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.

April 2020
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Introduction

The purpose of this document is to provide current best-practice/evidence-based guidelines for COVID-19 outbreak control and management in congregate settings. Please note that this is only a supplemental addition to existing guidelines; more detailed descriptions of general outbreak control strategies are available in the Alberta Health Services (AHS) outbreak guidelines:

- 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

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.

In addition, operators of licensed supportive living (SL), long-term care (LTC) facilities and service providers licensed under the Mental Health Services Protection Act (MHSPA) in Alberta must follow the requirements set out in all Orders issued by the Chief Medical Officer of Health (CMOH), with particular attention to: Order 03-2020, Order 09-2020 and Order 10-2020. Italized sections below are requirements for these facilities and service providers. Other 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 outbreaks and other infectious disease threats in Alberta is mandated under Section 26 of the provincial Public Health Act, and each Medical Officer of Health (MOH) is accountable for outbreak investigation and management (Section 29).

Early recognition and swift action is critical for effective management of COVID-19 outbreaks in congregate settings because of the increased risk of severe symptoms from COVID-19, and the increased risk of spread when vulnerable individuals live in close contact.

**Reporting of newly suspected outbreaks:** To initiate discussion about newly suspected outbreaks i.e., one symptomatic staff or resident/client that exhibits any symptoms of COVID-19 (see Table 1) at a site that does not already have an outbreak, call the AHS Coordinated COVID-19 Response at 1-844-343-0971.

Sites that do not already have an identified outbreak must promptly report newly symptomatic staff/resident/clients that exhibit any symptoms of COVID-19 (see Table 1) to the AHS Coordinated COVID-19 Response 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.

**Continuous masking:** By CMOH Order 10-2020, there is a requirement for continuous masking effective April 15, 2020, applicable for licensed supportive living (SL), long-term care (LTC) facilities and service providers licensed under the Mental Health Services Protection Act (MHSPA), as well as lodge accommodation. AHS has a continuous masking strategy, in addition to use of personal protective equipment (PPE) as part of droplet and contact precautions.

Staff, Infection Control Professionals (ICP)/Infection Control Designate (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, see [https://connection.albertahealthservices.ca](https://connection.albertahealthservices.ca). Note - you will be required to register the first time you use the site.

**Note:** This is not a comprehensive infection prevention and control (IPC) document. Only the minimum updates necessary for managing outbreaks of COVID-19 are outlined here. Please continue to use your AHS Guidelines for Outbreak Prevention, Control and Management for general information on outbreak management. For detailed information about IPC, please consult your ICP/ICD for your facility or Public Health.
GENERAL GUIDELINES FOR COVID-19 OUTBREAK MANAGEMENT

1. Principles of Outbreak Management

1.1 Surveillance

Conduct ongoing monitoring and surveillance for symptoms of COVID-19 (see Table 1) in staff and residents/clients and prompt identification of possible outbreaks. An outbreak is suspected if a single staff or resident/client exhibits symptoms of COVID-19.

- Sites that have newly identified suspect, probable or confirmed outbreaks (see Table 1) must contact the AHS Coordinated COVID-19 Response at 1-844-343-0971
  - Note: for outbreaks that have already been reported, do not contact the AHS Coordinated COVID-19 Response line as Public Health is already managing those.

1.2 Assessment

Assess staff and residents/clients for symptoms of COVID-19* (see Table 1).

Even if a single case of COVID-19 has already been identified, continue to collect and submit nasopharyngeal swabs for any newly symptomatic individuals until otherwise directed by Public Health.

(a) Symptomatic staff:

- regardless of where exposure occurred, all staff with symptoms of COVID-19* (see Table 1) must immediately contact their manager/designate and Workplace Health and Safety (WHS)/Occupational Health and Safety (OHS). In settings that do not have WHS/OHS, contact Public Health.

- staff that become symptomatic while at work must not remove their mask and be sent home immediately in their private vehicle, or if public transit is normally used, by taxi ordered by operator with staff wearing a mask.

- symptomatic staff are managed as per WHS/OHS/Public Health recommendations for lab testing, isolation and safe return to work.

