Saint John Regional Hospital
Department of Emergency Medicine

SJRH ED COVID-19 Clinical Treatment Guidance

V17April2020

Mild
Alert
RR12-20
SpO2>95%
HR 51-110

Mod
Alert
RR21-24
SpO2 94-95%
HR 111-130

Severe
AMS
RR>24
SpO2 92-93%
HR >130

Critical
AMS, end organ dysfunction
RR>24 >8
SpO2 ≤91%
HR>130; AbN perfusion

Airborne/Contact (N95+)
*Cardiac arrest/Critical O/A
*Aerosol Gen. Procedure

Droplet/Contact : no **AGPs**/mild
No specific role for steroids
Limit IV fluid administration
Caution vs NSAIDs >mild, contraindicated

Ix:+/- NPS

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CXR- portable

Normal

Abnormal:
>25- 50% bilat infiltrates
and/or at risk conditions

Investigations: NPS
CXR- portable
Sepsis bloods +LFTs
ECG

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$$LIMIT AND PROTECT VS. AGPs
HFNO/Optiflow- **Limit, surgical mask pt**
NIPPV (CPAP/BiPAP)- **Avoid**
Nebulized treatments- **Avoid**
BVM, Intubation- **Protected**
Suction , disconnections, Surg. Airway

Walk:30m SpO2≥94%
Access All: ☑Shelter ☑Food/H_2O☑Phone ☑Adult

Home: education & h/o
Fam Med- prn clinical f/u pending result. Call oncall
RTED/Direct Admit:
AMS **or** unwell **or** RR>20 **or** SpO2≤94% **or** ↑ dyspnea

General Treatment:
FiO2:lowest flow possible to maintain SpO_2≥90%$$
IVF: +/-maintenance (limited)
Abx:cefuroxime 1.5g IV q8h + azithromycin IV/po x48h (r/a)
if allergic: moxifloxacin 400mg IV/po q24x48h (r/a)
Antiviral IF influenza circulating:
oseltamivir 75mg po bid –D/C if neg influenza swab
Bronchodilators by MDI (COPD/Asthma)
Consider Conscious Proning –per guidance document

General Treatment:
FiO2: to SpO2 94% until stabilized, and 90% thereafter
IVF: Adults 250-500ml q30-60ml. Stop if overload, no effect
Peds 10-20ml q15-30min x2
Abx: ceftriaxone 2gIVq24 + azithromycin 500mg IV q24 x48h (r/a)
Antiviral IF influenza circulating; d/c if swab (-):
oseltamivir 75mg po bid—D/C if neg influenza swab
Bronchodilators by MDI (COPD/Asthma)
Consider Conscious Proning- per guidance document

Legend:
AMS= altered mental status
AGP (aerosol generating procedure)
NIPPV= noninvasive positive pressure ventilation
RTED- return to ED
ETT/MV= intubation & mechanical ventilation
HF(N)O= high flow (nasal) O_2
BVM= bag-valve-mask ventilat'n
PBW= predicted body weight
CVA= central venous access
At risk conditions include: >65, end organ dysfunction, CAD, DM, CHF, COPD/asthma, HTN, immunocompromised

Persistent Hypoxemia:
Failing O2 5L/np (with surgical mask)- consider evolving ARDS
Plan ETT/MV ➤ Checklist ➤ AIRBORNE PRECAUTIONS

5 person team: In Room- MD/RN/RT
Outside- MD/RN
Limit and protect NIPV, HF(N)O ➤ AIRBORNE PRECAUTIONS
2 person BVM, VL best option, most experienced provider
LMA for rescue oxygenation
Inflate cuff before bagging/MV post-intubation
HEPA filter at patient end for all circuits
Liberal sedation/analgesia
ARDS MV: TV6ml/kg PBW; higher PEEP, Plateau <30cmH2O
Consider Prone Ventilation if refractory hypoemia

Shock:
Trial IVF as above w/ freq r/a (VS, POCUS)
Early vasopressors to MAP 65mmHg (60-65 >65yo):
Adults 1) norepinephrine 0.01-3mcg/kg/min
2a) epinephrine 0.1-0.5mcg/kg/min
or
2b) Vasopressin 0.03 units/min
Peds 1) epinephrine 0.1-1.5mcg/kg/min
2) norepinephrine 0.01-3mcg/kg/min
Vasopressors should be infused through CVA ASAP.

Hydroxychloroquine: only in select/**confirmed** cases in consultation and for compassionate care and/or enrolled in a clinical registry. **NOT STANDARD**
Mild to Mod AND at risk disease: 400mg po q12h x1d, then 200mg po q12h x4d
Severe/Critical: above regimen AND azithromycin 500mg IV q24h x3d