

Interim Guidance: SARS-CoV-2 (COVID-19) and Field Trauma Triage Principles

Product (EMS46) Purpose

This document provides a brief overview of how the Coronavirus Disease 2019 (COVID-19) impacts trauma triage for first responders, including Emergency Medical Service (EMS), fire & rescue, and law enforcement. The contents of this guidance document do not have the force and effect of law and are not meant to bind the public in any way. This guidance document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

Developed By

The Federal Healthcare Resilience Task Force (HRTF) is leading the development of a comprehensive strategy for the U.S. healthcare system to facilitate resiliency and responsiveness to the threats posed by COVID-19, the disease caused by the SARS-CoV-2 virus. The Task Force's EMS/Pre-Hospital Team is comprised of public and private-sector EMS and 911 experts from a wide variety of agencies and focuses on responding to the needs of the pre-hospital community. This team is composed of subject matter experts from the National Highway Traffic Safety Administration (NHTSA) Office of Emergency Medical Services (OEMS), National 911 Program, Federal Emergency Management Agency (FEMA), U.S. Fire Administration (USFA), U.S. Army (USA), U.S. Coast Guard (USCG), Department of Homeland Security (DHS) Cybersecurity and Infrastructure Security Agency (CISA) as well as non-federal partners representing stakeholder groups. Through collaboration with experts in related fields, the team develops practical resources for field providers, supervisors, administrators, medical directors and associations to better respond to the COVID-19 public health emergency. This document had collaboration from the HRTF Telemedicine team and was reviewed by key stakeholder groups related to trauma medicine prior to being submitted into clearance.

Intended Audience

State, Local, Tribal, and Territorial Governments (SLTTs) First Responders (Law Enforcement Fire & Rescue, Emergency Medical Services (EMS) and 911 communication personnel).

Expected Distribution Mechanism

EMS.gov, stakeholder calls, and EMS stakeholder organization's membership distribution email mechanisms, the USFA website, HRWG external affairs, and the Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange (ASPR TRACIE); the Indian Health Service tribal EMS distribution list; the Emergency Medical Services for Children (EMS-C) distribution. Request assistance distributing to FEMA regions and Department of Health and Human Services (HHS) Regional Emergency Coordinators (REC).

Primary Point of Contact

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Date Published

August 11, 2020

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The SARS-CoV-2 virus (the virus that causes COVID-19) has spread widely throughout the globe and is still continuing to spread. Emergency Medical Services (EMS) systems may experience a trauma-based mass casualty event -that necessitates triage while COVID-19 remains a significant threat to public health. Several factors related to SARS-CoV-2 infection should be considered when planning for, or responding to, trauma and mass casualty events in which field triage principles or schema are applied. Appropriate use of Personal Protective Equipment (PPE), universal precautions, and other scene safety considerations must be in place at all times:

- Due to widespread community spread of the SARS-CoV-2 virus and the potential for asymptomatic and pre-symptomatic transmission between people, it should be assumed that all patients and other persons on-scene are potentially infectious.
 - This assumption should continue until other aspects of the COVID-19 public health emergency have been mitigated, such as a large proportion of the public has been vaccinated or herd immunity established.
- Patients and other persons on-scene, such as bystanders and other public safety responders, may transmit the SARS-CoV-2 virus without exhibiting symptoms.
- There may be COVID-19 patients with significant physiological findings, including asymptomatic hypoxia, without exhibiting symptoms of shortness of breath or respiratory distress.
- Screening for temperature and other COVID-19 symptoms (e.g., cough, shortness of breath) can define certain levels of risk, but these actions lack known levels of sensitivity and specificity, especially in emergent or triage settings.
- Healthcare providers, including EMS providers, physicians, nurses, respiratory therapists, and others, are known to be at risk of exposure during patient care encounters. Proper use of PPE is effective at significantly reducing this risk.

General Principles for Trauma and Mass Casualty

- All healthcare and first responder personnel responding to trauma and mass casualty incidents should follow Centers for Disease Control and Prevention ([CDC guidelines](#)) for COVID-19 PPE protection, including respiratory protection at the level of N-95 respirators or above, eye protection/goggles, gowns, and gloves.
- All patients should be assumed to be positive and infectious for COVID-19 until proven otherwise.
- When possible, all patients and others on-scene who are not wearing face coverings should be given and encouraged to don a surgical mask or other facial covering to decrease the risk of transmitting virus.
- Interaction among patients, bystanders, and persons not providing medical care should respect guidelines for social distancing, including physical separation of six feet or more from others to the extent possible.

Trauma Management

- Priorities for trauma management remain unchanged regarding hemorrhage control, airway, breathing and circulation.

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- Increased risk exists related to airway management. Should active airway management be required certain principles require additional attention due to risk to staff related to COVID-19:
 - Numbers of first responder personnel treating patients should be kept to the absolute minimum necessary to provide emergency patient care.
 - First responder personnel should take additional precautions involving invasive airway procedures, including but not limited to aerosol-generating procedures, bag-valve-mask ventilation, intubation, suctioning, and cricothyroidotomy.
 - Invasive airway management should be performed by the responder with the most experience and skills in airway procedures in the most safe, deliberate, and expeditious manner possible and using procedures designed to minimize aerosolization.
- Transport should be limited to only patients and the minimum number of required care providers. Family or friends should not be placed in the transporting vehicle.
- Transfers of care within and outside of facilities should include communications regarding COVID-19 risk and any anticipation of risk related to airway management which may involve aerosol-generating procedures.

Mass Casualty Management

- All principles for acute trauma management listed above apply to all patients during mass casualty management.
- Under mass casualty triage conditions, the ability to discern likelihood of survival of trauma patients relative to the potential for having concomitant COVID-19 infection is not possible.
- To the extent possible, extra attention should be paid to management of potential cross-contamination with aerosols, fluids, and fomites during mass casualty management.
- To the extent practicable, all ambulatory and/or non-respiratory compromised patients should wear source-control facial coverings or simple masks to minimize aerosolized spread of the virus.
- Maximize space among all patients, with particular attention to applying principles of social distancing to patients determined not to need urgent or emergent treatment, including during transport.
- Security and crowd management should include, as much as feasible, principles of social distancing to minimize potential for viral transmission.
- Decontamination and disinfection of personnel, apparatus, and equipment should occur according to established protocols.