Provincial Population & Public Health
Communicable Disease Control
Safe Healthy Environments

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

Includes Respiratory & Gastrointestinal Illness

Alberta Health Services

Do you have feedback about the guide?

We welcome your feedback for the following:

- Incorrect information
- Spelling errors
- Inconsistencies

Submit feedback in an email to: CDCResourceFeedback@share.albertahealthservices.ca.

Note: If you have questions about a specific outbreak, or site-specific processes, always direct your questions to your designated site lead or the AHS Public Health Outbreak Team investigator.

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Introduction

Congregate care settings such as Long Term Care (LTC), Designated Supportive Living (DSL) and Hospice are high-risk settings for the spread of communicable disease due to the close living proximity of residents. Residents may be at higher risk of severe disease and death as they tend to have complex, chronic health conditions. Early detection of viral respiratory illness and gastrointestinal illness is important to reduce the spread of disease and prevent an outbreak[1]. Infectious disease outbreaks occur year-round, but they are more common during outbreak season (fall and winter).

The notification of outbreaks and other infectious disease threats in Alberta is mandated under Section 26 of the provincial Public Health Act. For that reason, the AHS Public Health outbreak Team, which includes the Medical Officer of Health (MOH), is accountable for outbreak investigation and management. Early recognition and response are essential for effective outbreak prevention and management.

Outbreak management requires a multidisciplinary approach. This guide outlines the roles of:

- The Alberta Health Services (AHS) Public Health Outbreak Team.
  - This team is made up of Medical Officers of Health (MOH), the Communicable Disease Control (CDC) Nurses and Environmental Public Health (EPH) officers.
- Infection Prevention and Control (IPC)/Designate
- Facility Administration/Facility Management
- Workplace Health and Safety (WHS) / Occupational Health and Safety (OHS)
- Onsite Staff
- Provincial Laboratory for Public Health

Refer to the glossary for a description of each team.

This guide contains evidence-based best practice from the Alberta Health Public Health Disease Management Guidelines. Content was written in collaboration with the following partners:

- Alberta Health Services:
  - Infection Prevention & Control
  - Workplace Health & Safety
  - Seniors Health
- Covenant Health:
  - Infection Prevention & Control
  - Occupational Health & Safety

Land Acknowledgement

Our work takes place on historical and contemporary Indigenous lands, including the territories of Treaty 6, Treaty 7 & Treaty 8 and the homeland of the Métis Nation of Alberta and 8 Metis Settlements. We also acknowledge the many Indigenous communities that have been forged in urban centres across Alberta.

In compliance with the Alberta Continuing Care Health Services Standards (Standard 11), Alberta Health Services 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 facilities.

[1] **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.

Section 1: Preparing for outbreak season

Facilities are responsible to prepare for outbreaks all year long and especially prior to outbreak season in the fall. The AHS Public Health Outbreak collaborates with stakeholders to ensure that facilities and community partners (such as physicians and pharmacists) have access to up-to-date resources.

Prior to outbreak season, the AHS Public Health Outbreak Team:

- Updates outbreak guides and other resources and posts on the Notifiable Disease & Outbreak Management webpage at ahs.ca/outbreak.
- Invites LTC, DSL and Hospice site representatives to participate in annual outbreak training.
- Sends preparation letters to facilities and community partners outlining general responsibilities for outbreak preparation (such as preparing for advance prescriptions for residents).
    - The Annex contains samples of form letters that are adapted and distributed by each zone.

Routine best practices

Routine best practices are important to prevent the spread of all communicable diseases. These everyday measures are key to stopping the spread of respiratory and gastrointestinal (GI) illnesses that cause outbreaks. Outbreak prevention practices support a healthy environment for residents and staff.

Support a healthy environment

- Perform routine cleaning and disinfection. It protects residents and staff from infection by removing germs from environmental surfaces. It is one of the most important ways to stop illness from spreading.

Prevent illness spread

- Remind staff, residents and visitors to stay home and away from others when ill.
- Perform frequent, effective hand hygiene and respiratory etiquette.
- Get immunized against COVID-19 and seasonal influenza.
- Wear personal protective equipment (PPE).
- Follow routine food safety practices.

Roles and responsibilities for outbreak preparation[2]

Staff, IPC/ICD, and the AHS Public Health Outbreak Team in congregate settings work collaboratively with facility administrators and HCW/staff to prevent outbreaks. For ongoing updates relevant to congregate settings, log in to Continuing Care Connection.

Note: Registration is required the first time the website is accessed.

> Due to the complex nature of LTC/DSL/Hospice facilities, staffing and resident populations, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below. Some facilities may combine the roles of IPC and WHS or may have designated staff to fulfill these roles.

The AHS Public Health Outbreak Team (MOH, CDC, EPH)
• Outline standard of practice for outbreak prevention and control. • Develop, maintain, and distribute provincial outbreak resources (such as this guide). • Coordinate annual training each fall. • Provide an information package to facilities prior to outbreak season. Refer to the Annex for samples of the documents.
The AHS Provincial Partner Oversight (PPO) Team
• Collaborate with facilities to ensure residents and staff have access to outreach immunization services. This includes identifying immunization providers (such as onsite RNs, LPNs and pharmacists). • Provide Alberta Health with information collected from facilities (such as immunization provider, number of residents and staff to facilitate vaccine allocations. • Email the PPO team at: Congregatelivingimmsupport@albertahealthservices.ca • Visit the PPO web page: Provincial Partner Oversight Team
IPC includes AHS Infection Control Professional (ICP) and Site or facility Infection Control Designate (ICD) ***Note:*** *In the absence of formal ICP or ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual, or by a combination of ICD and supporting groups such as organizational/zone/AHS ICP.*
• Ensure Health Care Worker (HCW)/staff have access to and are familiar with the *Guide for Outbreak Prevention and Control in Long Term Care, Designated Supportive Living and Hospice*. • Collaborate with the AHS Public Health Outbreak team to provide annual training. • Update internal outbreak management resources and reviews with HCW/staff.   ○ Reviews routine infection control practices and additional (outbreak management) precautions with HCW/staff. • Recommend the type of personal protective equipment (PPE), signage and specimen collection supplies to have on hand for outbreak management. • Collaborate with facilities to complete site visits and provide routine follow up.

[2] The roles and responsibilities of AH, AHS Zone Operations (Executive Director for Seniors Health, Area Managers / Directors, Directors for NDSL) 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 partners, they are recommended to seek information directly from these groups as required.

Facility Administration/Facility Management or their Designate

• Facilitate annual influenza immunization and any recommended COVID-19 immunization of residents, and HCW/staff.
  ○ Refer to the Annex- Notice to Staff About Influenza and COVID-19
• Outline an influenza antiviral prophylaxis plan for residents (such as standing orders or advanced prescriptions) and for HCW/staff.
  ○ Use the Outbreak Antiviral Prophylaxis in Non-Designated and Designated Supportive Living Sites Worksheet to track residents who have an advance prescription.
  ○ Use the Advance Prescription for Oseltamivir (Tamiflu) fillable form to provide to residents to take to their physician to complete.
• Use this guide to implement an outbreak management plan that details surveillance, isolation, specimen collection, and immunization for residents and HCW/staff.
• Ensure adequate availability of current/valid outbreak management supplies (such as PPE, signage and specimen collection kits).
• Liaise with ICP/ICD to ensure facility/units have resources for reporting cases of notifiable diseases and suspected outbreaks as per Section 26 of the Public Health Act.
• Advise HCW/staff of criteria for reporting symptoms to AHS Population Public Health Support Team (PPHST) as per Table A and Table B.

Facility/Unit Manager/Designate
• Facilitate advanced treatment for antiviral prophylaxis. • Liaise with AHS WHS or OHS designate to ensure HCW have been N95 Respirator fit tested and use PPE as directed by the Infection Prevention and Control Risk Assessment (IPCRA) and refer to the Continuing Care tab on IPC Resource Manuals page. • Maintain ongoing surveillance to facilitate early recognition of symptoms, and identification of a possible outbreak. • Encourage adoption of the PPE Safety Coach program. Review existing complement of PPE coaches/equivalent. Consider “just in time” training if no unit-based PPE coaches available.
Occupational Health/Workplace Health and Safety/Designate ***Note:*** *In the absence of formal AHS WHS or facility OHS coverage, facility administration/manager designates responsibility for these roles*.
• Facilitate annual influenza immunization, COVID-19 immunization, and all other recommended immunizations for HCW/staff. • Reviews internal protocols for HCW/staff outbreak management. • Document HCW/staff health and immunization status and provide work restriction recommendations to the to the Facility/Unit Manager based on HCW/staff health and immunization status.
Onsite HCW/staff (staff hired directly by the facility, contracted staff, AHS staff)
• Review the *Guide for Outbreak Prevention and Control in Long Term Care, Designated Supportive Living and Hospice*.   ○ Review the symptoms for reporting to PPHST as found in Table A and Table B. • Adhere to the proper use of PPE prior to resident interactions as per the Infection Prevention and Control Risk Assessment (IPCRA).

Section 2: Assessing a potential outbreak

Surveillance and reporting

Surveillance takes place prior to, during and after outbreaks. Facilities are responsible to conduct ongoing surveillance for unusual clusters of illness/symptoms.

Surveillance cases

- **Respiratory Illness**: Surveillance cases are residents who are symptomatic or who have confirmed illness.
- **GI Illness**: Surveillance cases are residents and/or HCW/staff who are symptomatic or who have confirmed illness.

HCW/staff monitor for surveillance cases to determine if a potential outbreak may be occurring. The criteria for surveillance cases are found in Table A and Table B.

When to report to the AHS Population Public Health Support Team (PPHST)
The tables below outline when facility HCW/staff are recommended to report symptomatic residents to PPHST. The staff responsible for reporting to PPHST is determined by the facility.

- Table A outlines the respiratory illness reporting criteria.
- Table B outlines the gastrointestinal (GI) illness reporting criteria.

> Individuals with symptoms not listed in Table A and Table B do not need to be reported, but are recommended to be assessed by their most responsible health practitioner.

Table A: When to report respiratory symptoms to PPHST

Symptoms to watch for	When to report to PPHST
Residents Residents will count as a surveillance case if they develop any of the following new or worsening symptoms: • Fever[3] (may not be present in those over 65 years of age) • 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 • Nausea or diarrhea[3]	Two or more surveillance cases in a seven-day period

[3] A resident may develop fever, nausea and/or diarrhea following immunization with COVID-19 or influenza vaccine. The resident will not count as a surveillance case if:

- Onset is within 24 hours of being immunized **AND**
- They have no other symptoms from Table A **AND**
- Fever, nausea and/or diarrhea resolve within 48 hours of onset.

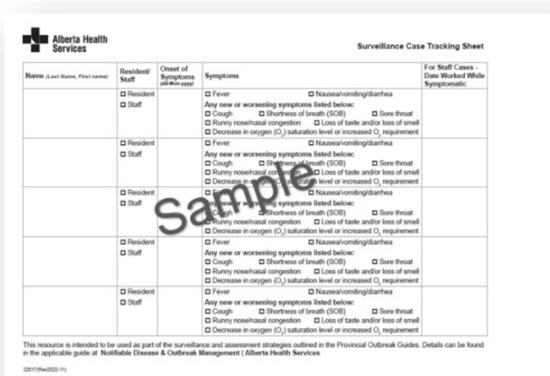
Table B: When to report GI illness symptoms to PPHST

Symptoms to watch for	When to report to PPHST
Residents and HCW/staff Residents and HCW/staff will count as a surveillance case if they develop at least one of the following that are not caused by something else (such as *Clostridioides difficile* diarrhea, medication, laxatives, diet, or prior medical condition): • Two 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** • Two or more episodes of vomiting in a 24-hour period **OR** • One or more episodes of vomiting AND diarrhea in a 24-hour period **OR** • One 1 episode of bloody diarrhea **OR** • Laboratory confirmation of a known enteric pathogen **Note**: Laboratory confirmation is not required.	Two or more residents and/or HCW/staff who have GI illness symptoms **only** with onset within 48 hours of each other. Report even if the HCW/staff were not present at work with symptoms.

If symptomatic resident(s) are identified

Implement infection control strategies (listed in Section 4.1) immediately for any resident with respiratory or GI illness symptoms.

- **Have a plan for tracking symptomatic residents and when to contact PPHST.**
    - Advise supervisors/managers when there is one symptomatic resident, and that surveillance tracking has started.
    - An optional Surveillance Case Tracking Sheet is available for use.
- **If there is only one symptomatic resident, reporting to PPHST is not required.**
    - Continue to monitor for symptoms of illness in other residents.



Specimen collection prior to meeting the reporting criteria

- Specimen collection is not required prior to meeting the reporting to PPHST criteria.
- Facilities may determine that specimen testing is warranted for the diagnosis and medical management of symptomatic residents (such as Oseltamivir treatment for influenza cases or Paxlovid for the treatment for COVID-19 cases.

Roles and responsibilities for assessing a potential outbreak

Due to the complex nature of LTC/DSL/Hospice facilities, staffing and resident populations, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below. Some facilities may combine the roles of IPC and WHS or may have designated staff to fulfill these roles.

