• Level I Trauma Center, Stroke Center, STEMI Center

• Overall decreased volume since mid-March

• Increase in respiratory complaints/fevers in last 2 weeks with proportionally more admissions.

• “South” and “North” in routine operations vs. surge

• Deployed a tent in drop off area at ED entrance

• Expanded Urgent Care assessment area to a portion of waiting room.
Splitting the Flow

• Initial contact occurs in tent outside front door.

• Patients are sorted into “Respiratory/Fever” or “Non-Respiratory” categories.

• All patients are given a surgical mask to wear.

• Patients presenting without respiratory complaints or fever, are labeled “A” and proceed through first look and triage as normal.

• Those presenting with respiratory/fever complaint are labelled “B”.
At triage, if the patient has stable VS, an ambulatory Pulse Oximetry reading is obtained.

Those patients with stable VS and an ambulatory pulse oximetry >93% are evaluated by a midlevel provider/physician in the expanded evaluation area in the waiting room.

Portable Xray machine has been staged in order to obtain a chest X-ray without leaving the waiting room.

Rapid Influenza swab is obtained and decision to test for Covid-19 is made.*

Goal of expanded area in waiting room is to rapidly evaluate and discharge those with stable vital signs without bringing them in the back.*
If vital signs abnormal or ambulatory oxygen saturation is <93%, the patient is brought to a room on the South side of the ED.

If patient is likely to require a procedure that has been deemed higher risk for aerosolizing the virus, they are placed in a negative pressure room under Airborne and Contact precautions.

If not likely to require one of those procedures, they are placed in a regular room with door closed on Contact and Droplet precautions.

ALL patients must remain masked in surgical mask.

Attempting to cohort these patients in one area of ED- minimizing exposure to providers and other patients while trying to most efficiently use PPE.
Codes/Activations

• Full PPE with N95/PAPR used in all cardiac arrest patients and trauma activations.
• LUCAS device
• Intubations
  • GlideScope
  • Plexiglass intubation boxes
  • Intubation teams staffed by anesthesia on call
• STEMIes screened in ED for fevers, cough, SOB and recent contacts prior to transfer to Cath lab
Clinical considerations

- Rapid flu (PCR)
- CBC
- CMP
- Lactate
- Troponin
- EKG
- Chest Xray
- Procalcitonin, Ferritin, CRP, LDH, CPK
- Limiting fluid resuscitation
- Proning patients
- CXR favored over CTs
Discharged patients

- Follow up phone calls
  - Incorporating our community providers and relying on their assistance
  - Also using our Hospitalists and Transitional Clinic providers
- Proning instructions
- +/- Antibiotics, Albuterol MDI
- Self-quarantine instructions
Initially followed Virginia Dept of Health guidelines for testing, LabCorp, then Quest testing became available.

- Allowed us to send out testing for those patients who were admitted (3-4 day turn around)
- Currently we have a limited supply of testing that can be done at the hospital which we are reserving for those patients admitted to the hospital.
- If patient is to be discharged, we are sending sample to Quest for testing.
- Considerations for sending test:
  - Preexisting medical conditions, VS, ambulatory pulse oximetry, Chest X-ray, and social considerations
  - Sole caregiver, Healthcare worker, First Responder
PPE Conservation

• One N95 per provider per shift*
  • Used in airborne precaution rooms with surgical mask layered on top
  • Otherwise in surgical mask
  • Brown paper bag for storing N95
  • Process of “cleaning/disinfecting” N95s and returning to same user is currently being instituted.
  • If N95 worn during aerosolizing procedure it is changed out
  • *PAPR or respirator options available

• Using iPads in rooms with PUI or confirmed positive patients and desktops with video links to minimize times in and out of rooms.