	Frederick County, Maryland Division of Fire and Rescue Services	
	SPECIAL ORDER 20-013 Rev.2	
	Date: May 22, 2020	Page 1 of 19

COVID-19 Operational Guidelines

Overview

COVID-19 cases are now present in Maryland This has resulted in significant actions taken by the State of Maryland that have proven to be successful in combating the spread of this disease. This document is intended to provide the emergency responders of Frederick County with procedures and guidelines to assist in dealing with this disease process.

Definitions

- **Aerosol-Generating Procedures –** Any medical procedure that has the potential to create small particles that may linger in the air. This includes oropharyngeal suctioning, endotracheal or nasal intubation, intra-nasal medications, nebulizers, or any form of positive pressure ventilation or cardiopulmonary resuscitation (CPR).
- **Close Contact** - Being within six (6) feet of an infected patient, or being within the patient's care area or room. Brief interactions such as, walking by a person, or moving past their room does not constitute close contact.
- **Coronavirus -** A large family of viruses, some causing illness in people and others that circulate among animals.
- **COVID-19** – Is a new strain of the much larger Coronavirus (CoV) family and is a betacoronavirus, like MERS and SARs. "2019-nCoV" was first detected in Wuhan City, Hubei Province, China but has since expanded to include the United States. For confirmed 2019-nCoV infections, reported illnesses have ranged from people with little to no symptoms, to people being severely ill and dying. Symptoms can include: cough, fever, muscle aches, respiratory symptoms, loss of smell or taste.
- **Excessive Body Contact** - Direct body to body contact, extremity carries, rolling of patient, etc. Taking a temperature or getting vital signs **IS NOT** extensive body contact.
- **High Risk Exposure**
  - Less than 6 feet from a PUI, without Standard PPE,
  - High Risk Procedures without High Risk PPE.
  - Extensive Body Contact with a PUI without High Risk PPE
- **High Risk PPE -** Tyvek Suit/Impervious Gown, N95 respirator mask, eye protection/face shield, and gloves
- **High Risk Procedures –** CPAP administration, BVM assistance, CPR, intubation, suctioning, or administration of atomized or nebulized medications.

- **Low Risk Exposure**
  - Less than 6 feet of a PUI, with Standard PPE
  - High Risk Procedures with High Risk PPE.
  - Extensive Body Contact with a non-PUI, with Standard PPE
- **Patient PPE –** Surgical Mask
- **PUI Inclusion Criteria is patient with one (1) of the following:**
  - Confirmed cough
  - Fever (>99.0 degrees)
  - New onset of respiratory distress with an unknown origin (ex COPD, Asthma)
  - Positive COVID -19 test within 28 days.
- **or any two (2) of the following:**
  - Muscle aches
  - Loss of smell or taste
  - Contact with COVID positive patient within 28 days.
- **Standard PPE –** N95 respirator mask, eye protection/face shield, and gloves.

General Hygiene

Fire/Rescue/EMS Stations

- Regular cleaning with appropriate disinfectants is essential.
- Frequently touched areas must be cleaned several times per day with appropriate disinfectant.
- When appropriate, windows should be open to allow free flow of air.

Crewmembers

- Have a minimum of two (2) uniforms at work at all times. It is strongly recommended that crewmembers shower prior to leaving work, and either launder their duty uniforms at the station, or bag and launder them at home.
- Personnel should place a change of clothes and alternative footwear in an exterior compartment on the apparatus in case they need to be decontaminated.
- Volunteer and career employees will not report for duty if they are experiencing any fever (>100.0 degrees), signs and symptoms of respiratory infection (i.e. sore throat, cough, runny nose).
- Personnel with known seasonal allergies and presenting with the above symptoms excluding fever, may report to work and report symptoms through the daily checks.
- Personnel should not respond on incidents with personal belongings (i.e. phones, wallets, etc.) on their person as these items may become contaminated and may not survive decontamination procedures.

Apparatus

- Apparatus doors should be left open when in quarters to allow the free flow of air.
- The stretcher, patient compartment floors, action area, seats, etc., shall be cleaned at the beginning of each shift and after each transport with an appropriate disinfectant.
- The driver compartment shall also be disinfected at the beginning of each duty shift, and as warranted throughout the shift. Particular attention shall be paid to frequently touched areas (door handles, steering wheel, radio mic, etc.).

General Potential PUI Response

The information contained in this procedure is intended to be consistent with the EMS and ECC interim guidance given by the Centers for Disease Control and Prevention for management of patients with known or suspected 2019-nCoV. In some cases, our local implementation of infection control procedures will exceed those recommended by the CDC.

ECC PATIENT SCREENING

- The Frederick County Emergency Communications Center will screen callers requesting emergency services for **any** patient or person on the scene that has a fever or cough or has the patient or anyone in the house tested positive for COVID 19 in the past 28 days.
- An incident involving a patient that has been identified as satisfying the inclusion criteria symptoms above, shall be considered a **Potential PUI (Person Under Investigation)** however the "call type" will no longer be a "PUI".
- The Frederick County ECC will dispatch these incidents based on their normal "call type" determinants and will enter comments in CAD identifying a "Potential PUI" and highlight the known patient information for responders to see on the MDT.

