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**GFFR Guide for Coronavirus Planning and Response Updated 3/31/20**

The 2019 novel Coronavirus (COVID-19) is creating a rapidly changing environment for public safety agencies especially for Fire and EMS agencies. This is a dynamic event that will likely stretch out for months and with recommended changes coming in daily. As a result, recommendations will undoubtedly change over time. We request that everyone stays up to date on changes coming in from reliable sources including IAFC, IAFF, CDC, and Department of labor.

The City of Great Falls, Cascade County, in conjunction with the City/County Health Department have and will continue to plan and respond to Coronavirus (COVID-19) occurrences within our State, this document will establish GFFR’s guide to identify key recommendations, best practices, and considerations.

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**Dispatch Screening and Protocols**

The Great Falls Cascade County Emergency Center (911 Dispatch Center/PSAP) will be the primary answering point for all 911 emergencies and should be their first line of infection control and force protection. When COVID-19 first began to spread, many PSAPs focused their questions on a caller’s travel history and contact with confirmed COVID-19 patients. Over the past few weeks, many patients have contracted COVID-19 despite not traveling to heavily impacted locations or having contact with known COVID-19 patients. These cases of unexplained occurrences of COVID-19 are known as “community spread” and indicate the virus is in a more pervasive state across the nation.

Due to the community spread of COVID-19, PSAPs should ask all callers seeking emergency medical assistance about whether they are experiencing flu-like symptoms such as a cough, difficulty breathing, fever, and/or body aches. First Responders should work closely with their medical director to identify a full list of symptoms that are consistent with COVID-19. All agencies should review the CDC’s guide for evaluating individuals who suspected of having COVID-19, as well as CDC Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs).

Upon identifying a possible COVID-19 called based upon the pre-determined screening questions, PSAP dispatchers should immediately notify responding personnel of the patient’s potential status as a COVID-19 patient and **REQUIRE** “Droplet Protection” for all prehospital providers. EMS personnel should don the appropriate level of PPE prior to interacting with any patients identified as being suspect for Flu-like symptoms or COVID-19.

If transportation of the patient is required, EMS personnel will notify the receiving hospital that a suspected Flu-like/COVID-19 patient is enroute to their facility.

The current EMD dispatch protocol for screening of Flu-like/COVID-19 patients is follows:

Update 3/26/20



911 PSAP screening for Covid-19/Flu-like symptomsA

Does Patient have a fever? Cough? And/or Respiratory Illness without respiratory Hx

 NO YES 

Does the patient have Flu-like symptoms? Can the patient walk outside their home or complex and meet responders at the front door? If so, notify responders that Pt will meet at door

Proceed with Caution

YES NO

6’ distance for providers during Patient Assessment

911 Dispatcher will REQUIRE “Droplet Protection” on dispatch to prehospital providers

If Positive

Critical Pt Non-Critical Pt

1 GFFR Provider attempts to make contact with Pt to determine Medical need, 6’ distancing. Wait for GFES to arrive

If Negative, place a surgical mask on Pt and use standard resp precautions

1st Due resource unit will wear full PPE, Tyvek, gloves, N95 mask, Glasses

If Pt is non-critical, advise to self-quarantine at home. Contact Benefis Healthcare Charge Nurse for Determination of need to Transport

2nd Due unit stages outside. Be prepared to enter if needed by 1st Due resource.

Provide Appropriate Care

GFFR stages

NO

**Personal Protective Equipment**

Identifying and selecting the appropriate personal protective equipment (PPE), is a crucial component to protecting EMS personnel when assessing, treating, and transporting potential Flu-like/COVID-19 patients. Firefighters and EMS personnel should exercise the same precautions when treating confirmed and suspected Flu-like/COVID-19 patients.

*Patient Assessment and Care*

The following PPE will be required for all GFFR personnel when responding to known or suspected Flu-like/COVID-19 patients.

* **Masks/Respiratory Protection:** Any EMS clinician coming into close contact with a known or suspected COVID- 19 patient should wear a facemask. An N95 mask is ideal; however massive global demand for N95 masks likely will lead to shortages. In cases when N95 masks are unavailable, EMS personnel should wear a surgical mask at a minimum. All suspected COVID-19 patients also should be given a surgical mask.
* **Eye Protection:** EMS clinicians should wear a disposable face shield, goggles, glasses, or other protection that covers the front and sides of the face.
* **Gloves/Gowns:** EMS clinicians should wear a single pair of disposable gloves and a disposable gown. Shortages of gowns also are possible. GFFR currently does not have gowns in supply inventory and will utilize TYVEK suits. Suits are mandatory to wear when performing aerosolizing procedures, physically transferring patients to/from a cot, and other high-contact patient care activities
* **High Risk Procedures:** Aerosol-generating procedures, such as oral suctioning and intubation, convey an especially high risk of exposing EMS personnel to Flu-like/COVID-19 symptoms. As a result, GFFR personnel will wear an N95 mask, eye protection, a Tyvek suit, and disposable gloves when performing these procedures. If possible, high-risk procedures like these should be performed with the ambulance stopped and all doors and windows opened to allow as much ventilation as possible within the ambulance.

