UAMS MEDICAL CENTER TRAUMA and CRITICAL CARE SERVICES MANUAL

SUBJECT: Minimum Contact ICU Care (COVID-19)

SUPERSEDES: New PAGE: 1 of 3

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

<u>**PURPOSE:**</u> 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

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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

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- 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