Provincial Population & Public Health

Guide for Outbreak Prevention & Control in Continuing Care Homes

Includes Respiratory & Gastrointestinal Illness

Alberta Health Services

If you have feedback about this guide email: CDCResourceFeedback@albertahealthservices.ca.

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

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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 within Alberta and 8 Metis Settlements. We also acknowledge the many Indigenous communities that have been forged in urban centres across Alberta.

Introduction

Continuing care homes (Type A, B and C) are high-risk settings for the spread of communicable disease. Early detection of viral respiratory and gastrointestinal (GI) illness is important to reduce the spread of disease and prevent outbreaks[1]. Although infectious disease outbreaks occur year-round, they are more common during 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. Early recognition and rapid response are essential for effective outbreak prevention and management.

Outbreak management uses a multidisciplinary approach

Appendix A outlines the roles and responsibilities of:

- **The Alberta Health Services (AHS) Public Health Outbreak team**
  - This includes Medical Officers of Health (MOHs), Communicable Disease Control (CDC) Nurses and Safe Healthy Environments Public Health Inspectors
- AHS Provincial Partner Oversight (PPO) team
- **Infection Prevention & Control (IPC) / designate**
- **Facility operator / facility management**
- **Workplace Health and Safety (WHS) / Occupational Health and Safety (OHS)**
- Onsite **Health Care Worker (HCW) / staff**
- Provincial Laboratory for Public Health (ProvLab)

This guide was developed by CDC and Safe Healthy Environments, in collaboration with the following partners:

- AHS:
  - Infection Prevention & Control
  - Medical Officers of Health
  - Provincial Seniors Health and Continuing Care
  - Workplace Health and Safety
  - Zone Public Health
- Covenant Health:
  - Infection Prevention & Control
  - Occupational Health, Safety & Wellness

[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.

Best practice recommendations

This guide provides evidence-based best practice recommendations and follows the Alberta Health Public Health Disease Management Guidelines. It supports facilities to fulfill their obligation to prevent and control outbreaks. Use this guide in conjunction with requirements outlined in other provincial acts and standards and with facility policies.

Facilities are responsible to prepare for outbreaks

In compliance with the Alberta Continuing Care Health Services Standards, AHS facilities and contracted service providers will develop and implement documented policies and procedures for outbreak prevention, identification, management, control, surveillance and reporting of notifiable diseases (Standard 11, 2024).

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

- Develops outbreak guides and supporting resources and posts on the Outbreak Management webpage at ahs.ca/outbreak.
- Provides outbreak information to continuing care home representatives at zone fall education sessions.
- Sends preparation letters to facilities and community partners outlining general responsibilities for outbreak preparation such as Advanced Prescriptions for oseltamivir (Tamiflu).

1. Outbreak prevention

This section includes best practice recommendations to prevent outbreaks. These are routine actions for every facility and every resident.

Key Actions

- Promote immunization of residents, HCW/staff and visitors.
- Handle food safely.
- Facilitate safe visiting practices.
- Post signs to remind and visitors to defer visit if ill.
- Complete routine environmental cleaning and disinfection.
- Use hand hygiene and respiratory etiquette.
- Conduct an Infection Prevention Control Risk Assessment (IPCRA) prior to providing resident care.
- Isolate symptomatic or confirmed residents.
- Offer antiviral treatment if the pathogen is COVID-19 or influenza.
- Prevent illness spread by monitoring for symptoms of illness and not attending work when ill.
- Restrict symptomatic HCW/staff from attending work while ill.

Supporting resources

- Outbreak Prevention Checklist for Continuing Care Homes

1.1 Prevent the spread of illness

These routine everyday practices are essential to stop the spread of respiratory and GI illnesses that cause outbreaks. Outbreak prevention practices support a healthy environment for residents and HCW/staff.

Promote immunization of residents, HCW/staff and visitors

- Immunization is the best way to protect residents, HCW/staff and visitors from vaccine-preventable diseases. Refer to Recommended Vaccines.
- The AHS Provincial Partner Oversight (PPO) team supports facilities in providing annual influenza and COVID-19 immunization for residents and HCW/staff, as well as pneumococcal and RSV immunization to eligible residents.

Handle food safely

- Follow routine safe food handling practices to reduce the spread of illness by contamination.
  - Keep raw meat, poultry, eggs, fish and shellfish away from other foods/surfaces that will come into contact with ready-to eat foods.
  - To further separate raw and ready-to-eat foods, use separate cutting boards, preparation areas if possible, and frequent kitchen cleaning/disinfection.
  - Wash hands when they become contaminated.
  - Keep perishable food in the safe temperature zones and use within appropriate timeframes.
  - Store and use pantry items to prevent contamination.
- Refer to information from Environmental Public Health for Food Facilities at Information for Your Business.

Facilitate safe visiting practices

Help plan a safe visit

- Refer to Family/Visitors of Patients and Residents.
- Request **designated family / support persons (DFSPs**) and **visitors** follow facility directions.
- Post signage to remind DFSPs and visitors if they have symptoms or are feeling unwell to defer their visit.
- Request that DFSPs and visitors reschedule visits if they are ill.
  - Determine if exemption will be made due to extenuating circumstances.
  - Offer compassionate exemptions for visits to residents who are at end of life.
- Advise DFSPs and visitors to use respiratory etiquette and hand hygiene.
  - How to use alcohol-based hand rub
  - How to hand wash.

How to safely visit isolating residents

Provide the following messages to DFSPs and visitors:

- There is a risk of exposure to illness.
- Use personal protective equipment (PPE) as per additional precautions signage.
  - Demonstrate how to use PPE.
- Use physical distancing if not wearing PPE while visiting residents with respiratory illness.
- Only visit the isolating resident and then leave the facility promptly.

1.2 Use routine IPC practices

Implementing routine IPC practices is essential to prevent the spread of illness from person to person.

- Use routine IPC practices when caring for every resident, every time.
- Click on the Continuing Care tab on the IPC Resource Manuals web page for more information.
- Support on PPE selection and use is available. Refer to the AHS Provincial PPE Safety Coach Program.

Complete routine environmental cleaning and disinfection

- Perform routine cleaning and disinfection. A clean environment protects residents and HCW/staff from infection by removing germs from environmental surfaces. It is one of the most effective ways to stop the spread of illness.
- Always use a wipe twice procedure (a two-step process) to clean and then disinfect surfaces.
  - **Cleaning** refers to using soap or detergent to remove visible dirt, grime, and impurities. Cleaning does not kill germs but helps remove them from the surface.
  - **Disinfection** refers to using chemicals to kill germs on surfaces.

Steps for cleaning and disinfection

- First: Clean surfaces using a cleaning product such as soap or detergent, paying special attention to removing any visible dirt.
- Second: Wipe again with a clean cloth saturated with product that is an approved disinfectant.
- If the product is a cleaner and also a disinfectant, use the same product for each step (first to clean and then to disinfect). Follow the manufacturer instructions for use.

- Follow Public Health Recommendations for Environmental Cleaning and Disinfection of Public Facilities for direction on:
  - How to clean and disinfect
  - Frequency of cleaning and disinfection
  - What cleaning products to use
  - Cleaning during respiratory and GI illness outbreaks.
- Follow Principles for Environmental Cleaning and Disinfection for direction on

cleaning the environment and non-critical medical devices / equipment where care is provided.
- Follow Linen in Community-based Services for laundry instructions.
- Refer to Laundering Personal Patients Items in Washing Machine.

Use hand hygiene

- Hand hygiene (washing or sanitizing your hands) is the most effective way to prevent the spread of illness.
- 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 and body fluids
  - Before, during, and after handling food
  - When removing gloves after caring for a resident with vomiting and/or diarrhea
  - Immediately after using the washroom.
- Use hand hygiene after glove removal. Glove use is not a substitute for hand hygiene.
- Follow the AHS Hand Hygiene Policy and Procedure for product selection, location, and use.

Use respiratory etiquette

- Cover coughs and sneezes with a sleeve or tissue.
- Dispose used tissues in the garbage.
- Clean hands after coughing or sneezing.

Conduct an IPCRA prior to providing any resident care

- Refer to the IPCRA to assess the task, the resident, and the environment prior to each interaction.
- Use PPE including an **appropriate mask**, eye protection, gown and gloves as indicated by the IPCRA.

1.3 Isolate symptomatic or confirmed residents

Immediately isolate any resident who is **symptomatic** (the resident has symptoms) or is **confirmed** (the resident has tested positive for a respiratory or GI pathogen).

- Do not wait for a pathogen to be identified through specimen collection if the resident is symptomatic.
- Consult IPC for additional support.

Use a private room

- A private room is preferred.
- Use a dedicated washroom or commode.
  - If not available, clean and disinfect the commode or washroom between use.

- Place isolation carts outside of the resident's room.
- Post additional precaution signage outside the door of the resident's room to alert HCW/staff and visitors that additional precautions are required.

Use additional precautions based on symptoms

For respiratory symptoms

- Isolate on Droplet and Contact precautions. For duration of isolation refer to Appendix B: Resident isolation for respiratory illness.

For GI symptoms

- Isolate residents until 48 hours after the last episode of vomiting and/or diarrhea.
  - Diarrhea only: Use Contact precautions.
  - Vomiting with or without diarrhea: Use Droplet and Contact precautions.

How to care for an isolating resident

Maintain distance from other residents

- Provide meal service to the resident in their room and assist resident to complete hand hygiene before their meal.
- Provide a mask to a resident with respiratory symptoms if they need to leave their room.
- Delay participation in group activities until the isolation period has ended.
- Provide treatment such as physiotherapy in the resident's room.
- Request the resident bath or shower after completing isolation for GI illness.

Facilitate medically necessary appointments using additional precautions

- Arrange virtual visits when possible.
- Notify the receiving provider so that precautions can be taken.
- For transfers to an **acute care** facility, notify the EMS dispatcher, the transport staff (EMS crew) and the acute care facility.

Support social engagement for residents who are isolating

- Provide activities that engage/support the isolating resident such as social, spiritual care and mental health.
- Support safe visits with DFSPs and visitors.
- Provide one-on-one support for residents who need 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 isolating.