For all other EMS responses, the following PPE is required:

* Disposable gloves
* Eye protection
* GFFR issues EMS coat

Once the appropriate PPE has been identified, all EMS personnel should become familiar with proper donning and doffing procedures.

GFFR will implement limited interventions with patients who are displaying Flu-like/COVID-19 symptoms. Unless an EMS provider has had close contact with a suspected Flu-like/COVID-19 patient, the Tyvek and N95 mask will be reused.

Close contact is defined as:

* Being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, OR
* Having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

Patient interactions should be limited unless patient is in critical distress. When possible,

* One provider will triage/exam if possible and maintain a line of sight with crew and situational awareness
* See if Patient can walk outside or come to you.
* Apply a surgical mask to the Patient

*Discarding Expired PPE*

Due to the likelihood of PPE shortages from high PPE use, N95 masks and Tyvek suits will only be discarded if they are contaminated from direct contact with a known Flu-like/COVID-19 patient or have become saturated from moisture from breathing, torn or physically damaged.

N95 masks will be stored in a brown paper bag in-between calls and allowed to dry. Masks are not to be folded or crumpled as this degrades the integrity of the mask. The storage area for EMS jackets and masks will be in the old turnout area of each Fire station.

*Patient Transportation*

With the Declaration of Emergency through the Federal Government and the State of Montana, we have implemented the following Influenza Pandemic Protocol:

**Montana Board of Medical Examiners: Montana Prehospital Treatment Protocols**

**INFLUENZA PANDEMIC PROTOCOL**

**General Comment:**

In the event that there is a public health or safety emergency in which health care resources are overwhelmed by demand, the EMT response will have to adapt to the severity of the situation and the available resources. This Influenza Pandemic protocol is to be used as a guide in the development of a local plan (based on the severity of the situation and the available resources) remembering that the local situation will change frequently, perhaps daily or hourly. This protocol is assuming that an Influenza Pandemic has overwhelmed the medical community and normal EMT operating procedures are not feasible or practical. The Montana Board of Medical Examiners recognizes that an organized “treat and release protocol” would not only be advantageous but necessary to maintain control and order to providing medical assistance in the community.

**ALL RESPONDERS:** Physical Assessment:

When conducting your initial assessment a patient, maintain a safe distance (6 feet) and utilize personal protection until you determine if influenza like symptoms exist. If no symptoms exist, then proceed with your patient assessment as normal. If influenza symptoms are present, utilize the triage tool identified below to assess and determine the severity of the illness and assist in transport decisions. The local medical director must determine, in consultation with the local public health department and health care facilities, what scores would facilitate transport or treat and release; this could change

depending on the evolving characteristics of the viral infection and may change daily or even hourly depending on available medical resources.

**Demographics: \_\_\_\_Score\_\_\_\_O2 saturation: \_\_\_\_Score\_\_\_\_\_\_\_**

Age <6 months: 2 > or = to 90% 0

6 mo – 5 yrs 1 86% - 89% 3

5 yrs- 65 yrs 0 76% - 85% 4

65 yrs- 75 yrs 1 = to or < 75% 5

>75 yrs 5

Caregiver at home -1

**Respiratory rate: \_\_\_\_\_Score\_\_\_\_\_\_\_ Heart rate: \_\_\_\_\_\_\_\_\_Score\_\_\_\_**

8 - 24 resp / min 0 < 6 mo & > 150 HR 2

24 - 60 2 Children > 6 mo & > 120 HR 2

< 8 or > 60 3 Adults: > 110 HR 2

**Blood pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_Score\_\_\_\_\_\_\_ Temperature: \_\_\_\_\_Score\_\_\_\_\_\_\_**

