

Management of Patient with COVID-19: Considerations for the Long Term Care Setting

The following table provides some guidance relating to the types of treatments that can be provided feasibly in the long-term setting and contrasts them with the typical treatments provided to COVID-19 patients in the acute care setting. This summary can serve to inform treatment decisions as well as goals-of-care conversations with LTC residents and families. Version date January 5, 2022.

	Long-term care setting	Acute care setting
Oxygen <ul style="list-style-type: none"> Target SpO₂ > 92% (unless prior chronic lung disease, where lower SpO₂ levels could be targeted) 	Supplemental oxygen up to 5L/min via nasal prongs	Supplemental oxygen, including Venturi mask, high flow nasal cannula, mechanical ventilation
Fluids <ul style="list-style-type: none"> LTC residents are at high risk of decreased PO intake and volume depletion 	Hypodermoclysis up to a rate of approximately 50 cc/hour	IV fluids – higher rates possible including boluses as needed
Dexamethasone <ul style="list-style-type: none"> Recommended for individuals requiring supplemental oxygen (or have an increase in O₂ requirements if on chronic O₂ therapy) 	Dexamethasone 6 mg PO daily for 10 days (IM Dexamethasone 10 mg per day is an option for people with poor swallowing)	Dexamethasone 6 mg PO / IV daily for 10 days (or until discharge, whichever is less)
Anticoagulation <ul style="list-style-type: none"> Higher doses are recommended for moderately ill patients admitted to hospital (but not in the ICU) – extrapolated to LTC, could consider adding prophylactic dose anticoagulation for duration of acute COVID illness 	Prophylactic dose anticoagulation for duration of acute illness (if not already on therapeutic dose): <ul style="list-style-type: none"> Enoxaparin 40 mg sc daily Enoxaparin 30 mg daily for pts with CrCl<30 mL/min or weight < 50 kg Enoxaparin 60 mg daily for pts with weight > 100 kg Limited use code = 188 For homes where SC dosing might be challenging, could consider Apixaban 2.5 mg PO BID	Varies by hospital site, but for non-ICU patients, intermediate to full dose anticoagulation prescribed In the ICU setting, prophylactic doses prescribed
Inhaled Budesonide <ul style="list-style-type: none"> Consider for residents with symptomatic COVID (but not on oxygen) to reduce duration of symptoms 	800 mcg inhaled BID for 14 days	Not typically given to hospitalized patients
Fluvoxamine <ul style="list-style-type: none"> Consider for individuals with mild illness; may prevent hospitalization 	Evidence of benefit not very strong, and side effect profile of high dose Fluvoxamine and high potential for drug-drug interactions makes this treatment challenging for most LTC residents	Not typically given to hospitalized patients

<p>Remdesivir</p> <ul style="list-style-type: none"> Recommended for individuals requiring supplemental oxygen (or have an increase in O₂ requirements if on chronic O₂ therapy) – but not high-flow oxygen or ICU 	<p>Requires 5 days of IV administration and daily monitoring of CBC, renal function and liver enzymes, so would require acute care transfer if consistent with goals of care</p>	<p>200 mg IV on day 1, and then 100 mg IV per day on days 2-5</p> <ul style="list-style-type: none"> Contraindicated in patients with renal dysfunction (CrCl<30 mL/min), ALT>5x upper limit of normal
<p>Tocilizumab</p> <ul style="list-style-type: none"> Recommended for patients with severe illness (either patients who have not improved or worsened with dexamethasone, or patients admitted to the ICU) 	<p>Illness severity, need for evaluation of CRP, IV route of admission, and drug availability make Tocilizumab administration very challenging in LTC, and so would require acute care transfer if consistent with goals of care</p>	<p>400 mg one time IV dose</p> <ul style="list-style-type: none"> Given to patients on high flow oxygen or in the ICU For patients on supplemental oxygen, only given if they have not shown improvement with Dexamethasone after 24-48 hours and their CRP level > 75
<p>Monoclonal antibodies</p> <ul style="list-style-type: none"> Recommended in patients with mild illness not on oxygen) who are at high risk of disease progression Sotrovimab is the only monoclonal Ab with activity against Omicron 	<p>Sotrovimab 500mg IV x 1 dose for symptomatic residents of LTC</p> <p>New guidance forthcoming on which groups will be prioritized due to drug shortages provincially</p>	<p>Recommended for nosocomially-acquired COVID only</p>
<p>Nirmatrelvir and ritonavir (Paxlovid)</p> <ul style="list-style-type: none"> This new antiviral agent is not yet approved by Health Canada nor available in Canada; however, it will possibly be approved/available in coming weeks If approved for use – will most likely be for patients with mild illness (not on oxygen) within 3-5 days of symptom onset 	<p>Nirmatrelvir 300mg and Ritonavir 100mg given together PO BID x 5 days</p> <ul style="list-style-type: none"> Dose-adjust to 150/100mg po BID if CrCl 30-60 mL/min Not recommended if CrCl <30 mL/min <p>High potential for drug-drug interactions due to ritonavir</p>	<p>Not applicable</p>
<p>Antibiotics</p> <ul style="list-style-type: none"> Consider if there is concern for bacterial co-infection, which is rare with COVID-19 	<p>Amox-Clav (PO) or Levaquin (PO) Ceftriaxone (IM)</p>	<p>In addition to PO, can give IV antibiotics</p>

For most up-to-date COVID Clinical Practice Guidelines, please see the Ontario COVID-19 Science Table Clinical Care site: <https://covid19-sciencetable.ca/brief-category/infectious-diseases-clinical-care/>