(b) Symptomatic residents/clients

- isolate immediately using droplet and contact precautions. Cohorting may be necessary.

- if symptomatic resident has an asymptomatic roommate, consider quarantining this individual

- contact the AHS Coordinated COVID-19 Response at 1-844-343-0971 for an EI number prior to sending initial specimens for testing.

- for residents/clients that have symptoms of COVID-19* (see Table 1), arrange for nasopharyngeal specimen collection and testing as soon as possible.

- follow IPC risk assessment for respiratory illness and implement contact and droplet infection prevention and control precautions and other outbreak strategies immediately, while waiting for test results.

By CMOH Order, staff must immediately tell their supervisor at any and all sites where they work if either of the following applies:

- if they have worked at or are working at a congregate setting where there is a confirmed COVID-19 outbreak

- if they have symptoms of COVID-19, or have been exposed to any individual with suspected, probable or confirmed COVID-19 (including if a close or household contact has been told to self-isolate, but has not been tested for COVID-19), or if they have been tested for COVID-19.

1.3 Outbreak Identification

Initiate full outbreak management precautions as soon as one symptomatic staff/resident/client is identified.

One positive specimen result for COVID-19 is considered a confirmed outbreak. (see Table 1).

Even when a COVID-19 case is identified and an outbreak is declared, continue testing all newly symptomatic staff and residents/clients throughout the outbreak until otherwise directed by Public Health.
1.4 Case and Outbreak Definitions

Early recognition of COVID-19 outbreaks is extremely important. Ongoing surveillance of staff and residents/clients should be conducted using the following definitions for early detection of COVID-19 cases/outbreaks (see Table 1).

### Table 1: COVID-19 Case and Outbreak Definitions

<table>
<thead>
<tr>
<th>Case Definition/COVID-19: Symptoms in residents/clients</th>
<th>Case Definition/COVID-19: Symptoms in staff</th>
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<tbody>
<tr>
<td>* Fever (37.8°C or higher)</td>
<td>New onset/exacerbation of: fever (38°C or higher), cough, shortness of breath/difficulty breathing, sore throat or runny nose, feeling unwell/fatigued, nausea/vomiting/diarrhea.</td>
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<td>Any new or worsening respiratory symptoms:</td>
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<td>- sore throat</td>
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<td>- difficulty swallowing</td>
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<td>Any new onset atypical symptoms including but not limited to:</td>
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<td>- feeling unwell/fatigue/malaise</td>
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<td>- headache</td>
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</table>

**Outbreak Definitions**

- **Suspected COVID-19 outbreak**
  - one resident/client or staff member who exhibits any of the symptoms of COVID-19

- **Probable COVID-19 outbreak**
  - two or more individuals (residents/clients or staff) who are linked with each other who exhibit any of the symptoms or COVID-19. Individuals who are linked have a connection to each other (e.g. share a room, dine at the same table, received care from the same staff member, etc.)

- **Confirmed COVID-19 outbreak**
  - any one individual confirmed to have COVID-19 including:
    - any resident/client who is confirmed to have COVID-19
    - any staff member who is confirmed to have COVID-19.

**NOTE:** Even if a confirmed case is identified, continue to collect and submit nasopharyngeal swabs for newly symptomatic individuals until otherwise directed by Public Health.

1.5 Notification

In order to initiate an outbreak investigation promptly, immediately report a single suspected case of COVID-19 in residents/clients or staff to the AHS Coordinated COVID-19 Response (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 and testing recommendations will be provided.

Public Health will advise regarding further notifications to be made (see Table 2) e.g. to your IPC/ICD (where available) and will use established protocols to collect and report data. (see Attachment 1). For sites where there is no one assigned the role of infection prevention and control (IPC), Public Health assumes that role.
1.6 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 strategy, in addition to use of personal protective equipment (PPE) as part of droplet and contact precautions.

Additional precautions are necessary (see Table 3) if performing aerosol-generating medical procedures (AGMP). If staff/resident/client tests positive, maintain full IPC precautions until the outbreak is declared over.

