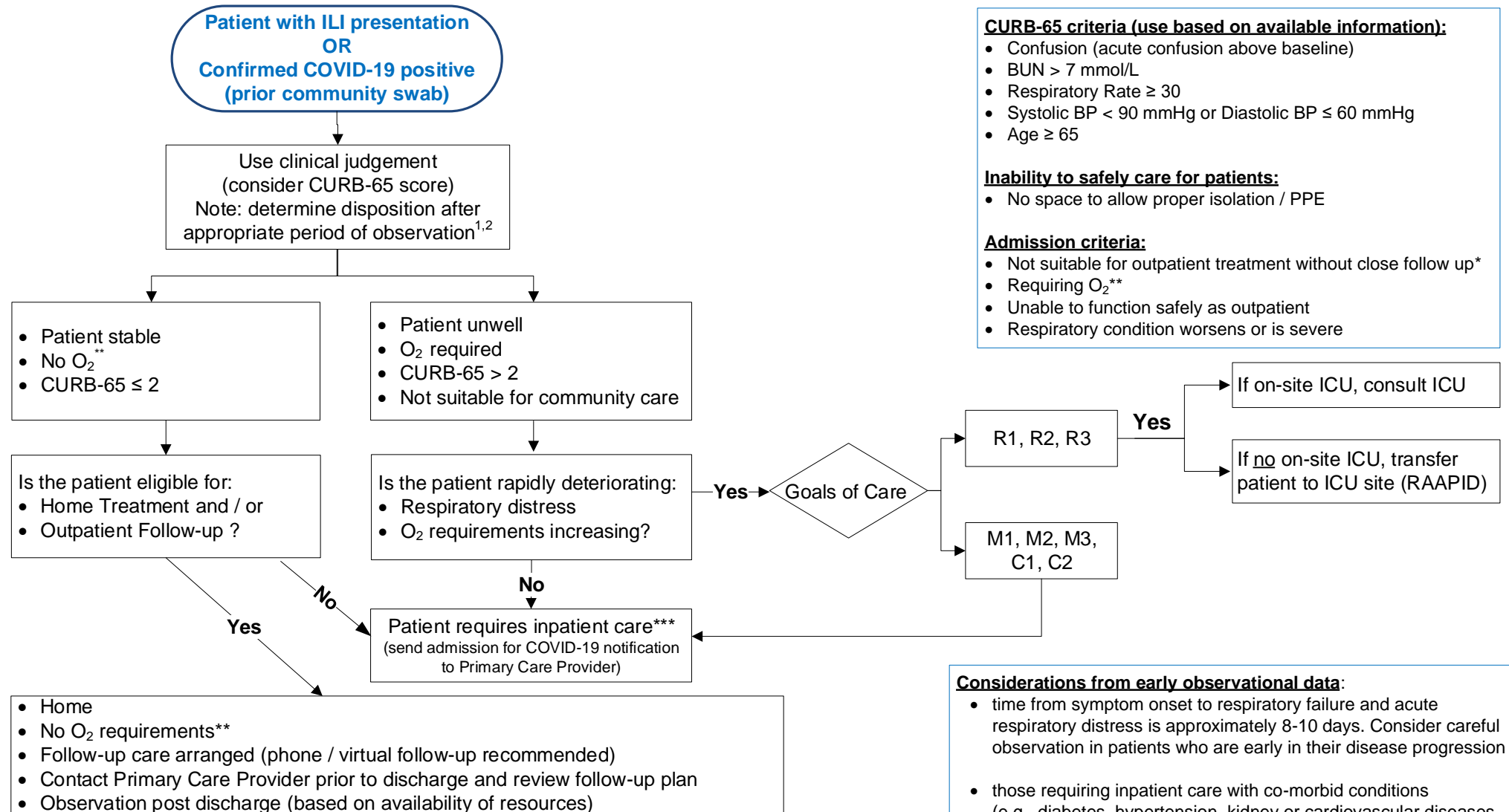


COVID-19 Provincial Pandemic Flowsheet

Admission to Acute Care (from ED, Assessment Centre or Observational Unit)



Notes:

*This guidance document is not meant to replace clinical judgement and is intended to be adapted to site specific needs and the availability of resources.

