OLD TOWN FIRE RESCUE

RULES AND REGULATIONS

SUBJECT: Temp. COVID-19 Policy **NUMBER: FD9-1**

EFFECTIVE DATE: March 19, 2020

AMENDS/SUPERSEDES: N/A **APPROVED:**

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Public Safety Director

Definitions:

AHJ – Authority Having Jurisdiction

PPE – Personal Protective Equipment for specific emerging infectious disease. (*Maine EMS 3.15.20*)

- A single pair of disposable patient examination gloves.
- Disposable isolation gown
- Respiratory protection (i.e., N-95 or higher-level respirator), and
- Eye Protection

PUI – Person(s) Under Investigation, person who has met criteria for inclusion in emerging infectious disease but has not tested positive.

Universal Precautions – Term used to indicate the use of specific PPE ensemble by the CDC/medical control for a given emerging infectious disease.

Procedures

Responder Role

Response

Personnel will follow department policies and procedures. Personnel shall utilize appropriate Personal Protective Equipment (PPE) per current CDC or medical control guidance when responding to calls identifying the patient as a PUI or test confirmed. Personnel will monitor the radio/cad notes for Dispatch updates. Personnel will maintain a high index of suspicion for all calls that do not meet the above-mentioned criteria and be prepared to utilize PPE as necessary.

Arrival

Personnel should maintain a high index of suspicion for the above responses. Crews should maintain limited exposure and coordinate with assist companies for any equipment needs. The minimum number of personnel needed to effectively assess and render medical care should be utilized. If PPE is not worn prior to patient contact, then providers should maintain a distance of 6 feet or more and begin assessment to include signs, symptoms, patient travel history, and patient exposure history. **Crews should have PPE readily accessible to be applied immediately if patient presentation warrants.**

Personnel will apply the following:

- Medical exam gloves
- Minimum N95 respirator or greater
- Barrier gown
- Eye protection

Patient contact should be minimized to the extent possible until a facemask is on the patient (an oxygen mask can be used if clinically indicated). **Assist companies should stage outside of the structure to include building lobbies or apparatus.** If an automatic/mutual aid ambulance is responding for transport, the appropriate minimum number of AHJ personnel should apply PPE for patient care until the transporting ambulance arrives.

- Assist unit equipment utilized for patient care (BP cuff, stethoscope etc…) shall be disinfected with and EPA approved disinfectant prior to returning the equipment to the apparatus.
- Assist units having assisted with patient care shall remove all PPE and disinfect hands prior entering the apparatus cab.

EMS Transport of a PUI or Patient with Confirmed COVID-19 to a Healthcare Facility (including interfacility transport)

If a patient with an exposure history and signs and symptoms suggestive of COVID-19 requires transport to a healthcare facility for further evaluation and management (subject to EMS medical direction), the following actions should occur during transport:

- EMS clinicians should notify the receiving healthcare facility that the patient has an exposure history and signs and symptoms suggestive of COVID-19 so that appropriate infection control precautions may be taken prior to patient arrival.
- Keep the patient separated from other people as much as possible.
- Family members and other contacts of patients with possible COVID-19 should **not** ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask.
- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
    - Close the door/window between these compartments before bringing the patient on board.
    - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
    - If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
    - Some vehicles are equipped with a supplemental recirculating ventilation unit that passes air through HEPA filters before returning it to the vehicle. Such a unit can be used to increase the number of air changes per hour (ACH)
- If a vehicle without an isolated driver compartment and ventilation must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting. This will create a negative pressure gradient in the patient area.
- Follow routine procedures for a transfer of the patient to the receiving healthcare facility (e.g., wheel the patient directly into an examination room).

Precautions for Aerosol-Generating Procedures

- If possible, consult with medical control before performing aerosol-generating procedures for specific guidance.
- An N-95 or higher-level respirator, instead of a facemask, should be worn in addition to the other PPE described above, for EMS clinicians present for or performing aerosol-generating procedures.,
- EMS clinicians 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 or cardiopulmonary resuscitation (CPR)) is necessary.
    - BVMs, and other ventilatory equipment, should be equipped with HEPA filtration to filter expired air.
- If possible, the rear doors of the transport vehicle should be opened, and the HVAC system should be activated during aerosol-generating procedures. This should be done away from pedestrian traffic.

Transport

If not completed, crews should apply a surgical facemask (NOT N-95) to patient as tolerated; patient should be moved to the ambulance as soon as practical, isolating them from the public as much as

possible. The window between the patient compartment and cab will be closed (If equipped). **PPE is not to be worn in the cab of the ambulance.** The driver will remove all PPE or an assist company can be utilized to provide a driver as practical. Family members and other contacts of patients with possible COVID-19 should not ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask (Coronavirus disease 2019 (COVID-19).2020).

