	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5200.08
	PROGRAM DOCUMENT: **Emerging Infectious Diseases 2019 Coronavirus (COVID-19) **EFFECTIVE IMMEDIATELY****	Draft Date:	11/24/14
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EMS Medical Director

EMS Administrator

Purpose:

A. To specify the procedures to be followed when COVID-19 infectious disease is suspected during emergency call taking and response; or confirmed prior to interfacility transport.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definitions:

A. SARS-CoV-19 – The Coronavirus identified in 2019 as the cause of COVID-19
B. COVID-19 – The disease caused by SARS-CoV-19
C. Confirmed case: Patient with laboratory confirmation of emerging infectious disease.

Protocol:

A. This Policy is effective immediately in response to the current COVID-19 emerging infectious disease pandemic and shall remain in effect until terminated by the Medial Director or Public Health Officer (PHO).

Notes for Dispatch:

A. In the current situation, any patient with or without symptoms of a respiratory infection or a fever potentially has COVID-19. Due to this, and the current prevalence of COVID-19 infection in the community, no special screening questions are required. All patients shall be presumed to possibly have COVID-19, and appropriate infection control and PPE requirements shall be taken with all patients.

Employer Actions:

A. Review and implement any Infection Control and PPE disease specific guidelines issued by the CDC, CDPH, and/or the Sacramento County EMS Agency.
B. Check your PPE supplies to ensure items are present and in good working order. Review manufactures training materials if that was provided.
C. Ensure that EMS personnel with patient contact have been properly fit-tested and provided the proper N-95 mask or higher (P100), face mask, and gown.
D. Staff wearing respirators must be medically evaluated to see if it's safe for them to wear the respirator.
E. Work closely with your Occupational Health staff to ensure the health of your workforce.

F. All employees should be monitored at beginning of each shift for temperature or respiratory symptoms, and taken off work for fever or positive respiratory symptoms as noted under; Follow-Up and Reporting Measures, below.
G. Employers shall notify SCEMSA of all field and dispatch staff positive COVID-19 test, so SCEMSA can maintain awareness of workforce impacts.
~~H. Employers shall notify SCEMSA whenever > 10% of their EMS work force is off duty due to quarantine or isolation for COVID-19, so SCEMSA can maintain awareness of workforce impacts.~~

Procedures for First Response and Transport Personnel Patient Assessment Appropriate for all Emerging Infectious Diseases:

A. Due to the current prevalence of COVID-19 infection in the community, all patients shall be presumed to possibly have COVID-19, and appropriate infection control and PPE requirements shall be taken with all patients.
B. Use standard contact and droplet precautions (gloves, N95 or higher (P100) respirator) and eye protection (goggles) for all patient encounters.
C. Patients with symptoms of an infectious respiratory illness shall undergo the following questioning and management:
    1. Place a surgical mask on the patient
    2. Initiate standard contact and airborne precautions (gloves, gown, N95 or higher (P100) respirator) and eye protection (goggles) for EMS clinicians.
    3. Minimize aerosol generating procedures:
        a. Use nebulized Albuterol treatments only for patients with severe wheezing who cannot wait until arrival to the destination facility. Metered dose Albuterol inhalers do not produce increase aerosol secretions and can safely be used in place of nebulized treatments when available. The patient's own MDI may be used.
        b. Use CPAP/BiPAP only when patient is in extremis
        c. Whenever possible, manage airways needing support with BLS airway
        d. Intubate only if BLS airway management is ineffective
    4. Properly doff and dispose of PPE according to protocol.
    5. Cleaning and disinfection using EPA registered disinfectants with known effectiveness against human coronaviruses
    6. Disposable medical waste from patients with respiratory illness which is not soaked in secretions or blood is regular garbage and does not require medical waste bags.
D. All IFTs and patients being taken to non-Emergency Department locations (L&D, CT, Cath Lab, etc.) shall have documentation of temperature and presence of any respiratory symptoms. It is sufficient to document these based on history provided by sending medical facility. EMS personnel should confirm receiving facility is aware of any fever or respiratory symptoms.

NOTES:

A. All respiratory patients who are being treated with an aerosol nebulizer (including Asthma, COPD, etc.) shall have all aerosol nebulized treatments discontinued prior to entering the destination facility. This shall remain in effect until terminated by the Medial Director or Public Health Officer (PHO).

B. Fever may not be present in all patients; those who are immunocompromised, very young, elderly or taking fever-lowering medications.

**Close contact is defined as being within about 6 feet, or within the same room or care area, or a patient with confirmed COVID-19 without wearing PPE for a prolonged period of time OR having direct contact with COVID-19 patient secretions.

