

## Planning for Point Prevalence Surveys in Long-Term Care Facilities

Due to the large impact COVID-19 is having on Long-Term Care Facilities (LTCFs) and other congregate settings, Governor Northam and the COVID-19 Long-Term Care Task Force have initiated the VDH Point Prevalence Survey (PPS) project. A PPS entails testing all individuals in a designated area of a facility, whether or not they have symptoms, on one day. Experience to date suggests that there are often positive but asymptomatic residents and staff in LTCFs, which contributes to silent transmission. The results will inform facility administrators about the extent and distribution of infection with the virus that causes COVID-19 on that specific day. A PPS is a powerful tool that can be used to intervene **early** in outbreaks, especially in LTCFs, as a PPS can help guide decisions regarding cohorting residents and staff.

This guidance describes a systematic approach to PPS testing and answers some important questions:

1. How can the facility prepare for a PPS?
2. When should a PPS be conducted and how?
3. What interventions should be implemented based on testing results?

If a LTCF is experiencing any barriers to conducting a PPS or needs assistance with the steps outlined below, please call your [LHD](#).

### I. Checklist Prior to Conducting PPS

- Implement infection prevention and control recommendations included in the [VDH Interim Guidance for Long-Term Care Facilities](#)
  - Universal masking for source control
  - Adhere to the [recommendations for cleaning and disinfection in healthcare settings](#)
    - Ensure that high-touch surfaces and multi-use non-critical patient care equipment are frequently cleaned and disinfected (e.g., each shift)
- Implement best practices. Resources are described in the [VDH LTCF Playbook](#).
  - Daily monitoring and reporting of staffing, personal protective equipment (PPE), number of sick residents and staff
  - [Public health testing](#) is available for staff and residents with COVID-19 symptoms in, or newly arriving to, LTCFs
  - Develop a collaborative network with healthcare systems and corporate organization
    - Utilization of telemedicine and real-time decision support (when possible)
  - Plan to communicate results with staff, residents, and families
  - Continuous infection prevention and control training and monitoring
- Make a plan for cohorting according to [CDC guidance](#)
  - Designate a portion of the facility (e.g., a wing, ward, floor or end of a hallway) to care for residents with COVID-19
    - The cohorting area should be physically separated from the rest of the care areas in the facility with clear signage
    - Positive and negative residents should not share common areas or bathrooms
    - Equipment should be dedicated to each cohort (positive and negative)

- ❑ If equipment must be shared, make a plan to clean and disinfect equipment
- ❑ Facilities might consider creating three types of units: Cold (negative COVID-19 residents), Warm (unknown COVID-19 status, symptomatic residents who tested negative for COVID-19, roommates of COVID-19 positive residents or others considered exposed), and Hot units (positive COVID-19 residents). That approach helps with cohorting staff and preserving PPE.
- ❑ Assign dedicated HCP to work only on the COVID-19 care unit
  - ❑ Designate separate space (e.g., breakrooms, bathrooms) for HCP
  - ❑ Cohort staff to care for positive or negative residents
- ❑ Make a plan for managing staff with positive or negative test results, which may include furloughing staff who test positive
  - ❑ Mitigate staffing shortages per [CDC guidance](#)
  - ❑ Increase staff incentives
  - ❑ Review staffing resources that may be available, as described in the [VDH LTCF Playbook](#)

## **II. Facility PPS Strategy**

There are two strategies for PPS:

1. **Facilities with a COVID-19 outbreak** (or at least one confirmed COVID-19 case): PPS should be conducted for ALL staff and ALL residents regardless of the presence of symptoms. VDH is supporting this initiative and is collaborating with the Virginia National Guard (VANG) to conduct specimen collection and several laboratories to perform testing. The prioritization outlined below is based on the Commonwealth's data regarding the number of settings experiencing COVID-19 outbreaks.
  - a. Priority #1: Skilled nursing facilities/nursing homes, assisted living facilities
  - b. Priority #2: Targeted units of state correctional facilities and local jails
  - c. Priority #3: Other congregate living facilities (e.g., homeless shelter, group home, rehabilitation facility, or residential behavioral health facility)
2. **Facilities without any reported COVID-19 cases:** Can consider a pre-emptive intervention where a random sample of 20% of residents and staff will be tested. Facilities wishing to conduct this type of testing should work with a [private laboratory](#). If all results are negative, retest the same group after 7 days or select another 20% sample. If any positives are detected, a facility-wide PPS should be conducted. VDH and public health resources can support a facility-wide PPS.

### **How to conduct a PPS**

The goal is to collect specimens on all residents (or those on a particular wing/floor) and staff on one day. If there are more residents than lab testing/collection capacity for a specific day, specimen collection may be split over more than one day. The [LHD](#) will reach out to the facility to schedule testing; a facility can opt out of a PPS.

- The facility is responsible for obtaining consent from residents or families for testing.
- The [LHD](#) or the VANG will deliver specimen collection supplies to the facility.

- The facility should identify staff to collect, label, and package the specimens (nasopharyngeal swab). The facility should supply the necessary PPE for those who collect specimens (gloves, goggles, facemask).
  - The facility could use VANG to collect the specimens; VANG provides its own PPE.
  - Facility staff are responsible for collecting data on each resident tested, including name, date of birth, location within the facility, temperature, and signs or symptoms of illness.
- Specimens should be packaged and transported to the laboratory by DCLS courier, commercial courier (e.g., FedEx) or VANG transport.
- Results will be reported back to the facility within 24 hours of the testing laboratory receiving the specimens.

