COVID 19
CORONAVIRUS DISEASE

STOP THE SPREAD

NIH Safety Guidance & COVID-19 Safety Plan

for *Working Onsite During the Coronavirus Pandemic*

COLLABORATING PROGRAMS:

Office of Research Services, Division of Occupational Health and Safety, Office of Research Facilities Division of Operations and Maintenance and Division of Environmental Protection

National Institutes of Health

Contents

Executive Summary

The COVID-19 pandemic has presented the NIH with one of its most significant operational challenges ever. Since March 2020, the dedicated researchers, healthcare professionals, maintenance personnel, and administrative support staff have been forced to adapt to new work practices and develop new strategies for coping with the impacts of Covid-19.

Since the pandemic began much has changed; in our knowledge of the virus, the tools at our disposal, and the reality that some level of COVID-19 within the community is likely to persist for years to come. This document, which serves as a revision to previous versions of the NIH Return to the Physical Workplace and COVID-19 Plan, lays out the principles and practices that the NIH will base its decision-making on for minimizing the risk of workplace transmission. The basic principles that the NIH will follow are:

- **Risk Assessment.** Understanding the virus and how it spreads is fundamental to understanding how to protect ourselves. The risk of exposure is determined by a number of factors, including (but not limited to) the infectious dose and transmissibility and virulence of the viral variant, the size of the space, the vaccination rates of staff, the ventilation and air filtration in buildings, the use of protective equipment, the duration of exposure, and the number of personnel present. We also consider host factors such as whether the individual is immunocompromised, has a condition that places them at high risk for a poor outcome if infected, and whether or not they live or work closely with immunocompromised or high-risk individuals. Understanding these factors allows us to make informed decisions that reduce risk to an acceptable level and limit (or eliminate) workplace transmission.
- **Vaccinations.** The introduction of multiple highly effective vaccines has greatly reduced the threat of COVID-19 to NIH staff members. Maintaining near-universal vaccination rates among NIH employees and contractors is fundamental to minimizing risk of workplace transmission of the SARS-CoV-2 virus.
- **Symptom Self-monitoring and COVID-19 Testing Programs.** Each of us knows our physical health better than anyone else. NIH staff experiencing any COVID-19 symptoms must stay home (or leave immediately if at work). Notify your supervisor to discuss options for leave or telework. Routine surveillance (e.g., asymptomatic) testing is also an important tool to detect asymptomatic infection and ensure safety of staff.
- **Masking.** Use of face coverings, surgical masks, and N95 respirators prevent the spread of the SARS-CoV-2. They serve as source control, reducing the potential to infect others. N95s, and to a lesser extent surgical masks and face coverings, can also provide protection from infection if exposed to SARS-CoV-2 positive personnel.
- **Physical Distancing.** Occupancy must be limited to 1 person per 125 sq. ft. AND NIH staff must maintain 6 feet of physical distancing from others whenever possible. To safely achieve this distancing in areas with extremely high transmission rates staff may need to use improved face coverings, such as Level 3 surgical masks. When 6 feet of physical

distancing is not possible other measures must be implemented, including minimizing time in close proximity to others, enhanced personal protective equipment (PPE), and increased screening practices.

- **Workplace Flexibility.** The greatest tool in the NIH toolbox is our adaptability to the challenges presented by the COVID-19 pandemic. Maximizing the use of telework, leave options, and other administrative controls can greatly reduce to potential for workplace exposure by minimizing contact with others that may be infected. The NIH staff has demonstrated remarkable resilience and the ability to perform exceptional science and provide the highest customer service despite being forced to remotely work for much of the past two years. Using the tools we have refined (including virtual meetings) will allow us to continue to adjust to conditions that can quickly change.

This document will address each of the topics in detail, as well as provide a framework for safe return to work guidance. The document includes information on a safe return to the physical workplace, universal workplace expectations, travel and meeting guidance, testing and vaccination information, staff wellness and the OSHA temporary standard for Healthcare (Appendices VIII and IX). Additionally, there are appendices included which provide supporting materials for the main body of this document, including definitions, illustrations, and background information that contributed to the requirements laid out in this document.

Applicability. This document applies to all NIH operations, at all facilities throughout the country. However, the NIH recognizes that a one-size-fits-all approach is not sustainable, and that risk assessments and local conditions may require customized solutions to the challenges of each location. Rather than prescriptive solutions, this document establishes baseline expectations. Where modifications from these baseline expectations is necessary, the changes should be thoroughly documented and supported by a risk assessment conducted by the supervisor, in consultation with the Division of Occupational Health and Safety (DOHS) and approved by the Institute/Center/Office (ICO) leadership.

Return to Work Expectations

On November 4th, 2021, HHS notified all NIH employees of the plan for personnel to return to the physical workplace. The framework identifies 4 groups and anticipated return timelines. The four phases, personnel expected to return within each phase, and timeline for return are listed in the table below.

Phase	Personnel Affected	Tentative Timeline (subject to change based on pandemic trends and NIH-specific requirements)
Phase 1. Voluntary Return	Personnel that have continued to report to work during the pandemic and other personnel eligible to return	Ongoing – Throughout December 2021

Phase 2A. Leadership Return	HHS leadership, support staff to leadership, and additional critical on-site employees	December 5-18, 2021
Phase 2B. Full Return (group a).	Employees in specific cross-agency positions including the following functions: budget/finance, grants, acquisition, human resources (HR), equal employment opportunity (EEO), and information technology (IT). *	On hold
Phase 2C. Full Return (group b).	All remaining agency employees. *	On hold

* - contingent upon the successful completion of NIH collective bargaining obligations.

ICO leadership should note that, although personnel are permitted to return during these phases, OPDIV leadership should still maximize the availability of telework and workplace flexibilities to keep our workforce both safe and the NIH competitive with other employers.

It is important to note, that the only persons allowed on NIH campuses or in NIH leased spaces are staff, patients, study subjects, and approved visitors (e.g., deliveries, vendors, contractors). Children are not permitted to be in office, laboratory, or other administrative spaces (e.g., office) in any NIH location. They are permitted to be on campus when in route to day care facilities but should not be brought into other buildings or locations. This same requirement applies to any family member or friend.

Until further notice, properly worn face coverings or face masks will be required for all persons physically present in any NIH owned or leased facility. Face coverings must be worn whenever in or operating an NIH-owned or controlled vehicle (e.g., van or bus). Face coverings or face masks must also be worn outside on any NIH campus when 6’ of physical distancing cannot be maintained (excluding incidental contact during passing). Supervisors will be responsible for ensuring that staff comply with this policy.

Reporting Unsafe Conditions

If you see something at the NIH that you think may create a risk of coronavirus exposure, please report it to your supervisor or your ICO Health and Safety Committee. Concerns can also be reported anonymously through the COVID-19 Reporting Tool or to the Coronavirus Hotline at 301-480-8990. All reported concerns will be investigated and shared with appropriate staff, including NIH and ICO senior leadership, if necessary.

Universal Workplace Expectations

This section establishes expectations for all personnel working at owned or leased NIH properties and facilities, as well as expectations for personnel conducting any official government business at locations outside NIH facilities. NIH personnel must meet these expectations whenever feasible.

Self-Monitoring.

Self-monitoring can prevent the spread of SARS-CoV-2 by limiting the exposure of others to symptomatic personnel. Each day prior to work staff shall assess themselves for any symptoms associated with coronavirus. Staff should also determine if any people living with them have COVID-19 symptoms. According to the most recent CDC Guidance these symptoms are:

- Fever, chills
- Cough
- New loss of taste or smell
- Congestion or runny nose
- Headache
- Sore throat
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Diarrhea
- Nausea or vomiting

NIH staff experiencing any of these symptoms (or that have contact with people with these symptoms within the last 14 days) should contact Occupational Medical Service (OMS) for an evaluation by completing the OMS COVID-19 screening questionnaire. A variety of factors, including vaccination status, exposure risk, and what locations at NIH that you work will be used to determine if you should go to work, receive testing, or self-quarantine. Please contact your supervisor to discuss your leave or duty status. Notify your supervisor. If you experience severe symptoms, you should immediately contact your healthcare provider, go to the Emergency Room, or call 911.

Symptomatic Personnel

Personnel who are symptomatic must:

- Refrain from reporting to work or, if at work, immediately leave work if symptoms develop during the work shift
- Submit an OMS COVID-19 Screening questionnaire. This is used for both screening and scheduling a test as well as reporting community positive test results,
- Receive a PCR-based SARS-CoV-2 test at the earliest For-Cause testing opportunity
    - If COVID test is negative - remain away from work until at least 24 hours after fever has resolved and other symptoms are improving. Fever must not be resolved with - fever-reducing medications (e.g., Ibuprophen, Tylenol, aspirin, etc.)
    - If COVID test is positive isolate for 10 days after onset of symptoms

Employees working in healthcare settings should be referred to Clinical Center Infection Control and Prevention policies for additional guidance.

Risk Factors for Severe Illness

COVID-19 can affect anyone, and the disease can cause symptoms ranging from mild to very severe. The elderly, persons with underlying medical conditions (e.g., cancer, immune compromising conditions or medications, diabetes, obesity, COPD, etc.), and pregnant or recently pregnant people are at higher risk. However, ANYONE can contract COVID-19 and become severely ill, including younger populations and vaccinated people. The CDC defines severe illness for COVID-19 as requiring hospitalization, intensive care, or a ventilator to breathe or death.

Facial Coverings (Cloth Face Coverings, Surgical Masks, and N95 Respirators)

All staff and visitors at the NIH must wear a facial covering when inside NIH owned or leased facilities. Personnel in an enclosed private office are exempt from the facial covering requirements while in their office with the door closed. Cubicles with doors are not enclosed offices, and face coverings must be worn by staff in cubicles. Staff and visitors must also wear facial coverings on any NIH outdoor property when 6’ of physical distancing cannot be maintained (excluding passing incidental contact). Face coverings act as source control and reduce the spread of virus from symptomatic, asymptomatic, and pre-symptomatic infected people.

Appropriate use of facial coverings minimizes transmission because you can spread COVID-19 to others even if you do not feel sick or have any of the cited symptoms. Appropriate use of facial coverings at the NIH means:

- Wearing a well-fitted cloth face cover, KN95, ASTM Level 3 surgical mask, or N95 respirator that covers your nose and mouth, and
    - Is constructed of a minimum of two breathable layers, including a synthetic fiber (preferably non-woven) layer, and
    - Includes a formable nose piece (i.e., wire or malleable plastic) to allow for forming a tight fit around the nose, and
- Replacing soiled, stained, or damaged face coverings, and
- Using a lab dedicated-disposable surgical mask when in the laboratory conducting work at the bench.

Face shields worn alone (without a facial covering underneath) are NOT permitted. The mask or cloth face covering is not a substitute for physical/ distancing and should be used to supplement other controls recommended in this document. Staff should evaluate the need for a separate mask to be used during their commute to their worksite and home. In addition, cloth face coverings should only be used in a laboratory environment (BSL2 and below) if the individual is not performing research.

It is strongly recommended that cloth face coverings be changed and laundered daily. If reuse of a facial covering is necessary, facial coverings and/or masks should be stored in paper bags or in some other protective device to reduce the potential for damage or contamination that could occur if the facial covering was placed on a desk or in a backpack, pocket, or purse alone. Paper bags are recommended because the facial covering may be damp from breath condensation, and the paper allows the facial covering to dry out. A plastic bag would trap this condensation inside and not allow the facial covering to dry out.

Cloth facial coverings should be laundered using a mild detergent and warm water. They can be cleaned in a washing machine, a bowl, or a sink. The use of a washing machine and dryer may damage some facial coverings (e.g., elastic straps) and they should be carefully inspected each time they are used.

The Clinical Center has issued its own facial covering policy. Persons entering the building will be issued a disposable surgical mask (ASTM Level 3). Cloth face coverings must be replaced by (or worn under) the provided surgical mask whenever inside the Clinical Center. Any type of disposable mask worn at the time of entry into the Clinical Center should be discarded into a trash can or in Medical Pathological Waste (MPW) containers that are commonly found in laboratories and clinical areas. For other NIH buildings and leased spaces, disposable facial coverings can also be disposed in the MPW containers or white step cans. For convenience, white step cans have been placed at the entries/exits of buildings, at common points of departure from NIH campuses, leased facilities and in the Clinical Center.

Voluntary use of N95 respirators is permitted at the NIH. However, there are requirements for personnel choosing to use an N95. Personnel wishing to voluntarily use an N95 respirator must complete the Voluntary Respirator Use Certification Form. This form acknowledges that you have watched the brief training video on the limitations, use, and care of N95 respirators, as well as ensuring your supervisor is aware that you are enrolled. Supervisors will need to conduct work assessments to ensure an N95 is appropriate. Personnel must not use an N95 if wearing it creates an additional hazard. They must also enroll in the full respiratory protection program if the use is mandatory rather than voluntary.

Use, Care and Changing of Facial Coverings

- If changing from a cloth face covering to a mask intended for use in the laboratory, do so at least 6 feet from others before performing laboratory work so as not to expose others.
- Wash your hands with soap or use hand sanitizer containing 60% ethyl or 70% isopropyl alcohol before putting the mask on, before adjusting and after removing.
- Make sure your mouth and nose are fully covered, pull the mask down over your chin and pinch the bridge of the nose. Assure there are no gaps in the mask and that it fits against the side of your face.

- Remove your mask using the ear loops/ties and avoid touching your eyes, nose, and mouth.
- Place your used mask in a paper bag for storage and wash your hands immediately after removing.
- Use designated locations to take a break for a drink or to eat, ensuring adequate distance from others. After finishing your food or drink, immediately put your face covering back on.

Physical Distancing

Building occupant density must be limited to 1 person per 125 sq. ft. Additionally, in accordance with CDC guidance, staff should always maintain at least 6 feet from other individuals. Avoid unnecessary person-to-person contact, such as handshakes. In-person meetings should be limited as much as possible. For more detailed guidance on how to maintain physical distance in the workplace, see the section in this document called Guidance for Re-Occupying Specific NIH Workplaces beginning on page 25. Spaces with poor ventilation (e.g., no air supply vent, stagnant air, high humidity, etc.) should contact DOHS for further assistance in determining a safe occupancy limit.

See also page 3 of OSHA's COVID-19 Healthcare Worksite Checklist & Employee Job Hazard Analysis for assistance in implementing physical distancing measures.