POTENTIAL PUI RESPONSE ASSIGNMENT

- When the Frederick County ECC determines there is a person that conforms to the COVID-19 **Potential PUI** criteria, the incident assignment will include the following:
    - Engine Company
    - Ambulance
    - DFRS Supervisor (EMS Supervisor, Battalion Chief, or Safety Officer)
    - ALS Resources (if indicated by the call type)
- Units responding to or on-scene of an incident will not cancel or alter the above response assignment, only the responding DFRS Supervisor has that discretion. These units have roles and responsibilities in the management of these incidents to include data collection.

ARRIVAL PROCEDURES FOR ALL EMS CALLS

- Refer to attached **Reference #1**.

VIRAL SYNDROME PANDEMIC TRIAGE PROTOCOL

- This emergency protocol will assist EMS clinicians in identifying patients that may be appropriate to care for themselves safely at home, without transport to the emergency department. ALS or BLS clinicians may use this protocol.
- PPE shall be doffed on the scene in accordance with Doffing of PPE section of this document.
- Refer to attached **Reference #2** for protocol details.

TREATMENT PLANS

- For patients meeting the potential PUI criteria, clinicians will determine if this is an **Ambulatory Stable Patient** case or an **Unstable** case.
    - A **STABLE** case is a patient presenting with no to mild respiratory distress and will not require any advanced airway procedures.
    - An **UNSTABLE** case is defined as a patient that is actively expelling body fluids to include, saliva/sputum, **AND/OR** a patient that will require advanced airway treatment to include BVM assistance, intubation, atomized or nebulized medication, CPAP, or BLS airway placement.

"Ambulatory /Stable Patient" TREATMENT PLAN

- The initial provider should be in High Risk PPE and the only person in close contact with the patient.
    - All other personnel are to stay in the warm/cold zone unless requested by the primary provider.
- All personnel not functioning as a qualified Aide 1 provider or ALS designate will refer to the attached **Reference #7**.
- If the patient is conscious, alert, and in minor distress, ask the patient to place a surgical mask on themselves.
- A surgical mask will be placed over a nasal cannula or non-rebreather mask.
- The initial provider will obtain all vital signs and make a clinical determination if the patient should, and is capable of walking to the unit, or if the patient qualifies for the Viral Syndrome Pandemic Triage Protocol **(Reference #2)**.
    - If the patient is unable to walk, or has signs and symptoms which would exclude them from walking, the driver (and additional personnel if needed) will don the High Risk PPE and assist as needed.

* As long as personnel were in the appropriate PPE and have not been exposed to a High Risk Procedure and will not require donning of PPE upon arrival at FHH, they can properly doff their PPE at the scene and return to normal operations.
* **No family members or other persons from the scene shall ride in the ambulance or medic unit.**
* The DFRS Supervisor on-scene is the preferred method of contact to the receiving facility; if no DFRS Supervisor is on-scene, contact can be made via EMRC through the med radio by the transporting unit.
* Upon arrival at the receiving facility, a final determination will be made if the patient is capable of walking into the facility.
* When **advised by the receiving facility,** the aide provider will walk the patient into the facility and the driver will remain with the unit, whereas, stretcher bound patients **require** two people at all times for a safe transfer.

"Unstable" TREATMENT PLAN

In addition to the Ambulatory/Stable Patient criteria above, the following guidelines will be followed for the Unstable Treatment Plan.

* Potential limitation of procedures:
    - Patients should receive the care they need, and the procedures that are indicated.
    - Aerosolized (nebulizer) treatments should be avoided, but if needed, all personnel in the hot zone or same room are required to be in High Risk PPE no matter the duration of time. **Nebulizers will be stopped prior to exiting the ambulance.**
    - Non-essential interventions should be deferred to the hospital setting when treatment indications are such that deferral of those procedures is appropriate.
    - Life-saving procedures that are indicated by protocol shall be executed by clinicians using High Risk PPE.
    - Advanced airway management should utilize HEPA filters on CPAP, ETT and BVM ventilations. Video Laryngoscopy is the preferred method on all patients needing intubation.
* For patients requiring treatment enroute, consider utilizing a "clean provider/dirty provider approach".
    - The clean provider is in High Risk PPE and does not touch the patient. This provider can obtain supplies from bags and cabinets.
    - The dirty provider is in contact with the patient and provides all care.