The AHS Public Health Outbreak Team (MOH, CDC, EPH)
• Provide consultation on suspected clusters of illness/symptoms or potential outbreaks. • Determine the need to initiate an outbreak investigation. • Request information from their designated contact at the facility (such as facility Administrator, IPC, ICD) to meet the requirements for outbreak management.
IPC includes AHS Infection Control Professional (ICP) and Site or facility Infection Control Designate (ICD) ***Note:*** *In the absence of formal ICP or ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual, or by a combination of ICD and supporting groups such as organizational/zone/AHS ICP.*
• Act as a resource for HCW/staff to facilitate early recognition of possible outbreaks. • Obtain clinical status of all affected individuals and work with HCW/staff to identify new confirmed or symptomatic residents.
Facility Administration/Facility Management or their Designate
• Maintain operations to provide optimal care and services for symptomatic residents. • Notify facility management of the potential outbreak as indicated by internal protocols. • Notify IPC/ICD when an unusual cluster of illness is suspected. • Direct the immediate implementation of routine practices and additional IPC measures outlined in Figure 2, Section 4.
Onsite Staff (staff hired directly by the facility, contracted staff, AHS staff)
• Identify newly confirmed and symptomatic residents through ongoing surveillance. • Place newly confirmed and symptomatic residents on appropriate precautions and ensure symptoms of resident illness are documented. • Assess if symptomatic residents meet the reporting criteria in Table A or Table B. • Liaise with Most Responsible Health Practitioner and external partners. • Provides services to care and treat symptomatic residents in place as per Infection Prevention and Control Risk Assessment (IPCRA).

Section 3: Reporting illness to PPHST

Prompt reporting of a potential outbreak that meets the reporting criteria is important. It allows for early identification and interventions to interrupt transmission of illness as soon as possible. The staff responsible for reporting to PPHST is determined by the facility.

3.1 Report initial illness to PPHST

AHS Population Public Health Support Team (PPHST) is a provincial, centralized outbreak reporting and response resource (formerly known as CEIR). It is the first point of contact for facilities to report if the facility does not already have a confirmed outbreak.

- Table A outlines the respiratory illness reporting criteria.
- Table B outlines the gastrointestinal (GI) illness reporting criteria.

Report to PPHST at 1-844-343-0971 to receive initial guidance and support (such as control measures, directions on recommended specimen collection and PPE recommendations). See below for the initial information that is routinely reported to PPHST.

Note: Call PPHST the following day if reporting outside of operating hours**.**

Initial information reported to PPHST

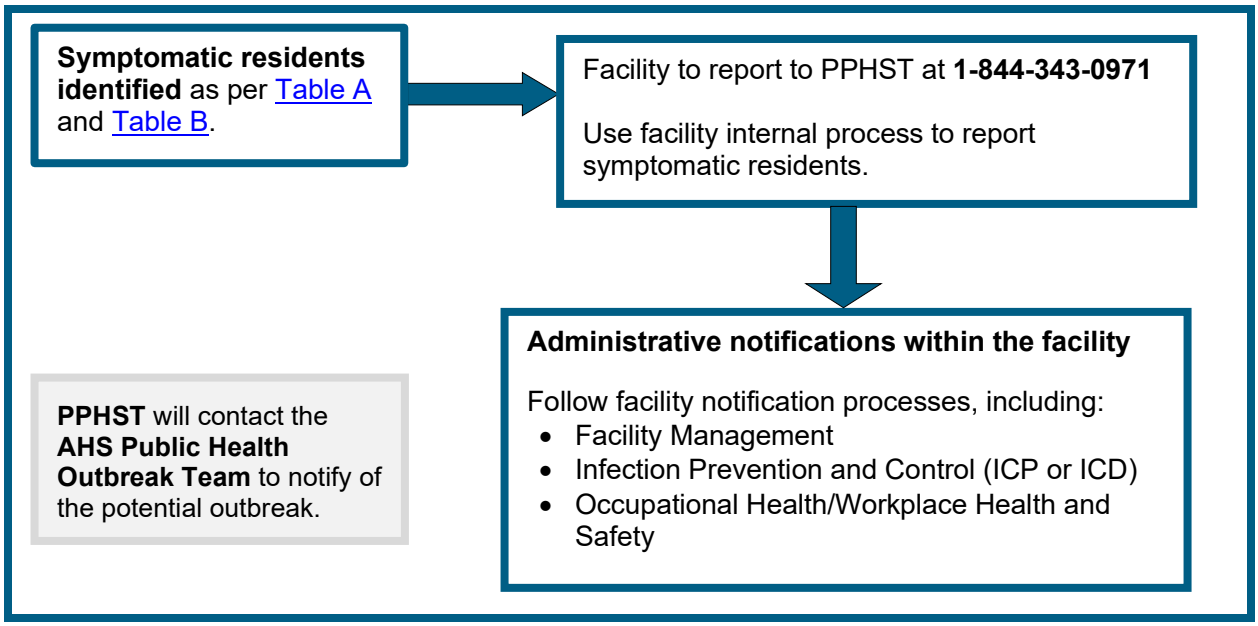
PPHST will request the following information during the initial report. Gather the information in the list prior to calling PPHST. The order may vary from the list.

Facility contact information
☐ Caller name and contact information
☐ Facility name, address and postal code
☐ Facility phone number
☐ Facility manager/site contact phone and email
Facility details
☐ Facility Type
☐ Zone
☐ Is this an AHS Facility?
☐ Total number of units and unit names
☐ Number of residents on affected units
☐ Total number of residents
☐ Number of staff on affected units
☐ Total number of staff
Operational details
☐ Can residents be kept to the affected units?
☐ Can staff be kept to the affected units?
☐ Do staff work in multiple facilities or units?
☐ Has the facility manager been notified?
Symptomatic resident information (Refer to the Surveillance Case Tracking Sheet for details)
☐ Number of symptomatic residents/when did symptoms begin?
☐ Details about symptomatic residents: ○ First name, last name, birth date and Personal Health Number ○ Unit residents reside on? ○ Are the symptomatic residents on additional precautions? ○ Specimens collected?
☐ Number of symptomatic staff/when did symptoms begin?
☐ Any hospitalizations or deaths? If so, provide additional details such as dates.

3.2 Internal notifications

- HCW/staff follow internal outbreak notification processes for administrative notifications once the reporting criteria are met and PPHST has been notified (see Figure 1).

Figure 1: Potential outbreak notification algorithm



3.3 Communication after initial reporting to PPHST

- PPHST will contact the AHS Public Health Outbreak Team after the initial report is made.
  - PPHST will advise the facility with an estimated timeline to expect a call from the AHS Public Health Outbreak Team.
- The AHS Public Health Outbreak team will review the information provided and contact the facility.
- **For respiratory illness cases** call the Intake Line at 1-888-522-1919 rather than contacting PPHST again if:
  - The site has extenuating circumstances (such as an increase in severity of illness) **and/or**
  - More than 24 hours have passed beyond the estimated timeline for contact by the AHS Public Health Outbreak Team.
- **For GI illness cases** call PPHST again if:
  - The site has extenuating circumstances (such as an increase in severity of illness) **and/or**
  - More than 24 hours have passed beyond the estimated timeline for contact by the AHS Public Health Outbreak Team.

Section 4: Managing a potential outbreak

Investigating a potential outbreak
After receiving notification from PPHST, the AHS Public Health Outbreak Team will review the PPHST report and contact the facility. During this time, the AHS Public Health Outbreak Team will investigate whether an outbreak will be opened or not. This is done by:

- Communicating regularly with the facility to get information about additional symptomatic residents.
- Determining if the symptomatic residents are epidemiologically linked. This is important to determine if illness was spread within the facility.
- Recommending that facilities start to implement the measures outlined in this section to manage the potential outbreak.
- Providing contact information for ongoing communication.
- Advising the facility if an outbreak will be opened.
    - If an outbreak is opened, refer to Section 5.

Facilities are recommended to:

- Continue to watch for and report additional symptomatic residents.
- Implement the following measures to manage a potential outbreak.

4.1 Infection Prevention & Control measures

Immediately implement additional precautions for symptomatic residents (see Figure 2).

- Do not wait for a specific pathogen to be identified.
- Consult IPC for additional support.

Figure 2: IPC practices and additional precautions

Additional Precautions for symptomatic residents

- **Residents that develop respiratory symptoms** from Table A**:** isolate confirmed or symptomatic residents immediately using Modified Respiratory precautions.
    - Follow the recommended additional precautions in Table D if a specific pathogen is identified.
- **Residents that develop gastrointestinal symptoms** from Table B**:** isolate confirmed or symptomatic residents immediately using recommended precautions.
    - Diarrhea only: Use Contact precautions.
    - Vomiting with or without diarrhea: Use Contact and Droplet precautions.

Isolate confirmed or symptomatic residents immediately using recommended precautions

- A private room is preferred.
- A dedicated washroom or commode is recommended. This is required for gastrointestinal illness symptoms.
- Place isolation carts in close proximity to resident room.
- Place additional precaution signage outside the door of the resident's room to alert HCW/staff and visitors that precautions are required.
- Provide meal service to confirmed or symptomatic residents in their room.
- Maintain a distance of at least two metres between residents sharing a room.
- Physical barriers (such as curtains or portable wipeable screens) are recommended in shared rooms. See IPC COVID-19 Additional Precautions Without Walls in Shared Patient Care Space.
- Dedicate care equipment to a single resident. If equipment is shared between residents, clean and disinfect after each use.

Personal Protective Equipment	
• In addition to the recommended additional precautions, always use the Infection Prevention and Control Risk Assessment (IPCRA) prior to providing resident care.	
Masking	• Wear appropriate mask/respirator as per IPCRA. • Aerosol-generating medical procedure (AGMP) is any medical procedure that can induce the production of aerosols of various sizes, including droplet nuclei. • Use N95 respirator (fit-tested) for any AGMP and residents on Modified Respiratory precautions (including those with a suspected or confirmed acute viral respiratory infection).
Eye Protection	• Use eye protection as per IPCRA. • Personal (prescription) eyewear does not provide adequate protection.
Gloves and Gown	• Wear gloves and gowns as per IPCRA.

Hand Hygiene	• Strict hand hygiene is the most important measure to prevent the spread of infection.
	  ○ Follow the AHS Hand Hygiene Policy and Procedure for information on product selection, location and use.
	• Use **alcohol-based hand rub** when performing hand hygiene except when plain soap and water is recommended.
	• Wash hands with **plain soap and water** when:
	  ○ Hands are visibly soiled with food, dirt or blood/body fluids
	  ○ Before, during, and after handling food
	  ○ Following glove removal (doffing) after caring for a resident with vomiting and/or diarrhea
	  ○ Immediately after using washroom facilities.
	• Glove use is not a substitute for hand hygiene. Hand hygiene is required after glove removal.

Infection Prevention and Control Posters and Resources
• Precautions posters are available at:
  ○ Posters | Alberta Health Services
  ○ Routine Practices in Continuing Care
  ○ Personal Protective Equipment (PPE)
  ○ Modified Respiratory Precautions
• Refer to the Infection Prevention & Control web page for more information and resources.	

4.2 Administrative measures

- Ensure HCW/staff are maintaining heightened surveillance to identify and report newly symptomatic residents as per Table A and Table B.
- Consult with the WHS/OHS or the AHS Public Health Outbreak Team when making decisions about HCW/staff assignments.
  - Direct HCW/staff to care for asymptomatic residents before symptomatic residents.
  - Cohort HCW/staff to work only in affected areas or only in unaffected areas.
  - Minimize movement of HCW/staff between floors/areas, especially if some areas are not affected.
- Consult with site ICP/ICD or the AHS Public Health Outbreak Team if considering cohorting residents.
  - Consider cohorting exposed asymptomatic residents.
  - Consider cohorting residents with the same illness.

- If residents have respiratory symptoms, assign HCW/staff that have been immunized against influenza and COVID-19 to care for symptomatic residents.
- HCW/staff assigned to housekeeping duties are not recommended to be involved in food preparation or food service during outbreaks. If this is not possible, request staff complete any required food preparation before beginning housekeeping.

Daily reporting

- Determine who at the facility will be responsible for daily reporting.
- Report daily to the AHS Public Health Outbreak Team (and to IPC per zone requirement).
- Respiratory Illness Reporting: A link to the Facility CDC Outbreak Daily Report Portal (RedCap) will be provided to facilities. This portal is used to enter newly symptomatic or confirmed resident and HCW/staff cases, hospitalizations, and deaths.

4.3 Resident restrictions

Resident activities

- Consult with IPC for assistance with adapting resident activities.
- Asymptomatic residents may participate in daily activities.
- Confirmed or symptomatic residents are recommended to remain in their rooms.
    - Recommend a medical mask if they need to leave their room.
- Participation in group activities is not recommended for confirmed or symptomatic residents.

Medical

- Treatments (such as physiotherapy) are recommended to be provided in the rooms of confirmed or symptomatic residents instead of in a centralized area.
- Medically necessary appointments are permitted for confirmed or symptomatic residents.
    - Recommend the resident wear a medical mask.
    - Notify the receiving provider of the symptomatic resident so that appropriate precautions can be taken during transport and on arrival.
    - Arrange virtual visits when possible.

Support social engagement while in isolation

- Provide activities that engage/support the isolating resident (such as social, spiritual care and mental health).
- Support safe visits with Designated Family/Support Person (DFSP) or visitors.
    - Facilitate outdoor visits when weather permits for residents with respiratory illness.
- Provide one-on-one support for residents to leave their room.
    - Use strategies to minimize spread of infection (such as wearing a mask, using hand sanitizer, maintaining distance from others, and avoid touching surfaces).
- Residents with dementia or cognitive impairment may require additional engagement and support while in isolation.