Share spaces and equipment safely

- Maintain at least two metres of distance between bed spaces of isolating residents who are sharing a room.
- Use physical barriers such as curtains or portable wipeable screens in shared rooms. Refer to Additional Precautions Without Walls in Shared Patient Care Space.
- Dedicate care equipment to a single resident.
- If equipment must be shared between residents, clean and disinfect after each use.

Antiviral treatment for residents

Early initiation of antiviral treatment for eligible residents is critical for effective treatment.

COVID-19 	**If the pathogen is COVID-19** • The **most responsible health practitioner** is accountable to determine eligibility and prescribe treatment. • Refer to COVID-19 Outpatient Treatment.

Influenza 	**If the pathogen is influenza**
	• The most responsible health care practitioner is accountable to determine eligibility and prescribe treatment.
	• Refer to the Health Canada Guidance for identification of suspect influenza cases and indications for early antiviral treatment.
	  ○ Flu (influenza): For health professionals - Canada.ca
	• Influenza antiviral treatment resource:
	  ○ Association of Medical Microbiology and Infectious Disease (AMMI) Canada resources on Influenza: https://ammi.ca/en/resources/

1.4 Prevent spread of illness from HCW/staff

Follow employer work restrictions and requirements

- HCW/staff are required to follow organization policies and procedures regarding work attendance, masking, and eye protection.
- HCW/staff employed or contracted by AHS
  - Follow AHS policies on work attendance, work restriction, masking and eye protection including the Attendance at Work and Respiratory Virus Symptoms Directive.

HCW/staff monitor for symptoms of illness

- Do not attend work when ill.

Symptoms of respiratory illness

- Any one of the following symptoms that are new or worsening and not related to a pre-existing illness or health condition:

- Fever or chills
- Runny or stuffy nose
- Sore throat
- Cough
- Difficulty breathing or shortness of breath
- Loss or altered sense of taste/smell.

Symptoms of GI illness

- New onset of diarrhea and/or vomiting.

If symptoms develop at work

Type of symptoms	Action
Respiratory illness	• Perform hand hygiene and respiratory etiquette such as washing hands, coughing into sleeve, using tissues, and wearing an appropriate mask. • Notify manager and leave the workplace as soon as possible.
GI illness	• Perform hand hygiene. • Notify manager and leave the workplace as soon as possible. ○ Manager to direct environmental cleaning (with PPE) of any washroom facilities used by the HCW/staff while ill.

Implement work restrictions for symptomatic HCW/staff

Do not report to work with respiratory symptoms

- Stay away from work until symptoms improve and fever-free for 24 hours without the use of fever-reducing medication.
- Use added precautions when returning to work after respiratory illness.
  - HCW/staff working in any setting where they have contact with others should continuously mask and perform thorough hand hygiene for five calendar days starting from the first day they are eligible to return to work.
- Report illness to the manager/designate.
- Report to WHS/OHS if symptoms are related to workplace exposure.
  - Follow direction provided by WHS/OHS regarding additional work restrictions and requirements.

Do not report to work with GI illness symptoms

- Stay away from work until at least 48 hours after last episode of vomiting and/or diarrhea.
- Report illness to the manager/designate.
- Report to WHS/OHS if symptoms are related to workplace exposure.
  - Follow direction provided by WHS/OHS regarding additional work restrictions and requirements.

2. Identify and report respiratory illness outbreaks

This section includes information on identifying and reporting respiratory illness outbreaks, including COVID-19, influenza and influenza-like illness (ILI).

Refer to 4. Identify and report gastrointestinal illness outbreaks for information on GI illness outbreaks.

Key Actions

- Monitor residents for symptoms of illness.
- Determine if residents meet criteria for a respiratory illness case.
- Keep track of respiratory illness cases.
- Report to the Population and Public Health Support Team (PPHST) if there are two or more respiratory illness cases within a seven-day period.
- Inform administrative staff that a report was made to PPHST.

Supporting resources

- Outbreak Prevention Checklist for Continuing Care Homes
- Surveillance Case Tracking Sheet

2.1 Monitor and report respiratory symptoms

Monitor for symptoms

Monitor for and keep track of residents who are symptomatic (cases). This is called surveillance.

- A Surveillance Case Tracking Sheet is available for facilities to record:
  - Resident name(s)
  - Symptoms
  - Date symptoms started.

Identify respiratory illness cases

Count residents as a respiratory illness case if they have either:

- A positive test[2] for pathogens in Appendix B: Resident isolation for respiratory illness OR
- Any of the following new or worsening symptoms:
  - Fever[3]
  - Cough
  - Shortness of breath (SOB)
  - Sore throat
  - Runny nose / nasal congestion
  - Loss of taste and/or loss of smell
  - Decrease in oxygen (O_2) saturation level or increased O_2 requirement
  - Nausea/diarrhea[3].

When to report

Report as soon as there are two or more resident respiratory illness cases within a seven-day period.

How to report

Call **1-844-343-0971** to report to the AHS Provincial Public Health Support Team (PPHST).

PPHST is a provincial, centralized outbreak reporting and response team. They provide initial outbreak support and direction to facilities.

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[2] Specimen collection is not required prior to reporting to PPHST. Facilities may determine that specimen collection is warranted for the diagnosis and medical management of symptomatic residents, including treatment with oseltamivir (Tamiflu) for influenza or Paxlovid for COVID-19. This testing is directed by the residents most responsible health practitioner.

[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 respiratory illness symptoms AND
- Fever, nausea and/or diarrhea resolve within 48 hours of onset.

PPHST will ask for facility details and operational information

- Facility name, address, phone number
- Caller name and contact information
- Manager/facility contact email and phone number
- Facility type, AHS or non-AHS facility
- Number of units / unit names
- Number of residents and HCW/staff on affected units
- Total number of residents and HCW/staff in facility
- Can residents be kept to the affected units
- Can HCW/staff be kept to the affected units
- Do HCW/staff work in multiple facilities or units
- Has facility manager been notified
- Information outlined on the Surveillance Case Tracking Sheet
- Date of any hospitalizations or deaths

Inform that a report was made to PPHST

- Make internal notifications to the following facility staff after reporting to PPHST:
  - Management
  - IPC
  - WHS/OHS.

2.2 After reporting to PPHST

PPHST notifies the AHS Public Health Outbreak team

- After the facility report is made, PPHST will:
  - Send a summary to the AHS Public Health Outbreak team.
  - Advise facility when to expect a call from the AHS Public Health Outbreak team.
- If the AHS Public Health Outbreak team has not contacted the facility within 24 hours of the expected response time, the facility may call back to PPHST.

The AHS Public Health Outbreak team contacts the facility

The AHS Public Health Outbreak team determines if the facility meets the criteria for an outbreak. Refer to Appendix C: Case and outbreak definitions. They will review the initial report and:

- Ask if there are additional respiratory illness cases since the initial report.
- Determine if cases are epidemiologically linked.

If an outbreak is opened, an email is sent to the facility providing ongoing contact information and instructions for how to complete daily outbreak reporting via the Facility CDC Outbreak Daily Report Portal (REDCap).

3. Respiratory illness outbreak control

This section includes information for the management of respiratory illness outbreaks including COVID-19, influenza and influenza-like illness (ILI).

For GI illness outbreak control, refer to Section 5. Gastrointestinal illness outbreak control.

Key Actions

- Isolate symptomatic or confirmed residents.
- Implement continuous masking and eye protection on the outbreak unit for HCW/staff.
- Inform HCW/staff, residents, family/guardians and partners of the outbreak.
- Identify and report new respiratory illness cases daily.
- Coordinate HCW/staff assignments.
- Complete outbreak environmental cleaning and disinfection.
- Plan safe activities for residents who are not isolating.
- Plan for safe visits.
- Follow admission, transfer and discharge restrictions.
- Facilitate admissions and transfers from an acute care facility.
- Initiate outbreak modifications for food service.
- Collect specimens as directed.

Influenza outbreaks:

- Administer influenza antiviral prophylaxis to residents.
- Offer influenza antiviral prophylaxis to HCW/staff.

Non-viral respiratory pathogens such as bacterial and fungal pathogens may be responsible for illness **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, due to their unique epidemiological properties.

Supporting resources

- Respiratory Illness Outbreak Checklist for Continuing Care Homes
- Visiting During Respiratory Illness Outbreaks

3.1 Isolate symptomatic or confirmed residents

How to isolate

- Use Droplet and Contact precautions.
- Refer to 1.3 Isolate symptomatic or confirmed residents.

How long to isolate

- Refer to Appendix B: Resident isolation for respiratory illness for isolation duration.

3.2 Communicate and coordinate

Implement continuous masking and eye protection for HCW/staff

- Wear an appropriate mask and eye protection:
  - In any resident space or common areas in the outbreak unit
  - During indirect activities such as when preparing meals or doing laundry.
- HCW/staff returning to work after respiratory illness during an outbreak:
  - Refer to 1.4 Implement work restrictions for symptomatic HCW/staff for added precautions for the first five calendar days after the HCW/staff is eligible to return to work.

Inform HCW/staff, residents, family/guardians and partners of the outbreak

- Use established communication channels to notify:
  - Residents and families/guardians
  - Departments/stakeholders inside and outside of the facility.
- Notify HCW/staff such as nursing, allied health, food services, environmental services and spiritual care to start implementing **outbreak control measures**.
- Notify laundry services of the increased need for supplies.
- Post outbreak signs at the facility/unit entrance.

Identify and report new respiratory illness cases daily

- Maintain heightened surveillance to identify new respiratory illness cases.
- Request HCW/staff complete twice daily self-assessment for respiratory illness symptoms.
  - Direct HCW/staff to not attend work when ill and report symptoms of respiratory illness to the facility/unit manager/designate.
  - Notify WHS/OHS if symptoms are related to a workplace exposure.
- Report respiratory illness cases including those that are hospitalized or deceased.
  - Review the email sent by the AHS Public Health Outbreak team for how to report new cases using the Facility CDC Outbreak Daily Report Portal (REDCap).

