



fraserhealth

# Regional Pre-Printed Orders for COVID-19 Confirmed or Presumed Long-Term Care (LTC)



Form ID: DRDO107351C

Rev: October 20, 2020

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DRUG & FOOD ALLERGIES

Mandatory  Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

- Review Advance Care Planning documents (ACP) Record, Advance Directive, Representation Agreements, Identification of Substitute Decision Maker (SDM) List
- Initiate or engage in conversations (utilize Serious Illness Conversation Guide (SICG SDM COVID-19)), document on ACP Record
- Update MOST with resident & SDM based on above
- If a transfer to acute care is recommended by the MRP, MRP to call receiving ER physician to discuss and accept transfer before calling EHS. Resident to wear a surgical/procedure mask during transportation.

### INFECTION PREVENTION AND CONTROL:

- Cohort and isolate (with droplet precautions) all residents with suspected or confirmed COVID-19.
- Ensure staff have reviewed proper donning and doffing techniques
- Stop all Aerosol Generating Procedures (AGP) including nebulized medications, CPAP, nocturnal BiPAP and high flow oxygen for all residents in the facility unless deemed clinically essential.
- Start nocturnal oxygen instead of CPAP treatment. If nocturnal BiPAP use is essential, the resident should be in a private room, on airborne precautions.

### MONITORING:

- Vital signs (BP, HR, RR, O<sub>2</sub>, Temperature) once daily and as clinically required
- Monitor resident's clinical status, symptoms, and comfort twice per shift
- Use O<sub>2</sub> PRN up to 6 L/min via Nasal Prong to maintain an O<sub>2</sub> sat of 92% or greater
- If on O<sub>2</sub> 6 L/min via Nasal Prong and resident unable to maintain an O<sub>2</sub> sat greater than 92%, continue O<sub>2</sub> at 6 L/min and start medications to support comfort with shortness of breath (see page 2, shortness of breath section).

### MEDICATIONS:

#### ANALGESICS AND ANTIPYRETICS:

- Treat fever only if presenting with associated discomfort:
- **acetaminophen** 650 mg PO/rectal Q6H PRN for pain/fever

Select one of the following:

Maximum **acetaminophen** from all sources 4000 mg per 24 hours

OR

Maximum **acetaminophen** from all sources 2000 mg in 24 hours (advanced liver disease)

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#



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### SHORTNESS OF BREATH:

- HYDROmorphone** 0.5 mg PO Q4H PRN
- AND/OR
- HYDROmorphone** 0.25 mg subcutaneous Q4H PRN
- OR
- HYDROmorphone** \_\_\_\_\_

If comfort needs are not met despite PRN opioid use, MRP to:

- Adjust the opioid dose if resident is already receiving scheduled narcotics and/or if comfort needs are not met despite PRN opioid use.
- Consider addition of regularly scheduled opioid in addition to PRN if shortness of breath persists.
- Review goals of care if resident is unable to maintain O<sub>2</sub> sat and is experiencing increased respiratory distress.
- Initiate actively dying protocol if appropriate.

### CORTICOSTEROID:

- dexamethasone** 6 mg PO daily for 10 days to be started if one of the following criteria is met:
  - If resident is requiring supplemental O<sub>2</sub> to maintain O<sub>2</sub> saturation 92% or above.
  - OR
  - If the resident is on baseline O<sub>2</sub> with increasing O<sub>2</sub> requirements.  
(Please note that is expert consensus based on data from acute care settings)
- Discontinue **dexamethasone** if no longer requiring supplemental O<sub>2</sub> or back to baseline O<sub>2</sub> for 24 hours.

### ANTIBIOTICS:

- Antibiotics not recommended for outpatients with COVID-19 who do not require supplemental oxygen.
- Consider antibiotics if suspected bacterial co-infection, rapidly increasing supplemental oxygen requirements, or evidence of sepsis.

- azithromycin** 500 mg PO daily x 3 days (caution if prolonged QTc)

AND ONE OF:

- amoxicillin-clavulanate** 500 mg-125 mg PO TID x 5 days if eGFR greater than or equal to 30 mL/min
- amoxicillin-clavulanate** 500 mg-125 mg PO BID x 5 days if eGFR less than 30 mL/min

OR

IF SEVERE PENICILLIN ALLERGY:

- MOXifloxacin** 400 mg PO daily x 5 days (addition of azithromycin not necessary)

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name <u>and</u> College ID#