Daily MD Assessment

Consider the following with each patient:

1. **COVID status**
   - ❑ Confirmed
   - ❑ Probable
   - ❑ Possible
   - ❑ Unlikely
   - ❑ Very Unlikely
   - ❑ Pg IP&C if d/c'ing C&D isolation
2. **Exam as clinically indicated** (daily physical not required)
3. **Labs** review daily and order as indicated
4. **Fluid Balance** conservative fluid strategy
5. **Goals of Care** Reassess & Update
6. **Diet Order & nutritional status**
7. **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 ≥3LPM/3 hours, or ≥6LPM
- New SBP <90
- New HR ≥120/min
- Increased RR ≥6 breaths/min or worsening dyspnea
- New onset confusion

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

Consider care escalation (involve POD lead)

- NEWS2 score: ↑ to ≥7 or any new 3-point item
- ≥ 3LPM/3 hours, or ≥ 6LPM
- 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

Pulmonary

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

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

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 oseltamavir (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

Consult Palliative Care Consult for severe or refractory symptoms

VTE & Prophylaxis

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

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

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

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

- 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

Department of Medicine

Alberta Health Services | University of Calgary

Physician Learning Program

Updated 2020.04.22 (v1.3)