

Ministry of Health

COVID-19 Provincial Testing Guidance Update

V. 11.0 March 5, 2021

This document is an update to the COVID-19 Provincial Testing Guidance Update issued February 17, 2021. This document also adds to the [Quick Reference Public Health Guidance on Testing and Clearance](#). This information is current as of March 5, 2021 and may be updated as the situation on COVID-19 continues to evolve. The following updated testing guidance should be used as appropriate.

It is expected that this guidance will be consistently applied across all regions in Ontario to help guide decision making regarding COVID-19 testing of further priority population groups, in conjunction with other [setting-specific guidance](#) as appropriate.

In the event of any conflict between this guidance document and any applicable legislation or orders or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the legislation, order or directive prevails. Please see Ontario's [COVID-19 website](#) for more general information as well as for updates to this document.

Updates to this document include:

- Moved Table 1: Interpretation of Results from Point of Care (POC) Testing to [Appendix 9: Management of Individuals with Point-of-Care Results](#)
- Updated information on molecular, antigen, and serology POCT (page 2-3)
- Updated to reflect recent changes to LSCCLA and HPPA (page 3)
- Updated list of Targeted Testing Groups (page 5-6)
- Updates to Antigen POCT section (page 6)
- Minor updates to Schools/Childcare section (page 10)

Types of tests available

There are three types of tests available in the province of Ontario:

1. Laboratory based molecular testing: nucleic acid amplification test (NAAT, e.g., polymerase chain reaction (PCR) test) detects virus or viral fragments

- a. Purpose: Molecular testing is used for diagnostic purposes only.
- b. [Preferred and Acceptable Specimen types](#): nasopharyngeal swab (NPS) is the preferred specimen due to its high sensitivity. Although less sensitive, acceptable specimens (in descending order) when an NPS is

contraindicated or unavailable, include a combined swab of throat and both nares or deep nasal swab, followed by anterior nares (both nostrils) or oropharyngeal (throat) swab. Saliva samples are also acceptable in non-hospitalized patients. A lower respiratory tract specimen (e.g. sputum, tracheal aspirate) is the preferred specimen in seriously ill patients.

2. Laboratory-based serology testing: detects antibodies to SARS-CoV-2

- a. Purpose: Serology testing is available for clinical use under specific clinical indications. **Serology should NOT be used for screening and diagnosis of acute COVID-19 infection or determining immune status.** A positive serology test does NOT mean a patient is immune to COVID-19. Diagnostic testing for acute COVID-19 infection should be done using a validated PCR assay. Where seroconversion over a four-week interval is documented, that is sufficient criteria for a confirmed case.
- b. Clinical indications for serology testing:
 - i. Patients presenting with symptoms compatible with [Multisystem Inflammatory Syndrome in Children \(MIS-C\)](#) who do not have laboratory confirmation of COVID-19 by PCR.
 - ii. Testing may be considered for patients with severe illness who have tested negative for COVID-19 by PCR and where serology testing would help inform clinical management and/or public health action. Serology testing for these patients requires consultation and approval by the testing laboratory.

3. Point of Care Testing

Point-of-care testing (POCT) refers to testing that employs a COVID-19 medical device authorized by the Minister of Health (Canada) for point-of-care use in which analysis is done at or near the point of specimen collection and is also referred to as 'rapid testing'. For interpretation of results from POCT, see [Appendix 9: Management of Individuals with Point-of-Care Results](#) or [Point of Care Testing Use Case Guidance](#). In some circumstances, additional testing (e.g. laboratory-based molecular testing) may be advised for negative antigen tests due to the risk of false negatives.

a. Point-of-Care Molecular (POC NAAT Assays)

- i. Purpose: Molecular testing is for diagnostic or screening purposes.
- ii. [Specimen types](#): Upper respiratory tract specimen, which can be collected using a nasopharyngeal swab (NPS) or other swabs approved by Health Canada and validated by PHO. Although less sensitive, acceptable specimens (in descending order) when an NPS is contraindicated or unavailable, include: a combined swab of throat and both nares, deep nasal swab, or anterior nares (both

nares).