PROVIDER PPE –

- Frederick County DFRS is following the minimum CDC recommendations for PPE protection. Below is a list of required PPE for patient contact:
    - Hot Zone (<= 6' from a PUI)
        - Tyvek Suit/Impervious Gown, N95 respirator mask, eye protection/face shield, and gloves
    - Warm Zone (Inside any structure on any call and > 6' away from the PUI)
        - N95 respirator mask, eye protection/face shield, and gloves
    - Cold Zone (> 6' away from the PUI in an open-air environment)
        - No PPE required
- On all Fire/Rescue incidents, personnel entering the Warm or Hot Zone shall at a minimum don the Standard PPE. If the incident requires full structural firefighting PPE you shall be considered properly protected only when you are "on air". If structural firefighting gear is contaminated the On-duty Battalion Chief (BC) shall be notified and will coordinate the transport and decon of personnel and gear. Do not place turnout gear, SCBA or other contaminated tools and equipment back on apparatus prior to receiving direction from the BC.
- No personal respirators will be worn on EMS calls.
- No facial coverings (cloth masks without filtration) will be worn on EMS calls.
- All personnel that don PPE shall strictly adhere to the outlined PPE Donning and Doffing Procedure along with Decontamination Procedures.
- Significant attention must be given to the PPE doffing process in order to prevent accidental contamination. See Doffing of PPE section.
- **The on-scene DFRS Supervisor will restock all provider PPE after every PUI incident. This will be done on a one-for-one basis.**

PREPARATION OF EMS TRANSPORT UNITS

- All Ambulances will keep the area between the patient compartment and the driver compartment segregated with a plastic barrier and duct tape at all times. This procedure will follow the guidelines provided by Station 33.
- Turn on the exhaust fan in the patient compartment.
- During transport, vehicle ventilation systems in both compartments should be on non-recirculated mode to maximize air exchanges.
- Keep cabinet doors closed unless supplies are needed. Once a cabinet has been opened, the entire interior of the cabinet must be disinfected.
- Tablets/computers should not be in the patient compartment.

CREW CONFIGURATION

- First Responder
    - Make every effort to limit the exposure of personnel.
- Ambulance
    - Provide patient care with every effort made to keep the driver of the ambulance from donning PPE or becoming exposed.
- Suppression Apparatus
    - Provide extra personnel to facilitate the movement of vehicles to the receiving facility.
    - The personnel from the suppression piece will make every effort to not don PPE and remain "clean".
    - If the DFRS Supervisor is not on the scene, it is the responsibility of the suppression unit officer to coordinate the incident. If the call meets the potential PUI criteria, complete the Possible PUI Personnel Tracking Report for all personnel on the scene. This form is located on the MDT under Quick Links/Coronavirus.
- ALS
    - Minimize exposure as much as possible and attempt to make the determination for ALS from 6 foot.
- DFRS Supervisor
    - Coordinate the incident.
    - Communicate with receiving facility and notification of potential PUI transport.
    - Document all personnel on the scene of a PUI, their level of protection and exposure. This will be completed on the Possible PUI Personnel Tracking Report. This form is located on the MDT under Quick links/Coronavirus.
    - **NO NOTIFICATION** is required to the Health Department.

FREDERICK HEALTH HOSPITAL (FHH) PROCEDURES

- All transported Potential PUI patients will require notification to the receiving facility. The on-scene DFRS Supervisor will complete this. If no DFRS Supervisor is present on the call, the ambulance crew will complete this. Announce the term **Potential PUI** during the consultation.
- Frederick Health Hospital will have two procedures upon arrival at their facility:
    - **Direct Bed Procedure**- The crew will be given a direct bed to report to upon arrival.
    - **Hold in Place Procedure**- The ambulance crew will hold in the ambulance until directed by FHH staff. The clean driver of the ambulance will go into the hospital and let the staff know they have arrived.
- No family members will be admitted through the Emergency Department EMS entrance, they should be directed to the front entrance to check in.

DECON OF APPARATUS, EQUIPMENT AND PERSONNEL - Reference Chart #3, #4 and #5

* **The below procedures will be completed for ALL EMS calls. The level of decontamination will be determined by the guidelines below.**
* **Low Risk Decontamination**
    - **Non Aerosolized Procedures**- Any patient care procedure that does not require aerosolized medications or positive pressure ventilations.
    - All patient compartment doors will remain open after patient removal to allow air exchange.
    - Don PPE or remain in current PPE after patient turnover to include: surgical mask, gloves and eye protection.
    - All exposed surfaces and patient contact areas must be decontaminated using an appropriate cleaning solution.
    - An appropriate cleaning solution.
        - An Environmental Protection Agency (EPA) registered hospital disinfectant with the label claim for disinfection of non-enveloped organisms (e.g. norovirus, rotavirus, adenovirus, and poliovirus). If a commercial disinfectant is used, follow the directions set forth by the manufacturer.
        - A freshly mixed 1:10 bleach to water solution, made by using 5-6% (household) bleach mixed with cold water in a spray bottle. This solution will remain effective as a disinfectant for 24 hours, and then discard.
    - Clean up any visible body fluids.
    - Discard all cleaning material appropriately.
    - Wash hands.
    - Shower at Station (Stations not equipped w/showers, should report to Station 33)
* **High Risk Decontamination**
    - **High Risk Procedures/Aerosolized Procedures**- Any medical procedure that has the potential to create small particles that may linger in the air. This includes atomized or nebulized medication administration, CPAP devices, patient intubation, or BVM use.
    - If a patient has used a home nebulizer within 60 minutes of EMS arrival and the patient is transported, the unit and exposed personnel will be transported to Station 33 for decon. If no patient transport is completed, exposed personnel will properly doff PPE on-scene and are to shower upon return to the station. (Stations not equipped w/showers, should report to Station 33)
    - If the patient vomits in the ambulance, the unit and personnel will decon at Station 33.

