**Pandemic COVID-19 - Testing**

**Policy Statement**

In response to the Centers for Medicare and Medicaid Services’ (CMS) [final rule](https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf), published September 2, 2020, [QSO Memo 20-38-NH](https://www.cms.gov/files/document/qso-20-38-nh.pdf); and in attempt to keep COVID-19 from entering and spreading through [Facility name]’s campus, the [Facility name] Emergency Preparedness (EP) and Infection Prevention and Control (IPC) committees have established a plan and parameters to test staff and residents for COVID-19. This plan includes considerations for routine and triggered testing based on resident, staff, campus, and county status.

**Definitions**

**Outbreak –** a new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident.

**Resident –** is any resident living in the NF or NF/SNF.

**Staff –**is all scheduled employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of [Facility name]. This includes students in [Facility name]’s nurse aide training programs or from other affiliated academic institutions.

**Fully Vaccinated –** an individual who is 14 days or more following receipt of the second dose in a 2-dose series vaccine or 14 days or more following receipt of one dose of a single-dose vaccine.

**Unvaccinated –** an individual who does not fit the definition of “fully vaccinated” including individuals whose vaccination status is not known.

**Implementation – Testing Method**

For the duration of the Public Health Emergency (PHE), [Facility name] will make every attempt to conduct or coordinate COVID-19 testing as set forth by the testing parameters outlined in this policy, (CMS) [final rule](https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf), and in accordance with [QSO Memo 20-38-NH](https://www.cms.gov/files/document/qso-20-38-nh.pdf). This testing may include, but is not limited to, Point of Care (POC) testing, contracted laboratory testing, State Hygienic Laboratory (SHL) testing, and local clinic testing.

1. Point of Care (POC)
	1. [Facility name] has secured the [Enter mfg. name here (BD/Quidel)] point of care antigen testing device.
	2. POC testing is the preferred method of conducting the routine and triggered testing outlined in this policy.
	3. POC testing supplies (e.g., kits) will be ordered from [Vendor name(s)]. In the event POC testing supplies cannot be obtained, all attempts to secure the supplies must be documented (click [here](https://lai.memberclicks.net/assets/EP%20Testing%20-%20acquisition%20attempts%20for%20vendor%20supplies.docx) for documentation template).
	4. [Facility name] has designated and trained an adequate number of employees to conduct POC testing in accordance with the testing parameters outlined in this policy. Additional employees may be trained at [Facility name]’s discretion.
		1. Employee POC testing training records will be maintained [Enter location e.g., by the IP] (click [here](https://lai.memberclicks.net/assets/EP%20Testing%20-%20staff%20training%20documentation%20record.docx) for documentation template).
	5. [Facility name] has established a secure location for POC testing to take place and for POC supplies to be stored. Such POC testing supplies will be managed and stored according to manufacturer’s instructions.
	6. [Facility name] will follow manufacturer’s instructions regarding quality control checks for the testing device.
2. Laboratory
	1. [Facility name] has contracted with the following lab(s) to assist in staff and resident COVID-19 testing needs.
		1. [Enter lab name]
		2. [Enter lab name]
	2. Contracted laboratory testing is the preferred method of completing staff and resident COVID-19 testing when POC testing is unavailable for any reason.
	3. Each contracted laboratory has been informed of the requirements set forth by this policy, CMS’ [final rule](https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf), and [QSO Memo 20-38-NH.](https://www.cms.gov/files/document/qso-20-38-nh.pdf) Specifically, upon identification of a staff or resident who becomes symptomatic, an outbreak occurs, or when [Enter county name] county COVID-19 activity levels dictate, testing must be completed with a turnaround time of <48 hours.
	4. The Iowa State Hygienic Laboratory (SHL) may also support [Facility name]’s testing efforts if they have capacity; after attempts of testing methods I and IIb. are unsuccessful.
	5. In the event contracted laboratory and SHL services cannot be obtained, all attempts to procure laboratory services for COVID-19 testing must be documented (click [here](https://lai.memberclicks.net/assets/EP%20Testing%20-%20acquisition%20attempts%20for%20laboratory%20support%20with%20testing.%20.docx) for documentation template).
3. Other
	1. In the event other types of testing are used (e.g., clinic), for either staff or resident testing, and [Facility name] intends to use the testing results to meet compliance with CMS’ [final rule](https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf), and [QSO Memo 20-38-NH](https://www.cms.gov/files/document/qso-20-38-nh.pdf), it is [Facility name]’s responsibility to obtain documentation of the test results. If [Facility name] is unable to obtain documentation of the test results, [Facility name] may require the staff or resident to participate in [Facility name] sponsored COVID-19 testing (e.g., POC or laboratory).

**Implementation – Testing Frequency**

Testing will be required based on parameters and a frequency set forth by this policy, CMS’ [final rule](https://www.govinfo.gov/content/pkg/FR-2020-09-02/pdf/2020-19150.pdf), and [QSO Memo 20-38-NH](https://www.cms.gov/files/document/qso-20-38-nh.pdf). Resident, staff, campus, and county status will be the deciding factors as to whether this testing be “triggered” or routine. F886 of Appendix PP of the SOM also outlines these requirements.

