COVID Care at UNM

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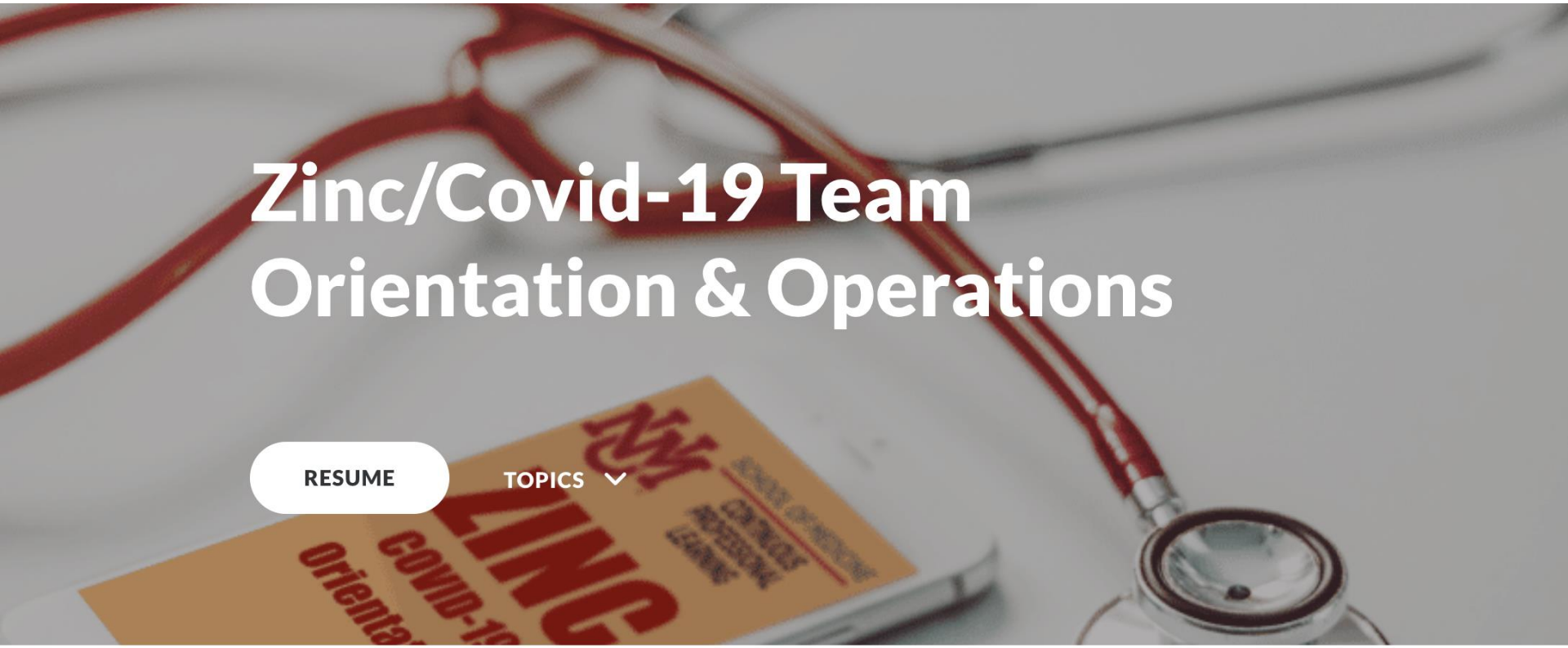
Activity
Walking + Running Distance
9.5 mi
Yesterday at 10:45 PM
Steps
18,823 steps
Yesterday at 10:45 PM
Flights Climbed
1 floor
Yesterday at 6:25 AM



Zinc/Covid-19 Team Orientation & Operations

RESUME

TOPICS

Welcome to Hospital Medicine! We are thankful for your service to our patients and for your assistance

Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19

Published by IDSA on 4/11/2020. Last updated, 12/2/2020

IDSA
Infectious Diseases Society of America

or avoided unless it will change management.

