UW Medicine Critical Care Management of COVID-19

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Key Updates from last version (marked with *):
- Universal testing of inpatients
- Loaner smartphones/tablets for patients without access needing communication resources
- ORCA order set (standardized daily labs, telemetry orders)
- High flow nasal cannula guideline
- VTE prophylaxis and anticoagulation
- Recommendation for enrollment in clinical trial of therapy if available

These recommendations supplement standard ICU care. Evidence and recommendations regarding the care of patients with potential, suspected, or confirmed COVID-19 are expected to evolve rapidly in the coming months. Clinicians treating patients with COVID-19 should review CDC’s updated recommendations frequently and consult with ICU leadership and/or infectious disease specialists as needed.

All UW Medicine guidelines can be found here: https://one.uwmedicine.org/coronavirus

I. OPERATIONAL CONSIDERATIONS

1. Level of care
   - Level of care is dictated by patient clinical condition, resources, and goals of care.
   - Low threshold for ICU admission/transfer; consider risk factors for worse disease (age >60, hypoxemia/dyspnea, comorbidities).
   - Establish goals of care (i.e., code status, ICU support) early, which may dictate available modes of oxygen delivery and disposition.
   - Consider Palliative Care consultation early.

2. Room Placement
   - Refer to UW Medicine Policy for current institutional policies.
   - Patients being tested for COVID-19 due to clinical concern should be isolated:
     - Patients not undergoing aerosol generating procedures (AGPs): Droplet + Contact precautions
     - Patients undergoing AGPs: Droplet + Airborne precautions
   - *Patients being tested for screening purposes (e.g. admission, pre-op) do not need isolation.
   - Negative pressure room if high risk for aerosol generation (e.g., mechanically ventilated, high flow nasal cannula, non-invasive positive pressure ventilation), if available.
   - Cohorting patients with proven COVID-19 acceptable in accord with surge plan.

3. Staffing
   - Refer to UW Medicine Policy
   - Minimize number of clinical staff who enter patient room. Consider log of staff on unit.
   - No medical students; consider appropriateness of resident/fellow involvement.
   - Check in on staff about their wellness.

4. Personal Protective Equipment (PPE)
   - Refer to UW Medicine Policy
5. Patient Visitors
   • Visitors currently restricted; see UW Medicine Policy. Consider communication with telephone or video. Tablets are available for patients to borrow from clinical units if they do not have their own device.

6. Physical Therapy
   • Therapist to assess patient as per current standards. Recommendations for therapy should account for limiting healthcare worker (HCW) exposure / PPE utilization. No ambulation outside room.

7. Patient Transport
   • Refer to UW Medicine Policy
   • Necessity should be confirmed by attending physician prior to transport.
   • Non-intubated patients should wear a face mask during transport.
   • Intubated patients should be transported on the ventilator (no bag mask ventilation).
   • Avoid transporting patient on non-invasive ventilation or face mask oxygen.

8. Provider Clothing and Equipment
   • Use only disposable stethoscopes.
   • Do not bring personal items (e.g., stethoscope, pager, phone, jewelry) into room.
   • Clean communication devices (e.g., phone, pager) often with germicidal wipes.
   • Wear hospital scrubs only and change to clean/street clothes before departure.
   • Wipe with Sani-wipes all equipment that enters room (e.g., ultrasound, Glidescope, etc.) per UW Medicine Policy

II. CLINICAL EVALUATION

9. Risk Stratification
   • Document age, comorbidities (cardiac, pulmonary, hepatic, renal, immunologic, etc.), pre-hospital location, baseline functional status, smoking status, suspected exposure, duration of symptoms, goals of care.

10. Laboratory Testing
    • COVID-19 and other respiratory virus testing per UW Medicine Policy
    • *Use the ORCA order set for COVID+ patients (not PUI)
    • Admission labs:
      o CBC with differential (absolute lymphocyte count), CRP, LDH, CK, DIC panel (includes D-dimer), ferritin, IL-6 level, troponin, BNP.
      o Consider repeating inflammatory markers (CRP, ferritin, IL-6, D-dimer, LDH) at serial intervals (e.g., q3 days) if concern for cytokine release syndrome
      o Consider daily cardiac biomarkers (troponin, BNP) for critically ill patients
    • Telemetry is recommended in ICU patients.
    • Minimize and batch lab testing to minimize HCW exposure risk.
    • Consider endotracheal aspirate (preferred) or mini-BAL (rather than bronchoscopy) to obtain lower respiratory tract sample if needed to assess for bacterial infection.
11. Imaging and Diagnostic Testing
• Consider utility of diagnostic studies in context of personnel exposure, travel, and potential for equipment contamination.
• Ensure careful cleaning of equipment (e.g., ultrasound) brought into room with purple top Sani-Wipes per Infection Control guidelines.
• Chest radiographs can be obtained through glass panes in doors and windows in some settings.
• *Consider POCUS for serial imaging of lungs, cardiac function and other bedside diagnostic studies.
  o Record POCUS images and document findings in EMR
  o Stored images may be reviewed by Cardiology/Radiology
• Routine CT scans unnecessary. If CT necessary, coordinate with other travel (e.g., from ED to ICU).
  o CT imaging unlikely to change management unless alternative diagnosis suspected (e.g., PE).
  o CT imaging may identify findings to guide repeat testing for SARS-CoV-2.

