Guide for Outbreak Prevention and Control in Long Term Care, Designated Supportive Living and Hospice Sites

Includes COVID-19, Respiratory Illnesses, Influenza, and Gastrointestinal Illness

Updated September 2022

Introduction

This guide is intended as an operational guide to practice. This document provides current best-practice and evidence-based guidance for outbreak control and management of respiratory and gastrointestinal (GI) illness in Long Term Care (LTC), Designated Supportive Living (DSL) and Hospice sites. Information within this document contains evidence-based best practice as outlined in the Alberta Health (AH) Public Health Disease Management Guidelines and in Public Health Agency of Canada documents.

This document discusses the roles of the Public Health Outbreak Team (which includes Medical Officers of Health, and Alberta Health Services (AHS) Zone Communicable Disease Control/Environmental Public Health Outbreak Teams); Infection Prevention and Control/Designate; Facility Administration/Facility Management or their Designate; Occupational Health/Workplace Health and Safety or their Designate; Onsite Staff; and Alberta Precision Laboratory for Public Health (ProvLab).

The roles and responsibilities of AH; AHS Zone Operations (Executive Director for Seniors Health, Area Managers / Directors, Directors for LTC, DSL and Hospice) AHS Provincial Seniors Health and Continuing Care are not discussed in this guide. If individuals or facilities require more information about the roles and responsibilities of these additional partners, they should seek information directly from the respective groups as required.

Infectious disease outbreaks occur year-round and in different settings, including LTC, DSL and Hospice sites. Outbreak management measures for respiratory and gastrointestinal illnesses outlined in this guide reflect a usual seasonal respiratory illness impact at the population level. Additional measures may be recommended where heightened levels of infection or newly emerging pathogens warrant increased surge levels of outbreak preparation, prevention, and management and are outside the scope of this guide.

Effective outbreak management requires a multidisciplinary approach and involves individuals with different responsibilities. In compliance with the Alberta Continuing Care Health Services Standards (Standard 11), Alberta Health Services (AHS) facilities and contracted service providers will develop and implement written procedures for identifying, reporting and investigating notifiable diseases, and controlling any suspect outbreaks within LTC, DSL and Hospice sites.

The notification of outbreaks and other infectious disease threats in Alberta is mandated under Section 26 of the provincial *Public Health Act*, and each Medical Officer of Health (MOH) is accountable for outbreak investigation and management (Section 29).

Early recognition of unusual clusters of illness and swift actions in response to these events are essential for effective management of outbreaks. The Public Health Outbreak Team, Infection Control Professionals (ICP)/Infection Control Designates (ICD) in LTC, DSL and Hospice sites work collaboratively with Facility Administrators and health care workers/staff to facilitate prompt response to help minimize the impact of the outbreak.

Note: Only the minimum IPC outbreak measures for respiratory or GI illnesses are outlined here. These standard recommendations may be enhanced or modified depending on the specific scenario. If considering implementation of outbreak control measures beyond those recommended in this guide, it is important to consider the potential impact on the well-being of residents (e.g., if a resident is receiving end of life care, a conversation with the family about visitation during an outbreak may be needed). Exceptions are recommended in consultation with the Public Health Outbreak Team. For more information, consult the Public Health Outbreak Team.

In the event of an outbreak, or threat of an outbreak of an unusual infectious disease, (such as a new pandemic or any other infrequent infectious disease), direction on best practices for outbreak management will be provided by the MOH and may broaden the recommendations in this guide.

In instances of unusual clusters or high severity of a circulating disease in the Alberta population, additional population-wide measures may be recommended or required that exceed the standard outbreak management and prevention strategies outlined in this guide.

While it is recognized that *Clostridioides difficile* and multi-drug resistant organisms (e.g., MRSA, VRE), can be responsible for clusters or outbreaks, and that some of the measures outlined in this guide may be applicable in preventing or controlling them, it is beyond the scope of this document to include these organisms, due to their unique epidemiological properties.

We would like to recognize that our work takes place on historical and contemporary Indigenous lands, including the territories of Treaties 6, 7 & 8, and the homeland of the Métis. We also acknowledge the many Indigenous communities that have been forged in urban centres across Alberta.

How to Use the Document

- Users are encouraged to familiarize themselves with the layout of the document. It is a comprehensive document that has been divided into eleven sections for user ease.
- Roles and responsibilities are presented for those that have a role in outbreak management. A user can refer to the information specific to their role and may review information about additional roles on an as-needed basis.
- To assist with using the document, the user can refer to the section that is appropriate to the type or stage of the outbreak. A brief description of each section is presented below.
- Due to the complex nature of LTC/DSL/Hospice settings, the individual fulfilling the roles and responsibilities within a site may vary. Refer to site roles and responsibilities.

Section 1 Preparing for a Potential Outbreak

- This section is to be used for review prior to the start of the outbreak season.
- Appendix A contains examples of the resources that the Public Health Outbreak Team will send out prior to the beginning of the outbreak season.
- Overview of the roles and responsibilities for outbreak preparation and prevention.

Section 2 Assessing a Potential Outbreak

- This section is provided to help the user determine if a resident or staff member has any of the symptoms that would require reporting to the Public Health Outbreak Team via CEIR. It also includes how to contact CEIR.
- Overview of the roles and responsibilities for assessing and reporting a potential outbreak.

Section 3 Managing a Potential Outbreak

- This section outlines the steps that need to be taken to contain the potential outbreak.

- These topics include Infection Prevention and Control, Resident Restrictions, Visitors, Volunteers, Specimen Collection, etc.
- Overview of the roles and responsibilities for managing the potential outbreak.

Section 4 Outbreak Definition and Determining Outbreak Type
- Includes case and outbreak definitions for COVID-19 Illness, Respiratory Illness, Influenza Illness and GI Illness.

Section 5 General Recommendations for Confirmed Outbreaks
- This section provides general outbreak control strategies that are to be implemented regardless of the identified pathogen. These strategies are used in combination with Section 3.
- Overview of the roles and responsibilities for confirmed outbreaks.

Section 6 Confirmed COVID-19 Outbreak
- This section provides guidance for COVID-19 specific outbreak measures in addition to those outlined in Sections 3 and 5
- Overview of the roles and responsibilities for a confirmed COVID-19 outbreak.

Section 7 Confirmed Respiratory Illness (RI) Outbreak
- This section provides guidance for when no pathogen is identified or when a non-COVID-19, non-Influenza pathogen is identified.
- The strategies in this section are implemented in addition to those in Sections 3 and 5.

Section 8 Confirmed Influenza Outbreak
- This section provides guidance on managing an Influenza outbreak.
- The strategies in this section would be implemented in addition to those in Sections 3 and 5.
- Provides direction on management of the unimmunized health care worker/staff.
- Information for the use of antivirals in an influenza outbreak is provided
- Overview of the roles and responsibilities for a confirmed Influenza outbreak.

Section 9 Confirmed Gastrointestinal Illness Outbreak
- This section provides additional outbreak management measures when a GI outbreak is declared.
- The strategies outlined in this section would be implemented in addition to those in Sections 3 and 5

Section 10 Closing an Outbreak
- This section provides direction on closing all types of outbreaks.

Section 11 Summary of Changes

Definition of Terms and Glossary

Acute Care - includes all urban and rural hospitals, psychiatric facilities, and urgent care facilities where inpatient care is provided.

Admission and transfer status - determined in consultation with the Outbreak Management Team (OMT) and categorized as follows:

- **"Open"** - The facility/unit remains open to all resident admissions, transfers, and discharges.
- **"Restricted"** - Depending upon the circumstances and the infectious agent involved, admission and transfer status may range from NO admission to selected resident admissions, transfers and discharges as permitted under the direction of the zone Medical Officer of Health and in consultation with the OMT. This approach is intended to be flexible allowing for individual assessments to be made based on established criteria without undue risk to residents/program/system.

Adult Day Program (ADP) - Day program designed for adults over the age of 18 who may have physical and/or memory challenges or are living with a chronic illness. They play a key role in allowing people to remain living in the community as long as possible by optimizing their physical, spiritual, social, and emotional function. This may include residents of Designated Supportive Living and Non-Designated Supportive Living sites. Adult day programs also provide respite and education for caregivers (e.g., CHOICE, C3, and Bridges).

AHS Home Care - publicly-funded health care and support services provided to eligible residents as governed by the Alberta Home Care Program Regulations of the *Public Health Act*. These services are provided to individuals living with frailty, disability, acute or chronic illness living at home or in a supportive living setting as defined in the AH/AHS "Home Care | Alberta Health Services

AHS Home Care Operations - this term applies to the AHS Zone Seniors Health and Continuing Care staff that have responsibility to participate in outbreak management leadership at LTC, DSL and Hospice sites where home care services are provided. Examples might include:

- AHS Case Manager (CM) - a regulated health care provider who coordinates and integrates health care services within and across the health care system; facilitates access to and continuity of health services across the continuum of care (e.g., when a resident is hospitalized or discharged from one continuing care service/program to another; and assists residents in accessing appropriate services within the community.
- AHS Allied Health
- Transition Services/Coordinated Access - coordination of resident care and movement between sites and to different levels of care including but not limited to assessment for Home Care services, and assessment and admission to designated living options (LTC, DSL).

AHS Provincial Seniors Health and Continuing Care - AHS Provincial Seniors Health and Continuing Care focuses on improving health care services and practices to enable seniors to optimize their health, well-being, and independence. The provincial program works closely with stakeholders across the province to align and optimize services to meet the healthcare needs of Alberta's seniors based on evidence and best practices.

AHS Zone Operations - This term applies to the AHS Seniors Health staff that have responsibility to participate in outbreak management leadership at AHS owned and contracted sites.

Alberta Precision Laboratory for Public Health – Also called ProvLab, the provincial lab for Alberta

Appropriate Mask - The type of mask (surgical, KN95, N95) recommended per the AHS IPC Point of Care Risk Assessment (PCRA).

CEIR - AHS Coordinated Early Identification and Response line (CEIR) 1-844-343-0971. A provincial, centralized outbreak reporting and response line. This is a collaborative effort to assist with initial site support for facilities with vulnerable populations. CEIR assists with the implementation of initial outbreak management and control measures including initial testing, isolation protocols, staffing, personal protective equipment (PPE), education, etc.

Cluster - aggregation of similar, relatively uncommon events or diseases in space and/or time in amounts that are believed or perceived to be greater than could be expected by chance.

CNPHI - Canadian Network for Public Health Intelligence

Cohorting - Controlling the movement of HCW/staff and residents for the purpose of limiting an outbreak to a specific unit/floor/area within a larger facility (instead of having the outbreak declared facility wide). The Public Health Outbreak Team will assess specific circumstances to assist in determining the appropriate scope for the outbreak investigation.

Congregate setting - refers to settings where residents receive care and/or services in a communal environment with other residents. Examples include: Acute care, long term care, designated supportive living, hospice, adult day programs, non-designated supportive living sites including lodges, private retirement residence.

Close Contact - any person suspected to have been exposed to an infected person or a contaminated environment to a sufficient degree to have had the opportunity to become infected or colonized with an organism.

Contact and Droplet Precautions - Figure 2.

Designated Supportive Living (DSL) - a home-like setting where people can maintain control over their lives while also receiving the support they need. The buildings are specifically designed with common areas and features to allow individuals to “age in place”. Building features include private space and a safe, secure, and barrier-free environment. DSL promotes resident independence and aging in place through the provision of services such as 24-hour monitoring, emergency response, security, meals, housekeeping, and life-enrichment activities. Publicly funded personal care and health services are provided to supportive living residents based on assessed unmet needs.

- **Designated Supportive Living Level 3 (DSL3)** - Setting that provides accommodation, meals, housekeeping, linen, and recreational services where healthcare services are provided on a scheduled basis but can be accessed as needed. Twenty-four hour on-site scheduled and unscheduled personal care and support services are provided by Health Care Aides. Professional health services including Registered Nurse services with 24 hour on-call availability, case management and other consultative services are provided through AHS.
- **Designated Supportive Living Level 4 (DSL4)** - Living option that provides accommodation, meals, housekeeping, linen, and recreational services where a higher level of personal care supports, and health care services are provided onsite for scheduled and unscheduled care needs according to the individuals plan of care. Twenty-four hour on-site scheduled and unscheduled professional and personal care, and support services are provided by Licensed Practical Nurses and Health Care Aides. Professional health services including Registered Nurse services with 24 hour on-call availability, case management and other consultative

services are provided through AHS.

- **Designated Supportive Living Level 4 Dementia (DSL4D)** - DSL4 that provides specialized dementia care.

Designated family/support person (DFSPs) - means one or more individuals identified by the resident/patient as an essential support, and who the resident/patient wishes to be included in any encounters with the health care system, including, but not limited to, family, relatives, friends, and informal or hired caregivers. Refer to Designated family / support person(s) DFSP)

Drug Identification Number (DIN) - a number assigned by Health Canada to a drug product prior to being marketed in Canada.

Emergency Medical Services (EMS) Community Paramedic (CP) Program - is a Mobile Integrated Healthcare Program designed to provide immediate or scheduled medical supervision and treatments that are currently unavailable in the community setting. This program works in collaboration with the resident's existing healthcare services. The target population are the medically fragile individuals requiring specialized treatments that are necessary to stay out of hospital, or support "at risk" individuals for readmission to hospital & /or visit to emergency (such as medical management during Outbreaks, which may include swab collection in some circumstances). A referral is required to access this service at the Zone level.

Exclusion - a measure that prevents symptomatic/infected/susceptible HCW/staff from working, until such time that the risk for residents or HCW/staff is low or minimal, as recommended by the Public Health Outbreak Team or Workplace Health and Safety or designate.

Exposure Investigation Number (EI Number) - a number assigned by the Alberta Precision Laboratory for Public Health for the purpose of tracking laboratory specimens associated to a specific event (e.g., a potential outbreak) at a specific location and time.

Facility Operator/Facility Management - A formal leader within the physical site, responsible for the day-to-day operations of the site. This may or may not be an AHS employee depending on the type of facility.

Family-style meal service - involves filling a common vessel, such as a tray or bowl, with a large portion of food and setting the vessel on the table allowing residents to serve themselves from the common vessel.

Gastrointestinal (GI) Illness - for GI illness case and outbreak definitions refer to Table F.

Health Care Workers (HCW) - as defined by Alberta Health (AH) includes all health practitioners and all individuals (including nutrition and food services, housekeeping, recreation etc.) at increased risk for exposure to, and/or transmission of, a communicable disease because they work, study, or volunteer in one or more of the following health care environments: hospital, nursing home (facility living), supportive living accommodations, or home care setting, mental health facility, community setting, office or clinic of a health practitioner, clinical laboratory.

Health Care Workers/Staff (HCW/staff) - For the purpose of this document, the term HCW/staff will consistently be used, and the facility is responsible for determining if an individual is considered to be a HCW or a staff member. The facility will determine when actions need to be taken by all members at the site or only those that are considered to be a HCW.

- Onsite Staff – The term onsite staff is used for HCW/staff that in some capacity of their job work directly at that site. When an individual is on-site, they are expected to fulfill the Roles and Responsibilities of onsite HCW/staff as outlined in each section. The examples listed below are not an all-inclusive list:
    - Staff employed directly by the site
    - Staff who are contracted service providers and work at the site (e.g., Contracted Pharmacy Services)
    - AHS staff who work and provide services at the site.

Hospice - any facility in which residential hospice services are offered or provided by Alberta Health Services or by a service provider under contract with Alberta Health Services.

Infection Control Designate (ICD) - someone assigned to be accountable for IPC issues in a facility.

Infection Control Professional (ICP) - is a health professional with specialized knowledge responsible for infection prevention and control within the facility or area of practice. ICPs come from several disciplines, including nursing, medicine, microbiology, medical technology and/or epidemiology and may be certified or working toward certification in infection control (CIC®).

IPC - Infection Prevention and Control

Long Term Care (LTC) Facility - Long term care refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems who require the oversight of a registered nurse 24-hours a day. Long term care services include traditional medical services, social services, and housing. Clients admitted into long-term care are required to pay accommodation fees (room and board and other costs associated) as set by government. Long term care may be referred to as auxiliary hospitals and nursing homes.

Most Responsible Health Practitioner - means the **health practitioner** who has responsibility and accountability for the specific treatment/procedure(s) provided to a resident and who is authorized by Alberta Health Services and/or the facility to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of his/her practice.

Occupational/Workplace Health and Safety (OHS/WHS) - designated personnel responsible for staff health and safety in facilities. In some facilities, Employee Health or the Site Management or the Site Medical Leader may fill this role.

Outbreak - "The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season" (World Health Organization, 2018). A common source of infection or the identification of transmission between cases are not required. The epidemiologic features of an outbreak and subsequent public health actions are assessed through the outbreak investigation process.

Outbreak Management Team (OMT) - a group of key individuals, including but not limited to, representatives from the Public Health Outbreak Team, Infection Prevention and Control (IPC/ICD), Occupational Health/ Workplace Health Safety (WHS), Facility Administration/Facility Management or their Designate who work cooperatively to ensure a timely and coordinated response to a suspect or confirmed outbreak. Composition of the OMT will depend on disease and facility type.

PPE - Personal Protective Equipment

Public Health Outbreak Team - for the purpose of this document, the Public Health Outbreak Team coordinates and leads the outbreak response. It also provides consultation and leadership in outbreak investigations in facility settings and is responsible for reporting of facility outbreaks to Alberta Health. This team encompasses the Medical Officer of Health (MOH), and the Communicable Disease Control (CDC) Outbreak Team and Environmental Public Health (EPH) Outbreak Team.

Residents - tenants who reside in congregate sites.

Visitor - means an individual who spends time with the resident/patient for a temporary period for the purposes of providing support to the resident/patient and is not an essential partner to care planning and/or decision-making. For more information refer to **Visitor**

How to Contact AHS Public Health Outbreak Team to Report Illness

Initial point of contact for the Public Health Outbreak Team Reporting

AHS Coordinated Early Identification and Response line (CEIR) 1-844-343-0971

- Acts as the first point of contact for sites in all zones to provide notification to the Public Health Outbreak Team when there are 2 symptomatic cases within 7 days in a congregate setting that **does not** already have a confirmed outbreak. If site attempts to contact CEIR outside hours of operation the notification should be completed the next day

Exception for GI illness: If two residents have GI symptoms only and meet the outbreak definition as outlined in Section 9 (2 residents meeting GI case definition with onsets within 48 hours of each other) a call should be made to CEIR at that time to report a potential GI outbreak.

Contacting the Public Health Outbreak Team after site has reported initial cases or an Outbreak is declared

Report additional **Respiratory** Illness information to the Public Health Outbreak Team or for questions regarding an open respiratory illness outbreak:

- The Facility CDC Outbreak Daily Report Portal (Redcap) is the preferred method to report new positive lab reports and newly symptomatic HCW/staff or residents.
- If a site does not have access to the Facility CDC Outbreak Daily Report Portal (Redcap) they are to call the Intake line (instead of calling CEIR) to report newly symptomatic HCW/staff or residents and/or new positive lab results.
    - The Intake Line is to be used by all facilities in the North, Edmonton, Central and Calgary Zones for related Respiratory Illness
    - Intake Line 1-888-522-1919
    - If facilities in the South Zone do not have access to the Facility CDC Outbreak Daily Report Portal (Redcap) they are to report using Zone specific processes
    - GI illness is **NOT** reported using the Facility CDC Outbreak Daily Report Portal (Redcap)
- If site attempts to report subsequent symptomatic or positive case outside hours of operation, the notification should be completed the next day
- Report additional **Gastrointestinal** Illness information to Environmental Public Health. The EPH Outbreak Response Lead will provide the site the zone process for reporting subsequent symptomatic residents and/or staff along with zone specific line lists as applicable.

Section 1: Preparing for Potential Outbreaks

It is the responsibility of a facility to always be prepared for the possibility of a respiratory or GI outbreak. Each site should:

- Ensure staff have access to and are familiar with current AHS outbreak management guides.
- Review and update internal protocols and procedures for outbreak management as necessary, including symptoms that require investigation and reporting to the Public Health Outbreak Team (Table A), and case and outbreak definitions for:
  - COVID-19 (Table C)
  - Respiratory illness (RI) (Table D),
  - Influenza (Table E)
  - Gastrointestinal illness (GI) (Table F)
- Work with key site personnel to ensure adequate availability of supplies for outbreak management including on site specimen kits for respiratory and stool specimen collection.
- The baseline supply inventory that the site requires will depend on the resident/staff number, proximity to the ordering centre and timeframe for supply delivery. Please work with your owner/operator/administration to determine the baseline needed for the site.
- Review routine infection control practices and additional (outbreak management) precautions with staff.
- Ensure staff are aware to contact the AHS CEIR at 1-844-343-0971 when there are 2 symptomatic cases within 7 days in a congregate setting that do not already have an established outbreak.

Zone Outbreak Preparation Resources

- Refer to local Zone process to access the necessary resources for outbreak preparation
- Long Term Care (LTC) Facility living sites, Designated Supportive Living (DSL), Hospice and Non-designated Supportive Living sites may participate in annual outbreak training through zone specific invitations and processes in the fall.
- Appendix A contains samples of the documents that facilities may utilize in preparing for outbreak season.

Roles and Responsibilities for Outbreak Preparation

Note: Due to the complex nature of LTC/DSL/Hospice settings, staffing and resident populations, the individual fulfilling the roles and responsibilities within a site may vary from what is outlined below (e.g., some sites may combine the roles for IPC and WHS, or may have designated staff to fulfill these roles)

The Public Health Outbreak Team (MOH, CDC, EPH)

- Sets the standard of practice for communicable disease surveillance and notification in relation to outbreak investigation and management.
- Develops, maintains, and distributes provincial outbreak resources
- Provides annual outbreak training to appropriate groups

Infection Prevention and Control (Infection Control Professional and/or Infection Control Designate)
***Note**: In the absence of formal IPC or site ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS ICP.*

- Ensures that HCW/staff have access to and are familiar with current AHS outbreak management guide.
- Reviews and updates internal protocols and procedures for outbreak management as necessary, including review of case and outbreak definitions and reporting protocols. Refer to criteria for COVID-19, RI, Influenza and GI illness case definitions, and outbreak definitions as listed in Tables in Section 4 and symptoms to initiate testing as found in Table A of this guide.
- Working with key site personnel, ensures adequate availability of supplies needed for outbreak management including PPE, signage and having unexpired respiratory and stool kits on site for specimen collection as appropriate.
- Reviews routine infection control practices and additional (outbreak management) precautions with HCW/staff.

Facility Administration/Facility Management or their Designate

- Supports and encourages the annual seasonal influenza immunization and any recommended COVID-19 immunization of residents, HCW/staff, and volunteers.
    - Refer to Appendix A - Important Notice to Staff About Influenza and COVID-19
- Develops an influenza response plan that details how antiviral prophylaxis will be implemented for residents (e.g., standing orders) and for HCW/staff (as required).
- Develops a COVID-19 response plan that details how surveillance, isolation, testing, and immunization will be implemented for residents and for HCW/staff.
- Liaises with ICP/ICD to ensure facility/units have protocols and procedures for reporting cases of notifiable diseases and suspected outbreaks as per Section 26 of the *Public Health Act*
- Liaises with ICP/ICD or site infection control designate to ensure facility/units have access to a current copy of the AHS outbreak guide and that key HCW/staff (ICP/ICD, front line managers, supervisors, administration on-call, charge nurse, etc.) in the facility have contact information for reporting outbreaks to the Public Health Outbreak Team via CEIR.
- Ensures HCW/staff awareness of symptoms for reporting to CEIR as found in Table A

Site/Unit Manager/Designate

- If required, facilitates DSL residents' Most Responsible Health Practitioner to complete the prescription of advanced treatment for antiviral chemoprophylaxis for use in the event of a confirmed influenza outbreak. **Note**: in some sites, this is done in collaboration with external partners such as pharmacy.
- In preparation for influenza season, compiles a list of residents (include names, contact and

other pertinent information) to be used in the event of an outbreak for implementing antiviral prophylaxis see Appendix A.
- Liaises with AHS WHS or site OHS designate to ensure HCW have been N95 Respirator fit tested and can use appropriate PPE as dictated by the Point of Care Risk Assessment (PCRA).
- Ensures proper use and adequate supplies of PPE as per AHS Infection Prevention and Control guidelines for Continuing Care.
- Maintains ongoing surveillance and monitoring for unusual clusters of illness in residents and staff to facilitate early recognition of cases, and identification of a possible outbreak at the site.

Occupational Health/Workplace Health and Safety/Designate

***Note**: In the absence of formal AHS WHS or site OHS coverage, facility administration/manager designates responsibility for these roles.*

- Promotes and provides as appropriate, annual influenza immunization, COVID-19 immunization, and all other recommended immunizations for HCW/staff.
- Develops, reviews and updates internal protocols for management of HCW/staff during an outbreak, as necessary.
- Maintains documentation on HCW/staff health and vaccine status and provides the Site/Unit Manager with a list of HCW/staff with reported immunization.
- Assesses staff use of PPE and hand hygiene

Onsite Staff (staff hired directly by the site, contracted staff, AHS staff)

- Ensures they are familiar with current AHS outbreak guide.
- Ensures they are aware of the symptoms for reporting to CEIR as found in Table A, also COVID-19, RI, Influenza and GI illness case and outbreak definitions as found in Section 4 and reporting protocols.
- Ensures they are aware of the proper use of PPE as per AHS infection prevention and control guidelines and are aware to use the Point of Care Risk Assessment (PCRA) prior to resident interactions.