Coordinate HCW/staff assignments

- Consult with the AHS Public Health Outbreak team when making decisions about

HCW/staff assignments.
    - Direct HCW/staff to care for asymptomatic residents before symptomatic and confirmed residents.
    - Cohort HCW/staff to work only in affected areas or only in unaffected areas.
    - Minimize movement of HCW/staff between units, especially if some areas are not affected.
    - Assign HCW/staff that are immunized against the outbreak pathogen to care for symptomatic or confirmed residents when possible.
- Refer to Congregate Living Settings - Recommendations for Staff Cohorting
- Consult with facility **Infection Control Practitioner** (ICP) or **Infection Control Designate** (ICD), or the AHS Public Health Outbreak team if considering **cohorting** residents.
    - Consider cohorting exposed asymptomatic residents.
    - Consider cohorting residents with the same illness.
- Refer to Congregate Living Settings - Recommendations for Cohorting Clients
- Assign HCW/staff to only housekeeping duties, or food preparation/service. If this is not possible, request staff complete any food preparation/service tasks before beginning housekeeping duties.

Influenza

If the outbreak pathogen is influenza.

- If HCW/staff is work restricted and works in more than one location, HCW/staff informs other work locations of the outbreak to determine if they may work in other settings.
- Refer to Appendix E: Influenza outbreak work restrictions for asymptomatic HCW/staff.

Administer influenza antiviral prophylaxis to residents

Influenza

If the outbreak pathogen is influenza.

- The resident's most responsible health care practitioner is accountable for prophylaxis.
- Offer oseltamivir (Tamiflu) prophylaxis to asymptomatic residents, regardless of immunization status.
- Antiviral prophylaxis is continued for seven days after onset of symptoms of the last resident case, for a minimum of 10 days.
- Monitor resident for symptoms of influenza and side effects of oseltamivir (Tamiflu).
- Refer to Association of Medical Microbiology and Infectious Disease (AMMI) Canada resources on influenza for prophylaxis dosing recommendations. The
- AHS Public Health Outbreak team will advise duration of prophylaxis for mixed outbreaks that include influenza.

Offer influenza antiviral prophylaxis to unimmunized HCW/staff

Influenza

If the outbreak pathogen is influenza

- Refer to Appendix E: Influenza outbreak work restrictions for asymptomatic HCW/staff for management of HCW/staff who are not immunized.
- The AHS Public Health Outbreak team may supply work restriction letters to the facility/unit that outline options for unimmunized HCW/staff.

3.3 Complete outbreak environmental cleaning and disinfection

Increase cleaning and disinfection frequency in all areas[4]

Clean and disinfect visibly dirty surfaces immediately. Prioritize high-traffic areas.

- Follow Public Health Recommendations for Environmental Cleaning and Disinfection of Public Facilities during respiratory outbreaks.

Areas to clean and disinfect	Frequency
• Low touch surfaces such as shelves, windowsills, and white boards • Resident personal equipment such as walkers and wheelchairs.	At least once daily and when visibly dirty
• High touch surfaces such as doorknobs, light switches, handrails, phones, and elevator buttons • Care/treatment areas, including PPE carts. • Dining areas and lounges	At least twice daily and when visibly dirty
• High touch table and chair surfaces, including the underneath edge of the chair seat and table.	After each use
• Equipment such as computer keyboards, mouse, screens, desks, telephones, and touch screens.	At least twice daily and when visibly dirty
• All affected areas	At the end of the outbreak.

Use a disinfectant that kills respiratory viruses

- Use a disinfectant with a drug identification number. Ensure it has a broad spectrum virucidal claim, or a specific virucidal claim against non-enveloped viruses and coronaviruses.
    - Refer to manufacturer instructions for product-specific cleaning and disinfection procedures, including compatible cleaners and disinfectants and contact time.

[4] Increased cleaning and disinfection are not required in settings such as private offices and administrative areas. Use routine cleaning and disinfection practices.

    - Use the product Safety Data Sheet for safety information.
- Alternatively, create a 1000 parts per million bleach solution by mixing 20 mL (four teaspoons) of unscented household bleach with 1000 mL (four cups) of water.
    - Store bleach solution in an opaque container and make a fresh solution at least every 24 hours. Bleach rapidly degrades in the presence of light and when mixed with water. Label container with date and time.
    - To effectively kill viruses, keep surfaces wet with the bleach water solution for at least one minute. Rinse food contact surfaces with clean water after cleaning with bleach.

Clean and disinfect rooms of isolating residents

- Wear PPE and use Droplet and Contact precautions.
- Clean and disinfect:
    - Resident room, moving from clean to dirty. Clean bathroom last.
    - Resident equipment such as wheelchairs and walkers according to manufacturer instructions.
    - Change linens (bed linens and towels)
- Change mop head (dry/wet), cloths, and cleaning solution after cleaning each room for any isolating resident.
- When additional precautions are discontinued:
    - Clean and disinfect the resident's room and equipment.
    - Discard disposable resident-care items.

Clean and disinfect shared rooms and equipment

- First clean and disinfect bedspaces of residents who are not isolating.
- Then clean and disinfect bedspaces of residents who are isolating.
    - Change mop head (dry/wet), cloths, and cleaning solution after cleaning each bedspace.
- 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.
- Clean and disinfect equipment only with a product listed in the manufacturer instructions. Follow the procedures outlined by the manufacturer.

3.4 Plan safe activities for residents who are not isolating

Type of activity	Action
Low risk resident activities	• Use physical distancing and hand hygiene for low-risk group activities such as art class, bingo and movies. • Limit personal services such as hairstyling to one resident at a time. • Encourage residents to wear a mask.

Type of activity	Action

High risk resident activities	• Consult with the AHS Public Health Outbreak team to determine if it is necessary to postpone/cancel high-risk group activities such as:
	  ○ Singing and bus outings
	  ○ Groups of residents who would not normally have contact with each other (mixing of residents from multiple units/floors).
	• Postpone/cancel previously scheduled resident events, such as holiday meals, parties, entertainers, school groups, and presentations.

Non-resident activities	• Postpone/cancel any non-resident events booked for areas in the outbreak facility/unit such as in-person meetings.

Medical appointments	• Permit all appointments for asymptomatic residents.
	  ○ Arrange virtual visits when possible.
	  ○ Request the resident wear a mask.
	  ○ Notify the receiving provider of the outbreak.

Transfers to acute care	• If any resident from the outbreak facility/unit requires acute medical attention or treatment at an acute care facility, notify the following so that precautions may be taken:
	  ○ EMS dispatcher and/or transport staff (for example the EMS crew)
	  ○ Receiving provider.

Adult day programs	Before determining that a program may continue, the o**utbreak management team (OMT)** and the AHS Public Health Outbreak team confirm the following: • It is physically separate from areas of the facility in which there have been symptomatic residents. • Residents attending the a**dult 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.

3.5 Plan safe visits during an outbreak

Visiting isolating residents

- Refer to 1.1 How to safely visit isolating residents.

Visiting guidance for all residents

- Visiting During Respiratory Illness Outbreaks resource is available for facilities to provide to DFSPs and visitors.
- Provide DFSPs and visitors with safe visiting recommendations during an outbreak.

Safe visiting recommendations during an outbreak
Continue to follow safe visiting practices in 1.1 Help plan a safe visit. **Before the visit:** • Reschedule the visit if ill. • Contact facility before arriving to determine if there are access limits. **During the visit:** • Check with reception prior to visiting any resident. • Wear a mask in common areas on outbreak units. • Minimize movement throughout the facility. • Limit the number of individuals visiting a resident at the same time. • Limit visit to one resident only. **After the visit:** • Exit the facility immediately.
Additional restrictions may be 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.

3.6 Admission, transfer and discharge restrictions

Determine if the outbreak facility/unit is open or restricted

- The ability of the outbreak facility/unit to accept admissions, transfers and discharges (whether it is open or restricted) is determined by the AHS Public Health Outbreak team at the time the outbreak is opened.
- The scope of restrictions depends on:
  - The extent of the outbreak activity within the facility (for example, one unit/floor/wing or the entire facility)
  - The ability to cohort HCW/staff to affected areas
  - The severity of the outbreak (for example, new cases continue to develop despite implemented control measures).
- Consult the AHS Public Health Outbreak team if issues related to admission, discharge and transfers arise during an outbreak.

Status	Action
Open	• Admissions, transfers, and discharges may proceed following usual non-outbreak processes.

Status	Action

Restricted	• Pause or delay admissions, transfers and discharges. This includes admissions to the outbreak affected facility/unit and transfers from the affected facility/unit to a different facility while restrictions are in place.
	  ○ Implementation of restrictions may not be possible due to resident circumstances or operational need (including bed pressures).
	  ○ If a facility with restrictions believes that an admission, transfer, or discharge is recommended to proceed despite restrictions, the facility follows the Risk Assessment Matrix and completes a Risk Assessment Worksheet.

Pathogen-specific restrictions to admission, transfer and discharge on the outbreak facility/unit

Restrictions depend on the outbreak pathogen.

COVID-19 	**If the outbreak pathogen is COVID-19** • Admissions, transfers, and discharges are restricted. • Admission restrictions remain in place for a minimum of seven days following symptom onset of the most recent resident case or as directed by the AHS Public Health Outbreak team.
Influenza 	**If the outbreak pathogen is influenza** • Admissions, transfers, and discharges are restricted. • Admission restrictions remain in place for a minimum of seven days following symptom onset of the most recent resident case or as directed by the AHS Public Health Outbreak team.
ILI 	**If the outbreak pathogen is influenza-like illness (ILI)** • Admissions, transfers, and discharges generally remain open unless given different direction by the AHS Public Health Outbreak team. • Admissions, transfers, and discharges may proceed following usual non-outbreak processes.
Mixed respiratory 	**If there is a mixed respiratory illness outbreak with more than one pathogen** • Admissions, transfers, and discharge restrictions depend on the pathogens identified. The AHS Public Health Outbreak team will provide direction.

