

Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Centres including Influenza and Gastrointestinal Illness



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Note:

Please note that many Corrections Infection Prevention and Control documents are located on the internal AHS website, Insite. Non-AHS stakeholders can contact the AHS site Infection Control Professional for access.

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Introduction

The purpose of this document is to provide current best practice/evidence-based guidelines for control and management of a communicable disease outbreak in Alberta's provincial correctional centres.

Correctional Centres are high-risk environments for communicable disease outbreaks due to communal living arrangements and continual close proximity between offenders. High turnover in population through admissions, discharges and transfers between centres and relatively crowded living conditions also facilitate the transmission of infection from one person to another in an outbreak. The potential severity of an outbreak within a correctional centre is also increased due to the increased incidence of respiratory illness (e.g., asthma), immunosuppression (e.g., due to HIV infection) and other underlying chronic medical conditions in the offender population.^{1, 2}

To ensure effective outbreak management in Alberta's provincial correctional centres, it is important that there are written procedures for identifying, reporting, investigating notifiable diseases and controlling suspected outbreaks. Implementing these procedures requires a multi-disciplinary healthcare approach and close collaboration with Justice and Solicitor General (JSG) to facilitate a prompt response to help minimize the impact of the outbreak. This document is intended to be used as a resource for both AHS and JSG in Correctional Centres. Information in this document is divided into 3 sections:

Section I: General Guidelines for Outbreak Management

Section II: Influenza Outbreak Management

Section III: Gastrointestinal Illness Outbreak Management

Note:

This is not a comprehensive Infection Prevention and Control (IPC) document. Only the minimum IPC strategies necessary for managing outbreaks of respiratory or GI illnesses are outlined here. These basic recommendations may be enhanced or modified depending on identification of the causative agent. For detailed information about IPC, please consult the ICP (Infection Control Professional) for your facility or Public Health.

In the event of an outbreak or threat of an outbreak of an unusual infectious disease, such as a new influenza pandemic or any other infrequent infectious disease, direction on best practices for outbreak management will be provided by the one Medical Officer of Health and Infection Prevention and Control and may be modified or enhanced beyond this document.

While it is recognized that *Clostridium difficile* and multi-drug resistant organisms (e.g., MRSA, VRE) can be responsible for clusters or outbreaks, and that some of the measures outlined in this protocol may be applicable in preventing or controlling them, it is beyond the scope of this document to include these organisms due to their unique epidemiological properties.

The notification of outbreaks and other infectious disease threats in Alberta institutions is mandated under Section 26 of the Alberta Public Health Act. Any health practitioner or person in charge of an institution (Correctional Centre Director) must notify the zone Medical Officer of Health (MOH) if there is a confirmed or suspected communicable disease in epidemic form or any other illness or health condition occurring at an unusually high rate.

The 2011 Corrections Amendment Act allows custodians of health information (as defined in the

Health Information Act) to “disclose individually identifying health information about an inmate, without the consent of the inmate, to a director of correctional institution” for the purposes of outbreak management within the correctional centre.

Upon notification of a confirmed or suspected outbreak, the MOH is accountable for investigation and management under Section 29 of the Alberta Public Health Act.

Definition of Terms and Glossary

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

AHS: Alberta Health Services.

Cluster: Aggregation of similar, relatively uncommon events or diseases in space and/or time in amounts that are believed or perceived to be greater than could be expected by chance.

Cohort: Controlling the movement of healthcare workers (HCW), Justice and Solicitor General Staff, and inmates for the purpose of limiting an outbreak to a specific unit/floor/area within a larger facility (instead of having the outbreak declared facility-wide). To meet the criteria for cohorting, HCW and inmate activities are confined to the outbreak area for the full duration of the outbreak i.e., the facility must (i) designate HCW as required that work only in the outbreak area, and (ii) manage all inmate activities within the outbreak area, except for specific services that are medically required.

Contact: Any person suspected to have been exposed to an infected person or to a contaminated environment to a sufficient degree to have become infected or colonized with an organism.

Contact precautions: See routine practices and additional precautions in [Table 4: Outbreak management routine practices and additional precautions](#).

Drug Identification Number (DIN): Number assigned by Health Canada to a drug product prior to being marketed in Canada.

Exclusion: Measure that prevents a symptomatic/infected/susceptible HCW worker from working, until such time that the risk for patients or HCW is low or minimal. Exclusion measures may be implemented during an outbreak as recommended by Public Health and in consultation with AHS Workplace Health Safety and JSG Occupational Health and Safety.

Exposure Investigation Number (EI#): Number assigned by Public Health Laboratories for the purpose of tracking laboratory specimens associated with a specific event (e.g., a potential outbreak) at a specific location and time.

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

Gastrointestinal illness (GI): For GI case and outbreak definitions, refer to [Table 3: Gastrointestinal \(GI\) illness definitions](#)

Healthcare-associated infection (HCA): Formerly referred to as nosocomial infections, infections that patients may have acquired during the course of receiving treatment for other conditions within a healthcare setting.

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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 Professional (ICP): Health professional with specialized knowledge responsible for Infection Prevention and Control within the Provincial Correctional Facility. Each provincial correctional centre has a designated ICP. ICPs come from several disciplines, including nursing, medicine, microbiology, medical technology, and/or epidemiology and may be certified or working toward certification in infection control (CIC®).

Infection Prevention and Control (IPC): Department within AHS that is dedicated to preventing infections acquired within healthcare facilities. IPC roles include: consultation, education, surveillance, research, outbreak management, and others.

Influenza-like-illness (ILI): For ILI case and outbreak definitions, refer to [Table 2: Influenza-like illness](#).

Joint Worksite Health and Safety Committee (JWHSC): Committee established by the centre employer in all correctional centres in accordance with the Alberta Government Occupational Health and Safety legislation and OHS program to bring together managers and workers 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.

Justice and Solicitor General (JSG): Government of Alberta ministry responsible for the operation of provincial correctional services, including all provincial adult and young offender correctional centres.

MOH: Medical Officer of Health.

MOH designate: Someone in Public Health designated by the zone MOH to act on behalf of the zone MOH for the purpose of outbreak management. The MOH may designate the zone Outbreak Response Lead or other Public Health personnel to fulfill this role.

Occupational Health and Safety JSG: Provincial department within the Justice Ministry providing occupational health and safety services to JSG employees. **See also:** [Joint Worksite Health and Safety Committee](#).

Offender: An individual serving an open or secure custody sentence in a provincial adult or young offender correctional centre. For the purposes of this document, the term offender is also used to describe inmates who are remanded into custody and not sentenced.

Offender Identification Number: A unique identifier assigned to offenders housed in provincial correctional centres. The identifier links the offender to information stored in the Offender Records and Correctional Administration (ORCA) system. This unique identifier is referred to as an “ORCA number” and links the offender to information on demographics, admissions, movements, charges and releases.

Outbreak: A distribution of cases of a communicable disease that is unusual in terms of time, place or persons affected.

Outbreak Management Team (OMT): A group of key individuals including, but not limited to, representatives from AHS Correctional Healthcare Site Management, Public Health, Infection Prevention and Control, Workplace Health and Safety and Justice and Solicitor General who work

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cooperatively to ensure a timely and coordinated response to a suspect or confirmed outbreak. Specific composition of the OMT will depend on disease and provincial correctional centre type.

Outbreak Response Lead: Public Health representative specializing in Communicable Diseases or a zone Environmental Health Officer working with and on behalf of the zone MOH.

Patient: For the purpose of this document, a patient refers to an offender during the time that he or she is receiving health services in a provincial correctional centre.

PPE: Personal Protective Equipment.

Public Health: For the purpose of this document, Public Health encompasses the zone Medical Officer of Health, Outbreak Response Lead or a Public Health designate who provides consultation and leadership in outbreak investigations occurring in the community and in public or healthcare facilities.

Public Health Laboratories: Provincial Laboratory for Public Health (Formerly called ProvLab).

Relapse Case: GI illness cases frequently “relapse,” i.e., 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.

Site Health Services Manager or designate: Key AHS Correctional Health Services position holding responsibility for the daily operation of health services within a provincial correctional centre including supervision of nursing and support staff and facilitation of the implementation of changes to structure, process & procedures as required. This person also generally functions as the main point of contact for health services concerns and requests from JSG leadership within the centre.

Workplace Health and Safety (WHS) (AHS): A team of professionals involved in occupational health training, consulting, and program development to support the protection and promotion of physical safety and overall well-being of AHS employees.

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Table 1: AHS Zone Public Health contacts (regular and after hours)

AHS Zone	Service Area and Centres	Regular Hours			After Hours and Holidays
		Business hours may vary slightly from Zone to Zone, but are typically 8:30 am – 4:30 pm			
Zone 1 - South	Lethbridge Correctional Centre	Influenza Like Illness (ILI)	Infection Prevention & Control	403-388-6169	(403) 388-6111 Chinook Regional Hospital Switchboard For MOH On-Call
	Medicine Hat Remand Centre	Gastrointestinal Illness (GI)			
Zone 2 - Calgary	Calgary Correctional Centre	Influenza Like Illness (ILI)	CDC Intake	403-955-6750	(403) 264-5615 MOH On-Call
	Calgary Remand Centre	Gastrointestinal Illness (GI)	EPH Disease Control	403-943-2400	
	Calgary Young Offender Centre				
Zone 3 - Central	Red Deer Remand Centre	Influenza Like Illness (ILI)	CDC Intake	403-356-6420	(403) 391-8027 CDC On-Call
		Gastrointestinal Illness (GI)	24 Hour Intake	1-866-654-7890	1-866-654-7890
Zone 4 - Edmonton	Edmonton Remand Centre	Influenza Like Illness (ILI)	CDC Intake Pager	780-445-7226	(780) 433-3940 MOH On-Call
	Edmonton Young Offender Centre	Gastrointestinal Illness (GI)	EPH		
	Fort Saskatchewan Correctional Centre				
Zone 5 - North	Peace River Correctional Centre	Influenza Like Illness (ILI)	CDC Intake	1-855-513-7530	1-800-732-8981 Public Health On-Call
		Gastrointestinal Illness (GI)	EPH		

For the Correctional Centre contact list, See [Appendix 29](#)

Section I - General Guidelines for Outbreak Management

1.0 Principles of Outbreak Management

1.1 Surveillance

The Site Health Services Manager or designate and frontline Correctional Health Services clinical staff should conduct ongoing surveillance and monitoring for unusual clusters of illness in offenders and staff to identify possible outbreaks. Surveillance takes place prior to, during and after outbreaks.

1.2 Assessment

Individual cases must be assessed by frontline Correctional Health Services clinical staff to confirm that the illness meets the ILI or GI case definitions outlined in this document. See [Table 2](#) and [Table 3](#).

1.3 Outbreak identification

For ILI and GI illness, Site Health Services Manager or designate must confirm that the outbreak definition criteria outlined in [Table 2](#) and [Table 3](#) are met.

1.4 Notification

With any suspected or confirmed outbreak in a correctional centre, the Site Health Services Manager or designate must immediately notify the Office of the zone Medical Officer of Health. See [Table 1: AHS Zone Public Health Contacts \(regular and after hours\)](#). It is the responsibility of the zone Medical Officer of Health to declare an outbreak and to recommend site restrictions.

When Public Health is investigating or has declared an outbreak, the site health services manager or designate must also immediately notify the:

- Director of the Correctional Centre (JSG) or Shift Manager
- Facilities Medical Director, Correctional Health
- Designated AHS Site Infection Control Professional (ICP)
- Designated AHS Site Workplace Health and Safety (WHS) representative
- Director, AHS Correctional Health

Refer to [Figure 3: Correctional health services outbreak notification algorithm](#)

1.5 Communication

The Site Health Services Manager or designate will act as a primary point of contact for Public Health regarding the outbreak investigation. Once an outbreak has been identified, an Outbreak Management Team (OMT) may be convened by the Site Health Services Manager to further facilitate coordination and communication between stakeholders.

In the absence of an OMT, the Site Health Services Manager or designate will be responsible to facilitate communication of information regarding the outbreak investigation and recommendations for outbreak control from Public Health to frontline Correctional Health Services staff and JSG operational leadership.

1.6 Outbreak control and management

Under the direction of the OMT, the site will implement initial and ongoing outbreak control strategies including as detailed in these guidelines.

1.7 Monitoring outbreak status

The Site Health Services Manager or designate is responsible to communicate and track outbreak status by completing and submitting case listings as directed by Public Health.

1.8 Declaring outbreak over and evaluation

An outbreak can only be declared over by AHS Public Health. Following an outbreak, key Correctional Health Services leads need to review and evaluate their role in the outbreak management and revise protocols where necessary for improvement.

A post-outbreak debriefing may be called by any member of the Outbreak Management Team (OMT) to address outbreak management issues. Depending on type and scale of the outbreak, a summary report including background, details of the investigation, results and recommendations may be written by a member of the and shared with internal/external partners.

2.0 Roles and Responsibilities

The model for outbreak management in Correctional Health is unique due to the shared responsibilities of AHS and JSG. A collaborative approach is required to ensure effective prevention and successful management of outbreaks in correctional facilities.

2.1 AHS Public Health / Office of the Zone Medical Officer of Health

As stated in the Public Health Act Sections 26 and 29, the MOH is responsible for management of outbreaks within his or her health region boundaries. For that reason, the office of the zone MOH (Public Health) must be notified immediately to initiate the outbreak investigation and provide direction on outbreak control measures.

See [Table 1: AHS Zone Public Health Contacts \(regular and after hours\)](#). The office of the zone MOH (Public Health) will also be responsible to coordinate outbreak investigation with the Public Health Laboratories including obtaining an exposure investigation number (EI#) and determining specimen type and testing appropriate for the outbreak.

2.2 Correctional Health Services

Correctional Health Services will oversee the clinical management of outbreak cases and provide leadership to coordinate a uniform approach between AHS and JSG for outbreak prevention, control and management in the correctional centre. The Site Health Services Manager will act as a liaison between JSG and other AHS departments including Public Health, Infection Prevention & Control and Workplace Health & Safety. All Correctional Health professionals are expected to be key collaborators in the planning, prevention and implementation process for outbreak management.

2.3 Justice and Solicitor General (JSG)

Outbreak management measures affecting facility operations such as security will be implemented in consultation with JSG site leadership.

If applicable, JSG officials will be responsible to implement measures involving the restriction of movement within the centre; placement and cohorting of offenders; procedure changes in admission; transfer or discharge of offenders; exclusion of ill JSG employees from work; restrictions on outside visitors; environmental cleaning and any other facility or security related matters.

2.4 Outbreak Management Team (OMT)

If activated, an OMT will function as an overall coordinating body for outbreak management. The decision to activate an OMT will be made by the Site Health Services Manager, in consultation with Public Health. In a correctional centre, the OMT will usually consist of the following members. See [Appendix 1: Position Checklist for Site Health Services Manager or designate](#):

- JSG Centre Director (or designate)
- Site Infection Control Professional and/or IPC Medical Lead;
- Correctional Health Director;
- Public Health Outbreak Response Lead (zone MOH or designate);
- Centre Physician/Nurse Practitioner and/or Facilities Medical Director;
- Occupational Health Nurse (WHS);
- JSG Occupational Health and Safety Advisor (or designate);
- Clinical Nurse Educator/Nurse Clinical/Assistant Head Nurse.

3.0 Case and Outbreak Definitions

Early recognition of suspected outbreaks is important. Ongoing surveillance of offenders and staff should be conducted using a standard definition for early detection of unusual clusters of Influenza-like (ILI) or gastrointestinal (GI) illnesses within correctional centres.

National and Provincial case and outbreak definitions of ILI and GI illness are provided below in [Table 2](#) and [Table 3](#). For both types of illness, there must be evidence of transmission *within* the correctional centre to meet outbreak criteria. In the event that the epidemiological link between an unusual cluster of cases is difficult to identify, the Site Health Services Manager or designate should consult with the zone MOH for direction.