Section 2: Assessing a Potential Outbreak

2.1 Surveillance and Threshold for Investigation

All sites are responsible for conducting ongoing surveillance and monitoring for unusual clusters of illness in residents and staff. Surveillance takes place prior to, during and after outbreaks.

Sites are responsible for monitoring resident and staff illness in between outbreaks and investigations.

Surveillance Cases

Symptomatic individuals or confirmed cases which are considered indicators of a potential outbreak are called "surveillance cases." The criteria for resident and staff surveillance cases are found in Table A. An optional Surveillance Case Tracking Sheet that can be used by sites/facilities can be found in Attachment 2.1.

Surveillance Reporting Definition

The threshold to report a potential outbreak to CEIR is called the surveillance reporting definition. The Surveillance Reporting Definition can be found in Table A. This could include either:

- 2 residents with symptoms from Table A
- 1 resident with symptoms from Table A AND 1 HCW/staff who **worked** while symptomatic with symptoms from Table A
- 2 HCW/staff who **worked** while symptomatic with symptoms from Table A

Exception for GI illness among HCW/staff: If there is an unusual increase in GI illness amongst HCW/staff (above the baseline of what would be expected) whether they were present at work with symptoms or not it should be reported to CEIR as this could be an indicator of a potential GI outbreak.

Table A: Determining when to report to CEIR based on symptomatic staff and residents

Surveillance Case Definition		Surveillance Reporting Definition
Residents Residents will count towards the threshold to report to CEIR if they develop any of the following: • Fever (may not always be present in the elderly) • Nausea/vomiting/diarrhea Any new or worsening symptoms listed below: • Cough • Shortness of breath (SOB) • Sore throat • Runny nose/Nasal congestion • Loss of taste and/or loss of smell • Decrease in oxygen (O_2) saturation level or increased O_2 requirements	**HCW/Staff** HCW/Staff will count towards the threshold to report to CEIR if they are **present at work** with any of the following: • Fever • Nausea/vomiting/diarrhea Any new or worsening symptoms listed below: • Cough • Shortness of breath (SOB) • Sore throat • Runny nose/Nasal congestion • Loss of taste and/or loss of smell Note: Symptomatic HCW/Staff who are **not present at work** do not count as surveillance cases.	2 or more surveillance cases in a 7-day period with a common epidemiologic link☆ If the Surveillance Reporting Definition is met, site should call to CEIR to report a potential outbreak. *☆Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period.*

***Note**: Symptoms not listed in Table A may still be indications of illness and should be managed at the discretion of the care team for the individual experiencing the symptoms. However, symptoms not listed in Table A do not need to be reported to the Public Health Outbreak Team*

Exception for GI illness: If two residents have GI symptoms **only** and meet the outbreak definition as outlined in *Section 9* (2 residents meeting GI case definition with onsets within 48 hours of each other) a call should be made to CEIR at that time to report a potential GI outbreak.

Assessing HCW/Staff Illness

- Site HCW/staff and site operations/administration share a joint responsibility for controlling illness in a facility.
- Site HCW/staff should advise their manager or site operator if they develop symptoms while at work.
- Assessing HCW/staff illness is a site responsibility.
- Site operators/administration should develop an internal policy to capture and monitor if a HCW/staff member develops illness at work and should be counted as a surveillance case.
- The Public Health Outbreak Team involvement is not required unless the site meets the Surveillance Reporting Definition.

Exception for GI illness among HCW/staff: If there is an unusual increase in GI illness amongst HCW/staff (above the baseline of what would be expected) whether they were present at work with symptoms or not it should be reported to CEIR as this could be an indicator of a potential GI outbreak.

Scenarios which do not meet the Surveillance Reporting Definition

- A single resident with symptoms, a single HCW/staff who worked while symptomatic, or HCW/staff who developed symptoms but did not work while symptomatic do not meet the Surveillance Reporting Definition and do not need to be reported to CEIR. Sites must continue to monitor for ongoing illness. An optional Surveillance Case Tracking Sheet can be found in Attachment 2.1.
- NOTE: Although sites do not need to report to CEIR until the Surveillance Reporting Definition is met, the infection control strategies listed in Figure 2 should be immediately implemented for any resident with symptoms. Prompt implementation of the strategies listed in Figure 2 may help to limit illness from spreading at the site and prevent an outbreak.
- Sites should update supervisors/mangers of one symptomatic resident or HCW/staff such that they are aware that a Surveillance Case Tracking Sheet has been started. Sites should have an internal policy that dictates how the Surveillance Case Tracking Sheet (or a site-specific tool) is used to track symptomatic residents or HCW/staff and when the call needs to be made to CEIR.

Testing Prior to Meeting the Surveillance Reporting Definition

- No testing is required for the Public Health Outbreak Team purposes prior to a site meeting the Surveillance Reporting Definition.
- Sites should follow internal processes to obtain testing (COVID-19 and RPP) for medical management of symptomatic residents as required. Testing may be required to inform interventions such as Oseltamivir (Tamiflu) treatment for influenza cases or treatment for COVID-19 cases (such as Paxlovid, Remdesivir, Evusheld).
- Symptomatic HCW/staff are recommended to be tested by connecting with their primary care provider, WHS / OHS or an AHS assessment centre, or alternatively may complete a Rapid Antigen Test at home.
- The Public Health Outbreak Team and CEIR will provide support and guidance with testing once the Surveillance Reporting Definition has been met.

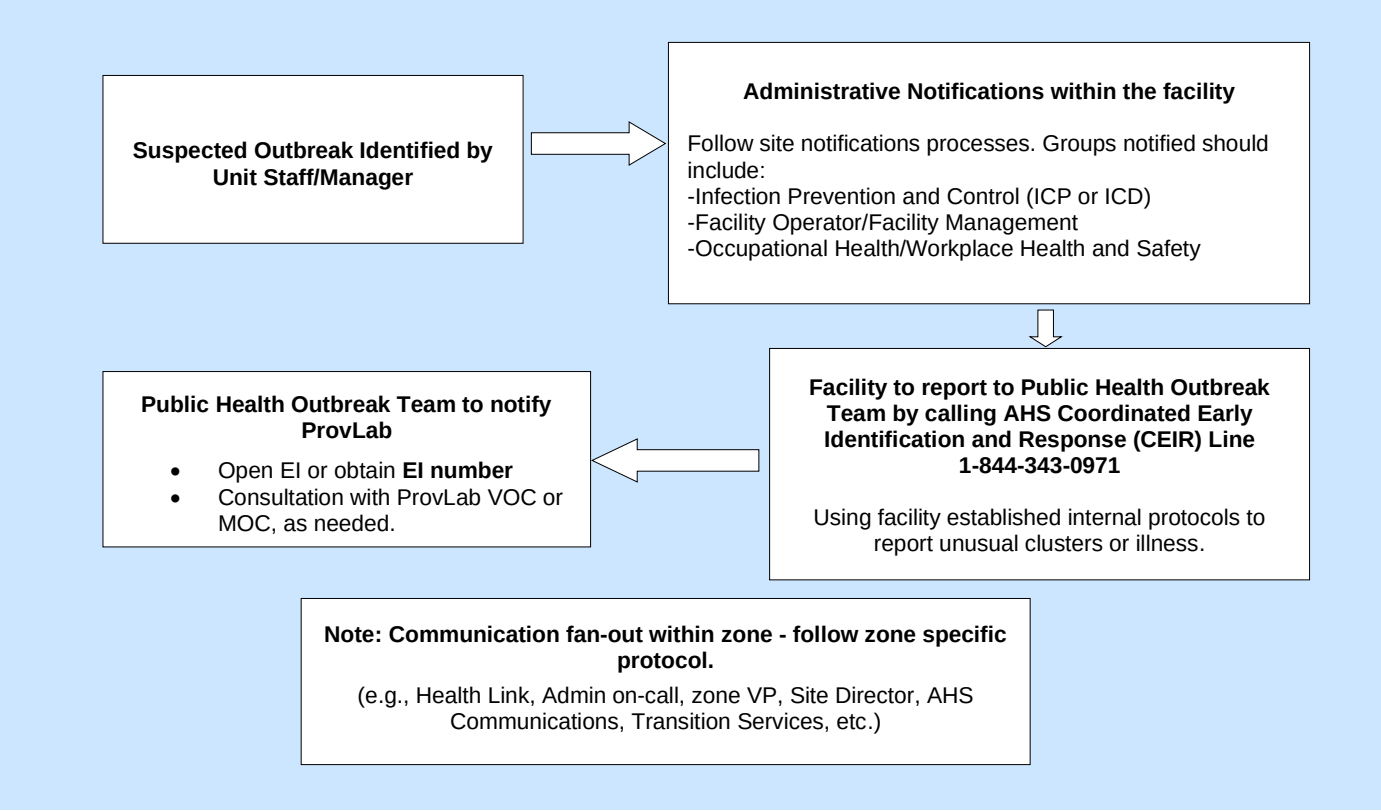
Resource - Symptoms? What Do I Do to Prevent a Potential Outbreak? (**Appendix B**)

- The Surveillance Reporting Definition directs sites to call when there are 2 surveillance cases at the site
- This resource has been developed to help facilities/sites manage symptomatic staff and residents before the Surveillance Reporting Definition is met (prior to calling CEIR).
- This resource could be printed and made available to the front-line staff for daily use.
- It provides the list of symptoms that a HCW/staff should be on the alert for, from Table A in the guide.
- It also provides a summary of the steps that should be taken if the symptomatic person is a resident or HCW/staff
- Communicate, who to tell when a resident and/or a HCW/staff is symptomatic is also outlined.

2.2 Reporting once the Surveillance Reporting Threshold is met

- Follow the established internal outbreak notification protocols to report residents and HCW/staff who display any of the symptoms listed in Table A. To connect with and report illness to the Public Health Outbreak Team, see section AHS Zone Public Health Outbreak Team Contacts (Regular and After Hours).
- Prompt reporting of a potential outbreak that meets the Surveillance Reporting Definition permits early identification and interventions to interrupt transmission of illness as soon as possible, reducing morbidity and mortality. Initial control measures, facilitation of testing and PPE recommendations will be provided.
- The Public Health Outbreak Team will follow up with sites after the CEIR notification is received and assess whether sites meet outbreak status. The Public Health Outbreak Team will be responsible for the decision to declare when an outbreak is to be opened.
- Follow internal protocols for site notification about residents that are being tested (e.g., to your IPC/ICD and WHS/OHS designate where available). Also follow the Public Health Outbreak Team instructions for collecting and reporting data if a confirmed outbreak is identified at your site (Figure 1).
- The information that sites must provide when reporting to CEIR is standardized. See Table B for a list of all information required.

Figure 1: Potential Outbreak Notification Algorithm*



**This document outlines outbreak reporting in most situations, but there may be variation within some Zones. It is recommended to periodically confirm outbreak reporting procedures within your Zone.*

Table B: Initial Data Required CEIR

Site Information:
Call Received:
Call Returned:
Confirmed Outbreak:
Call Redirected:
Caller Name:
Caller Phone Number:
Caller Email:
Zone:
City:
Site Type:
Is this an AHS Facility:
Site Name:
Site Manager Email:
Site Address:
Postal Code:
Site Phone Number:
Site Fax Number:
Number of Units in Site:
Names of the Unit:
How many residents reside on the unit of the case(s):
Are you able to keep residents to only that area for the duration of the outbreak?
How many staff work on the unit of case(s)?
Are you able to keep staff only to the area for the duration of the outbreak?
Manager Notified at the site?
Total number of residents at the site:
Total number of Staff working at the site:
Additional Notes about the site:
Number of Symptomatic Residents:
Number of Symptomatic Staff:
Do Staff work in multiple locations or on multiple units?
Any Hospitalizations?

2.3 Reporting Additional or Subsequent Cases to Public Health Outbreak Team

- After the site has made the initial report to CEIR, no further calls to CEIR are required. If the site has not received direction on whether they have a confirmed outbreak, any additional symptomatic residents, and HCW/staff, and/or positive cases (for respiratory illness) should be reported using the **Intake Line at 1-888-522-1919** (instead of calling CEIR).
    - If the Public Health Outbreak Team has provided the site with access to report additional symptomatic or positive residents through the Facility CDC Outbreak Daily Report Portal (Redcap), additional symptomatic residents may be reported here instead of reporting through the Intake Line.
- For South Zone, the intake line is NOT used to report additional cases of Illness. Zone specific processes are used.
- Report additional **Gastrointestinal** Illness information to Environmental Public Health. The EPH Outbreak Response Lead will provide the site the zone process for reporting subsequent symptomatic residents and/or staff along with zone specific line lists as applicable.

Roles and Responsibilities: Assessing for and Reporting Potential Outbreaks

Note: Due to the complex nature of LTC/DSL/Hospice settings, staffing and resident populations, the individual fulfilling the roles and responsibilities within a site may vary from what is outlined below (e.g., some sites may combine the roles or IPC and WHS, or may have designated staff to fulfill these roles)

The Public Health Outbreak Team (MOH, CDC, EPH)

- Provides consultation on suspected clusters of illness or outbreaks.
- Determines the need to initiate an outbreak investigation.
- Requests information from their designated contact at the Facility (e.g., site Administrator, IPC, ICD) to meet the Public Health Outbreak Team requirements for outbreak management.

Infection Prevention and Control (Infection Control Professional and/or Infection Control Designate)
***Note**: In the absence of formal IPC or site ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS ICP.*

- Acts as a resource for frontline HCW/staff to facilitate early recognition of possible outbreaks.
- Notifies the AHS CEIR line as soon as possible in the event of a suspected outbreak as per site process. See Figure 1. In facilities where there is no one assigned the role of IPC, the front line HCW/staff or manager at the outbreak unit/site notifies the AHS CEIR line.
- Obtains reports on the clinical status of all affected individuals and works with HCW/staff to identify new cases.

Facility Administration/Facility Management or their Designate

- Responsible for maintaining operations to provide optimal care and services for symptomatic residents.
- Notifies senior management within the site as indicated by internal protocols.
- Notifies IPC/ICD when an unusual cluster of illness is suspected. In facilities where there is no one assigned the role of IPC, contact the AHS CEIR line - see Figure 1.
- Directs the implementation of routine IPC measures immediately.
- Communicates resident assessment, monitoring, surveillance, and reporting to the Public Health Outbreak Team and IPC/ICD as appropriate.

Occupational Health/Workplace Health and Safety/Designate
***Note**: In the absence of formal AHS WHS or site OHS coverage, facility administration/manager designates responsibility for these roles.*

- Supports illness assessment and surveillance of HCW/staff from potential outbreak unit.
- Monitors and reports possible outbreak related HCW/staff illness.

Onsite Staff (staff hired directly by the site, contracted staff, AHS staff)

- Place symptomatic residents on appropriate precautions and ensure all signs and symptoms of resident illness are documented as per site standards
- Assesses that illness in symptomatic residents meets the reporting criteria in Table A.
- Notifies the AHS CEIR line promptly if assigned when the surveillance reporting definition has been met.
- Works collaboratively with all partners to ensure ongoing monitoring and surveillance at the site to identify new case defining illness in residents.
- Liaises with Most Responsible Health Practitioner and external partners, as necessary.
- Provides services to care and treat symptomatic residents in place as per Point of Care Risk Assessment (PCRA).

Attachment 2.1: Surveillance Case Tracking Sheet

Sites should update supervisors/mangers of one symptomatic resident or HCW/staff such that they are aware that a Surveillance Case Tracking Sheet has been started. Sites should have an internal policy that dictates how the Surveillance Case Tracking Sheet (or a site-specific tool) is used to track symptomatic residents or HCW/staff and when the call needs to be made to CEIR.

This resource can be printed and made available to the front-line staff for daily use. Please print copies directly from the web page online - [Outbreak Management | Alberta Health Services]

Alberta Health Services

Surveillance Case Tracking Sheet

Name ***(Last Name, First name)***	**Resident/ Staff**	**Onset of Symptoms** ***(dd-Mon-yyyy)***	**Symptoms**	**For Staff Cases - Date Worked While Symptomatic**
	☐ Resident ☐ Staff		☐ Fever ☐ Nausea/vomiting/diarrhea **Any new or worsening symptoms listed below:** ☐ Cough ☐ Shortness of breath (SOB) ☐ Sore throat ☐ Runny nose/nasal congestion ☐ Loss of taste and/or loss of smell ☐ Decrease in oxygen (O_2) saturation level or increased O_2 requirement	
	☐ Resident ☐ Staff		☐ Fever ☐ Nausea/vomiting/diarrhea **Any new or worsening symptoms listed below:** ☐ Cough ☐ Shortness of breath (SOB) ☐ Sore throat ☐ Runny nose/nasal congestion ☐ Loss of taste and/or loss of smell ☐ Decrease in oxygen (O_2) saturation level or increased O_2 requirement	
	☐ Resident ☐ Staff		☐ Fever ☐ Nausea/vomiting/diarrhea **Any new or worsening symptoms listed below:** ☐ Cough ☐ Shortness of breath (SOB) ☐ Sore throat ☐ Runny nose/nasal congestion ☐ Loss of taste and/or loss of smell ☐ Decrease in oxygen (O_2) saturation level or increased O_2 requirement	
	☐ Resident ☐ Staff		☐ Fever ☐ Nausea/vomiting/diarrhea **Any new or worsening symptoms listed below:** ☐ Cough ☐ Shortness of breath (SOB) ☐ Sore throat ☐ Runny nose/nasal congestion ☐ Loss of taste and/or loss of smell ☐ Decrease in oxygen (O_2) saturation level or increased O_2 requirement	
	☐ Resident ☐ Staff		☐ Fever ☐ Nausea/vomiting/diarrhea **Any new or worsening symptoms listed below:** ☐ Cough ☐ Shortness of breath (SOB) ☐ Sore throat ☐ Runny nose/nasal congestion ☐ Loss of taste and/or loss of smell ☐ Decrease in oxygen (O_2) saturation level or increased O_2 requirement	

This resource is intended to be used as part of the surveillance and assessment strategies outlined in the provincial outbreak Guides. Details can the found in the **Guide for Outbreak Prevention & Control in Non-Designated Supportive Living (NDSL) Sites** and the**Guide for Outbreak Prevention & Control in Long Term Care and Designated Supportive Living Sites**

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Section 3: Managing a Potential Outbreak

- Sites that have 2 or more surveillance cases and meet the Surveillance Reporting Definition listed in Table A, will receive further direction from CEIR.
- This direction will include information on IPC measures, specimen collection, and outbreak control strategies.
- The Public Health Outbreak Team will review the report from the site and will advise the site if they meet the Surveillance Reporting Definition and have a potential or confirmed outbreak.

Exception for GI illness: If two residents have GI symptoms only and meet the outbreak definition as outlined in Section 9 (2 residents meeting GI case definition with onsets within 48 hours of each other) a call should be made to CEIR at that time to report a potential GI outbreak.

Staff, IPC/ICD, and the Public Health Outbreak Team in congregate settings work collaboratively with facility administrators and HCW/staff to facilitate prompt response to help minimize the impact of the outbreak. For ongoing updates relevant to congregate settings, log in to Continuing Care Connection. **Note**: You will be required to register the first time you use the site.

3.1 Infection Prevention and Control Measures

- For even a single resident with symptoms in accordance with Table A the IPC Practices and Additional Precautions in Figure 2 shall be implemented immediately. Do not wait for the causative agent to be identified.
- Once the surveillance reporting definition has been met collect the appropriate sample:
    - Respiratory illness: all symptomatic residents should have a NP/throat swab collected to determine the causative agent.
    - Gastrointestinal illness: samples to be collected on the direction of the Public Health Outbreak Team
- Isolation of residents or HCW/staff with symptoms:
    - Symptomatic residents
        - Isolate immediately using additional precautions. Refer to Figure 2 or check the AHS website, IPC section for the most current recommendations.
        - Staff to wear appropriate PPE as determined by Point of Care Risk Assessment (PCRA)
        - Place signage outside the resident's room, near the door, alerting HCW/staff and visitors that the resident is symptomatic, and precautions are required
    - Symptomatic staff
        - Staff who develop any symptoms from Table A while at work must put on a mask, notify their supervisor/site contact, and go home as soon as possible.

Routine practices help prevent the spread of infection and reduce the possibility that HCW/staff will sustain accidental exposures to infectious organisms. Routine practices are used for every resident, every time regardless of their diagnosis or infectious status. Additional precautions such as droplet and contact precautions are determined and implemented based on presenting symptoms using the Point of Care Risk Assessment (PCRA).

- Strict hand hygiene is the most important measure in preventing spread of infections for both HCW/staff and residents.
    - Hand hygiene should be performed in accordance with the AHS Hand Hygiene Policy and Procedure that provides direction on product selection, location, and use.
    - Alcohol-based hand rubs containing a minimum of 60-90% alcohol are as effective as

soap and water when hands are not visibly dirty. They should be clearly labelled with a DIN or label claim as being effective and used prior to expiry date.

- Wash hands with soap and water when:
  - Hands are visibly dirty
  - Before and after handling food
  - After using the washroom
  - After removal of gloves
- Glove use is not a substitute for hand hygiene; hand washing is required after glove removal.
- Frequent hand hygiene should be performed by both HCW/staff and residents.

Figure 2: Routine Practices and Additional Precautions

Precautions for Respiratory Illness (including influenza and COVID-19) and GI Illness

All HCW/staff must conduct a Point of Care Risk Assessment (PCRA) prior to every resident interaction – check AHS website (search: 'infection control') for the most current recommendations.

Implement recommended precautions (Modified Respiratory Precautions and Droplet and Contact Precautions) when caring for symptomatic residents to control the spread of viruses.
(See AHS IPC website Precautions Posters at Posters | Alberta Health Services and Routine practices in Continuing Care for further information).

Resident Placement and Signage

- Single room preferred
- Maintain a distance of 2 metres between residents sharing a room use of physical barriers (curtains or portable wipeable screens) should be implemented as all times.

Mask

- Wear appropriate mask for any encounter, within two (2) metres, with a resident who has, or is suspected of having RI. Use the mask (surgical, KN95, N95) recommended by the PCRA.
    - N95 Respirator (fit-tested) - for aerosol generating medical procedures (AGMP) and residents on airborne precautions.
        - AGMPs are defined as any medical procedure that can induce the production of aerosols of various sizes, including droplet nuclei. See Aerosol Generating Medical Procedures.

Eye Protection

- When a mask or N95 respirator is worn, eye protection or face shields should be worn as indicated by the PCRA or additional precautions
- Personal (prescription) eyewear does not provide adequate protection

Gowns

- Gowns are used to protect clothing and forearms from contamination of droplets and from direct contact with residents or resident's environment

Gloves

- Wear clean non-sterile gloves for direct contact with resident or resident's environment and to protect from droplet exposure

Hand Hygiene (4 moments from AHS Hand Hygiene Policy)

- Before contact with a resident or resident's environment including but not limited to putting on (donning) personal protective equipment; before entering a resident's room; and, before providing resident care.
- Before a clean or aseptic procedure including but not limited to wound care; handling intravenous devices; handling food; or preparing medications.
- After exposure (or risk of exposure) to blood and/or body fluids including but not limited to when hands are visibly dirty, following removal of gloves.
- After contact with a resident or resident's environment including but not limited to removing (doffing) personal protective equipment, leaving a resident's environments and after handling resident care equipment.

Resident Care Equipment

- Dedicate to single resident or clean and disinfect after each use

Resident Transport

- Transport for essential purposes only
- Residents wear an appropriate mask during transport
- Notify receiving department that resident is on additional precautions.
  *If resident is confirmed to have a GI pathogen refer to Section 9 for further information

AHS PPE Donning and Doffing posters available at: COVID-19 Personal Protective Equipment (PPE) | Alberta Health Services

Visitors: Request visitors report to administration desk or nursing desk to discuss precautions before entering resident's room.

Environmental Services: change mop head, cloths, and cleaning solution after cleaning each room or bed space.

The Infection Prevention and Control in Continuing Care webpage has numerous additional resources.

