Guidelines for COVID-19

Outbreak Prevention, Control and Management in Congregate Living Sites

For the purposes of this document, “congregate” refers to settings where residents/clients receive care and/or services in a communal environment with other residents/clients.

August 2021
# Table of Contents

1.0 Introduction ......................................................................................................................................................... 3

2.0 General Guidelines for COVID-19 Outbreak Management .................................................................................. 4

3.0 Principles of Outbreak Management ..................................................................................................................... 4

   3.1 Surveillance .................................................................................................................................................. 4
   3.2 Assessment .................................................................................................................................................. 4
   3.3 Outbreak Identification ................................................................................................................................ 6
   3.4 Outbreak Definition ...................................................................................................................................... 7
   3.5 Outbreak Procedures ................................................................................................................................... 7
   3.6 Notification .................................................................................................................................................... 8
   3.7 Infection Prevention and Control Measures .............................................................................................. 9
   3.8 Isolation and Quarantine ............................................................................................................................ 14
   3.9 Specimen Collection .................................................................................................................................. 14
   3.10 Monitoring Outbreak Status ......................................................................................................................... 14
   3.11 Declaring Outbreak Over .......................................................................................................................... 14

Appendix 1 Management of Fully Vaccinated Resident COVID-19 Test Results ................................................. 15
Appendix 2 Management of Partially Vaccinated Resident COVID-19 Test Results ............................................. 16
Appendix 3 Management of Non-Vaccinated Resident COVID-19 Test Results ................................................ 17
Appendix 4 Alberta Precision Laboratories (formerly ProvLab) Respiratory Specimen Collection Guidelines ............................................................................................................................. 18
1.0 Introduction

The purpose of this document is to provide current best-practice/evidence-based guidelines for COVID-19 outbreak prevention, control and management in congregate settings. Please note that this is only a supplemental addition to existing guidelines as noted below; more detailed descriptions of general outbreak control strategies are available in the Alberta Health Services (AHS) outbreak guidelines*, which will include COVID-19 guideline in the updated additions.

- Guidelines for Outbreak Prevention, Control and Management in Acute Care and Facility Living Sites, July 2019
- Guidelines for Outbreak Prevention, Control and Management in Supportive Living and Home Living Sites, July 2019

In particular, refer to these existing guidelines for the prevention, control and management of influenza and other pathogens.

*If there is conflicting information between these documents and the operational and outbreak standards in any Orders of the Chief Medical Officer of Health (CMOH) then the Current CMOH Orders standards supersede. For the purposes of this document, “congregate” refers to settings where residents/clients live and receive care and/or services in a communal environment with other residents/clients.

In addition, operators of licensed supportive living (SL) (including group homes and lodges), long-term care (LTC) facilities and hospice settings in Alberta must follow the requirements set out in all Orders issued by the Chief Medical Officer of Health (CMOH), with particular attention to Current CMOH Orders. Other congregate settings not explicitly covered by these Orders should also follow these recommendations where possible to limit the spread of COVID-19 in their vulnerable populations.

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

As we prepare for a time when CMOH COVID-19 orders are no longer needed for these settings, the move towards routine management will include the preventative measures as outlined above in Alberta Health Services (AHS) outbreak guidelines that were developed to prevent and manage outbreaks in these settings.
2.0 General Guidelines for COVID-19 Outbreak Management

Current CMHO Orders, Alberta Health Notifiable Disease Guidelines and Information on Protecting residents at Congregate care facilities provide information on outbreak prevention measures related to staffing, admissions/transfers, testing, essential workers, visitor screening and other details.

Monitoring residents/clients/staff for COVID-19 will also identify symptoms that could be due to influenza-like illness (ILI) i.e., acute onset of respiratory illness with fever and cough, and with one or more of the following: sore throat; joint pain (arthralgia); muscle aches (myalgia); severe exhaustion (prostration). During influenza season, a critically important influenza outbreak prevention measure for residents/clients/staff is to be immunized against influenza every year to protect themselves and each other from influenza illness and its complications. Influenza immunization is especially important to help prevent influenza illness in our communities as COVID-19 continues to circulate and increase demand on hospital capacity.

As we move from managing COVID-19 as a pandemic to managing it as an endemic, it is strongly recommended that all Albertans become fully vaccinated against COVID-19 to protect not only themselves, but also their communities. Emerging real-world evidence from studies in many countries shows moderate to high vaccine effectiveness with one or two doses against severe COVID-19 outcomes, including COVID-19 related hospitalization and death. Since January of 2021 Alberta data shows that 95% of cases, 94% of hospitalizations, and 95% of deaths are in people who are not fully vaccinated. See Alberta COVID-19 Vaccine Program for more information.

