CHARLES COUNTY EMERGENCY SERVICES

SPECIAL ORDER 2021 – Coronavirus Disease 2019 (COVID-19)

Issue Date: 03/03/2020 **Revised:** 05/20/2021

Expiration Date: N/A

Tracked Changes – Release: May 20, 2021

1. Travel within the United States will no longer serve as a screening criteria.
2. Minimum PPE requirements for treating Persons Under Investigation (PUI) or those that are COVID+ will include N-95, eye protection, gloves and gowns.
3. Minimum PPE requirements for all non-PUIs will be determined by standard PPE requirements for the given situation. (MIEMSS PPE guideline attached below)
4. Provider screening criteria have been relaxed to include temperature and monitoring of signs and symptoms consistent with COVID-19. Documentation of screening is no longer required.
5. Facial coverings and social distancing are no longer required as long as personnel are not involved in patient care or in a healthcare setting such as a hospital or a skilled nursing facility.
6. It is recommended that personnel who are not fully vaccinated continue to wear face coverings in situations for which social distancing is not possible.
7. The MIH team will no longer provide testing for the presence of COVID-19 so that portion of the policy has been removed.

OVERVIEW

With the annual occurrence of influenza season, and with the recent developments regarding the Coronavirus, we are all reminded that the manner in which we approach infection control incidents is of the utmost importance. Many within the Charles County Department of Emergency Services (CCDES), Charles County Association of Emergency Medical Services (CCAEMS) and the Office of the Medical Director are remaining vigilant to emerging issues related to infection control. Of concern is the Coronavirus outbreak which originated in the Wuhan Province of China, and the subsequent cases that have occurred here in the United States and elsewhere throughout the world. This Special Order seeks to accomplish the following tasks.

- To outline the policy and procedure governing the preparation, mobilization, and demobilization required for the care and transport of suspected and known Coronavirus 2019 patients.

- To provide guidance, policies, and procedures for evaluating first responders for potential exposure to SARS COV-2, the provision of post-exposure management, and the determination of when providers are fit to return to work. In addition, this special order provides similar guidance to first responders and/or critical infrastructure employees who display signs and symptoms consistent with COVID-19 but have no obvious source of exposure.
- To proscribe appropriate and safe workplace behaviors that are intended to reduce the likelihood of spreading the COVID-19 virus to co-workers, fellow public safety agents, and the general public.

GENERAL

The information contained in this procedure is intended to be consistent with the EMS and PSAP interim guidance given by the Centers for Disease Control (CDC) and Prevention and by MIEMSS for management of patients with known or suspected COVID-19. In some cases, our local implementation of infection control procedures will exceed those recommended by the CDC. In addition, as this is a rapidly emerging situation, the policy is subject to frequent changes. It is our goal to update this plan in accordance with changes recommended by MIEMSS and/or the CDC as they develop.

DEFINITIONS

- **Active Monitoring** – regular communication with potentially exposed people to assess for the presence of fever or COVID-19 symptoms. This communication should occur once each day to include telephone calls or any electronic or internet-based means of communication. This will be delegated through the department's Infection Control Program. (1)

- **Aerosolizing Procedures** – any procedure that might lead to the aerosolization of sputum or other bodily fluids to include oxygenation, ventilation, CPAP application, nebulized medications or CPR.

- **Close Contact** - Close contact is defined as being within six (6) feet of a COVID-19 patient for longer than fifteen (15) minutes within a 24-hour period or being within the patient's care area or room for a prolonged period of time. Brief interactions such as walking by a person or moving past their room do not constitute close contact. Close contact can include distances greater than six (6) feet when aerosolizing procedures are being performed.

- **Community Exposure** – an exposure to a confirmed COVID-19 individual that does not occur in a patient care setting. It might occur at home, in a public space or work setting such as a fire station, rescue squad or government building.

- **Coronavirus 2019** - A novel coronavirus is a new coronavirus that has not been previously identified. The virus causing coronavirus disease 2019 (COVID-19), is not the same as the coronaviruses that commonly circulate among humans and cause mild illness, like the common cold. On February 11, 2020 the World Health Organization announced an official name for the disease that is causing the 2019 novel coronavirus outbreak, first identified in Wuhan China. The new name of this disease is coronavirus disease 2019, abbreviated as COVID-19. In COVID-19, 'CO' stands for 'corona,' 'VI' for 'virus,' and 'D' for disease. Formerly, his disease was referred to as "2019 novel coronavirus" or "2019-nCoV". There are many types off human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease, caused be a novel (or new) coronavirus that has not previously been seen in humans.