- **PPE** - wear appropriate PPE as per Interim IPC recommendations COVID-19 for staff providing care to all isolated residents/clients (symptomatic or asymptomatic) **Donning and Doffing PPE**
- **hand hygiene** is the most important measure in preventing spread of infections. Practice consistent hand hygiene and respiratory hygiene.
- place **Visitor poster** at the entrance of the facility/unit indicating the precautions required and screen any essential visitors prior to entering the facility.
- place posters regarding physical distancing, hand hygiene (hand washing and hand sanitizer use) and limiting the spread of infection in areas where they are likely to be seen.
- place signage and **Visitor poster** 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/stretcher spaces and any permitted designated essential visitor.

**Note:** Consult with IPC/ICD/Public Health as appropriate for assistance with IPC issues.
04-03-2020 update: Visitors: Effective immediately, long term care, supportive living and congregate settings have implemented a “No Visitor Policy” as per CMOH Order 09-2020. Visitor poster: Visiting residents and patients during a pandemic

EXCEPTIONS: For end of life situations, one Essential Visitor at a time is allowed. In rare situations, sites may allow one Essential Visitor where the resident’s/client’s care needs cannot be met without their assistance.

Essential Visitor: designated by resident/client or guardian (or other alternate decision maker) may be a family member, friend or paid caregiver over 18 years of age.

Essential Visitors must comply with all requirements:
- pre-arrange visits with facility manager, and be expected by site administration or charge nurse
- have a temperature check for fever (over 38 degrees Celsius)
- sign in and out of all visits and complete a standard screening questionnaire to assess health risk
- wear any required Personal Protective Equipment
- be escorted by site staff to resident’s/client’s room and remain in that room for the duration of the visit. Visitation with other residents is not permitted.

- Staff restrictions
  By CMOH Order 10-2020, beginning April 16, 2020 but no later than April 23, 2020, staff that usually work at multiple sites are limited to working within one single health care facility.
  Meanwhile, staff must immediately tell their supervisor at any and all sites where they work if either of the following applies:
  - if they have worked at or are working at a congregate setting where there is a suspected, probable or confirmed COVID-19 outbreak, or
  - if they have symptoms of COVID-19, or have been exposed to any individual with suspected, probable or confirmed COVID-19 (including if a close or household contact has been told to self-isolate, but has not been tested for COVID-19), or if they have been tested for COVID-19.

- effective immediately, when a facility has a confirmed outbreak, staff are limited to working within one single health care facility. This will help to prevent the spread of illness between facilities.
- staff who are following handwashing guidelines, using appropriate PPE and applying it correctly while caring for residents with suspected or confirmed COVID-19 are not considered “exposed” and may safely enter public spaces within the facility or other rooms, subject to review by Public Health.

It is strongly recommended that all congregate living settings (e.g. non-designated licensed supportive living, lodges, group homes, etc.), though not mandated, also implement this requirement.
Table 3: COVID-19 - Infection Prevention and Control Practices and Additional Precautions

**Interim IPC recommendations COVID-19.** More detailed IPC recommendations are available on the AHS website (search: ‘infection control’) for the most current recommendation.

**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** strategy, in addition to use of personal protective equipment (PPE) as part of droplet and contact precautions.

- **Resident/Client Placement and Signage**
  - Single-room preferred
  - Maintain a distance of two (2) metres between residents/clients sharing a room
- **Mask**
  - Wear procedure/surgical mask for any encounter, within two (2) metres, with a resident/client who has ILI, or has a suspected/confirmed case of COVID-19.
- **N95 Respirator (fit-tested)** - for aerosol generating medical procedures (AGMP)
- **Resident/Client undergoing an aerosol generating medical procedure (AGMP)** – AGMPs are defined as any medical procedure that can induce the production of aerosols of various sizes, including droplet nuclei. See the **IPC risk assessment for respiratory illness** for a list of AGMP
- **Eye Protection**
  - When a mask or N95 respirator is worn, eye protection or face shields should also be worn for all resident/client care activities
  - Personal (prescription) eyewear does not provide adequate protection
- **Gown**
  - For direct contact of clothing or forearms with resident/client or resident’s/client’s environment
- **Gloves**
  - Wear clean non-sterile gloves for direct contact with resident/client or resident’s/client’s environment
- **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 (laundry gowns, disinfect eye protection).

