Temporary Emergency Care Standards for EMS

Scope: applies to emergency care of possible COVID-19 in the setting of anticipated or declared epidemic

Effective Date: 3/15/2020
Expiration Date: TBD

Authority: In effect when authorized by the Anchorage Areawide EMS Medical Director and endorsed by the Chief of the Anchorage Fire Department

Goal: Decrease the chance of infection of EMS personnel during care of patients with known or potential COVID-19 infection

References: AFD MEC COVID-19 Treatment Protocols v3.11.2020); AFD EMS COVID-19 Non-Transport Protocols (3.11.2020); COVID-19 checklists

Specific Changes Initial Patient Encounter

1. All patients are initially assessed from a 6ft distance for the potential for an infectious cause of their current symptoms. There will situations in which this will be automatically excluded by the nature of the call
2. Patients with potential infection will be asked to apply a surgical mask that will be supplied by EMS from a ≥6 foot distance.
3. Bystanders and family will be asked to maintain the minimum same separation from personnel
4. When and if remote means of providing the initial interview become practical such as telemedicine or "facetime" videoconferencing becomes practical it will be considered as an acceptable means for initial patient encounter
5. Full PPE will be used if COVID-19 cannot be reasonably excluded
6. **See COVID 19 Checklists for Specific Information**

Approach to the patient

1. When circumstances permit, only one provider will directly assess the patient
2. If circumstances allow, interview the patient outside the residence in open air
3. The minimal expected amount of equipment will be brought to the patient's side however Sp02 is required
4. The interview should be done from the maximal distance that still allows for clear communication
5. Avoid standing directly in front of the patient

Patient Assessment

1. Temperature becomes a crucial first vital sign
2. Respiratory rate must be accurately recorded.
3. The use of stethoscope will be discouraged as it brings the provider closer to the patient and is a source of infection spread.

4. Recording of the BP is best done by automatic device but a palpable systolic pressure will often be sufficient.
5. The need for the LP15 will be determined by the situation but it will require careful decon if brought into the environment
6. Avoid asking the patient to open mouth
7. Auscultation of breath sounds will not routinely be done. Asking the patient to take a deep breath may stimulate cough. If the patient is considered for non-transport, auscultating posterior lung fields may be considered.
8. Movement to the ambulance: allow the patient to self-ambulate if appropriate

Patient Treatment

1. Avoid all aerosol-generating procedures to the extent possible
    a. Bronchodilator treatments by nebulizer
    b. CPAP
    c. BVM
    d. Suctioning
    e. Endotracheal intubation
    f. Examination of the oropharynx
    g. High flow 02 treatment
    h. Always use viral filter/HEPA filter on BVM/airway
2. If patient requires bronchodilator
    a. Consider IM epi
    b. Give the treatment outside of the ambulance prior to transport
    c. Patient may use their own MDI, strong preference prior to transport and in open air: coughing may occur!
3. If patient requires airway support
    a. First line: iGel
    b. This may in some cases require pharmacological treatment with sedative and paralytic
4. If intubation is required
    a. Provider should have maximal PPE
    b. Minimize the number providers in immediate area
    c. Preferably in best ventilated available area. If in the ambulance, open rear doors as possible
    d. Goal-directed therapy with achievement of Sp02 goals may have to be suspended to achieve the most rapid intubation and balloon inflation
    e. Pharmacological adjuncts should be used to optimize the attempt