Yale
NewHaven
Health

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 **P**erson **U**nder **I**nvestigation or COVID-19 test pending

Leadership and Decision Making:

1) Joint consensus with leadership from physician, advanced practice provider and nursing, as well as pharmacy, infection prevention, and other stakeholders.

Clinical Workflow:

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

2) Daily Rounding:

   a. Goal is to minimize patient contact and preserve PPE while maintaining high quality clinical care
   b. Staff should utilize InTouch telehealth 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) Night Coverage: Remotely or via use of InTouch telehealth technology with on-site provider availability for acute clinical concerns warranting in-person evaluation. In person evaluation if clinical status warrants. Limit to single provider as able

4) Ancillary Evaluations: Utilize InTouch telehealth technology or provide electronic recommendations until no longer PUI *or* evidence that COVID-19 has resolved *unless* in person evaluation is clinically indicated

5) Subspecialty Consults: When clinically appropriate and as *jointly* agreed upon by the consulting and the requesting services, consults will be managed remotely using InTouch telehealth technology or e-consults. The consultant will document the question posed and recommendations in an Epic consult note, and also note the type of patient interaction performed.

6) Care Management: Remote involvement with any necessary communication to the patient via phone or telehealth 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 provider and a single nurse
3) Admission orders should utilize the YNHHS COVID-19 Admission Order Set
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. Avoid offering NIPPV to patients with confirmed/suspected COVID-19

Care of Patients with COVID-19:

1) Isolation/Personal Protective Equipment
   a. COVID precautions and Negative pressure room; if unavailable, private room with door closed or double room with COVID-19 cohort
   b. Follow YNHHS PPE guidelines for inpatient care and procedures
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, unless other clinical indication
   b. Radiology studies should be limited and performed portably when able. Cluster imaging if possible.
4) Patient transport:
   a. All movement of patients throughout the hospital must be coordinated with the receiving department, and should be limited and clustered as able.
   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. Patients requiring > 5L oxygen should be transitioned to 100% NRB and ICU should be contacted for evaluation for escalation of care, if within the patient's goals of care
   b. Utilize Prone Positioning early on in care to optimize oxygenation if pt is otherwise stable. Refer to Non-ICU prone positioning guidelines.
   c. 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
   d. Nasotracheal/open suctioning and chest physiotherapy should be avoided
   e. 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
   f. 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 bedside assessment and consideration for ICU transfer
7) Hemodialysis:
   a. Contact Nephrology to inform of COVID status and to arrange for dialysis

Cases of Delayed Recognition of COVID:

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 receive immediate testing

Discharges:
Refer to YNHHS Clinical Guidelines for Discharge of COVID Inpatients for details

Patients should have an ambulatory oxygen saturation documented prior to discharge.
Consider providing a pulse oximeter for outpatient monitoring.

> According to CDC guidance, patient should continue self-isolation after hospital discharge if they meet the following criteria:
> a. For a minimum of 10 days since symptom onset or date tested positive (20 days for severe disease/ICU stay or immunocompromised patient) AND
> b. At least 24 hours have passed since the resolution of fever without the use of fever-reducing medications AND
> c. At least 24 hours with improvement of symptoms (ie cough, shortness of breath, fever).
> d. Instructions for patients should be included for patients in the Discharge AVS. Use "IP COVID 19 Discharge Education" document found in Clinical References.
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> All patients should have prompt follow-up with their PCP or another medical provider.
> Pulmonary follow-up (new or established) should be considered for every patient discharging home.
> All patients should be provided with an Incentive Spirometer on discharge

Procedure:
Patient discharge to home
1) If patient requires continued self-isolation, consider whether the patient and the patient's home environment is able to support self-isolation.

Patient discharge to facility
Per CDC, if plan to discharge to a long-term care or assisted living facility, AND Transmission-Based Precautions/isolation is still required:
1) Patient should go to a facility with an ability to isolate COVID-19 patients.
2) Patients with persistent symptoms from COVID-19 (e.g., persistent cough), will require continued isolation until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.

Note that a negative test result is not required for discharge if a facility is able to isolate the patient.

All patients should be given at least 1 face mask (non N95) to keep with them upon discharge.

Per CDC, hospitalized severely immunocompromised patients (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV) may have longer periods of SARS-CoV-2 RNA detection and prolonged shedding of infectious recovery. These groups may be contagious for longer than others.