## COVID Patient Management Tips

### Neuro:
- Given patient volume and need to don PPE prior to entry sedation is heavier than normal ICU patients
  - In patient not on paralytics: RASS target -2 to -3
  - Consider using enteral analgesics/anxiolytics to minimize frequency of titrating drips
- Physical restraints may be necessary to prevent self-extubation
- Not necessary to use train of 4 in paralyzed patient (continuous EEG monitoring is not necessary)
- If you think patient is appropriate for SAT/SBT, please make sure night team is aware so they communicate this with nursing/RT in the early morning
- Monitoring of daily triglycerides for pts on propofol infusions; consider alternatives to propofol if TG > 750

### Cardiovascular:
- Daily troponin, EKG for QTc
- Echocardiography available on limited basis; need to discuss with cardiology
- Consider esophageal doppler for volume responsiveness
- Keep the patient euvoletic

### Pulmonary:
- See UM ARDS ventilation algorithm (see below)
- No chlorhexidine oral care; regular oral care should continue for mechanically ventilated patients
- Continuous subglottic suctioning preferred over intermittent Yankauer suctioning
- Daily SAT/SBT not routine (risk of self-extubation and stretch of nursing/RT resources); SAT/SBT for appropriate patients should be at direction of attending intensivist. Consider specific strategies based on underlying conditions/physiology given high risk of extubation failure:
  - Less support than usual PSV 5/5; longer duration
  - Higher PEEP during SBT for obese patients
- Proning: vented and non-vented patients
  - Vented patients: suggest proning from 4pm to 10am; criteria-P/F <100 on high PEEP
  - All care team assists with proning
    - Short video: [https://vimeo.com/401852350](https://vimeo.com/401852350)
- Inhaled vasodilators: Nitric oxide available; preferred over other inhaled pulmonary vasodilators that require more frequent breaking of ventilator circuit
- Minimize/avoid bronchoscopy; Pepe de Cardenas available for consultation for urgent therapeutic bronchoscopy; disposable bronchoscopes available in anesthesia staging area
  - Consider a rescue catheter in patient with thick secretions and concern for developing endotracheal tube obstruction

### Gastrointestinal:
- Early enteral nutrition unless contraindication
- PPx:
  - No routine GI ppx unless home medication
  - Active GI bleeding: PPI
  - High risk for bleeding: H2 Blocker
- Implement bowel regimen early because of high dose narcotics/concern for ileus

Updated: McSparron 4/8/20
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### Hematology:
- Consider promotility agents if bowel regimen ineffective
- ***See algorithm from vascular team below regarding DVT PPx/Anticoagulation given high risk of DVT/PE in COVID patients***
  - All patients should be on chemical DVT ppx unless contraindication (Lovenox 30 mg bid [preferred] or subq heparin 7500 units tid [if Cr clearance < 30 mL/min])
  - If concern for DVT/PE and unable to obtain imaging begin heparin gtt (ACS nomogram)
  - If confirmed DVT/PE begin heparin gtt (DVT/PE nomogram)

### Renal:
- Renal team is on unit/available for consultation (multiple forms of RRT available)
- Discuss anticoagulation with renal team
- Preserve right IJ for dialysis line

### Infectious Disease:
- ID consulting on all new admissions (commenting on therapy and possible clinical trial entry)
- Inflammatory labs:
  - D-dimer, LDH, ferritin, CRP, PCT on admission and consider repeat x 1 if deterioration and were low initially
- Fever is expected in COVID-19 infection; see algorithm for when to draw blood cultures

### Endocrine:
- Hospital Intensive Insulin Program (HIIP) is following RICU patients and placing orders for RICU between 8am-5pm; RICU teams responsible for orders overnight (expanding to other units – contact Roma Gianchandani)
  - Goal BG 150-200 mg/dl especially if on tube feeds (different than our postsurgical goal which is tighter)
- General approach for tube feeds and hyperglycemia is basal Lantus plus scheduled “tube feed Regular insulin” q 6 hourly and a Regular insulin sliding scale
- If tube feeds stop, the “tube feed regular insulin” should be held otherwise pts get HYPOGLYCEMIC
- If regular insulin is given and tube feeds stop, the SAFETY order asks the nurse to start D5 at same rate as tube feeds

### Lines/Tubes/Drains/Airway:
- Consider bundling multiple procedures (intubation, CVC, a-line) if needed in order to minimize exposure and PPE use
  - Preserve right IJ for dialysis line
- Anesthesia teams in RICU to manage airways unless additional help is needed (MOTT airway team is available to respond)
- Identify primary team for airway management in specific unit; most experienced operator

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