b. Point-of-Care Antigen (POC Antigen Assays)

- i. Purpose: Antigen POC testing is used for screening purposes only. **Antigen POCT should NOT be used for diagnosis of Covid-19 infection in symptomatic individuals, or individuals with known contact with a positive COVID-19 case.**
- ii. [Specimen types](#): Upper respiratory tract specimen, which can be collected using a nasopharyngeal swab (NPS) or other swabs approved by Health Canada and validated by PHO. Although less sensitive, acceptable specimens when an NPS is contraindicated or unavailable include: anterior nasal (both nares), combined throat and both nares, or deep nasal.

c. Point-of-care serology

- i. Purpose: Serology POCT is not used for diagnostic or screening purposes. Results from serology POCT do not have to be reported.

For all test types:

All testing must be performed on technologies approved by Health Canada (HC) or otherwise validated by the licensed laboratory (i.e., laboratory-developed test or research use only test). Laboratories used to collect specimens and conduct testing for COVID-19 must be licensed under the *Laboratory and Specimen Collection Centre Licensing Act* ([LSCCLA](#)) or fall under an exemption under the LSCCLA. .

All molecular test results, including molecular POC tests, should be uploaded with minimum data elements required for laboratory results and uploaded into the Ontario Laboratories Information System (OLIS) or where OLIS is not available, through an alternate secure method, as per Ontario Health guidelines and in accordance with the *Health Protection and Promotion Act*.

All positive COVID-19 tests performed using a Health Canada approved test, including molecular POC tests, or an assay validated by the laboratory must be reported to the local public health unit as per the [LSCCLA's Reg 682](#) and/or under [Health Protection and Promotion Act](#). Reporting of positive results must be in accordance with CMOH guidance.

All preliminary positive COVID-19 results obtained using a Health Canada approved POC antigen test must be reported to the local public health unit in accordance with the *Health Protection and Promotion Act*.

Variants of Concern

The Ontario laboratory network is currently working to increase screening for variants of concern (VOCs) in SARS-CoV-2 positive specimens and conducting further analysis on all VOC screen-positive specimens. Timely reporting of VOC screen positive results

to health units will support intensified public health response to limit further transmission. Cases and outbreaks that warrant targeted testing for VOCs should follow instructions from Public Health Ontario's [COVID-19 Variants of Concern Test Information Sheet](#).

More guidance on VOCs is available on the [Ministry's website](#).

Guidance for Symptomatic Individuals

Any Ontarian presenting with at least one symptom or sign from the [COVID-19 Reference Document for Symptoms](#) should be considered for PCR or POC molecular testing for COVID-19. Clinicians should continue to use their clinical judgment during patient assessment and test facilitation, considering local epidemiology and exposure risks.

Influenza testing

The following populations who are symptomatic with acute respiratory infection (ARI) are eligible for molecular testing for influenza:

- Symptomatic hospitalized patients
- Outbreak investigations (up to 4 specimens from symptomatic patients only). This includes [symptomatic residents, staff and/or essential visitors](#) in an institutional/congregate living setting (e.g., long-term care homes, retirement homes, correctional facilities, shelters, group homes) with ARI. For additional testing in outbreak settings, contact [PHO's Laboratory Customer Service Centre](#) and reference PHOs [Respiratory Virus Testing Update](#).
- Persons residing in remote communities

When completing the [PHO Laboratory COVID-19 Virus Test Requisition Form](#), the appropriate test should be selected in the "Test(s) Requested" (box 5) – either COVID-19 virus alone or also including other respiratory viruses (if influenza and/or other respiratory virus testing is also requested).

