

# Adult Respiratory Care Practice Guidelines for COVID-19

## NEGATIVE or NOT SUSPECTED patients

These guidelines were structured to give health care providers (HCP) guidance for safe practices when administering inpatient respiratory treatments or devices in patients not known to be infected with COVID-19.

### COVID-19 STATUS

- COVID-19 testing is recommended within 24hrs of INITIATION of the following devices, assuming that a new requirement signals a change in respiratory status that may be consistent with COVID-19 infection.
- Routine COVID-19 testing should be done every 4 days on patients requiring daily NIV use.
- Treatment should not be delayed or withheld while awaiting testing. Rather, precautions, as detailed below may be followed while awaiting test results.

### Nebulized Medications

- A curtain can be drawn between 2 patients sharing a room in order to create space for respiratory distancing.
- MDI shortages currently dictate that nebulized bronchodilators, anticholinergics and inhaled corticosteroids be used in patients not known to be infected with COVID-19. *Nevertheless*, these medications should be limited to patients with clinical necessity, as in bronchospasm from asthma or COPD exacerbation.
- Nebulized bronchodilators and anticholinergics should not be ordered for asymptomatic patients.

### Oxygen Nasal Cannula / Oxymizer

- Patients wearing nasal cannula are asked to wear a face mask<sup>1</sup>.
- Oxymizer use is reserved for COVID positive patients transitioning off (descalating) from HFNC device. For COVID negative patients, it is reserved for patients that are already using an oxymizer at home or comfort measures (CMO) / hospice care.
- HCP should maintain arms length whenever possible.

### High Flow Nasal Cannula Device (HFNC)

- Nasal prongs should be placed, evaluated for good fit and face mask<sup>1</sup> placed prior to starting flow.
- Nasal prongs must be well seated in the nares with **minimal leak**.
- Patients wearing HFNC are asked to wear a face mask<sup>1</sup> when HCP are present.
- HCP should maintain arms length whenever possible.

### Non-Invasive Ventilation (NIV=BIPAP or CPAP)

- Home NIV devices will not be used - ALL NIV will be set up on hospital owned equipment with a **filtered circuit on the expire valve**.
- Mask interface should be placed and evaluated for good fit prior to starting NIV machine.
- **Good mask seal** *must* be ensured. Leaks >20% should be reported to respiratory supervisor and provider.
- HCP should keep their face and body to the side of the patient's mouth or nose to avoid direct alignment to the path of coughing.
- Routine COVID-19 testing Q4 days should be performed for patients on daily NIV.

### Suctioning / Physiotherapy

- Chest PT is limited to patients with clinical necessity. HCP should maintain arms length when administering.
- Nasotracheal/ open suctioning - HCP should maintain arms length when administering and keep their face and body to the side of the patient's mouth or nose to avoid direct alignment to the path of coughing.

### Patient's Home Equipment

- Chronic respiratory failure on a home ventilator should be transitioned to a hospital non-invasive ventilator with a filter on the exhale portion of the circuit.

## Tracheostomy Tube

- Standard humidification delivery system should be maintained (per institution).
- During suctioning, HCP should maintain arms length when administering and keep their face and body to the side of the patient's mouth and trach to avoid direct alignment to the path of coughing.
- Trials off the ventilator should be done with a filtered T-piece

## Extubation

- Resolving Respiratory Failure: *Per usual practice*. Do NOT stand directly in front of the patient. Position yourself optimally to avoid path of coughing. Suction as needed.
- Transitioning to Comfort Measures with ongoing respiratory failure:
  1. Titrate comfort medications to comfort prior to extubation.
  2. Extubate *per usual practice* with appropriate PPE on staff. Minimize staff in the room
  3. Supplemental oxygen via nasal cannula may be provided to the patient, depending on goals of care.
  4. A face mask may be placed on the patient, if comfortable.
  5. Family members should not be present during extubation. If family are present *immediately within 30 minutes post-extubation* in a negative pressure room or 60 minutes in regular pressure room, a respirator should be worn in addition to face shield/eye protection, gown and gloves. If 30-60 minutes passes post-extubation, a face mask (not respirator) is appropriate for use in addition to face shield/eye protection, gown and gloves.
- Patients that have expired while on mechanical ventilation can be extubated per our usual process. If the descendant is going for evaluation by the medical examiner or autopsy, ETT may be left in place with a plastic bag covering the hole.

## References:

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Please contact Respiratory Care or Infection Prevention leadership with any questions related to these practice guidelines.