3.0 Principles of Outbreak Management

3.1 Surveillance
Conduct ongoing monitoring and surveillance for symptoms of COVID-19 Table 1 in staff and residents/clients to enable prompt identification of possible outbreaks, including influenza.

Anyone with symptoms listed in Table 1 must be isolated and must be asked for consent to be tested for COVID-19. Initiate appropriate testing, isolation and contact and droplet precautions promptly if resident/client exhibits symptoms of COVID-19. If a staff member, service provider, volunteer, student or visiting person feels ill or develops any symptoms of COVID-19 while at work or on site, they must leave their mask on, notify their site contact and immediately leave the site.

Contact the AHS Coordinated Early Identification and Response (CEIR) team at 1-844-343-0971 about any symptomatic person in a congregate setting i.e., a symptomatic staff (who was at site during the communicable period) or resident/client that exhibits any symptoms of COVID-19 Table 1 at a site that does not already have a confirmed outbreak. Sites that do not already have a confirmed COVID-19 outbreak should continue to report newly symptomatic staff/residents/clients to the AHS CEIR team.

Sites that have not yet been contacted by Public Health about a confirmed COVID outbreak must report symptomatic staff/resident/clients that exhibit any symptoms of COVID-19 Table 1 promptly to the AHS (CEIR) team at 1-844-343-0971. They will be immediately provided with additional guidance and decision-making support, including access to Personal Protective Equipment (PPE) as necessary. The AHS CEIR team is also available to provide further assistance as needed if a site continues to see cases in staff or residents/clients UNLESS the site has already been contacted by Public Health to initiate a confirmed outbreak investigation in follow-up to a positive COVID-19 lab result. The Public Health team will ONLY be in contact with sites that have a confirmed outbreak to support outbreak prevention, management and control at that site.

3.2 Assessment
Assess staff and residents/clients for symptoms of COVID-19 Table 1. Also see COVID-19 Recognizing Early Symptoms in Seniors.

(a) Symptomatic staff (includes students or volunteers where applicable):
- Regardless of where exposure occurred, all staff with symptoms of COVID-19 Table 1 must immediately
contact their manager/designate.

- Staff that feel ill or develop any symptoms of COVID-19 while at work must leave their mask on, notify their supervisor/site contact and immediately go home.
- Staff should access onsite testing if available or use the AHS online self-assessment tool for Health Care Workers to arrange testing. Symptomatic staff are managed as per Workplace Health and Safety (WHS)/Occupational Health and Safety (OHS)/Public Health recommendations for isolation and safe return to work.
- Staff must not work while symptomatic, even if they have a negative test result and regardless of their COVID-19 immunization status.

In influenza outbreaks, unimmunized staff that are not on antiviral prophylaxis will be excluded from work as per usual process that is detailed in the AHS outbreak management guidelines referenced earlier.

(b) Symptomatic residents/clients

- Isolate immediately using contact and droplet precautions. Cohorting may be necessary when capacity issues and bed availability is a challenge.
- A resident within a shared room that is required to isolate should be moved to a private space, where possible.
  - Where this is not possible, residents/clients should not be within 2 metres of each other and use of physical/visual barriers (e.g., curtains or portable wipeable screens) should be implemented at all times. Any shared spaces, e.g., bathrooms, must be cleaned and disinfected after each use.
- Contact the AHS CEIR team at 1-844-343-0971 for an EI number prior to sending initial specimens for testing.
- Refer to COVID-19 Test Requisition Forms & Instructions to find up to date requisition forms for your zone.
- For residents/clients that have symptoms of COVID-19 Table 1, arrange for specimen collection and testing as soon as possible.
- Follow Respiratory Illness in Continuing Care and implement contact and droplet infection prevention and control precautions and other outbreak strategies immediately, while waiting for test results.

In influenza outbreaks, follow existing protocols for implementation of antiviral treatment and prophylaxis of residents/clients and staff, making appropriate adjustments for access to treatment or prophylaxis if COVID-19 is also identified at the site during the influenza outbreak.

Active Health Assessment Screening on Entry

- All staff, students, service providers, volunteers must be actively screened prior to the start of each worksite shift.
- All visiting persons entering the site must be actively screened at entry to the site.
- Residents who live within the facility do not require screening.
- Emergency response teams (Police, Fire, Ambulance) must not be stopped to be screened prior to entering the facility or worksite.

- Active Screening involves:
  - Satisfactory COVID-19 screening using Alberta Health Daily Checklist (as appropriate for children under 18; or for adults 18 and older) or an appropriate screening tool as per organization direction.
  - Screening may be completed electronically or on paper. This can be completed prior to arrival at the worksite, but must be confirmed by the screener prior to entry.

