supervision means public health authorities assume the responsibility for oversight of self-monitoring for certain groups of people. Depending on local priorities, CDC recommends that health departments consider establishing initial communication with these people, provide a plan for self-monitoring and clear instructions for notifying the health department before the person seeks health care if they develop fever, cough, or difficulty breathing. As resources allow, health authorities may also check in intermittently with these people over the course of the self-monitoring period.

Members requiring active monitoring may be quarantined at North Whidbey Fire and Rescue Station 25 or South Whidbey Fire/EMS Station 31. Members requiring self-monitoring should check twice daily for fever, shortness of breath, and sore throat.

Documentation

Document patient care after delivery of the patient and decontamination of the ambulance and equipment. Include all providers involved on the ePCR for infection control tracking. Document a primary and secondary impression based on signs and symptoms (e.g., cough, shortness of breath, fever).

Supplemental questions shave been added to the On-Scene Section, Patient Condition Panel:

- Is the patient under investigation (PUI) for COVID-19 (based the triage questions outlined in this General Order (GO))? Yes or no.
- What level of EMS PPE was worn? Level I, Level II, or Level III. Note that Level II is the minimum required for all EMS responses and Level III is required for critical patients, cohorted communities and any patient meeting the triage criteria specified in this GO.

These questions must be completed for all patient contacts.

Report any suspected exposure to COVID-19 to the district's infection control officer (Deputy Chief Smith) and complete exposure documentation. **CWIFR is not considering patient under investigation (PUI) for COVID-19 contact when wearing all required (Level III PPE) and source capture in place as an**

exposure. If there was no exposure or the exposure category is low, members will not be restricted from work. If exposure category is medium or high, members will be restricted from work for 14 days.

Continuing Developments

Dr. Zaveruha, the Island County Medical Program Director (MPD) continues to emphasize the concurrent Influenza risk and the importance of emergency medical technicians obtaining influenza (flu) vaccinations. Individuals who are unable to receive a vaccination or refuse for any reason should be using appropriate personal protective equipment, such as using a mask while entering healthcare facilities and/or interacting with patients.

Important: The situation surrounding spread and knowledge of this disease is dynamic and required and recommended actions are likely to change. Dr. Zaveruha will update protocol guidance as additional information becomes available. As communication from the Centers for Disease Control (CDC) must be vetted through the White House, the district is monitoring recommendations the World Health Organization (WHO) and other sources of authoritative scientific information as well as the CDC and taking a proactive approach to maximize the safety of our members, their families, and our community.

If you have any questions, please contact Deputy Chief Smith or Chief Ed Hartin.

References

Centers for Disease Control and Prevention (CDC). (2020). *Interim U.S. guidance for risk assessment and public health management of healthcare personnel with potential exposure in a healthcare setting to patients with Coronavirus Disease (COVID-19).* Retrieved March 10, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

Centers for Disease Control and Prevention (CDC). (2020). *Interim guidance for emergency medical services (EMS) systems and 911 public safety answering points (PSAPs) for COVID-19 in the United States.* Retrieved March 10, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html.

Centers for Disease Control and Prevention (CDC). (2020). Interim US guidance for risk assessment and public health management of persons with potential coronavirus disease 2019 (COVID-19) exposures: geographic risk and contacts of laboratory-confirmed cases. Retrieved March 17, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html.

Clawson, J. & Dernocoeur, K. (2001). Adapted from Determinant Codes Versus Response Understanding How It Is Done. Retrieved March 17, 2020 from https://www.emergencydispatch.org/articles/princdocpull03.pdf.

National Institute for Occupational Safety and Health (NIOSH). (2018). Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings. Retrieved March 12, 2020 from

Appendix A-Criteria Based Dispatch & PPE Flow Chart