<6 mo & cap refill > 2 seconds 2 >103 F (39.4 C) 1

90 - 100mmHg 2

< 90mmHg 4

**Mental Status: \_\_\_\_\_\_\_\_\_ Score\_\_\_\_\_\_\_\_\_ Able to tolerate PO? \_\_\_\_\_\_\_Score\_\_\_\_\_\_\_**

Confused 2 Yes -1

Unresponsive/ Obtunded 3 No 1

**Co morbidities: \_\_\_\_\_\_\_ Score \_\_\_\_\_\_\_Evaluator discretion: \_\_\_\_\_\_\_\_\_Score\_\_\_\_\_**

DM, asthma/COPD, CHF 1 each Evaluator may assign subjective -1, 0, or +1

Obesity 1

Pregnancy 2

**Patients who score:**

>14 Patient should remain home with comfort measures provided

8 - 14 Should be transported to the emergency department for treatment

4 - 8 Should be directed for additional screening/assessment but does not require

ambulance transport

< 4 Should not be transported and should remain home with provided instructions

Major Review: 2015 Current Revision# 1.10 on 12/2017

The Great Falls EMS System Medical Director Dave Simpson has implemented the following protocols effective immediately:

**Great Falls EMS Advisory Committee**

**COVID-19 Protocols**

**Does the Patient have the following symptoms?**

**Shelter in Place**

* Temperature < 100.4
* Heart rate < 90 bpm (Use the Patient’s baseline HR as a guideline)
* Dry cough
* SPO2 > 92% for patients with COPD
* SPO2> 94% for patients without respiratory compromise
* Respiratory rate between 12-20 bpm (Monitor bpm without the patient’s knowledge)
* Patient is A&Ox4

**Does the Patient meet 2 or more of the SIRS?**

**Prepare to transport and notify the receiving facility ASAP**

* Temperature > 100.4
* Heart rate > 90 bpm (Use the Patient’s baseline HR as a guideline)
* Respiratory rate > 20 breaths per minute (Monitor bpm without the patient’s knowledge)
* Difficulty breathing or shortness of breath
* Persistent pain or pressure in chest
* Altered mental status (recent onset)
* Evidence of Hypoxia

**Patient’s with the following documented conditions are high risk**

|  |  |  |
| --- | --- | --- |
| * Pneumonia | * COPD | * Over age 65 |
| * Heart Disease | * Type I & II DM | * Immunocompromised |
| * Severe Bronchitis | * Asemia | * Difficult Accessibility |

**\*\*Remember these are guidelines! Use your judgement as an EMS professional. When in doubt transport\*\***

Known or suspected COVID-19 patients ideally should be transported in an ambulance with an enclosed patient compartment. When an ambulance without an isolated driver’s compartment is used, the driver should wear a respirator or facemask. If the driver previously was wearing full PPE, they should doff their eye protection, gown, and gloves before performing full hand hygiene such as utilizing hand sanitizer. Their original respirator or facemask should remain in place.

*PPE Ordering and Needs Assessment*

GFFR has inventoried all of our PPE to include:

* Tyvek suits
* Disposable gloves
* N95 masks
* Decontamination wipes and spray

All healthcare agencies are beginning to run low on EMS supplies. GFFR has issued every member one N95 mask to utilize until it has been deemed unserviceable. When this happens, members will be issued another N95 mask from their Battalion Chief or any Administrative Chief. All manufacturers have EMS supplies on back order with no tentative timeline when orders will be filled and shipped. On 3/17/20, we placed a request through the County DES office to open the national stockpile of supplies for healthcare providers. We will update all personnel when we hear a response to our request.

**Decontamination and Disinfection**

Decontamination is always a central part of any infection control procedure. This step is especially important when preventing the spread of Flu-like/COVID-19 symptoms to other EMS providers and personnel.

GFFR personnel will arrive to work and leave work wearing civilian clothes. No GFFR uniform items will be worn home.

*Ambulance Decontamination Procedures*

After the patient has been transferred to a receiving facility, the ambulance crew should open the rear doors of the transport vehicle to allow an air exchange to facilitate the removal of infectious particles from the air. The CDC currently believes that the time spent transferring the patient and completing all patient care reports is sufficient to ventilate the ambulance.

When cleaning the ambulance, GFFR personnel will wear a Tyvek suit and gloves. A surgical mask or disposable face shield also is recommended if splashes of the cleaning agent are anticipated. Hospital-grade disinfectants are strong enough to kill the COVID-19 virus and should be used on any surface which may have come in contact with the patient or patient’s bodily fluids, regardless of whether the ambulance crew noticed contamination of the surfaces. Particular attention should be given to cleaning the following areas:

* Stretcher
* Rails
* Control panels and switches
* Floors
* Walls
* Seats
* Work surfaces
* Cabinets

Ambulance crews should adhere strictly to the usage instructions provided by the disinfectant manufacturer as well as any applicable standard operating procedures. Please see attached appendix of approved disinfectant products.

*Fire Apparatus Decontamination Procedures*

When cleaning fire apparatus, personnel should utilize an approved disinfectant to sanitize all touch surfaces in the apparatus.

All front line apparatus surface areas will be thoroughly cleaned at the start of each shift and after each call.

