Daily MD Assessment

Consider the following:

1. **COVID Status**
   - ❑ Confirmed
   - ❑ Probable
   - ❑ Suspect

All COVID patients continue to be eligible for clinical trials.

Get verbal consent to be contacted and document in SCM admission note.

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2. **Patient Isolation**
   Proper PPE protocols
   To discontinue isolation: *SCM Documents – COVID19 Discontinuation Isolation Precautions*
   Questions: contact IP&C
3. **Mobility**
   Encourage daily
   Movement is Good Medicine
4. **Labs (SCM order set)**
   On admission: urea, CRP, D-dimer
   Review daily: order as indicated
5. **Goals of Care**
   Reassess and update
6. **Prognosis (on admission)**
   4C Mortality Score
7. **Communication**
   - ❑ Patient
   - ❑ Care partner

Daily Vital Signs: Requiring Oxygen?

No → **Other Barriers to Discharge?**

No → **Consider Discharge**

Yes ↓

Improving ↑

Oxygen titration
- SpO2 92-96% (specific targets may apply, e.g. pregnancy keep >95%)

DEXAMETHASONE 6mg po or IV, up to 10 days
- Monitor for:
  - Delirium
  - Diabetes (BG>10 → Basal Bolus Insulin Therapy)

Managing Delirium / Dementia

If patient requires O2 but not yet mechanical ventilation
- Consider **REMDESIVIR**
- 200mg IV once, then 100mg IV Day 2-5
- For patients requiring O2 but not yet mechanical ventilation

Immuno-compromised patient

If immunocompromised
- Consider ID consult
- Consider **SOTROVIMAB**
- Consider **REMDESIVIR**

Outpatient Criteria SOTROVIMAB

If early nosocomial (<5d) or admitted for non-COVID & meet outpatient criteria
- **SOTROVIMAB** 500mg

If requires HF O2 at presentation
- Evidence stronger for **TOCILIZUMAB** compared to **REMDESIVIR**

Deterioration →

Oxygen requirement increasing
- >6 LPM O_2 / FiO_2 > 0.5

If ≤ 7 days in hospital
- **TOCILIZUMAB**
  - Single dose IV
    - ≤40 kg: 8 mg/kg
    - >40 kg: 400 mg

If **TOCILIZUMAB** unavailable:
- Consider **BARICITINIB** 4mg PO daily x14 days or until discharge OR **SARILUMAB** 400mg IV single dose

Consider **SELF PRONE** positioning if:
- Patient condition & RN / RT support allow
- Goal >8h prone per day
  - If R1 or R2 DO NOT delay ICU consult
  - If R3 or M1 (O2 ≥ 2 LPM) consider COVIPRONE study

Work-up for Deterioration
CXR (portable)
CBC, creat, lytes, INR, troponin T, blood cultures

If not fully anticoagulated,
Doppler US (R/O DVT)
+/- CT PE

Also consider:
ABG, ECG, BNP
Specialty Consult

On Antibiotics?
Consider starting or broadening coverage

Firstline App (Spectrum)

Further Deterioration ↓

NEWS2 Score
≥7 points or any new 3-point item
- High flow 02 (FiO2 80-100%)
- Hypercarbia
- Other change in clinical status

GOC
- R → **Consult ICU** NPO, IV access
- M → **Continue best supportive care**
- C → **End of life care**

Symptom Management Outside of ICU

VTE Prophylaxis
Note: D-dimers may be high due to COVID-19

On DOAC or WARFARIN?
Consider switch to **LMWH (TINZAPARIN)**

Assess Bleeding Risk
HAS-BLED Score

0-2 → If < HF O2 AND low bleeding risk, consider **therapeutic anticoagulation** with **LMWH**

≥ 3 → **Thromboprophylaxis** with **LMWH** (tinzaparin 75 U/kg rounded up to nearest prefilled syringe)

Symptom Management
- Dyspnea
- Secretions
- Cough
- Pain / myalgia
- Nausea / vomiting
- Fever
- Confusion
- Anxiety
- Headache

→ Palliative care consult for severe or refractory symptoms

Non-COVID Comorbidities
- Complete Med Reconciliation
- Manage within scope of practice
- Involve consult services and other health care providers as needed (phone advice if possible)

Discharge Planning — Begins at admission
- **VACCINATION**
- Functional status
  - cognitive / physical / nutrition vs. baseline
- Home living situation
- Home medications
- Follow-up plans

Specialist Link Post-COVID Care Resources

Additional Resources from Dept of Medicine

Additional COVID Information for AHS Staff & Health Professionals

REVISED

Physician Learning Program

Department of Medicine

Alberta Health Services

University of Calgary

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