Table 2: Influenza-like illness (adapted from PHAC FluWatch definition)

ILI Case Definition*	ILI Outbreak Definition (Hospitals and Residential Institutions)
<p>Acute onset of respiratory illness with fever and cough and with one or more of the following:</p> <ul style="list-style-type: none"> ○ Sore throat ○ Joint pain (arthralgia) ○ Muscle aches (myalgia) ○ Severe exhaustion (prostration) which is likely due to influenza. In children under age 5, gastrointestinal symptoms may also be present. In patients under age 5 or 65 years and older, fever may not be prominent. 	<p>Two or more cases of ILI within a seven day period, with a common epidemiological link, e.g., same location or same caregiver, and evidence of healthcare-associated transmission within the unit or facility), of which at least one is a laboratory confirmed case.</p> <p><i>In practice, AHS uses an adapted ILI outbreak definition whereby there is no requirement for a laboratory confirmed case.</i></p>

Figure 1: Influenza-like illness algorithm

<http://www.ahsweb.ca/ipc/tms-corr-ili-algorithm-z0-corr-outbreak-mgmt>

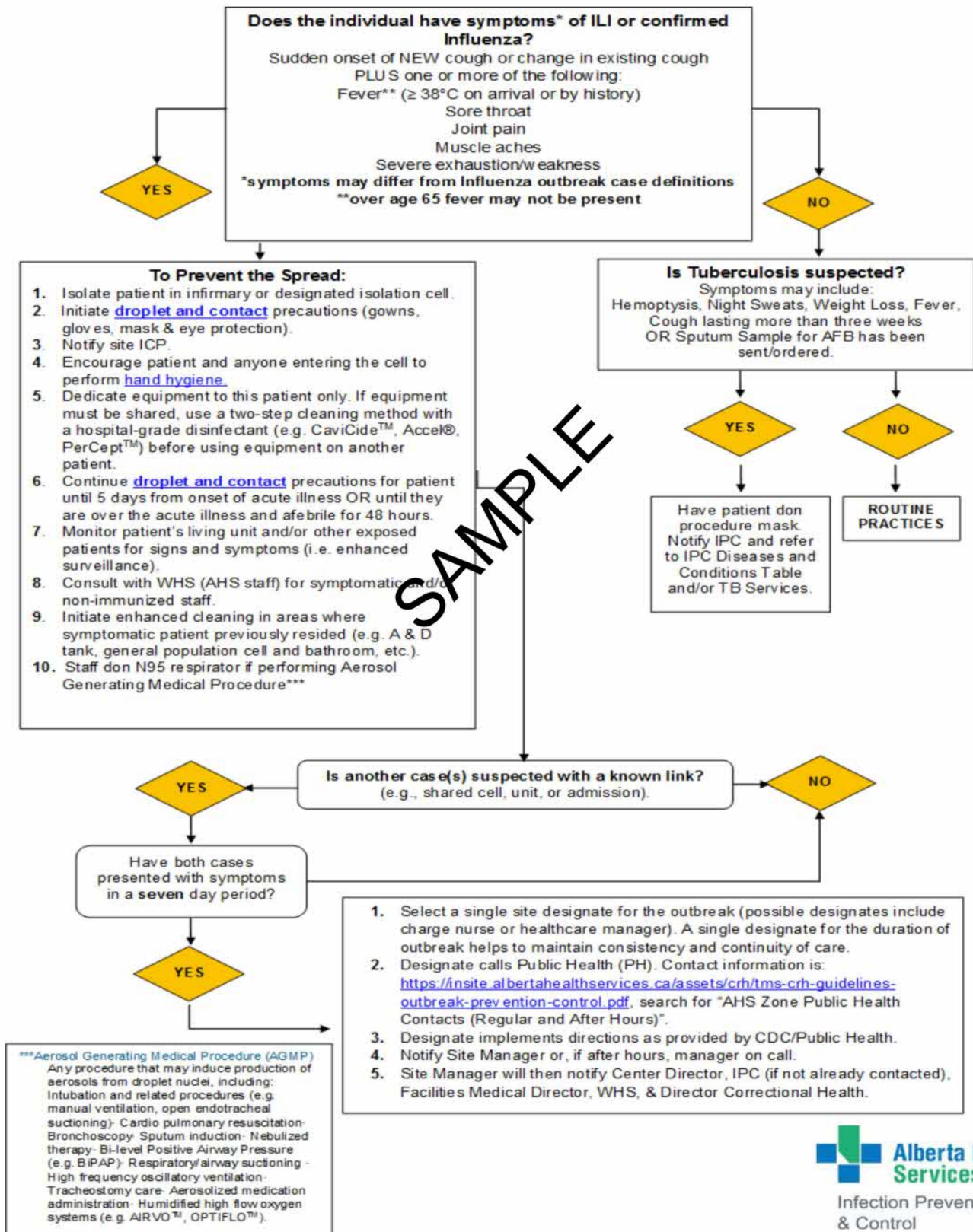


Table 3: Gastrointestinal (GI) illness definitions

Gastrointestinal (GI) Illness Case Definition	GI Outbreak Definition
<p>At least ONE of the following criteria must be met and not be attributed to another cause (e.g., <i>Clostridium difficile</i> associated diarrhea, medication, laxatives, diet or prior medical condition, etc.):</p> <p style="padding-left: 40px;">2 or more episodes of diarrhea (i.e., loose or watery stools) in a 24 hr. period above what is normally expected for that individual.</p> <p>OR</p> <p style="padding-left: 40px;">2 or more episodes of vomiting in a 24 hr. period.</p> <p>OR</p> <p style="padding-left: 40px;">1 or more episodes of vomiting AND diarrhea in a 24 hr. period.</p> <p>OR</p> <p style="padding-left: 40px;">Positive stool culture of a known enteric pathogen AND at least one symptom compatible with a GI infection e.g., nausea, vomiting, diarrhea, abdominal pain or tenderness.</p> <p>OR</p> <p style="padding-left: 40px;">One episode of bloody diarrhea</p>	<p>2 or more cases (with initial onset within one 48 hour period) of GI illness with a common epidemiological link*</p>

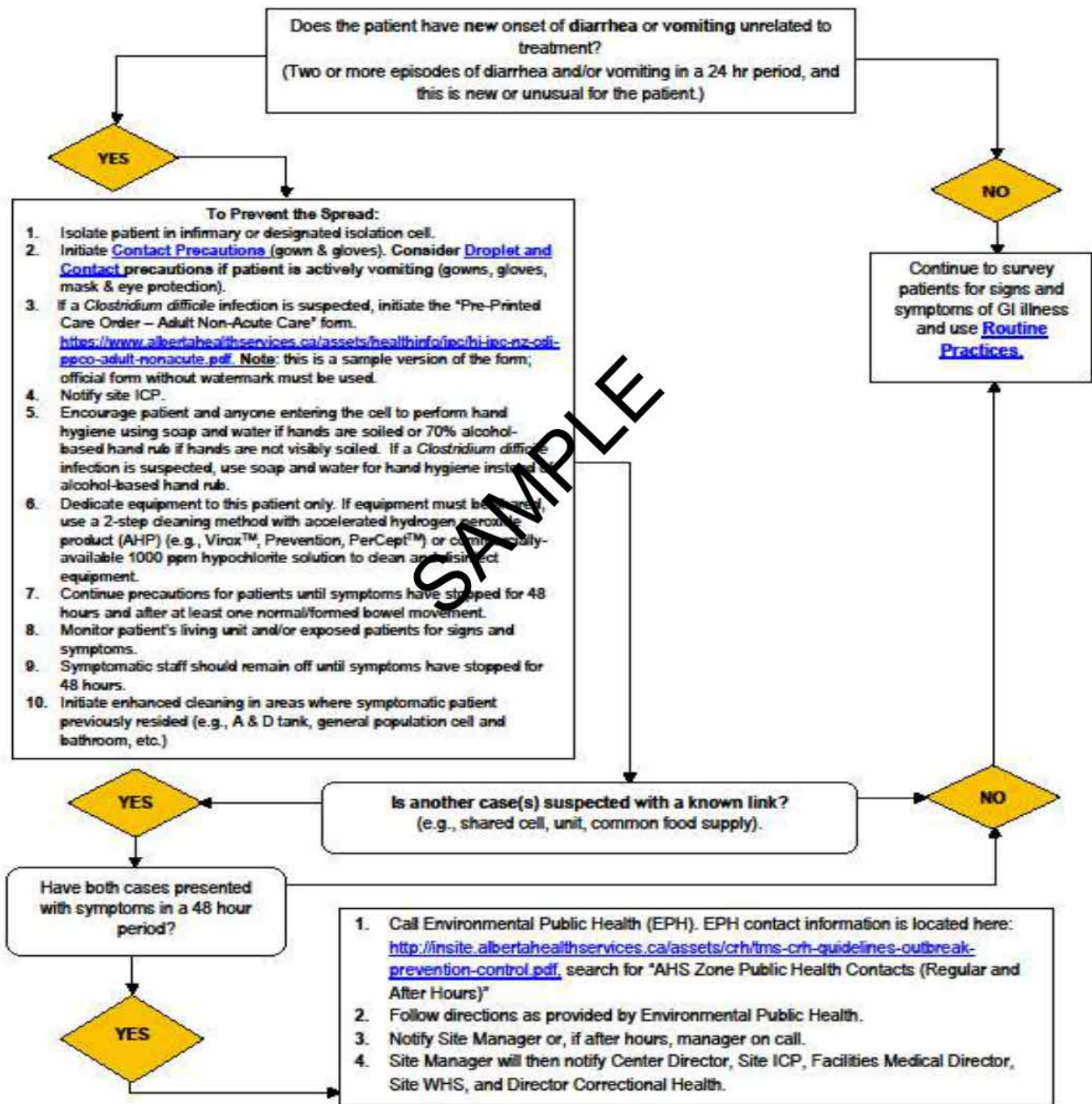
*Epidemiological links for GI illness in the correctional environment may include: common food supply, same admission date, court date or transport load, shared cell or unit at any time within the centre or prior to admission in police holding cells, attendance at same educational or work program, visit to healthcare on the same day and any other possible contact, as applicable.

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Figure 2: Gastrointestinal illness algorithm

<http://www.ahsweb.ca/ipc/tms-corr-gastro-illness-algorithm-z0-corr-outbreak-mgmt>

This document's content is based on the Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Centres which can be accessed here: <http://www.ahsweb.ca/ipc/tms-corr-guide-outbreak-prevention-z0-outbreak-mgmt>



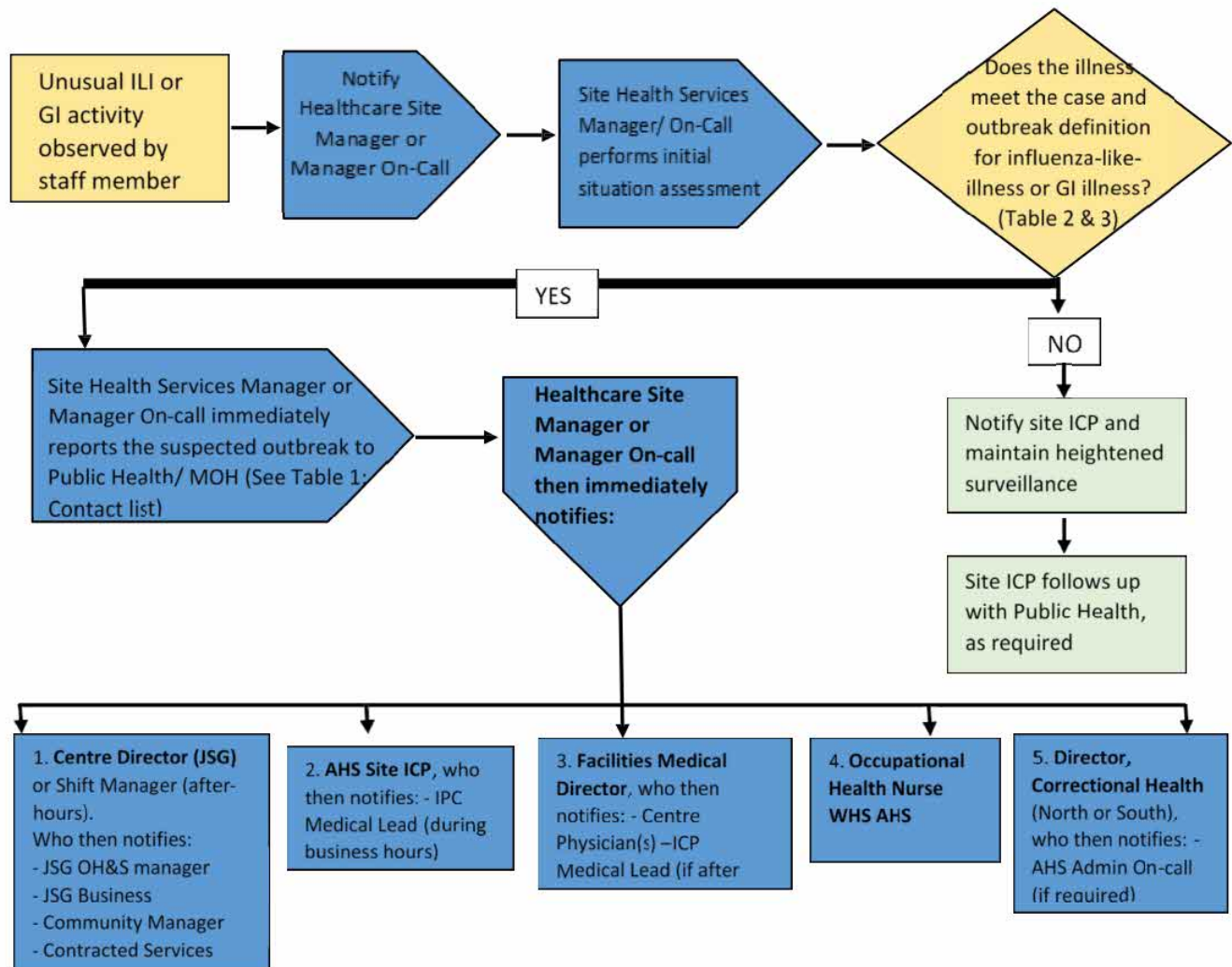
4.0 Reporting a Suspected Outbreak

Prompt reporting of outbreaks permits early identification and intervention to interrupt transmission, reducing morbidity and mortality.

In order to initiate an outbreak investigation promptly, clinical frontline staff should be educated to monitor the offender population for unusual GI or ILI activity and immediately report any suspected outbreaks to the Site Health Services Manager, designate or Health Services Manager On-call. After reviewing outbreak cases and other relevant clinical information, the Site Health Services Manager, designate or Health Services Manager on-call must then initiate the outbreak notification process as indicated below.

In the event that an outbreak is suspected, it should be reported immediately. See [Table 1: AHS Zone Public Health Contacts \(regular and after hours\)](#). The Site Health Services Manager or designate or Health Services Manager on-call will be responsible for initial and ongoing reporting of outbreak information from the centre. See [Appendix 10: How to Complete a Case Listing during an Outbreak](#); [Appendix 11: Respiratory Outbreak Case Listing - Correction Health Services](#) and [Appendix 12: Gastrointestinal Illness Outbreak Case Listing – Correctional Health Services](#).

Figure 3: Correctional health services outbreak notification algorithm



*There is a 24-hour on-call service for contacting an AHS Occupational Health Nurse; Page 1-855-450-3619 and enter the extension for appropriate zone. For AHS employees only.

5.0 Initial Infection Prevention and Control Measures

Based on the type of illness presenting (ILI or GI), implement the initial measures outlined below as soon as an outbreak is suspected to help reduce the spread of infection. It is not necessary to wait until the causative agent is identified before implementing enhanced IPC measures.

Routine practices help prevent the spread of infection and reduce the possibility that HCWs will sustain accidental exposure to infectious organisms. Routine practices are used for every patient, every time, regardless of their diagnosis or infectious status.

Routine practices reduce the spread of organisms and potential exposures to infectious organisms. Use of routine practices is the expected standard of care at all times in all healthcare settings.

Additional precautions such as droplet and contact precautions are determined by the presenting symptoms and type of outbreak. See [Table 4: Outbreak management, routine practices and additional precautions](#). Units experiencing an outbreak must implement additional IPC precautions to the extent that resources are available, (e.g., private cells with washroom facilities, isolation areas, housekeeping procedures and staffing patterns).

5.1 Strict hand hygiene is the most important measure in preventing spread of infections

- Hand hygiene should be performed in accordance with the AHS Hand Hygiene Policy:
- <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-hand-hygiene-ps-02-policy.pdf>
and
- Procedures: <https://extranet.ahsnet.ca/teams/policydocuments/1/clp-hand-hygiene-ps-02-01-procedure.pdf> which provides direction on product selection, location, and use.
- Alcohol-based hand rubs containing a minimum of 70% alcohol are as effective as soap and water when hands are not visibly soiled. They should be clearly labeled with a DIN, or claim as being effective and used prior to expiry date. Patient use should be monitored due to ingestion risk.
- Wash hands with soap and water when:
 - hands are visibly soiled;
 - after removal of gloves when caring for a patient that has diarrhea and/or vomiting.
- Glove use is not a substitute for hand hygiene; hand washing is needed before use and after glove removal.
- Frequent and thorough hand hygiene should be performed by both staff and patients.
- Hand hygiene is required:
 - before providing care to patients;
 - after providing care to patients and in between tasks on same patient;

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- after touching used patient care equipment;
- after touching soiled environmental surfaces.
- Assist the patient with hand hygiene if required.

5.2 Enhanced environmental cleaning measures

- Thorough cleaning and disinfection of frequently touched (high touch) surfaces and equipment can assist in disrupting disease transmission.
- High touch surfaces must be cleaned and disinfected frequently during an outbreak, i.e., if surfaces are being cleaned once this should be increased to more than once a day and as needed.
- Equipment should be cleaned and disinfected with products listed by its manufacturer.
- Cleaning and disinfecting refers to a two-step process i.e., must clean before disinfecting. Where a surface disinfectant claims to have both cleaning and disinfecting properties the product may be used for both steps.
- During ILI outbreaks, using a facility approved disinfectant may be sufficient; however, for GI outbreaks products must have a label claim against Norovirus with a DIN. Where a facility is experiencing both ILI and GI outbreaks it is imperative that a product with a label claim against Norovirus be used.
- When a patient is taken off isolation, the patient's cell and any other areas the patient had contact with should be thoroughly cleaned and disinfected.
- At the end of the outbreak, a thorough cleaning and disinfection of the affected unit should be completed including cells, holding tanks, shared toilet and shower areas and any high-touch surfaces.
- The OMT is responsible to coordinate the conduct of enhanced cleaning during and after the outbreak.

Note:

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.

Confirmed influenza outbreak and GI specific cleaning and disinfection information is provided in their respective sections within this document.

Consult with IPC for assistance with IPC issues.

5.3 Placement and restriction of symptomatic offenders

- Symptomatic offenders should be placed in dedicated isolation cells, single bunked, or alternatively, cohorted with symptomatic offenders infected with the same microorganism. See Corrections Cohorting document <https://insite.albertahealthservices.ca/main/assets/tms/ipc/tms-ipc-corr-additional-precautions-managment.pdf>. Cohorting of symptomatic offenders should be in

consultation with Infection Prevention and Control and the office of the zone MOH.

- Symptomatic offenders should remain in their cells as much as possible with their meals and medication served to them.
- The site health services manager or designate will provide recommendations to JSG on restricting movement of symptomatic offenders outside of the centre, including scheduled transfers to other centres and advising sentence administration if court hearings are scheduled during the period of isolation.

5.4 Refer to [Appendix 28: Court Cancellation Outbreak Letter for a template](#) to provide to JSG when recommending cancellation or postponing court appearances. Signage should be placed on the symptomatic offenders' cells indicating the additional precautions required. Infection Prevention and Control signage is available here: <https://www.albertahealthservices.ca/info/Page11362.aspx>

Note:

For symptomatic patients, if influenza is suspected, see early treatment recommendations in [Appendix 23: At-risk Criteria for Antiviral Chemoprophylaxis](#).

5.5 Specimen collection for ILI outbreaks

- Respiratory specimens for the purpose of outbreak investigation should be collected only after an EI number has been issued as directed by the Outbreak Response Lead. Specimen collection guidelines for detection of respiratory infections can be found in [Appendix 18: Nasopharyngeal \(NP\) and Throat Swab Specimen Collection Guidelines](#).
- General guidelines for completing a Public Health Laboratories test request for the purpose of outbreak investigation can be found in [Appendix 20](#) and sample requisition can be found in [Appendix 21: Public Health Laboratories Sample Requisition](#).

5.6 Other respiratory organisms commonly associated with ILI

- In addition to influenza A and B, there are other respiratory organisms commonly associated with Influenza-like-illness (e.g., RSV, parainfluenza, human metapneumovirus, coronavirus) and these are summarized in [Appendix 17](#). Additional precautions should be maintained until the results of the respiratory panel are final as recommended for other respiratory viruses in [Table 4](#) and in [Appendix 17](#).
- In the event that the outbreak is confirmed to be an organism other than influenza, appropriate infection control practices and additional precautions will be reviewed by the zone MOH at the time the outbreak is confirmed. Antiviral chemoprophylaxis is currently not recommended for organisms other than confirmed Influenza A or B. Depending on the circumstances, other recommendations for outbreak management and control, including facility

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restrictions, may be made by Public Health at the time of the outbreak.

5.7 Staffing

- Symptomatic AHS and JSG staff should be excluded from working. See 6.8 Staff Related Outbreak Control Measures for ILI and Control Measures for GI Illness.
- Where possible, AHS and JSG staff should be cohorted to care for either symptomatic or asymptomatic patients. For example, a nurse assigned to care for patients in a symptomatic isolation unit should not also be assigned to general population medication rounds. Alternatively, staff should be assigned to care first for asymptomatic offenders and then symptomatic offenders.
- During an influenza outbreak, staff immunized with the current seasonal influenza vaccine may be assigned to care for symptomatic patients.
- If Occupational Health and Safety questions arise from Justice and Solicitor General, these should first be directed to JSG OHS. AHS Infection Control Professionals and AHS Occupational Health Nurses cannot address issues dealing with JSG employees as this is beyond the scope of their responsibilities.
- It is the responsibility of the individual who works in more than one facility/unit to inform the alternate facility/unit that an influenza outbreak is in progress in the index facility, and determine whether or not they are permitted to work at the alternate facility/unit.
- If ILI or influenza occurs in a HCW during a confirmed influenza outbreak at their worksite, assess whether they were at work during their incubation period.

5.8 Group activities: Offender work and education programs

- For both GI and ILI outbreak investigations, the zone MOH/ Outbreak lead will advise the Site Health Services Manager or designate if offender work/education programs and other group activities should be suspended. These restrictions will be implemented in consultation with JSG. If group activities are an essential part of treatment, discuss with zone MOH/Outbreak lead.

5.9 Communication

- The Site Health Services Manager or designate will be the primary point of contact for Public Health to disseminate information and recommendations regarding the outbreak to JSG and frontline health services staff.
- Formal communication between the Site Health Services Manager or designate and JSG through the duration of the outbreak will be facilitated by Site Health Services Manager or designate attendance at daily JSG leadership meetings and

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JSG shift changeover briefings. Healthcare briefings should include the following information:

- Outbreak investigation status;
 - Isolation units/areas;
 - Restriction of symptomatic offenders/activities;
 - Recommendations relating to court attendances, inmate movements, transfers and visitor restrictions;
 - Routine and enhanced practices.
- The Outbreak Management Team (OMT), if activated, will also function to facilitate communication between Public Health, Correctional Health Services and JSG. Composition of the OMT will vary by centre. See 2.4 Outbreak Management Team.
 - In the event that media attention has occurred or is expected, all healthcare related inquiries will be directed to:
AHS Media Relations: <https://www.albertahealthservices.ca/about/Page265.aspx>
and
 - Facility and security-related inquiries will be directed to JSG Media Relations: <https://www.alberta.ca/justice-and-solicitor-general.aspx>.

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Table 4: Outbreak management, routine practices and additional precautions

Practice		Influenza-Like-Illness	GI Illness
Offender placement and signage		<ul style="list-style-type: none"> Isolate or Single-bunk Maintain a distance of two (2) metres between offenders 	<ul style="list-style-type: none"> Isolate or Single-bunk Maintain a distance of one (1) metre between bedspaces
Hand hygiene		<p>Strict hand hygiene is the most important measure in preventing spread of infections. Hand hygiene refers to washing hands with soap and water (where available or when hands are visibly soiled) or the use of alcohol-based hand sanitizer for a minimum of 15 seconds of wet (contact) time. Perform hand hygiene:</p> <ul style="list-style-type: none"> before direct contact with patient; before leaving patient's room or bed space; before donning and after doffing PPE, including gloves; before an aseptic procedure or after touching blood or body fluids. 	
Personal Protective Equipment (PPE)	Gloves	<ul style="list-style-type: none"> Wear non-sterile gloves on entry into an offender cell or bed space during any patient encounter (including gathering/handling of specimens). 	<ul style="list-style-type: none"> Use routine practices for protection from bodily fluids.
	Gown	<ul style="list-style-type: none"> Gowns are worn to protect clothing and exposed skin (i.e. forearms) of the healthcare worker during direct patient contact. Gowns must be single use, long-sleeved, cuffed at the wrist and tied at the back. 	
	Procedure/surgical mask	<ul style="list-style-type: none"> Wear procedure/surgical mask for any encounter, within two (2) metres of an offender who has, or is suspected of having ILI. 	
	N95 respirator (fit tested)	<ul style="list-style-type: none"> Don an N95 mask for a Point-of-care encounter with a combative/non-compliant offender or a patient undergoing aerosol generating medical procedures (AGMP). 	
	Eye protection	<ul style="list-style-type: none"> Eye protection should always be worn whenever a procedure mask or N95 mask is indicated. Single use equipment is preferred. Reusable goggles must be cleaned and disinfected between users. *Personal (prescription) eyewear does not provide adequate protection*. 	
Patient care equipment		<ul style="list-style-type: none"> Dedicate patient care equipment to a single patient or clean and disinfect after each use. 	
Offender transport		<ul style="list-style-type: none"> Transport for essential purposes only Site Health Services Manager or designate must notify transporting personnel (EMS, Sheriffs, Police, etc.) and receiving facility of outbreak. 	<ul style="list-style-type: none"> Enhanced environmental cleaning of JSG transport vehicles after transport¹
		<ul style="list-style-type: none"> Offenders must wear a procedure mask during transport. If offender is non-compliant, AHS recommends that escorting personnel don full PPE including gloves, gown¹, N95 mask and eye protection. 	

Alternatively, clothes should be changed and laundered post-transport if a gown cannot be worn due to security concerns.

Section II - Outbreak Control Strategies for Influenza-like Illness (ILI)

6.0 ILI and Case Outbreak Definitions

6.1 Case definition

- The symptoms of influenza disease are the same as the symptoms for many other respiratory illnesses; therefore, the ILI case definition is used to identify potential influenza cases as well as other respiratory illness cases. For ease of reference, ILI case definition is repeated here from Section 3.0.
- The following is the National ILI case definition (adapted from PHAC FluWatch, at time of review). In practice, each centre should follow the recommendations of their zone MOH to facilitate early recognition and reporting of unusual ILI activity and implementing appropriate infection control measures. Some zones may choose to use a more sensitive case definition.

Table 5: Influenza case and outbreak definition

ILI Case Definition*	ILI Outbreak Definition (Hospitals and Residential Institutions)
<p>Acute onset of respiratory illness with fever and cough and with one or more of the following:</p> <ul style="list-style-type: none"> ○ Sore throat ○ Joint pain (arthralgia) ○ Muscle aches (myalgia) ○ Severe exhaustion (prostration) <p>which is likely due to influenza. In children under age 5, gastrointestinal symptoms may also be present. In patients under age 5 or 65 years and older, fever may not be prominent.</p>	<p>Two or more cases of ILI within a seven day period, with a common epidemiological link, e.g., same location or same caregiver, and evidence of healthcare-associated transmission within the unit or facility), of which at least one is a laboratory confirmed case.</p> <p><i>In practice, AHS uses an adapted ILI outbreak definition whereby there is no requirement for a laboratory confirmed case.</i></p>

6.2 Infection prevention and control measures for influenza outbreak

- Symptomatic offenders should be placed in dedicated isolation cells, single bunked, or alternatively, cohorted with symptomatic offenders infected with the same micro-organism. Cohorting of symptomatic offenders should be in consultation with Infection Prevention and Control and the office of the zone MOH.
- Initiate enhanced precautions (in addition to Routine Practices). Refer to [Table 4](#) or check the AHS website at <https://insite.albertahealthservices.ca/ipc/Page13668.aspx> for the most current recommendations.
- Place signage on the symptomatic offenders' cells indicating the precautions required. Infection Prevention and Control signage is available here: <https://insite.albertahealthservices.ca/ipc/Page13668.aspx>.

- Wear appropriate PPE as determined by the routine practices Point-of-care Risk Assessment.
- Advise JSG personnel handling soiled laundry that PPE (e.g., gowns, gloves) are required if there is a risk of contamination of employee clothing from body fluids or secretions. Alternatively, inmate cleaners should be provided a dedicated set of clothing and gloves that can be laundered afterwards (or disposable) to change into before returning to general population.
- The site health services manager or designate should consult Public Health and the site ICP before implementing or providing recommendations to JSG for any of the following complex outbreak management strategies, including:
 - Cohorting staff to affected areas if practical, or alternatively, assigning staff to care for asymptomatic offenders first and then for symptomatic offenders.
 - Restricting movement of staff, offenders or visitors between floors or units when there are unaffected areas of the centre.
 - Cohorting of offenders with the same symptoms or confirmed illness.
 - Cohorting of exposed asymptomatic offenders, (e.g., an offender who shared a cell with another offender with confirmed influenza may be cohorted separately from the general population).

6.2.1 Environmental cleaning for ILI outbreaks

- Request enhancements to environmental cleaning using a facility approved disinfectant. Remember that the thoroughness of cleaning is more important than the choice of disinfectant used.
 - The frequency of cleaning and disinfecting “high touch” surfaces, offender cells, care areas and common areas should be more than the minimum of once daily. Recommendations for enhanced cleaning may be made by the Office of the zone MOH.
 - Use a “wipe twice” procedure (2 step process) to clean and then disinfect surfaces, (i.e., wipe surfaces thoroughly to clean visible soiled material, then wipe again with a clean cloth saturated with disinfectant to disinfect).
 - Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak.

6.3 Administrative measures for influenza outbreaks

- Follow the established Outbreak Notification/Management Algorithm (**Table 1**) to ensure timely notification of appropriate personnel.
- Ensure adequate availability of all supplies (e.g., hand hygiene products, PPE, linen, lab testing supplies).
- Ensure health professionals maintain heightened surveillance to identify and report newly symptomatic offenders and staff. The Site Health Services Manager

or designate, in consultation with the OMT, must communicate to JSG clear guidelines for signs/symptoms to monitor for in the offender population.

- Public Health will require regular reporting from the centre (frequency of reporting will be directed by Public Health at the time of the outbreak). In coordination with JSG, the Site Health Services Manager or designate will be responsible to gather information required by Public Health. See [Appendix 10: How to Complete a Case Listing During an Outbreak](#) and [Appendix 11: Respiratory Outbreak Case Listing](#).
- Communicate with staff, offenders, families and visitors regarding Public Health recommendations for vaccination and where to obtain vaccination via posters, notifications from staff, etc.

6.4 Restrictions on affected correctional centres for influenza outbreak

- Facility restrictions during an influenza 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 JSG Centre Director in consultation with the Site Health Services Manager and Public Health as required.
- The scope of restrictions recommended by the zone MOH or MOH designate will typically be dependent on the extent of the outbreak activity within the correctional centre, the ability to cohort staff to affected areas, and severity of the outbreak (e.g., many offenders and staff affected with new cases continuing to develop despite implementation of control measures).

6.5 Offender movement and activities in influenza outbreaks

- Symptomatic offenders should remain in their cells as much as possible with meal and medication service provided to them until 5 days from the onset of acute illness, or until they are over their acute illness and have been afebrile (no fever) for 48 hours.
- Ill offenders should not participate in group activities.

Note:

- Procedure masks contain a metal nose strip that can be removed. This has been identified as a security concern with offender use. Manually removing the strip prior to offender use reduces the effectiveness of the mask in preventing disease transmission. Mask distribution and inventory must be controlled to ensure secure disposal after offender use. At this time, procedure masks without a metal nose strip are not available.
- New admissions to affected units are not recommended unless reviewed by Public Health or the site Infection Control Practitioner.

- If an outbreak is confined to a unit, asymptomatic offenders from that outbreak unit should remain in their own area to avoid contact with offenders in other units. Some exceptions may apply based on security concerns and will be determined by the JSG Centre Director in consultation with the Site Health Services Manager and Public Health as required.
- Symptomatic offenders must wear a procedure/surgical mask (as tolerated) when out of their cell.

6.6 Transfers from an outbreak correctional centre to an acute care site in influenza outbreak

- If an offender requires acute medical attention or treatment offsite (e.g., ED, Urgent Care), the Correctional Centre must notify the receiving facility and escorting personnel (EMS, sheriffs, police) that an offender is being transferred from a facility experiencing an influenza outbreak. The receiving facility can then ensure infection prevention and control measures are in place when the offender arrives at the hospital/treatment centre.
- Symptomatic offenders should wear a general procedure/surgical mask during transfer. If the offender is non-compliant with wearing a procedure mask during transport, escorting staff should don an N95 mask, eye protection, gloves and gown throughout the escort. In the event gown cannot be worn due to security concerns, the clothes of escorting personnel should be changed and laundered post-transport. Escorted staff should be provided with extra procedure/surgical masks so the mask can be changed if it becomes wet.

6.7 Visitors during influenza outbreak

- Advise those who choose to visit during an outbreak to practice good hand hygiene, visit one (1) individual only and exit the correctional centre immediately after the visit.
- Persons visiting ill offenders must follow the instructions of health professionals for use of PPE and hand hygiene.
- JSG has the authority to enforce a complete closure of personal offender visitation for the protection of staff and offenders during an outbreak. Public Health will support this decision in the event it is determined to be necessary to control the outbreak.

6.8 Staff related confirmed influenza outbreak control measures

- All staff should be strongly encouraged to receive annual immunization(s) for influenza when available.
- Confirm with Public Health to determine if the outbreak influenza strain is covered in the seasonal vaccine. At the onset of the outbreak, non-immunized staff should be encouraged to receive immunization at the earliest opportunity.
- Despite the effectiveness of most vaccines, there is a minority of people who may not

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be fully protected even after vaccination; therefore, vaccinated individuals need to continue daily self-assessment for ILI during influenza season. In addition, vaccinated individuals should continue to use PPE to protect against new strains of influenza virus and other infectious respiratory agents when providing care to symptomatic individuals during influenza outbreaks.

- If the outbreak strain is covered in the seasonal vaccine, the Site Health Services Manager or designate should consult with WHS to determine vaccination status of AHS employees.
- Vaccination status of JSG employees is not routinely tracked. In the event an outbreak is declared by the MOH, JSG employees can be required to disclose vaccination status under the Public Health Act. If this is required, vaccination status information will be collected by JSG OH&S.
- AHS and JSG staff should be advised of the need for daily self-assessment for ILI symptoms to prevent spread of influenza by not coming to work when ill.
- Whether related to workplace exposure, or exposure in the community or home, any AHS, JSG or contracted staff member who exhibits ILI symptoms during an influenza outbreak should report the illness to his or her supervisor, perform respiratory hygiene practices (e.g., coughing into sleeve, using tissues, wearing a mask) and leave the workplace as soon as possible.
- The length of time for which an ill worker should stay off work will be recommended by the zone MOH at the time of the outbreak. Generally, a person with influenza is infectious for an average of five (5) days.
- Symptoms such as cough may continue for longer than five (5) days; however, if an individual is otherwise healthy, he or she is not likely to continue to be infectious after five (5) days following onset of symptoms.
- AHS and JSG each maintain their own records of N95 fit testing status of employees. Consistent with the Point-of-care Risk Assessment for ILI, employees must be N95 fit tested before being assigned to perform aerosol generating procedures for symptomatic offenders or providing care to symptomatic offenders who are non-compliant with respiratory hygiene.
- Notify appropriate HCW/departments within the site/facility as indicated by internal protocols (e.g., administration, OHS/WHS, lab services, pharmacy, transition services and admitting). This includes identifying if there are any other professions working in the facility/on the outbreak unit that are not HCW (e.g., contracted service providers) and consulting with Public Health regarding appropriate recommendations for these groups.

