PHILIPPINE HEART CENTER INCIDENT COMMAND POST	Document Type **GUIDELINES**	Document Code: GL-OED-ICP-001
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	Document Title **COVID-19 CLASSIFICATION, ADMISSION, DE-ESCALATION AND DISCHARGE**	Revision Number: 8
		Page: 1 of 9

REVISION HISTORY

Rev No.	Review Date	Description of Change	Date of Next Review
1	May 2020	Title Change Updated COVID-19 patient classification in accordance to the Department of Health (DOH) mandate Included PHC healthcare workers for admission	May 2022
2	May 25, 2020	Inclusion of Medical Strike Team definition and composition	May 2022
3	June 10, 2020	Changes in designated wards for COVID 19 patients Change in the criteria for discharge	May 2022
4	July 17, 2020	1.2.2 PHC HCW suspects 4E instead of 4D Asymptomatic HCW with high risk close contact shall complete 10 days instead of 14 days. Adopted DOH criteria for discharge.	May 2022
5	August 4, 2020	Adopted DOH criteria for discharge.	May 2022
6	December 1, 2020	Changed SICU 2 to SICU 1 as COVID unit. Changed 4E to 4D Removed 4A	May 2022
7	April 4, 2021	Added RT-PCR testing prior to transfer to non-covid unit. High risk exposure to complete 14 days instead of 10 days. Removed 4D, Changed SICU to SSU	May 2024
8	June 16, 2021	Revised and added functions of the Covid 19 Medical Strike Team Revised classification of Covid severity of illness based on DOH criteria Added process flow for admission of post emergency procedure patients pending RT-PCR result	May 2024

Reviewed by:	**GERARDO S. MANZO, MD** Incident Commander	Approved by:	**JOEL M. ABANILLA, MD** Executive Director

I. STATEMENT OF THE POLICY

It is the policy of the Philippine Heart Center to provide guidance in classifying and admitting suspected and confirmed COVID-19 cases, as well as in the de-escalation and discharging of such patients.

II. DEFINITION OF TERMS

1. Suspect Case

1.1. Individuals with Influenza-like illness (ILI). Symptoms include fever for at least 38°C and cough or sore throat, AND either of the following:

1.1.1 a history of travel to or residence in an area that reported local transmission of COVID-19 during the 14 days prior to symptom onset, OR

1.1.2 with contact to a confirmed or probable case of COVID-19 during the 14 days prior to symptom onset.

1.2 Individuals with sudden respiratory infection and severe symptoms such as shortness of breath, difficulty of breathing or severe pneumonia with unknown cause, and requires hospitalization.

1.3 Individuals with fever or cough or shortness of breath or other respiratory signs or symptoms and under any of the following conditions:

1.3.1 aged 60 years and above
1.3.2 with a comorbidity
1.3.3 assessed as having high-risk pregnancy
1.3.4 a health worker

2. Probable Case

2.1 Suspect case whom testing for COVID-19 is inconclusive

2.2 Suspect case who tested positive for COVID-19 but whose test was not conducted in a national or subnational reference laboratory, or an officially accredited laboratory.

3. Confirmed Case – An individual who was confirmed to have COVID-19 through laboratory testing using real time Reverse Transcription – Polymerase Chain Reaction (RT-PCR) in a national or subnational reference laboratory, or a DOH-certified COVID-19 testing center.

4. Severe Acute Respiratory Infection (SARI) CASE – A suspect, probable, or confirmed COVID-19 case requiring admission to Intensive Care Unit (ICU).

5. COVID-19 Medical Strike Team – From MEMORANDUM M-OED-2020-81 POLICY – COVID-19 MEDICAL STRIKE TEAM dated 16 March 2020. In Incident Command System terms, a strike team is a unit made up of the same resource category organized to accomplish a tactical objective. The

COVID-19 Medical Strike Team is tasked to decide on the management of COVID-19 patients as well as provide regular reports of admitted patients to the Incident Commander and Executive Director.

5.1 The medical strike team is composed of:

5.1.1 Infectious Disease Specialist
5.1.2 Infirmary Physician (If the patient is an employee)
5.1.3 Pulmonary Specialist
5.1.4 Critical Care Specialist
5.1.5 Chairperson of the Pharmacy and Therapeutics Committee

5.2 Functions of the COVID-19 Medical Strike Team:

5.2.1 The team shall provide a consensus-based management for COVID-19 patients

5.2.2 The team shall regularly update the director of admitted COVID-19 patients. Updates may be done through the COVID Core Strike Team viber group.

