



**CAL-MAT Alternate Care Site Field Guidance
For COVID-19**

**First Edition 1.0
November 24, 2020**

**Emergency Medical Services Authority (EMSA)
California Medical Assistance Team (CAL-MAT)
&
San Diego / Imperial County Unit**

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INTRODUCTION and PURPOSE

Definition: Alternate Care Sites (ACS) may be created to enable healthcare providers to provide medical care for injured or sick patients or continue care for chronic conditions in non-traditional environments during a public health emergency. These ACS may include locations that need to be converted (e.g., schools and stadiums) or they may include facilities like mobile field hospitals. While ACS are designed to accommodate a surge in those seeking care for acute conditions, medical shelter operations are designed to support chronic condition care.

However, due to the surge in COVID-19 cases overwhelming some of our hospital systems in California, our ACS must meet the needs of acutely ill COVID-19 patients as we try to help decompress in-patient volumes. It is important to note that not all hospital assets will be available to you, so it is important to adjust your mind-set in order to do the best you can with what you have (staff, space, and supplies).

Mission: The mission of CAL-MAT when deployed to an ACS (Alternate Care Center) is to take the pressure off local hospitals and care for COVID-19 patients that need step down care and management. CAL-MAT is composed of medical professionals and support personnel who rapidly come together from the state of California to serve the mission.

This guide is meant to serve as a field manual to assist the variety of clinicians responding to an ACS and was compiled by clinicians from the San Diego-Imperial CAL-MAT unit. Material has been adapted from a variety of sources and our collective personal experience. If there are any issues regarding appropriate care of a patient or general policies/procedure of care provided, please contact:

CAL-MAT Medical Director: Howard Backer, MD
howard.backer@emsa.ca.gov Mobile phone: (510) 219-8681

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Disclaimer: *Currently, this guide has not been officially approved by EMSA/CAL-MAT. It is a work in progress, and we hope it is helpful to everyone in the field. The treatments are recommendations only. You aren't required to follow the guidelines and you can adapt them to fit the situation and do what is best for patient care.*

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SECTION 1

Quick Start Materials

Quick Start Materials

1. Daily Schedule Sample
2. Intake Process Sample
3. Admission Criteria Sample
4. Intake Form Sample
5. Patient Care Record Documents (*see Annex J*)
6. Discharge Documents Standard (*see Discharge Planning Section 3*)

Daily Schedule Sample:

EMTs, Paramedics, & RNs

- 0600: Lights on in ACS

Charge RN documents patient census in online document

- 0650-0715: RN goes in to get report from previous shift's RN, MD Zooms in for RN hand-off
- 0800-0830: Vital sign collection, medication distribution and breakfast.

1st required nursing note

- 0900-1150: Showers, patient ambulation (q6h)
- 1200-1300: Lunch
- 1200-1850: Medication distribution, showers, patient ambulation (q6h)
- 1850-1915: Shift change, MD Zooms in for RN hand-off
- 1900-2200: night meds, patient ambulation (q6h)

2nd required nursing note

- 2200: Lights out in ACS

Charge RN documents final daily patient census in online document

MDs Daily Schedule:

- 0650-0720: Zoom in for RN hand-off
- 0730-0800: Hand-off with previous night MD
- 0800-0900: Morning rounds

Daily required MD note written

- 0900-1850: Coordinate daily discharges and admissions
- 1850-1915: Zoom in for RN hand-off
- 1900-0650: Night rounds as needed, and complete admissions as needed

Intake Process Sample

1. Hospital case manager calls 24/7 referral phone, carried by day and night providers.
 - a. Provider fills out intake form (*see page*) on the call, gathering as much relevant information as possible.
 - b. Request is made to case manager for all relevant records to be emailed or faxed to ACS.
 - i. Admission H&P, labs, discharge note, medications, face sheet
2. Provider calls hospitalist to gather remaining information and confirm patient status, if needed.
3. Provider notifies hospital case manager of admission decision.
 - a. Also needed: at least one week's worth of medication, plus an incentive spirometer and their hospital socks, and any Durable Medical Equipment (DME) required.
4. If decision is to decline, this is noted at the bottom of the intake form with the reason, e.g. patient is newly unstable.
5. If there is a persistent disagreement between ACS provider and hospital provider, ACS physician will consult with the County EMS Medical or CAL-MAT Medical Director, Howard Backer, MD (*see introduction section for contact information*)
6. Provider notifies Charge Nurse of pending admission
7. Charge Nurse and patient's hospital nurse communicate re:
 - a. Patient demographic details (ex: name, DOB)
 - b. All patient medications and plan for medication delivery to ACS
 - c. Transport plan and ETA
 - i. If anticipated > 4-hour ETA, updated status communicated to charge RN
 - d. Functional needs of patient, including Durable Medical Equipment with plan for DME delivery to ACS
8. Hospital discharge planner arranges:
 - a. Patient transport to ACS through local/regional transfer center

Admission Criteria Sample

CAL-MAT Alternate Care Site providing care for members of the local community known to be COVID-19 positive who require ongoing professional care. The aim is to decompress Imperial County hospitals so they can focus their care on higher acuity patients.

Inclusion Criteria:

- Age: ≥ 18 ; will consider young adults if family member also resides at the ASC
- If pregnant, < 20 weeks, and uncomplicated pregnancy
- COVID positive within the last month
- Hemodynamically stable in the last 24 hours, or as approved by the ACS provider:
 - SBP >90 and <160
 - DBP >60 and <110
 - SpO₂ $>92\%$ on supplemental O₂ up to 10 L/min via simple face mask
 - If on 6-10L, then must be stable for more than 24 hours
 - HR >60 or <110 and without new arrhythmias
- Hemodynamically stable in last 24 hours, or as approved by ACS physician
 - SBP >90 and < 160
 - DBP >60 and < 110
- SpO₂ $> 92\%$ or back to prior baseline. Must be stable or improving
 - Site is capable of 6 L/min O₂ by nasal cannula.
- HR >60 and < 110
- Behavioral
 - Cooperative and oriented
 - Able to communicate with medical staff
 - Aware and agrees to ACS conditions
- Functional
 - Self-feeding
 - Able to get up and ambulate with no more than 1 person assist
 - Low safety risk (falls, wandering, elopement)
 - Able to adhere to rules and be respectful to other patients
 - No significant rehabilitation needs
- Minor to moderate wound care ($<$ stage II)
- Saline lock for IV medications – Will leave in for 24 hours, remove if not needed
- Patients with Suspected COVID-19:** will be accepted under the following conditions:
 - Typical symptoms and findings of COVID-19 illness but test pending or initial test negative yet high suspicion
 - Meets other medical inclusion and exclusion criteria
 - Informed consent of both referring physician and patient
 - Enough room available in the ACS whereas the patient can be isolated in a separate walled off area that is more than 20 feet from other known COVID positive patients

Exclusion Criteria:

- Undifferentiated, potentially life-threatening conditions (e.g., chest pain, renal insufficiency)
- Need for recurrent/frequent lab testing (excluding blood glucose monitoring)
- Behavioral
 - Severe dementia, delirium or history of sundowning
 - No acute mental illness
 - No active substance abuse
 - No smoking, vaping (nicotine replacement OK)

- ❑ No hemodialysis unless logistics are established, without increased resource need
 - No individual isolation (e.g., varicella, *C difficile*, MRSA open wound)
 - No aerosolizing devices such as CPAP/BiPAP, suctioning, oxygen above 15L NRB
 - No need for vital more than q4h for 24 hours
 - No animals

Provider Intake Note Sample

Date/Time: _____ Patient Name: _____ M/F _____

Patient age and DOB: _____ Covid Sx onset: _____ Covid test date(s): _____

Requesting facility: _____ Requesting CM/Phone: _____

Requesting MD/Phone: _____

PCP/routine care provider name/phone: _____

Reason for referral/history of present illness: _____

Past Medical History: _____

Allergies: _____

Code Status: _____ POLST/DPAHC? Y / N Primary Language _____

Current Meds: _____

ADLs: (circle one) Independent / Stand-by Assist / Minimal Assist / Total Care

Ambulation: Independent/Stand-by Assist/Minimal Assist/Two-Person Assist/ Assistive Device (circle)

Meds to be DC'd and date: _____

Mental Status/Special Needs: _____

Oxygen status: _____ VS: _____

Care needs: _____

IV/tubes/drains/ostomy/etc? _____

Lab needs: _____ Special Diet: _____

Any other special needs: _____

Discharge Plan: **To** Where? _____ Contact: _____

What is goal for ACS stay (wean off O2? Finish isolation period? Placement? Other) _____

Notes: _____

Accepted: Y / N If no, reason: _____

Print/Sign name: _____

SECTION 2

ACS Guidelines for COVID-19 Patient Care

ACS Level of Care for COVID-19

A local surge in the need for medical care might require jurisdictions to establish alternate care sites (ACS) where patients with COVID-19 can remain and receive medical care for the duration of their isolation period. These are typically established in non-traditional environments, such as converted hotels or mobile field medical units.¹ Depending on the jurisdictional needs, ACS could provide three levels of care:

1. **Non-Acute Care:** General, low-level care for mildly to moderately symptomatic COVID-19 patients. These patients may require oxygen (less than or equal to 2L/min), but do not require extensive nursing care or assistance with activities of daily living (ADL). This level of care corresponds to Level 5 (ambulatory care) and Level 4 (minor acuity care) patients in medical care terminology.
2. **Hospital Care:** Mid-level care for moderately symptomatic COVID-19 patients. These patients require oxygen (more than 2L/min), nursing care, and assistance with ADL. This level of care corresponds to Level 3 (medical-surgical care) patients in medical care terminology.
3. **Acute Care:** Higher acuity care for COVID-19 patients. These patients require significant ventilatory support, including intensive monitoring on a ventilator. This level of care corresponds to Level 2 (step-down care) and Level 1 (intensive care unit [ICU] care) patients in medical care terminology.

The expected duration of care for patients in ACS would be based on their clinical needs and potentially the timeline for [discontinuation of Transmission-Based Precautions](#). If ACS will be used to care for both confirmed and suspected COVID-19 patients or for patients without COVID-19 who require care for other reasons, additional infection prevention and control considerations will apply. For example, planning would need to address physical separation between the cohorts and assigning different HCP with dedicated equipment to each section.

COVID-19 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)

Note: The studies used to inform this guidance did not clearly define “severe” or “critical” illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about duration of Transmission-Based Precautions, the definitions in the [National Institutes of Health \(NIH\) COVID-19 Treatment Guidelines](#) are one option for defining severity of illness categories. The highest level of illness severity experienced by the patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions.

1. **Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
2. **Moderate Illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO₂) ≥94% on room air at sea level.
3. **Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO₂ <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from

baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO₂/FiO₂) <300 mmHg, or lung infiltrates >50%.

4. **Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

The studies used to inform this guidance did not clearly define “severely immunocompromised.” For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

ACS Guidelines for Providers

HTN – Assess patient for CVA symptoms if >180/100

1. Symptomatic? Chest pain, dyspnea, altered mental status, headache, blurred vision – transfer to the Emergency Department. Obtain EKG while awaiting EMS donning PPE.
2. Asymptomatic
 - a. Re-check measurement and if appropriate size cuff used (e.g. thigh cuff if large patient)
 - b. Evaluate if regular BP meds have been held/discontinued
 - c. Check for anxiety, pain, fluid overload
 - d. Recheck in 15 minutes – is it still elevated?
 - e. If persistent SBP>180 give metoprolol 12.5 mg po x 1, hold for p <60, or amlodipine 5 mg po x 1
 - f. Readjust routine bp med regimen
 - g. Increase dose of existing med before adding second med
 - h. Assess diet if not on low Na+ diet (or getting food from outside)

DM – aim to keep bs 140-180 (to prevent hypoglycemia)

1. Basal (all day) coverage:
 - a. Give Lantus or glargine for 24 hour coverage
 - b. Or Lente or NPH can be given q 12 hours
2. Prandial (meal) coverage:
 - a. Regular, Humulin, Novolin can be given at least 20-30 min before mealtime
 - b. Humalog, Novolog, or Lispro can be given 10-15 min before mealtime
3. Corrective coverage:

- a. Sliding scale as needed according to 4x/day (before meals and at bedtime) blood sugars
- 4. If previously undiagnosed DM and BG between 140 and 200, check follow up FBS
 - a. If random BG >200: initiate sliding scale
- 5. Consider initiating oral hypoglycemic (avoid metformin if evidence of ongoing inflammatory disease and hypoxia)
- 6. Pay attention to diet – no juice, sodas, outside food; make sure ADA diet ordered
- 7. Resume usual home regimen (insulin or oral meds) 1-2 days before anticipated discharge, cover with sliding scale

Decadron

- 1. Standard dose is 6 mg/d x 10 days – no need to taper when completed
- 2. Check qam FBS until 3 days after Decadron course completed
- 3. If FBS >180, add sliding scale with qid ac and hs BG

Oxygen: [reviewed with RT]

- 1. Goals:
 - a. Maintain target O₂ sat >90%
 - b. Target SpO₂ 88-94% in patients with oxygen-dependent COPD
- c. Maintain stable work of breathing
 - a. Goal respiratory rate < 24
 - b. Target normal respiratory effort (no signs of accessory muscle use or obvious increased respiratory work)
- 2. Initial oxygen delivery should be nasal cannula (NC) titrated from 1 to 6 LPM to meet goals of therapy.
 - a. If goals of therapy are not met at 6 LPM NC then advance to *either*:
 - i. Simple mask ≤ 6L (RT only if available)
 - b. Venturi mask
 - i. Initiate at FiO₂ 40% (check device's instructions to determine minimum flow rate needed to achieve 40%)
 - ii. Titrate to maximum of FiO₂ 60% to meet goals of therapy (some devices are not able to achieve FiO₂ of 60%, please discuss with RT)
- 3. Considerations during oxygen support escalation:
 - a. Clarify goals of care
 - b. Consider awake self-proning in selected patients
 - c. Consider the rate of change of oxygen escalation as well as pre-existing cardiopulmonary disease in determining threshold for ED transfer (such as COPD patient with pre-existing supplement oxygen use at baseline)
 - d. Consider other etiologies of hypoxia
 - e. If SpO₂ < 92% (<88% in COPD) or unstable work of breathing Venturi mask at FiO₂ 50%
 - f. If sats remain <90 on 15L for 15 minutes or need more than 10L for more than an hour, initiate transfer to ED

Adapted from Brigham and Women's Hospital Covid Protocols

<https://covidprotocols.org/protocols/respiratory/#hypoxemia-managemen> K. Christensen MD, 8.18.2020

Procedure for Change in Patient Condition

If a patient is noted to have a detrimental change in vital signs, clinical assessment, mental status or work of breathing, the on-duty physician shall immediately assess the patient with on duty nursing staff.

If there is any concern for immediate life threat, critical illness or an urgent intervention is needed, the patient will be transferred to the ED via the AMR ambulance on site or 911 if the resource is unavailable. The Lead MD will also then be notified by phone and they will notify the County.

If the patient is noted to have a negative change in condition that does not require immediate transfer to the ED, the following actions will be taken:

1. Physician is alerted per parameters listed and assesses the patient; Lead MD is notified as needed or if the duty MD has concerns or questions.
2. If potential interventions are identified – they are provided as needed.
3. Reassessment following any intervention is completed and documented.
4. Serial reassessments will be performed, including a full set of vital signs at the following intervals. Reassessments will be documented in the chart.
 - a. Every 30 minutes for the first 2 hours
 - b. Every hour for the next 4 hours

Transfers from Alternate Care Site to the Hospital

Alternate care sites cannot offer the same breadth of services as a hospital. If a patient's condition deteriorates the patient will be transferred to a hospital via the 911 system. A patient may also be transferred to a hospital if a provider determines they require medical care beyond the level available at the alternate care site for an acute medical issue (e.g., new onset abdominal pain, signs of new infection, worsening respiratory status).

Criteria for Immediate Transfer to the Emergency Department

Patients who meet the below criteria should be immediately transferred to the closest hospital. The on-duty RN will initiate transfer as soon as decompensation is notified and will then contact the on duty and lead physician.

1. Acute change in oxygen requirements and/or requirement of 6 LPM of oxygen for more than one hour or any requirement of more than 6 LPM.
2. Chest pain or shortness of breath that is new or above the patient's baseline
3. Increased work of breathing even in the absence of subjective shortness of breath
4. Respiratory rate over 30 bpm
5. Any new neurological symptoms with the exception of generalized weakness, mild dizziness or mild headache
6. Any trauma requiring evaluation
7. Any other unexpected change or deterioration in condition.

Discontinuation of Transmission-Based Precautions for Patients with Confirmed COVID-19

Reference CDC Website <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

The decision to discontinue [Transmission-Based Precautions](#) for patients with confirmed SARS-CoV-2 infection should be made using a symptom-based strategy as described below. The time period used depends on the patient's [severity of illness](#) and if they are severely immunocompromised.

Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge from a healthcare facility.

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions

Patients with [mild to moderate illness](#) who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: For patients who are **not severely immunocompromised¹** and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Patients with [severe to critical illness](#) or who are severely immunocompromised¹:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

Note: For **severely immunocompromised¹** patients who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

As described in the [Decision Memo](#), an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patients had replication-competent virus more than 20 days after onset of symptoms. The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered in determining the appropriate duration for specific patient populations. For example, patients with characteristics of [severe illness](#) may be most appropriately managed with at least 15 days of isolation under Transmission-Based Precautions.

Test-Based Strategy for Discontinuing Transmission-Based Precautions

In some instances, a test-based strategy could be considered for discontinuing Transmission-based Precautions earlier than if the symptom-based strategy were used. However, as described in the [Decision Memo](#), many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised¹) in consultation with local infectious diseases experts if concerns exist for the patient being infectious for more than 20 days.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

SECTION 3

Discharge Planning

Disposition of Patients with COVID-19 (refer to Annex B for Patient Home Quarantine Discharge Instructions)

Patients can be discharged from the healthcare facility whenever clinically indicated.

If discharged to home:

- The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations. Guidance on [implementing home care of persons who do not require hospitalization](#) and the [discontinuation of home isolation for persons with COVID-19](#) is available.

If discharged to a nursing home or other long-term care facility (e.g., assisted living facility), **AND**

- If Transmission-Based Precautions *are still required*, the patient should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with SARS-CoV-2 infection. Preferably, the patient would be placed in a location designated to care for residents with SARS-CoV-2 infection.
- If Transmission-Based Precautions *have been discontinued*, the patient does not require further restrictions, based upon their history of SARS-CoV-2 infection

Alternate Care Site Discharge Process

Discharge Criteria:

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions.

Patients with [mild to moderate illness](#) who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Note: For patients who are **not severely immunocompromised**¹ and who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Patients with [severe to critical illness](#) or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

Note: For **severely immunocompromised** patients who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

As described in the [Decision Memo](#), an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patients had replication-competent virus more than 20 days after onset of symptoms. The exact criteria that determine which patients will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered in determining the appropriate duration for specific patient populations. For example, patients with characteristics of [severe illness](#) may be most appropriately managed with at least 15 days of isolation under Transmission-Based Precautions.

Test-Based Strategy for Discontinuing Transmission-Based Precautions.

In some instances, a test-based strategy could be considered for discontinuing Transmission-based Precautions earlier than if the symptom-based strategy were used. However, as described in the [Decision Memo](#), many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some patients (e.g., those who are severely immunocompromised¹) in consultation with local infectious diseases experts if concerns exist for the patient being infectious for more than 20 days.

The criteria for the test-based strategy are:

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

Patients can be discharged from the healthcare facility whenever clinically indicated.

If discharged to home:

- The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations. Guidance on [implementing home care of persons who do not require hospitalization](#) and the [discontinuation of home isolation for persons with COVID-19](#) is available.

If discharged to a nursing home or other long-term care facility (e.g., assisted living facility), **AND**

- If Transmission-Based Precautions *are still required*, the patient should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with SARS-CoV-2 infection. Preferably, the patient would be placed in a location designated to care for residents with SARS-CoV-2 infection.
- If Transmission-Based Precautions *have been discontinued*, the patient does not require further restrictions, based upon their history of SARS-CoV-2 infection.

Physical/Respiratory Fitness Status - Fulfill criteria testing by ACS personnel

- Able to perform unassisted ADLs or back to baseline prior to admission, and without significant vital sign abnormalities
- Ambulatory without assistance or back to baseline prior to admission
- Maintain O2 saturation >92% on room air, HR<120, unless O2 will be supplied at home

Transportation – If needing transportation other than POV, this is to be arranged by social worker/discharge planner from discharging hospital prior to ACS arrival

- To SNF or other facility – BLS Ambulance transport
- To Home – if stable patient is still COVID-19 Positive – BLS Ambulance transport coordinated through **local/regional transfer center # _____**
- To Home – if patient is COVID-19 Non-Infectious/Negative Testing – pick up by family/friends if the family/friend is COVID negative

(Refer to Annex B for COVID-19 Discharge Instructions)

Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670



California Medical Assistance Team
Alternate Care Site

Date:

To Whom it May Concern:

Mr./ Mrs./ Ms. _____, DOB _____, has been discharged from protective isolation at the Alternative Care Center. According to the CDC and the California Department of Public Health, COVID positive persons may be discontinued from transmission-based isolation precautions based on symptom-based, time-based, or test-based criteria.

According to the CDC guidance revised July 17, 2020:

"A test-based strategy is no longer recommended...because, in the majority of cases, it results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Patients with mild to moderate illness who are not severely immunocompromised:

- *At least 10 days have passed since symptoms first appeared and*
- *At least 24 hours have passed since last fever without the use of fever-reducing medications and*
- *Symptoms (e.g., cough, shortness of breath) have improved"*

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

The California Department of Public Health (CDPH) issued an All Facility Letter (AFL 20-33) directing that "Skilled Nursing Facilities (SNF) must accept the return of a resident from a hospital or alternate care site." It further states that "Patients hospitalized, or receiving treatment at an alternate care site, with COVID-19 can be discharged to a SNF when clinically indicated. Meeting criteria for discontinuation of transmission-based precautions is not a prerequisite for discharge from the hospital or alternate care site."

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-33.aspx?%2525255Fcldee=Y2RldmIAy2FsaG9zcGI0YWwub3Jn&recipientid=contact-fe5edad0afc9e911a842000d3a3b4cee-48206f15c736486aabe5c727209e14aa&esid=467d71bc-3675-ea11-a811-000d3a3abdcf>

Because Mr./ Mrs./ Ms. _____ has met these conditions, there is no need for further transmission-based precautions. Although no longer considered contagious for COVID-19, standard infection precautions should be followed. If an employer requires re-testing for return to work, that the employer must arrange the test.

Signed: _____

Title: _____

SECTION 4

SAFETY

Transmission Precautions and Personal Protection Equipment

Definitions: Standard & Transmission-Based Precautions

All healthcare workers and medical staff members are responsible for implementing and complying with precautions established in the following categories as they apply to their work or care processes at all times. The use of precautions and personal protective equipment is not mandated in life-threatening situations where quick action is required in order to remove the patient from imminent danger or loss of life.

1. **Standard Precautions** are based on the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered.
2. **Respiratory Hygiene and Cough Etiquette.** Implement for patients and visitors, with undiagnosed transmissible respiratory infections, or any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering a healthcare facility or patient home.
3. **Transmission-Based Precautions.** Personnel are expected to implement transmission-based precautions as appropriate based on patient presentation, history, test results or physician orders.
4. **Safe Injection Standards** are developed to provide for a consistent practice. All staff that use medication vials are expected to comply with these standards as a means of mitigating the transmission of contaminants during injection. Devices subject to safe injection practices include, but are not limited to: needles, cannulas, IV delivery systems and vials.
 - a. Use aseptic technique to avoid contamination of sterile injection equipment.
 - b. Needles, cannulas, and syringes are sterile, single-use items. They are not to be reused for another patient or to access a medication or solution that might be used for a subsequent patient.
 - c. IV fluid infusion and administration sets (i.e., intravenous bags, tubing, and connectors) are single patient use only and must be disposed of appropriately after use.
 - d. A syringe or needle/cannula is contaminated, once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
 - e. Before accessing single or multi-dose vials: Scrub rubber septum of vial using a 5-second scrub with alcohol and allow to air dry prior to access.
 - f. Single dose vials (SDVs) which lack preservatives are labeled as such or considered single dose if not labeled as a multi-dose vial. These vials are to be used for a single patient during the course of a single procedure and cannot be reused.
5. **Contact Precautions** for patients with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission.
6. **Droplet Precautions** as recommended in Appendix A for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (i.e., large-particle droplets

>5µ in size) that are generated by a patient who is coughing, sneezing or talking.

7. **Use Airborne Precautions** as recommended in Appendix A for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route

Airborne Precautions	Signs/Symptoms (Suspected Exposure)	Exam/Procedure Room
<ul style="list-style-type: none"> <input type="checkbox"/> Private Room (negative pressure if available) <input type="checkbox"/> Door Closed at all times <input type="checkbox"/> Post isolation door sign <input type="checkbox"/> N95/PAPR on staff <input type="checkbox"/> Surgical mask on patient at all times <input type="checkbox"/> Hand Hygiene 	<p>Known or suspected exposure:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chickenpox (Varicella) <input type="checkbox"/> Measles (<u>Rubeola</u>) <input type="checkbox"/> Tuberculosis (TB) <p>Examples of Signs/Symptoms:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever with diffuse rash <input type="checkbox"/> Night sweats, unexplained weight loss and/or cough for 2 or more weeks 	<ul style="list-style-type: none"> <input type="checkbox"/> Clean with disinfectant wipes. <input type="checkbox"/> Prior to cleaning, room remains closed for 1 hour if not negative pressure or per current Public Health recommendations
Contact Precautions	Signs/Symptoms (Suspected Exposure)	Exam/Procedure Room
<ul style="list-style-type: none"> <input type="checkbox"/> Private Room <input type="checkbox"/> Door May Remain open <input type="checkbox"/> Gown and Gloves <input type="checkbox"/> Hand Hygiene 	<p>Known or suspected exposure:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lice (Pediculosis) <input type="checkbox"/> Scabies (Mites) <input type="checkbox"/> Bed bugs <p>Examples of Signs/Symptoms:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Draining abscess/wound <input type="checkbox"/> Uncontrolled diarrhea 	<ul style="list-style-type: none"> <input type="checkbox"/> Clean with disinfectant wipes <input type="checkbox"/> No special air handling or ventilation required.
Droplet Precautions	Signs/Symptoms (Suspected Exposure)	Exam/Procedure Room
<ul style="list-style-type: none"> <input type="checkbox"/> Private Room <input type="checkbox"/> Door May Remain open <input type="checkbox"/> Surgical Mask on patient and staff <input type="checkbox"/> Hand Hygiene 	<p>Known or suspected exposure:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Influenza <input type="checkbox"/> Mumps <input type="checkbox"/> Meningitis, meningococemia, <input type="checkbox"/> Rubella (German Measles) <p>Examples of Signs/Symptoms:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever with diffuse rash 	<ul style="list-style-type: none"> <input type="checkbox"/> Clean with disinfectant wipes <input type="checkbox"/> No special air handling or ventilation required

Personal Protective Equipment from the CDC Guidance

Who Needs PPE

Patients with confirmed or possible SARS-CoV-2 infection should wear a facemask when being evaluated medically

Healthcare personnel should adhere to Standard and Transmission-based Precautions when caring for patients with SARS-CoV-2 infection. Recommended PPE is described in the [Infection Control Guidance](#)

How to Put On (Don) PPE Gear

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by other healthcare personnel.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
 - o **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
 - o **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **Healthcare personnel may now enter patient room.**

How to Take Off (Doff) PPE Gear

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the

shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. *

3. **Healthcare personnel may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).** Do not touch the front of the respirator or facemask.
 - **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
 - **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. **Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.***

CDC link to “How to Safely Don and Doff PPE: <https://youtu.be/H4jQUBAIBrI>

Hand Hygiene

- Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. Practicing hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role.
- The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate SARS-CoV-2.
- ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment

Methods

- CDC recommends using ABHR with 60-95% alcohol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink.
- Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Learn more about hand hygiene in [healthcare settings](#).

Respirator or Facemask

Put on a respirator or facemask (if a respirator is not available) before entry into the patient care area.

- N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure. Disposable respirators and facemasks should be removed and discarded after exiting a patient care area. Perform hand hygiene after discarding the respirator or facemask.

- If reusable respirators (e.g., powered air purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.

Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.

Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.

Eye Protection

- Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient care area. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- Remove eye protection before leaving the patient care area.
- Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use.

Gloves

- Put on clean, non-sterile gloves upon entry into the patient care area.
- Change gloves if they become torn or heavily contaminated.
- Remove and discard gloves when leaving the patient care area, and immediately perform hand hygiene.

Gowns

Put on a clean isolation gown upon entry into the patient care area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.

If there are shortages of gowns, they should be prioritized for:

- aerosol-generating procedures
- care activities where splashes and sprays are anticipated
- high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
 - dressing
 - bathing/showering
 - transferring
 - providing hygiene
 - changing linens
 - changing briefs or assisting with toileting
 - device care or use
 - wound care

Extended use of N95

Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters. Extended use is well suited to situation where multiple patients with the same infectious disease diagnosis are cohorted. A key consideration for safe extended use is that the respirator must maintain its fit and function. When practicing extended use of N95 respirators, the maximum recommended extended use period is 8-12 hours. Respirators should not be work for multiple work shifts and should not be reused after extended use. N95 respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.

Take the following steps to reduce contact transmission after donning:

Discard N95 respirators following use during aerosol generating procedures.

- Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.
- Discard N95 respirators following close contact with, or exit from, the care area of any patient co-infected with an infectious disease requiring contact precautions.
- Consider use of a cleanable face shield over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls) to reduce surface contamination.
- Perform hand hygiene with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary, for comfort or to maintain fit).