3.2 Administrative Measures

- Ensure adequate availability of all supplies (e.g., hand hygiene products, PPE, linen, lab testing supplies) through notification of appropriate departments.
- Ensure HCW/staff are maintaining heightened surveillance to identify and report newly symptomatic residents as per Table A.
- Consult with the ICP/ICD or the Public Health Outbreak Team when making decisions about cohorting HCW/staff assignments. Cohorting is recommended where operationally feasible (i.e., symptomatic residents receiving treatments after asymptomatic residents, or having designated HCW/staff treat symptomatic clients). Consider:
    - Cohorting HCW/staff to affected areas if practical or assigning HCW/staff to care for asymptomatic residents before symptomatic residents
    - Minimizing movement of HCW/staff, students, or volunteers between floors/areas, especially if some areas are not affected
    - Cohorting residents with the same illness
    - Cohorting exposed asymptomatic residents

3.3 Resident Restrictions

***Note**: If necessary, consult with IPC/ICD for assistance with adapting resident activities*.

- Asymptomatic residents and those who are not a case are able to participate in daily activities.
- Symptomatic residents should remain in their rooms. Additional precautions are required when entering a symptomatic resident's room (See Figure 2).
    - If a symptomatic resident must leave their room, they should wear an appropriate mask (as tolerated).
- Symptomatic residents should not participate in group activities.
- During a potential outbreak, symptomatic residents should only receive treatment such as physiotherapy or occupational therapy in their rooms instead of a centralized area. They should wear an appropriate mask (as tolerated).
- Symptomatic residents will be allowed to attend medically necessary activities or appointments, and they should wear an appropriate mask (as tolerated). Ensure receiving facility/unit is notified of the potential outbreak so that appropriate precautions can be taken for the resident on arrival.
- If resident chooses not to wear a mask, HCW should review their PCRA and adjust PPE accordingly (e.g., apply modified respiratory precautions until a thorough symptom and risk factor history can be obtained).
- For symptomatic residents, if COVID-19 or influenza is suspected, see early treatment recommendations in Section 6.2 and Section 8.2 respectively.
- Additional considerations for accommodations that may be supported for safe movement of residents with dementia or cognitive impairment who are in isolation:
    - Support the resident to leave their room only in ways that minimize spread of infection (e.g., one-on-one support to the resident at all times when they are out of their room, putting on PPE, using hand sanitizer, avoiding others, and avoid touching surfaces, etc.); and
    - Minimize contact with the isolated resident (e.g., minimize the possibility of other residents going into that person's room) by offering additional activities and interventions for non-isolated residents in the unit.

3.4 Restrictions on Affected Unit/Site

- No restrictions would be implemented at this point in the investigation.

3.5 Admissions/Transfers from Acute Care Site to an LTC, DSL or Hospice Site

- No changes from usual practices would be implemented at this point in the investigation.

3.6 Transfers from an Outbreak LTC, DSL or Hospice Site to an Acute Care Site

- If a symptomatic resident requires transfer to an acute care site, the facility must notify the EMS* Dispatcher, the transport staff (EMS crew) and the receiving care facility that the resident is under investigation and appropriate PPE must be maintained.
  **In some communities, EMS Community Paramedics can provide immediate or scheduled medical supervision and treatments that are currently unavailable in the community setting. A referral is required to access this service.*

3.7 Group/Social Activities and Other Events

- Symptomatic residents should not participate in group or social activities.
- No other changes to group or social activities are required at this point in the investigation.

3.8 Nourishment Areas/Sharing of Food

- Symptomatic residents should receive meal service in their room.

3.9 Adult Day Programs in sites Operating Adult Day Programs (e.g., CHOICE/C3)

- No changes from usual practice would be recommended by the Public Health Outbreak Team at this time.

3.10 Visitors and Designated Family/Support Person(s) (DFSPs)

- Request that all visitors/DFSPs report to the reception/nursing desk before visiting residents.
- Visitors/DFSPs should be advised of potential risk of exposure if visiting a symptomatic resident.
- Symptomatic visitors/DFSPs should not visit.
- Recommend visitors/DFSPs wear a mask while at the facility due to potential outbreak.
- In extenuating circumstances, site will determine if visitation is permitted when a visitor/DFS is symptomatic.
- Advise visitors/DFSPs visiting symptomatic residents to wear PPE (e.g., gloves, gown, appropriate mask, eye protection) and to clean hands with alcohol-based hand rub before putting on and removing the PPE.
- Demonstrate for visitors/DFSPs how to utilize PPE appropriately.
- Request visitors/DFSPs to follow the directions of HCW/staff and Facility Administration.

Designated Family/Support Person(s)

- DFSPs are essential partners in the provision of safe, quality resident care.
- Facilities should support the presence of residents DFSPs while balancing the safety of all residents, DFSPs, visitors and HCW/staff.
- Follow the AHS Family Presence: Designated Family/Support Person and Visitor Access Policy (or for non-AHS sites follow site policy regarding DFSPs)
- DFSPs should not be restricted from visits, but limits may be required. Refer to AHS Managing Limits To Designated Family/Support Person and Visitor Access Policy (or for non-AHS sites follow site policy regarding limits for DFSP visits).

3.11 Volunteers

- Advise volunteers of the importance of hand hygiene and routine precaution protocols.
- Symptomatic volunteers should not visit the site.
- Volunteers should follow the same PPE recommendations as HCW/staff (see 3.12).

3.12 HCW/Staff Outbreak Control Measures (Including volunteers, students, and physicians)

- HCW/staff should monitor themselves for signs and symptoms of illness
- Symptomatic HCW/staff should not report to work. They are recommended to report to their manager/designate and to WHS/OHS (as applicable), as per internal protocol, of any

symptoms (whether related to workplace exposure or exposure in the community or home).

- HCW/staff who develops RI symptoms at work should perform respiratory hygiene practices (e.g., coughing into sleeve, using tissues, wearing an appropriate mask) and leave the workplace as soon as possible.
- HCW/staff who develops GI symptoms at work should perform hand hygiene and leave the workplace as soon as possible.
- Cohort or assign HCW/staff to care for asymptomatic residents before symptomatic residents wherever possible.
- Consider minimizing movement of HCW/staff, students, or volunteers between units/floors, especially if some units are not affected.
- If possible, during initial investigation, assign HCW/staff that have been immunized against influenza and COVID-19 to care for symptomatic residents.
- Ideally, HCW/staff assigned to housekeeping duties should not be involved in food preparation or food service during outbreaks. If this is not possible, ensure meticulous attention is paid to IPC practices, and consider completing any required food preparation before beginning housekeeping

3.13 Specimen Collection

- Ensure proper collection and labelling of appropriate specimens as directed by the Public Health Outbreak Team including using assigned EI number on all specimens. Make internal arrangements for transporting specimens to the lab. See ProvLab Respiratory Specimen Collection and Transport Guidance Attachment 3.1.
- The Public Health Outbreak Team will advise the site of what testing (e.g., COVID-19, Influenza, RPP) should be ordered when the outbreak is opened.

3.14 Enhanced Environmental Cleaning and Disinfection

- Clean and disinfect:
    - Common/public areas
        - At least once per day for low touch surfaces (e.g., shelves, benches, windowsills, message, or white boards, etc.),
        - a minimum of two times daily for high touch surfaces (e.g., doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote), care/treatment area, dining areas and lounges.
        - Immediately on any visibly dirty surfaces.
    - Use a “wipe twice” procedure (a 2-step process) to clean and then disinfect surfaces (i.e., wipe surfaces thoroughly to clean visible dirt then wipe again with a clean cloth saturated with disinfectant to disinfect) while observing the appropriate contact time.
    - Health care equipment (e.g., wheelchairs, walkers, lifts) should be cleaned and disinfected according to manufacturer’s instructions.
    - Any shared resident health care equipment (e.g., commodes, blood pressure cuffs, thermometers, lifts, bathtubs, showers, shared bathrooms) should be cleaned and disinfected after use and prior to use by a different resident.
    - All HCW/staff equipment (e.g., computer keyboards/mouse/carts and/or screens, medication carts, charting desks or tables, telephones, touch screens, chair arms) should be cleaned and disinfected at least twice daily and when visibly dirty.
    - Refer to manufacturer instructions for cleaning and disinfection procedures, including compatible cleaners and disinfectants.
- Areas that are not considered common/public areas (e.g., private offices administrative areas, etc.) do not require enhanced cleaning/disinfection.
- Operators of facilities may develop an approach to environmental cleaning and disinfection that includes their HCW/staff, service providers (e.g., home care), designated family/support persons and visitors.

- If the surface disinfectant product used has cleaning properties (detergent/disinfectant), it may be used for both steps. Follow manufacturer's directions for use.
- Use a disinfectant with a Drug Identification Number (DIN) and broad spectrum virucidal claim, or a specific virucidal claim against non-enveloped viruses and coronaviruses for enhanced general environmental cleaning.
- Be sure to use the appropriate precautions when using chemicals for cleaning and disinfecting. Consult the products Material Safety Data Sheets. Perform cleaning using the proper personal protective equipment (PPE). Follow correct donning and doffing of PPE.
    - Putting on (Donning) Personal Protective Equipment and Taking off (Doffing) Personal Protective Equipment (PPE) instructions on the AHS IPC.
- Upholstered furniture, rugs or carpets contaminated with bodily fluid (emesis or stool) are difficult to clean and disinfect properly. Consult manufacturer's instructions for the cleaning instructions. If none available, remove the item from the resident area and steam clean as soon as possible. Consider discarding items that cannot be appropriately cleaned/disinfected, when possible/appropriate.
- HCW/staff handling soiled laundry should wear gloves, and gowns if there is a risk of contaminating clothing.
- If the laundry machine has been used to clean laundry soiled with diarrhea or vomiting, a bleach cycle of the laundry machine should be run (without a load of laundry) before washing other laundry.

Specific information about environmental cleaning can be found on the AHS IPC website: Principles for Environmental Cleaning and Disinfection (albertahealthservices.ca) and Environmental Public Health.

Roles and Responsibilities for Managing a Potential Outbreak

Note: Due to the complex nature of LTC/DSL/Hospice settings, staffing and resident populations, the individual fulfilling the roles and responsibilities within a site may vary from what is outlined below (e.g., some sites may combine the roles or IPC and WHS, or may have designated staff to fulfill these roles)

The Public Health Outbreak Team (MOH, CDC, EPH)

- Facilitates laboratory testing by recommending type of specimen to be collected and testing required.
- Recommends best practice outbreak control measures to be implemented including admission/transfer status (open or restricted), immunization, chemoprophylaxis if appropriate, and management of HCW/staff.
- Reviews daily illness reporting received from site, monitors potential outbreak progress, and provides consultation to the site when appropriate.
- Tracks all outbreak samples. Obtains or opens an Exposure Investigation number (EI number) through the ProvLab for the tracking of all outbreaks related specimens and communicates the EI number to the site.

Infection Prevention and Control (Infection Control Professional and/or Infection Control Designate)
Note: In the absence of formal IPC or site ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS ICP.

- Provides IPC recommendations for site to implement to prevent further transmission.
- Directs the implementation of initial IPC measures immediately; does not wait until the etiology is confirmed.
- Obtains reports on the clinical status of all affected individuals and works with HCW/staff to identify new cases.
- Provides the Public Health Outbreak Team with status updates of relevant changes to the investigation such as additional cases, hospitalizations, or deaths. The Public Health Outbreak Team will provide the method on how this information should be reported
- Provides resident details to OHS/WHS for possible staff close contact identifications as required for outbreak management.
- In collaboration with the Public Health Outbreak Team, coordinates the collection of clinical specimens as appropriate and provides instruction on completion of requisitions, including the EI number. The **EI Number MUST** be put on all outbreak related specimens to facilitate tracking and reporting to the Public Health Outbreak Team and outbreak facility.
- Completes site reviews/audits as needed.

Facility Administration/Facility Management or their Designate

- Responsible for maintaining operations to provide optimal care and services for symptomatic residents.
- Collaborates with IPC/ICD and the Public Health Outbreak Team on control strategies.
- Works collaboratively with the Public Health Outbreak Team to disseminate information to HCW/staff, residents, students, other professions working in the facility that are not HCW, other departments and families, as needed.
- Communicates with HCW/staff, residents, families, volunteers, students, and visitors within the facility as appropriate.
- Consult OHS/WHS and/or IPC/ICD as needed.
- Communicates to appropriate stakeholders outside of the facility.
- Communicates resident assessment, monitoring, surveillance, and reporting to the Public

Health Outbreak Team and IPC/ICD.
- Collaborates with WHS/OHS designate to identify and report symptomatic HCW/staff to the Public Health Outbreak Team.
- Will act as a contact for HCW/staff calling in ill and advise not to attend work.
- Anticipates and provides adequate unit resources for potential outbreak management.
- Ensures proper collection of appropriate specimens as directed by the Public Health Outbreak Team, including using assigned EI number on all specimens, and makes own internal arrangements for transporting specimens to the lab.
- Maintains clear and consistent channels of communication within the potential outbreak site as per established zone practices.
- Ensures proper use and adequate supplies of PPE as per AHS infection prevention and control guidelines.

Occupational Health/Workplace Health and Safety/Designate

Note: In the absence of formal AHS WHS or site OHS coverage, facility administration/manager designates responsibility for these roles.

- Maintains close communication with Frontline Unit/Site Manager with respect to HCW/staff work restrictions/return to work assessments as applicable.
- Provides information to HCW/staff about work restrictions. See Section 6.12 for COVID-19 and Section 8.12 for Influenza specific recommendations.
- Follows recommendations as directed by the Public Health Outbreak Team and/or WHS/OHS department.
- Supports illness assessment and surveillance of HCW/staff from potential outbreak unit.
- Reports HCW/staff illness directly to the Public Health Outbreak Team or provides the information to site designate for the Public Health Outbreak Team reporting.
- Assesses for HCW/staff PPE breaches or hand hygiene breaches as appropriate

Onsite HCW/Staff (staff hired directly by the site, contracted staff, AHS staff)

- Works collaboratively to facilitate outbreak investigations and implement appropriate initial infection control measures immediately. It is not necessary to wait until the etiology is confirmed.
- Coordinates the collection of clinical specimens as appropriate, under the direction of the Public Health Outbreak Team.
- Works collaboratively to ensure ongoing monitoring and surveillance at the site to identify newly symptomatic illness in residents according to Table A
- Maintains clear and consistent channels of communication within the potential outbreak site as per established Zone practices.
- Liaises with Most Responsible Health Practitioner, as necessary.
- Provides services to care and treat residents in place as per Point of Care Risk Assessment (PCRA).

Alberta Precision Laboratory for Public Health (ProvLab)

- Designates laboratory contact (e.g., microbiologist or virologist) for each outbreak, as required.
- Assigns EI number to facilitate specimen tracking in cases where the Public Health Outbreak Team has not opened the EI independently.
- As required, provides consultation to the Public Health Outbreak Team on specimen type and testing appropriate for the outbreak, including genotyping.
- Provides specimen collection supplies, as required.
- Ensures the Public Health Outbreak Team and IPC/ICD (if noted on the requisition) receive timely results of potential outbreak specimens.
- Tracks all samples submitted under the EI number.

Attachment 3.1: ProvLab Specimen Collection Guidance

Check ProvLab Bulletins for most current information on specimen collection, testing, and interpretation of lab results.
Public Health Laboratory (ProvLab) or Forms & Requisitions | Alberta Health Services

Instructions and demonstrations for collection of various types of specimens, including nasopharyngeal swabs can be accessed through the AHS ProvLab website:
Education Resources | Alberta Health Services

The Laboratory Policy for Acceptance of Laboratory Samples, Test Directories, TDG and other collection information can be found on the AHS ProvLab website:
Laboratory Test Directory & Collection Information | Alberta Health Services

The Requisition must be completed to include:

- Resident's full name (first and last names)
- Resident Personal Health Number (PHN) or unique numerical assigned equivalent
- Resident demographics including date of birth (DOB), gender, address, phone number
- Most Responsible Health Practitioner name (full name), address/location
- Test orders clearly indicated, including body site and sample type, date, and time of collection
- Clinical history and other clinical information
- Facility name, and if applicable, unit
- EI number (assigned by CEIR/ ProvLab/the Public Health Outbreak Team)
- Fax number of outbreak facility/unit or ICP/ICD office
    - Results will be faxed to the outbreak facility/unit or ICP/ICD **when it is noted on the requisition**.

Nasopharyngeal (Np) and Throat Swab for Detection of Respiratory Infections

General Information**:**

- Unless otherwise directed by the Public Health Outbreak Team, symptomatic residents should be tested for both COVID-19 and RPP.
- The amount of virus is greatest in acute phase of illness, usually within the first 48-72 hours of symptom onset.
- NP swabs are the preferred specimens for respiratory virus testing.
    - If nasopharyngeal swabs are difficult to collect, throat swabs collected in viral transport media are acceptable alternatives for COVID testing. An RPP cannot be completed on a throat swab.
- Once an etiologic agent has been identified, follow the Public Health Outbreak Team direction on the type of testing required for subsequent symptomatic residents and HCW/staff as appropriate.

Stool Specimen Information
Stool specimen results do not typically impact outbreak management strategies for GI illness outbreaks. However, from a Public Health perspective it is valuable to collect stool specimens from cases during outbreaks to try and identify the etiology, if possible. Please note that norovirus cannot presently be isolated from vomitus, therefore the collection of vomitus specimens is not recommended for GI illness outbreak management.

A unique EI number is assigned to each specific outbreak. The Public Health Outbreak Team/CEIR will obtain an EI number from the ProvLab when a GI illness outbreak is reported. Stool specimens submitted without an EI number on the requisition will not be analyzed for norovirus; therefore, it is important that an EI number be obtained **prior to** collection of outbreak stool specimens. The typical turnaround time for norovirus PCR results from the ProvLab (i.e., time between receipt of the specimen at the lab and report of results) is 48 hours. Results are also available on Netcare within 48 hours. The Public Health Outbreak Team will report the result to the ICP/ICD/designate within one business day of receipt of results from the lab.

Procedures to collect stool specimens

- As directed by the Public Health Outbreak Team, collect stool specimens from residents that are acutely ill with diarrhea, preferably within 24-48 hours of onset of symptoms.
- Collect one stool specimen from up to 5 symptomatic residents per outbreak investigation (EI number), preferably during the acute phase of illness. This number of specimens is usually sufficient to determine the etiology of the outbreak.
- Collect stool in a specimen collection “hat” or other clean and dry receptacle (e.g., bed pan, margarine container).
- Do not mix stool with urine or water
- Place the stool in a clean dry specimen container by using a scoop from stool collection kit, or a disposable tongue depressor or plastic spoon, keeping the outside of the container clean. Fill the container with stool up to one third or at least one tablespoon full and discard the remaining stool. (Sterile container may include container from stool collection kit or sterile urine container).
- Screw the lid tightly to avoid leakage.
- Put the container with the stool into the plastic (biohazard) bag and seal the bag.
- Complete the ProvLab requisition form to include the EI# and the resident’s full first and last names; Personal Health Number (PHN) or unique numerical assigned equivalent; resident demographics to include date of birth (DOB), gender, address, phone number; physician full name and complete address/location; test orders clearly specified including body site and sample type; date and time of collection.
- Label the sample container with the EI number, resident’s full first and last names, PHN or unique numerical equivalent, and date of sample collection.
- Keep stool specimens in the fridge (not the freezer) until ready for transport.
- Batch specimens together and transport to the ProvLab within 24 hours.
- If one or more of these samples are positive and an etiological agent has been identified, then further specimens should not be collected unless advised by the Public Health Outbreak Team. If additional specimens are received under the same EI# at some later period, these will not be tested unless the Public Health Outbreak Team has contacted the ProvLab point person for the EI number (e.g., MOC/VOC/Designate).
- If all batched samples received have been tested and if all are negative for a particular EI number, additional samples will not be tested unless there is consultation between the Public Health Outbreak Team and the ProvLab.
- The Public Health Outbreak Team will contact the ProvLab if the clinical situation for the outbreak has changed and additional testing needs to be done.

Specimen Transport:

- Sites must collect specimens as directed by the Public Health Outbreak Team and make their own arrangement for delivery to the laboratory.
- Follow current Alberta Precision Laboratory for Public Health standards for transporting specimens at Laboratory Test Directory & Collection Information | Alberta Health Services.
- AHS managers and staff can access WHS – Transportation of Dangerous Goods (TDG)

modules on My Learning Link for more information regarding safe specimen transport. If staff member does not have access to My Learning Link connect with manager to determine where this learning can be accessed.

The EI number must be included on each requisition so that specimens receive appropriate testing.

Rural facilities to transport lab specimens to ProvLab as directed by the Public Health Outbreak Team or by the fastest means possible.

Section 4: Outbreak Definitions and Determining Outbreak Type

Once specimen results are available, or if HCW/staff or residents decline testing, a decision can be made on whether the site has met an outbreak definition, and the type of outbreak occurring. Both the symptoms of the ill residents or HCW/staff and the specimen results are used in combination to determine the outbreak type.

Table C: COVID-19 Illness

COVID-19 Illness Case Definition	COVID-19 Illness Outbreak Definition
A person with laboratory confirmation of infection with the virus (SARS-CoV-2) that causes COVID-19 by: • A positive result on a molecular test (i.e., Nucleic acid amplification test (NAAT's) such as polymerase chain reaction (PCR)), loop-mediated isothermal amplification (LAMP) or rapid molecular test) that is Health Canada approved or approved by the lab accreditation body of the jurisdiction in which the test was performed OR • A positive result on a Health Canada approved rapid/point-of-care (POC) antigen test in a person with clinical illness (any one or more of the following: new or worsening cough, shortness of breath (SOB), sore throat, loss or altered sense of taste/smell, runny nose/nasal congestion, fever/chills, fatigue (significant and unusual), muscle ache/joint pain, headache, nausea/diarrhea) OR ▪ Two positive results on a Health Canada approved rapid/POC antigen test completed not less than 24 hours of each other in an asymptomatic person	2 or more confirmed COVID-19 cases in residents and/or HCW/staff who worked while symptomatic within a 7-day period, with a common epidemiological link☆ *☆Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period*

Table D: Respiratory illness (RI)

RI Case Definition	RI Outbreak (RIO) Definition
New onset of respiratory illness with TWO or more symptoms below, at least ONE of which MUST be respiratory: RESPIRATORY / OTHER Cough / Fever[1] Shortness of breath / Fatigue (significant and unusual) Sore Throat / Muscle ache/Joint Pain Loss of Sense of Taste/Smell / Headache Nasal Congestion/Runny Nose[2] / Nausea[2]/ Diarrhea[2]	2 or more cases of RI in residents within a 7-day period, with a common epidemiological link☆ AND No respiratory pathogen identified OR one case of any respiratory pathogen identified (e.g., Influenza; COVID-19; RSV) *☆Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period*

[1] Fever may not be present in elderly individuals.

[2] When symptomatic residents present with gastrointestinal symptoms (nausea, diarrhea) and report runny nose as their only respiratory symptom, these cases should be considered gastrointestinal illness cases and a GI outbreak investigation should be initiated if GI outbreak reporting criteria are met.

Table E: Influenza Illness

Influenza Illness Case Definition	Influenza Illness Outbreak Definition
A person with clinically compatible symptoms and laboratory confirmation of infection with seasonal influenza virus by: • detection of influenza RNA (e.g., real-time polymerase chain reaction [Rt-PCR]) OR • demonstration of influenza virus antigen in an appropriate clinical specimen OR • significant rise (e.g., fourfold, or greater) in influenza IgG titre between acute and convalescent sera OR • isolation of influenza virus from an appropriate clinical specimen	2 or more confirmed influenza cases in residents within a 7-day period, with a common epidemiological link☆ AND No respiratory pathogen identified OR one case of any respiratory pathogen identified (e.g., COVID-19; RSV) ☆*Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period*

Table F: Gastrointestinal Illness

Gastrointestinal (GI) Illness Case Definition	GI Illness Outbreak Definition
At least ONE of the following criteria must be met and not be attributed to another cause (e.g., *Clostridioides difficile* diarrhea, medication, laxatives, diet, or prior medical condition): • 2 or more episodes of diarrhea (i.e., loose, or watery stools) in a 24-hour period, above what is normally expected for that individual OR • 2 or more episodes of vomiting in a 24-hour period OR • 1 or more episodes of vomiting **AND** diarrhea in a 24-hour period OR • 1 episode of bloody diarrhea OR • Laboratory confirmation of a known enteric pathogen AND at least one symptom compatible with a GI infection e.g., nausea, vomiting, diarrhea, abdominal pain, or tenderness	2 or more cases (with initial onset within one 48-hour period) of GI illness with a common epidemiological link☆ ☆*Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period*

A mixed respiratory pathogen outbreak could result when a combination of lab positive respiratory pathogens/viruses are identified in a facility.

The Public Health Outbreak Team will advise which recommendations are applied where there is a mixed pathogen outbreak. The general principle of applying the more protective recommendation will be followed.

Section 5: General Recommendations for Confirmed Outbreaks

The strategies outlined in this section are to be implemented for any sites with a confirmed outbreak, regardless of the outbreak type. **The strategies outlined below would be implemented in addition to any strategies outlined in** Section 3. Additional strategies, specific to the type of outbreak, are discussed in subsequent sections. See Section 9 for GI specific illness.

Note: At the time this guide is written GI Outbreak will not utilize the Risk Assessment Worksheet and/or the Risk Assessment Matrix.

The Public Health Outbreak Team may choose to recommend outbreak measures that are not discussed in this guide if the outbreak situation warrants additional measures.

