EM Oldham

NHS
Oldham Care Organisation
Northern Care Alliance NHS Group

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Suspected or confirmed COVID-19 patients requiring respiratory support

Sats < 92% on 6L/min (FiO_2 0.4) oxygen (or < 88% if T2RF or respiratory distress/clinical concern)

- Target neutral fluid balance, address nutrition and ensure VTE reassessment,
- **Start dexamethasone 6mg od PO/IV for 10 days for all patients requiring oxygen** (or prednisolone 40mg od PO/hydrocortisone 80mg bd IV if pregnant or breastfeeding)
- **Consider remdesivir (must be requested via pharmacy by senior clinician involved in the patients care, contact 78961) and recruitment to RECOVERY clinical trials (contact 78165)**

Is escalation to Critical Care appropriate for CPAP or invasive ventilation?

Follow NICE guidance *COVID-19 rapid guideline: critical care in adults* and consider comorbidities
Assess frailty using pre illness Clinical Frailty Score (CFS) if over 65 years
If age < 65 years, or any age with stable long term disabilities, learning disability or autism, perform individualised assessment of frailty. If unclear follow algorithm for CFS < 5.

Critical care potentially appropriate

- For example CFS < 5 and no significant life limiting comorbidities so that invasive ventilation and multi-organ support would be appropriate

- Refer to ICU (bleep **7409**) for assessment

- **If ICU appropriate, then transfer to ICU for CPAP or invasive ventilation, or (depending on bed status) to designated Enhanced Respiratory Care area for CPAP with shared care**

Critical care not appropriate

- For example CFS ≥ 5 or significant comorbidities
- Ceiling of care decisions documented

Ward based care

- Increase oxygen to maximum of 15L/min via Non-Rebreather Mask (side room or cohort area) aiming for SpO_2 ≥ 92% (88-92% for T2RF)
- Trial of early prone positioning if tolerated
- Treat any coexisting conditions appropriately
- **Daily review of antibiotics as bacterial infection uncommon**
- Palliative prescribing if not for critical care escalation
- Complete uDNACPR as appropriate

Ward based care - CPAP for type 1 respiratory failure

- Consider ward based CPAP as ceiling of treatment on selected patients not suitable for escalation to critical care: refer to Respiratory Team
- CPAP 10cm H_2O FiO_2 0.6 in side room or dedicated area
- Take time to ensure CPAP mask fit and patient comfort
- Increase to 15cm H_2O if target saturation not achieved.
- Turn off machine before removing or re-applying CPAP mask to reduce aerosol exposure
- Do not use Nasal High Flow Oxygen unless as part of Recovery-RS trial or on specialist recommendation eg weaning (seek specialist advice)

Important notes

- CPAP, NIV and NHFO are significant aerosol generating procedures and must be carried out in a side room or dedicated area
- Appropriate PPE for AGP's must be worn (FFP3, gown, apron, gloves, visor/goggles).
- **Similar principles will apply to non-COVID Type 1 respiratory failure, patients suitable for invasive ventilation will receive CPAP on ICU if needed**
- Type 2 Respiratory Failure
  - Patients with CAP, ARDS or respiratory failure due to viral pneumonitis have a poor prognosis on NIV and it is not generally indicated
  - If NIV appropriate follow BTS and local guidance

RECOVERY trial: randomization to usual care v azithromycin or convalescent plasma, second randomization to tocilizumab if CRP >75 and requiring oxygen
RECOVERY -RS Trial: randomization to usual care v HFNO vCPAP, inclusion criteria FiO_2 0.4 with SpO2 < 94% ≈ 6 l/min**,** only if suitable for invasive ventilation therefore non-invasive respiratory support should *ideally* be in ICU. Usual care patients transferred to ICU when clinically necessary.
To recruit patients please contact the Research Nurses on **78165** or via **Bleepa**