Reuse of N95

Re-use refers to the practice of using the same N95 respirator by one HCP for multiple encounters with different patients but removing it (i.e. doffing) after each encounter. This practice is often referred to as "limited reuse" because restrictions are in place to limit the number of times the same respirator is reused. It is important to consult with the respirator manufacturer regarding the maximum number of donnings or uses they recommend for the N95 respirator model. If no manufacturer guidance is available, data suggest limiting the number of reuses to no more than five uses per device to ensure an adequate safety margin. N95 and other disposable respirators should not be shared by multiple HCP.

Ensure adherence to the need to minimize unnecessary contact with the respirator surface, strict adherence to hand hygiene practices, and proper PPE donning and doffing technique, including physical inspection and performing a user seal check

Take the following steps to reduce contact transmission:

- Discard N95 respirators following use during aerosol generating procedures.
- Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.
- Discard N95 respirators following close contact with any patient co-infected with an infectious disease requiring contact precautions.
- Consider use of a cleanable face shield (preferred³) over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls), when feasible to reduce surface contamination of the respirator.

- Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.
- Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the respirator (if necessary, for comfort or to maintain fit).
- Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene as described above.
- Use a pair of clean (non-sterile) gloves when donning a used N95 respirator and performing a user seal check. Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

Additionally, staff should be reminded of the following:

- Clean hands with soap and water or an alcohol-based hand sanitizer before and after touching or adjusting the N95 respirator.
- Avoid touching the inside of the N95 respirator.
- Use a pair of clean (non-sterile) gloves when donning and performing a user seal check.
- Visually inspect the N95 respirator to determine if its integrity has been compromised.
- Check that components such as the straps, nose bridge, and nose foam material did not degrade, which can affect the quality of the fit, and seal.
- If the integrity of any part of the N95 respirator is compromised, or if a successful user seal check cannot be performed, discard the N95 respirator.

References:

<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/>
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>

Filtering out Confusion: Frequently Asked Questions about Respiratory Protection

User Seal Check

Over 3 million United States employees in approximately 1.3 million workplaces are required to wear respiratory protection. The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace.¹ Once a fit test has been done to determine the best respirator model and size for a particular user, a **user seal check** should be done every time the respirator is to be worn to ensure an adequate seal is achieved.



What is a User Seal Check?

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being properly worn. The user seal check can either be a positive pressure or negative pressure check.

During a **positive pressure user seal check**, the respirator user **exhales** gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage.

During a **negative pressure user seal check**, the respirator user **inhales** sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure.

A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual.

How do I do a User Seal Check while Wearing a Filtering Facepiece Respirator?

Not every respirator can be checked using both positive and negative pressure. Refer to the manufacturer's instructions for conducting user seal checks on any specific respirator. This information can be found on the box or individual respirator packaging.

The following positive and negative user seal check procedures for filtering facepiece respirators are provided as examples of how to perform these procedures.



Centers for Disease Control
and Prevention
National Institute for Occupational
Safety and Health

How to do a positive pressure user seal check

Once the particulate respirator is properly donned, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of such evidence would be the feeling of air movement on your face along the seal of the facepiece, fogging of your glasses, or a lack of pressure being built up inside the facepiece.

If the particulate respirator has an exhalation valve, then performing a positive pressure check may be impossible. In such cases, a negative pressure check should be performed.

How to do a negative pressure user seal check



Negative pressure seal checks are typically conducted on particulate respirators that have exhalation valves. To conduct a negative pressure user seal check, cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.

In the case of either type of seal check, if air leaks around the nose, use both hands to readjust the nosepiece by placing your fingertips at the top of the metal nose clip. Slide your fingertips down both sides of the metal strip to more efficiently mold the nose area to the shape of your nose. Readjust the straps along the sides of your head until a proper seal is achieved.²

If you cannot achieve a proper seal due to air leakage, you may need to be fit tested for a different respirator model or size.

Can a user seal check be considered a substitute for a fit testing?

No. The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA (29 CFR 1910.134). A user should only wear respirator models with which they have achieved a successful fit test within the last year. NIOSH data suggests that the added care from performing a user seal check leads to higher quality donnings (e.g., reduces the chances of a donning with a poor fit).³

Where can I Find More Information?

This information and more is available on the [NIOSH Respirator Trusted-Source webpage](#).

References

1. OSHA [1998]. Respiratory Protection. 29 CFR 1910.134. Final rule. Fed Regist 63:1152-1300.
2. NIOSH [2010]. How to properly put on and take off a disposable respirator. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 2010-133 <https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf>
3. Viscusi DJ, Bergman MS, Zhuang Z, and Shaffer RE [2012]. Evaluation of the benefits of the user seal check on N95 filtering facepiece respirator fit. J Occup and Environ Hyg. 9(6):408-416. Photos courtesy of NIOSH

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DOI: <https://doi.org/10.26616/NIOSH/PUB2018130>
DHHS (NIOSH) Publication No. 2018-130

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BIOHAZARD MANAGEMENT

Biohazardous Material Spills

1. Gloves (for small spills [≤ 30 ml]), and gloves, mask, and a fluid-repellent gown (for large spills [> 30 ml]) must be worn during all cleaning and decontamination procedures, as well as shoe coverings when splashing or splattering may contaminate footwear.
2. If the spill contains broken glass or other sharp objects these items should not be picked up directly with the hands but should be cleaned by using a mechanical method such as a brush and dustpan (or two pieces of stiff cardboard), tongs, or forceps.
3. The spilled material should be absorbed with absorbent material (e.g., paper towels, gauze pads, or tissue wipes).
4. After the absorbed material is removed, the spill site should be cleaned with an environmental detergent-disinfectant so that the spilled material is further diluted, blood cells are lysed, and additional proteinous material is removed. The bulk of the cleaning agent should then be absorbed.
5. The spill site should then be disinfected using an intermediate level disinfectant. Alternatively, a freshly made 1:10 dilution (0.5%) of household bleach may be used.
6. The spill site should be flooded or wiped down with disposable towels soaked in the disinfectant so that the site is glistening wet. Commercially available absorbent materials which contain a chemical which releases chlorine upon wetting, should not be relied upon to disinfect the spill site.
7. The disinfectant must be allowed to remain in contact with the spill site for the specified contact time. If the site has been adequately cleaned before disinfection, and a household bleach solution is used as the disinfectant, a 2 – 10 minute contact time may be required.
8. After disinfection, the spill site should be rinsed with water to remove any noxious chemicals or odors and dried.
9. In spills involving large amounts of infectious agents such as microbiological cultures, the area should be flooded with a 1:5 dilution (1%) of household bleach and allowed to stand for a minimum of 20 minutes.
10. All contaminated materials used in the cleaning and decontaminating process should be discarded.

Linen and Laundry

1. All soiled linen must be bagged at the location where it is generated and processed in the same manner regardless of patient source.
2. Healthcare workers who handle grossly soiled linen must wear gloves and fluid-resistant gowns in order to reduce the risk of contaminating exposed areas of the skin and soiling clothing.
3. Soiled linen must be transported in plastic bags, secured in such a way as to prevent leakage, and should not be filled beyond two-thirds of its capacity.

Biohazardous Waste

1. Biohazardous waste must be collected and transported in separate waste streams.
2. Biohazardous waste must be red-bagged at the source using approved bags for transport.
3. Bags should not be filled beyond two-thirds of its capacity. Biohazardous waste bags may not be used for anything other than their intended purpose.
4. Used needles, syringes, and other sharp instruments must be placed in puncture-resistant containers located as close as practical to the point-of-use area. Sharps containers should

be filled with sharp items only and not used as trash receptacles. These containers must be sealed when three-fourths full.

5. All biohazardous waste bags or sharps containers must be labeled with the international biohazard symbol and the word Biohazard.

Communication Signage

1. Signs displaying the international biohazard symbol and the word Biohazard shall be used hospital wide to warn of the presence of biohazardous materials including biohazardous waste.
2. Biohazardous signage is required, but not limited to, biohazardous waste bags and sharps containers, blood/bandage containers in patient areas, biohazardous waste transfer carts, biohazardous waste holding areas, dirty utility areas, and work areas (such as the laboratory) where there may be a high concentration of clinical specimens and infectious agents.

Precautions for Biomedical Equipment

1. Gloves must be worn when handling equipment which is contaminated with blood or body substances. Unless the equipment has never been used, or is **known to be** decontaminated, it should be treated as if it is contaminated.
2. Generally, the external surfaces of equipment should be decontaminated prior to servicing.
3. However, when this is not done, or when working with inaccessible internal components which have not been decontaminated with an intermediate or high level disinfectant, gloves must be worn during cleaning, disassembly, and servicing.
4. Masks, protective eyewear, and fluid-resistant gowns must be worn when opening fluid lines under pressure or when there is a high probability of being splashed with blood or body substances.
5. Masks and protective eyewear must be worn when cleaning visible accumulations of dust from equipment. Dust cleaning procedures should be performed in an area where there is sufficient air exchange to minimize airborne contamination.

SECTION 5

Oxygen Management

Oxygen is used as a medical treatment for chronic and acute medical conditions and can be administered in medical facilities, by emergency medical service providers, and in home settings. In a disaster, access to oxygen can be challenging. Utility outages can impact electricity dependent machines, transportation and shipping difficulties can limit distribution of oxygen, and damage to oxygen generation and distribution plants can lead to reduction in supply.

Compressed Gas Storage

This type of oxygen is stored in gas cylinders at room temperature and can be used directly from the tank. Tanks vary in size from small, portable, short-term use tanks (designed to be used for a few hours) to large tanks that could last many hours to several days depending on use.

Instant Usage

An electrically powered oxygen concentrator is a device that uses regular air and through a chemical reaction, generates pure oxygen. Oxygen concentrators provide continuous oxygen, provided there is a continuous source of electricity and room air, for one patient. Industrial sized concentrators are available, but can only support a few patients per unit and are not really scalable. Oxygen concentrators are available from a variety of providers. Access this sample list of home concentrators for more information.



Delivery

Low Flow Oxygen Delivery: Low dose oxygen therapy is generally required for patients who need small amounts of oxygen to maintain adequate oxygenation. This is typically accomplished with a prescription of between 2-6 liters per minute of oxygen delivered through a nasal cannula or simple face mask.

High Flow Oxygen Delivery: High flow oxygen is generally delivered in acute care environments when the patient requires an oxygen concentration of near 100%. This is typically delivered at liter flows over 10 liters per minute and can be delivered by non-rebreather mask, or through a high flow nasal cannula.

Positive Pressure Delivery: Positive pressure delivery of oxygen is required for patients who cannot breathe on their own and can be delivered through a bag valve mask, intubation tube, or through the use of a mechanical ventilator.

Drug Delivery Route: In some patients, oxygen is used to deliver medication, such as through a nebulizer or other special equipment, and masks are used to deliver aerosolized medication.

Accessories Needed: In addition to the tanks, delivery accessories are required for effective oxygen treatment. These accessories can include nasal cannulas, oxygen masks, intubation tubes, reservoir tubing, humidifier bottles, carrying cases, and carts.

Oxygen Flow Rates and Use: The graphic below provides oxygen tank use timelines based on low flow use. If multiple patients are using the same tank or if patients are prescribed high flow oxygen treatment, the timeline will be shortened.

Oxygen Cylinder Use Timeline

	Flow Rate	Full Tank 2000 PSI	$\frac{3}{4}$ Tank 1500 PSI	$\frac{1}{2}$ Tank 1000 PSI	$\frac{1}{4}$ Tank 500 PSI
M - Cylinder	$\frac{1}{32}$	76 days	56 days	38 days	18 days
	$\frac{1}{16}$	38 days	28 days	19 days	9 days
	$\frac{1}{10}$	24 days	18 days	12 days	6 days
	$\frac{1}{8}$	19 days	14 days	9.5 days	4.5 days
	$\frac{1}{4}$	9.5 days	7 days	4.5 days	2 days
	$\frac{1}{2}$	4.5 days	3.5 days	2 days	1 day
	1	2.4 days	43 hours	28.75 hours	14 hours
E - Cylinder	$\frac{1}{10}$	100 hours	75 hours	50 hours	25 hours
	$\frac{1}{8}$	83 hours	62 hours	41 hours	20 hours
	$\frac{1}{4}$	41 hours	30 hours	20 hours	10 hours
	$\frac{1}{2}$	20 hours	15 hours	10 hours	5 hours
	1	13 hours	9 hours	6 hours	3 hours
	2	5 hours	3.5 hours	2.5 hours	1.1 hours
	3	3.4 hours	2.3 hours	1.5 hours	0.7 hours
	4	2.5 hours	1.75 hours	1.1 hours	0.5 hours
D - Cylinder	$\frac{1}{32}$	160 hours	96 hours	64 hours	48 hours
	$\frac{1}{16}$	80 hours	48 hours	32 hours	24 hours
	$\frac{1}{10}$	50 hours	30 hours	20 hours	15 hours
	$\frac{1}{8}$	40 hours	24 hours	16 hours	12 hours
	$\frac{1}{4}$	23 hours	17 hours	12 hours	6 hours
	$\frac{1}{2}$	11 hours	9 hours	6 hours	3 hours
	$\frac{3}{4}$	8 hours	6 hours	4 hours	2 hours
	1	5 hours	3 hours	2 hours	1.5 hours
	2	2.5 hours	1.5 hours	1 hour	0.75 hours
C - Cylinder	$\frac{1}{32}$	80 hours	60 hours	40 hours	20 hours
	$\frac{1}{16}$	40 hours	30 hours	20 hours	10 hours
	$\frac{1}{8}$	20 hours	15 hours	10 hours	5 hours
	$\frac{1}{4}$	11.5 hours	8.6 hours	5.6 hours	2.8 hours
	$\frac{1}{2}$	5.5 hours	4.1 hours	2.75 hours	1.4 hours
	1	2.5 hours	1.9 hours	1.25 hours	0.63 hours
	2	1.25 hours	0.95 hours	0.75 hours	0.31 hours
	3	0.75 hours	0.56 hours	0.38 hours	0.2 hours

Oxygen Cylinders and Storage Capacity of Gaseous Oxygen

Size of Cylinder	Liters (at 2200 psi)	Cubic Feet	Time in Use Estimate (at 10 L/min)	Time in Use Estimate (at 15 L/min)
C	255	9	17 min	11 min
D	425	15	34 min	22 min
E	680	24	68 min	44 min
F	1360	48	2 hr 16 min	1 h 30 min
H	7080	252	11 hr 48 min	7 hr 52 min
MM	3455	123	5 hr 45 min	3 hr 50 min

Oxygen Conservation in Disasters

Prepare: Optimally, planning can identify and mitigate resource shortfalls by stockpiling commonly needed (and often inexpensive) items such as morphine and intubation equipment.¹⁷ Preparation also includes methods to maintain the equipment and supplies; for example, adherence to preventative maintenance, stock rotation, and restocking schedules.

Conserve: Restrictions are placed on the use of certain therapies or interventions to maintain supply (for example, N95 masks, oxygen).

Substitute: A functionally equivalent medication or device is used (for example, using benzodiazepines instead of propofol for sedation of a tracheally intubated patient).

Adapt: Use of a device for purposes for which it was not intended (for example, using an anesthesia machine or Bi-level positive airway pressure machine as temporary ventilator or using an oxygen saturation monitor with high/low rate alarms instead of cardiac monitor to detect tachy or brady arrhythmias).

Reuse: After appropriate cleaning, disinfection, or sterilization, the majority of material resources can be reused.

Reallocate: Certain critical resources (ventilators, extracorporeal membrane oxygenation) may have to be allocated to those patients most likely to benefit, in extreme situations this may involve removal from one patient to give substantially better chance of a good outcome. This, clearly, is a last resort and should be done only when no other options exist and no relief is possible.

(Portable Oxygen Cylinders Training & Safety Guidelines for Patients see Annex 4)

OXYGEN

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

MINNESOTA HEALTHCARE SYSTEM PREPAREDNESS PROGRAM

RECOMMENDATIONS	Strategy	Conventional	Contingency	Crisis														
Inhaled Medications <ul style="list-style-type: none"> Restrict the use of Small Volume Nebulizers when inhaler substitutes are available. Restrict continuous nebulization therapy. Minimize frequency through medication substitution that results in fewer treatments (6h-12h instead of 4h-6h applications). 	Substitute & Conserve																	
High-Flow Applications <ul style="list-style-type: none"> Restrict the use of high-flow cannula systems as these can demand 12 to 40 LPM flows. Restrict the use of simple and partial rebreathing masks to 10 LPM maximum. Restrict use of Gas Injection Nebulizers as they generally require oxygen flows between 10 LPM and 75 LPM. Eliminate the use of oxygen-powered venturi suction systems as they may consume 15 to 50 LPM. 	Conserve																	
Air-Oxygen Blenders <ul style="list-style-type: none"> Eliminate the low-flow reference bleed occurring with any low-flow metered oxygen blender use. This can amount to an additional 12 LPM. Reserve air-oxygen blender use for mechanical ventilators using high-flow non-metered outlets. (These do not utilize reference bleeds). Disconnect blenders when not in use. 	Conserve																	
Oxygen Conservation Devices <ul style="list-style-type: none"> Use reservoir cannulas at 1/2 the flow setting of standard cannulas. Replace simple and partial rebreather mask use with reservoir cannulas at flowrates of 6-10 LPM. 	Substitute & Adapt																	
Oxygen Concentrators if Electrical Power Is Present <ul style="list-style-type: none"> Use hospital-based or independent home medical equipment supplier oxygen concentrators if available to provide low-flow cannula oxygen for patients and preserve the primary oxygen supply for more critical applications. 	Substitute & Conserve																	
Monitor Use and Revise Clinical Targets <ul style="list-style-type: none"> Employ oxygen titration protocols to optimize flow or % to match targets for SPO2 or PaO2. Minimize overall oxygen use by optimization of flow. Discontinue oxygen at earliest possible time. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Starting Example</th> <th>Initiate O2</th> <th>O2 Target</th> <th></th> </tr> </thead> <tbody> <tr> <td>Normal Lung Adults</td> <td>SPO2 <90%</td> <td>SPO2 90%</td> <td rowspan="3">Note: Targets may be adjusted further downward depending on resources available, the patient's clinical presentation, or measured PaO2 determination.</td> </tr> <tr> <td>Infants & Peds</td> <td>SPO2 <90%</td> <td>SPO2 90-95%</td> </tr> <tr> <td>Severe COPD History</td> <td>SPO2 <85%</td> <td>SPO2 90%</td> </tr> </tbody> </table>	Starting Example	Initiate O2	O2 Target		Normal Lung Adults	SPO2 <90%	SPO2 90%	Note: Targets may be adjusted further downward depending on resources available, the patient's clinical presentation, or measured PaO2 determination.	Infants & Peds	SPO2 <90%	SPO2 90-95%	Severe COPD History	SPO2 <85%	SPO2 90%	Conserve			
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Infants & Peds	SPO2 <90%	SPO2 90-95%																
Severe COPD History	SPO2 <85%	SPO2 90%																
Expendable Oxygen Appliances <ul style="list-style-type: none"> Use terminal sterilization or high-level disinfection procedures for oxygen appliances, small & large-bore tubing, and ventilator circuits. Bleach concentrations of 1:10, high-level chemical disinfection, or irradiation may be suitable. Ethylene oxide gas sterilization is optimal, but requires a 12-hour aeration cycle to prevent ethylene chlorohydrin formation with polyvinyl chloride plastics. 	Re-use																	
Oxygen Re-Allocation <ul style="list-style-type: none"> Prioritize patients for oxygen administration during severe resource limitations. 	Re-Allocate																	

Respiratory Therapy Protocol

Purpose: To provide clinical information on the use of oxygen therapy for all incoming patients with a prior history of requiring supplemental oxygen or who develop shortness of breath. To provide guidelines for weaning oxygen therapy for discharge from Alternative Care Site (ACS).

Responsibilities: This protocol is to be carried out by all medical staff participating in the COVID-19 response. The Chief Medical Officer will oversee the implementation of this protocol.

Procedure:

Indications for Oxygen Therapy: Intake

- Follow prior oxygen therapy settings from transferring facility upon intake, including oxygen therapy order from the transferring physician or respiratory therapist.
- The goal is to maintain SpO2 ≥ 92% with minimal exertion/ambulation, unless directed otherwise by the ordering physician.
- For patients who were intubated in the hospital or have underlying COPD or other chronic lung disease, the oxygenation target may be SpO2 ≥ 90%.

4. Nurses may use their assessment on intake to maintain SpO₂ ≥ 92%. A physician and/or respiratory therapist should be notified of any additional oxygen requirements. (See emergent O₂ evaluation chart.)
5. Patients arriving to FACS may require more oxygen, due to the exertion of transferring/ambulating in addition to physiological and environmental stressors.
6. Once SpO₂ is ≥ 92%, it should be maintained with an appropriate medical order for the required oxygen therapy.

Oxygen Therapy – Functional Assessment

1. If SpO₂ < 92% on room air, provide 2-4 liters per minute (lpm) of supplemental O₂ via nasal prongs (Provider may set target saturation at 88-90%, based on medical history).
2. While adjusting oxygen, check SpO₂ every 15 minutes.
 - a. May use continuous O₂ saturation monitor until stable requirement is reached. For flow of 6 lpm or greater
3. If oxygen saturation remains < 92%, use oxygen mask with 6-8 liters O₂ flow.
4. If oxygen saturation remains < 92%, increase flow with oxygen mask to 8-10 lpm.
 - a. Notify provider, if not previously done
5. If oxygen saturation remains < 92%, switch to non-rebreather mask at 8-10 lpm and reposition patient to prone or lateral position.
6. If still hypoxic, increase flow to 10-12 lpm and prepare to transfer to ED if requirement does not stabilize and decrease to 10 lpm or below.
7. Use positioning to optimize oxygenation: Lying prone or in a side lying position and/or in an upright position with support: semi-fowler's (30-45 degrees) or fowler's (45-60 degrees). Suggested position therapy is 2-3 times a day for 1-2 hours as tolerated, to increase or maintain SpO₂ greater than 90-92%.

Notes:

1. For requirements of 6 L of flow or above, O₂ monitoring should be done continuously.
2. A surgical mask should never be placed over an oxygen mask due to the risk of impeding adequate oxygenation and rebreathing carbon dioxide.

Weaning Procedure

1. Initiate an oxygen weaning protocol in all adult patients who have been on oxygen therapy for at least 48 hours and who have an oxygen saturation of greater than or equal to 92%, based on an order from a physician or respiratory therapist.
2. Proceed to wean from O₂ by decreasing oxygen in increments of 1-2 lpm. For example, a flow of 4 lpm will titrate down to 3 lpm; 3 lpm down to 2 lpm; 2 lpm to 1 lpm; and 1 lpm to room air. Take patients vitals after 15 mins to monitor response of oxygen titration.
3. Monitor O₂ saturation by continuous monitoring. Allow a minimum of 1-2 hours to assure maintenance of saturation of at least 92% (or target set by provider) at each level. Make titration changes in intervals based on patient status and proceed until patient is on room air.
4. If patient's SpO₂ drops below 92% then return the patient back to their previous O₂ settings to maintain SpO₂ ≥ 92%. Attempt weaning on next nursing shift as tolerated.

Patient Discharge

1. Patient discharge depends on level of oxygen needed and clearance from the Respiratory and Physical Therapist's evaluations.
2. Prior to discharge, all patients should have a 30 second sit to stand test and a 6-minute walk test while monitoring oxygen saturation. To pass, patients must not desaturate less than SpO₂ 90% on room air or (< 88% for COPD patients) during the activity test.

- a. Simple Ambulatory: Use portable pulse oximeter during testing to monitor and document O2 saturation and pulse before & after activity
- b. 30 second Sit to Stand Test for strength, balance, cardiopulmonary evaluation
 - i. The patient sits straight in the chair, both feet on ground shoulder width apart, if needed one foot slightly in front of the other for balance.
 - ii. The patient is encouraged to stand and sit as many times as tolerated, but at least two times, over 30 seconds. Use of arms is allowed, if needed, but if possible, the patient is encouraged to stand without the use of arms.
 - iii. Demonstrate the task both slowly and quickly and ask the patient to practice once.
 - iv. The tester documents the number of repetitions completed, whether use of arms is needed, problems with balance, and oxygen desaturation with effort.
- c. 6 Minute Walk Test – assess functional ability and cardiopulmonary testing while recording HR and Spo2 at rest, standing, and at each minute of the walk test.
 - i. Instruct the patient to walk for 6 minutes and explain where to walk, e.g., show 100-foot markers in hallway where they should turn around.
 - ii. Instruct the patient that they are permitted to slow down, to stop, and to rest as necessary, but resume walking as soon as they are able.
 - iii. A successful test is if the patient maintains an SPO2 90% or greater and heart rate (HR) within a normal range as well as reasonable functional performance given the patients age and diagnoses
 - iv. The patient fails this test if SPO2 drops below 90%. Stop test if patient dips below 88% and document time and distance walked. Document the use of assistive devices required.

6-Minute Walk Test Protocol

- 6MWT Protocol and Data Collection and Goal Setting Form on clipboard
- Heart rate (HR) monitor
- Blood pressure (BP) cuff
- Rating of Perceived Exertion Scale
- 3-4 armchairs (depending on patient's functional level)
- 2 pylons to mark the ends of the walkway
- Stopwatch*
- Length counter*
- Pen, piece of tape or beanbag to mark where the patient stops
- Transfer belt (if needed)
- Access to a telephone in case of an emergency
- An emergency plan

*Not needed if using the iWalkAssess smartphone application.

Patient Preparation: Patients should:

1. Wear comfortable clothing.
2. Wear appropriate shoes for walking.
3. Wear corrective eyewear (if applicable).
4. Use their presently used walking aids and orthoses during the test.
5. Take their medications as usual.

6. Not have exercised vigorously within 2 hours of beginning the test.

Test Set-Up:

Position a chair at each end of the 30-metre walkway and one or two chairs along the walkway as appropriate. Place a pylon inside each end point of the walkway.

iWalk Guide Online Resources 7. 6-Minute Walk Test Protocol

Screening for Contraindications:

Check the box if any of the following relative contraindications is present. Consult with a physician prior to proceeding with the test if one or more is checked:

- Resting HR > 120 bpm
- Resting HR < 60 bpm
- Resting systolic BP \geq 160 mmHg
- Resting diastolic BP \geq 100 mm Hg
- Left main coronary stenosis or its equivalent
- Moderate stenotic valvular heart disease

Complete for patients with stable exertional angina only:

- High-degree atrioventricular block
- Hypertrophic cardiomyopathy
- Significant pulmonary hypertension
- Advanced or complicated pregnancy
- Electrolyte abnormalities
- Orthopedic impairment that prevents walking
- Patients with stable exertional angina have NOT taken anti-angina medication. Rescue nitrate medication is NOT readily available.

Screening of relative contraindications completed

Check the box if any of the following absolute contraindications is present. Do not conduct the test if any one of the following is present:

- Myocardial infarction within 3-5 days
- Unstable angina
- Uncontrolled arrhythmias causing symptoms
- Syncope
- Active endocarditis
- Acute myocarditis or pericarditis
- Symptomatic severe aortic stenosis
- Uncontrolled heart failure
- Acute pulmonary embolus or pulmonary infarction
- Thrombosis of lower extremities

Screening of absolute contraindications completed

* If this occurs, provide patient with supplemental oxygen.

† If a patient has a respiratory condition, oxygen saturation should be monitored throughout the 6MWT and the test stopped if the level falls below 80%

- Suspected dissecting aneurysm
- Uncontrolled asthma
- Pulmonary edema
- Oxygen saturation $\leq 85\%$ on room air at rest*†
- Acute respiratory failure
- Acute non-cardiopulmonary disorder that may affect exercise performance or be aggravated by exercise (i.e. infection, renal failure, thyrotoxicosis)
- Mental impairment leading to inability to cooperate

iWalk Guide Online Resources 7. 6-Minute Walk Test Protocol

Testing:

Note: The patient does not need to be able to walk continuously for 6 minutes to perform the test. The test can be conducted to provide a baseline for comparing future performance.

1. While the patient is seated and at rest, measure and document perceived exertion, HR, and BP. Clients should be seated comfortably for a few minutes with legs uncrossed and feet resting firmly on the floor with back supported before taking HR and BP. Take BP using the unaffected arm, supporting the forearm at the level of the heart.
2. Put a transfer belt on the patient if appropriate.
3. The test should be performed once. The patient should not practice the test beforehand.
4. The evaluator should have hands free. A stopwatch can be worn around the neck with a mechanical length counter attached to the stopwatch string. Alternately, a smartphone can be worn in a lanyard around the neck.
5. With the patient seated at the start end of the walkway, say:

“The aim of this test is to walk as far as possible for 6 minutes. You will walk along this hallway between the pylons as many times as you can in 6 minutes. I will let you know as each minute goes past, and then at 6 minutes I will ask you to stop where you are. 6 minutes is a long time to walk, so you will be exerting yourself. You are permitted to slow down, to stop, and to rest as necessary, but please start walking again as soon as you are able. Please do not talk during the test unless you have a problem, are feeling unwell or need to tell me you need a rest. You must let me know if you have any chest pain or dizziness. Now I’m going to show you.”

Therapist demonstrates walking 30 meters and back.

6. Position the patient at the starting point and stand on the patient's affected side. Provide the minimum amount of manual assistance necessary to maintain patient safety. Say:

“Remember that the objective is to walk AS FAR AS POSSIBLE for 6 minutes, but don’t run or jog. Do you have any questions? When you are ready, please begin.”

