

Daily MD Assessment

Consider the following with each patient:

- COVID status**
 - Confirmed
 - Probable
 - Possible
 - Unlikely
 - Very Unlikely
 - Pg IP&C if d/c'ing C&D isolation
- Exam as clinically indicated** (daily physical not required)
- Labs** review daily and order as indicated
- Fluid Balance** conservative fluid strategy
- Goals of Care** Reassess & Update
- Diet Order & nutritional status**
- Patient Isolation** Update family

Is patient eligible for a clinical trial?

CATCO pg: 01815
CORONA-1 pg: 03977

Vital Signs Concern if:

- Increased O2 needs $\geq 3\text{LPM}/3$ hours, or $\geq 6\text{LPM}$
- New SBP < 90
- New HR $\geq 120/\text{min}$
- Increased RR ≥ 6 breaths/min or worsening dyspnea
- New onset confusion

Pulmonary

O2 Needs; NIV only for acute resp failure secondary to AECOPD/CHF; MDI (no nebs) for asthma / COPD; Avoid opiflow/airvo

Differential diagnosis of COVID patient with increasing O2 needs

COVID disease progression

- respiratory failure
- sepsis/cytokine release
- myocarditis

Complication of admission - acute

- Hospital acquired pneumonia
- Pleural effusion
- Acute PE
- Aspiration
- Pneumothorax
- Volume overload

Comorbidity exacerbation

- COPD/asthma exacerbation
- Congestive heart failure

Anti-microbials

Is the blood culture positive or high suspicion for bacterial infection

If yes: Continue antibiotics x 5-7 days, with stop date. BioK+

If no: Stop Antibiotics

Re-assess indication for oseltamivir (Tamiflu). If np swab + for influenza, continue x 5 days. If np swab negative and low suspicion, D/C.

Symptom Management

Assess Regularly

- Dyspnea
- Secretions/Cough
- Pain/Myalgia
- Nausea/Vomiting
- Fever
- Confusion
- Anxiety
- Headache

VTE & Prophylaxis

LMWH prophylaxis for all patients unless active bleeding or platelets < 30

If on DOAC or warfarin on admission, consider changing to LMWH

Non-COVID Comorbidities

- Ensure Med Rec completed
- Chemstrips for DM
- Manage within scope of practice
- Seek advice from POD LEAD
- Involve non-COVID consulting services as needed

Discharge Planning

Discharge planning begins at admission

NEWS2 scoring system
www.mdcalc.com/national-early-warning-score-news-2

Consider care escalation (involve POD lead)

- NEWS2 score: \uparrow to ≥ 7 or any new 3-point item
- $\geq 3\text{LPM}/3$ hours, or $\geq 6\text{LPM}$
- Any other concern of changing clinical status
- Make NPO, ensure IV patent
- If deterioration (increasing O2 requirement)
 - GOC R1-3, consider ICU consult
 - GOC M or CI, consider palliation

Work-up for patient deterioration
CXR (portable) + Labs – CBC, Cr, lytes, CRP, ferritin, LDH, ALT, AST, Tbili, INR, PTT, fibrinogen, D-Dimer, Trop T; Consider EKG and ABG if indicated

If suspect cytokine release syndrome Consult Rheumatology or Hematology

When to suspect:

- Consider as a cause of clinical deterioration
- High ferritin (typically > 700), CRP (> 70)
- Thrombocytopenia, lymphopenia, neutropenia
- High ALT/AST, LDH, TG, D-Dimer
- Low fibrinogen

Consult Palliative Care Consult for severe or refractory symptoms

Pulmonary embolism
D-Dimers may be elevated due to COVID19.

Consider VTE if unexplained:

- dyspnea
- increased O2 needs/RR
- hypotension
- chest pain
- tachycardia
- signs of DVT

If DVT suspected: Doppler U/S

If PE suspected: CTPE

- Functional status – cognitive/physical vs baseline
- Home living situation
- Mobility – encourage daily
- Minimize allied health consults unless necessary
- Remove lines/catheters
- Nutrition status
- Follow-up plans
- Ride home
- Home medications