3.7 Transfer and discharge from an acute care facility

Determine if residents from acute care may return to the outbreak facility/unit

- 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.
- Residents hospitalized prior or during an outbreak for an unrelated condition such as a fracture may return to the facility, based on open or restricted status.

Receiving facility/ unit status	Action
Open	• The resident may return.
Restricted	• The site follows the Risk Assessment Matrix and completes a Risk Assessment Worksheet. • Facility to coordinate with Transition Services for resident transfer and discharge.

Additional recommendations if the outbreak pathogen is influenza

Influenza

If the outbreak pathogen is influenza.

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

Residents may not be transferred until the following conditions are all met.

- The resident/guardian is informed about risks associated with the outbreak and consents to the transfer.
- The resident is immunized.
- The resident/guardian consents to take the antiviral.
- The most responsible health care practitioner has been informed.
- Consult with the AHS Public Health Outbreak team if the conditions are not met.

3.8 Use food service modifications in the outbreak facility/unit

- Wash hands before, during and after handling food.
- Provide meal service to isolating residents in their room.
- Close the kitchen and nourishment areas accessed by residents and visitors.
- Discontinue social sharing of food such as baking, birthday cakes and platters.

- Individually portion and/or plate food to avoid communal sources. This includes removing bulk foods such as candy jars and boxes of chocolate. Desserts may be served by staff members on individual plates.

Implement setting-specific food service modifications as directed by the AHS Public Health Outbreak team

Serve and prepare food safely

- Close buffet lines or have staff dispense food onto plates.
- Cease **family-style meal service**.
- Dispense snacks directly to residents and use prepackaged snacks.
- Cease resident participation in food preparation.
- Use physical distancing during group dining.

Limit the use of shared items

- Preset tables in common dining areas to minimize handling of cutlery.
- Remove shared food containers from dining areas such as shared pitchers of water, coffee cream dispensers, and salt and pepper shakers.
- Provide single-use condiment packets directly to each resident if used.

3.9 Specimen collection

Collect specimens as directed by the AHS Public Health Outbreak team

- Nasopharyngeal (NP) or throat swabs are collected to identify the pathogen causing the outbreak.
- Specimen collection is not required for all symptomatic residents.
- Notify the AHS Public Health Outbreak team:
  - If there is a new symptom presentation among residents OR
  - If the outbreak extends beyond the original unit.

If specimen collection is requested, the AHS Public Health Outbreak team will provide direction on

- The number of specimens to collect
- The method of collection
- Which pathogens to test for.
- The outbreak specific exposure investigation number (EI) to include on the lab requisition.

Collect specimens and complete the lab requisition form

- Refer to Appendix D: ProvLab specimen collection guidance for information on:
  - How to collect NP and throat swabs
  - How to complete the lab specimen requisition for respiratory specimens.
- Arrange for transport of specimens to the lab.

COVID-19

If the outbreak pathogen is COVID-19

- If a resident tested positive for COVID-19 within the last 90 days, do not retest with a molecular COVID-19 test.
    - Consult with the AHS Public Health Outbreak team on a case-by-case basis.

3.10 Control measures for complex outbreaks

The AHS Public Health Outbreak team collaborates with the facility and other stakeholders to monitor and assess each outbreak. To improve control during complex outbreaks, the AHS Public Health Outbreak team may request the facility implement the following examples of additional outbreak control measures, which are not routine for all outbreaks.

Screening and close contact identification

- Active screening of HCW/staff for symptoms prior to each shift
- Active screening of DFSPs and visitors prior to entering the facility or visiting residents
- Health screening of residents upon return from an absence
- Active screening and/or quarantine for resident admissions upon return from other health settings if the other facility/unit is on outbreak
- **Close contact** identification and management for COVID-19.

Additional masking for residents

- Request residents returning from an absence wear a mask in common areas of the facility/unit.

Masking outside of the outbreak unit

- Facility-wide HCW/staff continuous masking and eye protection
- Facility-wide masking for DFSPs and visitors.

3.11 End the outbreak

The AHS Public Health Outbreak team determines when the outbreak is over and advises the facility to discontinue restrictions. After the outbreak is over, facilities will:

- Clean and disinfect all affected areas.
- Review and evaluate the outbreak response with program leads and facility management. Revise internal protocols for improvement.
    - A debrief may be requested by any member of the outbreak management team.
- Follow the steps to monitor and report respiratory symptoms if residents become newly symptomatic within seven days of the outbreak ending. Refer to 2.1 Monitor and report respiratory symptoms.

4. Identify and report gastrointestinal illness outbreaks

This section includes information on identifying and reporting GI illness outbreaks.

Refer to Section 2. Identify and report respiratory illness outbreaks for information on respiratory illness outbreaks.

Key Actions

- ➔ Monitor for symptoms of GI illness in residents and HCW/staff.
- ➔ Determine if residents and HCW/staff meet criteria for a GI illness case.
- ➔ Keep track of GI illness cases.
- ➔ Report to Population and Public Health Support Team (PPHST) if there are two or more GI illness cases within 48 hours.
- ➔ Inform facility administrative staff that a report was made to PPHST.

Supporting resources

- Outbreak Prevention Checklist for Continuing Care Homes
- Gastrointestinal Outbreak Tracking Form - Clients
- Gastrointestinal Outbreak Tracking Form – Staff

4.1 Monitor and report gastrointestinal illness symptoms

Monitor for symptoms

Facilities keep track of residents and HCW/staff who are symptomatic (cases). This is called surveillance.

- Use the Gastrointestinal Outbreak Tracking Form - Clients and Gastrointestinal Outbreak Tracking Form – Staff to record residents and HCW/staff with symptoms.

Report GI illness cases

Count residents and HCW/staff as a GI illness 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 (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: Laboratory confirmation is not required.

When to report

- Report as soon as there are two or more residents and/or HCW/staff cases who have GI illness symptoms only with onset within 48 hours of each other.
- Report even if the cases are HCW/staff who were not present at work with symptoms.

How to report

Call **1-844-343-0971** to report to the AHS Provincial Public Health Support Team (PPHST).

PPHST is a provincial, centralized outbreak reporting and response team. They provide initial support and direction to facilities.

PPHST will ask for facility details and operational information

- Facility name, address, phone number
- Caller name and contact information
- Manager/facility contact email and phone number
- Facility type, AHS or non-AHS facility
- Number of units / unit names
- Number of residents or HCW/staff on affected units
- Number of residents or HCW/staff in facility
- 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 facility manager been notified
- Details from Gastrointestinal Outbreak Tracking Form - Clients and the Gastrointestinal Outbreak Tracking Form – Staff
- Date of any hospitalizations or deaths

Inform that a report was made to PPHST

- Make internal notifications to the following facility staff after reporting to PPHST.
  - Management
  - IPC
  - WHS/OHS

4.2 After reporting to PPHST

PPHST notifies the AHS Public Health Outbreak team

- After the facility report is made, PPHST will:
  - Send a summary to the AHS Public Health Outbreak team.
  - Advise facility when to expect a call from the AHS Public Health Outbreak team.
- If the AHS Public Health Outbreak team has not contacted the facility within 24 hours of the expected response time, the facility may call back to PPHST.

The AHS Public Health Outbreak team contacts the facility

The AHS Public Health Outbreak team determines if the facility meets outbreak criteria (refer to Appendix C: Case and outbreak definitions). They will review the initial report and:

- Ask if there are additional GI illness cases since the initial report.
- Determine if cases are epidemiologically linked.

If an outbreak is opened, an email is sent to the facility providing ongoing contact information and instructions for how to complete daily reporting.

5. Gastrointestinal illness outbreak control

This section includes information on GI illness[5] outbreak control.

For respiratory illness outbreak control, refer to Section 3. Respiratory illness outbreak control.

Key Actions

- Isolate symptomatic or confirmed residents.
- Perform hand hygiene.
- Inform HCW/staff, residents, family/guardians and partners of the outbreak.
- Identify and report new GI illness cases daily.
- Coordinate HCW/staff assignments.
- Complete outbreak environmental cleaning and disinfection.
- Plan safe activities for residents who are not isolating.
- Plan for safe visits.
- Follow admission, transfer and discharge restrictions.
- Facilitate admissions and transfers from an acute care facility.
- Initiate outbreak modifications for food service.
- Collect specimens as directed.
- Manage relapse GI cases.

Supporting resources

- Gastrointestinal Outbreak Checklist for Continuing Care Homes

Early detection is essential to reduce the spread of GI illness. It is vital that IPC measures are implemented immediately. Illness rates can be quite high (greater than 50%) in both residents and HCW/staff. GI illness is often mild, however residents with underlying health conditions are at risk of complications such as dehydration and aspiration pneumonia. Most outbreaks are due to norovirus which is extremely contagious.

[5] 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.

5.1 Isolate symptomatic or confirmed residents

How to isolate

- **Diarrhea only**: Use Contact precautions.
- **Vomiting with or without diarrhea:** Use Droplet and Contact precautions.
- Refer to 1.3 Isolate symptomatic or confirmed residents.

Handwashing with soap and water is preferred during GI illness outbreaks.
If a hand hygiene sink is not available within the resident's room:

- Use alcohol-based hand rub (minimum 60-90% alcohol) prior to leaving the room.
- Then locate a sink and wash hands with soap and water.

How long to isolate

- Isolate residents until 48 hours after the last episode of vomiting and/or diarrhea.

5.2 Communicate and coordinate

Inform HCW/staff, residents, family/guardians and partners of the outbreak

- Use established communication channels to notify:
  - Residents and families/guardians
  - Departments/stakeholders inside and outside of the facility.
- Notify HCW/staff such as nursing, allied health, food services, environmental services and spiritual care to start implementing outbreak control measures.
- Notify laundry services of the increased need for supplies.
- Post outbreak signs at the facility/unit entrance.