Hand Hygiene

The understanding of transmission of SARS-CoV-2 has greatly increased since the beginning of the pandemic. Previously it was thought that contact with contaminated surfaces played a significant role in transmission. However, this role has been demonstrated to be a less significant source of transmission than other routes (i.e., aerosol and droplet transmission). However, hand hygiene is still an important control against SARS-CoV-2 and other pathogens. Wash your hands often with soap and water for at least 20 seconds, especially after you have been in a public place, after blowing your nose, coughing, sneezing, or touching your face. Alternatively, use a hand sanitizer that contains at least 60% ethyl or 70% isopropyl alcohol when soap and water are not readily available.

Coughing/Sneezing Hygiene

Wearing your cloth face covering will reduce the dispersal of aerosolized respiratory secretions. If you are in a private setting and not wearing a cloth face covering, remember to cover your mouth and nose with a tissue or the inside of your elbow when coughing or sneezing. Immediately wash your hands or use hand sanitizer that contains at least 60% ethyl or 70% isopropyl alcohol. Staff should minimize touching their face and instead use disposable tissues. Tissues should be immediately discarded after use.

Gloves

The use of gloves outside of a laboratory or the healthcare setting is not advisable. Washing your hands frequently is the best practice after touching potentially contaminated surfaces.

When gloves are worn within the lab, they must be disposed in MPW boxes and after removing gloves, hand washing is required.

Workplace Flexibilities

It is important for supervisors to maximize the use of workplace flexibilities to reduce the risk of exposure to SARS-CoV-2. ICOs need to evaluate the best staffing options available for the identified work function or office. Staffing scenarios for the laboratory may differ significantly from an administrative office setting, which may, in turn, differ from a front-facing customer service operation. ICOs should consider options that allow maximum telework, or attendance at meetings virtually to reduce risk. This will also help ease the stress of staff that are returning after a long hiatus from in-person meetings.

Understanding there will be scenarios where physical distancing cannot be achieved, DOHS (301-496-2960) is available to consult and help develop alternative safety measures to mitigate risk. In these situations, ICOs will need to assure strict adherence to face coverings, other protective measures and administrative controls, and supervisors must minimize these situations to the best of their ability. Maximum use of telework and flexibilities is still highly encouraged.

COVID-19 Vaccination Requirements

In December 2020, the first COVID-19 vaccines were made available to the NIH Community. The NIH ORS manages the NIH COVID-19 Vaccine Program for NIH staff in coordination with the NIH Clinical Center and others. The goal of the NIH COVID-19 Vaccine Program is to minimize workplace transmission of SARS-CoV-2.

On September 9, 2021 President Biden issued an executive order mandating that all Federal employees be vaccinated. In brief, all Federal employees must be fully vaccinated by November 22, 2021, barring an approved or pending medical or religious exemption. Any Federal employee hired after November 22, 2021, must be fully vaccinated prior to starting work at the NIH. Any federal employee hired between the issuance of EO 14043 and November 22, 2021, should also be fully vaccinated before starting, with exceptions being made for mission critical staffing needs. Excepted employees in this category must be vaccinated within 60 days of starting work for the NIH.

Additionally, on September 9, 2021, President Biden issued an Executive Order (EO) requiring all federal contractors within the Executive Branch be vaccinated. Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors. The Safer Federal Workforce Task Force determined that federal contractors subject to the EO must be fully vaccinated by January 18, 2022, barring an approved or pending medical or religious exemption.

Employees will be considered fully vaccinated for COVID-19 two weeks after they have received the requisite number of doses of a COVID-19 vaccine approved or authorized for emergency

use by the U.S. Food and Drug Administration or that has been listed for emergency use by the World Health Organization. For Pfizer-BioNTech, Moderna, or AstraZeneca/Oxford, that is 2 weeks after an employee has received the second dose in a 2-dose series. For Johnson and Johnson (J&J)/Janssen, that is 2 weeks after an employee has received a single dose.

Participants in clinical trials within or outside the United States who received all of the recommended "active" (not placebo) primary series doses of a WHO-EUL COVID-19 vaccine that is not FDA-approved or FDA-authorized or a vaccine that is not listed for emergency use by WHO but for which a U.S. data and safety monitoring board or equivalent has independently confirmed efficacy (i.e., Novavax COVID-19 vaccine, Moderna COVID-19 vaccine in children aged 6-17 years) are also considered fully vaccinated.

If you don't meet these requirements, you are NOT fully vaccinated under HHS policy. Keep taking all precautions until you are fully vaccinated.

More information on the NIH vaccination policy and requirements can be found at https://employees.nih.gov/pages/coronavirus/vaccination-requirements.aspx.

Vaccination may have short-term side-effects and NIH vaccination paid leave options are available. This includes up to 4 hours of excused absence to receive/accompany a family member during normal tour hours for each dose of the vaccine and two administrative workdays for those who experience/must assist a family member who experiences side effects as a result of the vaccine.

Vaccines are one important pillar to an overall risk mitigation approach to minimizing workplace transmission of SARS-CoV-2. Even if vaccinated, the safety procedures outlined in this document must still be adhered to at all times. Vaccination is critical to prevent serious illness and hospitalization, and they do decrease the risk of becoming infected. Over time, immunity wanes and we know vaccinated persons can become infected and transmit infection to others. Thus, the best way to decrease transmission and reduce risk is to encourage self-screening and quarantine, wear face coverings, stay physically distant, and reduce staff densities where feasible.

Booster Shots

Between September and October 2021, the FDA authorized vaccination booster shots for Pfizer, Moderna, and Janssen (Johnson & Johnson) vaccinations. There is currently no federal mandate for booster shots, however, the CDC recommends that all personnel, especially those at high-risk, get boosters if it has been more than 6 months (or 2 months for the Janssen shot) since they completed their fully COVID-19 vaccination series. Vaccine boosters can be different than the original vaccine series (e.g., a person vaccinated with the Pfizer COVID-19 vaccination may receive a Moderna booster).

Some NIH personnel may be invited to receive booster shots through the NIH OMS. However, booster shots are readily available in the community and staff and contractors are encouraged

to seek them. Current guidelines do not require reporting of booster shots. However, this may be subject to change if the definition of fully vaccinated is modified.

Requirements for Persons After a High or Low Risk Exposure

The NIH OMS currently defines an exposure as high-risk if the contact was closer than six feet, for a 24-hour cumulative duration of 15 or more minutes to a person who has tested positive for SARS-CoV-2 infection, or involving exposure of a person's eyes, nose, or mouth to material potentially containing SARS-CoV-2. Low (or lower but not zero) risk exposures are evaluated on a variety of factors, including proximity to infected persons, the environment in which the exposure occurred, and the prevalence of face coverings or other PPE. Exposure risk level is independent of vaccination status and is not assessing risk of disease, only of exposure. The guidelines below incorporate assessments of both personal risk and risk of transmission to others. Definitions for terms in this section can be found in Appendix II - Exposure Risk Assessment Definitions.

Personnel with exposures

Personnel that have SARS-CoV-2 exposures will be subject to the following requirements, based upon the risk level of their exposure. The following requirements are mandatory except where reviewed and approved by NIH senior management.

- **High-risk Exposure Personnel.** Personnel experiencing a high-risk exposure will be enrolled in the OMS Case Management Program and:
    - will be followed by OMS Case Management and put on Active Monitoring. OMS will assign a case manager and will establish a daily contact schedule. You must report any change in health status to your case manager during the observation period.
    - During the active monitoring period, you must:
        - Quarantine away from the physical workplace for 14 days (unless released earlier by OMS based on negative consecutive PCR-based tests for SARS-CoV-2) as outlined below:
        - Get a PCR-based test for SARS-CoV-2 at least three days after the high-risk exposure
            - If the above test is negative get a second PCR-based test for SARS-CoV-2 at least five days after the high-risk exposure (to confirm that you have not developed COVID)
            - If both tests are negative, you will be allowed to return to work 7 days after your exposure
        - If any test results are positive, contact your case manager for further guidance

        - If symptoms develop, isolate for 10 days after onset of symptoms, and contact your case manager to determine testing and return-to-work expectations
    - Personnel that choose to not be tested must quarantine for the entire 14 days instead. If they become symptomatic during those 14 days, they must isolate until 10 days after onset of symptoms.

- **Low-Risk Exposure of Vaccinated Personnel.** Vaccinated personnel determined to have low-risk contact with positive SARS-CoV-2 patients are unlikely to be infected. However, the risk is not negligible, and these personnel should take additional precautions. Vaccinated personnel that are asymptomatic should continue to report to work and:
    - Self-monitor for symptoms for 14 days. If symptoms develop, no matter how mild, immediately leave work and contact OMS to determine testing and return-to-work expectations
    - Are highly encouraged to participate in surveillance (asymptomatic) testing. Tests should be three days after low-risk exposure and once more five days after exposure.
- **Low-Risk Exposure of Unvaccinated Personnel.** Unvaccinated personnel experiencing a low-risk exposure shall do the following:
    - Report to work as normal
    - Self-monitor for 14 days
    - Wear an ASTM Level 3 surgical mask at all times at NIH facilities during your observation period.
    - Participate in surveillance (asymptomatic) PCR-based testing.

COVID-19 Testing

The NIH has two in-house mechanisms for providing COVID-19 testing; for-cause and asymptomatic testing. For-cause testing is used for personnel that are experiencing COVID-19 symptoms or have recently tested positive for COVID-19. Asymptomatic testing is for personnel with no symptoms, and may include personnel that were exposed to COVID-19 positive cases, unvaccinated personnel with a medical or religious exemption, and personnel who are voluntarily submitting to routine testing.

For-Cause Testing

Personnel that report COVID-19 symptoms will be asked to have a COVID-19 PCR-based test. This may be performed in the community (at the employee's expense) or at the NIH "Car-Line" testing facility. This facility is staffed by NIH personnel, including nurses, safety professionals, and emergency responders.

Regardless of vaccination or exposure status, any symptomatic personnel must not report to work and should test at the earliest For-Cause testing opportunity. Symptomatic personnel

must report their change in health status to their case manager to confirm you received a PCR-base test during the appropriate timeframe. Personnel without an assigned case manager should complete the OMS COVID-19 Screening Questionnaire.

Asymptomatic Testing

The NIH Clinical Center has established a program for testing asymptomatic staff for SARS-CoV-2. The program is voluntary but strongly encouraged for those working onsite. Personnel can schedule an appointment for asymptomatic testing by going to https://clinweb.cc.nih.gov/cct. To access the site, you need to be on NIH VPN, NIH IC CITRIX or a NIH Workstation. This portal can be used to select schedule testing at all NIH asymptomatic testing sites for all NIH locations.

The program offers saliva testing in addition to mid-turbinate swab testing. Mid-turbinate testing is the preferred testing method. For saliva testing, it is best to avoid eating, drinking, smoking, or chewing gum or tobacco for at least 30 minutes before sample collection.

If a staff member needs results documented in time for travel, e.g., to make an international flight, it is ***absolutely vital*** that the staff member being tested informs the staff doing the collection that the test is not routine and results are needed within 48 hours. The specimen should have a priority label placed on it to receive the special handling required to receive the results on time.

Asymptomatic Testing Locations.

Testing Site	Testing Site Building and Room	Testing Hour Locations
Bethesda, Maryland (Main Campus)	10-CRC/5-4600	Monday, Tuesday, and Thursday 10:00AM to 4:30PM EST
Montgomery County, Maryland (Off-campus)	Shady Grove Gym, 9609 Medical Center Drive	Wednesday 9:00AM to 11:00AM EST
Baltimore, Maryland (BRC)	BRC NIDA-NIA Campus. BRC Atrium	Monday to Thursday 10:00AM to 2:00PM EST
Frederick, Maryland (NCI-Frederick and IRF)	Building 426 Asymptomatic Testing Trailer	Wednesday 12:30PM to 2:00PM EST
Research Triangle Park, North Carolina (NIEHS)	Building 101 Parking Lot Asymptomatic Testing Site	Monday 7:30AM to 12:00PM EST Tuesday 12:00PM to 5:00PM EST Wednesday 12:00PM to 5:00PM EST Thursday 7:30AM to 12:00PM EST
Hamilton, Montana (RML Campus)	Building A/Seminar A (A104)	Tuesday 7:30AM to 10:00 AM MST
Phoenix, Arizona (NIDDK Phoenix)	Building 1/Room 401	Monday 7:00AM to 12:30 MST

What Happens When Someone Tests Positive?

Every staff member (contract and federal) who receives a community-based COVID-19 test result indicating current infection must report that result to OMS through the OMS COVID-19 screening questionnaire. Personnel tested at the NIH testing sites are automatically reported to the system. Contact investigations (CI) are conducted upon receipt of report of a NIH worker newly diagnosed with COVID-19. OMS initiates the contact tracing process by calling the individual (index case) to discuss the result and conduct the index case interview the same evening. This interview aims to determine when the affected worker may have been infectious and whether others may have been at risk for exposure to SARS-CoV-2. The interviewer will collect details such as: where the person worked; what NIH facilities were visited; use of protective measures; and, who they came into contact with while working on site. Contact tracers confirm the employee's account with the supervisor. If indicated, they obtain relevant contact information, and initiate the risk assessment of contacts as soon as possible. The utmost care is taken not to identify the worker to others in the workplace. Within 24 hours of receipt of a new positive test result by OMS, an OMS clinician provides a form to the supervisor stating a general health condition prevents affected staff from coming to the worksite or into contact with others. Contact case interviews aim to estimate the level of risk of exposure and provide recommendations to contain further spread (see section below). Definitions and descriptions of the different risk levels are included in Appendix II - Exposure Risk Assessment Definitions.

Information from contact tracing is used to notify specific personnel who may have had high-risk (i.e., greater than 15 minutes, within 6 feet, and wearing appropriate PPE) contact with someone who has tested positive for COVID-19. It is also used to notify personnel who may have been in a location where a COVID-19 patient was present. These notifications improve awareness for potentially exposed personnel so that they may make educated choices regarding their personal health monitoring and testing. All notifications are made ensuring that no personal health information is shared. For all high-risk exposures, notifications are made using phone calls and e-mail. For healthcare settings, email, postings on NIH internet and intranet sites, and signs posted in affected locations will be used for personnel who may have been in an area where a positive case was present but did not have high-risk contact with those personnel.

