



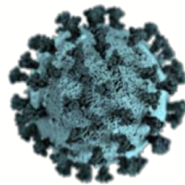
COVID-19 – QUICK GLANCE GUIDE

For management of adult non-ITU patients at UHBFT

TO BE READ IN CONJUNCTION WITH SPECIALTY SPECIFIC COVID-19 GUIDANCE

BACKGROUND

- COVID-19 is the illness caused by the novel Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)
- The latest guidance will be posted on the Coronavirus Microsite <https://www.uhb.nhs.uk/coronavirus-staff/clinical-info-pathways/key-clinical-info.htm>



SIGNS AND SYMPTOMS

- Fever (intermittent)
- Fatigue, myalgia, anorexia, anosmia, ageusia (loss of taste)
- Respiratory symptoms – SOB, cough, sore throat, coryza
- “Silent hypoxia” – Sats < 94% without breathlessness esp in elderly
- Other symptoms e.g. GI may be present
- May present in hospitalised patients as a hospital-acquired pneumonia
- May present in older people with delirium or falling

DIAGNOSIS – VIROLOGICAL - [Link](#)

- Regimes for SARS-CoV-2 testing change according to National Guidance
- There are different testing methods available that have different characteristics
- Near-patient testing must be confirmed with a laboratory PCR (or NAAT) test
- SARS-CoV-2 genotyping may be available where treatments are variant-specific
- No test has 100% sensitivity and may not exclude infection in clinically likely cases
- Consider testing for other respiratory viruses
- SARS-CoV-2 antibody levels cannot be used to diagnose active infection

INVESTIGATIONS

See PICS COVID blood panel / ICE bundle

- FBC, U&Es, LFT, CRP, Troponin, HbA1c, SARS-CoV-2 antibody test
- Coagulation profile – includes D-Dimer, PT and Fibrinogen
- ABG – Gas exchange, Lactate
- Blood cultures
- Blood borne virus screen
- ECG
- CRP is usually high and not indicative of bacterial infection
- Lymphocyte and eosinophil counts are usually low

POTENTIAL COMPLICATIONS

- Respiratory Failure
- Arterial and venous thromboembolism
- Arrhythmias/Heart Failure/Myocarditis
- Super-added bacterial infection is uncommon in COVID-19 pneumonitis and routine use of antibiotics for typical cases is discouraged
- Delirium is a frequent complication, particularly in and after Intensive Care

IMAGING

- CXR – all patients
- CT Thorax – rarely required in uncomplicated COVID pneumonia
- Imaging findings can be non-specific and overlap with other infections / presentations
- CTPA indicated when PE suspected (recognised complication)

RESPIRATORY SUPPORT - [Link](#)

Oxygen

Maintain Sats 92 - 96%
(88-92% in known COPD with CO₂ retention)
(≥94% in pregnancy)
Nasal Cannulae 1-5 litres/min
Face mask 5-10 litres/min
Non rebreath mask 10-15 litres/min

Reserve

- Fixed performance Venturi masks (24%-60%) for those at risk of hypercapnia
- RespiFlo humidified system 28% – 98% for sputum retention/upper airway dryness

Continuous positive airway pressure (CPAP)

- Patients for full escalation requiring ≥ 40% oxygen with O₂ sats < 94% should be managed on an appropriate COVID ward.
- They should be considered for CPAP on the Respiratory Support Unit (RSUs) where these have been established. [Link](#)

Proning

- Prone positioning may assist oxygenation in some patients – [Link](#)

End of life care

- There is useful guidance on managing respiratory failure with COVID-19 pneumonitis where the objective is palliative care [Link](#)

GENERAL MANAGEMENT

- At the initial senior review of patients with COVID-19 pneumonitis disease there are several therapeutic interventions that should be considered [Link](#)
- Hospital-onset mild cases may benefit from treatments to prevent deterioration. [Link](#)
- This ward review should follow a standardised check list.
- Early documented decisions about ceilings of treatment are essential and should involve senior medical staff. [Link](#)
- The ISARIC 4C mortality score may be helpful in making escalation decisions - [Link](#)
- Additional promising treatments are available to UHB patients through clinical trials only.

PALLIATION and END OF LIFE CARE ([Link](#))

- Patients with severe COVID-19 disease outside ITU may require palliation
- Reassurance and emotional support are key in the dying phase and early involvement of the palliative care team is advised
- Prescribe anticipatory medication (where available via PICS structured prescribing)

Ensure early decisions are made, and documented (DNACPR/TEAL or RESPECT form) about Ceiling of Care for all patients [Link](#)
Ask yourself “Would intensive care, ventilation and organ support be successful in this patient?”

ONGOING WARD CARE

- Use structured ward round templates to facilitate holistic care and comprehensive handover
- Strict attention to infection control [Link](#) with appropriate PPE for the situation. [Link](#)
- Consider nutritional requirements early and repeatedly
- Titrate Oxygen (both up and down) to maintain Sats in target range
- Monitor blood glucose according to guidance in all patients with diabetes mellitus, impaired glucose tolerance [Link](#), or on glucocorticoids [Link](#)
- AVOID vigorous fluid resuscitation (may lead to ARDS) but Do Not Run Patients “Dry” and consider insensible losses
- Prevent avoidable AKI through effective risk recognition, investigation, management and referral - [NICE guidance & Link](#)
- Ensure regular communications are made with relatives
- Use a holistic approach when caring for the recovering COVID-19 patient. [Link](#)
- Start discharge planning early – home when off Oxygen 24 hours with Sats ≥92% (or ≥88% if target range 88-92%) and any mobility and Social Care needs are met.

ESCALATION TO INTENSIVE CARE

Patients with severe COVID-19 disease who are for escalation should be referred to the on-call critical teams when their disease is severe as indicated by **any one** of:

RR>30; SBP <90mmHg
O₂ required at >50% to maintain SpO₂ ≥ 92%
Reduced level of consciousness

DISCHARGE

- Provide clear instructions to patients on discharge [Link](#) including written advice on subsequent COVID-19 vaccination [Link](#)
- Patients should be advised to self-isolate as per National Guidelines.
- Organise any follow up imaging if indicated (e.g. 3 month CXR and write to patient with results)
- For more information patients (and HCPs) can consult [Link](#)
- Assess individual patient risk factors for VTE (cancer, obesity, diabetes, mobility etc) and consider prescription to complete 7 days of prophylaxis.
- Pregnant women may require prolonged VTE prophylaxis. [Link](#)