Care of the Behavioral Health Patient

What's Changed: Added updated CDC guidance for daily screening of patients while admitted. Added guidance from The Joint Commission regarding patient evaluation for wearing a face mask. Added Molecular Testing Algorithm link instead of full guidance. Aligned guidance for return to work post COVID-19 illness.

Note: The final arbiter of appropriate illness management should be the local ministry, as defined by the local administration, following CDC, state, and local health department requirements.

Background

COVID-19 poses unique stressors on colleagues and patients in the behavioral health setting. The milieu encourages group participation and patient behaviors can be labile at times. The shift to wearing masks by colleagues and other patients can be disconcerting to a patient who is not accustomed to interacting with others via physical distancing and wearing masks. It is important to maintain a ‘person-centered’ approach to the care of the behavioral health patient. At a time when visitation is discouraged, effective communication with patients, patient representatives, and other family members about the patient’s needs becomes increasingly important to ensure that the patient feels the support of their personal team.

For inpatient behavioral health units, a key decision by the care team is to discern the most appropriate location of care for the person with symptoms consistent with COVID-19. Those with COVID-19 often require significant medical care and support that may therefore require transfer to an inpatient medical unit – or if developing severe respiratory distress, to an ICU.

Screening

• Although screening for symptoms will not identify asymptomatic or pre-symptomatic individuals with SARS-CoV-2 infection, symptom screening remains an important strategy to identify those who could have COVID-19 so appropriate precautions can be implemented. Screening for fever and symptoms should also be incorporated into daily assessments of all admitted patients. All fevers and symptoms consistent with COVID-19 among admitted patients should be properly managed and evaluated (e.g., place any patient with unexplained fever or symptoms of COVID-19 on appropriate Transmission Based Precautions and evaluate).

Universal Source Control

• All patients should be offered a cloth mask for source control and, if tolerated, should leave the mask on when not in their rooms. Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their rooms. Per current CDC recommendations for a patient with behavioral health needs, it is important to complete an assessment of the impact that the patient wearing a face covering or mask would have on the safety of a patient(s), staff and visitors.

  ● The expectation is to complete a clinical risk assessment of the individual for possible self-harm or harm to others.

  ● The organization must have a process to determine if the patient is capable of wearing a face covering, or mask, based on clinical assessment.

  ● One example of appropriate implementation might be that if a patient is in close observation because of risk of suicide or is unable to wear a mask because of respiratory compromise—
people within 6 feet of the patient would be required to wear a face mask to protect themselves and the patient from possible exposure when the patient is not given a mask.

If available, organizations should consider switching patients with respiratory symptoms (e.g. cough or sneeze), including patients with confirmed COVID-19, to a medical grade facemask.

- Masks may be removed when physical distancing of at least six feet is possible (e.g. after entering a private office). In order to ensure patients can take off their masks for meals and breaks, scheduling and location for meals and breaks should ensure that at least a six-foot distance can be maintained between patients so that they can remove their masks.

Testing for the Presence of SARS-CoV-2:

- Clinicians should use their judgment to determine if a patient with signs and symptoms compatible with COVID-19 should be tested based on availability of testing, community epidemiology, current CDC guidelines, and local/state health department requirements. Molecular RNA testing is becoming increasingly available and provides valuable information to help the provider manage the patient based on the presence or absence of a COVID-19 diagnosis. One negative test result may not necessarily indicate the patient is negative for the virus. The patient should also be assessed clinically for symptoms of COVID-19, although not all positive patients exhibit symptoms of COVID-19. A symptom-based strategy should be used for determining when to discontinue isolation precautions in suspect or positive patients.

  - Consider serial testing of residents and colleagues in the event of suspected outbreak until no new cases are detected after 14 days.

Quarantine and Isolation Guidelines

NOTE: CMS is temporarily allowing Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in the safety of their homes. Previously, clients had to travel to a clinic to obtain these intensive services. Now, Community Mental Health Centers can furnish certain therapy and counseling services (and may use the telehealth option) in a client’s home to ensure access to necessary services and maintain continuity of care. For patients who are PUI, are positive for, and/or recovered from COVID-19, this may be a preferred alternative to admission.

