

AFSCME Facts

Coronavirus 2019 (COVID-19) Industry-Specific Guidance

General Guidance for all U.S. Workers and Employers

For most people in the United States, including most types of workers, the risk of infection with COVID-19 is currently low. Employers and workers in operations where there is no specific exposure hazard should remain aware of the evolving outbreak situation. Conditions are changing on a daily basis, which may warrant additional precautions in other workplaces.

For all workers, regardless of specific exposure risks, it is always a good practice to:

- Frequently wash your hands with soap and water for at least 20 seconds. When soap and running water are unavailable, use an alcohol-based hand rub with at least 60% alcohol.
- Always wash hands that are visibly soiled.
- Avoid touching your eyes, nose, or mouth with unwashed hands.
- Avoid close contact with people who are sick.

The U.S. Centers for Disease Control and Prevention has developed [interim guidance](#) for businesses and employers to plan for and respond to COVID-19. The guidance is intended to help prevent workplace exposures to acute respiratory illnesses, including COVID-19, and to help employers prepare for more widespread, community outbreaks of the disease if it should occur.

This document is intended to give industry-specific guidance for AFSCME members in jobs with a higher risk of exposure to COVID-19. Those industries include healthcare, corrections, medical waste management, EMS/first responders, education and childcare workers, solid waste and wastewater workers and death care workers.

Health Care

Health workers are at the front line of any outbreak response and as such are exposed to hazards that put them at risk of infection. Hazards include exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma, and physical and psychological violence. Health care providers should work with their employer to ensure that proper protocols are in place. However, it is ultimately the employers' responsibility to assume to ensure all preventive and protective measures are taken in order to minimize occupational safety and health risks. Preventative measures and proper protocols include:

Limit the number of patients going to hospital or outpatient settings: Consider developing mechanisms to screen patients for acute respiratory illness prior to their non-urgent care or elective

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visits or procedures, such as through the appointment reminder system. Postpone and reschedule those with signs and symptoms presenting for these non-acute visits.

Exclude providers not directly involved in patient care: Limit the number of providers who enter the patient's room to only those providing direct patient care. Exclude staff such as dietary and housekeeping employees.

Limit face-to-face provider encounters with patient: Limit face-to-face contact between providers and patients with confirmed or suspected COVID-19. Bundle care activities to minimize room entries and have food trays delivered by providers performing other care. Use telephones, video monitoring, and video-call applications on cell phones or tablets where possible.

Exclude visitors to patients with known or suspected COVID-19: Restrict visitors from entering the room of known or suspected COVID-19 patients (also known as persons under investigation or PUI). Explore use of video-call applications on cell phones or tablets. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient's emotional well-being and care. Personal protective equipment and instruction on its use should be provided to visitors before entering patients' rooms.

Source control: Patients with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) presenting for care should use facemasks for source control until they can be placed in an airborne infection isolation room or a private room, and should be instructed in how to use facemasks. Patients with these symptoms should not use N95 respirators. If these patients need to leave their room for services in other areas of the hospital, they should also wear facemasks.

Cohorting patients: Cohorting is the practice of grouping together patients who are infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorting has been used extensively for managing outbreaks of other diseases including MRSA and SARS. When single patient rooms are not available, patients with confirmed COVID-19 may be placed in the same room.

Cohorting providers: Assigning designated teams of providers for all patients with suspected or confirmed COVID-19 can limit the number of providers exposed to the disease and the number who need to be fit tested for personal protective equipment such as N95 respirators.

Telemedicine: Nurse advice lines and telemedicine can screen and manage patients who may be infected with COVID-19 without exposure to the provider and can potentially reduce the influx of patients to healthcare facilities seeking evaluation.

Training on when to use N95 respirators: The OSHA Respiratory Protection standard requires employers to provide respirator training prior to requiring an employee to use a respirator in the

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workplace. The training must include the situations that require respirator use. For example, providers should use N95 respirators when caring for patients under airborne precautions for infectious diseases including COVID-19. However, providers should generally not need to use N95 respirators when caring for patients under droplet precautions for infectious diseases except under certain circumstances.

