Provincial Population & Public Health
Communicable Disease Control
Safe Healthy Environments

Guide for Outbreak Prevention & Control in Provincial Correctional Centres

Includes Respiratory & Gastrointestinal Illness

Alberta Health Services

Do you have feedback about the guide?
We welcome your feedback for the following:

- Incorrect information
- Spelling errors
- Inconsistencies

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

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

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Introduction

Correctional centres are high-risk environments for communicable disease outbreaks due to communal living arrangements and close proximity between residents. High turnover in population due to admissions, discharges, and transfers between centres and relatively crowded living conditions also facilitate the transmission of infection. The potential severity of an outbreak may be increased in correctional centres due to underlying chronic medical conditions in the resident population.

Early detection of viral respiratory illness and gastrointestinal illness is important to reduce the spread of disease and prevent an outbreak[1]. Infectious disease outbreaks occur year-round, although are more common during outbreak season (fall and winter).

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

The 2011 Alberta Corrections Amendment Act allows custodians of health information (as defined in the Health Information Act) to "disclose individually identifying health information about a resident, without the consent of the resident, to a director of correctional institution" for the purposes of outbreak management within the correctional centre.

This guide is intended to help staff to identify, report and manage outbreaks. A prompt response will minimize the impact of communicable disease outbreaks. Alberta Health Services and Correctional Services division (CSD) staff work closely together to ensure effective outbreak management.

This guide contains evidence-based best practice from the Alberta Health (AH) Public Health Disease Management Guidelines and was written in collaboration with the following Alberta Health Services programs:

- Infection Prevention & Control (IPC)
- Workplace Health & Safety (WHS)
- Corrections Health

Federal corrections facilities are outside the scope of this document.

Land Acknowledgement

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

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

Section 1: Preparing for outbreak season

Correctional centres are responsible to prepare for outbreaks all year long and especially prior to outbreak season in the fall. The AHS Public Outbreak Team updates outbreak guides and supporting resources and posts on the Notifiable Disease & Outbreak Management webpage at ahs.ca/outbreak.

Each centre is recommended to:

- Familiarize staff with the content of this guide.
- Update internal protocols and procedures for outbreak management to reflect the guidance within this document. This includes the symptoms that require investigation and reporting to the AHS Public Health Outbreak Team (see Table A and Table B).
- Work with key personnel to ensure adequate availability of supplies for outbreak management (such as specimen collection kits and personal protective equipment).
- Update staff annually on routine infection prevention control practices, additional precautions and outbreak management precautions.
- Ensure Correctional Health Services Managers/designate are aware when to report to the AHS Public Health Outbreak Team.

Routine best practices

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

Support a healthy environment

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

Prevent illness spread

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

Zone outbreak preparation resources

- Refer to local zone process to access the necessary resources for outbreak preparation.
- Correctional centres may participate in annual outbreak training through zone specific invitations and processes in the fall.

Roles and responsibilities checklists

A collaborative approach is required to ensure effective prevention and successful management of outbreaks. The model for outbreak management is unique due to the shared responsibilities of AHS Correctional Health and CSD. Refer to the glossary for a description of each team.

AHS Public Health Outbreak Team / Office of the Zone Medical Officer of Health

- Under the Public Health Act, the MOH is responsible for management of outbreaks within their health region boundaries. For that reason, the office of the zone MOH (AHS Public

Health Outbreak Team) must be notified immediately to initiate the outbreak investigation and provide direction on outbreak control measures.
- See the Zone Public Health Outbreak Team Contact List.
- The office of the zone MOH (AHS Public Health Outbreak Team) will also be responsible to coordinate outbreak investigation with the Public Health Laboratories (ProvLab) including obtaining an exposure investigation number (EI#) and determining specimen collection type and testing appropriate for the outbreak.
- The AHS Public Health Outbreak Team (which includes the Medical Officer of Health [MOH], Communicable Disease Control [CDC], and Environmental Public Health [EPH]) is responsible for:
    - Setting the standard of practice for communicable disease surveillance and notification in relation to outbreak investigation and management.
    - Developing, maintaining, and publish provincial outbreak resources.

Provincial Laboratory for Public Health (ProvLab)
- ProvLab consults with the AHS Public Health Outbreak Team about appropriate specimen types and collection.
- ProvLab coordinates specimen collection associated with exposure investigation numbers (EI#) in collaboration with the AHS Public Health Outbreak Team.

Correctional Health Services (Including AHS WHS and IPC)
- Correctional Health Services will oversee the clinical management of outbreak cases and provide leadership to coordinate a uniform approach between AHS and CSD for outbreak prevention, control, and management.
- The Site Health Services Manager/designate will act as a liaison between CSD and other AHS departments including Infection Prevention & Control and Workplace Health & Safety.
- All Correctional Health professionals are key collaborators in the planning, prevention, and implementation process for outbreak management.

Correctional Services division (CSD)
- Outbreak management measures impacting facility operations such as security will be implemented in consultation with CSD site leadership.
- If required for outbreak management, CSD officials will be responsible to implement measures involving:
    - the restriction of movement within the centre
    - placement and cohorting of residents
    - procedure changes in admission
    - transfer or discharge of residents
    - exclusion of symptomatic CSD employees from work
    - restrictions on outside visitors
    - environmental cleaning
    - any other facility or security related matter
- Correction centres vary across the province with regards to which individual (or group) is assigned a role in outbreak prevention and control.

The Corrections Outbreak Checklists (see below) outline the specific roles and responsibilities during an outbreak. The checklists can be printed from AHS - Notifiable Disease & Outbreak Management
- Corrections Outbreak Checklist 1 for the AHS Public Health Outbreak Team
- Corrections Outbreak Checklist 2 for the AHS Infection Control Practitioner/Designate or Medical Lead

- Corrections Outbreak Checklist 3 for the AHS Physician or Nurse Practitioner or Medical Director
- Corrections Outbreak Checklist 4 for the AHS Workplace Health & Safety Nurse
- Corrections Outbreak Checklist 5 for the AHS Clinical Nurse Educator or Nurse Clinician
- Corrections Outbreak Checklist 6 for the AHS Site Health Services Manager/Designate
- Corrections Outbreak Checklist 7 for the AHS Executive Director Correctional Health Services
- Corrections Outbreak Checklist 8 for the CSD Occupational Health & Safety Advisor/Designate
- Corrections Outbreak Checklist 9 for the CSD Centre Director/Designate

Correctional centres may modify the checklists where centre-specific processes differ.

Section 2: Monitoring for symptomatic residents (surveillance)

Respiratory Illness

Staff are responsible to routinely conduct surveillance.

- Table A outlines when symptomatic residents are to be reported.
- A single resident with symptoms does not need to be reported. Centres must continue to monitor for additional symptomatic residents.
    - Centres are recommended to have a plan for tracking symptomatic residents and when to contact the AHS Public Health Outbreak Team.

GI Illness

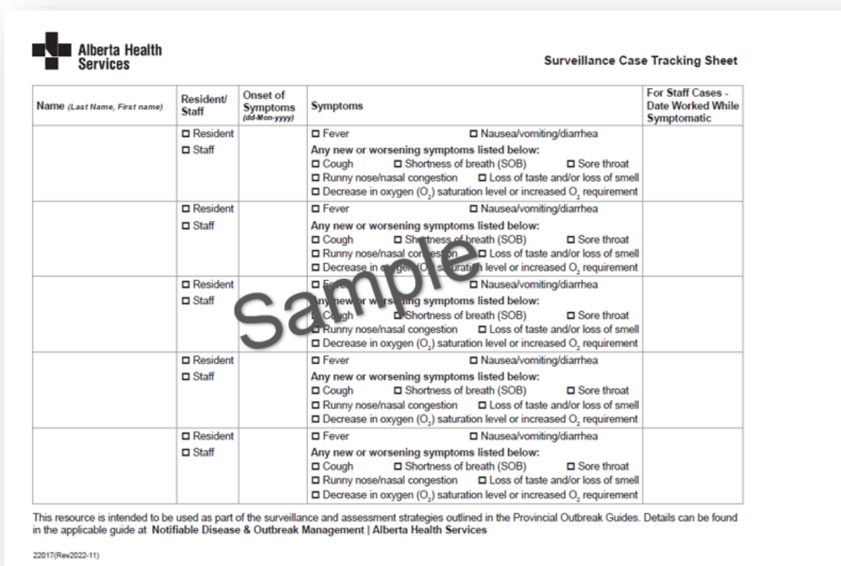
Staff are responsible to routinely conduct surveillance.

- Table B outlines when symptomatic residents and/or HCW/staff are to be reported.
- A single resident or HCW/staff with symptoms does not need to be reported. Centres must continue to monitor for additional symptomatic residents or HCW/staff.
    - Centres are recommended to have a plan for tracking symptomatic residents and HCW/staff. and when to contact the AHS Public Health Outbreak Team.

> Infection control strategies listed in Section 4.1 are recommended to be implemented immediately for any resident with respiratory or GI illness symptoms.

Notification when a symptomatic resident is identified

- A Surveillance Case Tracking Sheet can be printed to track symptomatic residents.