7. Start timing once the patient starts walking. Walk slightly behind the patient so as not to pace the patient. Provide physical assistance (e.g., for balance or weight-shifting) if necessary.
8. The evaluator must watch the participant closely and provide close supervision. Immediately stop the test if the patient exhibits ANY one of the following:

- Chest pain
- Severe dyspnea (shortness of breath)
- Leg cramps
- Staggering
- Diaphoresis (excessive perspiration or sweating) - Pale or ashen appearance

- Light-headedness
- Confusion
- Cyanosis (blue or grey skin color)
- Nausea
- Excessive fatigue
- Facial expression signifying distress

If the test is stopped for any of the above reasons, the patient should sit or lie down. If in the hospital, the patient's nurse should be immediately notified. The evaluator should assess HR, BP and blood oxygenation.

iWalk Guide Online Resources 7. 6-Minute Walk Test Protocol

9. If the patient chooses to sit down or lean against the wall during the test to rest, continue timing. Every 30 seconds, say:

"Please start walking again whenever you feel able."

10. The patient should not talk or be distracted during the test. The evaluator should provide the following standardized encouragement in even tones during the test:

At 1 minute At 2 minutes At 3 minutes At 4 minutes At 5 minutes

"You are doing well. You have 5 minutes to go."

"Keep up the good work. You have 4 minutes to go." "You are doing well. You are halfway."

"Keep up the good work. You have only 2 minutes left." "You are doing well. You have only 1 minute to go."

11. Count each length using the length counter or the iWalkAssess smartphone application.
12. If the patient chooses to stop the test before 6 minutes have passed, mark the exact spot where the patient stopped by placing a pen, piece of tape or bean bag on the floor. Assist the patient to the nearest chair. Record the time stopped, the reason for stopping, and the distance walked.
13. When 6 minutes has passed, tell the patient *"Please stop where you are."* Mark the exact spot where the patient stopped by placing a pen, piece of tape or bean bag on the floor. Assist the patient to the nearest chair.
14. With the patient seated, first take HR and obtain a rating of perceived exertion. Take BP last as it takes the longest to measure. Document findings.

15. Round the distance walked on the last length to the nearest meter and calculate the 6MWT distance as follows:

Distance (meters) = (# lengths completed x walkway distance) + partial distance on final length

16. In the patient's health record, document walk test performed with walkway distance (i.e., 6MWT distance walked, test details (i.e., assistance level, walking aid and orthosis used, shoes worn, RPE/HR/BP pre and post) for comparison at re-test, % of norm, norm value and source, and short- and long-term goal (STG, LTG)
17. Document oxygen weaning activities in the patient's chart.

Evaluation for Home Oxygen

1. Ambulate the patient 300 feet on room air
2. If oxygen saturation (pulse ox) is 89% or greater, no home O₂ is required
3. If pulse ox drops below 89%, allow the patient to rest for 5 minutes
4. If pulse ox returns to 89% or greater at 5 minutes, no home O₂ is required
5. If hypoxia <89/5 is still present after 5 minutes, prescribe home O₂ at ____L/min prn activity
6. Re-evaluation of patient and O₂ weaning
7. Discharge coordinator will contact local oxygen companies and have an Inogen Portable Concentrator delivered to the family member, who will be transporting patient at discharge. Training will be provided. (This device is covered by most insurance companies including MediCal.)
8. If the patient needs continuous oxygen at home, a home concentrator should be ordered along with the portable concentrator
9. Family member will bring the portable device to the Warm Zone for application at discharge. RN or RT should be present at discharge to ensure correct application of the device.
10. The Inogen Portable Concentrator can be recharged in the car or at home. Battery life 3-5 hours.

Insert home POC guide from CTS here

ATS Statement: Guidelines for the Six-Minute Walk Test THIS OFFICIAL STATEMENT OF THE AMERICAN THORACIC SOCIETY WAS APPROVED BY THE ATS BOARD OF DIRECTORS MARCH 2002 **Am J Respir Crit Care Med Vol 166. pp 111–117, 2002**

Post Ventilator Support

Aerosol Generating Procedures (From CDC)

Some procedures performed on patients are more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. These aerosol generating procedures (AGPs) potentially put healthcare personnel and others at an increased risk for pathogen exposure and infection.

Development of a comprehensive list of AGPs for healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures.

There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for healthcare settings.

Commonly performed medical procedures that are often considered AGPs, or that create uncontrolled respiratory secretions, include:

- open suctioning of airways
- sputum induction
- cardiopulmonary resuscitation
- endotracheal intubation and extubation
- non-invasive ventilation (e.g., BiPAP, CPAP)
- bronchoscopy
- manual ventilation

Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as:

- nebulizer administration*
- high flow O2 delivery

*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.

References related to aerosol generating procedures:

Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338532/#!po=72.2222external>.

From British National Health Service

AEROSOL GENERATING PROCEDURES

The following procedures are currently considered to be potentially infectious Aerosol Generating Procedures (AGP's) for COVID-19:

- Intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)

- Tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- Bronchoscopy and upper ENT airway procedures that involve suctioning
- Upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- Surgery and postmortem procedures involving high-speed devices
- Some dental procedures (for example, high-speed drilling)
- Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum
- High flow nasal oxygen (HFNO)

NON-AEROSOL GENERATING PROCEDURES

- Chest Compressions
- Chest Physiotherapy
- Passing a Nasogastric tube
- Suctioning oral/ nasal secretions
- Nebulizer
- Humidified oxygen
- Nasal oxygen
- High flow oxygen via trauma mask
- Patient with productive cough

SECTION 6

Emergency Response

Alternative Care Site – COVID-19 Unit Emergency Response Team Response for Hot Zone Staff

*This guide is to help facilitate efficient and **safe removal and resuscitation of Alternate Care Site personnel** in the event of an emergency in contaminated areas (Hot Zone). The following are recommendations to best avoid cross contamination from rescuer to victim in the event of a medical emergency involving a staff member.*

1. Designate a team of individuals on each shift who will respond to medical emergencies involving staff members working in the COVID-19 patient care area (Hot Zone)

Procedures

1. Notify Incident Command, activate Emergency Response Team (ERT), and provider on-call of medical emergency in the Hot Zone.
2. ERT should not enter the Hot Zone.
3. **If conscious, breathing, and ambulatory:**
 - a. Immediately remove the victim from the Hot Zone
 - b. Escort victim to Warm Zone
 - c. Assist in doffing of personal protective equipment (PPE) and initiate cooling procedures as indicated
 - d. Hand victim off to CAL-MAT ERT
4. **If victim is unconscious and breathing or unconscious and not breathing, but has a pulse:**
 - a. MST to notify on site EMS provider if available
 - b. MST to call 9-1-1 if EMS provider not available
 - c. Initiate BLS as indicated with PPE in place
 - d. Place victim on backboard
 - e. Transport victim to Warm Zone
 - f. Hot Zone personnel remove victim's PPE and begin cooling measures as indicated
 - g. ERT and on-call Provider (wearing N95 and gloves) take over resuscitation measures until Emergency Medical Services (EMS) personnel arrive
5. **If victim is unconscious, not breathing, and pulseless:**
 - a. Initiate compression-only CPR and Advanced Life Support (ALS) measures
 - b. Place victim on backboard and CODE gurney
 - c. Transport victim to Warm Zone
 - d. Hot Zone personnel remove victim's PPE
 - e. ERT and on-call Provider (wearing N95 and gloves) will bring Thomas Pack and cardiac monitor/defibrillator from the Command Center
 - f. Pads and monitoring equipment will be applied once PPE has been removed
 - g. ERT and Provider will continue ACLS measures until EMS arrival

ACS CODE BLUE PROTOCOL

1. Initiating a Code Blue

- Patient care provider recognizes patient in cardiac arrest
- Call for help
 - Use radio "Code Blue ACS"
 - Pre-identified code crew goes to bedside
 - Assign roles at start of shift
 - ALS transport provider will stand by outside
 - If ALS transport provider not on site, call 911
 - Request inside assistance from ALS transport provider if needed
 - They will need to don PPE

2. Conducting Code Blue

- Code stretcher to bedside with backboard and place patient on it
- Begin compressions
- Move patient to pre-identified code area close by
 - Continue compressions during transition
 - Continue code in code area
 - Crash cart/defibrillator and Thomas Pack at the ready
 - Follow Code Blue Protocol
 - Attach pads while doing compressions
 - Defibrillate, if shockable rhythm and no pulse
 - Cardioversion, if pulse but unresponsive or hypotensive
 - Prepare to place airway
- Airway
 - Position head to open airway
 - Oral or nasal airway as needed (supraglottic)
 - Ventilate with Bag Valve Mask (Ambu Bag) with HEPA filter 10-15L 30:2
 - Provider or Paramedic (if licensed in Sacramento for EMSA) should prepare to intubate as indicated with supraglottic, after first 2 rounds of shocks (if shockable rhythm)
 - 2-person technique recommended (to achieve tight mask seal)
 - Be ready to connect endotracheal tube with attached HEPA filter (if available) to resuscitation bag to limit pause between compressions (utilize safe disconnection procedures and endotracheal clamping procedure).
- Communications
 - Radio to command center/provider
 - MST to contact Emergency Medical Services provider on-site (if available) and instruct to meet at Resuscitation Area
 - If EMS not on-site MST to call 9-1-1
- 1. Outcome:
 - Resuscitation efforts may be abbreviated to 5 min, if deemed appropriate by Provider or Code Leader on a case-by-case basis
 - Viable rhythm/ROSC restored: patient transported to hospital
 - No viable rhythm/ROSC restored:
 - Code leader pronounces time of death
 - Body placed in body bag and private area away from patients
 - Do not remove any treatment materials (IVs, etc.)
 - Provider notifies:
 - Family (include interpreter if needed)
 - PCP

- Medical Director/Public Health Dept
- Varies by County:
 - Coroner
 - Mortuary if identified and Health Dept agrees

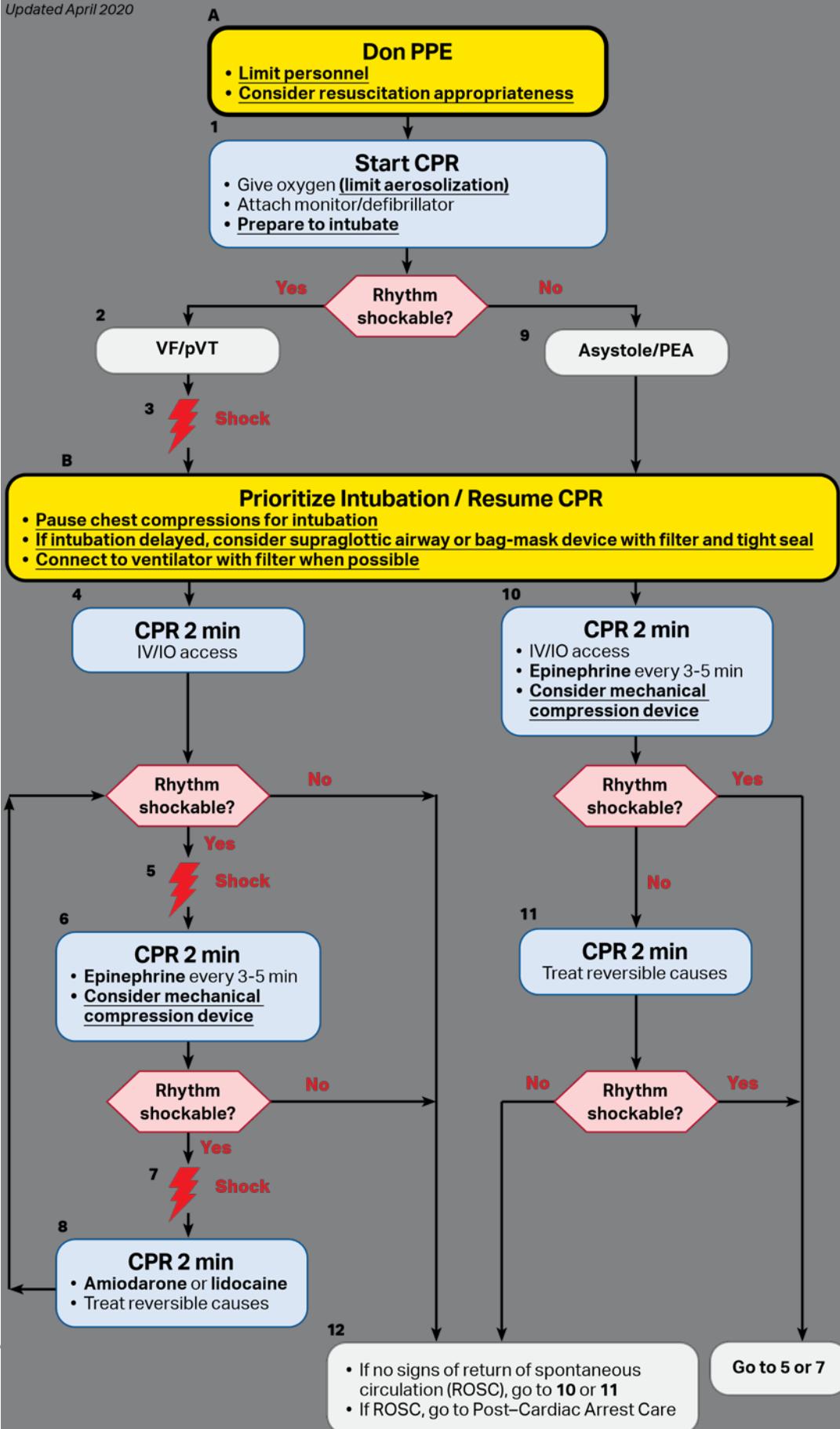
3. Responders

- Code leader: ACLS-certified RN, ALS ambulance medic or provider
- Recorder: RN or pharmacist
- Meds: RN or ALS ambulance medic
 - Pharmacist can provide meds to RN
- Stretcher/monitor: EMT/CALMAT medic
- Runner: EMT/CALMAT medic
- Compressions: 2 EMTs/CALMAT medics

Attached: algorithm from AHA

ACLS Algorithm for COVID-19 Patients

Updated April 2020



- Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.
- Minimize interruptions in compressions.
- Avoid excessive ventilation.
- Change compressor every 2 minutes, or sooner if fatigued.
- If no advanced airway, 30:2 compression-ventilation ratio.
- Quantitative waveform capnography
 - If Petco₂ <10 mm Hg, attempt to improve CPR quality.
- Intra-arterial pressure
 - If relaxation phase (diastolic) pressure <20 mm Hg, attempt to improve CPR quality.

Shock Energy for Defibrillation

- Biphasic: Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- Monophasic: 360 J

Advanced Airway

- Minimize closed-circuit disconnection
- Use intubator with highest likelihood of first pass success
- Consider video laryngoscopy
- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement
- Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions

Drug Therapy

- Epinephrine IV/IO dose:
1 mg every 3-5 minutes
- Amiodarone IV/IO dose: First dose: 300 mg bolus. Second dose: 150 mg.
or
Lidocaine IV/IO dose:
First dose: 1-1.5 mg/kg. Second dose: 0.5-0.75 mg/kg.

Return of Spontaneous Circulation (ROSC)

- Pulse and blood pressure
- Abrupt sustained increase in Petco₂ (typically ≥40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Reversible Causes

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Hypovolemia • Hypoxia • Hydrogen ion (acidosis) • Hypo-/hyperkalemia • Hypothermia | <ul style="list-style-type: none"> • Tension Pneumothorax • Tamponade, Cardiac • Toxins • Thrombosis, pulmonary • Thrombosis, Coronary |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SECTION 7

Physical Therapy

Physical Therapy Evaluation (may be done in collaboration with RN or EMS)

Assess every patient at facility for PT needs on admission and periodically, as clinically indicated:

- Prior abilities and home environment
- Cognition, Strength, Active range of motion (AROM), Balance, Coordination, Sensation, and Deep tendon reflexes (DTRs)
- Mobility impairments in bed mobility, transfers, and ambulation
- Ability to perform ADL's (Activities of daily living), such as dressing, bathing, and grooming
- Inquire about swallowing abilities and speech
- Needs for equipment such as for gait, bedside commode, potential integumentary breakdown

If the patient is independent, then document no further needs indicated; however, will follow up if there is a medical or physical status changes or as new needs arise.

After Initial Assessment of Patient:

- Communicate plan of care and patient goals to care team and patient
- If no further treatment is indicated, offer a Home Exercise Program (HEP) handout to the patient either at the initial evaluation or on follow-up and demonstrate exercises, so that patient can maintain strength while at the facility
- Write goals and mobility impairments on patient white board at nursing station and update RN, MD, and RT on oxygen needs and any desaturation during exercise, if applicable
 - Typical goals for all patients include:
 - Sitting up in chair for all meals
 - Ambulate 3x/day (please designate with or without staff and with or without O2)
 - Perform HEP daily (review with patient in a session and administer handout (available in English and Spanish versions)
 - Use incentive spirometer (frequency and goal to be designated by RT/MD)
- Support respiratory therapy evaluation and discharge assessment
 - Assist or perform cardiopulmonary testing in conjunction with respiratory therapy or other care staff

Physical Therapy Discharge Evaluation (PT may be required to perform RT evaluation if no RT on site):

- Assess and communicate to care team: Patient functional ability and safety assessments, including fall risk with mobility and equipment if needed
- Cardiopulmonary Testing: Use portable pulse oximeter during testing to monitor and document O2 saturation and pulse before & after the following:
 - 30 second Sit to Stand Test – assesses strength, balance, and cardiopulmonary status
 - The patient sits straight in the chair, both feet on ground, shoulder width apart, if needed one foot slightly in front of the other for balance.

- The patient is encouraged to stand and sit as many times as tolerated, at least two times, over 30 seconds. Use of arms is allowed, if needed, but if possible, the patient is encouraged to stand without the use of arms.
- Demonstrate the task both slowly and quickly and ask the patient to practice once.
- The tester documents the number of repetitions completed, whether use of arms is needed, problems with balance, and oxygen desaturation with effort.
- 6 Minute Walk Test – assesses functional ability and cardiopulmonary testing
 - Instruct the patient to walk for 6 minutes and explain where to walk, e.g., show 100-foot markers in hallway where they should turn around.
 - Instruct the patient that they are permitted to slow down, stop, and rest as necessary, but resume walking as soon as they are able.
 - Walk behind the patient and occasionally spot check vitals.
 - A successful test is if the patient maintains an SPO2 90% or greater and heart rate (HR) within a normal range as well as reasonable functional performance given the patients age and diagnoses

The patient fails this test if SPO2 drops below 90%. Stop test if patient dips below 88% and document time and distance walked. Document the use of assistive devices required.

SECTION 8

Behavioral Health

SECTION 9

Pharmacy Operations and Resources

Set up pharmacy (in secure location)

- Request for electronic CAL-MAT pharmacy cache inventory list from William.hartley@emsa.ca.gov
- Complete a full pharmacy cache inventory count from totes and note any discrepancy.
- Pharmaceuticals will be stored at controlled room temperature (59-86 F/ 15-30 C).
- Refrigerator temperature monitoring sheet placed on the door of refrigerator (create one if not available) check TWICE daily. Refrigerator: (36-46 F / 2-8 C) Freezer: (<32 F/ <0 C). (**Refer to Annex C for Temperature Log**)
- Ensure proper ventilation and lighting, bring headlamp if necessary.
- Secure scheduled/controlled substances, e.g., bring zip ties to secure lock box, and maintain a running inventory.
- Establish a CLEAN ROOM area for IV Admixture if needed.
- Survey and establish relationships with nearby retail pharmacies for hours, delivery service, possible sister stores of independent pharmacies who may share electronic records, and hospital pharmacy for drug(s) if necessary. Don't hesitate to speak to managers/directors for support. They're more than happy to hear from you.

Pharmacy Operation and Clinical Interventions

- Consult PULSE (Patient Unified Lookup System for Emergencies) for prior patient record if med vial or current med list is not available. It aggregates data from 13 health information organization (not Kaiser nor VA).
 - See training manual for further detail.
 - HIE.EMS@emsa.ca.gov for questions.
 - Login from <https://healthcarevolunteers.ca.gov/>
 - Then select log In To Pulse red button in the middle of the page and use same username/password.
- Work closely with CAL-MAT team members, shelter/ACS volunteers, county nurse/case worker, Red Cross staff for the optimal and continuity of patient care.
- Patient care round in tents to assess patient and provider needs.
 - Counsel on all meds administered inpatient and all outpatient.
 - In counseling, ask and listen for any barrier to care or payment, perhaps there is a lack of refrigeration, lack of measuring device, inability to follow-up with primary care provider.
- Create a written prescription for every drug dispensed as verbal order from prescriber.
- Ration dispensing quantities:
 - 3-5 day supply or return for more medication if no local retail pharmacy available.

- Be sure to dispense full course of antibiotic.
- Use your clinical judgment.
 - If dose is ½ tablet - CUT all tablets in half prior to dispensing and counsel accordingly.
- Help evacuees transition from either emergency supply from us or directly from pharmacies near shelter or ACS.
- Verify properly written prescriptions (including therapeutic substitution) for patients at retail pharmacy.
- Call in prescriptions to be helpful.
 - Be prepared with patient name, DOB, insurance info (Rx group#, PCN#, BIN #), prescriber's NPI or DEA.
- Maintain CAL-MAT Pharmacy Medication Tracking Record to monitor usage and a separate sheet to document interventions and provide continuity of care. (**Refer to Annex C for Tracking Record Log**)
- Document interventions in patient charts provider progress notes.

Monitor the changing needs of your practice environment at all times. Be flexible about maintaining adequate inventory with medical operations in our dynamic resource-constrained setting.

Communicate regularly with medical operations to order additional meds and supply.

VA Patients: be sure to get the last 4 digits of patient's social security number before calling local VA for patient information.

Financial Assistance: Red Cross nurse can provide info to limited funding (in the form of loaded cash card) to pay for patient meds. Ask to speak to the disaster health service lead if necessary. May need to make several phone calls.

Internet Browser: Some webpages don't open on Internet Explorer or Chrome on CAL-MAT laptop, be sure to try both browsers.

Online Resources:

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies Volume II: Government-Authorized Alternate Care Sites

https://www.cidrap.umn.edu/sites/default/files/public/php/258/258_acs.pdf

Health Emergency Declaration Related to Statewide Fires-August 18, 2020. Section 4062 Furnishing Dangerous Drugs during Emergency; Mobile Pharmacy. Section 4064 Emergency Refill of Prescription without Prescriber Authorization

https://www.pharmacy.ca.gov/about/news_release/state_of_emergency_081820.pdf

Health Care Ready <https://www.healthcareready.org/rxopen/faq>

Rx Open was created to help patients find nearby open pharmacies in an area impacted by disaster. When a disaster occurs, Healthcare Ready also activates Rx Open maps to help the

public and emergency responders see where pharmacies are open and closed in the affected area. Healthcare Ready also monitors international disasters that may affect the delivery of critical medicines in the United States.

Emergency Prescription Assistance Program (applies only if activated)

EPAP <https://www.phe.gov/Preparedness/planning/epap/Pages/default.aspx>
<https://www.phe.gov/Preparedness/planning/epap/Documents/epap-need2know-ENG.pdf>

Allows pharmacies to process claims for eligible people in a federally declared disaster area-program. Only for patients with NO health insurance (Medicare enrollees not eligible). Pharmacy must be registered with Express Scripts <https://www.express-scripts.com> and prescription or equipment must be covered. Confirm that the pharmacy is enrolled so they can assist patient with eligibility and registration. HOTLINE: 1-855-793-7470. A 30-day supply can be issued and renewed as long as program remains activated. Copay waiver during disaster is entirely up to the decision of the local pharmacy.

Document last reviewed 9/10//20

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4064. Emergency Refill of Prescription without Prescriber Authorization

(a) A prescription for a dangerous drug or dangerous device may be refilled without the prescriber's authorization if the prescriber is unavailable to authorize the refill and if, in the pharmacist's professional judgment, failure to refill the prescription might interrupt the patient's ongoing care and have a significant adverse effect on the patient's well-being. 84 (b) The pharmacist shall inform the patient that the prescription was refilled pursuant to this section. (c) The pharmacist shall inform the prescriber within a reasonable period of time of any refills dispensed pursuant to this section. (d) Prior to refilling a prescription pursuant to this section, the pharmacist shall make every reasonable effort to contact the prescriber. The pharmacist shall make an appropriate record, including the basis for proceeding under this section. (e) The prescriber shall not incur any liability as the result of a refilling of a prescription pursuant to this section. (f) Notwithstanding Section 4060 or any other law, a person may possess a dangerous drug or dangerous device furnished without prescription pursuant to this section. (g) During a proclaimed state of emergency, nothing in either this section or any other provision of this chapter prohibits a pharmacist, a clinic licensed under Section 4180, or a mobile pharmacy or clinic described in subdivision (c) of Section 4062 from refilling a prescription if the prescriber is unavailable, or if after a reasonable effort has been made, the pharmacist, clinic, or mobile pharmacy is unable to contact the prescriber.

https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf

4064. Emergency Refill of Prescription without Prescriber Authorization (a) A prescription for a dangerous drug or dangerous device may be refilled without the prescriber's authorization if the prescriber is unavailable to authorize the refill and if, in the pharmacist's professional judgment, failure to refill the prescription might interrupt the patient's

ongoing care and have a significant adverse effect on the patient's well-being. 84 (b) The pharmacist shall inform the patient that the prescription was refilled pursuant to this section. (c) The pharmacist shall inform the prescriber within a reasonable period of time of any refills dispensed pursuant to this section. (d) Prior to refilling a prescription pursuant to this section, the pharmacist shall make every reasonable effort to contact the prescriber. The pharmacist shall make an appropriate record, including the basis for proceeding under this section. (e) The prescriber shall not incur any liability as the result of a refilling of a prescription pursuant to this section. (f) Notwithstanding Section 4060 or any other law, a person may possess a dangerous drug or dangerous device furnished without prescription pursuant to this section. (g) During a proclaimed state of emergency, nothing in either this section or any other provision of this chapter prohibits a pharmacist, a clinic licensed under Section 4180, or a mobile pharmacy or clinic described in subdivision (c) of Section 4062 from refilling a prescription if the prescriber is unavailable, or if after a reasonable effort has been made, the pharmacist, clinic, or mobile pharmacy is unable to contact the prescriber.

https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf BPC 4064

SECTION 10

POSTMORTEM

Postmortem Notifications Procedure

1. Note the time of death.
2. Notification to:
 - a. Charge/Lead RN
 - b. On-call Provider
 - c. Operations
3. Notification to:
 - a. Follow local jurisdiction process, i.e., call coroner
4. Notification of kin.
 - a. The Provider or designee, in coordination with the Coroner's Office, will make notification.
5. In the event of an unexpected death, Operations will work with the decedent's family to coordinate mortuary service.
6. If decedent is a hospice patient, mortuary information will be included in the intake documentation or chart.
 - a. In the event of delay in mortuary service pick up of the decedent, the MST Director will contact the Coroner's Office to coordinate temporary storage.
7. MST Director will contact the mortuary Prepare decedent for transport.
8. Primary care giver will assist Mortuary upon their arrival.
9. Note time of pick up and Mortuary information in chart.
10. Contact EVS Vendor for the site to complete room disinfection and preparation.
11. Prepare chart & discharge documents.

Additional Considerations

- In the event of a suspicious death, OPS should be informed that the death is suspicious
 - The decedent will not be disturbed or moved
 - The room or area will be cordoned off and secured.
 - All personnel will remain on site and cooperate with Law Enforcement investigation.
- Personnel should be ready to provide emotional support to other patients who may have questions or have overheard activity and/ or information related to the death.
- Schedule a formal or informal debrief with staff as appropriate.
 - Allow enough time for spontaneous support group discussion.
 - Remind staff of CAL-MAT psychological services.
- Staff should report to Charge Nurse significant moral change noticed in colleagues that may affect patient care and safety.
 - If necessary, affected staff can be provided time off. Consider requesting for chaplain or behavioral health officer.

Transfer of Decedent to a Body Bag

If it is necessary to transfer a body to a bag, follow [Standard Precautions](#), including additional personal protective equipment (PPE) if splashing of fluids is expected. Standard body bagging procedures should be followed, consistent with procedures used for deaths where COVID-19 is not suspected. Given the varying weights of decedents and variety, construction, and conditions

of body bag materials, postmortem care workers should use prudent judgement determining if risks for puncture, tearing, or failure of body bags could occur and whether a second body bag or a body bag of thicker, stronger material (e.g. minimum of 6 mil thickness) is necessary. Risk factors include but are not limited to:

- Presence of sharp objects on the decedent that could cause punctures or tears (e.g. jewelry, piercings, medical instruments)
- Weight of the decedent that could cause the bag/bag handle to fail during transport (if available, verify body bag weight capacities as provided by the manufacturer)
- Bodily fluids posing exposure risks to workers transporting the body should a puncture, tear, or failure occur (e.g. SARS-CoV-2 has been detected in the feces of some patients diagnosed with COVID-19, though whether the virus in stool is infectious is unknown, [Standard Precautions](#) for bloodborne pathogens should always be taken.)
- Damage or degradation to the body bag that may have occurred in shipment or storage (e.g. the bag is broken or brittle)

SECTION 11

Self-Care Before, During & After Deployment

COVID-19 Testing for CAL-MAT Members

TO:	CAL-MAT Members	
FROM:	Dave Duncan, MD Director	
DATE:	8/6/20	

SUBJECT: COVID Testing for CAL-MAT

PURPOSE: To clarify when COVID testing should be done for personnel deployed at field sites

Background

COVID testing capability and capacity remain insufficient and problematic in most areas. CAL-MAT personnel are working with COVID patients and living in close proximity with one another. Questions frequently arise regarding availability of testing and directives for testing deployed health care providers.

Policy/Procedure

Testing capability

- Each deployment site should make an arrangement for testing healthcare and MST personnel through the local health department, a local medical facility, or a private laboratory.
- Attempt to arrange priority testing or rapid result testing.
EMSA plans to establish rapid testing for COVID antigen (BD Veritor) at each site.

