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	Document Title:	GUIDELINES AND POLICIES IN MANAGEMENT OF PEDIATRIC PATIENTS INITIALLY ADMITTED AT REGULAR PRIVATE ROOM AND DEVELOPED SYMPTOMS OF CORONAVIRUS (COVID-19) INFECTION

PURPOSE:

To reduce the risk of transmission of the virus caused by COVID-19 or other infectious disease from one pediatric patient to another.

OBJECTIVE:


To standardize protocols in management of patients with Emerging and Reemerging Infectious Diseases who are transferred from regular rooms to COVID Isolation Room or Intensive Care Unit.

RESPONSIBLE PERSON:

All Nurses and Medical Doctors


GENERAL CONSIDERATIONS:

1. The clinical spectrum of COVID -19 has not yet been fully defined. Until specific treatment is determined, a more meticulous supportive care is warranted in managing these patients.
2. The clinical spectrum of COVID -19 has not yet been fully defined. Until specific treatment is determined, a more meticulous supportive care is warranted in managing these patients.
3. Due to the small cases among children, the data on disease severity and pathogenesis of COVID-19 infection in children are limited and new signs and symptoms may emerge in the future. Clinical manifestations of COVID-19 infection among pediatric patients may present variably and less severe than in

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adults but there are reports of children with COVID-19 infection requiring intensive care.

- a. Consider referring to Pediatric Infectious Disease Specialist to classify non-COVID from COVID suspect and probable.
4. A dedicated healthcare worker should be in full Personal Protective Equipment (cap, N95 mask, goggles, face shield, full impermeable gown, gloves, and shoe covers) when handling the patient. Proper donning and doffing of PPEs and infection control measures should be observed at all times.
5. One caregiver is allowed to accompany patient to the designated isolation room and must be fully informed on the risk of possible transmission of the infection. The caregiver should properly wear a surgical mask and observe proper hygiene at all times.
6. Require all patients to wear mask that covers mouth and nose except children ≤ 2 years of age.
7. The WHO recommends standard, contact, and droplet precautions with eye and face protection, with addition of airborne precautions as needed during aerosol-generating procedures.


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DEFINITION OF TERMS:

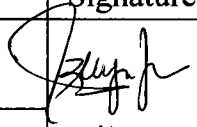



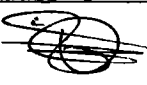





1. COVID Suspect—Any symptomatic child with history of travel or close contact within the last 14 days.
2. COVID Probable—Any COVID suspect case pending test results, or those whose results are either inconclusive or conducted by an unofficial laboratory.
3. COVID Confirmed—Any child with positive for SARS-CoV-2 on nucleic acid detection test such as RT-PCR regardless of symptoms.
4. Severe/Critical Symptoms
 - a. Any child with cough or difficulty of breathing PLUS at least ONE of the following:
 - i. Central cyanosis or $SpO_2 < 90\%$
 - ii. Severe respiratory distress (eg. Grunting, very severe chest indrawing)
 - iii. Signs of pneumonia with a general danger sign: inability to breast feed or drink, lethargy/movement only when stimulated, unconsciousness or convulsions
 - iv. Other signs: chest indrawing, fast breathing (in breaths/min):
 1. <2 months: $RR \geq 60$ bpm
 2. 2-11 months: $RR \geq 50$ bpm
 3. 1-5 years: $RR \geq 40$ bpm
 - b. Any child with suspected or proven infection and \geq SIRS criteria, of which one must be abnormal temperature or white blood cell count (Sepsis)


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- c. Any child presenting with septic shock, defined as hypotension (SBP <5th centile or > 2 SD below normal for age) or at least 2 of the following:
- i. Altered mental state
 - ii. Tachycardia (HR >160bpm in infants or HR >150 bpm in children) or bradycardia (HR < 90bpm in infants or HR < 70 bpm in children)
 - iii. Prolonged capillary refill (>2 seconds) or warm vasodilation with bounding pulses
 - iv. Tachypnea
 - v. Mottled skin or petechial or purpuric rash
 - vi. Increased lactate
 - vii. Oliguria
 - viii. Hyperthermia or hypothermia

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PROCEDURE:

1. Intubation

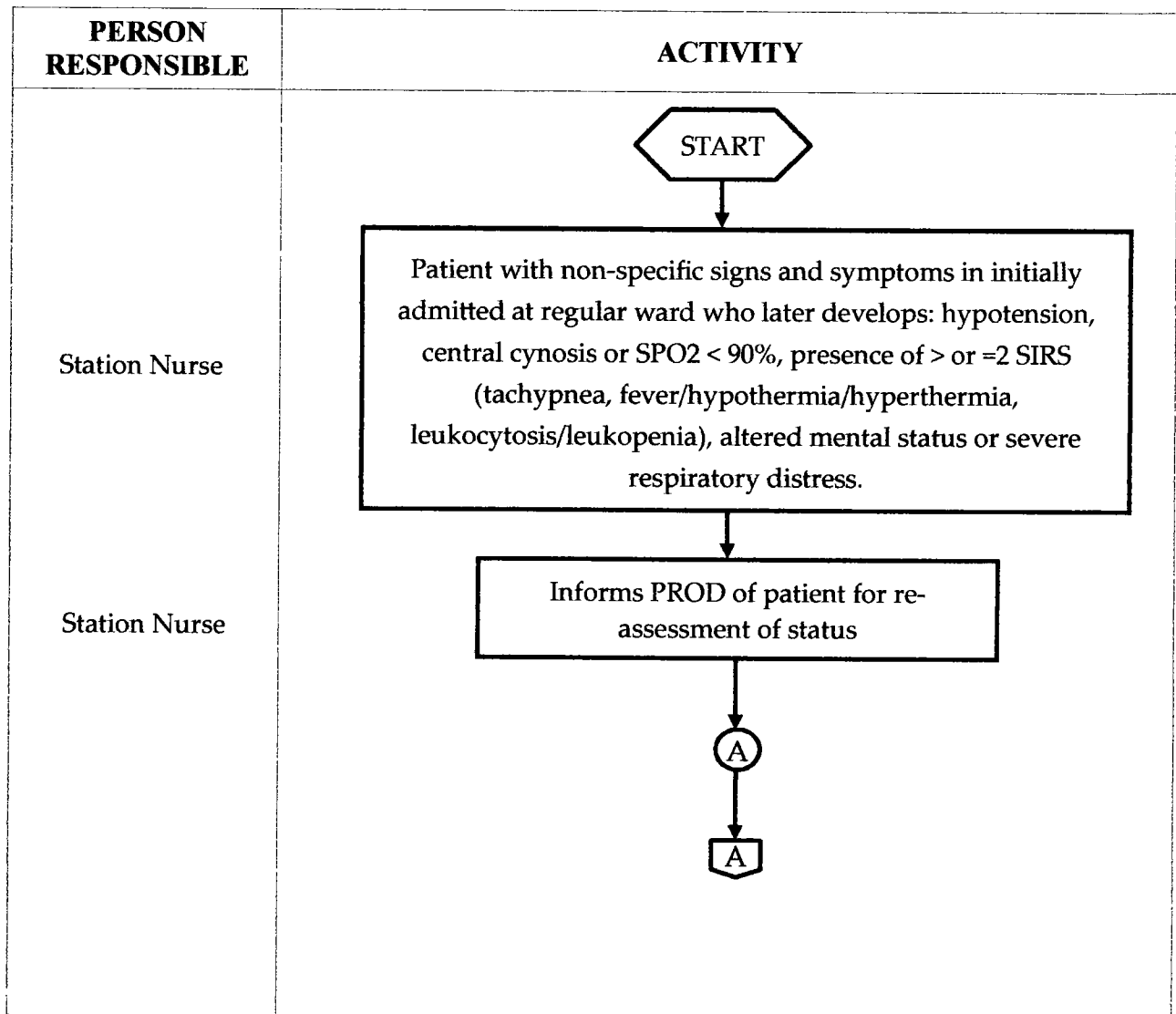
- (a) Intubation must be done only when full PPE is donned and must be done by the most skilled personnel.
- (b) Sedate/ paralyze patient then attempt rapid sequence intubation (RSI)
- (c) Avoid bag valve mask ventilation after intubation.
- (d) If pre-oxygenation is needed, do so using tightly fitting face mask with reservoir.
- (e) Avoid nebulization of intubated patients.
- (f) Intubation must be done with 2 attempts only. If successful, patient must be immediately hooked to the mechanical ventilator.
- (g) If unsuccessful, abandon further attempts, apprise parents/responsible folk and give best supportive care.
- (h) Materials needed
 - Videolaryngoscope
 - Macintosh Direct Laryngoscope/Intubation set (Pediatric blade sizes)
 - Endotracheal tube (cuffed and uncuffed)
 - Stylet, Bougie
 - Oxygen mask delivery systems: nasal prong, face mask, mask with rebreather
 - Syringes
 - Plaster
 - Lubricant

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- Capnography device/ETCO2 Monitor
- NGT/OGT
- Pediatric Optichamber
- N88 mask or surgical mask (for patient's use)
- Suction apparatus
- Oxygen supply
- Mechanical ventilator
- Medications: Epinephrine 1:1000, Propofol 3mg/kg, Rocuronium 0.6mg/kg, Midazolam 0.15 mg/kg, Lidocaine, Ketamine, Fentanyl, Methylprednisolone, Hydrocortisone, Metered Dose Inhalers: Salbutamol 100mcg/actuation, Salmeterol + Fluticasone (25/250mcg and 25/125mcg), Formoterol + Budesonide (4.5/80 mcg and 4.5/160mcg), Formoterol + Fluticasone (5/50mcg)

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FLOWCHART





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