CMG 45 – SUSPECTED OR CONFIRMED COVID-19 PATIENTS – Section a) case definition

(10 September 2021) Version 3.2

COVID-19 *symptom criteria*

Fever (≥37.5^{O}C) or history of fever (e.g. night sweat, chills, fatigue, headache) **OR**

Sudden onset of loss of sense of smell or taste **OR**

Acute respiratory infection (e.g. cough, sore throat, runny nose)

COVID-19 *epidemiological criteria*

Returning travellers to the ACT, with arrival within 14 days **OR**

Close contacts of confirmed or suspected COVID-19 cases within 14 days of contact **OR**

Healthcare, aged or residential care workers with COVID-19 contact irrespective of travel or contact history **OR**

International border staff **OR**

Air and maritime crew **OR**

COVID-19 quarantine and isolation service workers **OR**

People who have been in a setting where there is a COVID-19 case (exposure site)

Vaccinated and COVID-19 “recovered” patients

Continue COVID-19 specific management for vaccinated and “recovered” patients who meet the above Symptom Criteria and/or Epidemiological Criteria

Vaccinated patients who develop other flu like symptoms, that are severe, or last longer than 48 hours after vaccination should be assessed and managed as meeting Symptom Criteria

Vaccinated patients who develop a fever within 48 hours of vaccination and meet at least one Epidemiological Criteria in the 14 days prior to illness onset should be assessed and managed as meeting Symptom Criteria

IMPORTANT CONSIDERATIONS

This guideline is to be used in conjunction with the Operation Work Instruction (OWI) 'Response to suspect COVID- 19 case'.

If you are concerned about a potential personal exposure, inform your Duty Officer (Operations) and contact ACT Health Communicable Disease Control for notification and advice:

5124 9213 (bus. hours) or (02) 9962 4155 (ah.)

	PPE	
ICP	Based off MDT information, if the patient sounds non-critical, perform a 'doorstep' assessment to ascertain if anyone on scene is symptomatic or has been potentially exposed. Don PPE as outlined in the OWI.	**AP**
ICP	Place an appropriate face mask on the patient ASAP.	**AP**
ICP	Face-shields and goggles must be donned when performing and assisting in aerosol generating procedures (e.g. advanced airway, suction, CPR, etc.)	**AP**
ICP	Possible accidental exposure: refer to staff exposure flow chart.	**AP**

	Transport Considerations	
ICP	Only transport to ED if the patient is clinically unwell and requires hospital level management.	**AP**
ICP	In suspected COVID-19 cases (not requiring transport to ED), private or public transport is appropriate for them to attend an alternative testing facility. Provide them with a surgical mask.	**AP**
ICP	Confirmed COVID-19 cases must not use public transport, and encouraging private transport is essential if they require a GP or specialist medical assessment or management.	**AP**
ICP	Transport to closest ED and early notification of triage via radio (ensure you comply with the standard patient destination guideline for types of cases you may still divert to TCH with e.g.: STEMI).	**AP**

IMPORTANT

The following changes to normal patient management should be followed only if;

- the patient meets *symptom criteria* regardless of epidemiologic factors
- the patient is asymptomatic and meets *epidemiological criteria*

ICP	A surgical mask should be placed under Hudson, NRB and BVM masks, and over nasal prongs.	**AP**
ICP	Restrict oxygen therapy to cases where Sp02 is <88% or where otherwise clinically indicated.	**AP**
ICP	To spontaneously breathing patients, apply the LOWEST FLOW oxygen possible which achieves an SpO2 of >88%	**AP**
ICP	CPAP is contraindicated	**AP**
ICP	In place of CPAP, passive oxygenation with BVM with a PEEP valve and filter is appropriate but assisted ventilations should not occur in these circumstances.	**AP**
ICP	During airway manoeuvres, a maximum of two paramedics to be within 1.5m of the airway.	**AP**
ICP	When IPPV is clinically indicated, LMA placement (with sedation if required) is preferred over BVM. When BVM use is essential, a two handed "V-E" seal should be used.	**AP**
ICP	Aim to sit the patient 45^{O} up to reduce airway pressure which reduces the risk of breaking the LMA/mask seal.	**AP**
ICP	During cardiac arrest, LMA placement should be prioritised over all other management except compressions and defibrillation.	**AP**
ICP	When providing assisted ventilations via an advanced airway, use minimal pressure on the bag to not break the seal.	**AP**

<u>Intubation is only to be used as a LAST RESORT.</u>

The below recommendations are deviations from CMG 3, which should otherwise be followed as normal

ICP	RSI of the suspected or confirmed COVID-19 patient is contraindicated if Suxamethonium is contraindicated.	
ICP	Each additional attempt of intubation dramatically increases the risk of contamination. If intubation is assessed as difficult, strongly consider alternative advanced airways (LMA, surgical).	
ICP	All attempts should be made to intubate outside of enclosed areas, such as the back of the ambulance.	
ICP	Preoxygenate preferably via sedation facilitated LMA. If oxygenation is being achieved, reconsider the need to intubate.	
ICP	No apnoeic oxygenation via nasal prongs.	
ICP	After removing the LMA to attempt laryngoscopy, have the assisting paramedic deflate the LMA cuff in preparation for a potential failed attempt.	**AP**
ICP	In the event of a failed intubation, reoxygenation preferably via LMA.	**AP**
ICP	In cardiac arrest cases, intubation should only occur if ROSC is achieved and only if absolutely necessary.	