Identify and report new GI illness cases daily

- Maintain heightened surveillance to identify new GI illness cases.
- Request HCW/staff complete a twice daily self-assessment for GI illness symptoms.
  - Direct HCW/staff to report symptoms of GI illness to the facility/unit manager
  - Notify WHS/OHS if symptoms are related to a workplace exposure.
  - Restrict from work in all care facilities until 48 hours following the last episode of vomiting and/or diarrhea.
- Report GI illness cases including those that are hospitalized or are deceased.
  - Review the email sent by the AHS Public Health Outbreak team for how to report new cases.
  - The Data Collection for Gastrointestinal Illness Outbreak Management form at the end of this section outlines the information requested.

Coordinate HCW/staff assignments

- Consult with 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 facility Infection Control Practitioner (ICP) or Infection Control Designate (ICD), or the AHS Public Health Outbreak team if considering cohorting residents.
  - Consider cohorting exposed asymptomatic residents.
  - Consider cohorting residents with the same illness.
- Assign HCW/staff to only housekeeping duties, or food preparation/service. If this is not possible, request staff complete any food preparation/service tasks before beginning housekeeping duties.
- HCW/staff to inform other facilities/units of the outbreak.
  - Asymptomatic HCW/staff may work in outbreak unit as well as other locations.
- Cohort volunteers to work only in affected areas or only in unaffected areas.

5.3 Complete outbreak environmental cleaning and disinfection

Increase cleaning and disinfection frequency in outbreak areas[6]

Clean and disinfect visibly dirty surfaces immediately, including all surfaces soiled with vomit or stool. Prioritize high-traffic areas.

- Follow Public Health Recommendations for Environmental Cleaning and Disinfection of Public Facilities during GI illness outbreaks.

Areas to clean and disinfect	Frequency
• Low touch surfaces such as shelves, windowsills, and white boards. • Resident personal equipment such as walkers and wheelchairs.	At least once daily and when visibly dirty
• High touch surfaces such as doorknobs, light switches, handrails, phones, and elevator buttons • Care/treatment areas, including PPE carts • Dining areas and lounges.	At least twice daily and when visibly dirty

[6] Increased cleaning and disinfection is not required in settings such as private offices and administrative areas. Use routine cleaning and disinfection practices.

Areas to clean and disinfect	Frequency
• High touch table and chair surfaces, including the underneath edge of the chair seat and table	After each use
• Equipment such as computer keyboards, mouse, screens, desks, telephones, and touch screens	At least twice daily and when visibly dirty
• Upholstered furniture and rugs or carpets[7] • Privacy curtains	When visibly dirty or contaminated with vomit or stool
• All affected areas • Privacy curtains	At the end of the outbreak

Use a disinfectant that kills GI illness viruses

Choose either:

- A disinfectant with a drug identification number that has a broad spectrum virucidal claim, or a specific virucidal claim against norovirus, feline calicivirus, or murine norovirus.
    - Refer to manufacturer instructions for product-specific cleaning and disinfection procedures, including compatible cleaners and disinfectants and contact time.
    - Use the product Safety Data Sheet for safety information.
    - 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.

OR

- Use hypochlorite at a concentration of 1000 parts per million (ppm). Use commercially available hypochlorite-containing solutions (preferred).
    - Refer to manufacturer instructions for product-specific cleaning and disinfection procedures, including compatible cleaners and disinfectants.
    - Use the product Safety Data Sheet for safety information.
- Alternatively, create a 1000 parts per million bleach solution by mixing 20 mL (four teaspoons) of unscented household bleach with 1000 mL (four cups) of water.
    - Store bleach solution in an opaque container and make a fresh solution at least every 24 hours. Bleach rapidly degrades in the presence of light and when mixed with water. Label container with date and time.
    - To effectively kill viruses, keep surfaces wet with the bleach water solution for

[7] Upholstered furniture, and rugs or carpets may be difficult to clean and disinfect completely. Follow the manufacturer instructions for cleaning and disinfection of these surfaces. If the manufacturer instructions are not available, consult the AHS Public Health Outbreak team. Consider discarding items that cannot be cleaned and disinfected.

at least one minute. Rinse food contact surfaces with clean water after cleaning with bleach.

Clean and disinfect rooms of isolating residents

- Wear PPE and use the same additional precautions in place for the isolating resident.
  - **Diarrhea only**: Use Contact precautions.
  - **Vomiting with or without diarrhea:** Use Droplet and Contact precautions.
- Clean and disinfect:
  - Resident room, moving from clean to dirty. Clean bathroom last.
  - Resident equipment such as wheelchairs and walkers according to manufacturer instructions.
  - Change mop head (dry/wet), cloths, and cleaning solution after cleaning each room for any isolating resident and after cleaning vomit or stool.
- When additional precautions are discontinued:
  - Clean and disinfect the resident's room and equipment.
  - Discard disposable resident-care items.
  - Launder unused linens such as towels and sheets from resident rooms.
  - Change privacy curtains.

Clean and disinfect shared rooms and equipment

- First clean and disinfect bedspaces of residents who are not isolating.
- Then clean and disinfect bedspaces of isolating residents.
  - Change mop head (dry/wet), cloths, and cleaning solution after cleaning each bedspace.
- 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.
- Clean and disinfect only with a product listed in the manufacturer instructions. Follow the procedures outlined by the manufacturer.

Handle linen and laundry safely

Incorporate laundry rooms into the cleaning schedule. Monitor their use, minimize storage and clutter and focus on high touch cleaning and disinfection.

Wear PPE

There is a risk of contamination of HCW/staff clothing from body fluids or secretions.

- Handle all linen that is soiled with body fluids using the same additional precautions in place for the isolating resident.
  - **Diarrhea only**: Use Contact precautions.
  - **Vomiting with or without diarrhea:** Use Droplet and Contact precautions.
- Follow correct doffing of PPE once soiled laundry is placed in the laundry bag.

Handling soiled linen and laundry safely

- Remove soiling (for example stool) with a gloved hand and dispose into a toilet. Do not remove stool by spraying with water.
- Handle soiled laundry with minimum agitation to avoid contamination.
- Contain wet laundry before placing it in a laundry bag (for example wrap in a dry sheet or towel).
- Bag or contain soiled laundry at the point of care. It is not necessary to double bag.
- Tie laundry bags securely and do not overfill.

Keep linen and laundry used by isolating residents separate from other laundry

- Designate a specific laundry room to launder isolating resident's clothing and linens.
- Dedicate one washing machine for soiled laundry from isolating residents if laundry is done in a resident laundry room instead of a central laundry.
- Do not sort or pre-rinse soiled laundry in resident care areas.
- Disinfect washer with a bleach cycle (without a load of laundry) prior to use by others if used to launder soiled items from an isolating resident.

5.4 Plan safe activities for residents who are not isolating

Type of activity	Recommendation

Resident activities	• Postpone/cancel all group activities. Consult with the AHS Public Health Outbreak team if:
	  ○ There are extenuating circumstances
	  ○ Group activities are an essential part of treatment.
	• Postpone/cancel previously scheduled resident events, such as holiday meals, parties, entertainers, school groups, and presentations.

Non-resident activities	• Postpone/cancel any non-resident events booked for areas in the outbreak facility/unit such as in-person meetings.

Medical appointments	• Permit all appointments for asymptomatic residents.
	  ○ Arrange virtual visits when possible.
	  ○ Notify the receiving provider of the outbreak.

Transfers to acute care	• If any resident from the outbreak facility/unit requires acute medical attention or treatment at an acute care facility, notify the following so that precautions can be taken:
	  ○ EMS dispatcher and/or transport staff such as the EMS crew
	  ○ Receiving provider.

Adult day programs	Before determining that a program may continue, the outbreak management team (OMT) and the AHS Public Health Outbreak team confirm the following: • It is physically separate from areas of the facility in which there have been symptomatic residents.

Type of activity	Recommendation
	• 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.

5.5 Plan safe visits during an outbreak

Visiting isolating residents

- Refer to 1.1 How to safely visit isolating residents.

Visiting guidance for all residents

Provide DFSPs and visitors with safe visiting recommendations during an outbreak.

Safe visiting recommendations during an outbreak

Continue to follow safe visiting practices (refer to 1.1 Help plan a safe visit).

Before the visit:

- Reschedule the visit if ill.
- Contact facility before arriving to determine if there are access limits.

During the visit:

- Use hand hygiene.
- Check with reception prior to visiting any resident.
- Minimize movement throughout the facility.
- Limit the number of individuals visiting a resident at the same time.
- Limit visit to one resident only.

After the visit:

- Exit the facility immediately.

Additional restrictions may be implemented by the facility.

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

5.6 Admission, transfer and discharge restrictions

Determine if the outbreak facility/unit is open or restricted

- The ability of the outbreak facility/unit to accept admissions, transfers and discharges (whether the unit is open or restricted) is determined by the AHS Public Health Outbreak team in consultation with the outbreak management team at the time the outbreak is opened.
- Modifications or discontinuing of restrictions is only done by the AHS Public Health Outbreak team.

    - If restrictions are discontinued, continue to isolate symptomatic residents using additional precautions. Refer to 1.3 Isolate symptomatic or confirmed residents.
- The scope of restrictions depends on:
    - The extent of the outbreak activity within the facility (for example, one unit/floor/wing or the entire facility)
    - The ability to cohort HCW/staff to affected areas
    - The severity of the outbreak (for example, 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.

Status	Action
Open	• Admissions, transfers, and discharges may proceed following usual non-outbreak processes.
Restricted	• Pause or delay admissions, transfers, and discharges while restrictions are in place. ○ If restriction of admissions/transfers is impacting the availability of acute care beds or because of the expressed informed resident or family choice, the AHS Public Health Outbreak team will assess the circumstances surrounding the restriction including the degree of risk to the individuals requiring care.

5.7 Transfer and discharge from an acute care facility

Determine if residents from acute care may return to the facility/unit

- In extenuating circumstances the resident return can be discussed between acute care Transition Services and the AHS Public Health Outbreak team.
- Residents hospitalized prior to the outbreak are not recommended to return to the facility/unit until the outbreak is over.
- Consult the AHS Public Health Outbreak team in extenuating circumstances.
    - If a transfer must occur during an outbreak, HCW/staff will collaborate with the acute care facility prior to discharge.
        - HCW/staff must advise the resident/family about the potential risks and obtain consent prior to transfer.
        - Use of the Risk Assessment Matrix and/or the Risk Assessment Worksheet is based on Zone process. Use if directed by the AHS Public Health Outbreak team.