*Fire Station Decontamination Procedures*

In addition to the cleaning of transport and non-transport apparatus, GFFR will institute an annual station maintenance/cleaning of all areas of the station. This will be coordinated between platoons and station captains. Emphasis will be given to deep clean all areas. Appropriate disinfectant should be used to clean touch surfaces throughout the fire station as well as floors. Particularly close attention should be given to thoroughly cleaning all quarters, kitchens, gyms, bathrooms, and day rooms.

Scaffolding will travel between all the stations and a pressure washer will be used on all concrete and brick to remove grime and soot.

At the station level, we must remain vigilant and keep our areas clean. We are instituting a twice-a-day daily chore regiment. Surfaces such as door handles and light switches are sprayed down, all surfaces are cleaned with approved cleaners. Keep in mind that the kill time for most cleaners is 10 minutes for biological agents. Spray your surfaces and let them air dry for 10 minutes. Ensure your face pieces on your SCBAs are cleaned, bunk rooms disinfected, and surfaces within the cab of the apparatus are wiped down.

Disposal of Bio-hazard waste will continue as current guidelines dictate.

*Approved Disinfectants*

The U.S. Environmental Protection Agency (EPA) has identified a list of disinfectants that can be used to eliminate the COVID-19 virus. Please see appendix for specific disinfectants.

**Quarantine Guidance**

The most important information to know in the prevention of exposure and the need to quarantine or isolate an EMS provider can be nearly eliminated when:

a) Proper PPE adherence is achieved.

b) A surgical facemask is placed on a patient.

All GFFR personnel will ensure they follow proper PPE protocol and place a surgical facemask on patients with flu-like symptoms. If both goals are achieved, there likely is no need to quarantine an EMS provider.

Exposure is a considerable risk to all healthcare providers (HCP). This can be considerably increased due to the potential for those patients with an unknown infection/transmission. The WHO currently lists exposure risk of a HCP at high if the patient Is not wearing a surgical mask and no PPE is donned (13). A HCP with no PPE and a patient with a mask (source control) is rated as a medium risk for exposure. A HCP with full PPE and source control is rated at low risk for exposure. Also 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*.

A folder has been placed on the O-drive server labeled Covid-19 response. All Flu-like/COVID-19 symptom calls that our agency responds to will be entered into this spreadsheet. This will be done by the Officer of the responding company.

To prevent the possibility of cross-contaminating stations and personnel, **PLEASE stay home if you are sick.** This is the best way to limit the spread of viruses that will limit our personnel response force. To assist in this, we are implementing new criteria for the start of each shift.

At the beginning of every shift, personnel entering the station shall complete a self- check at the designated location to determine if “sick” or “not sick.” Each member must notify the assigned company officer/ Battalion Chief and verify they have completed the self-check. If a crew member has one or more of the following symptoms immediately leave the location and return to your vehicle and notify your chain of command:

* Fever with or without chills
* Uncontrollable secretions or excretions that would likely result in the employee sneezing or blowing their nose during the course of caring for a patient or talking to a colleague.
* Sore throat
* Productive or uncontrolled cough (unable to control cough during the course of seeing a patient or talking to a colleague) OR a cough lasting more than two weeks
* Influenza or COVID-19-like illness (fever and cough, shortness of breath, or sore throat)
* Diarrhea associated with an acute illness
* Body aches and pains

If an employee calls in sick with symptoms that are Flu-like in nature or develops Flu-like symptoms during shift, they should not report for duty. GFFR’s Health Safety Officer (HSO) Klippenes or alternate Jones, will be contacted and informed of any employee having Flu-like/COVID-19 symptoms.

GFFR’s HSO will then contact Benefis Occupational Health department and speak with either Dr. Johnson, Rita Peters, or Beth Yurek and schedule an appointment for the affected employee. The HSO will notify them that a GFFR first responder has symptoms that are Flu-like/COVID-19 in nature. The CCHD has designated first responders to meet Tier 1 criteria for immediate testing.

Benefis Occupational Health will arrange for a time for the employee (who has called in ill) to come to their facility and receive swabbing for Influenza A, B, RSV, and COVID-19. This will be done outside the building in a designated area. If the Influenza A, B, and RSV tests come in negative, the COVID-19 nasal swab test will be sent to the State for testing.

If the employee test positive for any of the respiratory panel tests, they will be notified and informed of their condition. If the respiratory panel comes back negative, the employee must stay away from work until the State COVID-19 test results are determined. If all tests come back negative, the employee will be available to return to work . The HSO will enroll the employee in the symptom tracker spreadsheet, which is simply a spreadsheet that logs and tracks the employee’s symptoms during the time they are symptomatic. The employee will be monitored twice daily via phone call from the HSO. This will occur for any employee who is being tested, under quarantine, or isolation. Please bring your insurance card to appointment for test processing. GFPD, CCSO, and GFES will be utilizing this procedure as well and will be coordinated through the GFFR HSO. The test will be billed to the employee’s insurance so please bring insurance card at time of testing.