5.1 Infection Prevention and Control Measures

- Maintain all measures discussed in previous section. See Infection Prevention and Control Measures Section 3.1

5.2 Administrative Measures

- Notify appropriate HCW/staff/departments within the site/facility as indicated by internal protocols (e.g., administration, OHS/WHS, IPC, pharmacy). This includes identifying any other professions working in the facility/on the outbreak unit that are not HCW (e.g., construction workers) and consulting with the Public Health Outbreak Team regarding appropriate recommendations for these groups.
- Ensure adequate availability of all supplies through notification of appropriate departments.
- Notify Laundry Services and Distribution Services of the increased need for supplies.
- Ensure that HCW/staff (e.g., nursing, allied health, food services, environmental services, pastoral) are advised of relevant recommendations and work restrictions.
- Ensure that outbreak signage Attachment 5.1 has been posted at the entrance of the facility/unit advising HCW/staff, other professions working in the facility that are not HCW, and visitors of necessary precautions.
- **Once the outbreak is declared, daily reporting of cases to the Public Health Outbreak Team** (and to IPC as per Zone requirement) is required.
    - The facility will use the Facility CDC Outbreak Daily Report Portal (RedCap) (Attachment 5.2) to report respiratory illness for both HCW/staff and residents.
    - The facility will use the data collection for GI illness (Attachment 9.1) or a zone-specific line list, as appropriate to report GI illness for both HCW/staff and residents.
        - Facilities should NOT use the Facility CDC Outbreak Daily Report Portal (RedCap) for reporting GI illness to the EPH team.
    - The Public Health Outbreak Team will provide direction on how to submit case data and data on case updates (such as hospitalizations and deaths).
- Residents requesting a pass to leave a site/facility may do so if the resident is asymptomatic. Residents should be advised that if they become symptomatic while away from their site/facility, they should contact their site/facility to request further direction before returning and seek medical attention if required
- Inform residents' families/guardians/agent of facility outbreak status.
- The Public Health Outbreak Team uses a variety of strategies to help control and manage the outbreak.
    - Outside of the infection prevention and control measures outlined in Section 3.1 other strategies that will be recommended by the Public Health Outbreak Team include:
        - Continuous masking for all HCW/staff
        - Continuous eye protection for all HCW/staff

        - Masking for all visitors and DFSPs
        - Cancelling high risk activities e.g., singing, bus outing and large group activities
        - Residents to wear masks and practice physical distancing during low-risk activities (e.g., playing cards, participating in an activity or craft) during the outbreak
    - Additional measures maybe recommended at the discretion of the Public Health Outbreak team including but not limited to:
        - Physical distancing in communal dining area
        - HCW/staff active screening for symptoms prior to each shift during the outbreak
        - Active screening of visitors and DFSPs prior to entering the facility or visiting residents during the outbreak
        - Resident health screening upon return from absence
        - Masking for unvaccinated residents upon return from absence
        - Quarantine and or active screening for residents' admissions upon return from other health settings if that other site is on outbreak
        - During a COVID-19 outbreak close contact identification and management of residents or HCW/staff may be implemented to control the outbreak

5.3 Resident Restrictions

- Maintain all measures discussed in Section 3.3 including isolation of symptomatic residents and additional precautions.
- Symptomatic residents will be allowed to attend medically necessary activities or appointments, they should wear an appropriate mask (as tolerated). Ensure transport staff and the receiving facility/unit is notified of the outbreak so that appropriate precautions can be taken for the resident on arrival. Virtual visits should be arranged when possible
- Symptomatic residents should avoid contact with other residents.

5.4 Restrictions to Admissions / Transfers / Discharges on Affected Units/Site

- The facility / unit's ability to accept admissions / transfers / discharges (e.g., whether the unit is open or restricted) will be determined by the Public Health Outbreak Team at the time the outbreak is declared.
    - Consult the Public Health Outbreak Team when issues pertaining to admission, discharge and transfers arise during an outbreak.
- If the Public Health Outbreak Team advises that the facility / unit status is "open," then admissions, transfers, and discharges may proceed following usual non-outbreak processes.
- The Public Health Outbreak Team may determine that the facility / unit is "restricted." This means that admissions (including new admissions to the outbreak affected unit/site), transfers (including transfers from the affected unit/site to a different site), and discharges should be paused or delayed while these restrictions are in place. However, implementation may not be possible or recommended due to resident circumstances or operational need (including bed pressures). If a site with restrictions believes that an admission, transfer, or discharge should proceed despite restrictions, sites should complete a Risk Assessment Worksheet and follow the Risk Assessment Matrix as appropriate per zone policy.
- The scope of unit restrictions is typically dependent on the extent of the outbreak activity within the facility (one unit, one floor, one wing or the entire facility), the ability to cohort HCW/staff to affected areas, and severity of the outbreak (e.g., many residents and HCW/staff affected, new cases continue to develop despite implemented control measures).

Restrictions regarding resident admissions/re-admissions/transfer and activities are ONLY modified or lifted by the Public Health Outbreak Team. In the event that restriction to admissions/transfers is unduly impacting the availability of acute care beds for individuals requiring urgent care, or because of the expressed informed individual resident or family choice in keeping with AHS's commitment to People Centered Care, the Public Health Outbreak Team will assess the circumstances surrounding the restriction, including the degree of risk to the full spectrum of individuals requiring care.

5.5 Admissions/Transfers from Acute Care to an Outbreak LTC, DSL or Hospice Site

- For residents who were hospitalized prior to the outbreak, or who were hospitalized during an outbreak for an unrelated condition (e.g., fracture), their ability to return to the site will depend on the status of any restrictions applied to the DSL/LTC/Hospice site. See Section 5.4 above, for more details.
    - If the outbreak DSL/LTC site is "open," then the resident can return to their site
    - If the outbreak DSL/LTC site is "restricted," sites should complete a Risk Assessment Worksheet and follow the Risk Assessment Matrix
- If a resident was hospitalized due to illness from the outbreak pathogen, they may return to their home site immediately upon discharge. The need for isolation should be assessed based on the resident status at the time of return to the site.

5.6 Transfers from an Outbreak LTC, DSL or Hospice site to an Acute Care Site

- If a resident requires acute medical attention or treatment off site (e.g., emergency room, urgent care, dialysis), the outbreak LTC, DSL or Hospice site should notify the EMS Dispatcher or the transport staff, and the receiving care facility that the resident is being transferred from a LTC site experiencing an outbreak. The transport staff and the facility receiving the resident can then ensure the appropriate precautions are in place when the resident arrives at the hospital/treatment centre. If tolerated, symptomatic residents should wear an appropriate mask during transfer.

5.7 Group/Social Activities and Non-Resident Events

- Symptomatic residents are not permitted to participate in group/social activities.
- Consult the Public Health Outbreak Team for recommendations on whether routine group activities may continue for asymptomatic residents.
- For respiratory illness outbreaks, outbreak measures (such as physical distancing, masking, hand hygiene, enhanced surveillance, etc.) may be used for low-risk group activities (e.g., art class, bingo, card games). These activities may continue at the discretion of the facility in consultation with the Public Health Outbreak Team.
- High risk group activities (e.g., singing, bus outing and large group activities) should be postponed.
- During GI outbreaks, all group activities should be postponed (Section 9.7).
- Essential medical treatment activities including but not limited to rehabilitation, physical or group therapy should be facilitated by the site whenever possible with appropriate precautions in place.
- It is recommended that non-resident events previously booked for areas in the outbreak DSL/LTC/Hospice site (e.g., meetings) be cancelled/postponed.

5.8 Nourishment Areas/Sharing of Food

- Symptomatic residents should have meals in their rooms
- The Public Health Outbreak Team will provide direction on any modifications, which may include:

  - Close buffet lines, or, have staff dispense foods from the buffet onto plates for residents
  - Cease Family-style meal service
  - Pre-set the tables in common dining areas to minimize resident handling of multiple sets of cutlery
  - Remove shared food containers from dining areas (e.g., shared pitchers of water, shared coffee cream dispensers, salt & pepper shakers, etc.)
  - For snack programs, dispense snacks directly to residents and use pre-packaged snacks only
  - If using single service packets of condiments, provide packet directly to each resident, rather than self-serve in a bulk container
  - Cease activities involving resident participation in food preparation
- Use of disposable plates and cutlery by symptomatic residents is not required.
- Close the kitchen/nourishment areas accessed by residents/visitors and ensure there is no communal sharing of food in outbreak areas.

5.9 Adult Day Programs in sites Operating Adult Day Programs (e.g., CHOICE/C3)

- If the outbreak facility operates an Adult Day Program, discuss continuance or stopping of this activity with the OMT/Public Health Outbreak Team.
- Generally, the Public Health Outbreak Team will recommend that Adult Day Programs continue to operate in a facility with an ongoing outbreak if:
  - The Adult Day Program is operating in an area physically separate from areas of the facility in which there have been resident cases with symptoms.
  - Residents attending the Adult Day Program do not socialize with the residents from the outbreak facility.
  - Adult Day Program HCW/staff do not provide care in the areas of the facility in which there have been outbreak cases.

5.10 Visitors and Designated Family/Support Person(s)

- Post outbreak signage Attachment 5.1 at the entrance(s) of the facility/unit advising HCW/staff and visitors of necessary precautions.
- Encourage visitors to postpone visiting if possible. Visitors who choose to visit should be advised of potential risk of exposure to practice good hand hygiene and limit visit to one (1) resident and exit the facility immediately after the visit.
- Visitation restrictions may be recommended by the Public Health Outbreak Team, depending upon the type of Outbreak confirmed (see additional details in the syndrome or pathogen specific sections that follow).
- A facility/unit may make an operational decision to implement visitation restrictions even if visitation restrictions are not recommended by the Public Health Outbreak Team. However, the facility/unit should consult with the Public Health Outbreak Team prior to implementing this operational decision and should consider the impact of the decision on resident and family well-being.
- If visitation restrictions are recommended by the Public Health Outbreak Team, exceptions may still be considered under certain circumstances (e.g., if a resident is receiving end of life care).
- Refer to Section 3.10 - Visitors and Designated Family/Support Persons

5.11 Volunteers

- Advise volunteers of the potential risk of acquiring illness during outbreaks.
- Have volunteers who continue to assist during an outbreak follow the same control measures as HCW/staff (Section 5.12 below).

5.12 HCW/Staff Outbreak Measures (including volunteers, students, physicians)

- It is recommended that HCW/staff who work in more than one facility/unit inform any additional facilities or units where they work that an outbreak is in progress to determine whether they are permitted to continue to work in all settings.
- Symptomatic HCW/staff should not attend work.
- Specific recommendations for HCW/staff work restrictions during a confirmed influenza outbreak are found in Section 8

5.13 Specimen Collection

- Ensure proper collection and labelling of appropriate specimens as directed by the Public Health Outbreak Team including using assigned EI number on all specimens. Make own internal arrangements for transporting specimens to the lab. See ProvLab Respiratory Specimen Collection and Transport Guidance Attachment 3.1.
- The Public Health Outbreak Team will provide direction on testing of subsequent cases.
- Outside of site-directed rapid testing programs, asymptomatic testing is NOT required unless directed by the Public Health Outbreak Team.

5.14 Enhanced Environmental Cleaning and Disinfection

- Maintain all measures discussed in Section 3.14 Enhanced Environmental Cleaning and Disinfection

Roles and Responsibilities for Confirmed Outbreaks

Note: Due to the complex nature of LTC/DSL/Hospice settings, staffing and resident populations, the individual fulfilling the roles and responsibilities within a site may vary from what is outlined below (e.g., some sites may combine the roles or IPC and WHS, or may have designated staff to fulfill these roles)

The Public Health Outbreak Team (MOH, CDC, EPH)

- Provides direction on outbreak management, including infection prevention and control measures, management of residents, management of HCW/staff, and restrictions.
- Provides direction on the need for ongoing specimen collection (if applicable)
- Reinforces the need to maintain outbreak control measures and infection control practices as outlined in Section 3.
- Sends out outbreak notifications and alerts as appropriate; and if relevant posts provincial and national Public Health alerts on Canadian Network for Public Health Intelligence (CNPHI).
- Reports outbreak to Alberta Health (AH), and to AHS Senior Public Health Executive (as established within Zone protocol).
- Reviews daily outbreak data received from outbreak site, monitors outbreak progress and provides consultation to the outbreak site when appropriate. The Public Health Outbreak Team should consider sharing timely outbreak status reports with Acute Care, Non-Designated Supportive Living, DSL, and/or LTC partners in their Zone (including AHS and contracted operators), as appropriate. It must be ensured that any shared reports comply with AHS corporate policies for collection, access, use, retention, and disclosure of personal and health information under the care and control of AHS.
- Responds to media inquiries in consultation with AHS Communications Media Advisor.
- Tracks all outbreak samples.
- Participates in OMT meetings.

Infection Prevention and Control (Infection Control Professional and/or Infection Control Designate)

***Note**: In the absence of formal IPC or site ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS ICP.*

- Directs the implementation of additional outbreak control strategies as indicated according to the type and scope of the outbreak, including prophylaxis if recommended by the MOH, in consultation with site Medical Lead.
- Notifies appropriate HCW/staff within the facility of outbreak as indicated by internal protocols (e.g., administration, medical director, pharmacy, etc.).
- Obtains reports on the clinical status of all affected individuals and works with HCW/staff to identify new cases.
- Provides the Public Health Outbreak Team with status updates of outbreaks within their facility, including relevant immunization status of residents.
- Completes or delegates daily submission of accurate and updated illness data related to the outbreak. The Public Health Outbreak Team will advise IPC, at the time of the outbreak, how daily illness data will be submitted to the Public Health Outbreak Team. See below:
  - Facility CDC Outbreak Daily Report Portal (RedCap) Attachment 5.2
  - Data collection for GI illness Attachment 9.1
- Participates in OMT meetings.
- Follows the Public Health Outbreak Team direction regarding the need for additional or subsequent specimens. The **EI Number MUST** be put on all outbreak related specimens to facilitate tracking and reporting to the Public Health Outbreak Team and outbreak facility.

Facility Administration/Facility Management or their Designate

- Responsible for maintaining operations to provide optimal care and services for residents during an outbreak.
- Collaborates with IPC/ICD and the Public Health Outbreak Team to implement outbreak management strategies.
- Works collaboratively with the Public Health Outbreak Team to disseminate information to HCW/staff, residents, students, other individuals working in the facility that are not HCW/staff, other departments, and families, as needed.
- Communicates with HCW/staff, residents, families, volunteers, students, and visitors within the facility as appropriate.
- Consult OHS/WHS and/or IPC/ICD as needed.
- Participates on OMT as appropriate.
- Consults with the Public Health Outbreak Team on issues pertaining to admission, discharge, and transfers during an outbreak.
- Notifies senior management within the site as indicated by internal protocols.
- Communicates to appropriate stakeholders outside of the facility.
- Complies with unit/facility restrictions as recommended by the Public Health Outbreak Team.
- Ensures outbreak control strategies are maintained until the outbreak is declared over.

Site/Unit Manager/Designate

- Is the single point of contact for HCW/staff calling in/reporting illness/symptoms.
- Anticipates and provides adequate resources for outbreak management.
- Ensures proper collection of additional or subsequent specimens as directed by the Public Health Outbreak Team, including using assigned EI number on all specimens, and makes own internal arrangements for transporting specimens to the lab.
- Communicates outbreak status to other programs that may be impacted by the Outbreak (i.e., Adult Day Programs, Child care programs or any other programs that operate within the facility that might be impacted by the outbreak).
- Participates on OMT as appropriate

Occupational Health/Workplace Health and Safety/Designate

***Note**: In the absence of formal AHS WHS or site OHS coverage, facility administration/manager designates responsibility for these roles.*

- Maintains close communication with Frontline Unit/Site Manager with respect to HCW/staff work restrictions/return to work assessments.
- Assesses HCW/staff suitability for return to work.
- Provides information to HCW/staff about work restrictions. The specific restrictions will be based upon the type of outbreak – see pathogen and syndrome specific sections which follow.
- Follows recommendations from OMT, as directed by the Public Health Outbreak Team and/or WHS/OHS.
- Supports illness assessment and surveillance of HCW/staff from outbreak unit.
- Identifies HCW/staff who may be at risk of exposure and infection (e.g., unimmunized).
- Participates in OMT meetings.
- Assesses for HCW/staff PPE breaches or hand hygiene breaches as required.

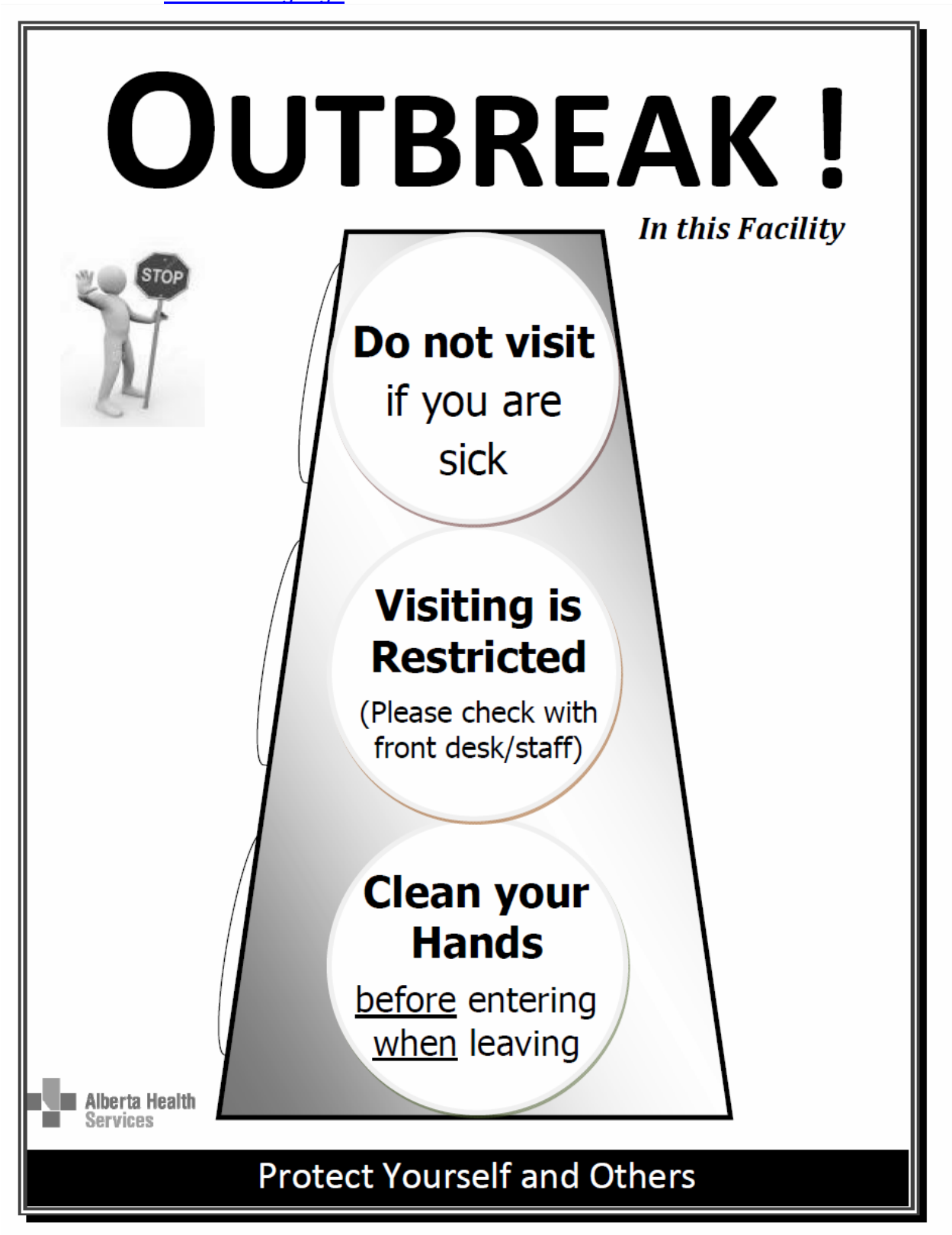
Onsite HCW/Staff (hired directly by the site; contracted HCW/staff, AHS HCW/staff)

- Works collaboratively to ensure ongoing monitoring and surveillance at the site to identify newly symptomatic illness in residents according to Table A
- Facilitates implementing outbreak control strategies as indicated in this document.
- Coordinates the collection of clinical specimens as appropriate, under the direction of the Public

Health Outbreak Team.
- May participate in OMT meetings.
- Works collaboratively to ensure ongoing monitoring and surveillance at the site to identify new symptomatic residents.
- Works collaboratively to provide the Public Health Outbreak Team with daily status updates on the outbreak. The Public Health Outbreak Team will advise, at the time of the outbreak, how daily illness data will be submitted to the Public Health Outbreak Team. Attachment 5.2 is a data tool for respiratory illness and Attachment 9.1 or a zone-specific line list as appropriate will be used for GI illness.
- Maintains clear and consistent channels of communication within the outbreak site as per established Zone practices.
- Liaises with Most Responsible Health Practitioner, as necessary.
- Provides services to care and treat residents in place as per Point of Care Risk Assessment (PCRA).
- Authorizes additional professional and support services, as needed, to manage the outbreak. This may include such things as: assessment/monitoring of symptomatic residents, laundry, bathing, meal tray delivery and environmental cleaning).
- Communicates outbreak status to other programs that may be impacted by the Outbreak (i.e., Adult Day Programs, Childcare programs or any other programs that operate within the facility that might be impacted by the outbreak).
- Reports PPE breaches or hand hygiene breaches to supervisor or Occupational Health/ Workplace Health and Safety as appropriate

Alberta Precision Laboratory for Public Health (ProvLab)
- Ensures the Public Health Outbreak Team and IPC/ICD (if noted on the requisition) receive timely results of outbreak specimens.
- Tracks all outbreak samples.

Attachment 5.1: Outbreak Signage



OUTBREAK !

In this Facility

Do not visit if you are sick

Visiting is Restricted

Please check with front desk or staff

Clean your Hands

before entering
when leaving

Alberta Health Services

Protect Yourself and Others

Attachment 5.2: Facility CDC Outbreak Daily Report Portal (RedCap)

Site Under Investigation / Confirmed Outbreak
Facility CDC Outbreak Daily Report Portal (RedCap) Email Template

Hello,

As discussed, Site Name is under investigation for a potential outbreak / has a confirmed outbreak of [pathogen]. You are required to submit daily notification, by 10:00 AM, of the following to the Public Health Outbreak Team for reporting purposes:

- Report if no new cases in staff or residents in the past 24 hours
- Newly symptomatic residents
- Newly symptomatic staff (includes contracted staff)
- Newly positive lab results (including positive Rapid Antigen Tests)
- Report new hospitalizations or deaths due to the illness in residents or staff, including those previously reported as only symptomatic
    - Include any death that occurs within 30 days of the positive lab
    - Include any death that occurs greater than 30 days from the positive lab AND COVID is attributed as a primary or secondary cause of death

The submission will now be completed electronically through the online portal at: https://redcap.link/FacilityCDCOutbreakReport2022

You must enter the EI number for your site with each entry and provide it when you call, so be sure to have this information with you. Your EI is: 202X-EI-XXXXX

The portal will require the following information:

- Demographic information name, DOB, ULI/PHN for resident and name; DOB, phone number for staff.
- Onset date of illness, symptoms, underlying medical conditions.
- Whether a swab has been obtained, and date of swab if obtained.
- Whether individual is hospitalized; and
- If an individual has died (include date of death).
- For **staff only**, it is not necessary to include ‘ethnicity’, select unknown
- To report lab confirmed cases in residents or staff (including asymptomatic cases):
    - Begin entry as if symptomatic by choosing “Newly Symptomatic resident/staff”
    - Use specimen collection date as onset date
    - Select “none” for all symptom lists if asymptomatic

NOTE: For ‘Date of Birth’ field, the clickable calendar does not have a drop-down option for years prior to 1920, however years prior to 1920 can be manually added in the DOB field.

Also attached is a letter from the Medical Officer of Health describing the legal authority to release the requested line list information to the Public Health Outbreak Team, for the purposes of outbreak management under the Alberta Public Health Act for your records.

If you have any questions regarding submission of the information through the portal, please email the CDC COVID outbreak email: CDOutbreak@albertahealthservices.ca or call the CDC COVID line at 1-888-522-1919.

Section 6: Confirmed COVID-19 Outbreak

COVID-19 Outbreak Definition

Outbreak definition: 2 or more confirmed COVID-19 cases in residents and/or HCW/staff who worked while symptomatic (as per Table A) that:

- Have an epidemiological link between the cases, and
- Occurred within a 7-day period

Duration of Outbreak

- The outbreak remains open for 14 days after the onset of the last resident case (will close on day 15).
- Note: HCW/staff cases will not extend the duration of the outbreak.

The following are baseline or minimum recommendations for a confirmed COVID-19 outbreak. Additional or more restrictive recommendations may be put in place at the discretion of the Public Health Outbreak Team or the facility in consultation with the Public Health Outbreak Team.