Patientcare and patientcare support staff are excluded from returning to their onsite workspace for the minimum duration of their infectious or at-risk period, as required by the OSHA ETS. Institutional policies may extend the exclusion period to protect vulnerable patient and employee groups. Guidance for others experiencing high and low risk exposures is provided below in the section "High and Low Risk Exposures to SARS-CoV-2". Decisions regarding an employee's return-to-work after COVID-19-related medical workplace removal are made by OMS providers. Removal from the workplace can be shortened for persons presumptively positive for COVID-19 if they have an appropriately timed negative PCR COVID-19 test. NIH

provides this testing at no cost to employees. An appropriately timed test means a test at least 3 to 5 days after high-risk exposure to a COVID-19 positive person.

For healthcare workers covered under the OSHA ETS, medical removal protection benefits apply unless an individual refuses an offered COVID-19 PCR test. Medical removal benefits include continuation of full pay and regular benefits while accommodated by working remotely or in isolation, or if accommodation is not feasible, with up to $1400 per week compensation. The latter is offset by any contemporaneous outside income, employer-funded compensation program (e.g., sick leave or administrative leave). An employee will not suffer any adverse action as a result of COVID-19-related medical removal.

For all other workers, the Safer Federal Workforce FAQs state that employees quarantined after positive diagnosis (technically this should be isolation) may request sick leave if they are unable to telework. Weather and Safety leave is no longer available for this purpose. Employees may also request accrued annual leave or other forms of paid or unpaid leave.
https://www.saferfederalworkforce.gov/faq/leave/

All work associated COVID-19 cases are logged within 24 hours. The COVID-19 log contains, for each instance, all information required by OSHA under the Emergency Temporary Standard for healthcare (29 CFR 1910.502), including the employee's name, one form of contact information, occupation, location where the employee worked, the date of the employee's last day at the workplace, the date of the positive test for, or diagnosis of, COVID-19, and the date the employee first had one or more COVID-19 symptoms, if any were experienced. This information is a confidential medical record. However, personnel may request their record by contacting the NIH Occupational Medical Service. A redacted version of all cases is also available upon request.

Guidance on Cleaning and Disinfection

Although recent research has indicated that surface transmission of SARS-CoV-2 is less likely that initially believed, there is still some potential for infection from contacting contaminated surfaces. As such, high-contact surfaces should be cleaned daily. This includes door handles, shared office and laboratory equipment, and light switches. These surfaces must be cleaned using a proper disinfectant. Information on approved disinfectants can be found at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2.

The NIH follows CDC guidance regarding space cleaning and disinfection after a COVID-19 case has been present in a building. The CDC guidance currently recommends that the space be vacated for 24 hours to allow natural decay of the virus, which does not live long on surfaces. In most scenarios, this means that no space will require being vacated. The turn-around time between the testing of a staff member and the notification of the staff member and supervisor is greater than 24 hours. This means that the symptomatic staff member will have already been quarantined away from work. Additionally, as discussed in the section "Guidance on Cleaning

and Disinfection", spaces should have a regular disinfection routine for high touch areas. This means that all high touch surfaces will have already been cleaned and disinfected by the time results are received. According to current CDC guidance, only standard cleaning is required after that 24-hour window.

In the rare instances where this does impact a facility, the ORF has developed a Standard Operating Procedure (SOP) which outlines procedures for communication and steps to be taken concerning the closure, ventilation, disinfection and reopening of NIH workspaces that may be contaminated by COVID-19. This SOP was developed for a scenario in which a staff member has been diagnosed with COVID-19 and has been in NIH workspaces (owned or leased) within 2 days prior to showing symptoms. This SOP describes the risk management decisions, and actions needed after a positive case is identified. This guide is shared with the ICO whenever contact tracing indicates that a space may need to be isolated or disinfected.

The supply store carries a variety of approved disinfectants. Ensure you read the label prior to use to ensure appropriate contact time and use of the material is performed. Be certain that disinfectants used are appropriate for coronavirus. Common laboratory disinfectants that are used at the NIH and are effective against coronavirus include: 10% bleach solutions (made fresh daily); 70% ethanol; Dispatch; Clorox hydrogen peroxide spray; Lysol wipes; Opticide; Peroxiguard; Vesphene III; Micro-Chem Plus; and Cavicide. Please review the label for efficacy and contact time instructions. Please be advised that the active ingredients may differ between brands (e.g., different Clorox products have differing ingredients and contact times). Active ingredients in the disinfectant, contact time and efficacy information are listed on the label of disinfectants (Appendix III – Disinfectant Labels).

Some disinfectants will require dilution prior to use (alcohols). Some of these items will be stronger and may be hazardous to humans and require gloves or other Personal Protective Equipment (PPE) for use. DOHS advises the non-laboratory areas to purchase materials that are ready to use, such as wipes. Laboratory areas will have protective equipment (e.g., chemical fume hoods and gloves) that can be used for dilution and cleaning with more concentrated chemicals.

In general, if the material is not already in wipe form, spray disinfectant onto a paper towel and then wipe the surface clean. It is not advised to directly spray a surface as that can create chemical aerosols.

For any questions on disinfectants, please contact DOHS at 301-496-2960.

Guidance for Re-Occupying Specific NIH Workspaces

Activity Hazard Assessments

An Activity Hazard Assessment (AHA) is a step-by-step review of a task that examines hazards that exist at each step and identifies controls that will eliminate or reduce the potential exposure to that hazard. These AHAs must be documented and should focus on COVID-19 associated risk but should not be limited to COVID-19 hazards exclusively. For example, when assessing a hands-on training for a research fellow, consideration should be given to potential SARS-CoV-2 exposures, but should also consider other hazards such as chemicals, sharps, or lasers.

When identifying the potential for SARS-CoV-2 exposure, supervisors should collaborate with the staff performing the task to determine when potential exposure points exist. Focus on scenarios in which physical distancing is not possible, or close contact is required for greater than 15 minutes. Additionally, the AHA should consider space ventilation and whether multiple personnel may occupy the space for an extended period. Physical distancing alone may not be an adequate control in a space where there is low ventilation and personnel occupy the space for hours. Also consider where equipment is likely to be shared.

The AHA should also include controls for exposure. The hierarchy of controls (i.e., the order of most reliable to least) is:

- Elimination: If the task or step is unnecessary, consider not doing it. This removes the potential for exposures. An example for COVID-19 might include eliminating a process or meeting that is unnecessary.
- Substitution: Identify an alternate means of accomplishing the goal that involves lower risk of exposure. For example, consider revising training to have self-guided or remote training where appropriate and supplement with specific, short duration, in-person training where self-guided training or remote training is inadequate.
- Engineering Controls: This involves the use of mechanical equipment to control exposure to hazards. Examples might include maximizing air exchanges in rooms where personnel must work closely together, using a down-draft table when demonstrating surgical techniques, or conducting work at a chemical fume hood or biological safety cabinet to reduce potential exposures.
- Administrative Controls. The use of procedures and practices to reduce risk of exposure. Physical distancing, working in shifts, room occupancy limits, floor markings, and signage reminding personnel of expected behaviors are examples of administrative controls.
- Personal Protective Equipment. This should be considered the last line of defense and should be in place in case other controls fail. For reducing SARS-CoV-2 exposure, this would include procedure/surgical masks, gloves, and where appropriate, respirators. Additional PPE controls beyond the standard requirements of the document should be

considered for any work that requires personnel to work in close proximity for greater than 15 minutes.

After the AHA has been conducted and controls have been identified, personnel must then be trained on the controls identified in the AHA to ensure they are properly implemented. Training on the AHA should be documented by the supervisor.

Lastly, an AHA should be considered a "living document." The AHA should undergo routine reevaluation to determine the effectiveness of the controls, the training of the personnel using the controls, and the potential for improving to more effective mitigations on the hierarchy of controls. DOHS recommends that these controls be reevaluated after the first implementation, revised to capture lessons learned, and then reevaluated at least once per year. The AHAs should also be reviewed and revised after any incident where employees were exposed to a hazard. The DOHS is available to assist with developing your AHAs.

Returning to Workspaces After Extended Absence

The COVID-19 pandemic has resulted in extended absence from may workspaces in facilities throughout the NIH. While there are few offices, laboratories, or other spaces that have had no activity, many of the spaces have had limited activity. This coupled with reduced or eliminated house-keeping support means that each space will need to be evaluated for problems that may have emerged during the long vacancy from the workspaces. Examples of emerging problems include:

- Unnoticed flooding from building leaks or mechanical failures
- Odor issues from:
    - Trashcans or refrigerators that were not cleaned out prior to departing the workspace,
    - Food or beverages left in the office
    - Sink or floor drain traps that have dried out
- Dust and debris from lack of housekeeping
- Pest management issues, including pest monitoring stations that were inaccessible to Integrated Pest Management technicians
- Stale or stagnant water in sinks, emergency showers, and ice makers

At least three weeks prior to employees' anticipated return-to-work date, it is recommended that supervisors physically survey the work environment and follow the workspace evaluation tool (found in Appendix VII - Workspace Re-Occupancy Evaluation Tool) to ensure the work environment is safe and comfortable for all.

Water Fixtures and Plumbed Appliances. Although the Office of Research Facilities (ORF) has taken actions to ensure that plumbing fixtures are flushed and serviced to prevent stagnant water and the formation of Legionella or other issues, there may be appliances and devices in your immediate workplace which may require additional attention upon return.

Some suggestions include:

- flush water in refrigerators equipped with water taps and/or ice makers.
- flush water through coffee machines and dishwashers.
- remove stagnant water/ice and replace filters in water-using appliances (BRITA pitchers, Keurig, coffee makers, ice machines, refrigerators with filtered water, etc.).
- flush water in eyewashes for 15 minutes when returning to the laboratory and weekly hereafter.

Residual water standing in pipes can be flushed by opening taps at all water points of use and letting the water run, typically for 5-10 minutes. Care should be taken to minimize splashing and aerosol generation during flushing. Flushing your water weekly will prevent stagnation of water. Flushing and removing stagnant water regularly in water-using appliances not only prevents stagnation, it also helps prevent bacterial growth, mold, algae and discoloration. Your water-using appliance may need cleaning steps in addition to flushing (e.g., discarding ice). Consult the device manufacturer's maintenance instructions; these may be available online, in the service/repair manual or directly from the manufacturer. Filters (if applicable) in water-using appliances also need to be replaced after a shutdown and/or non-use for over 7 days. Always follow the manufacturer's maintenance instructions in replacing the filters.

The following resources provide more information on restoring water quality after reduced operations:

- EPA Maintaining or Restoring Water Quality in Buildings with Low or No Use: https://www.epa.gov/sites/production/files/2020-05/documents/final_maintaining_building_water_quality_5.6.20-v2.pdf.
- Guidance for Reopening Buildings After Prolonged Shutdown or Reduced Operation: https://www.cdc.gov/coronavirus/2019-ncov/php/building-water-system.html.
- For drinking water concerns/complaints, please contact the Office of Research Facilities at 301-435-8000 and/or submit a maintenance service request at: https://www.orf.od.nih.gov/PropertyManagement/MaintenanceServiceRequests/Pages/default.aspx.

For illness concerns suspected to be caused from the consumption of potable water at NIH, please contact Division of Occupational Health and Safety (DOHS) Drinking Water Program Manager at 301-537-5970 or 301-496-2346.

Requirements and Considerations for the Use of Barriers

Plexiglass barriers are recommended by OSHA specifically for work situations where staff have the potential to come in contact with people known, or suspected, to be infected with COVID, or where there is high turnover and infection status of personnel is unknown.

Cleanable or disposable solid physical barriers are required at each fixed work location outside of direct patient care areas (e.g., entryway/lobby, check-in desk, triage, hospital pharmacy

windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance.

The CDC, OSHA and NIH do NOT recommend barriers as a replacement for physical distancing or personal protective equipment use (face coverings/face shields). Barriers should only be used in combination with physical distancing, face coverings and other administrative controls that reduce potential for exposure. DOHS and the NIH Fire Marshal are available to consult on the use of barriers to ensure they are utilized appropriately. Consultation should be performed before ordering or installing any barriers. Installers must ensure they are not obstructing fire safety features (e.g., sprinkler heads, fire alarm devices, exit signs, and emergency lights). It is important to ensure the NIH Fire Marshal approval for any barrier within 18 inches from the ceiling. Opaque barriers are not recommended.

When evaluating barriers remember their limitations. They do not allow for increased population in laboratories and administrative spaces. Additionally, they may have negative impact on airflow within a space. This is important to understand when in a laboratory where Biological Safety Cabinets (BSCs), Chemical Fume Hoods (CFHs), and other local exhaust ventilation are important for controlling biological and chemical hazards. Barriers may also provide a false sense of security, leading people to believe it is safe to remain near others for extended times.

Barriers are appropriate in some circumstances where they may provide added benefit. For example, barriers may add droplet protection in locations with frequent, short duration contact with personnel from outside your office or laboratory. When paired with physical distancing and proper face covering, reception areas may benefit from properly placed barriers. They can also be a good reminder of distancing requirements.

If you decide to use barriers, install them in a manner that reinforces physical distancing requirements:

- Design the barrier dimensions to exceed the breathing zone of partition users.
- Incorporate slots if items need to be passed between employees to minimize employees stepping around the barrier to conduct business.
- Always install with safety in mind, taking care not to hinder the user's escape in an emergency, blocking any emergency feature and ensure compliance with all fire code elements.
- Partitions should be secured to a surface to avoid falling/tipping.

For Maryland and Montana NIH facilities, please contact your assigned IC Safety and Health Specialist at https://go.usa.gov/x7YxK or call 301-496-2960. For NIEHS facilities in North Carolina, please contact the Health and Safety Branch at 984-287-3400.

Guidance and use of Portable HEPA Filtration

In some situations, a portable HEPA filtration unit may further reduce the concentration of airborne particles, especially in higher-risk settings such as healthcare areas that treat patients with known or suspected to COVID-19. The Clinical Center is taking the lead in identifying these healthcare settings in Building 10. Beyond these limited settings, it is important to recognize the transmission of aerosols in a room depends upon many factors such as size of the area, air currents, number of occupants, and movement of employees throughout the building. These variables are better understood through an activity hazard assessment. Such an assessment should be completed by the ICO prior to obtaining a portable HEPA filtration unit.

A portable HEPA filtration unit must be strategically placed to provide meaningful benefit to the user. Additionally, the unit should be designed for commercial use as models marketed for residential settings may not be appropriate. It is recommended that ICOs contact ORF to determine if further improvements can be made to the building's ventilation before purchasing a portable HEPA filtration unit.