Screening Documentation Storage

- For anyone permitted to enter, operators are required to record and store the following information for
a minimum of 4 weeks but no longer than required for the purposes of contact tracing (approximately 8 weeks)
- Name
- Contact Information (phone number, email, etc.)
- Date and time of entry and exit
• Any personal information that is collected for COVID-19 contact tracing can only be used for this purpose, unless an individual provides their consent.
• See Personal Information Protection Act for further details on the responsibilities of operators.
• The completed COVID-19 health screening records of persons entering the site should not be stored long term by the operators, but rather disposed of confidentially once the required time is past. Note: these documents contain health information.

3.3 Outbreak Identification
Initiate full outbreak management precautions as soon as one symptomatic staff/resident/client is identified. Obtain EI number from AHS CEIR Team and site will be under investigation/alert until swab results are available.

A confirmed outbreak is one positive specimen result for COVID-19 in a resident/client/staff (A staff member must have worked at the site during the communicable or symptomatic period to be considered a case linked to the outbreak, irrespective of the staff member’s immunization status). Even when a COVID-19 case is identified and an outbreak is declared, obtain consent to continue testing all newly symptomatic staff and residents/clients throughout the outbreak as directed by Public Health.

Note: Newly symptomatic residents/clients/staff that were previously positive for COVID-19 and have recovered should not be re-tested for COVID-19 if less than 90 days since their previous COVID-19 positive test, unless the MOH recommends testing. All symptomatic residents/clients/staff should also be tested for influenza and other respiratory pathogens (contact Public Health for current testing recommendations and ordering), regardless of previous positive COVID-19 results, and even if influenza or another respiratory virus has already been identified at a site.

If staff worked during the incubation period or during the communicable period WITHOUT appropriate PPE the site will need to be investigated further to confirm if there was exposure to residents and other HCWs. (See section on Management of HCW).
This also includes any staff who may have been symptomatic even while using continuous masking, eye protection and practicing good hand hygiene.
• The communicable period is defined as 48 hours before symptom onset to isolation date in symptomatic cases, OR 48 hours before lab specimen collection date to isolation date in asymptomatic cases.
NOTE: If staff worked at multiple sites in the 48 hours prior to symptom onset/lab test WITHOUT appropriate PPE, outbreak should be declared at those sites.
3.4 Outbreak Definition

**Confirmed COVID-19 outbreak**¹:

- any resident who is confirmed to have COVID-19 and/or
- any staff member who is confirmed to have COVID-19 that worked at the site during the communicable period without use of appropriate Personal Protective Equipment (PPE)

**NOTE:** Even if a confirmed outbreak (COVID-19, influenza or other pathogen) is identified, continue to collect and submit swabs for newly symptomatic individuals as directed by Public Health.

Early recognition of COVID-19 outbreaks is extremely important. If test results are negative for COVID-19, usual influenza-like illness (ILI) or gastrointestinal illness (GI) outbreak protocols should be followed as appropriate, including lab testing for respiratory or GI pathogens. Consult with Public Health as needed regarding additional testing recommendations.

3.5 Outbreak Procedures

Confirmed COVID-19 outbreak

See Table C1: Outbreak Definitions of COVID-19 in the *Alberta- Public Health Disease Management Guidelines - COVID-19* for the definition of an outbreak in Continuing Care settings

*Definition may be updated, so ensure you are referring to most recent version

¹ Sites with two or more individuals with confirmed COVID-19 will be included in public reporting.
Local MOHs continue to play a key role in outbreak management. MOHs, and their designates, will continue to lead each outbreak response and will direct any additional actions that are required to be put into place within a facility based on any unique circumstances, configuration considerations, specialized populations, etc.

- In the case of a confirmed COVID-19 outbreak:
  - All DSL and LTC facilities must require all staff to work at only one single DSL or LTC facility setting for the duration of the outbreak. Refer to Current CMOH Orders for information regarding restricting staff movement and working at a single site.
    - Essential service workers (as defined by the exemption for specified professions and roles) are exempt from being restricted to one single DSL or LTC facility unless there are exceptional circumstances in which the MOH/designate will provide direction.
  - Isolated and/or quarantined residents must not leave their rooms and therefore cannot participate in group activities including group recreation/shared dining, etc.
    - Group activities may continue. MOH (or designate) will provide direction if any additional restrictions to group activities should be applied
  - The MOH (or designate) will direct any necessary restrictions to visiting persons.
  - Operators may continue to accept admissions/ transfers into the site if able to manage the potential risk to other residents, continue to manage the outbreak requirements and the resident and family are informed about the risk and accept it.
  - Operators must be prepared to increase/ augment cleaning and disinfection as required by the MOH/designate/Environmental Public Health and IPC.