5.2.3 The team shall provide a regular report of admitted patients and submit to the Incident Commander

5.2.4 The team shall regularly review and update existing hospital policies on the management of COVID-19 patients

5.2.5 The team or a representative of the team shall work together with the attending physician of the patients and communicate plans for management

5.2.6 The team or a representative of the team shall update the family members or the authorized legal representative

5.2.7 The team is directly in charge of all COVID-19 patients including emergency room COVID-19 patients deemed for admission at our COVID units

5.2.8 In the event of management dilemma (initiation of any invasive procedures, hemoperfusion, hemodialysis, intimation of antiviral medications, immunotherapy, drugs for compassionate use, the consensus of the strike team shall supersede and be implemented

III. CRITERIA FOR SEVERITY OF SYMPTOMS:

1. Asymptomatic
- Exhibit no signs and symptoms

2. Mild Disease:

- Symptomatic patients presenting with fever, cough, fatigue, anorexia, myalgias; other non-specific symptoms such as sore throat, nasal congestion, headache, diarrhea, nausea and

vomiting; loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms with NO signs of pneumonia or hypoxia

3. Moderate Disease:

3.1 Adolescent or adult with clinical signs of non-severe pneumonia (e.g. fever, cough, dyspnea, respiratory rate (RR) = 21-30 breaths/minute, peripheral capillary oxygen saturation (SpO2) >92% on room air)

3.2 Child with clinical signs of non-severe pneumonia (cough or difficulty breathing and fast **Severe** breathing [< 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40] and/or chest indrawing)

4. Severe Disease

4.1. Adolescent or adult with clinical signs of severe pneumonia or severe acute respiratory infection as follows: fever, cough, dyspnea, RR>30 breaths/minute, severe respiratory distress or SpO2 < 92% on room air

4.2. Child with clinical signs of pneumonia (cough or difficulty in breathing) plus at least one of the following:

4.2.1 Central cyanosis or SpO2 < 90%; severe respiratory distress (e.g. fast breathing, grunting, very severe chest indrawing); general danger sign: inability to breastfeed or drink, lethargy or unconsciousness, or convulsions.

4.2.2 Fast breathing (in breaths/min): < 2 months: > 60; 2-11 months: > 50; 1-5 years: > 40.

5. Critical Disease - Patients manifesting with acute respiratory distress syndrome, sepsis and/or septic shock

5.1 Acute Respiratory Distress Syndrome (ARDS)

5.1.1 Patients with onset within 1 week of known clinical insult (pneumonia) or new or worsening respiratory symptoms, progressing infiltrates on chest X-ray or chest CT scan, with respiratory failure not fully explained by cardiac failure or fluid overload

5.2 Sepsis

5.2.1 Adults with life-threatening organ dysfunction caused by a dysregulated host response to suspected or proven infection. Signs of organ dysfunction include altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output, fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate or hyperbilirubinemia.

5.2.2 Children with suspected or proven infection and > 2 age-based systemic inflammatory response syndrome criteria (abnormal temperature [> 38.5 °C or < 36 °C); tachycardia for age or bradycardia for age if < 1 year; tachypnea for age or need for mechanical ventilation; abnormal white blood cell count for age or > 10% bands), of which one must be abnormal temperature or white blood cell count.

5.3 Septic Shock

5.3.1 Adults with persistent hypotension despite volume resuscitation, requiring vasopressors to maintain MAP > 65 mmHg and serum lactate level >2 mmol/L

5.3.2 Children with any hypotension (SBP < Sth centile or > 2 SD below normal for age) or two or three of the following: altered mental status; bradycardia or tachycardia (HR < 90 bpm or > 160 bpm in infants and heart rate < 70 bpm or > 150 bpm in children); prolonged capillary refill (> 2 sec) or weak pulse; fast breathing; mottled or cool skin or petechial or purpuric rash; high lactate; reduced urine output; hyperthermia or hypothermia.

IV. GUIDELINES

1. Triage and Admission of COVID-19 suspect patients presenting at the ER:

1.1 Asymptomatic patients with appropriate EXPOSURE history.
1.1.1 Provide instructions for quarantine for 10 days at home or Barangay isolation units.
1.1.2 Self monitoring for development of symptoms
1.1.2.1 Inform RESU/CESU
1.1.2.2.Testing on the 5th day of exposure for PHC HCWs
1.1.2.2.1 Consult ER ASAP if symptoms develop.
1.1.2.2.2 Follow-up at the Infirmary Clinic (with the AP for private patients)

1.2. Mild Disease

1.2.1 Disposition: Provide instructions for quarantine for 10 days at home or Barangay isolation units. Monitoring for the development of symptoms is done by ER nurse. Consult ER ASAP if symptoms develop. Follow-up at the Infirmary Clinic (with the AP for private patients) after 10 days.

