Supplement

RAND appropriateness panel to determine the applicability of UK guidelines on the management of acute respiratory distress syndrome (ARDS) and other strategies in the context of the COVID-19 pandemic

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Supplement Table 1. RAND Panel Members

*Member of the Faculty of Intensive Care Medicine and Intensive Care Society guideline development group for the Management of ARDS in adult patients

Statements	Median	Disagreement Index	Interpercentile range	Category
Investigations on admission to level 2 or 3 care (HDU or ITU)				
In all patients admitted to level 2 or 3 care (HDU or ICU) with confirmed or clinically suspected COVID-19, in the context of the pandemic, please rate the appropriateness of carrying out the following investigations routinely:				
Full community-acquired pneumonia microbiology screen	9*	0.00	0	Appropriate
Bronchoscopy if intubated	3†	1.04	4	Uncertain
CT thorax +/- CT pulmonary angiogram	5	0.97	3	Uncertain
Echocardiogram	8	0.13	1	Appropriate
Auto-immune screen	5	0.32	1	Uncertain
In all patients admitted to level 2 or 3 care (HDU or ICU) with respiratory failure or ARDS not associated with COVID-19 and outside the context of the pandemic, please rate the appropriateness of carrying out the following investigations routinely:				
Full community-acquired pneumonia microbiology screen	9*	0.00	0	Appropriate
Bronchoscopy if intubated	6	0.97	3	Uncertain
CT thorax +/- CT pulmonary angiogram	5	0.97	3	Uncertain
Echocardiogram	8	0.00	0	Appropriate
Auto-immune screen	7	0.00	0	Appropriate
In all patients with confirmed or clinically suspected COVID-19, in the context of the pandemic, please rate the appropriateness of performing the following on admission and repeated if clinically indicated:				
Circulating biomarkers of haemophagocytic lymphohistiocytosis (HLH)-like syndromes (lactate dehydrogenase (LDH), ferritin etc.)	5	0.32	1	Uncertain
Procalcitonin	5	0.97	1	Uncertain
Troponin	5	0.52	2	Uncertain
In all patients admitted to level 2 or 3 care (HDU or ICU) with respiratory failure or ARDS, not associated with COVID-19 and outside the context of the pandemic, please rate the appropriateness of performing the following investigations on admission and repeated if clinically indicated:				

Circulating biomarkers of haemophagocytic lymphohistiocytosis (HLH)-like syndromes (lactate dehydrogenase (LDH), ferritin etc.)	5	0.52	2	Uncertain
Procalcitonin	5	0.52	2	Uncertain
Troponin	5	0.52	2	Uncertain
Standard care – non-invasive ventilation strategies				
For patients with confirmed or clinically suspected COVID-19 in the context of the pandemic, for whom immediate invasive mechanical ventilation is not required, please rate the appropriateness of a trial of the following:				
Nasal high flow oxygen (NHFO)	6	0.32	1	Uncertain
Continuous positive airway pressure (CPAP)	6	0.85	2	Uncertain
Non-invasive ventilation (NIV)	2	0.16	1	Inappropriate
Awake proning	6	0.00	0	Uncertain
For patients with respiratory failure WITHOUT confirmed or clinically suspected COVID-19, and outside the context of the pandemic, for whom immediate invasive mechanical ventilation is not required, please rate the appropriateness of a trial of the following:				
Nasal high flow oxygen (NHFO)	6	0.32	1	Uncertain
Continuous positive airway pressure (CPAP)	6	0.32	1	Uncertain
Non-invasive ventilation (NIV)	3	0.16	1	Inappropriate
Awake proning	5	0.32	1	Uncertain
For patients with confirmed or clinically suspected COVID-19 in the context of the pandemic for whom immediate invasive mechanical ventilation is not required, please rate the appropriateness of using the following criteria as primary indicators of a failed trial of non-invasive respiratory support that has lasted for between 1 and 4 hours (assume that the variables are binary with arbitrary thresholds).				
“Unacceptable” arterial * blood gases	7	0.22	1	Appropriate
“Unacceptable” work of breathing	7	0.00	0	Appropriate
Failure to improve	8	0.16	1	Appropriate
For patients with respiratory failure or ARDS WITHOUT confirmed or clinically suspected COVID-19 and outside the context of the pandemic, for whom immediate invasive mechanical ventilation is not required, please rate the appropriateness of using the following as primary indicators of a failed trial of non-invasive respiratory support that has lasted for between 1 and 4 hours:				
“Unacceptable” arterial * blood gases	7	0.22	1	Appropriate
“Unacceptable” work of breathing	7	0.00	0	Appropriate

Failure to improve	8	0.16	1	Appropriate
For patients with confirmed or clinically suspected COVID-19 in the context of the pandemic, please rate the appropriateness of using the following means of respiratory support after a failed trial of your favoured first-line strategy:				
A trial of an alternative non-invasive ventilatory strategy	2	0.16	1	Inappropriate
Invasive mechanical ventilation	9	0.13	1	Appropriate
For patients WITHOUT confirmed or clinically suspected COVID-19 and outside the context of the pandemic, please rate the appropriateness of using the following means of respiratory support after a failed trial of your favoured first-line strategy:				
A trial of an alternative non-invasive ventilatory strategy	2	0.16	1	Inappropriate
Invasive mechanical ventilation	9	0.13	1	Appropriate
Standard Care – basic management strategies in mechanically ventilated patients				
The first 48 hours after intubation				
For patients with persistent moderate to severe ARDS associated with confirmed or clinically suspected COVID-19, in the context of the pandemic, who are being supported with invasive mechanical ventilation, rate the appropriateness of the following strategies for the first 48 hours after intubation:				
Lung protective ventilation; tidal volume <6ml/Kg ideal body weight (IBW) and plateau pressure <30cmH_2O	9*	0.00	0	Appropriate
Prone positioning	9*	0.13	1	Appropriate
Neuromuscular blocking agents	6	0.52	2	Uncertain
Higher positive end-expiratory pressure (PEEP)	7	0.00	0	Appropriate
Conservative fluid management	7	0.00	0	Appropriate
For patients with persistent moderate to severe ARDS NOT associated with confirmed or clinically suspected COVID-19 and outside the context of the pandemic, who are being supported with invasive mechanical ventilation, rate the appropriateness of the following strategies for the first 48 hours after intubation:				
Lung protective ventilation; tidal volume <6ml/Kg ideal body weight (IBW) and plateau pressure <30cmH_2O	9*	0.00	0	Appropriate
Prone positioning	8*	0.13	1	Appropriate
Neuromuscular blocking agents	6	0.52	2	Uncertain

Higher positive end-expiratory pressure (PEEP)	7	0.00	0	Appropriate
Conservative fluid management	7*	0.16	1	Appropriate
After the first 48 hours post-intubation				
For patients with persistent moderate to severe ARDS associated with confirmed or clinically suspected COVID-19, in the context of the pandemic, who are being supported with invasive mechanical ventilation, rate the appropriateness of the following strategies after the first 48 hours post-intubation:				
Lung protective ventilation; tidal volume <6ml/Kg ideal body weight and plateau pressure <30cmH_2O	9*	0.00	0	Appropriate
Prone positioning	7	0.16	1	Appropriate
Neuromuscular blocking agents	4	0.32	1	Uncertain
Higher positive end-expiratory pressure (PEEP)	7	0.22	1	Appropriate
Conservative fluid management	7	0.00	0	Appropriate
For patients with persistent moderate to severe ARDS NOT associated with confirmed or clinically suspected COVID-19 and outside the context of the pandemic, who are being supported with invasive mechanical ventilation, rate the appropriateness of the following strategies after the first 48 hours post-intubation.				
Lung protective ventilation; tidal volume <6ml/Kg ideal body weight and plateau pressure <30cmH_2O	9*	0.00	0	Appropriate
Prone positioning	7	0.37	2	Appropriate
Neuromuscular blocking agents	4	0.85	2	Uncertain
Higher positive end-expiratory pressure (PEEP)	7	0.22	1	Appropriate
Conservative fluid management	7	0.00	0	Appropriate
Standard Care – adjuncts for refractory hypoxia				
For patients with severe ARDS and refractory hypoxia (SaO2 <90% with FiO2 >80%) associated with confirmed or clinically suspected COVID-19 in the context of the pandemic, who are being supported with invasive mechanical ventilation, rate the appropriateness of the following strategies:				
Inhaled pulmonary vasodilators (nitric oxide or prostacyclin)	4	0.52	2	Uncertain
Recruitment manoeuvres	3	0.16	1	Inappropriate
Airway Pressure Release Ventilation	4	0.22	1	Uncertain