6.9 Post-exposure immunization, antiviral prophylaxis and work restrictions

- In the event an influenza outbreak in a correctional facility cannot be managed adequately with the preceding outbreak control strategies, the MOH may recommend additional measures to decrease the risk of transmission, including antiviral prophylaxis and work restrictions.
- These measures will be implemented in consultation with the site Outbreak Management Team (OMT), and will take into consideration resources, staffing and other constraints at the time of the outbreak.
- In the event the MOH/OMT recommends implementation of post-exposure immunization, prophylaxis and/or work restrictions in designated affected areas, the following guidelines can be applied to all staff members working in affected areas including AHS, JSG and contracted employees.
- Asymptomatic staff who are not immunized, or those who have been immunized with inactivated influenza vaccine less than 14 days prior to the outbreak, may continue to work if they begin and continue antiviral prophylaxis until 14 days post-immunization, or for the duration of the outbreak (whichever period is shorter).
- Asymptomatic staff taking antiviral prophylaxis must be alert to signs and symptoms of ILI, especially within the first 48 hours after starting prophylaxis, and should be excluded from work in the affected area if symptoms develop.
- Staff members who are unable or unwilling to receive influenza vaccine can continue to work if they take antiviral prophylaxis for the duration of the outbreak. These individuals must be alert to signs and symptoms of ILI, especially within the first 48 hours after starting antiviral prophylaxis, and should be excluded from work in the affected area if symptoms develop.
- Refer to [Appendix 23: At-risk Criteria for Antiviral chemoprophylaxis](#) for general guidelines on the use of antiviral prophylaxis. For dosing information, refer to [Appendix 24: Antiviral \(Oseltamivir\) Dosing Recommendations](#)
- Refer to [Appendix 26: Daily Outbreak Update Template for Healthcare workers](#) for more information on how staff can be prescribed and receive antivirals.

6.10 Restriction from work

- Recommended work restrictions for AHS employees will be implemented by the Site Health Services Manager or designate in consultation with WHS and Public Health.
- Recommended work restrictions for JSG employees may be implemented by the centre director (JSG) in consultation with JSG OH&S and Public Health. Recommended work restrictions for contracted employees will be implemented by the centre director in consultation with the contracted employer.
- In the event that work restrictions will be applied, clear guidelines should be

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communicated to all staff, including when the restrictions are lifted. [Appendix 26: Daily Outbreak Update Template for Healthcare Workers](#) and [Appendix 27: Daily Outbreak Update Template for Security and Contracted Staff](#) may be used for this purpose.

- Symptomatic workers must remain restricted from work as recommended by the zone MOH at the time of the outbreak; generally a person with influenza is infectious for an average of five (5) days.
- Work restrictions for asymptomatic staff will be implemented in consultation with the site OMT (Outbreak Management Team as defined in Definition of Terms and Glossary), taking into consideration resources, staffing and other constraints at the time of the outbreak.
- Asymptomatic staff generally fall into three categories, each subject to work restrictions.
- Unimmunized staff who are asymptomatic and agree to be immunized, but decline prophylaxis should be:
 - Excluded from work for three (3) days from the last day of work on the outbreak unit.
 - If they remain asymptomatic after three (3) days, they may be reassigned to a non-outbreak unit or site for the duration of the outbreak or for fourteen (14) days from date of immunization whichever occurs first. If reassignment of work is not possible, then the staff should be excluded from work for 14 days from the time of immunization or for the duration of the outbreak, whichever occurs first.
- Asymptomatic staff who are not immunized and are not taking recommended antiviral prophylaxis should be:
 - Excluded from working in the affected unit(s)/site until the outbreak is over,
OR
 - Relocated to a non-outbreak unit/site if they remain asymptomatic after waiting three (3) days from the last day of work on the outbreak unit. Relocated staff should not return to the outbreak unit/site for the duration of the outbreak.
- Asymptomatic staff immunized less than fourteen (14) days prior to the outbreak and are not taking recommended antiviral prophylaxis should be:
 - Excluded from working in the affected unit/site until 14 days from date of immunization, or for the duration of the outbreak whichever occurs first,
OR
 - Excluded from working at any site for three (3) working days from the last day of work on the outbreak unit/site. If they remain asymptomatic after

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waiting three (3) working days they can be relocated to a non-outbreak unit until 14 days from the date of immunization or for the duration of the outbreak at the manager's discretion.

Note:

It is the responsibility of the individual who works in more than one facility/unit to inform the alternate facility/unit that an influenza outbreak is in progress in the index facility and determine whether or not they are permitted to work at the alternate facility/unit.

Section III - Outbreak Control Strategies for Gastrointestinal (GI) Illness

7.0 GI Illness and Case Outbreak Definitions

7.1 Outbreak control strategies for GI illness outbreaks

- Outbreaks of infectious GI illness in communal living facilities can result in high morbidity and a strain on operations. Typically, the majority of these outbreaks are attributable to norovirus (or viruses that cause similar illnesses, such as sapovirus, rotavirus, astrovirus or adenovirus).
- Norovirus is extremely communicable and outbreaks are common. Outbreaks can present in sporadic episodes, or as intensely concentrated events occurring all at once. Attack rates can be quite high (> 50%) in both staff and offenders. Although GI illness outbreaks in communal living facilities can occur at any time of year, in Alberta most outbreaks occur between October and April.
- Most GI illness cases are mild and self-limiting; however, serious dehydration and/or aspiration pneumonia secondary to vomiting can occur in debilitated individuals. Symptoms of GI illness include any combination of nausea, vomiting, diarrhea, and/or abdominal pain, which may be accompanied by myalgia, headache, low-grade fever, and malaise. An outbreak control program is aimed at early detection and elimination of any common sources of exposure.
- Despite stringent IPC measures, outbreak control can be difficult. It is vital that infection control measures are implemented promptly, without waiting for laboratory confirmation of an etiologic agent. Transmission usually occurs via the fecal/oral or vomitus/oral route, requiring contact precautions. In the case of active vomiting, contact and droplet precautions are required.

7.1 Infection prevention and control measures for GI illness outbreaks

- Consult with your site Infection Control Professional for assistance with IPC issues.
- Ensure adequate availability of all supplies needed for outbreak management (e.g., hand hygiene products, PPE, linen, laboratory testing supplies) through notification of appropriate departments.
- In addition to routine practices, implement contact precautions when providing direct care for symptomatic patients.
- Implement Contact and Droplet Precautions if patient is actively vomiting.
- Maintain at least one (1) metre of physical separation between bed spaces.

Note:

If contact precaution signage on cell doors is not routinely used in their centre, there must be an effective alternate method of communicating required precautions to security and healthcare staff.

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- Place signage on the patient's cell indicating that contact precautions or contact & droplet precautions are required. Infection Prevention and Control signage is available here: <https://insite.albertahealthservices.ca/ipc/Page13668.aspx>.
- **Don gloves to:**
 - enter patient cell or bed space;
 - provide direct care to symptomatic patients;
 - handle contaminated patient items in the cell;
 - clean an area contaminated with feces or vomitus;
 - gather/handle specimens.
- **Don gown to:**
 - enter patient cell or bed space;
 - provide direct care to symptomatic patients;
 - handle contaminated patient items in the cell;
 - clean areas contaminated with feces or vomitus to protect against possible contamination of clothing.
- **Don mask/face protection to:**
 - protect your face (eyes, nose & mouth) when there is any risk of sprays of body fluids;
 - care for patients who are actively vomiting.
- The site health services manager or designate should consult Public Health and the site ICP before implementing or providing recommendations to JSG for any of the following complex outbreak management strategies:
 - Staffing strategies including cohorting staff to affected areas if practical, or alternatively, assigning staff to care for asymptomatic offenders first and then for symptomatic offenders.
 - Restriction of movement of staff, offenders or visitors between floors or units when there are unaffected areas of the centre.
 - Cohorting of offenders with the same symptoms or confirmed illness
 - Offender who had been sharing a cell with another offender with GI illness symptoms may be cohorted separately from the general population.

Note:

All PPE must be removed and hand hygiene must be performed before leaving the patient's area.

7.2 Strict hand hygiene is the most important measure in preventing the spread of infections

- Soap and water is the appropriate method of hand hygiene if caring for an individual who is vomiting or has diarrhea
- Reinforce the need for frequent and thorough hand hygiene before and after providing care to patients and after touching used patient care equipment or soiled environmental surfaces.

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- Plain soap and water are recommended following glove removal when caring for patients with diarrhea and/or vomiting.
- Wash hands with soap and water if visibly soiled or if they feel dirty.
- For GI illness outbreaks, hand hygiene performed by food handlers is of particular importance, and should be stressed with food handling staff, including inmate kitchen workers (where applicable).

Statement on use of Alcohol-based Hand Rub during GI Illness Outbreaks

- Plain soap and water are recommended following glove removal when caring for patients with diarrhea and/or vomiting.
- Alcohol-based hand rubs (minimum 60-90% alcohol) are an acceptable **alternative** to hand washing during GI illness outbreaks, when used according to label directions.
- If hands are visibly soiled wash with soap and warm, running water.

7.3 Administrative measures for GI illness outbreaks

- Follow the established Outbreak Notification/Management Algorithm to ensure timely notification of appropriate personnel.
- Ensure adequate availability of supplies (e.g., hand hygiene products, PPE, linen).
- Ensure health professionals maintain heightened surveillance to identify and report newly symptomatic offenders and staff. The Site Health Services Manager or designate, in consultation with the OMT, must communicate to JSG clear guidelines for signs/symptoms to monitor for in the offender population.
- The Outbreak Response Lead should advise the Site Health Services Manager or designate of enhanced environmental cleaning of affected areas as outlined above and additionally as recommended by the zone MOH.
- In coordination with JSG, the Site Health Services Manager or designate will be responsible to gather outbreak reporting information required by Public Health. Frequency of reporting and information required will be directed by Public Health at the time of the outbreak. **See [Appendix 10: How to Complete a Case Listing during an Outbreak](#) and [Appendix 12: Gastrointestinal Illness Outbreak Case Listing – Correctional Health Services](#).**

7.4 Restrictions on affected correctional centres for GI illness outbreak

- Facility restrictions during a GI 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 JSG Centre Director in consultation with the Site Health Services Manager and Public Health as required.

- The scope of restrictions recommended by the zone MOH or MOH designate will typically be dependent on the extent of the outbreak activity within the correctional centre, the ability to cohort staff to affected areas, and severity of the outbreak (e.g., many offenders and staff affected with new cases continuing to develop despite implementation of control measures).

7.5 Food safety precautions

- Close the kitchen/nourishment areas accessed by inmates and ensure there is no communal sharing of food in outbreak areas.
- In discussion with Public Health, ensure that food handling staff practice meticulous hand hygiene and are excluded from work if symptomatic. See 5.6 Staffing.
- Use of disposable plates and cutlery by symptomatic patients/residents is not required for GI illness outbreak management.
- Normal dishwashing and food preparation area surface sanitizing practices are appropriate during GI outbreaks, i.e., no additional/different disinfection of dishes or surfaces in food preparation areas is needed over and above what is normally done.
- Ensure that all touch surfaces of the tables and chairs (including the underneath edge of the chair seat) are cleaned and disinfected after each use.
- Staff assigned to housekeeping duties should not be involved in food preparation or food service. Consult Public Health with any questions.

7.6 Offender movement and activities in GI illness outbreaks

- Symptomatic offenders should be isolated with meals and medication delivered to them for the duration of the acute illness, and until 48 hours after the last episode of vomiting or diarrhea.
- Ill offenders should not participate in group activities, including offender education and work programs.
- Offenders working in the kitchen (at applicable centres) must be advised to immediately report symptoms of GI illness in themselves. Ill kitchen workers must be immediately excluded from work.
- If an outbreak is confined to a unit, asymptomatic offenders should remain in that unit for the duration of the outbreak to avoid contact with offenders in other units. If asymptomatic offenders are transferred to a different unit for operational reasons, JSG should notify the Site Health Services Manager or designate to ensure that appropriate follow-up measures are implemented.

7.7 Transfers from an outbreak correctional centre to an acute care site in GI illness outbreak

- If an offender requires acute medical attention or treatment off site (e.g., ED, Urgent Care), the Correctional Centre must notify the receiving facility and EMS (if applicable) that an offender is being transferred from a facility experiencing a GI outbreak. The receiving facility can then ensure infection prevention and control measures are in place when the offender arrives at the hospital/treatment centre.
- Environmental cleaning of JSG escort vehicles should be enhanced after transporting a symptomatic offender.

7.8 Staff related GI illness outbreak control measures

- All staff, including contracted employees, should be advised to immediately report symptoms of GI illness in themselves to their supervisor.
- Symptomatic staff that fit the case definition for GI illness should be excluded from work until 48 hours following the last episode of vomiting and/or diarrhea.
- Staff should be cohorted to affected areas if practical, or assigned to care for asymptomatic offenders before symptomatic offenders.
- Consider minimizing movement of staff and offenders between floors/units, especially if some areas of the centre are not affected.
- Staff that have no gastrointestinal illness during the outbreak, or are free of vomiting and diarrhea for at least 48 hours, may return/continue to work at any other healthcare or correctional centre even if they are employed at a site with an ongoing GI illness outbreak.
- Staff with symptomatic household members can report to work, provided the staff member is asymptomatic and practices appropriate personal hygiene.
- Ensure that all staff, including contracted employees, are advised of relevant recommendations and work restrictions recommended by Public Health.
- Notify appropriate HCW/departments within the site/facility as indicated by internal protocols (e.g., administration, OHS/WHS, pharmacy, transition services and admitting). This includes identifying if there are any other professions working in the facility/on the outbreak unit that are not HCW (e.g., construction workers) and consulting with Public Health regarding appropriate recommendations for these groups.

7.9 Visitors during GI Illness outbreak

- Advise those who choose to visit during an outbreak to practice good hand hygiene, visit one (1) individual only and exit the correctional centre immediately after the visit.

- Persons visiting ill offenders must follow the instructions of health professionals for use of PPE and hand hygiene.
- Complete closure of visitation will generally not be recommended by Public Health since it may cause emotional hardship to offenders and families; however, if a Correctional Centre is having difficulty controlling an outbreak, Public Health will support the decision of JSG to limit visitors.

7.10 Environmental cleaning for GI illness outbreaks

- Environmental surfaces often become contaminated with feces or vomitus (and norovirus) during GI illness outbreaks. Thorough cleaning and disinfection can help interrupt disease transmission during GI illness outbreaks.

Recommended disinfectants for GI Illness Outbreaks

It should be emphasized that thoroughness of cleaning is more important in outbreak control than the choice of disinfectant used; however, based on study findings in the literature, effectiveness of norovirus inactivation varies by disinfectant category. Many disinfectants in wide use in AHS facilities have active ingredients known as quaternary ammonium compounds, or “quats.” Quats may not be effective for complete disinfection of surfaces contaminated with norovirus at the concentrations recommended for general disinfection by the manufacturer. AHS facilities should consider making disinfectants available that are known to be effective in inactivating norovirus (see below) during outbreak situations.

The following disinfectant categories/concentrations are recommended for disinfecting surfaces and equipment during GI illness outbreaks (follow manufacturer’s directions for use):

1. Hypochlorite at a concentration of 1000 parts-per-million. Commercially-available hypochlorite- containing solutions are recommended.
2. A surface disinfectant with a Drug Identification Number (DIN) issued by Health Canada with a specific label claim against norovirus, feline calicivirus or murine norovirus.

An example of a product with this label claim currently in wide use in AHS facilities is 0.5% accelerated hydrogen peroxide. There are other products available with this label claim.

Notes:

1. 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.
2. 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.

- Follow recommended cleaning and disinfection protocols, such as:
 - Immediately clean and disinfect areas soiled with emesis or fecal material.
 - Use fresh mop head, cloths, cleaning supplies and cleaning solutions to clean affected rooms, and after cleaning large spills of emesis or fecal material.
 - The frequency of cleaning and disinfecting “high touch” surfaces in living units, healthcare areas and common areas such as dining areas and recreation areas should be more than the minimum of once daily. Recommendations for enhanced cleaning may be made by the office of the zone MOH.

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- Frequently touched surfaces include, but are not limited to, commodes, toilets, faucets, railings, telephones, door handles, and computer equipment.
- Clean and disinfect shared patient care equipment (e.g., commodes, blood pressure cuffs, thermometers) prior to use by a different patient.
- Consider discarding all disposable patient-care items and laundering unused linens (e.g., towels, sheets) from offender cells when the isolation precautions for GI illness are lifted.
- Conduct a thorough, enhanced cleaning in all affected areas at the end of the outbreak.
- Staff and offenders involved in cleaning vomit or diarrhea should don PPE as required. Refer to AHS environmental cleaning protocols for specific guidelines. Refer to the IPC Corrections Routine Practices document for more information: <http://www.ahsweb.ca/ipc/hi-ipc-corr-routine-practices-info.pdf>.

7.11 Laundry considerations in GI illness outbreaks

- Appropriate PPE (e.g., gowns) should be worn if there is a risk of contamination of employee clothing from body fluids or secretions.
- Gloves are not needed to transport the laundry bag to the soiled laundry room.
- PPE including gloves should be removed and hands cleaned once soiled laundry has been placed in the laundry bag.
- All linen that is soiled with body fluids should be handled using the same precautions regardless of the source.
- Remove gross soiling (e.g. feces) with a gloved hand and dispose into toilet. Do not remove excrement by spraying with water.
- Bag or contain soiled laundry at point of origin (i.e., in the affected cell/unit).
- Do not sort or pre rinse soiled laundry on the unit.
- Handle soiled laundry with minimum agitation to avoid contamination of surfaces & people, (e.g., roll up).
- Contain wet laundry before placing it in a laundry bag (e.g., wrap in a dry sheet or towel).
- Double bagging is not necessary & not recommended.
- Laundry bags should be tied securely & not over-filled.
- Transport, wash and dry as per routine laundering practices.