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Surveillance Case Tracking Sheet

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

This resource is intended to be used as part of the surveillance and assessment strategies outlined in the Provincial Outbreak Guides. Details can be found in the applicable guide at **Notifiable Disease & Outbreak Management | Alberta Health Services**

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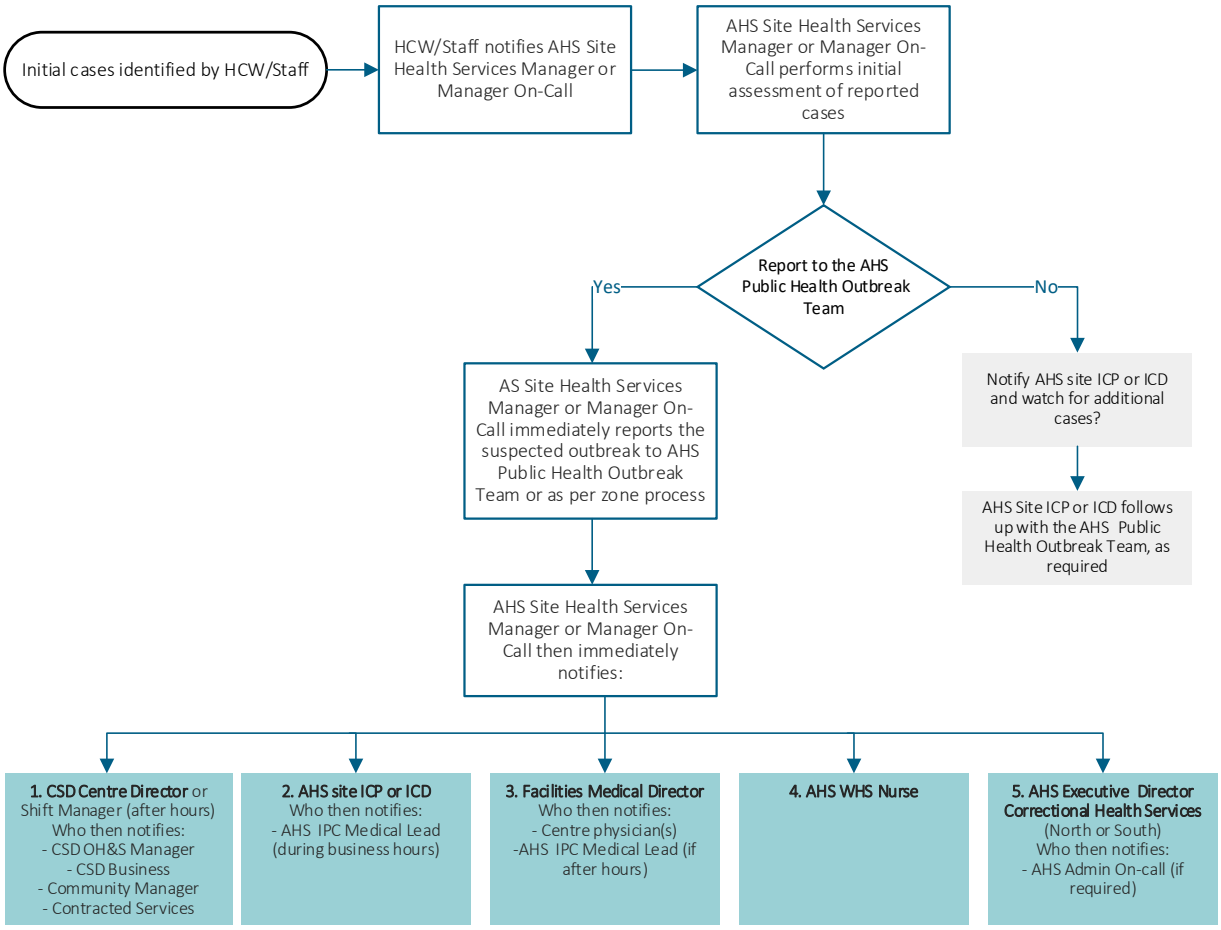
Sample

- Correctional Health Services Manager or designate will review potential cases and other relevant clinical information and will initiate the outbreak notification process (see algorithm below).
- HCW/staff are to follow the internal outbreak notification process for administrative notifications once a symptomatic resident has been identified (see algorithm below)



Reporting symptomatic residents to the AHS Public Health Outbreak Team

The tables below outline when to report to the AHS Public Health Outbreak Team:

- Table A - When to report residents with respiratory illness
- Table B - When to report residents and/or HCW/staff with GI illness symptoms

> Residents who have symptoms that are not listed in the tables below are managed at the discretion of the care team and do not need to be reported.

Table A: When to report respiratory symptoms

Symptoms to watch for	When to report
Residents Residents who develop any of the following new or worsening symptoms: • Fever[2] (may not be present in those over 65 years of age) • Cough • Shortness of breath (SOB) • Sore throat • Runny nose/Nasal congestion • Loss of taste and/or loss of smell • Decreased oxygen (O_2) saturation or increased O_2 requirements • Nausea or diarrhea[2]	Two or more symptomatic residents within a seven-day period

Table B: When to report GI illness symptoms

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

[2] A resident may develop fever, nausea and/or diarrhea following immunization with COVID-19 or influenza vaccine. The resident will not count as a surveillance case if:
- Onset is within 24 hours of being immunized **AND**
- They have no other symptoms from Table A **AND**
- Fever, nausea and/or diarrhea resolve within 48 hours of onset.

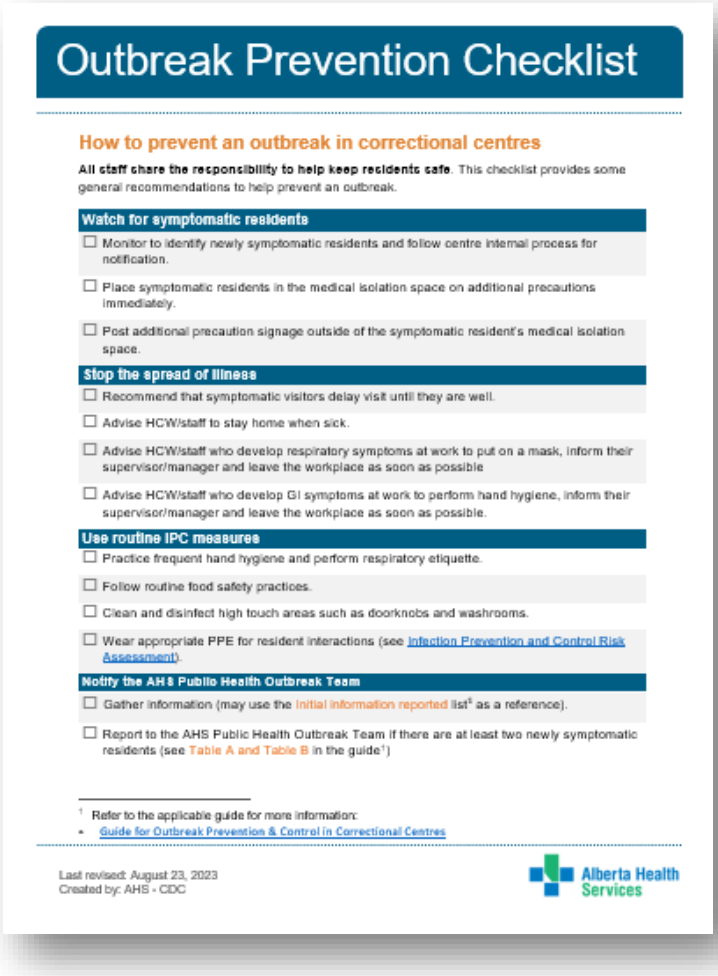
Specimen collection prior to meeting the respiratory reporting criteria

No specimen collection is required.

- The AHS Public Health Outbreak Team will make recommendations if specimen collection is indicated.
- Corrections centre medical staff may determine that specimen testing is warranted for the medical management of symptomatic residents (such as Oseltamivir treatment for influenza or Paxlovid for the treatment for COVID-19 cases).

Resource – Outbreak Prevention Checklist

- This checklist outlines strategies to prevent outbreaks in correctional centres.
    - This checklist can be printed and made available to staff for daily use. See the attached link: Notifiable Disease & Outbreak Management | Alberta Health Services



Outbreak Prevention Checklist

How to prevent an outbreak in correctional centres

All staff share the responsibility to help keep residents safe. This checklist provides some general recommendations to help prevent an outbreak.

Watch for symptomatic residents

- ☐ Monitor to identify newly symptomatic residents and follow centre internal process for notification.
- ☐ Place symptomatic residents in the medical isolation space on additional precautions immediately.
- ☐ Post additional precaution signage outside of the symptomatic resident's medical isolation space.

Stop the spread of illness

- ☐ Recommend that symptomatic visitors delay visit until they are well.
- ☐ Advise HCW/staff to stay home when sick.
- ☐ Advise HCW/staff who develop respiratory symptoms at work to put on a mask, inform their supervisor/manager and leave the workplace as soon as possible
- ☐ Advise HCW/staff who develop GI symptoms at work to perform hand hygiene, inform their supervisor/manager and leave the workplace as soon as possible.

Use routine IPC measures

- ☐ Practice frequent hand hygiene and perform respiratory etiquette.
- ☐ Follow routine food safety practices.
- ☐ Clean and disinfect high touch areas such as doorknobs and washrooms.
- ☐ Wear appropriate PPE for resident interactions (see Infection Prevention and Control Risk Assessment).

Notify the AHS Public Health Outbreak Team

- ☐ Gather information (may use the Initial information reported list[1] as a reference).
- ☐ Report to the AHS Public Health Outbreak Team if there are at least two newly symptomatic residents (see Table A and Table B in the guide[1])

[1] Refer to the applicable guide for more information:
- Guide for Outbreak Prevention & Control in Correctional Centres

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Created by: AHS - CDC

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Section 3: Reporting illness to the AHS Public Health Outbreak Team

Prompt reporting of symptomatic residents outlined in Section 2 allows for early intervention.

- Each centre will assign the staff responsible to report the potential outbreak.

3.1 How to report to the AHS Public Health Outbreak Team (CDC or EPH)

Refer to the Zone public health outbreak team contact list for contact information.