**(Updated 3/23/20)**

All fire stations will have one point of entry at the beginning of each day as described below. **All** employees will use this door and will be screened for flu-like/COVID-19 symptoms prior to being allowed to start work.

Fire Station 1 East Door

Fire Station 2 South Door

Fire Station 3 North Door

Fire Station 4 West Door

*Quarantine vs. Isolation*

GFFR definition of quarantine versus isolation:

* **Quarantine:** Quarantine is used to separate people who may have been exposed to COVID-19 from those who have not been exposed to COVID-19. Individuals placed into quarantine are not ill and are under observation to determine if they will develop symptoms. The CDC recommends that individuals who may have been exposed, or are known to have been exposed, to COVID-19 be placed into quarantine for 14 days. This quarantine period is most often completed in the individual’s home. If an individual is quarantined in their home, fire chiefs and medical directors may want to consider whether it is appropriate for the individual to distance themselves from other family members or roommates who have not experienced a potential COVID-19 exposure.
* **Isolation:** Isolation is meant to separate sick individuals from non-sick individuals. A helpful note to remember is that isolation = ill. In most cases, these individuals may complete their isolation at home. However, it is critically important to routinely monitor these individuals and transfer them to a hospital if their symptoms worsen.

*Quarantine/Isolation Locations*

It appears that current practice around the country is to have personnel who have been quarantined or deemed to be in isolation, will do so from the confinements of their personal residence. This will be under continuous review to determine best practices.

**Physical, Mental, and Behavioral Health Concerns**

GFFR will develop plans to ensure that individuals are routinely contacted throughout the day to assess their physical symptoms as well as to address any mental or behavioral health concerns which arise during the quarantine or isolation. The use of a peer support, chaplain, or critical incident stress management team may be especially helpful in monitoring and addressing mental and behavioral health concerns of individuals in quarantine or isolation.

Routine monitoring of an individual’s physical health symptoms also is important, as they may need medical attention if symptoms develop. GFFR will utilized phone and/or video conferencing systems to assess the health of quarantined/isolated individuals. Additionally, GFFR’s Medical Director will continue to play an active role in developing any plans to assess the physical, mental, and behavioral health of quarantined individuals.

Below are resources for supporting mental and behavioral for firefighters and EMS personnel.

• IAFC – Yellow Ribbon Report: A Proactive Approach to Ensuring Mental Wellness

• IAFF – Behavioral Health Program

• NFFF – Finding Peace of Mind and Wellness in the Fire Service

*Extent of Quarantine/Isolation Following a Workplace Exposure*

The CDC has developed a helpful guide for assessing the level of risk that an individual faces following interaction with a known or suspected COVID-19 patient. It is important to note that if an EMS provider was wearing their full PPE and adhered to proper donning and doffing procedures, their chances of contracting COVID-19 are minimal, and they should not be quarantined or isolated. Placing an individual under quarantine or isolation should only be done following an unprotected exposure to a known or suspected COVID-19 patient.

The CDC establishes that placing a face mask on a patient to achieve source control is one of the most effective means to reducing exposure risk for EMS personnel. All suspected COVID-19 patients should be instructed to don a surgical mask upon arrival of EMS personnel. We have changed protocol and procedures to limit the number of EMS personnel who interact directly with suspected or confirmed COVID-19 patients.

**Operational Changes During Pandemic Event**

We must adjust our operations to some extent. The (911) PSAP and GFFR have begun screening calls for COVID-19 symptoms. This was enacted on January 30th, 2020. If a patient complains of Flu-like/COVID-19 symptoms such as cough, fever or shortness of breath, that information is relayed to responding units to don appropriate PPE.

GFFR has adjusted our response matrix and how we approach EMS calls. For the time being, we will send in a minimum number of personnel to assess the patient. If additional help is needed, the Company Officer will radio outside to the remaining crewmember to bring in additional equipment. Ideally, if a patient is able to safely do so, have them walk outside to meet crews. Naturally, this is not always possible, and we must remember to put our patients first.

*Fire Prevention Bureau Changes*

* Fire Prevention members will only conduct outside inspections when relevant to a business final or acceptance test.
* During final or acceptance testing, members will wear a N95 mask, safety glasses and EMS Jacket. (shell only is approved)

*EMS Response Changes*

**For Code 3 Medical Emergency Response:**

* GFFR will respond to all Code 3 calls within our response coverage area.
* Two EMS providers will enter to assess patient. If additional work force or equipment is needed, Captain will request over the radio.

