



Health and
Wellness

Prince Edward Island Guidelines for the Management and Control of COVID-19

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Department of Health and Wellness
Chief Public Health Office

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National Case Definition

Confirmed case

A person with confirmation of infection with SARS-CoV-2 documented by:

The detection of at least 1 specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory)

or

The detection of at least 1 specific gene target by a validated point-of-care (POC) NAAT that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)

or

Seroconversion or diagnostic rise (at least 4-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS-CoV-2

Probable case

A person who:

1. Has symptoms compatible with COVID-19

and

Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) or was exposed to a known cluster or outbreak of COVID-19

and

Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive

or

Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset

or

2. Had a POC NAAT or POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive

or

3. Had a validated POC antigen test for SARS-CoV-2 completed and the result is positive

Deceased case

A probable or confirmed COVID-19 case whose death resulted from a clinically compatible illness, unless there is a clear alternative cause of death identified (e.g., trauma, poisoning, drug overdose).

A Medical Officer of Health, relevant public health authority, or coroner may use their discretion when determining if a death was due to COVID-19, and their judgement will supersede the above-mentioned criteria.

A death due to COVID-19 may be attributed when COVID-19 is the cause of death or is a contributing factor.

Resolved case

A case is considered resolved when:

1. Fever has resolved without the use of fever reducing medication, and other symptoms have improved

and

If the case is not immunocompromised and does not have severe illness, at least 10 days have passed since symptom onset or, if asymptomatic, the episode date

or

If the case is immunocompromised or has severe illness (e.g. admitted to hospital due to COVID-19), a minimum of 20 days have passed since symptom onset

or

2. Two consecutive validated laboratory-based NAAT tests for SARS-CoV-2 have been collected at least 24 hours apart and both have returned negative

Notes

A Medical Officer of Health or relevant public health authority (which may include other infection prevention and control experts) may use their discretion when determining if a COVID-19 case requires continued public health management, and their judgement will supersede the above-mentioned criteria.

A COVID-19 case which is classified as resolved may still have ongoing clinical indications and symptoms but should no longer require isolation measures or public health follow up.

If symptom onset date is unavailable or the case is asymptomatic, the earliest of the following dates (i.e. the episode date) could be used as proxy for classification: laboratory specimen collection date, laboratory testing date or reported date. If a case is lost to follow-up or information required for classification is unavailable, the case can be classified as resolved a minimum of 20 days after the initial report.

Reporting Requirements

Health Practitioners

Health practitioners, shall, in accordance with the [Notifiable Diseases and Conditions and Communicable Diseases Regulations](#), as part of the Prince Edward Island (PEI) [Public Health Act](#) report all confirmed and probable cases by phone and mail, fax or electronic transfer, as soon as suspected to the Chief Public Health Officer (CPHO) (or designate) and in any case not later than 1 hour after observation, as per the [PEI Reporting Notifiable Diseases, Conditions, and Events Regulations](#).

Laboratories

The Provincial Laboratory shall, in accordance with the PEI [Public Health Act](#), report all positive laboratory results by phone and mail, fax or electronic transfer, as soon as the result is known, to the CPHO (or designate) and in any case not later than 1 hour after observation, as per the [PEI Reporting Notifiable Diseases, Conditions, and Events Regulations](#).

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Etiology

Coronaviruses are a large family of viruses that are common in many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with Middle East Respiratory Syndrome (MERS), Severe Acute Respiratory Syndrome (SARS), and now with COVID-19.

Cases of COVID-19 were initially linked to exposure to live animals at a seafood market in Wuhan City but the substantial increase in cases thereafter is due to human-to-human transmission of the virus.

Clinical Presentation

COVID-19 includes clinical features that present in varying type, frequency, severity and within different age groups. Symptoms that are absent at the onset of illness may develop over time with disease progression. To date, there is no comprehensive list of symptoms that has been validated to have high specificity or sensitivity for COVID-19. It is possible, that as new variants emerge there may be changes in the patterns of symptoms that individuals display. Clinical diagnosis should therefore always be confirmed through SARS-CoV-2 laboratory testing. Patients should always be encouraged to seek medical consultation if experiencing new or worsening symptoms. **Table 1** below outlines the common, less frequent and rare symptoms in COVID-19 individuals.