12. Bedside Procedures
• Bundle procedures to minimize PPE (e.g., intubation, vascular access, proning)
• Residents/fellows may participate in procedures with appropriate supervision and if PPE trained
• Conduct pre-procedure huddle / checklist before entering room. Consider adequate supplies, coagulation status, consent, personnel, positioning, equipment

13. Bronchoscopy
• Recommend strongly against aerosol-generating diagnostic procedures, particularly bronchoscopy, unless specific clinical question that cannot otherwise be answered. Personnel should be in appropriate airborne PPE.
• Trainees should not participate in bronchoscopies on PUI or patients with proven COVID-19.
• For [rare] instances when bronchoscopy needed, use disposable bronchoscope, if available.

14. Non-Invasive Ventilatory and Oxygen Support
• *HFNC may be used with appropriate safety and efficacy considerations; see UW Medicine guideline for High Flow Nasal Cannula. Reevaluate within 1-2 hours for clinical improvement using clinical judgment and objective measures (e.g. work of breathing, ROX index = (SpO2/FiO2)/RR). Lack of clinical improvement should prompt consideration of intubation if consistent with goals of care and resources available. Patients who are “Do Not Intubate” may trial increased FiO2/flow and consider transition to comfort measures if failing. Must be in appropriate isolation (negative pressure room, airborne/droplet PPE, PAPR preferred).
• Controlled intubation is preferred if patient’s clinical trajectory is such that intubation is inevitable and consistent with goals of care. (1) HFNC/NIPPV may not prevent intubation; (2) initial NIPPV may yield worse outcomes; (3) high (patient-induced) driving pressure may lead to lung injury and (4) open systems may increase droplet dispersion (risk to HCW) with poorly fitting interface.
• If NIPPV utilized (e.g., COPD exacerbation, OHS/OSA), use closed expiratory circuit mask/device with HEPA filter and ensure good mask seal with appropriate isolation (negative pressure room, airborne/droplet PPE, PAPR preferred).

15. Endotracheal Intubation (personnel, location, PPE)
• See UW Medicine Anesthesia and Airway Care of the COVID-19 guideline
• Intubation by the most experienced operator (will vary by hospital).
• Perform intubation in negative pressure room, if possible. If going to operating room, intubate in negative pressure room first before transport to operating room.
• Minimize the number of staff in the room but consider having a qualified backup physician nearby (outside room) for support.
• Preferred PPE: PAPR with shroud, gown, and gloves that extend over gown cuffs.

16. Endotracheal Intubation (preparation)
• Perform pre-intubation timeout. Identify 1st to 4th intubation equipment. Only bring necessary supplies into the room.
• Peri-intubation hypoxemia is common and often profound.
  o *Gentle bag mask ventilation, HFNC or NIPPV may be used very selectively if needed to maintain pre-oxygenation
    ▪ If BVM necessary, use small tidal volumes, two-person technique to achieve tight mask seal, and ensure HEPA filter in place.
    ▪ If NIPPV felt to be indicated (e.g., COPD exacerbation), ensure good mask seal and viral filter. Use in airborne precautions. Discuss with RT & RN to ensure situational awareness for all staff.
    ▪ HFNC should not be initiated if intubation is imminent and within goals of care. If HFNC in use, discuss discontinuation strategy with RT & RN before intubation to avoid excess aerosol generation.
      o Maximize pre-oxygenation with nasal cannula, simple face mask, or non-rebreather.
      o Recommend apneic oxygenation with 6L/min nasal cannula if needed.

17. Endotracheal Intubation (equipment)
• Prefer video laryngoscopy as added distance from oropharynx and better visualization through PAPR hood.
• Keep backup equipment and extra supplies outside the room.
• Ensure bag valve mask & ventilator have appropriate HEPA filter placed on endotracheal tube proximal to sidestream capnography adapter.
• Ensure cleaning/transport protocol followed for reusable dirty equipment.

18. Endotracheal Intubation
• Use RSI procedure to avoid aerosol generating bag/mask ventilation if possible.

19. Mechanical Ventilator Management
• Initiate lung protective/low-tidal volume ventilation for ARDS.
• Use existing lung-protective ventilation or hypoxemia protocols
  Consider high-PEEP strategy for severe ARDS if oxygenation inadequate with standard PEEP ladder and hemodynamically tolerated.

20. Proning
• Consider early proning for patients with \(P_aO_2/F_iO_2\) ratio <150; goal duration is ≥16h / day.
• Alert staff as soon as proning anticipated to ensure adequate personnel available. Incorporate staff exposure in decision to prone. Have pre-prone huddle outside room before entering.
• Use existing institutional proning protocol; see updated version with Airborne Isolation addendum.
• Consider placing arterial line prior to proning.

21. Neuromuscular Blockade
• Routine neuromuscular blockade (NMB) has not shown benefit in ARDS. However, individual patients with severe/refractory hypoxemia, hypercarbia, or dyssynchrony may benefit. NMB should be titrated to ventilator synchrony if used.

