From: Hodge, Michele <michele.hodge@uchealth.com>
Sent: Friday, March 13, 2020, 7:02 PM
Subject: COVID-19 Update!! MANDATORY READING!!

Team,

First I would like to thank all of you for coming together and exemplifying the definition of teamwork. I have received multiple emails and texts offering to assist, and words cannot express how much your tenacity and dedication mean. You never cease to amaze!

So onto the details:

We have opened the RESPIRATORY ED as of 3pm on Friday, March 13th. Here are some additional details on how things will function, KEEPING IN MIND that things WILL change, perhaps frequently, depending on what this looks like. Planning for continued escalation is on-going. I very much appreciate your patience in the coming days, and the strain that we are about to put on our staff to accomplish our goals of keeping staff and patients/families safe.

1.) Patients will be screened at the front ED walk-in entrance by an ED staff member in droplet PPE (mask w/shield, paper gown, gloves) asking "Do you have fever, cough, or shortness of breath?" regardless of chief complaint.

a) If they screen positive for ANY respiratory complaint, they will be given a yellow surgical mask to put on and told not to remove and sent to the RESPIRATORY ED, the TENT outside of the decon room in the parking lot.

b) Patients entering by ambulance or prisoner with guard with c/o respiratory symptoms will be first triaged by the ED Charge (or nurse at box) and then directed to walk through ED double doors (across from women's locker rooms) and take a right to CDU main entrance.

c) ED Charge should call ED RN second triaging in the CDU to notify of patient en route.

2.) At this time patients will be screened by an ED RN in droplet PPE (mask w/shield, paper gown, gloves) in the tent who is completing first triage only.

a) ED RN will stick one patient sticker on the table and ask patient to place on chest. ED RN will then place sheet of patient labels with armband still attached to the sheet in the bin on the table (goal is not to have patient touch/contaminate the sheet of labels).
b) ED RN will ask patient to have a seat and they will be called when a room is available.

i. This tent will serve as a Respiratory Waiting Room.

ii. The tent is heated, has electric/Wi-Fi, a computer on wheels, label/wristband printer, and a droplet isolation cart.

iii. There are functional portable toilets and sinks set up behind the tent in the parking lot.

iv. Security WILL be present outside the tent.

v. This tent will LIKELY turn into a MD/APP driven screening area when volumes dictate.

3.) Patients will be walked from the tent by an ED/CDU associate wearing droplet PPE (mask w/shield, paper gown, gloves) into the CDU via the decon room and south (F-gate) hallway, which will be closed to general traffic.

a) ED/CDU associate will take the patient labels and a blank sheet to list staff who come in contact with the patient when walking patient to CDU and will hand to ED RN in 1-5 triaging.

b) An attending and an ED RN (who will have the CDU charge phone 688-5373) will be stationed in rooms 1-5 in appropriate droplet PPE where they will perform Medical Screening Exams on patients.

c) This is where we will determine the need for testing, transfer to ED for treatment, discharge, or admittance.

d) EVS will be cleaning rooms 6-16 according to isolation standards. ED/CDU staff will need to don droplet PPE and clean the chairs or surfaces contaminated with bleach wipes (blue top) allowing a 3 minute dwell time in between patients.

4.) Testing: Emergency Medicine Physicians will determine the following:

a) Guidelines on who we will considered for testing:

i. ANYONE who is getting admitted

ii. ANYONE who has been in contact with a COVID-19 positive patient in the last 2 weeks

iii. ANYONE who ODH sends in to be tested

iv. ANYONE MD determines through CLINICAL judgement who should be tested, i.e. just returned from Seattle w/symptoms, from China, etc.

b) Guidelines on how to test:

i. Swabs to be used for COVID19 testing cannot also be used for other microbiology studies. If other tests are needed in addition to the COVID-19 test, please send a separate swab for each test.

ii. Red tip Flu swab is used for testing. **Remember- doing an Nasopharyngeal swab requires Airborne + Droplet + Contact precautions (N95 or PAPR)**

5.) If a patient needs to be worked up/admitted (hypoxia, concerning co-morbidities, looks sick, etc.), move them to a room in CDU 6-16. There, an APP +/- resident can begin a full workup.

a) Workup for now should include: CBC, Renal, LFTs, INR, CRP, blood cultures, Influenza swab, +/- Respiratory panel (still confirming if Infection control wants this), CXR, +/- non-con CT chest

b) Admit to either medicine or MICU based on severity of illness. Goal is to get them to the admit floors QUICKLY.