5.8 Use food service modifications in the outbreak facility/unit

- Use stringent hand hygiene.
- Provide meal service to isolating residents in their room.
- Close the kitchen and nourishment areas accessed by residents and visitors.
- Discontinue social sharing of food such as baking, birthday cakes and platters.
- Use individually portioned and/or plate food to avoid communal sources. This includes removing bulk self-serve foods such as candy jars and boxes of chocolate. Desserts may be served by staff members on individual plates.
- Use extra diligence during routine dishwashing and during sanitizing practices for food preparation surfaces.

Implement setting specific food service modifications as directed by the AHS Public Health Outbreak team

Prepare and serve food safely.

- Cease resident participation in food preparation.
- Close buffet lines or have staff dispense food onto plates.
- Cease family-style meal service.
- Dispense snacks directly to residents and use prepackaged snacks.
- Use dining table coverings that can be easily cleaned and disinfected.
    - Discontinue use of cloth/linen table coverings.

Limit the use of shared items

- Preset tables in common dining areas to minimize handling of cutlery.
- Remove shared food containers from dining areas such as shared pitchers of water, coffee cream dispensers, and salt and pepper shakers.
- Provide single-use condiment packets directly to each resident if used.

5.9 Specimen collection

Collect specimens as directed by the AHS Public Health Outbreak team

- Stool specimens are collected to identify the pathogen causing the outbreak.
- Specimen collection is not required for all symptomatic residents.
- Notify the AHS Public Health Outbreak team:
    - If there is a new symptom presentation among residents, OR
    - If the outbreak extends beyond original the unit.

If specimens are requested the AHS Public Health Outbreak team will provide direction

- The number of specimens to collect
- Which pathogens to test for
- The outbreak specific exposure investigation number (EI number) to include on the lab requisition.

Collect specimens and complete the lab requisition form

- Refer to Appendix D: ProvLab specimen collection guidance for information on:
  - How to complete the lab specimen requisition for stool specimens.
  - How to collect stool specimens
- Arrange for transport of specimens to the lab.

After initial specimen collection

- Do not collect additional specimens unless directed by the AHS Public Health Outbreak team.
- ProvLab will only test additional specimens after consultation with the AHS Public Health Outbreak team.
- 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.

5.10 Control measures for complex outbreaks

The AHS Public Health Outbreak team collaborates with the facility and other stakeholders to monitor and assess each outbreak. To improve control during complex outbreaks, the AHS Public Health Outbreak team may request the facility implement the following additional outbreak control measures, which are not routine for all outbreaks.

- Active screening of DFSPs and visitors prior to entering the facility or visiting residents.
- Health screening of residents upon return from an absence.
- Active screening and/or quarantine for resident admissions upon return from other health settings if that other facility is on outbreak.

5.11 How to manage relapse gastrointestinal illness cases

GI illness cases frequently relapse. That is, they experience onset of vomiting or diarrhea after being asymptomatic for up to 48 hours.

- The relapse is likely due to malabsorption during an existing norovirus infection rather than being a new infection.

If a relapse GI illness case is identified:

- Isolate resident in their room until free of vomiting and/or diarrhea for 48 hours. Refer to 1.3 Isolate symptomatic or confirmed residents.
- Do not count as a new outbreak case if the 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 and transfer 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.

5.12 End the outbreak

The AHS Public Health Outbreak team determines when the outbreak is over and advises the facility to discontinue restrictions. After the outbreak is over, facilities will:

- Conduct a thorough cleaning and disinfection in all affected areas.
- Review and evaluate the outbreak response with program leads and facility management. Revise internal protocols for improvement.
    - A debrief may be requested by any member of the outbreak management team.
- Follow the steps to monitor and report GI illness symptoms if residents become newly symptomatic within seven days of the outbreak ending. Refer to 4.1 Monitor and report gastrointestinal illness symptoms.

Data Collection for Gastrointestinal Illness Outbreak Management

The AHS Public Health Outbreak team will direct facilities on how to report when the GI illness outbreak is opened. The individual responsible for completing and submitting the list of cases is facility specific. Reporting may be done by site ICP/ICD, facility/unit manager or another responsible HCW/staff in the facility/unit.

Report the following data daily to the AHS Public Health Outbreak team:

- **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/ exposure investigation number (EI)** (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)

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 Public Health Outbreak team: This team is made up of Medical Officers of Health (MOH), the Communicable Disease Control (CDC) Nurses and Safe Healthy Environments Public Health Inspectors. 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 a pathogen.

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.

Continuing care home: Continuing care home means a facility or part of a facility where facility-based care is provided to residents, some of whom must be eligible residents. Continuing care homes are publicly funded facility-based accommodations that provide care (health and support services) appropriate to meet the resident's assessed needs. The type of care needed is determined through a standardized assessment and single point of entry process and consists of Type A, Type B and Type C. Individuals admitted into Continuing Care Homes Type A and B are required to pay accommodation fees (room and board and other costs associated) as set by Alberta Health.

Continuing Care Home Type A (formerly long term care): This environment provides onsite registered nurse (RN) and/or registered psychiatric nurse (RPN) care, assessment and/or treatment 24-hours a day. Licensed practical nurses (LPNs) may also be onsite. In addition, onsite personal care and support provided by health care aides (HCAs). CCH Type A may

also have a secure space. Some facilities may have specialized programs and services available for residents with complex clinical or complex functional care requirements (e.g., rehabilitation).

Continuing Care Home Type B (formerly designated supportive living): This environment provides a purposeful home-like design with 24-hour a day onsite scheduled and unscheduled professional and personal care provided by LPNs and HCAs. Case management and specialty services (e.g., Allied Health, palliative resource nurse, etc.) are available on a scheduled onsite, on-call or virtual basis based on resident's care needs. The buildings are specifically designed with common areas and features, including private space and a safe, secure and barrier-free environment. Type B facilities promote independence and provides services such as meals, housekeeping, recreational activities and 24-hour monitoring.

Continuing Care Home Type B – secure space (formerly designated supportive living dementia): This environment provides a purposeful home-like design with small groupings of private bedrooms and associated spaces with security features (i.e., secured spaces).

Continuing Care Home Type C (hospice): Hospice care is a specialized service that provides 24/7 care to individuals who are approaching end-of-life and their families. Services are available for both adult and pediatric populations and may include respite. The care teams focus on your comfort and quality of life and can support you and your family throughout the last months, weeks, or days of life. Services are provided by a specialized interprofessional palliative care team that includes (but is not limited to): doctors, registered nurses, licensed practical nurses, social workers, and healthcare aides. Availability of other professionals such as spiritual counsellors and other services such as volunteers may be different for each hospice.

Designated family / support persons (DFSPs): individuals identified by the resident as an essential support, and who they want included in care planning and decision making. This includes but is not limited to family, relatives, friends, and informal or hired caregivers. Refer to Family/Visitors of Patients and Residents.

Exposure investigation number (EI number): A number assigned by the ProvLab 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 it on the table allowing residents to serve themselves.

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: hospitals, continuing care homes, supportive living accommodations or home and community care settings, mental health facilities, community settings, offices or clinics of a health practitioner, clinical laboratories.

Health care workers / staff (HCW/staff): For the purpose of this guide, the term HCW/staff is used consistently. The facility is responsible to determine if an individual is considered a HCW or a staff member. The facility determines 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: HCW/staff that in some capacity of their job work directly at that facility. When an individual is onsite, they are expected to fulfill the roles and responsibilities of onsite HCW/staff.
    - 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.

Infection control designate (ICD): Person accountable for IPC issues in a facility usually, facility based.

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®).

Infection Prevention & Control (IPC): Department responsible for preventing infections acquired within facility. IPC includes roles such as consultation, education, surveillance, research and outbreak management.

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 an outbreak. Membership on the OMT depends on the type of outbreak and facility. Membership may include representatives from the AHS Public Health Outbreak team, Infection Prevention and Control (IPC or ICD), Workplace Health and Safety / Occupational Health and Safety, facility administration / facility management or their designate. Any member may request an OMT is formed.

Outbreak control measures: Actions to control the spread of disease during an outbreak. Outbreak control measures may fall into the following categories:

- Routine measures: measures for all respiratory or GI illness outbreaks.
- Pathogen-specific measures: measures specific to the outbreak pathogen.
- Control measures for complex outbreaks: measures that are not routinely used. They are implemented only at the discretion of the AHS Public Health Outbreak team if the outbreak warrants additional control measures.

Visitor: An individual who temporarily supports or socializes with the patient. They are not an essential partner in 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 and Safety / Occupational Health and Safety (WHS/OHS): Designated personnel responsible for HCW/staff health and safety in facilities. This role may be filled by HCW/staff or the facility management.

Work restriction: A measure that prevents symptomatic/infected/susceptible health care workers/staff from working until the risk for residents or health care worker/staff is low or minimal.

Appendix A: Roles and responsibilities

This appendix outlines roles and responsibilities to prevent and manage outbreaks[8]. Due to the complex nature of staffing and resident populations in continuing care homes, the individual fulfilling the roles and responsibilities within a facility may vary from what is outlined below.

An outbreak management team (OMT) may be formed during an outbreak to facilitate a timely and coordinated response to the outbreak. Any of the groups identified below may request that an OMT be formed.

AHS Public Health Outbreak team	
Prior to the outbreak	• Develop, maintain, and distribute provincial outbreak resources. • Participate in fall education sessions. • Consult on suspected clusters of illness, symptoms or potential outbreaks. • Determine if an outbreak will be opened.

