

ICU Snapshot for COVID-19 Patients

Last Updated: 6/30/2020

ICU Operations:

- Morning huddle for the entire unit to review relevant updates and plans
- Early call to anesthesia for all intubations
- Early discussions with patients and families (by phone) about code status
- Consult ID and palliative care for all confirmed COVID patients in the ICU
- Start dexamethasone 6mg daily (or its corticosteroid equivalent) x 10 days for all ICU patients unless contraindicated

PPE:

- ACE for all patients
- Staff safety is our top priority. NEVER enter a patient room without PPE, even for a code blue

Neuro:

- Some of these patients may require higher doses of sedation
- Opioids (e.g., fentanyl) as first line analgesic; consider parenteral opioids as adjunct
- Propofol/ketamine as first line for sedation; avoid benzodiazepenes as able, although consider in patients difficult to sedate
- Consult neurology/neurocritical care if concern for encephalitis, stroke, seizure, etc.

Pulmonary:

- Early intubation is favored
- A trial of HFNC can be considered on a case-by-case basis, with intubation for patients with persistent tachypnea (RR > 25) or high FiO₂ (>60%)
- For intubated patients, lung protective ventilation with low tidal volumes (6 mL/kg) and goal Pplat < 25-30
- Many patients have relatively preserved lung compliance and may not require high PEEP
- For refractory hypoxia with low compliance, high PEEP ladder, advanced ventilator modes, paralytics, proning, and flolan can be considered
- Consider mucomyst or hypertonic saline for thick secretions
- Extubate when confident of success; patients may have a prolonged inflammatory state
- Encourage good pulmonary toilet after extubation

Cardiac:

- As able, document bedside POCUS TTE on admission
- Trend daily troponin and SvO₂ for all; daily EKG for patients on QT prolonging medications
- Norepinephrine remains pressor of choice for shock (which has been relatively uncommon)

Renal:

- Aim for euvolemia, consider foley to assist with strict I/O's and keeping patients "dry"
- Robust electrolyte repletion for goal K > 4.5, Mg > 2.5, Phos > 2.5

GI:

- Dobhoff tube with a bridle for enteral feeds during and after intubation

VTE:

- Use standard or intermediate prophylaxis for those without known clot with D-dimer above/below 3000
- Use treatment dose anticoagulation for known or suspected clot

Codes:

- No one enters the room without PPE
- Patient is not disconnected from the ventilator; FiO₂ is increased to 100% and alarms can be increased
- Duration of code is at the discretion of the code team leader and care team

Access:

- Early placement of central lines and arterial lines