Supplies:

A. PPE based upon the selection from the "Personal Protection" section below.

Infection Control:

A. First response and transport personnel can safely manage a patient with symptoms of an infectious respiratory illness by following recommended isolation and infection control procedures, including standard, contact, and droplet precautions. Various means of protection will include protecting the Caregiver from all routes of entry through the use of PPE, barriers in the patient compartment of the ambulance, proper decontamination of the ambulance/equipment and proper disposal of the waste generated. Early recognition and identification of patients with a potentially infectious disease is critical. The following minimum standards will be observed when personnel are within 6 feet of all patients ~~during these processes~~:
   1. Wearing of appropriate PPE – Eye protection, N95 or higher (P100) mask, gloves ~~(surgical mask).~~
   2. Limit activities, especially during transport that can increase the risk of exposure to infectious material (e.g., airway management, cardiopulmonary resuscitation, use of needles).
   3. Limit the use of needles and other sharps as much as possible. All needles and sharps shall be handled with extreme care and disposed in puncture-proof, sealed containers.
   4. Phlebotomy, procedures, and laboratory testing shall be limited to the minimum necessary for essential diagnostic evaluation and medical care.
   5. Prudent hand hygiene including hand washing and/or alcohol based hand rub.
   6. If blood, body fluids, secretions, or excretions from a patient with a suspected emerging infectious disease come into direct contact with the provider's skin or mucous membranes, then the provider shall immediately stop working. They shall wash the affected skin surfaces with soap and water and report exposure (PPE breech) to a supervisor for follow-up.
B. ~~When not engaged with patient care, call EMS personnel on duty will wear face coverings (surgical mask) at all times (except when eating), including in all work areas, in public spaces and in /around care facilities.~~ All provider agencies will develop and enforce on-duty face covering policies in compliance with CDPH and CDC regulations.

Personal Protective Equipment (PPE):

A. Use of standard, contact, and airborne precautions is sufficient for most situations when treating patients with symptoms of an infectious respiratory illness. Personnel who anticipate being within 6 feet of patients shall wear:
   1. Gown (fluid resistant or impermeable)
   2. Eye protection (goggles or face shield that fully covers the front and sides of the face)
   3. N95 or higher (P100) Facemask

4. Gloves

B. Additional PPE might be required in certain situations (e.g., large amounts of blood and body fluids present in the environment), including but not limited to double gloving, disposable shoe covers, and leg coverings.
C. Pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation frequently result in a large amount of body fluids, such as saliva and vomit. Performing these procedures in a less controlled environment (e.g., moving vehicle) increases risk of exposure. If conducted, perform these procedures under safer circumstances (e.g., stopped vehicle, hospital destination).

Transfer to Receiving Facility:

A. Transport personnel shall do early notification to the receiving hospital when transporting a patient with symptoms of an infectious respiratory illness, so that appropriate infection control precautions may be prepared prior to patient arrival.

Arrival at the Hospital:

A. The driver should take all previous mentioned PPE precautions when assisting with the patient movement.
B. Any bodily fluid contamination on gurney wheels will be disinfected with an EPA-registered hospital disinfectant with label claims against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) or using a 1:10 bleach to water solution and allowed to dry for 10 minutes.
C. Patient will be transferred into hospital by patient crew at the direction of hospital staff.

Managing EMS Workforce COVID+ Infections and Exposures (from patients or co-workers)

A. With community spread of SARS-CoV-2, EMS workforce exposures are very likely to occur off-duty, and can occur when wearing inadequate PPE with a patient who is subsequently found to test COVID+, from PPE breaches with COVID+ patients, or from the community or co-workers on shift.
B. Managing EMS workforce infections- Criteria to work for EMS with SARS-CoV-2 Infection:
    a. EMS Provider Agencies shall follow CDC guidelines for healthcare workers posted at : https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
C. Management of EMS Workforce exposures shall follow the algorithm below, developed by CDC, which can be found at:
    a. Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified
    b. Following the algorithm below:
        i. Tier 1 exposures shall remain off work until results of the 3-day test are available, and can return to work with symptom and temperature monitoring if day-3 test is negative.
        ii. Personnel riding in the back of the ambulance, or with direct physical contact at any time without wearing adequate PPE with a patient who subsequently is confirmed COVID+ are considered Tier 1 contacts

Tier 2 and Tier 3 contacts may continue to work after negative baseline testing with symptom and temperature monitoring.

iii. Personnel riding in the cab of the ambulance and without direct physical contact with the patient are considered Tier 2 exposures

D. Managing critical staffing shortages ~~With advanced approval by the SCEMSA~~, EMS agencies facing critical staffing shortage may follow CDC guidelines for "Strategies to Mitigate healthcare personnel Staffing Shortages." ~~Approval can be obtained by submission to the SCEMSA of a summary of mitigation strategies to be implement, including the triggers used to implement and cancel those mitigation strategies~~.

   a. https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

E. Reporting of EMS workforce COVID-19 impact-EMS providers are required to submit a weekly report including:

   a. New EMS provider COVID infections (for the prior week)
   b. Total number of EMS provider's off-duty for isolation or quarantine.