- All patient compartment doors will remain open after patient removal to allow air exchange.
- When decon at Station 33 is required personnel shall remain in their PPE and ride in the patient compartment of the ambulance to Station 33. At no point are they to ride in the clean cab of an ambulance or other vehicle (ALS, BC, Safety buggy, etc.). A “clean” responder will drive the unit to Station33.
- Any additional “clean” personnel will be transported back to their station or to Station 33 via another unit. The DFRS Supervisor will arrange transportation.
- Upon arrival at Station 33, the personnel will be directed through the fogging operation and showering procedures.

At any time, the DFRS Supervisor may increase the level of decon for units/personnel.

DOFFING OF PPE:

- Doffing Procedures will be completed after every EMS incident.
- Adherence to proper PPE Doffing Procedures is critical. In general, work from clean to dirty. The following order is recommended:
    - Alcohol based hand sanitizer will be used to decontaminate gloves prior to any doffing procedures.
    - Hair protection (if used)
    - Impervious Gown/Tyvek Suit
    - Arm covers (if used)
    - Leg covers (if used)
    - Shoe covers (if used)
    - Eye protection
    - Full Face Shield/Respiratory protection
    - Gloves
    - Alcohol based hand sanitizer
    - Wash hands
- PPE doffed at FHH, excluding the N95 masks will be placed in a regular trash bin in the doffing room and left at the receiving facility. Once the trash bin is full, notify the charge RN and they will have it emptied. The doffing room is the backboard storage room at FHH.
- All used N95 masks not meeting the ineligible mask criteria below will be placed in the labeled recycle container in the doffing room at FHH. Labeling of the N95 masks will be in accordance with the attached **Reference #6.**
    - Ineligible N95 Mask criteria:
        - Masks worn in the presence of a High Risk Procedure.
        - Masks that are wet or soiled (blood, vomit, secretions, dirt, etc.).
        - Masks that are damaged or where breathing became difficult.
- PPE doffed on the scene, excluding the N95 masks, will be placed in a Red Bag. The red bag should be double bagged with a focus on not contaminating the outer bag. This is to avoid contaminating the clean vehicle. The doubled bagged PPE is to be placed in the RED bag container at the station.
- All (eligible) N95 masks doffed on-scene shall be transported to the station in a small paper bag, and then placed in the large paper collection bag at the station.
- Station 33 personnel will provide direction on the disposal of PPE at Station 33.
- Cot linens will go in the normal linen baskets as designated by the receiving facility. Dirty linens should not go back to your station or to Station 33.

DECON PROCEDURES OF PERSONNEL - Reference Chart #3 #4 and #5

POST CALL PROCEDURES

- The DFRS Supervisor is responsible for documenting all personnel on the scene of a PUI, their level of protection and exposure. This will be completed on the Possible PUI Personnel Tracking Report. This form is located on the MDT under Quick links/Coronavirus.
- If a DFRS Supervisor is not on the scene, it is the responsibility of the suppression unit officer to complete the Possible PUI Personnel Tracking Report.
- Personnel who come into contact with a Potential PUI or a laboratory confirmed COVID-19 patient **without proper PPE** may be placed in quarantine for up to 14 days.
- The Division will follow the current CDC guidelines to address exposures. Quarantine Procedures will be completed at the provider's residence or other arranged location.
- The DFRS Supervisor will restock the PPE supplies used by the units on these incidents.
- Clinicians will complete their Patient Care Report.

BY ORDER OF: 