Guidance for Asymptomatic Individuals

Only high-risk asymptomatic individuals, and individuals from targeted testing groups should be considered for PCR testing as follows:

1. Contacts of confirmed positive cases:

Asymptomatic contacts of a confirmed case should undergo testing at an assessment centre within 14 days from their last exposure or notification from the COVID Alert app.

- Contacts who have had ongoing exposure to the case while they have been infectious, or who had similar acquisition exposures as the case, should be tested as soon as possible. If the initial specimen was collected on day 0-6 after the last exposure, a second specimen should be collected on or after day 10 after the last exposure.

- Contacts who are part of an outbreak investigation should be tested as soon as possible, and have repeat testing as directed by the local public health unit.
- Contacts who were only exposed to the case and who do not share acquisition exposures should be tested on or after day 7 after their last exposure to the case. If an initial test was collected between days 0-6 after their exposure, all high risk of exposure contacts need to repeat testing on or after day 10 of quarantine.

If the test result is negative, asymptomatic contacts must remain in self-isolation for 14 days from their last exposure to the case. If an asymptomatic contact tests negative and then subsequently becomes symptomatic, they should be re-tested.

2. Outbreak Investigations:

Asymptomatic workers and residents at specific outbreak sites may be considered for testing at the direction of public health. These individuals should be directed to seek PCR testing at an assessment centre.

3. Targeted Testing Groups:

Asymptomatic individuals without known high-risk exposures and not part of outbreak investigations, but from certain populations may be considered for testing. These individuals should be directed to seek testing at an [approved specimen collection location](#).

This includes any individual identified as part of a targeted testing campaign as directed by the Ministry of Health, Ministry of Long-Term Care, Ministry of Seniors and Accessibility, Ministry of Education or by local public health as listed:

1. Workers (including support workers), visitors (including caregivers) and government inspectors of long-term care homes
2. Workers (including support workers), visitors (including caregivers) and government inspectors of retirement homes
3. Residents or workers in homeless shelters or other congregate settings
4. International students that have passed their 14-day quarantine period
5. Farm workers
6. Individuals who identify as Indigenous
7. Individuals, and one accompanying caregiver, with written prior approval for out-of-country medical services from the General Manager, OHIP
8. Individuals who are travelling into remote/isolated First Nation and Indigenous communities for work purposes.
9. School staff inclusive of itinerant, supply, specialty teachers, and childcare staff, and school bus drivers

Additionally, asymptomatic individuals with a positive result obtained through a POC test and requiring a confirmatory test including, but not limited to, individuals who are part of an organization or setting that is participating in the Provincial Antigen Screening Program are eligible for confirmatory testing at assessment centres only.

4. Antigen POCT

Antigen POCT is used for screening purposes only and should NOT be used for symptomatic individuals, individuals with known close contact with a positive COVID-19 case, or diagnosis of acute COVID-19 infection in symptomatic individuals or individuals with known close contact with a positive COVID-19 case

Guidance for Specific Settings

1. Facility Transfers

Any patient transferred between facilities (i.e. leaving one facility and entering another, even within same multi-site organization, regardless of symptomology), should be tested (using molecular/PCR testing) upon admission to the destination facility. For patients entering a residential treatment facility (e.g. a mental health or addiction program), testing should also be conducted prior to admission into the program.

Examples include, but are not limited to:

- Admission to hospital from another hospital, long-term care home, retirement home or other congregate living setting/institution (including group homes and equivalent higher-risk settings)
- Transfers from, or repatriation to community hospitals and regional tertiary/quaternary centres; or
- Transfers from an acute site to a post-acute site (e.g. patient transferred to complex continuing care/rehab) within a multi-site organization

There are two exclusions to the above guidance:

1. The first in relation to [Directive #3](#), involving admissions and transfers to long-term care homes or retirement homes.
 - a. Individuals who are being admitted or transferred from acute care settings, such as hospitals, should be tested and results reported prior to their arrival to the home. Where there are delays in reporting of test results individuals may be transferred to the home but must remain in isolation under Droplet/Contact precautions as per Directive 3.
 - b. Individuals who are being admitted or transferred from all other settings (e.g. from the community) may be tested on arrival to the long-term care home or retirement home, provided that they remain in isolation under Droplet/Contact precautions as per Directive 3.
2. The second in relation to newborn infants (<48 hours old at time of transfer) born to women who are asymptomatic and screen negative. Such newborns

should be considered exempt from routine COVID-19 testing on admission to the destination facility. See [Appendix A](#) on newborn testing.

