**COVID PROVIDER TIPS**

**ADMISSIONS**

* **Criteria for admission:**
	+ Fever at home or recorded in ED (100.4)
	+ Respiratory Distress, Hypoxia
	+ +/- CXR findings
	+ Stable patients with positive CXR findings can be discharged from ED with COVID tele-health (ED will do this)
* Patients are being isolated in ED before going to the floor
* Ensure all patients have had influenza A/B NAAT, COVID-19 PCR, CMP, Procalcitonin, CBC w/diff, CXR
* Droplet/Contact precautions for all patients
* If patient is requiring NRB and appears unstable, please ask ED to call ICU first
* NO patient should be on HFNC or NIPPV, currently these patients are being directly intubated
	+ \*unless patient is DNR/DNI, then we can try HFNC, but speak with RT/ICU
* AVOID home CPAP/BiPAP unless clear that patient requires it (ie: hypercarbic/retainer etc.) most patients can tolerate NOC 2-4L NC
	+ \*if they must have their CPAP/BiPAP, patient will need to be on Airborne Precautions at all times
* AVOID Nebulizer treatments, as these need Airborne Precautions
	+ Albuterol inhaler 4 puffs scheduled has been sufficient
* Please add the sticky note M/S and sticky note ID to your columns workflow
* Please use the Med/Surg Sticky note with the following:
	+ Sx onset:
	+ COVID swab sent:
	+ Anything pertinent we need to communicate

**COMMUNICATION WITH PATIENTS**

* **Avoid entering room unless you need to**. Ask nurse for their physical exam
* In ED to speak with patients:
	+ Walkie talkies available, ask RN if you don’t see them
	+ Use patient’s call light to call into patient room (find the white call light phone at the desk dial patient room number
	+ Call patient on their personal cell phone
	+ If none of above options work, gown up and go in, stand at the doorway, or if you think you really need a physical exam, gown up and go in
* On the Floor:
	+ Walkie talkie if available
	+ Call into patient room
	+ Gown up and go in, stand in doorway if need to speak with patient (helpful with dementia patients)

**WORK FLOW**

* This is a work in process, adjust as needed, keep steering on call in the loop with changes
* COVID R/O and Positive patients will be allocated to designated inpatient unit
* Generally: 10N for r/o, 10S for positive (may overflow to 6N, 9N, 9S)
* COVID huddles conference room at 8:35 AM
	+ Go over list of COVID pts. Brief update on clinical status, test status, dc plan
* Lab turn around is 24-48 hr. House Sup has been calling us with results, and the faxed copies are being scanned for chart after.
* If you are waiting on a lab you can call **lab** and they will give you result over the phone
* If your test in Inconclusive, send a new swab
	+ Orders: Type: COVID (it will pull up Coronavirus (COVID-19) PCR), will auto route to MISC lab order
	+ Let ID know it’s inconclusive
* When patient becomes positive, check with ID if patient would benefit from RDV trial.
	+ Criteria: fever, +CXR findings
	+ CrCl 50 or greater
	+ Some patients may get hydroxychloroquine instead
* If an RN is worried and wants to you examine the patient, please do. We are still responsible for our patients.

**DISCHARGES**

* If COVID test pending and patient is stable for DC they can be discharged WITH pending result.
* Ensure patient has own home they can go to and quarantine in. Ideally, separate bathroom and room from other family. Likely cannot dc if needs SNF, ALF
* Make sure oxygen saturation is around 94% or higher, or the clinical trend is one of improvement. Discuss with ID during huddles to ensure they agree.
* Send ID docs text page as FYI, alert RN and case manager.
* Use **.dccovid** for discharge instructions (I’ve edited it and shared it with the team)
* Floor RN to call tele-health backdoor number to set up patient
* Floor RN to give patient thermometer and pulse ox
* Floor RN to train patient on use of pulse ox and thermometer
* Patient wears surgical mask. RN/transporter wears surgical mask and gloves
* If tests come back after the patient has discharged, house supervisor will be notifying the patient.
* Ideally, once patient is >3 days without fever and >7 days from onset of symptoms, they should be ok to be off isolation per CDC. We have been able to get patient home health services and back to OP wound care once they have met that criteria.