


A113	A113 – Standards of Care During the COVID-19 Pandemic	A113
2020	Academy of Medicine of Cincinnati - Protocols for SW Ohio	2020
ALL	<p>I. PURPOSE</p> <p>A. Demand for EMS response during the ongoing COVID-19 pandemic is anticipated to exceed capacity of the EMS system at times. EMS provider exposures threaten to further deplete available resources available to provide additional emergency response. Emerging guidelines and expert recommendations regarding best practices during pandemic conditions may conflict with standards of care outlined in existing EMS protocols.</p> <p>B. This protocol outlines acceptable modifications to prehospital care during pandemic conditions and shall supersede standard protocols for the duration that this document is enacted.</p> <p>C. This protocol shall be enacted and active at the discretion of an agency’s administration and medical director. Continued clinical necessity should be regularly assessed to determine timing of return to routine operational protocols.</p> <p>II. BEST PRACTICES</p> <p>A. EMS providers should refer to reputable sources such as the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO) for up to date information on subjects including:</p> <ol style="list-style-type: none"> 1. Appropriate personal protective equipment (PPE) for evaluating patients with suspected/confirmed COVID-19. 2. Methods of minimizing crew exposure during patient assessment and treatment 3. Decontamination of equipment 4. Management of crew exposures including isolation and home quarantine procedures <p>B. The CDC’s COVID-19 Information for Healthcare Professionals can be reached using the URL or the QR code below:</p> <div style="text-align: center;">  </div> <p style="text-align: center;">https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html</p> <p>III. Dispatch</p> <p>A. Departments should work closely in conjunction with their dispatch center to ensure adequate screening processes for symptoms of viral respiratory illness are in place for all calls to enable early crew notification.</p> <p>B. Patients should be advised on all calls, if possible and condition permits, to meet responding crews outside to minimize additional crew infection risks.</p> <p>IV. PROTOCOL</p> <p>A. General Airway Management—ALL ages:</p> <ol style="list-style-type: none"> 1. The following supersedes guidance from Protocol T705 – Airway Protocol: 2. Unless absolutely necessary to prevent patient deterioration, aerosol-generating procedures should be avoided. Common aerosol-generating procedures include: <ol style="list-style-type: none"> a. Use of continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) b. Administration of nebulized medications (albuterol, ipratropium, epinephrine, saline, etc.) c. Any use of a bag valve mask to provide ventilations via a mask, supraglottic airway, or endotracheal tube d. Endotracheal intubation e. Oral suctioning 	

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	<ol style="list-style-type: none"> 3. Bag-mask ventilation should be reserved for apneic patients or patients with inadequate respirations. <ol style="list-style-type: none"> a. Providers should utilize a two-handed technique to ensure a tight mask seal. b. Early placement of a supraglottic airway (SGA) should be considered to minimize the increased aerosolization of secretions associated with bag ventilations via mask. 4. Supraglottic airway (SGA) placement should be prioritized over intubation with an endotracheal tube to avoid prolonged periods of aerosol generation. 5. Use of certified bacterial and viral filters (eg, HEPA filters) between the bag and face mask, supraglottic airway, or endotracheal tube is highly recommended. 6. If use of a metered dose inhaler (MDI) is clinically necessary, it is acceptable to utilize the patient’s own inhaler after confirmation of appropriate medication, dose, and expiration date <p>B. Adult Asthma / COPD Management—Ages 16 and older:</p> <ol style="list-style-type: none"> 1. The following supersedes guidance from Protocol M403 - Asthma-COPD: 2. Use of nebulized medications (eg, albuterol, ipratropium, DuoNeb) should be avoided unless absolutely necessary. 3. Metered dose inhalers (MDI) containing Albuterol are an appropriate alternative to nebulized medications for asthma and COPD patients in respiratory distress. MDIs should be used with a spacer if available. It is acceptable to use the patient’s personal MDI after ensuring it is the correct medication, is prescribed to the patient, and is not expired. 4. Dosing: 4-10 puffs, waiting 30-60 seconds between each puff <ol style="list-style-type: none"> a. Have patient hold their breath for 10 seconds after inhaling each puff to allow the medication to reach the small airspaces. 	
MEDIC	<ol style="list-style-type: none"> 5. Adjunctive medications for the treatment of bronchospasm should be administered early and potentially replace the use of nebulized medications: <ol style="list-style-type: none"> a. Epinephrine (1 mg/mL): 0.3 mg IM b. (Asthma only) Magnesium sulfate: 2 g IV, given over 20 minutes 6. For patients requiring multiple puffs from MDI, steroids should be administered using one of the following reduced dose options: <ol style="list-style-type: none"> a. Prednisone: 40-60 mg PO b. Solu-Medrol (Methylprednisolone): 40 mg IV or PO 	
ALL	<p>C. Pediatric Respiratory Distress (Wheezing or Asthma)—Ages 15 and under:</p> <ol style="list-style-type: none"> 1. The following supersedes guidance from Protocol 607 – Pediatric Respiratory Distress (Wheezing or Asthma): 2. Administer corticosteroids aggressively and early in the course of treatment of all patients, dosed according to Protocol P607. 3. Use of a metered dose inhaler (MDI) with a spacer should be prioritized over nebulizer treatments if possible. Consider using a patient supplied MDI with spacer (after ensuring the medication is the appropriate medication, prescribed to the patient, and not expired). 4. If nebulized medications are absolutely required, treatments should be completed in an open environment prior to patient loading if possible. 5. No albuterol nebulizer or MDI treatments should be administered for patients under 2 years of age. 6. The PRAM score should be used to classify patient severity and guide treatment. Reference Protocol P607 for guidance on determining the PRAM score and appropriate medication dosing. 	