Questions of portable HEPA filters are often accompanied by use of ionization technologies – especially for use to disinfect bioaerosols. Some manufacturers market negative ion air purifiers, which may or may not include a HEPA filter. Ionizers typically produce very small amounts of ozone as an unwanted byproduct of the ionization process, which is adverse for one's health. Air purifiers or filtration device that generate ozone are not permitted in NIH owned or leased facilities, as the device may create a hazardous environment. NIH also does not recommend the use of germicidal ultraviolet (UV) light for general or HVAC disinfection purposes in office workspaces given the potential for exposure to hazardous light.

Office Environments

If you work in an open office environment, be sure to maintain at least 6 feet distance from co-workers. Density must be limited to 1 person per 125 sq. ft. This may mean leaving at least one workspace open separating you from co-workers. Where possible, rearrangement of offices may help maintain effective separation of personnel. All staff are required to wear a face covering while in any shared workspace. Visitors such as maintenance staff, IT help desk personnel, and delivery workers will be required to furnish and wear a face covering at NIH locations. Personnel working at a reception/front desk should consider how visitors and co-workers interact with them. These personnel may have more frequent contact with delivery personnel, customers, visitors and the public, and spaces should be configured and marked to promote safe distancing.

ICO leadership will assess office environments and processes to identify measures that facilitate physical distancing and minimize the potential for personnel to come within 6 feet of one another. Example measures include:

- Limit occupancy to 125 square feet per employee.

- Eliminate or reduce processes that prevent effective physical distancing. For example, if processes can be performed online with a brief in-person visit to verify information or identity, this will greatly reduce the duration of visitors in a space.
- Use engineering controls such as barriers that prevent interactions closer than 6 feet. In some places transparent shielding between customers and service providers may be appropriate or required per OSHA regulations. For instance, in patient care and patient care support areas, if a customer must have in-person, face-to-face interaction with an employee, a Lexan or Plexiglass barrier will minimize droplet transmission. Please refer to section above for guidance on locations safe selection and uses.
- Use administrative controls such as floor markings to indicate appropriate physical distancing between tasks or personnel or traffic directional flow. These markings help personnel and visitors better visualize spacing that will minimize droplet transmission.
- Use scheduling to control traffic flow within workspaces. Minimize overlapping appointments. Schedule appointments to allow maintaining adequate physical distancing.
- Shared equipment like copiers, printers, coffee pots, etc., should be cleaned regularly to reduce the risk of contamination.
- If support personnel (e.g., ORF, CIT, OIIT, etc.) needs to visit your work location ensure physical distancing is met. Step out of your workspace if necessary while they do their work. Limit in-person contact as much as possible, and face coverings must be worn at all times if in-person contact is needed. Most IT functions can be done using a feature where the IT specialist can remotely install and work on your computer from their office or home location. These features should be used to the fullest extent possible to avoid in person work.

The ORS Medical Arts Branch has created visual graphics to assist with these recommendations. Please visit their website to order posters, flyers, stickers, etc., for your location. The site includes free downloads, which can be printed from any printer, as well as instructions for ordering larger specialty signage, posters, and templates.

Common Areas

Restrooms: Where possible, use of restrooms should be limited based on size to ensure at least 6 feet distance between individuals. Wash your hands thoroughly before and afterward to reduce the potential transmission of the virus. Use a paper towel to turn on/off the water spigot and to grab door handles as you leave the restroom.

Elevators: Minimize elevator use to whatever extent possible and avoid elevators where physical distancing cannot be maintained. Consider using the stairs as an alternative where possible. Markings should be placed on the floors of elevator lobbies to remind personnel of 6-foot physical distancing requirements. Floor markings should be used inside the elevator as they are helpful visual tools to identify density numbers and locations for standing while in transit. Floor markings are available from the ORS Medical Arts Branch.

Ensure that while using the elevator you allow a minimum of 4 feet of clearance per person. Although 6 feet is preferred, this recommendation comes with the understanding that it is a brief, transient exposure, that will make up probably less than one minute of someone's daily potential exposure. No elevators at the NIH should ever exceed a 4-person occupancy. An elevator with its longest dimension (length or width) less than 6 feet, should have a maximum 1-person occupancy. An elevator with a longest dimension of 6 to 8 feet should have a maximum occupancy of 2 people. A larger elevator can have an occupancy of 4 people.

The lead ICO in each building should work with ORF building managers on deploying signage. Signage should include reminders to minimize touching of elevator surfaces, to disinfect hands after touching surfaces, and to minimize conversation.

Stairwells: Staff must wear face coverings in the stairwell. Any encounter is transient, and the use of face coverings greatly reduces exposure risk. Upon exiting the stairwell, wash your hands thoroughly or use an alcohol-based hand sanitizer with greater than 60% ethyl or 70% isopropyl alcohol. As a general reminder, stairwell doors must not be propped open as they exist in part to control smoke and provide a safe egress path out of buildings. In addition, for fire safety, stairwells should not be designated one way. They should continue to be utilized as both up and down. The NIH Fire Marshal must be consulted if a one-way designation for routine use is desired. Under emergency egress situations, all stairwells must allow persons to exit safely.

Break Areas: Managers must identify appropriate break locations for staff with sufficient physical distancing. These break locations should be established where personnel can take a short rest from wearing a mask or to drink fluids. Physical distancing measures must be maintained in break areas and during mealtimes. It is recommended that persons minimize communal food or food-based celebrations/gatherings at this time. The ORS Medical Arts Branch has signage for break rooms to designate proper usage.

Meeting Spaces and Conference Rooms: HHS guidelines require that any gatherings with more than 50 personnel be approved at the Department (HHS) level. Maximize the use of online meeting tools such as WebEx, Microsoft Teams and Zoom. If meetings are required with in-person attendance select a room with a capacity that exceeds the normal needs of your meeting. Remember that the Safer Federal Workforce Task Force discourages gatherings of greater than 50 people. Should an agency intend to host an in-person meeting, conference, or event that will be attended by more than 50 participants—regardless of whether participants include members of the public—the agency must first seek the **approval** of its agency head, in consultation with the agency's COVID-19 Coordination Team. Ideally, meetings will be limited to one hour or less. Space chairs apart to facilitate physical distancing. Wear face coverings at all times when holding these meetings. Personnel should consider additional measures to improve the fit and filtration of their face covering. Prior to and at the completion of these meetings, disinfect tables and chairs and other contact surfaces using an EPA List N approved disinfectant. Contact DOHS for assistance with identifying an appropriate disinfectant if needed.

Tips for Internal NIH In-person Meetings

Some groups that will return to the NIH may need to hold in-person meetings. In this case, onsite participation should only include personnel that are already onsite. Staff on telework or in a different return phase should not be returned just to attend in person. Small groups, or groups that have a large space to meet can make in-person meetings safe by following these basic guidelines. It is recommended to keep the groups small, and to minimize the time gathering in person to the best extent possible. Sometimes, when staff are located in multiple areas, the continued use of virtual formats ensures a consistent and inclusive, as well as safety optimal experience.

1. Know how many people you want to bring together in-person. The number of people that will be in-person will let you know what size limitations of your room. Limit occupancy to 1 person per 125 sq. ft. and plan to have room for 6' of spacing. If you have more than 50 people, you will need HHS approval.
2. Remind personnel of the importance of self-assessment of symptoms. If personnel have any symptoms, no matter how mild, they should not be at work. This is even more important for personnel attending meetings in-person.
3. Assess the space you are meeting in. Check the size of your room. The square footage is very important, but not the only factor. Rooms with high ceilings are better than those with low or standard height ceilings. More importantly, make certain your room has good ventilation. If the room you are proposing does not have a supply air vent, it may not be adequate.
4. Offer remote call-in options. Meeting in person is great but continue to offer remote participation options in order to reduce the number of people that will be in the room. More options mean fewer people in the space. Fewer people mean lower risk.
5. Keep the meetings brief. If your meeting only needs an hour, then keep it to an hour. Risk of infection is directly related to the duration of exposure. If there is an asymptomatic infected person in the room then keeping a meeting brief and being succinct reduces the chance of infection.
6. Strictly enforce masking and distancing requirements. It is easy to let your mask slip down or to lean into close to whisper something to a colleague. There must be zero tolerance for those behaviors for this to work. And all of us have to be open to correction when we slip up.
7. Make sure sufficient appropriate disinfectant supplies are available and used before and after the meeting.

Remember, between our high vaccination rates, adherence to safety principles regarding transmission control, and assessment and selection of appropriate locations we can find ways to safely gather for important business.

Hosted Conference Information

Hosted conferences and visiting external groups may be able to be accommodated for longer term occupancy. When hosting a conference, effort should be made to encourage remote attendance. At this time on-site conferences and larger groups especially including outside visitors are on pause and should not be scheduled/ planned. Groups interested in hosting conferences, essential in person visits, or external audits lasting longer than two hours should consult with the Division of Occupational Health and Safety. There are many factors that will influence appropriate controls for these events, including the size of space and the duration of occupancy. In general, the larger conference spaces at the NIH (Masur and Natcher auditoriums) will accommodate up to 50 people for conferences with an 8-hour per day attendance. Considerations such as vaccination rates, travel considerations, and duration of the event may also affect the final permissions for the conference.

All visitors to the NIH for in-person gatherings must be screened for COVID-19 symptoms prior to attendance, and personnel with symptoms should not be permitted to attend the event in person. Visitors must also declare their vaccination status prior to attending in-person meetings or events at the NIH. Unvaccinated visitors may provide a negative COVID-19 test (performed in the last 72 hours) in lieu of a vaccination. Event organizers should use the COVID-19 Vaccination Certification form to collect information on visitors and determine their attendance eligibility. Visitors should print and carry this form with them while on NIH property. **NIH personnel should NOT collect or maintain these forms.**

Food Services and Cafeterias: When using NIH dining facilities, always wear a face covering for the selection and purchase of your food items and when navigating the public space of the cafeteria. NIH dining facilities have conducted site-specific hazard assessments and have specialized practices in place tailored to protecting patrons and staff. Follow guidance from the food service facilities. Individuals are encouraged to consume their meals outside or back in their personal office space. Remember that food or drink must not be consumed in the laboratories.

Food service areas shall consider physical distancing when establishing their operations. These considerations must consider limiting available seating, reducing seating at tables in a manner that prevents multiple personnel from sitting at a table, or guarantees that personnel can maintain physical distancing. Dining facilities should identify ways that encourage outdoor dining. This will help improve physical distancing and allow for the natural ventilation of the outdoors to reduce exposure among diners.

Eating meals or snacks with colleagues should be avoided or minimized unless 6’ of spacing can be maintained. Since eating requires removal of face coverings, this is considered a high-risk activity, especially if persons sit too close together. Ensure if eating in the same area, that minimum distance is maintained, talking is at a minimum when the face coverings are off, and that areas are cleaned before and after eating. If sharing a larger table, sitting diagonal from the

other person is preferred to sitting next to or directly across from them. Smaller tables should have only one person at a time, unless all parties can be distanced and wear face coverings.

Fitness Centers: NIH fitness centers present an increased risk of transmission due to elevated respiration from personnel exerting themselves during exercise. Some studies also suggest that viral load may exist in sweat from SARS-CoV-2 positive patients. The NIH expects strict adherence to masking requirements, physical distancing, and disinfection practices to reduce the risk of exposure. Additionally, fitness centers should:

- Request that the building facility manager maximize fresh air exchanges in the fitness center
- Ensure that an adequate supply of EPA List N approved disinfectant is available and used after each time equipment is used
- Space all equipment at least six feet apart
- Place floor marking signs near check-in stations to remind visitors and members of proper physical distancing
- Place signage throughout the facility reminding staff that masking and physical distancing are mandatory
- If equipment cannot be spaced adequately, unplug of place “Do Not Use” signs on equipment to ensure adequate spacing
- The facility capacity should be posted on the door and staff assigned to monitor the occupancy of the space to ensure the capacity is not exceeded
- Thoroughly clean and disinfect all equipment periodically throughout the day, including disinfecting all equipment at the end of each day or before opening in the morning

Please note that these facilities have been vacant for nearly two years. All equipment must be inspected and serviced prior to being returned to service.

Laboratories

Research staff should carefully schedule activities to minimize overcrowding laboratories. Experiments should be planned out to ensure that shared equipment and space is not overpopulated with staff. Laboratory staff will be responsible for cleaning high touch surfaces within the laboratory, and it is recommended that each laboratory establish a schedule with written procedures and clearly defined responsibilities. In most cases, the disinfectant already in use for research purposes will also be effective against SARS-CoV-2. Laboratory staff may contact DOHS to assist with this assessment.

A review of required PPE to conduct research should be performed to assess the operational and hazard requirements before changes are implemented or new items introduced. In most situations, your cloth face covering will not meet the necessary PPE requirements to perform research. Do not get complacent and forget that there are other serious hazards encountered every day in laboratories. Follow established SOPs and safety guidance to ensure you meet additional requirements regarding safe laboratory practices. If COVID-19 guidance and SOPs

conflict, you should discuss it with your supervisor or consult with your ICO-assigned DOHS Safety Specialist.

Laboratory Scheduling Precautions

Laboratory staff shall maintain physical distancing in the workplace whenever possible. This may involve scheduling work in shifts, maintaining cohorts of staff, or spacing work appropriately on the bench and in the bays. Laboratory managers and PIs should consider coordinating the use of shared laboratory spaces to ensure there is no inadvertent double-booking of space. A well-defined schedule or online calendar will help control access to and use of equipment. Consider moving shared equipment into a space where physical distancing is possible.

Laboratory workers should plan their experiments thoroughly, taking extra care to identify when they will do the work, what equipment they will need, and where they will work. A thoroughly planned experiment will allow staff to reduce time in the laboratory and reduce the likelihood of encountering other staff members. Use appropriate disinfection procedures and PPE to reduce possible exposure to SARS-CoV-2.

Laboratory Cleaning and Disinfection Precautions

Although it is now known that contact with contaminated surfaces is not a common route of infection proactive and thorough disinfection and cleaning of high touch surfaces can still reduce risk of exposure to SARS-CoV-2 and other pathogens. Laboratories should establish routines for disinfection of high contact surfaces. Supervisors should clearly identify the personnel responsible and procedures for disinfecting the laboratory space. These additional recommendations are not a replacement or substitute for general laboratory practices that are ongoing prior to this pandemic. Good work practices include cleaning of laboratory benches/ biological safety cabinets prior to and after completing work, timely cleanup of spills and preventing contamination of common surfaces by laboratory materials (e.g., not using dirty gloves on common surfaces). Gloves are worn for many tasks in the laboratory, and when they are removed, they should not be reused, and hands should be washed with soap and water immediately. It is important to be aware that some laboratory chemicals may not be compatible with disinfectants, so take care if using disinfectant cloths in wiping down reagent bottles.

