HealthCap
RISK MANAGEMENT SERVICES

RESIDENT TEST POSITIVE FOR COVID-19 CARE PLAN

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I tested positive for COVID-19 on _________	My risk of developing complications of COVID-19 will be reduced.		☐ I require supplemental oxygen: ______________________________ ☐ I need opportunities to socialize. Please accommodate as possible within the limits of my isolation precautions. ☐ I am worried and need opportunities to verbalize my fears. ☐ Administer my medications as ordered. Monitor for side effects. ☐ Take my vital signs Q shift, including pulse oximetry or as ordered by my physician. Report abnormal findings. ☐ Implement and Maintain Transmission-Based Precautions ☐ Monitor for presence or absence of symptoms: • Fever • Cough • Shortness of breath • Sore throat o Report to my physician worsening signs and symptoms of infection or lack of improvement from treatment. ☐ Report any of the following immediately: • Trouble breathing/oxygen saturation <90%	

SAMPLE

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			• Persistent pain or pressure in my chest • New confusion or inability to arouse • Bluish lips or face ☐ Monitor lab work as ordered and report results to my physician. ☐ Encourage me to use clean hygiene techniques to avoid cross-contamination, especially handwashing before meals and after bowel movements. ☐ Remind me to cough or sneeze into a tissue or my elbow. Keep tissues and trash can within easy reach. ☐ If I must leave my room or the facility, place a facemask over my nose and mouth. Assist me with handwashing before leaving. ☐ Notify any transport personnel or receiving healthcare facility of my diagnosis and the precautions I need. Offer and encourage me to drink adequate fluids (if appropriate for medical diagnosis). ☐ Assess my need for dietary modification and consult RD as indicated. ☐ Honor my advance directives.	

RESIDENT NAME____ROOM #__________

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RISK MANAGEMENT SERVICES

Suspected COVID-19 Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am suspected of having COVID-19, I have the following signs and symptoms of COVID-19: ☐ Fever or chills ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Fatigue ☐ Muscle or body aches ☐ Headache ☐ New loss of taste or smell ☐ Sore throat ☐ Congestion or runny nose ☐ Nausea or vomiting ☐ Diarrhea	My risk of developing complications of COVID-19 will be reduced.		☐ Notify my physician and perform a COVID-19 test as ordered. ☐ I need opportunities to socialize. Please accommodate as possible within the limits of my isolation precautions. ☐ I am worried and need opportunities to verbalize my fears. ☐ Notify my responsible party, legal decision maker ☐ Take my vital signs Q shift, including pulse oximetry. Report abnormal findings. ☐ Implement and Maintain Transmission-Based Precautions ☐ Monitor for presence or absence of symptoms: • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue	

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			• Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea • Report to my physician worsening signs and symptoms of infection or lack of improvement from treatment. ☐ Report any of the following immediately: • Trouble breathing/oxygen saturation <90% • Persistent pain or pressure in my chest • New confusion or inability to arouse • Bluish lips or face ☐ Monitor lab work as ordered and report results to my physician. ☐ Encourage me to use clean hygiene techniques to avoid cross-contamination, especially hand washing before meals and after bowel movements.	

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			☐ Remind me to cough or sneeze into a tissue or my elbow. Keep tissues and trash can within easy reach. ☐ If I must leave my room or the facility, place a facemask over my nose and mouth. Assist me with handwashing before leaving. ☐ Notify any transport personnel or receiving healthcare facility of my diagnosis and the precautions I need. Offer and encourage me to drink adequate fluids (if appropriate for medical diagnosis). ☐ Assess my need for dietary modification and consult RD as indicated. ☐ Honor my advance directives.	

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New Admission/Readmission to Facility Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
☐ I am a New Admission to the Facility. ☐ I have been Re-Admitted to the facility	☐ I will be monitored for signs and symptoms of COVID-19 ☐ I will be provided with opportunities to have activities of choice within my transmission based precautions. ☐ I will report signs and symptoms of COVID-19 to the nursing staff.		☐ Perform a COVID-19 Test as ordered by my physician. ☐ Place me on isolation for 14 days. ☐ Provide opportunities for socialization and accommodate as possible within the limits of my isolation precautions. ☐ Take my vital signs Q shift, including pulse oximetry or as ordered by my physician. Report abnormal findings. ☐ Implement and maintain Transmission-Based Precautions ☐ Educate and monitor for presence of symptoms for COVID-19: • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache	

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Released 6/23/2020

			• New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea • Report to my physician worsening signs and symptoms of infection or lack of improvement from treatment. ☐ Report any of the following to my physician immediately: • Trouble breathing/oxygen saturation <90% • Persistent pain or pressure in my chest • New confusion or inability to arouse • Bluish lips or face ☐ Encourage me to use clean hygiene techniques to avoid cross-contamination, especially handwashing before meals and after bowel movements. ☐ If I must leave my room or the facility, place a facemask over my nose and mouth. Assist me with handwashing before leaving.	