- Asymptomatic patients with a known or suspected exposure:

  Quarantine is used to separate someone who might have been exposed to COVID-19 and may develop illness away from other people. Quarantine helps prevent spread of disease that can occur before a patient knows that they have the virus. CDC recommends a 14-day quarantine based on prolonged close contact with someone with SARS-CoV-2 infection. Patients in this 14-day quarantine period should be isolated in a single-person room and cared for by HCP using all PPE recommended for a patient with suspected or confirmed SARS-CoV-2 infection. However, these patients should NOT be cohorted with patients with SARS-CoV-2 infection unless they are also confirmed to have SARS-CoV-2 infection through testing. This strategy maximally reduces post-quarantine transmission risks and is the strategy with the greatest collective experience at present.

  - Alternatives to the 14-day quarantine period are described in the Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. Health care facilities could consider these alternatives as a measure to mitigate staffing shortages, space limitations, or PPE supply shortages but, due to the special nature of health care settings (e.g., patients at risk for worsening outcomes, critical nature of health care personnel, challenges with social distancing), not as a preferred option. Health care facilities should understand that shortening the duration of quarantine might pose additional transmission risk. They should closely monitor these patients for
development of symptoms and, if they occur, immediately implement appropriate Transmission-Based Precautions and viral testing. Patients should also be counseled about the importance of adhering to all recommended non-pharmaceutical interventions.

- Individuals who cannot comply with requests to wear a cloth mask should be at higher priority for receiving a private room.
- This patient’s care team should monitor and assess for developing symptoms, where the patient is in the incubation period. etc.

Clinicians should contact their Infectious Disease physician for situations where shortening the duration of quarantine may be appropriate, and to determine timing and, if indicated, testing for SARS-CoV-2

- **Symptomatic Patient:** If the patient presents as symptomatic, but has previously tested negative, treat as PUI until symptoms abate. Assess the appropriate location for care based on the severity of symptoms. Cohort with other PUIs based on bed availability. The patient should remain in the single room or in a designated isolation room/area if a single room is unavailable. Meals and medication should be taken in the room, and they should stay in their room to the extent it is feasible and wear a mask (if tolerated) when not able to remain in the room.

- **Known COVID-19-Positive Patients:** Patients who are positive for COVID-19 on admission should be in a private room or cohorted with other positive patients. Assess how long it has been since the date of the positive test. Refer to System IPC guideline on duration of isolation precautions and apply those criteria to determine if the patient is likely no longer able to transmit infection. If still in acute phase of illness – assess appropriateness for inpatient behavioral health. If stable and can be in this type of unit, the patient needs to wear a mask if leaving their room and should not participate in group therapy. Exposed roommates should, if possible, also have their own rooms for 14 days and if they remain symptom-free, can then share a room with others.

**Physical Distancing:**

- Ministries should consider physical distancing practices when determining the capacity for accepting new patients. Determine how many patients the ministry can accept if all patients and staff remain at least six feet apart at all times and that figure becomes maximum census. In the event that patient care mandates that colleagues be closer than six feet, PPE should be worn (gown, mask, face shield, gloves) to reduce the potential for exposure.

**Group Therapy Sessions**

- Group counseling, therapy, and discussion sessions are a critical component of psychiatric treatment and care plans, but the traditional set-up for these activities is not compatible with social distancing recommendations. When possible, use virtual methods, or decrease group size so social distancing can be maintained. In the event that COVID-19 is transmitted in the facility, sessions should stop or move to a video discussion forum until additional infection prevention measures are in place to stop the spread.