Other cleaning and disinfection considerations include:

- Core facilities and shared spaces should implement clear expectations for shared equipment and require that personnel clean and disinfect equipment prior to start and after the completion of all work.
- Identify high-contact laboratory surfaces, equipment, and tools and disinfect before and after use. When equipment must be shared, implement cleaning and disinfection protocols for all laboratory users. Many of the common NIH disinfectants will be acceptable, and laboratory staff should consider the pros and cons when determining

the best agent. Concerns include whether the disinfectant could corrode items, leave sticky film, etc. DOHS is available to answer questions as needed.
- Scientific equipment may require specialized disinfecting procedures to avoid damaging the equipment. Review manufacturer guidance prior to disinfecting.
- Consider using disposable benchtop coverings (e.g., Chux pads, diapers, etc.) and properly disposing after use. Disposable plastic covers may be considered for keyboards.
- Follow the NIH Exposure Control Plan for further guidance.

Personal Protective Equipment (PPE) Precautions

Laboratory staff must not become complacent when selecting PPE for their work. Face coverings used when performing research should not be worn out of the laboratory. Masks or face coverings used outside of the laboratory should not also be used in the laboratory. Depending on your laboratory environment, this may require you to change from a cloth face covering to a disposable laboratory covering before starting an experiment. This recommendation is to avoid contamination of a personal face covering that would be worn in personal areas and would not be easily cleaned/discarded if accidentally contaminated with chemicals or biological materials. If you are sitting at your desk working in a laboratory environment, the cloth face covering is appropriate. If working with animals, it is not, as it will absorb allergens and is directly in your breathing zone. Appendix V of this document outlines specific recommendations for face coverings and other items, especially if work requires closer proximity than 6 feet. For additional questions or guidance, please contact your Safety Specialist.

While performing laboratory work, wear appropriate PPE according to your laboratory protocols. Remember:

- Avoid touching your face while wearing gloves.
- Do not wear gloves used for laboratory work outside of the laboratory.
- Dispose of all used laboratory PPE in Medical Pathological Waste (MPW) containers.
- Do not wear laboratory PPE outside of laboratory areas.
- Disposable face coverings that are worn in the laboratory should be disposed of as Medical Pathological Waste (MPW). As an alternative, laboratory staff may choose to dispose of face coverings in the general trash.

NIH Centralized Services

ORS programs (e.g., Division of Library Services, Division of Immigration Services, Division of Amenities and Travel Services, Division of Personnel Security and Access Control, etc.) have conducted activity hazard assessments of services and workflows for their operations. Follow specific guidance provided at these service locations. Personnel should always wear a cloth face covering when they visit ORS service locations and wash their hands or use an alcohol-based sanitizer when leaving those locations.

Activity hazard assessments of centralized service locations have been conducted with the support of DOHS staff and are available upon request.

Mechanical Spaces

Mechanical space access is limited to authorized personnel only. Limit the number of personnel working inside the mechanical space based on 6-feet physical distancing requirements. Cloth face coverings should be worn in addition to all PPE required to enter the mechanical space (closed-toed shoes, hard hat/bump cap, eye protection, work gloves, etc.). Wash hands prior to putting on and after removing PPE. ORF staff will be responsible for cleaning high touch surfaces within the mechanical space, and it is recommended to establish a schedule with written procedures. Pay special attention to "high touch" areas, such as handles, buttons, switches, and control panels. Tools needed to work inside the mechanical space should be disinfected after use. Personnel should always wash their hands or use an alcohol-based sanitizer as soon as possible when leaving those locations.

General Travel Guidance

Travel risk can also occur within one's state, depending on local hotspots, via attendance at events where public health measures are not followed, or through personal behaviors not in line with public health recommendations. It is important to remember that behaviors outside of the workplace affect our risk inside the workplace.

Travel continues to be associated with increased risk of exposure to SARS-CoV-2. Fully vaccinated travelers are less likely to get and spread COVID-19 and the CDC has recently revised its guidance for fully vaccinated domestic and international travelers in light of the increased transmissibility of the Delta and Omicron variants. Whenever you are travelling, or you are gathering with people outside your household or pod, it's important that you check for changes in CDC guidance, and follow the most current CDC Guidance to reduce the risk to yourself and others.

Best Practices for all Travelers

Utilizing best practices helps to reduce the spread of SARS-CoV-2. Determining when it is safe for you to return to NIH facilities depends on the level of risk of exposure within two weeks of your coming to campus, presence of symptoms, and whether you are fully vaccinated. See "Instructions for Official Government Travel" below for more details.

Travel destination, or the location of origin of visitors, is a factor to consider when evaluating risk of exposure to SARS-CoV-2. The NIH uses the CDC COVID Data Tracker and the CDC COVID Travel Recommendations by Destination webpages in making risk determinations. Other websites maintained by state health departments and reputable media outlets are also resources to geographically inform employees of COVID cases. For example, data used to construct metrics indicating hotspots are maintained by the Johns Hopkins University Coronavirus Resource Center at https://coronavirus.jhu.edu/us-map.

Standard precautions for all travelers:

- Get fully vaccinated
- Must report upon return from travel any potential high-risk exposures via the OMS COVID-19 Screening Questionnaire within 24 hours of return. High-risk exposures are discussed in the section "High-Risk and Low-Risk Exposures to SARS-CoV-2".
- Wear a properly fitted mask (Consider double masking or other options for improving mask fit and filtration found in Appendix I - Mask Fit-Enhancement Techniques)
- Adhere to physical distancing, facial covering, and hand hygiene at all times.
- Understand the risks that you are taking, e.g., activities, destinations, or modes of transportation, and maintain awareness of ill persons in your vicinity.
- Investigate the local case rates and safety requirements for your destination. If cases rates are substantial (greater than 50 cases per 100,000) or higher additional caution and adherence to recommended behaviors is critical.

Risk factors that may increase travel-associated COVID-19 exposure

- Travel by public transportation (air, bus, or train).
- Prolonged presence in public areas (shopping districts, pedestrian zones, narrow walkways, etc.).
- Crowded settings such as bars, casinos, movie theaters, and gyms and large gatherings such as concerts, sporting events and re-unions or parties with family or friends outside of your household.
- Travel to a high-risk area, i.e., with ongoing, widespread community transmission, or visitors from such an area coming into your home.

Attending Conferences and Large Professional Gatherings on OGT

Personnel on OGT to attend conferences and large professional gatherings (e.g., meetings, training sessions, site visits, etc.) may encounter elevated exposure risk even if the location that they are visiting is considered a low-risk destination by the CDC. These events may be attended by people from a wide geographic area and present an increased chance for exposure.

When considering attendance at a conference or large event (e.g., 50+ people) request the event organizer's COVID-19 plan. A proper and thorough plan will demonstrate that the organizers have considered ways to reduce potential COVID-19 transmission. The plan will discuss vaccination requirements, local jurisdiction requirements, social distancing, facial coverings, ventilation, cleaning, screening, and reporting of COVID-19 cases. The elements covered in this plan should be covered in the event plan. DOHS recommends that you consider not attending conferences or large professional gatherings where vaccination is not mandatory.

General

Regardless of vaccination status, you should not travel (without a negative COVID test) or return to work (without clearance by OMS) if you or any of your travel companions:

- Are sick with symptoms of COVID-19 (even if fully vaccinated against COVID-19 or have recovered from COVID-19 in the past).
- Have suspected or diagnosed COVID-19 (even if you don't have symptoms)

- Have been around someone with suspected or diagnosed COVID-19 in the past 14 days (even if they did not have symptoms).

Instructions for Official Government Travel (OGT)

General

Effective October 29, 2021, restrictions on non-mission critical OGT are lifted for all fully vaccinated employees. Unvaccinated personnel are still limited to **mission critical OGT and based on approval from IC senior management in coordination with the NIH Office of the Director.** These limitations will be re-assessed periodically based on COVID-19 case levels.

Requirements for Domestic OGT

While travel restrictions have been reduced, supervisors are still responsible for assessing the risk of travel and for ensuring that all applicable NIH requirements are met by the traveler before, during, and after travel.

The overall risk determination for the trip and the recommended and required practices will be determined based on the highest risk level of any location visited. If a trip is approved more than 2 weeks in advance, it is a best practice to reassess the risk level immediately prior to departure and adjust recommended and required practices accordingly. If the case rate has increased to the High-Risk level, it may be appropriate to postpone the trip.

Fully vaccinated travelers should take appropriate precautions when traveling. Strategies and practices that will minimize risk of COVID-19 include:

- Implement COVID-19 mitigation strategies during travel and at the destination including:
    - Follow all standard precautions listed above.
    - In locations with high transmission rates, avoiding indoor dining to the extent feasible and refraining from entering bars, casinos, movie theaters, gyms, concerts, or sporting events.
    - Continue COVID-19 mitigation strategies after travel including:
        - Self-monitoring for COVID-19 symptoms with immediate isolation, reporting to OMS via the OMS COVID-19 Screening Questionnaire, and testing if symptoms develop.
        - Following all state and local recommendations or requirements.
- If you have had a high-risk contact (see “High-Risk and Low-Risk Exposures” section below) during travel, obtain a COVID test 3-5 days after completing travel. COVID testing can be done through the asymptomatic testing program at an NIH facility or with a PCR based test in the community (under private insurance). If your COVID test is positive, isolate and report your illness to OMS immediately. Do not return to campus until cleared by OMS.

- Even if you have not had high-risk exposure during travel DOHS recommends getting a COVID test 3-5 days post travel. This will help catch asymptomatic and early-stage symptomatic cases and reduce potential exposure of other NIH personnel. This is not a requirement, just a best practice.

Unvaccinated travelers. If you are unvaccinated or partially vaccinated, only mission-critical OGT is permitted. The travel should be approved by your IC Executive Officers and the NIH Office of the Director, Deputy Director for Management. **All OGT for unvaccinated persons is considered high-risk exposure.**

The recommended practices for vaccinated travelers are elevated to mandatory practices. Additionally, unvaccinated travelers must take the following precautions when travelling:

- Get tested 1-3 days before travel and cancel travel plans if testing is positive.
- Get a PCR-based test for SARS-CoV-2 at least 3-5 days after return
    - If the test result is positive, contact the OMS by completing the OMS COVID-19 screening questionnaire and await further guidance.
- Self-quarantine for 7 days regardless of test results.
- If you are unable or unwilling to test, you must self-quarantine for 14 days.
- If symptoms develop, isolate immediately for 10 days after onset of symptoms and contact OMS to determine testing and return-to-work expectations
- Avoid being around people who are at increased risk for severe illness for 14 days, whether you get tested or not (this is a CDC requirement).
- Follow all state and local recommendations or requirements.
- In the interim, if able to, use telework to conduct work duties (with supervisor approval). If you are unable to telework, contact your supervisor for options such as excused absence, sick or annual leave, or emergency leave (if available).

Additional Requirements for International OGT

International OGT travelers are subject to the same requirements as domestic travelers but will also have additional requirements to follow and information that is critical for successful travel. Until further notice, countries listed by CDC as Level 4 countries or with undetermined status in regards to COVID risk, are restricted to mission critical travel only regardless of vaccination status. International travelers:

- Must understand and follow all airline and destination requirements related to travel, testing, or quarantining, which may differ from U.S. requirements. Failure to follow the destination's requirement may result in denial of entry and require return to the United States.
- Must provide proof or attestation of the following for re-entry into the United States:

  - If you are fully vaccinated: Proof of vaccination and a negative COVID-19 test result taken no more than 72 hours before travel to the United States.
  - If you are NOT fully vaccinated: A negative COVID-19 test result taken no more than 24 hours before travel to the United States.
  - your positive COVID-19 viral test result on a sample taken no more than 90 days before the flight's departure from a foreign country and a letter from a licensed healthcare provider or a public health official stating that you were cleared to travel.
- Non-US citizens are required to be vaccinated prior to entry into the country. International staff members should remember to keep vaccination records available, or they may be denied entry after international travel.
- Must take the following actions after return to the United States:
    - All travelers
      - Get tested with a COVID-19 viral test 3-5 days after travel.
      - Self-monitor for COVID-19 symptoms; isolate and get tested if you develop symptoms.
      - Follow all state and local recommendations or requirements after travel.
    - Travelers who are not fully vaccinated, **in addition to the testing recommendations above**
      - Stay home and self-quarantine for a full 7 days after travel, even if you test negative at 3-5 days.
      - If you don't get tested, stay home and self-quarantine for 10 days after travel.

Personal Travel

Personnel engaging on personal travel are not covered under this document. For guidance on personal travel please refer to CDC guidance on domestic and international travel. This information can be found at:

- Domestic travel. https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html
- International travel. https://www.cdc.gov/coronavirus/2019-ncov/travelers/international-travel/index.html

General References and Travel Advisory Resources

Domestic travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-the-us.html
International travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

Staff Wellness

The COVID-19 pandemic has been stressful for many reasons – it can be difficult to cope with fear and anxiety, changing daily routines, and a general sense of uncertainty. Although people respond to stressful situations in different ways, taking steps to care for yourself and your family can help you manage stress.

Stress during an infectious disease outbreak can include:

- Fear and worry about your own health and the health of your loved ones
- Changes in sleep or eating patterns
- Difficulty sleeping or concentrating
- Worsening of chronic health problems
- Increased use of alcohol, tobacco, or other drugs

If you are experiencing stress or other mental health concerns, you can find additional resources at https://employees.nih.gov/pages/coronavirus/how-to-cope.aspx.

You can also directly contact the **NIH Employee Assistance Program** (EAP) at 301-496-3164.

