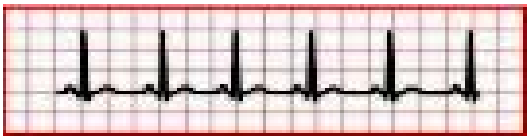

# The Monitor

The monthly electronic newsletter for the Southern Illinois Regional EMS System.

June 2020

**COMMAND:** Dr. Haake wanted to share his COVID-19 story in hopes that it adds perspective to the SIREMS protocols pertaining to the Novel Coronavirus.

*I wanted to share a personal experience with all of my pre-hospital providers in an attempt to provide first hand perspective and insight into the gravity of COVID-19. None of us in medicine were ever comfortable with the changes that we had to make to our daily practices due to this disease. We all got accustomed to the masks, gowns, gloves, screening questions, decontaminating our gear, etc. somewhat quickly. However, the one thing that most of us were not comfortable with was limiting our abilities to provide life-saving respiratory care. It's a wild time when we can't nebulize, provide high flow O2, use of positive airway pressure, or insert airways without incurring significant personal risk. We have all read about the prehospital and ED providers that contracted COVID, gotten extremely ill, and even died and we all understand the risks, but it just didn't feel right to not practice like we did prior to the pandemic. I never felt easy about changing the EMS protocols but I knew the risk was not worth the possible benefit in most circumstances and I followed standard of care for EMS care on a national level. It was weird to take a utilitarian approach to medicine in a world that previously had great resources. The one resource that is most valuable is the one that I had to worry about the most as EMS Medical Director: You. The providers. The people with the hearts, minds and hands that are supposed to care about the rest of society. If we all get sick trying to care for the rest of the world in a dangerous pandemic, there is no care. It's the first rule of EMS response: provider safety. It's a bit different for us in the ED and I often felt hypocritical and spoiled when I would perform airway procedures in the ED that I knew my EMS crews wanted to do in the field. The differences were our hospital resources: we had negative airflow rooms; we had PAPRs; we had video largyngoscopy; we had 4 team members in each respiratory room to watch each other's backs, literally. All these advanced safeguards were in place in the ED and seemed to be our best option for mitigating risk. However, all of the case reports and other reliable literature told us that we were still at significant risk and that the biggest amount of risk came from aerosolizing procedures and from high viral loads being transmitted into the room onto the providers. Why am I telling you this? Because I want you to understand why the protocols are protective of the providers. Because I did everything right as an ER Doctor and I still got COVID. I wore a gown, 2 sets of gloves, an N95, and eye protection; I intubated with a video laryngoscope; I was in a negative airflow room. With all of these protective measures, I still got sick as shit. I had a fever for 6 days. I sweat through multiple sets of clothing each day for a week. I felt so fatigued that it took all the energy I had to get up and use the bathroom. I could only stay awake for 4 hours at a time for 12 days. My muscles felt like I beaten with a bat for over a week. I lost 8 pounds even after drinking 4 liters of water and Gatorade per day. My friends had to bring me food and drink because I couldn't go out in public and expose others. I couldn't be around my wife and kids for a week and a half. My colleagues had to pick up my shifts for 2 weeks. I'm 39 years old, have zero medical conditions, and am a fitness enthusiast and, yet, this virus knocked me down for 2 weeks. Another staff member in the same patient encounter got so sick that they had to be hospitalized. Unlike some of our fine EMS agencies in SIREMS that have smaller rosters, losing a couple of staff members at once from the ED didn't*

*cause a big personnel issue. I understand that we all know people that have been through much worse illness and we all certainly take care of much worse. I'm not telling you this for sympathy or attention or any reason other than perspective. I hope that this anecdote reveals to you that even with the best safeguards we have in healthcare, we can still get sick. I hope that you see why our protocols limit what we can do prehospital to protect the providers. I hope that you read this and feel less uncomfortable with our restrictive yet protective protocols. Above all, I hope that you read this and feel motivated to stay diligent when it comes to protecting yourself and everyone around you.*

*Thank you for taking the time to read this.*

*Stay safe.*

*Dr. Haake*

**FINANCE:** Nothing new on the financial front at this time.

**LOGISTICS:** The EMS Office continues to work with IDPH and National Registry to secure the guidance needed for signing up for testing through www.NREMT.org. The information is not moving as quickly as we would like, but the collaboration continues. As soon as we receive the guidance, it will be posted on the system's website.

The IDPH extension for EMS license renewals due in March, April, and May are all due by June 30, 2020. If you have a license that has expired but remains active through the extension, please contact the EMS Office as soon as possible. We do not want to inadvertently lose EMS personnel right now, during a national pandemic.

**OPERATIONS:** Be sure to document the PPE used in the patient care report. We have encountered issues with PCR vendor software having areas on the backside for EMS personnel to document PPE, but it does not show up on the printed report. EMS Personnel writing the PCRs must document what PPE was worn for each crewmember as well as documenting a face covering was present on the patient. WE MUST make sure the PPE documentation appears on the printed PCR. Whether the information is part of the software or it appears in the narrative, it MUST be on the printed PCR that is left at the hospital.

There continues to be issues and questions about refusals. We want to address the following concerns below.

- Completing an assessment and the patient refusal checklist
  - The assessment should be done by the highest level EMS personnel in the crew and properly documented.
  - The patient refusal checklist (protocol A-6.2) **must** be completed on every refusal case.
- Assess mental competence
  - CAOx4 is a great starting point, but it's not enough.
  - Is your patient capable of understanding the nature of their condition and consequences of refusing treatment.

    - Do they have the ability to take care of themselves after refusing treatment/transport and plan of action if help is later needed.
- Medical Control **SHALL** be contacted when:
    - The condition indicates medical care is needed
        - This means a mechanism of injury or complaint that would normally warrant treatment and transport. This is not exclusive to whether ALS treatment would be performed, it's if any treatment would be needed…period.
    - The patient is not mentally competent
    - Refusal of treatment or transport could further harm the patient
- Lastly, be patient advocates and EMS clinicians! Look for reasons to take someone to the emergency department, not for reasons to keep you from transporting to the ED. For example:
    - If a patient falls and needs help up
        - Did you do an assessment to make sure there is not another problem not yet discovered? Geriatrics have a high tolerance for pain.
        - Can the patient hear and understand you? Did a hearing aid become dislodged during the fall? Is there a language barrier?
        - Can they ambulate on their own to later get food or go to the restroom? If not, it's really not safe for them…and you'll be back.
        - Where did the fall occur? How long were they on the floor? Carpet, tile, hardwood, or concrete? Is hypothermia a concern?
            - Though average room temperature is 72°F, normal body temperature is 98.6°F. Patients on the floor can lose significant body heat through conduction.
        - Did they hit their head? Are they on blood thinners/anticoagulants?
        - Are they medication compliant?
        - Is there food in the house?
        - Is the phone nearby?
        - I could go on and on. I hope we are driving some points home here.

**PLANNING:** Don't forget about our EMS Calendar at www.sirems.com

June 21: Father's Day

June 26: Scheduled date to enter Phase 4 of the Restore Illinois Plan

*TIP OF THE MONTH*: Consider contacting Medical Control as a form of telemedicine. EMS has been consulting with Medical Control physicians since the days of the show Emergency. You never heard Johnny Gage or Roy DeSoto complain about calling Nurse Dixie or Dr. Brackett, did ya?

If you have any questions or information for "The Monitor", please contact me at Brad.Robinson@sih.net or SouthernIllinoisRegionalEMS@gmail.com (06-18-2020).