7.12 Specimen collection in GI illness outbreaks

- Stool specimen results do not typically impact outbreak management strategies for GI illness outbreaks; however, from a public health perspective it is valuable to collect stool specimens from cases during outbreaks to try and identify the etiology, if possible. Stool specimens should be collected only after an EI number has been issued as directed by the Outbreak Response Lead. Typical GI illness outbreak stool specimen collection procedures can be found in [Appendix 19](#):

[Stool Specimen Collection Guidelines for GI Illness Outbreaks.](#)

- General guidelines for completing a Public Health Laboratories test request for the purpose of outbreak investigation can be found in [Appendix 21: Public Health Laboratories Sample requisition](#).

7.13 Management of “relapse” cases

- GI illness cases frequently “relapse,” i.e., 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.

AHS recommends that “relapse” GI illness cases:

- Be isolated until they are free of vomiting and diarrhea for 48 hours as they may still be infectious.
- Should NOT be counted as new outbreak cases (and should therefore NOT be included on daily case listings) - these are not new outbreak cases, and a patient should only be counted as a new case once on a daily case listing; therefore, relapse case(s) alone would not result in the extension of admission restrictions.

7.14 Heightened surveillance post-outbreak

- A 48-hour period from symptom resolution of the last case OR 96 hours from the onset date of the last case (whichever occurs first) is usually indicative of the end of a GI illness outbreak.
- It is strongly recommended that heightened GI illness surveillance be maintained for at least 72 hours after restrictions are lifted in the event that unrecognized transmission is occurring in the facility.
- Report any new cases during this period in the same manner that an outbreak is reported. The zone MOH will assess to determine if restrictions should again be implemented.

Note:

If a previously identified GI illness case has onset of GI illness symptoms after being symptom free for **at least seven (7) days**, it is considered a new case.

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Appendices

Appendix 1: Position Checklist for Site Health Services Manager or Designate

Note:

Appendix 1 – 9 Position Checklists are intended to be used as outbreak management tools as they are not all-inclusive lists of duties associated with Outbreak Management.

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with these Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Promote staff awareness of communicable disease outbreak procedures, existing outbreak definitions for ILI and GI cases and reporting protocols	Ongoing
<input type="checkbox"/> Maintain vigilance in identifying suspected individual cases of communicable disease, unusual clusters and suspected outbreaks.	Ongoing
Upon notification of a confirmed or suspected outbreak in the centre	
<input type="checkbox"/> Notify the Office of the Zone Medical Officer of Health. See Table 1: AHS Zone Public Health Contacts (regular and after hours) .	Immediate
<input type="checkbox"/> Notify, or assign someone to complete initial notification (as per Figure 3): <ul style="list-style-type: none"> ○ Centre Director or shift manager (JSG) ○ Site ICP ○ Facilities Medical Director ○ AHS WHS representative ○ Director ○ Correctional Health 	Immediate
<input type="checkbox"/> Direct the implementation of infection prevention and control measures immediately; do not wait until the etiology is confirmed. Ensure routine precautions are enhanced and collaborate with JSG to isolate confirmed or suspected ill offenders. Ensure appropriate signage (i.e., contact and droplet precautions) is posted to indicate IP&C measures. Signage is available here: https://insite.albertahealthservices.ca/ipc/Page13668.aspx .	Immediate
<input type="checkbox"/> Activate the Outbreak Management Team (OMT) if required and act as Chair of the OMT. Determine appropriate membership and schedule of ongoing meetings.	As required
<input type="checkbox"/> Develop an influenza response plan that details how antiviral prophylaxis will be implemented for patients and staff (if required).	As required
<input type="checkbox"/> Obtain reports on the clinical status of all affected individuals, and work with clinical staff to identify new cases.	Immediate
<input type="checkbox"/> Provide Public Health with relevant immunization status of patients.	As required
<input type="checkbox"/> Ensures proper collection of appropriate specimens as directed by Public Health, including using assigned EI# on all specimens, and makes own internal arrangements for transporting specimens to the lab. "Transportation of Dangerous Goods" protocols to be followed during	As required

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Task / Responsibility	Timeline / Frequency
transport	
<input type="checkbox"/> In consultation with the site ICP and WHS representative identify AHS personnel who are symptomatic or directly exposed to symptomatic Patients.	As required
<input type="checkbox"/> Gather reporting information from the centre as requested by Public Health. See Appendix 10: How to Complete a Case Listing during an Outbreak, Appendix 11: Respiratory Outbreak Case Listing and Appendix 12: Gastrointestinal Illness Outbreak Case Listing – Correctional Health Services.	Immediate
<input type="checkbox"/> In consultation with the site ICP and WHS representative, identify AHS personnel directly exposed to symptomatic patients.	Immediate
<input type="checkbox"/> Identify other individuals who may have been exposed (i.e. JSG staff, visitors, lawyers). Notify JSG Centre Director or OH&S as required.	Immediate
<input type="checkbox"/> Distribute daily reporting outbreak reporting memos to AHS and JSG staff using the templates provided in Appendix 26: Daily Outbreak Update Template for Healthcare Workers and Appendix 27: Daily Outbreak Update Template for Security and Contracted Staff .	Ongoing
<input type="checkbox"/> Anticipate resource needs (staffing, supplies, and equipment) required to manage the outbreak and initiate action to authorize and deploy required resources.	Ongoing
<input type="checkbox"/> In consultation with Public Health, review cases of ill or exposed offenders and collaborate with JSG to determine appropriate isolation or cohorting measures for offenders.	Ongoing
<input type="checkbox"/> Notify appropriate personnel (AHS and JSG) within the centre when the outbreak has been declared over.	Post-outbreak
<input type="checkbox"/> In consultation with the Centre Director and Provincial Director for AHS Corrections Health, initiate a post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post-outbreak

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Appendix 2: Position Checklist for Centre Director or Designate (JSG)

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with the JSG role in Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Promote JSG staff awareness of communicable disease outbreak prevention and management procedures. Outbreak management awareness tools are available from IPC and/or Public Health at the beginning of each influenza season.	Ongoing
<input type="checkbox"/> Promote collaboration between JSG and AHS in identifying suspected individual cases of communicable disease, unusual clusters and suspected outbreaks in the general population.	Ongoing
Upon notification of a confirmed or suspected outbreak in the centre	
<input type="checkbox"/> Act as, or designate a JSG representative to the Outbreak Management Team (OMT), if activated, functioning as a liaison between AHS and JSG throughout the duration of the outbreak.	Immediate
<input type="checkbox"/> Collaborate with the Site Health Services Manager or designate/Lead, ICP and the Office of the zone MOH to determine appropriate isolation, cohorting, and movement restriction of offenders who are symptomatic or may have been exposed and implement these measures. Outbreak management decision-making must account for JSG resources and space available to implement recommendations.	Immediate
<input type="checkbox"/> Ensure wide distribution of the daily outbreak reporting memos for security and contracted staff, which will be prepared daily by the Site Health Services Manager or designate.	Immediate
<input type="checkbox"/> Apply facility restrictions in consultation with the zone MOH or MOH designate, such as restriction of visitors, admissions or transfers, as appropriate.	Immediate
<input type="checkbox"/> Direct appropriate personnel to enhance environmental cleaning and disinfection within the centre as recommended by the zone MOH or MOH designate and centre Infection Control Professional (ICP).	Immediate
<input type="checkbox"/> Identify JSG staff members who may have been exposed, notify the Site Health Services Manager or designate of numbers and initiate JSG OH&S protocols as required.	Immediate
<input type="checkbox"/> Provide current daily JSG staffing and offender population numbers to the Site Health Services Manager or designate for reporting to Public Health.	Immediate
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post- outbreak

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Appendix 3: Position Checklist for Centre Infection Control Professional / IPC

Medical Lead

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> In consultation with Site Health Services Manager and/or Public Health, act as designate during business hours to assist with outbreak management functions such as outbreak notifications and communications to other stakeholders.	Immediate
<input type="checkbox"/> In collaboration with the Site Health Services Manager or designate, assist in coordinating the collection of clinical specimens as appropriate and provide instruction on completion of requisitions.	Immediate
<input type="checkbox"/> If applicable to zone reporting requirements, obtain reports on the clinical status of all affected individuals and work with clinical staff to identify new cases.	Immediate
<input type="checkbox"/> Maintain vigilance in identifying suspected individual cases of communicable disease, unusual clusters and suspected outbreaks.	Ongoing
<input type="checkbox"/> Provide training to frontline staff to facilitate early recognition of possible outbreaks	Ongoing
<input type="checkbox"/> Review and update internal protocols and procedures for outbreak management as necessary, including review of cases and outbreak definitions and reporting protocols.	Ongoing
<input type="checkbox"/> Present an initial and annual staff education on the Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities to AHS staff.	Ongoing
<input type="checkbox"/> Advise the Site Health Services Manager or designate on required supplies for outbreak management (i.e., PPE, specimen collection kits, etc.).	Ongoing
<input type="checkbox"/> In collaboration with the Site Health Services Manager or designate, assist in providing training as required for specimen collection, and clinical outbreak management skills	Ongoing
<input type="checkbox"/> Promote staff awareness of communicable disease outbreak procedures, existing outbreak definitions for ILI and GI cases and reporting protocols.	Ongoing
<input type="checkbox"/> Act as a resource for frontline staff to facilitate early recognition of possible outbreaks.	Ongoing
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated).	As required
<input type="checkbox"/> Direct the implementation of additional outbreak control strategies as indicated according to the type and scope of the outbreak.	As required
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post-outbreak

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Appendix 4: Position Checklist for Correctional Health Provincial Directors

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Assume overall responsibility for maintaining health operations in Correctional Health services to provide optimal care for offenders during an outbreak.	Ongoing
<input type="checkbox"/> Complete and distribute the “Urgent Notification to an Emerging Issue” form, if appropriate.	As required
<input type="checkbox"/> Support the implementation of outbreak management control strategies by authorizing the deployment of additional staffing, equipment and other resources required to effectively manage the outbreak.	Immediate
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated) to assist in high-level decision making and management of provincial resources.	As required
<input type="checkbox"/> Provide representation in the Zone Emergency Operations Centre (if activated) to provide overall leadership relative to the Correctional Health response in an outbreak affecting more than one facility in the zone.	As required
<input type="checkbox"/> In consultation with the Site Health Services Manager, initiate a post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post- outbreak

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Appendix 5: Position Checklist for Public Health (MOH, Outbreak Response Lead)

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities. Set the standard of practice for communicable disease surveillance and notification in regards to outbreak investigation and management.	Ongoing
<input type="checkbox"/> Provide consultation on suspected clusters of illness or outbreaks reported in correctional centres.	Immediate
<input type="checkbox"/> Determine the need to initiate an outbreak investigation at a correctional centre and, if appropriate, declare an outbreak.	Immediate
<input type="checkbox"/> Facilitate laboratory testing by recommending the type of specimen to be collected and testing required.	Immediate
<input type="checkbox"/> Obtain an Exposure Investigation number (EI#) from Public Health Laboratories for the tracking of all outbreak related specimens and samples and communicate the EI# to the site.	Immediate
<input type="checkbox"/> Advise the Site Health Services Manager or designate on appropriate outbreak control measures to be implemented including administrative, staffing and facility-related measures.	Immediate and ongoing
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated) to assist in high-level decision making and management of provincial resources.	As required
<input type="checkbox"/> Send out outbreak notifications and alerts as appropriate. If relevant, post provincial and/or national public health alerts on Canadian Network for Public Health Intelligence (CNPHI).	As required
<input type="checkbox"/> Report outbreak to Alberta Health (AH), and to AHS Senior Public Health Executive as established within Zone protocol.	Immediate
<input type="checkbox"/> Review daily outbreak line lists received from outbreak site, monitor outbreak progress and provide consultation to the Site Health Services Manager or designate as required.	Ongoing
<input type="checkbox"/> Respond to media inquiries in consultation with AHS Communications Media Advisor.	As required
<input type="checkbox"/> Provide advice on immunization, antiviral prophylaxis and work restrictions as required for OHS management of JSG staff and contracted services, if requested.	As required
<input type="checkbox"/> Declare the outbreak over and advise the Site Health Services Manager or designate to lift restrictions when appropriate.	As required
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post-outbreak

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Appendix 6: Position Checklist for Centre Physician/Nurse Practitioner / Facilities Medical Director

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated) to assist in clinical decision making and management.	As required
<input type="checkbox"/> Review health status of symptomatic offenders and provide updates to the OMT (if activated) or Site Health Services Manager.	As required
<input type="checkbox"/> In consultation with the zone MOH, develop and implement a nursing care plan for symptomatic offenders including clinical priorities.	Immediate
<input type="checkbox"/> Coordinate evaluation of susceptible contacts and cases for antiviral prophylaxis.	As required
<input type="checkbox"/> If applicable and directed by the zone MOH, prescribe antiviral prophylaxis to patients deemed to be at-risk. See Appendix 23 regardless of immunization status. If resources permit and you are comfortable doing so, prescribe antiviral prophylaxis to AHS and JSG staff members in consultation with AHS WHS and JSG OH&S.	As required
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post-outbreak

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Appendix 7: Position Checklist for AHS WHS Occupational Health Nurse

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Review and update internal protocols for management of AHS staff during an outbreak as necessary.	Ongoing
<input type="checkbox"/> Support illness assessment and surveillance of AHS staff working in the outbreak centre.	Ongoing
<input type="checkbox"/> Maintain documentation on AHS staff health and vaccine status and provide information on individual indicators as appropriate to identify AHS staff risk of exposure and infection.	Ongoing
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated) to advise on Workplace Health and Safety issues affecting AHS staff.	As required
<input type="checkbox"/> Assess Health Professionals' suitability to return to work.	As required
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post-outbreak

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Appendix 8: Position Checklist for JSG Occupational Health & Safety Advisor or Designate

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Review and updates internal protocols for management of staff during an outbreak as necessary.	Ongoing
<input type="checkbox"/> Support illness assessment and surveillance of JSG staff working in the outbreak centre.	Ongoing
<input type="checkbox"/> Maintain documentation on JSG Correctional Services staff health and vaccine status (if available) and provide information on individual indicators as appropriate to identify JSG staff risk of exposure and infection.	As required
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated) to advise on Occupational Health and Safety issues affecting JSG staff.	As required
<input type="checkbox"/> Provide information from Public Health to JSG staff regarding vaccination available to JSG staff.	As required
<input type="checkbox"/> Assess JSG Correctional Services staff suitability to return to work.	As required
<input type="checkbox"/> Consult with Public Health for advice on immunization, antiviral prophylaxis and work restrictions as required for OHS management of JSG staff.	As required
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post- outbreak

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Appendix 9: Position Checklist for Clinical Nurse Educator or Nurse Clinician

Task / Responsibility	Timeline / Frequency
<input type="checkbox"/> Review and maintain familiarity with Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	Ongoing
<input type="checkbox"/> Ensure AHS staff have access to a current copy of the Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities and are aware of where to locate them.	Ongoing
<input type="checkbox"/> Participate in the Outbreak Management Team (if activated) to advise on nursing considerations.	Ongoing
<input type="checkbox"/> Coordinate with site ICP to provide an initial and annual staff education on the Guidelines for Outbreak Prevention, Control and Management in Provincial Correctional Facilities.	As required
<input type="checkbox"/> Participate in the centre post-outbreak debriefing to address outbreak management issues, provide recommendations and revise internal protocols where necessary for improvement.	Post-outbreak

Appendix 10: How to Complete a Case Listing during an Outbreak

It is important that as soon as an outbreak is suspected, frontline staff assess and track symptomatic offenders and staff for surveillance, monitoring and reporting purposes.

Accurately completed lists of cases should be reported to Public Health, Infection Prevention & Control and the Centre Director (JSG) on a daily basis (or as directed by Public Health) from the time the outbreak has been declared until the outbreak has been declared over by the zone MOH or MOH designate.

Specific reporting requirements, including frequency and the use of zone-specific case listing forms will be communicated to the Site Health Services Manager or designate by Public Health at the time of the outbreak.

Ensure that the case listing of newly symptomatic offenders is filled out completely each day, including:

- EI number
 - Facility name
 - Full name of offender
 - Personal Health Number (PHN)
 - Date of Birth (DOB)
 - Gender
 - Unit
 - Symptoms and onset date and time
 - Specimen collection information
 - Influenza immunization information (ILI outbreak only)
- Email or fax the case listing to Public Health daily or as requested.
 - Include information about newly symptomatic offender cases only on the case listing form.
 - Only the number of ill staff needs to be reported (if available), it is not necessary to include their names or other personal information on the case listing form.
 - The case listing should include new case activity for the previous 24-hour period.
 - Include information or updates regarding related hospitalizations and/or deaths on any offenders reported or previously reported.
 - The first case listing submitted should include the names of all the cases identified since the onset of the outbreak.
 - "Relapse cases" as defined in the Outbreak Management Guidelines, should not be included on daily case listings.
 - If there are no new cases to report in a given 24-hour period, write "no new cases" and fax the form as requested.
 - If there have been no new cases in more than 48 hours, indicate this on the case listing form, contact Public Health to declare outbreak over.
 - Discontinue daily faxing of case listings when it has been confirmed (by telephone) with Public Health that outbreak restrictions have been lifted.
 - Any new cases identified after restrictions have been lifted should be reported and discussed with Public Health before completing/faxing a new case listing form.