1.2.1.1 Inform RESU
1.2.1.2 Fill out CIF
1.2.1.3 Diagnostics: CXR, CBC, Fecalysis (if with diarrhea)
1.2.1.4 Therapeutics: As indicated
1.2.1.5 Precaution: Personnel and patient to wear appropriate PPE***
1.2.1.5 Provide printed home care instructions

1.2.2 For PHC healthcare workers who are suspects or considered as high risk close contacts and are unable to do strict home quarantine, admit to designated PHC quarantine

1.2.3. Mild symptoms + Comorbid conditions* or age ≥ 60 years old
1.2.3.1 Put patient in ER isolation room, then admit to Ward 4A/4B
1.2.3.2 Diagnostics:
1.2.3.2.1. Labs: CBC, Na, K, Crea, BUN, SGPT, SGOT, TBDB, LDH CRP, Procalcitonin, D-dimer, Ferritin, Serum Albumin, Protime, ABG, 12L ECG, Blood Culture X 2 sets, ETA or Sputum GS, Fecalysis (if with diarrhea)
1.2.3.2.2 NPS / OPS
1.2.3.2.3 Imaging: CXR, Focus Echocardiogram** in the ER isolation room; Chest CT Scan (Plain), if warranted on transport to Ward 4 A/B

1.2.3.3. Therapeutics: As Indicated
1.2.3.4 Precautions: All personnel to wear PPEs***; Let the patient wear mask.

1.3. Moderate to Critical Disease

1.3.1 Disposition: Put patient in ER isolation room, then admit to the appropriate COVID unit

1.3.1.1 Admit to the designated COVID unit (Petal 4A/4B) for adult and pediatric patients with moderate symptoms to severe symptoms or high probability suspect case, or confirmed COVID-19 case. If fully occupied, patients with severe symptoms may be admitted to MICU1).

1.3.1.2 Admit to COVID ICU (MICU1) for severe to critically ill adult and pediatric patients

1.3.1.3 SSU must be used for admission of all COVID 19 suspects, confirmed, and/or recovered who underwent surgery or cardiac catheterization. Once stable, these patients shall be transferred to Petal 4B or 4D. For recovered patients, they may be transferred to regular room once stable.
1.3.1.4 Patients who came in for emergency procedures such as coronary angiogram, primary percutaneous coronary intervention (PCI), Intraaortic balloon pump (IABP) insertion, and temporary pacemaker insertion (TPI) are deemed COVID suspects and will be admitted at the Short Stay Unit (SSU) post procedure. Patient who will test positive will be transferred to the COVID intensive care unit (See process flow for admission of post emergency procedures)

1.3.2 Diagnostics:

1.3.2.1 Labs: CBC, Na, K, Crea, BUN, SGPT, SGOT, TBDB, LDH CRP, Procalcitonin, D-dimer, Ferritin, Serum Albumin, , Protime, ABG, 12L ECG, Blood Culture X 2 sets, ETA or Sputum GS, Fecalysis (if with diarrhea)

1.3.2.2 NPS / OPS

1.3.2.3 Imaging: CXR, POCUS (if with severe symptoms), Focus Echocardiogram ** in the ER isolation room; Chest CT Scan (Plain) on transport to Petal 4A/B

1.3.2.4 Therapeutics: As Indicated

1.3.2.5 Precautions: All personnel to wear PPEs***; Patients should wear at least a surgical mask

2. For de-escalation criteria:

2.1 RT-PCR testing should be done to patients who already met the de-escalation criteria prior to transfer from COVID to NON-COVID unit

3. For asymptomatic healthcare worker who has a history of COVID-19 exposure and strict home quarantine cannot be established, the personnel shall be admitted to the PHC quarantine facility for isolation for 14 days

3.1 Self-monitoring and care shall be implemented
3.2 They shall be periodically checked by the virtual/monitoring nurse and fellow on duty
3.3 The virtual/monitoring nurse shall update the Safety Officer and Nurse Supervisor on Duty.

4. The decision to discontinue transmission-based precautions shall be made using a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy).

4.1 If a higher level of clinical suspicion for COVID-19 exists, consider maintaining transmission-based precautions and performing a second test for SARS-CoV-2.
4.2 Meeting the criteria for discontinuation of transmission-Based Precautions is not a prerequisite for discharge.