Extra-corporeal membrane oxygenation (ECMO)/Referral to an ECMO centre	8	0.37	1	Appropriate
For patients with severe ARDS and refractory hypoxia (SaO2 <90% with FiO2 >80%) NOT associated with confirmed or clinically suspected COVID-19 and outside the context of the pandemic, who are being supported with 4invasive mechanical ventilation, rate the appropriateness of th3e following strategies:				
Inhaled pulmonary vasodilators (nitric oxide or prostacyclin)	3	0.37	2	Inappropriate
Recruitment manoeuvres	3	0.16	1	Inappropriate
Airway Pressure Release Ventilation	4	0.37	2	Uncertain
Extra-corporeal membrane oxygenation (ECMO)/Referral to an ECMO centre	8	0.13	1	Appropriate
Pharmacotherapy				
For patients with confirmed or clinically suspected COVID-19 in the context of the pandemic, with established or incipient organ failure(s), please rate the appropriateness of the following treatments:				
Standard course of antibiotics for community acquired pneumonia on admission	6	0.32	1	Uncertain
Remdesevir on admission	5	0.85	2	Uncertain
Low dose corticosteroids for 10 days on admission	9*	0.13	1	Appropriate
Other agents to counter the "cytokine storm" (e.g. tociluzimab)	4	0.37	2	Uncertain
Late steroids for failed weaning (for example methylprednisolone 2mg/kg/day for 2-4 weeks)	5	0.32	1	Uncertain
Pulmonary vasodilators (e.g. sildenafil) for pulmonary hypertension and right ventricular failure	5	0.32	1	Uncertain
Anti-fibrotic therapy (e.g. nintedanib) for persistent respiratory failure with radiological evidence of lung fibrosis	3	0.37	2	Inappropriate
Anticoagulation				
For all patients with confirmed or clinically suspected COVID-19 in the context of the pandemic, with established or incipient organ failure(s) and without a contra-indication to anticoagulation, please rate the appropriateness of the following treatments:				
Standard thromboprophylaxis	8	0.16	1	Appropriate

Enhanced thromboprophylaxis (for example double the standard prophylactic dose of low molecular weight heparin)	6	0.32	1	Uncertain
Full anti-coagulation	5	0.32	1	Uncertain
Anti-platelet therapy	4	0.52	2	Uncertain
For patients with confirmed or clinically suspected COVID-19 in the context of the pandemic, with established or incipient organ failure(s) and without a contra-indication to anticoagulation, please rate the appropriateness of the following indications for full anti-coagulation:				
Standard indications e.g. diagnosis of venous thromboembolism	9	0.00	0	Appropriate
Clinical suspicion of thrombo-embolism	7	0.00	0	Appropriate
Moderately raised D-dimer (≥4 times upper limit of normal)	5	0.32	1	Uncertain

Supplement Table 2. Final Assessment of Statements by RAND Panel

For each survey question, median scores were calculated with a score of <3.5 being considered inappropriate (red background), ≥3.5 and <6.5 uncertain (amber background), and ≥6.5 appropriate (green background).

* Denotes questions where the level of appropriateness was agreed unanimously

† Denotes disagreement index >1

Interpercentile range (IPR) is the difference between the 70th and 30th percentiles.