[Appendix 11](#): Respiratory Outbreak Case Listing - Correctional Health Services

Refer to the next page for Appendix 11

Appendix 11: Respiratory Outbreak Case Listing Correctional Health Services

Daily Line Listing for the 24-hour period starting at 0700h(yyyy/mm/dd) _____

EI (outbreak) #: _____

REPORT **NEWLY SYMPTOMATIC CASES** OR A STATEMENT THAT THERE HAVE BEEN **NO NEW CASES** IN THIS TIME PERIOD

Case Definition of ILI: Acute onset of fever and cough with ONE or more of the following: sore throat, joint pain, muscle aches, severe exhaustion

Send to:

Name of Facility: _____

Contact person at facility: _____

Phone # of Facility: _____

of newly symptomatic offenders in last 24 hours: _____

of newly symptomatic staff in last 24 hours: _____

Cumulative # of symptomatic offenders since start of outbreak: _____

Cumulative # of symptomatic staff since start of outbreak: _____

Demographic Information					Signs and Symptoms								Lab Work	Result	Prophylaxis received?	Vaccine	Outcome			
Surname, First name Report newly symptomatic offender cases	Personal Health Number	DOB (yyyy/mm/dd)	Gender M/F	Unit	Onset Date		NEW Cough or change in cough	Fever	Sore throat	Myalgia	Arthralgia	Prostration	Other	Indicate (✓) if NP swab sent	+ / -	Yes /No	Date of Influenza			Please provide details below on any offender hospitalizations or deaths
					mm	dd											yy	mm	dd	
Update on Hospitalizations or Deaths of Above or Previously																				
Name of Hospital and Date Admitted												Date and Cause of Death								

Modified for use in Correctional Health based on Edmonton Zone September 2018 report

[Appendix 12](#): Gastrointestinal Illness Outbreak Case Listing - Correctional Health Services

Refer to the next page for Appendix 12

Appendix 12: Gastrointestinal Illness Outbreak Case Listing Correctional Health Services

Daily Line Listing for the 24-hour period starting at 0700h (yyyy/mm/dd):

EI (outbreak) #:

REPORT **NEWLY SYMPTOMATIC CASES** OR A STATEMENT THAT THERE HAVE BEEN **NO NEW CASES** IN THIS TIME PERIOD

DO NOT include 'relapse' cases on this case listing

Case definition for Gastroenteritis for staff and/or offenders - **at least ONE of the following criteria must be met** and not be attributable to another cause (e.g. Clostridium difficile diarrhea, medication, laxatives, diet or prior medical condition etc):

- 2 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
- 2 or more episodes of vomiting in a 24 hour period, OR
- one episode of vomiting and diarrhea in a 24 hour period, OR
- positive stool culture of a known enteric pathogen AND at least one symptom compatible with a gastrointestinal infection e.g. nausea, vomiting, diarrhea, abdominal pain or tenderness, OR

Send to:

Name of Facility: _____ Contact person at facility: _____

Phone # of Facility: _____

Newly symptomatic offender(s) in last 48 hours? (Please circle) Yes No (if 'no' contact Public Health to discuss lifting of outbreak restrictions)

of newly symptomatic offenders in last 24 hours: _____ # of newly symptomatic staff in last 24 hours: _____

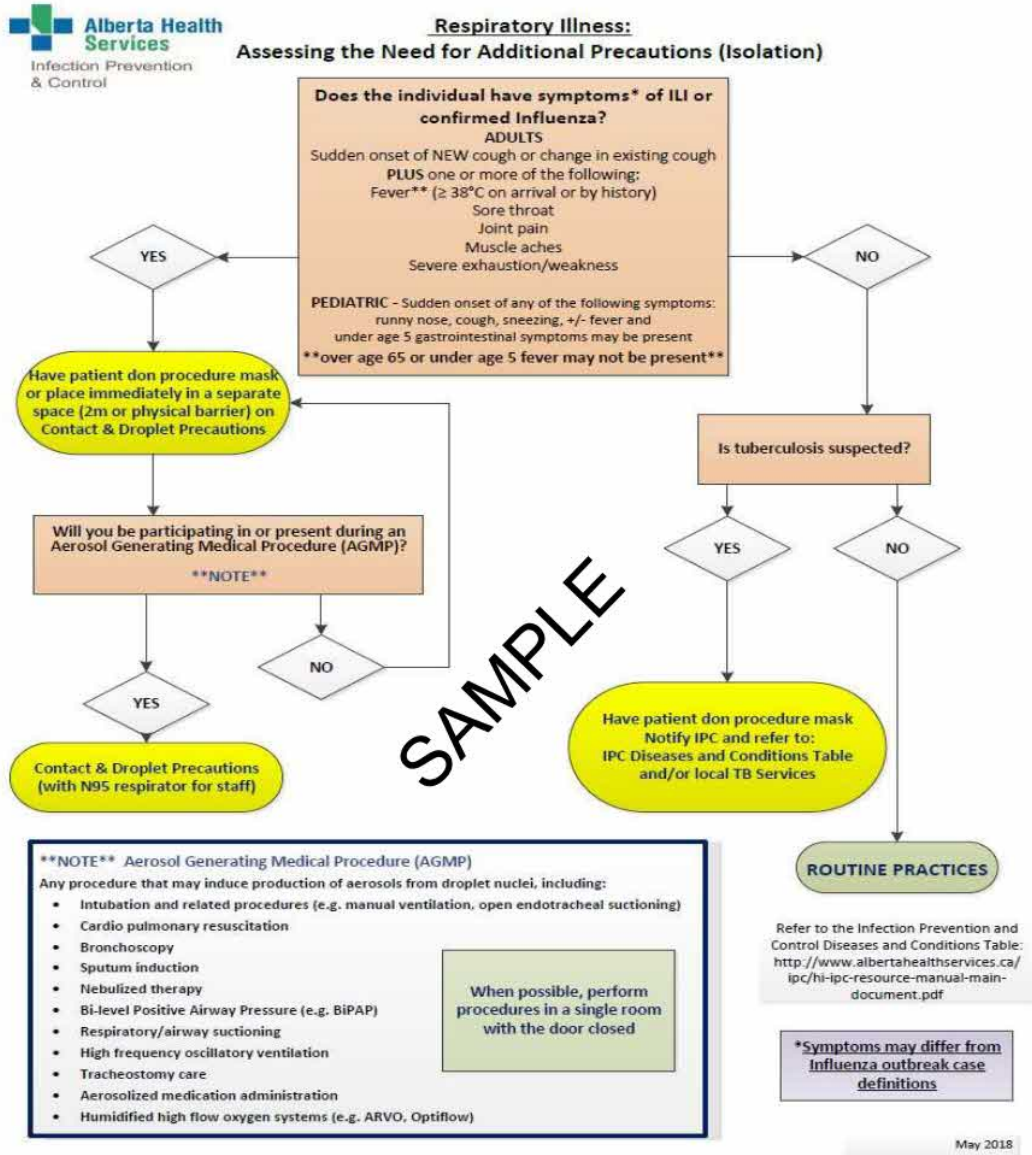
Cumulative # of symptomatic offenders since start of outbreak: _____ Cumulative # of symptomatic staff since start of outbreak: _____

Demographic Information						Signs and Symptoms				Lab Work		Result	Outcome										
Surname, First name Report newly symptomatic offender cases only	Personal Health Number (use ORCA# only if PHN not yet assigned)	DOB			Gender M/F	Unit	Onset Date/Time			Diarhea	Vomitting	Other	Date stool specimen collected		+	-	Please provide details below on any offender hospitalizations or deaths						
		yyyy	mm	dd			mm	dd	24 hr clock				mm	dd									
Update on Hospitalizations or Deaths of Above or Previously Reported Ill Offenders																							
Name of Hospital and Date Admitted																							
Date and Cause of Death																							

Modified for use in Correctional Health based on Edmonton Zone September 2018 report

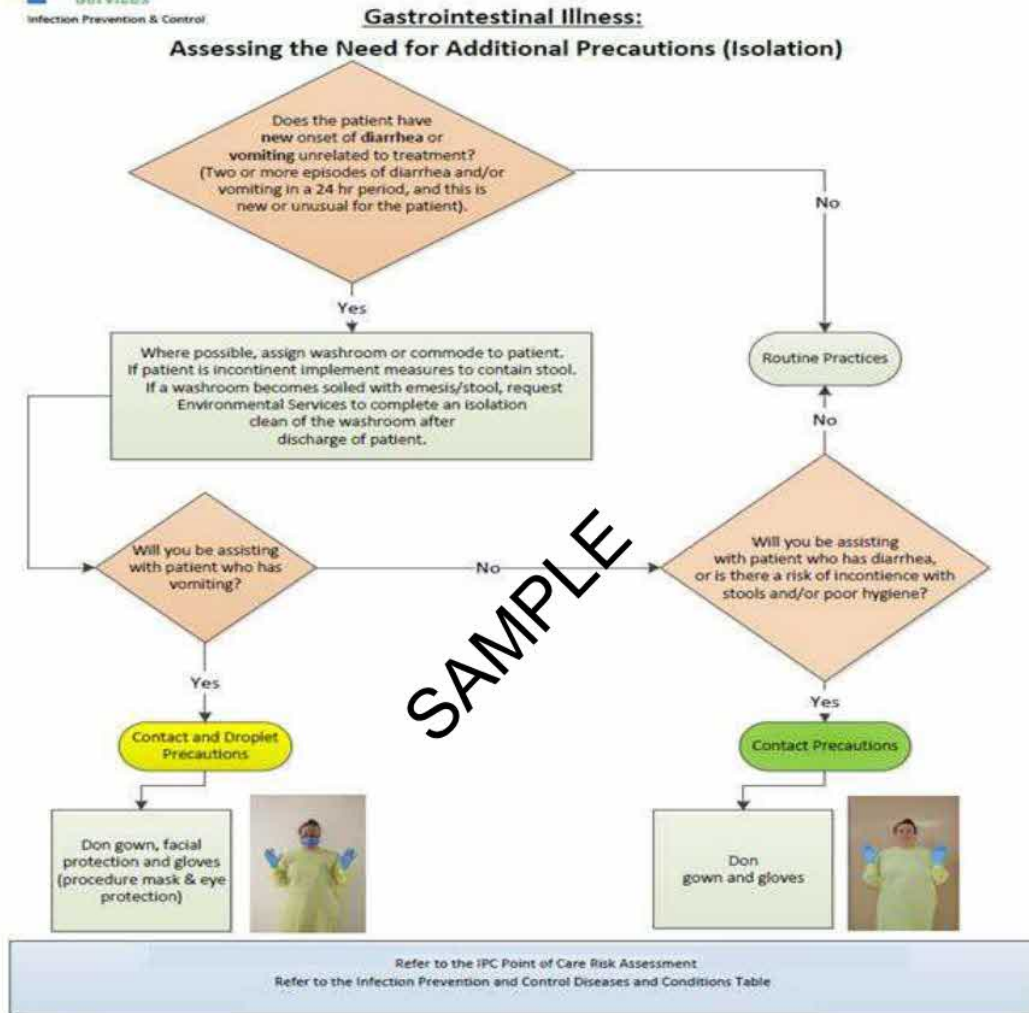
Appendix 13: Assessing the Need for Additional Precautions for ILI

<http://www.ahsweb.ca/ipc/respiratory-ili-additional-precautions-algorithm-isoln-z0-rm-ac>



Appendix 14: Assessing the Need for Additional Precautions for GI

<http://www.ahsweb.ca/ipc/gi-additional-precautions-isoln-algorithm-z0-rm-ac>



Jan 2017



Appendix 15: Putting on (donning) Personal Protective Equipment

<http://www.ahsweb.ca/ipc/donning-ppe-poster-z0-res-topics-gen-info>



Infection Prevention and Control

Putting on (Donning) Personal Protective Equipment (PPE)


1 HAND HYGIENE



A Using an alcohol-based hand rub is the preferred way to clean your hands.

B If your hands look or feel dirty, soap and water **must** be used to wash your hands.

2 Gown



A Make sure the gown covers from neck to knees to wrist.

B Tie at the back of neck and waist.

3a Procedure/Surgical mask

- ◆ Secure the ties or elastic around your head so the mask stays in place.
- ◆ Fit the moldable band to the nose bridge. Fit snugly to your face and below chin.



3b N95 respirator

There are different styles of N95 respirators (pictured below). They include: a) molded cup, b) duckbill, c) flat-fold and d) v-fold



All styles have the same basic steps for donning; molded cup and duckbill are pictured below. Refer to the manufacturer for specific donning instructions.



A Pre-stretch both top and bottom straps before placing the respirator on your face.

B Cup the N95 respirator in your hand.

C Position the N95 respirator under your chin with the nose piece up. Secure the elastic band around your head so the N95 respirator stays in place.

D Use both hands to mold the metal band of the N95 respirator around the bridge of your nose.

E Fit check the N95 respirator.

4 Eye protection or face shields



- ◆ Place over the eyes (or face).
- ◆ Adjust to fit.

5 Gloves



- ◆ Pull the cuffs of the gloves over the cuffs of the gown.



May 2014

Appendix 16: Taking off (doffing) Personal Protective Equipment

<http://www.ahsweb.ca/ipc/doffing-ppe-poster-z0-res-topics-outbreak-mgmt-gen-info>



Infection Prevention and Control

Taking off (Doffing) Personal Protective Equipment (PPE)

1 Gloves

A Grasp the outside edge of the glove near the wrist and peel away from the hand, turning the glove inside-out.

- ◆ Hold the glove in the opposite gloved hand.
- B Slide an ungloved finger or thumb under the wrist of the remaining glove.
- C Peel the glove off and over the first glove, making a bag for both gloves.
- ◆ Put the gloves in the garbage.

2 HAND HYGIENE

A Using an alcohol-based hand rub is the preferred way to clean your hands.

B If your hands look or feel dirty, soap and water must be used to wash your hands.

3 Gown

A Carefully unfasten ties.

B Grasp the outside of the gown at the back of the shoulders and pull the gown down over the arms.

C Turn the gown inside out during removal.

- ◆ Put in hamper or, if disposable, in the garbage.

4 HAND HYGIENE

- ◆ Clean your hands. (See No. 2)
- ◆ Exit the patient room, close the door and clean your hands again.

5 Eye protection or face shield

- ◆ Handle only by headband or ear pieces.
- ◆ Carefully pull away from face.
- ◆ Put reusable items in appropriate area for cleaning.
- ◆ Put disposable items into garbage.

6 Mask or N95 respirator

- ◆ Bend forward slightly and carefully remove the mask from your face by touching only the ties or elastic bands.
- ◆ Start with the bottom tie, then remove the top tie.
- ◆ Throw the mask in the garbage.

There are different styles of N95 respirators but all styles have the same basic steps for doffing.

7 HAND HYGIENE

- ◆ Clean your hands. (See No. 2)

May 2014



Appendix 17: Organisms Commonly Associated with ILI Reference

<http://www.ahsweb.ca/lpoc/diseases-conditions-table-z0-rm-ac>

Organisms	Clinical Presentations/ Symptoms	Infectious Substance/How it is Transmitted	Incubation Period	Period of Communicability	Outbreak Restrictions/Recommendations for Facility Living
Influenza, Seasonal Type A or B	Sudden onset of fever, cough, muscle aches, fatigue, sore throat, runny nose & sneezing. Note: fever may not be prominent in those >65 years.	<ul style="list-style-type: none"> Infectious substance is respiratory secretions; Direct contact, indirect contact and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions. 	1-3 days	<ul style="list-style-type: none"> For duration of symptoms – usually 3-7 days from onset of symptoms; For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding. 	<ul style="list-style-type: none"> Confirmed or symptomatic cases should remain on precautions for 5 days from the onset of acute illness; OR until they are over their acute illness and have been afebrile x48 hours; Patients may have a prolonged post-viral cough for weeks but this may not represent ongoing acute illness or infectiousness; Admission/transfer restrictions for confirmed influenza remain in place for “7 days” after onset of symptoms in the last case.
Respiratory Syncytial Virus (RSV)	Runny nose, coughing, sneezing, fever, wheezing.	<ul style="list-style-type: none"> Infectious substance is respiratory secretions; Direct contact, indirect contact and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions. 	2 to 8 days	<ul style="list-style-type: none"> For duration of symptoms; For immunocompromised patient maintain precautions for a longer duration due to prolonged viral shedding. 	<ul style="list-style-type: none"> Confirmed or symptomatic cases should remain in their rooms for the duration of the illness, which is the resolution of acute respiratory infection symptoms or return to baseline; Admission/transfer restrictions only when recommended by local MOH.
Parainfluenza Type 1, 2, 3, 4	Fever, runny nose, cough, sneezing, wheezing, sore throat, croup, bronchitis.	<ul style="list-style-type: none"> Infectious substance is respiratory secretions; Direct contact, indirect contact and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions. 	2 to 6 day	<ul style="list-style-type: none"> 1-3 weeks; For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding. 	<ul style="list-style-type: none"> Patients should remain on precautions for 5 days from the onset of acute illness OR until they are over the acute illness and have been afebrile x48 hours, which is resolution of acute respiratory infection symptoms or return to baseline; Admission/transfer restrictions only when recommended by local MOH.
Human Metapneumovirus (HMPV)	Cough, fever, nasal congestion, shortness of breath.	<ul style="list-style-type: none"> Infectious substance is respiratory secretions; Direct contact, indirect contact and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions 	3 to 5 days	<ul style="list-style-type: none"> For duration of symptoms; For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding. 	<ul style="list-style-type: none"> Confirmed or symptomatic cases should remain in their rooms for the duration of the illness, which is resolution of acute respiratory infection symptoms or return to baseline; Admission/transfer restrictions only when recommended by local MOH.
Other Common Respiratory Viruses such as Enteroviruses, Rhinovirus, Coronavirus	Sore throat, runny nose, coughing, sneezing.	<ul style="list-style-type: none"> Infectious substance is respiratory secretions; Direct contact, indirect contact and large droplets - Person to person by large droplets or direct contact with articles recently contaminated with respiratory secretions. 	Enteroviruses: usually 2-3 days Coronaviruses: usually 2-4 days	<ul style="list-style-type: none"> For duration of symptoms; For immunocompromised patient, maintain precautions for a longer duration due to prolonged viral shedding. 	<ul style="list-style-type: none"> Confirmed or symptomatic cases should remain in their rooms for the duration of the illness, which is resolution of acute respiratory infection symptoms or return to baseline; Admission/transfer restrictions only when recommended by local MOH.