Appendix I - Mask Fit-Enhancement Techniques

Improving Fit and Filtration for Face Coverings

Selection and use of a proper face covering are the most important decisions for protecting the public and personnel from SARS-CoV-2. A properly selected and worn face covering will have two or more layers of washable, breathable fabric and have a tight fit along the edges where the mask meets the skin. The CDC has provided information on techniques to improve the fit and filtration of face coverings. The main enhancement options include 1) knotting and tucking of surgical masks, 2) mask fitters/braces, and 3) double masking. Each identified option has limitations, and it is important that the appropriate strategy for the specific task or work environment is selected. Fit and filtration enhancement may be appropriate in the following scenarios:

- Indoor settings where physical distancing is not feasible, and personnel will work within 6 feet of any other person for a cumulative total of 15 minutes or more over a 24-hour period
- When work requires travel in a shared vehicle (e.g., animal transport)
- Public settings such as public transportation or grocery stores

The DOHS is available to provide consultation regarding the appropriate enhancements based on worksite Activity Hazard Assessments (AHAs). Please note that these guidelines apply primarily to non-patient care areas. The Clinical Center has published an update on the use of masks within the Building 10 complex. In general, this guidance should not supersede the CC policy. For specific questions on mask requirements and risk assessment as it pertains to patient care protocols, please consult Hospital Epidemiology.

Knot and Tuck of Procedure/Surgical Masks. This is a technique, as opposed to additional equipment. By tying knots in the ear loops (near the weld points on the mask) and tucking the ends inside the mask, the gaps that often exist at the corners of the mask are closed, reducing leakage. Research indicates that this can effectively reduce 95% of cumulative exposure to personnel when all personnel in a space use this technique. Personnel require instruction to properly tie the knots and tuck the ends. This solution is excellent for mentoring and teaching scenarios where scientists must demonstrate hands-on research skills. It will also be very helpful for procedures where personnel must work in close proximity for greater than 15 minutes. (e.g., surgical procedures, imaging, etc.).

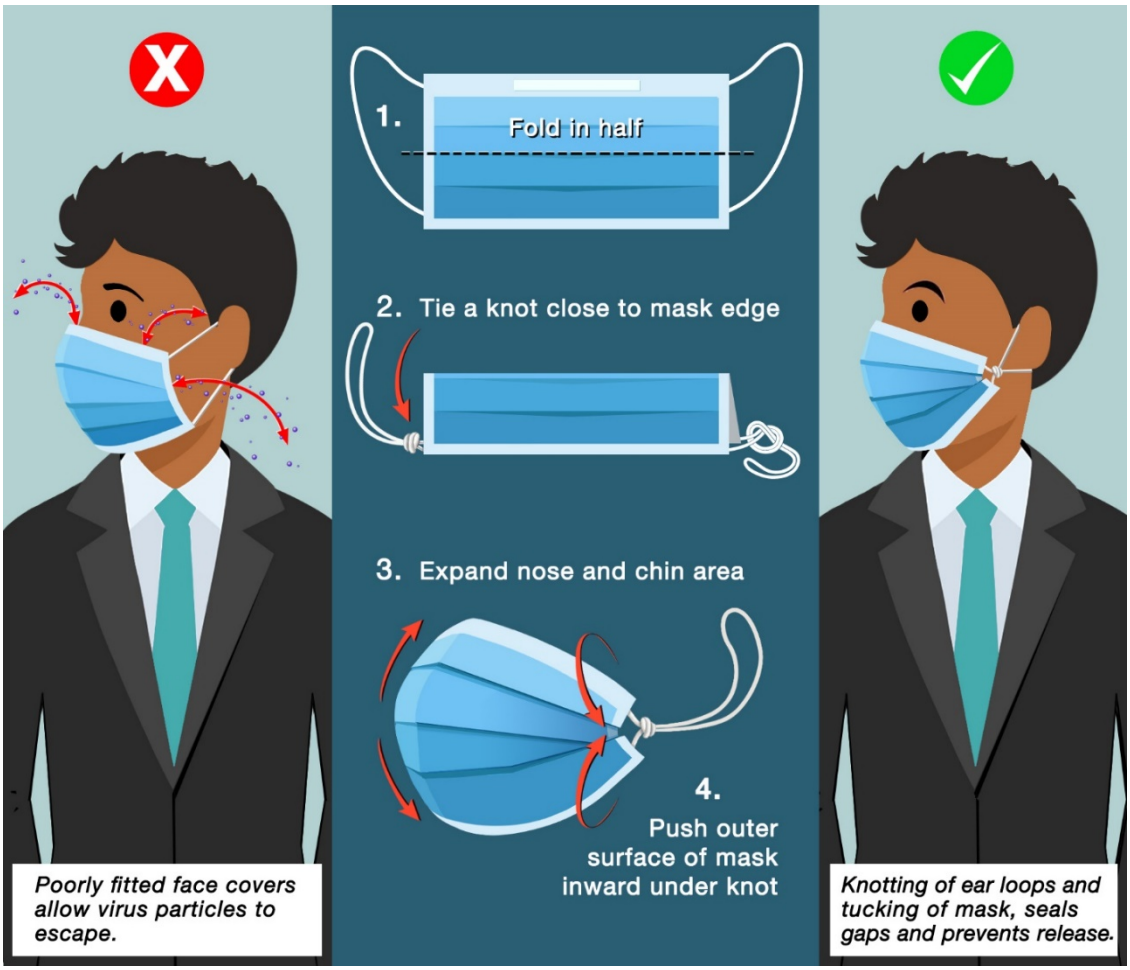
A helpful video on this technique can be found at https://www.youtube.com/watch?v=UANi8Cc71A0&feature=youtu.be.

There are 4 basic steps to the knotting and tucking technique. They are illustrated below.

1. Fold the mask in half so the bottom corners meet the top corners.
2. Tie a knot close to the mask edge.
3. Expand the mask to its full size, unfurling the pleats.

4. Fold the excess fabric so that it is inside the mask.

It's now ready to wear and will provide a much better seal to your face.



Mask Fitters. These are simple frames that are worn **over** cloth or disposable face coverings (not KN95s or N95s). They hold the mask tightly to the face around the nose and mouth. They are simple to use, effective on a wide variety of face coverings, and are easily cleanable if they are constructed of silicone or other non-porous material. There is a significant cost associated with these devices and they require training on wearing, disinfection, and storage. Free plans for 3D printed versions are available through a variety of online resources. Selection: Mask fitters/braces should be constructed of a non-porous, easily cleanable material that is compatible with disinfectants that will be used for cleaning them. The device should be constructed from a silicone-based or plastic material, with smooth surfaces, that are easy to clean and disinfect.

Donning a Mask Fitter When wearing a mask fitter there are some important things to consider for ensuring the best fit.

1) Clean your hands with soap and water or hand sanitizer before touching the mask.
2) Properly place a disposable face covering on you face, securing properly.
3) Inspect your mask fitter thoroughly. If there is dirt or debris on the fitter, clean it properly before use. If the mask fitter shows signs of degradation (i.e., tearing, cracking, loss of elasticity, etc.) dispose of it and replace with a new mask fitter.
4) Follow the instructions for the style of mask fitter you have (ear loop or bands)
    a) Mask fitters with ear loops (NOTE: Ear loop mask fitters may cause discomfort for longer use periods. If your work requires extended use (>1 continuous hour) then a mask fitter of this style is not preferred.):
        i) Hold the mask fitter by the ear loops.
        ii) Place a loop around each ear.
    b) Mask fitters with bands:
        i) Hold the mask fitter in your hand with the top of the mask fitter at fingertips, allowing the headbands to hang freely below hands
        ii) Place the frame of the mask fitter over the disposable face covering, placing it so that it forms a good fit around the mouth and nose. The frame should not touch skin and the edges of the mask should be outside the frame.
        iii) Pull the top strap over your head so that it rests on the crown of your head
        iv) Pull the bottom strap over your head so that it rests at the nape of your neck.
        v) Do not cross the straps on your head. Crossing these straps will reduce the effectiveness of the seal.
5) Try to "tent" your face mask around your mouth such that your mouth does not touch the face mask material and get it wet.
6) Adjust the tension to be comfortable but not overly tight. If the straps are too tight it may cause discomfort. The pressure from the frame should be uniform on the mask.

Doffing a Mask Fitter

1) Clean your hands with soap and water or hand sanitizer before touching the mask. Avoid touching the front of the mask and mask fitter as the mask may be contaminated. Only touch the ear loops or bands.
2) Mask fitter with ear loops: Hold both ear loops and gently lift and remove the mask fitter.
3) Mask fitter with bands: First, lift the bottom strap over your head, then pull the top strap over your head.
4) Clean mask fitter (see below).
5) Clean your hands with soap and water or hand sanitizer.

Cleaning and Disinfection of Mask Fitters

1) Mask fitters should be cleaned after each use.
2) Use an EPA approved List N disinfectant to thoroughly disinfect the mask fitter. Be certain that the disinfectant contacts all parts of the mask brace and allow for adequate contact time per the disinfectant manufacturer's guidance.
3) Wash components in warm (43 deg. C [110 deg. F] maximum) water with a mild detergent or with a cleaner recommended by the manufacturer. A stiff bristle (not wire) brush may be used to facilitate the removal of dirt.
4) Rinse components thoroughly in clean, warm (43 deg. C [110 deg. F] maximum), preferably running water. Drain. The importance of thorough rinsing cannot be overemphasized. Detergents or disinfectants that dry on facepieces may result in dermatitis. In addition, some disinfectants may cause deterioration of rubber or corrosion of metal parts if not completely removed.
5) Components should be hand-dried with a clean lint-free cloth or air-dried.

Storage of Mask Fitters

1. Follow the manufacturer's instructions for proper storage.
2. After the mask fitter is thoroughly dry, place into a sealable, airtight container (e.g. Ziploc Bag ®) to prevent dust from gathering on it.
3. Store in a cool, dry place, out of direct sunlight. The mask fitter should be stored in a manner that does not create folds or creases in the fitter (e.g., flat in a cabinet or drawer, with nothing stored on top of it).
4. DO NOT store in your car, in extreme temperatures, or excessive humidity as this may degrade the mask fitter.

Double Masking. The addition of an additional mask layer may have significant benefits if done properly. Specifically, the use of a two-layer cloth mask over a disposable procedure/surgical mask helps improve the seal of the mask to the face and improves droplet filtration. Like knotting and tucking, research shows increased effectiveness at reducing cumulative exposure (i.e., approximately 95%) when all personnel are properly double masking. This additional cloth

mask should not be used when performing laboratory work including work with biologicals, chemicals, radioactive material, and animals, or anywhere animals are present, as only disposable masks are currently permitted for these tasks in any research setting on campus. NOTE: Double masking should not use two disposable masks as this will not improve the fit of the mask to the face and may reduce effectiveness. Also, double masking does not apply to layering two N95s or two KN95s over each other. Only a cloth mask over a disposable mask has been demonstrated to improve fit and filtration.

Limitations. The CDC acknowledges that some personnel may experience challenges when using some of these practices or equipment to improve fit and filtration. Personnel may experience breathing issues due to the increased filtration layers. In some instances, these enhancements may cause masks to obscure the wearer's vision. Personnel that experience these conditions should stop the work they are performing and seek alternative means of reducing their potential exposure.

Appendix II - Exposure Risk Assessment Definitions

Definitions

- **Active monitoring** – Our program of post exposure monitoring requires a symptom log and follow up with OMS regardless of symptoms. An OMS representative will contact you on a schedule that that is mutually agreed upon. You are not allowed to be present in NIH facilities if you are in active monitoring. Unvaccinated individuals who are assessed to have high-risk exposures will typically be assigned to an active monitoring program. Active monitoring usually lasts 14 days after exposure but may be ended early with an appropriately timed negative PCR based test for COVID-19. Advice on the timing on this test will be given by the OMS case manager following your case. NIH provides this testing at no cost to employees and contractors. You may also be tested for free at many locations in the community under public programs or private insurance. Medical removal benefits under the OSHA Emergency Temporary Standard for COVID-19 will apply if you are a healthcare worker.

- **High-risk exposure** – The most common type of high-risk exposure involves being in close contact (<6 ft), for a cumulative 15 minutes in a 24 hour period, to a person with COVID-19 who has symptoms (in the period from 2 days before symptom onset until they meet criteria for discontinuing home isolation; can be laboratory-confirmed or a clinically compatible illness) or a person who has tested positive for COVID-19 (laboratory confirmed) but has not had any symptoms (in the 2 days before the date of specimen collection until they meet criteria for discontinuing home isolation).
  High-risk exposures may also involve exposure of the eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if the individual was present in the room for an aerosol-generating procedure without using proper personal protective equipment (PPE)[2]. In a non-clinical setting examples of high-risk exposures include shared meals or attending a meeting where a positive case was reported but there was no close contact or close contact was transitory.

- **Low-risk Exposure -** Examples of exposures that would be classified as low-risk in a healthcare setting include having body contact with the patient (e.g., rolling the patient) without gown or gloves, taking vital signs, phlebotomy, assisting with toileting, and changing linens. They may impart some risk for transmission, particularly if proper hand hygiene is not performed and HCPs then touch their eyes, noses, or mouths. Low-risk contacts in a non-healthcare setting could include masked work within the same workspace as a known positive for a short duration <15 minutes, or riding in an elevator masked with a known positive, or eating outdoors with appropriate social distancing as examples.

- **Isolation** – A procedure that separates people *who are sick* with a contagious disease from people who are not sick. You will be placed in isolation if you are diagnosed with COVID-19 or have symptoms suggestive of COVID – 19 pending further evaluation. Isolation is usually voluntary, but in a public health emergency, officials have the authority to isolate people who are sick. If you become sick with COVID – 19, OMS will ask you to self-isolate at home if you are not ill enough to be admitted to a hospital. Your County Public Health Authority may order you to isolate. For most people with COVID-19 illness, isolation and precautions can be discontinued 10 days after symptom onset and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. Medical removal benefits under the OSHA Emergency Temporary Standard for COVID will apply if you are a healthcare worker.

- **Quarantine** – A procedure that separates people *who have been exposed* to a contagious disease from unexposed people. Quarantine can be voluntary, but in a public health emergency, officials have the authority to quarantine people who have been exposed to an infectious disease. If you have a high-risk exposure to COVID–19, OMS will ask you to self-quarantine at home. Depending on the circumstances, your County Public Health Authority may order you to quarantine. Removal from the workplace can be shortened for high-risk contacts and persons presumptively positive for COVID-19 if they have an appropriately timed negative PCR COVID-19 test. NIH provides this testing at no cost to employees and contractors. You may also be tested for free at many locations in the community under public programs or private insurance. Medical removal benefits under the OSHA Emergency Temporary Standard for COVID will apply if you are a healthcare worker. Workers with approved telework agreements are expected to work from home during quarantine. If they are unable to work from home, they will need to work with their supervisor on the appropriate leave to record.