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	<ul style="list-style-type: none"> a. PRAM 0-3 (mild): <ul style="list-style-type: none"> i. No nebulized medications ii. Administer Albuterol using MDI with spacer, if available. 	
MEDIC	<ul style="list-style-type: none"> b. PRAM 4-7 (moderate): <ul style="list-style-type: none"> i. Give patients 3 back-to-back treatments of Albuterol using MDI with spacer if available ii. If no MDI is available, consider giving 3 back-to-back treatments of Albuterol and Ipratropium in an open space with parent/guardian assistance in administration to allow EMS personnel to distance during this aerosol generating procedure. Mix all 3 treatments in the nebulizer chamber at once to avoid unnecessary crew exposure to respiratory secretions. iii. If it is not possible to administer nebulized medications in an open space with EMS personnel at a distance, defer nebulized treatments. Monitor the patient closely and treat aggressively if symptoms progress to the severe range (see below). c. PRAM 8-12 (severe): <ul style="list-style-type: none"> i. Give patients 3 back-to-back treatments of Albuterol using MDI with spacer if available ii. If Albuterol MDI with spacer is unavailable, administer 3 back-to-back nebulized treatments with Albuterol and Ipratropium if available. Mix all 3 treatments in the nebulizer chamber at once to avoid unnecessary crew exposure to respiratory secretions. Administer in an open space if possible and consider enlisting parent/guardian assistance in administration to allow EMS personnel to distance during this aerosol generating procedure. iii. Place an IV line and administer a bolus of normal saline per protocol P607. iv. Consider early administration of IM epinephrine (1 mg/mL): 0.01 mg/kg (max dose 0.3 mg). 	
ALL	<ul style="list-style-type: none"> D. Cardiac Arrest Management—ALL ages <ul style="list-style-type: none"> 1. The following instructions supersede guidance from Protocols SB204 - Cardiac Arrest and T705 - Airway Protocol: 2. Placement of a supraglottic airway (SGA) should be prioritized over intubation. 3. The number of EMS providers who physically contact the patient during resuscitation should be minimized. All other crewmembers should remain greater than 6 ft away from the patient if possible. Any crewmember within 6 ft should be wearing PPE as recommended by the CDC for aerosol generating procedures as all airway management techniques are considered aerosol generating. 	
MEDIC	<ul style="list-style-type: none"> E. Termination of Resuscitation—ALL ages <ul style="list-style-type: none"> 1. The following instructions supersede guidance from Protocol A105 – Determination of Death/Termination of CPR, Part III: 2. Early contact with Medical Control is recommended for all cardiac arrest patients who do not rapidly achieve sustained ROSC. Based on the clinical scenario, the medical control physician may choose to terminate the resuscitation before 30 minutes of resuscitative efforts have elapsed and/or in cases where not all of the standard termination criteria are met. 3. Most patients without ROSC should not be transported unless directed to do so by medical control or if there is a concern for the safety of personnel on scene. 	

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ALL	<p>F. Opioid Overdose Management—ALL ages</p> <ol style="list-style-type: none"> 1. The following instructions supersede guidance from Protocol M411 Section C - Opioid Overdose: 2. Intramuscular (IM) or intravenous (IV) administration of naloxone should be considered preferentially over intranasal (IN) route if possible. 3. Although unnecessary use should be avoided, patients who are apneic or have inadequate respirations should receive assisted ventilations using BVM. 	
MEDIC	<p>G. Prehospital Pain Management—ALL ages:</p> <ol style="list-style-type: none"> 1. The following supersedes guidance from Protocol S505 – Prehospital Pain Management, Part IV, Section D and Protocol P612 – Pediatric Pain Management, Part II, Section D: 2. When administering pain medications including fentanyl and morphine, use of the intranasal (IN) route should be avoided, and alternate routes of administration should be used (IV, IM, IO) 	
ALL	<p>V. DISPOSITION</p> <ol style="list-style-type: none"> A. Providers should refer to protocol A112 COVID-19 Non-Transport Guideline, if currently enacted per their agency leadership and medical director, for guidance in determining which lower acuity patients exhibiting viral respiratory symptoms are appropriate for non-transport and home care. B. For all complaints: If transport is required, priority in transport destination should be to the closest appropriate facility, rather than per patient request, in absence of extenuating circumstances or necessity for specialized care. Patients requiring more specific transport destination may include: <ol style="list-style-type: none"> 1. Patients meeting typical criteria for Trauma, STEMI, Stroke, or Pediatric specific destinations per SWOH protocol 2. Patients with LVAD devices 3. If Disaster Net is open destination will be dictated by Net control C. Where available, telemedicine evaluation by specially trained medical personnel in conjunction with on scene EMS providers may provide additional guidance on non-transport or alternative transport decisions. D. Transport should be conducted with the minimum number of crew necessary to safely do so. E. Patient family or caregiver riders should not be transported within the ambulance in the absence of extenuating circumstances or other department specific guidance except in the case of the parent or guardian of a minor child. If accompanying transport is required as determined by EMS personnel, this should be limited to one individual. F. Hospital notification for patients with viral respiratory symptoms shall be made per current local EMS system/hospital guidance to enable the receiving facility to mobilize resources and determine the appropriate treatment space for the patient on arrival. G. As the pandemic progresses, transport of low acuity patients to alternative destinations other than an emergency department may become a viable option as a result of the declared state of emergency. Any such process should be only be enacted by agency administration and medical direction in accordance with federal and state regulations. <p>VI. DOCUMENTATION</p> <ol style="list-style-type: none"> A. Clinical documentation should pay special attention to notation of any deviation from typical operating standards of care and an explanation of the underlying clinical reasoning. 	