Note: Antigen tests are not as sensitive as nucleic acid amplification assays such as PCR. Thus, positive results tend to be accurate, but a negative result should be interpreted with caution, and should be considered in the context of clinical suspicion of disease and risk status of the patient. Negative results for the BD Veritor antigen test should be treated as presumptive negative.

- Negative tests using either PCR or antigen testing can be repeated serially every 2-3 days if there is high suspicion for infection or high-risk exposure.

Symptomatic CAL-MAT or other healthcare worker on site

- Any person on site of a medical mission who develops symptoms suggesting possible COVID-19 infection should be immediately isolated and tested with a PCR test from a naso-pharyngeal swab.

- Rapid antigen test can be used, if available, subject to limitations noted above.
- See *CAL-MAT COVID-19 Isolation, symptom management, notification, and return to work (Rev 7-25-20)* for management of isolated staff.

Testing Asymptomatic CAL-MAT member during deployment

Possible exposure

- Per CDC Guidance: When a confirmed case of COVID-19 is identified, interviewing and testing potentially exposed co-workers should occur as soon as possible to reduce the risk of further workplace transmission.
- If staff at a mission site are exposed to a known positive colleague, testing may be requested or mandated (in consultation with CAL-MAT Medical Director or EMSA Medical Director) for all staff as a condition of on-going employment
- CAL-MAT receive worker's compensation and occupational health benefits as well as continued housing and support during isolation (See Isolation policy below)
- Staff with very high exposure risk should be quarantined while awaiting test results (prolonged close contact without face masks, e.g., roommate, close contact for prolonged periods without wearing masks)
- Other staff with casual contact wearing masks may be allowed to continue work while awaiting testing.

1. CDC guidance for risk assessment *Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19*
2. *Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified*
3. and testing strategy flow diagram from CDC <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/Testing-Strat-flow-diagram.pdf>

Other request for testing during deployment

- EMSA will arrange testing for a CAL-MAT or other employee on site who requests testing due to concerns of exposure
- Employees who request testing for other personal reasons should be directed to local resources for testing at their expense

CAL-MAT testing on deployment

- EMSA/CAL-MAT will not perform routine testing on deployment.
- This is not possible due to frequent urgency of deployment
- When antigen tests are available at all sites, this can be considered as an option, but there is no requirement at this time.
- This is consistent with other acute care healthcare sites.

CAL-MAT testing on demobilization

- Testing on demobilization from a CAL-MAT mission should be offered to employees.
- However, there are multiple limitations to this policy, since testing may not be readily available on-site and results may not be rapidly available.
- CAL-MAT members who have concern about returning to their household or other site of employment may use the State Quarantine Program, which offers paid hotel accommodations for up to 14 days (or until test results have returned). Hotel site can be near the site of EMSA deployment or near the employee's home.
- <https://covid19.ca.gov/hotel-rooms-for-california-healthcare-workers/>
- Salary is not paid during quarantine, but would be paid during the isolation period, if the test comes back positive.

The following individuals can perform NP swabs (per CDPH)

- EMTs and paramedics are authorized by the Director of the California Emergency Medical Services Authority to collect nasopharyngeal swabs only for COVID-19 testing and only for the duration of the COVID-19 emergency. Additional information about the local option scope of practice allowing them to do this is available on the California Emergency Medical Services Authority webpage.
- Registered nurses can collect specimens using nasopharyngeal or oropharyngeal swabs.
- Respiratory care practitioners are authorized under their scope of practice to collect specimens using swabs, including NP and OP swabs.
- Nasopharyngeal or oropharyngeal swab collection is within the scope of practice for a licensed vocational nurse (LVN) as long as the LVN:
 - Receives specialized instruction in the proper procedure from a registered nurse or licensed physician;
 - Demonstrates the requisite knowledge, skills and ability prior to performance of the procedure; and
 - Performs the procedure in accordance with a licensed physician's order.

Resources, Links, and Attachments

EMSA/CAL-MAT policy: CAL-MAT COVID-19 Isolation, symptom management, notification, and return to work (Rev 7-25-20)

Cal-FIRE-EMSA policy for COVID antigen testing

Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified

<https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>

Testing Strategy for Coronavirus (COVID-19) in High-

Density Critical Infrastructure Workplaces after a COVID-19 Case is Identified

<https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/Testing-Strat-flow-diagram.pdf>

Hotel Rooms for California Health Care Workers

<https://covid19.ca.gov/hotel-rooms-for-california-healthcare-workers/>

Program eligibility

To be eligible for this program, you must:

- Work in a California healthcare facility, including:
 - Medical transport providers and non-medical staff within health care facilities
 - Workers in California's Health Corps or CAL MAT, as designated by the State
 - Correctional facility staff
 - First responders
- Have presumed exposure to COVID-19
 - This facility needs to be documented by a state or county public health official or medical professional to house COVID-19 positive patients
 - Or healthcare workers who test positive for COVID-19 but do not require hospitalization
- Be unable to self-isolate or quarantine at home

How to reserve a room

- Call [1-877-454-8785](tel:1-877-454-8785) to complete a screening process. Do not share personal health information.
- Show your healthcare facility employee identification at check-in.
- Provide a credit card or another form of deposit at check-in.
- The Program does not include extra services from the hotel, such as food, room service, valet, parking, or laundry. You will be responsible for incidentals.

BD Veritor System instructions for use <https://www.fda.gov/media/139755/download>

CAL-MAT PACKING LIST

Since we vary in disciplines, what may be essential to one group may not necessarily apply to the other. Some of you may have missed the presentations on “Ready” and “Go” bags in our earlier meetings, and we will revisit this once again in an upcoming meeting. Please keep in mind that you should not pack more than you can physically carry, as we will not always have the luxury of using wheels.

DAY PACK/BACKPACK

DOCUMENTS

<input type="checkbox"/> 2 forms of identification (i.e., passport, driver’s license, etc.)	<input type="checkbox"/> Professional license (with copy)
<input type="checkbox"/> Flight confirmation (if applicable)	<input type="checkbox"/> Emergency contact information
<input type="checkbox"/> Billiting information (if applicable)	<input type="checkbox"/> Cash- (small bills), personal credit card,

PERSONAL ITEMS

<input type="checkbox"/> Eyeglasses, contact lens supplies	<input type="checkbox"/> Powdered electrolyte replacement/Gatorade
<input type="checkbox"/> Personal hygiene (toothbrush), baby wipes	<input type="checkbox"/> Pens, pencils, small notebook
<input type="checkbox"/> Snacks	<input type="checkbox"/> Reading material/tablet
<input type="checkbox"/> Sunglasses	<input type="checkbox"/> Small neck pillow, small blanket
<input type="checkbox"/> Durable Head Lamp	<input type="checkbox"/> Ear plugs
<input type="checkbox"/> Personal Medication	<input type="checkbox"/> Pocket tissues (toilet paper)
<input type="checkbox"/> Water	<input type="checkbox"/> Cell phone/charger/spare battery
<input type="checkbox"/> Water purification/ HEPA filtration	<input type="checkbox"/> Any pocket guides for your job
<input type="checkbox"/> Sleeping bag (optional)	<input type="checkbox"/> Basic first aid kit-band aides, cleanser and Tylenol/Motrin
<input type="checkbox"/>	<input type="checkbox"/>

PROTECTIVE ITEMS

<input type="checkbox"/> Work gloves	<input type="checkbox"/> Sunscreen (small for TSA)
<input type="checkbox"/> Eye protection	<input type="checkbox"/> Lip balm
<input type="checkbox"/> Hand sanitizer (small for TSA)	<input type="checkbox"/> Insect repellent with DEET (small for TSA)
<input type="checkbox"/> Scarf or bandana (to cover mouth/face if needed)	<input type="checkbox"/>

CLOTHING

<input type="checkbox"/> Extra pair of socks/underwear	<input type="checkbox"/> Hat
<input type="checkbox"/> Wear boots during travel	<input type="checkbox"/> Extra team shirt
<input type="checkbox"/> Jacket or sweatshirt	<input type="checkbox"/> Rain poncho-disposable

WHAT NOT TO BRING

- Items of value
- Large sums of cash
- Weapons

NOTE: Keep in mind the Transportation Security Administration (TSA) guidelines when preparing your backpack (carry-on items) should you need to travel via the airlines.

MAIN PACK

<input type="checkbox"/> Sleeping bag, (optional ground pad and/or air mattress)	<input type="checkbox"/> Extra batteries (if needed for headlamps, etc.)
<input type="checkbox"/> Leatherman/Swiss army knife	<input type="checkbox"/> Laundry detergent (small bag or pods)
<input type="checkbox"/> Mosquito net	<input type="checkbox"/> Zip lock bags
<input type="checkbox"/> Luggage locks	<input type="checkbox"/> Shower shoes/flip flops
<input type="checkbox"/> Clothesline/rope/bungie cords	<input type="checkbox"/> Medical supplies (your tools)
<input type="checkbox"/> Extension cord/power strip	<input type="checkbox"/> Sunscreen
<input type="checkbox"/> Insect repellent with DEET	<input type="checkbox"/> Hand Sanitizer
<input type="checkbox"/> Camp pillow	<input type="checkbox"/> Travel/hostel sack/sheet/pillow case (can serve as pillow when stuffed w/clothes)
<input type="checkbox"/> Cup, utensils	<input type="checkbox"/> Zip lock baggies (gallon size)

CLOTHING

<input type="checkbox"/> Sleepwear/slippers	<input type="checkbox"/> Tennis shoes
<input type="checkbox"/> Under garments	<input type="checkbox"/> Bath towels/wash cloths (quick dry travel towels)
<input type="checkbox"/> Socks	<input type="checkbox"/> BDU pants, blouse, t-shirts, (3 pairs at least)
<input type="checkbox"/> Civilian clothes when off duty (won't need many)	<input type="checkbox"/> Laundry bag for dirty clothes
<input type="checkbox"/> Sleepwear/slippers	<input type="checkbox"/>

TOILETRIES

<input type="checkbox"/> Ditty bag to carry to shower	<input type="checkbox"/> Eyeglasses/eyeglass repair kit
<input type="checkbox"/> Toothbrush/paste	<input type="checkbox"/> Prescription medicine
<input type="checkbox"/> Shampoo/soap	<input type="checkbox"/> Tylenol, NSAIDS, or any other OTC meds you may want
<input type="checkbox"/> Comb/brush	<input type="checkbox"/> Band-Aids/moleskin
<input type="checkbox"/> Razor/shaving cream	<input type="checkbox"/> Tape
<input type="checkbox"/> Deodorant	<input type="checkbox"/> First aid kit
<input type="checkbox"/> Contact lens supplies	<input type="checkbox"/>

Optional Items: Medical Personnel

__ Nitrile Gloves	__ Medical Tape	__ Bacitracin	__ Pen Light
__ Nasacort	__ Antihistamine Cream	__ Alcohol Swabs	__ Pulse Ox
__ Electrolyte Tablets	__ Steroid Cream	__ Bandages	
__ OTC Pain Relief	__ OTC Antihistamine	__ Saline Eye Drops	



Disclaimer: Please note all items noted in this document are recommendations only as CAL-MAT does not endorse any specific product.

Disclaimer: Please note all items noted in this document are recommendations only as CAL-MAT does not endorse any specific product.

Provider Suggestions:

Pre-Disaster Planning: Go-Bag ~30lbs



- uniform w/2-3shirts
- 3days of sox etc.
- sunglasses/sunscreen
- insect repellent-towelettes
- small-size toiletries
- pillow roll, small blanket
- iPad, solar lantern/charger, phone
- wipes/sanitizer/washcloth
- food, snacks, \$, baggies
- umbrella, work gloves
- stethoscope, pulse ox
- facts/formulas, pens
- Sanford & Pharmacopeia
- licenses, DEA, Rx, ID
- flashlight, trauma shears
- first-aid kit, batteries
- cipro/doxy/flagyl/amox
- probiotics, caffeine, powder drinks, Vit C immune stuff
- life-straw, allergy meds
- your own meds, xtra lenses



The Secrets of Great Teamwork

Assembling a team to work together on a CAL-MAT mission is different from teams assembled in a hospital setting. Putting a team together to work at an Alternate Care Site (ACS) for COVID care or to respond to an Evacuation Shelter considers not only numbers of the patient / evacuee population but the nature and scope of the mission. The professionals chosen for CAL-MAT missions are brought from all areas of the state. On many missions, few people know each other, but are expected to hit the ground running and function well as a team. So, it's not far-fetched to suggest that conflict might develop between team members which could compromise team performance.

Today's teams are different from the teams of the past: They're far more diverse, dispersed, digital, and dynamic (with frequent changes in assignment). But while teams face new hurdles, their success still hinges on a core set of fundamentals for group collaboration.

The basics of team effectiveness were identified by J. Richard Hackman, a pioneer in the field of organizational behavior who began studying teams in the 1970s. In more than 40 years of research, he uncovered a groundbreaking insight: What matters most to collaboration is not the personalities, attitudes, or behavioral styles of team members. Instead, what teams need to thrive are certain **“enabling conditions.”** In studies, it was found that three of Hackman's conditions—a compelling direction, a strong structure, and a supportive context—continue to be particularly critical to team success. In fact, today those three requirements demand more attention than ever. But we've also seen that modern teams are vulnerable to two corrosive problems—“us versus them” thinking and incomplete information. Overcoming those pitfalls requires a fourth critical condition: a shared mindset.

The key takeaway is this: Though teams face an increasingly complicated set of challenges, a relatively small number of factors have an outsized impact on their success. Teams can achieve big returns if they understand what those factors are and focus on getting them right.

The Enabling Conditions

Let's explore in greater detail how to create a climate that helps diverse, dispersed, digital, dynamic teams—what we like to call **4-D teams**—attain high performance.

Compelling direction.

The foundation of every great team is a direction that energizes, orients, and engages its members. Teams cannot be inspired if they don't know what they're working toward and don't have explicit goals. Those goals should be challenging (modest ones don't motivate) but not so difficult that the team becomes dispirited. They also must be consequential: People have to care about achieving a goal, whether because they stand to gain extrinsic rewards, like recognition, pay, and promotions; or intrinsic rewards, such as satisfaction and a sense of meaning.

On 4-D teams, direction is especially crucial because it's easy for far-flung members from dissimilar backgrounds to hold different views of the group's purpose. Solving tension requires a frank discussion to reach consensus on how the team as a whole defines its objectives.

Mission Leaders and team members placed in charge, must keep the goals of the mission as the guide for all decision making. Keeping team members informed is key. Group members should meet together at the beginning of the mission to discuss the setting infrastructure and mission goals but also to define CAL-MAT team goals, staff roles, shift assignments, equipment and paperwork specifics as well as behavior standards. The mission importance is uppermost but team members will be able to relax and focus on their role once they know the plan for their personal needs to be met. Knowing where they will sleep, how long their shift will be, where to find a restroom, where the showers are and the location and times that food will be available are important aspects of the mission to address early on.

Strong structure.

Teams also need the right mix and number of members, optimally designed tasks and processes, and norms that discourage destructive behavior and promote positive dynamics. Although, EMSA decides which team members will deploy to each mission, this principle should be kept in mind when deciding which CAL-MAT team members will be assigned to each shift.

High-performing teams include members with a balance of skills. Every individual doesn't have to possess superlative technical and social skills, but the team overall needs a healthy dose of both. Diversity in knowledge, views, and perspectives, as well as in age, gender, and race, can help teams be more creative and efficient.

Team members from diverse backgrounds often interpret a group's goals differently.

This is one area where 4-D teams often have an advantage. Research has shown that teams benefit from having a blend of backgrounds. For instance, combining people who have a lot of world experience and have navigated multi-faceted situations with those that have little world experience but have deep roots at one job and in one community is an optimal practice. Both groups have unique wisdom and perspective to share when solving problems and working together. By nature of the job, EMSA does this each time a CAL-MAT team is put together for a mission. Wise mission leaders will see this as an opportunity, not an obstacle.

When team members are added, as individuals demobilize at different times, the opportunity arises to either keep the new person on the perimeter of the group, or utilize the strength that CAL-MAT team has already built to accept the new person and mentor them into the operation.

Team assignments should be designed with equal care. Not every task has to be highly creative or inspiring; many require a certain amount of drudgery. But leaders can make any task more motivating by ensuring that the team is responsible for a significant piece of work from beginning to end, that the team members have a lot of autonomy in managing that work, and that the team receives performance feedback on it.

When on a mission, holding meetings each day at shift change is a great venue for communication exchange and public notice of performance done well and problem solving for the processes that need improvement. Sometimes, making little changes can increase motivation and engagement and improve the quality, quantity, and efficiency of CAL-MAT work.

Destructive dynamics can also undermine collaborative efforts. We've all seen team members withhold information, pressure people to conform, avoid responsibility, cast blame, and so on. Teams can reduce the potential for dysfunction by establishing clear norms—rules that spell out a small number of things members must always do (such as arrive at meetings on time and give everyone a turn to speak) and a small number they must never do (such as interrupt or be disrespectful). Instilling such norms is especially important when team members operate across different personal and professional cultures (and may not share the same view of, for example, the importance of punctuality or rule following). And in teams like CAL-MAT, whose personnel mix can be fluid, explicitly reiterating norms at regular intervals is key (ex: Code of Conduct)

Supportive context.

Having the right support is the third condition that enables team effectiveness. This includes maintaining a reward system that reinforces good performance, an information system that provides access to the data needed for the work, and an educational system that offers training, and last—but not least—securing the material resources required to do the job. For example: Obtaining resupply materials for each mission can be challenging for both the Logistics Leader and the team members. Working together to creatively solve problems is key to success of the mission. Resisting the urge to blame and complain will benefit all involved.

CAL-MAT Mission Leaders and Charge Staff should have great listening skills and model this for the group. Daily team meetings including “round table” feedback, in which each team member is called on and asked, “What did we do well today? And, “What could we do better tomorrow?” gives forum and license for each person to voice concerns and possible solutions. If each team member feels heard, communication stays open.

Shared mindset.

Establishing the first three enabling conditions will pave the way for team success. But research indicates that today's teams need something more. Distance and diversity can make CAL-MAT teams prone to the problems of “us versus them” thinking. The solution to both is developing a shared mindset among team members—something team leaders can do by fostering a common identity and common understanding.

As a normal human response, our brains use cognitive shortcuts to make sense of our increasingly complicated world, and one way to deal with the complexity of a 4-D team is to lump people into categories. But we also are inclined to view our own subgroup—whether it's our function, our unit, our region, or our culture—more positively than others, and that habit often creates tension and hinders collaboration.

Incomplete information can be prevalent in 4-D teams. Very often, certain team members have important information that others do not, because they are experts in specialized areas (ie...knowledge of equipment

or procedures or processes). That information won't provide much value if it isn't communicated to the rest of the team. After all, shared knowledge is the cornerstone of effective collaboration; it gives a group a frame of reference, allows the group to interpret situations and decisions correctly, helps people understand one another better, and greatly increases efficiency.

Digital dependence can impede or enhance information exchange. In face-to-face teams, participants can rely on nonverbal and contextual cues to provide insight into what's going on. CAL-MAT missions often employ the use of "Whats App" to disperse information to all team members who might not be in the same location or are off shift.

When we walk into an in-person meeting, for example, we can immediately sense the individual and collective moods of the people in the room—information that we use (consciously or not) to tailor subsequent interactions. Be aware when choosing words for digital communication, since it has the ability to erode the transmission of this crucial type of intelligence.

Fortunately, there are many ways CAL-MAT team leaders can actively foster a shared identity and shared understanding and break down the barriers to cooperation and information exchange. One powerful approach is to ensure that each member feels valued for their contributions toward the team's overall goals. Due to persistent efforts, team members can view the team not as "us and them" but as "we."

Teamwork has never been easy—but is well worth the effort it takes to set up and maintain a cohesive group. As our CAL-MAT team grows and the number of our missions increase, we have an opportunity to learn from each deployment. Many times, the most knowledge is gained from experiencing what does not work, and then strengthening the system with processes learned in that setting.

Thank you for being willing to put in the work to be part of a highly-functioning CAL-MAT team, knowing that our ultimate goal is to use our time and talents to serve others in the unique disaster setting.

HM: Aug 2020

Concepts excerpted from : *The Secrets of Great Teamwork*, Martine Hass; *Harvard Business Review*, (pp 70-76), June 2016. <https://hbr.org/2016/06/the-secrets-of-great-teamwork>

HOW TO COPE WITH STRESS & BUILD RESILIENCE DURING THE COVID-19 PANDEMIC

Providing care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions. How you cope with these emotions can affect your well-being, the care you give to others while doing your job, and the well-being of the people you care about outside of work. During this pandemic, it is critical that you recognize what stress looks like, take steps to build your resilience and cope with stress, and know where to go if you need help.

Recognize the symptoms of stress you may be experiencing.

- Feeling irritation, anger, or denial
- Feeling uncertain, nervous, or anxious
- Feeling helpless or powerless
- Lacking motivation
- Feeling tired, overwhelmed, or burned out
- Feeling sad or depressed
- Having trouble sleeping
- Having trouble concentrating

Know about stress-related disorders, compassion fatigue, and burnout:

Experiencing or witnessing life threatening or traumatic events impacts everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, [post-traumatic stress disorder \(PTSD\)](#)^{external icon}, or [secondary traumatic stress](#) (also known as vicarious traumatization). Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic.

Tips to cope and enhance your resilience.

- Communicate with your coworkers, supervisors, and employees about job stress.
 - Talk openly about how the pandemic is affecting your work.
 - Identify factors that cause stress and work together to identify solutions.
 - Ask about how to access mental health resources in your workplace.
- Remind yourself that everyone is in an unusual situation with limited resources.
- Identify and accept those things which you do not have control over.
- Recognize that you are performing a crucial role in fighting this pandemic and that you are doing the best you can with the resources available.
- Increase your sense of control by keeping a consistent daily routine when possible — ideally one that is similar to your schedule before the pandemic.
 - Try to get adequate [sleep](#).
 - Make time to eat healthy meals.
 - Take breaks during your shift to rest, stretch, or check in with supportive colleagues, coworkers, friends and family.
- When away from work, get exercise when you can. Spend time outdoors either being physically activity or relaxing. Do things you enjoy during non-work hours.
- Take breaks from watching, reading, or listening to news stories, including social media. Hearing about the pandemic repeatedly can be upsetting and mentally exhausting, especially since you work with people directly affected by the virus.
- If you feel you may be [misusing alcohol or other drugs](#) (including prescriptions), ask for help.
- Engage in [mindfulness techniques](#), such as breathing exercises and meditation.
- If you are being treated for a mental health condition, continue with your treatment and talk to your provider if you experience new or worsening symptoms.

Know where to go if you need help.

If you're concerned that you or someone in your household may harm themselves or someone else:

- [National Suicide Prevention Lifeline](#)
 - Toll-free number 1-800-273-TALK (1-800-273-8255)
 - The [online Lifeline Crisis Chat](#) is free and confidential. You'll be connected to a skilled, trained counselor in your area.
- [National Domestic Violence Hotline](#)
 - Call 1-800-799-7233 and TTY 1-800-787-3224

If you feel overwhelmed with emotions like sadness, depression, or anxiety:

- [Disaster Distress Helpline](#)
 - Call 1-800-985-5990 or text TalkWithUs to 66746

If you need to find treatment or mental health providers in your area:

- [Substance Abuse and Mental Health Services Administration \(SAMHSA\) Find Treatment](#)

If you want more information on coping with stress and building resilience:

- [CDC Coronavirus \(COVID-19\) Stress and Coping](#)
- [NIOSH Safety and Health Information for Healthcare Workers](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\) Disaster Preparedness](#)
- [The Joint Commission Quick Safety: Developing resilience to combat nurse burnout](#)

Reference: www.cdc.gov

SECTION 12

PULSE / ReddiNet / E-PCR

PULSE

The California EMS Authority has activated PULSE to support California's response to the COVID-19 public health emergency.

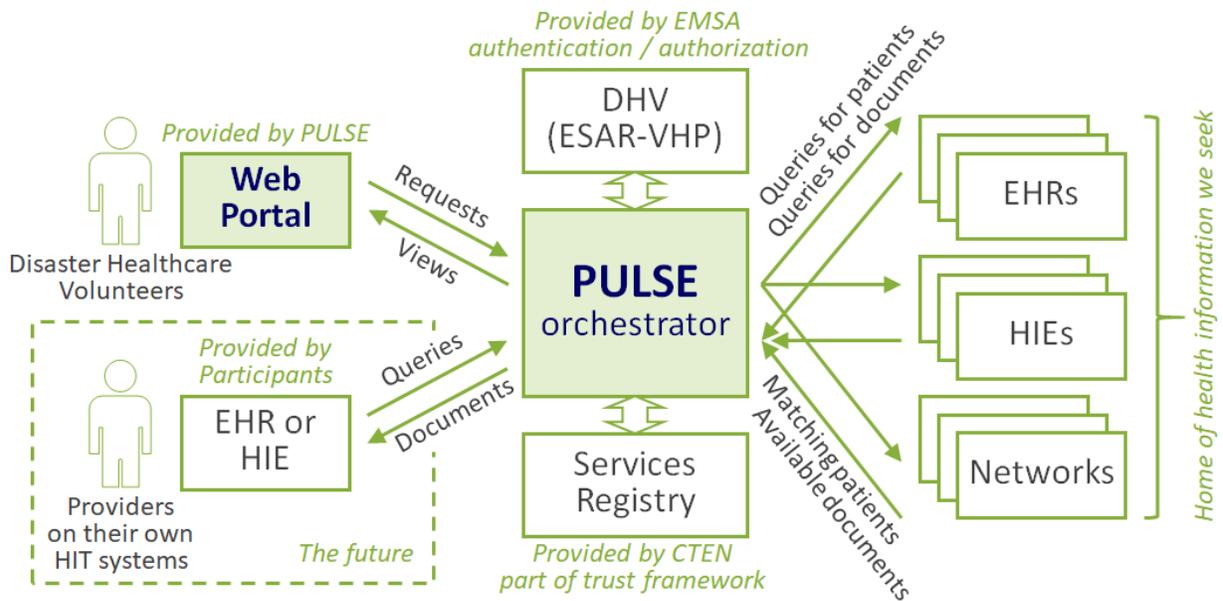
CAHIE has been collaborating with the Office of the National Coordinator for Health Information Technology (ONC) and the **California EMS Authority** (EMSA) since 2014 to identify opportunities for HIE to support emergency response. One outcome was the development of a disaster response health information portal called the **Patient Unified Lookup System for Emergencies**, or PULSE.

PULSE was developed to provide disaster healthcare volunteers with access to electronic health information during times of large-scale emergency or disaster. It is intended to support five primary use cases, which are retrieving health information for:

1. Patients evacuated from healthcare facilities in the affected area
2. Injured victims transported by first responders
3. Injured victims transported by themselves, family members, or neighbors
4. Walking wounded presenting with minor injuries requiring treatment
5. Evacuees seeking primary care for chronic conditions or health issues unrelated to the disaster

Users of PULSE are granted access through the **California Disaster Healthcare Volunteers** (DHV) database, which provides a vetted registry for individuals who have volunteered to serve during an emergency or disaster. Currently, DHV authorizes licensed physicians, pharmacists, nurses, nurse practitioners, physician assistants, paramedics, and EMTs to access health information for treatment purposes.

PULSE will most often be deployed during a declared disaster to alternative care facilities, such as field hospitals or evacuation centers offering medical services. When a disaster healthcare volunteer needs health information on a victim or evacuee, PULSE connects to HIEs, health systems, and other data sources across California to search for and retrieve health information on victims and evacuees. PULSE operates as a participant on the **California Trusted Exchange Network** (CTEN), and uses the technical standards developed for the eHealth Exchange and in common use on the CTEN.



ReddiNet

ReddiNet is a service of the Hospital Association of Southern California (HASC). ReddiNet is a web-based emergency medical communications system that is used to report hospital, patient, and emergency event status. ReddiNet is used by hospitals, EMS, first responders, and other health care providers. ReddiNet helps save lives by providing critical information in emergencies.

Electronic Patient Care Record

In process

ANNEX A:

EMSA Guidelines for COVID-19 Testing



TO:	CAL-MAT Members
FROM:	Dave Duncan, MD Director
DATE:	8/6/20

Revision/Version: New	Replaces: N/A
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SUBJECT: COVID Testing for CAL-MAT

PURPOSE: To clarify when COVID testing should be done for personnel deployed at field sites

Background

COVID testing capability and capacity remain insufficient and problematic in most areas. CAL-MAT personnel are working with COVID patients and living in close proximity with one another. Questions frequently arise regarding availability of testing and directives for testing deployed health care providers.

Policy/Procedure

Testing capability

- Each deployment site should make an arrangement for testing healthcare and MST personnel through the local health department, a local medical facility, or a private laboratory.
- Attempt to arrange priority testing or rapid result testing.
- EMSA plans to establish rapid testing for COVID antigen (BD Veritor) at each site.
 - Note: Antigen tests are not as sensitive as nucleic acid amplification assays such as PCR. Thus, positive results tend to be accurate, but a negative result should be interpreted with caution, and should be considered in the context of clinical suspicion of disease and risk status of the patient. Negative results for the BD Veritor antigen test should be treated as presumptive negative.
- Negative tests using either PCR or antigen testing can be repeated serially every 2-3 days if there is high suspicion for infection or high-risk exposure.

Symptomatic CAL-MAT or other healthcare worker on site

- Any person on site of a medical mission who develops symptoms suggesting possible COVID-19 infection should be immediately isolated and tested with a PCR test from a naso-pharyngeal swab.
- Rapid antigen test can be used, if available, subject to limitations noted above.
- See *CAL-MAT COVID-19 Isolation, symptom management, notification, and return to work (Rev 7-25-20)* for management of isolated staff.