6.1 Infection Prevention and Control Measures

- See information in Section 3.1 Infection Prevention and Control Measures.
- Once a COVID-19 outbreak is declared, HCW/staff are recommended to use continuous masking and eye protection for the duration of the outbreak. Additional precautions are necessary if performing aerosol-generating medical procedures (AGMP) or a resident is on airborne precautions. COVID-19 Aerosol-Generating Medical Procedure Guidance Tool | Alberta Health Services.
- If resident tests positive for COVID-19 or another organism (see Table G for isolation recommendations) maintain full IPC precautions until the resident is released from isolation as directed by IPC/ICD or the Public Health Outbreak Team.
- All HCW/staff and residents in outbreak setting should be made aware of the outbreak and be advised to monitor for symptoms.
- HCW/staff shall wear a surgical/procedure mask, seal-checked KN95 or fit-tested N95 respirator (mask) in accordance with the Point of Care Risk Assessment (PCRA)
- HCW/staff should report PPE breaches or hand hygiene breaches to supervisor or Occupational Health/ Workplace Health and Safety as appropriate.

6.2 Administrative Measures

- Antiviral treatments may be available for COVID-19. Sites should have policies in place to ensure residents that meet the criteria have timely access to the medication.
- In general, asymptomatic/prevalence testing is not recommended but may be done under the direction of the Public Health Outbreak Team in extenuating circumstances
    - Site would proceed with symptomatic testing only.
- Post signs that facility is on outbreak at entrances Attachment 5.1.

6.3 Resident Restrictions

- Residents who test positive for COVID-19 or who the Public Health Outbreak Team advises they are considered as COVID-19 cases must isolate in their room with appropriate precautions as per the Point of Care Risk Assessment (PCRA) for a minimum 5 days or until symptoms improve AND they are afebrile for 24 hours without the use of fever reducing medications, **whichever is longer**.
    - A mask must be worn for an additional 5 days when the resident leaves their room.

        - During this 5-day masking period residents must return to their room whenever the mask needs to be removed (e.g., meals and snacks).
    - If a mask is not tolerated, the resident must complete 10 days of isolation in their room.
- At the time of publishing the guide the isolation recommendations for severely immunocompromised residents is under review by SAG (Scientific Advisory Group). Facilities should discuss with the Most Responsible Health Practitioner what the recommended isolation is for these residents.

6.4 Restrictions on Affected Unit/Site

- Facility / unit status (open or restricted) will be determined by the Public Health Outbreak Team. In some Zones, the Public Health Outbreak Team may permit admissions and transfers under certain conditions, while in other Zones the affected unit/site may be restricted for the duration of the COVID-19 outbreak.
- If the Public Health Outbreak Team advises that the facility/unit status is "open," then admissions, transfers, and discharges may proceed following usual non-outbreak processes.
- The Public Health Outbreak Team may determine that the facility/unit is "restricted." This would mean that admissions, transfers, and discharges should be paused or delayed while these restrictions are in place. However, implementation may not be possible or recommended due to resident circumstances or operational need (including bed pressures). If a site with restrictions believes that an admission, transfer, or discharge should proceed despite restrictions, sites complete a sites should complete a Risk Assessment Worksheet and follow the Risk Assessment Matrix as per the zone process.

6.5 Admissions/Transfers from Acute Care to an Outbreak LTC, DSL or Hospice Site

- For residents who were hospitalized prior to the outbreak, their ability to return to the site will depend on the status of any restrictions applied to the DSL/LTC/Hospice site. See Section 6.4 above for more details.
- If a resident was hospitalized due to COVID-19, they may return to their home site immediately upon discharge.
- If a resident was hospitalized during an outbreak for an unrelated condition (e.g., fracture), their ability to return to the site will depend on the status of any restrictions applied to the DSL/LTC/Hospice site. See Section 6.4 above for more details.

6.6 Transfers from an outbreak facility to an acute care site

- No change to recommendations outlined in Section 5.6

6.7 Group / Social Activities and Other Events

- Symptomatic residents are not permitted to participate in group/social activities.
- Residents that are on isolation are advised to remain in their room but may attend appointment as outlined in Section 5.3.
- Consult the Public Health Outbreak Team for recommendations on whether routine group activities may continue for asymptomatic residents.
- For COVID-19 outbreaks, outbreak measures (such as physical distancing, masking, hand hygiene, enhanced surveillance, etc.) may be used for low-risk group activities (e.g., art class, bingo, card games). These activities may continue at the discretion of the facility in consultation with the Public Health Outbreak Team.
- High risk group activities (e.g., singing, bus outing and large group activities) should be postponed.
- Essential medical treatment activities including but not limited to rehabilitation, physical or group therapy should be facilitated by the site whenever possible with appropriate precautions in place.

- It is recommended that non-resident events previously booked for areas in the outbreak DSL/LTC/Hospice site (e.g., meetings) be cancelled/postponed.
- Personal services (e.g., hair styling) are allowed to continue for asymptomatic residents. The personal service provider is required to wear a mask and eye protection and the resident receiving the service is also recommended to wear a mask when possible. PPE will be provided by the facility.
    - Personal services should be provided to one resident at a time for residents from outbreak units.

6.8 Nourishment Areas / Sharing of Food

- The Public Health Outbreak Team will provide direction on any modifications, which may include moving to single serve items and discontinuing family style dining.
- Group dining may continue – with IPC (such as physical distancing and hand hygiene) measures in place.

6.9 Adult Day Programs in sites Operating Adult Day Programs (e.g., CHOICE/C3)

- No change from recommendations in Section 5.9

6.10 Visitors and Designated Family/Support Person(s)

- No visitor restrictions see Section 3.10 and Section 5.10 for further information.

6.11 Volunteers

- Advise volunteers of the potential risk of acquiring illness during outbreaks.
- Have volunteers who continue to assist during an outbreak to follow the same control measures as HCW/staff. See Section 6.12

6.12 HCW/Staff Outbreak Measures (Including volunteers, students, and physicians)

- It is recommended that HCW/staff who work in more than one facility/unit inform any additional facilities or units where they work that an outbreak is in progress to determine whether they are permitted to continue to work in all settings.
- HCWs should stay home when they have symptoms of illness – refer to Table A and are recommended to be tested for COVID-19
- Encourage all HCW/staff to get all recommended COVID-19 vaccines.
- HCW/staff can choose to use a self-administered Rapid Antigen Test or request an appointment at a swabbing centre for molecular testing.
- Confirmation of Rapid Antigen Tests by molecular testing is only recommended for:
    - Symptomatic HCW/staff with a negative Rapid Antigen Test
    - Asymptomatic HCW/staff with a positive Rapid Antigen Test
- HCW/staff with a household member (or other close contacts) that is COVID-19 positive should monitor for symptoms for 7 days after last exposure. They should wear a mask when at work during this period.
- Once a COVID-19 outbreak is declared, HCW/staff are recommended to use continuous masking and eye protection
- Additional precautions are necessary if performing aerosol-generating medical procedures (AGMP). COVID-19 Aerosol-Generating Medical Procedure Guidance Tool | Alberta Health Services.

Table H: HCW/Staff Testing and Work Restrictions

HCW/staff COVID-19 Testing Recommendations and Resulting Work Restrictions *Note: Asymptomatic testing is not recommended, however if test is completed follow recommendation below.*	
Scenarios	**Recommendations**
Scenario A Positive Molecular test (Symptomatic or asymptomatic)	• Work restricted for at least 5 days or until symptoms improve and fever free for 24 hours without use of fever reducing medication (whichever is longer). • Once work restriction is complete, if returning prior to day 10 then a mask must be always worn while at the work site (no exceptions) Note: Masking is not necessary if HCW/staff already isolated for 10 days or more. • Note that some symptoms may persist beyond 10 days (e.g., loss of taste or smell).
Scenario B Symptomatic with negative Rapid Antigen Test	• HCW/staff should have a molecular test or complete a second Rapid Antigen Test not less than 24 hours from the first Rapid Antigen Test • If completing a molecular test: ○ POSITIVE molecular result - follow restrictions for **Scenario A** above ○ NEGATIVE molecular result or declined molecular test – continue to stay home until symptoms improve/are fever-free for 24 hours without use of fever reducing medication, whichever is longer and well enough to resume normal activities • If completing a second Rapid Antigen Test: ○ Second Rapid Antigen Test POSITIVE: Follow directions in **Scenario D** below ○ Second Rapid Antigen Test NEGATIVE: continue to stay home until symptoms improve/are fever-free for 24 hours without use of fever reducing medication, whichever is longer and well enough to resume normal activities
Scenario C Asymptomatic with positive Rapid Antigen Test	• HCW/staff should have a molecular test for confirmation: ○ POSITIVE molecular result - follow restrictions for **Scenario A** above ○ NEGATIVE molecular result – return to work and continue to monitor for symptoms ○ If molecular testing declined – discuss with the Public Health Outbreak team
Scenario D Symptomatic with positive Rapid Antigen Test	• Work restricted for at least 5 days or until symptoms improve and fever free for 24 hours without use of fever reducing medication (whichever is longer). • Once work restriction is complete, if returning prior to day 10 then a mask must be always worn while at the work site. Note: Masking is not necessary if HCW/staff already isolated for 10 days or more. • Note that some symptoms may persist beyond 10 days (e.g., loss of taste or smell).
Scenario E Symptomatic (Symptoms from Table A) HCW/staff not tested	• Encourage HCW/staff to complete testing. If testing is declined • The Public Health Outbreak team will guide an assessment to determine if HCW/staff meets probable case definition. • HCW/staff is a probable case: ○ Work restricted for at least 5 days or until symptoms improve and fever free for 24 hours without use of fever reducing medication (whichever is longer). ○ Once work restriction is complete, if returning prior to day 10 then a mask must be always worn while at the work site (no exceptions) Note: Masking is not necessary if HCW/staff already isolated for 10 days or more. • HCW/staff is NOT a probable case: ○ Continue to stay home until symptoms improve/are fever-free for 24 hours without use of fever reducing medication, whichever is longer and well enough to resume normal activities
Scenario F Symptomatic HCW/staff Symptoms NOT in Table A	• Testing not required • Continue to stay home until symptoms improve and well enough to resume normal activities

Note: Severely immunocompromised individuals who test positive for COVID-19 should stay home for 14 days from onset of symptoms or until symptoms have improved AND they are fever free for 24 hours without the use of fever reducing mediations, whichever is longer.

6.13 Specimen Collection

- After the outbreak has been confirmed, symptomatic residents should be tested for both COVID-19 and influenza for the duration of the outbreak. RPP testing is not required unless otherwise directed by the Public Health Outbreak Team.
- Testing and Management of resolved COVID-19 Cases
    - Previous cases within 90 days should not be retested.
    - If a case is retested and the result is positive consult with the Public Health Outbreak Team for determination of case status

6.14 Enhanced Environmental Cleaning and Disinfection

- Maintain all measures discussed in Section 3.14

Roles and Responsibilities for Confirmed Outbreaks

Note: Due to the complex nature of LTC/DSL/Hospice settings, staffing and resident populations, the individual fulfilling the roles and responsibilities within a site may vary from what is outlined below (e.g., some sites may combine the roles or IPC and WHS, or may have designated staff to fulfill these roles)

Only actions and tasks above and beyond those discussed in previous sections are listed here. See Section 5 Roles and Responsibilities for Confirmed Outbreaks for additional details.

The Public Health Outbreak Team (MOH, CDC, EPH)

- Provides direction on restrictions to admissions / transfers / discharges to the outbreak unit / facility
- Provides direction on isolation of resident cases
- Provides direction on management of HCW/staff
- Provides direction on changes to activities (if applicable) within the unit / facility
- Reinforces the need to continue testing all symptomatic residents and HCW/staff
- Provides direction on when prevalence / asymptomatic testing is indicated

Infection Prevention and Control (Infection Control Professional and/or Infection Control Designate)
***Note**: In the absence of formal IPC or site ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS ICP.*

- Directs the isolation of resident cases
- Identifies high risk activities which should be stopped during the outbreak

Facility Administration/Facility Management or their Designate

- Supports assessment of HCW/staff and resident cases in determining whether site meets outbreak definition
- Anticipates and manages the impact of HCW/staff exclusion on site operations
- Ensures that, if recommended, restrictions to admissions / transfer / discharges to the outbreak facility are implemented
- If facility has restrictions to admissions / transfers / discharges, oversees completion of Risk Assessment Worksheets for operationally necessary resident moves
- Communicates the status of the facility (open or restricted) to partners and stakeholders

Site/Unit Manager/Designate

- Provides information about HCW/staff shift patterns (when HCW/staff member last onsite and onsite during infectious period) to the Public Health Outbreak Team and OHS / WHS
- Collects information about HCW/staff immunization status. Shares this information with OHS / WHS and the Public Health Outbreak Team.
- Supports assessment of HCW/staff and resident cases in determining whether unit meets outbreak definition
- Anticipates and manages the impact of HCW/staff exclusion on unit operations
- Ensures that, if recommended, restrictions to admissions / transfer / discharges to the outbreak unit are implemented
- If unit has restrictions to admissions / transfers / discharges, oversees completion of Risk Assessment Worksheets for operationally necessary resident moves
- Communicates the status of the unit (open or restricted) to partners and stakeholders

Occupational Health/Workplace Health and Safety/Designate

***Note**: In the absence of formal AHS WHS or site OHS coverage, facility administration/manager designates responsibility for these roles.*

- Participates in unit/site investigation to determine if HCW/staff cases should be linked to the site investigation and communicates conclusions to the Public Health Outbreak Team
- Confirms HCW/staff cases and implements HCW/staff work restrictions as required.

Onsite HCW/Staff (hired directly by the site; contracted HCW/staff, AHS HCW/staff)

- Each HCW/staff member is responsible for reporting their personal immunization status with Facility Administration / Facility Management and / or Occupational Health / Workplace Health and Safety.
- Complies with work restrictions, if applicable

Alberta Precision Laboratory for Public Health (ProvLab)

- If applicable, completes additional testing on COVID-19 outbreak specimens to identify variants of interest or variants of concern

Section 7: Confirmed Respiratory Illness (RI) Outbreak

7A. Respiratory Illness (RI) Outbreak Definition

- 2 or more cases of RI in residents within a 7-day period, with a common epidemiological link

And

- No respiratory pathogen identified OR 1 case of any respiratory pathogen identified (e.g., Influenza; COVID-19; RSV)

7B. Syndromic or Pathogen Specific Respiratory Illness (RI) Outbreaks

- An RI outbreak can be syndromic (based only on the symptom presentation of resident cases). However, an RI outbreak may also have a non-influenza, non-COVID respiratory pathogen identified. Examples of common respiratory pathogens can be found in Table G

7C. Duration of Outbreak

- If a non-influenza, non-COVID-19 respiratory pathogen is identified, the outbreak will remain open for a single incubation period for that pathogen (See Table G for incubation periods for common respiratory pathogens). For example, the incubation period for RSV is 2 to 8 days, so an RSV outbreak would remain open until the 9th day following the last case onset.
- If no pathogen is identified, an RI outbreak would remain open for 7 days (would close the 8th day following the last case onset).

Table G: Organisms Commonly Associated with RI

(Reference: IPC Diseases and Conditions Table for Management of Residents in Acute Care, IPC Diseases and Conditions Table Recommendations for Management of Residents Continuing Care and Alberta Public Health Disease Management Guidelines - COVID-19)

ORGANISM	CLINICAL PRESENTATION /SYMPTOMS	INFECTIOUS SUBSTANCE/ HOW IT IS TRANSMITTED	INCUBATION PERIOD	PERIOD OF COMMUNICABILITY	OUTBREAK RESTRICTIONS/ RECOMMENDATIONS for Sites
INFLUENZA, SEASONAL TYPE A OR B	Sudden onset of fever, cough, muscle aches, fatigue, sore throat, runny nose & sneezing. **Note**: fever may not be prominent in those >65 years.	Infectious substance is respiratory secretions. Direct contact, indirect contact, and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions.	1-3 days	For duration of symptoms – usually 3-7 days from onset of symptoms. For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding[%].	Refer to Section 8: Confirmed Influenza Outbreak
COVID-19 (SARS-CoV-2)	Fever, new onset or worsening of cough, new or worsening shortness of breath or difficulty breathing, sore throat, runny nose, and loss of sense of smell or taste. Extended symptoms include chills, painful swallowing, stuffy nose, headache, muscle, or joint ache, feeling unwell, fatigue or sever exhaustion, nausea, vomiting, diarrhea or unexpected loss of appetite, conjunctivitis.	Infectious substance is respiratory secretions. Droplet, direct and indirect contact. Person to person by large droplets or smaller droplets (aerosols) that in certain circumstances (such as with AGMPs, indoor spaces with poor ventilation) have the potential to be infectious over longer distances; or direct contact with articles recently contaminated with respiratory secretions.	1-14 days	May begin up to 48 hours prior to symptom onset and continue throughout the symptomatic period. Current studies indicate that by day eight of illness/symptoms, no live virus was recovered from patients with upper respiratory tract disease or limited lower respiratory tract disease. People with more severe disease are likely to be infectious for a few days longer.	Refer to: Section 6: Confirmed COVID-19 Outbreaks
RESPIRATORY SYNCYTIAL VIRUS (RSV)	Runny nose, coughing, sneezing, fever, wheezing.	Infectious substance is respiratory secretions. Direct contact, indirect contact, and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions.	2 to 8 days	For duration of symptoms For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding[%].	Confirmed or symptomatic cases should remain in their rooms for the duration of the illness, which is the resolution of acute respiratory infection symptoms or return to baseline. Admission/transfer restrictions only when recommended by local MOH.
PARAINFLUENZA Type 1, 2, 3, 4	Fever, runny nose, cough, sneezing, wheezing, sore throat, croup, bronchitis.	Infectious substance is respiratory secretions. Direct contact, indirect contact, and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions.	2 to 6 days	1-3 weeks For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding[%].	Confirmed or symptomatic cases should remain on precautions for 5 days from the onset of acute illness OR until they are over the acute illness and have been afebrile x48 hours (whichever is longer) Admission/transfer restrictions only when recommended by local MOH.

ORGANISM	CLINICAL PRESENTATION /SYMPTOMS	INFECTIOUS SUBSTANCE/ HOW IT IS TRANSMITTED	INCUBATION PERIOD	PERIOD OF COMMUNICABILITY	OUTBREAK RESTRICTIONS/ RECOMMENDATIONS for Sites
HUMAN METAPNEUMOVIRUS (hMPV)	Cough, fever, nasal congestion, shortness of breath.	Infectious substance is respiratory secretions Direct contact, indirect contact and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions.	3 to 5 days	For duration of symptoms For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding[%].	Confirmed or symptomatic cases should remain in their rooms for the duration of the illness, which is resolution of acute respiratory infection symptoms or return to baseline. Admission/transfer restrictions only when recommended by local MOH.
Other Common Respiratory Viruses such as: Entero/Rhinovirus, Non-COVID-19 Coronaviruses Adenovirus	Sore throat, runny nose, coughing, sneezing.	Infectious substance is respiratory secretions Direct contact, indirect contact, and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions	Entero / Rhinoviruses: usually 2-3 days Non-COVID-19 Coronaviruses: usually 2-4 days Adenovirus: 2-14 days	For duration of symptoms For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding[%].	Confirmed or symptomatic cases should remain in their room for the duration of the illness, which is resolution of acute respiratory infection symptoms or return to baseline. Admission/transfer restrictions only when recommended by local MOH.

**First day is designated as Day 0; after the first 24 hours is Day 1. The Public Health Outbreak Team declares the facility outbreak to be over 7 days after onset of symptoms in the last case (e.g., closes outbreak on the morning of day 8).
[%]Consult with IPC on a case-by-case basis for these individuals

7.1 Infection Prevention and Control

- Outbreak measures and Infection control practices will remain unchanged from Section 5.

7.2 Administrative Measures

- After the RI outbreak has been confirmed, the Public Health Outbreak Team will provide direction on how to report additional HCW/staff or resident cases. Reporting will occur through Facility CDC Outbreak Daily Report Portal (RedCap)

7.3 Resident Restrictions

- Maintain all measures discussed in Section 3.3
- Symptomatic residents should be placed on appropriate precautions. The duration of the precautions depends on the cause of the RI outbreak.
    - If a specific pathogen has been identified, maintain Contact and Droplet Precautions for the duration discussed in Table G: Organisms Commonly Associated with RI.
    - If no specific pathogen has been identified, symptomatic residents should remain in their rooms for the duration of the illness, which is resolution of acute respiratory infection symptoms or return to baseline.
- Symptomatic residents will be allowed to attend medically necessary activities or appointments, they should wear an appropriate mask (as tolerated). Ensure receiving facility/unit is notified of the potential outbreak so that appropriate precautions can be taken for the resident on arrival. Virtual visits should be arranged when possible
- If symptomatic residents cannot remain in their room, they should avoid contact with other residents in common areas as much as possible.

7.4 Restrictions to Admissions / Transfers / Discharges on Affected Unit / Site

- No change from recommendations discussed in Section 5.4.
- In general, facility/unit would remain “open” during an RI outbreak, meaning that admissions, transfers, and discharges may proceed following usual non-outbreak processes.
    - Note: for mixed pathogens including RI + Influenza, or RI + GI the facility/unit would generally be closed.

7.5 Admissions/Transfers from Acute Care to an Outbreak LTC, DSL or Hospice Site

- Unless the Public Health Outbreak Team advises the Unit / Site that is “restricted” (see Section 7.4), admissions / transfers from acute care may proceed.

7.6 Transfers from an Outbreak Facility to an Acute Care Site

- If a resident requires acute medical attention or treatment off site (e.g., emergency room, urgent care, dialysis), the outbreak facility must notify the EMS Dispatcher, the transport staff (EMS crew) and the receiving care facility that the resident is being transferred from a facility experiencing an RI outbreak. The transport staff (EMS crew) and the facility receiving the resident can then ensure contact and droplet precautions are in place when the resident arrives at the hospital/treatment centre. If tolerated, symptomatic residents should wear an appropriate mask during transfer.

7.7 Group / Social Activities and Other Events

- Symptomatic residents are not permitted to participate in group/social activities.
- Unless otherwise directed by the Public Health Outbreak Team, routine group activities may continue for asymptomatic residents.

7.8 Nourishment Areas / Sharing of Food

- The Public Health Outbreak Team will provide direction on any modifications, which may include

moving to single serve items and discontinuing family style dining.
- Group dining may continue.

7.9 Adult Day Programs in sites Operating Adult Day Programs (e.g., CHOICE/C3)

- No change from recommendations in Section 5.9

7.10 Visitors and Designated Support Person(s)

- Section 3.10
- Section 5.10

7.11 Volunteers

- Advise volunteers of the potential risk of acquiring illness during outbreaks.
- Have volunteers who continue to assist during an outbreak to follow the same control measures as HCW/staff. See Section 7.12.

7.12 HCW/Staff Outbreak Measures (Including volunteers, students, physicians)

- It is recommended that HCW/staff who work in more than one facility/unit inform any additional facilities or units where they work that an outbreak is in progress to determine whether they are permitted to continue to work in all settings.
- Exclude symptomatic HCW/staff from working.
- HCW/staff should stay home until symptoms improve and they feel well enough to resume normal activities and have been free of fever for 24 hours without the use of fever reducing medication, whichever is longer.

7.13 Specimen Collection

- Ensure proper collection of appropriate specimens as directed by the Public Health Outbreak Team including using assigned EI number on all specimens and make own internal arrangements for transporting specimens to the lab. See ProvLab Respiratory Specimen Collection and Transport Guidance Attachment 3.1.
- The Public Health Outbreak Team will provide direction on testing of subsequent cases.

7.14 Enhanced Environmental Cleaning and Disinfection

- Maintain all measures discussed in Section 3.14

Roles and Responsibilities for Confirmed Outbreaks

Roles and responsibilities for an RI outbreak are similar to those in previous sections. See Section 5 Roles and Responsibilities for Confirmed Outbreaks for additional details.

Section 8: Confirmed Influenza Outbreak

The symptoms of influenza disease are similar to the symptoms for many other respiratory illnesses. See the Health Canada Guidance for further information for identification of suspect influenza cases and indications for early treatment with antivirals: Flu (influenza): For health professionals - Canada.ca

Influenza Outbreak Definition

- 2 or more cases of laboratory confirmed influenza in residents, with a common epidemiological link☆, within a seven-day period

AND

- No respiratory pathogen identified OR one case of any respiratory pathogen identified (e.g., COVID-19; RSV)

☆*Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period.*

Duration of Outbreak

- Outbreak remains open for 7 days after symptom onset of most recent influenza case

Additional information about influenza disease, including the incubation period and, period of communicability, can be found in Table G: Organisms Commonly Associated with RI

8.1 Infection Prevention and Control

When an influenza outbreak is confirmed at a site, it is imperative to maintain:

- The infection prevention and control measures discussed in Section 3.1
- Enhanced environmental cleaning and disinfection discussed in Section 3.14

The Outbreak measures listed below are specific to a confirmed influenza outbreak. See Section 5 for additional General Measures recommended during any confirmed outbreak.

8.2 Administrative Measures

- The major interventions for an influenza outbreak include:
  - Antiviral prophylaxis for all residents Section 8.3
  - Antiviral prophylaxis for unimmunized HCW/staff Section 8.12
  - Restrictions to admissions, transfers, and discharges Section 8.4

8.3 Resident Restrictions

- Resident cases and symptomatic residents should remain on isolation for 5 days from the onset of acute illness OR until they are over their acute illness and have been afebrile for 48 hours, whichever is longer.
- Resident influenza cases and symptomatic residents who become ill during a confirmed influenza outbreak should receive Oseltamivir (Tamiflu) treatment. See Appendix A to review Antiviral (Oseltamivir) Dosing Recommendations.
- Asymptomatic residents, regardless of immunization status, should receive Oseltamivir (Tamiflu) prophylaxis. Antiviral prophylaxis is continued for 7 days after onset of symptoms of the last resident case, usually a minimum of 10 days. See Appendix A to review Antiviral (Oseltamivir) Dosing Recommendations.
  - In the situation of a mixed outbreak: COVID-19 and influenza, contact the Public Health Outbreak Team to discuss the length of Tamiflu prophylaxis.

8.4 Restrictions on Affected Units/Site

- The Public Health Outbreak Team will make a best practice recommendation that the facility / unit is "restricted." This means that admissions, transfers, and discharges should be paused or delayed during the influenza outbreak. However, implementation of this best practice recommendation may not be possible or recommended due to resident circumstances or operational need (including bed pressures). If a site with restrictions believes that an admission, transfer, or discharge should proceed despite restrictions, sites should follow the zone Risk Assessment Process and follow the Risk Assessment Matrix
- For confirmed influenza outbreaks, **admission restrictions will remain in place at minimum for 7 days following the onset of symptoms in the last case**, based on recommendations from the Association of Medical Microbiology and Infectious Disease (AMMI) Canada, and as directed by the Public Health Outbreak Team.

Restrictions regarding resident admissions/re-admissions/transfer and activities are ONLY modified or lifted by the Public Health Outbreak Team. In the event that restriction to admissions/transfers is unduly impacting the availability of acute care beds for individuals requiring urgent care, or because of the expressed informed individual resident or family choice in keeping with AHS's commitment to People Centered Care, the Public Health Outbreak Team will assess the circumstances surrounding the restriction, including the degree of risk to the full spectrum of individuals requiring care.

8.5 Admissions/Transfers from Acute Care to an Outbreak LTC, DSL or Hospice Site

- If a resident was hospitalized prior to the outbreak or due to an unrelated condition (e.g., fracture), the acute care site and the outbreak site must collaborate on the Risk Assessment Process to explore if the resident may return to the facility. Oseltamivir (Tamiflu) prophylaxis for the resident may be required.
- If a resident was hospitalized due to influenza, they may return to their home site immediately upon discharge.

If an admission/transfer to a LTC, DSL or Hospice site must occur during a confirmed influenza outbreak at the site, following the assessment of the circumstances and consultation with the Public Health Outbreak Team (as described in the box above), LTC, DSL or Hospice HCW/staff should collaborate with the acute care contact before the resident is discharged. See Risk Assessment Worksheet.
The resident should not be transferred until the LTC, DSL or Hospice site HCW/staff ensures that:

- The resident/guardian has information on risks associated with the outbreak and consents to the transfer AND
- The resident is immunized AND
- The resident/guardian is able to and agreeable to take antiviral medication as indicated.

8.6 Transfers from an Outbreak Facility to an Acute Care Site

- No change from the recommendations described in Section 5.6

8.7 Group / Social Activities and Other Events

- No change from the recommendations listed in Section 5.7

8.8 Nourishment Areas / Sharing of Food

- No change from the recommendations listed in Section 5.8

8.9 Operating Adult Day Programs during an Outbreak

- No change from the recommendations listed in Section 5.9

8.10 Visitors and Designated Support Person(s)

- Visitors are strongly encouraged to receive annual immunization for influenza when available.
- Advise those who choose to visit during an outbreak to practice good hand hygiene, visit one (1) resident only and exit the facility immediately after the visit.
- See Section 5.10
- Designated Support Person(s) - See Section 3.10

8.11 Volunteers

- Volunteers are strongly encouraged to receive annual influenza immunization when available.
- Have volunteers who continue to assist during an outbreak follow the same control measures as HCW/staff. See Section 8.12.

8.12 HCW/Staff Outbreak Measures (Including volunteers, students, physicians)

- HCW/staff are strongly encouraged to receive an annual dose of seasonal influenza vaccine when available.
- The Public Health Outbreak Team will advise whether the outbreak influenza strain is covered in the seasonal influenza vaccine. If the outbreak strain is not covered in the seasonal vaccine, the Public Health Outbreak Team may provide additional direction beyond what is described below.
- Assign HCW/staff who have been immunized to care for symptomatic residents where possible.
- It is recommended that individuals who work in more than one facility/unit to inform the alternate facility/unit that an influenza outbreak is in progress in the index facility and determine whether they are permitted to work at the alternate facility/unit.

Management of Asymptomatic Unimmunized HCW/Staff

Recommendations for post-exposure immunization, prophylaxis and/or work restrictions to control influenza A or B outbreaks will be directed by the Public Health Outbreak Team. Oseltamivir (Tamiflu) antiviral treatment and prophylaxis is administered as per the most current Alberta Health Influenza Antiviral Drug Policy. It is the responsibility of the facility to clearly communicate instructions to their HCW/staff on how to access antiviral prophylaxis. See Appendix A for further information.

Asymptomatic HCW/staff on the outbreak unit/facility who have not received a dose of the current season's vaccine (are considered unimmunized) generally fall into three categories, each subject to work restrictions:

- **Unimmunized** HCW/staff who are asymptomatic at time of assessment **and** who agree to be immunized, **but** decline prophylaxis should be:
    - Excluded from work for 3 days from the last day of work on the outbreak unit/site.
        - If they remain asymptomatic after 3 days and receive immunization, they may be reassigned to a non-outbreak unit/site for the duration of the outbreak or for 14 days from date of immunization, whichever occurs first.
        - If reassignment of work is not possible, then the HCW/staff should be excluded from work for 14 days from the time of immunization or for the duration of the outbreak, whichever occurs first.
- **Asymptomatic** HCW/staff who are not immunized **and** are not taking recommended antiviral prophylaxis should be:
    - Excluded from working in the affected facility/unit(s) until the outbreak is over,
      OR
    - Relocated to a non-outbreak unit/site if they remain asymptomatic after waiting 3 days from the last day of work on the outbreak unit and should not return to the outbreak unit/site for

the duration of the outbreak.

- **Asymptomatic HCW/staff immunized less than 14 days prior to the outbreak and are not taking recommended antiviral prophylaxis should be:**
  - Excluded from working in the affected unit/facility until 14 days from date of immunization, or for the duration of the outbreak whichever occurs first,
    OR
  - Excluded from working at any site for 3 working days from the last day of work on the outbreak unit. If they remain asymptomatic after waiting the 3 working days, they can be relocated to a non-outbreak unit until 14 days from the date of immunization or for the duration of the outbreak at the manager's discretion.
- If required, the Public Health Outbreak Team may supply letters that the unit/site can provide to unimmunized HCW/staff to reinforce their options.
  - Attachment 8.1 MOH Notice to all Unimmunized HCW - Exclusion from Work (SAMPLE) Letter used for Confirmed Influenza Outbreaks
  - Attachment 8.2 MOH Notice to HCW Immunized less than 14 days prior to declaration of Outbreak - Exclusion from Work (SAMPLE) Letter used for Confirmed Influenza
- For asymptomatic HCW/staff, no waiting period is required between starting Oseltamivir (Tamiflu) prophylaxis and returning to work.
- Oseltamivir (Tamiflu) prophylaxis for HCW/staff is NOT publicly funded. Sites are responsible for developing a site policy on who is responsible for the cost of HCW/staff prophylaxis.

Management of Symptomatic HCW/Staff

- If HCW/staff on antiviral prophylaxis develop symptoms, they should stay home and contact OHS/WHS or designate for instructions about changes to medications. (This may ultimately be a referral to their Most Responsible Health Practitioner).
  - In addition to OHS/WHS, HCW/staff must also contact their manager or supervisor to let them know that they have developed symptoms.
- The length of time for which a symptomatic HCW/staff should stay off work will be recommended by the Public Health Outbreak Team at the time of the outbreak. Generally, a person with influenza is considered infectious for 5 days.
- Symptoms such as cough may continue for longer than 5 days. Generally, if a HCW/staff is otherwise healthy, they are not likely to continue to be infectious after 5 days following onset of symptoms.

8.13 Specimen Collection

- Ensure proper collection and labelling of appropriate specimens as directed by the Public Health Outbreak Team including using assigned EI number on all specimens. Make own internal arrangements for transporting specimens to the lab. See ProvLab Respiratory Specimen Collection and Transport Guidance Attachment 3.1.
- After the outbreak has been confirmed, symptomatic residents should be tested for both influenza and COVID-19 for the duration of the outbreak. RPP testing is not required unless otherwise directed by the Public Health Outbreak Team.

8.14 Enhanced Environmental Cleaning and Disinfection

- Maintain all measures discussed in Section 3.14

Roles and Responsibilities for Confirmed Outbreaks

Note: Due to the complex nature of LTC/DSL/Hospice settings, staffing and resident populations, the individual fulfilling the roles and responsibilities within a site may vary from what is outlined below (e.g., some sites may combine the roles or IPC and WHS, or may have designated staff to fulfill these roles)

Only actions and tasks above and beyond those discussed in previous sections are listed here. See Section 5 Roles and Responsibilities for Confirmed Outbreaks for additional details.

The Public Health Outbreak Team (MOH, CDC, EPH)

- Provides direction on restrictions to admissions/transfers/discharges to the outbreak unit/facility
- Provides direction on preventative measures for resident cases
- Provides direction on restrictions of HCW/staff cases
- Provides direction on management of unimmunized HCW/staff
- Provides direction on changes to activities (if applicable) within the unit/facility
- Advises whether the seasonal influenza vaccine provides adequate protection against the strain of influenza causing the outbreak
- Directs recommendations for Oseltamivir (Tamiflu) prophylaxis for residents and for unimmunized HCW/staff

Infection Prevention and Control (Infection Control Professional and/or Infection Control Designate)
***Note**: In the absence of formal AHS IPC or site ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS ICP.*

- Directs additional preventative measures required for resident cases
- Collaborates to implement resident Oseltamivir (Tamiflu) prophylaxis
- Collaborates to ensure symptomatic residents receive Oseltamivir (Tamiflu) treatment
- Identifies high risk activities which should be stopped during the outbreak

Facility Administration/Facility Management or their Designate

- Supports assessment of HCW/staff and resident cases in determining whether site meets outbreak definition
- Anticipates and manages the impact of HCW/staff exclusion on site operations
- Ensures that, if recommended, restrictions to admissions / transfer / discharges to the outbreak facility are implemented
- If facility has restrictions to admissions / transfers / discharges, oversees completion of Risk Assessment Worksheets for operationally necessary resident moves
- Communicates the status of the facility (open or restricted) to partners and stakeholders

Site/Unit Manager/Designate

- Provides information about HCW/staff shift patterns (when symptomatic HCW/staff was last onsite) to the Public Health Outbreak Team and OHS / WHS
- Collects information about HCW/staff immunization status. Shares this information with OHS / WHS and the Public Health Outbreak Team.
- Supports assessment of HCW/staff and resident cases in determining whether unit meets outbreak definition
- Anticipates and manages the impact of HCW/staff exclusion on unit operations
- Ensures that, if recommended, restrictions to admissions / transfer / discharges to the outbreak unit are implemented
- If unit has restrictions to admissions / transfers / discharges, oversees completion of Risk Assessment Worksheets for operationally necessary resident moves

- Communicates the status of the unit (open or restricted) to partners and stakeholders

Occupational Health/Workplace Health and Safety/Designate

***Note**: In the absence of formal AHS WHS or site OHS coverage, facility administration/manager designates responsibility for these roles.*

- Confirms HCW/staff cases and implements HCW/staff exclusions
- Assesses HCW/staff suitability for return to work
- Collaborates to determine the immunization status of HCW/staff
- Identifies HCW/staff who are not fully immunized and communicates work restrictions
- Implements site plan for how unimmunized HCW/staff should access and pay for Oseltamivir (Tamiflu) prophylaxis

Onsite HCW/Staff (hired directly by the site; contracted HCW/staff, AHS HCW/staff)

- Each HCW/staff is responsible for reporting their personal immunization status with Facility Administration/Facility Management and/or Occupational Health/Workplace Health and Safety.
- For unimmunized HCW/staff – Provides decision on whether accepting of Oseltamivir (Tamiflu) prophylaxis or not to Facility Administration/Facility Management and / or OHS / WHS.

Alberta Precision Laboratory for Public Health (ProvLab)

- If applicable, completes additional testing on influenza outbreak specimens.
- Provides guidance regarding match between outbreak strain and strains in the seasonal influenza vaccine.

Attachment 8.1: MOH Notice to all Unimmunized HCW

Exclusion from Work (SAMPLE) Letter used for Confirmed Influenza Outbreaks

The Medical Officer of Health (MOH) or designate has declared an outbreak of influenza at _____ effective _____. Influenza is a serious infectious disease, especially in persons who are elderly or have underlying medical conditions. Workers in health care facilities who come into contact with these vulnerable persons have a duty of care to protect them by being immunized against influenza.

Facility records indicate that you were not immunized against influenza during the _____ influenza season. Under Section 29(2) of the Public Health Act of Alberta, the MOH has the legal authority to undertake whatever steps are necessary to prevent the spread of a communicable disease to others and may prohibit a person from engaging in their occupation if this activity could transmit an infectious agent.

Because of the risk that you could transmit influenza to vulnerable individuals in your care, effective immediately, the MOH has ordered your manager to **exclude you from further work** in the outbreak facility until:

a) You receive the influenza immunization now AND commence antiviral prophylaxis for a period of 10 days, or up to a maximum of 14 days dependent on outbreak duration. Protection from immunization takes two weeks to develop completely. Vaccine may be available from pharmacies, Public Health, your family physician, Nurse Practitioner, or your facility. Your family physician, another physician, Nurse Practitioner, or a prescribing pharmacist can also prescribe the appropriate antiviral agent.

OR

b) You start antiviral prophylaxis immediately WITHOUT receiving influenza immunization. Prophylaxis must be taken for the duration of the outbreak and an initial 10-day supply should be obtained by prescription from your family physician or through special arrangements at your facility if they exist. Without immunization, you will not develop immunity against influenza, and to continue to work in the event of other influenza outbreaks you will need to take antiviral prophylaxis again.

OR

c) Two weeks after you have been immunized if you DO NOT take antiviral prophylaxis.

OR

d) The outbreak is declared over (7 days following onset of symptoms in the last case at the outbreak facility) if you refuse a, b, or c.

You may return to work **immediately** after commencing prophylaxis, provided you do not have any symptoms of influenza (acute onset of headache, chills, and dry cough, followed by fever, muscle aches and pains, runny nose, and/or malaise). If you develop symptoms, the length of time for which you should stay off work will be recommended by the Public Health Outbreak Team at the time of the outbreak. Generally, a person with influenza is considered infectious for five (5) days.

If you work at health care facilities in addition to the outbreak facility, you may continue to report for work at these facilities if you have complied with either of option (a) or (b) above. If you have not, you are excluded from working in any non-outbreak facility for a period of **three (3) days** after your last shift at the outbreak facility (assuming you remain symptom free), in order to ensure you do not spread influenza to other facilities.

If you have questions about this exclusion, please contact your manager.

Medical Officer of Health

Attachment 8.2 MOH Notice to HCW Immunized less than 14 days prior to declaration of Outbreak

Exclusion from Work (SAMPLE) Letter used for Confirmed Influenza

The Medical Officer of Health (MOH) or designate has declared an outbreak of influenza at _____ effective _____. Influenza is a serious infectious disease, especially in persons who are elderly or have underlying medical conditions. Workers in health care facilities who come into contact with these vulnerable persons have a duty of care to protect them by being immunized against influenza.

Facility records indicate that you were vaccinated against influenza during the _____Influenza season, but it has been less than 14 days from the date of your immunization and protection from immunization takes two weeks to develop completely. Under Section 29(2) of the Public Health Act of Alberta, the MOH has the legal authority to undertake whatever steps are necessary to prevent the spread of a communicable disease to others and may prohibit a person from engaging in their occupation if this activity could transmit an infectious agent.

Because of the risk that you could transmit influenza to vulnerable individuals in your care, effective immediately, the MOH has ordered your manager to **exclude you from further work** in the outbreak facility until:

a) You commence antiviral prophylaxis. Protection from immunization takes two weeks to develop completely, you therefore must take the prophylaxis until it has been 14 days post-immunization with the current season's influenza vaccine OR for the duration of the outbreak (whichever is shorter). Your family physician, another physician, Nurse Practitioner, or a prescribing pharmacist can prescribe the appropriate antiviral agent.

OR

b) Two weeks after you have been immunized if you DO NOT take antiviral prophylaxis.

OR

c) The outbreak is declared over (7 days following onset of symptoms in the last case at the outbreak facility) if you refuse (a).

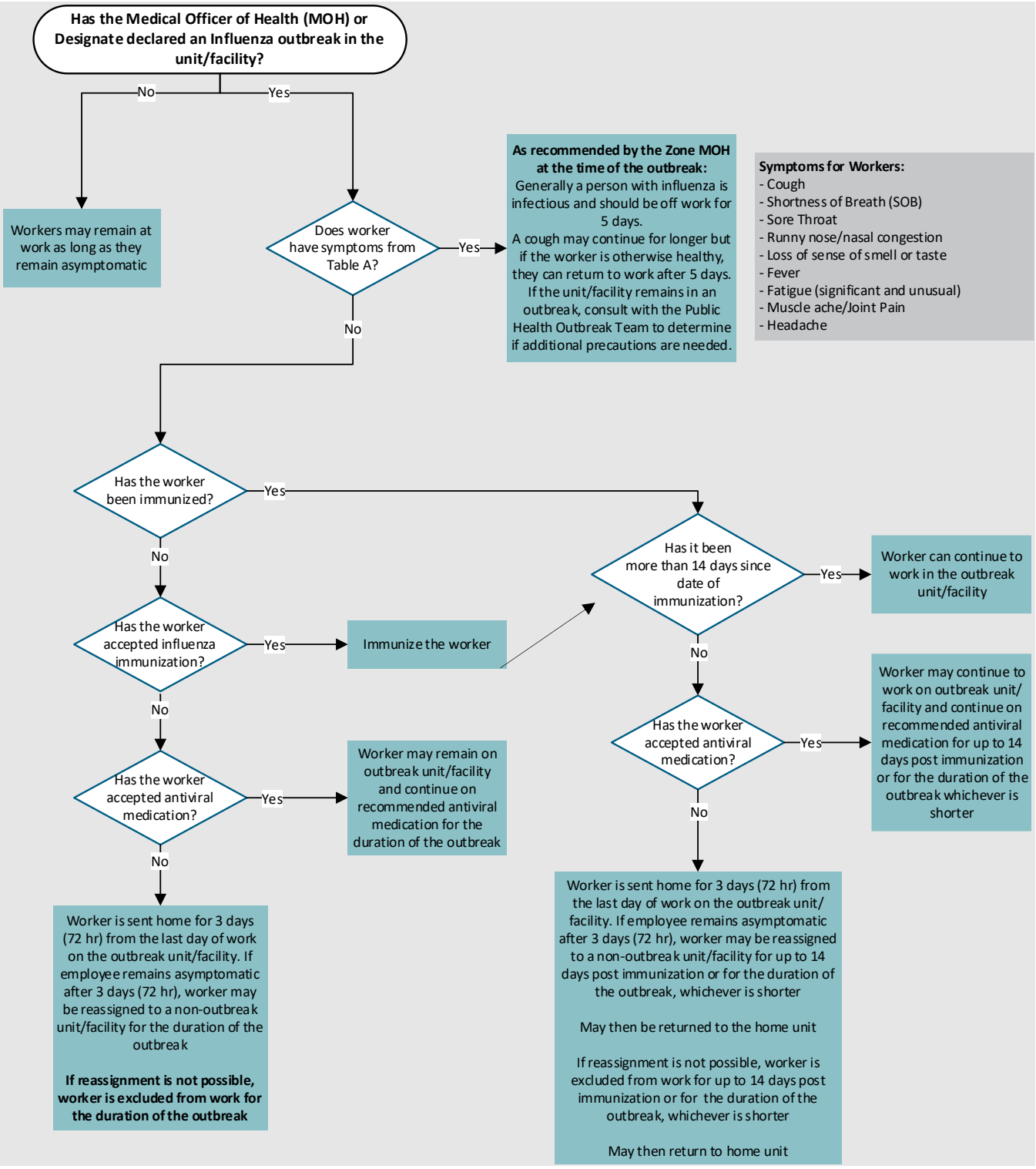
You may return to work **immediately** after commencing prophylaxis, provided you do not have any symptoms of influenza (acute onset of headache, chills, and dry cough, followed by fever, muscle aches and pains, runny nose, and/or malaise). If you develop symptoms, the length of time for which you should stay off work will be recommended by the Public Health Outbreak Team at the time of the outbreak. Generally, a person with influenza is considered infectious for five (5) days.

If you work at health care facilities in addition to the outbreak facility, you may continue to report for work at these facilities if you have complied option (a) above. If you have not, you are excluded from working in any non-outbreak facility for a period of **three (3) days** after your last shift at the outbreak facility (assuming you remain symptom free), in order to ensure you do not spread influenza to other facilities.

If you have questions about this exclusion, please contact your manager.

Medical Officer of Health

Attachment 8.3: Influenza Vaccine Decision Tool for HCW/staff



Section 9: Confirmed Gastrointestinal Illness Outbreak

GI Illness Case Definition

At least one of the following criteria must be met and not be attributed to another cause (e.g., *Clostridioides difficile* diarrhea, medication, laxatives, diet, or prior medical condition etc.):

- 2 or more episodes of diarrhea (i.e., loose, or watery stools) in a 24-hour period, above what is normally expected for that individual

  OR

- 2 or more episodes of vomiting in a 24-hour period

  OR

- 1 or more episodes of vomiting AND diarrhea in a 24-hour period

  OR

- 1 episode of bloody diarrhea

  OR

- Laboratory confirmation of a known enteric pathogen AND at least one symptom compatible with a GI infection e.g., nausea, vomiting, diarrhea, abdominal pain, or tenderness

Note: Laboratory confirmation is not required

GI Illness Outbreak Definition

- 2 or more cases of GI illness with a common epidemiological link (e.g., same location or same care giver, and evidence of healthcare-associated transmission within the facility), with initial onset within one 48-hour period.

While it is recognized that *Clostridioides difficile* and multi-drug resistant organisms (e.g., MRSA, VRE) can be responsible for clusters or outbreaks, and that some of the measures outlined in this protocol may be applicable in preventing or controlling them, it is beyond the scope of this document to include these organisms, due to their unique epidemiological properties.

See Section 5: General Recommendations for Confirmed Outbreaks.

Outbreaks of infectious GI illness in healthcare facilities can result in high morbidity and a strain on operations. Typically, most of these outbreaks are attributable to norovirus (or viruses that cause similar illnesses, such as sapovirus, rotavirus, astrovirus or adenovirus). Norovirus is extremely communicable, and outbreaks are common. Outbreaks can present in sporadic episodes, or as intensely concentrated events occurring all at once. Attack rates can be quite high (> 50%) in both HCW/staff and residents. Although GI illness outbreaks in healthcare facilities can occur at any time of year, in Alberta most outbreaks occur between October and April.

Most GI illness cases are mild and self-limiting; however, serious dehydration and/or aspiration pneumonia secondary to vomiting can occur in debilitated individuals. Symptoms of GI illness include any combination

of nausea, vomiting, diarrhea, and/or abdominal pain, which may be accompanied by myalgia, headache, low-grade fever, and malaise. An outbreak control program is aimed at early detection and elimination of any common sources of exposure. Despite stringent IPC, outbreak control can be difficult. It is vital that infection control measures are implemented promptly, without waiting for laboratory confirmation of an etiologic agent. Transmission usually occurs via the fecal/oral or vomitus/oral route but can also include contact or droplet spread.

9.1 Infection Prevention and Control Measures

- Consult with ICP/ICD for assistance with IPC issues as required
- Ensure adequate availability of all supplies as recommended in Section 3.14
- When a resident GI case is identified, place signage on the outside of the resident's room door indicating that the appropriate precautions are required.
- Appropriate PPE must be worn Putting on (Donning) Personal Protective Equipment and Taking off (Doffing) Personal Protective Equipment (PPE). Instructions are available on the AHS IPC webpage.
- All PPE must be removed, and hand hygiene must be performed before leaving the resident's room.
- Strict hand hygiene is the most important measure in preventing spread of infections for both HCW/staff and residents.
    - Alcohol-based hand rub (ABHR) is the Infection Prevention and Control preferred product for performing hand hygiene, except when providing care for residents/ patients with diarrhea and/or vomiting AHS Hand Hygiene Procedure

Statement on use of Alcohol-based Hand Rub during GI illness Outbreaks
Alcohol-based hand rubs (minimum 60-90% alcohol) are an acceptable alternative to hand washing during GI illness outbreaks when hands are not visibly dirty and when used according to label directions.