** First day is designated as Day 0, after the first 24 hours is Day 1. MOH-designate declares the facility outbreak to be over 7 days after onset of symptoms in the last case (e.g., closes outbreak on the morning of day 8)

Appendix 18: Nasopharyngeal (NP) and Throat Swab Specimen Collection Guidelines 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 and pertussis testing.
- If nasopharyngeal swabs are difficult to collect, or if nasal secretions are minimal, throat swabs collected in viral transport media are acceptable alternatives.
- Collect NP or throat swabs from separate cases as directed by Public Health in the acute phase of illness, to determine the etiological agent of a suspected viral respiratory outbreak.
- Contact Public Health. See [Table 1: AHS Zone Public Health Contacts \(regular and after hours\)](#) for the EI# anytime, if the clinical situation for the EI# has changed and additional testing needs to be done.
- Results of the Respiratory Virus Panel (RVP) by molecular testing are usually available within 48 hrs.

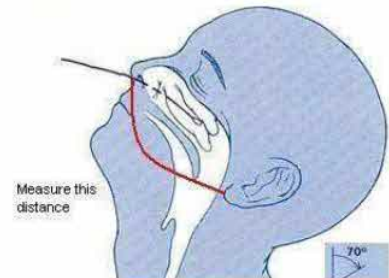
Swab description

The NP swab has a white plastic shaft, with three (3) different thicknesses, ending in a “furry” or flock tip. Each swab is individually packaged and labeled “Copan sterile swab applicator”. After specimen is collected, to fit the swab onto the transport medium container, please use break or cut the swab shaft where there is a deep score mark on the thick part of the shaft (**See** graphic).



Collection of a Nasopharyngeal (NP) swab

1. Access the respiratory outbreak specimen collection kit (contains NP flock swab, Universal Transport Media, Public Health Laboratories requisition), and appropriate PPE
2. Check expiry date of Universal Transport Medium (UTM). Do not use if the media is leaking, has turned color, is cloudy or has expired.
3. Perform hand hygiene by washing hands with soap and water or using alcohol-based hand rub.
4. Put on appropriate PPE.
5. Have the patient sit in a chair or lie on a bed – elevate the head of the bed so that their head can be tilted back (**See** diagram).
6. Remove any mucous from the patient’s nose with a tissue or cotton tipped swab prior to collecting the NP swab.
7. How deep is the NP swab inserted into the nasopharynx? Measure the distance from the corner of the nose to the front of the ear and insert the shaft **ONLY half this length**. In adults, this distance is usually about four (4) cm, (finest thickness of this swab shaft). In children this distance is less.
8. Tilt the patient’s head back slightly (about 70°) to straighten the passage from the front of the nose to the nasopharynx to make insertion of the swab easier.



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9. **Gently** insert the swab along the medial part of the septum, along the base of the nose until it reaches the posterior nares – gentle rotation of the swab may be helpful. (If resistance is encountered on one site, try the other nostril, as the patient may have a deviated septum)
10. Rotate the swab several times to dislodge the columnar epithelial cells, and then remove the swab.

Note: insertion of the swab usually induces a cough.

11. Put the NP swab into the transport medium and break or cut at the score mark on the shaft so that it does not protrude above the rim of the container. Failure to do so will result in the transport medium leaking and the **sample being discarded**.
12. Ensure that the lid of the container is screwed on tight, and put the specimen in the biohazard zip lock bag.
13. Remove and discard gloves. Perform hand hygiene by washing hands with soap and water or using alcohol-based hand rub.
14. Remove and discard face mask and eye protection, and repeat hand hygiene if hands become contaminated.
15. Follow the labelling and transport instructions given in the collection kit insert. Ensure to label the UTM container with patient information.

Source: Provincial Laboratory for Public Health (Public Health Laboratories)

Collection of a throat swab (TS in viral transport media)

1. Access the respiratory outbreak specimen collection kit (contains NP flock swab, Universal Transport Media, Alberta Laboratory Services requisition) and appropriate PPE.
2. Check expiry date of Universal Transport Medium (UTM). Do not use if the media is leaking, has turned color, is cloudy or has expired.
3. Perform hand hygiene by washing hands with soap and water or using alcohol-based hand rub.
4. Put on appropriate PPE
5. Using the plastic shafted swab in the kit, vigorously swab the back of the throat around the tonsillar area,
6. Place the swab into the transport medium and break off the shaft so that it does not protrude above the rim of the container. Failure to do so will result in the transport medium leaking and the **sample being discarded**.
7. Ensure that the lid of the container is screwed on tight.
8. Remove and discard gloves. Perform hand hygiene by washing hands with soap and water or using alcohol-based hand rub.
9. Remove and discard face mask and eye protection, and repeat hand hygiene if hands become contaminated.
10. Follow the labelling and transport instructions given in the collection kit insert. Ensure to label the UTM container with patient information.

Note:

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

Source: Provincial Laboratory for Public Health (Public Health Laboratories).

Appendix 19: Stool Specimen Collection Guidelines for GI Illness Outbreaks

Stool specimen results do not typically impact outbreak management strategies for GI illness outbreaks; however, from a Public Health perspective it is valuable to collect stool specimens from cases during outbreaks to try and identify the etiology, if possible. Please note that norovirus cannot presently be isolated from vomitus; therefore, the collection of vomitus specimens is not recommended for GI illness outbreak management.

Stool specimens submitted without EI # on the requisition will not be analyzed for norovirus; therefore, it is important that EI # be obtained **prior to** collection of outbreak stool specimens. The typical turnaround time for norovirus PCR results from the Public Health Laboratories (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. Public Health will report the result to the ICP/ICD within one business day of receipt of results from the lab.

Procedures to collect stool specimens

- As directed by Public Health, collect stool specimens from patients that are acutely ill with diarrhea, preferably within 24-48 hours of onset of symptoms. Collect one stool specimen from up to 5 symptomatic patients per outbreak investigation (EI#), 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 other clean and dry receptacle (i.e. bed pan, margarine container). **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. (Clean, dry specimen container may include container from stool collection kit or sterile urine container).
- Screw the lid tightly to avoid leakage then put the container with the stool into the plastic (biohazard) bag, and seal the bag.
- Complete the Public Health Laboratories requisition form to include the EI# and the patient’s full first and last names; Personal Health Number (PHN) or unique numerical assigned equivalent; patient 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#, patient’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 Public Health Laboratories within 24-hours.
- If one or more of these samples are positive and an etiological agent has been identified, then further specimens should not be collected. If additional specimens are received under the same EI# at some later period, these will not be tested unless Public Health has contacted the Public Health Laboratories point person for the EI# (e.g., MOC/VOC).
- If all batched samples received have been tested and if all are negative for a particular EI#, additional samples will not be tested unless there is consultation between Public Health and the Public Health Laboratories.
- Public Health will contact Public Health Laboratories if the clinical situation for the outbreak has changed and additional testing needs to be done.

Specimen transport

- Follow current Provincial Laboratory standards for handling and transport of specimens.

Appendix 20: Public Health Laboratories Test Request (Requisition)

Requirements for Outbreaks

Note:

Check Public Health Laboratories Bulletins for most current information on specimen collection, testing and interpretation of lab results: <https://www.albertahealthservices.ca/lab/page3317.aspx/>

This requisition must be completed to include:

- Patient's full name (first and last);
- Patient's Personal Health Number (PHN) (use ORCA number only if patient has not been issued a PHN);
- Patient's demographics including: date of birth (DOB), gender, address, phone number;
- Specimen type and source (also include date and time of collection for Public Health Laboratories Requisition);
- Test orders clearly indicated;
- Site of the outbreak (name of the correctional centre);
- EI# (assigned by the lab and provided to Outbreak Response Lead);
- Physician name (full name), address/location, phone and fax number (when the centre physician is not available, a Public Health physician assigned by the Outbreak Response Lead will be listed as the ordering physician);
- Name and contact information of the assigned Outbreak Response Lead to receive a copy of the results.

Note:

Symptom and patient history information is not required as long as the EI# is clearly recorded on the requisition.
Specimen must be labelled as well.

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Appendix 21: Public Health Laboratories Sample Requisition

Alberta Health Services		Provincial Laboratory for Public Health Serology and Molecular Testing Requisition		Accession # (lab only)				
Edmonton Site 8440-112 St. T6G 2J2 Phone 780.407.7121 Fax 780.407.3864 Virologist/Microbiologist-on-call 780.407.8822		Calgary Site 3030 Hospital Dr NW T2N 4W4 Phone 403.944.1200 Fax 403.270.2216 Virologist/Microbiologist-on-call 403.944.1200						
■ Consult the Site Virologist/Microbiologist-on-Call listed above for STAT requests, and when specified in the Guide to Services ■ See the Guide to Services (https://www.albertahealthservices.ca/lab/page3317.aspx/education.htm) for information on sample type, transport and testing ■ For Zoonotic Infections (eg. mosquito-borne, tick-borne) use form 20087 Zoonotic Testing Requisition (https://www.albertahealthservices.ca/fm-20087.pdf)								
Patient	PHN		Alternate Identifier		Date of Birth (yyyy-Mon-dd)			
	Last Name		First Name		Middle	Gender	Phone	
	Address		City/Town		Prov	Postal Code	Location	
Requestor	Requestor Name (last, first)		Location/Facility/Address		Phone	Healthcare Provider ID		
	Copy to (last, first)		Location/Facility/Address		Phone	Healthcare Provider ID		
Specimen/Type Source - Specify								
Date Collected (yyyy-Mon-dd)		Time (24 hr)	Location	Collector ID	Outbreak (EI) if applicable (yyyy-###)			
Blood <input type="checkbox"/> Blood <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Cord Blood		Fluid <input type="checkbox"/> CSF <input type="checkbox"/> Auger Suction <input type="checkbox"/> Bronchoalveolar Lavage (BAL) <input type="checkbox"/> Eye (Aqueous) <input type="checkbox"/> Eye (Vitreous) <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Urine		Swab <input type="checkbox"/> Buccal <input type="checkbox"/> Cervical <input type="checkbox"/> Eye (specify) _____ <input type="checkbox"/> Lesion (specify) _____ Other <input type="checkbox"/> Stool <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Mouth <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> Throat <input type="checkbox"/> Urethral		
Provide Clinical History or Reason for Testing below - Test results will NOT proceed if this section is incomplete								
Reason for Testing				List Countries visited within past 3 months of symptom onset OR provide relevant travel history <input type="checkbox"/> No Travel				
Symptoms (Check all that apply) <input type="checkbox"/> Fever <input type="checkbox"/> Rash (type) _____ <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Respiratory (specify) _____ <input type="checkbox"/> Neurologic <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Polyarthrits				Date of return (yyyy-Mon-dd)		Relevant immunizations and dates		
Date of onset OR Duration of symptoms				Immunocompromised <input type="checkbox"/> No <input type="checkbox"/> Yes (details) _____				
Viral Serology		Hepatitis A		Hepatitis B		Hepatitis C		
<input type="checkbox"/> CMV IgG <input type="checkbox"/> EBV Panel <input type="checkbox"/> HSV IgG <input type="checkbox"/> Measles IgG <input type="checkbox"/> Mumps IgG <input type="checkbox"/> Parvovirus B19 IgG <input type="checkbox"/> Rubella IgG <input type="checkbox"/> Varicella zoster IgG <input type="checkbox"/> CMV IgM <input type="checkbox"/> Measles IgM <input type="checkbox"/> Mumps IgM <input type="checkbox"/> Parvovirus B19 IgM <input type="checkbox"/> Rubella IgM <input type="checkbox"/> Varicella zoster IgM <input type="checkbox"/> HIV Serology		CMV IGG EBV AB HSV IGG MEAS IGG MUMPS IGG PARVO IGG RUB IGG PROV VZV IGG CMV IGM MEAS IGM MUMPS IGM PARVO IGM RUB IGM PROV VZV IGM HIV AB		<input type="checkbox"/> HAV IgG <input type="checkbox"/> HAV IgM <input type="checkbox"/> HBsAg <input type="checkbox"/> HBsAb <input type="checkbox"/> HBc IgM Ab <input type="checkbox"/> HBc Total Ab <input type="checkbox"/> HBe Ag <input type="checkbox"/> HBe Ab HAV IGG PROV HAV IGM PROV HBV SAG PROV HBV SAB PROV HBC IGM PROV HBC TOT PROV HBEAG PROV HBEAB PROV		<input type="checkbox"/> HCV Serology HCV AB Blood/Body Fluid Exposure BBFE (HBsAg, HBsAb, HIV and HCV) <input type="checkbox"/> Source <input type="checkbox"/> Recipient		
Specify Other Serology and Molecular Tests		Parasite Serology		Bacterial Serology		Fungal Serology		
		<input type="checkbox"/> Strongyloides STRONG <input type="checkbox"/> Toxoplasma TOXO IGG		<input type="checkbox"/> Brucella BRUC <input type="checkbox"/> Diphtheria antitoxin DIPHT <input type="checkbox"/> Mycoplasma pneumoniae <input type="checkbox"/> Syphilis SYPH PROV <input type="checkbox"/> Tetanus antitoxin TET.ATOX		<input type="checkbox"/> Blastomyces BLAST ID <input type="checkbox"/> Coccidioides <input type="checkbox"/> Cryptococcal Antigen <input type="checkbox"/> Galactomannan <input type="checkbox"/> Histoplasma HISTO ID		
		Molecular Detection (NAT)		Restricted Molecular Testing				
		<input type="checkbox"/> Bordetella Panel BP PCR <input type="checkbox"/> CSF Viral Panel CSF PANEL <input type="checkbox"/> Entero/Parvovirus EV PEV PCR <input type="checkbox"/> Eye Viral Panel EYE PANEL <input type="checkbox"/> Gastroenteritis Viral Panel GI PANEL <input type="checkbox"/> Herpes simplex virus HS VZ PCR <input type="checkbox"/> Measles virus MEAS PCR <input type="checkbox"/> Mumps virus MUMPS PCR <input type="checkbox"/> Respiratory Pathogen Panel <input type="checkbox"/> Varicella zoster virus HS VZ PCR <input type="checkbox"/> Syphilis SYPH PCR		<input type="checkbox"/> Adenovirus AD PCR <input type="checkbox"/> BK virus BKV PCR <input type="checkbox"/> Cytomegalovirus CMV PCR <input type="checkbox"/> Epstein-Barr virus EBV PCR <input type="checkbox"/> HBV DNA HBV QUANT <input type="checkbox"/> HCV RNA HCV QUANT <input type="checkbox"/> HIV QUAL HIV QUANT <input type="checkbox"/> HIV Viral Load HIV QUANT <input type="checkbox"/> JC Virus HPOLYVIR PCR				

SAMPLE

[Appendix 22: 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 should not 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).

Note:

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

- Symptomatic individuals do not require antiviral prophylaxis. **Early treatment** with antiviral medication may be considered for patients or staff who have had symptoms for less than 48 hours.
- During a correctional facility outbreak, antiviral prophylaxis may be recommended for all unimmunized staff working in affected areas, and all exposed, asymptomatic offenders (regardless of their influenza immunization status) meeting at-risk criteria ([See Appendix 23: At-risk Criteria for Antiviral Chemoprophylaxis](#)), unless a contraindication is present.
- Each attending physician is responsible for prescribing antiviral medication, either for prophylaxis or treatment for their individual patients.
- Staff members who require antiviral prophylaxis may consult with AHS WHS or their own family physician for prescriptions and monitoring.
- For prescribing purposes, the recommended length of antiviral prophylaxis is 10 days. If the outbreak continues past 10 days, antiviral prophylaxis should be extended until the outbreak is declared over. If the outbreak duration is less than 10 days, antiviral prophylaxis may be discontinued – consult with Public Health. If cases persist, consult with Public Health promptly for further direction.
- During outbreaks caused by influenza strains that are not well matched by the vaccine, prophylaxis should also be considered for exposed, asymptomatic staff regardless of their immunization status.
- When antiviral prophylaxis is administered simultaneously to all eligible patients and staff as soon as an outbreak is confirmed, the number of new cases usually decreases quickly. If cases continue beyond the first 72 hours after initiating prophylaxis, consult with Public Health promptly for further direction.

Antivirals for early treatment

Treatment decisions are the responsibility of the attending physician. Antivirals for early treatment of symptomatic patients and staff must 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 patients meeting at-risk criteria ([See Appendix 23: At-risk Criteria for Antiviral Chemoprophylaxis](#)) should be considered for antivirals for early treatment.

Appendix 23: At-risk Criteria for Antiviral Chemoprophylaxis

The following criteria are based on the Association of Medical Microbiology and Infectious Disease (AMMI) Canada Guidelines on the use of antiviral drugs for 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, facility prescribers may use the following at-risk criteria to identify offenders that should receive antiviral prophylaxis.

Offenders who are identified as at-risk should 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 CD₄ is <200x10⁶ L), 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.