Treatment:

- **For patients with COVID and hypoxia, IDSA and NIH recommend evaluation for dexamethasone and Remdesevir unless contraindications are present**. No trials have been done nor do guidelines specifically address the care of patients at higher altitudes and possibly lower resting oxygenation.
    - Dexamethasone and remdesevir should not be used in patients who do not require hospitalization, or in hospitalized patients who do not receive supplemental oxygen (in absence of an independent clinical indication).
    - Remdesevir and evaluation for dexamethasone are recommended in patients with severe disease including those hospitalized with hypoxia requiring supplemental oxygen. Be aware that steroids may prolong viral shedding, and are most beneficial in those with more severe disease.
    - For patients with oxygenation </=94% but not requiring supplemental oxygen, treatment decisions should be made on a case by case basis considering risks and benefits. There are divergent recommendations from IDSA and NIH in this group.

    - Dosing:
        - Dexamethasone is dosed as 6mg IV/PO once daily for 10 days or until hospital discharge. *Dexamethasone should generally be stopped at discharge.*
        - Remdesivir is 200mg IV x1 day then 100mg IV once daily x 4 days. Treatment may be extended to up to 10 days for patients on ECMO or mechanical ventilation.
            - ESRD or LFTS >5x normal are contraindications to Remdesevir, and 10x ULN are an indication to stop Remdesevir.
            - Patients getting Remdesevir should ideally stay in the hospital for their entire treatment course, and at least 3 days. Clinical improvement due to Remdesevir is indistinguishable from improvement due to the natural course of the infection.
- You may be contacted by Drs Harkins or Sosa about your patient enrolling in a clinical trial. If that's the case, continue management as you would usually provide, and they will speak with you and your patient about the trial.
- **Evaluate daily for diuretics.** A common dose is 20mg IV Lasix daily.

There is no known effective agent for post-exposure prophylaxis.

Bamlanivimab cannot be given to inpatients.

UNMH COVID-19 Anticoagulation and Coagulopathy Management Protocol

Revision Date: 8/20/2020

Questions regarding this protocol may be directed to: aburnett@salud.unm.edu

Highly suspected or confirmed COVID-19+ patient

Labs on admission: D-dimer, PT, aPTT, fibrinogen and CBC with differential
Elevated D-dimer: unknown clinical significance. Should not be lone criterion in driving care decisions
Inpatient labs every 2-3 days: CBC, PT, aPTT, consider D-dimer and fibrinogen

- If worsening parameters, consider more aggressive critical care support
- Do not use blood products to correct non-bleeding coagulopathy

VTE prophylaxis for ALL hospitalized highly-suspected or confirmed COVID-19+ patients

Non-critically ill

Enoxaparin 40 mg SQ q24h

BMI> 40: enoxaparin 0.5 mg/kg SQ Q24h
CrCl 15-30 ml/min: enoxaparin 30 mg SQ q24h*
CrCl <15 ml/min: UFH 5,000 units SQ q8h*
CrCl <15 ml/min+BMI>40: UFH 7500 units SQ q8h

If pharmacologic prophylaxis contraindicated (active bleeding, PLT <25K): SCDs

*For patients <50 kg, dose adjustment based on multidisciplinary discussion is necessary

Critically ill

(ICU or on ward & needs high-flow nasal cannula or non-invasive ventilation for rescue)

Enoxaparin 0.5 mg/kg q12h*

CrCl 15-30 ml/min: enoxaparin 0.5 mg/kg q24h*
CrCl <15 ml/min: UFH 7,500 units q8h*

If pharmacologic prophylaxis contraindicated (active bleeding, PLT <25K): SCDs

*For patients <50 kg, dose adjustment based on multidisciplinary discussion is necessary

De-escalate to standard dosing when no longer critically ill

Post-hospitalization VTE prophylaxis:

- Severely ill COVID-19+ patients may experience prolonged hospital stay, significant deconditioning, and may not fully recover to baseline mobility or health status by time of discharge
- **Extending VTE prophylaxis beyond discharge should be considered** for COVID-19 patients who:
  - were admitted to the ICU, intubated, sedated and possibly paralyzed for multiple days
  - have ongoing VTE risk factors at the time of discharge such as diminished mobility and weakness
  - are discharging to a post-acute care facility for continued medical care
  - are low bleed risk
- Enoxaparin 40 mg SQ q24h or rivaroxaban 10 mg PO daily for 6-30 days beyond hospitalization may be reasonable in appropriately selected patients with reduced mobility and increased thrombotic risk factors (e.g. IMPROVE VTE score ≥4, IMPROVE VTE score ≥2 with D-dimer >2 times ULN, etc.) **AND** without elevated bleeding risk factors including, but not limited to, use of dual antiplatelet therapy, active GI ulceration, bleeding episodes in prior 3 months, bronchiectasis/pulmonary cavitation, and active cancer.
- Access to and affordability of extended VTE prophylaxis is required prior to prescribing
- **Pharmacists and primary teams are asked to contact the antithrombosis stewardship service on all COVID-19 patients that are discharging so we can assist with post-discharge VTE prophylaxis transitions of care issues.**