**For Code 1 Medical Emergency Response:**

* GFFR resources will respond and stage outside the patients building or residence. IF GFFR arrives prior to GFES, one ems provider will attempt to make contact with the patient and have them walk outside. Only do this is if it is safe to do so or confirm verbally that no immediate life threat is ongoing. If it is confirmed that there is no immediate threat to life of the patient, GFFR will wait until the transport provider (GFES) arrives and have them make patient contact. GFFR members will remain in the “Cold” zone until it has been determined that no additional work force is needed.
* GFFR will not respond to Medical code 1 calls that originate from a Nursing home or a Law Enforcement (PD) out with……… calls during this Pandemic event.

*Training, Travel, and Operational Changes*

Some inconveniences will occur within our department during the near future. The following are changes that have already been enacted within out department.

* For the next few weeks, we will suspend normal training to concentrate on proper PPE donning and doffing training and cleaning/disinfecting the stations. This time may be used to get caught up on Fire Rescue 1 online training and other web based training or projects that have not had time to work on.
* Zoom web conferencing will be installed on iPads and station desk top computers to allow for remote training (such as blue card) and to have morning shift meetings with all companies and the BC. This will occur at 0800 each morning. This will be a simple check in amongst the entire platoon to have new information or planning delivered versus the BC making numerous phone calls. This will continue moving forward post-pandemic.
* All outside training has been cancelled until further notice.
* **No visitors are allowed in any GFFR facility** until further notice. This includes family members. Vendors who come to maintain facility maintenance will be follow GFFR one point of entry and be screened for Flu-like/COVID 19 symptoms prior to being allowed entry to any GFFR facility.
* GFFR personnel will not be allowed to enter restaurants, grocery stores, or other places of business for personal business while on-duty. Deliveries of food or personal supplies must be delivered outside the Fire Station with no contact with the delivery person.
* The Training Center garage will utilized by the City Shops personnel to be the maintenance facility for both Police and Fire apparatus. Doug Alm will have his office in the office area at the TC. His number for now will be 781-8993 to schedule apparatus repairs.
* A storage container has been placed near the testing pad and will house all of the equipment and supplies that were located in the shop area or needed for storage by other stations.
* Fueling of Fire and Police apparatus will only happen at Station 1. No fueling will at the City shops until further notice.
* Deliveries will be accepted at door # 2 at Fire Station 1 and remain outside until they can be sprayed with a decontamination solution.
* The Montana Fire Fighter testing consortium has been moved to Sept 11-12 for practice and Oct 11-15 for testing.
* March FSTS FF1 is cancelled
* Ice Breaker Road Race has been moved to October 4th, 2020.

**(Updated 3/20/20)**

*GFFR IAP PLAN Updated 3/26/20*

Incident Name: GFFR Pandemic 2020

Situation: Currently there are 5 confirmed COVID-19 cases in Cascade County and about 71 in the state of Montana. Operations staff have developed Covid-19 precaution and protocol. A City declaration of emergency has been established by the City Manager. Cascade County Health Department is concerned that the two new cases may indicate, “community spread” which means at least one of them contracted the disease locally. This situation increases the risk to the community. (edit 3 26 2020)

Concerns

1. Keeping GFFR and GFES responders’ healthy and preventing exposure.
2. Conservation of biological PPE supplies that are at critical levels and shortages may increase risk of COVID-19 exposure
3. Consider essential services and build plans to continue to provide emergency services and limited non-emergency services
4. Focus on continuation of operations and continuity of City government
5. Opening the Emergency Operations Center and not expose dispatch center employees

**Phase-1**

Occurrences of COVID-19 cases are the jurisdiction or multiple cases in the state requiring additional universal precautions and more substantial PPE based on the Center for Disease Control (CDC) recommendations to prevent spreading the disease to first responders. Community-spread of the disease will mean people are contracting COVID-19 locally and not from out of county travel.

1. Staffing by current 4-shift system with backfill by hire-back or call-back to maintain minimum staffing of 13.
2. Changes to Emergency Medical Dispatch question protocol to identify high risk patients
3. EMS Code III calls Fire and Ambulance respond
   1. Two EMS will enter (to limit exposing all) to assess the patient.
   2. Others available at the door when needed with Captain
4. EMS Code I calls Fire and Ambulance respond
   1. GFFR on scene one EMS provider attempts patient contact if possible have them come outside
   2. If no immediate life threat exists, wait for GFES to make first patient contact. GFFR members will remain in the cold zone (> 6’ distance and/or outside of building)
5. DECON procedures strictly adhered to for any incident that exposure was possible.
6. No GFFR responses to Police Officer wellness checks for suspects
7. No GFFR responses to licensed Nurse care facilities
8. No visitors at the fire stations to include family
9. The Fire Prevention Bureau will:
   1. Curtail normal operations.
   2. Cease Fire Safety Inspections except for temporary shelters
   3. Continue to inspect and approve construction projects
   4. Continue to review construction plans and projects – work with Community Develop and Planning over phone and video conferencing as much as possible
   5. Safety Inspection Certificate invoices shall be paid by mail only
10. Administrative Staff will;
    1. Lock-down the office and not allow customers to enter the office
    2. Senior Administrative Assistant shall limit exposure to emergency operations staff
    3. Plan to work from home in the event Phase – 2 is instituted**Phase – 2**

