Med/Surg COVID-19 Management Recommendations for Admissions

Issue	COVID-19 suspicion		Recommendation
	PUI	Confirmed COVID-19	
GENERAL INPATIENT MANGEMENT			
Goals of care	X	X	Immediate goals of care discussion; repeat as needed with changes in status
Level of care	X	X	Level of care is dictated by patient clinical condition.
	X	X	Low ICU admission/transfer threshold if risk for severe COVID, deteriorating
Room placement	X	X	Private room if available
	X	X	Cohorting proven COVID-19 and PUI patients according to facility surge plan.
	X	X	Negative pressure room only if critically ill/ICU, undergoing aerosolizing procedure
Communication	X	X	In person wearing appropriate PPE, through patient telephone, or through TeleHealth platform
Nursing ratio	X	X	Staff according to standard Med/Surg criteria.
	X	X	During crisis surge staffing, ratios to change to 7:1 – 10:1
Staffing	X	X	Minimize number of clinical staff who enter patient room.
PPE	X	X	Airborne (PAPR) plus gown/gloves for any aerosolizing procedure. If N95 used, add full face shield
	X	X	Gown, gloves, procedural mask, & eye shield if no aerosolizing procedure.
	X	X	If possible: dedicated observer monitors/assists all PPE donning/doffing.
	X	X	Wear gown outside PAPR. Ensure glove cuffs extend over gown cuffs.
	X	X	Post PPE donning/doffing instruction both inside and outside room.
	X	X	Ensure hand sanitizer dispenser is available inside patient room near door.
	X	X	Provide a clean and a dirty PPE table for PAPR cleaning outside room.
Family and patient support	X	X	Visitors restricted. (see visitor guidelines)
	X	X	Utilize facility plan of utilizing iPads and Tablets to communicate with family members through video communication apps
Patient transport outside room	X	X	Necessity should be confirmed by attending physician prior to transport.
	X	X	Non-intubated patients should wear a face mask during transport.
	X	X	No transport on BIPAP or HFNC. OK for up to 15L/min non-rebreather mask.
Telemedicine	X	X	Utilize TeleHealth stations on unit to communicate with patients and provide care.
Rehabilitation Services	X	X	Standard care. No ambulation outside room. Limit exposure.
Personal clothing & equipment	X	X	Use only disposable stethoscope
	X	X	Clean communication devices (e.g. phone, pager) often with germicidal wipes.
	X	X	Consider changing scrubs and shoes to clean clothes before leaving hospital.
Cardiac arrest	X	X	Request/announce Code Blue events as “Code Blue Special.”
	X	X	Limit team in room to 5-6. Stage others outside.
	X	X	Perform intubation early with CPR held for intubation.
	X	X	Use N95 w/ face shield or PAPR when entering room
CLINICAL EVALUATION			

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Laboratory testing	X	X	Expeditiously submit specimens/paperwork for COVID-19 testing.
	X	X	Send infectious and immunologic markers per order set.
	X	X	Low procalcitonin does not rule out bacterial pneumonia and elevated level does not rule out COVID-19 (or other viral pneumonia).
	X		For COVID-19 testing, collect one NP swab collected from both nasopharyngeal areas and submit in appropriate media. UTM, VTM, M4 are acceptable at this time.
	X		For high risk patients with negative COVID-19 testing, consider repeat of COVID-19 testing, along with serologic COVID-19 test if patients have had sx >7 days
	X		Asymptomatic patients going to SNF or high-density residence (inpatient behavioral health, post-acute sites, extended rehab facilities, shelters) need to have COVID19 testing completed prior to discharge
***Asymptomatic patients**	X	X	Consider utility of bedside & other imaging/diagnostic studies in context of personnel exposure and potential for equipment contamination.
Imaging and diagnostic testing	X	X	Very carefully clean any equipment (e.g. ultrasound) brought into room.
	X	X	Routine or serial CT scans unnecessary.
	X	X	Incorporate risk of exposure when considering risk/benefit of potential aerosol-generating diagnostic procedures, particularly bronchoscopy.
Endoscopic procedures	X	X	Incorporate risk of exposure when considering risk/benefit of potential aerosol-generating diagnostic procedures, particularly bronchoscopy.
RESPIRATORY SUPPORT FOR NON-INTUBATED PATIENTS*			
Method of oxygenation support*	X	X	Rapid sequence of intubation could happen in med/surg negative pressure room before transportation to ICU
			Avoid NIPPV as a bridging strategy to the ICU
	X	X	Proning per protocol

PHARMACOLOGIC TREATMENT			
Treatment of bacterial pneumonia	X	X	Consider stopping empiric antibiotics after 48-72 hours if (1) cultures and urinary antigens negative; (2) no neutrophilia/bandemia; (3) no purulent sputum; (4) lobar pneumonia absent; (5) procalcitonin <0.25 (optional)
Systemic corticosteroids		X	Contraindicated as specific COVID-19 Rx (viral shedding, possible harm).
Stress-dose steroids	X	X	Clinician discretion for refractory hypotension
DVT prophylaxis	X	X	Increased DVT risk. Ensure VTE prophylaxis: enoxaparin 40 mg daily or 30 mg q12h, SQH 5000 units q8h-12h if CrCl <30.
Therapeutic treatment	X	X	Ex. Antivirals, IL-6 blockers, convalescent plasma. Consider consultation with infection disease specialist.
Bronchodilators	X	X	Prefer high-dose MDI + spacer (e.g. 8 puffs) for non-intubated patients.

GOAL OF MANAGEMENT PLAN

Provide quality care for a surge of patients at multiple facilities while also keeping our caregivers safe. Hospitalist staffing must be adequate to cover needs and flexible enough to cover variation in patient flow at different facilities while remaining responsive to system needs.

POPULATIONS

I. Screened from ED and admitted for COVID-19 compatible symptoms requiring Med Surg level support.

II. Direct transfers with medical illness requiring Med/Surg level care, who need to be screened before or on arrival to unit. (May or may not have a compatible respiratory syndrome)

III. Patients who have been in our hospital, admitted with negative risk screening, who then become ill with symptoms compatible for COVID-19 (in hospital exposure).

IV. Patients who are planned to discharge to SNF/Acute Rehab/High Density Residence or ECF, who may end up staying in the hospital for extra days if a discharge to an outside facility is not deemed safe.

COVID-19 HOSPITALIST SURGE MANAGEMENT PLAN

1. Trauma and community hospitals have drafted surge plans for staffing our Hospitalist groups.

2. Rural hospitals currently using TeleHospitalist (BR, Heber, SP), will expand from nighttime admitting coverage to 24 hour a day admitting and unit coverage for hospital to support the rural facilities.
   - Rural hospital surge planning has been expanded to Cassia, Delta, Filmore, and Sevier

3. Flexibility to redirect Hospitalist staffing to facilities or units where patients with Moderate/High/COVID-19 + status are cohorted.

4. Limit residents or students involved in caring for PUI or COVID-19 + patients.

5. Confirm comfort of caregivers donning and doffing PPE. Provide additional training if needed.

6. A daily Hospitalist contact will be identified to work with facility Incident Command.

7. Patients discharging to SNF, Acute Rehab, ECF, or other high density residences will be tested for COVID-19 prior to discharge (test results can be pending at discharge if facility will accept patient).

8. Home is the safest discharge to prevent spread of COVID-19. We will minimize discharge to other facilities. We will add a time-out for every patient discharging to SNF, Acute Rehab, or ECF. These patients might be kept longer in the hospital if it is felt that they might be able to discharge to home.