SUBJECT: Minimum Contact ICU Care (COVID-19)

SUPERSEDES: New **PAGE:** 1 of 3

RECOMMENDATION(S): Benjamin Davis, MD **APPROVAL: 4/9/2020**

CONCURRENCE(S): Surgical and Neurocritical Care Teams **EFFECTIVE: 4/9/2020**

PURPOSE: To provide a framework for reduction in *unnecessary* contact between UAMS health care personnel and COVID + patients without undue reduction in quality of care.

DEFINITIONS:
Health care worker: any physician, nurse, advanced practice nurse/CRNA, physician assistant, therapist (respiratory, speech, physical, occupational), chaplain, technologist, environmental services employee, and others involved in direct patient care, or in support of direct patient care during the current COVID-19 pandemic.

BACKGROUND: COVID-19 is a highly contagious viral illness. Health care workers (HCW) are not immune. Quarantined and ill HCWs are, through no fault of their own, a source of strain on the health care system at a time when demand is expected to surge beyond capacity. Additionally, inefficient delivery of bedside care creates additional strain on the PPE supply. Rethinking care to eliminate duplicated and unnecessary procedures & bedside care is best practice in normal times and critical during the current pandemic.

INCLUSIONS:
1. UAMS patients known or highly suspected to be critically ill from COVID-19.

EXCLUSIONS:
1. Critically ill UAMS patients with low suspicion for COVID-19 (or who have tested negative) who have other *known* etiologies of their critical illness.
2. Otherwise salvageable COVID-19 patients, who, at the discretion of their attending intensivist, are determined to have life or limb threatened by compliance with these guidelines

INTERVENTIONS:
1. These guidelines may need to be adjusted if pandemic conditions alter nurse to patient ratios.

2. IV PUMPS: Whenever possible, pumps should be kept outside of the room to allow for delivery/titration of medications and fluid without donning PPE
    a. Please refer to pharmacy best practice statement regarding IV tubing

3. CHEST X-RAY: Daily chest XRs should be avoided, even on intubated patients. Unless there is a concern for an *actionable* finding on chest x-ray *that will change patient management*, avoid routine CXR.
    a. CXR is still standard practice for placement confirmation AFTER ETT/CVL placement

4. ABG: Consider limiting use of ABGs to those patients who are clinically decompensating in

whom then ventilator is actively being adjusted.
   a. Consider monitoring end-tidal CO2 if available (as on some vents)
   b. Consider following PaO2 for oxygenation

5. Labs:
   a. Serial labs should be avoided unless results will change clinical management
   b. All labs that will not result in a change in patient management *today* should be ordered for collection with next am blood.
   c. Add-on labs should be used if at all possible.

6. Bedside patient care: The following bedside procedures should be "bundled" if possible:
   a. Lab draws
   b. Vital signs
   c. Turns/baths/proning
   d. Medication administration
   e. Oral care
   f. Patient Assessments
   g. Proning: if prone team available, should coordinate timing with bedside nurse
   h. IV tubing: please refer to pharmacy COVID Recommendations best practice statement

7. Imaging: imaging requiring expedition to radiology should be limited that which will change management

8. Items under investigation:
   a. Alternative patient/nurse communication (walkie-talkies, baby monitor)
   b. Use of iStat for labs to avoid hand walking specimens

SPECIAL PATIENT POPULATIONS

1. Neurocritcal Care patients
   a. Q1 hour neurochecks only with clearance from attending intensivist
      i. Post-op NSGY patients and TBI patients determined on case-by-case basis
   b. Neuro checks may be limited to remote call in for awake & alert patients
   c. Q2 hour neuro checks for the following:
      ii. Large vessel occlusion
      iii. ICH > 30
      iv. Large intraventricular hemorrhage/hydro watch
      v. Cerebral edema with midline shift
      vi. Subarachnoid hemorrhage with vasospasm

i. During EVD weaning

b. Q4 (or >) neuro checks for the following:
   i. Status epilepticus
   ii. Myasthenia gravis
   iii. Guillain-Barre syndrome
   iv. Stroke with low NIHSS and no large vessel occlusion

c. Stat imaging:
   i. to be determined by NCC attending and radiology attending
   ii. Do only if it will directly change management (eg emergent thrombectomy, EVD, surgical intervention)

d. EEG:
   i. No routine EEG
   ii. Indication for video EEG
      1. NCC attending to clear with EEG attending
      2. Indications:
         a. Status epilepticus not returning to baseline despite first line AEDs

e. TCD: hold daily TCD until COVID-19 negative