COVID-19 has community spread meaning there are no indications of how patients have contracted the disease. High acuity patients with COVID-19 symptoms requesting EMS. Supplies are at critical levels especially PPE. Minimum staffing of 13 firefighters is becoming problematic due to quarantine and isolation.

1. Consideration of changing from a 4 shift (42 hour) system to a 3 shift (56 hour) workweek.
2. A fire unit shall be designated to respond to all flu-like symptom calls to protect other crews. The members of the crew will be wearing HazMat Level B splash protection, this shall require minimum staff increase to at least 15 (edit 3 26 2020)
3. Set-up Emergency Operations Center (EOC) to address resource needs and to develop City plans for 12 hour work periods. Minimum of Planning, Operations, Logistics and Public Information shall be formed at the EOC to coordinate with multiple private and public agencies. Public Health will be the lead agency but unified command is necessary.
4. GFFR staff will only leave the firehouse to respond to calls or restock.
5. Work with EMS system Medical Director to adjust EMS response standard
6. EMS Code III calls
   1. GFFR will follow same protocol as noted in Phase-1
7. EMS Code I calls
   1. GFFR will follow same protocol as noted in Phase-1 respond but avoid contact unless the medical condition of patient warrants.
8. Notify supervised Assisted Living Facilities that GFFR will not be responding to any lift assists
   1. Change Dispatch response protocol to no longer respond to supervised assisted living facilities
   2. GFFR will only respond to Assisted Living homes that have a Code III EMS emergency
9. DECON procedures strictly adhered to for any incident that exposure was possible.
10. Continue to not respond to GFPD Code I calls
11. Continue to not respond to Nursing home Code I calls
12. No visitors at the fire stations to include family
13. Employees on days off not allowed to come to station
14. Fire Prevention Bureau will;
    1. May be tasked to staff EOC as Logistics and Planning Staff
    2. Inspectors may be tasked with Emergency Operations Duties
    3. Cease Fire Safety Inspections except for temporary shelters
    4. Continue to inspect and approve construction projects
    5. Continue to review construction plans and projects – work with Community Develop and Planning over phone and video conferencing as much as possible
    6. Safety Inspection Certificate invoices shall be paid by mail only
15. Administrative Staff
    1. Institute abbreviated work schedule and work from home
    2. Report to Chief via phone daily for assignments
    3. Assist at the EOC on the order of the Fire Chief

**Phase – 3**

Widespread infection with potential for high mortality rates of patients. First responder staffing has become critical due to quarantine and isolation. Hospitals have been overwhelmed requiring alternate treatment centers. PPE and other critical EMS supplies are out or at critical levels. State and Federal resources are also in short supply.

1. GFFR will do all that is possible to continue operations. Administrative staff will be split between operations and EOC staffing. Consideration of changing from a 3 shift 56 (hour) workweek to a 2 shift, 72 hour workweek. GFFR staff will only leave the Fire Stations for a call or restock supplies.
2. Revise EMS dispatch protocol as needed to change GFFR and GFES response procedure
3. GFFR shall only respond to Code III EMS emergencies, rescues, HazMat and Fire calls. GFFR will not be responding to Code 1 EMS calls or any non-emergency calls unless the BC thinks a response is warranted. Dispatch will keep the BC informed
4. DECON procedures strictly adhered to for any incident that exposure was possible.
5. EOC staff, at least one Chief Officer (Administrator) will be required at the EOC when it is open
6. Notify supervised Assisted Living Facilities that GFFR will not be responding to any lift assists
   1. Change Dispatch response protocol to no longer respond to supervised assisted living facilities
   2. GFFR will only respond to Assisted Living homes that have an EMS emergency
7. No GFFR responses to Police Officer wellness checks for suspects
8. No GFFR responses to licensed Nurse care facilities
9. No visitors at the fire stations to include family
10. No use of GFFR facilities for off-duty personnel
11. Fire Prevention Bureau will;
    1. Continue to support the EOC operations.
    2. Support as much as possible fire investigations and reports
    3. Logistics support for EOC and Emergency Operations Staff
    4. Cease Fire Safety Inspections except for temporary shelters
    5. Continue to inspect and approve construction projects
    6. Continue to review construction plans and projects – work with Community Develop and Planning over phone and video conferencing as much as possible
    7. Safety Inspection Certificate invoices shall be paid by mail only
12. Administrative Staff
    1. Institute abbreviated work schedule and/or work from home
    2. Report to Chief via phone daily for assignments
    3. Assist at the EOC on the order of the Fire Chief