- Report respiratory illness to Communicable Disease Control
- Report GI Illness to Environmental Public Health in the applicable zone

Zone public health outbreak team contact list

AHS Zone	8:30 – 4:30 (may vary slightly between zones)	
Zone 1 South	Communicable Disease Control	1-888-522-1919 CD_Outbreak@ahs.ca
	Environmental Public Health	SZ.EPHCDC.Triage@albertahealthservices.ca
Zone 2 Calgary	Communicable Disease Control	1-888-522-1919 CD_Outbreak@ahs.ca
	Environmental Public Health	CAL.GIOutbreaks.CalZone@albertahealthservices.ca
Zone 3 Central	Communicable Disease Control	1-888-522-1919 CD_Outbreak@ahs.ca
	Environmental Public Health	AHS.CZ.EPH.DiseaseControlTeam@albertahealthservices.ca
Zone 4 Edmonton	Communicable Disease Control	1-888-522-1919 CD_Outbreak@ahs.ca
	Environmental Public Health	EDM.EPH.GIOutbreak@albertahealthservices.ca
Zone 5 North	Communicable Disease Control	1-888-522-1919 CD_Outbreak@ahs.ca
	Environmental Public Health	AHS.NZ.EPH.DiseaseControlTeam@albertahealthservices.ca

Initial information reported

The AHS Public Health Outbreak Team will request the following information during the initial report. Gather the information in the list prior to calling. The order may vary from the list.

Centre contact information
☐ Caller name and contact information
☐ Centre name, address and postal code
☐ Centre phone number
☐ CSD manager / contact phone and email
☐ Site Health Services manager / contact phone and email
Centre details
☐ Centre Type
☐ Zone
☐ Total number of units/ranges and unit/range names
☐ Number of residents on affected units/ranges
☐ Total number of residents
☐ Number of staff on affected units/ranges
☐ Total number of AHS and CSD staff
Operational details
☐ Number of medical isolation spaces
☐ Can residents be kept to the affected units/ranges?
☐ Can staff be kept to the affected units/ranges?
☐ Do staff work in multiple centres or units/ranges?
☐ Has the centre manager been notified?
Symptomatic resident information (refer to the Surveillance Case Tracking Sheet for details)
☐ Number of symptomatic residents/when did symptoms begin?
☐ Details about symptomatic residents: ○ First name, last name, birth date and Personal Health Numbers ○ Cell/Unit/Range residents reside on ○ Are the symptomatic residents on droplet and contact isolation? ○ Specimens collected? ○ Date admitted or transferred into the facility
☐ Number of symptomatic AHS and CSD staff/when did symptoms begin?
☐ Any hospitalizations or deaths? If so, provide additional details such as dates.

Section 4: Managing a potential outbreak

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

- Working collaboratively with the Correctional Health Services Manager or designate, ICP/ICD and IPC Medical Lead, Correctional Managers and HCW/staff to facilitate a prompt response to help minimize the impact of the potential outbreak.
- Determining if the symptomatic residents are epidemiologically linked. This is important to determine if illness was spread within the centre.
- Recommending that centres start to implement the measures outlined in this section to manage the potential outbreak.
- Providing contact information for ongoing communication.
- Advising centre if an outbreak will be opened.
    - If an outbreak is opened refer to Section 5.

Centres are recommended to:

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

4.1 Infection Prevention & Control measures

Immediately implement additional precautions for symptomatic residents (see Figure 1).

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

Figure 1: IPC practices and additional precautions

Precautions for symptomatic residents

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

Medically isolate confirmed or symptomatic residents immediately using recommended precautions

- Confirmed or symptomatic residents are recommended to remain in their cell/medical isolation space.
    - A medical mask is recommended if they must leave their cell/medical isolation space.
- A single cell is preferred.
- Place additional precaution signage outside cell/medical isolation space to alert that precautions are required.
- Provide meals to confirmed or symptomatic residents in the cell/medical isolation space.
- Discourage double bunking, when possible, as 2 metres of distance may not be possible between residents.

- Physical barriers are recommended in shared cells/medical isolation spaces.
- Dedicate care equipment to a single resident. Clean and disinfect after each use if equipment is shared between residents.

Personal Protective Equipment

In addition to the recommended additional precautions, always use the Infection Prevention and Control Risk Assessment (IPCRA) prior to providing resident care.

Masking	• Wear appropriate mask/respirator as per IPCRA. • Aerosol-generating medical procedure (AGMP) is any medical procedure that can induce the production of aerosols of various sizes, including droplet nuclei. • N95 respirator (fit-tested) for any AGMP and residents on Modified Respiratory precautions (including those with a suspected or confirmed acute respiratory infection).
Eye Protection	• Use eye protection as per IPCRA. • Personal (prescription) eyewear does not provide adequate protection.
Gloves and Gown	• Wear gloves and gown as per IPCRA.

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

Resident Transport	• Transport for essential purposes only. • Residents are recommended to wear a medical mask during transport. • Notify receiving department/unit that resident is on additional precautions.

Infection prevention and control posters and resources

- Precautions posters are available at:
  - Posters | Alberta Health Services
  - Routine practices in Continuing Care
  - Personal Protective Equipment (PPE)

4.2 Administrative measures

- Ensure HCW/staff are maintaining heightened surveillance to identify and report newly symptomatic residents as per Table A and Table B
- Consult with AHS WHS / CSD OHS or the AHS Public Health Outbreak Team when making decisions about HCW/staff assignments.
    - Assign HCW/staff to care for asymptomatic residents before symptomatic residents.
    - Cohort HCW/staff to affected areas.
    - Minimize movement of HCW/staff or volunteers between units/range, especially if some areas are not affected.
- Consult with site ICP/ICD or the AHS Public Health Outbreak Team if considering cohorting residents.
    - Consider cohorting exposed asymptomatic residents.
    - Consider cohorting residents with the same illness.
- If residents have respiratory symptoms, assign HCW/staff that have been immunized against influenza and COVID-19 to care for symptomatic residents.
- AHS staff: For information on *Cohorting Isolation for Patients in AHS Corrections Health* visit Insite page IPC Corrections Health Resource Manual.

Daily reporting

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

4.3 Resident restrictions

Resident activities

- Consult with IPC/ICD for assistance with adapting resident activities.

Court attendance

- Recommend restricting in person court attendance for residents who are symptomatic or have tested positive for a respiratory or GI pathogen.

Medical

- Medically necessary appointments are permitted for confirmed or symptomatic residents.
    - Recommend the resident wear a medical mask.
    - Notify the receiving provider of the symptomatic resident so that precautions can be taken during transport and on arrival.
    - Arrange virtual visits when possible.
- For symptomatic residents, if COVID-19 suspected see recommendations in COVID-19 outpatient treatment or if influenza is suspected, see Appendix E.
- Treatments (such as physiotherapy) are recommended to be provided in the cell/medical isolation space of confirmed or symptomatic residents instead of in a centralized area.

Medical isolation

- Centres will implement medical isolation measures as operationally feasible.
- Factors that will impact the ability to medically isolate confirmed or symptomatic residents include the physical layout of the centre, the number and type of residents in

the centre and the number and type of dedicated medical isolation spaces.
- See the Corrections Health Resource Manual on Insite for *Cohorting Isolation for Patients in AHS Corrections Health*.
- Choose areas where supervision can occur to ensure residents are monitored for worsening health symptoms, and medical supports can be provided where necessary.
- See medical isolation strategies for symptomatic residents.

Medical isolation strategies for symptomatic residents

Private washroom
• Designate a private washroom. If a dedicated washroom is not available, cleaning and disinfection is recommended at between every confirmed or symptomatic resident use, or hourly if that is not possible.
Medical isolation space based on centre capacity (choose most appropriate option)
• Single cell: Medically isolate residents in their cells with meal service. • Double bunked with shared washroom: Follow IPC Cohorting Guidelines and consult IPC and/or the AHS Public Health Outbreak team to review options before cohorting. • Dorm: Medically isolate residents with similar symptoms together in a separate cell, separate area, or separate dorm.

4.4 Restrictions on affected unit/range

- No changes from routine practices.

4.5 Admissions/transfers to other correctional centres

- The site Health Services Manager or designate will provide recommendations to CSD staff on restricting movement of symptomatic residents outside of the centre, including scheduled transfers to other centres and advising sentence administration if court hearings are scheduled during the period of medical isolation.

4.6 Transfers to an acute care site

- Notify the EMS dispatcher, the transport staff (EMS crew) and the acute care site if a symptomatic resident is being transferred.

4.7 Group/social activities and education programs

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

4.8 Nourishment areas / sharing of food

- No changes from routine practices.

4.9 Visitors

- Symptomatic visitors are not recommended to visit.
- Advise visitors of the potential risk of exposure.
- Advise to wear PPE if visiting symptomatic residents.
    - Demonstrate how to use PPE.

4.10 HCW/staff outbreak measures

HCW/staff employed by CSD:

- Follow CSD Occupational Health and Safety policies on work attendance, masking, and eye protection.

AHS HCW/staff

- Follow AHS policies regarding work attendance, masking, and eye protection.
- Table C outlines detailed recommendations on COVID-19 rapid antigen testing and work restrictions for symptomatic HCW/staff.

Monitoring for symptoms

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

General recommendations

- HCW/staff with respiratory or gastrointestinal symptoms are recommended to:
  - Not report to work
  - Report illness to the manager/designate.
  - Report to WHS/OHS if symptoms are related to a workplace exposure.

Additional Recommendations for AHS HCW/staff with respiratory symptoms:

- Take a COVID-19 at-home rapid antigen test.
  - Table C outlines recommendations for COVID-19 at-home rapid antigen testing and work restrictions for symptomatic HCW/staff.

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

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

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

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

Scenario C
Symptomatic AND no rapid antigen test completed **OR** only one negative COVID-19 rapid antigen test
	• Complete testing.
	• If testing is not completed:
	  ○ Work restricted for a minimum period of five days from the onset of symptoms or until symptoms improve and are fever-free for 24 hours (without use of fever reducing medication) whichever is longer.
	  ○ Wear a mask for a total of 10 days from onset of symptoms.
	  ▪ Masking is not necessary if AHS HCW/staff already isolated for 10 days or more.

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

4.11 Specimen collection

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

4.12 Enhanced environmental cleaning and disinfection

Initiate enhanced cleaning and disinfection

- The cleaning requirements listed in Principles for Environmental Cleaning and Disinfection must be followed.

