NORTHWEST COMMUNITY EMERGENCY MEDICAL SERVICES SYSTEM
EST 1972

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Date: April 20, 2020

System Memo: #392

To: All System members

From: Matthew T. Jordan, MD, FACEP
EMS Medical Director

Connie J. Mattera, MS, RN, PM
EMS Administrative Director

RE: **EMS Covid-19 updates**

***PLEASE DISTRIBUTE IMMEDIATELY***

***New additions in RED***

**We continue operating under a state of CONTINGENCY CAPACITY**

**This memo is divided into 4 categories: Situation – Staff well-being – Safety – SOP/Procedures**

## S – Situation Report: What we know today

**Take-home lessons for healthcare workers (HCW) are summarized here:**

- **Transmission:** The onset and duration of viral shedding and the period of infectiousness are not yet known. Studies have documented SARS-CoV-2 transmission for **up to 2 days before onset of S&S**. SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset, similar to infections with MERS-CoV and SARS-CoV. However, detection of viral RNA does not necessarily mean that infectious virus is present.

  The virus is believed to spread primarily via person-to-person through respiratory droplets produced when an infected person talks, coughs, sneezes or sings. It also could be spread if people touch an object or surface with virus present from an infected person, and then touch their mouth, nose or eyes.

  **Body fluids that can transmit disease:** Viable, infectious SARS-CoV has been isolated from respiratory, blood, urine, and stool specimens (raising the possibility of transmission through the fecal/oral route). It is not yet known whether other non-respiratory body fluids from an infected person such as vomit, urine, breast milk, or semen contain viable, infectious SARS-CoV-2.

- **Incubation period**: Symptoms can appear 2 to 14 days, (median of 5 to 7 days) after exposure. One study reported that 97.5% of persons who develop symptoms will do so within 11.5 days of SARS-CoV-2 infection which supports the current 14-day quarantine recommendations.

- **PREVENTION CRITICAL**
  - Careful hand hygiene is essential: Wash your hands for at least 20 sec with soap and water or use hand sanitizer with at least 60% alcohol if no soap and water is available
  - Limit contact with people to at least 6 feet apart regardless of how you feel
  - **Prolonged (>10 min) and unprotected** exposures as well as some aerosol-generating procedures are associated with HCP acquisition of SARS-CoV-2 infection.

- **To protect Healthcare practitioners (HCP):** Continue to follow CDC, state, and local infection control and PPE guidance (See below). Early recognition and prompt isolation, including source control (e.g., patient wearing a facemask), will help minimize unprotected and high-risk HCP exposures. This includes protection for the **hands, mouth, nose and eyes** when caring for persons potentially infected with SARS-CoV-2. Remain vigilant in disinfecting surfaces and materials possibly contaminated by respiratory secretions from infected patients.

- All personnel should be **screened for possible COVID-19 S&S** at the beginning and half way through each shift. If present or any new onset occurs, send home with instructions to self-isolate immediately.

| Signs and Symptoms COVID-19 | |
|---|---|
| Fever > 100° F (HCP) | Abnormal vital signs and/or hypoxia by $SpO_2$ |
| Cough (new onset or worsening of chronic cough) | Severe headache or new onset altered mental status |
| Shortness of breath (dyspnea) | Congestion in the nasal sinuses or lungs |
| Abnormal breath sounds/sputum production | GI S&S: anorexia, abd. cramping or pain; nausea/vomiting |
| Loss of taste or smell | Diarrhea (≥3 loose/looser than normal stools/24hr period) |
| Sore throat, body aches, unusual fatigue | Conjunctivitis and/or eye pain |
| Complications in severe cases: pneumonia, renal failure, cardiomyopathy, encephalopathy | |

No one should report to or remain in an employment setting while symptomatic in any way

Older HCP and those with underlying health conditions should consult with their healthcare providers and employee health programs to better understand and manage risk.