*Medical Director Simpson Guidance on Advanced Airway Procedure Usage*

After seeing a number of inquiries about the potential uses for CPAP in [COVID-19](https://www.ems1.com/coronavirus-covid-19/) treatment, we reached out to EMS1 contributors from the [Montgomery County Hospital District](https://www.ems1.com/columnists/mchd/), Robert Dickson, MD, FAAEM, FACEP, FACEM, MCHD medical director; and Casey Patrick, MD, MCHD assistant medical director, to get their take.

“The COVID-19 pandemic has forced EMS and all emergency providers to reassess our approach to airway management and treatment. This is especially true when we must care for patients with cough, fever and difficulty breathing, prior to knowing their infectious status,” Dr. Dickson said. “Coronaviruses are transmitted via patient droplets. However, prehospital providers can increase the risk of viral transmission by aerosolizing patient droplets.” This is thought to occur in several situations, he noted, including:

* Suctioning
* Intubation
* Utilizing a BVM
* During non-invasive positive pressure ventilation (NIPPV)
* With high-flow oxygen use (>6L/min)
* When administering nebulized medications.

“The bottom line is to avoid all nebs in patients who are not in frank respiratory failure – and, if you have to give them – do it “in line” with NIV, only if you have the proper kit with filter.”

Dr. Patrick agrees. “I would avoid NIPPV if at all possible. From all the critical care information, I’ve read (e.g., [PulmCrit](https://emcrit.org/category/pulmcrit/)/EMCrit, and various anesthesia society recommendations) it seems that they even prefer high flow nasal cannula (HFNC) to NIPPV (not that we have access to HFNC in the field). I would stick to <6L NC, if at all possible, at this time to avoid aerosol generation.”

He noted he has seen some CPAP setups online that utilize O2 at 6L/peep valve/Ambu/viral filter and NIV mask that are nearly a closed circuit. Dr. Patrick said if he were going to use NIV, he would have two main considerations:

1. Do I think the patient has an exacerbation of [obstructive lung disease](https://www.ems1.com/ems-products/capnography/articles/copd-exacerbation-5-things-ems-providers-need-to-know-7eqYA3rm6fK4rKrO/) or acute pulmonary edema? If not, NIV is unlikely to be of significant benefit in the first place (in pneumonia specifically).
2. If the answer to No. 1 is yes, then I want to have a system set up with a viral filter as close to the patient as possible. Also, I want the system to be as closed-circuit as possible with an additional viral filter on the inhalation limb as well. Ideally, NIV would be used in a negative pressure/flow environment as well (realizing that these stipulations are often not available on the ambulance).

If you decide to use CPAP/NIV, be sure to put a surgical mask over the NIV mask for an additional layer of protection, he cautioned.

“It seems that COVID patients demonstrate ‘silent’ hypoxia and atalectasis, which is seen clinically with oxygen saturation values in the mid/low 80s with minimal distress,” Dr. Patrick reported. “In the EMS setting, we need to be vigilant in treating patients and not numbers. If a patient is relatively comfortable and hemodynamically stable at 82% on 4L NC, then in the age of COVID-19, less is more. Transport and allow the ED/ICU folks to further sort the patient (HFNC likely). Do not further increase viral transmission risk to fix an O2 sat value.”

**HOW TO PROTECT YOURSELF DURING AIRWAY INTERVENTIONS**

MCHD shared the following video, in which Dr. Dickson and MCHD Paramedic Brad Ward discuss [how providers can stay safe](https://www.ems1.com/ems-products/personal-protective-equipment-ppe/articles/stretching-your-services-supply-of-n95-respirators-9mo8t0YTVYsUobmU/) while caring for respiratory failure patients. The strategy behind minimizing risk of any aerosolizing is focused on either filtering the exhaled air or utilizing a surgical mask barrier to contain potential airborne viral particles when utilizing high flow oxygen by face mask.

“We are all working without a net in the era of COVID-19, as this is a new world for everyone. This isn’t the only way, it’s just MCHD’s best way following synthesizing heaps of current data and best practice guidelines. There are many new methods and ideas surrounding airway management and preventing aerosol-generating procedures. Collaboration is key, so please reply and share any variations or other protocols you may be utilizing in your service.”

Appendix:

