

COVID-19 Best Practice Preparedness Checklist Level II

March 13, 2020

This checklist is the second in a series of communications and readiness objectives. These should be implemented as soon as possible. The most valuable resources are the providers. The efforts should focus on preventing any providers from getting exposed at work.

**ALL HOSPITALS MUST OPEN INCIDENT COMMAND AND DECLARE AN INTERNAL DISASTER
BEFORE THE FIRST COVID19 PATIENT IS ADMITTED**

PROTECTING HEALTH CARE WORKERS (HCW)

1. Prior to ED entrance, SEPARATE all respiratory illness patients from rest of Main ED.
2. All respiratory illness patients OR febrile infectious patients are to be categorized as Patients Under Investigation (PUI) or presumed COVID and masked immediately.
3. Mask all PUI patients immediately and practice strict infection control for droplet precautions with full PPE.
4. Perform MSE, and stable patients may be DC to home with pre-developed follow-up instructions. Nurses can do these per recent CMS ruling. Hospital regulations may need to be changed to allow for this.
5. May utilize personal vehicles for patients to wait for MSE as pre-triage or telehealth solutions to isolate all PUI from general ED patients and staff.
6. Limit contact with PUI to essential personnel only.
7. Outreach to EMS and fire regarding PUI transport and isolation of workers with potential exposures.
8. Review and require 2-person donning and doffing for PAPRs.

EVALUATION AND MANAGEMENT of PUI

9. Perform testing per CDC recommendations and local health system capabilities as appropriate.
10. Isolate "sick" PUI patients to negative pressure or private room as available in main ED; cohort as much as possible and minimize staff and removal of PPE protections.
11. **CORRECT PPE MUST BE WORN AT ALL TIMES WITH CONTACT OF ANY PUI.**
12. **Avoid O2 by face mask;** use High Flow O2 via NC.
13. Intubate with video assist.
14. **Avoid nebulized treatments;** utilize MDI with disposable spacers for bronchodilators if needed.

Disclaimer: This content is intended as a resource for clinicians caring for critically-ill COVID-19 patients, based on available evidence and recommendations of governing bodies. The recommendations do not replace clinical judgment or the need for individualized patient care plans. While we attempt to keep this information up-to-date, the literature on COVID-19 is rapidly evolving, and we suggest that practitioners search for the most up-to-date literature on any specific topic. These guidelines will also rapidly evolve as they are implemented into clinical practice and we receive feedback from practitioners. Additionally, local factors should be taken into account if utilized.

15. **Avoid BIPAP** - Quickly progress to rapid sequence intubation and mechanical ventilation using viral filters.
16. If possible, avoid the use of suction during intubation.
17. Develop surge capacity for inpatient and critical care beds as part of Incident Command.
18. Develop trigger with hospital administration for cancelling elective admissions and converting operating suites for expanded ICU capacity.
19. Develop plans for re-assigning medical staff to disaster management duties, (e.g. Anesthesia managing 'OR ICU').

STAFFING

20. Have a full jeopardy call schedule or surge staffing plan for ED.
21. Begin reworking shift duration and staffing to anticipate a 25% reduction in staff.

COMMUNICATION AND EDUCATION

22. Review the CDC page daily for updates: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>
23. Communicate essential information multiple times and send out at least twice weekly emails about the state of preparedness.
24. Consider having staff meetings with only call-in or WebEx options.