TABLE 1: Common, less frequent and rare symptoms for adults with COVID-19*

Common symptoms >50%	Less frequent (≤ 50%)	Rare symptoms (<10%)
<ul style="list-style-type: none"> • fever • chills • new or worsening cough • fatigue and myalgia • headache • gastrointestinal symptoms (nausea, vomiting, diarrhea) 	<ul style="list-style-type: none"> • shortness of breath or difficulty breathing • sore throat • painful and/or difficulty swallowing • conjunctivitis • new or unusual exacerbation or chronic conditions • delirium • decreased or loss of appetite • new loss of smell and/or taste 	<ul style="list-style-type: none"> • skin manifestations • confusion • runny/stuffy nose • eye manifestations

*Note: It is important to evaluate whether the patient's symptoms are new, worsening, or different from their baseline.

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Cough, fever and shortness of breath are the three most common features amongst hospitalized adult patients, while cough, fever and myalgia were the most common symptoms amongst non-hospitalized individuals.

Clinicians should be aware of signs and symptoms that warrant more urgent or emergency medical attention. Patients with mild disease should be informed to seek medical attention should they experience any of the following:

- Trouble breathing or severe shortness of breath
- Persistent pressure or pain in the chest
- New confusion or altered level of consciousness
- Inability to wake or stay awake
- Pale, gray, or blue-colored skin, lips, or nail beds

Signs and Symptoms of COVID-19

Fever

The frequency of fever varies amongst studies but remains one of the primary symptoms of COVID-19. A patient may not present with a fever, but may progress to one after a few days of experiencing other symptoms. Older adults and those with underlying comorbidities may experience fever and respiratory symptoms later during the course of illness, when compared to younger persons or those without comorbidities. In some cases, COVID-19 may occur without fever.

Cough and shortness of breath

Other more prevalent symptoms that have been reported include cough and shortness of breath. Cough is one of the most prevalent symptoms along with fever. Both dry (58%) and productive (25%) coughs have been described in the literature. Shortness of breath was more frequently reported in hospitalized patients and associated with more severe disease.

Other symptoms

Many other symptoms have been associated with COVID-19. Of particular note, fatigue, myalgia, and loss of taste and/or smell are experienced in about 1/3 of all cases. Some uncommon symptoms found in COVID-19, but reported during acute illness include congestion or runny nose, skin rashes and eye issues (including conjunctivitis, eye pain and light sensitivity). These other symptoms do not typically occur on their own, and are found in conjunction with the more prevalent symptoms. Some of the more uncommon symptoms may also become more prevalent as new variants emerge. Two rare but important syndromes associated with SARS-CoV-2 have been described in the literature and are called Multisystem Inflammatory Syndrome – Children (MIS-C) and Multisystem Inflammatory Syndrome – Adults (MIS-A). These are described below.

Multisystem Inflammatory Syndrome – Children (MIS-C)

In early 2020, this syndrome in children was newly recognized as related to SARS-CoV-2 infection and characterized by hyper-inflammation and multi-organ involvement, and presenting with clinical features similar to Kawasaki disease and toxic shock syndrome.

MIS-C signs and symptoms include:

- Kawasaki disease-like features: conjunctivitis, red eyes; red or swollen hands and feet; rash; red cracked lips, and swollen glands. In some children, coronary artery enlargement and/or aneurysms have been described. Some children presenting with

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Kawasaki disease-like syndrome have been noted to have a broader age range and presentation with more gastrointestinal (abdominal pain or diarrhea) and neurologic (headaches or meningitis) manifestations

- Gastrointestinal symptoms such as abdominal pain, diarrhea, nausea/vomiting (patients have presented with colitis, hepatitis, and questionable appendicitis)
- Toxic shock syndrome-like features with hemodynamic instability and poor heart function. Cytokine storm/macrophage activation or hyper-inflammatory features
- Thrombosis or acute kidney injury
- Shortness of breath

Common laboratory findings in case reports have included:

- An abnormal level of inflammatory markers in the blood, including elevated ESR/CRP and ferritin, LDH
- Lymphopenia, thrombocytopenia, neutrophilia
- Elevated B-type natriuretic peptide (BNP) or NT-proBNP (pro-BNP), hyponatremia, elevated D-dimers

In children presenting with a persistent fever (≥ 3 days) who are moderately to severely ill with clinical signs of organ dysfunction (e.g. gastrointestinal, respiratory, cardiac, skin, or neurologic), the diagnosis of MIS-C should be considered.