**Dining:**

- As part of social distancing, communal dining is generally not recommended. However, eating needs to remain supervised due to the potential for self-harm with eating utensils and because commonly used psychiatric medications may cause side effects (e.g., tardive dyskinesia, dysphagia, hypo- and hypersalivation) that increase choking risk for patients. One option is to position staff in patients’ rooms to monitor their dining. Another option is to allow communal dining in shifts so that staff can monitor patients while ensuring they remain at least 6 feet apart. A third option is to have patients sit in appropriately spaced chairs in the hallway outside their rooms so they can be monitored while they eat.
Hand Hygiene:

- All patients and colleagues should increase the frequency of hand hygiene practices. In addition to posted handwashing protocols, there should be adequate availability of hand sanitizer throughout the unit. For inpatient behavioral health colleagues will need to oversee dispensing of alcohol-based hand rub, encourage patients to use handwashing with soap and water, or provide alcohol-saturated, disposable hand wipes for hand hygiene.

Environmental Services:

- Follow routine procedures for cleaning of dishes, eating utensils and linens after use.
- When washing clothes, staff (or family care providers) should be instructed to not “hug” dirty laundry while transporting it to maintain distance from their own clothes and face. Use of a hamper is recommended. After handling linens or clothing of someone who tested positive for COVID-19, staff should wash their hands with soap and water.
- Colleagues should disinfect high-touch surfaces frequently (tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, etc.) and remove items that cannot be cleaned easily (board games, puzzles, books). Products with Environmental Protection Agency (EPA) registration as effective against emerging viral pathogens claims are recommended for use.

Care Planning

- It is also important that the patient remains engaged in their care plan during this time of uncertainty and stress about the virus. Colleagues should take steps to educate and empower the patient to be a part of the solution, so that they understand their role in limiting the spread of the virus through physical distancing and wearing of masks (when possible).

Group Activities:

- Group counseling, therapy, and discussion sessions are a critical component of psychiatric treatment and care plans, but the traditional set-up for these activities is not compatible with social distancing recommendations. During the monitoring period, the patient may participate in group therapy. However, the patient must wear a procedural face covering and practice physical distancing during all group sessions.
- When possible, use virtual methods, or decrease group size so social distancing can be maintained. In the event that COVID-19 is transmitted in the facility, sessions should stop or move to a video discussion forum until additional infection prevention measures are in place to stop the spread.

Partial Hospital Programs – Phase 2:

Community Mental Health Centers can furnish certain therapy and counseling services (and may use the telehealth option) in a client’s home to ensure access to necessary services and maintain continuity of care. This is the preferred option for patients with known or suspected COVID-19 in lieu of attendance at in-person group settings during Phase 1.

Follow your resuming operations guidance prior to beginning Phase 2 and resumption of the on-site hospital program.

All participants should be tested ONCE using the molecular test for SARS-CoV-2 prior to beginning on-site treatment. There may be a level of prevalence within the community below which the need for testing may no longer be required. Check with your Infection Control professional prior to discontinuing the testing requirement prior to treatment.
If a patient tests positive for COVID-19, the patient may not participate in on-site activities until 10 days (20 days for severely ill or immunocompromised patients) have passed since the initial, positive test, the patient is afebrile for 24 hours without the use of fever-reducing medications, and has experienced improvement in symptoms. If the patient meets the above criteria, the patient will be considered as having recovered from COVID-19 infection. The patient should NOT be re-tested prior to beginning on-site treatment.

All participants should be screened prior to each day they attend the program using screening questions and a temperature check as outlined in Screening at Facility Entrances guidance.

Limit therapy group size to the minimal therapeutic number of participants. The program should keep lists of all participants in each group therapy session by date of service. These lists may aid contact tracing efforts in the event of an unintentional COVID-19 exposure.

If a patient exhibits symptoms of COVID-19 disease, Infection Prevention and Control (IPC) Overview during their time at the program, the patient should immediately be isolated from the other participants and sent to a Fever and Upper Respiratory Infection (FURI) testing site to be re-tested for COVID-19. The patient should not attend any on-site activities until the results have returned. Then follow your ministry’s exposure plan for further guidance.

References:


