COVID+ by CT scan or symptomology

- Increase O2 for SpO2 > 90%
- Hypoxemia SpO2 < 90% on nonrebreather

**HFNC preferred non-invasive strategy**

- HFNC Management
  - FiO2 should always be set at 100%.
  - Initial LPM should be set at 20LPM.
  - LPM should be titrated up with a maximum of 50LPM as needed in order to achieve an SpO2 >88%.

- NPPV Management
  - **Should be performed in negative pressure room. If this is not possible, should be performed behind closed curtains with HEPA filter bedside.**
    - FiO2 should always be set at 100%
    - EPAP should be set at 5.

- NRB w/ 5L NC

ALL PATIENTS ON NPPV

On NRB w/ 5L NC w/ SpO2 < 85

**PRIORITY 1 – Patient’s at HIGH risk for requiring intubation**

- Proneing should be encouraged in all patients and may be considered in PRIORITY 1 patients however Physician should be aware that proneing appears to induce a non-sustainable improvement in SpO2. Proneing should therefore be seen as “buying time” rather than “recruiting.” Regardless of SpO2 improvement, PRIORITY status should not change based on SpO2 improvement during proneing.

- Consider intubation:
  - Hypoxemic patient on maximal non-invasive oxygen with SpO2 <85 – 88% w/ distress. (Presenting typically in the form of anxiety and tachypnea).
  - Hypoxemic patient on maximal non-invasive oxygen with sustained SpO2<80%

Post intubation Vent Settings
- FiO2 100%
- TV 6- 8 cc/kg, RR <20
- PEEP 5 - 10
- Target Sat > 80 % (higher the better)

If SpO2 < 80%, carefully consider the clinical context and determine as best we can whether increased PEEP (vent lung injury) or low SpO2 is more injurious to the patient.

- Vitals should look the same after intubation as before. If hypotensive, consider decreasing PEEP

Patient should ideally have the following placed:
- NG tube
- Central line (L IJ preferred site)
- Arterial line
- Foley

Post-intubation sedation
- Sedatives/Pain drip
- Paralytic drip x 24hrs
- Rocuronium 100mg 30 min – 1hr after intubation

- If POSSIBLE
- PRONE