Multisystem Inflammatory Syndrome – Adults (MIS-A)

Since June 2020, several case reports and series have been published reporting a similar multisystem inflammatory syndrome in adults (MIS-A) that was previously identified in children. Three studies identified 27 patients who had cardiovascular, gastrointestinal, dermatologic, and neurologic symptoms without severe respiratory illness and who also have positive test results for SARS-CoV-2 by PCR or antibody assays indicating recent infection. Clinicians should consider MIS-A in adults with similar signs and symptoms as seen with MIS-C. It is important to note that 30% of adults and 45% of children with MIS-C/A reported a negative PCR and a positive SARS-CoV-2 antibody test results, suggesting MIS-A and MIS-C might represent a post-infectious process. If suspicious of MIS-C/A and a patient has a negative PCR test, consider both antibody and viral testing to assist with diagnosis.

COVID-19 Disease Symptoms in children

A recent systematic review of the signs and symptoms of laboratory-confirmed COVID-19 disease in children and youth under 19 years of age found cases of asymptomatic positive laboratory tests ranged from 15% to 42%. Fever and cough were the most common symptoms; with the proportions with fever ranging from 46% to 64% and for cough from 32% to 56%. All other signs and symptoms were present at less than 10% to 20%. Vomiting, diarrhea and abdominal ranged from 7% to 18%.

One should also consider when assessing children, that the signs and symptoms of COVID-19 are similar to those of other infections and non-infectious processes, including influenza, other viral upper respiratory infections, streptococcal pharyngitis, asthma and allergies. The lack of specificity of signs or symptoms and the significant proportion of asymptomatic infections make symptom-based screening for identification of SARS-CoV-2 in children difficult.

Symptoms in older adults

Symptoms amongst older adults may be atypical or subtle. Confusion, delirium, and/or loss of movement, mobility and speech may occur in older people. Fever, cough and shortness of breath may be absent or less common.

Symptoms in older adults that differ from typical symptoms include:

- fever and other symptoms may take longer to manifest
- delirium, confusion, falls, functional decline
- decrease in blood pressure
- hypoxia without respiratory symptoms

Asymptomatic, pre-symptomatic and pauci-symptomatic infection

A person who is **asymptomatic** is someone with a positive SARS-CoV-2 test who never develops any symptoms, whereas a person who is **pre-symptomatic** is someone who is infected with SARS-CoV-2 and may have detectable virus, but is not yet showing symptoms (these individuals develop symptoms later on in the course of infection). Individuals who are **pauci-symptomatic** will have a positive SARS-CoV-2 test in the presence of very limited symptomatology. A systematic review and meta-analysis looking at prevalence of SARS-CoV-2 in persons who are asymptomatic from 28 studies, found that 25% of COVID-19 cases were asymptomatic (95%CI: 16–38). Asymptomatic, pre-symptomatic and pauci-symptomatic SARS-CoV-2 infection and how much each of these contributes to transmission is still unknown.

Diagnosis

Diagnosis is made by isolation of the virus in a mid-turbinate swab, nasopharyngeal swab, throat and nose swab, or mouth gargle by PCR at the provincial lab with a confirmatory result. Abbot ID Now point of care (POC) anterior nasal testing may be completed as a screen but a positive result must be confirmed by PCR.

Epidemiology

Reservoir

Early on, many of the patients in the outbreak of respiratory illness caused by COVID-19 in Wuhan, China had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread.

Transmission

The understanding of COVID-19 transmission has evolved since the beginning of the pandemic and has informed the public health measures (PHM) used in Canada. Infected individuals generate respiratory droplets and aerosols, which can be transmitted to others. Activities that are more likely to generate respiratory droplets and aerosols include: heavy breathing (e.g., during exercise), talking, singing, shouting, coughing, and sneezing. The droplets vary in size from large droplets that may fall to the ground relatively quickly near the person who is infected, to small droplets called aerosols which may remain suspended in the air and travel on ambient air currents. The risk of transmission via respiratory aerosols is greater in poorly ventilated indoor environments where there is a high density of people and extended duration of contact.