**III. Recommendations Based on Results**

**Table 1. Resident Placement and Infection Prevention**

	<b>Tested Positive</b>	<b>Tested Negative</b>
<b>Symptomatic at the time of testing</b>	<ul style="list-style-type: none"> <li>● Should be cohorted on a COVID-specific (hot) unit/facility</li> <li>● Transmission-based precautions until <a href="#">discontinuation criteria</a> has been met</li> </ul>	<ul style="list-style-type: none"> <li>● Isolate away from both COVID positive and COVID negative residents, if possible (warm unit)</li> <li>● Retesting might be considered for further disposition guidance<sup>^</sup></li> </ul>
<b>Asymptomatic at the time of testing</b>	<ul style="list-style-type: none"> <li>● Should be cohorted on a COVID-specific (hot) unit/facility</li> <li>● Transmission-based precautions until <a href="#">discontinuation criteria</a> has been met</li> </ul>	<ul style="list-style-type: none"> <li>● Cohort with COVID negative residents<sup>^</sup> (cold unit)</li> </ul>

<sup>^</sup>If exposed to a confirmed COVID case (roommate or HCP): Retest resident

**Table 2. HCP Work Exclusions**

	<b>Tested Positive*</b>	<b>Tested Negative<sup>^</sup></b>
<b>Symptomatic at the time of testing</b>	<ul style="list-style-type: none"> <li>Exclude from work until all <a href="#">Return to Work Criteria</a> are met</li> </ul>	<ul style="list-style-type: none"> <li>If an alternative diagnosis is provided, criteria for return to work should be based on that diagnosis</li> <li>If no alternative diagnosis, exclude from work until all <a href="#">Return to Work Criteria</a> are met</li> <li>Retesting might be considered for further evaluation</li> </ul>
<b>Asymptomatic at the time of testing</b>	<ul style="list-style-type: none"> <li>Exclude from work until all <a href="#">Return to Work Criteria</a> are met*</li> <li>Retest if/when become symptomatic</li> </ul>	<ul style="list-style-type: none"> <li>No work exclusions</li> <li>HCP should continue to monitor for signs and symptoms</li> <li>If HCP develops even mild symptoms, they must cease patient care activities, leave work and be retested</li> </ul>

\*In severe staff shortage, consider the decision to let asymptomatic staff work ONLY with SARS-CoV-2 positive residents and positive staff. For more information refer to [CDC Strategies to Mitigate HCP Shortages](#).

<sup>^</sup>HCP with previous positive test results who test negative during a PPS must meet all criteria in the [test-based strategy](#) (e.g., negative results from at least two consecutive respiratory specimens collected ≥24 hours apart) to return to work.

### **Implementing Resident Cohorting Plan**

The predetermined resident cohorting plan might not be feasible based on the number of positive residents and the types of rooms available, matching resident gender for room assignments, or a high census. If cohorting is not possible, two other alternatives might be considered:

1. Temporary physical barriers/screens/curtains that separate residents by at least 6 feet
2. Transport COVID-19 residents to a dedicated facility (if available and after consulting with the [LHD](#))

### **Relocating Residents**

If a facility decides to relocate residents who tested negative, the following should be communicated to the receiving facility:

- Residents should be quarantined for 14 days in a private room (if available) on transmission-based precautions.
- Close daily monitoring for COVID-19 signs and symptoms.
- If a resident becomes symptomatic, they should be retested.

### **Repeat Testing for HCP or Residents**

- Decisions regarding retesting can be made in conjunction with the [LHD](#).
- Use [private laboratories](#) for retesting if possible; public health resources may not be sufficient for retesting.
- Tables 1 and 2 list considerations for retesting individual HCP or residents. Additionally, retesting should occur for the following:
  - Retest COVID-19 negative residents or HCP with known exposure to infected residents (such as roommates) or HCP.
  - Retest residents who frequently leave the facility for dialysis or other services.
  - Retest HCP who are known to work at other healthcare facilities with cases of COVID-19.
  - Consider retesting to inform decisions when a resident with positive results can be moved out of COVID-19 ward.
- Subsequent PPS could be considered according to [CDC guidance](#); consider retesting COVID-19 negative residents at regular intervals (e.g., weekly) until PPS do not identify any new cases.

### **New Admissions or Readmissions after a PPS**

- Residents with confirmed COVID-19 who have not met [criteria for discontinuation of Transmission-Based Precautions](#) should go to the designated COVID-19 care (hot) unit.
- Residents who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit UNLESS the patient has persistent COVID-19 symptoms (e.g., persistent cough), they should be placed in a single room (and/or on a warm unit), be restricted to their rooms and wear a facemask during care activities until all their symptoms are completely resolved.
- New admissions and readmissions whose COVID-19 status is unknown or residents with a single negative test should be placed in a single room, if available, and/or on a warm unit.
  - All [recommended COVID-19 PPE](#) should be worn during care of residents.
  - Carefully consider staff cohorting on the warm unit.
  - Residents could be transferred out of the warm unit to a cold unit, or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission).