

## **Annex 2j : MANAGEMENT OF CONFIRMED COVID-19 CASE IN LOW RISK COVID-19 QUARANTINE AND TREATMENT CENTERS (PKRC)**

### **1. Admission criteria**

Patients in clinical category 1, 2 and those in category 3 but not hypoxic and are from low risk groups can be safely managed in low risk COVID-19 quarantine and treatment centers (PKRC) provided the following safety nets are in place.

Patients fitting the following criteria can be admitted directly to low risk COVID-19 quarantine and treatment centers (PKRC):

- i. Age < 50 years
- ii. No comorbid such as DM, cardiovascular disease, chronic pulmonary disease including asthma, chronic renal disease, hypertension, obesity (BMI  $\geq 30$  kg/m<sup>2</sup>)
- iii. Able to ambulate without assistance and self-administer medications
- iv. Do not have ongoing clinical needs such as haemodialysis
- v. Not pregnant

1.1. Such patients can be further triaged over the phone or at PKRC itself by asking for the following:

- i. Exertional dyspnea
- ii. Chest pain
- iii. Unable to tolerate orally
- iv. Unable to ambulate without assistance

1.2. On arrival to PKRC, they must be examined by medical officers to ensure that they have:

- i. Stable vitals
- ii. Not hypoxic, SpO<sub>2</sub> >95% in room air, RR <20
- iii. Chest x-ray is not routinely recommended in asymptomatic patients (category 1). Checking for exertional desaturation using 1-minute sit-to-stand test (in which the patient goes from sit to stand as many times as they can in one minute; >3% drop in SpO<sub>2</sub> indicates the presence of exertional desaturation) is an alternative for these patients. However, chest x-ray is required for those who develop warning signs.

Patients who are not stable based on criteria under **1.1** and **1.2** above can be transferred to hospital for further management.

### **2. Monitoring for deterioration**

2.1. All patients should be monitored daily for clinical warning signs, this includes:

- i. Persistent or new onset fever
- ii. Worsening or persistent symptoms such as lethargy or cough
- iii. Reduced level of consciousness

2.2. Blood investigation can be done after admission and need to be repeated when the patient has clinical warning signs. The lab parameters suggestive of progressive disease include:

- i. Dropping absolute lymphocyte count or single value  $< 1$  cells/uL
- ii. Neutrophil-lymphocyte ratio (NLR)  $>3.13$
- iii. Increasing CRP of a single value  $>50\text{mg/L}$
- iv. Increasing LDH or a single value  $>245\text{U/L}$

2.3. Following practices help better assessment of patients and recognizing early deterioration:

- i. Have a proper clinic space with blood taking facilities in all PKRC where patients can be brought in for assessment one by one
- ii. Have a separate area in the PKRC where patients who seem to be at higher risk of deterioration can be placed, hence close monitoring can be done
- iii. Educate the paramedics on the warning signs, so that they can ask the relevant questions to the patients when the vital signs are being measured
- iv. Educate patients to do self-assessment by putting up posters in the PKRC encouraging patients to call the staff if they themselves or their neighbours are experiencing vomiting, breathlessness, or fever

### **3. Admission of higher risk but stable patients to PKRC**

With the establishment of good system to monitor for deterioration and with the availability of better trained staff, progressively higher risk patients can be admitted into PKRC. These include those who are:

- i.  $< 50$  years old but with stable comorbid
- ii. 50-70 years old without any comorbid

### **4. Stepping down stable patients to PKRC from hospital**

In addition, higher risk group patients who seem to be in recovery phase can be transferred to PKRC before discharge. The criteria for step-down include:

- i. More than 7 days since onset of illness
- ii. Stable vitals and no hypoxia
- iii. Stable comorbid if any
- iv. Improved or stable laboratory data including inflammatory markers (especially C-reactive protein or lactate dehydrogenase)
- v. Able to ambulate without assistance and self-administer medications
- vi. Do not have ongoing clinical needs such as haemodialysis