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The relative infectiousness of droplets of different sizes, and the amount of virus in respiratory droplets needed to cause infection (i.e., infectious dose), is not clear.

Infectious droplets or aerosols may come into direct contact with the mucous membranes of another person's nose, mouth, or eyes, or they may be inhaled into the nose, mouth, and airways, with smaller aerosols penetrating deeper into the lungs. The virus may also spread when a person touches another person (e.g., a handshake) or an object (referred to as fomites) that has the virus on it, and then touches their mouth, nose, or eyes with unwashed hands.

Other factors that may affect the transmission of COVID-19 are age, infectiousness, presence of symptoms, illness severity, and characteristics of the virus itself (e.g., VOC), as well as adherence to personal preventive practices, such as physical distancing, proper use of well-constructed and well-fitting masks, hand hygiene, and respiratory etiquette. There is no evidence to date to suggest differences in mode of transmission of circulating VOC.

Environmental factors, settings, and specific activities can contribute to the risk of viral transmission, including enclosed spaces, especially those with poor ventilation, crowded settings, and close interactions. Settings where these factors overlap or involve activities such as singing, shouting or heavy breathing (e.g., aerobic exercise) are considered higher risk. Examples of these settings include family gatherings and other social gatherings, religious services, funerals, and choir practices, as well as in occupational settings including health care facilities and meat processing plants. The duration of exposure in such settings is also likely to increase the risk of transmission. It is exceedingly important that PHM be applied in a “layered” manner in these settings to reduce the risk of transmission

Incubation Period

The incubation period for COVID-19 has been estimated to range from 2 to 14 days, with a median of 5-6 days from exposure to symptom onset. Of all individuals who develop symptoms, 97.5% of the symptoms occur within 11.5 days of exposure and 75% will develop symptoms between 6.7 and 8.5 days.

Period of Communicability

The time period in which an individual with COVID-19 can transmit the virus is said to be at a maximum of 10 days after symptom onset for immunocompetent people who have COVID-19. Evidence has shown that an individual may be infectious for up to 3 days prior to any presentation of symptoms. The levels of viral RNA from nasopharyngeal, saliva/sputum samples, upper respiratory specimens, and stool samples appear to be highest soon after symptom onset.

Note that SARS-CoV-2 RNA may be detectable in the upper or lower respiratory tract for weeks after illness onset. However, detection of viral RNA does not necessarily mean that the patient can transmit the virus.

A recent systematic review and meta-analysis found that SARS-CoV-2 cases with serial upper respiratory tract samples showed peak viral loads within the first week of symptom onset. The highest viral loads were reported soon after or at the time of symptom onset or at day 3–5 of illness, followed by a consistent decline.

Disease severity and risk factors for severe disease

There is a spectrum of COVID-19 disease severity, ranging from asymptomatic to mild, to moderate, severe and critical disease. Severe disease more often occurs in those with increasing age and those with underlying medical conditions, with the risk increasing with the number of underlying conditions.

Two large cohort studies in the USA and the UK found the most common comorbidities were hypertension (46.7%), hyperlipidemia (28.9%), diabetes (27.9%), and chronic pulmonary disease (16.1%). High risk for mortality was associated with increasing number of comorbid conditions. A comprehensive CDC scientific evidence review process and a Canadian rapid review have recently been published to update the list of underlying medical conditions associated with more severe COVID-19 disease. The conditions identified in these reviews are listed in Table 2 below:

Table 2: Underlying medical conditions associated with more severe COVID-19 disease