- **Self-Isolation**
  - Any individual (resident/client, staff or designated essential visitor) who has had direct contact with a person with confirmed COVID-19 without wearing recommended PPE is required to self-isolate as per the Order of the CMOH.
  - Any individual (resident/client, staff or visitor) who is experiencing symptoms of COVID-19 is required to isolate as per the Order of the CMOH.

- **Admissions/transfers**
  - Consult with AHS Zone Medical Officer of Health (MOH) before accepting admissions and/or transfers into the site if an outbreak is suspected or probable. Stop admissions and/or transfers into the site if a COVID-19 outbreak is confirmed, unless at the direction of the AHS Zone MOH.
  - Any new admissions and/or transfers to the facility should be placed on contact/droplet isolation for 14 days from arrival to facility.
  - **Residents/clients whose families take them home to provide care for them during an outbreak will not be re-admitted while the facility is on outbreak**
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).

1.7 Specimen Collection
- Contact the AHS Coordinated COVID-19 Response line at 1-844-343-0971 to report a new outbreak; they will provide instructions on specimen collection and an EI number for the lab requisition. Sites that have already collected specimens should not send these to the laboratory until they have contacted the AHS Coordinated COVID-19 Response line at 1-844-343-0971 and obtained an EI number to ensure coordination of testing.

1.8 Additional Outbreak Control Strategies
- authorize and deploy additional resources to manage the outbreak as needed.
- where possible, restrict symptomatic residents/clients to their room (with dedicated bathroom if possible, with meal tray service in room, etc.); if not possible, restrict to own unit/wing.
  - for residents/clients requiring urgent medical care, ensure that appropriate IPC precautions are maintained during transport and at the receiving site, AND ensure that the transport team and receiving site are advised of the possibility of COVID-19.
  - residents/clients who are not required to isolate must remain on the facility’s property (except in the case of necessity) if there is a probable or confirmed outbreak at the site.
- group dining may continue for non-isolated residents, if appropriate and feasible, subject to requirements set out in CMOH Order 10-2020.
- scheduled resident group recreational/special events must be cancelled/postponed with a probable or confirmed outbreak; they may continue with a suspected outbreak subject to requirements of CMOH Order 10-2020, Appendix A.
- recreational activities for non-isolated residents should be one-on-one activities while maintaining physical distancing
- apply site-level restrictions and other control measures as recommended by Public Health.

1.9 Environmental and Equipment Cleaning
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, particularly of frequently touched surfaces, can kill the virus, making it no longer possible to infect people. AHS recommendations for cleaning can be found here Environmental Cleaning in Public Facilities:
- staff handling soiled laundry should wear gloves. Gowns should also be worn if there is a risk of contaminating clothing.
- enhance general environmental cleaning using a disinfectant with a Drug Identification Number (DIN) and virucidal claim. The thoroughness of cleaning is more important than the choice of disinfectant used.
- 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. If the surface disinfectant product used has cleaning properties (detergent/disinfectant), it may be used for both steps. Follow manufacturer’s directions for use.
- clean and disinfect:
  - 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) before use in the care of another resident/client.
  - all staff equipment (e.g. computer carts and/or screens, medication carts, charting desks or tables, telephones, touch screens, chair arms) at least daily or when visibly soiled
- the frequency of cleaning and disinfecting “high touch” surfaces (e.g., doorknobs, light switches, call bells, handrails, phones, elevator buttons, TV remote) in resident/client rooms, care areas and common areas such as dining areas and lounges should be a minimum of three times per day.
- room cleaning and disinfection should be performed at least once per day on all low touch surfaces (e.g. shelves, bedside chairs or benches, windowsills, headwall units, over-bed light fixtures, message or white boards, outside surfaces of sharps containers)
• 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.**

• 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.

• 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.