SAMPLE

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At Risk for COVID-19 CARE PLAN SAMPLE

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk for developing COVID-19	My risk of developing COVID-19 will be minimized.		☐ I should stay in my room ☐ Provide me with activities in my room that meet my interest. ☐ Provide opportunities for me to communicate with my family and friends. ☐ Take my vital signs daily and report any abnormal findings. ☐ Educate me to report any of the following symptoms: • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea	

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Released 6/25/2020

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PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
			☐ Remind me to cough or sneeze into a tissue or my elbow. Keep tissues and trash can within easy reach. ☐ Educate me on proper hand hygiene. ☐ If I must leave my room or the facility, place a facemask over my nose and mouth. Assist me with handwashing before leaving.	

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Aspiration/Choking Risk Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I require supervision when I eat my meals related to my risk for aspiration and/or choking. My risk may be increased related to the restriction of communal dining.	My risk of aspiration and/or choking will be decreased.		☐ Provide me with the diet prescribed by my physician. ☐ Speech Therapy evaluation as needed. ☐ Ensure that I am in an upright position during meals. ☐ Allow sufficient time for me to eat and drink ☐ Utilize feeding strategies per Speech Therapist recommendations. ☐ Monitor me for signs and symptoms of aspiration during meals, ie., wet or gurgling sound when I speak ☐ Monitor me for signs and symptoms of choking during meals such as coughing. ☐ Monitor me for signs of difficulty swallowing (dysphagia)	

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Released 6/22/2020

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COVID-19 ACTIVITIES CARE PLAN

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am required to social distance and group activities with other residents have been discontinued due to the COVID-19 Pandemic.	I will not have an increase in anxiety or signs/symptoms of depression I will be involved in an independent activity of my choice ___ x week.		☐ Assist me in "connecting" with loved ones via social media, facetime, skype, etc. ☐ Arrange phone conversations with my family and friends ☐ Provide me with needed PPE ☐ Provide safe ways for me to continue to be active, such as staff walking with me outside, or walking alone if appropriate ☐ Provide independent activities based on my personal preferences ☐ Allow time for me to express myself through art projects, building/constructing kits such as bird houses, etc. ☐ Provide "activities on the go". Place small games, craft projects and other items that can be easily sanitized after use into a bin and take them to my room. If I need assistance with these activities, remain with me and work 1:1 (maintain social distancing) to	

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			engage me in the activities and/or conversation when able ☐ Social Engagement activities "Doorway Soccer, doorway large muscle exercises, yoga/stretching, tai chi, noodles, scarf, stretchy band exercises. Group singing in hallways with staff and residents Church services: via TV, radio, livestream or recorded, Prayer CDs Bingo numbers announced daily for an ongoing weekly game, doorway bingo	

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Environmental Considerations Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk for decreased function and safety related to environmental risks and isolation secondary to COVID-19 isolation.	I will not experience negative outcomes related to modifiable environmental risks	Phase 2	• I will be educated on personal device use to decrease the risk of injury • Staff will assess my environment and address modifiable risk areas to assist in preventing falls and injuries • Staff will declutter my room to increase mobility safety • My personal belongings will be stored in areas I am able to access independently and safely • Staff will provide daily orientation exercises, problem solving and sequencing for daily tasks • I am provided with a clock and calendar to encourage me to maintain orientation tasks such as telling time and knowing the day of the week	

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Mobility Care Plan

DATE INTITATED__________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am experiencing a loss of opportunity for mobility secondary to COVID-19 isolation. I am at risk for falls, skin integrity issues, musculoskeletal disorders, increased pain, pneumonia, circulatory problems and debility.	I will not experience unexpected declines or injuries during isolation	Phase 2	• Staff will assess my range of motion/strength, presence of pain and functional mobility independence with/without support devices • Distances from bed/chair to the restroom, bed to chair, chair to doorway, etc. will be measured • The environment will be assessed for fall risk • Adaptive equipment will be modified as indicated to enhance my confidence/safety and encourage independent mobility • Treatments will be adapted to utilize interval training such as repetition of routine (bed to chair, sit to stand) versus distance • Music and movement will be incorporated into my treatment plan to provide social stimulation and assist with balance • I have been educated on the risks of immobility and the importance of exercise	

RESIDENT NAME______________________________________ROOM #_________

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Cognitive Well Being Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk for decreased cognitive well-being, a lack of stimulation and a deviation from previous routines related to COVID-19 isolation.	I will not experience unexpected declines in cognitive well-being aeb my participation in self-care and independent activities	Phase 2	• If I am able, I will use my call light when I am in need of assistance to promote my personal safety • If I need corrective eyewear I will clean and don them daily to assist in maintaining a safe environment • Staff will provide daily orientation exercises, problem solving and sequencing for daily tasks • I am provided with a clock and calendar to encourage me to maintain orientation tasks such as telling time and knowing the day of the week • Staff will provide a timer for me to remind me when I should perform my in room exercises • Staff will provide me with word search, crossword puzzles, etc. to stimulate my mind	