<p>Asthma (moderate to severe) Cancer Chronic kidney and end-stage disease Chronic lung diseases Cystic fibrosis Dementia or other neurological conditions Diabetes (type 1 or type 2) Down syndrome Epilepsy Heart conditions</p> <ul style="list-style-type: none"> • such as heart failure, coronary artery disease, cardiomyopathies or hypertension 	<p>HIV infection Immunocompromised state Interstitial lung disease Liver disease Motor neuron diseases Overweight and obesity* Pregnancy Pulmonary hypertension Sickle cell disease or thalassemia Smoking, current or former Solid organ or blood stem cell transplant Stroke or cerebrovascular disease Substance use disorders</p>
<p>*Overweight = body mass index (BMI) > 25 kg/m² but < 30 kg/m², obesity (BMI ≥30 kg/m² but < 40 kg/m²), or severe obesity (BMI of ≥40 kg/m²)</p>	

Patients with certain medical and/or social vulnerabilities, including people experiencing intellectual and developmental disabilities, persons who use substances regularly, people experience cognitive disabilities, mental health conditions or experiencing homelessness or are unhoused, may make it more difficult for the patient to recognize, clearly communicate, or act on symptom progression. These patients need closer attention and monitoring.

Variants of concern (VOC)

Viruses naturally mutate or change over time. Mutations do not always increase transmissibility or virulence, or lead to suboptimal immune or therapeutic responses compared to non-variant viruses. Multiple SARS-CoV-2 variants have emerged in recent months and have shown increased transmissibility when compared with the original strain of SARS-CoV-2. These have been labeled variants of concern (VOCs). The reason for the increased transmissibility of some SARS-CoV-2 variants has not been fully determined, though it may be related to changes in receptor binding or viral load.

Clinical Reinfection

Reinfections have been confirmed to occur in several individuals through the detection of two different viral genomes associated with what appear to be separate episodes of infection. While these are rare, clinical reinfection of COVID-19 should be considered in a patient with a previously confirmed COVID-19 infection (as determined by a positive SARS-CoV-2 molecular test), who is experiencing a recurrence of COVID-19 symptoms and has a subsequent positive SARS-CoV-2 PCR test. This reinfection should include a sufficient time period between the first infection and the second (using clinical judgement and epidemiological investigation). As new variants are introduced, reinfection may become more common. Fully vaccinated people who are admitted to hospital with COVID-19 should have genetic sequencing performed.

As variants of concern (VOC) emerge in Canada it will be important to continue to assess patients with symptoms of COVID-19, particularly as breakthrough cases may occur amongst the vaccinated and those previously infected.

Occurrence

General

Novel coronavirus (COVID-19) was first detected in Wuhan City, China in December 2019. As of June 21, 2021 over 178.8 million cases have been detected across the world with over 3.8 million deaths (global case fatality rate: 2.2%).

Canada

There have been 1,409,607 cases and 26,087 deaths (case fatality rate 1.9%) as of June 21, 2021. Updated numbers of COVID-19 in Canada are available on the [Public Health Agency of Canada](#) website.

Prince Edward Island

As of June 20, 2021 there are 206 cases of COVID-19 reported in PEI and no deaths due to the virus.

Control

Management of a Case

A case diagnosed in the Community:

- Lab notification is made to the CPHO on call physician
- Patient is contacted by the CPHO physician/nurse to notify of the test result, preliminary information is collected and isolation capabilities are confirmed.
- Follow-up is completed by public health nurses (PHNs) to collect information regarding contacts and completion of the case report form
- PHNs also make daily calls to monitor health status of the infected person, and answer any questions/concerns they may have.

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- Isolation can be discontinued for a case 10¹ days after symptoms began or since the positive test, as long as the infected person feels well and is not taking any immunosuppressive therapies.
- If the infected person is a health care worker, they may return to work after their isolation is complete.

Management of Contacts

Follow up and education is to be completed² for all close contacts of all confirmed cases. Contacts of cases should be assessed for immune compromise, and other factors that would make them more likely to contract COVID-19.

A close contact is defined as:

- those who provided care for the case, including healthcare workers, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment, OR
- those who lived with or otherwise had close prolonged³ contact (within 2 metres) with a probable or confirmed case while the case was ill or within 48 hours of symptom onset, OR
- those who have had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended personal protective equipment.
- Other exposure scenarios not specifically mentioned here may arise and may be considered at the discretion of the CPHO.