Figure 3: Additional Precautions for GI Illness

Implement **Contact Precautions** in addition to Routine Practices for symptomatic residents. Contact Precautions are implemented for symptomatic residents to control the spread of gastrointestinal viruses during GI illness outbreaks (see AHS IPC website Precautions Posters at Posters | Alberta Health Services for definitions of contact, droplet and droplet and contact precautions).

Implement **Droplet and Contact Precautions if resident is actively vomiting**.

- **Wear** clean **Gloves** to enter resident room or bedspace when providing direct care to symptomatic residents or when having any contact with items in the resident room, when cleaning an area contaminated with feces or vomitus or gathering/handling specimens.
- **Wear** a new **Gown** to enter resident room or bedspace when providing direct care to symptomatic residents or when having any contact with items in the resident room' or when cleaning areas contaminated with feces or vomitus to protect against possible contamination of clothing.
- **Wear Eye Protection and a Procedure Mask** to protect your face when there is any risk of sprays of body fluids or when caring for residents who are actively vomiting.

Refer to site IPC guidelines and Doffing poster on the AHS IPC website for instructions Posters | Alberta Health Services.

Maintain at least 2 metres of physical separation between bed/stretcher spaces for contact precautions if diarrhea only.

Maintain at least 2 metres of physical separation between bed/stretcher spaces for droplet and contact precautions if there is active vomiting and diarrhea.

9.2 Administrative Measures

- Advise HCW/staff to report symptoms of GI illness in themselves during the outbreak to the unit/facility Manager, so that their illness can be tracked for the scope of the outbreak.
- Case reporting for GI illness will be completed using Attachment 9.1 or zone-specific line lists.

9.3 Resident Restrictions

Resident activities are restricted during GI illness outbreaks; the overarching principle is to prevent congregation of residents in the site during the outbreak, where feasible, to help prevent transmission of GI. The specific resident restrictions at the outbreak site will be discussed among the Public Health Outbreak Team and partner(s) involved in managing the outbreak. General recommendations are outlined below:

- Whenever possible, symptomatic residents should be isolated (i.e., remain in their rooms) with meals delivered to them for the duration of the acute illness, and until 48 hours after the last episode of vomiting or diarrhea.
- Symptomatic residents should only leave the outbreak unit/facility when it is medically necessary; in which case the receiving site should be alerted that the resident is symptomatic and coming from a facility experiencing a GI illness outbreak and that contact precautions (contact/droplet precautions if vomiting) are to be implemented by the receiving site.
- If an outbreak is confined to a unit, all residents on that unit should remain on their own unit to avoid contact with other residents in the facility.
- Residents requesting a pass to leave a facility that is under restrictions due to a GI illness outbreak may do so if the resident is asymptomatic. Residents should be advised that if they become symptomatic while away from their facility, they should contact their facility, or seek medical attention.
- During an outbreak, consideration should be given to providing treatment such as physiotherapy or occupational therapy in the resident's room instead of a centralized area; however, residents may be allowed to attend medically necessary activities or appointments provided measures are taken to minimize transmission.

9.4 Restrictions on Affected Units/Site

- Facility/unit status (e.g., open, or restricted admissions) will be determined by the Public Health Outbreak Team at the time the outbreak is declared.
- Decisions regarding GI illness outbreak unit restrictions will be made by the OMT or the Public Health Outbreak Team in consultation with the facility/unit administration.
- Even when admission restrictions are lifted at the recommendation of the OMT or the Public Health Outbreak Team, some residents may still be symptomatic with GI illness. Isolation precautions for symptomatic residents should remain in effect to prevent further spread of infection.
- The scope of unit restrictions is typically dependent on the extent of the outbreak activity within the facility (one unit, one floor, one wing or the entire facility), the ability to cohort HCW/staff to affected areas and severity of the outbreak (e.g., many residents and HCW/staff affected, new cases continue to develop despite implemented control measures).
- Restrictions typically remain in place until the outbreak has been declared over by the Public Health Outbreak Team or designate. Outbreaks are generally closed following the timeframes below, but

may vary due to outbreak assessment on a case-by-case basis, **whichever occurs first:**

- 48 hours from symptom resolution in the last case
  OR
- 96 hours from onset of symptoms in the last case

Restrictions regarding resident admissions/re-admissions/transfer and activities are **ONLY** modified or lifted by the Public Health Outbreak Team. In the event that restriction of admissions/transfers is unduly impacting the availability of acute care beds for individuals requiring urgent care, or because of the expressed informed individual resident or family choice in keeping with AHS's commitment to People Centered Care, the Public Health Outbreak Team will assess the circumstances surrounding the restriction including the degree of risk to the full spectrum of individuals requiring care.

9.5 Admissions/Transfers from Acute Care to an Outbreak LTC, DSL or Hospice Site

- A resident who is hospitalized at another facility prior to the outbreak should not be transferred back to the facility until the outbreak is declared over. If there are extenuating circumstances, an outbreak facility/site may initiate discussion with the Public Health Outbreak Team to further assess the specific situation.

If an admission/transfer to a site must occur during a GI illness outbreak at the site, following the assessment of the circumstances and consultation with the Public Health Outbreak Team. HCW/staff should collaborate with the acute care contact before the resident is discharged. The resident should not be transferred until the site HCW can ensure that the resident/ guardian has information on risks associated with the outbreak and consents to the transfer.

9.6 Transfers from an Outbreak Facility to Acute Care

- If a resident requires acute medical attention or treatment off site (e.g., emergency room, urgent care, dialysis), the outbreak facility must notify the EMS* Dispatcher, the transport staff (EMS crew) and the receiving care facility that the resident is being transferred from a facility experiencing a GI illness outbreak. The transport staff (EMS crew) and the facility receiving the resident can then ensure contact precautions (contact/droplet if resident is vomiting) are in place when the resident arrives there.

*In some communities, EMS Community Paramedics can provide immediate or scheduled medical supervision and treatments that are currently unavailable in the community setting. A referral is required to access this service

9.7 Group/Social Activities and other Events

- It is recommended that previously scheduled resident social and special events/activities (e.g., entertainers, school groups, community presentations, and/or communal meals for special holidays) on the affected unit(s) be canceled/postponed for the duration of the outbreak. Consult the Public Health Outbreak Team about group/social activities, or other situations where residents may congregate. If group activities are an essential part of treatment, discuss with the Public Health Outbreak Team.
- Non-resident events (e.g., meetings) previously booked for areas in proximity to areas under restriction in the outbreak facility should be cancelled or postponed.

9.8 Nourishment Areas / Sharing of Food

- Close the kitchen/nourishment areas accessed by residents/visitors and ensure there is no communal sharing of food in outbreak areas.

- In discussion with the Public Health Outbreak Team, implement measures to minimize resident handling of shared food and surfaces that may touch another resident's food:
    - Close buffet lines, or, have HCW/staff dispense foods from the buffet onto plates for residents
    - Cease Family-style meal service
    - Pre-set the tables in common dining areas to minimize resident handling of multiple sets of cutlery
    - Remove shared food containers from dining areas (e.g., shared pitchers of water, shared coffee cream dispensers, salt & pepper shakers, etc.)
    - For snack programs, dispense snacks directly to residents and use pre-packaged snacks only
    - If using single service packets of condiments, provide packet directly to each resident, rather than self-serve in a bulk container
    - Cease activities involving resident participation in food preparation
    - Other measures as necessary/appropriate
- Ensure that food handling HCW/staff:
    - Practice meticulous hand hygiene
    - Are excluded from work if symptomatic Section 9.12
- Use of disposable plates and cutlery by symptomatic residents is not required for GI illness outbreak management.
- Normal dishwashing and food preparation area surface sanitizing practices are appropriate during GI outbreaks, i.e., no additional/different disinfection of dishes or surfaces in food preparation areas is needed over and above what is normally done.
- Use dining table coverings that can be easily cleaned and disinfected (i.e., discontinue use of cloth/linen table coverings until the outbreak is over).
- Ensure that all touch surfaces of the tables and chairs (including the underneath edge of the chair seat) are cleaned and disinfected after each use.
- Staff assigned to housekeeping duties should not be involved in food preparation or food service. Consult the Public Health Outbreak Team with any questions.

9.9 Adult Day Programs in sites Operating Adult Day Programs (e.g., CHOICE/C3)

If the outbreak facility operates an Adult Day Program (e.g., CHOICE/C3), discuss this with the OMT/Public Health Outbreak Team at the time the outbreak is first reported. Generally, the Public Health Outbreak Team will recommend that Adult Day Programs continue to operate in a facility with an ongoing GI illness outbreak **IF**:

- the Adult Day Program is operated in an area physically separate from areas of the facility in which there have been resident cases with GI illness symptoms
- residents attending the Adult Day Program do not mix with the residents from the outbreak facility
- Adult Day Program HCW/staff do not provide care in areas of the facility in which there have been outbreak cases

9.10 Visitor and Designated Family/Support Person(s) (DFSPs)

- Post outbreak signage Attachment 5.1 at the entrance of the facility/unit advising HCW/staff, other professions working in the facility that are not HCW, and visitors of necessary precautions.
- Visitors should be advised of the potential risk of acquiring illness and advised to practice hand hygiene before and after visiting.
- Advise those who choose to visit during an outbreak to practice good hand hygiene and limit visit to one (1) resident only and exit the facility immediately after the visit.
- Those visiting symptomatic residents must be advised to practice Contact Precautions (contact/droplet precautions if vomiting) to protect themselves.
- Complete restriction of visitation during GI illness outbreaks is typically not recommended by AHS

as it may cause emotional hardship to both residents and families. However, if a facility is having difficulty controlling an outbreak, consult the Public Health Outbreak Team.
- Designated Family/Support Person(s) - See Section 3.10

9.11 Volunteer Restrictions

- Volunteers should be advised of the potential risk of acquiring illness.
- Advise volunteers of the importance of hand hygiene
- Volunteers who continue to help during an outbreak are managed as outlined in Section 9.12
- Exclude non-essential volunteers from working in affected areas of the facility (if any can be deemed "non-essential").

9.12 HCW/Staff Outbreak Measures (Including volunteers, students, physicians)

- HCW/staff should be advised of the need for daily self-assessment for GI illness symptoms.
- Symptomatic HCW/staff that fit the case definition for GI illness should be excluded from work at all care facilities until 48 hours following the last episode of vomiting and/or diarrhea.
- Asymptomatic HCW/staff may work in the outbreak unit as well as other work locations during different shifts.

GI illness among HCW/staff: If there is an unusual increase in GI illness amongst HCW/staff (above the baseline of what would be expected) whether they were present at work with symptoms or not it should be reported to CEIR as this could be an indicator of a potential outbreak.

9.13 Specimen Collection

- Stool specimen results do not typically impact outbreak management strategies for GI illness outbreaks. However, from the Public Health Outbreak Team perspective it is valuable to collect stool specimens from cases during outbreaks to try and identify the etiology, if possible. Typical GI illness outbreak stool specimen collection procedures are found in Attachment 3.1**.** Sites must collect specimens as directed by the Public Health Outbreak Team and arrange for delivery of specimens to the laboratory.

9.14 Enhanced Environmental Cleaning and Disinfection

- Environmental surfaces often become contaminated with feces or vomitus containing viruses or bacteria causing GI illness. Thorough cleaning and disinfection of frequently touched surfaces and equipment can help interrupt disease transmission during GI illness outbreaks. Perform cleaning and disinfection of frequently touched environmental surfaces and equipment in isolation and cohorted areas, as well as high-traffic clinical areas. Frequently touched surfaces include, but are not limited to, commodes, toilets, faucets, hand/bed railing, telephones, door handles, and computer equipment.
- Specific information about environmental cleaning can be found at Principles for Environmental Cleaning and Disinfection (albertahealthservices.ca) and at Environmental Public Health.

Recommended disinfectants
The following disinfectant categories/concentrations are recommended for disinfecting surfaces and equipment during GI illness outbreaks (follow manufacturer's directions for use):

1. Hypochlorite at a concentration of 1000 parts-per-million. Commercially available hypochlorite-containing solutions are recommended.

2. A surface disinfectant with a Drug Identification Number (DIN) issued by Health Canada with a specific label claim against norovirus, feline calicivirus, or murine norovirus.

An example of a product with this label claim currently in wide use in AHS facilities is 0.5% accelerated hydrogen peroxide. There are other products available with this label claim.
Notes:

- Equipment should be cleaned and disinfected only with a product listed in and following the procedures outlined in the manufacturer's directions for that equipment.
- Surfaces must first be cleaned prior to disinfection (2 step process). If the surface disinfectant product used has cleaning properties (detergent/disinfectant) it may be used for both steps. Follow manufacturer's directions for use.

Follow recommended cleaning and disinfection protocols (refer to Enhanced Cleaning in Section 3.14 for General Outbreak related Cleaning and disinfection)

- Immediately clean and disinfect areas soiled with emesis or fecal material.
- Use fresh mop head, cloths, cleaning supplies and cleaning solutions to clean affected rooms, and after cleaning large spills of emesis or fecal material.
- Consider discarding all disposable resident-care items and laundering unused linens (e.g., towels, sheets) from resident rooms when the isolation precautions for GI illness are lifted.
- Privacy curtains should be changed if visibly dirty and when isolation precautions for GI illness are lifted.
- Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak.

Note: upholstered furniture and rugs or carpets should be cleaned and disinfected when contaminated with emesis or stool but may be difficult to clean and disinfect completely. Consult manufacturer's recommendations for cleaning and disinfection of these surfaces. If manufacturer's recommendations are not available, consult the Public Health Outbreak Team. Consider discarding items that cannot be appropriately cleaned/disinfected, when possible/appropriate.

Linen/Laundry

- Appropriate PPE (e.g., gowns) should be worn if there is a risk of contamination of HCW/staff clothing from body fluids or secretions
- PPE including gloves should be removed and hands cleaned once soiled laundry has been placed in the laundry bag.
- If laundry is done in resident laundry rooms (vs. a central laundry room) dedicate one laundry room for soiled laundry from resident's sick with the outbreak illness.
- All linen that is soiled with body fluids should be handled using the same precautions regardless of the source.
- Remove gross soiling (e.g., feces) with a gloved hand and dispose into toilet. Do not remove excrement by spraying with water.
- Bag or contain soiled laundry at point of care.
- Do not sort or pre rinse soiled laundry in resident care areas
- Handle soiled laundry with minimum agitation to avoid contamination of surfaces & people. (e.g., roll up)
- Contain wet laundry before placing it in a laundry bag (e.g., wrap in a dry sheet or towel).
- Double bagging is not necessary & not recommended.
- Laundry bags should be tied securely & not over-filled.
- If the laundry machine has been used to clean laundry soiled with diarrhea or vomiting a bleach cycle of the laundry machine should be ran (without a load of laundry) before washing other laundry

9.15 Management of "Relapse" Cases

GI illness cases frequently "relapse," i.e., experience onset of vomiting or diarrhea after being asymptomatic for 24 to 48 hours. The relapse is likely due to malabsorption during an existing norovirus infection rather than being a new infection. These "relapse" GI illness cases:

- should be isolated until they are free of vomiting and diarrhea for 48 hours, as they may still be infectious.
- should NOT be counted as new outbreak cases (and should therefore NOT be included on daily case listings) - these are not new outbreak cases, and a resident should only be counted as a new case once on a daily case listing. Therefore, relapse case(s) alone would not result in the extension of admission restrictions.

  Note: If a previously identified GI illness case has onset of GI illness symptoms after being symptom free for **at least seven (7) days,** it is considered a new case.

Attachment 9.1: Data Collection for Gastrointestinal Illness Outbreak Management

It is important that as soon as an outbreak is suspected, front line HCW/staff assess and track symptomatic residents and HCW/staff for surveillance, monitoring, and reporting purposes. Accurately completed lists of cases should be reported to the Public Health Outbreak Team on a **daily basis** once an outbreak has been declared. The individual responsible for completing and submitting the list of cases should be determined by site/zone process but may be taken on by site ICP/ICD, unit/facility manager or another responsible HCW/staff in the unit/site. Outbreak data elements that should be reported daily to the Public Health Outbreak Team include:

Outbreak Facility/Site (name, unit/floor, contact person, phone, and fax)

Date of Report

Population affected at the time outbreak is reported (total resident and HCW/staff population at risk on the outbreak unit/site, number of residents and HCW/staff who meet the case definition)

Outbreak/EI number (as provided by the Public Health Outbreak Team)

Demographics of Cases

- Residents: name, personal health number, date of birth, gender, unit/room number
- HCW/staff: initials, gender, occupation, unit they work on

Signs and Symptoms

- Onset date
- Signs and symptoms meeting case definition (vomiting, diarrhea, bloody diarrhea)
- Duration of illness

Lab tests/Results

- Stool specimen (date sent)
- Results

Hospitalization or Death of Cases

- Cases hospitalized (name, personal health number, date of admission, name of hospital)
- Cases who died (name, personal health number, date, and cause of death)

Section 10: Closing an Outbreak

The Public Health Outbreak Team will declare the outbreak over and lift any site restrictions. Restrictions can only be lifted by the Public Health Outbreak Team.

Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak as per facility protocols.

Following an outbreak, key program leads need to review and evaluate their role in the outbreak management and revise internal protocols where necessary for improvement. A debriefing may be called by any member of the Outbreak Management Team (OMT) to address outbreak management issues. Depending on type and scale of the outbreak, a summary report including background, details of the investigation, results and recommendations may be written by a member of the OMT and shared with internal/external partners.

If additional residents develop symptoms within 7 days of the outbreak being closed, the Site / Unit should follow the steps for assessing a potential outbreak in Section 2 and managing a potential outbreak in Section 3 but should disclose to CEIR that that had recently closed an outbreak.

Section 11: Summary of Changes

Date	Section	Revision/Addition
Sep 19, 2022	Throughout	Grammatical changes
	Throughout	Designated Support Person changed to Designated Family/Support Person
	Throughout	Nourishment Areas/Sharing of Food sections additional guidance incorporated
	Section 4	• COVID-19 clinical illness symptoms added to the case definition • Respiratory Illness Case Definition updated to align with AH • Influenza Illness Case Definition updated to align with AH
	Appendix A	• Letter and Forms for 2022-23 outbreak season updated • Links provided to online forms to be used for Influenza season
	Appendix C	*NEW* Outbreak Checklists for front line staff • COVID-19 • Respiratory • Influenza • Gastrointestinal

Date	Section	Revision/Addition
June 30, 2022	Throughout	Addition of Hospice sites (to Guide title and throughout document)
	Throughout	Designated Family/Support person definition and recommendations
	Definitions	Add “Appropriate Mask”, “HCW/Staff”; “Most Responsible Health Practitioner”, “Public Health Outbreak Team” (previously Public Health); “Visitor” “Surveillance Case” “Surveillance Reporting”
	Throughout	Updates to align with Living With COVID-19 updates - Add Surveillance Case Definition and Surveillance Reporting Definition
	Throughout	HCW/Staff
	Section 2	Add Table A – revised list of symptoms in residents and HCW/staff
		Add Surveillance Case Tracking Form – used by sites to track symptomatic residents and staff. Attachment 2.1
		Exception for GI illness: If two residents have GI symptoms only and meet the outbreak definition as outlined in Section 9 (2 residents meeting GI case definition with onsets within 48 hours of each other) a call should be made to CEIR at that time to report a potential GI outbreak
	Section 3	Update – sites require 2 cases that meet Surveillance Reporting Definition prior to reporting to CEIR
		Exception for GI illness: If two residents have GI symptoms only and meet the outbreak definition as outlined in Section 9 (2 residents meeting GI case definition with onsets within 48 hours of each other) a call should be made to CEIR at that time to report a potential GI outbreak
	Section 4	- COVID-19 Outbreak Definition – 2 or more within a 7-day period (was 10) - Respiratory Illness Outbreak Definition – 2 or more within 7 days (was 14)
	Section 6	- Duration of Outbreak now 14 days (was 20 days) - Resident isolation now 5 days in room (followed by 5 days masking) - Add Table H outlining HCW/staff testing and work restrictions

		- Removed Algorithm 1and 2 How to Manage Unimmunized staff
	Appendix A	Coming Soon – Sample documents for outbreak season preparation
	Appendix B	Add New Resource “Symptoms? What Do I Do to Prevent a Potential Outbreak” – overview and clean copy for printing 2-page document

Appendix A: Sample Letters and Forms for Outbreak Season Preparation

Samples of the following letters are found in Appendix A:

- Letter to Prescribers - Advance Prescriptions for Antiviral Medication during Influenza Outbreaks (including Antiviral (Oseltamivir) Dosing Recommendations)
- Letter to Pharmacist - Provision of Antiviral Medication During Influenza Outbreaks
- Letter to Designated (DSL) and Non-Designated Supportive Living (NDSL) Site Operators, AHS Home Care Seniors Health Program Managers/Operation Managers and Case Managers
- Important Notice to Staff about Influenza and COVID-19
- Letter to Resident or Decision Maker

Links to forms that may be used during influenza season (samples not included in guide):

- Advance Prescription for Oseltamivir (Tamiflu®) (albertahealthservices.ca)
- Outbreak Antiviral Prophylaxis in Non-Designated and Designated Supportive Living Site Worksheet (albertahealthservices.ca)

Click here to enter a date.

Advance Prescriptions for Antiviral Medication during Influenza Outbreaks – (Insert zone) Zone

Dear Colleagues,

Provision of antiviral medication during influenza outbreaks for:

- **All residents living in Long Term Care (LTC) and Supportive Living settings**
- **Unimmunized Staff working in LTC and Supportive Living settings**

Influenza viruses circulate throughout our communities every year. In anticipation of influenza outbreaks occurring in LTC and Supportive Living sites, we are requesting your assistance with preparing individuals under your care (i.e., living or working in an LTC or Supportive Living site) for the upcoming influenza season. Supportive Living sites include lodges, manors, seniors' residences, and designated supportive living facilities.

All individuals should be encouraged to receive their annual influenza immunization. However, even with good immunization rates, outbreaks of influenza commonly occur in sites in which there is communal dining.

OSELTAMIVIR RECOMMENDATIONS DURING INFLUENZA OUTBREAKS

When an influenza outbreak is declared, the Medical Officer of Health (MOH) recommends the following:

- All residents, whether immunized or not, receive oseltamivir antiviral prophylaxis.
- Unimmunized staff (**including unimmunized physicians making site visits)** are required to take oseltamivir antiviral prophylaxis. Staff who are not immunized and are not taking the recommended antiviral prophylaxis should be excluded from working as outlined in the AHS Guide for Outbreak Prevention and Control in non-designated supportive living and in LTC and designated supportive living.
- A prescription for a prophylactic dose of oseltamivir for ten (10) days with two (2) refills for five (5) days each is recommended. Antiviral prophylaxis is recommended for 7 days after onset of symptoms of the last resident case. An oseltamivir dosing chart can be found in the Roche Canada Tamiflu product monograph: [Product Monograph Template - Standard] (rochecanada.com). An oseltamivir dosing chart, excerpted from the AHS Guide for Outbreak Prevention and Control, is attached as Appendix A of this letter.

ACCESS TO OSELTAMIVIR PROPHYLAXIS - RESIDENTS

If you provide care to residents within an LTC or Supportive Living site:

- Collaborate with the site operator or site administrator to plan for how you will ensure that residents under your care will have timely access to oseltamivir prophylaxis if an influenza outbreak is declared.

If you provide care to Supportive Living residents outside of the site (in the community):

- Residents of Supportive Living sites where the site does not coordinate access to oseltamivir prophylaxis may be asked to contact a prescriber (a physician, nurse practitioner, or prescribing pharmacist) in order to receive an advance prescription for oseltamivir antiviral prophylaxis in preparation for the start of influenza season.
- If a resident requests an oseltamivir prophylaxis advance prescription, please fax a ten (10) day prescription with two (2) refills for five (5) days to the resident's pharmacy. Prescriptions will remain on hand until such time the MOH declares an influenza outbreak at the resident's site or for 1 year (whichever comes first).

ACCESS TO OSELTAMIVIR PROPHYLAXIS – STAFF

- Covenant Health OHS and Alberta Health Services WHS have a process in place for staff requiring antiviral prophylaxis. Staff will be advised to contact their respective OHS/WHS department at the time of an influenza outbreak for assessment and advice.
- Non-AHS/Covenant Health staff may be directed to contact a prescriber (a physician, nurse practitioner, or prescribing pharmacist) at the time of an influenza outbreak to obtain a prescription (if indicated).

ALBERTA INFLUENZA ANTIVIRAL DRUG POLICY

The **Alberta Influenza Antiviral Drug Policy as Applied to Vulnerable Populations Living in Congregate Living Settings** defines who is eligible for provincially funded antiviral medication during influenza outbreaks.