Division Signature

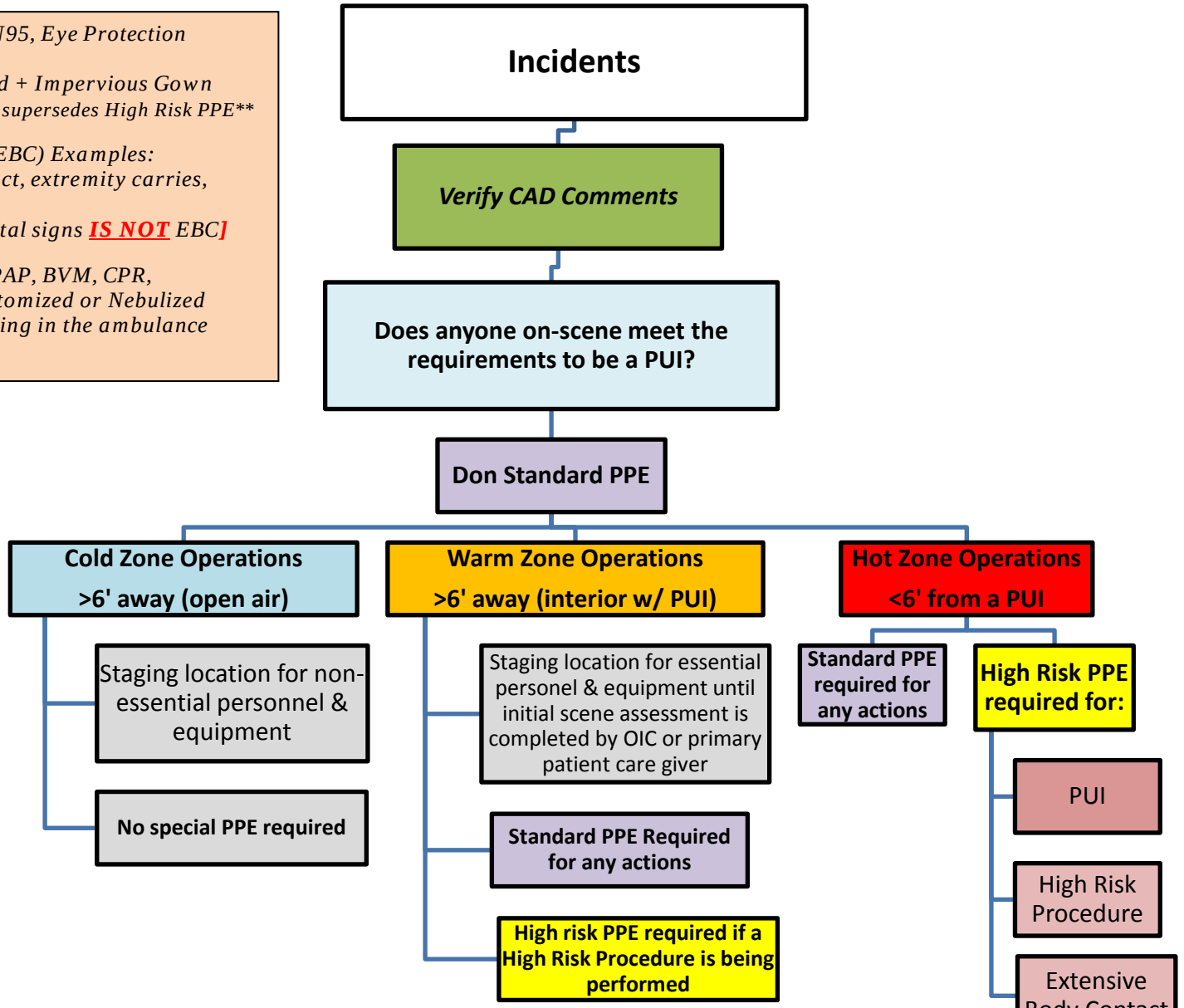
Incident Action Chart

Standard PPE: Gloves, N95, Eye Protection

High Risk PPE: Standard + Impervious Gown
Breathing air from SCBA, supersedes High Risk PPE

Extensive Body Contact (EBC) Examples:
Direct body to body contact, extremity carries, rolling of patient, etc.
*[taking temperature or vital signs **IS NOT** EBC]*

High Risk Procedures: CPAP, BVM, CPR, Intubation, Suctioning, Atomized or Nebulized medications, active vomiting in the ambulance



COVID-19 Initial Action Chart

Incident Action Chart (back)

General Operating Guidelines

- Upon arrival if possible, confirm prior to engaging on-scene subjects or entry into the structure if anyone there is a PUI
  - ECC, MDT, Phone Triage
- If personnel must enter the scene with no additional information they will maintain an initial distance of >6' from individuals present on the scene
- Any personnel entering the **warm or hot zone** must at least wear **Standard PPE** (Gloves, N95, Eye Protection)
- Minimize the number of personnel entering / utilized
  - *We still must handle the issue, just minimize the number of personnel making entry to those absolutely necessary*
- Only necessary equipment will be taken into the scene, staged in the warm zone unless absolutely required in the hot zone
- Any EMS patients who are PUI's will be placed in a surgical mask
- If any personnel inside the structure or the patient are a PUI, the incident will be upgraded to a PUI through ECC
- Cardiac arrests or unconsciousness warrant High Risk PPE at all times
- At no point will O/S units cancel or alter the PUI dispatch assignment, this can only be done by the responding DFRS staff Officer
- Patients should receive all appropriate care they need in accordance with MD Medical Protocols in the appropriate PPE
  - All High Risk Procedures indicated should be executed using High Risk PPE without delay
- Ambulatory patients can be escorted / moved by a single provider
- Non-ambulatory patients requiring transfer or assistance is a 2- person operation at all times by trained personnel
- No family members or other persons from the scene will ride in Fire Department vehicles
- The DFRS staff Officer will assist with FHH communications & exchange of information for all PUI's
- If an incident warrants the use (breathing of air) of an SCBA that shall replace standard / high risk PUI PPE

PUI Inclusion Criteria

- **(1) of the following:** Confirmed cough, Fever (99.0 F), New onset respiratory distress with an unknown origin (ex COPD, Asthma), Positive COVID-19 test
- **(2) or more of the following:** Muscle aches, loss of smell of taste, contact with a COVID-19 positive patient within the last 28 days
- **COVID-19 positive person in the structure**