Keep distance from other residents

- Minimize contact with the isolated resident (for example minimize the possibility of other residents going into that person's room) by offering additional activities and interventions for non-isolated residents in the facility/unit.

4.4 Restrictions to admissions/transfers/discharges

- No changes from routine practices.

4.5 Admissions/transfers from an acute care site

- No changes from routine practices.

4.6 Transfers to an acute care site

- If a confirmed or symptomatic resident is being transferred, notify the EMS dispatcher, the transport staff (EMS crew) and the acute care site.

4.7 Group/social activities and other events

- Asymptomatic residents may participate in daily activities.
- Participation in group or social activities with other residents is not recommended for confirmed or symptomatic residents.

4.8 Nourishment areas/sharing of food

- Provide meal service to isolating residents in their room.

4.9 Adult day programs

- No changes from routine practices.

4.10 Visitors and Designated Family/Support Persons

Notify

- Request that visitors/Designated Family/Support Persons (DFSPs) report to the reception/nursing desk before visiting residents.
- Advise visitors/DFSPs of potential risk of exposure if they are visiting an isolating resident.

Safe visiting

- Advise visitors/DFSPs visiting symptomatic residents to wear PPE as outlined on the posted additional precautions signage, and to clean hands with alcohol-based hand rub before putting on and after removing the PPE.
- Demonstrate for visitors/DFSPs how to use PPE.
- Isolating residents may participate in social activities with visitors and DFSPs. This includes participating in one-to-one activities, as long as additional precautions are followed such as hand hygiene, masking and physical distancing.
    - Facilitate outdoor visits when weather permits for residents with respiratory illness.
- Request visitors/DFSPs to follow the directions of HCW/staff and Facility Administration.

When visiting is not recommended

- Symptomatic visitors/DFSPs are not recommended to visit.
    - In extenuating circumstances, the facility will determine if visitation is recommended when a visitor/DFSP is symptomatic.
    - Compassionate exemptions should be considered to support visitation by symptomatic visitors/DFSPs of residents who are at end of life.

Designated Family/Support Person(s)

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

4.11 HCW/staff measures

- All HCW/staff are required to follow organization policies and procedures regarding work attendance, masking, and eye protection.

Monitoring for symptoms

- HCW/staff are recommended to monitor themselves for symptoms of illness.
- HCW/staff who develop respiratory symptoms at work are recommended to perform hand and respiratory hygiene practices (such as washing hands, coughing into sleeve, using tissues, wearing an appropriate mask) and leave the workplace as soon as possible.
- HCW/staff who develop GI symptoms at work are recommended to perform hand hygiene and leave the workplace as soon as possible.

General recommendations

- Symptomatic HCW/staff with respiratory symptoms are recommended to not report to work and:
  - Take a COVID-19 at-home rapid antigen test.
    - Table C outlines recommendations for COVID-19 at-home rapid antigen testing and work restrictions for symptomatic HCW/staff.
  - Report illness to the manager/designate.
  - Report to WHS/OHS if symptoms are related to workplace exposure.
- Symptomatic HCW/staff with gastrointestinal symptoms are recommended to not report to work and:
  - Report illness to the manager/designate.
  - Report to WHS/OHS if symptoms are related to workplace exposure.

Facility-specific recommendations

- Additional work restrictions and requirements may apply to symptomatic staff based on the direction provided by WHS/OHS.
- Facilities may elect to follow their own WHS/OHS policies regarding HCW testing recommendations and work restriction or may refer to Table C.

Table C: HCW/staff COVID-19 rapid antigen testing and work restrictions

- Symptomatic refers to the new onset of fever, cough, shortness of breath, sore throat, runny nose/nasal congestion, loss of taste and/or loss of smell, nausea, diarrhea.
- HCW/staff who are experiencing the above symptoms are recommended to complete a COVID-19 rapid antigen test.
- Negative testing requires two negative COVID-19 rapid antigen tests completed at least 24 hours apart.

Scenario	Recommendation
Scenario A Symptomatic AND positive COVID-19 rapid antigen test	• Work restricted for a minimum period of five days from the onset of symptoms or until symptoms improve and are fever-free for 24 hours (without use of fever reducing medication), whichever is longer. • Wear a mask for a total of 10 days from onset of symptoms. ○ Masking is not necessary if HCW/staff already isolated for 10 days or more.

Scenario B
Symptomatic AND first COVID-19 rapid antigen test is negative
	• Complete a second test at least 24 hours after the first test.
	• If second test is **POSITIVE**: Follow directions in **Scenario A**.
	• If second test is **NEGATIVE**: Work restricted until symptoms improve and are fever-free for 24 hours (without use of fever reducing medication).
	  ○ Wear a mask for a total of 10 days from onset of symptoms.
	  ▪ Masking is not necessary if HCW/staff already isolated for 10 days or more.
	• Follow directions in **Scenario C** if a second test was not completed.

Scenario C
Symptomatic AND no rapid antigen test completed **OR** only one negative rapid antigen test
	• Complete testing.
	• If testing is not completed:
	  ○ Work restricted for a minimum period of five days from the onset of symptoms or until symptoms improve and are fever-free for 24 hours (without use of fever reducing medication), whichever is longer.
	  ○ Wear a mask for a total of 10 days from onset of symptoms.
	  ▪ Masking is not necessary if HCW/staff already isolated for 10 days or more.

Scenario D Symptomatic HCW/staff with symptoms NOT listed above.	• Testing is not recommended. • Continue to stay home until symptoms improve and well enough to resume normal activities.

4.12 Specimen collection

- Specimen collection is not required for all residents.
- The AHS Public Health Outbreak Team will make specimen collection recommendations:
  - Method (such as NP swab, stool specimen)
  - Pathogens (COVID-19, RSV, Influenza, Norovirus)
  - Number of residents
- If specimen collection is recommended, ensure proper collection and labelling (including using assigned Exposure Investigation [EI] number on all specimens). Refer to Appendix B.
- Make internal arrangements for transporting specimens to the lab.
- Specimen collection is ordered by the Most Responsible Health Practitioner (not by Zone MOH).

4.13 Enhanced environmental cleaning and disinfection

Initiate enhanced cleaning and disinfection.

Enhanced cleaning and disinfection frequency

- Immediately clean and disinfect visibly dirty surfaces.
- At least once daily for low touch surfaces (such as shelves, windowsills, and white boards).
- At least two times per day for care/treatment areas, dining areas, lounges, and high touch surfaces (such as doorknobs, light switches, handrails, phones and elevator buttons).
- At least two times per day or when visibly dirty, clean and disinfect HCW/staff equipment (such as computer keyboards/mouse/ carts and/or screens, medication carts, charting desks or tables, telephones, touch screens and chair arms).

Enhanced cleaning and disinfection recommendations

- Use a “wipe twice” procedure (a two-step process) to clean and disinfect surfaces.
    - Clean visible dirt and then wipe again with a clean cloth saturated with disinfectant. Observe the appropriate contact time.
- In a shared room where not all residents are on isolation, bedspaces of residents not on isolation/additional precautions should be cleaned first.
- For each room, bathrooms should be cleaned last.
- Health care equipment (such as wheelchairs, walkers, and lifts) are to be cleaned and disinfected according to manufacturer instructions.
    - Clean and disinfect shared health care equipment (such as commodes, blood pressure cuffs, thermometers, lifts, bathtubs, showers, and shared bathrooms) after use and prior to use by another resident.
- Change mop head (dry/wet), cloths, and cleaning solution:
    - After cleaning each room for any resident on isolation
    - After cleaning each bedspace if shared room and not all residents in the room are on isolation
- Upholstered furniture, rugs or carpets contaminated with bodily fluid (such as stool or vomit) are difficult to clean and disinfect properly. Consult manufacturer’s instructions for the cleaning instructions. If not 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.
- Areas that are not considered common areas (such as private offices and administrative areas) do not require enhanced cleaning and disinfection.

Cleaning products

- Refer to manufacturer instructions for cleaning and disinfection procedures, including compatible cleaners and disinfectants.
- Use a disinfectant with a DIN. Ensure the disinfectant also has a broad spectrum virucidal claim, or a specific virucidal claim against non-enveloped viruses and coronaviruses for enhanced general environmental cleaning.
- Refer to the product Material Safety Data Sheets for safety information.

Personal Protective Equipment

- 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.

Laundry

- Wear gloves and gowns when handling soiled laundry.
- Run a bleach cycle in the empty washing machine after it is used to clean laundry soiled with stool or vomit.
- See Linen in Community-based Services resource for additional details.

Additional resources

- Principles for Environmental Cleaning and Disinfection
- Public Health Recommendations for Environmental Cleaning and Disinfection of Public Facilities
- Personal Items and Laundry Tip Sheet for Continuing Care Residents Families and Visitors

Roles and responsibilities for managing a potential outbreak

Continue with the roles and responsibilities from Section 1 and Section 2 in addition to those outlined below.

Due to the complex nature of LTC/DSL/Hospice facilities staffing and resident populations, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below. Some facilities may combine the roles or IPC and WHS or may have designated staff to fulfill these roles.

The AHS Public Health Outbreak Team (MOH, CDC, EPH)
• Recommend specimen collection. • Recommend best practice outbreak control measures to be implemented including, immunization and management of HCW/staff. • Monitor potential outbreak progress and provide consultation to the facility. • Obtain a ProvLab EI number for the tracking of all outbreak-related specimens. • Provide the EI number to the facility.
IPC includes AHS Infection Control Professional (ICP) and Site or facility Infection Control Designate (ICD) ***Note:*** *In the absence of formal ICP or ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual, or by a combination of ICD and supporting groups such as organizational/zone/AHS ICP.*
• Provide IPC recommendations to prevent further transmission. • Provide support and consultation to sites (AHS IPC). • Direct the implementation of initial IPC measures immediately. • Obtain reports on the clinical status of confirmed and symptomatic residents. • Collaborate with HCW/staff to identify newly confirmed or symptomatic residents. • Provide resident details to WHS/OHS/designate for staff close contact identifications if required for outbreak management. • Provide the AHS Public Health Outbreak Team with status updates of relevant changes to the investigation such as additional confirmed or symptomatic residents, hospitalizations, or death (site ICD). • Coordinate specimen collection in collaboration with the AHS Public Health Outbreak Team (site ICD) • Complete facility reviews and outbreak visits as needed (AHS IPC).
Facility Administration/Facility Management or their Designate
• Collaborate with IPC/ICD and the AHS Public Health Outbreak Team on outbreak control measures.

• Provide information to HCW/staff, residents, families, other working in the facility and departments/stakeholders outside of the facility. • Communication within the potential outbreak facility as per established zone practices. • Communicate resident assessment, monitoring, surveillance, and reporting to the AHS Public Health Outbreak Team and/or IPC/ICD. • Collaborate with WHS/OHS designate to identify and report symptomatic HCW/staff to the AHS Public Health Outbreak Team. • Establish a process for HCW/staff calling in ill. • Coordinate specimen collection in collaboration with the AHS Public Health Outbreak Team. • Direct the immediate implementation of initial IPC measures.
Site/Unit Manager/Designate
• Coordinate reporting of HCW/staff GI illness to the AHS Public Health Outbreak Team. • Coordinate specimen collection in collaboration with the AHS Public Health Outbreak Team. • Maintain clear and consistent channels of communication within the potential outbreak facility as per established zone practices.
Occupational Health/Workplace Health and Safety/Designate ***Note:*** *In the absence of formal AHS WHS or facility OHS coverage, facility administration/manager designates responsibility for these roles*.
• Maintain close communication with Facility/Unit Manager regarding HCW/staff work restrictions. • Support illness assessment and surveillance of HCW/staff from potential outbreak unit. • Coordinate reporting of HCW/staff GI illness to the AHS Public Health Outbreak Team. • Assess for HCW/staff exposures.
Onsite HCW/staff (staff hired directly by the site, contracted staff, AHS staff)
• Collaborate to facilitate outbreak investigations and implement initial infection control measures immediately. • Collect specimens. • Identify newly symptomatic residents according to Table A or Table B. • Liaise with Most Responsible Health Practitioner and external partners. • Adhere to additional precautions when indicated and the Infection Prevention and Control Risk Assessment (IPCRA) when providing care and services.
Provincial Laboratory for Public Health (ProvLab)
• Designates laboratory microbiologist or virologist for each outbreak. • Provides specimen collection supplies. • Ensures the AHS 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.

Section 5: General recommendations for confirmed outbreaks

When an outbreak is opened the AHS Public Health Outbreak Team will recommend that the facility implement outbreak control measures. These measures are critical for controlling outbreaks of any kind by stopping the spread of disease.

The measures outlined in this section are to be implemented for facilities with a confirmed outbreak, regardless of the type. These measures build on those outlined in Section 4.

- The AHS Public Health Outbreak Team will make additional recommendations for specific types of outbreaks, such as COVID-19, Influenza-Like Illness, Influenza and GI.
- The AHS Public Health Outbreak Team may recommend additional outbreak measures not discussed in this guide for outbreak control.

GI outbreaks will use the Risk Assessment Worksheet and/or the Risk Assessment Matrix based on Zone process as directed by the AHS Public Health Outbreak Team.

5.1 Infection Prevention & Control measures

Maintain all measures recommended in Section 4.1.

For **respiratory outbreaks** also implement the following:

- HCW/staff who have direct or indirect interactions with residents from the outbreak unit are recommended to use continuous masking and eye protection for the duration of the outbreak.
- Masking is recommended for all visitors and DFSPs in common areas on outbreak units.

5.2 Administrative measures

Maintain all measures recommended in Section 4.2 and implement the following:

Outbreak notification

- Notify residents, family/guardian/agent, staff and partners of the confirmed outbreak (such as WHS/OHS, IPC and, pharmacy).
- Advise HCW/staff (such as nursing, allied health, food services, environmental services and spiritual care) to implement outbreak measures.
- Notify Laundry Services of the increased need for supplies.

Outbreak signage

- Post outbreak signs at the facility/unit entrance (see Appendix D).

Daily reporting

- Determine at the outset of the outbreak who will be responsible at the facility for daily reporting (such facility/unit staff or manager, IPC/ICD, etc.).
- Report **daily** to the AHS Public Health Outbreak Team (and to AHS ICP as per zone requirement).
    - **Respiratory Illness Reporting:** A link to the *Facility CDC Outbreak Daily Report Portal (RedCap)* will be provided to facilities. This portal is used to enter newly symptomatic or confirmed resident and HCW/staff cases, hospitalizations, and deaths.
    - **GI Illness Reporting**: Case reporting will be at the direction of the AHS Public Health Outbreak Team. See Attachment 9.1 for the type of information that may be requested.

Additional outbreak measures

- The AHS Public Health Outbreak Team will collaborate with the facility and other stakeholders to monitor and assess the outbreak. The additional measures listed below may be recommended, by the AHS Public Health Outbreak Team to improve outbreak control when necessary:
    - Physical distancing in communal dining areas
    - Active screening of HCW/staff for symptoms prior to each shift
    - Active screening of visitors and DFSPs prior to entering the facility or visiting residents
    - Health screening of residents upon return from absence
    - Masking for unimmunized residents upon return from absence
    - Quarantine and or active screening for resident admissions upon their return from other health settings if that other site is on outbreak
    - Close contact identification and management of residents or HCW/staff (during COVID-19 outbreak)
    - Facility wide HCW/staff masking and eye protection
    - Facility wide masking for visitors.

5.3 Resident restrictions

Maintain all measures recommended in Section 4.3 and implement the following:

- Medical appointments are permitted for all residents.
    - Recommend an appropriate mask.
    - Notify the receiving provider of the outbreak so that appropriate precautions can be taken for the resident during transport and on arrival.
    - Arrange virtual visits when possible.

5.4 Restrictions to admissions/transfers/discharges

- The ability of the facility/unit to accept admissions/transfers/discharges (whether the unit is open or restricted) is determined by the AHS Public Health Outbreak Team at the time the outbreak is opened.
    - If status is “open,” then admissions, transfers, and discharges may proceed following usual non-outbreak processes.
    - If the status is “restricted” then admissions (including new admissions to the outbreak affected facility/unit), transfers (including transfers from the affected facility/unit to a different facility), and discharges are recommended to be paused or delayed while these restrictions are in place.
        - Implementation may not be possible or recommended due to resident circumstances or operational need (including bed pressures).
        - If a facility with a respiratory outbreak with restrictions believes that an admission, transfer, or discharge is recommended to proceed despite restrictions, the facility is recommended to complete a Risk Assessment Worksheet and follow the Risk Assessment Matrix.
- The scope of restrictions depends on:
    - The extent of the outbreak activity within the facility (such as one unit/floor/wing or the entire facility)
    - The ability to cohort HCW/staff to affected areas
    - The severity of the outbreak (new cases continue to develop despite implemented control measures).
- Consult the AHS Public Health Outbreak Team when issues related to admission, discharge and transfers arise during an outbreak.

5.5 Admissions/transfers from an acute care site

- Residents hospitalized prior to the outbreak, or during an outbreak for an unrelated condition (such as a fracture) may return to the facility, based on the status of restrictions at the facility. See Section 5.4 above, for more details.
  - If the facility status is "open," the resident can return.
  - If the facility with a respiratory outbreak status is "restricted", the facility completes a Risk Assessment Worksheet and follow the Risk Assessment Matrix.
- Residents who were hospitalized due to illness from the outbreak pathogen may return to the facility immediately upon discharge.
  - The need for isolation is assessed based on the resident status at the time of return to the facility.

5.6 Transfers to an acute care site

Maintain all measures recommended in Section 4.6 and implement the following:

- If **any resident** from the outbreak facility/unit requires acute medical attention or treatment at an acute care site (such as urgent care, dialysis, emergency department) notify the following so that appropriate precautions can be taken:
  - EMS dispatcher and/or the transport staff (for example the EMS crew)
  - Receiving provider.

5.7 Group/social activities and non-resident events

Activities for confirmed or symptomatic residents

- Participation in group or social activities with other residents is not recommended for isolating residents.

Activities that may continue

- The AHS Public Health Outbreak Team will recommend whether group activities may continue for asymptomatic residents.
- For respiratory illness outbreaks, outbreak measures (such as physical distancing, masking, and hand hygiene) may be used for low-risk group activities (such as art class, bingo, card games, movies).

Activities that are postponed/cancelled

- Postpone/cancel all high-risk group activities (such as singing, bus outing and large group activities).
- During GI outbreaks, postpone/cancel all group activities (Section 9.7).
- Postpone/cancel any non-resident events booked for areas in the outbreak LTC/DSL/Hospice facility (such as meetings).

5.8 Nourishment areas / sharing of food

- Provide meal service to isolating residents in their room.
  - Use of disposable plates and cutlery is not recommended or required.
- Close the kitchen/nourishment areas accessed by residents and visitors.
- Cease communal sharing of food in outbreak areas.
- Use hand hygiene.
- The AHS Public Health Outbreak Team may recommend other modifications such as:
  - Close buffet lines or have staff dispense food onto plates.
  - Cease family-style meal service.
  - Pre-set tables in common dining areas to minimize handling of cutlery.

- Remove shared food containers from dining areas (such as shared pitchers of water, shared coffee cream dispensers, and salt and pepper shakers).
- Dispense snacks directly to residents and use prepackaged snacks.
- When using single-use condiment packets, provide directly to each resident.
- Cease resident participation in food preparation.
- For respiratory outbreaks, use physical distancing during group dining.

5.9 Adult day programs

- The Outbreak Management Team (OMT) and the AHS Public Health Outbreak Team will consider the following to determine if an Adult Day Program will continue:
  - It is physically separate from areas of the facility in which there have been symptomatic residents.
  - Residents attending the Adult Day Program do not socialize with residents from the outbreak facility/unit.
  - 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 Persons

Maintain all measures recommended in Section 4.10 and implement the following:

- Encourage visitors to postpone visiting if possible.
- Limit visit to one resident only and advise visitors to exit the facility immediately after the visit.
- Residents with respiratory illness may participate in social activities with visitors and DFSPs outdoors.

Additional restrictions implemented by the facility

- A facility/unit may choose to limit visitation further than above in accordance with applicable organizational policy and in consultation with the AHS Public Health Outbreak Team.
- Consider the impact of the decision on resident and family well-being.

5.11 HCW/staff outbreak measures

Maintain all measures recommended in Section 4.11 and implement the following:

- HCW/staff who work in more than one facility/unit are recommended to inform the other facilities/units of the outbreak to determine whether they may continue to work in all settings.

5.12 Specimen collection

Maintain all measures recommended in Section 4.12 and implement the following:

- Notify the AHS Public Health Outbreak Team:
  - If there is a new symptom presentation among residents within the outbreak facility
  - If the outbreak extends beyond original facility/unit.

5.13 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.13.

Roles and responsibilities for confirmed outbreaks

Continue with the roles and responsibilities from Section 1, Section 2 and Section 4 in addition to those outlined below.

> Due to the complex nature of LTC/DSL/Hospice facilities, staffing and resident populations, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below. Some facilities may combine the roles or IPC and WHS or may have designated staff to fulfill these roles.

The AHS Public Health Outbreak Team (MOH, CDC, EPH)
• Provide direction on restrictions to admissions/transfers/discharges to the outbreak facility/unit. • Consult on resident isolation. • Consult on HCW/staff management. • Makes recommendations regarding group activities. • Send outbreak notifications and alerts; and if relevant posts provincial and national Public Health alerts on Canadian Network for Public Health Intelligence (CNPHI). • Report outbreak to Alberta Health (AH), and to AHS Senior Public Health Executive. • Review daily outbreak data, monitors outbreak progress and provides consultation to the outbreak facility when appropriate. • Share timely outbreak status reports with Acute Care, LTC and DSL, and partners in their Zone (including AHS and contracted operators). • Respond to media inquiries in consultation with AHS Communications Media Advisor. • Track outbreak specimens. • Participate in OMT meetings.
IPC includes AHS Infection Control Professional (ICP) and Site or facility Infection Control Designate (ICD) ***Note:*** *In the absence of formal ICP or ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual, or by a combination of ICD and supporting groups such as organizational/zone/AHS ICP.*

• Direct the implementation of additional outbreak control measures, including prophylaxis if recommended by the MOH, in consultation with facility Medical Lead.
• Direct management of confirmed and symptomatic residents.
• Identify high risk activities that need to be postponed or cancelled.
• Notify HCW/staff of outbreak.
• Coordinates daily submission of illness data.
  ○ Respiratory Outbreaks: Facility CDC Outbreak Daily Report Portal (RedCap)
  ○ GI Outbreaks: Data collection for GI illness or zone-specific process
• Participate in OMT meetings.
• Follow the AHS Public Health Outbreak Team direction regarding the need for collection of additional or subsequent specimens.

Facility Administration/Facility Management or their Designate
• Maintain optimal care and services for residents. • Work collaboratively with the AHS Public Health Outbreak Team to provide information to HCW/staff, residents, families, students, other professions working in the facility that are not HCWs and other departments and stakeholders outside of the facility.

- Participate in OMT meetings.
- Consult with the AHS Public Health Outbreak Team on issues pertaining to admission, discharge, and transfers during an outbreak.
- Comply with facility/unit restrictions recommended by the AHS Public Health Outbreak Team.
- Communicate the status of the facility (open or restricted) to partners and stakeholders.
- Maintain outbreak control measures until the outbreak is ended.

Site/Unit Manager/Designate

- Maintains clear and consistent channels of communication within the outbreak site.
- Participates on OMT as appropriate.
- Consults with the AHS Public Health Outbreak Team on issues pertaining to admission, discharge, and transfers during an outbreak.
- Complies with restrictions recommended by the AHS Public Health Outbreak Team.

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

- Provide information to HCW/staff about work restrictions.
- Communicate with facility/unit Manager regarding HCW/staff work restrictions.
- Identifies HCW/staff who may be at risk of exposure and infection (such as unimmunized).
- Participates in OMT meetings.

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

- Collaborate to facilitate outbreak investigations and implement IPC measures.
- Collect specimens.
- May participate in OMT meetings.
- Collaborate to provide the AHS Public Health Outbreak Team with daily status updates.
- Communicate within the outbreak site as per established Zone practices.
- Liaise with Most Responsible Health Practitioner.
- Provides services to care and treat residents in place as per Infection Prevention and Control Risk Assessment (IPCRA).
- Authorize 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.
- Communicate outbreak status to other programs that may be impacted by the Outbreak (such as Adult Day Programs, Childcare programs or any other programs that operate within the facility that might be impacted by the outbreak).
- Report PPE breaches or hand hygiene breaches to supervisor or Occupational Health/ Workplace Health and Safety/designate.
- Comply with work restrictions.

Provincial Laboratory for Public Health (ProvLab)

- Ensures the AHS Public Health Outbreak Team and IPC/ICD (if noted on the requisition) receive timely results of outbreak specimens.
- Tracks all outbreak specimens.

Section 6: Confirmed COVID-19 outbreak

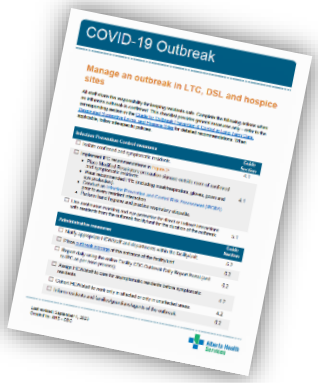
When a COVID-19 outbreak is opened the AHS Public Health Outbreak Team will provide additional COVID-19 specific measures.

The measures outlined in this section are to be implemented for a facility with a confirmed COVID-19 outbreak. These measures build on those outlined in Section 4 and Section 5.

- The AHS Public Health Outbreak Team may recommend outbreak measures not discussed in this guide for outbreak control.
- Refer to Table E for the COVID-19 case and outbreak definitions.

Duration of outbreak

- The outbreak remains open for 14 days (two incubation periods) after the onset of the most recent resident case and will end on day 15.



A checklist is available that summarizes key steps in **COVID-19** outbreak management. Click here to get a printable version.

Checklists:

- Outline key tasks or responsibilities.
- Are used with the guide. The relevant section is shown on the right side where you can find more detail.
- Are used in combination with site-specific policies.

6.1 Infection Prevention & Control measures

Maintain all measures recommended in Section 4.1 and Section 5.1.

6.2 Administrative measures

Maintain all measures recommended in Section 4.2 and Section 5.2 and implement the following:

- Inform HCW/staff, residents and families of the COVID-19 outbreak and recommend they monitor for symptoms.
- Implement antiviral treatment (see COVID-19 Outpatient Treatment | Alberta Health Services).
    - The resident's most responsible health care practitioner is responsible for ensuring appropriate treatment.

6.3 Resident restrictions

Maintain all measures recommended in Section 4.3 and Section 5.3 and implement the following:

Confirmed or symptomatic residents are recommended to isolate in their room with Modified Respiratory precautions for a minimum of 5 days from the onset of symptoms. The isolation period ends and Modified Respiratory precautions are lifted when symptoms improve and the resident is fever-free for 24 hours without the use of fever-reducing medications, whichever is longer.

After the isolation period ends:

- Lift Modified Respiratory precautions.
- Complete a post isolation/additional precautions cleaning and disinfection of the resident room.
- Remove isolation cart and signage.

Resident mask recommendation after isolation period ends:

- When outside of their room, residents are recommended to **mask*** for a total of 10 days from the onset of symptoms.
- Residents are recommended to return to their room when the mask is removed such as eating meals or snacks.

***If a mask is not tolerated:**

- The resident is recommended to complete 10 days of isolation on Modified Respiratory precautions in their room.
- After the isolation period ends:
  - Lift Modified Respiratory precautions.
  - Complete a post isolation/additional precautions cleaning and disinfection of the resident room.
  - Remove isolation cart and signage.

6.4 Restrictions to admissions/transfers/discharges

Maintain all measures recommended in Section 5.4.

- The AHS Public Health Outbreak Team will recommend that the facility is “restricted.” This means that admissions, transfers, and discharges are recommended to be paused or delayed during the outbreak.
  - Implementation of this recommendation may not be possible due to resident circumstances or operational need.
- Admission restrictions will remain in place for a minimum of seven days following the onset of symptoms in the most recent resident case or as directed by the AHS Public Health Outbreak Team.

6.5 Admissions/transfers from an acute care site

Maintain all measures recommended in Section 5.5.

6.6 Transfers to an acute care site

Maintain all measures recommended in Section 4.6 and Section 5.6.

6.7 Group/social activities and other events

Maintain all measures recommended in Section 4.7 and Section 5.7 and implement the following:

- Personal services (such as 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 for residents from outbreak units are recommended to be provided to one resident at a time.

6.8 Nourishment areas / sharing of food

Maintain all measures recommended in Section 5.8.

6.9 Adult day programs

Maintain all measures recommended in Section 5.9.

6.10 Visitors and Designated Family/Support Person(s)

Maintain all measures recommended in Section 4.10 and Section 5.10.

6.11 HCW/staff outbreak measures

Maintain all measures recommended in Section 4.11 and Section 5.11 and implement the following:

- Encourage all HCW/staff to get recommended COVID-19 vaccines.
- HCW/staff who are a close contact are recommended to monitor for symptoms of COVID-19 for seven days from the last date of contact.

6.12 Specimen collection

Maintain all measures recommended in Section 4.12 and Section 5.12 and implement the following:

- The AHS Public Health Outbreak Team may recommend additional specimen collection for outbreak management.
- Retesting with a molecular test is not recommended for residents who tested positive for COVID-19 within 90 days.
    - Consult with the AHS Public Health Outbreak Team for direction on a case-by-case basis.

6.13 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.13.

Roles and responsibilities for confirmed COVID-19 outbreaks

Continue with the roles and responsibilities from Section 1, Section 2, Section 4 and Section 5 in addition to those outlined below.

> Due to the complex nature of LTC/DSL/Hospice facilities, staffing and resident populations, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below. Some facilities may combine the roles or IPC and WHS or may have designated staff to fulfill these roles.

The AHS Public Health Outbreak Team (MOH, CDC, EPH)
• Recommend additional specimen collection for outbreak management.
IPC includes AHS Infection Control Professional (ICP) and Site or facility Infection Control Designate (ICD) ***Note:*** *In the absence of formal ICP or ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual, or by a combination of ICD and supporting groups such as organizational/zone/AHS ICP.*
• Reinforce routine precautions for confirmed and symptomatic residents.
Facility Administration/Facility Management or their Designate
• Anticipates and manages the impact of HCW/staff absence on facility operations.
Site/Unit Manager/Designate
• Provides information about HCW/staff shift patterns (when HCW/staff member last onsite and onsite during infectious period) to the AHS Public Health Outbreak Team and WHS/OHS. • Collects information about HCW/staff immunization status. Shares this information with WHS/OHS and the AHS Public Health Outbreak Team. • Anticipates and manages the impact of HCW/staff absence on facility operations.
Occupational Health/Workplace Health and Safety/Designate ***Note****: In the absence of formal AHS WHS or facility OHS coverage, facility administration/manager designates responsibility for these roles.*
• Determine if HCW/staff are linked to the facility investigation and communicates with the AHS Public Health Outbreak Team
Onsite HCW/Staff (hired directly by the site; contracted HCW/staff, AHS HCW/staff)
• Report relevant immunization status to Facility Administration / Facility Management and/or WHS/OHS.
Provincial Laboratory for Public Health (ProvLab)
• Completes additional COVID-19 testing to identify variants of interest or variants of concern.

Section 7: Confirmed influenza-like illness outbreak

When an Influenza-like illness (ILI) outbreak is opened, the AHS Public Health Outbreak Team will provide additional ILI-specific measures.

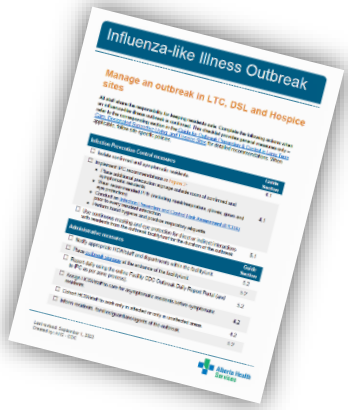
The measures outlined in this section are to be implemented for facilities with a confirmed ILI outbreak. These measures build on those outlined in Section 4 and Section 5.

- The AHS Public Health Outbreak Team may recommend outbreak measures not discussed in this guide for outbreak control.
- Refer to Table F for the influenza-like illness case and outbreak definitions.

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 D for incubation periods for common respiratory pathogens). For example, the incubation period for Respiratory Syncytial Virus (RSV) is two to eight days and would close the ninth day following the last resident case onset.
- If no pathogen is identified, an ILI outbreak will remain open for seven days and would close the eighth day following the last resident case onset.

Non-viral respiratory pathogens (such as bacterial and fungal pathogens) can be responsible for clusters or outbreaks. Although some measures outlined in this section may be applicable in preventing or controlling them, it is beyond the scope of this guide to include these organisms, due to their unique epidemiological properties.



A checklist is available that summarizes key steps in **Influenza-like Illness** outbreak management. Click here to get a printable version.

Checklists:

- Outline key tasks or responsibilities.
- Are used with the guide. The relevant section is shown on the right side where you can find more detail.
- Are used in combination with site-specific policies.

Table D: Organisms commonly associated with respiratory illness

(Reference: 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	How it is Transmitted	Incubation Period[4]	Period Of Communicability	Outbreak Restrictions / Recommendations	Additional Precautions
Influenza, Seasonal Type A or B	Fever, cough, muscle aches, fatigue, sore throat, runny nose & sneezing. **Note**: Fever may not be prominent in those 65 years of age and older.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	1-4 days	Communicable for duration of symptoms.	Refer to Section 8: Confirmed Influenza Outbreak.	Contact and Droplet
COVID-19 (SARS-CoV-2)	Any one or more of the following: new or worsening cough, shortness of breath, 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.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP, indoor spaces with poor ventilation) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	1-14 days The incubation period may differ depending on the variant. For the Omicron variants, most incubation periods fall between one and six days. This guide is based on an incubation period of seven days.	May begin up to 48 hours prior to symptom onset and continue throughout the symptomatic period up to 10 days. The period of communicability may differ depending on variant strain.	Refer to: Section 6: Confirmed COVID-19 Outbreaks.	Modified Respiratory

[4] First day is designated as Day 0; after the first 24 hours is Day 1.

Organism	Clinical Presentation / Symptoms	How it is Transmitted	Incubation Period[4]	Period Of Communicability	Outbreak Restrictions / Recommendations	Additional Precautions
Respiratory Syncytial Virus (RSV)	Runny nose, coughing, sneezing, fever, wheezing.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	2 to 8 days	Communicable for duration of symptoms.	Confirmed or symptomatic cases are recommended to 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.	Contact and Droplet
Parainfluenza Type 1, 2, 3, 4	Fever, runny nose, cough, sneezing, wheezing, sore throat, croup, bronchitis.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	2 to 6 days	Communicable for duration of symptoms; however, cough may persist for one to three weeks post-acute infection.	Confirmed or symptomatic cases are recommended to remain on precautions: • **for five days** from the onset of acute illness **OR** • until they are **over the acute illness and** have been **fever free for 48 hours** without the use of fever reducing medications. Admission/transfer restrictions only when recommended by local MOH.	Contact and Droplet

Organism	Clinical Presentation / Symptoms	How it is Transmitted	Incubation Period[4]	Period Of Communicability	Outbreak Restrictions / Recommendations	Additional Precautions
Human Metapneumo-Virus (hMPV)	Cough, fever, nasal congestion, shortness of breath.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	3 to 5 days	Communicable for duration of symptoms.	Confirmed or symptomatic cases are recommended to 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.	Contact and Droplet
Other common respiratory viruses such as: • **Enterovirus/ Rhinovirus** • **Non-Covid-19 Coronaviruses** • **Adenovirus**	Sore throat, runny nose, coughing, sneezing.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	**Enterovirus/ Rhinoviruses:** usually 2-3 days **Non-COVID-19 Coronaviruses:** usually 2-4 days **Adenovirus:** 2-14 days	Communicable for duration of symptoms.	Confirmed or symptomatic cases are recommended to 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.	Contact and Droplet

7.1 Infection Prevention & Control

Maintain all measures recommended in Section 4.1 and Section 5.1 and see Table D for additional precautions.

- If no organism is identified, continue to use Modified Respiratory precautions.

7.2 Administrative measures

Maintain all measures recommended in Section 4.2 and Section 5.2.

7.3 Resident restrictions

Maintain all measures recommended in Section 4.3 and Section 5.3 and implement the following:

Residents who have symptoms are recommended isolate in their room and be placed on additional precautions. The type and duration of the precautions depends on the cause of the ILI outbreak.

If a specific outbreak pathogen has been identified

Maintain Contact and Droplet precautions for the duration of time recommended in Table D.

- Refer to Section 6 if the outbreak pathogen identified is COVID-19.
- Refer to Section 8 if the outbreak pathogen identified is influenza.

If no specific outbreak pathogen has been identified

Confirmed or symptomatic residents are recommended to isolate in their room with Modified Respiratory precautions for a minimum of 5 days from the onset of symptoms. The isolation period ends and Modified Respiratory precautions are lifted when symptoms improve and the resident is fever-free for 24 hours without the use of fever-reducing medications, whichever is longer.

After the isolation period ends:

- Lift Modified Respiratory precautions.
- Complete a post isolation/additional precautions cleaning and disinfection of the resident room.
- Remove isolation cart and signage.

Resident mask recommendation after isolation period ends:

- When outside of their room, residents are recommended to **mask*** for a total of 10 days from the onset of symptoms.
- Residents are recommended to return to their room when the mask is removed such as eating meals or snacks.

***If a mask is not tolerated:**

- The resident is recommended to complete 10 days of isolation on Modified Respiratory precautions in their room.
- After the isolation period ends:
    - Lift Modified Respiratory precautions.
    - Complete a post isolation/additional precautions cleaning and disinfection of the resident room.
    - Remove isolation cart and signage.

7.4 Restrictions to admissions/transfers/discharges

Maintain all measures recommended in Section 5.4 and consider the following:

- In general, facility/unit would remain "open" during an ILI outbreak, meaning that admissions, transfers, and discharges may proceed following usual non-outbreak processes.

> For mixed pathogens (including ILI + Influenza, or ILI + GI) the facility/unit would generally be restricted.

7.5 Admissions/transfers from an acute care site

Maintain all measures recommended in Section 5.5.

7.6 Transfers to an acute care site

Maintain all measures recommended in Section 4.6 and Section 5.6.

7.7 Group/social activities and other events

Maintain all measures recommended in Section 5.7 and consider the following:

- Consult with the AHS Public Health Outbreak Team to determine if high risk group activities and non-resident events need to be cancelled.

7.8 Nourishment areas / sharing of food

Maintain all measures recommended in Section 5.8.

7.9 Adult day programs

Maintain all measures recommended in Section 5.9.

7.10 Visitors and Designated Support Person(s)

Maintain all measures recommended in Section 4.10 and Section 5.10.

7.11 HCW/staff outbreak measures

Maintain all measures recommended in Section 4.11 and Section 5.11.

7.12 Specimen collection

Maintain all measures recommended in Section 4.12 and Section 5.12 and consult the AHS Public Health Outbreak Team for recommendations on specimen collection and testing for newly symptomatic residents.

7.13 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.13.

Roles and responsibilities for confirmed outbreaks

Roles and responsibilities for an Influenza-like Illness outbreak are similar to those in previous sections. Continue with the roles and responsibilities from Section 1, Section 2, Section 4 and Section 5.

Section 8: Confirmed influenza outbreak

When an Influenza outbreak is opened the AHS Public Health Outbreak Team will provide additional influenza specific measures.

