NPHET Paper - Serial Testing of Healthcare workers in Nursing Homes - 10 June 2020

In your recent letter to Paul Reid dated June 4th 2020 the HSE was requested to prepare how to operationalise the weekly PCR/RNA testing for COVID-19 for healthcare workers in nursing homes. This papers presents a summary of progress made on the preparatory work done at a national level and highlights any issues.

The complexity and scale of this undertaking should not be underestimated. We have identified 586 Nursing Home facilities, geographically dispersed, with an estimated 33,000 healthcare workers who will be targeted for testing as part of this undertaking. 80% of the facilities are private nursing homes and 20% are HSE owned and staffed by HSE employees.

Our plan has been developed taking the scale of this testing required into account. We also understand that its success will be mutually dependent on our HSE teams and the participation of each nursing home and their staff of healthcare workers along with Nursing Homes Ireland.

To initiate the testing, each nursing home will receive a pack of information in advance which will include; standard operation procedures presenting roles and responsibilities, data templates to be populated for each healthcare worker and key information explaining the testing requirement, process and timetable.

There are five key areas we have addressed in establishing this implementation plan for nursing home testing each of which are presented below:

Referral & Clinical Governance

We considered how healthcare workers will be referred for this testing activity. We are applying the approach that all referrals need to be clinically led (as in the Testing Strategy Recommendation 11) and that a physician will have overall clinical governance and responsibility for the healthcare worker being tested.

In the case of testing 33,000 healthcare workers this is not straightforward. Firstly we do not have GP information for any staff members, secondly some healthcare workers do not have their own GP and thirdly if an individual GP was to refer each test it would not enable bulk referral uploads and significantly impact the time it takes to refer the test.

Our approach

Step one: In order to refer we will need to confirm all the healthcare worker data with each of the 586 facilities. We intend to do this centrally if possible (or via the CHOs). This will take at least one week. Again tests will be ordered centrally if possible with the support of PCRS, CHO or central administration teams.

Step two: as regards who refers the healthcare workers for tests we investigated three potential options, taking into account the potential requirement for this type of testing to be repeated across other facilities in the future. The three options considered are below and the preferred option:

1. *Occupational Health Referrals:* Where facilities have occupational health support they could potentially act as the test referrer and take responsibility for communicating results to individual GPs. We know for the 20% of nursing homes which are public, occupational health support is available, however the availability of occupational support in the remaining 80% is unknown. Since occupational health support is currently not universal, this option was not deemed feasible in a reasonable timeframe

2. *GPs*: Individual GP information can be gathered as referrers for each of the c33,000 healthcare workers to be tested. The collation of this data requires considerable manual effort estimated at 2,500 administration work hours which will delay mobilisation. This approach may have significant cost implications. It was not deemed feasible.

   Preferred Option
3. *Public Health Department Referral with the support of GP per Dept*: Previously for mass testing, Public Health teams acted as the referrer. In this option public health doctors order the test. Each Public Health Department will then have the support of a GP to help manage (in the event of a positive case) the result communication to the healthcare workers' own GP or in the case of there not being one, they can provide care to the positive healthcare worker. Each Public Health Department will need to assign a GP to their area. We expect this can be arranged quickly enabling swabs to be taken in the week commencing 22 June.

Swabbing

Where feasible, facilities will be asked to undertake self-swabbing for this testing exercise. This will ensure swabs can be gathered efficiently and with minimal interruption to the daily running of each nursing home. Where facilities cannot complete self-swabbing, we will provide support using our community testing teams and the National Ambulance Service.

Each of the 586 nursing homes will be allocated a swabbing day each week across the four-week period. All staff will be requested to be tested on the designated testing day to allow us to process results for facilities as a group and feedback to each facility quickly and efficiently, as appropriate.

A central HSE team will arrange for the delivery of the necessary swabbing kits and PPE to each nursing home the day before testing. This will allow testing of both night and day staff on the designated testing day. A courier will be allocated to collect the swabs at the end of the day from each facility and transfer to a designated laboratory.

Laboratories

To ensure swift processing of the swabs taken we will centralise the laboratory testing using two labs, Enfer and NVRL. These labs hold our most advanced data processing systems and will ensure we minimise data issues across the full end-to-end process which will enable swift turnaround of results to the healthcare workers.

Contact Tracing

Communication of results will be undertaken via our central contact tracing team. This will include communication of negative results via text message and positive result via phone calls to each healthcare worker. The combined results for each facility will be provided to the nursing home via Public Health teams to allow timely action in the case of COVID-19 being detected.

Data Management

To enable swift communication of results, key data is required for each healthcare worker in advance. A central HSE team will work with each facility to gather this data including name, gender, DOB, mobile number and address. Each healthcare worker will also be tagged to a facility ID for each nursing home and an individual COVID-ID to ensure results can be batched into each of the 586 nursing homes. Public Health accepted the available data capture as suitable in the interests of speed. We will therefore report weekly on the proportion of healthcare workers tested and the

proportion of these where COVID-19 is detected. This reporting will commence after the first full week or testing is completed and reported.

To note, our Public Health teams have advised there are additional desirable data points which could be gathered as part of this process e.g. type of healthcare worker (nurse, doctor, HCA etc.), ethnicity, symptomatic or not. It is not currently planned to gather these data points, due to the speed at which we will intend to mobilise.

Gathering this further data would require both additional preparatory work with each facility and also system enhancements across SwiftQueue, the laboratory systems and the CovidCare Tracker (CRM). This will take a number of weeks to have in place, our estimated timeline is c. 6th July. As a result we recommend going with the existing available data sets.

Next Steps

We commence immediately with detailed scheduling and implementation tasks with a view to taking the first swabs in the week commencing 22 June.