Therapeutic anticoagulation (TX AC)

On TX AC prior to admission

- Continue TX AC if no contraindications
- Consider switch to enoxaparin (preferred) or IV UFH if:
  - Severe illness/instability
  - Possible drug interactions with COVID-19 therapies
  - Inability to take PO
  - Anticipated procedure(s)
- Use anti-Xa-based heparin protocols whenever possible
- For patients recently on FXa inhibitor (apixaban, rivaroxaban, edoxaban), IV UFH cannot be monitored via anti-Xa
  - Use enoxaparin if CrCl ≥ 15 ml/min and no AKI
  - If CrCl <15 ml/min or AKI, multidisciplinary discussion

Highly-suspected or confirmed VTE

- If unable to get imaging & high *clinical* suspicion for VTE (D-dimer alone not reliable), recommend TX AC if no contraindications ***(see algorithm next page)***
- Abnormal PT/PTT are not contraindications to TX AC
- Options:
  - Enoxaparin 1.5 mg/kg SQ Q24h (non-ICU only)
  - Enoxaparin 1 mg/kg SQ 12h (ICU)
  - CrCl 15-30 ml/min: Enox 1 mg/kg SQ Q24h
  - CrCl <15 ml/min or AKI: IV UFH high-intensity protocol

Post-hospitalization VTE management:

- As per usual, DOACs preferred over warfarin in appropriate patients
- If acute VTE confirmed at time of suspicion, continue TX AC for ≥3 months then re-assess
- If VTE unconfirmed & treated empirically, continue TX AC for 3 months regardless of subsequent (negative) imaging findings

Instructions for patients with cough or trouble breathing:

Please try to not spend a lot of time lying flat on your back!

Lying on your stomach and in different positions will help your body to get air into all areas of your lungs.

Your healthcare team recommends trying to change your position every **30 minutes to 2 hours** and even sitting up is better than lying on your back.

If you are able to, please try this:

1. 30 minutes – 2 hours: lying on your belly

2. 30 minutes – 2 hours: lying on your right side

3. 30 minutes – 2 hours: sitting up

4. 30 minutes – 2 hours: lying on your left side

Then back to **Position 1:** Lying on your belly!

RWJBarnabas HEALTH

COVID treatment is more than medications

- Dexamethasone 6mg daily x 10 days or until DC
- Remdesevir 200mg IV x once then 100mg daily x 4 days*
- ?Lasix
- VTEp for all
- Oxygen, proning
- Humanity, kindness

BRIEF REPORT

Effectiveness of SIESTA on Objective and Subjective Metrics of Nighttime Hospital Sleep Disruptors

Vineet M Arora, MD MAPP[1]*; Nolan Machado, BA[2]; Samantha L. Anderson, BA[1]; Nimit Desai, MD[1]; William Marsack, MSN[1]; Stephenie Blossomgame, MSN[1]; Ambrosio Tuvilleja, RN[1]; Jacqueline Ramos, RN[1]; Mary Ann Francisco, MSN[1]; Cynthia LaFond, PhD, RN, CCRN[3]; Edward KY Leung, PhD[3]; Andres Valencia, BA; Shannon K Martin, MD, MS[1]; David O Meltzer, MD, PhD[1]; Jeanne M Farnan, MD, MHPE[1], Jay Balachandran, MD[4], Kristen L Knutson, PhD[5], Babak Mokhlesi, MD, MSc[1]

[1]University of Chicago Medicine, Chicago, Illinois; [2]Pritzker School of Medicine, Chicago, Illinois; [3]Children's Hospital Los Angeles, Los Angeles, California; [4]Columbia-St. Mary's, Mequon, Wisconsin; [5]Northwestern University, Chicago, Illinois.

Journal of Hospital Medicine

Nursing Care Clustering Care Procedure for COVID-19 (PUI and Confirmed)

Purpose: Minimize nursing risk of exposure and decrease utilization of PPE

Process: Standardization of nursing care in time intervals by pairing scheduled tasks into care clusters in the efforts of minimizing amount of room entry/exit per shift.

Patient Population: Progressive Care (Floor/SAC) Non-Pregnant Adult COVID-19 (PUI and Confirmed)

Vital Signs:
Full set of VS will be done at: 0900, 1400, and 2100.
O2 saturation + O2 therapy will be documented in EHR at: 2400 and 0400
* More frequent full VS can still be done if patient clinical status warrants it.

Capillary Blood Glucose (CBGs):
Continue as AC/HS unless there is a clinical indication warranting more frequent checks. If more frequent checks are ordered without a clear indication, nurse will question the order.

Medication Administration:
Zinc Medicine pharmacist will adjust timing based on the guidance of the IM Zinc (COVID-19) Medication Administration Times Procedure.

Provider Order Timing Clarification:
If a provider orders a lab, medication, etc. without a clear clinical indication of urgency outside of the clustering of care times, nurse will send a TigerConnect message to primary team to clarify urgency of order completion.

Clustering Nursing Care:
Efforts will be made to cluster all other nursing care (example: dressing changes, physical assessments, education, etc.) by pairing this with VS, CBGs, and medication administration times to occur at 0900, 1400, and 2100. Patient will be educated and asked to wear a protective mask every time a healthcare worker is inside of their room.

Patient Rounding:
Efforts will be made to conduct patient rounding over the phone, call light system, or smart electronic device in between nursing care cluster sessions, whenever patient is capable of utilizing this methods of communication.

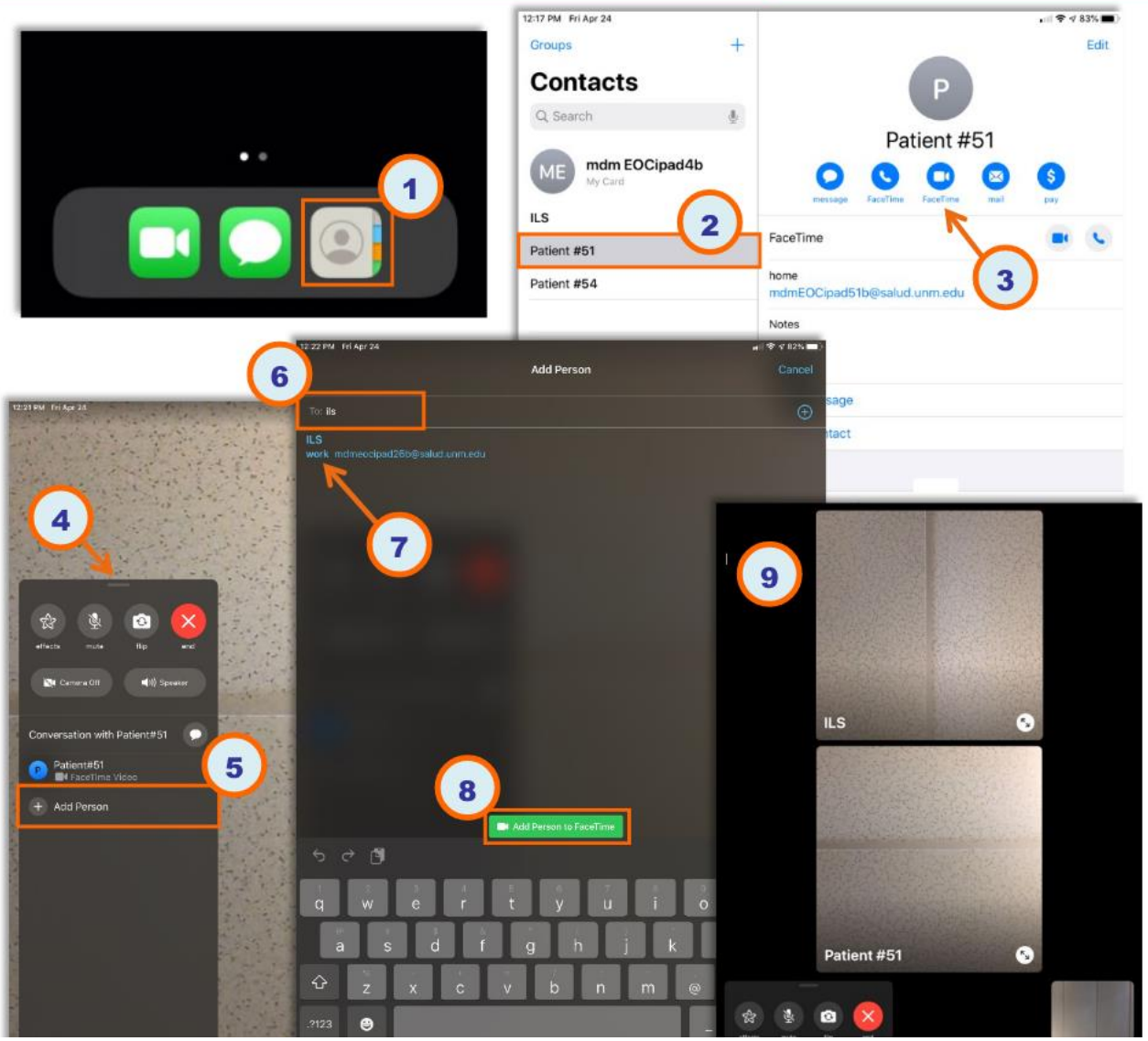
For Healthcare Workers:
FaceTime with a Patient and Interpreter Language Services (ILS)