The isolation and testing for **close contacts** of a case is based on vaccine status:

Household close contacts

- If not fully vaccinated (non-immunized or partially immunized)
 - Required to self-isolate and monitor for symptoms for 14 days from the date of the last exposure to the positive case
 - Required to test three times – day 0-1, day 4-6 and day 9-11
- If fully vaccinated
 - Required to self-isolate and monitor for symptoms for seven days and until you receive two negative tests
 - Required to test three times – day 0-1, day 4-6 and day 9-11

Non-household close contacts

- If not fully vaccinated (non-immunized or partially immunized)

¹ Viable virus has not been obtained from a recovered case infected with COVID after 10 days post symptom onset or positive test result. 14 days of isolation for contacts is still required since the incubation of the virus can be up to 14 days.

² To be completed by Public Health Nursing.

³ There is insufficient evidence available to define risk in terms of the length of exposure time required for transmission. For public health contact identification and management purposes only, a period of 15 cumulative minutes over 24 hours has been selected to distinguish between brief and prolonged exposure. This parameter should not replace the conclusions derived from an individual risk assessment, conducted by the public health authority that addresses a variety of factors (i.e. infectiousness of the case at time of exposure, exposure is to a VOC, likely route of transmission, risk factors, etc.) that will more precisely inform risk.

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- Required to self-isolate and monitor for symptoms for 14 days from the date of the last exposure to the positive case
- Required to test three times – day 0-1, day 4-6 and day 9-11
- If fully immunized⁴
 - **Non-household** close contacts who are asymptomatic are not required to do strict isolation but should for the first 7 days:
 - Maintain public health measures such as wearing a mask, physical distancing and washing hands when in public places
 - Minimize contacts
 - Limit activities to essential tasks such as school, work, grocery shopping etc.
 - Do not have sleepovers, play dates or other social gatherings
 - Required to test on day 0, 3, 6 and 9
 - If symptoms occur isolate immediately and get tested

All immunosuppressed individuals⁵ who are a close contact of a case, including those who are fully immunized, will isolate x14 days post exposure.

A **casual contact** is a person who attended the same location at the same time as a case but did not have prolonged direct contact with the case of COVID 19.

All **casual** contacts will monitor for symptoms and test at day 4-6 and all contacts should isolate and test immediately if symptoms occur.

Each case and contact situation will have a risk assessment completed by public health and precautions adjusted as required.

Public Health Nursing (PHN) will notify both casual and close contacts of their contact status with an initial call. Follow up will continue with close contacts daily as required. If symptoms occur between scheduled tests, testing will be arranged.

Outbreak management

Outbreaks may occur in a variety of settings in the Community. LTC homes and hospitals and other high-risk settings. These settings have specific guidelines that address outbreak management. Other exposure scenarios not specifically mentioned in the close contact

⁴ Definition of Fully Vaccinated: 14 days after receiving the second dose of a Health Canada approved 2-dose vaccine series, or 14 days after receiving an mRNA vaccine following a full series of a non-Health Canada approved vaccine series.

⁵ Immunosuppressed individuals are those with the following conditions:

- Active treatment for solid tumour or hematologic malignancies
- Receipt of solid-organ transplant and taking immunosuppressive therapy
- Receipt of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- Moderate to severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Stage 3 or advanced untreated HIV infection and those with acquired immunodeficiency syndrome
- Active treatment with the following categories of immunosuppressive therapies: anti-B cell therapies (monoclonal antibodies targeting CD19, CD20 and CD22), high-dose systemic corticosteroids (refer to the CIG for suggested definition of high dose steroids), alkylating agents, antimetabolites, or tumor-necrosis factor (TNF) inhibitors and other biologic agents that are significantly immunosuppressive.

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definition may arise and may be considered at the discretion of the CPHO. For example, an outbreak in a community of unimmunized people would require a broader definition of close contact and casual contacts. These groups may be followed up more closely e.g. at a wedding, due to the nature of interactions, the entire gathering might be considered close contacts.

Each outbreak situation will have a risk assessment by the CPHO to determine parameters for contact management. If there are a large number of *casual contacts* (e.g. in the same place at the same time but no *prolonged close contact*) for example at a hockey tournament, large work site or school setting, contacts would be asked to monitor for symptoms and be tested if symptoms occur.

