



# COVID19 CLINICAL PATHWAY FOR UN HEALTH FACILITIES

Clinical Governance Section

Division of Healthcare Management and Occupational Safety and Health (DHMOSH)

Department of Operational Support (DOS)

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## TRIAGE, CLINICAL HISTORY AND EXAMINATION

Screen and isolate all patients with suspected COVID-19 at the first point of contact with the health care system. Consider COVID-19 as a possible etiology of patients with acute respiratory illness. Triage patients using standardized triage tools and start first-line treatments. Initiate Infection Prevention Control at the point of entry of the patient for moderate and severe cases. Mild cases to be evaluated by phone only and no test is indicated.

For moderate and severe cases take and record a medical history:

- Symptoms: Fever or recent history of fever, chills, headaches, muscle pains, fatigue, anosmia, nausea and vomiting, cough, shortness of breath, anorexia, diarrhea, neurological symptoms
- History of travel to or residence in a location reporting community transmission of having been in contact with a confirmed or probable COVID-19 disease during the 14 days prior to symptom onset;
- Conduct an examination:
- Vital signs: Axillary temperature >37.5°C
- Pulse ox SO2

PERSON RESPONSIBLE:

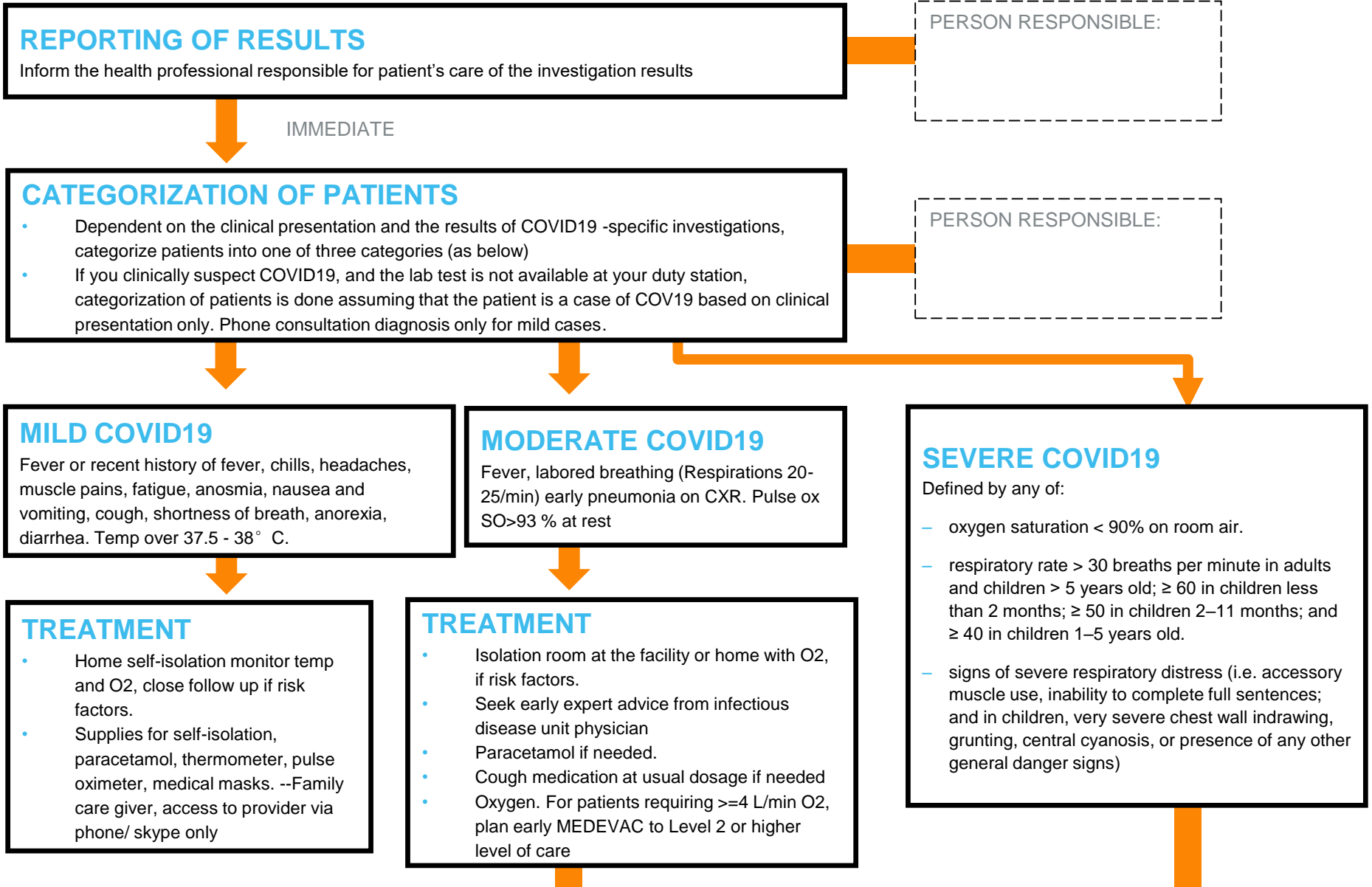
IMMEDIATE (IF THERE IS  
CLINICAL SUSPICION OF  
COVID 19)

## INVESTIGATIONS FOR MODERATE AND SEVERE CASES

- Send to laboratory for PCR COVID19 if available:
- Request other laboratory investigations:
  - Bloods: Complete blood count (CBC), urea, electrolytes & creatinine (UEC), liver function tests (LFT), hemoglobin, lactate, glucose, blood cultures of pneumonia causing bacteria.
  - For baseline: LDH, Ferritin, D-dimer, CRP, procalcitonin,
  - X-ray if suspicion of pneumonia only

PERSON RESPONSIBLE:

IMMEDIATE



IMMEDIATE

PERSON RESPONSIBLE:

IMMEDIATE

## INITIATE EVACUATION

- Hospitalisation in Isolation unit prior to MEDEVAC to Special Acute Respiratory Illness treatment facility
- Conservative fluid strategy. Avoid continuous maintenance fluids to avoid precipitating Adult Respiratory distress syndrome (ARDS)
- Lactated ringer's fluid boluses 250-500cc to get to perfusion targets up 30ml/kg of ideal body weight
- As per WHO recommendations, use systemic corticosteroids rather than no systemic corticosteroids for the treatment of patients with severe and critical COVID-19 (strong recommendation, based on moderate certainty evidence).
- As per WHO recommendation, do not use corticosteroids in the treatment of patients with non-severe COVID-19 (conditional recommendation, based on low certainty evidence)
- Consult infectious disease specialist or host country protocol before starting experimental drugs treatment.
- If the patient needs mechanical ventilation before MEDEVAC, most experienced provider should perform intubation.
- Minimize bedside proceduralists and bedside providers.
- Perform early in ARDS
- Utilize standard low stretch ARDS ventilation strategies with moderate PEEP until MEDEVAC takes place. (Target SO<sub>2</sub> 92-96%)
- Consider heavy sedation +/- paralytics for patient- ventilator dyssynchrony, severe ARDS, unable to achieve target ventilation or refractory hypoxia.