1. Triggered
2. Symptomatic – Residents or staff with signs and symptoms of COVID-19 must be tested.
	1. Symptomatic residents or staff must be tested immediately, regardless of vaccination status.
3. Outbreak – When a new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident is identified, all staff and residents must be tested, regardless of vaccination status. Using the results of the outbreak response testing, any staff or resident that previously tested negative must be tested every [Enter # of days; this must be between 3 and 7 days] days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.
4. If the 48-hour turn-around time cannot be met due to POC testing supply shortages, limited access or the inability of [Facility name]’s contracted laboratories or the SHL to process tests within 48 hours, [Facility name] must document all efforts to obtain quick turnaround test results with the identified laboratories and contact with the local and state health departments (documentation templates are found at Ic., Id., and II e.).

Example A (7-day testing spans are used in this example):

During routine pre-shift screening, Staff A is identified as symptomatic and triggers a COVID-19 test.

On September 1st, the test results come back positive and outbreak testing is triggered. During outbreak testing, all residents and staff are tested. Two additional staff and one resident test positive on September 1st. The positive staff members must be taken off the schedule and follow the return to work criteria before returning; and the positive resident must be isolated. Each of the remaining staff and residents who tested negative must be tested again in 7 days.

During this second round of outbreak testing, one more resident tests positive on September 8th. This resident must also be put into isolation. All remaining staff and residents who tested negative must be tested again in 7 days.

During this third round of outbreak testing, all staff and residents tested negative on September 15th. Because it has only been 7 days since the last positive result, another round of outbreak testing is required.

During this fourth round of outbreak testing, all staff and residents tested negative again on September 22nd. Because it has been 14 days since the last positive test, triggered outbreak testing can stop.

Example B (7-day testing spans are used in this example):

During routine post-shift screening, Staff B is identified as symptomatic and triggers a COVID-19 test.

On September 1st, the test results come back positive and outbreak testing is triggered. During outbreak testing, all residents and staff are tested, and all test results are negative on September 2nd. All negative residents and staff must be tested again in 7 days.

During this second round of outbreak testing, all residents and staff test negative again on September 9th. All negative residents and staff must be tested again in 7 days because it has only been 8 days since the last positive result.

During this third round of outbreak testing, all residents and staff test negative for a third time on September 16th. Because it has been at least 14 days since the last positive test, triggered outbreak testing can stop.

1. Routine
2. County Activity – [Enter county name] county COVID-19 activity dictates the frequency of routine staff testing.
3. [Enter county name] county activity rates will be retrieved from CMS’ data [website](https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg), which is updated weekly.
	1. [Facility name] will check the CMS database at least **every other** [Enter the day of the week here e.g., Monday].
	2. If [Enter county name] county’s positivity rate increases to a higher level of activity, [Facility name] will begin testing staff at the frequency shown in Table 1 below as soon as the criteria for the higher activity are met.
	3. If [Enter county name]’s positivity rate decreases to a lower level of activity, [Facility name] will continue testing staff at the higher frequency level until [Enter county name] county’s positivity rate has remained at the lower level for at least two weeks before reducing testing frequency.
4. The minimum frequency of routine testing for [Facility name] staff will be **monthly**.
5. Routine testing of asymptomatic residents is not recommended. However, [Facility name]’s Infection Preventionist (IP) may determine routine COVID-19 testing is warranted for a resident with elevated risk factors (e.g., frequently leaves the facility for scheduled appointments). If this determination is made, the resident’s care plan will be updated to include this rationale and the recommended frequency of routine testing. The resident has the right to decline testing.

Table 1. Routine Testing Frequency Intervals for Unvaccinated Staff Based on County Activity

|  |  |  |
| --- | --- | --- |
| County COVID-19 Activity | County Positivity Rate in the past week | Minimum Testing Frequency |
| Low | <5% | Once a month |
| Medium | 5% - 10% | Once a week\* |
| High | >10% | Twice a week\* |

**Resident and Staff Testing Refusals**

There will be times when [Facility name] residents decline, or staff refuse testing.

1. Residents
2. Residents or their representatives have the right to decline testing.
3. [Facility name] will make every effort to discuss the importance of COVID-19 testing with residents using a person-centered approach. These discussions will occur each time testing is required.
4. If a resident who is symptomatic declines COVID-19 testing, the resident will be placed in transmission-based precautions until the criteria for discontinuing such precautions have been met.
5. If an asymptomatic resident declines COVID-19 outbreak testing, the following precautions will be taken:
6. The unvaccinated resident will be required to wear a mask during all cares, when staff enters their room and are within 6 ft. of the resident, and when they are out of their room (except when eating),
7. The unvaccinated resident will be required to social distance at all times, and
8. The resident will be required to routinely and effectively complete hand hygiene.
9. All resident declinations of testing will be documented in the resident’s clinical record.
10. If a resident declines testing on more than one occasion, the resident’s physician will be notified, and the resident’s care plan will be updated to reflect the resident’s choice.
11. All residents who decline testing will continue to be screened each ~~shift~~ at least daily for symptoms of COVID-19. In the event of an outbreak resident screening will be increased to every shift.
12. Staff
13. Any symptomatic staff member who refuses testing will be taken off work until all return to work criteria are met.
14. If outbreak testing has been triggered, and a staff member refuses testing, the staff member will be taken off work until the procedures for outbreak testing have been completed (e.g., the outbreak testing cycle reaches the 14 day timeframe since the last positive COVID-19 test).
15. Any asymptomatic staff member who refuses routine testing will be required to follow IDPH’s recommendation for staff refusals:
16. If the unvaccinated staff member has been exposed to COVID-19, the unvaccinated staff should be quarantined in accordance with the following guidance. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
17. If the staff member was NOT exposed to COVID-19, staff should use PPE in accordance with the following guidance without reuse or extended use strategies, while working with quarantined or isolated COVID-19 residents. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>