Training on how to use N95 respirators: Training employees on the proper use of respirators, including putting on and removing them, limitations on their use, and maintenance is essential for effective use of respiratory protection. Providers should be thoroughly trained before they are fit tested to ensure they are comfortable donning the respirator and know how to conduct a user seal check. Providers should be trained on the respirator they are expecting to use at work.

Just in time fit testing: Facilities may also adopt a plan to use the “just-in-time” method for fit testing, which has been incorporated into pandemic plans for many facilities. For large facilities, it may not be feasible to fit test all employees, especially if their job does not typically place them at risk for exposure to airborne infectious diseases such as tuberculosis. These hospitals have the capacity to do larger scale training and fit testing of employees when necessary during a pandemic. If health care facilities are expecting to receive COVID-19 patients, they should begin training and start to plan for fit testing now. It is essential to have providers trained and fit tested prior to receiving patients.

Limiting respirators during training: In order to conserve the supply of N95 respirators, healthcare facilities should be clear on which of their HCP do and do not need to be in a respiratory protection program and thus medically evaluated, trained, and fit tested. If training and fit testing are conducted during two separate steps, it may be possible to allow limited re-use of N95 respirators used by individual providers during both steps. Employees should be fit tested after they are comfortable donning the respirator and have passed a user seal check. Employees should be trained on the respirator they are expecting to use at work. The respirator can be saved and used for fit testing and patient care.

Qualitative fit testing: Health care systems that use quantitative fit testing should consider switching to qualitative testing, as qualitative testing allows more rapid testing of large numbers of providers and allows a provider to re-use the tested respirator. (A qualitative fit test is a pass/fail test to assess the adequacy of respirator fit that relies on the individual’s sensory detection of a test agent. A quantitative fit test numerically measures the effectiveness of the respirator to seal with the wearer’s face, without relying on the wearer’s voluntary or involuntary response to a test agent. Quantitative fit tests involve adaptation of the respirator to the fit testing equipment, which can involve making holes in the respirator.

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The CDC and WHO also recommend that health care facilities:

- Familiarize personnel with technical updates on COVID-19 and provide appropriate tools to assess, triage, test and treat patients.
- Advise workers on self-assessment, symptom reporting and staying home when ill.
- Maintain appropriate working hours with breaks to avoid undue fatigue.
- Remind workers to exercise the right to remove themselves from a work situation that they have reasonable justification to believe presents an imminent and serious danger to their life or health.
- Swiftly follow established public health reporting procedures of suspected and confirmed cases.
- Provide or reinforce accurate infection prevention and control, and public health information.

Health care employers should ensure they have adequate amounts of personal protective equipment and other infection prevention and control supplies for both providers and patients, such as hand hygiene supplies and patient facemasks. Other recommendations include:

- Have contingency plans if the demand for PPE or other supplies exceeds supply.
- Review surge capacity procedures and crisis standards of care.
- Review procedures for laboratory submission of specimens for COVID-19 testing.
- Assess environmental cleaning procedures.
- Provide education/refresher training for environmental services personnel.
- Ensure that appropriate personnel have been medically cleared, fit-tested, and trained for respirator use.

Corrections

In China, the prison system has become an area of great concern with the outbreak of COVID-19. Hundreds of prisoners as well as correctional officers have been confirmed, with one official saying that China's jails are the new battleground for the disease.

Unfortunately, the CDC does not yet appear to have developed any coronavirus-specific materials aimed at correctional workers. The American Correctional Association was scheduled to present a [webinar on fighting the spread of COVID-19](#) in February, but it has been postponed until March 10. We have reached out to the ACA to inquire into other resources or suggestions for best practices and will continue to monitor the CDC and the ACA for more information.