Appendix 24: Antiviral (Oseltamivir) Dosing Recommendations

From TAMIFLU Product Monograph, Roche Canada, Feb.2017 and Lexicomp online accessed April 30, 2018		
Adults and adolescents 13 years and older		
Creatinine clearance +	Prophylaxis (10 days or duration of outbreak, whichever is longer*)	Treatment (5 days)
Over 60 mL/min	75 mg once daily	75 mg twice daily
31- 60 mL/min	30 mg once daily or 75 mg every other day**	30 mg twice daily or 75 mg once daily**
10-30 mL/min	30 mg every other day	30 mg once daily
Less than 10 mL/min and not on dialysis	30 mg PO suspension/capsule x 1 dose for duration of outbreak	75 mg PO x 1 dose for duration of illness
On routine hemodialysis	30 mg immediately, then 30mg after alternate hemodialysis sessions for duration of outbreak	30 mg immediately, then 30 mg after every dialysis session over 5 days
On peritoneal dialysis	30 mg immediately, then 30 mg once weekly for duration of outbreak	30 mg immediately as a single dose (single dose provides a 5- day duration)
Continuous Renal Replacement Therapy (CRRT, high flux)	30 mg once daily	30 mg twice daily
Pediatrics 1-12 years) Normal Renal Function		
Body Weight	Prophylaxis (10 days or duration of outbreak, whichever is longer*)	Treatment (5 days)
Less than or equal to 15 kg (less than or equal to 33 lbs.)	30 mg once daily	30 mg twice daily
greater than 15 kg to 23 kg (greater than 33 lbs. to 51 lbs.)	45 mg once daily	45 mg twice daily
greater than 23 kg to 40 kg (greater than 51 lbs. to 88 lbs.)	60 mg once daily	60 mg twice daily
Greater than 40 kg (greater than 88 lbs.)	75 mg once daily	75 mg twice daily
<i>Commercially manufactured TAMIFLU for Oral Suspension (6 mg/mL) is the preferred product for pediatric and adult patients who have difficulty swallowing capsules or where lower doses are needed.</i>		
Reviewed by U. Chandran, S. Fryters and Dr. L. Saxinger, AHS Antimicrobial Stewardship Committee		

* If influenza outbreak duration is less than 10 days, oseltamivir prophylaxis may be discontinued. Consult with Public Health.

** If supply of 30 mg preparations is not available or accessible.

+ Serum creatinine tests for residents/patients should be adequate if done within the past year, provided there has not been a sudden change in kidney function or change in weight. Facilities should prepare for respiratory virus outbreak season each year by ordering serum creatinine and recording resident weights. A baseline temperature should also be taken and recorded. Ultimately, prescribers are responsible for determining the appropriate antiviral dose for their patients.

Early initiation of antiviral treatment is critical for treatment effectiveness. In situations where 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 prior, antiviral treatment can be started using the most recent creatinine clearance estimate for dosing, with blood work sent off within 24 hours, and the result used to adjust the timing and amount of subsequent doses.

Note:

In the event of antiviral resistance in the outbreak influenza strain, alternate recommendations for antiviral prophylaxis will be provided by the zone MOH.

Appendix 25: Staff Antiviral Prophylaxis Procedures

In the event the MOH recommends staff antiviral prophylaxis as an additional control measure during influenza outbreaks, unimmunized or at-risk AHS, JSG and contracted staff may be prescribed antiviral prophylaxis.

AHS staff	<ul style="list-style-type: none">▪ AHS staff can receive a prescription through AHS Workplace Health and Safety (WHS).▪ The Site Health Services Manager or designate must submit a list of non-immune exposed or at-risk AHS staff to WHS using the Worksheet in Communicable Disease Exposures Template for Influenza Exposure (available from WHS). WHS will then contact the employees directly to arrange for a prescription.
JSG and contracted staff	<ul style="list-style-type: none">▪ JSG and contracted staff requiring a prescription for antivirals will be instructed to obtain a prescription from a community physician.

All staff must be referred to a community pharmacy to have their prescription filled. A letter from the zone MOH which includes the EI# will be provided by Public Health to distribute to employees who have been prescribed antiviral prophylaxis. Distribution of this letter will be coordinated by the Outbreak Management Team. This letter will include all the necessary information for the community pharmacy to fill the prescription at no cost to the employee.

Note:

If an AHS employee taking antiviral prophylaxis develops symptoms of ILI, they should stay home and contact WHS for instructions about changes to medications (this may ultimately be a referral to their family physician). Non-AHS employees taking antiviral prophylaxis who develop symptoms of ILI should stay home and contact their physician for instructions about changes to medications.

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Appendix 26: Daily Outbreak Update Template for Healthcare Workers

Date: Month/day/year
To: AHS correctional health staff
From: AHS site management
Re: Outbreak

A(an) ILI outbreak has been declared/is being investigated at the centre. At this time, (# of cases:) have been identified on (affected units). The following outbreak management measures are being implemented to minimize the spread and ensure everyone's safety. For additional information, please refer to the Corrections Outbreak Guidelines on the AHS intranet website or click:

Summary of Outbreak Prevention, Control and Management Measures	
Enhanced surveillance	<ul style="list-style-type: none"> ▪ All new admissions must be screened for signs and symptoms. Maintain heightened surveillance for signs and symptoms in the current population. ▪ If you identify a suspected case: <ul style="list-style-type: none"> ○ Isolate the patient immediately; ○ Notify your supervisor and ICP immediately; ○ Collect specimens as directed by your supervisor/ICP.
Movement and placement	<ul style="list-style-type: none"> ▪ Symptomatic patients must be isolated in the infirmary or designated area. ▪ Double bunking of symptomatic cases should only be done in consultation with IPC/Public Health. ▪ CCTV court and visits may proceed provided the patient is compliant with precautions. ▪ Transfers and out-of-town courts for symptomatic patients may only proceed after review by Public Health/IPC. ▪ ILI: Symptomatic patients are under contact and droplet precautions and must wash their hands before leaving their cell and wear a non-wired surgical mask when outside of their cell at all times. ▪ GI: Symptomatic patients are under contact precautions and must wash their hands and be wearing clean clothing before leaving their cell.
PPE and hand hygiene	<ul style="list-style-type: none"> ▪ ILI: Staff having contact within 2 meters of a symptomatic patient must wear gown, gloves eye protection and a surgical mask. ▪ ILI: N95 masks are only required when performing aerosol-generating medical procedure (AGMPs) or if patients are non-compliant with wearing a surgical mask. ▪ GI: Staff should wear a gown and gloves during direct contact with symptomatic patients. Strict hand hygiene is the most important measure in preventing the spread of infections. Staff must perform hand hygiene: <ul style="list-style-type: none"> ○ Before and after providing care to patients; ○ After exposure to contaminated patient care equipment or environmental surfaces. ▪ Staff must educate patients to perform hand hygiene: <ul style="list-style-type: none"> ○ After coughing, sneezing, or using tissues; ○ After using the washroom. ▪ Before eating
Enhanced cleaning	<ul style="list-style-type: none"> ▪ AHS equipment must be dedicated to one patient or cleaned and disinfected with a facility-approved disinfectant (e.g., Cavicide™, PerCept™, Prevention) before next use. ▪ Frequent cleaning is recommended by inmate or contracted cleaners to high touch surfaces. ▪ A two-step cleaning process (clean -> disinfect) must be used at all times. Talk to your ICP for more information.
Staffing (ILI only)	<ul style="list-style-type: none"> ▪ Staff working on affected units must have been immunized at least 14 days ago or be receiving antiviral prophylaxis. ▪ Staff refusing immunization and antiviral prophylaxis may be excluded from work, without pay. ▪ Symptomatic staff should report to their supervisor immediately.
Immunization and antiviral prophylaxis (ILI Only)	<ul style="list-style-type: none"> ▪ If applicable, insert information on immunization and antiviral prophylaxis here <ul style="list-style-type: none"> ○ Staff immunization clinics; ○ How to access antiviral prophylaxis. ▪ Patient immunization/prophylaxis information

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Appendix 27: Daily Outbreak Update Template for Security and Contracted Staff



*Infection Prevention and Control
Workplace Health and Safety*

Date: Month/Day/Year
 To: All Staff
 From: AHS Site Management
 Re: Outbreak

A(an) ILI outbreak has been declared/is being investigated at the centre. At this time, (**# of cases:**) have been identified on (**affected units**). To help minimize the spread and ensure everyone's safety, we are asking all staff to follow these guidelines:

Summary of Outbreak Prevention, Control and Management Measures	
Enhanced surveillance	<ul style="list-style-type: none"> ▪ ILI: Notify nursing staff immediately if you encounter an offender with influenza-like symptoms (fever, cough, sore throat, joint pain, muscle aches and exhaustion) ▪ GI: Notify nursing staff immediately if you encounter an offender with vomiting and/or diarrhea.
Movement and placement	<ul style="list-style-type: none"> ▪ Patients with symptoms must be isolated in the infirmary or designated area, and should only be double-bunked in consultation with IPC. ▪ ILI: Patients with symptoms are under contact and droplet precautions and must wash their hands before leaving their cell and wear a non-wired surgical mask when outside of their cell at all times. ▪ ILI: Offenders from affected units must wear a non-wired surgical mask when outside of the unit at all times. ▪ GI: Patients with symptoms are under contact precautions and must wash their hands and be wearing clean clothing before leaving their cell. ▪ Patients with symptoms may attend CCTV court and have visits as long as they are compliant with precautions. Transfers and out-of-town courts may only proceed after review by Public Health/IPC.
PPE and hand hygiene	<ul style="list-style-type: none"> ▪ ILI: Staff having contact within 2 meters of an offender with symptoms must wear gown, gloves, eye protection and a surgical mask. ▪ ILI: N95 masks are only required if the offender is non-compliant with wearing a surgical mask. ▪ GI: Staff should wear a gown and gloves during direct contact with an offender with symptoms. ▪ Strict hand hygiene is the most important measure in preventing the spread of infections. Wash your hands after contact with an offender with symptoms, after coughing, sneezing or using tissues, after using the washroom and before eating.
Enhanced cleaning	<ul style="list-style-type: none"> ▪ Frequent cleaning is recommended by inmate or contracted cleaners to high touch surfaces. Cleaning products are available from AHS. ▪ A two-step cleaning process (clean -> disinfect) must be used at all times. Ask an AHS staff member for more information or if you require cleaning products.
Staffing (ILI Only)	<ul style="list-style-type: none"> ▪ Staff working on affected units must have been immunized at least 14 days ago or be receiving antiviral prophylaxis. ▪ Staff refusing immunization and antiviral prophylaxis may be excluded from work, without pay. ▪ Symptomatic staff should report to their supervisor immediately.
Immunization and antiviral prophylaxis (ILI Only)	<ul style="list-style-type: none"> ▪ If applicable, insert information on immunization and antiviral prophylaxis here <ul style="list-style-type: none"> ○ Staff immunization clinics ○ How to access antiviral prophylaxis ○ Patient immunization/prophylaxis information

Appendix 28: Court Cancellation Outbreak Letter

Refer to the next page for Appendix 28

DATE
_____Name of Facility:

Dear Judge:

Re: Attendance of Patient name (DOB: _____);
(ORCA: _____) in Court.

The Name of Correctional Facility is currently experiencing an influenza outbreak. Pursuant to section 29 of the *Public Health Act*, the Zone Medical Officer of Health investigated the outbreak and has recommended that movement of inmates be restricted to prevent further transmission of the seasonal influenza virus.

As a result, it is recommended that Patient Name (DOB: _____) not attend court at this time in order to prevent transmission of the seasonal influenza virus.

Sincerely,

Alberta Health Services
Name Correctional Facility

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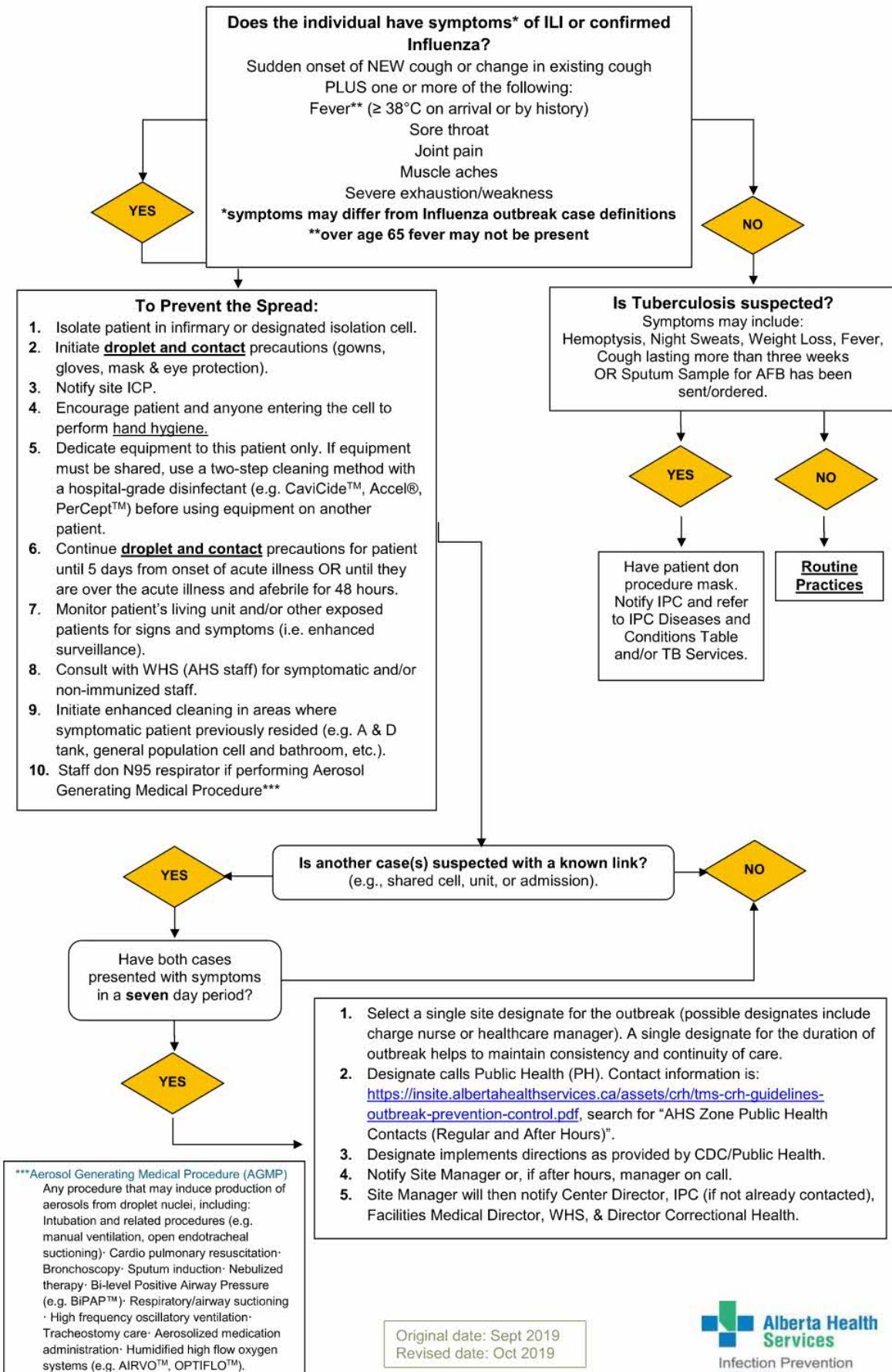
Appendix 29: Correctional Centre Contact List

Zone	Centre	Address	Healthcare Unit	Manager/Designate
Calgary	Calgary Correctional Centre	11808 85 St. NW Calgary, AB T5R 1J3	20(1)(m); 25 (1) (b)	Theresa Bund Theresa.Bund@ahs.ca Office: 403-662-3723 Cell: 403-698-0211
	Calgary Young Offender Centre	12626 85 St. NW Calgary, AB T3R 1J3		Theresa Bund Theresa.Bund@ahs.ca Office: 403-662-3723 Cell: 403-698-0211
	Calgary Remand Centre	12200 85 St. NW Calgary, AB T3R 1J3		Tiffany Murray Tiffany.Murray@ahs.ca Office: 403-695-2054 Cell: 403-701-4422
South	Lethbridge Correctional Centre	Bag 3001 Lethbridge, AB T1J 3Z3		Kristie Knoll Kristina.Knoll@ahs.ca Office: 403-388-3099 Cell: 403-634-8380
	Medicine Hat Remand Centre	874 - 2 Street SE Medicine Hat, AB T1A 8H2		Kristie Knoll Kristina.Knoll@ahs.ca Office: 403-388-3099 Cell: 403-634-8380
Central	Red Deer Remand Centre	4720 – 49 Street Red Deer, AB T4N 1T7		Sandra Dalton Sandra.Dalton@ahs.ca Ph: 403-340-4070
North	Peace River Correctional Centre	Bag 900-40 Peace River, AB T8S 1T4		Barb Elder Barb.Elder@ahs.ca Office: 780-624-5480 Cell: 780-219-1117 Pager: 780-625-7927
Edmonton	Edmonton Remand Centre	18415 – 127 Street Edmonton, AB T6V 1B1		Candace Kercher Candace.Kercher@ahs.ca Office: 780-638-5496 Cell: 587-991-6866
	Edmonton Young Offender Centre	18621 127 Street Edmonton, AB T6V 1B1		Cheryl Mueller Cheryl.mueller@ahs.ca Office: 780-698-5495
Edmonton	Fort Saskatchewan Correctional Centre	7802 – 101 Street Fort Saskatchewan, AB T8L 2P3		Cheleen Letwin Cheleen.Letwin@ahs.ca Office: 780-992-6853

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Correctional Health Influenza-like Illness Algorithm



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 Revised date: Oct 2019