Three-way FaceTime with a Patient and ILS Using Hospital iPads

From the iPad's home screen:

1. Tap **Contacts.**
2. From Contacts, select the patient.
3. Tap **FaceTime.**
4. Swipe up.
5. Tap **Add Person.**
6. Type **ILS** in the **To field.**
7. Tap **ILS.**
8. Tap **Add Person to FaceTime.**
9. Three-way FaceTime screen.

Note:
This method of communication is designed for FaceTime between *hospital-issued* iPads. If you FaceTime with a patient using your own personal device to communicate with the patient's hospital-issued iPad, your



Speak English/Spanish/Navajo/Vietnamese

- Feeding tube
- Foley catheter
- Telemetry

- Feeding tube

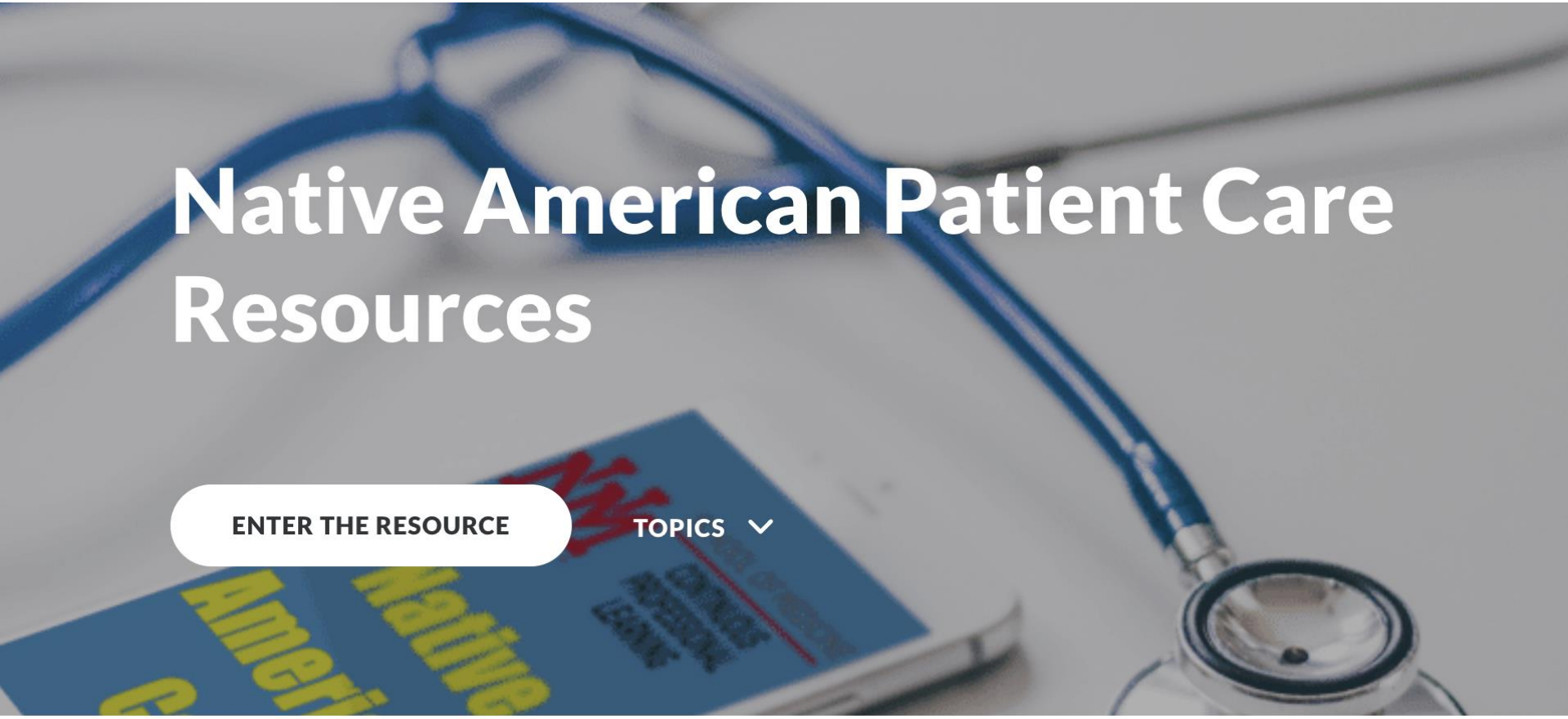
A feeding tube is a thin tube that goes through the skin/nose/mouth/stomach wall. It goes directly into the stomach. We use a tube when someone can't eat or drink safely.