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Medical Waste Management

OSHA guidance for waste management is based on the CDC's determination that COVID-19 is not a Category A infectious substance. As such, workers and employers should manage waste contaminated with COVID-19 as they would other regulated medical waste. OSHA also states that workers use appropriate engineering and administrative controls, safe work practices, and personal protective equipment, such as puncture-resistant gloves and face/eye protection, to prevent worker exposure to medical waste, including sharps and other items that can cause injuries or exposures to infectious materials. Other guidance includes:

- Ensure red bags are properly closed and tied with an overhand balloon knot so that they are leakproof before being moved.
- Red bags should be placed in a container with a secure lid.
- All sharps containers should be fully closed and placed in a bag and placed in a container. Preferably, single use disposable sharps containers should be used in place of reusable sharps containers.
- Containers should be single use and in compliance with DOT regulatory requirements for regulated medical waste.
- Single use containers can be treated at a permitted medical waste facility.
- Avoid taking medical waste to a facility that shreds in an open atmosphere prior to treatment to reduce potential worker exposure. Shredding in an enclosed treatment process is acceptable.
- Notify the hauler about wastes that contain 2019-nCoV.

EMS/First Responders

This guidance applies to all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work. Workers and employers involved in EMS or other medical transport operations will likely need to adapt guidelines for the mobile work environment. That may mean relying on personal protective equipment such as respirators to protect workers when use of isolation rooms or other isolation mechanisms are not practical and when staff have potentially prolonged, close contact with suspected or confirmed COVID-19 patients in transit.

When preparing for and responding to patients with confirmed or possible COVID-19, close coordination and effective communications are important among 911 call centers (also known as public safety answering points or PSAPs), the EMS system, healthcare facilities, and the public health system. Each call center and EMS system should seek the involvement of an EMS medical director to provide appropriate medical oversight. When COVID-19 is suspected in a

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patient needing emergency transport, prehospital care providers and healthcare facilities should be notified in advance that they may be caring for, transporting, or receiving a patient who may have COVID-19 infection. EMS clinician practices should be based on the most up to date COVID-19 clinical recommendations.

Patient assessment:

- If call takers advise that the patient is suspected of having COVID-19, EMS clinicians should put on appropriate [personal protective equipment](#) before entering the scene.
- If information about potential for COVID-19 has not been provided, EMS clinicians should exercise appropriate precautions when responding to any patient with signs or symptoms of a respiratory infection.
- A facemask should be worn by the patient for source control. Alternatively, an oxygen mask can be used if clinically indicated.
- During transport, limit the number of providers in the patient compartment to essential personnel to minimize possible exposures.

Recommended personal protective equipment:

- EMS clinicians who will directly care for a patient with possible COVID-19 infection or who will be in the compartment with the patient should follow Standard, Contact, and Airborne Precautions, including the use of eye protection. Recommended PPE includes:
 - A single pair of disposable patient examination gloves. Change gloves if they become torn or heavily contaminated.
 - Disposable isolation gown.
 - Respiratory protection such as an N-95 or higher-level respirator.
 - Eye protection such as goggles or disposable face shield that fully covers the front and sides of the face.
- Drivers, if they provide direct patient care such as moving patients onto stretchers, should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment. If the transport vehicle does not have an isolated driver's compartment, the driver should remove the face shield or goggles, gown and gloves and perform hand hygiene. A respirator should continue to be used during transport.
- All personnel should avoid touching their face while working.
- On arrival, after the patient is released to the facility, EMS clinicians should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures.

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EMS employer responsibilities:

The responsibilities described in this section are not specific for the care and transport of persons under investigation or patients with confirmed COVID-19. However, this interim guidance presents an opportunity to assess current practices and verify that training and procedures are up to date:

- EMS units should have infection control policies and procedures in place, including describing a recommended sequence for safely donning and doffing personal protective equipment.
- Provide all EMS clinicians with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- Ensure that EMS clinicians are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.
- Ensure EMS clinicians are medically cleared, trained, and fit tested for respiratory protection device use such as N95 filtering facepiece respirators, or medically cleared and trained in the use of an alternative respiratory protection device such as Powered Air-Purifying Respirator, or PAPR, whenever respirators are required.
- EMS units should have an adequate supply of PPE.
- Ensure an adequate supply of or access to EPA-registered hospital grade disinfectants for adequate decontamination of EMS transport vehicles and their contents.
- Ensure that EMS clinicians and biohazard cleaners are educated, trained, and have practiced the process according to the manufacturer's recommendations or the EMS agency's standard operating procedures.

Education and Childcare Workers

As with corrections, the CDC does not appear to have developed any coronavirus-specific materials aimed at education and childcare workers. However, several jurisdictions have put out guidance for childcare and preschool settings.