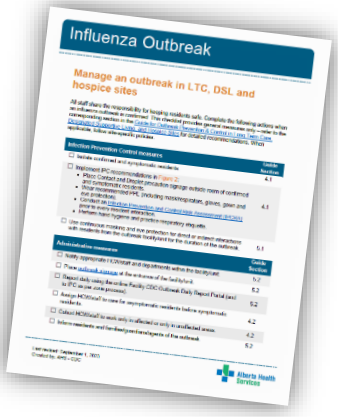
The symptoms of influenza disease are similar to the symptoms for many other respiratory illnesses. See the Health Canada Guidance for further information for identification of suspect influenza cases and indications for early treatment with antivirals: Flu (influenza): For health professionals - Canada.ca

The measures outlined in this section are to be implemented for a facility with a confirmed Influenza outbreak. These measures build on those outlined in Section 4 and Section 5.

- The AHS Public Health Outbreak Team may recommend outbreak measures not discussed in this guide for outbreak control.
- Refer to Table G for the influenza case and outbreak definitions.

Duration of outbreak

- The outbreak remains open for seven days after symptom onset of most recent resident influenza case and will end on day eight.
- Additional information about influenza disease (such as incubation period and period of communicability) is in Table D.



A checklist is available that summarizes key steps in **Influenza** outbreak management. Click here to get a printable version.

Checklists:

- Outline key tasks or responsibilities.
- Are used with the guide. The relevant section is shown on the right side where you can find more detail.
- Are used in combination with site-specific policies.

8.1 Infection Prevention and Control

Maintain all measures recommended in Section 4.1 and Section 5.1 and see Table D for additional precautions.

8.2 Administrative measures

Maintain all measures recommended in Section 4.2 and Section 5.2.

8.3 Resident restrictions

Maintain all measures recommended in Section 4.3 and Section 5.3.

Resident precautions

- Confirmed or symptomatic residents are recommended to isolate in their room on Contact and Droplet precautions for five days from the onset of acute illness OR until they are over their acute illness and have been fever free for 48 hours without the use of fever reducing medications.

Antiviral treatment and prophylaxis

- Confirmed and symptomatic residents are recommended to receive Oseltamivir (Tamiflu) treatment. See the Appendix E to review Antiviral (Oseltamivir) Dosing Recommendations.
    - The resident's most responsible health care practitioner is accountable for ensuring appropriate treatment.
- Asymptomatic residents, regardless of immunization status, are recommended to receive Oseltamivir (Tamiflu) prophylaxis.
    - The resident's most responsible health care practitioner is accountable for ensuring appropriate prophylaxis for residents.
    - Antiviral prophylaxis is continued for seven days after onset of symptoms of the last resident case, usually a minimum of 10 days. See the Appendix E to review Antiviral (Oseltamivir) Dosing Recommendations.
    - In the situation of a mixed outbreak of COVID-19 and influenza, contact the AHS Public Health Outbreak Team to discuss the length of Tamiflu prophylaxis.

8.4 Restrictions on affected facility/units

Maintain all measures recommended in Section 5.4 and implement the following:

- Admission restrictions will remain in place for a minimum of seven days following the onset of symptoms in the most recent resident case, based on Influenza recommendations from the Association of Medical Microbiology and Infectious Disease (AMMI) Canada, and as directed by the AHS Public Health Outbreak Team.

8.5 Admissions/transfers from an acute care site

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

If an admission/transfer to a LTC, DSL or Hospice facility is required during a confirmed influenza outbreak at the facility, following the assessment of the circumstances and consultation with the AHS Public Health Outbreak Team (as described in the box above), LTC, DSL or Hospice HCW/staff are recommended to collaborate with the acute care contact before the resident is discharged. See Risk Assessment Worksheet.

The resident is not recommended to be transferred until the LTC, DSL or Hospice facility 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.

Inform the most responsible health practitioner.

8.6 Transfers to an acute care site

Maintain all measures recommended in Section 4.6 and Section 5.6.

8.7 Group/social activities and other events

Maintain all measures recommended in Section 4.7 and Section 5.7.

8.8 Nourishment areas / sharing of food

Maintain all measures recommended in Section 5.8.

8.9 Adult day programs

Maintain all measures recommended in Section 5.9.

8.10 Visitors and Designated Family/Support Person(s)

Maintain all measures recommended in Section 4.10 and Section 5.10. and consider the following:

- Visitors are encouraged to receive annual immunization for influenza when available.

8.11 HCW/staff outbreak measures

Maintain all measures recommended in Section 4.11 and Section 5.11

- HCW/staff are strongly encouraged to be immunized with the seasonal influenza vaccine. See Work Restriction Decision Tool for Influenza Outbreaks (see Attachment 8.1).
- The AHS 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 AHS Public Health Outbreak Team may provide additional direction beyond what is described below.

Management of asymptomatic HCW/staff who are not immunized.
The AHS Public Health Outbreak Team will provide recommendations for post-exposure immunization, prophylaxis and/or work restrictions to control influenza A or B outbreaks. Oseltamivir (Tamiflu) antiviral treatment and prophylaxis is administered as per the most current

Alberta Health Influenza Antiviral Drug Policy. Facilities are responsible to clearly communicate instructions to their HCW/staff on how to access antiviral prophylaxis. See Appendix E for further information.

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

- **Asymptomatic** HCW/staff who are not immunized **and** who agree to be immunized, **but** do not take prophylaxis are recommended to be:
    - Excluded from work for three days from the last day of work on the outbreak facility/unit.
        - If they remain asymptomatic after three days and receive immunization, they may be reassigned to a non-outbreak facility/unit 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 is recommended to 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 do NOT take** the recommended antiviral prophylaxis are recommended to be:
    - Excluded from working in the affected facility/unit(s) until the outbreak is over,

    OR
    - Relocated to a non-outbreak facility/unit if they remain asymptomatic after waiting three days from the last day of work on the outbreak unit and are not recommended to return to the outbreak facility/unit for the duration of the outbreak.
- **Asymptomatic** HCW/staff who are not immunized and **do take** the recommended antiviral prophylaxis have no required waiting period between starting Oseltamivir (Tamiflu) prophylaxis and returning to work.
- **Asymptomatic HCW/staff immunized less than 14 days prior to the outbreak and do not take recommended antiviral prophylaxis are recommended to be:**
    - Excluded from working in the affected facility/unit until 14 days from date of immunization, or for the duration of the outbreak whichever occurs first,

    OR
    - Excluded from working at any facility for three working days from the last day of work on the outbreak facility/unit. If they remain asymptomatic after waiting the three 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.
- The AHS Public Health Outbreak Team may supply letters for facility/unit to provide to unimmunized HCW/staff outlining options.
    - See Appendix F for sample form letters used for confirmed influenza outbreaks:
        - MOH Exclusion Letter (Immunized less than 14 days prior to outbreak)
        - MOH Exclusion Letter (Not immunized)
- Oseltamivir (Tamiflu) prophylaxis for HCW/staff is NOT publicly funded. The facility is responsible for developing a policy outlining who is responsible for the cost of HCW/staff prophylaxis.

Management of symptomatic HCW/staff

- If HCW/staff develop symptoms, they are recommended to stay home and follow recommendations in Section 4.11 and Section 5.11.

8.12 Specimen collection

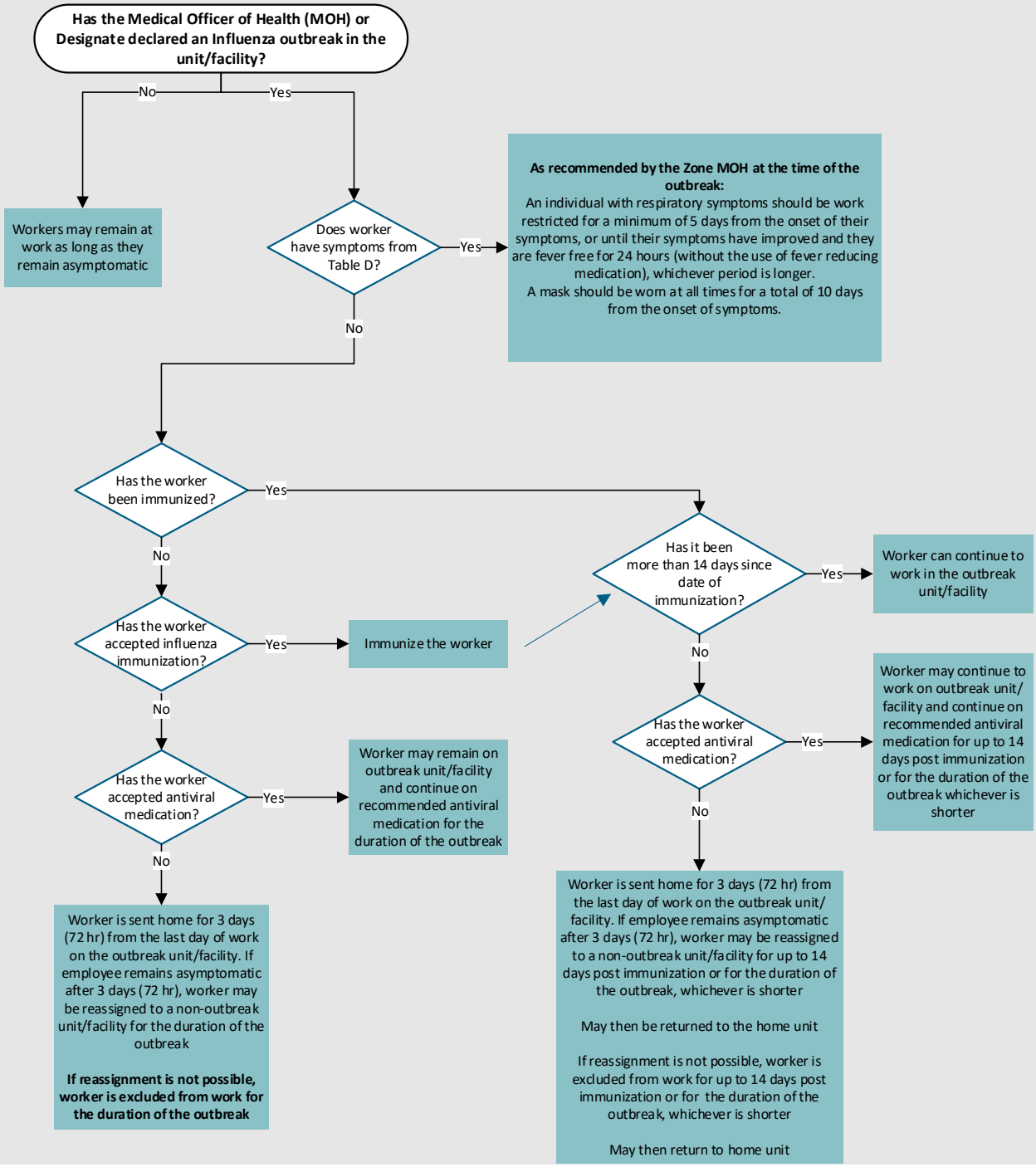
Maintain all measures recommended in Section 4.12 and Section 5.12 and implement the following:

- The AHS Public Health Outbreak Team may recommend additional specimen collection for outbreak management.

8.13 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.13.

Attachment 8.1: Work Restriction Decision Tool for Influenza Outbreaks



Roles and responsibilities for confirmed outbreaks

Continue with the roles and responsibilities from Section 1, Section 2, Section 4 and Section 5 in addition to those outlined below.

Due to the complex nature of LTC/DSL/Hospice facilities, staffing and resident populations, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below. Some facilities may combine the roles or IPC and WHS, or may have designated staff to fulfill these roles).

The AHS Public Health Outbreak Team (MOH, CDC, EPH)
• Provides direction on management of unimmunized HCW/staff. • 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.
IPC includes AHS Infection Control Professional (ICP) and Site or facility Infection Control Designate (ICD) ***Note:*** *In the absence of formal ICP or ICD coverage, facility administration/manager designates responsibility for these roles. This role may be fulfilled by a single individual, or by a combination of ICD and supporting groups such as organizational/zone/AHS ICP.*
• Collaborate to implement resident Oseltamivir (Tamiflu) prophylaxis. • Collaborate to ensure symptomatic residents receive Oseltamivir (Tamiflu) treatment.
Facility Administration/Facility Management or their Designate
• Collaborate on the plan for unimmunized HCW/staff to access and pay for Oseltamivir (Tamiflu) prophylaxis.
Facility/Unit Manager/Designate
• Provide information about HCW/staff shift patterns (when symptomatic HCW/staff was last onsite) to the AHS Public Health Outbreak Team and WHS/OHS. • Collect information about HCW/staff immunization status. Shares this information with WHS/OHS and the AHS Public Health Outbreak Team.
Occupational Health/Workplace Health and Safety/Designate ***Note****: In the absence of formal AHS WHS or facility OHS coverage, facility administration/manager designates responsibility for these roles.*
• Identify HCW/staff who are not fully immunized and communicates work restrictions. • Implement facility plan for unimmunized HCW/staff to access and pay for Oseltamivir (Tamiflu) prophylaxis.
Onsite HCW/Staff (hired directly by the facility; contracted HCW/staff, AHS HCW/staff)
• Report relevant immunization status to Facility Administration / Facility Management and/or WHS/OHS. • Advise Facility Administration/Facility Management and/or WHS/OHS if accepting oseltamivir (Tamiflu) prophylaxis.
Provincial Laboratory for Public Health (ProvLab)
• Completes additional testing on influenza outbreak specimens.

Section 9: Confirmed gastrointestinal illness outbreak

Early detection is essential to reduce the spread of GI illness. Even with IPC measures, outbreaks can be difficult to control. It is vital that IPC measures are implemented immediately. There is no need to wait for testing to confirm the infectious pathogen. Although GI illness outbreaks can occur at any time of year, in Alberta most outbreaks occur in the fall and winter.

Illness rates can be quite high (greater than 50%) in both residents and HCW/staff. Outbreaks can result in high morbidity and a strain on operations. GI illness is often mild, however residents with underlying health conditions are at risk complications such as dehydration and aspiration pneumonia. Most outbreaks are due to norovirus which is extremely communicable. Transmission of GI illness usually occurs via the fecal/oral or vomitus/oral route but can also include contact or droplet spread.

The measures in this section are recommended to be implemented for a confirmed GI outbreak. These measures build on those outlined in Section 4 and Section 5.

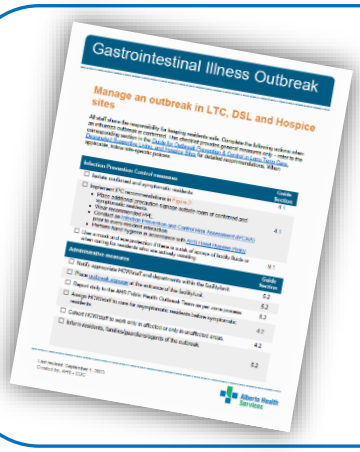
The AHS Public Health Outbreak Team may recommend additional outbreak measures not included in this guide.

- Refer to Table H for the GI illness case and outbreak definitions.

Duration of outbreak

- Outbreak duration may vary. The AHS Public Health Outbreak Team determines outbreak duration on a case-by-case basis.
    - Generally outbreaks are ended according to either timeframe below (**whichever comes first**):
        - 48 hours from symptom resolution in the most recent case **OR**
        - 96 hours from onset of symptoms in the most recent case

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



A checklist is available that summarizes key steps in **Gastrointestinal** outbreak management. Click here to get a printable version.

Checklists:

- Outline key tasks or responsibilities.
- Are used with the guide. The relevant section is shown on the right side where you can find more detail.
- Are used in combination with site-specific policies.

9.1 Infection prevention and control measures

Maintain all measures recommended in Section 4.1 and implement the following:

Hand hygiene

- Glove use is not a substitute for hand hygiene. Remove gloves first and then perform hand hygiene.
- **When caring for a resident with diarrhea**, always use soap and water instead of alcohol-based hand rub after removing gloves.
- Handwashing with soap and water is preferred during GI outbreaks. However, if a hand hygiene sink is not available, then use alcohol-based hand rub (minimum 60-90% alcohol) when leaving the room prior to accessing a sink within or outside of the resident room.

Additional precautions

- Immediately put on additional precautions based on symptoms:
  - Diarrhea only: Use Contact precautions.
  - Vomiting with or without diarrhea: Use Contact and Droplet precautions.

Gloves and gown

- Wear clean gloves and new gown to enter resident room or bedspace when providing direct care to symptomatic residents or when in contact with items in the resident room.
- Wear clean gloves and new gown when cleaning an area contaminated with stool or vomit or gathering/handling specimens.

Mask and eye protection

- Wear a mask and eye protection if there is a risk of sprays of body fluids or when caring for residents who are actively vomiting.

Bed spacing

- If resident has diarrhea and/or vomiting maintain at least two metres of physical separation between bed/stretcher spaces.

9.2 Administrative measures

Maintain all measures recommended in Section 4.2 and Section 5.2 and implement the following:

- Advise HCW/staff to report symptoms of GI illness in themselves during the outbreak to the facility/unit Manager.
- How to submit daily case reporting for GI illness will be directed by the AHS Public Health Outbreak Team when the outbreak is opened. Attachment 9.1 outlines the type of information that may be requested.

9.3 Resident restrictions

During outbreaks, resident activities are restricted. The AHS Public Health Outbreak Team may provide specific resident restrictions.

Isolation

- Symptomatic residents are to be isolated with meal service in their room for the duration of the acute illness, and until 48 hours after the last episode of vomiting or diarrhea.

Transport

- Symptomatic residents are recommended to only leave the outbreak facility/unit when medically necessary.

- Ensure the receiving site is notified that the resident is symptomatic and coming from a facility experiencing a GI illness outbreak and that precautions are to be implemented by the receiving site.

Asymptomatic residents

- Residents are recommended to remain on the unit if the outbreak is confined to the unit.
- Asymptomatic residents may leave the facility.
  - Residents who become symptomatic while away from the facility are recommended to advise the facility.

Treatment

- Treatments (such as physiotherapy or occupational therapy) are recommended to be provided in the symptomatic resident's room.

9.4 Restrictions to admissions/transfers/discharges

- Facility/unit status (such as open, or restricted admissions) will be determined by the AHS Public Health Outbreak Team in consultation with the OMT.
  - If restrictions are lifted, additional precautions for symptomatic residents are recommended to remain in effect.
- The scope of restrictions depends 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
  - The severity of the outbreak (such as new cases despite control measures).
- Restrictions remain until the AHS Public Health Outbreak Team ends the outbreak.

Restrictions regarding resident admissions/re-admissions/transfer and activities are **ONLY** modified or lifted by the AHS Public Health Outbreak Team.

If 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 AHS 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 an acute care site

- Residents hospitalized prior to the outbreak onset are not recommended to return to the facility until the outbreak is ended.
  - Consult the AHS Public Health Outbreak Team in extenuating circumstances.
  - If an admission/transfer must occur during an outbreak, HCW/staff will collaborate with the acute care site prior to discharge.
    - HCW/staff must advise the resident/family about the potential risks and obtain consent prior to transfer.

9.6 Transfers to an acute care site

- If a symptomatic resident requires acute medical attention or treatment at an acute care site (such as urgent care, dialysis, emergency department):
  - Notify the EMS dispatcher, the transport staff (EMS crew) and the acute care site so that appropriate precautions can be taken during transport and on arrival.

9.7 Group/social activities and other events

- Consult the AHS Public Health Outbreak Team if:
  - Group/social activities may be considered in extenuating circumstances.
  - Group activities are considered an essential part of treatment.
- Previously scheduled resident social and special events (such as entertainers and school groups) on the affected facility/unit are recommended to be cancelled/postponed for the duration of the outbreak.
- Postpone or cancel any non-resident events booked for areas in the outbreak facility/unit (such as meetings).

9.8 Nourishment areas / sharing of food

Maintain all measures recommended in Section 5.8 and implement the following:

- Extra diligence is recommended for routine dishwashing and food preparation area surface sanitizing practices during GI outbreaks.
- Use dining table coverings that can be easily cleaned and disinfected (that is, discontinue use of cloth/linen table coverings until the outbreak is over).

9.9 Adult day programs

Maintain all measures recommended in Section 5.9

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

Maintain all measures recommended in Section 4.10 and Section 5.10 and implement the following:

- Those visiting symptomatic residents must be advised to practice additional precautions.
- Although restriction of visits is not recommended, the AHS Public Health Outbreak Team may be consulted if a facility is having difficulty controlling an outbreak.

9.11 HCW/Staff outbreak measures

- Prior to work, HCW/staff are to complete daily self-assessment for GI illness symptoms.
- Symptomatic HCW/staff that fit the case definition for GI illness are recommended to contact WHS/OHS and 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.
- Exclude non-essential volunteers from working in affected areas of the facility (if any can be deemed “non-essential”).

9.12 Specimen collection

Maintain all measures recommended in Section 4.12 and Section 5.12 and implement the following:

- The AHS Public Health Outbreak Team may recommend additional specimen collection for outbreak management.

9.13 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.13 and implement the following:

Enhanced cleaning and disinfection details

Environmental surfaces often become contaminated with feces or vomitus containing viruses or bacteria causing GI illness.

Recommended disinfectants

- The following disinfectant categories/concentrations are recommended for disinfecting surfaces and equipment during GI illness outbreaks (follow manufacturer's directions for use):
    - Hypochlorite at a concentration of 1000 parts-per-million. Commercially available hypochlorite-containing solutions are recommended.
    - 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.
- Equipment is recommended to 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, if the surface is visibly clean. Follow manufacturer's directions for use.
- 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 (such as towels and sheets) from resident rooms when the isolation precautions for GI illness are lifted.
- Privacy curtains are recommended to be changed if visibly dirty and when isolation precautions for GI illness are lifted.
- Conduct a thorough cleaning in all affected areas at the end of the outbreak.

Note: upholstered furniture and rugs or carpets are recommended to 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 AHS Public Health Outbreak Team. Consider discarding items that cannot be appropriately cleaned/disinfected, when possible/appropriate.

Linen/laundry

- Wear PPE (such as gloves and gown) as there is a risk of contamination of HCW/staff clothing from body fluids or secretions.
- Follow correct doffing of PPE 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/machine for soiled laundry from resident's sick with the outbreak illness.
- Handle all linen that is soiled with body fluids using the same precautions regardless of the source.

- Remove soiling (for example feces) with a gloved hand and dispose into toilet. Do not remove feces 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 and people.
- Contain wet laundry before placing it in a laundry bag (for example wrap in a dry sheet or towel).
- Do not double bag.
- Tie laundry bags securely and do not overfill.
- Disinfect washer with a bleach cycle (without a load of laundry) prior to use by others if used to launder soiled items from a symptomatic resident.

9.14 Relapse GI cases

GI illness cases frequently “relapse” (that is, 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.

- Manage relapse GI illness cases as follows:
    - Resident to remain in their room until free of vomiting and diarrhea for 48 hours.
    - Do not count as new outbreak cases if relapse is within seven days of original symptom resolution.
        - Relapse cases are not included on new daily case listings.
        - Relapse case(s) alone will not extend admission restrictions.
- If a previously identified GI illness case has onset of GI illness symptoms after being symptom free for **at least seven days**, manage as 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. The AHS Public Health Outbreak Team will direct sites on how to report when the outbreak is opened.

Accurately completed lists of cases are recommended to be reported to the AHS Public Health Outbreak Team **daily** once an outbreak has been declared. The individual responsible for completing and submitting the list of cases is site specific, and may be done by site ICP/ICD, facility/unit manager or another responsible HCW/staff in the unit/site.

Outbreak data elements that are recommended to be reported daily to the AHS 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 AHS Public Health Outbreak Team)
- **Demographics of Cases**
  - Residents: name, personal health number, date of birth, gender, unit/room number
  - HCW/staff: number of new cases
- **Signs and Symptoms**
  - Onset date
  - Signs and symptoms meeting case definition (vomiting, diarrhea, bloody diarrhea)
- **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: Ending an outbreak

The AHS Public Health Outbreak Team will advise the facility when the outbreak is ended and lift any facility restrictions. After the outbreak is ended, the following are recommended:

- Conduct a thorough cleaning and disinfection in all affected areas at the end of the outbreak.
- Key program leads review and evaluate the outbreak management and revise internal protocols for improvement.
    - A debriefing meeting may be called by any member of the Outbreak Management Team to discuss outbreak management issues.
    - A report summarizing the investigation results and recommendations may be shared with internal/external partners depending on the outbreak type and scale.

If additional residents develop symptoms within seven days of the outbreak being ended, the facility/unit is recommended to follow the steps for assessing and reporting a potential outbreak Section 2 and Section 3.

Glossary

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

Adult Day Program: Day program designed for adults with physical and/or memory challenges or chronic illness.

AHS Provincial Seniors Health & Continuing Care: A provincial program focusing on optimizing the health, well-being, and independence of seniors. They work closely with stakeholders across the province to align and optimize services.

AHS Public Health Outbreak Team: This team is made up of Medical Officers of Health (MOH), the Communicable Disease Control Nurses and Environmental Public Health (EPH) officers. It provides consultation and leadership in outbreak investigations in facilities and reports outbreaks to Alberta Health.

Appropriate mask: The type of mask (such as medical, KN95, N95) recommended per the AHS IPC Infection Prevention and Control Risk Assessment (IPCRA).

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.

Cluster: A grouping 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.

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. The physical separation of people who have been or might have been exposed to infection from those who have not been exposed.

Confirmed resident: A resident who the AHS Public Health Outbreak Team identifies as a case to be included in the outbreak (such as those who have tested positive on a laboratory test, those who have tested positive for COVID-19 on a rapid antigen test).

Congregate settings: Facilities where residents receive care and/or services in a communal environment with other residents. This includes acute care, long term care, designated supportive living, hospice, adult day programs, and non-designated supportive living sites (such as lodges and private retirement residence).

Designated Family / Support Person (DFSPs): one or more individuals identified by the resident as an essential support, and who the resident 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 Visiting a Loved One at an AHS Facility.

Designated Supportive Living (DSL): A home-like setting where residents 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.

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 AHS Public Health Outbreak Team or Workplace Health and Safety or designate.

Exposure Investigation Number (EI Number): A number assigned by the Provincial Laboratory for Public Health to track laboratory specimens associated with an outbreak at a specific location and time.

Facility Operator / Facility Management: A formal leader within the facility who is responsible for the day-to-day operations.

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.