During the outbreak	• Recommend best practice outbreak control measures.
	• Obtain a ProvLab EI number and provide to the facility.
	• Direct outbreak specimen collection.
	• Track and assess outbreak specimen results.
	• Review daily outbreak data and monitor outbreak progress.
	• Provide consultation on outbreak control measures such as:
	  ○ Resident isolation
	  ○ Masking and eye protection for HCW/staff for respiratory illness outbreaks.
	  ○ HCW/staff management
	  ○ Oseltamivir (Tamiflu) for residents and unimmunized HCW/staff during influenza outbreaks.
	  ○ Outbreak environmental cleaning
	  ○ Group activities
	  ○ Safe visiting of residents
	  ○ Restrictions to admissions, transfers and discharges
	  ○ Food service modifications
	• Discuss facility-specific adaptations to outbreak control measures.
	• Direct control measures for complex outbreaks.
	• Report outbreak to Alberta Health.
	• Participate in OMT meetings.

[8] The roles and responsibilities of Alberta Health, AHS Zone Operations (Executive Director for Provincial Seniors Health, Area Managers / Directors) and AHS Provincial Seniors Health and Continuing Care are not discussed in this guide. For information about the roles and responsibilities of these partners, contact these groups directly.

	• Declares the end of the outbreak.

AHS Provincial Partner Oversight team

Prior to the outbreak	• Supports continuing care home operators to provide access to outreach immunization services for residents and staff. • Report data such as immunization provider, number of residents and staff to facilitate vaccine allocations to Alberta Health. • Shares regular communication such as monthly newsletters and the PPO webpage.

Facility administration / managerment or designate

Prior to the outbreak	• Implement an outbreak management plan that details surveillance, isolation, process for specimen collection and immunization for residents and HCW/staff.
	• Provide an annual update on outbreak prevention and control for facility HCW/staff. Include review of:
	  ○ The facility outbreak management plan
	  ○ This guide (AHS Guide for Outbreak Prevention & Control in Continuing Care Homes).
	  ○ When and how to report to PPHST.
	• Facilitate immunizations for residents and HCW/staff, including COVID-19 and influenza.
	• Develop an influenza antiviral prophylaxis plan for residents and HCW/staff.
	• Provide the Advance Prescription for Oseltamivir (Tamiflu) fillable form to residents for completion by their most responsible health care practitioner.
	  ○ Track residents with advanced prescriptions using the Outbreak Antiviral Prophylaxis in Supportive Living Accommodation and Continuing Care Homes Type B Sites Worksheet.
	  ○ Develop policy outlining who is responsible for the cost of HCW/staff prophylaxis.
	• Stock non-expired outbreak management supplies including PPE and specimen collection kits.
	• Direct the implementation of routine practices and additional IPC measures.
	• Notify IPC or ICD when an unusual cluster of illness/symptoms is suspected or a report has been made to PPHST.
	• Log in to Continuing Care Connection for ongoing practice guidance updates relevant to continuing care homes. Registration is required the first time the website is accessed.

During the outbreak	• Collaborate with IPC or ICD and the AHS Public Health Outbreak team on outbreak control measures. • Coordinate specimen collection as directed by the AHS Public Health Outbreak team. • Communicate about the outbreak. • Communicate the status of the facility (open or restricted) to partners and stakeholders. • Consult with the AHS Public Health Outbreak team on issues pertaining to admission, discharge, and transfers. • Collaborate with WHS/OHS designate to identify and report symptomatic HCW/staff who may have been exposed at work. • Distribute to HCW/staff letters provided by the AHS Public Health Outbreak team. • Collect and report HCW/staff immunization status. Communicate during an influenza outbreak that antiviral prophylaxis for HCW/staff is not publicly funded. • Anticipates and manages the impact of HCW/staff absence on facility operations. • Participate in OMT meetings.

IPC, including AHS Infection Control Professional (ICP) and facility Infection Control Designate (ICD)

The following tasks are generally managed by the facility ICD. In the absence of a facility ICD, administration / manager or designate assigns 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 or Covenant ICP.
AHS/Covenant ICP is available to assist and guide where needed.

Prior to the outbreak	• Ensure HCW/staff have access to and are familiar with this guide (Guide for Outbreak Prevention and Control in Continuing Care Homes). • Collaborate with the AHS Public Health Outbreak team to provide fall education sessions. • Update internal outbreak management resources and review with HCW/staff, including routine IPC practices and additional precautions. • Maintain ongoing surveillance and support HCW/staff to facilitate early recognition and reporting of symptomatic residents (and HCW/staff for GI illness symptoms). • Direct IPC practices for symptomatic residents to prevent further transmission. • Encourage adoption of the PPE Safety Coach program. • Liaise with WHS/OHS designate to ensure HCW/staff have been N95 respirator fit tested.

During the outbreak	• Consult on IPC measures. • Complete facility reviews and outbreak visits (AHS ICP). • Implement outbreak control measures, including prophylaxis for influenza outbreaks, in consultation with facility Medical Lead. • Coordinates daily submission of outbreak data. • Identify high risk activities that need to be postponed or cancelled in consultation with the AHS Public Health Outbreak team. • Collaborate with facility administration / manager or designate to coordinate specimen collection. • Consult with the AHS Public Health Outbreak team. • Facilitate antiviral prophylaxis during an influenza outbreak. • Participate in OMT meetings.

Workplace Health and Safety / Occupational Health and Safety / designate

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

Prior to the outbreak	• Facilitate immunizations for HCW/staff, including COVID-19 and influenza in collaboration with the PPO Team. • Reviews internal processes for HCW/staff outbreak management. • Arrange HCW/staff N95 respirator fit testing.
During the outbreak	• Support facility administration / manager or designate to identify HCW/staff exposures. • Document HCW/staff health and immunization status and provide work restriction recommendations during influenza outbreaks to the Facility/Unit Manager. • Identifies unimmunized HCW/staff who may be at risk of exposure and infection. • Communicates with the AHS Public Health Outbreak team if HCW/staff are linked to the outbreak. • Implement facility plan for unimmunized HCW/staff to access and pay for oseltamivir (Tamiflu) prophylaxis. • Participates in OMT meetings.

Onsite HCW/staff

Prior to the outbreak	• Review this guide (Guide for Outbreak Prevention and Control in Continuing Care Homes).
	• Use PPE as per the Infection Prevention and Control Risk Assessment (IPCRA) prior to providing resident care.
	• Identify newly symptomatic or confirmed residents through ongoing surveillance.
	  ○ Place on additional precautions.
	  ○ Assess if symptomatic residents meet the reporting criteria to PPHST.

During the outbreak	• Identify newly symptomatic or confirmed residents through ongoing surveillance. ○ Place on additional precautions. • Collect specimens as directed by the AHS Public Health Outbreak team. • Submit outbreak data daily to the AHS Public Health Outbreak team. • Communicate outbreak status to other facility programs that are impacted by the outbreak such as Adult Day Programs and child care. • Report PPE and hand hygiene breaches. • Comply with work restrictions. • Report relevant immunization status. • Participate in OMT meetings.

Provincial Laboratory for Public Health (ProvLab)	
Prior to the outbreak	• Provide specimen collection supplies.
During the outbreak	• Designate laboratory microbiologist or virologist for each outbreak. • Track samples submitted under the EI number. • Report outbreak specimen results. • Complete additional testing on outbreak specimens.

Appendix B: Resident isolation for respiratory illness

Use Droplet and Contact precautions for a symptomatic or confirmed resident

Isolation period

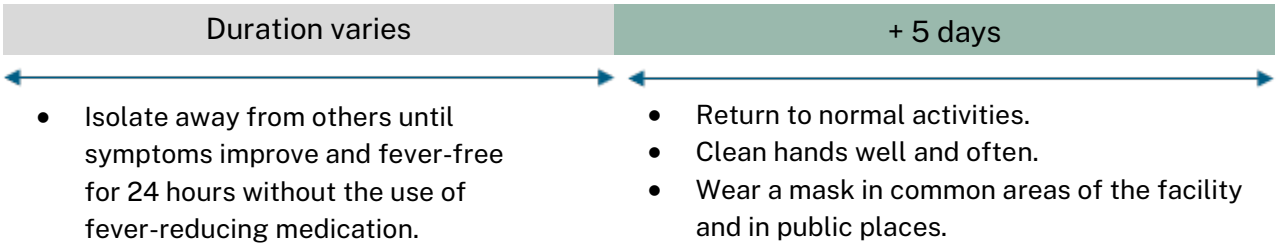
- Duration of resident isolation will vary based on clinical presentation.
- Isolate resident with respiratory illness[9] on Droplet and Contact precautions until:
  - Symptoms have improved AND
  - Resident is feeling well enough to resume normal activities AND
  - Resident has been fever-free for 24 hours without the use of fever-reducing medication.
- Encourage resident to clean hands well and often.

Added precautions after isolation ends

For five days after isolation ends, resident is strongly encouraged to:

- Clean hands well and often.
- Wear a mask in common areas in the facility and in public spaces.
  - Practice physical distancing or return to room if needing to remove mask, such as during meals.

Figure 1: Isolation period and added precautions after isolation ends



[9]This includes the following:

- Adenovirus
- COVID-19
- Enterovirus/ Rhinovirus
- Human Metapneumovirus (hMPV)
- Influenza A and Influenza B
- Non-COVID-19 Coronaviruses
- Parainfluenza Type 1, 2, 3, 4
- Respiratory Syncytial Virus (RSV)
- No pathogen has been identified.

Appendix C: Case and outbreak definitions

Case and outbreak definitions are set by Alberta Health and are used to open and report outbreaks.

COVID-19	
Case Definition	A person with the virus (SARS-CoV-2) that causes COVID-19 by: • A positive result on a molecular test [that is Nucleic acid amplification test (NAATs) 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[10] **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.
Outbreak Definition	Two or more confirmed COVID-19 cases in residents within a seven-day period, with a common epidemiological link[11].
Outbreak Duration[12]	14 days (two incubation periods). The outbreak ends on the 15th day following symptom onset of the last resident case.

[10] 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).

[11] Epidemiological link means the cases need to have been in the setting (same facility/same unit) during their incubation period or communicable period.

[12] Day zero is the first day of symptoms Day one is the first full day after symptoms develop. If the person tested is asymptomatic, use date of specimen collection as day zero.