Testing Asymptomatic CAL-MAT member during deployment

Possible exposure

- Per CDC Guidance: When a confirmed case of COVID-19 is identified, interviewing and testing potentially exposed co-workers should occur as soon as possible to reduce the risk of further workplace transmission.

- If staff at a mission site are exposed to a known positive colleague, testing may be requested or mandated (in consultation with CAL-MAT Medical Director or EMSA Medical Director) for all staff as a condition of on-going employment
- CAL-MAT receive worker's compensation and occupational health benefits as well as continued housing and support during isolation (See Isolation policy below)
- Staff with very high exposure risk should be quarantined while awaiting test results (prolonged close contact without face masks, e.g., roommate, close contact for prolonged periods without wearing masks)
- Other staff with casual contact wearing masks may be allowed to continue work while awaiting testing.
- See
 1. CDC guidance for risk assessment *Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19*
 2. *Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified*
 3. and testing strategy flow diagram from CDC

<https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/Testing-Strat-flow-diagram.pdf>

Other request for testing during deployment

- EMSA will arrange testing for a CAL-MAT or other employee on site who requests testing due to concerns of exposure
- Employees who request testing for other personal reasons should be directed to local resources for testing at their expense

CAL-MAT testing on deployment

- EMSA/CAL-MAT will not perform routine testing on deployment.
- This is not possible due to frequent urgency of deployment
- When antigen tests are available at all sites, this can be considered as an option, but there is no requirement at this time.
- This is consistent with other acute care healthcare sites.

CAL-MAT testing on demobilization

- Testing on demobilization from a CAL-MAT mission should be offered to employees.
- However, there are multiple limitations to this policy, since testing may not be readily available on-site and results may not be rapidly available.
- CAL-MAT members who have concern about returning to their household or other site of employment may use the State Quarantine Program, which offers paid hotel accommodations for up to 14 days (or until test results have returned). Hotel site can be near the site of EMSA deployment or near the employee's home.
- <https://covid19.ca.gov/hotel-rooms-for-california-healthcare-workers/>
- Salary is not paid during quarantine, but would be paid during the isolation period, if the test comes back positive.

The following individuals can perform NP swabs (per CDPH)

- EMTs and paramedics are authorized by the Director of the California Emergency Medical Services Authority to collect nasopharyngeal swabs only for COVID-19 testing and only for the duration of the COVID-19 emergency. Additional information about the local option scope of practice allowing them to do this is available on the California Emergency Medical Services Authority webpage.

- Registered nurses can collect specimens using nasopharyngeal or oropharyngeal swabs.
- Respiratory care practitioners are authorized under their scope of practice to collect specimens using swabs, including NP and OP swabs.
- Nasopharyngeal or oropharyngeal swab collection is within the scope of practice for a licensed vocational nurse (LVN) as long as the LVN:
 - Receives specialized instruction in the proper procedure from a registered nurse or licensed physician;
 - Demonstrates the requisite knowledge, skills and ability prior to performance of the procedure; and
 - Performs the procedure in accordance with a licensed physician's order.

Resources, Links, and Attachments

EMSA/CAL-MAT policy: CAL-MAT COVID-19 Isolation, symptom management, notification, and return to work (Rev 7-25-20)

Cal-FIRE-EMSA policy for COVID antigen testing

Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>

Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified <https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html>

Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case is Identified <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/Testing-Strat-flow-diagram.pdf>

Hotel Rooms for California Health Care Workers <https://covid19.ca.gov/hotel-rooms-for-california-healthcare-workers/>

Program eligibility

To be eligible for this program, you must:

- Work in a California healthcare facility, including:
 - Medical transport providers and non-medical staff within health care facilities
 - Workers in California's Health Corps or CAL MAT, as designated by the State
 - Correctional facility staff
 - First responders
- Have presumed exposure to COVID-19
 - This facility needs to be documented by a state or county public health official or medical professional to house COVID-19 positive patients
 - Or healthcare workers who test positive for COVID-19 but do not require hospitalization
- Be unable to self-isolate or quarantine at home

How to reserve a room

- Call [1-877-454-8785](tel:1-877-454-8785) to complete a screening process. Do not share personal health information.
- Show your healthcare facility employee identification at check-in.
- Provide a credit card or another form of deposit at check-in.
- The Program does not include extra services from the hotel, such as food, room service, valet, parking, or laundry. You will be responsible for incidentals.

BD Veritor System instructions for use <https://www.fda.gov/media/139755/download>

CAL-MAT SARS-CoV-2 (COVID-19) Antigen Testing Patient Log Sheet

Test Kit		Patient Name/Result		Personnel Initials
Date	Lot #	Expiration	(Circle One)	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	
			<div style="text-align: center;"> <input type="checkbox"/> POSITIVE <hr style="border-top: 1px dotted black;"/> <input type="checkbox"/> NEGATIVE </div>	

**EMERGENCY MEDICAL SERVICES AUTHORITY
SARS-CoV-2 (COVID-19) Molecular Abbott ID Now Testing Patient Log Sheet**

Test Kit		Patient Name/Result		Personnel Initials	Public Health Notified? If yes, which County?
Date	Lot #	Expiration	(Circle One)		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		
			<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE		

ANNEX B: COVID-19 Patient Discharge Instructions

Home Quarantine/Isolation Recommendations

Name: _____

Date _____

Home quarantine is recommended because:

- You have been diagnosed with COVID-19

This means:

- Do not go to work, school or public areas where others are present which includes the grocery store.
- Avoid traveling and do not use public transport, including ridesharing.
- Avoid places where you can come into contact with others.
- Restrict activities outside your home, except for getting medical care
 - Call ahead if you need to seek medical care
- You may take walks outside as long as you practice social distancing which means do not come in contact with others within 6 feet and wear a facial covering.
- Separate yourself from other people and animals in your home. Refer below for specific recommendations. Monitor yourself for symptoms, fever of ≥ 100.0 , cough, shortness of breath.

Duration of home quarantine or home isolation

Close contacts must be in home quarantine for 14 days after the last contact with the patient diagnosed with the virus.

Home isolation for symptomatic individuals needs to be continued until:

1. At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); and,
2. At least 10 days have passed since symptoms first appeared.

Home isolation for asymptomatic individuals needs to be continued until:

1. At least 10 days have passed since the date of specimen collection of the first PCR-positive test.

Steps to prevent spread to people in your home

- Choose a room in your home that can be used to separate quarantined members from those who are healthy.
- Identify a separate bathroom for the quarantined person to use, if possible, and clean frequently.
- Avoid close contact with family members
 - Social distancing – 6 feet
 - Wear surgical mask when around family.
 - The purpose of this is to minimize the spread of droplets from any cough or sneeze to surfaces or to others.

- You may improvise by using a bandana or homemade mask if no masks are available.
- Use proper respiratory cough etiquette.
 - Cover cough/sneezes with a tissue or your elbow, not into your hand.
 - Single use of tissues and dispose of in a lined trash can.
- Frequently clean touched surfaces and objects daily (e.g., tables, countertops, light switches, doorknobs, and cabinet handles) using a household disinfectant.
 - If surfaces are dirty, they should be disinfected. (Bleach or other household products).
- Use proper hand hygiene.
 - Wash your hands often with soap and water for at least 20 seconds. (Before and after eating, after going to the bathroom and sneezing or coughing).
 - If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol.
 - Always wash your hands with soap and water if your hands are visibly dirty.
- Animals- When possible have another member of your household care for your animals.
 - If you must care for your pet or be around animals, wash your hands before and after you interact with them and wear a surgical mask.

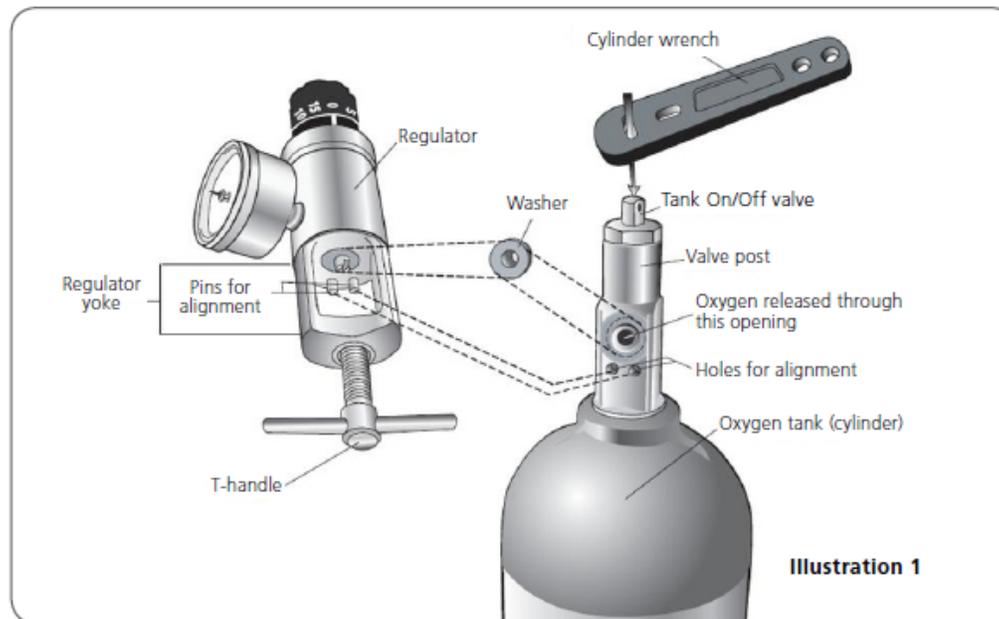
For further information please go to the Centers for Disease Control and Prevention at www.cdc.gov

Resources for Home:

<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/index.html>

Portable Oxygen Cylinders

Training and Safety Guidelines



For your safety

It is very important to understand that oxygen can be dangerous if not used correctly. Oxygen makes things burn more easily and can even explode. Following these safety guidelines will help reduce potential risks. See the manufacturer website for more information about your equipment.

- Post the *Oxygen in Use* sign that comes in your oxygen kit where visitors can see it.
- Keep your oxygen tanks (cylinders) away from all heat sources, including radiators, heat ducts, stoves, fireplaces, matches, and lighters.
- Do not permit open flames, sparks, or burning tobacco in the room where oxygen is being used.
- Use only as prescribed by your physician.
- While using oxygen, do NOT use:
 - Aerosols such as hair spray or paint
 - Oil-based face creams or lotions on your nose or face
 - Petroleum-based products such as Vaseline
- Keep the cylinder you are using in a stand or cart.
- Store extra cylinders lying on their sides. Block them so they do not roll around. If the valve post were to break off of a cylinder, it could cause considerable harm to anything in its path.

- Always keep oxygen cylinders in a well-ventilated area because it is normal for small amounts of oxygen to leak. Do not store cylinders in a closet unless there is a vent in the closet door. If you keep cylinders under the bed, make sure the covers do not interfere with the air circulating.

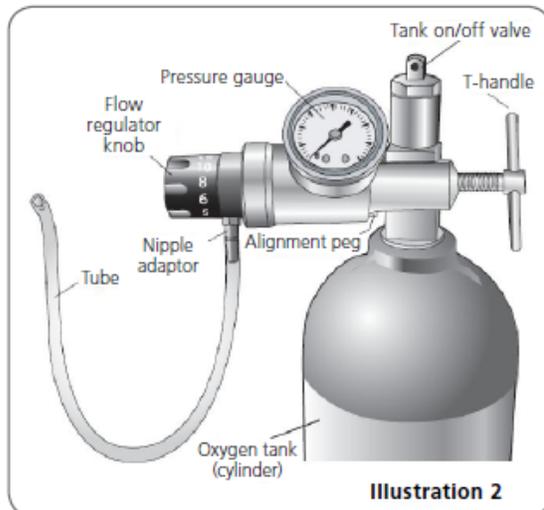


Illustration 2

How to use oxygen cylinders

- 1 Be sure the flow regulator knob is set at zero (see *illustration 2*).
- 2 Make sure the T-handle is tight.
- 3 Place the cylinder wrench on the cylinder's on/off valve, located at the top of the cylinder.
- 4 Open the valve by turning it counter-clockwise one full turn. As the valve opens, the gauge on the regulator will show the amount of pressure in the cylinder. A full cylinder will read about 2000 psi (pounds per square inch).
- 5 Adjust the flow regulator knob to the flow rate your doctor prescribed.
- 6 Attach tubing to the nipple adaptor on the regulator.

How to use the nasal cannula

You will receive an oxygen kit that has two lengths of tubing, a connector, and nasal cannulas. You'll use a nasal cannula to breathe the oxygen. The cannula is a narrow tube with soft prongs that are placed in the nostrils. Be sure to place the prongs in your nostrils with the curve facing down.

- Change your cannula every 2–4 weeks to avoid infection. Also change it after you've been sick.
- Change your oxygen tubing every 3–6 months. If it's damaged, change it right away.

When to change your oxygen cylinder

Check your pressure gauge often to make sure you don't run out of oxygen (see the *Cylinder Use Timeline* on page 4). Always check the gauge when the valve is turned on. When the needle gets to the lower part of the red section on the gauge, it is time to change the cylinder. Be sure to change the cylinder before the needle gets below 200 psi.

It is important to keep a sufficient supply of full cylinders in your home in case of an emergency. Intermountain Homecare & Hospice will supply you with enough oxygen cylinders to last 1 month. Call to order more cylinders when your supply gets down to two cylinders or about 20% of the amount you received at your first delivery.

How to change your oxygen cylinder

Turn off the oxygen flow

- 1 Using the small cylinder wrench, turn the cylinder on/off valve clockwise to close it.
- 2 Bleed off the pressure in the valve by opening the flow regulator knob.
- 3 When the gauge reads zero, turn the flow regulator knob to zero.

Change the cylinder

- 1 Remove the regulator by loosening the T-handle.
- 2 Slide the pegs out of the holes on the valve post and remove the regulator.
- 3 Remove the tab from the valve post on the new cylinder (see *illustration 1*).
- 4 Make certain there is a washer on the large post on the regulator.
- 5 Attach the regulator to the cylinder by slipping the regulator over the valve post of the cylinder.
- 6 Align the pegs located on the inside of the regulator yolk with the holes in the valve post.
- 7 Slide the regulator forward so the pegs go into the holes (see *illustration 1*).
- 8 Turn the T-handle on the regulator until it is tight. If the handle is not tight enough or if the washer is not in place, the cylinder will leak when the valve is opened (see *illustration 2* for proper placement).

Turn on the oxygen flow

Be sure that the flow regulator knob is set to zero.

- 1 Make sure the T-handle is tight.
- 2 Place the cylinder wrench on the cylinder's on/off valve, located at the top of the cylinder.
- 3 Open the valve by turning it counter-clockwise one full turn. As the valve opens, the gauge on the regulator will show the amount of pressure in the cylinder. A full cylinder will read about 2000 psi (pounds per square inch).
- 4 Adjust the flow knob on the regulator until the gauge reaches the flow rate your doctor prescribed.
- 5 Attach tubing to the nipple adaptor on the regulator.

How to travel with your oxygen cylinders

- Secure oxygen cylinders in your vehicle so they do not roll or bump against other cylinders or objects.
- Crack a window in the vehicle to increase ventilation.
- Keep cylinders out of direct sunlight.
- Do not store cylinders in the trunk of a vehicle.
- If you will be traveling outside of our service area for an extended amount of time, please call us. We will help you coordinate appropriate oxygen services while you travel.

Call your doctor if...

- You think the amount of oxygen you are receiving should be changed.

Call Intermountain Homecare & Hospice if...

- You experience any problems with your oxygen equipment.

If you are observed in violation of any of these oxygen safe use guidelines, Intermountain Homecare & Hospice reserves the right to discontinue your oxygen services for your safety and the safety of those around you.

Oxygen Cylinder Use Timeline

	Flow Rate	Full Tank 2000 PSI	¾ Tank 1500 PSI	½ Tank 1000 PSI	¼ Tank 500 PSI
M - Cylinder	1/32	76 days	56 days	38 days	18 days
	1/16	38 days	28 days	19 days	9 days
	1/10	24 days	18 days	12 days	6 days
	1/8	19 days	14 days	9.5 days	4.5 days
	1/4	9.5 days	7 days	4.5 days	2 days
	1/2	4.5 days	3.5 days	2 days	1 day
	1	2.4 days	43 hours	28.75 hours	14 hours
E - Cylinder	1/10	100 hours	75 hours	50 hours	25 hours
	1/8	83 hours	62 hours	41 hours	20 hours
	1/4	41 hours	30 hours	20 hours	10 hours
	1/2	20 hours	15 hours	10 hours	5 hours
	1	13 hours	9 hours	6 hours	3 hours
	2	5 hours	3.5 hours	2.5 hours	1.1 hours
	3	3.4 hours	2.3 hours	1.5 hours	0.7 hours
	4	2.5 hours	1.75 hours	1.1 hours	0.5 hours
D - Cylinder	1/32	160 hours	96 hours	64 hours	48 hours
	1/16	80 hours	48 hours	32 hours	24 hours
	1/10	50 hours	30 hours	20 hours	15 hours
	1/8	40 hours	24 hours	16 hours	12 hours
	1/4	23 hours	17 hours	12 hours	6 hours
	1/2	11 hours	9 hours	6 hours	3 hours
	¾	8 hours	6 hours	4 hours	2 hours
	1	5 hours	3 hours	2 hours	1.5 hours
	2	2.5 hours	1.5 hours	1 hour	0.75 hours
C - Cylinder	1/32	80 hours	60 hours	40 hours	20 hours
	1/16	40 hours	30 hours	20 hours	10 hours
	1/8	20 hours	15 hours	10 hours	5 hours
	1/4	11.5 hours	8.6 hours	5.6 hours	2.8 hours
	1/2	5.5 hours	4.1 hours	2.75 hours	1.4 hours
	1	2.5 hours	1.9 hours	1.25 hours	0.63 hours
	2	1.25 hours	0.95 hours	0.75 hours	0.31 hours
	3	0.75 hours	0.56 hours	0.38 hours	0.2 hours

This chart shows about how long a cylinder will last if you use your oxygen all the time. Use this chart to help you plan when to order more cylinders.

Instructions for patients with cough or trouble breathing:

Instrucciones para pacientes con tos o dificultad para respirar:

Please try to not spend a lot of time lying flat on your back! Laying on your stomach and in different positions will help your body to get air into all areas of your lung.

¡Por favor, trate de no estar mucho tiempo acostado sobre su espalda (boca arriba)! Acostarse sobre su estómago (boca abajo), y en diferentes posiciones, le ayudará a su cuerpo a que le llegue aire a todas las áreas de sus pulmones.

Your healthcare team recommends trying to change your position every 30 minutes to 2 hours and even sitting up is better than laying on your back. **If you are able to, please try this:**

El grupo de sus cuidadores de salud le recomienda tratar de cambiar de posición entre cada 30 minutos y 2 horas, y aún permanecer sentado es mejor que estar acostado de espalda. **Si puede, por favor, intente esto:**

1. 30 minutes – 2 hours: lying on your belly
30 minutos – 2 horas: acostado sobre su estómago (boca abajo)
2. 30 minutes – 2 hours: lying on your right side
30 minutos – 2 horas: acostado sobre su lado derecho
3. 30 minutes – 2 hours: sitting up
30 minutos – 2 horas: sentado
4. 30 minutes – 2 hours: lying on your left side; then back to position #1.
30 minutos – 2 horas: acostado sobre su lado izquierdo; y luego vuelva a la posición # 1

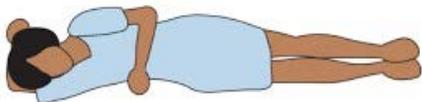
PHOTOS BELOW TO DEMONSTRATE THIS:

LAS FOTOS DEBAJO DEMUESTRAN ESTO:

1. 30 minutes – 2 hours: laying on your belly
1. 30 minutos – 2 horas: acostado sobre su estómago (boca abajo)



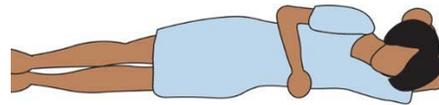
2. 30 minutes – 2 hours: laying on your right side
2. 30 minutos – 2 horas: acostado sobre su lado derecho



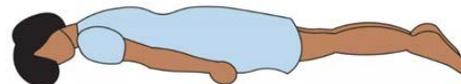
3. 30 minutes – 2 hours: sitting up
3. 30 minutos – 2 horas: sentado



4. 30 minutes – 2 hours: lying on your left side
4. 30 minutos – 2 horas: acostado sobre su lado izquierdo



Then back to Position 1. Lying on your belly!
Luego, vuelva a la posición 1. ¡Acostado sobre su estómago (boca abajo)!



Self Positioning Guide_ElmhurstHospital_SB



Tuesday Tips

Incentive Spirometer Basics



Using an incentive spirometer helps prevent lung issues. They come in different shapes & sizes but their function is the same. Below are the basics on how to use them.

- 1 Sit up tall** holding the incentive spirometer upright and seal your lips tightly around the mouthpiece
- 2 Breathe in** slowly and deeply. Hold your breath as long as possible. Then exhale slowly and allow the piston to fall to the bottom of the column.
- 3 As you inhale, notice the yellow indicator** rise and reach the blue outlined area. Position the yellow indicator at the side of the spirometer to show your best effort. Use the indicator as a goal to work toward during each slow deep breath
- 4 Repeat** the process 10 times an hour.
Note, after each set of 10 deep breaths, **cough** to be sure your lungs are clear. If you have an incision, support your incision when coughing by placing a pillow firmly against it.

ANNEX C: Order Sets and Forms

Basic Admission Orders for an Alternate Care Site

Patient Name:	ACS Site:
Date:	Allergies:
Time:	DOB:

Diet:

Regular Low Fat Low Salt Diabetic Carb Control Pureed Chopped Bland
Other: _____

Vital signs (including SpO₂) on admission and:

- Daily – BID (0700, 1900) TID (0700, 1600, 2100) QID (0600, 1100, 1600, 2100)
 SpO₂ Q_____hr While awake Around the clock
 Call medical provider for HR <50, or >120, BP < 90/60, or BP > 160/100 RR<8 or>30, SpO₂<90 on RA, T>100.4° (if prev. afebrile).
 Notify provider for change in systolic BP > 40 mmHg with symptoms, including positive orthostatic vitals

Activity

- Out of Bed to Chair Bathroom Privileges Ambulate with Assistance
 Ambulate with assist Ambulate as tolerated Ambulate with walker/cane

Wound Care: assess and treat as per physician order

- Not Applicable
 Frequency: _____
 Directions: _____

Respiratory / Physical Therapy:

- Respiratory Therapy to perform baseline assessment upon admission – *titrates O₂ to keep SaO₂ ≥ 92%*
 Notify medical provider on call if O₂ Saturation < 92% or if more than 6 liters required to maintain ≥ 92%
 Albuterol MDI 2 puffs Q6hr prn (while awake)
 Atrovent MDI 2 puffs Q6hr prn (while awake)

 Physical Therapy to perform baseline assessment upon admission

Labs

- Blood glucose level via finger stick:
 Before meals After Meals Bedtime
 If prior or current steroid use – discontinue blood sugar testing 2 days after if BS < 200 and notify medical provider

Additional Orders:

- _____
- _____
- _____

Provider Printed Name

Provider Signature

RN Printed Name

RN Signature

Medication Order Sheet

Patient Name:	ACS Site:
Date:	Allergies:
Time:	DOB:

COVID Specific Medications:

Steroids:

- Decadron 6 mg po qd Start Date: _____ Discontinue Date: _____
- Methylprednisolone 32 mg po qd Start Date: _____ Discontinue Date: _____

DVT Prophylaxis:

- Lovenox 40 mg SQ qd (*Body Mass Index (BMI) <40*)
- Eliquis 2.5 mg po BID (*BMI < 40*)

Multivitamins:

- Zinc Sulfate 220 mg po qd
- Vitamin C 1000 mg po qd

PRN Medications:

- Robitussin DM 1 teaspoon q6hr PRN cough
- Benzonatate 100 mg perles – 1 tab PO TID prn for cough
- Zofran 4mg po q4hr prn nausea / vomiting
- Diarrhea: Administer Loperamide 2 mg 2 tabs PO with onset of diarrhea, and then administer 1 PO with each subsequent diarrheal event. No more than 16 mg per day. Call on-call clinician if unremitting.
- Senokot 8.6 mg po q hs prn constipation
- Milk of Magnesia (MOM) 30ml PO q AM prn persistent constipation. Notify clinician if no BM in 3 days post administration.
- Headache/Mild Pain/Temperature:
 - o Administer Acetaminophen 325 mg 2 tabs po q4hrs prn HA/mild pain/temperature >100.4 and **DO NOT EXCEED** 3000 mg per day
 - o ****Call Clinician for severe pain or temperature over 101.5F***
- Epigastric pain: Administer Calcium Carbonate 2 tabs q2hr prn
- Insomnia:
- Pruritis
 - o Administer Diphenhydramine 25 mg po q6h prn severe itching
 - o Administer Hydrocortisone cream 1%, to apply to affected skin BID prn mild/moderate itching
- Other

Provider Printed Name: _____ Provider Signature: _____ Date: _____ Time: _____

RN Printed Name: _____ RN Signature: _____ Date: _____ Time: _____

Drug Protocols for COVID-19: Brigham and Women's Hospital <https://covidprotocols.org/protocols/therapeutics/> Dexamethasone: <https://www.medrxiv.org/content/10.1101/2020.06.22.20137273v1> Oxygen Therapy: <https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-ta-oxygen-therapy.pdf>
 DELIVERING ACUTE CARE TO CHRONICALLY ILL ADULTS IN SHELTERS-Fundamentals of Disaster Medicine, SCCM. Asha Devereaux, MD, MPH, Suzanne M. Burns RRT, ACNP, CCRN, FCCM, Robert Gougelet, MD

COVID-19 ACS Respiratory Medications

Benzonatate 100mg 1-2 tablets orally q 8h prn severe cough

Albuterol via MDI: 2 puffs every 6h prn cough spasms or wheezing usually in a patient with prior asthma or COPD diagnosis

- Ok to use if HR<120bpm
- Ask patients / families to bring in their home inhalers if possible or obtain refill from their pharmacy.

Dexamethasone 6mg p.o. once/daily for up to 10 days

- OK to use in patients with fever, receiving oxygen, pulmonary infiltrates c/w COVID19, and no contraindications
- Averaged 6d

Due to shortage of dexamethasone, alternative options include:

- Dexamethasone 6mg IV or PO daily x 10 days;
- Hydrocortisone 50mg IV Q8h x 10 days;
- Methylprednisolone 15mg IV BID x 10 days;
- Prednisone 40mg PO daily x 10 days

Remdesivir a nucleotide prodrug metabolized to an analog of adenosine triphosphate, which inhibits viral RNA-dependent RNA polymerase, 200 mg IV loading dose, followed by 100 mg IV daily for a total of 5-10 days. Watch for elevated liver function tests (AST, ALT), phlebitis, constipation, headache, nausea (this will most likely have been initiated or administered in the hospital setting and transferred to you).

Monoclonal Antibodies; Bamlanivumab:

Monoclonal antibodies are laboratory-made proteins that block the virus from infecting cells. In preliminary studies, the treatment also appears to reduce levels of the virus that causes COVID-19 in patients. While, the effectiveness of monoclonal antibody treatment continues to be evaluated, an emergency use authorization for bamlanivimab was granted for patients 12 years of age and older who are positive for COVID-19 and are at high risk for progressing to severe COVID-19 and/or hospitalization. This includes patients who are 65 or older or who have certain chronic medical conditions. It is not authorized for patients hospitalized due to COVID-19 or those requiring supplemental oxygen therapy or increase in baseline oxygen therapy due to COVID-19

Patient INCLUSION CRITERIA (Must meet ALL criteria from A-LIST and AT LEAST one (1) criteria from B-LIST.

A-LIST (Must meet all criteria in this list)

1. Age \geq 12
2. Weight \geq 40kg
3. Outpatient (ie. not requiring hospitalization)
4. Not requiring supplemental oxygen therapy due to COVID-19
5. Mild/Moderate symptoms with symptom onset within the last 10 days - including at least three (3) of the following symptoms:
 - a. T>100.4 °F or chills
 - b. Cough
 - c. Shortness of Breath
 - d. Muscle aches
 - e. Headaches

- f. New loss of tast or smell
- g. Sore throat
- h. Congestion or Runny Nose
- i. Nausea or vomiting
- j. Diarrhea

B-LIST (Must include at least one (1) from this list)

1. If within the ages of 12 – 17 years old, would need to have one of the following:
 - a. BMI \geq 85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm,
 - b. sickle cell disease, OR
 - c. congenital or acquired heart disease, OR
 - d. neurodevelopmental disorders, for example, cerebral palsy, OR
 - e. a medical-related technological dependence, for example, tracheostomy, gastrostomy,
 - i. or positive pressure ventilation (not related to COVID-19), OR
 - f. asthma, reactive airway or other chronic respiratory disease that requires daily medication for control.
 1. BMI \geq 35
 2. Chronic kidney disease
 3. Diabetes
 4. Immunosuppressive disease *See Definition below.
 5. Currently receiving immunosuppressive treatment *See Definition below.
 6. \geq 65 years of age
2. Are \geq 55 years of age AND have
 - a. Cardiovascular disease, OR
 - b. Hypertension, OR
 - c. Chronic obstructive pulmonary disease/other chronic respiratory disease, OR
 - d. Healthcare Workers: (Highest Risk: front line clinical staff who care for patients in high risk settings (e.g. ED, ICU, urgent care, respiratory therapists, anesthesiologists, lab, etc.)

*An immunocompromised host who has an immunosuppressive disease is a patient who does not have the ability to respond normally to an infection because of an impaired or weakened immune system.