- Foley catheter

A tube that goes into the bladder to drain pee/urine.

- Telemetry

Wires that attach by stickers to the skin that let us measure how the heart is beating.



Native American Patient Care Resources

ENTER THE RESOURCE

TOPICS

This resource, created by collaboration between the University of New Mexico School of Medicine, University of New Mexico Hospital,

UNM HOSPITALS

The patient presenting this card would like a

Navajo

interpreter.

At UNM Hospitals we commit to giving quality care to all patients. When patients are more comfortable receiving care in a language other than English, they have the legal right to a trained/qualified interpreter. It is our responsibility to offer free language services.

To get an interpreter by phone or video (24 hours a day, 7 days a week):

- Call **272-TALK** (272-8255) from a video unit, cell phone, or any UNMH phone

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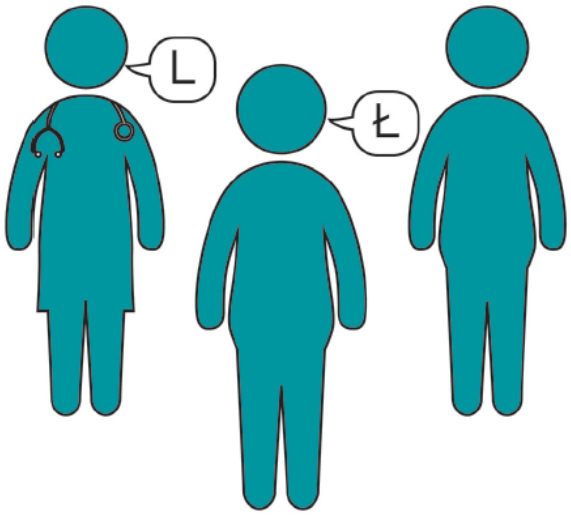
To get an in-person interpreter (Monday – Friday 8:00 AM to 5:00 PM):

- Call **272-5399** to reach Interpreter Language Services (ILS)
- Check **AmIOn**
- Review the UNMH qualified dual role interpreter list: **hospitals.unm.edu/language**

UNM HOSPITALS

Ata' halne' é nínízingo bee nahaz' ą,
doo bąąh ilíigo!

T' áá shǫǫdí, díí naaltsoos éí kwe' é
nidaalnishígíí baa diiłtóós,
akó' ata halne' é ła' naadoogáál, éí doodaii'
nikh' i naalkidi biyí' doo ná ata' hane' é doo.