The patient compartment ventilation system will be turned on throughout transport and patient transfer. The crew will coordinate with the receiving hospital and provide notification indicating that they are transporting a PUI for COVID-19. If the driver of a two personnel crew has removed PPE to drive, a request should be made to the receiving hospital to meet the ambulance at the bay and assist in removing the patient from the ambulance or the driver shall don appropriate PPE prior to patient contact.

**If the patient compartment and cab cannot be isolated the driver should utilize a N-95 throughout transport with the ventilation system on high without recirculation (ASPR, 2017)*

Upon arrival at the hospital, all doors to the ambulance will be left open during the patient transfer.

Decontamination (Hospital)

Decontamination will occur before leaving hospital utilizing the PPE indicted above. PPE will be removed in an effective, safe manner after patient care. It will be placed in a red bag and left at the hospital if possible. EPA approved viricidal agents will be utilized according to the manufacturer's recommendation. All contaminated surfaces will be decontaminated including, but not limited to: walls, ceilings, stretcher, stretcher and ambulance rails, seats, floor, equipment, PCR tablet. Non-reusable equipment will be discarded at the hospital.

(Station)

Upon return to the station the "UV Tower light" should be utilized inside the ambulance for decontamination. The light should be used according to manufacturer's instruction and placed in the patient compartment for 30 minutes. This should not routinely place the ambulance "out of service" during the light use. It is to be employed as an extra measure of decontamination.

COVID-19 Quick Tips

- Dispatch should be prescreening ALL patients for fever, flu like symptoms, cough or respiratory distress. If yes to any of the above questions, dispatch shall advise crews to utilize full PPE consisting of gloves, googles, gowns, N95 or higher mask. Place a facemask on the patient, if tolerated.
- Follow recommended CDC steps for donning and doffing PPE.

- Limit the number of providers in the room, do a "doorway" assessment of the patient as well as other people in the room for fever, cough, signs of flu like symptoms. Add PPE and personnel as needed. Have patient self-ambulate to the ambulance if possible.
- Limit treatment or be extremely cautious if medical control will not allow modified treatment of patients with respiratory support needs, such as nebulized medications, suction or intubation.
- If your transport unit does not have an isolated driver compartment it is recommended that after the driver assists with patient care they should properly remove their PPE outside away from the patient. Preform hand hygiene. Don N95 or higher mask. Drive to the hospital. Don full PPE again prior to assisting with patient transfer.
- While transporting the patient it is recommended to utilize the vehicles patient compartment exhaust fan
- Medical equipment should be disposed of if possible or cleaned per manufacturers recommendations with EPA-approved emerging viral pathogens cleaning agents.

Definitions Used in this Guidance

Self-monitoring: means HCP should monitor themselves for fever by taking their temperature twice a day and remain alert for respiratory symptoms (e.g., cough, shortness of breath, sore throat)[*]. Anyone on self-monitoring should be provided a plan for whom to contact if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

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 or respiratory symptoms (e.g., cough, shortness of breath, sore throat)[*]. For HCP with *high*- or *medium-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.

For HCP, active monitoring can be delegated by the health department to the HCP's healthcare facility occupational health or infection control program, if both the health department and the facility are in agreement. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Self-Monitoring with delegated supervision in a healthcare setting means HCP perform self-monitoring with oversight by their healthcare facility's occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the facility are in agreement. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, a facility may consider having HCP report temperature and absence of symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

Close contact for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the patient; or sitting within 6 feet of the patient in a healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

Healthcare Personnel: For the purposes of this document HCP refers to all employees in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

Defining Exposure Risk Category

While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put HCP at risk of COVID-19.

Table 1 describes possible scenarios that can be used to assist with risk assessment. These scenarios do not cover all potential exposure scenarios and should not replace an individual assessment of risk for the purpose of clinical decision making or individualized public health management. Any public health decisions that place restrictions on an individual's or group's movements or impose specific monitoring requirements should be based on an assessment of risk for the individual or group. Healthcare facilities, in consultation with public health authorities should use the concepts outlined in this guidance along with clinical judgement to assign risk and determine need for work restrictions.

For this guidance ***high-risk*** exposures refer to HCP who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the healthcare providers' eyes, nose, or mouth were not protected, is also considered *high-risk*.

Medium-risk exposures generally include HCP who had prolonged close contact with patients with COVID-19 who were wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some *low-risk* exposures are considered *medium-risk* depending on the type of care activity performed. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure. If an aerosol-generating procedure had not been performed, they would have been considered *low-risk*. See Table 1 for additional examples.

