MONTGOMERY COUNTY FIRE AND RESCUE SERVICE

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April 12, 2020

TO: All Credentialed MCFRS EMS Clinicians

FROM: Roger M. Stone MD, MS
MCFRS Medical Director

SUBJECT: Changes to the standard of care during the COVID-19 Emergency

Effective immediately and until further notice, I am altering the standards of care for MCFRS EMS Clinicians in the following ways:

1.) To minimize aerosolization of viral particles and clinician exposure, clinicians are to minimize aerosol generating procedures (AGPs) by:

   a. Using the patient's albuterol metered dose inhaler when available. If also available, clinicians should encourage the patient to use an MDI spacer

   b. Discontinuing the use of intranasal route of medication administration in favor of the intramuscular route. Naloxone, Midazolam, Fentanyl and Glucagon (common intranasal medications) are all suitable for intramuscular administration

   c. Administering Terbutaline where appropriate and in accordance with the emergency protocol addition to the formulary recently distributed by MIEMSS

   d. Avoiding endotracheal intubation except when absolutely necessary

   e. Oxygenating hypoxic breathing patients in an escalating manner, beginning with a nasal cannula then progressing to an NRB then CPAP Mask with Viral Filter

      i. Cover an NC or NRB with a surgical mask after application

      ii. The best knowledge available about pulse oximetry in COVID-19 patients leads me to believe that maintaining an oxygen saturation

of 88% or greater is acceptable if the patient's work of breathing is comfortable. Adjust the aggressiveness of your oxygen administration based on this lower tolerable oxygen saturation.

iii. If BVM ventilation is necessary use the following steps:

1. Secure a CPAP mask with HEPA filter using a harness
2. Connect the BVM to oxygen with a flow rate of 6-10 lpm
3. Ventilate the patient at a rate of 6-10 breaths per minute
4. Only deliver enough volume to observe gentle chest rise

f. Using the following best practices to limit the number of attempts and reduce the risk of disease transmission during endotracheal intubation:

i. The clinician with the most airway management experience will perform the procedure

ii. Use video laryngoscopy to place distance between the clinician and the airway

iii. Pre-assemble a viral filter on the end of the ET tube prior to the intubation attempt

g. Administering nebulized medications only when absolutely necessary. If you must administer nebulized medications, find a large, open, well-ventilated space in which to perform the administration

h. Using the best-practices illustrated in this video: https://www.youtube.com/watch?v=etgqYxfjDxU

2.) To reduce exposure to clinicians, avoid the transport of the adult (age 18 or greater) cardiac arrest patient undergoing resuscitation by:

a. Resuscitating on scene until the patient achieves ROSC or you reach TOR

b. If you terminate a resuscitation in a public place or other area that is not suitable for leaving the body, you should transport the body to the closest hospital-based emergency department (not free-standing emergency department) after TOR, *without a resuscitation in progress*

c. Endotracheal intubation is strongly deemphasized in the cardiac arrest patient, especially when you are able to ventilate and oxygenate the patient using a BVM and basic airway adjuncts. Use guidance in this video: https://www.youtube.com/watch?v=qw81uq0xvhg

d. When you reach TOR consideration (15 2-min cycles in medical, 5 2-min cycles in trauma)

   i. If the patient's rhythm is asystole at the time of TOR consideration, you shall terminate the resuscitation

   ii. If the patient's rhythm at the time of TOR consideration is anything other than asystole you may terminate resuscitation without consideration of ETCO2. **Caution should be exercised when terminating the resuscitation of patients whose arrests were witnessed and had an initial rhythm that was shockable.**

   iii. **Select the right patient:** the intent of this adjustment is to limit your exposure to patients with COVID-19. An elderly febrile patient with a 5-day history of COVID symptoms is very different from a young adult who experiences witnessed cardiac arrest

e. Timing of the transport of a pediatric (<18 years of age) cardiac arrest patient **remains unchanged** from the current Maryland Medical Protocol; it can occur at any time after the administration of the 3rd epinephrine

3.) To improve the treatment of **suspected COVID-19** patients based on the best current knowledge about the disease, ALS and BLS clinicians should encourage and implement the following patient positioning:

a. Target patient: suspected COVID-19 with respiratory signs/symptoms
   i. Alert (GCS 15)
   ii. Moderate dyspnea or hypoxia
   iii. Able to tolerate this positioning without increased distress
   iv. Able to be secured to the stretcher in the alternate position

b. Procedure:
   i. Apply supplemental oxygen in an escalating matter as needed
   ii. Position patient on left side (left lateral recumbent) on the cot
   iii. Monitor for worsening hypoxia, nausea or increased work of breathing
   iv. If hypoxia improves, adjust oxygen flow downward to maintain oxygen saturation of 88% or greater

The following steps are <u>NOT</u> authorized immediately but they are listed for your advance knowledge. If MCFRS operates in Phase III of the MCFRS COVID-19 Surge Plan, I authorize the following:

1.) To reduce the need for ED staff to answer the EMRC radio, the routine practice of medical consultation via EMRC is suspended

   a. Medical Consultation for any patient may be obtained at any time if you feel you need it; however,

   b. Hospital notification of all patients should be performed on Zone 79 until such time as a disposition and communications officer takes over this function

   c. Hospital notifications should still include specific information about suspected PUI patients

   d. **You are authorized to administer any medication or perform any skill consistent with your level of credentialing and the Maryland Medical Protocol without online authorization**

2.) To facilitate transport unit availability and to expedite a return to service, I am expanding the Direct to Triage (DTT) Program:

   a. Any patient who meets the previous DTT criteria of low acuity complaint, stable clinical findings and able to sit in a chair or wheelchair may be placed directly in the hospital's triage queue using their normal walk-in procedure **without charge nurse consultation**

   b. **Clinicians must ensure that the patient begins the hospital's process to be seen, including patient registration.**

   c. If possible, give a case synopsis to the triage nurse however a unit's return to service should not be unusually delayed in order to exchange this information. Unusually delayed is defined as being held longer than the period of time it takes to complete the ePCR.

   d. If a hospital signature is not able to be obtained for the eMEDS report, use the code "Not signed – Transferred care / No access to obtain signature"