COVID-19 Pandemic Critical Care Practice: Changes in Frequency of Care Assessments

APRIL 9, 2020

General Principles

1. We have reviewed routine assessments and documentation that support normal critical care practice and re-established frequency of these assessments to respond to increased volumes of critically ill patients, cluster care, minimize risk and align with our PPE strategy.
2. Nurses who have not worked in critical care will be asked to provide care to these patients within a team-based model of care and will work with the support and direction of the critical care nurse who will function as the Team Captain.
3. We recognize that higher patient volumes, availability of skilled staff, and changing model of care are significant challenges during this time. Osler firmly supports all of our professionals facing these challenges and asks for full commitment, focus, professionalism, and best effort in the provision of patient care.
4. We will provide the best care to every patient under these extraordinary circumstances. All professional staff will apply their professional judgment in the application of this document.
5. Additional written documentation and increased monitoring are expected for significant changes in a patient's clinical status.
6. These changes are in effect until further notice

Definitions

Level 2 Critical care services meet the needs of patients who require more detailed observation or intervention including support for a single failed organ system, short-term non-invasive ventilation, post-operative care, patients "stepping down" from higher levels of care or "step ups" from lower levels of care. Level 2 services do not provide invasive ventilatory support

Level 3 Critical Care services meet the needs of patients who require advanced or prolonged respiratory support, or basic respiratory support together with the support of more than one organ system

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OSLER COVID CLINICAL RESPONSE COMMITTEE

Changes in Frequency of Care Assessments

William Osler Health System

	Pre-pandemic Standard Current Practice	Pandemic: Level 3 Patient	Pandemic: Level 2 patient	Pandemic: Non-Covid Long Term Vent Patient
Vital Signs	q1h + PRN Print rhythm strip at beginning of shift and q4h Temperature* q4h	q2h + PRN Rhythm analysis at beginning of shift Temperature* q6h	q4h + PRN Rhythm analysis at beginning of shift	q shift + PRN No rhythm analysis Temperature* q12h
Physical Exam ** (head to toe exam)	*Beginning* of shift & q4h focused assessments	*Beginning* of shift	*Beginning* of shift	*Beginning* of shift
Auscultation	Auscultation of heart, lungs, abdomen with physical exam.	**No auscultation as part of routine physical exam.** Auscultate with disposable stethoscope if clinically indicated.	**No auscultation as part of routine physical exam.** Auscultate with disposable stethoscope if clinically indicated.	**No auscultation as part of routine physical exam.** Auscultate with disposable stethoscope if clinically indicated.
Neurologic assessment (GCS, RASS, CPOT, ICDS)	q4h	q shift	q shift	PRN
Ventilator/Respiratory Assessment	q1h + PRN	q2h + PRN	q4h + PRN	q shift + PRN
Spontaneous breathing trial		RN to provide continuous observation of SBT for COVID/PUI patient (may be inside or outside room).		
Urine Output	q1h	q4h	q6h	q shift
Weight	On admission + q24h	On admission + qMon/Thu	On admission + qMon/Thu	Monthly (1st of the month)
Invasive lines/tubing/bags (Exception: TPN tubing always	q96h	q7 days **COVID: change to MRI tubing*	q7 days	q7 days
Turning & Repositioning	q2h	q2h if 1:1 RN:patient q3h if 1:2 RN:patient	q2h if 1:2 RN:patient q3h if 1:3 or 4 RN:patient	q2h

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Approved by COVID Clinical Response Committee, Critical Care Quality Program Committee, Incident Management Team, Nursing Advisory Committee, Medical Advisory Committee

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Medication Administration Record (MAR)	No change	No change	No change	No change
Bathing	q shift	q24h (day shift)	q24h (day shift)	q24h (day shift)
		**COVID patients: use CHG SAGE wipes if available.*		
Incontinent/Peri-care	PRN	PRN	PRN	PRN
Family Engagement	In person updates on rounds – family presence policy. RN updates at family request if available. Pre-arranged family meetings as required with MD, RN, SW.	Shift updates are given via telephone by RN to 1 SDM MD to provide updates as available – target daily. SW to arrange Conferences/meetings as required (telephone or video conference)	Shift updates are given via telephone by RN to 1 SDM MD to provide updates as available and required. SW to arrange Conferences/meetings as required (telephone or video conference)	Shift updates are given via telephone by RN to 1 SDM MD to provide updates as available and required. SW to arrange Conferences/meetings as required (telephone or video conference)
TGLN (current guidelines being re-assessed)	GIFT triggers -> call TGLN Call TGLN once expired	Resource RN identify in report. No change	Resource RN identify in report No change	Resource RN identify in report No change
Braden Score	q shift	No assessment – presumed high risk.	q24h	q24h
Falls Risk Assessment	q shift	No assessment – presumed high risk.	q24h	q24h

* insert continuous temperature reading as per Targeted Temperature Management and as indicated

** Follow order sets/clinical protocols for documentation and assessment for the following: APS, Post PCI, CVAD, VAP

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