Viral Syndrome Pandemic Triage Protocol

Protocol Procedures:

1. All EMS clinicians (**ALS or BLS**) when completing an assessment of a Potential PUI (fever or cough) may implement the Viral Syndrome Protocol.
2. During the assessment, the EMS clinician will complete the Viral Syndrome Pandemic Triage Protocol question sheet. This sheet should be in hand and completed for each relevant patient.
    a. **If the patient meets the criteria for the Viral Syndrome Protocol, the EMS clinicians will explain to the patient, at this time, their illness does not require them to go to the emergency department and all of their vital signs are within acceptable ranges.**
    b. If the patient agrees to home care, the clinicians will give the patient a copy of the **Home Care Instruction Sheet** and will not transport.
    c. The EMS clinician will explain to the patient the importance of continuing self-treatment and monitoring of their condition.
    d. The EMS Clinician WILL get the patients phone number for the Mobile Community Healthcare follow-up phone call. This MUST be documented in the eMEDS report.
    e. If the patient does NOT meet the viral syndrome criteria, the EMS clinician shall refer to the appropriate treatment protocol in the Maryland Medical Protocols for EMS.
    f. Viral Syndrome Protocol sheets will be kept in the ambulances at all times. (Minimum of 10)
    g. **All PPE MUST be properly doffed and equipment decontaminated prior to the crew entering the patient or driver compartment of the ambulance if the patient is not transported.**

Documentation Requirements:

1. All EMS clinicians MUST document every use of the Viral Syndrome Triage Protocol under the COVID-19 tab in eMEDS. All paper copies of the Protocol question sheets used to gather information on the scene shall be shredded at the station after the information has been added into the electronic eMEDS report.
2. Complete patient assessment and vital signs will be completed in the eMEDS report
3. Patient phone number MUST be documented in the eMEDS report under the COVID -19 tab.
4. Clinicians should not take the eMeds tablet into these scenes or have these patients sign electronically.
5. Signature Reason (Patient) - The “Release at Scene” option will be used to capture a signature from the patient who qualifies for the home self-care emergency protocol.
6. Signature Status (Patient) - Preferably use “Not Signed-Patient Contamination Concern”. This will decrease the need to decontaminate the tablet.

Patient Follow Up Procedures:

1. The Mobile Community Healthcare paramedic will run a daily report to identify all uses of the Viral Syndrome Pandemic Triage Protocol through ImageTrend Report Writer.
2. Follow-up phone calls will be conducted within 24 hours for all identified patients.

Follow Up Documentation:

1. All follow-up documentation will follow the COVID -19 Follow-Up Documentation Guidance released from MIEMSS. This will be completed by the Mobile Community Healthcare paramedic.

Decon of Apparatus, Equipment and Personnel Chart

Standard PPE: Gloves, N95, Eye Protection

High Risk PPE: Standard + Impervious Gown
Breathing air from SCBA, supersedes High Risk PPE

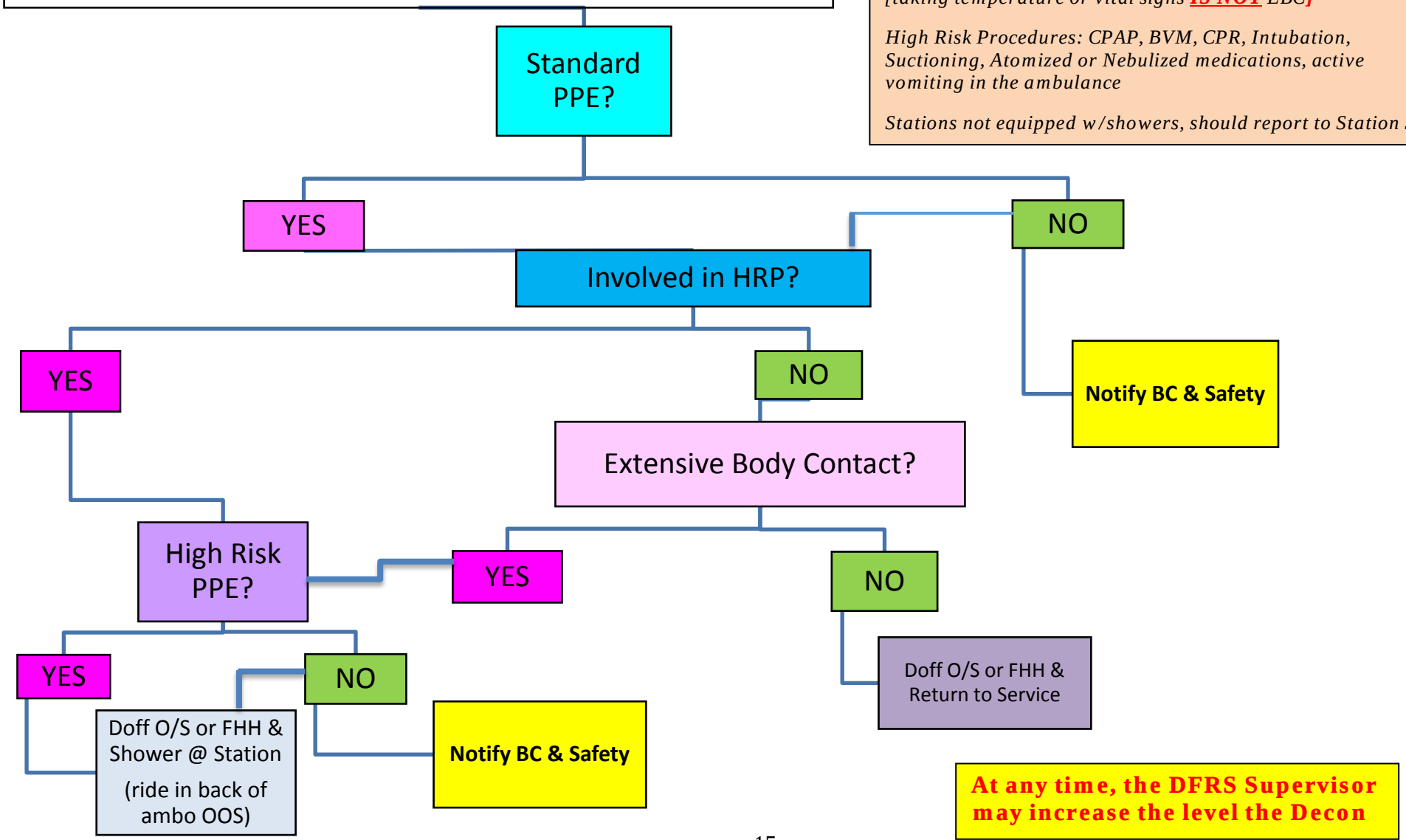
Extensive Body Contact (EBC) Examples: Direct body to body contact, extremity carries, rolling of patient, etc.
*[taking temperature or vital signs **IS NOT** EBC]*