- **COVID-19 Signs and Symptoms** – includes fever or chills, cough, shortness of breath, fatigue, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, sore throat, diarrhea, myalgia, and malaise. (2)

- **Critical Infrastructure Employees –** Includes personnel that are not direct first responders including workers in Emergency Management, 911 call centers, and animal shelters. (3)

- **First Responder** – For the purpose of this Special Order, a first responder includes the following personnel: Emergency Medical Technicians, Paramedics, Firefighters, Rescue Squad Members, Police Officers, Correctional Officers and Animal Control Officers.

- **Fully Vaccinated -** A provider shall be considered fully vaccinated after two weeks have elapsed since receiving the final vaccination recommended for their specific vaccine.

- **Infectious Period -** The time period during which a person can transmit a virus. The infectious period for COVID-19 is considered to be forty-eight (48) hours before symptom onset (if symptomatic) or before specimen collection date (if asymptomatic) until the infected individual completes their isolation period. Determining the infectious period for an asymptomatic case is challenging due to the absence of an illness onset. The period beginning forty-eight (48) hours prior to specimen collection should be considered an estimate instead of a precise timeframe.

- **Isolation -** Separates sick people with a contagious disease from people who are not sick

- **Non-exposure** – The following individuals are NOT considered "exposed" to COVID-19:
  - Providers who are farther than six (6) feet from the patient or,
  - Providers who are within six (6) feet of the patient for less than five (5) minutes and not performing respiratory procedures,
  - First responders who are within six (6) feet of the patient for less than fifteen (15) minutes and not performing respiratory procedures,
  - Providers who are wearing appropriate PPE when interacting with a PUI patient

- **Person Under Investigation (PUI)** – A person who meets the CDC established criteria for COVID-19 symptoms and epidemiological risk factors. Symptoms include a fever or chills,

cough, shortness of breath, fatigue, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, sore throat, diarrhea, myalgia, and malaise

- **Personal Protection Equipment (PPE) –** For the purpose of this Special Order, PPE is considered those items in accordance with the recommendations of the Maryland Institute for Emergency Medical Services Systems – Infection Control and PPE Guidance (attachment). Such items included are gloves, respiratory protection masks, eye protection and gowns.

- **Quarantine** – First responders who are deemed to have had a suspected moderate to high risk exposure and are required to be segregated from their work peers and others for the purpose of social distancing and stopping the potential spread of disease. The quarantine period for healthcare workers is ten (10) or fourteen (14) days from time of known exposure, dependent upon symptomology and circumstance. (7)

- **Seasonal Flu -** Influenza is spread by cough, sneeze, or by common contact with virus-contaminated surfaces.

- **Self-Monitoring with Delegated Supervision** – Individuals perform self-monitoring with oversight by the department's Infection Control Program. On the days an individual is scheduled to work, they must measure temperature and assess symptoms before starting work. This information will be relayed to the Infection Control Program through telephone calls or any electronic or internet-based means of communication. (1)

- **Suspected Low Risk Exposure** – This event is defined when an EMS Clinician comes in contact with a known COVID-19 patient and the following are place:
  - The patient is wearing a mask, and
  - The EMS Clinician is wearing all appropriate PPE.

- **Suspected Moderate to High-Risk Exposure** – This event is defined when an EMS Clinician comes in contact with a PUI and/or known COVID-19 patient, and the following are true:
  - There is a prolonged (greater than 15 minutes within a 24-hour period) close contact within six (6) feet of a suspected PUI and/or known COVID-19 patient without appropriate PPE,
  - An EMS clinician performs any respiratory procedures (intubation, nebulizer treatments, CPAP, oxygen) without wearing appropriate PPE.
  - An EMS clinician comes in direct exposure to respiratory secretions.

- **Suspected Low Risk Exposure** – This event is defined when an EMS Clinician comes in contact with a known COVID-19 patient and the following are place:
  - The patient is wearing a mask, and
  - The EMS Clinician is wearing all appropriate PPE.