Childcare centers and preschools can take common-sense precautions to prevent the spread of all infectious diseases. These precautions for families and staff will also be helpful to prevent the spread of other common illnesses such as influenza and gastroenteritis:

- Stay home when sick.
- Remain at home until fever has been gone for at least 24 hours without the use of fever-reducing medicines.

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- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Seek immediate medical care if symptoms become more severe, such as a high fever or difficulty breathing.
- Use “respiratory etiquette:” cover your mouth and nose with a tissue or your sleeve, not your hands, when coughing or sneezing. If you use a tissue, throw it in the trash.
- Provide adequate supplies of tissues and no-touch trash cans within easy reach.
- Wash hands frequently. Encourage hand washing by children and staff through education and scheduled time for handwashing.
- Routinely clean frequently touched surfaces.
- Separate sick infants, children, and staff from others until they can go home. When feasible, identify a “sick room” through which others do not regularly pass.
- Encourage flu vaccine for those who haven’t had it this season to reduce illnesses and absences on campus. This will not prevent COVID-19 but can reduce the risk of developing pneumonia for those who contract it.
- Develop plans now to respond to outbreaks of communicable diseases.

Solid Waste and Wastewater Management Workers

This guidance for solid waste and wastewater management workers and employers supplements the general, interim guidance for U.S. workers and employers with potential occupational exposures to COVID-19. Generally, management of waste that is suspected or known to contain or be contaminated with COVID-19 does not require additional precautions beyond those already used to protect workers from the hazards they encounter during their routine job tasks in solid waste, including medical waste, and wastewater management.

Solid waste

Workers and employers should manage solid waste contaminated with COVID-19 as they would other regulated medical waste. COVID-19 is not a Category A infectious substance. Use typical engineering and administrative controls, safe work practices, and personal protective equipment, such as puncture-resistant gloves and face/eye protection, to prevent worker exposure to medical waste, including sharps and other items that can cause injuries or exposures to infectious materials. For additional information, consult the regulated medical waste information in CDC’s guidelines for [environmental infection control in healthcare facilities](#).

Wastewater

Coronaviruses are susceptible to the same disinfection conditions in the healthcare setting as other viruses, so current disinfection conditions in wastewater treatment facilities is expected to

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be sufficient. This includes conditions for practices such as oxidation with chlorine bleach and peracetic acid, as well as inactivation using ultraviolet irradiation.

There is no evidence to suggest that additional, COVID-19-specific protections are needed for employees involved in wastewater management operations, including those at wastewater treatment facilities. Wastewater treatment plant operations should ensure workers follow routine practices to prevent exposure to wastewater, including using the engineering and administrative controls, safe work practices, and personal protective equipment normally required for work tasks when handling untreated wastewater.

Death Care

This guidance for death care workers, such as coroners, medical examiners, autopsy technicians, funeral directors, and other mortuary workers supplements the general, interim guidance for U.S. workers and employers of workers with potential occupational exposures to COVID-19. Until more is known about how the COVID-19 spreads, CDC and OSHA recommend using a combination of standard precautions, contact precautions, airborne precautions, and eye protection such as goggles or face shields to protect mortuary and other death care workers with exposure to the virus.

Mortuary and other death care workers who have contact with the remains of people who have died from COVID-19 infection must be protected from exposure to infected blood and body fluids, contaminated objects, or other contaminated environmental surfaces. Employers of mortuary and other death care workers are responsible for following applicable OSHA requirements, including OSHA's Bloodborne Pathogens, Personal Protective Equipment, and Respiratory Protection standards.

Prompt cremation or burial of the remains of individuals who have died of COVID-19 can help prevent worker exposure to the virus. State and local requirements may dictate whether the remains of individuals who have died of certain infectious diseases can be buried or if they must be cremated.

Follow recognized good biosafety practices to prevent or minimize transmission of infectious agents. To protect workers from COVID-19 exposure, OSHA recommends suspension of postmortem or autopsy procedures on patients with suspected or confirmed COVID-19 infection because of the potential for very high viral load (or the number of viral particles in the body) at death. If an autopsy is deemed necessary and appropriate, OSHA recommends strict adherence to basic safety procedures.