Enhanced cleaning and disinfection frequency

- At least once per day for low touch surfaces (such as shelves, benches, windowsills, message, or white boards, etc.),
- A minimum of two times daily for high touch surfaces such as tabletops, chairs (including the underneath edge of the chair seat), light switches, doorknobs, taps, handles, handrails and other shared high traffic areas.
- Immediately on any visibly dirty surfaces.

Enhanced cleaning and disinfection recommendations

- Use a "wipe twice" procedure (a 2-step process) to clean and then disinfect surfaces (i.e., wipe surfaces thoroughly to clean visibly dirty material then wipe again with a clean cloth saturated with disinfectant to disinfect) while observing the appropriate contact time.
- Health care equipment is recommended to be cleaned and disinfected according to manufacturer's instructions.
- Any shared resident health care equipment (such as commodes, blood pressure cuffs, thermometers, bathtubs, showers and shared bathrooms) is recommended to continue to be cleaned and disinfected after use and prior to use by a different resident.
- Additional cleaning and disinfection are recommended to also occur when:
    - A confirmed or symptomatic resident moves from one cell/medical isolation space to another, or after inhabiting a waiting area, a video court terminal, care/treatment area or other shared areas.
    - Prior to re-occupying the cell/medical isolation space of a symptomatic/positive inmate.
    - A medical isolation is completed by the resident.

Cleaning products

- If the surface disinfectant product used has cleaning properties (detergent/disinfectant), it may be used for both steps. Follow manufacturer's directions for use.
- Use a disinfectant with a Drug Identification Number (DIN) and broad spectrum virucidal claim, or a specific virucidal claim against non-enveloped viruses and coronaviruses for enhanced general environmental cleaning.
- Be sure to use the precautions when using chemicals for cleaning and disinfecting.
- Refer to the product Material Safety Data Sheets for safety information.

Personal Protective Equipment

- Perform cleaning using the proper personal protective equipment (PPE). Follow correct donning and doffing of PPE.
- Putting on (Donning) Personal Protective Equipment and Taking off (Doffing) Personal Protective Equipment (PPE) instructions on the AHS IPC.

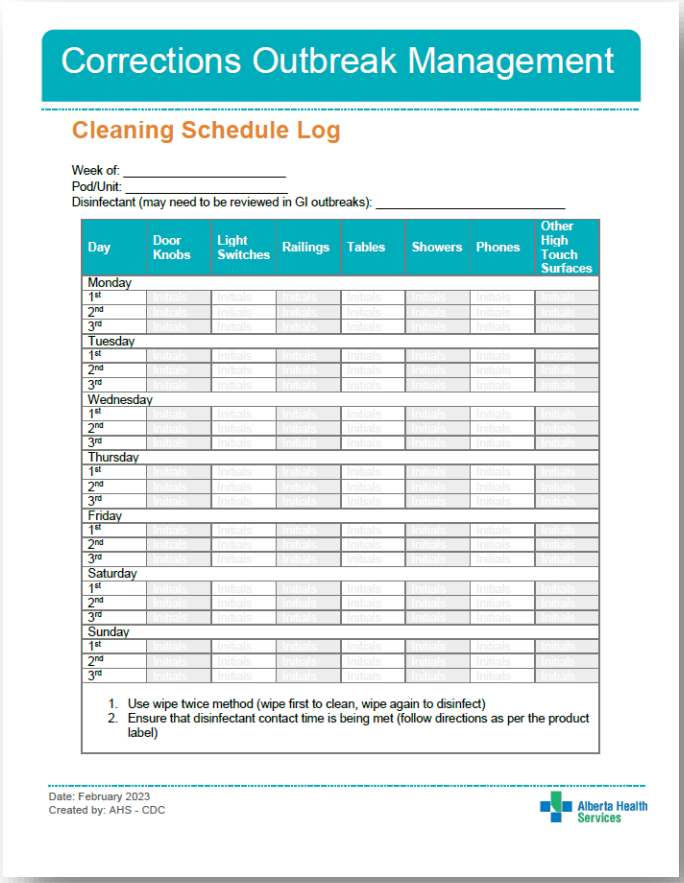
Laundry

- Staff handling soiled laundry are recommended to wear gloves, and gowns if there is a risk of contamination.
- A bleach cycle of the laundry machine must be completed after washing diarrhea/vomit soiled clothing.

- See Linen in Community-Based Services for additional details.

Cleaning Schedule Log

- The Corrections Outbreak Management Cleaning Schedule Log is used to document cleaning activities. Facilities may adapt or develop their own resource.
- Access the log Notifiable Disease & Outbreak Management | Alberta Health Services.



Corrections Outbreak Management

Cleaning Schedule Log

Week of: _____
Pod/Unit: _____
Disinfectant (may need to be reviewed in GI outbreaks): _____

Day	Door Knobs	Light Switches	Railings	Tables	Showers	Phones	Other High Touch Surfaces
Monday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Tuesday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Wednesday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Thursday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Friday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Saturday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
Sunday							
1st	Initials	Initials	Initials	Initials	Initials	Initials	Initials
2nd	Initials	Initials	Initials	Initials	Initials	Initials	Initials
3rd	Initials	Initials	Initials	Initials	Initials	Initials	Initials

1. Use wipe twice method (wipe first to clean, wipe again to disinfect)
2. Ensure that disinfectant contact time is being met (follow directions as per the product label)

Date: February 2023
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Alberta Health Services

Section 5: General recommendations for confirmed outbreaks

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

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

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

5.1 Infection prevention and control measures

Maintain all measures recommended in Section 4.1.
For **respiratory outbreaks** also implement the following:

- HCW/staff who have direct or indirect interactions with residents from the outbreak unit(s)/range(s) are recommended to use continuous masking and eye protection for the duration of the outbreak.
- Masking for all visitors on outbreak unit(s)/range(s).

5.2 Administrative measures

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

Outbreak notification

- Notify appropriate personnel (AHS and CSD) and residents within the centre of the confirmed outbreak.
    - Notify HCW/staff to implement outbreak measures.
- Ensure adequate availability of all supplies through notification of appropriate departments (for example notify Laundry Services and Distribution Services of the increased need for supplies).

Outbreak signage

- Post outbreak signage Appendix D at the entrance(s) of the centre/unit/range advising HCW/staff, residents, others working in the centre, and visitors of precautions.

Daily reporting

- Site Health Services Manager/designate reports **daily** to the AHS Public Health Outbreak Team (and to IPC as per centre process).
    - **Respiratory illness reporting:** A link to the *Facility CDC Outbreak Daily Report Portal (RedCap)* will be provided (Appendix C). This portal is used to enter newly symptomatic or confirmed resident and HCW/staff, hospitalizations, and deaths.
    - **GI illness reporting**: Case reporting will be at the direction of the AHS Public Health Outbreak Team. See Attachment 9.1 for the type of information that may be requested.
- The AHS Public Health Outbreak Team will provide direction on how to submit case data and updates (such as hospitalizations and deaths).

Additional outbreak measures

- The AHS Public Health Outbreak Team will collaborate with the centre to monitor and assess the outbreak. The additional measures listed below may be recommended by the

AHS Public Health Outbreak Team to improve outbreak control when necessary:

- Physical distancing in communal dining area
- Active screening of HCW/staff for symptoms prior to each shift
- Active screening of visitors prior to entering the centre
- Quarantine and or active screening for residents/admissions upon return from other health settings if that other unit/range is on outbreak.
- Masking for residents upon return from absence outside of the centre
- Close contact identification and quarantine of residents or HCW/staff (during a COVID-19 outbreak).

5.3 Resident restrictions

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

Medical

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

Court Attendance

- Confirmed or symptomatic residents are restricted from in person court attendance.
- Asymptomatic residents may attend court using routine preventive measures such as hand hygiene, wearing a medical mask (for source control), physical distancing and notifying the court officers that an outbreak is ongoing at the centre/unit/range.

5.4 Restrictions on affected units/range

- Centre/unit status (open or restricted) will be recommended by the AHS Public Health Outbreak Team.
- Centre restrictions during an outbreak, including restrictions on transfers to or from the correctional centre and restrictions on new admissions of remanded or sentenced offenders, will be determined by the CSD Centre Director in consultation with the Centre Health Services Manager and the AHS Public Health Outbreak Team.
- The scope of restrictions depends on:
  - The extent outbreak activity (one unit/range, selected units or the entire centre)
  - The ability to cohort HCW/staff to affected area(s)
  - The severity of the outbreak (new cases continue to develop despite implemented control measures)
- Consult the AHS Public Health Outbreak Team when issues related to admission, discharge and transfers arise during an outbreak.

5.5 Admissions/transfers from an acute care site

- If a resident was hospitalized due to illness from the outbreak pathogen, they may return to the centre/unit/range immediately upon discharge.
- Residents hospitalized prior to the outbreak, or who were hospitalized during an outbreak for an unrelated condition (such as a fracture), their ability to return to the centre/unit/range will depend on the status of any restrictions applied to the centre.

5.6 Transfers to an acute care site

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

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

5.7 Group/social activities and education programs

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

- Consult the AHS Public Health Outbreak Team for recommendations on whether group activities may continue for asymptomatic residents.
- High risk activities are recommended to be postponed.

5.8 Nourishment areas / sharing of food

- Provide meal service to medically isolating residents in their cell/medical isolation space.
    - Use of disposable plates and cutlery is not recommended or required.
- Cease communal sharing of food in outbreak areas.
- Use hand hygiene.
- The AHS Public Health Outbreak Team may recommend other modifications:
    - Close buffet lines or dispense foods onto plates.
    - Remove shared food containers from dining areas (such as shared pitchers of water, shared coffee cream dispensers and salt and pepper shakers).
    - Dispense snacks directly to residents and use prepackaged snacks.
    - Cease resident participation in food preparation.
    - For respiratory outbreaks, use physical distancing during group dining.

5.9 Visitors

Maintain all measures recommended in Section 4.9 and consider the following:

- CSD may enforce a complete closure of personal resident visitation for the protection of HCW/staff and residents during an outbreak. The AHS Public Health Outbreak Team will support this decision if it is necessary to control the outbreak.