Testing Recommendations

Testing is recommended for the diagnosis of individuals with COVID-19 compatible symptoms as listed in Table 1: Symptom List for COVID-19 Testing. Individuals with these symptoms who are working in high risk settings, including HCWs as well as residents/clients in congregate settings, should always be offered testing to confirm the diagnosis. An individual with symptoms not listed in Table 1 such as “COVID toes” or altered mental status may also be considered for testing at the discretion of the individual’s clinician.

Refer to Current CMOH Orders for Management of Resident COVID-19 Symptoms and COVID-19 Test Results

Please see Appendix 1, Appendix 2 and Appendix 3 for management of COVID-19 test results in fully, partially and unvaccinated residents.

- Alberta Health recommends that individuals who are immunocompromised and fully-immunized follow the protocol for partially-immunized individuals outlined in Appendix 2. If an immunocompromised person is partially immunized, it is recommended they follow the protocol for those who have not been immunized in Appendix 3.
- The MOH (or designate) responsible for a public health investigation may require additional measures be put in place at the site or zone level to limit spread of a potential infection such as requiring individuals to quarantine and/or isolate for periods longer than the timeframes included.

3.6 Notification

In order to initiate a site investigation promptly, immediately report a single suspected case of COVID-19 in residents/clients or staff to the AHS CEIR team (1-844-343-0971). Prompt reporting permits early identification and interventions to interrupt transmission of COVID-19 as soon as possible, reducing morbidity and mortality. Initial outbreak control measures, staff restrictions, facilitation of testing and Personal Protective Equipment recommendations will be provided.
Follow internal protocols for site notification to Infection Prevention Control/Infection Control Designate (IPC/ICD) where available regarding staff or residents/clients that are being tested and follow Public Health instructions for collecting and reporting data once a confirmed outbreak is identified at your site Table 2.

**Table 2: Outbreak Notification Algorithm for sites that have IPC/ICD**

Refer to **Current CMOH Orders** for Management of Residents Admission/Return/Transfers from Outbreak Unit

- If a resident transfers or returns from a unit within a health care facility that is on outbreak:
  - Unvaccinated residents must quarantine for 14 days unless exempted by a zone MOH (or designate).
  - Partially vaccinated residents must quarantine for 10 days OR have a negative PCR test on day 7 or later after their return, which would release them from quarantine as long as they remain asymptomatic.
  - Fully vaccinated residents are not required to quarantine unless directed by the MOH (or designate) after a clinical assessment, as long as they remain asymptomatic.
  - The MOH (or designate) responsible for a public health investigation, having conducted a clinical assessment, may require individuals to quarantine for periods longer than the timeframes included.

- Resident vaccination status disclosure is voluntary, though explaining to the resident the benefits of sharing this information may encourage confidential disclosure. If not disclosed, an operator may consider the resident “unvaccinated”.
- While under investigation the facility may continue to accept admissions/transfers if they can continue to manage the outbreak requirements and be able to manage the potential risk to other residents. The resident and family must be informed about the risk and accept it. Once the Outbreak is open CDC will provide further guidance regarding admission and transfers via MOH or designate approval.

**3.7 Infection Prevention and Control Measures**

While waiting for test results, implement full contact and droplet precautions in addition to routine IPC measures including consistent hand hygiene, respiratory hygiene, appropriate personal protective equipment (PPE) and isolation of symptomatic staff or residents/clients, as possible. AHS has a [continuous masking guideline](#), in addition to use of personal protective equipment as part of contact and droplet precautions.
- Continuous masking Guidelines: Refer to Current CMOH Orders and your Organizational Policies if applicable (e.g. AHS directive: Use of mask in COVID-19)
  - All staff, students, service providers, and volunteers must wear a surgical/procedure mask (continuously, at all times and in any areas of the site where care/treatment is being provided, along with any non-care areas of the site except when working alone in an office or when a barrier is in place.
  - If staff are providing care to a resident with communication challenges where a mask would inhibit care being provided, operators have discretion to determine if circumstances are appropriate to use alternate Personal Protective Equipment (PPE), for example fully vaccinated staff using a face shield instead of a mask.
  - Visiting persons must wear a surgical/procedure mask in all indoor common areas of the building. If the resident prefers their visiting persons not to wear a mask, it can be removed in resident rooms or other private areas of the building.
    - Masks can be removed in shared rooms as long as all roommates agree and 2 metres distance can be maintained from the other resident(s) and any other visiting person(s) in the room.

- Continuous Eye Protection remains an important component of contact and droplet precautions in addition to a medical mask, gloves and gown. Continuous eye protection must be used when providing care or services within two meters of a patient with COVID-19, suspected COVID-19 or who is experiencing symptoms consistent with a respiratory tract infection. Where there is evidence of ongoing transmission (two or more lab confirmed cases of COVID-19), continuous use of eye protection (e.g. goggles, visor, face shield) is recommended for staff providing direct face-to-face care of residents/clients

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

- Additional precautions are necessary (see Table 3) if performing aerosol-generating medical procedures (AGMP). If staff/resident/client tests positive for any organism, maintain full IPC precautions until the resident/client is released from isolation.

