UPHS: PPE and COVID Testing Recommendations for Respiratory RRTs, Intubations, Codes, and Escalating O2 requirements >6 L NC
Updated: December 2020

Purpose: In order to protect staff from COVID-19 exposures in the setting of aerosol generating procedures, in the setting of **clinical emergencies involving respiratory decompensations, codes, intubations, and escalating O2 requirements >6L NC**, we recommend repeat COVID-19 testing at time of decompensation (or at 24 hours from last test if negative test within the past 24 hours), escalation of PPE (N95/face shield or PAPR) until results of repeat rapid COVID-19 testing are known, and transfer of patient to a private room with door closed, or negative pressure room, if indicated and available.

<table>
<tr><td>1</td><td>Protection</td><td colspan="2">☐ Upgrade PPE to airborne precautions*: N95 + face shield (or PAPR) + gown + gloves
☐ Place “Aerosol Generating Procedure” signage outside of patient room
☐ Keep door closed (if possible)
☐ Limit number of people in room to only essential personnel (7 people max)</td></tr>
<tr><td>2</td><td>Testing</td><td colspan="2">☐ Order “RAPID” COVID-19 testing (SARS CoV-2 NP swab) on ALL patients unless they have had negative testing within the past 24 hours
NOTE:
- If negative testing within 24 hours, repeat testing at 24 hours from last negative test and remain in upgraded PPE
- Patients who have recovered from COVID infection and cleared from isolation should NOT have repeat testing within three months of initial positive test
- For patients placed on NPPV, follow COVID-19 special isolation precautions until day # 7 of hospitalization and repeat testing</td></tr>
<tr><td rowspan="3">3</td><td rowspan="3">Room selection</td><td>Floor patient remaining on floor</td><td>LOW clinical suspicion** for COVID-19:
○ Remain in native unit pending repeat COVID-19 testing, negative pressure room NOT needed
○ Can remain in semi-private room
○ Keep patient and roommate masked (if possible), keep door closed while repeat testing pending
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HIGH clinical suspicion** for COVID-19:
○ Remain in native unit pending repeat COVID-19 testing
○ Transfer to private room with door closed OR negative pressure room if available
○ Keep patient masked (if possible), keep door closed while repeat testing pending</td></tr>
<tr><td>Floor patient requiring ICU transfer</td><td>LOW clinical suspicion** for COVID-19:
○ Transfer to native ICU, negative pressure room NOT needed
○ Keep patient masked (if possible), keep door closed while repeat testing pending
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HIGH clinical suspicion** for COVID-19:
○ Transfer patient to private ICU room with door closed OR negative pressure room if available
○ Keep patient masked (if possible), keep door closed while repeat testing pending</td></tr>
<tr><td>ICU patient remaining in ICU</td><td>LOW clinical suspicion** for COVID-19:
○ Remain in native ICU
○ Keep patient masked (if possible), keep door closed while repeat testing pending
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HIGH clinical suspicion** for COVID-19:
○ Remain in native ICU
○ Patient can remain in private room with door closed OR transfer to negative pressure room if available
○ Keep patient masked (if possible), keep door closed while repeat test pending</td></tr>
</table>

*Providers should REMAIN in upgraded PPE until results of repeat COVID testing known, and continue upgraded PPE if clinical concern for COVID persists despite negative testing
**Clinical suspicion for COVID will ultimately be judgment call of attending of record (for floor patients) or ICU arbitrator (MICU, SICU, neuro ICU) or ICU fellow/attending. For clinical situations felt to have low clinical suspicion for COVID, these physicians may decide not to re-test for COVID or upgrade PPE at their discretion.