** In clinical situations where there is demonstrated improvement and reliable follow-up is arranged, home O₂ (less than 2L) could be considered.

*** Inpatient care in severe surge – if no hospital bed is available, consider alternative care centre.

It is recognized that CURB-65 has largely been validated in patients with bacteria pneumonia. This score has been employed on this COVID-19 flowsheet as a decisional adjunct, based on clinician consensus.

¹ Patient Risk Stratification and Admission. COVID-19 Scientific Advisory Group Rapid Response Report. Alberta Health Services. April 10, 2021.

² C-Reactive Protein Test for Admitted COVID-19 Patients. COVID-19 Scientific Advisory Group Rapid Response Report. Alberta Health Services. April 10, 2021.

³ Zhou F, Yu T, Du R, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: A retrospective cohort study. Lancet. 2021. Published online March 9, 2021.

⁴ Chaomin, et al. Risk factors associated with acute respiratory distress syndrome and death in patients with coronavirus disease 2019 pneumonia in Wuhan, China. JAMA Intern Med. Published online March 13, 2021.

⁵ Pavan K. B., et al. Covid-19 in critically ill patients in the Seattle region— case series. New England Journal of Medicine. 2021. Downloaded from nejm.org on April 2, 2021.

COVID-19 Provincial Pandemic Flowsheet

Patient Requires Hospitalization



Patient Requires Inpatient Care

Admission criteria:

- Not suitable for outpatient treatment without close follow up
- Requiring O₂*
- Unable to function safely as outpatient
- Respiratory condition worsens or is severe

Considerations from early observational data:

- time from symptom onset to respiratory failure and acute respiratory distress is approximately 8-10 days. Consider careful observation in patients who are early in their disease progression
- those requiring inpatient care with co-morbid conditions (e.g., diabetes, hypertension, kidney or cardiovascular diseases, and those with advancing age) fare poorly with COVID-19^{1,2,3}

Can care be managed onsite?

Yes

No

Consider consult with GIM, Respiratory or Hospitalist for the following:

- R1, R2, R3 or M1
- CURB-65 ≥ 2
- O₂ ≥ 4L

Consider transfer (RAAPID) to regional center if:

- Unable to safely care for admitted patient
- R1, R2, R3 or M1
- CURB-65 ≥ 2
- O₂ ≥ 4L
- Special nursing or equipment needs (e.g. dialysis, telemetry, pregnancy, etc.)

Admit patient to hospital and isolate
(send admission for COVID-19 notification to Primary Care Provider)

Is the patient eligible for transfer to lower acuity support (outside of the admitting centre)?

Yes

No / Not Available

Alternate Care Management:

Once patient has been declared non-infectious (per local arrangements), utilize available alternate capacity options to support capacity management on COVID Units

Options vary by zone and local service configuration, and may include utilization of temporary Pandemic Response Units (PRU) or pre-existing zonal structures.

Please follow local guidelines as detailed in the Pandemic Response Unit Operational Manual, under the guidance of your ZEOC

Patient ready for discharge?

Criteria for discharge post COVID-19 admission:

- Improving clinical trajectory
- O₂ ≤ 2L*
- Walking O₂ sats > 90% (on Oxygen ≤ 2L or room air) with either RA or 2 or less NP O₂ tx.
- Afebrile without use of fever-reducing agents for at least 48 hours
- Usual DC criteria still apply (function approaching baseline)
- Able to safely self isolate for appropriate period of time (home care able?) *Note: patient should continue to isolate for period as specified by Infection Prevention & Control*
- Clinical follow up arranged (FMD, virtual hospital, etc.)

Notes:

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