Influenza illness	
Case Definition	A person with clinically compatible signs and symptoms of syndromic ILI[13] and laboratory confirmation of infection with seasonal influenza virus by: • Detection of influenza virus RNA such as via real-time reverse transcriptase polymerase chain reaction (RT-PCR) **OR** • Demonstration of influenza virus antigen in an appropriate clinical specimen such as nasopharyngeal/throat swabs **OR** • Significant rise (that is fourfold, or greater) in influenza IgG titre between acute and convalescent sera **OR** • Isolation of influenza virus from an appropriate clinical specimen
Outbreak Definition	Two or more confirmed influenza cases in residents within a seven-day period, with a common epidemiological link[1111].
Outbreak Duration[12]	Seven days. The outbreak ends on the eighth day following symptom onset of the last resident case.

[13] **Syndromic ILI** is 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 or arthralgia.

Influenza-like illness (ILI)	

Case Definition	**Syndromic ILI:**
	• Acute onset of respiratory illness which includes cough (new or worsening) and one or more of the following symptoms:
	  ○ fever[14]
	  ○ shortness of breath
	  ○ sore throat
	  ○ myalgia
	  ○ arthralgia
	
	Pathogen-specific ILI:
	• Positive for non-influenza, non-COVID-19 pathogen from the Respiratory Pathogen Panel (RPP)

Outbreak Definition	Two or more cases of ILI in residents within a seven-day period, with a common epidemiological link[11]
	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.
	
	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 a pathogen-specific case definition.
	• Examples of pathogen-specific ILI outbreaks include:
	  ○ Two or more residents with the same non-influenza, non-COVID pathogen from the RPP.

Outbreak Duration[12]	• If **no pathogen is identified:** ILI outbreak remains open for seven days. The outbreak ends on the eighth day following symptom onset of the last resident case. • If a **non-influenza, non-COVID-19 respiratory pathogen is identified:** the outbreak remains open for a single incubation period for that pathogen.

[14] In people 65 years and older, fever may not be prominent.

Pathogen	Outbreak Duration
Adenovirus	14 days (a single incubation period). The outbreak ends on the 15th day following symptom onset of the last resident case.
Enterovirus Rhinovirus	Three days (a single incubation period). The outbreak ends on the fourth day following symptom onset of the last resident case.
Human Metapneumovirus	Five days (a single incubation period). The outbreak ends on the sixth day following symptom onset of the last resident case.
Non-COVID-19 Coronavirus	Four days (a single incubation period). The outbreak ends on the fifth day following symptom onset of the last resident case.
Parainfluenza Type 1, 2, 3, 4	Six days (a single incubation period). The outbreak ends on the seventh day following symptom onset of the last resident case.
Respiratory Syncytial virus	Eight days (a single incubation period). The outbreak ends on the ninth day following symptom onset of the last resident case.

Gastrointestinal illness	
Case Definition	At least ONE of the following criteria must be met and not be attributed to another cause (such as Clostridioides difficile diarrhea, medication, laxatives, diet, or prior medical condition): • Two or more episodes of diarrhea (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.
Outbreak Definition	Two or more cases (with initial onset within one 48-hour period) of GI illness with a common epidemiological link[11].

Outbreak Duration	Outbreak duration may vary. The AHS Public Health Outbreak team determines outbreak duration.
	• 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.

Mixed respiratory pathogen and mixed pathogen outbreaks

A **mixed respiratory pathogen outbreak** may result when a combination of lab positive respiratory pathogens/viruses are identified. Similarly, a **mixed pathogen outbreak** could result when virus(es) causing respiratory and GI illness symptoms are co-circulating in a facility.

Outbreak Duration	The AHS Public Health Outbreak team determines if the facility has a mixed pathogen outbreak. The general principle of applying the more protective outbreak control measures will be followed.

Note: During mixed respiratory and GI illness outbreaks, the AHS Public Health Outbreak teams from Communicable Disease Control and Safe Healthy Environments collaborate with the facility and each other to control the outbreaks. Processes may vary by zone.

Appendix D: ProvLab specimen collection guidance

Resources for specimen collection

- Check the ProvLab Bulletins for the most current information on specimen collection, testing, and interpretation of lab results.
- Use the Specimen Collection Kit/Requisition Order Form to order specimen collection supplies.
- Use Education Resources from the Public Health Laboratory (ProvLab) for instructions and demonstrations on specimen collection.

Respiratory specimens

Collect respiratory specimens for respiratory illness outbreak management when directed by the AHS Public Health Outbreak team.

How to complete the lab specimen requisition for Respiratory Specimens

- Complete COVID-19 and Other Respiratory Viruses Requisition (Provincial)

Follow directions in the General Test Ordering and Specimen Collection Information – Clinical Specimens to complete the requisition.

- Include the Exposure Investigation Number (EI Number) provided by the AHS Public Health Outbreak team for the current outbreak.
- Use the Most Responsible Health Practitioner as the **Authorizing Provider Name.** Do not use the Zone MOH.

How to collect nasopharyngeal (NP) and throat swabs.

- The amount of virus is greatest in acute phase of illness, usually within the first 48-72 hours of symptom onset. This is the optimal window for specimen collection.
- NP swabs are the preferred specimens for respiratory virus testing.
    - Refer to Collection of a Nasopharyngeal and Throat Swab for Detection of Respiratory Infection.
    - If nasopharyngeal swabs are difficult to collect, throat swabs collected in viral transport media are acceptable alternatives for COVID-19 testing. An RPP cannot be completed on a throat swab.

GI specimens

Collect stool specimens for GI illness outbreak management when directed by the AHS Public Health Outbreak Team.

- Norovirus can be detected in stool by ordering a Gastroenteritis Viral Panel (LAB

1901) but cannot be isolated from vomit. Do not collect vomit specimens.
- An EI number is required on the requisition or norovirus testing may not be completed in the analysis. Obtain an EI number from the AHS Public Health Outbreak team prior to collecting outbreak stool specimens.
- Results are usually 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.

How to complete the lab specimen requisition for stool specimens.

- Complete the Serology and Molecular Testing Requisition form.

Follow directions in the General Test Ordering and Specimen Collection Information – Clinical Specimens to complete the requisition.

- Include the EI number provided by the AHS Public Health Outbreak team for the current outbreak.

How to collect stool specimens.

- Follow instructions in How to Collect a Stool Specimen.
- Collect stool specimens from residents with acute diarrhea illness. Preferably, collect within 24-48 hours of onset of symptoms.
- When directed, collect one stool specimen from up to five symptomatic residents per outbreak investigation (EI number). This number of specimens is usually sufficient to determine the etiology of the outbreak

Transport specimens to ProvLab.

- Facilities are responsible for arranging transport of specimens.
- Follow ProvLab standards for transporting specimens at Laboratory Test Directory & Collection Information.
- **Urban facilities:** Batch together and transport specimens to the ProvLab within 24 hours of collection.
- **Rural facilities:** Transport lab specimens to ProvLab as directed by the AHS Public Health Outbreak team or by the fastest means possible.
- AHS managers and staff can access the My Learning Link Transportation of Dangerous Goods (TDG) Class 6.2 Infectious Substances modules on 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.

Appendix E: Influenza outbreak work restrictions for asymptomatic HCW/staff

The AHS Public Health Outbreak team will provide recommendations for immunization, antiviral prophylaxis and/or work restrictions for HCW/staff during influenza outbreaks. Oseltamivir (Tamiflu) antiviral prophylaxis is recommended according to the Alberta Health Influenza Antiviral Drug Policy. Facilities are to identify HCW/staff who are recommended to take antiviral prophylaxis and advise them how to access it.

For HCW/staff with symptoms, manage as per symptomatic HCW/staff.

Assessment to determine if asymptomatic HCW/staff may work on the outbreak unit

A HCW/staff is considered to be **adequately protected** against influenza if:

- they have had the annual influenza vaccine **AND**
- It has been at least 14 days since influenza immunization.

Asymptomatic HCW/staff who were immunized at least 14 days prior

- HCW/staff immunized 14 days prior are considered to have adequate protection against influenza.
    - There is no work restriction. HCW/staff may continue to work on the outbreak facility/unit.
    - Antiviral prophylaxis is not recommended.

Asymptomatic HCW/staff without adequate protection against influenza

Refer to the table below for work restriction and antiviral prophylaxis recommendations for HCW/staff who are:

- Immunized with annual influenza vaccine less than 14 days ago **OR**
- Not immunized with annual influenza vaccine
    - Offer influenza vaccine immediately to unimmunized HCW/staff.

Antiviral prophylaxis and work restriction recommendations

Asymptomatic HCW/staff	Accepts antiviral prophylaxis	Does not accept antiviral prophylaxis

Immunized with annual influenza vaccine **less than 14 days ago**	• May continue to work on the outbreak facility/unit **AND**
	• Take antiviral prophylaxis until at least 14 days since immunization or until the outbreak is over (whichever is shorter).
	• There is no waiting period between starting antiviral prophylaxis and working.
		First 3 days (72 hours)
		• Restricted from working at any facility and will monitor for symptoms for 3 days (72 hours) from last day worked on outbreak facility/unit.
		Day 4 to end of outbreak if remains asymptomatic
		• **May be reassigned** to a non-outbreak facility/unit for at least 14 days since immunization or until the outbreak is over (whichever is shorter).
		  ○ May then return to home facility/unit.
		• **If reassignment is not possible** restrict from work for at least 14 days since immunization or until outbreak is over (whichever is shorter).
		  ○ May then return to work.

Not immunized with annual influenza vaccine	• May continue to work on the outbreak facility/unit if they take antiviral prophylaxis until the outbreak is over.
	• There is no waiting period between starting antiviral prophylaxis and working.
		First 3 days (72 hours)
		• Restricted from working at any facility and will monitor for symptoms for 3 days (72 hours) from last day worked on outbreak facility/unit.
		Day 4 to end of outbreak if remains asymptomatic
		• **May be reassigned** to a non-outbreak facility/unit for the duration of the outbreak.
		  ○ May then return to home facility/unit.
		• **If reassignment is not possible** restrict from work until outbreak is over.
		  ○ May then return to work.