- This policy applies to residents of Supportive Living sites
    - Pharmacies that fill prescriptions for antiviral prophylaxis under this policy are compensated under Alberta Blue Cross as per their Pharmacy Benefact; the resident does not have to pay for these medications (antiviral prophylaxis or treatment doses).
- The following individuals are not eligible for publicly funded antiviral medication under this policy:
    - Residents of LTC facilities or nursing homes and patients in a hospital
        - Residents of LTC are covered under the Nursing Homes Act and patients admitted to hospital are covered under the Hospitals Act
    - Health care workers (HCWs) in any setting
        - Although HCWs (employees or volunteers) are not eligible for publicly funded antiviral medication under this policy, unimmunized staff should still take antiviral prophylaxis. Their employer must have a process in place regarding coverage of cost of antiviral prophylaxis.

If you have questions, please contact (Zone MOH or Zone CDC Nursing) at (contact number).

Thank you for your continued assistance and co-operation.

NAME
Lead Medical Officer of Health - ZONE

Antiviral (Oseltamivir) Dosing Recommendations

From TAMIFLU® Product Monograph, Roche Canada (revised February 2020) and Lexicomp online (accessed September 21, 2020).

Adults and adolescents (13 years and older)		
Creatinine clearance +	Prophylaxis (10 days or duration of outbreak, whichever is longer*)	Treatment (5 days)
Over 60 mL/min	75 mg once daily	75 mg twice daily
31- 60 mL/min	30 mg once daily or 75 mg every other day **	30 mg twice daily or 75 mg once daily **
10-30 mL/min	30 mg every other day	30 mg once daily
Less than 10 mL/min and not on dialysis Ψ	30 mg PO suspension/capsule x 1 dose for duration of outbreak ¥	75 mg PO x 1 dose for duration of illness ¥
On routine hemodialysis	30 mg immediately, then 30 mg after alternate hemodialysis sessions for duration of outbreak	30 mg immediately, then 30 mg after every dialysis session over 5 days
On peritoneal dialysis	30 mg immediately, then 30 mg once weekly for duration of outbreak	30 mg immediately as a single dose (single dose provides a 5-day duration)
Continuous Renal Replacement Therapy (CRRT, high flux) Ψ	30 mg once daily	30 mg twice daily
Pediatrics (1-12 years) Normal Renal Function		
Body Weight	Prophylaxis (10 days or duration of outbreak, whichever is longer *)	Treatment (5 days)
Less than or equal to 15 kg (less than or equal to 33 lbs)	30 mg once daily	30 mg twice daily
Greater than 15 kg to 23 kg (greater than 33 lbs to 51 lbs)	45 mg once daily	45 mg twice daily
Greater than 23 kg to 40 kg (greater than 51 lbs to 88 lbs)	60 mg once daily	60 mg twice daily
Greater than 40 kg (greater than 88 lbs)	75 mg once daily	75 mg twice daily
Commercially manufactured TAMIFLU for Oral Suspension (6 mg/mL) is the preferred product for pediatric and adult patients who have difficulty swallowing capsules or where lower doses are needed		
Reviewed by U. Chandran and S. Fryters, AHS Antimicrobial Stewardship Committee in 2020		
* If influenza outbreak duration is less than 10 days, oseltamivir prophylaxis may be discontinued. Consult with Public Health.		
** If supply of 30 mg preparations is not available or accessible.		
Ψ Note: these dosages are not found in the Roche Canada product monograph		
¥ Reference: Lexicomp August 2012		
+ Serum creatinine tests for residents/patients should be adequate if done within the past year, provided there has not been a sudden change in kidney function or change in weight. Facilities should prepare for respiratory virus outbreak season each year by ordering serum creatinine and recording resident weights. A baseline temperature should also be taken and recorded. Ultimately, prescribers are responsible for determining the appropriate antiviral dose for their patients. Early initiation of antiviral treatment is critical for treatment effectiveness. In situations where renal function has been unstable in the past, or patient/resident oral intake/urine output has been poor in the immediate prior period, or where creatinine results are older than one year prior, antiviral treatment can be started using the most recent creatinine clearance estimate for dosing, with blood work sent off within 24 hours, and the result used to adjust the timing and amount of subsequent doses.		
In the event of antiviral resistance in the outbreak influenza strain, alternate recommendations for antiviral prophylaxis will be provided by the Zone MOH.		

Click here to enter a date.

Provision of Antiviral Medication During Influenza Outbreaks – (insert zone)

Dear Community Pharmacist,

Re: Provision of antiviral medication during influenza outbreaks for:

- **All residents living in Long Term Care (LTC) and Supportive Living settings including lodges, manors, seniors' residences, and designated supportive living facilities**
- **Unimmunized staff working in LTC and Supportive Living settings**

Over the next several weeks, in preparation for the upcoming influenza season, your pharmacy may be receiving advance influenza antiviral prophylaxis prescriptions from prescribers for residents living in LTC and Supportive Living sites. **Please do not dispense these advance prescriptions until you are notified of a laboratory-confirmed influenza outbreak by the Alberta Health Services (AHS) (insert zone) Zone Medical Officer of Health (MOH) or Communicable Disease Control (CDC) nursing team, or by the facility.**

When an influenza outbreak is declared at a congregate living site, the MOH recommends that all residents, whether immunized or not, receive oseltamivir antiviral prophylaxis. Unimmunized staff are also required to take antiviral prophylaxis if they are working during the outbreak. You may receive notification of a confirmed outbreak directly from a facility or from the (insert zone) MOH or CDC Outbreak Team. **In the event you do not receive this notification, you must contact the outbreak facility directly and speak to the outbreak site designate to gather the necessary information.**

- Following a notification of a laboratory-confirmed influenza outbreak at a site, please dispense advance prescriptions for antiviral prophylaxis as soon as possible, and deliver resident antiviral medications, as appropriate.
- At the time of an influenza outbreak, you may receive prescriptions for antiviral **prophylaxis** for residents **without** advance prescriptions and for unimmunized staff working at the outbreak site. You may also receive prescriptions for antiviral **treatment** for symptomatic residents.

Alberta Influenza Antiviral Drug Policy

The **Alberta Influenza Antiviral Drug Policy as Applied to Vulnerable Populations Living in Congregate Living Settings (CLS)** defines who is eligible for provincially funded antiviral medication during influenza outbreaks.

- **This policy applies to residents of Supportive Living sites only**
  - Pharmacies that fill prescriptions for antiviral prophylaxis under this policy are compensated under Alberta Blue Cross as per their Pharmacy Benefact; the resident does not have to pay for antiviral medication (prophylaxis or treatment doses).

- **The following individuals are not eligible for publicly funded antiviral medication under this policy:**
  - Residents of LTC facilities (including nursing homes and auxiliary hospitals) and patients in a hospital
    - Residents of LTC are covered under the Nursing Homes Act and patients admitted to hospital are covered under the Hospitals Act
  - Health care workers (HCWs) in any setting
    - Although HCWs (employees or volunteers) are not eligible for **publicly funded** antiviral medication, unimmunized staff should still take antiviral prophylaxis if they are working during the outbreak. Their employer will advise their employees regarding coverage of the cost of antiviral prophylaxis.

Prescribing Pharmacists

- Supportive Living sites may look to collaborate with a prescribing pharmacist to obtain antiviral prophylaxis prescriptions.

- If you are a prescribing pharmacist, you may receive requests from Supportive Living sites or from individual residents to assist with influenza antiviral prophylaxis advance prescriptions or with antiviral prophylaxis prescriptions at the time an influenza outbreak is declared.

Important Things to Note

- Any resident without an Alberta Personal Health Number is covered by this policy (**Please refer to the Pharmacy Benefact for additional information)**. Please ensure you are a party to the Alberta Blue Cross Pharmacy Agreement prior to submitting the prescribed Antivirals Dispensing claims.

- Refer to the current Tamiflu (Roche Canada) product monograph for Tamiflu dosing recommendations.

- Covenant Health OHS and Alberta Health Services WHS have a process in place for staff requiring antiviral prophylaxis. Covenant and AHS staff will be advised to contact their respective OHS/WHS department at the time of an influenza outbreak for assessment and advice. Staff working at all other LTC, and Supportive Living facilities should contact their OHS/WHS designate.

- **If you have questions about billing, you must contact Alberta Blue Cross directly.**

If you have clinical questions, please contact (Zone MOH or Communicable Disease Control) at (contact number for MOH or CDC). When calling, please indicate that you are calling about ***(insert zone)*** Zone advance antiviral prophylaxis prescriptions for influenza outbreaks.

Thank you for your continued assistance and co-operation.

ADD MOH Signature

Name, designation
Lead Medical Officer of Health – Zone
Alberta Health Services

Date:

To: All Designated (DSL) and Non-Designated Supportive Living (NDSL) Site Operators, AHS Home Care Seniors Health Program Managers/Operation Managers and Case Managers

Subject: Outbreak Preparation for 2022/23 Season

Dear Operators and Seniors Health Staff:

Outbreaks of respiratory illness (including influenza and COVID-19) and gastrointestinal illness are possible in Supportive Living facilities. Preparing for and responding to outbreaks is a shared responsibility.

Alberta Health Services Public Health kindly requests your assistance in preparing for the 2022-2023 outbreak season. These tasks will help to protect both staff and residents and will facilitate an effective response if an outbreak occurs at your site.

1. Ensure that all residents have a prescription for influenza antiviral prophylaxis (Oseltamivir [Tamiflu]) available in-advance of, or within a very short time of, an outbreak being confirmed.

    a. **Arrange for advance prescriptions:**
        i. **DSL Site Operators in collaboration with AHS Home Care**: Options to ensure advance prescriptions are in place include:
            1. Arranging for resident influenza prophylaxis prescriptions through each resident's most responsible health provider (a physician, prescribing pharmacist, or nurse-practitioner). OR
            2. Working with or contracting a single prescriber for the whole site (a physician, prescribing pharmacist, or nurse-practitioner).
        ii. **NDSL Site Operators in collaboration with Residents:** Options to ensure advance prescriptions are in place include:
            1. Working with or contracting a single prescriber for the whole site (a physician, prescribing pharmacist, or nurse-practitioner). OR
            2. Advising residents to see their primary care provider or another community prescriber (a physician, prescribing pharmacist, or nurse practitioner) to request an advance prescription. Please distribute to residents or guardians/substitute decision-makers the *Resident Outbreak Preparation Letter* and the *Advance Prescription for Oseltamivir (Tamiflu)* prescription template, within the next month. Please continue to distribute the letter for future admissions until April 30, 2023.

    b. **Make a plan for how to respond at the time of an outbreak:** Contact a local prescriber (a physician, prescribing pharmacist, or nurse-practitioner) to make arrangements in preparation for immediate access to antivirals for all residents who did not obtain an advance prescription at the time of an outbreak notification. For your convenience, a prescribing pharmacist can be found at this link: Alberta College of Pharmacy (abpharmacy.ca)

2. Consider creating and maintaining an up-to-date list of residents throughout the outbreak season until April 30, 2023, using the Outbreak antiviral prophylaxis in non-designated and designated supportive living sites worksheet. We suggest the worksheet be completed in advance of an outbreak to ensure timely and effective management at the facility. Please note the following:
    a. Information about whether residents have received annual influenza vaccine and the number of COVID-19 vaccine doses received may be requested by CDC nursing.

   b. When an influenza outbreak occurs, residents who do not have an advance prescription for antiviral prophylaxis will need to see a prescriber to get a prescription as soon as possible.
   c. Information about whether residents have received influenza antiviral prophylaxis may be requested by CDC nursing at the time of an influenza outbreak.

3. Recommend that staff receive all doses of COVID-19 vaccine that they are eligible for (including boosters) and an annual dose of seasonal influenza vaccine. Provide a copy of the letter *Important Notice to Staff About Influenza and COVID-19* to all staff, including new hires, until April 30, 2023.

4. Recommend that residents receive all doses of COVID-19 vaccine that they are eligible for (including boosters) and an annual dose of seasonal influenza vaccine.

5. Develop a site plan for how to access testing supplies at the time of an outbreak.

Although roles and responsibilities can vary between sites, site operators, AHS Home Care Managers and Case Managers should collaborate to ensure that each site is prepared for the upcoming outbreak season.

Outbreak Management Resources:

Outbreak management recommendations and resources changed frequently in the past outbreak season and will likely continue to change frequently during the upcoming season. For the most up to date information, please review the following resources frequently:

- Zone MOH website: (zone specific link)
- AHS Infection Prevention & Control (IPC) Outbreak Management: https://www.albertahealthservices.ca/ipc/Page6421.aspx
- Guide for Outbreak Prevention and Control in Non-Designated Supportive Living Sites: https://www.albertahealthservices.ca/assets/healthinfo/flu/hi-flu-care-and-treat-guidelines.pdf
- Guide for Outbreak Prevention and Control in Long Term Care, Designated Supportive Living and Hospice Sites: https://www.albertahealthservices.ca/assets/healthinfo/flu/hi-flu-prov-hlsl.pdf
- AHS Health Professionals COVID-19 information: https://www.albertahealthservices.ca/topics/Page16947.aspx

Questions regarding outbreak preparation and response can be directed to (zone specific contact information).

Thank you very much for your partnership in outbreak management!

Name, designation
Lead Medical Officer of Health – Zone
Alberta Health Servi**ces**

Important Notice to Staff about Influenza and COVID-19

Date

Why is it important to receive a complete COVID-19 immunization series (including any recommended boosters)?

We all must do our part to protect one another. Immunization is the single most effective means of protecting yourself, your loved ones, and the greater community from COVID-19. Without immunization, Albertans are at risk of developing severe illness and even death from this virus. Vaccines strengthen your immune system by building antibodies to help prevent diseases. Immunization is safe. It is still recommended to get the vaccine even if you were previously infected.

If you do not get immunized and a COVID-19 outbreak occurs, what happens?

In the event of a COVID-19 outbreak at your site, the <insert zone>Medical Officer of Health may make recommendations that will impact unimmunized or partially immunized staff members. **This may include being excluded from work.**

Why is it important for you to be immunized with influenza vaccine every year?

Getting immunized against influenza every year is the most effective way to prevent the spread of the virus. Healthcare workers (HCWs) have a unique responsibility to protect their own health as well as the wellbeing of those around them who may be at risk. Other reasons to get immunized include: 1) HCWs are at a higher risk of exposure to influenza than adults in non-healthcare work settings; 2) HCWs may transmit influenza to vulnerable patients, and their own family and friends; and 3) Immunized HCWs decrease risk of illness, serious outcomes and even death for themselves and others.

If you do not get immunized and an influenza outbreak occurs, what happens?

In the event of an influenza outbreak at your site, the <insert zone>Medical Officer of Health may make recommendations that will impact unimmunized staff members. **This may include being excluded from work or starting a prescription antiviral medication called Oseltamivir for the duration of the outbreak.** Depending on employer/employee health insurance arrangements, you may be required to pay for the antiviral.

For more information, please speak with your manager or call Health Link Alberta at 811.
Visit AHS websites: COVID-19 information - https://www.albertahealthservices.ca/covid19
Influenza information - https://www.albertahealthservices.ca/influenza

Thank you for your attention to this important matter.
Sincerely,

Medical Officers of Health
Alberta Health Services, Zone

Date

Dear Resident or Alternate Decision Maker,

Fall is the time to prepare for respiratory outbreak season. An outbreak is an increase in the number of people who live at a facility and become sick with the same kind of infection. Individuals living in lodges and supportive living facilities may be exposed to different kinds of respiratory infections including influenza and COVID-19. Those who are age 65 or older and anyone with chronic medical conditions are most at risk of serious illness and hospitalization.

Outbreaks may occur at the facility you live in. The table below shows some ways to keep yourself from becoming sick, and to protect yourself if there is an outbreak.

How to protect yourself from infections
• Wash your hands often and thoroughly with soap and water or use an alcohol-based hand rub. • Practice physical distancing (2 meters/6 feet) when in public places. • Stay in your room when you are sick. Tell someone in your facility when you are feeling sick. • Consider wearing a mask in public places. • Cough or sneeze into your sleeve or a tissue - not your hands.
How to protect yourself from influenza

• Get your annual influenza vaccine every fall.
• A prescriber (physician, nurse practitioner, or prescribing pharmacist) can give you a prescription for a medicine called Oseltamivir (Tamiflu®) that can help to keep you from getting ill **if there is an influenza outbreak** at your site. See a prescriber as soon as possible to get a prescription in advance. Bring the attached form called *Advance Prescription for Oseltamivir (Tamiflu®)* with you.
  ○ This medication is filled and taken **during an outbreak** even if you have been immunized against influenza as an extra level of protection.
  ○ There is no charge for this medication.

How to protect yourself from COVID-19
• Get all recommended doses of COVID-19 vaccine. • For the most updated information please visit: https://www.albertahealthservices.ca/topics/Page16944.aspx

If you have further questions, please contact the manager at your site.

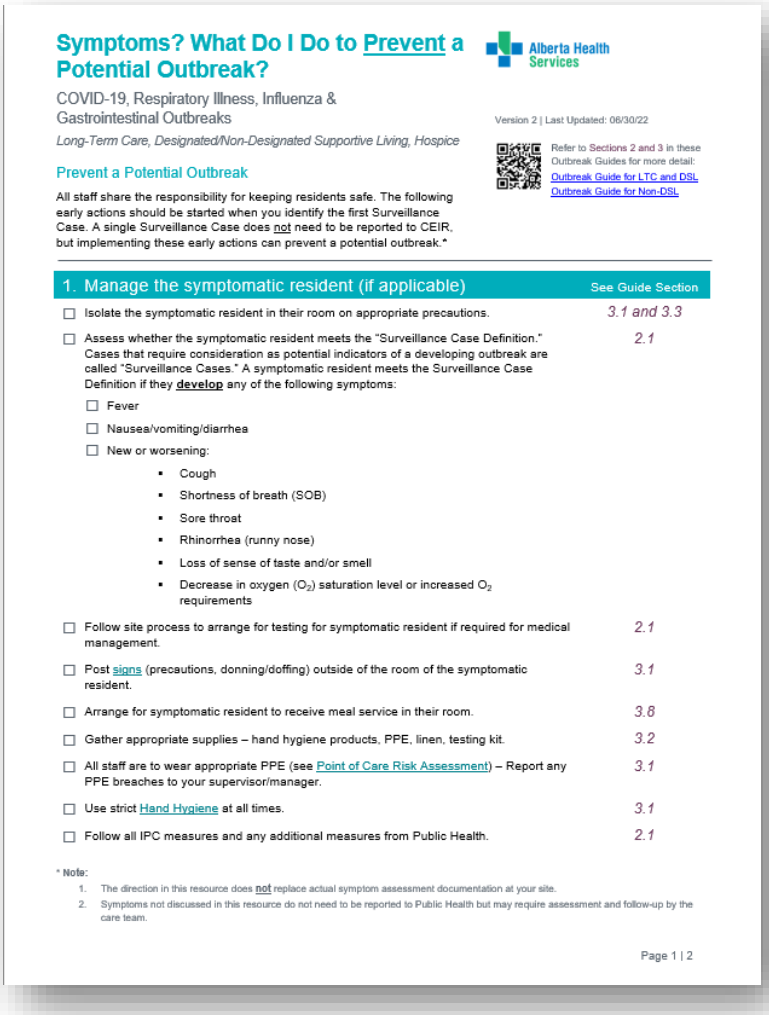
Thank you for your attention to this important health matter.

Medical Officer of Health
Zone

Appendix B: Symptoms? What Do I Do to Prevent a Potential Outbreak

This resource was developed to help facilities/sites manage symptomatic staff and residents before the Surveillance Reporting Definition is met (prior to calling CEIR).

- This resource can be printed and made available to the front-line staff for daily use. Print copies directly from the web page online - Outbreak Management | Alberta Health Services
- It provides the list of symptoms that a HCW/staff should be on the alert for, from Table A in the guide.
- It also provides a summary of the steps that should be taken if the symptomatic person is a resident or HCW/staff
- Communicate, who to tell when a resident and/or a HCW/staff is symptomatic is also outlined.



Symptoms? What Do I Do to Prevent a Potential Outbreak?

Alberta Health Services

COVID-19, Respiratory Illness, Influenza & Gastrointestinal Outbreaks

Long-Term Care, Designated/Non-Designated Supportive Living, Hospice

Version 2 | Last Updated: 06/30/22

Refer to Sections 2 and 3 in these Outbreak Guides for more detail:
Outbreak Guide for LTC and DSL
Outbreak Guide for Non-DSL

Prevent a Potential Outbreak

All staff share the responsibility for keeping residents safe. The following early actions should be started when you identify the first Surveillance Case. A single Surveillance Case does not need to be reported to CEIR, but implementing these early actions can prevent a potential outbreak.*

1. Manage the symptomatic resident (if applicable)	See Guide Section
☐ Isolate the symptomatic resident in their room on appropriate precautions.	*3.1 and 3.3*
☐ Assess whether the symptomatic resident meets the "Surveillance Case Definition." Cases that require consideration as potential indicators of a developing outbreak are called "Surveillance Cases." A symptomatic resident meets the Surveillance Case Definition if they **develop** any of the following symptoms: ☐ Fever ☐ Nausea/vomiting/diarrhea ☐ New or worsening: ▪ Cough ▪ Shortness of breath (SOB) ▪ Sore throat ▪ Rhinorrhea (runny nose) ▪ Loss of sense of taste and/or smell ▪ Decrease in oxygen (O_2) saturation level or increased O_2 requirements	*2.1*
☐ Follow site process to arrange for testing for symptomatic resident if required for medical management.	*2.1*
☐ Post signs (precautions, donning/doffing) outside of the room of the symptomatic resident.	*3.1*
☐ Arrange for symptomatic resident to receive meal service in their room.	*3.8*
☐ Gather appropriate supplies – hand hygiene products, PPE, linen, testing kit.	*3.2*
☐ All staff are to wear appropriate PPE (see Point of Care Risk Assessment) – Report any PPE breaches to your supervisor/manager.	*3.1*
☐ Use strict Hand Hygiene at all times.	*3.1*
☐ Follow all IPC measures and any additional measures from Public Health.	*2.1*

* Note:
1. The direction in this resource does not replace actual symptom assessment documentation at your site.
2. Symptoms not discussed in this resource do not need to be reported to Public Health but may require assessment and follow-up by the care team.

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Appendix C: Outbreak Checklists

These new resources were developed to help facilities manage outbreaks by outlining the key tasks or responsibilities that should be considered when an outbreak is opened. The checklists are to be used in combination with the guide so the relevant guide section is indicated on the right-hand side indicating where more information and detail can be found. These checklists should be used in combination with site-specific protocols as applicable.

- The four different checklists are:
  - COVID-19
  - Respiratory
  - Influenza
  - Gastrointestinal
- The checklists can be printed and made available to the front-line staff for use.
- Below is an example of the COVID-19 checklist. All the checklists can be printed directly from the webpage online - [Outbreak Management | Alberta Health Services]

COVID-19 Outbreak Management

Long-Term Care, Designated/Non-Designated Supportive Living, Hospice

Alberta Health Services

Manage a Confirmed Outbreak

Version 1 | Last Updated: 09/14/2022

All staff share the responsibility for keeping residents safe. The following actions should be completed once a COVID-19 outbreak has been confirmed. This checklist provides general measures only – always refer to the corresponding section in the guide for detailed recommendations. When applicable, follow site-specific protocols.

Outbreak Guide for LTC and DSL
Outbreak Guide for Non-DSL

1. Infection Prevention Control Measures	Guide Section
☐ Monitor to identify newly symptomatic residents at the site – see Table A.	2.1/3.2
☐ Isolate and collect swabs for all residents with symptoms in Table A.	
☐ Place signage outside the room of symptomatic residents, alerting HCW/staff and visitors of precautions required.	3.1
☐ Conduct a Point of Care Risk Assessment (PCRA) prior to every resident interaction.	6.1
☐ Wear continuous mask and eye protection in all resident care areas. Additional PPE may be required based on Point of Care Risk Assessment.	5.2
☐ Perform strict hand hygiene in accordance with AHS Hand Hygiene Policy or site policy.	3.1
☐ Report PPE breaches or hand hygiene breaches to supervisor, OHS, or WHS as appropriate.	6.1
2. Administrative Measures	**Guide Section**
☐ Notify appropriate HCW/staff/departments within the site/facility as indicated by internal protocols.	5.2
☐ Advise HCW/staff of relevant work recommendations and/or restrictions.	5.2
☐ Place outbreak signage at the entrance of the facility/unit.	5.2
☐ Inform residents' families/guardians/agents of the facility outbreak status.	5.2
☐ Report every day using *Facility CDC Outbreak Daily Report Portal* (and to IPC as per Zone process).	2.1/5.2
☐ Ensure adequate availability of all supplies.	5.2
☐ Assign HCW/staff to care for asymptomatic residents before symptomatic residents whenever possible.	3.12
☐ Follow site process for COVID-19 treatments as applicable.	6.2
☐ Alert transport staff and the receiving site to put in place appropriate precautions, if symptomatic resident is attending another site for a medical appointment.	5.3
3. Resident Restrictions	**Guide Section**
☐ Isolate residents who develop symptoms (as per Table A) or who test positive in their room with appropriate precautions.	6.1/6.3
☐ Facilitate essential medical treatment for symptomatic and COVID-19 positive residents in their room when possible.	6.7

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