High Risk Procedures: CPAP, BVM, CPR, Intubation, Suctioning, Atomized or Nebulized medications, active vomiting in the ambulance

Stations not equipped w/showers, should report to Station 33

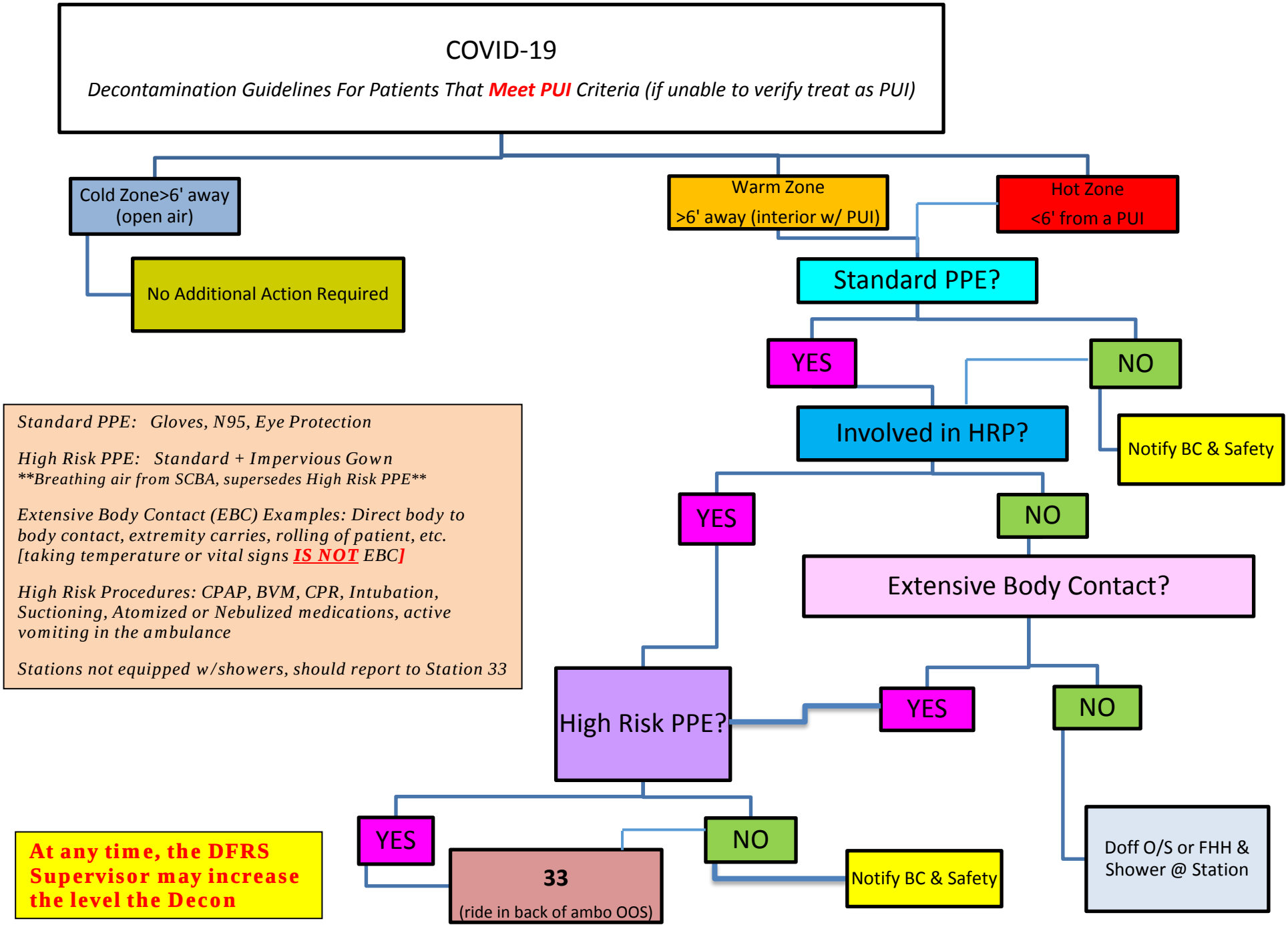
COVID-19

*Decontamination Guidelines For Patients That **DO NOT** Meet PUI Criteria*
*(**if unable to verify, refer to PUI chart**)*



At any time, the DFRS Supervisor may increase the level the Decon

Decon of Apparatus, Equipment and Personnel Chart



Reference #5

Station 33 Decon Operations

- Personnel should make their way to the East side of the decontamination tent and take the following actions with instruction being provided by Hazmat personnel who will maintain at least a 6' separation distance.
- Adherence to proper PPE Doffing Procedures is critical. In general, work from clean to dirty. The following order is recommended:
    - Alcohol based hand sanitizer will be used to decontaminate gloves prior to any doffing procedures.
    - Hair protection (if used)
    - Impervious Gown/Tyvek Suit
    - Arm covers (if used)
    - Leg covers (if used)
    - Shoe covers (if used)
    - Eye protection
    - Full Face Shield/Respiratory protection
    - Gloves
    - Alcohol based hand sanitizer
    - Wash hands
- Secure personal items in the provided bags for decontamination later.
- Enter the tent and completely disrobe all clothes by stepping into a trash bag and pulling the clothes off directly into the trash bag.
- The bag should then be secured and placed on the exit (*station side*) of the tent.
- Personnel should thoroughly wash themselves in the shower using the provided shampoo and soap.
- Upon completion of decon personnel will don the spare clothing they have with them or a post decon kit supplied by Station 33.
- **At any time, the DFRS Supervisor may increase the level of decon for personnel.**

Reference#6

Labeling of Used N95 Masks for Decontamination Process

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Reference #7

Personnel without Aide 1 Status

DFRS Probationary Firefighters (PFF)

Week 1 & 2

- The PFF will don the appropriate PPE and enter scenes alongside the Aide 1 provider.
- The PFF will be considered to be in an assist and observe type of roll, and the Aide 1 will be the lead provider.
