YNHHS Practice Guidelines for the Care of Adult Non-ICU

Inpatients with COVID-19 or PUI

Scope: Adult patients in YNHHS with COVID-19 or PUI not being cared for in an ICU

Definitions:

1) COVID-19 refers to those with positive testing
2) PUI refers to Person Under Investigation or COVID-19 test pending

Leadership and Decision Making:

1) System Adult Non-ICU Inpatient Guidelines arrived at through consensus jointly with leadership from physician, advanced practice provider and nursing.

Clinical Workflow:

1) Staffing: Decided by local RN/MD/APP leadership in conjunction with YNHH(s) leadership - will vary based on patient volume and staffing availability and may include clinicians working remotely

2) Rounding:
   a. Goal is to minimize patient contact and preserve PPE while maintaining high quality clinical care
   b. Staff should utilize tele-care technology when available and appropriate clinically
   c. Direct patient care should be clustered (VS, lab draws, medications, food delivery, etc)
   d. RNs should continue hourly visualization/rounding with purpose with an in-person focused assessments every 4 hours
   e. MD/APPs should limit in-person assessments to a single provider once per day unless clinical status dictates otherwise

3) Evening Coverage: Remotely or via use of tele-care technology with on-site provider availability for acute clinical concerns warranting in-person evaluation

4) Ancillary Evaluations: Defer or provide electronic recommendations until no longer PUI or evidence that COVID-19 has resolved unless clinically indicated

5) Subspecialty Consults: When clinically appropriate and as jointly agreed upon by the consulting and the requesting services, consults will be managed electronically. The consultant will document the question posed and recommendations in an Epic consult note

6) Care Management: Remote involvement with any necessary communication to the patient via phone or telecare technology

Admitting PUI or COVID-19 patients:

1) Receiving unit/provider is notified regarding identification of patient as PUI or COVID+ prior to transfer
2) Initial assessment and physical examination should be limited to a single clinician and a single nurse
3) Admission orders should include the following, which can be accessed via the YNHHS COVID-19 Admission Order Set:
   a. Isolation orders in accordance with the PPE for Hospital Setting Suspected or Known COVID-19 document
   b. Nasopharynx swab for SARS CoV-2 (COVID-19) and Respiratory virus PCR panel; specimen must be walked to the lab
   c. Baseline labs (CBC with differential, LFTs, CK, ferritin, CRP, LDH, procalcitonin, troponin T, d-dimer)
4) A discussion regarding code status/goals of care should be had with the patient/next-of-kin and well-documented in the medical record
   a. DNR should be recommended in patients with advanced ARDS with multi-system organ dysfunction or advanced underlying disease
   b. Avoid offering NIPPV to patients with confirmed/suspected COVID-19

Care of Patients with COVID-19:

1) Isolation/Personal Protective Equipment
   a. Modified Airborne + Contact - Negative pressure room; if unavailable, private room with door closed or double room with COVID-19 cohort
   b. N95/PAPR, eye shield/goggles, gown, gloves

2) Vital signs
   a. Every 4 hours
   b. Continuous pulse oximetry monitoring when available

3) Diagnosting testing:
   a. Labs should be clustered and performed no more frequently than q12 hours
   b. Radiology studies should be limited and performed portably

4) Patient transport:
   a. All movement of patients throughout the hospital must be coordinated with the receiving department
   b. Surgical mask is to be placed on the patient over any supplemental O2

5) Respiratory therapies:
   a. Oxygenation
      i. Nasal cannula use is limited to 5L or less outside of the ICU
      ii. Oxygen requirements of > 3L should be communicated to the ICU attending
      iii. Patients requiring > 5L oxygen should be transitioned to 100% NRB and ICU should be contacted for immediate escalation of care
   b. MDI treatments are preferred for all patients; small volume nebulized therapies should only be utilized in patients who have failed MDI and are in a negative pressure space
   c. Nasotracheal/open suctioning and chest physiotherapy should be avoided
   d. High-flow nasal cannula (HFNC) and non-invasive positive pressure ventilation (NIPPV, BiPap) should not be initiated outside of the ICU unless advised by an ICU attending
   e. Refer to Respiratory Care – Adult COVID-19 Practice Guidelines for additional information

6) Patient Decompensation/Respiratory Distress
   a. Direct patient care should be limited to a single attending physician, primary and/or SWAT nurse and respiratory therapist
   b. ICU attending physician should be contacted for immediate bedside assessment and consideration for ICU transfer
   c. Refer to Interim Guidance for Adult Emergency Team Response During the COVID-19 Pandemic for additional information

7) Hemodialysis:
   a. Patient will require private room
   b. Contact Nephrology to inform of COVID status and to arrange for dialysis in room

Discharges:

1) Patients who meet the following criteria are likely stable for discharge
   a. Afebrile x 48 hours
   b. O2 sat > 93% on RA or baseline O2
   c. Repeat chest x-ray at least 48 hours from prior imaging with stability or improvement
   d. Stable or improving inflammatory markers (CRP, LDH, ferritin)
   e. Improvement in symptoms of acute illness/overall clinical stability
   f. Documentation of adequate follow-up via telemedicine
2) According to CDC guidance, patient should continue self-isolation after hospital discharge if they meet the following criteria:
   a. 7 or fewer days since symptom onset
   b. 3 or fewer days since recovery, defined as resolution of fever without the use of fever reducing medications and improvement in respiratory symptoms

3) Discharge setting specific recommendations
   a. Home – Patient must have the mental and physical ability to comply with self-isolation (if required) and participate in follow-up with a medical provider within 48 hours of discharge
   b. Nursing facility – Patient must have documentation of resolved infection via SARS CoV-2 PCR x 2 over 24 hours

4) Refer to Guidance for Patients Discharged with Respiratory Infection Symptoms for further information

Cases of Delayed Recognition:

1) For adult inpatients hospitalized for non-COVID reasons, concern for COVID infection may arise. In this situation:
   a. Place a surgical mask on the patient, exit the room and contact the Charge RN and covering MD/APP
   b. The patient should be moved to a negative pressure or private room for immediate testing

COVID Testing Requests for Discharge to a Congregate Setting:

1) SARS CoV-2 testing may be performed at the request of an outside facility to facilitate discharge of a patient not believed to be infected with COVID-19. In this situation:
   a. The patient does not require any isolation precautions
   b. Testing may be performed in the patient’s current room