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 ○ 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 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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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	

			• 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.	

			☐ 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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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	

			• 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.	

RESIDENT NAME_____ROOM #_____

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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	

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.	

RESIDENT NAME_____ROOM #_____

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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)	

RESIDENT NAME_____ROOM #_____

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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	

			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	

RESIDENT NAME_____ROOM #_____