Low-risk exposures generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

Both high- and medium-risk exposures place HCP at more than low-risk for developing infection; therefore, the recommendations for active monitoring and work restrictions are the same for these exposures. However, these risk categories were created to align with risk categories described in the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease (COVID-19) Exposure in Travel-associated or Community Settings, which outlines criteria for quarantine and travel restrictions specific to high-risk exposures. Use that Interim Guidance for information about the movement, public activity, and travel restrictions that apply to the HCP included here.

The highest risk exposure category that applies to each person should be used to guide monitoring and work restrictions.

Note: While respirators confer a higher level of protection than facemasks, and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into our assessment of risk.

Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with 2019 Novel Coronavirus (2019-nCoV) Infection or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a COVID-19 patient who was wearing a facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves[a]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None

Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with 2019 Novel Coronavirus (2019-nCoV) Infection or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a COVID-19 patient who was not wearing a facemask (i.e., no source control)			
HCP PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection[b]	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves[a,b]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b]	Low	Self with delegated supervision	None

HCP=healthcare personnel; PPE=personal protective equipment

[a]The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).

[b]The risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.

Additional Scenarios:

- Refer to the footnotes above for scenarios that would elevate the risk level for exposed HCP. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.
- Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.

- HCP not using all recommended PPE who have only brief interactions with a patient regardless of whether patient was wearing a facemask are considered low-risk. Examples of brief interactions include: brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or the patient's secretions/excretions; entering the patient room immediately after the patient was discharged.
- HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room are considered to have no identifiable risk.

Recommendations for Monitoring Based on COVID-19 Exposure Risk

HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work

1. ***High- and Medium-risk* Exposure Category**
   HCP in the high- or medium-risk category should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature >100.0oF or subjective fever) OR respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat)* they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.
2. ***Low-risk* Exposure Category**
   HCP in the *low-risk* category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic HCP in this category are not restricted from work. They should check their temperature twice daily and remain alert for respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat)*. They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or respiratory symptoms they may report to work. If they develop fever (measured temperature $\geq$ 100.0 °F or subjective fever) OR respiratory symptoms they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority or healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, facilities could consider having HCP report temperature and symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.
3. **HCP who Adhere to All Recommended Infection Prevention and Control Practices**
   Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

4. ***No Identifiable risk* Exposure Category**
   HCP in the *no identifiable risk* category do not require monitoring or restriction from work.
5. **Community or travel-associated exposures**
   HCP with potential exposures to COVID-19 in community settings, should have their exposure risk assessed according to CDC guidance. HCP should inform their facility's occupational health program that they have had a community or travel-associated exposure. HCP who have a community or travel-associated exposure should undergo monitoring as defined by that guidance. Those who fall into the *high*- or *medium- risk* category described there should be excluded from work in a healthcare setting until 14 days after their exposure. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

Additional Considerations and Recommendations:

Facilities should shift emphasis to routine practices, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not report to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP. This could include having HCP report absence of fever and symptoms prior to starting work each day.

Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.

* Fever is either measured temperature $\geq$100.0°F or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0°F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by public health authorities.

*** All personnel should have their temperature taken twice during their 24 hour shift. This is to be recorded on the Maine EMS COVID 19 Clinician Screening form.**

Law enforcement response

PPE: PPE for close patient contact shall follow guidelines set above for EMS.

Law enforcement personnel wearing eye protection and a facemask while performing normal law enforcement operations should be considered low risk category for exposure. Social distancing of a minimum of six feet should be observed when at all possible during police operations.

Staging: Law enforcement should not respond inside a residence to ANY medical call unless there are emergency circumstances. Marking the driveway with the cruiser is permissible. Officers should not make contact with potential PUI patients as reported by dispatch or other responding agencies without proper PPE. Officers shall use their best judgment in responding to EMS calls where PPE will not be available. If the nature of the call sounds suspicious for possible Covid-19 (Fever, respiratory symptoms, cough) officers should defer response until EMS from responding service has arrived. In the event this is an outside agency, this will cause a foreseeable but necessary delay in regard to responder safety.

On Scene Operation: Once EMS is on scene, law enforcement should remain in vehicle at roadside until needed. No contact with patient or crew should be initiated without prompting unless safety of the responders becomes a concern. EMS is to incorporate law enforcement only when absolutely needed and make sure they have proper PPE prior to patient contact. EMS to clear law enforcement ASAP.

Decon: In the event a cruiser needs to be decontaminated observation of above stated decon procedures and chemicals shall be followed. In the event a suspected Covid-19 individual is transported in a cruiser every effort possible must be made to have the individual wear a surgical mask.

Exposure: Exposure risk levels and mitigation shall follow the same as in place for EMS (self-monitoring with delegated supervision).