- Control measures include:
  - PPE - wear appropriate PPE as per Interim IPC recommendations COVID-19 for staff providing care to all isolated residents/clients (symptomatic or asymptomatic), following instructions for Donning and Doffing PPE.
  - Hand hygiene is the most important measure in preventing spread of infections. Practice consistent hand hygiene and respiratory hygiene.
  - Posters/signage - Place visitor poster at the entrance of the facility/unit and screen any visitors prior to entering the facility.
    - Posters regarding physical distancing, hand hygiene (hand washing and hand sanitizer use), safe relaunch and limiting the spread of infection in areas where they are likely to be seen. At a minimum, this includes placing them at entrances, in all public/shared washrooms, treatment and dining areas. Consider placing signs at outdoor spaces where there is shared use (e.g. benches, tables, etc.).
    - Post the physical distancing poster in a place that is available to all residents designated family/support person and/or visitors and staff.
    - Place signage inside the symptomatic resident's/client’s room, near the door, alerting staff/visitors that the resident/client is symptomatic and precautions are required.
  - Place symptomatic residents/clients in single rooms if possible. If a single room is not available, residents/clients with infection due to the same micro-organism may be cohorted following consultation with IPC/Public Health. Maintain at least two (2) metres of physical
separation between bed/stretchers spaces and any permitted designated family/support person or visitor.

Note: Consult with IPC/ICD/Public Health as appropriate for assistance with IPC issues. All COVID-19 concerns or outbreak concerns in continuing care for all settings are being addressed through the central intake email continuingcare@albertahealthservices.ca.

- **Enhanced Environmental Cleaning and Disinfection**
  - Cleaning and disinfecting any high touch surfaces (e.g., doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote), care/treatment areas, dining areas and lounges twice per day.
  - Areas that are not considered common/public areas (e.g. resident rooms, private offices, administrative areas, etc.) do not require enhanced cleaning/disinfection.
  - The virus that causes COVID-19 has the potential to survive in the environment for up to several days. A person who has contact with an inanimate object such as contaminated surfaces and objects is at risk of infection. Cleaning and disinfecting, particularly of frequently touched surfaces, can kill the virus, making it no longer possible to infect people.
  - Operators of facilities may develop an approach to environmental cleaning and disinfection that includes their staff, service providers (e.g. home care), designated family/support persons and visitors.
  - Disinfection and cleaning is a two-step process. Use of disinfectant after cleaning is best and is most effective to reduce the spread of infection.
    - Surfaces must first be cleaned prior to disinfection. Cleaning refers to the removal of visible dirt, grime and impurities. Cleaning alone does not kill the virus but helps remove it from the surface. If the surface disinfectant product used has cleaning properties (detergent/disinfectant), it may be used for both steps. Follow manufacturer’s directions for use.
    - Enhance general environmental cleaning using a disinfectant with a Drug Identification Number (DIN) and broad spectrum virucidal claim, or a specific virucidal claim against non-enveloped viruses and coronaviruses.
    - Be sure to use the appropriate precautions when using chemicals for cleaning and disinfecting. Consult the products Material Safety Data Sheets. Cleaning should be performed using the proper personal protective equipment (PPE). The correct donning and doffing of PPE should be followed. Donning and Doffing PPE.
  - Clean and disinfect:
    - **Common/public areas**
      - at least once per day on low touch surfaces (e.g. shelves, benches, windowsills, message or white boards, etc.),
      - a minimum of two times daily on high touch surfaces (e.g. doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote), care/treatment area, dining areas and lounges.
      - immediately any visibly dirty surfaces
    - Any health care equipment (e.g. wheelchairs, walkers, lifts) according to manufacturer’s instructions.
    - Any shared resident health care equipment (e.g. commodes, blood pressure cuffs, thermometers, lifts, bathtubs, showers, shared bathrooms) prior to use by a different resident/client.
    - All staff equipment (e.g. computer keyboards/mouse/carts and/or screens, medication carts, charting desks or tables, telephones, touch screens, chair arms) at least daily and when visibly soiled.
    - Equipment should be cleaned and disinfected only with a product listed in and following the procedures outlined in the manufacturer’s directions for that equipment.
- Residents/clients that do not have staff or designated family/support person and/or visitors entering their room on a regular basis do not require an increase to their regular scheduled weekly cleaning by the operator.

- Residents/clients that have staff and/or designated family/support person and/or visitors entering their room on a regular basis require:
  - Low touch (e.g. shelves, benches, windowsills, message or white boards) areas cleaning daily.
  - High touch (e.g., doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote) area cleaning two times per day.