22. Sedation
• Ensure adequate analgesia and sedation with RASS goal 0 to -2 to reduce anxiety and ventilator dysynchrony requiring increased RN interactions.

23. Other Respiratory Care
• Avoid mechanical insufflation-exsufflation or chest physiotherapy if possible
• Aggressive suctioning may be required as thick secretions leading to endotracheal tube obstruction are common; consider hypertonic saline nebulizers in discussion with RT if tenacious secretions.
• *Tracheostomy placement is an aerosol generating procedure. Therefore, ideally, patients do not undergo tracheostomy until clear of virus.

24. Cardiovascular Support and Fluid Management
• Obtain baseline 12-lead ECG and maintain telemetry while in ICU.
• After initial resuscitation, consider conservative fluid management strategy.
• Vasopressor-dependent shock is not uncommon.
• *Cardiomyopathy has been reported – current institutional recommendations are to obtain baseline troponin and BNP and monitor with telemetry. Serial (daily) cardiac biomarkers are recommended for patients with severe illness or abnormal values.

25. *VTE Prophylaxis and Systemic Anticoagulation
• Strongly recommend chemoprophylaxis for VTE with either LMWH or heparin using standard dosing (adjust for BMI > 40 or low GFR) unless there are contraindications (platelets ≤ 25k/uL, bleeding)
• Systemic anticoagulation for usual indications (e.g. known VTE, atrial fibrillation) is indicated as long as the platelet count ≥ 50k/uL and fibrinogen ≥ 100g/dL
• Serial coagulation parameter monitoring is recommended (included in ORCA order set)
• Anticoagulation and blood products are not recommended to treat abnormal lab values or coagulation parameters (e.g. thromboelastography) unless there is a clinical indication (e.g. procedure, bleeding, thrombosis).

26. ECMO
• Apply UW Medicine ECMO Guideline patient selection criteria. Consider staff exposure, between-unit transfer, and availability of negative pressure rooms.
• Perform cannulation and ECMO in negative pressure room.
• External facility transfers for ECMO to be discussed with on-call ECMO physician and Medical Director

27. Cardiac Arrest
• Have goals of care discussion early in admission.
Consider informed assent approach for DNAR based on severity of illness, premorbid status, and resource availability.
Consider unilateral DNAR for patients with refractory shock or worsening despite maximal support.
Note high likelihood of delay in CPR due to PPE donning may reduce efficacy.
• See UW Code Blue – COVID Guideline

28. Palliative Care and End of Life
• Consider early Palliative Care involvement in ICU admissions. See UW Medicine Policy.
• *Consider video visitation for family members. Loaner tablets available to patients who do not have (or cannot use) their own devices.
• Death certificate should note:
  o Primary cause (e.g. ARDS, pneumonia, respiratory failure)
  o Second line: COVID-19
• List comorbidities in Medical Issues not directly related to death (e.g., diabetes, CHF, frailty)

III. PHARMACOLOGIC TREATMENT
See UW Infectious Disease COVID Treatment Guidelines

*Given the paucity of data and potential for harm, this guide supports considering enrollment in a clinical trial to study the effectiveness of unproven therapies rather than empiric therapy. Refer to the UW Infectious Disease COVID Treatment Guidelines or consult the Infectious Disease service based on resource availability.

Treatment of Bacterial Pneumonia
• Imaging appearance, symptoms, or exam findings consistent with bacterial PNA should be treated for CAP/HAP. Recommend obtaining cultures prior to antibiotics.
• Consider stopping empiric antibiotics after 48-72 hours if no suggestive culture data or low clinical concern.

Anti-inflammatory Therapy
• Systemic Corticosteroids
  o Not recommended for treatment of inflammatory syndrome/cytokine storm due to COVID-19 due to risk of prolonged viral shedding and possible harm. Steroids could be considered in the context of a clinical trial for patients with ARDS due to COVID-19.
  o Consider for patients with COPD or asthma in exacerbation.
  o Clinician discretion for refractory hypotension.

• Tocilizumab
  o Consider in the context of a clinical trial or in consultation with Infectious Disease. Check inflammatory markers (IL-6, CRP, ferritin)
  o Based on limited experience, may be most helpful in patients with moderate-severe cytokine release syndrome phenotype (Grade 2 or higher based on score)

Anti-Viral Therapy
• Remdesivir
- Contact ID/Pharmacy to discuss trial enrollment or expanded access program.

**Hydroxychloroquine**
- Consider enrollment in a clinical trial rather than empiric therapy.
- Consider/clinician judgment in consultation with Infectious Disease for confirmed disease
- Treatment duration is 5 days; monitor QTc.

**Lopinavir/Ritonavir**
- Recent negative prospective trial and low availability reduce enthusiasm for use.

**IVIG**
- Consider/clinician judgment in consultation with Infectious Disease.

**Convalescent Plasma**
- Clinical trial and compassionate use protocols are under development.

**References**
- UW Medicine COVID public site: covid-19.uwmedicine.org
- UW Medicine COVID OneDrive (internal site): https://one.uwmedicine.org/coronavirus