Qualifying examples include but is not limited to:

1. Active cancer diagnosis with therapy ongoing.
2. Unmanaged HIV disease.
3. Transplant patient on immunosuppressant medications.
4. Autoimmune or rheumatic conditions undergoing active immunosuppressant treatment.
5. Inherited immune deficiency disorders.
6. Patient taking immunosuppressive medications (examples include):
 - a) Chronic, high dose corticosteroid therapy (\geq 20 mg/day or equivalent $>$ 1 month)
 - b) Azathioprine (Imuran)
 - c) Mycophenolate mofetil (Cellcept)
 - d) Cyclosporine (Neoral, Sandimmune, Gengraf)
 - e) Methotrexate (Rheumatrex)
 - f) Leflunomide (Arava)
 - g) Cyclophosphamide (Cytosan)
 - h) Chlorambucil (Leukeran)
 - i) Nitrogen mustard (Mustargen)

**California Emergency Medicals Services Authority
CAL-MAT Daily Nurse's Notes**

Date:		Triage Tag #:
Name:		Patient ID #:
CARDIOVASCULAR	0700 - 1900	1900 - 0700
1. Heart Rate/Rhythm 2. Peripheral Pulses/Edema 3. Skin Color/Capillary Refill		
RESPIRATORY		
1. Breath Sounds 2. Secretions 3. O2 (Type)		
GASTROINTESTINAL		
1. Description 2. Bowel Sounds 3. Stools: Characteristics		
GENITOURINARY		
1. Urine: Characteristics 2. Foley 3. Discharge		
NEUROLOGICAL		
1. Orientation/LOC 2. Perla 3. Parasthesia/Weakness		
MUSCULOSKELETAL		
1. Mobility/ROM 2. Joint Swelling		
HEENT		
1. Inflammation 2. Discharge 3. Mucus Membranes		
ITEGUMENTARY		
1. Rash 2. Lesions 3. Pressure Ulcer 4. Turgor		
PSYCHOSOCIAL NEEDS		
1. Level of Anxiety 2. Social Interactions		
PAIN (0 -10) Comfort Goal		

**California Emergency Medicals Services Authority
CAL-MAT EKG / LAB Results**

Name:	Triage Tag #:
Date:	Patient ID #:

Place all printed lab and EKG strips in area below

SHRED AT END OF SHIFT AFTER DOCUMENTATION, DO NOT PLACE IN CHART

Daily Worksheet

Date: _____ Bed # _____ (circle one) Day Shift Night Shift

VS (q4 hrs or MD order)	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials
Temperature	C°	C°	C°	C°	C°	C°
Pulse	bpm	bpm	bpm	bpm	bpm	bpm
Respiratory Rate	bpm	bpm	bpm	bpm	bpm	bpm
Blood Pressure	/	/	/	/	/	/
Oxygen Sat	%	%	%	%	%	%
Room Air (RA)/Nasal Canula (NC)						
Pain level or concern?						
Glucose Check	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials
Measurement	mg/dL	mg/dL	mg/dL	mg/dL	mg/dL	mg/dL
Input & Output	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials
Toileting check (approx. q2 hrs)						
Bowel movement						
BM Notes (color, consistency)						
Urine at bathroom						
Catheter bag emptied						
Urine Notes (amount, color, odor)						
Brief change (note BM or urine above)						
Personal Care	Time/Initials	Notes	Time/Initials	Notes	Time/Initials	Notes
Bed bath/shower (QD)						
Linen change (QD)						
Hair/skin care						
Nail/foot care						
Oral/denture care (QD)						
Perineal care						
Gown/clothing change (QD)						
Meals	Time/Initials	Independent?	Assisted?	% Food eaten	Fluid intake (oz)	Fluid type
Breakfast				%	oz	
Notes						
Lunch				%	oz	
Notes						
Dinner				%	oz	
Notes						
Other liquid intake notes						
Activity	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials	Time/Initials
Reposition (q 2hr) or						
Patient ambulation						
Distance	ft	ft	ft	ft	ft	ft
Up to chair						
Time in chair	min	min	min	min	min	min
Active/passive ROM						
Notes for ROM						
Facility activity						
Activity description						

ACS Medication Administration Record

ACS Site: _____

Patient Name:	Provider:	Month:	Year:
ALLERGIES:			

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Initials	Signature	Initials	Signature	Initials	Signature

Prescription Blanks

FOR _____

ADDRESS _____ DATE _____

℞

REFILL _____ TIMES

DO NOT SUBSTITUTE _____ M.D. _____ SUBSTITUTION PERMISSIBLE _____ M.D.

DEA NO. _____ ADDRESS _____

BioRx Labs 1-888-550-5452

FORM NO. PD5000

FOR _____

ADDRESS _____ DATE _____

℞

REFILL _____ TIMES

DO NOT SUBSTITUTE _____ M.D. _____ SUBSTITUTION PERMISSIBLE _____ M.D.

DEA NO. _____ ADDRESS _____

BioRx Labs 1-888-550-5452

FORM NO. PD5000

FOR _____

ADDRESS _____ DATE _____

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FOR _____

ADDRESS _____ DATE _____

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REFILL _____ TIMES

DO NOT SUBSTITUTE _____ M.D. _____ SUBSTITUTION PERMISSIBLE _____ M.D.

DEA NO. _____ ADDRESS _____

BioRx Labs 1-888-550-5452

FORM NO. PD5000



STANDARD PRECAUTIONS



(If you have questions, ask nursing staff)

Everyone Must:



Clean hands when entering and leaving room

Cover mouth and nose with arm or tissue when coughing or sneezing

Wear gown, glove, and face protection for any risk of body fluid contact



Doctors and Staff Must:

Wear appropriate mask, eye cover, gown and gloves if contact with body fluids likely





CONTACT PRECAUTIONS

(In addition to Standard Precautions)
(If you have questions, ask nursing staff)



Everyone Must:



Clean hands when entering and leaving room

AND



Gown and glove at door



Doctors and Staff Must:



Use patient-dedicated or disposable equipment
Clean & disinfect shared equipment



DROPLET PRECAUTIONS



(In addition to Standard Precautions)

(If you have questions ask nursing staff)

Everyone Must:



Clean hands when entering and leaving room



Wear mask

Doctors and Staff Must:

Wear eye protection with respiratory symptoms and standard precautions if contact with secretions likely.





AIRBORNE RESPIRATOR PRECAUTIONS

(In addition to Standard Precautions)



RESTRICTED VISITATION

(If you have questions, ask nursing staff)

Everyone Must:



Clean hands when entering
and leaving the room

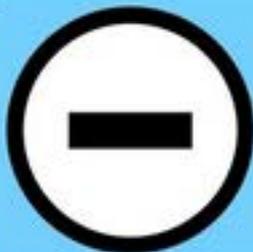
Doctors and Staff Must:



Wear CAPR/PAPR or
fitted N95 mask prior
to entering room



Patient Placement:



Airborne Infection
Isolation Room Required
(negative pressure)
Keep door closed



ANNEX E: TRAINING

CAL-MAT Infection Control Procedures Training



CALMAT Infection Control Procedures

California 2020 Covid-19 Response

Intended as training aid for CAL-MAT teams and healthcare facility staff

Revision date 5/21/20



Clean Zone

- Area with
 - ❖ NO entry of confirmed *or suspected* covid-19 patients
 - ❖ No entry by staff with dirty gown and gloves
- May include lobby, offices, break rooms
 - ❖ may be designated for donning of PPE
- At a minimum, all persons entering a healthcare facility in should wear a face mask and use hand sanitizer.

Facility Infection Control

- All employees and visitors should be screened for symptoms on entry
- Everyone must wear a mask to enter the building
- Minimize traffic between COVID negative and positive areas
 - Go clean to dirty not dirty to clean without change of PPE
- Housekeeping should wear healthcare worker minimum PPE if entering patient rooms
- If adequate staff, dietary may leave cart outside patient wing and HCWs distribute trays

Dirty (Contaminated or Infectious) Zones

- Rooms used by confirmed or suspected covid-19 patients.
- Proper PPE must be worn by healthcare workers at all times in infectious areas.

**COVID 19
TREATMENT
AREA
PROPER PPE
REQUIRED**

Non-COVID patient areas

- Unless recently and regularly tested, cannot assume patients remain negative
- Minimum PPE for healthcare workers in Non-COVID patient area
 - Surgical mask (fabric masks should not be used)
 - Gloves
 - Gown, if adequate supply
- If patient develops symptoms, should be put in single room or in separate area for PUI (Person Under Investigation--unknown status)
- Do not use same PPE between these patients, since status not known



Cohorting (Grouping) Patients

- Group patients into separate areas of the healthcare facility based on who tested positive or negative for COVID-19.
- If patients are of uncertain COVID-19 status, separation from either cohort is ideal.

COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel



Preferred PPE – Use	N95 or Higher Respirator	Acceptable Alternative PPE – Use	Facemask
Face shield or goggles	N95 or higher respirator When respirators are not available, use the best available alternative, like a facemask.	Face shield or goggles	Facemask N95 or higher respirators are preferred but facemasks are an acceptable alternative.
One pair of clean, non-sterile gloves		One pair of clean, non-sterile gloves	
Isolation gown		Isolation gown	

 [cdc.gov/COVID19](https://www.cdc.gov/COVID19)

Employees providing direct patient care should all be fit tested on N95 Respirator



See notes for reference links

Donning: Putting on PPE

DONNING



Please watch this 4 minute CDC video:
<https://www.youtube.com/watch?v=of73FN086E8>

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

DONNING PROCEDURE

1. Gown

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



Isolation gown, simple plastic gown, surgical gown, or washable cloth (optimally fluid resistant) are all effective for COVID patients

SEQUENCE FOR DONNING PPE (2)

3. MASK or RESPIRATOR

- Secure ties or elastic bands at middle of head and neck.
- Fit flexible band to nose bridge.
- Fit snug to face and below chin.
- Fit-check respirator.

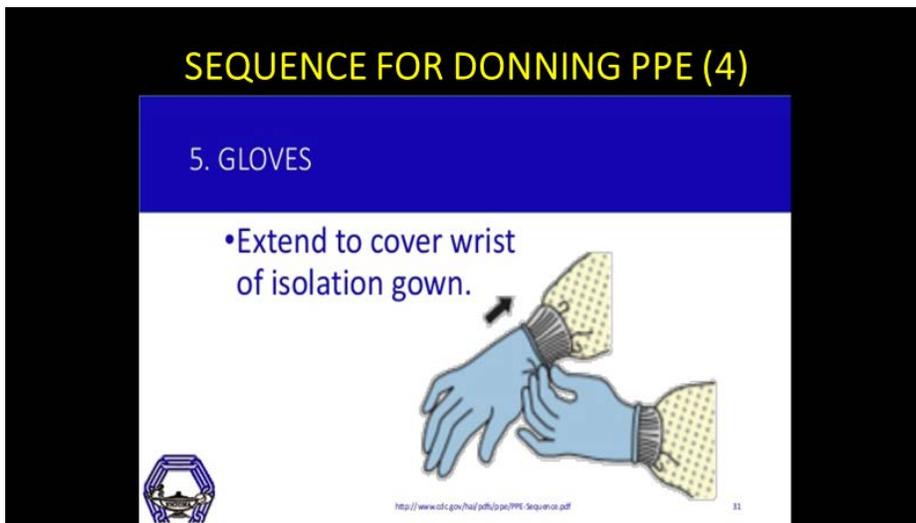


- N95 masks should be used for COVID + patients or suspect patients
- Surgical masks can be used for COVID negative wards and for other “clean” areas of facility



N95 Respirator User Seal Check

- Should be done every time the respirator is to be worn to ensure an adequate seal
- *Whether or not* you are fit tested on that model of N95
- **Negative pressure user seal check:** cover the filter surface with your hands as much as possible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.
- See NIOSH link to instructions



- ### PPE best practices: Gloves
- Single gloves protective for patient encounters
 - DO NOT tape gloves to gown
 - May double glove for “messy” jobs like cleaning up fecal matter or vomitus
 - Allows for continued care of same patient with inner gloves
 - Change gloves between patients
 - Only use for multiple patients *if severe shortage*
 - Hand hygiene during glove changes between each patient contact should include either hand washing or hand sanitizer

PPE Donning Summary

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

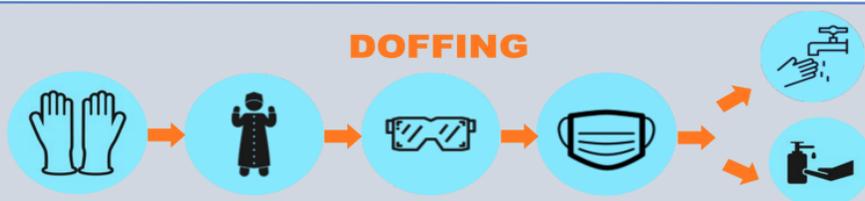


4. GLOVES

- Extend to cover wrist of isolation gown



DoFFing: Removing PPE
Should be separate from donning area



Please watch this 3 ½ minute video from the CDC:

<https://www.youtube.com/watch?v=PQxOc13DxvQ>

DoFFing Area

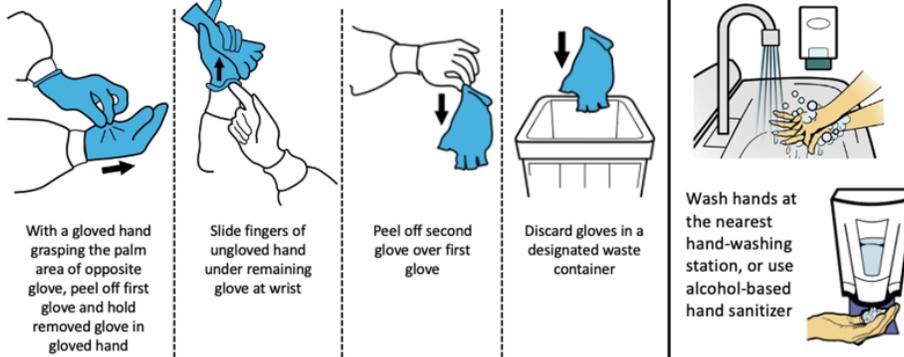
Best location at exit from patient care area
Example outside facility



Key items

- Waste bins
 - May dispose in usual waste bag
- Hand sanitizer
- Sanitizing wipes
- Boundary tarp
- Rack to hang reusable items like face shield

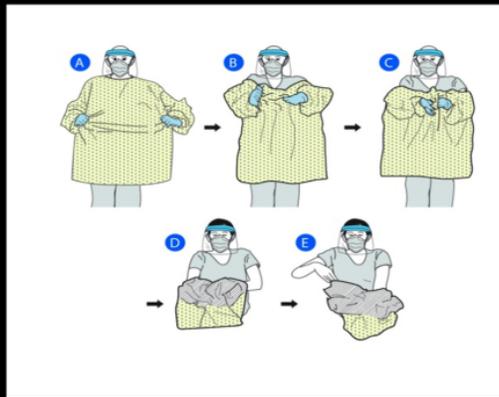
Changing or removing gloves only



Sequence for Doffing PPE (2) Gown and Gloves

Carefully remove the gown and pull off gloves as the sleeves come off. Place in the designated waste bin unless reusable cloth gown.

Red waste bag not required.



Doffing PPE (3) Face Shield or Goggles

- Carefully remove face shield or goggles by the strap
- Place in the designated waste container or set aside for cleaning with sanitizing wipe for reuse.
- If reusing, clean inside first then outside



Sequence for Doffing PPE (4)

Mask Removal

Remove your mask or respirator by grabbing the straps and pulling them forward until the mask pulls away from the face. Place the mask in the waste bin or in paper bag labeled with name for reuse .



Sequence for Doffing PPE (5) Hand Hygiene

Thoroughly wash hands with soap and water OR use alcohol-based hand sanitizer.



Procedure for effective hand hygiene

Precautions for Aerosol Generating Procedures

- Limit aerosolizing procedures
- Honor DNR status
- Consider likelihood of successful resuscitation
- Limit people in room
- Use Viral/HEPA in-line filter
- Negative pressure room, where available
- If available, use intubation hood



Strategies for extending scarce resources

- **Conventional** capacity: usual practices
- **Contingency** capacity strategies used when shortages are expected but some supplies are available.
- **Crisis** capacity strategies used during severe shortages and uncertain supply chain.
- **Currently most facilities and areas are using Contingency strategies**
- In general, **extended use if preferred over reuse** to reduce risk of self-contamination from repeated donning and doffing of same PPE

See notes for reference links



Contingency strategies for N95 and Face Masks

Extended use

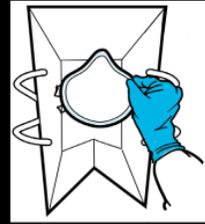
- Mask or respirator may be worn to care for multiple patients or throughout shift without donning and doffing

Re-use

- N95 can be reused for several shifts if not visibly soiled
(see next slide)
- Surgical masks should not be reused unless crisis mode

N95 Re-use

- Label mask with name prior to use
- Remove mask with clean gloves and place outer side down in plain paper bag. Label bag with name
- Facility may issue several masks to allow rotation of masks.
 - 72 hours considered limit of viability of virus on surface
- Facility may send masks to be re-sterilized.
 - California has Battelle units and contract for overnight or same day shipping
 - Masks should be labelled with HCPs initials as well as facility code

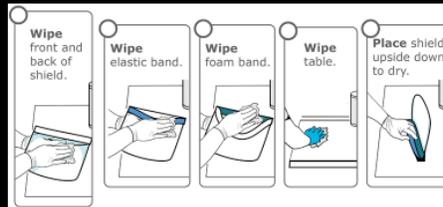


Place mask facedown into the storage bag. Avoid touching inside or outside of bag and hold mask by handles.

Face shield reuse

- May be used for multiple patients and throughout shift
- Label strap with initials or name
- After use, clean with disinfection wipe and hang on hook
- Preferably replace *disposable* shields for each shift
- May reuse multiple days as long as plastic remains clear

Note: Wipe inner surface of face shield first, then outer surface



Reuse of Gowns

- Reuse depends on supply
- Isolation or simple plastic gowns
 - ✓ Optimally change after each patient
 - ✓ May re-use for multiple patients on COVID ward if necessary
 - ✓ Do not reuse if
 - ❖ visibly soiled
 - ❖ other infections like *C. difficile* or drug resistant organisms
- Remove gowns during breaks or to work at nursing station

Nursing station should be maintained as relatively clean area on COVID unit

Remove contaminated gown and gloves to work at station

May continue to wear N95 and facemask

Perform hand hygiene prior to charting and med prep

May put on clean gloves to work at station

Perform hand hygiene after touching charts, meds, computers



Should be clean gloves and gowns



Common areas—break rooms

- Keep break rooms clean
- Remove used gown, gloves, mask
- Use hand hygiene on entry and exit
- Use facemask if not eating
- Maintain appropriate social distancing
 - ✓ Convert unused space to break areas
 - ✓ Common dining areas, gym, outdoor areas
 - ✓ Stagger break times

End of shift

- Remove ALL PPE prior to getting in car
- Better to change out of scrubs or work clothes in the facility and carry home in a bag or have facility launder
- Dedicate a pair of washable tennis shoes for work
- Shoe covers OK but remove carefully
- If scrubs worn home, remove work clothes and shoes in garage or just inside door and place in hamper for wash
- Wash in hot water and dry on hot (if fabric can tolerate)
- Chlorine and oxygen-based bleach detergents inactivate viruses.
- Shower as soon as possible

Self-monitor for COVID-19 symptoms

- Cough
 - Shortness of breath or difficulty breathing
 - Fever
 - Chills
 - Muscle pain
 - Sore throat
 - New loss of taste or smell
-
- Do not work if symptoms of illness
 - If develop symptoms during work, notify supervisor
 - CalMAT: File form (**e3301**) Potential Eligibility for Workers Comp

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

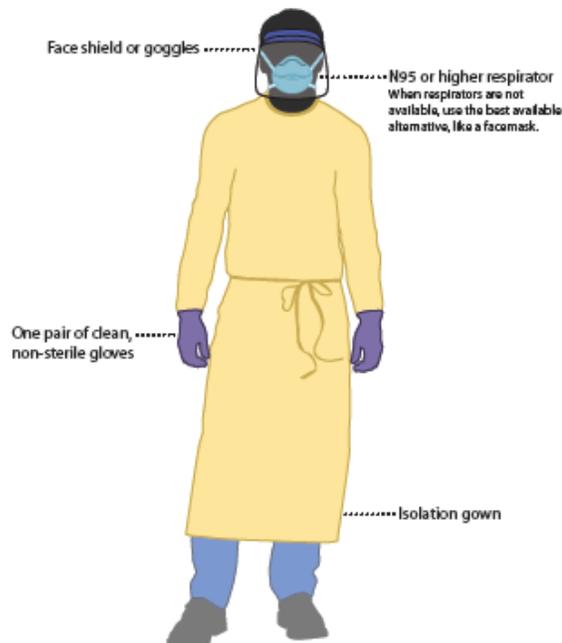
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Acceptable Alternative PPE – Use Facemask



CS316134-A 06/03/2020

www.cdc.gov/coronavirus

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

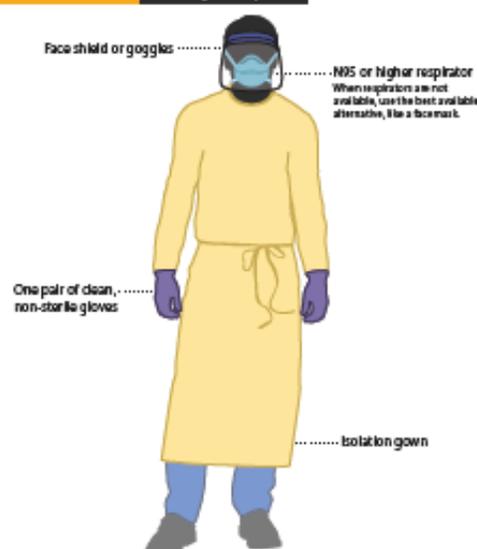
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- Receive comprehensive training on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- Demonstrate competency in performing appropriate infection control practices and procedures.

Remember:

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- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Acceptable Alternative PPE – Use Facemask



Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training).
2. Perform hand hygiene using hand sanitizer.
3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).
If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
 - Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
 - Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. Put on face shield or goggles. When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. Put on gloves. Gloves should cover the cuff (wrist) of gown.
7. HCP may now enter patient room.

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. HCP may now exit patient room.
4. Perform hand hygiene.
5. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. Remove and discard respirator (or facemask if used instead of respirator).* Do not touch the front of the respirator or facemask.
 - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
 - Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.



*Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate these practices.

Facemask Do's and Don'ts

For Healthcare Personnel

When putting on a facemask

Clean your hands and put on your facemask so it fully covers your mouth and nose.



DO secure the elastic bands around your ears.



DO secure the ties at the middle of your head and the base of your head.

When wearing a facemask, don't do the following:



DON'T wear your facemask under your nose or mouth.



DON'T allow a strap to hang down. DON'T cross the straps.



DON'T touch or adjust your facemask without cleaning your hands before and after.



DON'T wear your facemask on your head.



DON'T wear your facemask around your neck.



DON'T wear your facemask around your arm.

When removing a facemask

Clean your hands and remove your facemask touching only the straps or ties.



DO leave the patient care area, then clean your hands with alcohol-based hand sanitizer or soap and water.



DO remove your facemask touching ONLY the straps or ties, throw it away*, and clean your hands again.

*If implementing limited-reuse: Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. Folded facemasks can be stored between uses in a clean, sealable paper bag or breathable container.

Additional information is available about how to safely put on and remove personal protective equipment, including facemasks:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>.



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[cdc.gov/coronavirus](https://www.cdc.gov/coronavirus)

Respirator On / Respirator Off

When you put on a disposable respirator

Position your respirator correctly and check the seal to protect yourself from COVID-19.



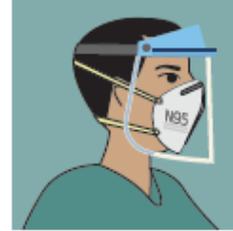
Cup the respirator in your hand. Hold the respirator under your chin with the nose piece up. The top strap (on single or double strap respirators) goes over and rests at the top back of your head. The bottom strap is positioned around the neck and below the ears.



Place your fingertips from both hands at the top of the metal nose clip (if present). Slide fingertips down both sides of the metal strip to mold the nose area to the shape of your nose.



Place both hands over the respirator, take a quick breath in to check the seal. Breathe out. If you feel a leak when breathing in or breathing out, there is not a proper seal.



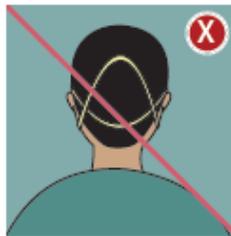
Select other PPE items that do not interfere with the fit or performance of your respirator.



Do not use a respirator that appears damaged or deformed, no longer forms an effective seal to the face, becomes wet or visibly dirty, or if breathing becomes difficult.



Do not allow facial hair, jewelry, glasses, clothing, or anything else to prevent proper placement or to come between your face and the respirator.



Do not crisscross the straps.



Do not wear a respirator that does not have a proper seal. If air leaks in or out, ask for help or try a different size or model.



Do not touch the front of the respirator during or after use! It may be contaminated.

When you take off a disposable respirator



Remove by pulling the bottom strap over back of head, followed by the top strap, without touching the respirator.



Discard in a waste container.



Clean your hands with alcohol-based hand sanitizer or soap and water.

Employers must comply with the OSHA Respiratory Protection Standard, 29 CFR 1910.134, which includes medical evaluations, training, and fit testing.

Additional information is available about how to safely put on and remove personal protective equipment, including respirators: <https://www.cdc.gov/coronavirus/2019-ncov/hq/using-ppe.html>



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Training for ACS Care

Training For Shelter Care

- On-line
- Just-in-time
- Mentoring strategies

Online Options:

Fundamentals of Critical Care course by Society of Critical Care Medicine:.

CALMAT-SD has a license for the FCCS course. We can sign up as many learners as we like and they are free to take the course at their leisure w/in an 8 week period of time. There will be a course certificate and 6.5 CME. (\$56/pp).

<https://www.sccm.org/Fundamentals/Fundamental-Critical-Care-support/FCCS-Director-Led-Courses/FCCS-Online-Licensed-Course>

Required:

- Recognition and Assessment of the Seriously Ill Patient
- Airway Management*
- Cardiopulmonary/Cerebral Resuscitation**
- Diagnosis and Management of Acute Respiratory Failure
- Mechanical Ventilation I
- Mechanical Ventilation II
- Monitoring Oxygen Balance and Acid-Base Status
- Diagnosis and Management of Shock
- Neurologic Support
- Basic Trauma and Burn Support***
- Acute Coronary Syndromes**
- Life-Threatening Infections: Diagnosis and Antimicrobial Therapy Selection
- Management of Life-Threatening Electrolyte and Metabolic Disturbances
- Special Considerations

Optional (based on services provided at institution):

- Critical Care in Pregnancy
- Ethics in Critical Care Medicine
- Critical Care in Infants and Children: The Basics

To better prepare the non-intensivist for the first 24 hours of management of the critically ill patient until transfer or appropriate critical care consultation can be arranged.

To assist the non-intensivist in dealing with sudden deterioration of the critically ill patient.

To prepare house staff for intensive care unit (ICU) coverage.

To prepare nurses and other critical care practitioners to deal with acute deterioration in the critically ill patient.

Prioritize assessment needs for critically ill and injured patients.

Select appropriate diagnostic tests.

Identify and respond to significant changes in unstable patients.

Recognize and initiate management of acute life-threatening conditions.

Determine the need for expert consultation and/or patient transfer.

[What is the Fundamental Critical Care Support Course?](#)

The Society of Critical Care Medicine's (SCCM) internationally renowned two-day Fundamental Critical Care Support (FCCS) course is the go-to resource for training non-intensivists, house staff, nurses, and other critical care practitioners how to effectively manage critically ill and injured patients. The FCCS course offers new pre- and posttests for measuring participants' growth as well as an online administrative binder, which contains the policies, processes and tools needed to offer a successful course. Individuals who successfully complete the provider or instructor course will receive a Certificate of Successful Completion.

[Why should I attend this FCCS course?](#)

The FCCS Course offers an approach to initial management of the critically ill patient for providers not formally trained in critical care. Participants will learn useful information about the extended care of critically ill patients, especially care related to mechanical ventilation, monitoring, organ hypoperfusion, and neurologic support. Providers will receive guidance for acute problems encountered in the ICU and for sudden patient deterioration. The FCCS Course content is an ideal curriculum for critical care residency training programs.