Any individuals who have previously tested positive for COVID-19 and have since recovered do NOT need to be tested prior to or after transfer between facilities, unless they have had a new high-risk exposure and symptoms. The decision to test should use clinical judgment and/or be at the discretion of public health.

2. Hospitals

Testing prior to a scheduled (non-urgent/emergent) surgery in a hospital or other surgical setting:

- A regional approach to testing prior to scheduled surgery should be adopted, after review of local epidemiology and risk assessment by COVID-19 Regional Steering Committee/Response Table.
- For areas with low community transmission of COVID-19, testing prior to a scheduled surgical procedure is not required. In areas where community transmission of COVID-19 is not low, any patient with a scheduled surgical procedure requiring a general anaesthetic should be tested 24-48 hours prior to procedure date. This includes any setting where a surgical procedure is taking place (e.g., hospital, independent health facility, etc.).
- Patients should self-isolate for a period of at least 14 days prior to a scheduled procedure.
- In the event of a positive test result, the scheduled non-urgent/emergent procedure should be delayed for a period of at least 10 days and until cleared by public health.

Testing of hospitalized patients:

In the event a patient develops **laboratory-confirmed COVID-19**, within a 14-day period where the case could have reasonably acquired their infection in the hospital, and the patient was not cared for on Droplet/Contact Precautions, asymptomatic contacts of the confirmed patient, determined in consultation with the hospital's Infection Prevention and Control and Occupational Health, should be tested including:

- All patients on the unit/care hub
- All staff working on the unit/care hub while the patient was not on Droplet/Contact Precautions
- All essential visitors that attended the unit/care hub
- Any other contacts deemed appropriate for testing based on a risk assessment by infection prevention and control

Infection Prevention and Control/Occupational Health may also, based on a risk assessment, determine if any additional testing is required, or whether any of the

above-mentioned individuals do not require testing.¹

In asymptomatic persons, a negative result should not change infection control management as the individual may still be in the 14-day incubation period.

In the event a hospitalized patient is diagnosed with community acquired **laboratory-confirmed COVID-19**, and the patient was not cared for on Droplet/Contact Precautions, asymptomatic contacts of the confirmed patient, while the confirmed patient was infectious, should be tested, determined in consultation with Infection Prevention and Control and Occupational Health:

- Any patient in the same patient care area when the case was not under Droplet and Contact precautions
- Any staff who cared for the patient who had close prolonged contact within 2 meters not wearing appropriate personal protective equipment.

Infection Prevention and Control/Occupational Health may also, based on a risk assessment, determine if any additional testing is required, or whether any of the above-mentioned individuals do not require testing.

In asymptomatic persons, a negative result should not change infection control management, as the individual may still be in the 14-day incubation period.

3. Long-Term Care and Retirement Homes

Definitions:

- **Long-term care homes:** has the same meaning as in the *Long-Term Care Homes Act, 2007*
- **Retirement homes:** Privately-owned, self-funded residences that provide rental accommodation with care and services for seniors who can live independently with minimal to moderate support.

In the event a resident living in a long-term care or retirement home develops symptoms compatible with COVID-19, asymptomatic residents living in the same room should be tested immediately along with the symptomatic resident under the direction of local public health.

As per Directive #3, in the event an outbreak of COVID-19 is declared in the home, all staff in the entire home **and** all residents in the long-term care home or retirement home must be offered molecular testing. Any exception to this must be approved by the Chief Medical Officer of Health.