Transport of Infectious Disease Patients Under Investigation for COVID-19

A. PATIENT SCREENING

1. Utilizing the State's Emergency Infectious Diseases Surveillance Tool, the Charles County 911 Communications Center will screen callers requesting emergency medical services for possible COVID-19 symptoms to include the presence of respiratory illness, cough or fever. Additional factors may include travel to a COVID-19 outbreak country or travel on a cruise ship porting at areas with COVID-19 outbreaks within fourteen (14) days as well as close contact with someone who has laboratory confirmed COVID-19 within the previous fourteen (14) days as well.

2. Most patients with confirmed COVID-19 have developed fever, malaise, and/or symptoms of acute respiratory illness (e.g., dry cough, difficulty breathing). Some patients have displayed GI related symptoms such as vomiting and diarrhea.

3. An incident involving a patient that has complaints of respiratory illness, sore throat, cough and/or fever shall be considered a PUI incident.

4. 911 Communications Center shall communicate to field personnel the aforementioned findings of a respiratory illness, sore throat, cough and/or fever so that proper PPE selection and procedures can be made prior to patient contact.

5. The same indicators of a suspected PUI should be used in field screenings of patients. Field screening questions should be asked at a distance of six (6) feet or more if possible, prior to implementing direct patient contact.

B. RESPONSE

1. When the Charles County 911 Communications Center determines there is a patient that conforms to the COVID-19 PUI criteria, the closest appropriate EMS units will be dispatched.

2. All personnel who are dispatched to the scene of a known or suspected COVID-19 PUI must don the appropriate PPE prior to entering the scene. This PPE is defined in the

Maryland Institute for Emergency Medical Services Systems – Infection Control and PPE Guidance (attachment).

3. For patient encounters in which a potential PUI patient Incident has not been identified at the time of dispatch, yet on-scene providers suspect the patient may be a PUI candidate, prior to establishing close contact; personnel should remotely interview and assess the patient from outside of a six (6) feet perimeter to determine whether the patient meets the criteria for being a COVID-19 PUI. If the patient meets the established criteria; immediately back out of the scene and don the appropriate level of PPE.

4. If a crew establishes close contact with a PUI patient prior to donning the appropriate PPE personnel should, in a professional and compassionate manner, explain to the patient that additional PPE precautions will need to be taken given the patient's situation, that there will be a slight delay to their care and remove themselves from the patient's room.

5. If after a proper medical evaluation has been performed and the patient is deemed to not be a PUI, personnel may downgrade to standard PPE.
6. The number of EMS clinicians and other first responders encountering patient contact should be limited to the minimum number of personnel necessary to treat and safely care for the patient.

    a. If possible, only a single EMS clinician should make contact with the patient.
    b. Once the patient is assessed, the single lead EMS clinician can call in additional resources as required.

7. Once a clinical assessment has determined that the patient is ambulatory, have them come to you or even meet you outside as to limit contact and additional exposure potential.

8. Personnel who are pregnant or immunocompromised should not provide care for known or suspected COVID-19 patients.

C. TREATMENT AND TRANSPORT Of PUI or KNOWN COVID+ PATIENT

1. Place a surgical mask on the patient. If an oxygen mask or nasal canula is clinically indicated, a surgical mask should be placed over the device.

2. Have patient utilize alcohol-based hand cleaner if feasible.

3. All persons in the patient compartment shall use the appropriate level of PPE.

    a. Personnel should don eye protection, an N-95 mask, a gown, and gloves

4. Isolate the driver's compartment from the patient treatment compartment by either shutting the door or window. If the ambulance is not equipped with a mechanical way to isolate the two compartments, a piece of plastic may be affixed to the opening.

    a. Ensure good ventilation at all times.
    b. Increase ventilation by operating the ventilation system in non-recirculation mode and bringing in as much outdoor air as possible by opening windows.
    c. In the rear compartment, activate the ventilation fan.

5. Contact the receiving hospital via EMRC prior to initiating transport. You must notify the ED staff that the patient is complaining of respiratory illness and/or fever.

6. Family members and other contacts of patients (outside of parents or legal guardians) should not ride in the transport vehicle, if possible. If it is necessary for a family member, parent or guardian to ride in the transport vehicle, they too should wear a facemask.

7. Transport to the closest appropriate hospital-based emergency department.

8. Drivers, if providing direct patient care (e.g., moving patients onto stretchers), should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.

9. Potential limitation of procedures:

    a. Patients should be provided the care they need, and the procedures that are indicated.
    b. Aerosolized (nebulizer) treatments and CPAP should be avoided except for patients experiencing severe distress.
    c. The State has authorized the use of intra-muscular terbutaline sulfate as a treatment for asthma and reversible airway obstruction associated with bronchitis or emphysema in lieu of aerosolized medical treatments.
    d. Minimize intranasal administration of medications.

e. Minimize endotracheal intubation, instead utilize supraglottic airways (LMA's or King LT) whenever possible.
f. Non-essential (lifesaving) interventions, such as elective IVs or elective advanced airway procedures should be deferred to the hospital setting when treatment indications are such that deferral of those procedures is appropriate.
g. Life-saving procedures that are indicated by protocol shall be instituted by providers using the appropriate PPE.
h. Aeromedical transport is not recommended.

10. Prior to arrival at Charles Regional Medical Center, consult with the 911 Communications Center when you are three (3) to five (5) minutes out. The 911 Communications Center will notify the ED staff. Priority One (1) and Two (2) patients should have a medical consult performed via the EMRC radio.

    a. Inform ED staff if the patient cannot wear a mask or is on CPAP.
    b. Upon arrival at the ED, the patient may be unloaded at the ED entrance and brought by stretcher or wheelchair into the ED.
    c. The lead EMS Clinician will give triage information to the EMS RN or Resource RN who will direct them to a designated patient room.
    d. Transfer of patient care will be conducted in the patient's room.
    e. Equipment decontamination processes should be performed outside of the ED.

11. If a family member or the patient's legal guardian accompanied the patient to the ED, they are not to follow the patient into the ED. Instead, instruct them to report to the waiting area and await further instruction from ED staff.

12. If the patient is receiving a nebulized medication treatment or CPAP, that treatment should be suspended while transferring the patient through public areas. Example: Hallways, patient care areas, and waiting areas.

D. DECONTAMINATION OF PERSONNEL:

1. On arrival, after the patient is released to the facility, EMS clinicians should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures.

2. If effective PPE was not in place for a portion of the incident, and a provider was in close contact with a COVID-19 PUI, decontamination measures for that provider will be commensurate with the level of contamination.

    a. Any known areas of contamination should be washed with soap and water. Do not use bleach or hospital disinfectant on skin. An alcohol-based gel or foam can be used following washing with soap and water. Shower as required.
    b. Clothing should be removed and placed in double red biohazardous waste bags.
    c. Once decontaminated, a person cannot spread the virus unless they actually contract the virus (develop an infection). If infection occurs, symptoms can develop in two (2) to fourteen (14) days from exposure.

E. DECON OF APPARATUS AND EQUIPMENT:

1. After transporting the patient, leave the rear doors of the transport vehicle open to allow for sufficient air exchange to remove potentially infectious particles. The time to complete the transfer of patient to the receiving facility and complete all documentation should provide sufficient air exchange.

2. When cleaning the vehicle, EMS clinicians should wear a disposable gown and gloves. A face shield or facemask and goggles should also be worn if splashes or sprays during cleaning are anticipated.
3. A stocked decontamination station is available at CRMC for personnel to use when performing decontamination procedures. The decon station will be stocked with:

    a. An Environmental Protection Agency (EPA) registered hospital disinfectant,
    b. Hand and pump sprayers,
    c. Paper towels,
    d. Waste disposal bin,
    e. And the Material Data Safety Sheet for the disinfectants being provided.

4. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle.

    a. Carefully bag any linens used in red biohazardous waste bags.

b. All high contact surfaces should be decontaminated, including the interior of any cabinets or compartments opened and any equipment that was present in the patient compartment area.
c. Use an appropriate cleaning solution:

- An EPA registered hospital disinfectant with the label claim for disinfection of non-enveloped organisms (e.g. norovirus, rotavirus, adenovirus, poliovirus). If a commercial disinfectant is used, follow the direction set forth by the manufacturer.
- A freshly mixed 1:10 bleach solution, made by using 5-6% (household) bleach that is less than one (1) year old mixed with cold water in a spray bottle. This solution will remain effective as a disinfectant for twenty-four (24) hours, then discard.

d. Clean up any visible body fluids.
e. Spray all surfaces with an appropriate cleaning solution, allow to sit for at least ten (10) minutes.
f. Wipe remaining solution as necessary.
g. If available, wipe all surfaces with hospital disinfectant cloths. This provides a further level of decontamination.
h. Double bag any red biohazardous waste bags generated.
i. If sharps were generated, seal sharps container and process as biohazardous medical waste.

5. Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.

F. REPORTING PROCEDURES

1. Personnel that have a suspected moderate to high-risk exposure, should complete an Incident Report and First Report of Injury paperwork.

2. In the patient care report submitted to the Elite reporting system, the provider should complete the COVID-19 Panel and the Crew Exposures/Injury tab found on the Narrative panel. The following fields should be completed:

a. Crew Member
b. PPE Used
c. Type of Exposure – Other = "COVID-19"

3. In order to maximize the protection of our first responders, a new signature option was created in Elite which no longer requires the signature of a patient if cross-contamination is a concern. EMS clinicians may now select "Not Signed – Patient Contamination Concern" in the Elite drop down of the patient signature section.

G. EXPOSURES

1. Patients who test positive for COVID-19 will be tracked through the State-designated Health information exchange, the Chesapeake Regional Information System for Our Patients, Inc. (CRISP).

2. CRISP shall notify the Infection Control Officer of the EMS Operational Program who in turn will process appropriate notifications to all affected providers.

3. Personnel who are deemed to have a confirmed low risk exposure will be instructed to self-monitor and report the onset of fever, cough, or another respiratory symptomology.

4. Personnel who are deemed to have a confirmed moderate to high-risk exposure and are not fully vaccinated should be instructed to stay at home and self-isolate for fourteen (14) days. During quarantine, personnel will be expected to measure their temperature daily and report this information along with any signs or symptoms to their designated healthcare provider.

5. Personnel who are fully vaccinated and asymptomatic will not be required to quarantine but should self-monitor for the onset of symptoms. If a fully vaccinated provider becomes ill during this period, they must contact their infection control officer and will be required to self-isolate for a minimum of ten (10 days.

6. Personnel who complete the fourteen (14) days of self-isolation without fever or respiratory illness for at least twenty-four (24) hours, should be cleared to return to full duty.

7. Personnel who develop fever or respiratory illness during quarantine must contact their primary care physician for further guidance and/or treatment.

8. Personnel under quarantine who experience the aforementioned symptoms must be cleared by a physician prior to return to full duty.

H. STANDARDS & BEST PRACTICES:

1. If you are sick, stay home.

2. Wellness checks should be performed at the beginning of each shift. A wellness check should include a temperature screening and the monitoring of signs or symptoms consistent with COVID-19. A provider experiencing these symptoms or who has a temperature of 100.4° F or higher must leave the building and report them to their supervisor immediately.

3. Personnel should be without a fever or other aforementioned symptoms for at least twenty-four (24) hours before they are cleared to return to duty.

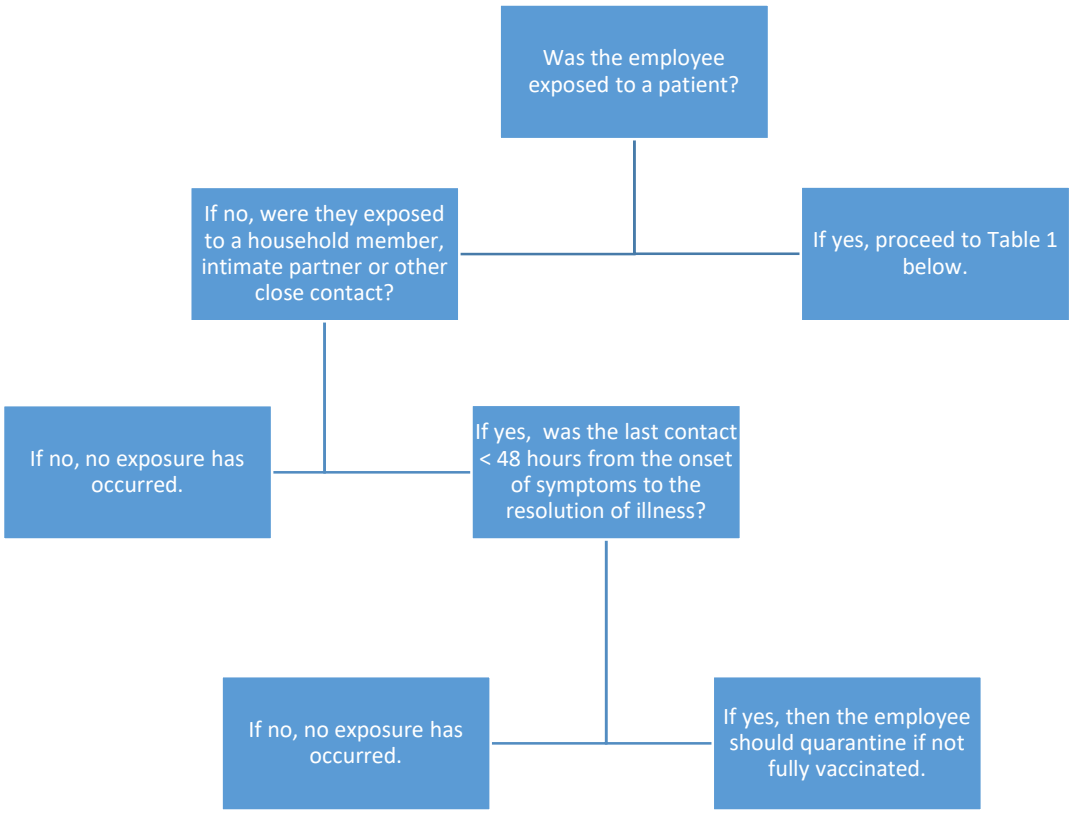
4. Personnel are no longer required to wear a face covering when not involved in healthcare activities.

5. It is recommended that all personnel that have not been fully vaccinated use a commercial surgical or cloth style mask throughout the day whenever it is anticipated that six (6) feet social distancing will be a challenge.

6. Hand washing remains an effective means of preventing disease transmission. It is recommended that personnel wash their hands frequently throughout the day and after every patient contact.

Evaluating, Monitoring, and Testing for First Responders, EMS Providers & Critical Infrastructure Employees

EXPOSURE DETERMINATION



PPE Protection for Provider	Patient Wearing a Cloth Covering or Facemask	Exposure Category
No facemask or respirator	Yes	Medium
No gown or gloves while maintaining heavy body contact	Yes	Medium
No eye protection or gown or gloves	Yes	Low
All PPE in place to include a facemask instead of a respirator	Yes	Low
No facemask or respirator	No	High
No eye protection while performing aerosolizing procedures	No	High
No eye protection	No	Medium
No gown or gloves while performing aerosolizing procedures or maintaining heavy body contact.	No	Medium
No gown or gloves	No	Low
All PPE in place to include a facemask instead of a respirator	No	Low

Table 1: COVID Exposure Level

3. If you recently traveled outside of the United States or have traveled on a cruise, you may be prohibited from reporting for duty upon your return.

    a. If an employee elects to not be tested, they will be required to quarantine for ten (10) days.
    b. Employees with negative COVID-19 test results may return to work with no restrictions.
    c. Employees who test positive for COVID-19 will be required to isolate and will be eligible to return to work in accordance with the prevailing Return-to-Work policy.

POST-EXPOSURE MANAGEMENT

A. Asymptomatic Community Exposure

1. Instruct individual to quarantine at home for fourteen (14) days from last contact with positive COVID-19 patient.
2. Individual is subject to active monitoring.
3. If individual becomes symptomatic for COVID-19, they must contact their designated Infection Control Officer as soon as possible.
4. Asymptomatic providers who have been fully vaccinated will not be required to quarantine but should self-monitor.

B. Asymptomatic High or Medium Risk Exposures

1. Instruct individual to quarantine at home for fourteen (14) days from contact with source of exposure.
2. Individual is subject to active monitoring.
3. If individual becomes symptomatic for COVID-19, they must contact their designated Infection Control Officer as soon as possible.
4. Asymptomatic providers who have been fully vaccinated will not be required to quarantine but should self-monitor

C. Asymptomatic Low Risk Exposures

1. Individual is subject to self-monitoring with delegated supervision.

2. Individual is not restricted from work.
3. If individual becomes symptomatic for COVID-19, they must contact their designated Infection Control Officer as soon as possible.
4. Asymptomatic providers who have been fully vaccinated will not be required to quarantine but should self-monitor

D. Employees with Laboratory-Confirmed or Suspected COVID-19

1. Contact their designated Infection Control Officer as soon as possible.
2. If signs or symptoms (two or more) are consistent with COVID-19, the individual will be instructed to isolate at home for a minimum of ten (10) days from the onset of signs and symptoms.
3. Employees should contact their primary care provider for management.
4. Self-management should include fever reducing medications, hydration with clear fluids and plenty of rest.
5. Individuals who develop shortness of breath should contact their physician and/or seek emergency help.
6. All symptomatic employees should seek COVID-19 testing.

POLICY & PROCEDURE – POST VACCINATION EVALUATION

The COVID-19 vaccine was produced using cutting edge technology. It was created to provide a protein to stimulate immunity while not exposing the host to undue risks, including that of a live COVID virus. This technology made it possible to develop a vaccine in a record time frame, more efficiently, and more safely than ever before. Many first responders have been or will be vaccinated with one form of the COVID vaccine. Most persons who are administered the COVID vaccine report some form of symptomology after the first or second dosing. In order to differentiate work restrictions based of symptoms related to post vaccination, supervisor's and contact tracers should use this guidance based off of evidence-based recommendations to determine employee work restrictions.

A. EMS clinicians and healthcare providers (HCP) who have been infected with the COVID-19 virus, should wait ninety (90) days after infection before receiving the COVID-19 vaccine.

B. Symptoms after vaccination can be broken into two categories:

1. Systemic symptoms: fever, chills, fatigue, mild headache, muscle aches, joint aches.

i. Preliminary data from COVID-19 vaccine trials indicate that most systemic post-vaccination signs and symptoms are mild to moderate in severity, occur within the

first three (3) days following vaccination (most occurring in the day after vaccination), resolve within 1-2 days of onset, are more frequent and severe following the second dose and among younger persons compared with those who are over the age 55.

2. Infectious Symptoms: cough, shortness of breath, rhinorrhea, sore throat, loss of taste or smell.

    i. These are NOT consistent with post-vaccination systemic symptoms, and instead may be symptoms of SARS-CoVID-2 or another infection.

3. Respiratory infectious symptoms: rhinorrhea, loss of taste or smell, sore throat, cough, shortness of breath are NOT associated with post-vaccination effects and should be considered originating from another infection, influenza, COVID or other.

C. Evaluation and management of new-onset signs and symptoms post-vaccination:

1. Symptomatic EMS clinicians within fourteen (14) days of moderate or high-risk exposure to COVID in the community (including non-work exposure) should be excluded from work and assumed to be infectious with COVID until proven otherwise.

2. The following signs and symptoms, typically represent vaccine-related side effects, and presenting alone, are not consistent with COVID-19 infection:

    i. Immediate hypersensitivity reactions (e.g. urticaria, anaphylaxis)
    ii. Local symptoms (e.g. pain, swelling or redness at injection site)

3. Approaches suggested should be tailored to fit the clinical and epidemiological characteristics of each specific case.

4. Afebrile means no temperature over 100.3, 24 hours after the last anti-pyretic dose (Tylenol, Motrin, Advil, Aspirin, et. al.)

5. *Table 2: Post Vaccination Symptoms & Restriction Chart* provides a quick reference for supervisors and contact tracers.

Post Vaccination Symptoms	Symptom Characteristic	Work Restrictions
Systemic Post Vaccinations: **fever, chills, fatigue, mild headache, muscle aches, joint aches**	Preliminary data from COVID-19 vaccine trials indicate that most systemic post-vaccination signs and symptoms are mild to moderate in severity, occur within the first 3 days following vaccination (most occurring in the day after vaccination), resolve within 1-2 days of onset, are more frequent and severe following the second dose and among younger persons compared with those who are over 55.	Work restrictions for 2 days while symptoms are present. May return to duty once symptoms subside and the employee has been afebrile for 24 hours without the use of anti-pyretics. Note: Afebrile means no temperature over 100.3, 24 hours after the last anti-pyretic dose (Tylenol, Motrin, Advil, Aspirin, et. al.)
Vaccine Side Effect: • **Immediate hypersensitivity reactions (e.g. urticaria, anaphylaxis)** • **Local symptoms (e.g. pain, swelling or redness at injection site)**	These signs and symptoms typically represent vaccine-related side effects, and presenting alone, are not consistent with COVID-19 infection.	No quarantine indicated. May return to duty once symptoms permit.
Infectious Symptoms: **rhinorrhea, loss of taste or smell, sore throat, cough, shortness of breath**	These signs and symptoms are NOT associated with post-vaccination effects and should be considered originating from another infection, influenza, COVID or other disease process.	A 14-day quarantine period is indicated for employees experiencing these signs and symptoms post vaccination.