- **Clinical progression:** Among patients who develop severe disease, the medium time to dyspnea after onset of S&S ranges from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranges from 8 to 12 days, and the median time to ICU admission ranges from 10 to 12 days.

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**S- Staff well-being**: See System memo #391 for more details

The CDC has some great tips and resources for coping with stress during this pandemic.
See: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html

**COVID-19 TESTING** - State-operated **Community Based Testing Sites** Priority candidates:

- Healthcare workers with symptoms
- First responders with symptoms
- Persons 65 and older with symptoms
- Persons with underlying health conditions with symptoms

No physician referral is needed.
Patients will receive verbal confirmation of CARS-Co-V-2 testing results within 3-7 days.

**Location in our area**: **Chicago – Harwood Heights** - EPA Emissions Testing Facility
6959 W. Forest Preserve Drive | Hours: 7:30 am – 3:30 pm or until max specimens collected.

Instructions on what to do while waiting for test results: See System memo #391

CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (April 13, 2020) – **See System memo #391** that supersedes all previous guidelines.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Also see new **IDPH steps for releasing a person from quarantine;** rev. 4/13/20

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**IDPH Covid-19 Antibody Testing** Interim Guidance: See System memo #391

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**S – Safety (PPE): – Some PPE (gowns) are moving to CRISIS capacity**

- All PPE items need careful conservation and optimum use per CDC guidelines.
- Hospitals moving to universal masking protocols and re-use of surgical and N95 masks. Example: Wear a surgical mask whenever entered a hospital with a patient unless aerosolized procedures in place, then keep N95 masks on HCPs.

  April 13, 2020, the CDC issued updates to the Guidelines for PPE use. **https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html**

**Reminders re PPE and staff protection:**

- CDC PPE optimization standards: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html
- Follow **Donning and Doffing guidelines** (with video link): See EMS Micro-learning module posted to System website under Breaking News.
- **Required PPE REQUIRED under contingency operation:**
  - **NO aerosolized procedures**:
    Contact/droplet precautions: Surgical/procedural mask on patient. PPE for 2 EMS personnel; gloves; surgical mask; gown (if you have it); eye protection (goggles OK)
  - **Aerosolized procedures** (ETI, CPR, BVM ventilations):
    Airborne precautions: gloves; **N95 mask; full face shield; gown**

  Minimize the # of EMS personnel within 6 feet of the patient for 10 minutes or longer.
- **If NO isolation gowns are available**; EMS CDC Gown optimization guidelines
- **Restocking:**
  - Hospitals will restock EMS from their stores for appropriate use
  - Restock from internal inventories if EMS use exceeds guidelines and/or you have surplus stock
  - Inform Connie Mattera if you need central restocking from the Resource Hospital due to lack of supplies at a receiving hospital
- Locally made **face shields:** Link to the Google form to request the face shields. https://docs.google.com/forms/d/e/1FAIpQLSdIrzouOwsZuHyL0ErOddYrxJXxJeQ5sLe6eKFLG0BwvHlNQQ/viewform?vc=0&c=0&w=1
- **Approved products for surface disinfection**: See: https://www.epa.gov/newsreleases/epa-continues-add-new-surface-disinfectant-products-list-n-effort-combat-covid-19 .
- **Guidelines for Fire station transmission reduction:** https://www.fireapparatusmagazine.com/2020/04/15/guidelines-for-covid-19-fire-station-exposure-reduction/

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**S - Standard operating procedures**:

- Covid-19 SOPs are still current with evolving guidelines from the CDC, IDPH, and AHA.
- Goal: Keep things as normal as possible for as long as possible w/o unnecessary change.
- **Be particularly vigilant for hypoxia per $SpO_2$ and hypotension.**

**Current System Drug and Supply List – 4-8-20:** Email sent 4-9-20: Also attached were **photos of approved HEPA filters** and how they are used for easy reference.