Health Care Workers (HCW): As defined by Alberta Health (AH) includes all health practitioners and all individuals (including nutrition and food services, housekeeping and recreation) 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 settings: 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 be used consistently, 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 staff members at the facility (such as administrative staff, support staff, and

regulated health care providers) or only those that are considered to be a HCW (such as health care aid, licensed practical nurse, registered nurse, professional and non-professional therapies/Allied Health).

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

Hospice: Any facility in which residential hospice services are offered or provided by AHS or by a service provider under contract with AHS.

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

Infection Control Professional (ICP): 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®).

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. Residents 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 also be called auxiliary hospitals and nursing homes.

Most Responsible Health Practitioner: The health care provider who has responsibility and accountability for the specific treatment/procedure(s) provided to a resident and who is authorized by AHS and/or the facility to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

Outbreak Management Team (OMT): A group of key individuals working 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. Membership may include representatives from the AHS Public Health Outbreak Team, Infection Prevention and Control (IPC/ICD), Occupational Health/ Workplace Health Safety (WHS), Facility Administration/Facility Management or their Designate. Any group that participates in the OMT may request an OMT is formed.

Outbreak Measures: Management strategies that are recommended to be implemented to control the spread of disease during an outbreak. Outbreak measures may fall into the following categories:

- Routine measures: measures are recommended for all outbreaks.
- Pathogen specific measures: measures that are specific to the pathogen causing the outbreak.
- Additional measures: measures that are not routinely recommended. They are

recommended only at the discretion of the AHS Public Health Outbreak Team if the outbreak warrants additional control measures.

Visitor: An individual who spends time with the resident for a temporary period of time for the purposes of providing support. Visitors are not an essential partner to care planning and/or decision-making. For more information refer to the AHS Family Presence: Designated Family / Support Person and Visitor Access policy.

Workplace Health & Safety / Occupational Health & Safety (WHS/OHS): Designated personnel responsible for staff health and safety in facilities. This role may be filled by employee or the facility site management.

Appendix A: Case and Outbreak Definitions

Once specimen results are available or residents decline specimen collection, a decision can be made on whether the facility has met an outbreak, and the type of outbreak occurring.

Table E: COVID-19 illness

COVID-19 Illness Case Definition	COVID-19 Illness Outbreak Definition
A person 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.	Two or more confirmed COVID-19 cases in residents within a seven-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 F: Influenza-like-illness (ILI)

ILI Case Definition	ILI Outbreak Definition
Syndromic ILI: Acute onset of respiratory illness which includes cough (new or worsening) and one or more of the following symptoms: • fever • shortness of breath • sore throat • myalgia • arthralgia • prostration In children under 5 years, GI symptoms may also be present. In people under 5 years or 65 years and older, fever may not be prominent. **Pathogen Specific ILI:** Positive for non-influenza, non-COVID-19 pathogen from the Respiratory Pathogen Panel (RPP) - see Table D	Two or more cases of ILI in residents within a seven-day period, with a common epidemiological link **AND** No respiratory pathogen identified OR only one case of any respiratory pathogen identified (such as Influenza; COVID-19 and RSV) OR at least two cases of a non-influenza, non-COVID-19 respiratory pathogen. Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period.

Note: ILI outbreaks can be either syndromic or pathogen specific.

- Examples of Syndromic ILI outbreaks include:
  - Two or more residents who meet the syndromic case definition **OR**
  - One resident who meets the syndromic case definition PLUS at least one other resident who meets the pathogen-specific case definition **OR**
  - One resident positive for influenza or COVID PLUS at least one other resident who meets the syndromic case definition
- Examples of Pathogen-specific ILI outbreaks include:
  - Two or more residents with the same non-influenza, non-COVID pathogen from the RPP

Table G: Influenza illness

Influenza Illness Case Definition	Influenza Illness Outbreak Definition
A person with clinically compatible signs and symptoms (as outlined above under syndromic ILI) and laboratory confirmation of infection with seasonal influenza virus by: • detection of influenza virus RNA (e.g., via real-time reverse transcriptase polymerase chain reaction [RT-PCR]) **OR** • demonstration of influenza virus antigen in an appropriate clinical specimen (e.g., nasopharyngeal/throat swabs) **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	Two or more confirmed influenza cases in residents within a seven-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 H: 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): • Two 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** • Two or more episodes of vomiting in a 24-hour period **OR** • One or more episodes of vomiting **AND** diarrhea in a 24-hour period **OR** • One episode of bloody diarrhea **OR** • Laboratory confirmation of a known enteric pathogen **Note:** Lab confirmation is not required.	Two 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. Similarly, a **mixed pathogen outbreak** could result when virus(es) causing respiratory and gastrointestinal symptoms are co-circulating in a facility.

The AHS Public Health Outbreak Team will determine if the facility has a mix pathogen outbreak and will make recommendations. The general principle of applying the more protective recommendation will be followed.

Appendix B: 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 specimen 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/unit name
- EI number (assigned by PPHST/ ProvLab/the AHS 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**:**

- 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. See ProvLab education resources for information on collection of NP and Throat swabs.
    - 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 AHS Public Health Outbreak Team direction on the type of testing required for subsequent symptomatic residents and HCW/staff as appropriate.

Stool specimen information

- Sites must collect specimens as directed by the AHS Public Health Outbreak Team and arrange for delivery of specimens to the laboratory. It is valuable to collect stool specimens from cases during outbreaks to try and identify the etiology, if possible.
- Please note that norovirus can be detected by ordering Gastro Viral Panel (GVP) if in stool but 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 AHS Public Health Outbreak Team will obtain an EI number from the ProvLab when a GI illness outbreak is declared. Stool specimens submitted without an EI number on the requisition may 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 AHS 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 AHS 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 bedpan.
- 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 number 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 are not recommended to be collected unless advised by the AHS Public Health Outbreak Team. If additional specimens are received under the same EI number at some later period, these will not be tested unless the AHS Public Health Outbreak Team has contacted the ProvLab point person for the EI number (for example 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 AHS Public Health Outbreak Team and the ProvLab.
- The AHS Public Health Outbreak Team will contact the ProvLab if the clinical situation for the outbreak has changed and additional testing needs to be done.

Outbreak specimen transport:

Sites must collect specimens for outbreak management as directed by the AHS Public Health Outbreak Team and make their own arrangement for delivery to the laboratory.

- Follow current Provincial 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 AHS Public Health Outbreak Team or by the fastest means possible.

Appendix C: 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 AHS 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-19 OR influenza is attributed as a primary or secondary cause of death

The submission is 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.
- 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).
- 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.

Appendix D: Outbreak Signage

Sites may print black and white or colour outbreak signage from: [Outbreak Management (General Information and & Signage section)].

Stoplight Sign Link:
https://www.albertahealthservices.ca/assets/healthinfo/ipc/if-hp-ipc-facility-outbreak-stoplight-poster-colour.pdf.

Appendix E: Antiviral Dosing Recommendations

Antiviral (Oseltamivir) Dosing Recommendations
Influenza antiviral treatment and prophylaxis resources:

- Association of Medical Microbiology and Infectious Disease (AMMI) Canada resources on Influenza: https://ammi.ca/en/resources/
- TAMIFLU® Product Monograph, Roche Canada: https://www.rochecanada.com/PMs/Tamiflu/Tamiflu_PM_E.pdf
- AHS Healthcare providers can access Lexicomp through Pharmacy Services, Drug Information on AHS Insite

Dosing recommendations for treatment and prophylaxis varies with age and health (including weight and renal function).

Serum creatinine tests for residents may be required for determining antiviral dosage. Facilities are recommended to prepare for respiratory virus outbreak season each year by ordering serum creatinine and recording resident weights. A baseline temperature is recommended to also be taken and recorded. Ultimately, prescribers are responsible for determining the appropriate antiviral dose for their residents.

Early initiation of antiviral treatment is critical for treatment effectiveness. Providers are recommended to consider whether antiviral treatment can be started using the most recent creatinine clearance estimate for dosing while awaiting blood work and adjusting the timing and dose based on testing results. Most responsible health care practitioner may consider this approach in the following situations:

- Renal function has been unstable in the past, or
- Resident oral intake/urine output has been poor in the immediate prior period, or
- Where creatinine results are older than one year

In the event of antiviral resistance in the outbreak influenza strain, the Zone MOH (along with the AHS Public Health Outbreak team) will make recommendations on antiviral prophylaxis.

Appendix F: MOH Exclusion from Work Letters

MOH Exclusion Letter (Immunized less than 14 days prior to outbreak)

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 are recommended to 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

MOH Exclusion Letter (Not immunized)

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 is recommended to 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 are recommended to 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

Annex: Outbreak Season Preparation Resources

Outbreak preparation letters and resources

Following are samples of **outbreak preparation letters** that the AHS Public Health Outbreak Team sends to facilities and community partners outlining general responsibilities for outbreak preparation. Additionally, links are provided to fillable forms that facilities may use to plan and track advance resident oseltamivir (Tamiflu) prescriptions.

Outbreak preparation letters

Letter Recipient	Overview
Prescribers	• Oseltamivir (Tamiflu) advance prescription request for residents. • Notice that staff may present during an influenza outbreak with prescription request. • Appendix A attachment in the letter provides dosing recommendations.
Pharmacists	• Process for filling prescriptions during an influenza outbreak. • Includes information on role of prescribing pharmacists.
Operators and Seniors Health staff	• General outbreak preparation recommendations (such as planning for advance oseltamivir (Tamiflu) prescriptions, planning for COVID-19 and influenza immunization and developing a plan for accessing supplies). • Letters to current and new staff, and to the resident/decision maker are included with this letter.
Current and New Staff	• Information on annual influenza immunization and COVID-19 immunization. • Work restriction for HCW/staff who do not receive the annual influenza immunization. • Provide to existing and new staff. • Disseminated through zone-specific distribution lists
Resident/Decision Maker	• Information about how residents can protect themselves from infection. • Disseminated by facility and/or seniors health

Resources used to prepare for outbreaks

Resource	Overview
Advance Prescription for Oseltamivir (Tamiflu®)	• Use the *Advance Prescription for Oseltamivir (Tamiflu)* fillable form to provide to residents to take to their physician to complete.
Outbreak Antiviral Prophylaxis in Non-Designated and Designated Supportive Living Site Worksheet	• Use the *Outbreak Antiviral Prophylaxis in Non-Designated and Designated Supportive Living Sites Worksheet* fillable form to track residents who have an advance prescription.
Outbreak Prevention Checklist	• Checklist to guide staff when there are symptomatic resident(s) prior to an outbreak.

Letter to prescribers on advance prescriptions for antiviral medication

Alberta Health Services

Click here to enter a date.

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

Dear Colleagues,

We are requesting advanced prescriptions for antiviral medication for use during an influenza outbreak for all residents living in Long Term Care (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.

Outbreaks of influenza commonly occur in sites in which there is communal dining. All individuals should be encouraged to receive their annual influenza immunization.

➢ **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).

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➢ **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 in regard to 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

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APPENDIX A - Antiviral (Oseltamivir) Dosing Recommendations

Most responsible care providers can access information on influenza antiviral treatment and prophylaxis from the following resources:

- Association of Medical Microbiology and Infectious Disease (AMMI) Canada resources on Influenza: https://ammi.ca/en/resources/
- TAMIFLU® Product Monograph, Roche Canada: https://www.rochecanada.com/PMs/Tamiflu/Tamiflu_PM_E.pdf
- AHS Healthcare providers can access Lexicomp through Pharmacy Services, Drug Information on AHS Insite

Dosing recommendations for treatment and prophylaxis varies with age and health (including weight and renal function).

Serum creatinine tests for residents may be required for determining antiviral dosage. Facilities are recommended to prepare for respiratory virus outbreak season each year by ordering serum creatinine and recording resident weights. A baseline temperature is recommended to also be taken and recorded. Ultimately, prescribers are responsible for determining the appropriate antiviral dose for their residents.

Early initiation of antiviral treatment is critical for treatment effectiveness. Providers are recommended to consider whether antiviral treatment can be started using the most recent creatinine clearance estimate for dosing while awaiting blood work and adjusting the timing and dose based on testing results. Most responsible care providers may consider this approach in the following situations:

- Renal function has been unstable in the past, or
- Resident oral intake/urine output has been poor in the immediate prior period, or
- Where creatinine results are older than one year

In the event of antiviral resistance in the outbreak influenza strain, the Zone MOH in combination with the Public Health Outbreak team will make recommendations on the use of antiviral prophylaxis.

Letter to pharmacist on antivirals during influenza outbreaks

Alberta Health Services

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

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during the outbreak. Their employer will advise their employees in regards to 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

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Outbreak preparation letter to operators and Seniors Health staff

Alberta Health Services

NDSL and DSL Outbreak Preparation
2023-2024

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 2023/24 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 2023-2024 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, 2024.

    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, 2024 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 or not residents have received annual influenza vaccine and the number of COVID-19 vaccine doses received may be requested by CDC nursing.

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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 or not 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, 2024.

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
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Important notice to staff about influenza and COVID-19

Alberta Health Services

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.

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 and to protect against infection from these changing influenza viruses. 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,

Annual influenza immunization is recommended

Medical Officers of Health
Alberta Health Services, Zone

Zone information
www.albertahealthservices.ca

Resident or alternate decision maker

Alberta Health Services

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. • Consider getting immunized to protect yourself against vaccine preventable illness [e.g., Pneumonoccal
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

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