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

- Staff handling soiled laundry should wear gloves, and also gowns if there is a risk of contaminating clothing.

- Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak as per facility protocols.
Interim IPC recommendations COVID-19.

Implement Contact and Droplet Precautions in addition to Routine practices when caring for symptomatic residents/clients to control the spread of respiratory viruses: AHS has a continuous masking guideline, in addition to use of personal protective equipment (PPE) as part of contact and droplet precautions. Where there is evidence of ongoing transmission (two or more lab confirmed cases of COVID-19), continuous use of surgical/procedure mask and eye protection (e.g., goggles, visor, face shield) is recommended for staff providing direct face-to-face care of residents/clients.

- Resident/Client Placement and Signage
  - Single-room preferred
  - maintain a distance of two (2) metres between residents/clients sharing a room

Personal Protective Equipment (PPE): Gowns, Gloves and Facial Protection

- Wear new PPE to enter patient room or bedspace. Healthcare workers are to wear contact and droplet PPE even if the patient is wearing a mask.
- Do not wear PPE outside a patient room or bedspace unless transporting contaminated items.
- Remove soiled PPE as soon as possible.
- Gloves are single-use. Use only once, then dispose of immediately after use.
- Change gloves between care activities for the same patient (e.g., when moving from a contaminated body site to a clean body site). Sterile gloves are for sterile procedures.
- For more detailed information on glove use see Glove Use and Selection: IPC Best Practice Guidelines or Proper Glove Use as part of Personal Protective Equipment.
- Prescription glasses do not meet Workplace Health and Safety regulations for eye protection.
- New guidance released for continuous masking. Proper wearing of masks includes:
  - ensuring a snug fit over the nose and under the chin;
  - discard mask when it becomes wet/moist or soiled and replace with a new one.
- Refer to the AHS Donning and Doffing PPE posters for details on careful removal and disposal of PPE. Do not reuse or disinfect single-use PPE. Reusable PPE must be cleaned before reuse (launder gowns, disinfect eye protection).

Effective and appropriate use of PPE keeps staff uniforms and clothing clean. Staff may change before leaving healthcare facility, and take soiled clothing home in a bag. Soiled uniforms/clothing do not need any special handling in the laundry. Refer to Staff Tips: COVID-19 Personal Clothing and Cleaning Surfaces. Further information and resources on PPE can be found here.

- Hand Hygiene (4 moments from AHS Hand Hygiene Policy)
  - Before contact with a resident/client or resident’s/client’s environment including but not limited to: putting on (donning) personal protective equipment; before entering a resident’s/client’s room; and, before providing resident/client care.
  - Before a clean or aseptic procedure including but not limited to: wound care; handling intravenous devices; handling food; or, preparing medications.
  - After exposure (or risk of exposure) to blood and/or body fluids including but not limited to: when hands are visibly soiled; following removal of gloves.
  - After contact with a resident/client or resident’s/client’s environment including but not limited to: removing (doffing) personal protective equipment; leaving a resident’s/client’s environment and after handling resident/client care equipment.

- Resident/Client Care Equipment
  - Dedicate to this resident/client or clean and disinfect after use

- Resident/Client Transport
  - Transport for essential purposes only
  - Residents/clients wear mask during transport and hands should be cleaned
  - Notify receiving department

Refer to the AHS Donning and Doffing PPE posters for details on careful removal and disposal of PPE. Do not reuse.
or disinfect single-use PPE. Reusable PPE must be cleaned before reuse (launder gowns, disinfect eye protection).

3.8 Isolation and Quarantine
Indications for isolation and quarantine are outlined in the Alberta - Public Health Disease Management Guidelines. Isolation and quarantine may still be applied as control measures in outbreak situations as required by MOH/designate.
The term isolation refers to separating and restricting the movement of an individual with symptoms of COVID-19, or who is confirmed to have COVID-19, to prevent their contact with others and to reduce the risk of transmission.
The term quarantine refers to separating and restricting the movement of an individual who was potentially exposed to COVID-19. This is to reduce the risk of transmission if that individual becomes a COVID-19 case. During the quarantine period, the individual should monitor for symptoms and if symptoms develop, they should be offered testing for COVID-19.

Sites/floors/wings experiencing a COVID-19 outbreak must implement additional IPC precautions to the extent that resources are available (e.g., private rooms with washroom facilities, physical layout of care units, housekeeping procedures and staffing patterns)

3.9 Specimen Collection
Contact the AHS CEIR Team to report newly symptomatic staff or residents/clients; they will provide instructions on specimen collection and an EI number for the lab requisition Appendix 4. Sites that have already collected specimens should not send these to the laboratory until they have contacted the AHS CEIR Team and obtained an EI number to ensure coordination of testing.
Refer to COVID-19 Test Requisition Forms & Instructions to find up to date requisition forms for your zone.

