

COVID-19 screening tool for residential aged care services

INSTRUCTIONS

- Complete **daily** in the morning
- Tick the box that answers the question
- Ensure you have consent from the resident (where possible)

Date		Resident	
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SECTION 1: PERSONAL CARE ASSISTANT OR NURSE TO COMPLETE

Is the resident 'different' from before? Are they 'not themselves'? (compared to the last 24 hours)

YES to any of the below

NO

Needing more help with tasks

Sleeping more

Seeming unwell

Eating less/refusing food

Trouble walking

Wanting to stay in their room when they normally come out

Trouble talking

Upset/angry

Has the resident had a fall in the last 24 hours?

YES

NO

DON'T KNOW

Is the resident's temperature greater than 37.5°C?

If pattern of "low grade temperature" 37.0 and above consider marking YES and testing for COVID-19

YES

NO

Temperature: °C




If answered **YES** or **DON'T KNOW** to any question:

- Tell the nurse in charge the result
- Nurse to turn over and complete **Section 2**

If answered **NO to all questions** in Section 1, go to **Section 3** and mark screen as negative

Name		Signature		Time	
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SECTION 2 ON NEXT PAGE

SECTION 2: NURSE TO COMPLETE					
Has the resident had a fall in the past 24 hours?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
What is the respiratory rate?	breaths per minute	Is this greater than 24 breaths per minute?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does the resident have a recent history of exposure to a confirmed case of COVID-19? (Exposure to a person means spending 15 minutes in close contact or two hours in the same room as the person)				<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does the resident have any new TYPICAL symptoms of COVID-19?					
Cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Short of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fever/ Chills	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sore throat	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Runny nose	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Muscle aches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Feeling tired	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Vomiting or diarrhoea	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Change in taste/ smell	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Headache	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does the resident have any new ATYPICAL symptoms of COVID-19?					
Confusion	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Responsive behaviours (e.g. restlessness, wandering, aggression)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Irritability	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Withdrawn	<input type="checkbox"/> YES	<input type="checkbox"/> NO
 <p>If answered YES or DON'T KNOW to any question:</p> <ul style="list-style-type: none"> go to Section 3 and mark screen as positive refer urgently to GP or specialist clinical service e.g. RIR for assessment and consideration of COVID-19 and/or Influenza testing <p>If COVID-19 suspected:</p> <ul style="list-style-type: none"> wear PPE as per current guidance isolate suspected case call pathology service to arrange test 					
Name		Signature		Time	
SECTION 3: SCREEN RESULT (TICK RELEVANT BOXES)					
Screen result:	<input type="checkbox"/> Any YES or DON'T KNOW boxes selected = Positive (+)		<input type="checkbox"/> All NO boxes selected in Section 1 and 2 = Negative (-)		
Care provided:	<input type="checkbox"/> Resident care escalated (referred to GP and/or RIR)	<input type="checkbox"/> Resident swabbed for COVID-19	<input type="checkbox"/> Resident swabbed for influenza	<input type="checkbox"/> Resident NOT swabbed for COVID-19 / influenza. Why?	<input type="checkbox"/> Underlying condition managed <input type="checkbox"/> No consent <input type="checkbox"/> Not appropriate