COVID−19 ASSESSMENT CHART (Version 2. 2020Apr30)

This Assessment Chart applies ONLY to NSHA Mental Health and Addictions Inpatient Units

Patient location: ________________________________

For patients presenting with concern of COVID−19 / SARS−CoV−2 infection (check any boxes that apply):

Any patients who are unable to participate in MHA COVID−19 Assessment Chart process will be swabbed. (See *COVID−19 Guidance for MHA Inpatient Units*)

PATIENT RISK COVID−19 ASSESSMENT IDENTIFICATION

Does the patient have two or more of the following symptoms:

- ❑ New or worsening cough
- ❑ Fever greater than 38°C
- ❑ Sore throat
- ❑ Headache
- ❑ Runny nose

Has patient travelled outside of Maritime Canada (outside of NB, NS, PEI) within the last 14 days:

❑ No: ❑ Yes: Location: ____________________ Dates: ____________________

Has the patient had close contact with:

❑ Suspected case ❑ Known case

Does the patient live within a known:

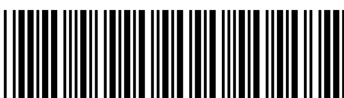
❑ COVID−19 Community cluster ❑ COVID−19 Facility cluster

If any of the above criteria are met, swab the patient.

- If the patient is symptomatic, swab and admit on droplet and contact precautions as per ***COVID−19 Guidance for MHA Inpatient Units*.**
- If the patient is a close contact with known or suspected cases or facility cluster of COVID−19, place patient on droplet and contact precautions, swab patient (if not already done), and keep on droplet and contact precautions for 14 days. Monitor for symptoms as per "*COVID−19 ILI Symptom Monitoring for Inpatients".*
- If the patient is from known community cluster or has traveled outside of Maritime Canada, place patient on droplet and contact precautions, swab patient, and keep on droplet and contact precautions until confirmation of negative swab, when patient can come off precautions. Continue to monitor for symptoms twice daily as per "*COVID−19 ILI Symptom Monitoring for Inpatients".*
- In the event that it is not possible to assess a patient's risk of COVID−19 because the patient's physical or mental health precludes them from providing a history of symptoms or exposure, place the patient on droplet and contact precautions and test for and manage as suspected COVID−19 for 48h. If asymptomatic at 48h, exposure risk has been determined to be negative and COVID−19 swab is negative, remove patient from droplet and contact precautions and manage with routine practices.

❑ **Person does NOT meet above symptom / travel / exposure criteria: No further action required.**

Name of Assessor (Printed)	Signature of Assessor	Date (YYYY/MON/DD)	Time



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If unsure if the patient meets symptom criteria, consult the medical physician on duty / call.

Baseline Vital Signs (Note Adult Red Flag criteria page 3):

HR: __________ bpm RR: __________ BP: _____/_____

SpO_2: __________ on room air Temperature: __________ ° C

Reportable Symptoms / items check all that apply):

- ❑ Shortness of breath
- ❑ Malaise / fatigue
- ❑ Vomiting
- ❑ Muscle / joint pain
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Medication: ACE–I (e.g.: Ramipril, Lisinopril, Captopril, Enalopril or medication that ends in "pril")

Medical Risk Factors (check all that apply):

- ❑ Immune suppression*
- ❑ Age greater than 65 years
- ❑ Diabetes mellitus
- ❑ Chronic heart disease (i.e. CHF, IHD)
- ❑ Neurodegenerative disorder
- ❑ Current or recent smoking history (e.g. tobacco, cannabis, vaping)
- ❑ Chronic Pulmonary disease (e.g. asthma – treated within 12 months, COPD, emphysema, pulmonary fibrosis, CF)

* **Immune Suppression:** Any cancer, chemotherapy, radiation therapy, any transplant (solid or hematologic), HIV / AIDS, immunosuppressive medication (e.g. chronic steroid use greater than 20 mg/d for greater than 2 weeks (greater than 2 weeks, cytotoxic drugs, calcineurin inhibitors, biological response modifiers, antibodies that target lymphocytes) or history of immune suppression not otherwise specified.

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Adult Red Flags + / – risk factors requires consultation with Physician on–duty / call

Adult Red Flags	
Heart rate greater than 110	New confusion
Respiration rate greater than 30	New dizziness / pre–syncope
Systolic BP less than 95 mmHg	Chest pain
SpO_2 less than 92% on room air	New cannot walk
New decline in self–care	

Patient Disposition Flowsheet

Swab all patients who are unable to participate in MHA COVID–19 Assessment Chart process due to physical / mental condition.

Meets symptom criteria?

- If unsure, consult medical physician on–duty / call

NO → **No swab indicated.**

- Explain to the individual why no swab is required.
- Continue to monitor for symptoms.

YES ↓

NO **Red Flags AND** NO **Risk Factors** — YES → **Send one swab**

- Isolate individual using contact and droplet precautions until results are received.
- Seek medical attention, if symptoms worsen, or do not improve.

OR ↓

Risk Factors present **AND No Red Flags** — YES → **Send one swab**

- Isolate individual using contact and droplet precautions until results are received.
- Seek medical attention, if symptoms worsen, or do not improve.

OR ↓

Red Flags present + / – *Risk Factors* — YES → **Patient requires physician assessment**

- Isolate individual using contact and droplet precautions.
- RN to immediately notify medical physican–on–duty / call using SBAR for communication strategy
- Physician may provide oversight by the following:
  - Attending clinician to the bedside and maintain care on MHA inpatient unit (if appropriate)
  - Contact the closest COVID unit physician and engage EHS (if appropriate).
  - If the inpatient COVID unit is not a feasible transfer, the on–call COVID secondary assessment centre physician should be contacted to assess the patient.

  RN to swab if directed.
  - **In the event of transfer, ensure swab collection status is communicated to receiving department / unit / secondary assessment centre.**

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Advise patients who meet symptom / travel / exposure criteria but no Red Flags + / – Risk Factors:

Provide education on the following:

- Isolation is required until the Health Care Team is notified with a positive or negative for COVID–19 by Infection Control and they will advise on next steps.
- Drink plenty of fluids.
- Direct individual to wash hands with soap.
- Avoid touching face.
- Cough into sleeve or into tissues and dispose of them and wash hands
- When interacting face–to–face with staff, wear **surgical mask** (don't share).
- Advise nursing staff if beginning to feel unwell or if symptoms *worsen* and / or experience any of the following:
  1) Difficulty breathing
  2) Chest pain
  3) Palpitations or rapid heart rate
  4) Confusion
  5) Dizziness of faintness

For patients with Red Flags + / – Risk Factors:

Patient requires physician assessment

- Isolate individual using contact and droplet precautions.
- RN to immediately notify medical physician–on–duty / call using SBAR for communication strategy
- Physician may provide oversight by the following:
  - Attending clinician to the bedside and maintain care on MHA inpatient unit (if appropriate)
  - Contact the closest COVID unit physician and engage EHS (if appropriate).
  - If the inpatient COVID unit is not a feasible transfer, the on–call COVID secondary assessment centre physician should be contacted to assess the patient.
- RN to swab if directed
- **In the event of transfer, ensure swab collection status is communicated to receiving department / unit / secondary assessment centre.**

Check all that apply:

- ❑ Swab collected
- ❑ Instructions provided to patient as above
- ❑ Physician assessment needed and arranged
- ❑ In the event of transfer, ensure swab collection status is communicated to receiving department / unit / secondary assessment centre.
- ❑ Additional documentation, if required, completed in nursing notes

Name of Assessor (Printed)	**Signature of Assessor**	**Date (YYYY/MON/DD)**	**Time**

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