[Who is eligible to become an FCCS Instructor?](#)

FCCS Instructor applicants may become Instructors in any of the FCCS Provider courses as well as Instructor courses. The necessary credentials to become an instructor can be viewed on the FCCS web page,

ANNEX F:
Formulary

Thomas Pack

Thomas Pack ACLS Yellow Bag D1 Product Name	PK Size	Qty Per Bag	ABC #	Package Size	Total Needed Each	Packs
Atropine Sulfate inj 1mg	10ml	5	523-340	10x10ml syr.	90	9
Calcium Cl inj 10%	10ml	1	517-854	10x10ml syrg	18	2
Lidocaine HCl 1% inj	10ml	1	127-506	10x5ml syrg	18	2
Lidocaine 2% inj (100mg/5ml)	5ml	4	521-120	10X5ml syrg	72	8
Aspirin 81mg tablets	36	1	208-009	100	18	18
Glucagon for Injection 1mg w/ 1 ml	1	1	741-751	1 Kit	18	18
Sodium Bicarbonate 8.4%	50ml	2	125-724	10x50ml syrg	36	4
Epinephrine 1:10,000	10ml	6	132-431	10x10ml syrg	108	11
Dextrose 50%	50ml	2	774-604	10x50ml syrg	36	4
Epi-Pen 0.3mg	1	1	599-654	1	18	18
Magnesium Sulfate 50% (5gm/10ml)	10ml	2	518-870	10x50ml Syr	36	4
Albuterol Sulfate ampules 2.5mg/3ml	3ml	5	051-615	30x3ml UD	90	3
Diphenhydramine HCl inj 50mg/ml	1ml	2	535-740	25x1ml vl	36	2
Furosemide inj 100mg/10ml	10ml	1	947-648	10x10ml syrg	18	2
Promethazine 25mg/ml	1ml	2	673-222	25x1ml vl	36	2
Digoxin 500mcg/2ml	2ml	3	005-611	25x2ml	54	3
Verapamil inj. 5mg/2ml	2ml	2	376-129	5x2ml vl	36	8
Nitroglycerin 50mg/10ml	10ml	1	730-320	25x10ml vl	18	1
Amiodarone inj. 150mg/3ml	3ml	3	683-577	10x3ml	54	6
Vecuronium Bromide inj 10mg	10ml	1	777-086	10x10ml vl	18	2
Etomidate inj 40mg (2mg/ml)	20ml	1	481-556	10x20ml vl	18	2
Epinephrine 1:1000	30ml	1	776-450	30ml vl	18	18
Dopamine HCl 200mg	5ml	1	156-604	25x10ml vl	18	1
Sterile Water for Inj.	20ml	2	162-149	25x20ml vl	36	2
Ketorolac Tromethqamine inj 60mg/2ml	2ml	1	974-469	20x2ml vl	18	1
Vasopressin inj (synthetic) 20units/ml	1ml	1	830-070	25x1ml vl	18	1
Phenytoin inj 250mg/5ml	5ml	2	837-029	25X5ML vl	36	2
Propranolol HCl inj 1mg/ml	1ml	2	856-013	10x1ml vl	36	4
Nitroglycerin sublingual tabs 0.4mg	25	2	208-959	4x25	36	5
Naloxone HCl 0.4mg/ml	1ml	3	376-855	10x1ml vl	54	6
Procainamide HCl 500mg/ml	2ml	1	377-077	25x2ml	18	1
Adenocard 6mg/2ml	2ml	5	661-607	2ml syrg	90	90
Prescription Blanks, 20/pad	1	1	non-stock		18	18
Total						278
						0
Controlled Substances -- Seal #						0
Midazolam 2mg/2ml	2ml	5	624-433	10x2ml syrg	90	9
Morphine Sulfate 10mg/ml	1ml	5	484-434	10x1ml c/j	90	9

Controlled Pharmaceuticals

Product Name	PK Size	Schedule	Location
Controlled Substance Lock-Up:			
Acetaminophen w/ Codeine, 300mg / 30mg Tablets	100 tabs	III	Locker
Alprazolam, 0.25mg Tablets	100 tabs	IV	Locker
Diazepam LL Inj., 5mg / mL, 2mL C-J Syringe	10x2mL syr/bx	IV	Locker
Diazepam Rectal Gel 10mg delivery system	2 syr/bx	IV	Locker
Diazepam Tablets, 5mg	100 tabs	IV	Locker
Diazepam Tablets, 10mg (Fire Cache)	100 tabs	IV	Locker
Guaifenesin AC Syrup, 100mg-10mg / 5mL	12x4oz bt cs	V	Locker
Hydrocodone Bitartrate/APAP, 10mg / 325mg Tablet	100 tabs	II	Safe
Lorazepam (Ativan), 1mg Tablets	100 tabs	IV	Locker
Lorazepam (Ativan), 2mg / mL, 1mL Vial (REF)	25x1mL vl	IV	REFER
Midazolam (Versed), 10mg /5ml	10x5ml cup	IV	Locker
Midazolam (Versed), 10mg/10ml, (Fire Cache)	10 x 10ml vl	IV	
Morphine, 30mg ER Tablets	100 tabs	II	Safe
Morphine, 4mg / mL, 1mL Vial	25x1mL vl	II	Safe
Phenobarbital, 30mg Tablets	500	IV	Locker
Phenobarbital Elixir, 20mg / 5mL	473mL	IV	Locker
Tramadol, 50mg Tablets	100 tabs	IV	Locker

ACLS CACHE

Product Name
Adenocard (Adenosine), 3mg / mL, 12mg / 4mL Syringe
Adenocard (Adenosine), 3mg / mL, 6mg / 2mL Syringe
Albuterol Inh., 0.83%, 2.5mg / 3mL, 3mL Solution
Amiodarone HCL Inj., 50mg / mL, 150mg / 3mL Vial
Aspirin, Chewable Tabs 81mg
Atropine Sulfate, 0.1mg / 10mL, Syringe
Calcium Chloride 10%, 100mg / mL, 10mL Syringe
Dextrose 50%, 25 gm, 0.5 gm / mL, 50 mL Syringe
Digoxin Injection, 500mcg / 2mL Ampule
Diphenhydramine Inj., 50mg / mL, 1mL Vial
Dopamine, 400mg, 40mg / mL, Vial
Epinephrine, 1:1000, Inj. 1mg / mL, 30mL Vial
Epinephrine, 1:10000, 0.1mg / mL, 1mg / 10mL Syringe
Epinephrine, 1:10000, 0.1mg / mL, 1mg / 10mL Syringe
Epinephrine, Auto-Injector, 0.3mg Epi Pen (2-pack)
Epinephrine, Auto-Injector, 0.3mg Epi Pen (2-pack)
Etomidate (Amidate) Inj., 2mg / mL, 10mL Vial
Furosemide Inj., 10mg / mL, 100mg / 10mL Syringe
Glucagon Inj., 1mg w/ 1mL Syringe
Glucagon Inj., 1mg w/ 1mL Syringe
Glucose Paste, 24gm
Ketorolac Tromethamine Inj., 30mg / mL, 60mg / 2mL Vial
Lidocaine 1%, 50mg / 5mL, 5mL Syringe
Lidocaine 2%, 20mg / mL, 100mg / 5mL Syringe
Naloxone HCL Inj., 0.4mg / mL, 1mL Vial
Nitroglycerin Inj., 5mg / mL, 10mL Vial
Nitroglycerin Tablets, Sub-lingual, 0.4mg, 100 tab Bottle
Phenytoin Sodium Inj., 50mg / mL, 250mg Vial
Propranolol HCL Inj., 1mg / mL, 1mL Vial
Sodium Bicarbonate, 50mEq, 1mEq / mL, 50mL Syringe
Sodium Chloride Inj., 0.9%, 1000mL
Vecuronium Bromide Inj., 10mg Vial
Sterile Water Inj., 10mL Vial
Ondansetron Inj., 4mg/2ml
Zofran (Ondansetron), 4mg Tablets
Lab Cache
One Touch Ultra Control Solution (Breeze2/Bayer)
FreeStyle Lite Test Strips, 50 strips/bottle
FreeStyle Lite Test Strips, 50 strips/bottle

CACHE ONE

Product Name	Location
Acetaminophen Oral Sol, 160mg/5ml	TW
Acetaminophen Suppository, 120mg	REFER
Acetaminophen Suppository, 325mg	REFER
Acetaminophen Tablets, 325mg	b1
Acetaminophen UNBX Cherr ELX, 4oz	b1
Acetaminophen UNBX Cherr ELX, 4oz	b1
Acetazolamide Tablets, 250mg	b1
Activated Charcoal, 50gm	b1
Albuterol Inh (Ventolin) 8g	b1
Albuterol Inh (Ventolin) 8g	b1
Albuterol Inh Sol 0.63mg/3ml	b1
Albuterol Syrup, 2mg / 5mL	b1
Albuterol Tablets, 4mg	b1
Amlodipine Besylate), 5mg Tablets	b1
Amitriptyline, 25mg Tablets	b1
Amoxicillin / Clavulanic Oral Susp., 200mg / 28.5mg / 5mL	b2
Amoxicillin / Clavulanic Tablets, 400mg / 57mg	b2
Amoxicillin / Clavulanic Tablets, 400mg / 57mg	b2
Amoxicillin / Clavulanic Tablets, 875mg / 125mg	b2
Amoxicillin Capsules, 250mg	b2
Amoxicillin Oral Susp., 250mg / 5mL	b2
Ampicillin Sodium Inj., 1gm Vial	b2
Antacid, Liquid, Reg. Strength, 12oz	TW
Antacid, Liquid, Reg. Strength, 12oz	TW
Artificial Tears, 15mL	b2
Artificial Tears, 15mL	b2
Aspirin Tablets, 325mg	b3
Aspirin Tablets, 325mg	b3
Atenolol Tablets, 50mg	b3
Atropine Sulf Ophthalmic Solution 5%, 5mL	b3
Atropine Sulf Ophthalmic Solution 5%, 5mL	b3
Atrovent HFA Inh., 17mcg.	b3
Atrovent HFA Inh., 17mcg.	b3
Azithromycin Susp., 200mg / 5mL	b3
Azithromycin Tablets, 250mg	b3
Azithromycin Tablets, 250mg	b3
Bacitracin Ointment (w/Zinc), 500un / gm	b3
Baclofen Tablets, 10mg	b3
Beclomethasone Dipropionate AQ, 42mcg, NS Spy, 25gm	b3
Benazepril HCl Tablets, 5mg	b3
Benzoin Topical Solution, 2oz	b3
Bupivacaine (Marcaine) 0.5%, 30mL Vial	b3
Calamine Lotion, 4oz	b3
Calamine Lotion, 4oz	b3
Carbamazepine Tablets, 200mg	b3
Cefazolin Sodium Inj., 1gm Vial	b3
Ceftriaxone Inj., 1gm Vial	b4

Ceftriaxone Inj., 1gm Vial	b4
Cephalexin Capsules, 500mg	b4
Cephalexin Capsules, 500mg	b4
Cephalexin Oral Susp., 250mg / 5mL	b4
Chloraseptic Throat Lozenges, (36 bx/cs)	TW
Clarithromycin Susp., 250mg / 5mL	b4
Clarithromycin XR Tablets (Biaxin XL), 500mg	b4
Clarithromycin XR Tablets (Biaxin XL), 500mg	b4
Clindamycin, 150mg Tablets	b4
Clindamycin, 150mg Tablets	b4
Clonidine HCl Tablets, 0.1mg	b4
Cyclobenzaprine HCl Tablets, 10mg	b4
Cyclobenzaprine HCl Tablets, 10mg	b4
Desitin Paste (Diaper Rash Paste)	b4
Dexamethasone Sodium Phosphate Inj 100mg/10ml	b4
Dexamethasone Oral Sol 1mg / ml	b4
Dextrose 5% & Sodium Chloride, 0.45% Inj. 500mL	TW
Dextrose 5% & Sodium Chloride, 0.9% Inj. 1000mL	TW
Dextrose 5% & Sodium Chloride, 0.9% Inj. 1000mL	TW
Dextrose 5% & Water Inj., 500mL	TW
Dextrose 5% Inj., 50mL	TW
Dibucaine Oint 1%	b4
Diclofenac Sodium Ophthalmic Solution 0.1%, 5mL	b4
Diclofenac Sodium Ophthalmic Solution 0.1%, 5mL	b4
Dicloxacillin Sodium Capsules, 250mg	b4
Digoxin Tablets, 0.125mg	b4
Diltiazem Hydrochloride Inj., 5mg / mL, 5mL (REF)	REFER
Diltiazem Hydrochloride, 120mg Caplets	b4
Diphenhydramine Caplets (Banophen), 25mg	b4
Diphenhydramine Caplets (Banophen), 25mg	b4
Diphenhydramine Oral Sol (Banophen), 12.5mg / 5mL	b5
Diphenhydramine Oral Sol (Banophen), 12.5mg / 5mL	b5
Divalproex Sodium Tablets, 250mg	b4
Dobutamine Hydrochloride Inj., 250mg, 20mL Vial	b4
Doxycycline Hyclate Tablets, 100mg	b5
Enalaprilat Inj., 1.25mg / 2mL Vial	b5
Enalapril Tablets, 5mg	b5
Enoxaparin, 100mg / 1mL Syringe	b5
Erythromycin Enteric Coated Tablets, 250mg	b5
Erythromycin Ophthalmic Ointment 0.5%, 5mg / gm, 3.5gm	b5
Erythromycin Ophthalmic Ointment 0.5%, 5mg / gm, 3.5gm	b5
Etomidate Inj., 20mg / 10 mL, 10mL Vial	b5
Eugenol, 1/8oz (tooth ache)	b5
Famotidine Tablets, 20mg	b5
Fluocinonide Cream, 0.05% Tube	b5
Fluorescein Sodium Ophthalmic Strips, 1mg, "FUL-GLO"	b5
Fluoxetine Hydrochloride Caplets, 20mg	b5
Fosphenytoin Sodium Inj., 100mg / 2mL Vial (Refrig)	REFER
Furosemide Tablets, 40mg	b5
Furosemide, 10mg / mL, 100mg / 10mL Vial	b5

Gabapentin Capsules, 300mg	b5
Gabapentin Capsules, 300mg	b5
Gentamicin Ophthalmic Solution 0.3%, 5mL	b5
Gentamicin Ophthalmic Solution 0.3%, 5mL	b5
Gentamicin Ophthalmic Solution 0.3%, 5mL	b5
Glyburide, 2.5mg Tablets	b6
Guaifenesin Syrup SF, 100mg / 5mL	TW
Guaifenesin DM Syrup, 8 oz	TW
Haloperidol Inj., 5mg / mL, 1mL Vial	b6
Haloperidol Tablets, 1mg	b6
Heparin Sodium, 1,000units / mL, 10mL Vial	b6
Humalog KwikPen insulin lispro (REF)	REFER
Humulin / Novolin-NPH, 100U / mL, 10mL Vial	REFER
Humulin / Novolin-Regular, 100U / mL, 10mL Vial	REFER
Hydralazine, 20mg / mL, 1mL Vial	b6
Hydrochlorothiazide Tablets, 25 mg	b6
Hydrochlorothiazide Tablets, 50mg	b6
Hydrocortisone Cream 1%, 30gm	b6
Hydroxyzine Hydrochloride Tablets, 50mg	b6
Ibuprofen Oral Drops (Advil), 50mg / 1.25mL, 15mL	b6
Ibuprofen Oral Drops (Advil), 50mg / 1.25mL, 15mL	b6
Ibuprofen Oral Susp., 100mg / 5mL, Child Berry, 8oz	TW
Ibuprofen Tablets, 600mg	b6
Ibuprofen Tablets, 600mg	b6
Inhalation Chamber Spacer for MDI	b6
Isosorbide Dinitrate Tablets, 10mg	b6
Lactated Ringers Inj., 1000mL	TW
Lantus, 100U/mL, 3mL Syringe (REF)	REFER
Levaquin (Levofloxacin), 500mg Tablets	b7
Levaquin (Levofloxacin), 500mg Tablets	b7
Levemir (Insulin detemir inj (REF)	REFER
Levofloxacin, 250mg Tablets	b7
Levothyroxine Sodium Tablets, 0.1mg	b7
Levothyroxine Sodium Tablets, 50mcg	b7
Lice Creme Rinse (Permethrin), 2oz	TW
Lice Egg Remover (GNP) Gel, 2oz	TW
Lidocaine 1% Inj., 10mg/ mL, 20mL Vial	b7
Lidocaine 1% w/ Epinephrine Inj., 1:100,000, 30mL MD Vial	b7
Lidocaine 2% Viscous Solution, 100mL	b7
Lithium Carbonate Tablets, 300mg	b7
Loperamide HCl Capsules, 2mg	b7
Loperamide HCl Capsules, 2mg	b7
Loperamide Oral Solution, 1mg / 5mL	b7
Loperamide Oral Solution, 1mg / 5mL	b7
Magnesium Sulfate 50% Inj, 5gm / 10mL Vial	b7
Mannitol Inj. 25%, 50mL Vial	b5
Meclizine Hydrochloride Tablets, 25mg	b7
Metformin Hydrochloride (Glucophage) Tablets, 500mg	b7
Methylprednisolone Sodium Succinate, Inj 125mg/2ml vl	b7
Methylprednisolone Tablets, 4mg dosepack	b7

Methylprednisolone Tablets, 4mg dosepack	b7
Metocloperamide Hydrochloride Tablets, 10mg	b7
Metoprolol Tablets, 50mg	b7
Metronidazole Inj., 500mg / 100mL	TW
Metronidazole Tablets, 500mg	b7
Miconazole Nitrate 2% CD Cream, 14gm	b7
Miconazole Vaginal Cream 2%, 45gm	b7
Nafcillin Sodium Inj., 1gm Vial	b8
Nasal Spray, Oxymetazoline 0.05%	b8
Neomycin / Polymyxin HC Otic Susp., 10mL	b8
Nifedipine Tablets, 10 mg	b8
Nitroglycerin Inj., 5mg / mL, 10mL Vial	b8
Nitroglycerine, 0.2mg / HR Patch	b8
Novolin-n, Insulin Human and Insulin Isophane Susp., 70/30 Vial	REFER
Nystatin Cream Top, 100,000/gm, 15gm	b8
Nystatin Oral Susp., 100,000mun / mL	b8
Ophthalmic Irrigating Solution, 4oz	b8
Oseltamivir Phosphate 45mg Capsules	b8
Oseltamivir Phosphate 75mg Capsules	b8
Oxytocin, 10units / mL, 10mL Vial	b8
Pediatric Electrolyte, Apple Liq., 8oz	TW
Penicillin G Sodium, 5MMU Vial	b8
Pepto Bismol, 4oz w/ 30mL dose cup	TW
Pepto Bismol, 4oz w/ 30mL dose cup	TW
Phenytoin Oral Susp., 125mg / 5mL, 8oz	b9
Phenytoin Sodium Capsules, 100mg	b9
Potassium Chloride Inj., 20mEq (2 mEq / mL), 10mL Vial	b9
Potassium Supplement ER Tablets, 10mEq	b9
Prednisone Tablets, 10mg	b9
Prednisone Tablets, 5mg	b9
Promethazine Pediatric Suppository, 12.5mg	REFER
Promethazine Pediatric Suppository, 12.5mg	REFER
Promethazine Pediatric Suppository, 25 mg	REFER
Propranolol HCl Inj., 1mg / mL, 1mL Vial	b9
Propranolol HCl Tablets, 20mg	b9
Pseudoephedrine Tablets 30mg	b8
Racepinephrine Inh. Solution 2.25%, 0.5mL x 30 ampules	REFER
Risperidone Tablets, 1mg	b9
Silver Sulfadiazine Cream 1%, 50gm	b9
SMZ / TMP Oral Susp., 800mg / 160mg, 20mL UD	TW
Sodium Chloride Inh. 0.9% BRC Solution, 3mL	b9
Sodium Chloride Inj. 0.9% (Bacteriostatic), 30mL Vial	b9
Sodium Chloride Inj. 0.9%, 1000mL	TW
Sodium Chloride Inj. 0.9%, 100mL	TW
Sodium Chloride Inj. 0.9%, 250mL	TW
Sodium Chloride Irrigation 0.9%, 1000mL	TW
Sodium Chloride Irrigation 0.9%, 1000mL	TW
SoluMedrol, 1gm AOV 8mL Vial	b9
Sterile Water Irrigation, 1000mL	TW
Succinylcholine Chloride Inj. (Anectine), 200mg /10 mL,	REFER

Sulfacetamide Sodium 10% Ophth. Solution, 15mL	b6
Sulfacetamide Sodium 10% Ophth. Solution, 15mL	b6
Sulfacetamide Sodium 10% Ophth. Solution, 15mL	b6
Sulfamethoxazole/Trimethoprim Tablets, 800mg / 160mg	b9
Sulfamethoxazole/Trimethoprim Tablets, 800mg / 160mg	b9
Terbutaline Sulfate Inj., 1mg / mL, 1mL Vial	b9
Tetanus & Diphtheria Toxoids Abs, 0.5mL Vial	REFER
Tetracaine (Proparacaine) Ophth. Solution 0.5%, 15mL	b9
Theophylline Anhydrous SR Tablets, 200mg	b9
Thiamine Hydrochloride, 100mg / mL, 2mL Vial	b9
Timolol Maleate Ophthalmic Solution 0.5%, 5mL	b9
Tobramycin Inj., 80mg / 2mL, 2mL Vial	b9
Trazadone Hydrochloride Tablets, 50mg	b9
Triamcinolone Acetonide Cream 0.1%, 15gm	b9
Triamcinolone Acetonide Cream 0.1%, 15gm	b9
Triple Antibiotic Ointment BAC/NEO/POLY, 0.5 oz	b9
Triple Antibiotic Ointment BAC/NEO/POLY, 0.5 oz	b9
Valporic Acid Capsules, 250mg	b9
Vancomycin Inj. FTV, 1gm Vial	b10
Verapamil ER Tablets, 240mg	b10
Verapamil Tablets, 80mg	b10
Warfarin, 1mg Tablets	b10
Warfarin, 5mg Tablets	b10
Water / Sterile Inj. (Bacteriostatic), 30mL Vial	b10
Xopenex, (Levalbuterol) 0.31mg / 3mL, 3mL Vial	b10
Zofran (Ondanstron), 2mg / mL SDV Vial	b10
Zofran (Ondanstron), 4mg tablets	b10
Zosyn (Piperacillin), 3.375gm vial	b10

Lab Cache:

Clinical Analyzer, Calibration VER SOL	
Clinical Analyzer, CG8+ Cartridge, 25's	
Clinical Analyzer, G3+ Cartridge, 25's	
Clinical Analyzer, Level-1 Aqueous Control (10 Amps x 1.7mL)	
Clinical Analyzer, Level-3 Aqueous Control (10 Amps x 1.7mL)	
Pregnancy Kit (Urine), Single test	
Urine Strips 100's	

Counting Tray	Supply
Label, Shake Well	Supply
Label, Discoloration of Urine and Feces, Apothecary products #40006	Supply
Label, Drowsiness/No Alcohol, Apothecary products #40001	Supply
Label, External Use Only, Apothecary products #40111	Supply
Label, For the ear, Apothecary products #40804	Supply
Label, For the eye, Apothecary products #40803	Supply
Label, For the nose, Apothecary Products #40805	Supply
Label, May Cause Drowsiness	Supply

Label, Take with food/milk	Supply
Prescription Blanks, 100/pad	Supply
Vials, Plastic Lock w/ Cap, 8 dram (Kerr)	
Vials, Plastic Lock Cap, 20 dram (Kerr)	
Vials, Safety Caps, 20 dram (Kerr)	TW
Vials, Safety Caps, 8 dram (Kerr)	TW
Bottle, Kerr Plast OV amb 4oz CR	
Bottle, Kerr Plast OV amb 8oz CR	
Bottle, Plastic, Amber, Liquid, 4oz, 100's	

CACHE TWO

Product Name	Location
Acetaminophen UNBX Cherr ELX, 4oz	b1
Acetaminophen Oral Sol, 160mg/5ml	TW
Acetaminophen Suppository, 120mg	REFER
Acetaminophen Suppository, 325mg	REFER
Acetaminophen Tablets, 325mg	b1
Acetazolamide Tablets, 250mg	b1
Activated Charcoal, 50gm	b1
Albuterol Syrup, 2mg / 5mL	b1
Albuterol Inh Sol 0.63mg/3ml	b1
Albuterol Inh (Ventolin) 8g	b1
Albuterol Tablets, 4mg	b1
Amitriptyline, 25mg Tablets	b1
Amoxicillin Capsules, 250mg	b2
Amoxicillin Oral Susp., 250mg / 5mL	b2
Amoxicillin / Clavulanic Tablets, 400mg / 57mg	b2
Amoxicillin / Clavulanic Tablets, 875mg / 125mg	b2
Amoxicillin / Clavulanic Oral Susp., 200mg / 28.5mg / 5mL	b2
Amoxicillin / Clavulanic Oral Susp., 200mg / 28.5mg / 5mL	b2
Ampicillin Sodium Inj., 1gm Vial	b2
Antacid, Liquid, Reg. Strength, 12oz	TW
Artificial Tears, 15mL	b2
Aspirin Tablets, 325mg	b3
Atenolol Tablets, 50mg	b3
Atropine Sulf Ophthalmic Solution 5%, 5mL	b3
Atrovent HFA Inh., 17mcg.	b3
Azithromycin Susp., 200mg / 5mL	b3
Azithromycin Tablets, 250mg	b3
Bacitracin Ointment (w/Zinc), 500un / gm	b3
Baclofen Tablets, 10mg	b3
Beclomethasone Dipropionate AQ, 42mcg, NS Spy, 25gm	b3
Benazepril HCl Tablets, 5mg	b3
Benzoin Topical Solution, 2oz	b3
Bupivacaine (Marcaine) 0.5%, 30mL Vial	b3
Calamine Lotion, 4oz	b3
Carbamazepine Tablets, 200mg	b3
Cefazolin Sodium Inj., 1gm Vial	b3

Chloraseptic Throat Lozenges, (36 bx/cs)	TW
Ceftriaxone Inj., 1gm Vial	b4
Cephalexin Capsules, 500mg	b4
Cephalexin Oral Susp., 250mg / 5mL	b4
Clarithromycin Susp., 250mg / 5mL	b4
Clarithromycin Susp., 250mg / 5mL	b4
Clarithromycin XR Tablets (Biaxin XL), 500mg	b4
Clindamycin, 150mg Tablets	b4
Clindamycin, 150mg Tablets	b4
Clonidine HCl Tablets, 0.1mg	b4
Cyclobenzaprine HCl Tablets, 10mg	b4
Dexamethasone Oral Sol 1mg / ml	b4
Dexamethasone NA Phosphate Inj., 10mg / 1mL Vial	b4
Dextrose 5% & Sodium Chloride, 0.45% Inj. 500mL	TW
Dextrose 5% & Sodium Chloride, 0.9% Inj. 1000mL	TW
Dextrose 5% & Water Inj., 500mL	TW
Dextrose 5% Inj., 50mL	TW
Desitin Paste (Diaper Rash Paste)	b4
Diclofenac Sodium Ophthalmic Solution 0.1%, 5mL	b4
Dicloxacillin Sodium Capsules, 250mg	b4
Digoxin Tablets, 0.125mg	b4
Diltiazem Hydrochloride, 120mg Caplets	b4
Diltiazem Hydrochloride Inj., 5mg / mL, 5mL (REF)	REFER
Diphenhydramine Caplets (Banophen), 25mg	b4
Diphenhydramine Oral Sol (Banophen), 12.5mg / 5mL	b5
Diphenhydramine Oral Sol (Diphenhist), 12.5mg / 5mL	b5
Divalproex Sodium Tablets, 250mg	b4
Dobutamine Hydrochloride Inj., 250mg, 20mL Vial	b4
Doxycycline Hyclate Tablets, 100mg	b5
Enalapril Inj., 1.25mg / 2mL Vial	b5
Enalapril Tablets, 5mg	b5
Erythromycin Enteric Coated Tablets, 250mg	b5
Erythromycin Ophthalmic Ointment 0.5%, 5mg / gm, 3.5gm	b5
Etomidate Inj., 2mg / mL, 10mL Vial	b5
Eugenol, 1/8oz (tooth ache)	b5
Famotidine Tablets, 20mg	b5
Fluorescein Sodium Ophthalmic Strips, 1mg, "BIO GLO"	b5
Fluocinonide Cream, 0.05% Tube	b5
Fluoxetine Hydrochloride Caplets, 20mg	b5
Fosphenytoin Sodium Inj., 100mg / 2mL Vial (Refrig)	REFER
Furosemide, 10mg / mL, 100mg / 10mL Vial	b5
Furosemide Tablets, 40 mg	b5
Gabapentin Capsules, 300mg	b5
Gentamicin Ophthalmic Solution 0.3%, 5mL	b6
Glyburide, 2.5mg Tablets	b6
Graduated Cylinder, 250 ml, Apothecary Products #29284	b6
Guaifenesin Syrup SF, 100mg / 5mL	TW
Guaifenesin DM Syrup, 8 oz	TW
Haloperidol Inj., 5mg / mL, 1mL Vial	b6
Haloperidol Tablets, 1mg	b6

Heparin Sodium, 1,000units / mL, 10mL Vial	b6
Humalog KwikPen insulin lispro (REF)	REFER
Humulin / Novolin-NPH, 100U / mL, 10mL Vial	REFER
Humulin / Novolin-Regular, 100U / mL, 10mL Vial	REFER
Hydralazine, 20mg / mL, 1mL Vial	b6
Hydrochlorothiazide Tablets, 50mg	b6
Hydrocortisone Cream 1%, 30gm	b6
Hydroxyzine Hydrochloride Tablets, 50mg	b6
Ibuprofen Oral Drops (Advil), 50mg / 1.25mL, 15mL	b6
Ibuprofen Oral Susp., 100mg / 5mL, Child Berry, 8oz	TW
Ibuprofen Tablets, 600mg	b6
Inhalation Chamber Spacer for MDI	b6
Novolin-n, Insulin Human and Insulin Isophane Susp., 70/30 Vial	REFER
Isosorbide Dinitrate Tablets, 10mg	b5
Pepto Bismol, 4oz w/ 30mL dose cup	TW
Lactated Ringers Inj., 1000mL	TW
Lactated Ringers Inj., 1000mL	TW
Lactated Ringers Inj., 1000mL	TW
Lantus, 100U/mL, 3mL Syringe (REF)	REFER
Lantus, 100U/mL, 3mL Syringe (REF)	REFER
Levemir (Insulin detemir inj (REF)	REFER
Levemir (Insulin detemir inj (REF)	REFER
Levofloxacin, 250mg Tablets	b7
Levaquin (Levofloxacin), 500mg Tablets	b7
Levothyroxine Sodium Tablets, 0.1mg	b7
Levothyroxine Sodium Tablets, 50mcg	b7
Lice Egg Remover (GNP) Gel, 2oz	TW
Lice Creme Rinse (Permethrin), 2oz	TW
Lidocaine 1% Inj., 10mg/ mL, 20mL Vial	b7
Lidocaine 1% w/ Epinephrine Inj., 1:100,000, 30mL MD Vial	b7
Lidocaine 2% Viscous Solution, 100mL	b7
Lithium Carbonate Tablets, 300mg	b7
Loperamide HCl Capsules, 2mg	b7
Loperamide Oral Solution, 1mg / 5mL	b7
Enoxaparin, 100mg / 1mL Syringe	b7
Magnesium Sulfate 50% Inj, 5gm / 10mL, 20mL Vial	b7
Mannitol Inj. 25%, 50mL Vial	TW
Meclizine Hydrochloride Tablets, 25mg	b7
Metformin Hydrochloride (Glucophage) Tablets, 500mg	b6
Methylprednisolone Tablets, 4mg dosepack	b7
Methylprednisolone Sodium Succinate, Inj 125mg/2ml vl	b7
Metocloperamide Hydrochloride Tablets, 10mg	b7
Metoprolol Tablets, 50mg	b7
Metronidazole Inj., 500mg / 100mL	TW
Metronidazole Tablets, 250mg	B7
Miconazole Nitrate 2% CD Cream, 14gm	b7
Miconazole Vaginal Cream 2%, 45gm	b7
Nafcillin Sodium Inj., 1gm Vial	b8
Nasal Spray, Oxymetazoline 0.05%	b8
Neomycin / Polymyxin HC Otic Susp., 10mL	b8