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**UPDATED:** DOCUMENTATION for possible COVID-19 patients

Reference: Webinar slides Page, Wolfberg and White – April 17, 2020

- **Who exactly entered the scene** and their distance from a patient or contacts?
  Level of contact that each caregiver had with the patient
  ✓ "No contact w/patient"
  ✓ "Provided direct patient care"
  Document: all potential exposures.
- **Who was already there?** Identify agencies and specific personnel, and all family members and bystanders present.
- Complete description of **PPE and isolation precautions used by EMS personnel**
  This serves two purposes:
  1. Documents your compliance with self-protection infection control practices
  2. Protects EMS personnel from claims they may have contaminated a patient or others
- **Document full Patient assessment per IMC + Covid-19 SOP**
  - What does the patient look like? Level of distress?
  - $SpO_2$ & level of distress before and after $O_2$ administration.
    **Source control measures when giving O2:** Document steps used to correct hypoxia and prevent aerosolization and infecting others - surgical mask over a NC, NRM, or BVM with HEPA filter when ventilating patients in severe respiratory distress
  - **Full patient history**: Present or recent (SAMPLE; OPQRST); ask about and document usual and unusual COVID-19 S&S (listed above); co-morbidities and risk factors.
  - **Physical exam**: Document full set of VS including temperature; breath sounds in all lung fields; anterior and posterior. Note presence of wheezes, crackles - specific location.
  - **Treatment:** what treatment, why indicated, description of tx
  - Results or **reassessment** after tx
- **NARRATIVE and Primary and Secondary impressions**.
  - EMS documentation in the ePCR and narrative must be detailed and accurate to make the case why a COVID-19 patient cannot be safely transported by other means.
    **Example of acceptable charting in narrative to prove Medical Necessity:**
    - "Patient confirmed COVID-19 positive on 3/30/20 via positive test result from county health dept.
    - Infectious disease protocols in place.
    - Crew in full PPE and isolation precautions being followed.
    - Patient currently complaining of SOB with $SPO_2$ of 88%.
    - Patient has fever of 102.2° F and experiencing dry cough.
    - Patient placed on $O_2$ at 15 L via non-rebreather mask and transported to isolation section of ED."
  - **How was patient's known or suspected COVID-19 status determined?** If you suspect COVID-19 as a primary or contributing factor, document the term "COVID" somewhere in the clinical narrative so that this is a searchable term.
  - **Document in narrative:**
    ✓ Positive test? What facility? When was patient tested?
    ✓ "Presumptive positive" - waiting for test results?
    ✓ PUI based on S&S
    ✓ Exposure to a known COVID-19 patient? When?

- **FOR REGIONS 8 & 9 Image Trend Documentation**:
  - The **Provider Primary Impression** should be the "*patient's primary problem or most significant condition which led to the management given to the patient (treatments, medications, or procedures)*, so in a COVID-19 patient it should be the signs/ symptoms that the patient was treated for (shortness of breath, fever, etc.)
  - There are three codes that can be used in **Provider Secondary Impression** related to patients with suspected/confirmed COVID-19 or with signs/symptoms of a viral illness that are suspicious of being coronavirus-related:
    - COVID-19 Confirmed by testing
    - Patient with known or suspected exposure to COVID-19
    - Patient with signs/symptoms consistent with infectious disease but unknown exposure to COVID-19
- **Document patient disposition: TRANSPORT or NO TRANPORT**
  - ✓ Assessment that supports treatment in place
  - ✓ OLMC contact; Medical direction given
  - ✓ Patient acknowledgement/refusal

## How to document patient signatures obtained verbally - updated

CMS announced on April 13, 2020, that it is improper to ask physically and mentally decisional patients or surrogate decision makers for patients with suspected or known Covid-19 illness to handle styluses, pens, and other devices or equipment used to obtain signatures on EMS forms due to the risk of infection. They authorize ambulance crews to obtain "verbal consent" from the patient to sign on the patient's behalf.