- The PFF will remain in the warm zone to observe until such time the Aide 1 determines the patient is not a Potential PUI or the required medical treatment cannot be completed by just the Aide 1 provider and/or medic.
- For incidents ruled not to be a potential PUI the PFF will engage in patient care to the level of their ability (observation only is NOT an option).
- During **ANY** High Risk Procedure, the PFF shall only be in the hot zone when they are needed to render care. This includes in the back of the ambulance while enroute to the hospital.

Week 3 & 4

- The PFF will don the appropriate PPE and enter scenes alongside the Aide 1 provider.
- The PFF is considered to be in more of a lead provider roll, with the Aide 1 provider observing, directing and stepping in when necessary.
- The PFF will engage the patient and the Aide 1 provider will remain in the warm zone if possible to observe and coach the PPF.
- The PFF and Aide 1 will work together to determine if the patient is a Potential PUI, however the Aide 1 will have the final say.
- The Aide 1 provider is required to remain engaged with the PFF at all times unless agreed to and relieved by a medic because the PFF has not yet achieved Aide 1 status.
- During High Risk Procedures, the PFF can remain engaged in patient care so long as proper PPE is donned. (Note: consideration still needs to be given to limiting the number of personnel being exposed to these types of procedures.)

ALS Designates

- The ALS DESIGNATE will don the appropriate PPE and enter scenes alongside the ALS Preceptor provider.
- The ALS DESIGNATE is considered to be in more of a lead provider roll, with the ALS Preceptor provider observing, directing and stepping in when necessary.
- The ALS DESIGNATE will engage the patient and the ALS Preceptor provider will remain in the warm zone if possible to observe and coach the Designate.
- The ALS DESIGNATE and ALS Preceptor will work together to determine if the patient is a Potential PUI, however the ALS Preceptor will have the final say.
- The ALS Preceptor is required to remain engaged with the ALS DESIGNATE at all times.
- During High Risk Procedures, the ALS DESIGNATE can remain engaged in patient care so long as High Risk PPE is donned. (Note: consideration still needs to be given to limiting the number of personnel being exposed to these types of procedures).