Nifedipine Tablets, 10 mg	b8
Nitroglycerin Inj., 5mg / mL, 10mL Vial	b9
Nitroglycerine Transdermal System, 0.2mg/hr	b8
Norvasc (Amlodipine Besylate), 5mg Tablets	b8
Nupercainal HC 1% Cream (Dibucaine), 28gm	b8
Nystatin Cream Top, 100Mun /gm, 15gm	b8
Nystatin Oral Susp., 100,000mun / mL	b8
Ophthalmic Irrigating Solution, 4oz	b8
Oseltamivir Phosphate 45mg Capsules	b8
Oseltamivir Phosphate 75mg Capsules	b8
Oxytocin, 10units / mL, 10mL Vial	b8
Pediatric Electrolyte, Apple Liq., 8oz	TW
Penicillin G Sodium, 5MMU Vial	b8
Phenytoin Oral Susp., 125mg / 5mL, 8oz	b9
Phenytoin Sodium Capsules, 100mg	b9
Potassium Chloride Inj., 20mEq (2 mEq / mL), 10mL Vial	b9
Potassium Supplement ER Tablets, 10mEq	b9
Prednisone Tablets, 10mg	b9
Prednisone Tablets, 5mg	b9
Promethazine Pediatric Suppository, 12.5mg	REFER
Propranolol HCl Inj., 1mg / mL, 1mL Vial	b9
Propranolol HCl Inj., 1mg / mL, 1mL Vial	b9
Propranolol HCl Tablets, 20mg	b9
Pseudoephedrine Tablets 30mg	b8
Racinephrine Inh. Solution 2.25%, 0.5mL x 30 ampules	REFER
Risperidone Tablets, 1mg	b9
Silver Sulfadiazine Cream 1%, 50gm	b9
Sulfamethoxazole/Trimethoprim Tablets, 800mg / 160mg	b9
SMZ / TMP Oral Susp., 800mg / 160mg, 20mL UD	TW
Sodium Chloride Inj. 0.9%, 1000mL	TW
Sodium Chloride Inj. 0.9%, 100mL	TW
Sodium Chloride Inh. 0.9% BRC Solution, 3mL	b9
Sodium Chloride Inj. 0.9%, 250mL	TW
Sodium Chloride Inj. 0.9% (Bacteriostatic), 30mL Vial	b9
Sodium Chloride Irrigation 0.9%, 1000mL	TW
SoluMedrol, 1gm AOV 8mL Vial	b9
Sulfacetamide Sodium 10% Ophth Solution, 15mL	b6
Sulfacetamide Sodium 10% Ophth Solution, 15mL	b6
Sterile Water Irrigation, 1000mL	TW
Succinylcholine Chloride Inj. (Anectine), 20mg / 10 mL,	REFER
Terbutaline Sulfate Inj., 1mg / mL, 1mL Vial	b9
Tetanus & Diphtheria Toxoids Abs, 0.5mL Vial	REFER
Tetanus & Diphtheria Toxoids Abs, 0.5mL Vial	REFER
Tetracaine (Proparacaine) Ophth. Solution 0.5%, 15mL	b9
Tetracaine (Proparacaine) Ophth. Solution 0.5%, 15mL	b9
Tetracaine (Proparacaine) Ophth. Solution 0.5%, 15mL	b9
Theophylline Anhydrous SR Tablets, 400mg	b9
Thiamine Hydrochloride, 100mg / mL, 2mL Vial	b9
Timolol Maleate Ophthalmic Solution 0.5%, 5mL	b9
Tobramycin Inj., 80mg / 2mL, 2mL Vial	b9

Trazadone Hydrochloride Tablets, 50mg	b9
Triamcinolone Acetonide Cream 0.1%, 15gm	b9
Triple Antibiotic Ointment BAC/NEO/POLY, 1oz	b9
Triple Antibiotic Ointment BAC/NEO/POLY, 1oz	b9
Valporic Acid Capsules, 250mg	b9
Vancomycin Inj. FTV, 1gm Vial	b10
Verapamil ER Tablets, 240mg	b10
Verapamil Tablets, 80mg	b10
Warfarin, 1mg Tablets	b10
Warfarin, 5mg Tablets	b10
Water / Sterile Inj. (Bacteriostatic), 30mL Vial	b10
Xopenex, (Levalbuterol) 0.31mg / 3mL, 3mL Vial	b10
Xopenex (Levalbuterol), 1.25mg / 0.5mL amp	b10
Zofran (Ondanstron), 2mg / mL SDV Vial	b10
Zofran (Ondanstron), 4mg tablets	b10
Zosyn (Piperacillin), 3.375gm vial	b10
Lab Cache:	
Clinical Analyzer, Calibration VER SOL	
Clinical Analyzer, CG8+ Cartridge, 25's	
Clinical Analyzer, G3+ Cartridge, 25's	
Clinical Analyzer, Level-1 Aqueous Control (10 Amps x 1.7mL)	
Clinical Analyzer, Level-3 Aqueous Control (10 Amps x 1.7mL)	
Pregnancy Kit (Urine), Single test	
Urine Strips 100's	
Counting Tray	Supply
Label, Shake Well	Supply
Label, Discoloration of Urine and Feces, Apothecary products #40006	Supply
Label, Drowsiness/No Alcohol, Apothecary products #40001	Supply
Label, External Use Only, Apothecary products #40111	Supply
Label, For the ear, Apothecary products #40804	Supply
Label, For the eye, Apothecary products #40803	Supply
Label, For the nose, Apothecary Products #40805	Supply
Label, May Cause Drowsiness	Supply
Label, Take with food/milk	Supply
Prescription Blanks, 100/pad	Supply
Vials, Plastic Lock w/ Cap, 8 dram (Kerr)	
Vials, Plastic Lock Cap, 20 dram (Kerr)	
Vials, Safety Caps, 20 dram (Kerr)	TW
Vials, Safety Caps, 8 dram (Kerr)	TW
Bottle, Kerr Plast OV amb 4oz CR	
Bottle, Kerr Plast OV amb 8oz CR	
Bottle, Plastic, Amber, Liquid, 4oz, 100's	

ANNEX G:

CAL-MAT COVID-19 Isolation, Symptom Management, Notification, and Return to Work

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



TO:	CAL-MAT Members
FROM:	Dave Duncan, MD Director Howard Backer, MD CAL-MAT Medical Director
DATE:	July 13, 2020

Revision/Version: Revised 7/13/20	Replaces: July 8, 2020
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SUBJECT: CAL-MAT COVID-19 Isolation, symptom management, notification, and return to work

PURPOSE:

Management of CAL-MAT members who develop symptoms of illness while on deployment

Summary and New information

- Members who develop symptoms of illness while deployed during COVID 19 will stop work and isolate
- Testing for COVID-19 will be done
- Notification made to EMSA Medical Director and to HR via automated reporting form
- CAL-MAT unit leader should be notified but no medical information unless consent
- Workers Compensation management by HR
- Determination of exposure risk for health care workers and their work colleagues and return to work based on CDC guidance
- Procedure for RTW or demobilization

Background

On behalf of the California Emergency Medical Services Authority (EMSA) and the CAL-MAT Program, we would like to recognize and thank you for your incredible support to the most vulnerable citizens of California during this COVID-19 response.

Protecting the health and safety of our personnel is a top priority. To support this goal, EMSA has adopted the CDC guidelines for infection control and the use of Personal Protection Equipment (PPE) when treating COVID-19 patients. Additionally, EMSA works diligently to assure an adequate supply of recommended PPE and that infection control and PPE training occurs at each treatment site EMSA supports with CAL-MAT members.

EMSA recognizes that there is still a possibility that a CAL-MAT member will contract COVID-19 while supporting the response. Moreover, due to the unusual nature of response teams in the field, there is a high probability that co-workers will be exposed when a colleague develops symptoms and becomes a Person under Investigation (PUI) or tests positive for COVID19.

The following protocols apply to all deployed personnel.

Policy/Procedure

Pre-deployment

- Routine pre-deployment COVID 19 testing is not required or recommended.
- No pre-deployment physical exam is required for CAL-MAT members. They are expected to self-select with informed knowledge of work conditions and job description

Development of clinical symptoms during COVID

- Any member who develops a temperature higher than 100 F or has symptoms of cough, shortness of breath, fever, chills, muscle pain, sore throat, or new loss of taste or smell must report their illness to the Team Lead and isolate themselves in their hotel room.

Testing

- COVID testing will be conducted on-site, when available. If on-site testing is unavailable, testing will be arranged with the closest County testing site. The isolated member may be tested at a nearby ER if the need for further medical evaluation is indicated.

Isolation

- The decision to continue isolation and further testing of the member for COVID 19 shall be made by the on-site Medical Officer, if available, or by the CAL-MAT or EMS Authority Medical Director.
- While isolated, staff must record and report temperature twice a day and any change in symptoms via phone to the CAL-MAT Team lead or provider on-call.
- The medical provider on-call will evaluate symptoms at least once daily.
- Logistics will arrange to have meals and any needed medications delivered.

Notification

- The MST Director/Team Lead shall notify the CAL-MAT medical director and EMSA HR of any occupational infection or injury. This is to be done using a form stack report, which automatically sends the completed form.

Initial reporting form: https://EMSADMS.formstack.com/forms/exposure_report

Follow-Up reporting form: https://EMSADMS.formstack.com/forms/exposure_report_copy

- When a CAL-MAT member is taken off shift for illness or injury, the Unit Leader should be informed; no waiver is required as long as specific medical information is not shared.
- The member may provide medical information to the Unit Leader if they choose.
- Medical information (e.g., COVID test results or specific diagnosis) may be shared with the Unit Leader only with the member's consent that can be given when a member becomes ill or injured or through consent/waiver when the CAL-MAT member arrives on site.

Workers Compensation

- CAL-MAT members are eligible to receive Workers Compensation insurance while employed by the State.
- Once the Team Lead will fill out the forms above, **EMSA HR** will take the following actions in compliance with Workers Compensation rules:
 - Facilitate referral to an occupational health provider if needed
 - Send the e3301 to the employee and will follow up with the employee to receive it.
 - Coordinate emergency paid sick leave with both the employee and with State Compensation Insurance Fund (SCIF) in accordance with workers comp policies.
 - Work with employee on time sheet submittal upon demobilization or when the SCIF medical provider releases the employee to return to work.

- Any CAL-MAT member isolated while supporting the EMSA COVID-19 response will receive 8 hours of pay daily until cleared from isolation.
- CAL-MAT members should not be demobilized while in isolation or being treated for illness. If they do not plan to continue their deployment, members should be demobilized when they are no longer ill and the isolation period is completed.

Return to Work or Demobilization

- If the test comes back negative and the symptoms continue to diminish, the individual may return to work 2 days after all symptoms have resolved, consistent with the likely diagnosis and judgment of the site Chief Medical Officer, or the CAL-MAT Program Medical Director. If symptoms have not resolved or there remains high concern for COVID, the member should be retested at least 48 hours after the first test.
- If the test comes back positive, the member should have the option to remain isolated in a hotel through the health care worker isolation program or to self-isolate at home.
- EMSA will arrange transport home, to a hospital for evaluation, or to another isolation facility.
- All team members who had close, prolonged contact without PPE (See CDC definitions) with the positive member within two days of symptom onset should quarantine and receive testing.
- The team members with contact while wearing PPE or contact that does not meet the definition of close and prolonged, may continue working with appropriate following CDC PPE/infection control protocols unless develops symptoms. They must continue to take precautions including face mask use and social distancing around their colleagues and the public.
- All potentially exposed members must wear a facemask at all times outside of the patient care area and maintain appropriate social distancing from their colleagues for 14 days. According to [State Public Health Officer Order](#), facemasks may be removed when eating, exercising, or not in proximity to others, but social distancing must be maintained.
- With the member's permission to share information, the MST Director/Team Lead shall notify the member's CAL-MAT Unit Leader of the member's situation. Only the minimally required information may be shared.
- Employees should not be released back to work without notifying HR. This is an important step so that HR has this information for the State Compensation Insurance Fund and possibly DGS
- All employees need a medical release from CAL-MAT Program Medical Director or the Chief Medical Officer on site whether they:
 - Return to the mission site (whether after testing negative or positive), or
 - Demobilize from site and from mission

A work release template is available on-line (Sharepoint: *Documents/CAL-MAT Medical/Policy Procedures/RTW release*)
- The medical release that allows the employee to return to work will be forwarded by email to Kristi Holst so that the file can be documented accordingly.

Preventing cross-exposure among CAL-MAT members

During the COVID 19 response, CAL-MAT members provide healthcare in a high-risk infectious environment. Many infections are asymptomatic or can be spread for 2 days prior to symptoms.

- To avoid spreading possible infection to colleagues, CAL-MAT members must follow public infection control recommendations when outside of a health facility.
- This includes wearing a surgical or cloth mask when appropriate social distancing is not possible. This is especially important when multiple members are riding in the same vehicle or when socializing after work.
- Changing out of work clothes and performing frequent hand hygiene are other important measures.

Determination of exposure risk for health care personnel

This guidance applies to HCP with potential exposure in a healthcare setting to patients, visitors, or other HCP with confirmed COVID-19. Exposures can also be from a person under investigation (PUI) who is awaiting testing. Work restrictions described in this guidance might be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. Therefore, a record of HCP exposed to PUIs should be maintained. If test results will be delayed more than 72 hours or the patient is positive for COVID-19, then the work restrictions described in this document should be applied.

Exposure	Personal Protective Equipment Used	Work Restrictions
HCP who had prolonged ¹ close contact ² with a patient, visitor, or HCP with confirmed COVID-19 ³	<ul style="list-style-type: none"> • HCP not wearing a respirator or facemask⁴ • HCP not wearing eye protection • HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure 	<ul style="list-style-type: none"> • Exclude from work for 14 days after last exposure⁵ • Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19⁶ • Any HCP who develop fever or symptoms consistent with COVID-19⁶ should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
HCP other than those with exposure risk described above	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • No work restrictions • Follow all recommended infection prevention and control practices, including wearing a facemask for source control while at work, monitoring themselves for fever or symptoms consistent with COVID-19⁶ and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19⁶ at the beginning of their shift. • Any HCP who develop fever or symptoms consistent with COVID-19⁶ should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

Definitions for exposure risk

1. Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged.
2. Data are limited for the definition of close contact. For this guidance it is defined as: a) being within 6 feet of a person with confirmed COVID-19 or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.
3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 could have been infectious:
 - a. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 48 hours before symptom onset through the time period when the individual meets [criteria for discontinuation of Transmission-Based Precautions](#)
 - b. For individuals with confirmed COVID-19 who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with COVID-19 may have been exposed could help inform the period when they were infectious. In general, individuals with COVID-19 should be considered potentially infectious beginning 2 days after their exposure until they meet [criteria for discontinuing Transmission-Based Precautions](#). If the date of exposure cannot be determined, using a cutoff of 10 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions is a conservative approach to identify potentially exposed HCP.

Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

Symptomatic HCP with suspected or confirmed COVID-19 (**Either strategy is acceptable depending on local circumstances**):

- *Symptom-based strategy*. Exclude from work until:
 - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
 - At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy*. Exclude from work until:
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)[1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

- *Time-based strategy*. Exclude from work until:
 - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it

is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

- *Test-based strategy.* Exclude from work until:
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
 - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work in a [crisis capacity strategy to address staffing shortages](#) if they wear a facemask for source control for 14 days after the exposure. This time period is based on the current incubation period for COVID-19 which is 14 days.

Developing plans to allow asymptomatic HCP who have had an [unprotected exposure to SARS-CoV-2](#) (the virus that causes COVID-19) but are not known to be infected to continue to work.

- These HCP should still report temperature and absence of symptoms each day before starting work. These HCP should wear a facemask (for source control) while at work for 14 days (this is the time period during which exposed HCP might develop symptoms, i.e., the current incubation period for the virus) after the exposure event. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
 - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.
- If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.

If HCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all [Return to Work Criteria Prioritizing HCP with suspected COVID-19 for testing](#), as testing results will impact when they may return to work and for which patients they might be permitted to provide care.

**ANNEX H:
CAL-MAT Code of Conduct**



TO:	CAL-MAT Members
FROM:	Craig Johnson DMS Division Chief
DATE:	July 22, 2020

Revision/Version: Revised 7/22/20	Replaces: Various
------------------------------------------	--------------------------

SUBJECT: California Medical Assistance Team (CAL-MAT) Code of Conduct

PURPOSE: Establish parameters of conduct for members when deployed.

Summary and New information

- Describes acceptable and unacceptable behavior of CAL-MAT members when deployed, in uniform, or otherwise representing the CAL-MAT Program or the State of California.

Background:

Serving on CAL-MAT carries great responsibility and demands professionalism at all times. This Code of Conduct sets forth the minimum expectations of behavior for CAL-MAT members.

Policy/Procedure

1. When activated by EMSA to deploy to a mission supported by CAL MAT, you are a temporary State employee hired under at-will status subject to applicable state collective bargaining agreements.
2. As a CAL-MAT member, you represent the State of California.
 - a. Appropriate behavior, on and off shift, is expected of all members.
3. If activated, notify your Unit Leader.
4. While deployed, wearing of the CAL-MAT uniform is required. The uniform includes:
 - a. ID badge.
 - b. CAL-MAT T-shirt (tucked in).
 - c. Khaki 5.11 pants.
 - d. Black or khaki belt.
 - e. Black or tan boots (steel or composite toe are preferred) – Not supplied; this is an individual purchase item.
 - f. Sports-type shoes may be authorized for certain missions, as deemed appropriate by EMSA and the Team Leader.
 - g. EMSA cap (optional, depending on assignment and supply levels).
 - h. Exceptions will be granted when uniforms (or uniform items) are not available for distribution. We request khaki colored pants and navy tee shirt with black or tan boots.

5. No disclosure of deployment location or mission specifics is allowed without EMSA approval. Immediate family members should be provided with general contact information.
6. No social media posts related to your deployment are allowed unless approved by the on-site Team Leader.
7. No photos may be released unless approved by the on-site Team Leader.
8. If taking photos of yourself, NO patients are allowed to appear in the photos, remove your ID badge, ensure pictures are tasteful, and represent you and CAL-MAT favorably.
9. All questions from the media or requests for interviews should be referred to the MST or your Team Leader.
10. If this is your first deployment, let your Team Leader know.
11. Follow the Chain of Command while deployed; know the organizational structure of your particular deployment. CAL-MAT utilizes the Incident Command System (ICS), members should be familiar with ICS 100, 200, and 700.
12. Do not take a clinical assignment outside of the scope of practice allowed by your license or certification.
13. Professional license standards apply, but specific waivers and emergency orders may allow modified scope of practice or regulatory exemptions.
14. Treat all members on the mission with professionalism and respect. Report any difficulties with other personnel to your supervisor.
15. State and legal standards apply for workplace discrimination and harassment, based on protected characteristics such as race, ethnicity, and sexual orientation.
16. All members work as a collaborative team to provide the best possible medical care given the situation and resources available.
17. Inappropriate, offensive, or profane language, is not allowed.
18. Members must be honest and not cheat or steal under any circumstances. These situations will not be tolerated and will lead to immediate demobilization.
19. CAL-MAT members may be asked to perform tasks not directly related to their mission assignment, such as:
 - a. Assisting with the set-up and tear down of the CAL-MAT Base of Operations (bring work gloves).
20. If you become injured or ill, report it immediately to the site Team Leader - **DO NOT** work if you are sick or injured. Notify your Unit Leader as soon as practicably possible.
21. Know and use the Buddy System at all times.
22. Do not leave the Base of Operations (BoO) unless granted permission by the Incident Commander and/or Team Leader.
23. Deployed staff shall not leave the worksite without supervisor approval. When leaving, let your Team Leader, or designee, know where you are going, when you will be back, and who authorized your departure.
24. Have self-awareness of your surroundings. Do not go into restricted areas unless specifically approved to do so by the appropriate authorities and Team Leader.
25. Prescription medications or any other substances that alter judgment or ability to function while working are prohibited at all times.
26. Smoking and vaping shall occur only in areas designated by the Team Lead and Safety Officer.
27. Alcohol:
 - a. Alcohol consumption is prohibited within 12 hours of a scheduled shift.
 - b. Alcohol purchase and consumption are prohibited while in uniform and/or in a marked vehicle.

- c. Driving a state-owned or state rented vehicle after having consumed any amount of alcohol is cause for demobilization and removal from the program.
 - d. Arriving on shift with evidence of alcohol consumption warrants disciplinary action, potential demobilization, and removal from the program.
 - e. Alcohol consumption **is not permitted** on Fire Base Camp missions or other deployments requiring members to reside at the CAL-MAT Base of Operations.
28. Off Duty: It is the expectation that members will get enough rest and sleep during their time off to perform their duties and responsibilities safely while on shift. To ensure effective shift turnover and operations, day staff should not be at the Base of Operations (BoO) during the hours of 10 PM to 5 AM. Respectively, it is the expectation night shift should not be at the BoO from 10 AM to 5 PM. Exceptions may be made for specific circumstances and mission requirements.
29. Staff shall adhere to all EMSA leadership approved incident-specific policies and directives as determined by the MST Director or Team Leader.

Printed Name

Signature

Date

ANNEX I:

California Labor Code for Emergency Responders

LABOR CODE - LAB

DIVISION 2. EMPLOYMENT REGULATION AND SUPERVISION [200 - 2699.5] (*Division 2 enacted by Stats. 1937, Ch. 90.)*

PART 1. COMPENSATION [200 - 452] (*Part 1 enacted by Stats. 1937, Ch. 90.)*

CHAPTER 1. Payment of Wages [200 - 273] (*Chapter 1 enacted by Stats. 1937, Ch. 90.)*

ARTICLE 1. General Occupations [200 - 244] (*Article 1 enacted by Stats. 1937, Ch. 90.)*

230.3.

(a) An employer shall not discharge or in any manner discriminate against an employee for taking time off to perform emergency duty as a volunteer firefighter, a reserve peace officer, or emergency rescue personnel.

(b) An employee who is discharged, threatened with discharge, demoted, suspended, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because the employee has taken time off to perform emergency duty as a volunteer firefighter, a reserve peace officer, or emergency rescue personnel shall be entitled to reinstatement and reimbursement for lost wages and work benefits caused by the acts of the employer. Any employer who willfully refuses to rehire, promote, or otherwise restore an employee or former employee who has been determined to be eligible for rehiring or promotion by a grievance procedure, arbitration, or hearing authorized by law, is guilty of a misdemeanor.

(c) (1) Subdivisions (a) and (b) of this section shall not apply to any public safety agency or provider of emergency medical services if, as determined by the employer, the employee's absence would hinder the availability of public safety or emergency medical services.

(2) An employee who is a health care provider shall notify his or her employer at the time the employee becomes designated as emergency rescue personnel and when the employee is notified that he or she will be deployed as a result of that designation.

(d) (1) For purposes of this section, "volunteer firefighter" shall have the same meaning as the term "volunteer" in Section 50952 of the Government Code.

(2) For purposes of this section, "emergency rescue personnel" means any person who is an officer, employee, or member of a fire department or fire protection or firefighting agency of the federal government, the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state, or of a sheriff's department, police department, or a private fire department, or of a disaster medical response entity sponsored or requested by this state, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services as defined by Section 1799.107 of the Health and Safety Code.

(3) For purposes of this section, "health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

ANNEX J:

Incident Command Structure

1. All personnel on site will fall and practice within the ICS command structure (refer to Organizational Chart in Section 9 of this document).
2. Each branch will have a chief or lead with decision-making authority in unclear or divisive decisions
3. All resource needs should follow chain of command, seeking local, then regional, then state, then federal resources as needed if unable to fill need at most proximal level
4. A leader's span of control will optimally oversee a maximum of five persons reporting to them. If a lead has greater than five reports, consider dividing further to streamline delegation responsibilities.

Please review FEMA online courses:

IS-100.C: Introduction to the Incident command System

<https://training.fema.gov/is/courseoverview.aspx?code=IS-100.c>

IS-200.C: Basic Incident Command System for Initial Response

<https://training.fema.gov/is/courseoverview.aspx?code=IS-200.c>

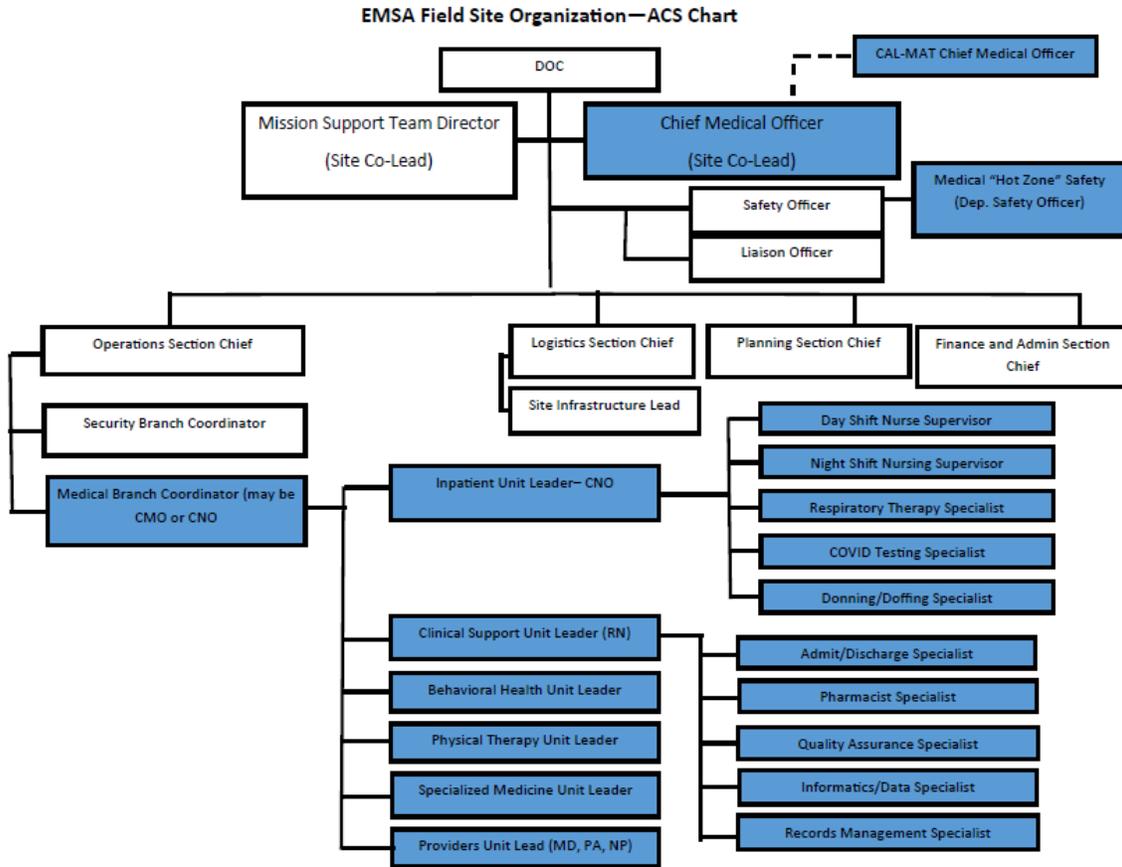
IS-700.B: An Introduction to the National Incident Management System

<https://training.fema.gov/is/courseoverview.aspx?code=IS-700.b>

IS-800.D: National Response Framework, An Introduction

<https://training.fema.gov/is/courseoverview.aspx?code=IS-800.d>

ACS Organizational Chart



ACS Communication Guide

ACS Provider Email for Patient Records:	_____@emsa.ca.gov
AMR Local Transfer Center:	
Local ACLS Transport Provider Name & Phone:	
Local ACLS Transport Provider Name & Phone:	
Local BLS Transport Provider Name & Phone:	
Local BLS Transport Provider Name & Phone:	
Regional MHOAC Name & Number:	
ACS Chief Medical Officer Name & Phone:	
ACS Lead Provider Name & Phone:	
ACS After Hours On Call Provider Name & Phone:	
ACS Chief Nursing Officer Name & Phone:	
MST Director Name & Phone:	
MST Operations Chief Name & Phone:	
MST Logistics Officer Name & Phone:	
MST Planning Chief Name & Phone:	
MST Admin/Finance Chief Name & Phone:	
ACS AM Lead Nurse Name & Phone:	
ACS PM Lead Nurse Name & Phone:	
Local Hospital:	
Local Hospital:	
Local Case Manager Lead Name & Phone:	
Local Case Manager Name & Phone:	
ACS Pharmacist Name & Phone:	