5.10 HCW/staff outbreak measures

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

- HCW/staff who work in more than one centre are recommended to inform the other centre of the outbreak to determine whether they may continue to work in both settings.

5.11 Specimen collection

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

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

5.12 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.12.

Section 6: Confirmed COVID-19 outbreak

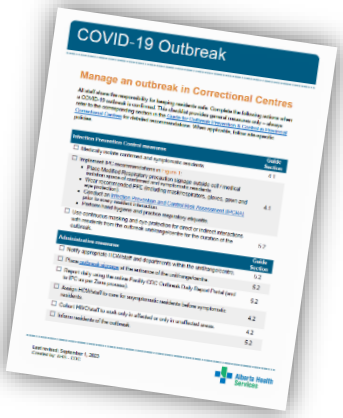
When a COVID-19 outbreak is opened the AHS Public Health Outbreak Team will provide additional COVID-19 specific measures.

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

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

Duration of outbreak

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



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

Checklists:

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

6.1 Infection prevention and control measures

Maintain all measures recommended in Section 4.1 and Section 5.1.

6.2 Administrative measures

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

- Inform HCW/staff, residents and visitors of the COVID-19 outbreak and recommend they monitor for symptoms.
- Antiviral treatments may be available for COVID-19.
    - Centres are recommended to have policies in place to ensure that symptomatic residents that meet the criteria have timely access to the medication. See AHS COVID-19 outpatient treatment for more information.

6.3 Resident restrictions

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

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

After the medical isolation period ends:

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

Resident mask recommendation after medical isolation period ends:

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

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

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

6.4 Restrictions on affected unit/range

Maintain all measures recommended in Section 5.4.

- The AHS Public Health Outbreak Team will recommend that the centre/unit/range is “restricted.” This means that admissions, transfers, and discharges are recommended to be paused or delayed during the outbreak.
    - Implementation of this recommendation may not be possible due to resident circumstances or operational need.

6.5 Admissions/transfers from an acute care site

Maintain all measures recommended in Section 5.5.

6.6 Transfers to an acute care site

Maintain all measures recommended in Section 4.6 and Section 5.6.

6.7 Group/social activities and education programs

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

- For COVID-19 outbreaks, outbreak measures (such as physical distancing, masking, hand hygiene, enhanced surveillance, etc.) may be used for low-risk group activities. These activities may continue at the discretion of the centre in consultation with the Public Health Outbreak Team and CSD.
- Essential medical treatment activities including, but not limited to, rehabilitation, physical or group therapy are recommended to be facilitated by the centre whenever possible with precautions.
- Personal services are allowed to continue. The personal service provider is required to wear an appropriate mask and eye protection and the resident is also recommended to wear a mask. PPE will be provided by the centre.
    - Personal services are recommended to be provided to one resident at a time for residents from outbreak units.

6.8 Nourishment areas / sharing of food

Maintain all measures recommended in Section 5.8.

6.9 Visitors

Maintain all measures recommended in Section 4.9.

6.10 HCW/staff outbreak measures

Maintain all measures recommended in Section 4.10 and Section 5.10.

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

6.11 Specimen collection

Maintain all measures recommended in Section 4.11 and Section 5.11

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

6.12 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.12.

Section 7: Confirmed influenza-like illness (ILI) outbreak

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

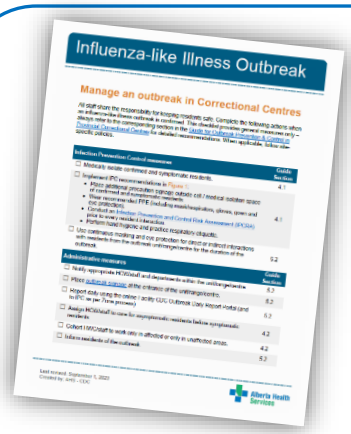
The measures outlined in this section are to be implemented for centres with a confirmed ILI outbreak. These measures build on those outlined in Section 4 and Section 5.

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

Duration of outbreak

- If a non-influenza, non-COVID-19 respiratory pathogen is identified, the outbreak will remain open for a single incubation period for that pathogen (See Table D for incubation periods for common respiratory pathogens). For example, the incubation period for Respiratory Syncytial Virus (RSV) is two to eight days and would close the ninth day following the last resident case onset.
- If no pathogen is identified, an ILI outbreak will remain open for seven days and will close the eighth day following the last resident case onset.

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



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

Checklists:

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

Table D: Organisms Commonly Associated with Respiratory Illness

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

Organism	Clinical Presentation / Symptoms	How is it Transmitted	Incubation Period[3]	Period of Communicability	Outbreak Restrictions/ Recommendations	Additional Precautions
Influenza, Seasonal Type A or B	Fever, cough, muscle aches, fatigue, sore throat, runny nose & sneezing. **Note**: fever may not be prominent in those 65 years of age or older.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	1-4 days The influenza outbreak ends seven days after onset of symptoms in the last case (That is the outbreak ends on the morning of day eight).	Communicable for duration of symptoms.	Refer to Section 8: Confirmed Influenza Outbreak.	Contact and Droplet
COVID-19 (SARS-CoV-2)	Any one or more of the following: new or worsening cough, shortness of breath, sore throat, loss or altered sense of taste/smell, runny nose / nasal congestion, fever/chills, fatigue (significant and unusual), muscle ache / joint pain, headache, nausea/diarrhea	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP, indoor spaces with poor ventilation) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	1-14 days The incubation period may differ depending on the variant. For the Omicron variants, most incubation periods fall between one and six days. This guide is based on an incubation period of seven days.	May begin up to 48 hours prior to symptom onset and continue throughout the symptomatic period. The period of communicability may different depending on variant strains.	Refer to Section 6: Confirmed COVID-19.	Modified Respiratory

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

Organism	Clinical Presentation / Symptoms	How is it Transmitted	Incubation Period[3]	Period of Communicability	Outbreak Restrictions/ Recommendations	Additional Precautions
Respiratory Syncytial Virus (RSV)	Runny nose, coughing, sneezing, fever, wheezing.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	2 to 8 days	Communicable for duration of symptoms	Confirmed or symptomatic cases are recommended to remain in a medical isolation space for the **duration of the illness,** which is the resolution of acute respiratory infection symptoms or return to baseline. Admission/transfer restrictions only when recommended by local MOH.	Contact and Droplet
Parainfluenza Type 1, 2, 3, 4	Fever, runny nose, cough, sneezing, wheezing, sore throat, croup, bronchitis.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	2 to 6 days	Communicable for duration of symptoms however cough may persist for one to three weeks.	Confirmed or symptomatic cases are recommended to remain on precautions • **for 5 days from the onset of acute illness** **OR** • until they are **over the acute illness** and have been **fever free for 48 hours** without the use of fever reducing medication. Admission/transfer restrictions only when recommended by local MOH.	Contact and Droplet

Organism	Clinical Presentation / Symptoms	How is it Transmitted	Incubation Period[3]	Period of Communicability	Outbreak Restrictions/ Recommendations	Additional Precautions
Human Metapneumovirus (hMPV)	Cough, fever, nasal congestion, shortness of breath.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	3 to 5 days	Communicable for duration of symptoms	Confirmed or symptomatic cases are recommended to remain in the medical isolation space for the **duration of the illness**, which is resolution of acute respiratory infection symptoms or return to baseline. Admission/transfer restrictions only when recommended by local MOH.	Contact and Droplet
Other common respiratory viruses such as: • **Enterovirus/ Rhinovirus** • **Non-COVID-19 Coronaviruses** • **Adenovirus**	Sore throat, runny nose, coughing, sneezing.	Respiratory secretions transmitted person-to-person by: • Large respiratory droplets • Aerosols (such as AGMP) • Direct/indirect contact with surfaces, equipment, or body parts recently contaminated with respiratory secretions.	Entero / Rhinoviruses: usually 2-3 days Non-COVID-19 Coronaviruses: usually 2-4 days Adenovirus: 2-14 days	Communicable for duration of symptoms	Confirmed or symptomatic cases are recommended to in the medical isolation space for the **duration of the illness** which is resolution of acute respiratory infection symptoms or return to baseline. Admission/transfer restrictions only when recommended by local MOH.	Contact and Droplet

7.1 Infection prevention and control

Maintain all measures recommended in Section 4.1 and Section 5.1.

7.2 Administrative measures

Maintain all measures recommended in Section 4.2 and Section 5.2.

7.3 Resident restrictions

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

Residents who have symptoms are recommended to medically isolate in their cell/medical isolation space and be placed on additional precautions. The type and duration of the precautions depends on the cause of the ILI outbreak.

If a specific outbreak pathogen has been identified

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

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

If no specific outbreak pathogen has been identified

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

After the medical isolation period ends:

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

Resident mask recommendation after medical isolation period ends:

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

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

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

7.4 Restrictions on affected unit/range

Maintain all measures recommended in Section 5.4.

7.5 Admissions/transfers from an acute care site

Maintain all measures recommended in Section 5.5.

7.6 Transfers to an acute care site

Maintain all measures recommended in Section 4.6 and Section 5.6

7.7 Group/social activities and education programs

Maintain all measures recommended in Section 4.7 and Section 5.7.

7.8 Nourishment areas / sharing of food

Maintain all measures outlined in Section 5.8

7.9 Visitors

Maintain all measures recommended in Section 4.9

7.10 HCW/staff outbreak measures

Maintain all measures recommended in Section 4.10 and Section 5.10

7.11 Specimen collection

Maintain all measures recommended in Section 4.11 and Section 5.11 and consult the AHS Public Health Outbreak Team for recommendations on specimen collection and testing for newly symptomatic residents.

7.12 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.12

Section 8: Confirmed influenza outbreak

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

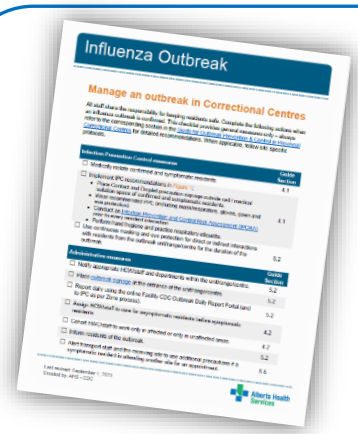
The symptoms of influenza disease are similar to the symptoms for many other respiratory illnesses. See the Health Canada Guidance for further information for identification of suspect influenza cases and indications for early treatment with antivirals: Flu (influenza): For health professionals - Canada.ca

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

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

Duration of outbreak

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



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

Checklists:

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

8.1 Infection prevention and control

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

8.2 Administrative measures

Maintain all measures recommended in Section 4.2 and Section 5.2.

8.3 Resident restrictions

Maintain all measures recommended in Section 4.3 and Section 5.3.

Resident precautions

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

Antiviral treatment and prophylaxis

- Confirmed and symptomatic residents are recommended to receive oseltamivir (Tamiflu) treatment. See the Appendix E to review Antiviral (oseltamivir) Dosing Recommendations.
    - Treatment is the responsibility of the corrections centre medical staff.
- Asymptomatic residents, regardless of immunization status, are recommended to be assessed for eligibility for oseltamivir (Tamiflu) prophylaxis.
    - Prophylaxis is the responsibility of the corrections centre medical staff.
    - Antiviral prophylaxis is continued for seven days after onset of symptoms of the last resident case, usually a minimum of 10 days.
    - In the situation of a mixed outbreak of COVID-19 and influenza, contact the AHS Public Health Outbreak Team to discuss the length of oseltamivir prophylaxis.

8.4 Restrictions on affected units/range

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

- The AHS Public Health Outbreak Team will recommend that the centre/ unit/range is “restricted.” This means that admissions, transfers, and discharges are recommended to be paused or delayed during the influenza outbreak.
    - Implementation of this recommendation may not be possible due to resident circumstances or operational need.
- For confirmed influenza outbreaks, admission restrictions will remain in place at minimum for 7 days following the onset of symptoms in the last case, based on Influenza recommendations from the Association of Medical Microbiology and Infectious Disease (AMMI) Canada, and as directed by the AHS Public Health Outbreak Team.

8.5 Admissions/transfers from an acute care site

Maintain all recommendations in Section 5.5.

8.6 Transfers to an acute care site

Maintain all measures recommended in Section 5.6.

8.7 Group/social activities and education programs

Maintain all measures recommended in Section 5.7.

8.8 Nourishment areas/sharing of food

See all measures recommended in Section 5.8.

8.9 Visitors

Maintain all measures recommended in Section 5.9.

8.10 HCW/staff outbreak measures

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

- HCW/staff are strongly encouraged to receive an annual dose of seasonal influenza vaccine when available.
- AHS WHS will provide specific work restriction recommendations for unimmunized AHS HCW/staff during a confirmed influenza outbreak.
- HCW/staff employed by CSD are recommended to follow all policies as directed by CSD Occupational Health & Safety (OHS) during a confirmed influenza outbreak.
- The AHS Public Health Outbreak Team will advise whether the outbreak influenza strain is covered in the seasonal influenza vaccine. If the outbreak strain is not covered in the seasonal influenza vaccine, the AHS Public Health Outbreak Team may provide additional direction.
- Recommendations for post exposure immunization, and/or the prophylaxis use of Oseltamivir (Tamiflu) for HCW/staff in a confirmed influenza outbreak will be made by the respective WHS/OHS department.

8.11 Specimen collection

Maintain all measures recommended in Section 4.11 and Section 5.11.

8.12 Enhanced environmental cleaning and disinfection

Maintain all measures recommended in Section 4.12.

Section 9: Confirmed gastrointestinal illness outbreak

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

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

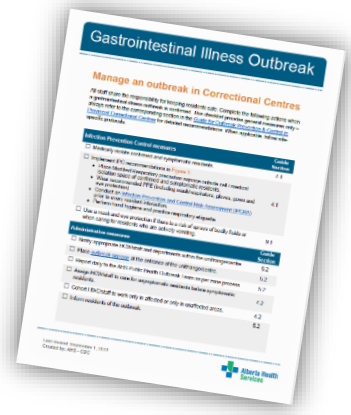
The measures in this section are recommended to be implemented for a confirmed GI outbreak. These measures build on those outlined in Section 4 and Section 5.

- The AHS Public Health Outbreak Team may recommend additional outbreak measures not included in this guide.
- Refer to Table H for the GI illness case and outbreak definitions.

Duration of outbreak

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

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



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

Checklists:

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

9.1 Infection prevention and control measures

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

- Consult with ICP/ICD for assistance with IPC issues as required.

Hand hygiene

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

Additional Precautions

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

Gloves and Gown

- Wear clean gloves and new gown to enter resident cell/medical isolation space when providing direct care to symptomatic residents or when having contact with resident items.
- Wear clean gloves and new gown when cleaning an area contaminated with stool or vomit or gathering/handling specimens.

Mask and eye protection

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

9.2 Administrative measures

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

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

9.3 Resident restrictions

Resident activities

- During outbreaks, resident activities are restricted. The AHS Public Health Outbreak Team will collaborate with CSD for resident restrictions.

Isolation

- Confirmed or symptomatic residents are recommended to be medically isolated with meal service in their cell/medical isolation space for the duration of the acute illness, and until 48 hours after the last episode of vomiting or diarrhea.

Transport

- Confirmed or symptomatic residents are recommended to leave the outbreak centre/unit/range only when medically necessary.
  - Ensure the receiving site is notified that the resident is symptomatic and coming from a centre on outbreak and that precautions are required at the receiving site.

Asymptomatic residents

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

Treatment

- Treatments (such as physiotherapy or occupational therapy) are recommended to be provided in the cell/medical isolation space of the confirmed or symptomatic resident.

9.4 Restrictions on affected units/range

Determining restrictions

- Centre/unit/range status (such as open, or restricted admissions) will be determined by the AHS Public Health Outbreak Team in consultation with CSD.
    - If restrictions are lifted, isolation precautions for confirmed or symptomatic residents are recommended to remain in effect.
- The scope of restrictions depends on:
    - The extent of the outbreak activity within the centre/unit/range.
    - The ability to cohort HCW/staff to affected areas.
    - The severity of the outbreak (such as new cases despite control measures).
- Restrictions typically remain until the outbreak has ended by the AHS Public Health Outbreak Team.

9.5 Admissions/transfers from acute care

- If a resident was hospitalized due to illness from the outbreak pathogen, they may return to the centre/unit/range immediately upon discharge.
- Residents hospitalized prior to the outbreak, or who were hospitalized during an outbreak for an unrelated condition (such as a fracture), they are not recommended to return to the centre/unit/range until the outbreak has ended.

Centre restrictions, including restrictions on transfers to or from the correctional centre and restrictions on new admissions of residents, are determined by the CSD Centre Director in consultation with the Centre Health Services Manager and the AHS Public Health Outbreak Team.

9.6 Transfers to an acute care site

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

9.7 Group/social activities and education programs

- Consult the AHS Public Health Outbreak Team if:
    - Group/social activities may be considered in extenuating circumstances.
    - Group activities are considered an essential part of treatment.
- Previously scheduled resident events on the affected centre/unit/range are recommended to be cancelled/postponed for the duration of the outbreak.

- Postpone or cancel any non-resident events booked for areas in the centre/unit/range (such as meetings)

9.8 Nourishment areas/sharing of food

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

Confirmed and symptomatic residents

- Provide meal service to isolating residents in their cell/medical isolation space.
    - Use of disposable plates and cutlery is not required.

General recommendations

- Close the kitchen/nourishment areas accessed by residents and visitors.
- Cease communal sharing of food in outbreak areas.
- The AHS Public Health Outbreak Team will provide direction on any modifications (such as moving to single serve items).
    - Close buffet lines or dispense foods onto plates.
    - Remove shared food containers from dining areas (such as shared pitchers of water, shared coffee cream dispensers, salt and pepper shakers).
    - Dispense snacks directly to residents and use prepackaged snacks.
    - When using single-use condiment packets, provide directly to each resident.
    - Cease resident participation in food preparation.

Cleaning and disinfection

- Use routine cleaning and disinfection for dishes or food preparation surfaces.
- Clean and disinfect all high touch table and chair surfaces (including the underneath edge of the chair seat and table) after each use.
- Staff assigned to housekeeping duties are not recommended to prepare or serve food.

9.9 Visitors

Maintain all measures recommended in Section 4.9 and implement the following

- Post outbreak signage Appendix D at the entrance of the centre advising HCW/staff, other professions working in the centre/unit/range and visitors of precautions.
- Advise visitors of the potential risk of acquiring illness and to practice hand hygiene before and after visiting.
- Advise those visiting confirmed or symptomatic residents to practice precautions.
- Symptomatic visitors are not recommended to visit.
    - In extenuating circumstances, the centre will determine if visitation is recommended when a visitor is symptomatic.
- Complete visitor restriction is not recommended due to emotional hardship for residents and families.
    - If a centre/unit/range is having difficulty controlling an outbreak, the AHS Public Health Outbreak Team will support the decision of CSD to limit visitors.

9.10 HCW/staff outbreak measures

- Prior to work, HCW/staff are to complete daily self-assessment for GI illness symptoms.
- Symptomatic HCW/staff that fit the case definition for GI illness are recommended to contact WHS/OHS and be excluded from work at until 48 hours following the last episode of vomiting and/or diarrhea.
- Asymptomatic HCW/staff may work in the outbreak centre/unit/range as well as other work locations.

GI Illness in HCW/staff could be an indicator of a potential outbreak.

- Report to the Public Health Outbreak Team if there is an unusual increase in GI illness (above the expected baseline) in HCW/staff.
- Report even if the HCW/staff were not present at work with symptoms.

9.11 Specimen collection

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

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

9.12 Enhanced environmental cleaning and disinfection

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

Enhanced cleaning and disinfection details

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

Recommended disinfectants

Environmental surfaces often become contaminated with stool or vomit containing viruses or bacteria causing GI illness.

- The following disinfectant categories/concentrations are recommended for disinfecting surfaces and equipment during GI illness outbreaks (follow manufacturer directions):
    - Hypochlorite at a concentration of 1000 parts-per-million. Commercially available hypochlorite-containing solutions are recommended.
    - A surface disinfectant with a Drug Identification Number (DIN) issued by Health Canada with a specific label claim against norovirus, feline calicivirus, or murine norovirus.
    - An example of a product with this label claim currently in wide use in AHS centres is 0.5% accelerated hydrogen peroxide. There are other products available with this label claim.
- Equipment is recommended to be cleaned and disinfected following the procedures outlined in the manufacturer's directions for that equipment.
- Surfaces must first be cleaned prior to disinfection (2 step process). If the surface disinfectant product used has cleaning properties (detergent/disinfectant) it may be used for both steps. Follow manufacturer's directions for use.
- Immediately clean and disinfect areas soiled with emesis or fecal material.
- Use fresh mop head, cloths, cleaning supplies and cleaning solutions to clean affected areas, and after cleaning large spills of emesis or fecal material.
- Consider discarding all disposable resident-care items and laundering unused linens (such as towels and sheets) from medical isolation space when the isolation precautions for GI illness are lifted.
- Conduct a thorough cleaning in all affected areas at the end of the outbreak.

Note: upholstered furniture and rugs or carpets is recommended to be cleaned and disinfected when contaminated with emesis or stool but may be difficult to clean and disinfect completely. Consult manufacturer's recommendations for cleaning and disinfection of these

surfaces. If manufacturer's recommendations are not available, consult the AHS Public Health Outbreak Team. Consider discarding items that cannot be appropriately cleaned/disinfected.

Linen/laundry

- Wear PPE as there is a risk of contamination of HCW/staff clothing from body fluids or secretions.
- Follow correct doffing of PPE once laundry has been placed in the laundry bag.
- Handle all linen that is soiled with body fluids are to be handled using the same precautions regardless of the source.
- Remove soiling (such as stool) with a gloved hand and dispose into toilet. Do not remove stool by spraying with water.
- Bag or contain soiled laundry at point of care.
- Do not sort or pre rinse soiled laundry in resident care areas.
- Handle soiled laundry with minimum agitation to avoid contamination of surfaces and people.
- Contain wet laundry before placing it in a laundry bag (for example wrap in a dry sheet or towel).
- Do not double bag.
- Tie laundry bag securely and do not over-fill.
- Laundry bags are recommended to be tied securely & not over-filled.
- Disinfect washer with a bleach cycle (without a load of laundry) prior to use by others if used to launder soiled items from a symptomatic resident.
- see Domestic Laundry Machine for further information.
- Transport, wash & dry as per routine laundering practices.

9.13 Relapse GI cases

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

- Manage relapse GI illness cases as follows:
    - Isolate until the resident is free of vomiting and diarrhea for 48 hours.
    - Do not count as new outbreak cases if relapse is within seven days of original symptom resolution.
        - Relapse cases are not included on new daily case listings.
        - Relapse case(s) alone will not extend admission restrictions.
- If a previously identified GI illness case has onset of GI illness symptoms after being symptom free for at least seven days, manage as a new case.

Attachment 9.1: Data collection for gastrointestinal illness outbreak management

It is important that as soon as an outbreak is suspected, front line HCW/staff assess and track symptomatic residents and HCW/staff for surveillance, monitoring, and reporting purposes. The AHS Public Health Outbreak Team will direct sites on how to report when the outbreak is opened.

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

Outbreak data elements that are recommended to be reported daily to the AHS Public Health Outbreak Team include:

- **Outbreak Centre/Unit/Range** (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/range, number of residents and HCW/staff who meet the case definition)
- **Outbreak/EI number** (as provided by the AHS Public Health Outbreak Team)
- **Demographics of Cases**
  - Residents: name, personal health number, date of birth, gender, unit/range number
    HCW/staff: number of new cases
- **Signs and Symptoms**
  - Onset date
  - Signs and symptoms meeting case definition (vomiting, diarrhea, bloody diarrhea)
- **Lab tests/Results**
  - Stool specimen (date sent)
  - Results
- **Hospitalization or Death of Cases**
  - Cases hospitalized (name, personal health number, date of admission, name of hospital)
  - Cases who died (name, personal health number, date and cause of death)

Section 10: Ending an outbreak

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

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

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

Glossary

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

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

AHS Public Health Outbreak Team: Coordinates and leads the outbreak response, provides consultation and leadership in outbreak investigations and is responsible for reporting of outbreaks to Alberta Health. This team encompasses:

- The Medical Officer of Health (MOH)
- Communicable Disease Control (CDC) Outbreak Team for respiratory illness outbreaks
- Environmental Public Health (EPH) Outbreak Team for gastrointestinal illness outbreaks

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

Centre(s): Refers to all provincial correctional institutions.

Centres Medical Director: Reporting to the Associate Chief Medical Officer, the Centres Medical Director, and Correctional Health provides medical oversight and leadership for Correctional Health centres.

Close contact: Any person suspected to have been exposed to an infected person or a contaminated environment to a sufficient degree to have had the opportunity to become infected or colonized with an organism.

Cohorting: Controlling the movement of healthcare workers (HCW), Correctional Services division (CSD) staff and residents for the purpose of limiting an outbreak to a specific unit/floor/area within a larger centre (instead of having the outbreak declared centre wide). The AHS Public Health Outbreak Team will assess specific circumstances to assist in determining the scope for the outbreak investigation.

Correctional Services division (CSD): Government of Alberta ministry responsible for the operation of provincial correctional services, including all provincial adult and young offender correctional centres.

Health Care Workers/Staff (HCW/staff): HCW/staff refers to all staff that work in the corrections centre.

- **HCW/Staff employed by AHS:** Staff will be required to follow all policies as directed by AHS Workplace Health and Safety (WHS).
- **HCW/Staff employed by or contacted by CSD:** Staff will be required to follow all policies as directed by CSD Occupational Health and Safety (OHS).

Health Services Manager/designate - Key AHS Correctional Health Services position responsible for the daily operation of health services including supervision of nursing and support staff and implementation of changes to structure, process and procedures. This person also is the main point of contact for health services concerns and requests from CSD leadership.

Health Services Manager on-call: AHS Correctional Health Services Manager on-call after hours to respond to incidents and concerns from provincial correctional centres.

Infection Control Designate (ICD): Is accountable for infection prevention and control. This role may be designated to an individual at the site, or by a combination of a site Infection Control Designate and supporting groups such as organizational/zone/AHS IPC.

Infection Control Professional (ICP): A health professional with specialized knowledge responsible for infection prevention and control within the centre or area of practice.

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

Joint Worksite Health & Safety Committee (JWHSC): Committee established by the centre employer in correctional centres in accordance with the Alberta Government Occupational Health and Safety legislation and OHS program to bring together managers and staff from a local site/program area to promote health and safety. The committee provides input, recommendations and support to leaders who have the legislated responsibility to create a safe and healthy workplace.

Medical isolation: Refers to confining a resident that has a confirmed or suspected respiratory or gastrointestinal illness (ideally to a single cell with solid walls and a solid door that closes and access to their own washroom if operationally feasible), to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established clinical and/or testing criteria for release from medical isolation, in consultation with clinicians.

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

Occupational Health & Safety CSD: Provincial department within the Ministry of Justice providing occupational health and safety services to CSD employees.

Outbreak Management Team (OMT): A group of key individuals, including but not limited to, representatives from The AHS Public Health Outbreak Team, Infection Prevention and Control (ICP/ICD), Occupational Health/ Workplace Health Safety (WHS), who work cooperatively to ensure a timely and coordinated response to a suspect or confirmed outbreak. Composition of the OMT will depend on disease and centre type.

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

- Routine measures: measures are recommended for all outbreaks.
- Pathogen specific measures: measures that are specific to the pathogen causing the outbreak.
- Additional measures: measures that are not routinely recommended. They are recommended only at the discretion of the AHS Public Health Outbreak Team if the outbreak warrants additional control measures.

Public health zone contact:- Refer to the Zone public health outbreak team contact list for the respective contact in each zone to report a respiratory or gastrointestinal illness.

Resident: Individuals who are legally held in a correctional centre. This can include individuals who are:

- remanded
- sentenced
- immigration holds
- serving intermittent sentences
- in parole violation

Workplace Health & Safety (WHS): Provincial department within AHS providing occupational health and safety services to AHS employees.

Appendix A: Case and Outbreak Definitions

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

Table E: COVID-19 illness

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

Table F: Influenza-like-illness (ILI)

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

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

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

Table G: Influenza illness

Influenza illness case definition	Influenza illness outbreak definition
A person with clinically compatible signs and symptoms (as outlined above under syndromic ILI) and laboratory confirmation of infection with seasonal influenza virus by: • detection of influenza virus RNA (e.g., via real-time reverse transcriptase polymerase chain reaction [RT-PCR]) **OR** • demonstration of influenza virus antigen in an appropriate clinical specimen (e.g., nasopharyngeal/throat swabs) **OR** • significant rise (e.g., fourfold, or greater) in influenza IgG titre between acute and convalescent sera **OR** • isolation of influenza virus from an appropriate clinical specimen	Two or more confirmed influenza cases in residents within a seven-day period, with a common epidemiological link. Epidemiological link means the cases need to have been in the setting (same site/same unit) during their incubation period or communicable period

Table H: Gastrointestinal illness

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

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

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

Appendix B: ProvLab Specimen Collection Guidance

Check ProvLab Bulletins for most current information on specimen collection, testing, and interpretation of lab results.

Public Health Laboratory (ProvLab) or Forms & Requisitions | Alberta Health Services

Instructions and demonstrations for collection of various types of specimens, including nasopharyngeal swabs can be accessed through the AHS ProvLab website:

Education Resources | Alberta Health Services

The Laboratory Policy for Acceptance of Laboratory Samples, Test Directories, TDG and other collection information can be found on the AHS ProvLab website:

Laboratory Test Directory & Collection Information | Alberta Health Services

The specimen requisition must be completed to include:

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

Nasopharyngeal (NP) and Throat Swab for Detection of Respiratory Infections
General Information**:**

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

Stool Specimen Information

- Sites must collect specimens as directed by the AHS Public Health Outbreak Team and arrange for delivery of specimens to the laboratory. It is valuable to collect stool specimens from cases during outbreaks to try and identify the etiology, if possible. Please note that norovirus can be detected by ordering Gastro Viral Panel (GVP) if in stool but cannot presently be isolated from vomit, therefore the collection of vomit

specimens is not recommended for GI illness outbreak management.

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

Procedures to collect stool specimens

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

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

- Follow current Provincial Laboratory for Public Health standards for transporting specimens at Laboratory Test Directory & Collection Information | Alberta Health Services.
- AHS managers and staff can access WHS – Transportation of Dangerous Goods (TDG) modules on My Learning Link for more information regarding safe specimen transport. If staff member does not have access to My Learning Link connect with manager to determine where this learning can be accessed.
- The EI number must be included on each requisition so that specimens receive appropriate testing.
- Rural facilities to transport lab specimens to ProvLab as directed by the AHS Public Health Outbreak Team or by the fastest means possible.

Appendix C: Facility CDC Outbreak Daily Report Portal (RedCap)

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

Hello,

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

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

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

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

The portal will require the following information:

- Demographic information name, DOB, ULI/PHN for resident and name; DOB, phone number for staff.
- Onset date of illness, symptoms.
- Whether a swab has been obtained, and date of swab if obtained.
- Whether individual is hospitalized; and
- If an individual has died (include date of death).
- To report lab confirmed cases in residents or staff (including asymptomatic cases):
    - Begin entry as if symptomatic by choosing “Newly Symptomatic resident/staff”
    - Use specimen collection date as onset date
    - Select “none” for all symptom lists if asymptomatic

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

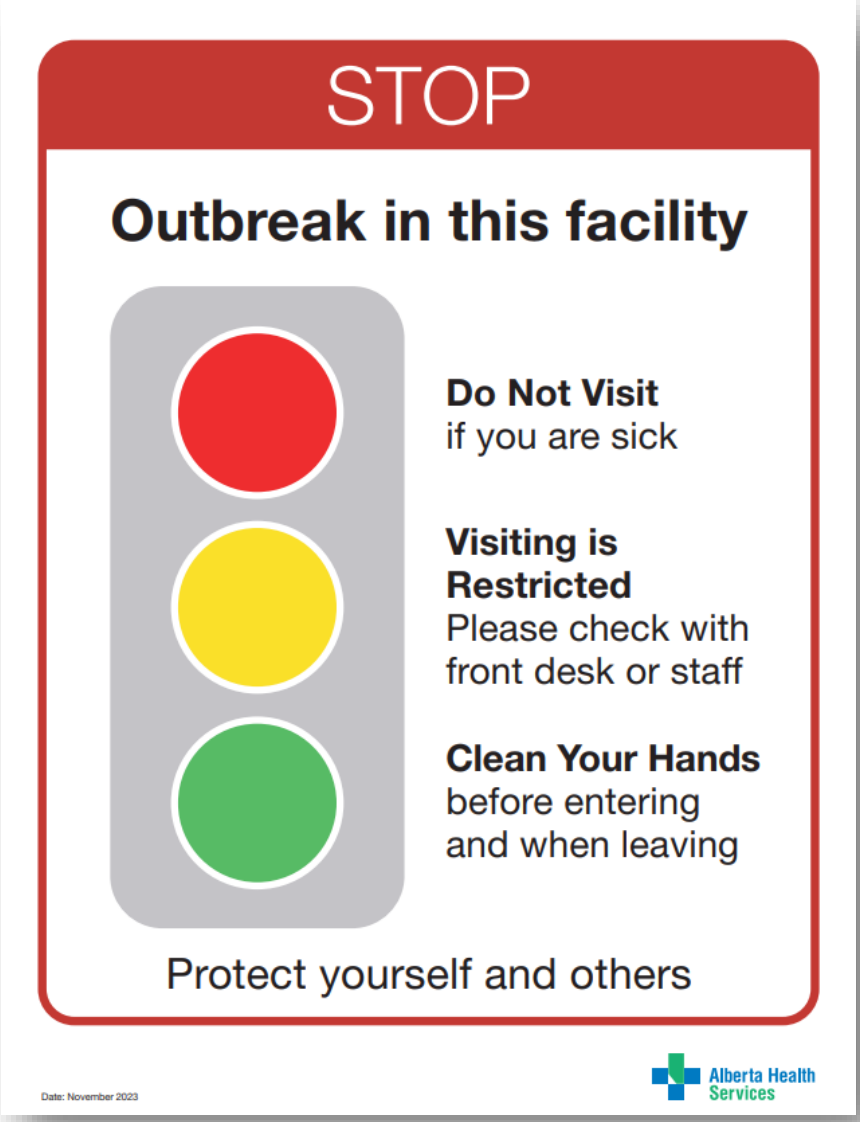
Also attached is a letter from the Medical Officer of Health describing the legal authority to release the requested line list information to the AHS Public Health Outbreak Team, for the purposes of outbreak management under the Alberta Public Health Act for your records.

If you have any questions regarding submission of the information through the portal, please email the CDC COVID outbreak email: CDOutbreak@albertahealthservices.ca.

Appendix D: Outbreak Signage

Sites may print black and white or colour outbreak signage from:

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



Appendix E: Influenza Prophylaxis

Antiviral (Oseltamivir) Dosing Recommendations
Most responsible health practitioner can access information on influenza antiviral treatment and prophylaxis from the following resources:

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

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

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

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

- renal function has been unstable in the past, or
- patient/resident oral intake/urine output has been poor in the immediate prior period, or
- where creatinine results are older than one year

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

Post-Exposure Antiviral Chemoprophylaxis Guidelines During Influenza Outbreaks
General Guidelines
Alberta Health Services (AHS) supports the National Advisory Committee on Immunization (NACI) recommendations for influenza control published annually in the Canada Communicable Disease Report.

Influenza immunization is the primary strategy for prevention of influenza infection and illness. **Antiviral prophylaxis is not recommended to replace annual influenza immunization;** instead, it may be used as an adjunct to immunization during influenza outbreaks, depending on the situation.

Both oseltamivir and zanamivir can be used for the prevention of influenza A and B. The mechanism of action of these neuraminidase inhibitors is to prevent release of influenza virus from infected cells. Because of high levels of amantadine resistance in recent years, amantadine is not recommended for prophylaxis against influenza; in addition to increasing resistance of Influenza A, Influenza B is inherently resistant to it. Neither oseltamivir nor zanamivir are effective for

prophylaxis in preventing respiratory infections other than influenza (e.g., RSV, Parainfluenza).

The recommendation to implement antiviral prophylaxis for outbreak management is made by the Zone MOH.

- Symptomatic individuals do not require antiviral prophylaxis but are recommended to be offered early treatment with antiviral medication. This is most effective when provided to individuals who have had symptoms for less than 48 hours.
- During an outbreak, antiviral prophylaxis may be recommended for asymptomatic residents (regardless of their influenza immunization status) meeting at-risk criteria, unimmunized HCW/staff working in affected areas, and all exposed individuals, unless a contraindication is present.
- An attending physician or NP is responsible for prescribing antiviral medication, either for prophylaxis or treatment for the residents of the centre.
- Staff members who require antiviral prophylaxis will consult with their appropriate WHS/OHS department or primary health care provider.
- For prescribing purposes, the recommended length of antiviral prophylaxis is 10 days. If the outbreak continues past 10 days, antiviral prophylaxis is recommended to be extended until the outbreak is declared over. If the outbreak duration is less than 10 days, antiviral prophylaxis may be discontinued after consultation with the AHS Public Health Outbreak Team.

Antivirals for early treatment
Treatment decisions are the responsibility of the primary health care provider. Antivirals for early treatment of symptomatic residents and staff are recommended to be started within 48 hours of onset of symptoms to be effective in reducing the duration and severity of illness and decreasing the rate of complications. Symptomatic residents meeting at-risk criteria are recommended to be considered for antivirals for early treatment.

At-Risk Criteria for Antiviral Chemoprophylaxis
The following at-risk criteria are based on the Association of Medical Microbiology and Infectious Disease (AMMI) Canada resources on Influenza.

The Zone MOH may recommend antiviral prophylaxis in a confirmed influenza outbreak based on a risk assessment of the situation. Once the decision to recommend antiviral prophylaxis has been made, prescribers may use the following at-risk criteria to identify residents that are recommended to receive antiviral prophylaxis.

Residents who are identified as at-risk are recommended to receive antiviral prophylaxis **regardless of influenza immunization status.**

At-risk groups and co-morbid medical conditions that predispose to severe influenza:

- Individuals 65 years of age or older
- Diabetes mellitus and other metabolic diseases
- Asthma and other chronic pulmonary diseases, including bronchopulmonary dysplasia, cystic fibrosis, chronic bronchitis, and emphysema
- Cardiovascular disease (excluding isolated hypertension; including congenital and acquired heart disease such as congestive heart failure and symptomatic coronary artery disease)

- Immunosuppression or immunodeficiency due to disease (e.g., HIV infection, especially if CDR4R is <200x10PL), or iatrogenic due to medication
- Pregnant women and women up to 4 weeks post-partum regardless of how the pregnancy ended
- Obesity with a BMI≥40 or a BMI >3 z-scores above the mean for age and gender
- Malignancy
- Chronic renal insufficiency
- Hemoglobinopathies such as sickle cell disease
- Neurologic disease and neurodevelopmental disorders that compromise handling of respiratory secretions (cognitive dysfunction, spinal cord injury, seizure disorders, neuromuscular disorders, cerebral palsy, metabolic disorders)
- Individuals <18 years of age who are on chronic aspirin therapy.