In asymptomatic persons who have been identified as a close contact of a known case, a negative result should not change public health management as the individual

¹ Note: Testing recommendations based on a single case are at the direction of the acute care Infection Prevention and Control and Occupational Health. If an outbreak is declared, additional testing recommendations are determined by the Outbreak Management Team including the local public health unit.

may still be in the 14-day incubation period.

Re-testing of asymptomatic individuals who initially test negative is recommended if they develop symptoms.

In general, asymptomatic persons who have previously had a laboratory-confirmed case of COVID-19 and have since recovered do NOT require COVID-19 testing, unless otherwise directed by local public health. Testing is recommended if they become symptomatic.

In the event of ongoing transmission in an outbreak, following the initial testing of the home at the time of outbreak declaration, repeat testing of all residents and staff who initially tested negative should be conducted within 3-7 days from when the initial testing was conducted. If additional cases are identified, continue repeat testing of residents and staff who tested negative every 3-7 days until no new cases are identified.

4. Other Congregate Living Settings and Institutions

Definition: Other congregate living settings and institutions include homeless shelters, group homes, community supported living, disability-specific communities/congregate settings, short-term rehab, hospices, and other shelters.

Note: correctional facilities should follow sector-specific guidance on testing.

In the event of an outbreak declared in the setting, all staff in the facility AND all residents/attendees in the facility should be tested under the direction of local public health. Local public health may also, based on a risk assessment, determine if any additional testing is required or, whether any of the above-mentioned individuals do not require testing.

In asymptomatic persons, a negative result should not change public health management as the individual may still be in the 14-day incubation period.

Re-testing of asymptomatic individuals who initially test negative, is recommended if they develop symptoms.

In general, asymptomatic persons who have previously had a laboratory-confirmed case of COVID-19 and have since recovered do NOT require testing, unless otherwise directed by local public health. Testing is recommended if they become symptomatic.

In the event of ongoing transmission in an outbreak, repeating testing of asymptomatic persons who initially tested negative in the outbreak may be advised by the local public health unit to assess for additional asymptomatic/pre-symptomatic cases in an outbreak.

Asymptomatic patients transferred from a hospital to a hospice setting should be tested and results received prior to transfer, unless previously positive.

5. Remote/Isolated/Rural/Indigenous Communities

In the event of a confirmed case of COVID-19 in a remote, isolated, rural or Indigenous

community testing of contacts at low-risk of exposure, in addition to contacts at high-risk of exposure, should be considered in consultation with the local public health unit.

6. Workplaces and Community Settings – Enhanced Contact-Based Testing

In the event of **one laboratory-confirmed case of COVID-19** identified in a workplace or community setting (e.g. religious gathering, recreational centre) during their period of communicability, exposed individuals in the workplace or community setting, determined in consultation with local public health, should be tested including:

- Any close contacts of the case
- In settings where contacts are difficult to determine, broader testing may be considered at the discretion of local public health

In the event of an **outbreak in a workplace or community setting**, as determined by local public health, all individuals associated with the outbreak area should be considered for testing.

In asymptomatic persons, a negative result should not change public health management as the individual may still be in the 14-day incubation period.

In general, asymptomatic persons who have previously had a laboratory-confirmed case of COVID-19 and have since recovered do NOT require testing, unless otherwise directed by local public health.

In the event of ongoing transmission in an outbreak, repeating testing of asymptomatic persons who initially tested negative in the outbreak may be advised by the local public health unit to assess for additional asymptomatic/pre-symptomatic cases in an outbreak.

7. Schools and Childcares

Access to molecular point-of-care testing for symptomatic children under 18 through assessment centres and community testing sites (i.e. for the purpose of obtaining clearance to return to school or childcare) should be prioritized in public health unit regions where lab-based PCR testing turnaround times are not meeting provincial targets.