5. Discharge Criteria shall be the following

4.1 A COVID-19 Probable or Suspect Case may be discharged once the following conditions are met:

4.1.1 Clinically improved and/or stable
4.1.2 There is no other indication for admission
4.1.3 An alternative diagnosis is available
4.1.4 The probability of COVID-19 has been ruled out

4.2 Criteria for discharge of patients with confirmed COVID-19 infection

4.2.1 Patients who have clinically recovered (with resolution of symptoms) and are no longer symptomatic for at least 3 days may be discharged from the hospital. The patient should still complete 14 days quarantine either at home or at a quarantine facility. If asymptomatic, the patient may be tagged as recovered.

*** Comorbidities:**

1. Pre-existing Pulmonary Disease
2. Chronic Kidney Disease
3. Diabetes Mellitus
4. Immunocompromised Status

5. Hypertension or Cardiovascular Disease
6. Transplant

**** Focus Echocardiogram – for evaluation of:**

1. Chamber enlargement
2. Wall motion abnormality
3. Left ventricular ejection fraction

***** PPE:**

1. Medical Mask or Fit-tested respirator mask for AGP
2. Eye protection (goggles or face shield)
3. Coveralls/ Gown
4. Clean gloves

****** Resolution of symptoms**

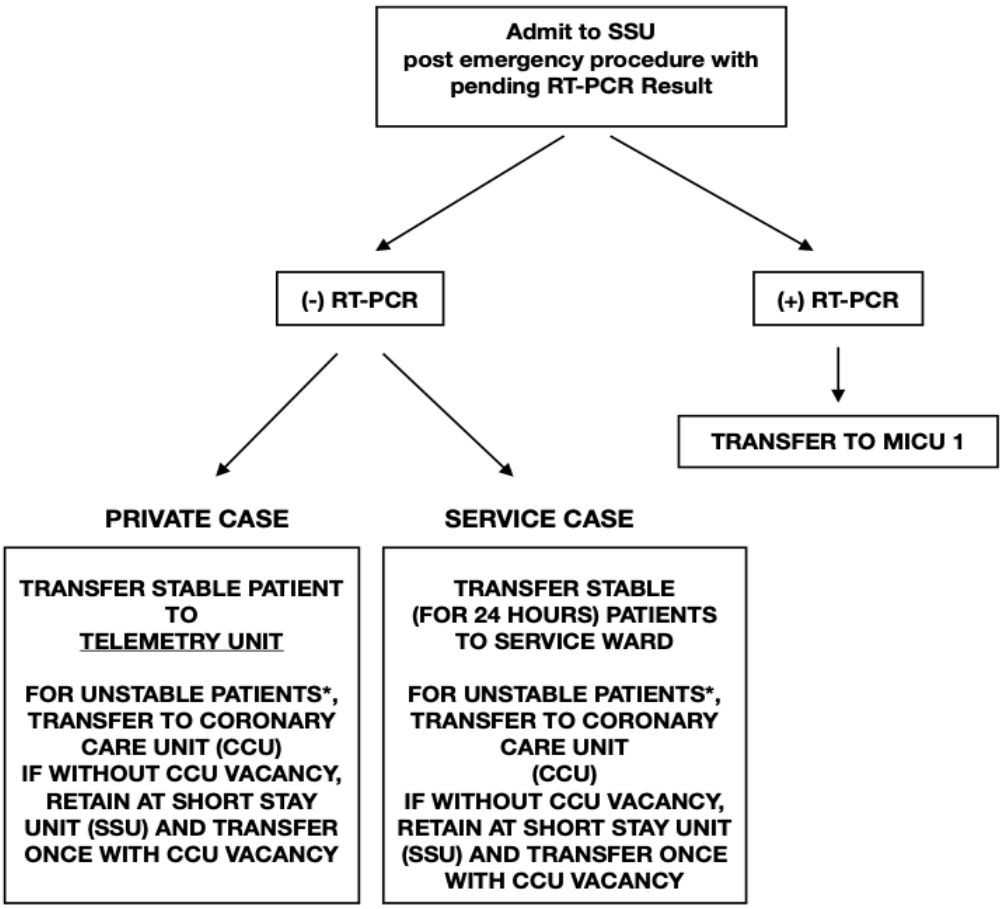
1. The body temperature returns to normal> 3 days
2. Respiratory symptoms have improved significantly
3. Chest radiograph shows significant improvement

6. For admission of emergency procedures, please see Annex A.

ANNEX A
PROCESS FLOW FOR ADMISSION

Emergency procedures include coronary angiography, percutaneous coronary intervention (PCI), Intraaortic balloon pump insertion (IABP), temporary pacemaker insertion (TPI)

***Unstable patients:**
- Hypotensive patients
- With Intraaortic balloon pump
- Cardiac arrhythmia
- Procedural complications such as coronary dissection, perforation, cardiac tamponade



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