Treatment

Treatment is mostly supportive; however, people who are hospitalized with COVID-19 and require respiratory assistance may be treated with dexamethasone. More information on medications authorized in Canada to treat COVID-19 can be found here:

<https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments.html>

Self-Isolating

Up to date information on self-isolation can be found at:

<https://www.princeedwardisland.ca/en/information/health-and-wellness/covid-19-self-isolation>

Testing

There are two type of testing available on PEI, point of care (POC) testing and lab-based PCR testing. Testing at the point of entry to the province is completed with the ID Now POC test. This is considered a screening test and must be confirmed with a lab-based PCR test. People who receive a presumptive positive POC test are asked to isolate until they receive their lab-based PCR test results.

For more testing information visit: <https://www.princeedwardisland.ca/en/information/health-and-wellness/covid-19-testing-in-pe>

Rotational Workers

Guidance for rotational workers can be found at:

<https://www.princeedwardisland.ca/en/information/health-and-wellness/rotational-workers>

Patients Admitted to Acute Care

Health PEI Acute Care COVID guidance can be found on the Spectrum app.

Residents Admitted to Long Term Care (LTC) or Community Care Facility (CCF)

Refer to [Prince Edward Island Guidelines for the Management and Control of COVID-19 in Long-Term Care Facilities](#) and [Guidelines for Infection Prevention and Control of COVID-19 in Community Care Facilities](#) for specific information.

Infection Prevention and Control in the Community

As the rate of immunization for COVID- 19 increases, Public Health Measures will decrease. At this time the following are still recommended.

- Wash your hands frequently with soap and water or use alcohol-based hand rub. Use soap and water when hands are visibly soiled.
- Cough and sneeze into your elbow or a tissue. If using a tissue, immediately place it in a waste disposal and wash your hands.
- If possible, stay home when ill with acute respiratory symptoms; if this is not possible, limit close contact with others.
- Limit touching your eyes, nose, and mouth.
- Use of masks by members of the general public when in public places
- Physical distancing (2 metres/6 feet) is recommended in public spaces

National COVID-19 and Infection Prevention and Control Guidelines

[Infection Prevention and Control for Novel Coronavirus \(COVID-19\): Interim Guidance for Acute Healthcare Settings](#)

[Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings](#)

[Interim guidance: Public health management of cases and contacts associated with novel coronavirus disease 2019 \(COVID-19\)](#)

[Public Health Guidance for Schools \(K-12\) and Childcare Programs \(COVID-19\)](#)

[Risk-informed decision making for mass gatherings during COVID-19 global outbreak](#)

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Appendix A

At a Glance:

Contact Management for *Fully Immunized* Individuals without Immunocompromise

Scenario	Population	Initial Contact Recommendations	Public Health Unit Follow-Up Responsibilities
Symptomatic	All individuals	Self-isolate and get tested	Should be followed daily by PHN
Tests Positive	All individuals	Self-isolate	Followed as a Case by PHN
Asymptomatic non-household close contact	Residents of high-risk congregate living settings/ Inpatients	Self-isolate and get tested	Per facility protocol
	Healthcare Workers	Not required to self-isolate. Get tested 0-1, 4-6, 9-11	These individuals must report exposure to employer and/or Employee Health/ICP and follow any work restriction requirements.
	All other individuals	Not required to self-isolate. Get tested 0-1, 3,6, 9	These individuals must report exposure to employer and/or Occupational Health Department and follow any work restriction requirements
Asymptomatic Household Close contact	All individuals	Self-isolate and monitor for symptoms 7days and until you receive 2 negative tests Get tested 0-1, 4-6 and 9-11	Must have 2 negative tests and totally isolating away from the case for 7 days.

COVID-19

Appendix B: Symptom Diary for Self- Isolation

Name:								
MRN:								
Start Date of Isolation:								
Day	Symptoms							
	No Symptoms	Temperature C°/F°	Sore Throat	Cough	Runny Nose	Shortness of Breath	Other Symptoms	Have you had contact with anyone outside of isolation ?
0	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
1	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
2	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
3	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
4	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
5	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
6	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
7	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
8	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
9	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
10	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
11	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
12	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
13	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
14	<input type="checkbox"/> None		<input type="radio"/> Yes <input type="radio"/> No					
...								