

**Stage 0. Patient is a possible COVID-19 case:**

1. New continuous cough **OR**
2. Temperature >37.8°C **OR**
3. Loss of, or change in, normal sense of taste or smell **OR**
4. Patients with acute respiratory infection, influenza-like illness, clinical or radiological evidence of pneumonia, or acute worsening of underlying respiratory illness, or fever without another cause should have SARS-CoV-2 test **OR**
5. Other clinical situations where COVID-19 testing should be considered

If considering discharge perform 40 step desaturation test and given national covid [discharge advice](#)

IF Admission required

**Stage 1 Baseline Assessment in Suspected COVID-19**

1. Manage patient in side room/cohort area, use correct COVID-19 PPE
2. Observations – including O2 saturations – see [‘oxygen guidelines’](#)
3. Blood tests – see COVID-19 panel on ICE
4. Consider ABG, especially if patient at risk of hypercapnia or sats<92% (e.g. COPD, BMI>35, neuromuscular disease)
5. [Nose & throat swab for COVID-19 PCR](#)
6. Send influenza swab if indicated – [separate swab needed](#).
7. Use IV fluids with caution, aim for ‘euvolaemia’, monitor urine output
8. Consider appropriate [venous thromboembolism \(VTE\) prophylaxis](#)
9. Request CXR – include COVID-19 risk on ICE
10. Calculate Clinical Frailty Scale (CFS) – see below
11. Complete completing an Escalation Plan in the notes/DNACPR form as appropriate.
12. Assess need for dexamethasone/remdesivir/tocilizumab treatment (see below)
13. Assess need for ICU/CPAP – see guidance [‘Escalation of respiratory support’](#)
14. Assess Blood Glucose in all patients, check blood ketones in blood glucose>12 or known Diabetic
15. Patient usually takes corticosteroids → see steroid guidelines as will need increased doses!

NTAP PROCESS [HERE](#)

Infection prevention and control (IPC) – See [COVID-19](#) guidance on the HDFT intranet

**Stage 2 Antibiotic Assessment**

**COVID-19 is a virus, antibiotics are only indicated if bacterial pneumonia is suspected**

**Factors associated with COVID-19**

- Respiratory distress after 5 – 7 days of influenza-like illness
- Loss of sense of smell/taste
- Non-lobar bilateral CXR infiltrates

**Factors associated with bacterial infection**

- Lobar pneumonia on CXR
- Increased sputum volume/purulence
- Rapidly unwell after a few days
- History of COPD/bronchiectasis

If antibiotic treatment indicated:

- Consider sputum for MC&S
- Use appropriate [HDFT guidance for antibiotic](#) choice:
  - Community-acquired pneumonia
  - Hospital-acquired pneumonia
  - Neutropenic sepsis (Adults)
- Please note, severity of pneumonia is based on clinical judgement if COVID-19 present

The research team will identify suitable patients for COVID-19 trials (no need to refer)

**Stage 3 Review with results**

COVID POSITIVE – DO RESEARCH KNOW? COULD THE PATIENT BE IN RECOVERY STUDY? Contact the Harrogate Research office on extension 5692

1. Assess need for oxygen/ICU/CPAP: [Escalation of respiratory support](#) for patients with COVID-19
2. If COVID-19 positive, treat as confirmed case
3. If COVID-19 negative but a high index of suspicion remains, continue IPC interventions, see HDFT diagnostic guidance for COVID-19
4. Review need for antibiotic therapy – see below. If for discharge and oral antibiotic indicated, use relevant [HDFT guidance](#)

## Stage 4 Assessment for COVID-19 specific treatment

### Dexamethasone Treatment for COVID-19 (once admitted to inpatient ward/department)

#### For non-pregnant adults\*:

**Dexamethasone** 6mg po/iv od for 10 days is recommended for patients fulfilling the following criteria:

i) Suspected of confirmed COVID-19 infection and requiring hospital admission

**AND**

ii) Patient requiring supplemental oxygen therapy, non-invasive ventilation or invasive ventilation

**AND**

iii) Patient is not pregnant or breastfeeding (see below)

Treatment should be discontinued if patient is discharged home prior to completing 10 day course

#### For adults\* who are pregnant or breastfeeding

**Prednisolone** 40mg PO od (or iv hydrocortisone 80mg bd) for 10 days is recommended for patients fulfilling the following criteria:

i) Suspected of confirmed COVID-19 infection and requiring hospital admission

**AND**

ii) Patient requiring supplemental oxygen therapy, non-invasive ventilation or invasive ventilation

Treatment should be discontinued if patient is discharged home prior to completing 10 day course

**\*16 years and over (paediatric data not yet available)**

#### CONSIDER Remdesivir (with senior clinical input)

Remdesivir is indicated for COVID-19 patients requiring supplemental oxygen at flow rates  $\leq 15\text{L/min}$ ,  $\text{eGFR} \geq 30\text{ ml/min}$  and  $\text{ALT} < 5$  times the normal limit. **Do not** prescribe Remdesivir for patients with COVID-19 on HFNO, CPAP, NIV or IMV

Consider Remdesivir 200mg 1<sup>st</sup> dose followed by 100mg OD for up to 5 days (1 day at 200mg and 4 days at 100mg)

#### CONSIDER only after senior clinical input

**Sarilumab/Tocilizumab** are indicated for COVID-19 patients requiring corticosteroids

**And**

CRP  $>75$  or within 48 hours of starting HFNO, CPAP, NIV or IMV

**And**

No evidence of bacterial infection that might be worsened by Tocilizumab/Sarilumab

*Prescribe* Sarilumab 400mg once only OR *Prescribe* Tocilizumab 8mg/kg (max. 800mg) once only - use ePMA 'COVID-19 Protocols' to prescribe ('COVID-19 Treatment Options')

**Commissioning Policy for IL-6 Inhibitors** [here](#)

#### CONSIDER only after senior clinical input

**Ronapreve**<sup>®</sup> is no longer indicated for COVID-19 unless the patient can be proven to be infected with a 'non-omicron' variant (this is not possible routinely at HDFT) **AND** Negative anti-spike antibodies against SARS-CoV-2.

**Commissioning Policy for nMABs** [here](#)

## Stage 5 Daily review

5. Assess need for oxygen/ICU/CPAP: See [Escalation of respiratory support](#) for patients with COVID-19
  1. Review need for antibiotics – **See below**
  2. Review need for ongoing dexamethasone treatment – can be stopped if patient well enough for [discharge home](#)
  3. For COVID-19 positive patients – [see guidance for advice on repeat swabs and patients step-down](#)

## Antibiotic review for patients with suspected COVID-19

## COVID-19 PCR positive patients

COVID-19 is a viral infection, antibiotics are only required if there is evidence of secondary bacterial infection.

**Can empiric antibiotics be stopped?** Use the following signs, symptoms and test results to help inform the overall clinical assessment and decision about when to safely stop antibiotics:

- No evidence of bacterial infection in blood cultures or sputum culture
- CXR or CT consistent with COVID-19, see report coding for COVID-19
- Fever resolved or resolving
- NB: CRP may be raised in COVID-19 infection and is not a reliable marker for bacterial infection

- **Low admission PCT <0.25 µg/L**

**If continuing antibiotic therapy required:**

- **Review antibiotics** with microbiology results, switch to a narrow spectrum regime if possible
- **Consider oral switch if:**
  - Patient is clinically improving
  - Patient is eating
  - No evidence of 'deep' infection (e.g. heart, bone, brain, bloodstream).
- **Duration:** Give 5 days antibiotics and then stop unless there is a clear indication to continue

## COVID-19 PCR negative patients

**If first COVID-19 PCR test is negative but COVID-19 still clinically suspected, see** HDFT diagnostic guidance for COVID-19

**Can empiric antibiotics be stopped?** Use the following signs, symptoms and test results to help inform the overall clinical assessment and decision about when to safely stop antibiotics:

- No clinical or radiological focus of infection
- No evidence of bacterial infection in blood cultures or other microbiology samples
- Alternative non-infection diagnosis accounts for signs and symptoms on admission (e.g. pulmonary oedema)
- Fever resolved

- **Low PCT <0.25 µg/L**

**If continuing antibiotic therapy required:**

- **Consider additional tests** if patient has radiological pneumonia:
  - Sputum MC&S
  - Legionella urinary antigen
  - Respiratory viral PCR
  - HIV test
- **Review antibiotics** with microbiology results, switch to a narrow spectrum regime if possible
- **If immunocompromised**, please seek specialist advice from microbiology/ID/respiratory
- **Consider oral switch if:**
  - Patient is clinically improving
  - Patient is eating
  - Fever resolved or resolving
  - No evidence of deep infection

## Clinical Frailty Scale\*

### Clinical Frailty Scale\*

-  **1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
-  **2 Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.
-  **3 Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.
-  **4 Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.
-  **5 Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
-  **6 Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



**7 Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



**9. Terminally Ill** - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

#### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.  
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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#### References:

1. NICE. COVID-19 rapid guideline: antibiotics for pneumonia in adults in hospital (NG173)
2. PHE. COVID-19 infection prevention and control guidance
3. PHE. Investigation and initial clinical management of possible cases
4. WHO. Clinical management of severe acute respiratory infection when COVID-19 is suspected
5. ERS COVID-19 clinical summaries
6. Kings critical care COVID-19 evidence summary
8. Recovery trial <https://ascpt.onlinelibrary.wiley.com/doi/pdf/10.1111/cts.12815>
9. <https://www.rcog.org.uk/globalassets/documents/guidelines/2020-06-18-coronavirus-covid-19-infection-inpregnancy.pdf>