- **Self-monitoring** – A program of post exposure monitoring to carefully watch for COVID-19 symptoms and promptly self-isolate, report to OMS via OMS COVID-19 screening questionnaire, and obtain testing if symptoms develop. Individuals who are assessed to have low-risk exposures and vaccinated individuals with high-risk exposures are typically assigned to self-monitoring. Self-monitoring usually lasts 14 days after exposure but may be ended early with an appropriately timed negative PCR based test for COVID–19. NIH provides this testing at no cost to employees and contractors. You may also be tested for free at many locations in the community under public programs or private insurance.

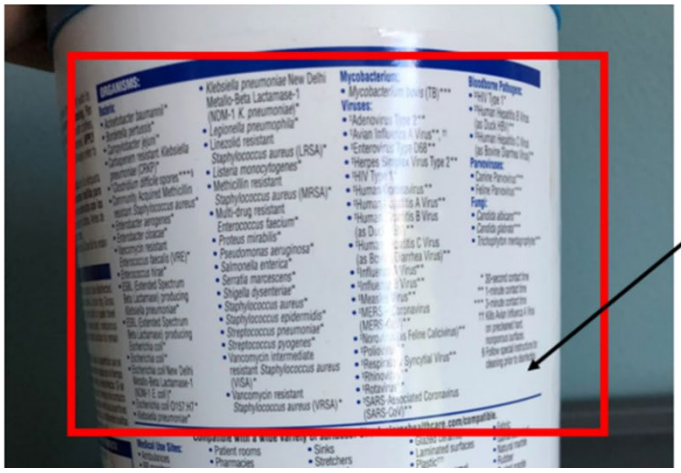
Appendix III – Disinfectant Labels

Reading Disinfectant Labels

It's important to use a disinfectant that is listed on the EPA List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19) https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

When reviewing a disinfectants label, take note of the following:

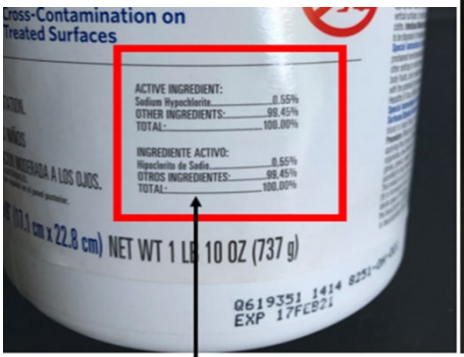
1) Active ingredients
2) List of microorganisms the disinfectant is effective at killing
3) Contact time for the organism of interest (coronavirus)
4) EPA registration number (this can be cross-checked for effectiveness against coronavirus using the link above)



Clorox Germicidal Wipes for Healthcare
https://www.cloroxpro.com/wp-content/uploads/2018/09/Clorox-HC-Bleach-Grm-Wipes-tech-info-NI-38488.pdf

List of Microorganisms this Disinfectant will Kill. Look for Human Coronaviruses or SARS Coronavirus

This disinfectant has a contact time of 1 min for human coronaviruses (key located on far right)

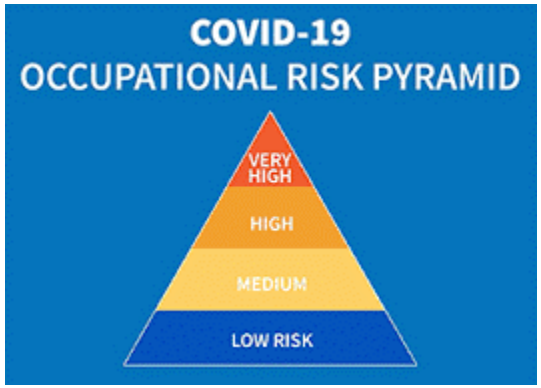


Active Ingredients

Note: Regular Clorox wipes typically do NOT contain bleach or sodium hypochlorite as an ingredient

Appendix IV – Risk Matrix for Workplace Operations

OSHA's Occupational Risk Pyramid for COVID-19 categorizes workers based on their risk of exposure to COVID-19. This risk pyramid reflects ranking workplace risks by using the hierarchy of controls which provides guidance to the effectiveness of different measures that can be used to mitigate a risk of exposure. Attention should focus on elimination and engineering controls, before applying administrative controls or personal protective equipment (PPE) as these are less effective measures to control hazards. This pyramid was applied to the NIH workplace, predominantly applicable to laboratory settings, resulting in the following risk categories. Please note, that clinical settings must consult the NIH clinical center infection control procedures and requirements, as they may differ due to health concerns of their patient populations. Administrative settings may employ a wide variety of technological and spacing controls, and likely are outside the scope of this appendix.



Caveat: the risk matrix below is assuming several factors to decrease the potential exposure to SARS-CoV-2 in the workplace. This assumes persons are healthy and are not coming to work when experiencing symptoms indicative of COVID-19 infection. If persons are sneezing or coughing, there is a potential for leakage around the facial covering, and this risk matrix assumes normal breathing parameters. The data are not fully conclusive, and a combination of factors must be in place to reasonably prevent COVID-19 disease. These measures need to be followed inside and outside of the workplace. This means that physical distancing, face coverings, hand hygiene and symptom assessment are performed as a standard of behavior. This risk matrix also assumes staff have operational guidelines for density in the lab, cleaning protocols, as well as operational requirements (unidirectional flows, scheduling) to assist in minimizing risk. The risk mitigation measures in this document do not supersede or replace measures outlined in pathogen or recombinant DNA registration documents.

- Low: Work activities that follow NIH Safety guidance recommendations, maintaining >6 ft distance between persons.
- Medium: Work activities that are performed within 3-6 ft distance between persons or less than 3 ft distance for <15 minutes.
- High: Work activities that are performed with <3 ft distance between persons for >15 minutes duration.
- Very High: Work activities that are performed with known COVID-19 positive sample types (serum/blood/respiratory/stool), work with live SARS-CoV-2 virus or aerosol generating procedures with known, suspected or confirmed positive patients.

In addition to use of facial coverings as described in the NIH Return to Work Safety guidance document, some work activities requiring closer interactions may dictate use of additional precautions. Research has shown that use of surgical masks reduces the potential to spread contaminants when compared to a standard disposable mask[1,4-5]. Recent data has demonstrated that the fit and filtration of face coverings can be improved using simple techniques or equipment. Knotting and tucking of medical procedure/surgical masks, use of mask fitters/braces, and double masking (a cloth mask over a disposable procedure/surgical mask) have been shown to improve the effectiveness of facial coverings. Additionally, face shields are a good protective measure for acutely expelled aerosols (within 1-3 ft) and offer the advantage of guarding the entire face[2]. One study demonstrated a 96% reduction in infectious particles when using a face shield near the source of particles[3]. Of note, face shields have been shown to be less effective when further away from the source[2]. Additionally, face shields mean the full-face shields that attach at the forehead and cover the entire face. Face masks with attached eye protection only do not meet the layering requirement for a facial covering plus face shield.

The chart below outlines PPE and in some cases engineering/administrative controls recommended for activities that fall under each of the following NIH risk level categories. Note that face shields can be disposable or reusable. If reusable face shields are used, they should be assigned to individual staff members and not shared. If reused, they must be decontaminated after use with an EPA approved disinfectant effective against coronavirus for the appropriate contact time (even if they are not shared). If a film is left over after the contact time is achieved, using a damp paper cloth will remove this film to allow better vision through the shield.

As a reminder, any use or installation of a barrier or plexiglass shield must follow the requirements outlined earlier in the Safety Guidance. It is recommended that DOHS and the NIH Fire Marshal be consulted prior to install.

Risk Level	Admin/Engineering Controls	Recommended PPE	References
Low	Refer to *NIH Safety Guidance for Return to Physical Workplace* Maintain at least 6 ft Use of plastic barriers may be useful to provide physical barrier between persons. Exercise virtual options, telework or telehealth options to reduce face-to-face contact	Lab coat, gloves and eye protection as required by NIH Manual Chapter 1340 plus disposable facial covering* for source control in accordance with Safety Guidance. ***Procedure mask or ASTM Level 1 mask[1]**	https://www.osha.gov/Publications/OSHA3990.pdf https://aip.scitation.org/doi/10.1063/5.0016018
Medium	Consider addition of partitions that don't disrupt other engineering controls (airflow of downdraft table, BSC). Perform this assessment in conjunction with your safety specialist. Consider arranging work so that tasks are separately physically and temporally where possible. This will assist in limiting staff in close proximity to each other. Exercise virtual options, telework or telehealth options to reduce face-to-face contact	Standard lab PPE plus a medical or surgical grade mask* should be used if within 3-6 feet for less than 15 minutes. Staff should consider knotting and tucking or surgical masks or using a mask fitter to improve mask fit. Face shields should be considered as an additional layer of protection. ***ASTM Level 2 or 3 mask[1]**	https://science.sciencemag.org/content/368/6498/1422 https://www.nature.com/articles/s41591-020-0843-2.pdf https://www.cardinalhealth.com/content/dam/corp/web/documents/whitepaper/Face%20Mask%20Selection%20Guide.pdf https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2931142-9 https://www.tandfonline.com/doi/full/10.1080/15459624.2015.1095302

Risk Level	Admin/Engineering Controls	Recommended PPE	References
High Risk	Record close proximity work (date, names, length of time in contact) Avoid standing directly across from others, stagger location. Include frequent training and reminders on self-assessment for symptoms and reporting of symptoms to supervisor. Operations in this category must be reviewed by supervisor, DOHS is available for consult on activity hazard analyses and risk assessment guidance.	Standard lab PPE plus a face shield and a medical or surgical grade mask.* The knot and tuck method or a mask fitter should be used. Some procedures and patient settings may warrant use of N95s. Lab and animal care personnel should utilize a knot and tuck technique or use a mask fitter/brace. Double masking (cloth on top of disposable) may be appropriate for some areas outside of a lab or animal research setting. Consult DOHS for a risk assessment. ***ASTM Level 2 or 3 mask [1]**	https://www.cdc.gov/niosh/topics/eye/eye-infectious.html https://www.tandfonline.com/doi/full/10.1080/15459624.2012.725986 https://www.tandfonline.com/doi/full/10.1080/15459624.2013.877591

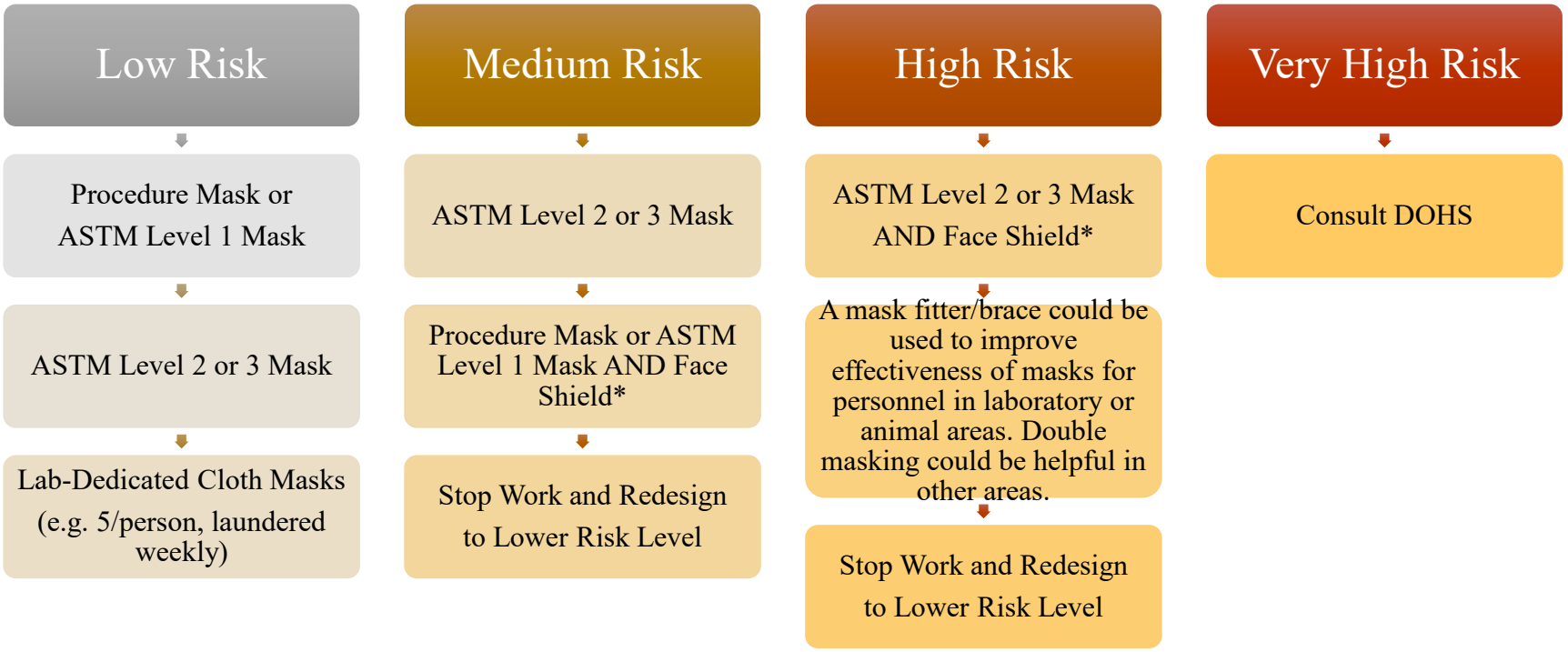
Risk Level	Admin/Engineering Controls	Recommended PPE	References
Very High Risk	All lab work in this category requires pathogen registration with the Institutional Biosafety Committee. Recommendations will be provided upon approval to commence the research Clinical operations should be reviewed with your supervisor, and where appropriate, Clinical Center Epidemiology Services and DOHS.	Follow requirements outlined in pathogen registration document. Procedural SOP and PPE should be determined by supervisor to be commensurate with the risk. Likely requires respiratory protection, and compliance with medical clearance and fit test requirements. Additional PPE will be warranted based on procedures and infection control measures.	Manual Chapter 3035 NIH Recombinant DNA Guidelines(Risk Group 3)

[1] Face masks are rated by ASTM International based on five criteria according to the ASTM F2100-11 standard. Below are the criteria that are most commonly listed by manufacturers to help determine the rating level. The bacterial and particulate filtration efficiency tests help determine the material's ability to filter out aerosols of bacteria and particulates respectively. Fluid penetration resistance is measured by a horizontal projection of synthetic blood at known velocities corresponding to human blood pressure (mm hg).

