Policy and Procedure

Title: Facility COVID-19 Testing

Policy

Conduct COVID-19 testing as outlined by CMS and state regulatory bodies.

Procedure

Types of Testing

Symptomatic Testing

1. Screen all staff, residents and other visitors for common symptoms of COVID-19 (listed on Attestation Log)
2. Secure order and get written consent to test any staff or resident with symptoms of COVID-19.
    A. Per CDC Symptoms may include:
        i. Fever or chills
        ii. Cough
        iii. Shortness of breath or difficulty breathing
        iv. Fatigue
        v. Muscle or body aches
        vi. Headache
        vii. New loss of taste or smell
        viii. Sore throat
        ix. Congestion or runny nose
        x. Nausea or vomiting
        xi. Diarrhea

    Please note: Staff exhibiting symptoms prior to their shift should notify facility management before traveling to the facility

3. Conduct test according to manufacture or laboratory instructions
    A. If antigen testing is used and a positive result is received, facilities in Virginia must confirm with a molecular PCR test.
4. The following must occur until test results are received:
    A. Staff are to be restricted from the facility
    B. Residents should be placed on transmission-based precautions and moved to the "warm" unit if appropriate
5. Complete the Symptomatic/ Outbreak Testing Form

Outbreak Testing

An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak.

1. Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents will be tested
2. Secure order and get written consent for each resident and staff member
3. Conduct test according to manufacture or laboratory instructions
    A. Staff and residents that tested negative will be retested every 7 days until testing identifies no new cases of COVID-19 among staff or residents for at least 14 days
    B. Individuals who tested positive do not need to be retested and are exempt from routine surveillance testing for 90 days
4. Complete the Symptomatic/ Outbreak Testing Form

Routine Surveillance Testing

Routine testing will be conducted based on the spread of the virus in the community. Facilities will use data provided by CMS to determine community spread in their area.

1. On the 1st and 3rd Monday of each month the NHA will check the county positivity rate provided by CMS at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg
2. Testing frequency will be determined as follows:

Community COVID-19 Activity	County Positivity Rate in the past week	Minimum Testing Frequency[1]
Low	<5% (less than 5%)	Once a month
Medium	5%-10%	Once a week
High	>10% (more than 10%	Twice a week

    A. If the rate decreases: continue testing staff at higher frequency level until rate has remained at lower level for at least two weeks.
    B. If the rate increases: immediately adjust testing frequency
3. The NHA is to complete the Surveillance Testing Form (attached) to document a good faith effort for conducting testing.
    A. If a facility is unable to secure testing supplies or a lab that can return timely results with in 48 hours the facility must contact the local and state health departments
4. Ensure orders and consents are in place and conduct testing for all staff, consultants, contractors, volunteers, according to manufacture or laboratory instructions

Please note: Facility staff can be tested elsewhere (e.g. by another employer) if it is completed in the same timeframe and the results are documented by the facility.

Attachments: Symptomatic/ Outbreak Testing Form
Surveillance Testing Form
COVID-19 Resident Testing Consent
COVID-19 Employee Testing Consent

Symptomatic / Outbreak Testing Form

Symptomatic Testing

When where signs / symptoms identified? Date: _____ Time: _____

Type of test conducted: _____ Date test was conducted: _____

Test results: ☐Positive ☐Negative When were results received? _____

Type of test conducted: _____

Action taken: _____

_____

_____

*If positive result is received, complete the Outbreak Testing section of this form and refer to Phase IV for further guidance

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Outbreak Testing

Date case was identified: _____ Date residents /staff were tested: _____

Steps:

1. Print list of current residents
2. Print a list of active employees from ADP
3. List date of testing at the top of each list
4. Highlight each individual as testing is completed
5. Circle positive residents and staff in red ink
6. Attach lists to this form

Date for next round of testing: _____

Surveillance Testing Form

Date: _____

Instructions: Check county positivity rates on the 1st and 3rd Monday of each month by using the following link. https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg and answer the questions below.

1. Check which category applies:

	Community 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***

Please note: If the rate decreases: continue testing staff at higher frequency level until rate has remained at lower **level for at least two weeks.** If the rate increases: immediately adjust testing frequency

2. Do you have a POC testing machine? ☐Yes ☐No
3. Do you have tests /kits? ☐Yes ☐No Number of tests: _____
4. Do you have access to PCR molecular testing? ☐Yes ☐No
5. Can your lab process tests within 48 hours? ☐Yes ☐No
6. Please select the contracted labs you have spoken with:
   - ☐Current Lab: _____
   - ☐Vista
   - ☐American (AHA)
   - ☐Vikor
7. If the above labs were unable to assist, have you reached out to the VP of Purchasing?
   ☐Yes ☐No ☐N/A

If the facility has a shortage of testing supplies, or cannot obtain test results from a lab within 48 hours, the state and local health departments must be contacted.

Who made the call? _____ Date & Time: _____

Who did they speak with? _____

If the facility is able to conduct testing, on what date did it occur? _____

NHA Attestation

I do hereby attest that this information is true, accurate and complete to the best of my knowledge.

NHA Signature: _____ Date:_____

COVID-19 Resident Testing Consent

☐ I hereby **AGREE** to a COVID-19 test

☐ I hereby **REFUSE** to submit to a COVID-19 test. By declining testing, I understand that I will be treated as if I tested positive and will be placed on transmission based precautions for 20 days

_____

Name of Person Tested (Print)

☐Resident ☐Verbal Consent Given – Must be witnessed by two nurses

_____ _____ _____

Resident / Responsible Party Date Time

_____ _____ _____

Witness Date Time

_____ _____ _____

Witness Date Time

Test Results

Record test results below. After sharing results with the resident or responsible party this form is to be placed into the residents medical record.

☐Positive ☐ Negative

I attest that I been made aware of my COVID-19 test results.

_____ _____ _____

Resident / Responsible Party Date Time

_____ _____ _____

Witness Date Time

_____ _____ _____

Witness Date Time

COVID-19 Employee Testing Consent

☐ I hereby **AGREE** to a COVID-19 test paid for by the facility. I understand that all relevant health information will be maintained in a private medical record.

☐ I hereby **REFUSE** to submit to a COVID-19 test for **symptomatic /outbreak** testing. By declining testing I understand that I will be treated as if I tested positive. I understand that I will not be allowed to work in the facility and will be required to quarantine for 15 days. In addition, I understand that PTO may be used to cover my absence but no sick time will be approved due to the lack of illness confirmation.

Please note: COVID-19 routine surveillance testing is MANDATORY for ALL staff

_____ _____

Employee Signature Date

Test Results

Record test results below. After sharing results with the staff member this form is to be placed into the protected portion of the employee record.

☐Positive ☐ Negative

I attest that I been made aware of my COVID-19 test results.

_____ _____

Employee Signature Date