3.10 Monitoring Outbreak Status
Once a confirmed COVID-19 Outbreak has been declared by Public Health, communicate and track outbreak status by completing and submitting daily case listings by 1000h to Public Health through the secure, online entry portal on the Alberta Health Services external website (link will be sent to site directly by email when either Outbreak investigation or Outbreak is declared) for the purpose of Public Health outbreak management.

3.11 Declaring Outbreak Over
Public Health will determine when to declare the confirmed COVID-19 outbreak over and lift any site restrictions.
- An outbreak in licensed supportive living (including group homes and lodges), long-term care, nursing homes and auxiliary hospitals) may be declared over after 28 days (two incubation periods) from date of onset of symptoms in the last resident case. The outbreak would be closed on day 29.
- When confirmed COVID-19 cases are only identified in staff at the site, the outbreak can be declared over 14 days after their last day of work if no further cases were identified at that site. The outbreak would be closed on day 15.

Upon closing the outbreak, the site will be advised to maintain enhanced surveillance and to contact 1-844 CEIR Team again if staff/residents become symptomatic in the future

Following a confirmed outbreak, key program leads need to review and evaluate their role in the outbreak management and revise internal protocols for improvement where necessary. Any member of the Outbreak Management Team (OMT) can request a debrief session to address outbreak management issues.
## Appendix 1 Management of Fully Vaccinated Resident COVID-19 Test Results

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>COVID-19 Test</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic</td>
<td>Positive</td>
<td>Isolate with Contact and Droplet precautions for a minimum of 10 days from the onset of symptoms or until symptoms improve AND they are afebrile (have no fever) for 24 hours without the use of fever reducing medications, whichever is longer. Isolation may be extended to 14 days at the discretion of the MOH or Site IPC (where applicable).</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No swab taken and the resident has fever, cough, shortness of breath, runny nose, sore throat, or less of taste or smell.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>With known exposure to COVID-19 (e.g. close contact) Apply IPC precautions according to normal risk assessment of symptoms and suspected etiology, including Contact and Droplet precautions for vomiting and/or diarrhea. Discontinue precautions once symptoms are fully resolved. At the discretion of the MOH, retesting for COVID-19 may be considered</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No swab taken, with other symptoms not listed above</td>
<td></td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Positive</td>
<td>Isolate with Contact and Droplet precautions for a minimum of 10 days from the collection date of the swab. Monitor for the development of symptoms. If symptoms develop, follow recommendations for symptomatic residents. Note: If symptoms develop, the resident may be isolated for more than 10 days.</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>With known exposure to COVID-19 (e.g. close contact): No quarantine required.</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO swab taken</td>
<td>With NO known exposure: No quarantine required.</td>
</tr>
</tbody>
</table>

Alberta Health recommends that individuals who are immunocompromised and fully-immunized follow the protocol for partially-immunized individuals outlined in Appendix 2.
### Appendix 2 Management of Partially Vaccinated Resident COVID-19 Test Results

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>COVID-19 Test</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic</td>
<td>Positive</td>
<td>Isolate with Contact and Droplet precautions for a minimum of 10 days from</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
<td>the onset of symptoms or until symptoms improve AND they are afebrile (have</td>
</tr>
<tr>
<td></td>
<td>No swab taken</td>
<td>no fever) for 24 hours without the use of fever reducing medications,</td>
</tr>
<tr>
<td></td>
<td>and the resident has fever, cough,</td>
<td>whichever is longer. Isolation may be extended to 14 days at the discretion</td>
</tr>
<tr>
<td></td>
<td>shortness of breath,</td>
<td>of the MOH or Site IPC (where applicable).</td>
</tr>
<tr>
<td></td>
<td>runny nose, sore</td>
<td></td>
</tr>
<tr>
<td></td>
<td>throat, or loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of taste or smell</td>
<td></td>
</tr>
</tbody>
</table>
| Negative         | OR            | With known exposure to COVID-19 (e.g. close contact)
| OR               | No swab taken, | Quarantine with Contact and Droplet precautions for 10 days from exposure.  |
|                  | with other symptoms not | If symptoms persist past 10 days, continue to apply IPC precautions according to normal risk assessment of symptoms and suspected etiology. |
|                  | listed above   | OR a negative PCR test on day 7 or later after exposure would release the close contact from quarantine. |
| Asymptomatic     | Positive      | Isolate with Contact and Droplet precautions for a minimum of 10 days from  |
|                  | OR            | the collection date of the swab.                                           |
|                  | No swab taken  | Monitor for the development of symptoms. If symptoms develop, follow          |
|                  |               | recommendations for asymptomatic residents. Note: If symptoms develop, the resident may be isolated for more than 10 days. |
|                  | With known exposure to COVID-19 (e.g. close contact) | Quarantine with Contact and Droplet precautions for 10 days from date of exposure OR a negative test on day 7 or later after exposure would release the close contact from quarantine. |
|                  | With NO known exposure: No quarantine required. | |