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In Room Exercise Program Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk for decreased physical functioning due to a lack of structured exercise programming related to COVID-19 isolation.	I will not experience unexpected declines in functional status aeb my ability to participate in personal exercise programming	Phase 2	• Restorative nursing or skilled therapy staff will develop an in-room exercise program based on my current level of function • My program may include core strengthening exercises during bed mobility to decrease the risk of skin breakdown • Core strengthening exercises will be performed seated on the edge of my bed if able • I will incorporate exercises into my usual routine such as sit to stands during TV programs • I may be provided with a program for improving balance such as tai chi, chair yoga, etc. • Adaptive equipment will be modified as indicated to enhance my confidence/safety and encourage independent exercise programs	

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Nutrition and Hydration Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk for unplanned weight loss/gain, dehydration and nutritional imbalance secondary to in room dining related to COVID-19 isolation.	I will not experience avoidable weight loss/gain, signs and symptoms of dehydration/nutritional imbalance	Phase 2	• Staff will encourage me to consume fluids throughout the day • I will ask for assist devices to be modified as needed to allow me to consume meals and fluids independently • The dietitian will assess my diet to identify the need for modifications quarterly and with change in condition • Staff will provide me with visual cues for strategy implementation during dining • I will consume my meals seated in a chair versus in bed • I will demonstrate appropriate hand hygiene techniques before and following meals • Staff will encourage conversation during meals • I will be provided with communication devices to allow me to "dine" with family and friends	

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SAMPLE

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Activities of Daily Living Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk of poor personal hygiene and decreased psychosocial well-being related to COVID-19 isolation.	I will not experience unexpected declines in personal hygiene or psychosocial well-being	Phase 2	• Adaptive equipment will be modified as indicated to enhance my confidence/safety and encourage independent activities of daily living • Positional impact on my respiratory status and oxygen saturation levels will be assessed • Staff will assess my ability to execute independent personal hygiene tasks such as shaving, oral care, etc. • I will be challenged to use bilateral hands during care, and to focus on core/trunk stability and fine/gross motor coordination • I will perform hand hygiene per proper technique while seated and standing and before and after meals • I will perform daily hygiene activities and dress in appropriate clothing daily • My dentures and/or hearing aids will be clean, charged and in place daily • I have been educated on the importance of maintaining my airway via upright sitting throughout the day	

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In Room Exercise Program Care Plan

DATE INTITATED___________

PROBLEM	GOALS	TARGET DATE	APPROACHES/INTERVENTIONS	DISCIPLINES
I am at risk for decreased physical functioning due to a lack of structured exercise programming related to COVID-19 isolation.	I will not experience unexpected declines in functional status aeb my ability to participate in personal exercise programming	Phase 2	• Restorative nursing or skilled therapy staff will develop an in-room exercise program based on my current level of function • My program may include core strengthening exercises during bed mobility to decrease the risk of skin breakdown • Core strengthening exercises will be performed seated on the edge of my bed if able • I will incorporate exercises into my usual routine such as sit to stands during TV programs • I may be provided with a program for improving balance such as tai chi, chair yoga, etc. • Adaptive equipment will be modified as indicated to enhance my confidence/safety and encourage independent exercise programs	

RESIDENT NAME____ROOM #__________

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PPE - Common Observation Concerns Checklist

Staff Member: ________________________________ **Date:** ____________________

Donning Issues	**Yes**	**No**	**Comments**
Performed Hand Hygiene			
Tied gown and fastened at the neck and waist			
Selected appropriate mask or respirator			
Applied mask appropriately			
Selected eye protection if appropriate			
Applied gloves to cover cuffs			
Doffing Issues			
Used proper glove in glove technique for removal			
Performed hand hygiene			
Removed face shield or goggles without touching face			
Removed gown using appropriate rolling technique			
Took care not to have outside of gown touch clothing			
Performed hand hygiene			
Observation			
Took care not to touch unprotected areas of the body or clothing			
Did not adjust mask or clothing during care			

SAMPLE

Random observations allow observer to assess adherence during "normal" work however requires large number of observations on all shifts.

Planned observations can be scheduled to ensure that all individuals demonstrate regular competency. Scenarios can provide feedback on individual's ability to choose PPE appropriate for the situation. However, planned observations do not observe behavior during the routine course of duties.

______________________________ ______________________________
Signature of Assessor Date

https://www.cdc.gov/infectioncontrol/pdf/strive/CBT102-508.pdf

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