6.) Intubations/patient management in the CDU:

a) Can be completed in rooms 8-16 (16 is preferable).
b) If a patient is sick enough to need to be intubated in the CDU, we must follow Airborne precautions and donning/doffing recommendations based on institutional guidelines as well as outlined by Dr. Carleton in the most recent I.C.Cordes email. If there are residents (R4/R1) in the Respiratory ED, the R4 will be the only resident that can intubate currently. The Attending will be back up. If there are no residents, the attendings will intubate.
c) DO NOT use NIPPV (CPAP/BILevel) on these patients, attempt to use Hi-Flo NC at MOST.
    a. Start with regular NC up to 4-6L, transition to HFNC, and if you continuing to increase HFNC without improvement- INTUBATE the patient.
d) AVOID nebulized treatments in almost all these patients except the bad asthmatics or bad COPD patient.
e) AVOID steroids in most of these patients except the severe asthma/COPD patient.
f) AVOID empiric antibiotics if your clinical suspicion is related to COVID-19 viral infection/pneumonia- draw cultures and let the team follow.
g) AVOID IV FLUIDS in most of these patients who have no hemodynamic instability- most of these patients are NOT "septic" or in shock on presentation. Excess fluid administration dramatically worsens patients who progress to ARDS (common in these sicker patients).

7.) Care of OB patients. We will assist in keeping potential COVID-19 patients out of the maternity NICU areas if possible. Here is what we have devised:

a) All OB patients (including >16 weeks) with respiratory complaints will come through the Respiratory ED. Screen them the same way you would a normal patient.
    a. If the patient appears sick or has lung pathology (asthma), move them to a room, MD will work them up (standard) and call OB- they will come to the bedside, and work to expedite that patient upstairs to the 7th floor (MSD or MICU.)
b) OB Patients who arrive to the ED without respiratory complaints will still be sent up to the 3rd floor per our usual practice.
c) Laboring mothers who have concern for COVID-19 should be masked immediately and sent upstairs to the saved negative pressure room on the 3rd floor in the OBED. The ED charge RN will alert the OB Charge RN.

8) **Staffing of the ED, Respiratory ED**

a) ED Coverage:

i. ED will be covered by ED staff and CDU RN's not needed to care for patients in CDU.
ii. CDU RN's can be placed in I-Pod or C-Pod to care for patients.

iii. ED/CDU float RN's can cover all pods except triage and SRU.

iv. ED RN, PCA, or Medic (1) will screen patients at walk-in entrance.

b) Respiratory ED (Tent) Coverage:

i. ED RN will complete first triage in Respiratory ED.

ii. CDU PCA will walk patients from tent to CDU.

iii. ED MD will assist with Medical Screening Exam when volume deems necessary (lack of care spaces in CDU)

c) CDU Coverage:

i. ED RN (1) will second triage/screen patient with ED MD in rooms 1-5.

ii. CDU RN's (2—but flex up or down as needed) will care for patients in 6-16 if treatment within scope (no critical care/vent patients).

iii. CDU or ED PCA will be provided if volume deems necessary.

iv. CDU HUC will cover HUC duties and assist to support during normal hours 7a-3p.

Please let us know if you should have any questions. This is a work in progress and your input is valued and important to providing safe excellent care!

Sincerely,

Michele Hodge, MSN, RN, NE-BC
Clinical Manager
Center for Emergency Care
University of Cincinnati Medical Center
234 Goodman Street | Cincinnati, Ohio 45219-2316
513.584.0786 (Office) | 513.584.2349 (Fax)
Michele.Hodge@UCHealth.com
www.uchealth.com