



Paramedic Considerations COVID-19 Frequently Asked Questions

Airway/Breathing

Bronchoconstriction

- Q 1. **Why is it that I have to withhold salbutamol MDI for mild respiratory unless respiratory distress becomes moderate to severe?**

The potential benefit for salbutamol for mild respiratory distress does not outweigh the increased risk of droplet exposure therefore it is recommended to withhold salbutamol in these situations.

- Q 2. **For patients who screen negative for COVID-19, can medics use CPAP?**

Paramedics should consider withholding CPAP for all respiratory patients. We advise paramedics to apply the guidance in the latest MAC memo to all respiratory patients at this time.

- Q 3. **When a patient is COVID-19 positive, can salbutamol MDI be administered?**

For patients of any COVID-19 status who meet the Bronchoconstriction Medical Directive and who are in moderate to severe respiratory distress, Paramedics should consider salbutamol administered by MDI. Paramedics should consider withholding salbutamol for a respiratory patient who

- *is in mild respiratory distress.*

For severe respiratory distress requiring ventilations, paramedics may consider IM epinephrine if the patient is less than 50 years of age and has a history of asthma.

- Q 4. **If a patient is in severe respiratory distress, MAC's COVID-19 considerations suggest IM epinephrine as per the Bronchoconstriction medical directive. Does the requirement for a history of asthma still apply?**

Yes, a history of asthma is still required for IM administration of epinephrine in bronchoconstriction. The patient must also be less than 50 years of age to receive IM epinephrine for severe bronchoconstriction. Paramedics should in all cases withhold all nebulized medication administration, but may continue to consider salbutamol administration using an MDI for a patient with moderate to severe respiratory distress. A paramedic may withhold salbutamol via MDI for a respiratory patient who is in mild respiratory distress.



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Q 5. What is the “tidal breathing technique”?

Shake the inhaler well

- 1. Put the inhaler into the end of your spacer, with the indent for the nose on the mask pointing upwards.*
- 2. Put the mask to the patient’s face, making a seal so no medicine can escape.*
- 3. Have the patient tilt their chin up as it helps the medicine reach their lungs.*
- 4. Press the canister to put one puff of salbutamol into the spacer.*
- 5. Have the patient breathe in and out slowly and steadily five times through the mask.*
- 6. Remove the mask from the patient’s face and shake the canister again to repeat the administration.*

Continuous Positive Airway Pressure (CPAP)

Q 1. Why are we no longer using CPAP for any patients?

Currently the use of CPAP conveys an increased degree of risk. It is not always possible to know which patients who qualify for CPAP do or do not have COVID-19. CPAP is not a closed system; therefore the virus may be aerosolized which then creates an increased risk to providers as well as anyone within the vicinity of the treatment. Paramedics have other treatments that should be used while this revision is in place (e.g. nitroglycerin, salbutamol, oxygen)

Cardiac/Circulation

Medical Cardiac Arrest

Q 1. Given the likelihood of a neonate having COVID-19, would “no drugs down the tube for any age” include the newborn/neonate?

The OBHG COVID-19 considerations refer to all cases of endotracheal medications including in the case of a neonatal resuscitation. The AHA Interim guidelines for COVID-19 state that the preferred route for the administration of epinephrine during neonatal resuscitation is IV/IO as epinephrine via ETT is an AGMP. In situations where IV/IO is unobtainable, paramedics should consider initiating a patch the BHP for discussion of risk potential for ETT medications in this situation.

In addition, there is limited evidence that ETT medications have proven effectiveness. Although there is likely less risk of transmission of the virus from the neonate, NRP guidelines indicate that effective ventilations are effective in more than 99% of all cases. Emphasis should be on effective ventilations.



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Reference:

Edelson, D.P. et al, (2020, June 23). Interim Guidance for Basic and Advanced Life Support in Adults, Children, and Neonates with Suspected or Confirmed COVID-19. Retrieved from <http://ahajournals.org>.

Opioid Toxicity

- Q 1. **For the suspected opioid overdose, do I delay naloxone treatment to obtain a blood glucose first?**

During COVID-19 it is reasonable to consider naloxone immediately for the suspected opioid overdose patient without obtaining a blood glucose prior. However, paramedics should obtain a blood glucose as soon as possible following the naloxone administration.

General Questions

- Q 1. **Are these revisions for all respiratory distress patients or only patients that have a positive screen test for COVID-19?**

NO.

The application of this document is for ALL patients experiencing respiratory distress. There was a lot of provincial discussion regarding illness vs distress and it was decided that even a negative screen could be a patient at risk. Paramedics are in close distance to patients and at increased risk of droplet and aerosol contamination.