Table 2: Post Vaccination Symptoms & Restriction Chart

POLICY - REPORTING & NOTIFICATIONS

Employee's Responsibility

1. Report exposures and/or potential exposures to your identified contact tracer, immediate supervisor, or station officer.
2. If quarantined, update your health status to your identified contact tracer.

Contact Tracer's Responsibility

1. Report exposures and/or potential exposures to impacted personnel and senior leadership.
2. Follow-up with personnel who have been quarantined or infected with COVID-19.
3. Track and report to senior leadership the quarantine/isolation status of personnel placed out due to COVID-19.

Senior Leadership's Responsibility

1. Coordinate data with jurisdictional response partners and stakeholders.
2. Report required testing and exposure data to the appropriate identified authority/partner agency/s.
3. Ensure the free flow of critical information and data up and down the chain.

POLICY - RETURN TO WORK

A. Return to work criteria will be determined using the *MD Department of Health Employee Screening Form* (attached).

B. Asymptomatic Individuals with exposure may return to work after fourteen (14) days from their last known date of exposure provided, they remained asymptomatic throughout the period of quarantine.

C. Symptomatic Individuals with Known or Suspected COVID-19:

1. Resolution of fever without the use of fever reducing medications for at least twenty-four (24) hours **AND,**
2. Improvement in respiratory symptoms **AND,**

3. At least ten (10) days have passed since the onset of signs and symptoms.

D. Symptomatic Critical Infrastructure Workers with Known or Suspected COVID-19:

1. Resolution of fever without the use of fever reducing medications for at least twenty-four (24) hours **AND,**
2. Improvement in respiratory symptoms **AND,**
3. At least seven (7) days have passed since the onset of signs and symptoms.
4. Must wear a facemask while working for fourteen (14) days after the initial onset of signs and symptoms.
5. Must have no chance of patient contact for fourteen (14) days after the initial onset of signs and symptoms.

E. Asymptomatic individuals with confirmed COVID-19 can return to work after ten (10) days have passed since their first positive COVID-19 test provided they did not subsequently develop symptoms after their positive test.

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Executive Director

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State EMS Medical Director

Date: May 18, 2021

RE: **UPDATE: PPE for EMS Clinicians**

We have made incredible progress in the fight against COVID-19 over the past several months. Cases and hospitalizations have declined from their peaks. Millions of Marylanders have been vaccinated. However, with the lifting of the public mask mandate on May 15, 2021, questions have surfaced regarding the appropriate use of masks and PPE by EMS clinicians.

Based on guidance from CDC and MDH, **masks should still be worn in all health care settings, which includes EMS patient encounters**. EMS clinicians should continue to wear a minimum of a surgical mask for all calls, and place surgical masks (not N-95s) on all patients. If the patient shows signs or symptoms of possible COVID-19 illness, EMS should wear an N-95 mask, gown, gloves, and eye protection.

While vaccines are highly effective at preventing symptomatic COVID-19 infection and decreasing the risk of hospitalization, it is not clear that they prevent transmission of the disease altogether. As we care for vulnerable or unvaccinated patients, we should continue to use masks at this time. Additionally, our partners in hospitals and health care facilities continue to observe universal mask use.

When in the station or other communal settings, fully vaccinated health care professionals ($\geq$ 2 weeks since a single dose vaccine was given or $\geq$ 2 weeks since 2nd dose of 2-dose vaccine), may dine, socialize or meet without masks or social distancing. However, if unvaccinated personnel are present, everyone should wear a mask and unvaccinated people should physically distance from others.

Thank you for your continued attention to helping our clinicians protect themselves and our patients.

CHARLES COUNTY EMERGENCY SERVICES

APPROVAL

Approved: Michelle Lilly Date: 5/24/21

Michelle Lilly, Director

Approved: Date: 05/24/21

Dr. Kevin Seaman, Jurisdictional Medical Director

Approved: Date: 05/24/2021

Andrew Spalding, Volunteer Chief; CCAEMS

Approved: Date: May 24th 2021

Mark Kaufman, Volunteer Chief; CCVFA