I SPEAK
SPANISH

I USE
SIGN LANGUAGE

I SPEAK
VIETNAMESE

I SPEAK
ARABIC

I SPEAK
NAVAJO

I NEED AN
INTERPRETER

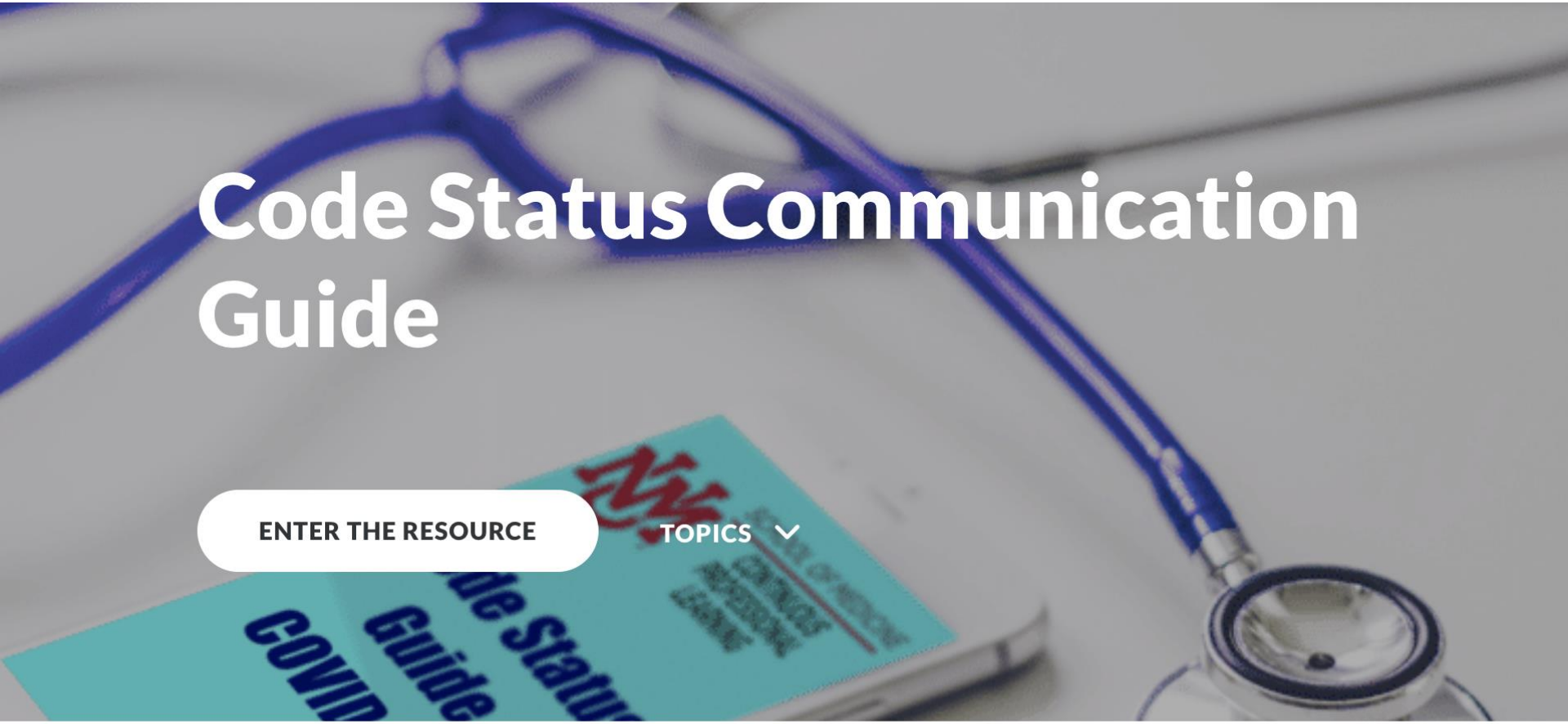
unstable)	
[redacted] UH 3-N [redacted] DoA: [redacted] DoB: [redacted] 89.8kg Navajo	Stable COVID +
[redacted] UH 3-[redacted] DoA: [redacted] DoB: [redacted] 58kg English	Stable Covid+

- A 56 year old White noncompliant polysubstance abuser.

- An 80 year old Jewish hypertensive noncompliant former smoker with a lung mass.

COVID treatment is more than medications

- Dexamethasone 6mg daily x 10 days or until DC
- Remdesevir 200mg IV x once then 100mg daily x 4 days*
- ?Lasix
- VTEp for all
- Oxygen, proning
- Humanity, kindness



Code Status Communication Guide

ENTER THE RESOURCE

TOPICS

Your feedback makes CPL resources sustainable; please answer this on question

if you get tired, learn to rest, not to quit.

+ Banksy