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Last Updated: 4/1/20

- Determine code status

 Biblical considerations (see Biocommendations regarding CPR in patients sits DCOM_15 for additional detail)

 CPR should be performed for unexpected cardiac annests in COVID—19 indicated annivabusal in Consistent in planter preferencesscools status

 CPR should NOT be performed for expected cardiac arrest due to proyective chiracid delereration from COVID—19 indicated by an annual information of the control of the c
- Cardiac arrest secondary to COVID-19 infection is not an indication for Extracorporeal Cardiopulmonary Resuscitation
- For OHCA patients who arrive with ongoing CPR by EMS, a max of 3 rounds of CPR is recommended unless history strongly suggests a
- Don appropriate PPE (e.g. N95/Respirator, eye protection, gown, & gloves)

- Variety opposed PPC (g), Nor-Incorporate, yes plotection, yours, o.
 United personnel in the root to only flore essential
 Avoid Baug-Mass Ventilation in It all possible
 Avoid Baug-Mass Ventilation in It all possible
 Androider organs via nor-othersafter face mass
 Androider organs via nor-othersafter face mass
 I required or expensioned prosition or professor BVM with filter,
 provided a flyit seaf case the maintained (consider a second provider
 to hold 40 mass in palice)
 When always established, connect to mechanical ventilator rather
 man loag.
 Followed or with the connect of the provider of the connect of the con

- Regulared, must use filter
 Keep the crash cart outside the room
 Defibrilate as needed
 Pause compressions to intubate
 Post arrest considerations

Resources & Updates

UCM Coronavirus (COVID-19) Resource Center

Surviving Sensis Campaign: Guidelines on the Management of Critically III
Adults with Coronavirus Disease 2019 (COVID-19)

American Heart Association CPR & Emergency Cardioascular Care: Interim. Guidance for Healthcare Providers during COVID-19 Outbreak

Basics of Mechanical Ventilation

Contemporary Ventilator Management for ARDS

ARDS management outside the ventilator

For clinical questions regarding the care of COVID PUIs or COVID patients, page the COVID Resource Team (p30028).

- Replaced less relevant Aerosol Generating Procedures information with link to the UCM Aerosol Generating Pro Guidelines
- Guidelines

 Added links to SCCM/Surviving Sepsis and AHA/ECC recommendations

 Removed outdated COVID Cohort Unit phone numbers 3/26/2020:
- Allowed for HFNC, BiPAP/CPAP in COVID Cohort Units

- Add link to Recommendations Regarding CPR in Patients with COVID-19 document.
- Added ED/OHCA considerations including termination of resuscitation recommendation for OHCA without ROSC in the field and post arrest recommendations.



- Notify FCP / Responsible Provider
 If Med/Surg Activate RRT (if not already at bedside)

Confirm Goals of Care With Patient/Family

- Document any new treatment limitations:
 DNAR
 DNAR with Treatment Limitations
 DNAR/DNI
 DNAR/DNI with Treatment Limitations Document discussion in event note
 - Escalation of Care Appropriate

Impending Respiratory Failure?

- FiO2 requirement >44% (e.g. 6L nasal cannula) to maintain O2 saturation >91% OR
 Ventilatory Failure
- COVID Cohort Unit or Adult ED Rooms with an Ante room?
- Don appropriate PPE (e.g. N9S/Respirator, eye protection, gown, & gloves)
 Dial 147 to activate 4-ball anesthesia response outside the ED
- RN to bring Crash Cart / Respiratory therapist to bring Advanced Airway Cart

- Advanced Airway Carst

 A Keep cants outside the room at all times

 Filamental to pass enclassions and equipment as needed
 RN to bring Anesthesia Medication / RSI Kit from Commost
 Limit personnel in the room to the minimum necessary
 Rapid Sequence Institution

 Financian College and the Ventilation of the College and t

- The most experienced provider available should perform the intubation using video larygoscopy
 Connect to ventilator at first apportunity

If not already there, transfer to ICU or COVID-19 Cohort Unit

- Critical care or ED RN, respiratory therapist, and anesthesiologist or ED INI to accompany intuitieted patients to the ICU

 Maintain full PPE (e.g. NBS/Respirator, eye protection, govan, & gloves)

 Hold at ETTV-entillator tubing junction to prevent disconnection during transportation.

- Note: Inhibeted positives with suspected or continued COVAD-19 do not require
 a Derryatifier Text for transportation as long as the habiting circuit remains
 closed at all filters.
 Follow: SOP: Transporting a Suspected or Confirmed
 Commodeling Illinoise.

- Commercius Resease
 P-CMAPCM notes ruraing leadership on the unit the patient is being transferred to in order to give them advanced notice to huddle with the ecopling nursing team
 Once the patient is transported, RN contacts RVS at 5-6337 for, 7-100-100 for Twoel Concentrativa clean. Sign. Perindensmetal Concentration, and Wistes Removal for Suspecied of Confirmed Coronavirus. Bleases 2019 (COMD-19).

Initial Ventilator Management

- Set tidal volume to 6cc/kg of ideal body weight (IBW)
- Calculate IBW using height and sex (<u>amcalculator</u>)
 Titrate FiO2 down from 100% to 60% to achieve saturation 90-95%
- If unable to wean to 60%, increase PEEP in increments of 2 and check plateau pressure
- For every increase in PEEP there should be a change in plateau by the same amount or less
- plateau by the same amount or less
 Increase PEEP until FIO2 can be brought down to 60% or less, plateau pressure >30, or plateau pressure increases more than PEEP change
 If PIF ratio <150 after initial PEEP thration, consider Proning
 Inform hardwise critical care nurse of intent to prone patient.
- Inform bedside critical care nurse of intent to prone pati
 Call 8South Charge RN for proning help (x6-8500), if needed.

- urasion and adequate sedation

 Consider neuromuscular blockade (NMB) with
 Cisatricurium only if patient is deeply sedated (RASS = -4
 or -5)

 Do not strate analgesic or sedative until NMB is
 discontinued

Initial Analgesia and Sedation Settings

- If significant ventilator dyssynchrony persists despite PEEP titration and adequate sedation

Continued Ventilator Management and Weaning

- Liberation from Mechanical Ventilation Educational video
 For promed petients, attempt suprisation daily and can remain surpria if IPF ratio 150 after suprisation of the Ventilation of California (Scholler) of California (Scholler) of California diversia as tolerated
 Continua diversia as tolerated

- Wean FIC2 as tolerated
 Wean FIC2 as tolerated to maintain adequate saturation on nontoxic FiO2 80% or less
 Wean FICE PS as tolerated to am H2O or less may consider spontaneous breathing that (SBT)
 Parts spontaneous breathing that with availabning from sedation
 If passes SBT, outbate to HFNC if FiO2 is >40% or PEEP requirement was >50m H2O
- Discuss possible extubation to helmet NIV especially for patients on PEEP of 8-10cmH20
- Heimet Ventilation Education Video
 Heimet Ventilation resource: call 6-1888 for Lead RT support

Treatment Limitations

Comfort Care

Floor Comfort Care Order Set
 Comfort measures only ICU Order Set

No Impending Respiratory Failure

Continue to Monitor Respiratory Status

- Consider continuous puls
 Assess RR q30 min x 3

Able to protect airway AND

- Trial of High Flow Nasal Cannula (HFNC)
- Don appropriate PPE (e.g. N95/Respirator, eye protection, gown, & gloves)
 Start HFNC at 40 lpm / 100% FIO2
- Titrate flow rate up to max of 60 lpm if needed to decrease work of breathing and maintain RR <30 bpm

- Titrating off HFNC
- Decrease FIO2 as tolerated to maintain saturation 92-96%
 Once FIO2 weemed to 40%, transition to 6L NC and assess for desaturation and/or respiratory distress (i.e. RR >30)
 If any distress, transition back to previous FIO2 of 40% and flow rate on HFNC

- CPR, Infubetion, BIPAPICPAP and HFNC are aerosol generating procedures
 Don appropriate PPE (e.g. NSiGRepirator, eye protection, gown, & glowes)
 Maintain for 45 minutes post infubationiaerosol generating procedure
 After 45 min, surgical mask is appropriate generating procedure
 The followine is contrainfused and should
- generating procedure

 The following is contraindicated and shou be avoided except with the express permission of Dr. Kress or Dr. O'Connor:
- Any use of BiPAP/CPAP in suspected or confirmed COVID patients
- confirmed COVID patients

 Use of 1+RVID in suspected or confirmed
 COVID patients located outside a COVID
 Cohert LIM
 Helmet ventilation may be considered at the
 direction of the MICU service
 See LICAL General Guidelines for Aerosol
 Generating Procedures for ARUIT COVID
 Full and COVID Positive Patients for
 Additional recommendations