Alberta Health recommends that individuals who are immunocompromised and partially immunized follow the protocol for those who have not been immunized in Appendix 3.
Appendix 3 Management of Non-Vaccinated Resident COVID-19 Test Results

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>COVID-19 Test</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic</td>
<td>Positive</td>
<td>Isolate with Contact and Droplet precautions for a minimum of 10 days from the onset of symptoms or until symptoms improve AND they are afebrile (have no fever) for 24 hours without the use of fever reducing medications, whichever is longer. Isolation may be extended to 14 days at the discretion of the MOH or Site IPC (where applicable).</td>
</tr>
<tr>
<td></td>
<td>OR No swab taken and the resident has fever, cough, shortness of breath, runny nose, sore throat, or loss of taste or smell.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>With known exposure to COVID-19 (e.g. close contact) Quarantine with Contact and Droplet precautions for 14 days from the last day of exposure. If symptoms persist past 14 days, continue to apply IPC precautions according to normal risk assessment of symptoms and suspected etiology. <em>At the discretion of the MOH, retesting for COVID-19 may be considered.</em></td>
</tr>
<tr>
<td></td>
<td>OR No swab taken, with other symptoms not listed above</td>
<td></td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>Positive</td>
<td>Isolate with Contact and Droplet precautions for a minimum of 10 days from the collection date of the swab. Monitor for the development of symptoms. If symptoms develop, follow recommendations for asymptomatic residents. Note: If symptoms develop, client may be in isolation for more than 10 days.</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>With known exposure to COVID-19 (e.g. close contact) Quarantine with Contact and Droplet precautions for 14 days from the last date of exposure. Monitor for the development of symptoms. If symptoms develop, follow recommendations for asymptomatic residents. <em>With NO known exposure:</em> No quarantine required.</td>
</tr>
<tr>
<td></td>
<td>OR NO swab taken</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 Alberta Precision Laboratories (formerly ProvLab) Respiratory Specimen Collection Guidelines

Requisition for COVID-19 and other Respiratory Viruses

Check Alberta Precision Laboratories (formerly ProvLab) Bulletins for most current information on specimen collection, testing and interpretation of lab results. Home | Alberta Precision Laboratories (albertaprecisionlabs.ca)

Alberta Precision Laboratories Laboratory Bulletin (July 10, 2020) – COVID-19 Collection Kit Guidance

Acceptable Swab Types for COVID Testing

The Requisition must be completed to include:

- Resident’s/Client’s full name (first and last names)
- Resident’s/Client’s Personal Health Number (PHN) or unique numerical assigned equivalent
- Resident’s/Client’s demographics including: date of birth (DOB), gender, address, phone number
- Physician name (full name), address/location
- Test orders clearly indicated, including body site and sample type, date and time of collection
- Ensure Clinical history and other clinical information is complete
- Facility/site name, and if applicable, unit
- EI# (assigned by the Public Health lab and provided to Public Health Lead investigator) – for both symptomatic and for asymptomatic individuals.
- Request testing for both COVID-19 and other respiratory pathogens (contact Public Health for current testing recommendations).
- Fax number of outbreak facility/unit or ICP/ICD office
- EI# must be clearly recorded on the requisition
- Rural facilities must transport lab specimens to the Alberta Precision Laboratories as directed by the AHS CEIR Team/Public Health or by the fastest means possible

Specimen Transport

- Settings must collect specimens as directed by the AHS CEIR Team/Public Health and arrange for delivery to the laboratory.
- For current information refer to Alberta Precision Laboratories standards for transporting specimens at https://www.albertaprecisionlabs.ca/tc/Page13876.aspx

Specimen Collection for Detection of Respiratory Infections

- Acceptable specimen types for COVID-19 testing include NP swab, throat swab, NP aspirate, endotracheal tube (ETT) suction/sputum, or bronchoalveolar lavage/bronchial wash (BAL/BW). Nasopharyngeal (NP) and throat swabs are
recommended over nasal swabs for COVID-19 testing. See Acceptable Swab Types for COVID Testing.

- Use contact and droplet precautions to collect specimens as directed by Public Health
- Results for COVID-19 are usually available within 48-96 hrs. or sooner but are dependent on each of the steps involved in the entire process (e.g., time to book appointment (as applicable), time to swab and time to reach lab, time to process at the lab)