8. Other Populations

Definition: Patients requiring frequent contact with the healthcare system due to the nature of their current course of treatment for an underlying condition (e.g. patients undergoing chemotherapy/cancer treatment, dialysis, pre-/post-transplant, pregnant persons, neonates).

Specific guidance (including asymptomatic groups) has been developed for the following populations:

- Newborn testing – See Appendix A
- Testing for Cancer Patients- See Appendix B

- Testing for Hemodialysis Patients – See Appendix C

Appendix A:

Testing Newborns

Newborns born to mothers with confirmed COVID-19 at the time of birth should be tested for COVID-19 within 24 hours of delivery, regardless of symptoms.

If maternal testing is pending at the time of mother-baby dyad discharge, then follow-up must be ensured such that if maternal testing is positive the baby is tested in a timely manner. If bringing the baby back for testing is impractical, the baby should be tested prior to discharge.

Newborns currently in the NICU/SCN born to mothers with confirmed COVID-19 at the time of birth should be tested within the first 24 hours of life and, if the initial test is negative, again at 48 hours of life, regardless of symptoms.

Appendix B:

Testing Asymptomatic Cancer Patients

Routine testing of all patients prior to Radiation or Systemic treatment is not recommended but instead a regional approach should be adopted after reviewing local epidemiology by regional COVID response committees. In regions with low community transmission of COVID-19, routine testing prior to treatment is not required but should be done at the discretion of the treating physician if he/she feels it is necessary or indicated, in particular when:

- High dose multidrug chemotherapy is planned
- Radiation treatment will involve treatment of lung tissue
- Treatment is planned in patients with a new ground glass lung opacity
- Treatment (Radiation or Systemic) is planned in patients who are significantly immunosuppressed

Recommendations for Hematopoietic Cell Therapy (HCT)

- 1) All patients booked for hematopoietic cell therapy should be tested 24-48 hours before their appointment apart from exceptional circumstances (e.g., Priority A case requiring urgent same day treatment).

Appendix C:

Testing for Hemodialysis Patients

1. Testing for symptomatic in-centre hemodialysis patients

- Test symptomatic patients using a low-threshold approach, incorporating ["atypical symptoms"](#)
- Patients with persistent respiratory symptoms or fever despite a negative test should be managed on Droplet and Contact Precautions and be tested as appropriate, based on clinical judgement.

2. Testing for in-centre hemodialysis patients who reside in LTC/retirement homes (~450 patients total) or other congregate living settings

- Given that there have been no new cases of COVID-19 detected in in-centre hemodialysis patients residing in LTC homes since the first week of June 2020, periodic testing of asymptomatic patients from LTC or retirement homes is not at present recommended where the patient's home does not have known cases.
- Surveillance testing of hemodialysis patients from LTC/retirement homes with known cases or outbreaks should continue regularly until the outbreak is considered cleared.
- If a LTC/retirement home patient comes from a home where there is or subsequently has a declared COVID-19 outbreak and the patient becomes a laboratory-confirmed case, decisions around additional testing of asymptomatic patients and staff should be left to the discretion of local infection prevention and control as testing decisions will be informed by the size and layout of the unit.
- Testing for in-centre hemodialysis patients who reside in LTC or retirement homes to be conducted in the hemodialysis unit, or in accordance with hospital and local Public Health protocols, if not already done in the home.

There may be consideration given to periodic testing of staff not known to be positive, however, this should be coordinated with the ongoing active testing occurring in the homes. However, this should not be used as a basis for additional precautions in the homes, such as isolation and droplet precautions for these patients in a facility upon their return (e.g. long-term care homes).

3. Testing for in-centre hemodialysis patients in hemodialysis unit where outbreak declared

- If an outbreak is declared in a hemodialysis unit, test all patients in that unit regardless of whether they are symptomatic. In addition, all staff working in that hemodialysis unit must be tested.
- Retesting should be directed by the outbreak management team overseeing the outbreak, in collaboration with local public health.