Clinical Treatment for Patient with Suspected or Confirmed COVID-19

I. Applicable patients:
   Patients prescreened or encountered by EMS personnel who may or may not have been pre-
   identified by 911/EMD as a potential COVID-19 patient:
   A. Have signs and symptoms of respiratory illness (cough, shortness of breath)
   B. Have signs and symptoms of respiratory illness (cough, shortness of breath) AND known
      exposure to patient with suspected COVID-19
   C. Have other signs or symptoms associated with COVID-19 (fever, chills, shaking with chills,
      sore throat, loss of sense of taste/smell, muscle pain, headache, profound fatigue).

II. Personal Protective Equipment:
   A. Standard, contact, and airborne precautions
   B. Surgical masks for personnel may be substituted for N95 masks when no aerosolized
      procedures are taking place and when not in an enclosed area (e.g. ambulance patient
      compartment) with actively coughing patient.
   C. Surgical masks or non-rebreather masks with supplemental oxygen for patients in
      respiratory distress should be applied to the patient whenever possible to perform
      source control. All patients regardless of COVID-19 suspicion should have surgical mask
      applied for source control.

III. Treatment:
   A. Follow General Prehospital Care Protocol and other applicable protocols modified as
      below
   B. Patients should receive oxygen to maintain SPO2 ≥94%
      i. Nasal cannula should be applied under a surgical mask.
      ii. Non-rebreather masks, for patients with hypoxia or respiratory distress should be
          used in lieu of surgical masks.
      iii. Combined nasal cannula at 6 LPM and non-rebreather mask at 12-15 LPM may be
          considered in patients remaining hypoxic after non-rebreather alone.
   C. Assess breath sounds
      i. For patients with clear breath sounds, continue supportive oxygenation.
      ii. For patients with wheezing
          1. Preferred mechanism for pharmacological intervention is albuterol by
             metered dose inhaler (MDI) with spacer (including assisting patient with
             personal inhaler of albuterol), if available.
                a. Administer 4 puffs over 30-60 seconds (equivalent to 2.5 mg of
                   albuterol)
                b. Dose may be repeated as needed every 5 minutes.
          2. If patient has wheezing with moderate to severe dyspnea and there is not
             access to MDI and the patient has a known history of asthma/COPD
                a. Administer bronchodilator via nebulizer in open area with
                   maximum air ventilation, with N95 or greater respirator applied to
                   personnel, and single rescuer monitoring patient from maximal
                   distance possible. Contact medical control for direction, as needed.

Bay County Medical Control Authority
MCA Name: EMERGENCY PROTOCOL
MCA Board Approval Date: 5/11/2020
MCA Implementation Date: 5/11/2020
Protocol Source/References: https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html
b. DO NOT administer nebulized medication in closed ambulance.

c. For patients with known history of asthma/COPD and in moderate to severe dyspnea WITH wheezing, may administer:
epinephrine (1 mg per mL) 0.3 mL IM. (Skill may be BLS or MFR, depending on MCA selection.)

iii. For patients with severe respiratory distress AND a history of CHF or COPD and positioning, oxygenation, and other treatments (e.g. nitroglycerin 0.4 mg SL q 3 minutes for CHF) are not effective:

1. Apply CPAP per protocol.
2. Use HEPA filter for exhalation port, if available.
3. CPAP being utilized in the patient compartment should be limited to necessity and only when all providers in the patient compartment have N95 respirators in place.
4. Contact receiving hospital as early as possible to advise them of patient requiring CPAP to allow for appropriate transition of care upon arrival.

D. Hypotensive patients – those with SBP <90mmHg with signs and symptoms of shock

i. Administer normal saline 250 mL bolus.
ii. Reassess BP and signs and symptoms of shock prior to administering more fluid

iii. Normal saline boluses of 250 mL may be repeated to a maximum of one liter as signs/symptoms persist before contacting medical control.

E. Airway management

i. DO NOT Intubate or perform (mouth to mask/mouth) rescue breathing on patients with suspected COVID-19.

ii. Utilize supraglottic airways with ETCO2 if an advanced airway needs to be placed.

iii. Place filter inline for ventilations or utilize a BVM with filtration capability, if available.

IV. Time sensitive patients:

A. Patients in need of immediate intervention will be treated with a minimum of gloves, eye protection, and mask

V. Transport:

A. Interventions should be performed PRIOR to loading into or closing patient compartment of the ambulance.

B. Only one provider will remain with patient for transport, if possible.

C. Follow COVID-19 Destination and Transport Protocol

VI. Cardiac arrest- Follow CARDIAC ARREST IN A PATIENT WITH SUSPECTED COVID-19

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