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

1.10 **Communication**

*Operators will notify all residents/clients, staff and families according to the requirements in the CMOH Order 10-2020.*

1.11 **Monitoring Outbreak Status**

• Communicate and track outbreak status by completing and submitting daily case listings by 1000h to Public Health by email at [CDOutbreak@albertahealthservices.ca](mailto:CDOutbreak@albertahealthservices.ca).

• Each setting is also responsible to maintain their own visitor log and tracking of all entry and exit in case this information is needed in future.

1.12 **Declaring Outbreak Over**

Public Health will determine when to declare the confirmed COVID-19 outbreak over and lift any site restrictions. 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.
Attachment 1: Data Collection for COVID-19 Outbreak Management

It is important for effective containment to track symptomatic residents/clients and staff for surveillance, monitoring and reporting purposes. Once a probable or confirmed outbreak has been declared, sites must send daily line lists of newly symptomatic persons to Public Health by email (or by fax for sites that do not have access to email) to CDOutbreak@albertahealthservices.ca. Accurately completed lists (one for staff and a separate list for residents/clients) must be reported to Public Health by 1000h daily (by site Infection Control Professional/designate or as per zone processes where variation in this responsibility exists). Outbreak data (sample shown below) must be reported to Public Health daily using the Provincial Tracking Form provided by Public Health.

<table>
<thead>
<tr>
<th>Outbreak EI number</th>
<th></th>
<th>Outbreak Opened</th>
<th>Initial Onset</th>
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<tbody>
<tr>
<td>Centre Name</td>
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<td>Click here to enter a date.</td>
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<tr>
<td>Address (+postal code)</td>
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<td>Click here to enter text.</td>
<td>Total number of residents on affected unit</td>
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<tr>
<td>Name</td>
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<td>Click here to enter text.</td>
<td>Unit/Floor Affected</td>
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<td>Contact / Designate</td>
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<td>Total number of staff on affected unit</td>
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<tr>
<td>Phone</td>
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<td>Total number of residents on affected unit</td>
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NONE ADD NEWLY SYMPTOMATIC PERSONS TO DAILY LINE LISTS (use separate lists for staff and residents/clients)

<table>
<thead>
<tr>
<th>Day =&gt; midnight to 2359 hours</th>
<th>Symptoms</th>
<th>Co-morbidities</th>
<th>Any visitors</th>
<th>Travel</th>
<th>Lab Results</th>
<th>Influenza</th>
<th>Outcome</th>
<th>Comments</th>
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Line lists must be submitted by email to public health @ CDOutbreak@albertahealthservices.ca (or by fax for sites that do not have access to email) by 1000h daily for all probable and confirmed outbreaks.
Attachment 2: ProvLab Respiratory Specimen Collection Guidelines

Check ProvLab Bulletins for most current information on specimen collection, testing and interpretation of lab Results [http://provlab.ab.ca](http://provlab.ab.ca) or [http://www.albertahealthservices.ca/3290.asp](http://www.albertahealthservices.ca/3290.asp)

ProvLab Bulletin (May 11, 2011) - New Laboratory Policy, Acceptance of Laboratory Samples and Test Requests.

ProvLab Bulletin (August 22, 2011) – Reminder Laboratory Policy, Acceptance of Laboratory Samples and Test Requests.

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
- Clinical history and other clinical information
- Facility/site name, and if applicable, unit
- EI# (assigned by the ProvLab and provided to Public Health Lead investigator)
- Fax number of outbreak facility/unit or ICP/ICD office

**Note:** EI# must be clearly recorded on the requisition.

Specimen Transport:

- Settings must collect specimens as directed by Public Health and arrange for delivery to the laboratory.

NASOPHARYNGEAL (NP) AND THROAT SWAB FOR DETECTION OF RESPIRATORY INFECTIONS

General Information:

- NP swabs are the preferred specimens for respiratory virus testing
- Use contact and droplet precautions to collect NP swabs as directed by Public Health
- Results for COVID-19 are usually available within 48-96 hrs. or sooner

If the specimens are for outbreak diagnosis, ensure specimen is transported to the lab ASAP. The EI# must be included on each requisition so that specimens receive appropriate testing. Rural facilities to transport lab specimens to the Provincial Lab as directed by Public Health or by the fastest means possible.