**Process** Depends on the form provided or electronic screen format:

**Option #1:** After obtaining a decisional patient's consent to sign their name, EMS personnel mayl sign the PATIENT's name in the usual box reserved on the PCR, Refusal, and Non-transport forms for patient signature; then place a forward slash mark and enter the initials of the person signing on behalf of the patient. They should then enter their own names under the crew signature sections as usual.

**Example:** If the patient's name is John Smith and the paramedic's name is Mark Johnson – the patient signature box should contain the following notation written by the PM: John Smith / MJ

The same process is used if a **surrogate decision-maker** is authorizing or refusing consent for a minor or non-decisional patient. In this case, write the surrogate decision maker's name in the box for the representative signature followed by the initials of the EMS personnel who obtained their verbal consent to sign.

## Option #2: NEW ALTERNATIVE SIGNATURE OPTION per PWW website Monday 4-20-20

| | |
|---|---|
| Patient / surrogate signature | Date |

☐ **CHECK HERE** if patient/surrogate gave verbal consent for EMS to sign on the patient's behalf

| | |
|---|---|
| EMS member PRINTED NAME & Signature (Do NOT sign patient's name) | Date |
| Witness (PRINT Last NAME/Signature Paramedic/ PHRN) | Date |

This box has been incorporated into the NWC EMSS Non-transport form. See attached.

In the **narrative section of the PCR**, **document the following**:

1. That the patient had suspected or known Covid-19 illness (and the clinical documentation supports that conclusion); and
2. That verbal consent of the patient or surrogate decision-maker to sign on their behalf was obtained by the EMS crew.

**ELECTRONIC DEVICES – Cleaning and disinfecting:**

Document: Devices used and procedures used to clean them:

✓ Keyboards
✓ Touch screens
✓ Stylus/pen
✓ External mouse or other peripherals
✓ Microphone areas (voice-to-text enabled applications)
✓ Device cases, mounts and storage locations

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**Reminders of previously sent information:**

- **Cleaning and reuse of face shields**/eye protection: See System memo #390
- System **IS NOT endorsing the plastic cube** for ETI. See System memo #391.
- The System is **NOT yet asking for extended or reuse of face masks** as we respond to multiple different patients with varying conditions. See System memo #391.
- Use of **cloth masks**: See System memos #390 and 391
- Steps to take to **protect the safety of your family**: See System memo #390:
- Guidelines for processing **Triple Zero pts** with suspected COVID-19: See System memo #390
- **Contingency System Practice Privileges**: See S3- ALS/BLS Staffing Requirements (3/27/20)
- If asked to send **EMS vehicles out of state to other disaster hot spots**: See IDPH memo forwarded on 4-14-20; 041320_Authority System Amendments for Providers .docx

Resource links: For previously sent, see System memo #390

Gubernatorial Disaster Proclamation issued March 9, 2020; Gubernatorial Disaster Proclamation issued April 1, 2020. Proclamations and related executive orders available at https://coronavirus.illinois.gov/s/resources-for-executive-orders.

Information about the Illinois Emergency Operations Plan (IEOP) is available at: https://www2.illinois.gov/iema/Preparedness/Pages/IEOP.aspx

IDPH, "Emergency Support Function 8 (ESF-8) Plan," Feb. 2018, available at: http://www.dph.illinois.gov/sites/default/files/publications/idph-esf-8-plan-2018-final-public-version-032718.pdf

IDPH, "ESF-8 Plan: Catastrophic Incident Response Annex," March 2018, available at: http://www.dph.illinois.gov/sites/default/files/publications/catastrophic-incident-response-annex-052218.pdf

CDC COVID-19 Response Team. Characteristics of health care personnel with COVID-19 — United States, February 12–April 9, 2020. MMWR Morb Mortal Wkly Rep. 2020 Apr 4. doi: 10.15585/mmwr.mm6915e6 [Epub ahead of print.] https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e6.htm

CDC: Updated frequently. https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html
IDPH: https://www.dph.illinois.gov/covid19