	LEVEL 1	*LEVEL 2*	*LEVEL 3*
BFE (Bacterial Filtration Efficiency) at 3.0 micron *PFE (Particulate Filtration Efficiency) at 0.1 micron*	≥ 95%	≥ 98%	≥ 98%
Fluid Resistance to Synthetic Blood (mm Hg)	80	120	160

Appendix V – Recommended PPE Decision Chart

The chart below is complimentary to the risk matrix contained in the previous appendix (Appendix IV). After determining the risk level for your (non-clinical) work task from this appendix, look at the column below which matches that risk level. Recommended PPE is listed below each risk level, in descending order of preference. As availability of PPE in the marketplace continues to fluctuate, you can select less preferred PPE (lower on the chart) if preferred PPE (higher on the chart) is unavailable. As a reminder, using the knot and tuck technique can improve the effectiveness of procedure and surgical masks. For more information, reference the section in this document on Improving Fit and Filtration of Face Coverings. Always consult DOHS before considering the provision of respirators where procedure or surgical masks are listed as the recommended PPE.



*Masks with integrated face shields are not equivalent protection to the combination of a mask and a full-face shield. For these risk levels, separate masks and full-face shields are required.

PPE and masks are available from the NIH Supply Center.

Appendix VI – Hazard Assessments and Standard Operating Procedures

The NIH has developed a repository for workplace hazard assessments mandated under 29 CFR 1910.502. The employer must conduct a workplace-specific hazard assessment to identify potential workplace hazards related to COVID–19 in all healthcare facilities.

Clinical Center Patient Care Hazard Assessments and Policies and Other COVID-19 documents can be found at:
https://intranet.cc.nih.gov/hospitalepidemiology/emerging_infectious_diseases

All other workplace hazard assessments and SOPs can be found at:

https://orsweb.od.nih.gov/sites/dohs/covidahassops/

Appendix VII - Workspace Re-Occupancy Evaluation Tool

At least three weeks prior to employees' anticipated return-to-work date, it is recommended that supervisors physically survey the work environment and follow this workspace evaluation tool to ensure the work environment is safe and comfortable for all:

- For the health and safety of staff, housekeeping did not enter most office spaces after March of 2020. Submit a request for housekeeping to perform a basic cleaning of areas that will be reoccupied (vacuuming, wiping of surfaces).
    - You must submit your requests for housekeeping to the Office of Research Facilities (ORF) help desk at 301-435-8000 or online at https://58000.nih.gov. **Your request must include "Return to Work" in the description as this will allow ORF to prioritize and track housekeeping tickets.**
    - Wipe down any surfaces that show obvious dust with a damp paper towel or cloth.
- Are there any odors present? If yes:
    - Check all trash receptacles in common areas and individual offices that may not have been emptied. Place all trash in hallways outside offices for housekeeping to empty.
    - Check refrigerators and dispose of any food or beverages present. Do not consume anything of unknown origin.
    - Clean and dry any dirty dishes left in common area sinks.
    - Run all faucets in sinks that may have dried out for approximately 5 minutes. Run any dish disposals with water and dish soap.
    - Return after a few days to see if odors have lessened. If not, contact ORF at 301-435-8000 or submit a request online at https://58000.nih.gov.
- Is there any water damage on walls or ceiling tiles, visible mold growth, or musty odors? Contact ORF for remediation. Call 301-435-8000 for ORF support or submit a request online at https://58000.nih.gov.
    - Do not reoccupy the affected space until ORF has indicated that remediation is complete.
- Is there any evidence of pest activity?
    - Follow the steps listed above for dealing with odors.
    - Return after a few days to see if pest activity has lessened. Call DOHS at 301-496-4294 to request pest management services.
    - Please note, pest monitoring devices may not have been accessible during the pandemic and may show signs of pest activity. This is not necessarily indicative of a major problem. Please contact the NIH Integrated Pest Management Program for assistance.

Appendix VIII. OSHA Emergency Temporary Standards

In June 2021 the Occupational Health and Safety Administration issued an Emergency Temporary Standard (ETS) for Healthcare Facilities (29 CFR 1910.502) and a mini-respiratory protection ETS (29 CFR 1910.504). The guidance outlined in the document should be considered mandatory for locations that are covered by these standards. The following locations shall adhere to the guidance in this document relevant to 29 CFR 1910.502 and 504:

- Clinical Center Patient Care Areas
- Clinical Center Hospital Support Services
- The NIH Bethesda Campus COVID-19 Carline Testing Site
- Contractors entering the NIH Patient Care or Hospital Support Services areas
- NIH Fire Department when emergency health services are provided

Other locations that provide non-hospital, ambulatory care (e.g., any vaccine clinic, asymptomatic testing site, or the NIH Occupational Medical Service (OMS) clinic outside the clinical center) are exempt from the ETS because personnel and visitors entering those sites are screened for COVID-19 symptoms and excluded from entry if they have suspected or confirmed COVID-19. **This should not be construed to mean that physical distancing, masking, population densities or other guidance in this document is not required, but rather that those locations that are covered by the standard are subject to additional scrutiny.**

Specific elements covered by the OSHA Healthcare ETS include a requirement for a **COVID-19 Safety Plan** that includes workplace hazard assessments, input from non-managerial personnel, monitoring for plan effectiveness, and methods to minimize transmission of the virus causing COVID-19. This document will serve as the COVID-19 Safety Plan for areas requiring it under the OSHA ETS. Links to Workplace Hazard Assessments and Standard Operating Procedures are included in Appendix VI - Hazard Assessments and Standard Operating Procedures of this document.

COVID-19 Safety Coordinators

The OSHA Healthcare ETS requires that the employer identifies COVID-19 Safety Coordinators. The NIH COVID-19 Safety Coordinators by area of responsibility are listed below.

Location (Areas of Responsibility)	**COVID-19 Safety Coordinator**	**Contact**
NIH Clinical Center	Hospital Epidemiologist	301-827-9089
NIH ORF and ORS services supporting the Clinical Center	Division of Occupational Health and Safety Director	301-496-2960
NIH Car-Line Testing Site	Division of Occupational Health and Safety Director	301-496-2960
NIH Fire Department	Division of Fire and Rescue Services Chief	301-496-2372

The COVID-19 Safety Coordinator's role is to implement and monitor the COVID–19 plan. The COVID–19 safety coordinators are knowledgeable in infection control principles and practices as they apply to the workplace and employee job operations. The safety coordinators are NIH personnel that have the authority to ensure compliance with the COVID–19 plan. Additional details on the areas of responsibility are found in Appendix IX.

COVID-19 ETS Requirements Summary and Reference

OSHA Healthcare ETS Requirement	**Requirement Summary**	**NIH Policy or Plan Reference**
Patient Screening and Management	Requires that access to facilities be limited and that visitors are screened for suspected or confirmed COVID-19 cases. Also Includes Patient management strategies	This document, Self-Monitoring Appendix VI – Hazard Assessments and Standard Operating Procedures The COVID-19 Phone Screening Tool is completed for Clinical Center patients within 48 hours prior to arrival, followed by screening upon entry to Building 10, and again for CRIS Emerging Infections Screening upon arrival to Clinic/Patient Care unit Coronavirus (COVID-19) Fact Sheet for NIH Clinical Center Patients and Visitors New COVID-19 Testing Plan for Clinical Center Inpatient Admissions Update to Patient Visitor Policy Clinical Center verify CDC's patient management strategies are incorporated: Infection Control During COVID-19 (Inpatients and Visitors) Contract language drafted for incorporation into all contracts supporting healthcare service at the NIH. Require multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace. See 1910.502(n)(1)(v)
Standard and Transmission-	Develop and implement policies and	Appendix VI – Hazard Assessments and Standard Operating Procedures

OSHA Healthcare ETS Requirement	Requirement Summary	NIH Policy or Plan Reference
Based Precautions	procedures in accordance with CDC regarding standard and transmission-based precautions	
Personal Protective Equipment (PPE)	Mandate facemasks and their proper wearing, provide and ensure PPE usage when performing aerosol-generating procedures on suspect or confirmed COVID-19 patients, provide respirators and other PPE in accordance with standard and transmission-based precautions, allowance of voluntary respiratory usage per 1910.504	This document, Facial Coverings (Cloth Face Coverings, Surgical Masks, and N95 Respirators) This document, Appendix IV – Risk Matrix for Workplace Operations, Appendix V – Recommended PPE Decision Chart This document Appendix VI – Hazard Assessments and Standard Operating Procedures Clinical Center Guidelines for Use of Masks for Patient Care Clinical Center Guidelines for Use and Care of Face Shields NIH Respiratory Protection Program Voluntary Respirator Use Information and Certification
Aerosol-Generating	Where there are suspected or confirmed	Clinical Center Intranet Hospital Epidemiology Emerging Infections Diseases webpage

OSHA Healthcare ETS Requirement	Requirement Summary	NIH Policy or Plan Reference
Procedures (AGP)	COVID-19 cases, limit staff to essential employees; Perform procedures in an airborne infection isolation room (AIIR), if available, and clean and disinfect surfaces and equipment once the procedure is completed	Clinical Center Infection Control Guidelines Managing Symptomatic Patients in the Clinical Center: Bringing Patients with Active and Suspected COVID-19 Infection (PUIs) to the Clinical Center Testing Symptomatic Patient (Inpatient / Outpatient) Transport of COVID-19 Patients and PUIs Discontinuing Enhanced Respiratory Isolation Bronchoscopy Department of Perioperative Medicine Preoperative Screening for COVID-19 GI Endoscopy Interventional Radiology Metabolic Clinical Research Unit Studies Nasal Endoscopy Pulmonary Function Testing Tracheostomy Managing Recovered COVID-19 Patients: Clinician Fact Sheet Additional Resources for Clinical Center Staff: COVID-19 Surveillance Testing for Inpatients – Staff Fact Sheet Inpatient Visitors: Rooming-In

OSHA Healthcare ETS Requirement	Requirement Summary	NIH Policy or Plan Reference
		Managing CC Patient Visitors During the COVID19 Pandemic: Requesting an Exception Mask and Face Shield Reminder Trach and Neck Stoma Patients: COVID-19 Source Control and COVID-19 Testing NIH FRS SOP on Patient Transport Available upon request See also this document, Appendix VI – Hazard Assessments and Standard Operating Procedures
Physical Distancing	Maintain 6' of physical distancing whenever possible	This document, Physical Distancing
Physical Barriers	Where physical distancing cannot be maintained, use physical barriers to limit exposure to droplets	This document, Requirements and Considerations for the Use of Barriers
Cleaning and Disinfection	Follow CDC guideline regarding disinfection and cleaning of areas	This document, Guidance on Cleaning and Disinfection Clinical Center: Policies require that spaces are thoroughly disinfected between patients.
Ventilation	Maximize fresh air in the HVAC system and utilize MERV-13 or higher filters for the HVAC system	ORF COVID-19 Ventilation memo (Available upon request)

OSHA Healthcare ETS Requirement	Requirement Summary	NIH Policy or Plan Reference
Health Screening and Medical Management	Screen employees (self-monitoring is acceptable). Each employee must report COVID-19 symptoms or suspected or confirmed COVID-19 to the employer. Employers must notify all employees who were not wearing respirators and/or required PPE of any COVID-19 exposure at the workplace. Personnel removed for COVID symptoms must be paid by the employer	This document, Self-Monitoring SAFER-COVID Tool https://www.saferfederalworkforce.gov/faq/screening/ Contact tracing and notifications: This document, What Happens When Someone Tests Positive? Clinical Center: Appendix VI – Hazard Assessments and Standard Operating Procedures COVID-19 Staff Self-Isolation Guidance Periodic Testing of Asymptomatic CC Staff
Vaccination	Vaccines offered to employees are at no cost and paid time-off is given for vaccinations	This document, COVID-19 Vaccine Program NIH COVID-19 vaccination plan, https://employees.nih.gov/pages/coronavirus/vaccination-plan-nih-staff.aspx https://employees.nih.gov/pages/coronavirus/vaccination-requirements.aspx

OSHA Healthcare ETS Requirement	Requirement Summary	NIH Policy or Plan Reference
	and side effects	
Training	Training for personnel and contractors on the elements of this plan	The NIH Safety Guidance Video, available in English online in the Learning Management System (LMS) is required for all personnel prior to entry into physical workspaces. Safety Guidance Video Technical Tips
Recordkeeping	Requires establishment of a COVID-19 log and make records available to employees	This document, What Happens When Someone Tests Positive?
Reporting	Any hospitalization of an employee due to COVID-19 must be reported to OSHA within 24 hours of the employer being notified. COVID-19 fatalities must be reported within 8 hours of employer being notified.	OMS and TAB OSHA Injury Reporting Requirements Procedure (available upon request)
Medical Removal from Workplace	If an employee is confirmed, diagnosed, or suspected of having COVID-19 by a licensed healthcare	If an NIH staff member tests positive for COVID-19, specific steps are taken, including communication from OMS to the supervisor that the staff member cannot report to work

OSHA Healthcare ETS Requirement	Requirement Summary	NIH Policy or Plan Reference
	provider, or is experiencing certain symptoms, they must be immediately removed from the workplace and kept away until return to work criteria are met	

This "Return to Work Guidance and COVID-19 Safety Plan, referred to subsequently as "this plan" has been shared with the NIH Occupational Safety and Health Committee (OSHC), the ORF Safety Committee, the ORS Safety Committee, the Clinical Center Safety Committee, and federal collective bargaining unit representatives. Feedback from these committees, which are composed of managerial and non-managerial staff has been used to ensure this plan is acceptable and feasible.

Personnel wishing to provide additional feedback on this plan and to provide input on its continual improvement may provide feedback through their IC Safety and Health Committees, their designated IC Safety and Health Specialist, the NIH Reporting Hazardous Conditions website, or through the COVID-19 Reporting tool. This plan will be reviewed quarterly to ensure it is relevant and that provided resources in the plan are current.

Training

All affected NIH personnel shall receive training on this plan and 29 CFR 1910.502. All health care personnel and healthcare support personnel, as well as impacted contractors must take this training. This training will be hosted on the NIH Learning Management System (LMS) and provide employees training on:

- COVID–19, including how the disease is transmitted (including pre-symptomatic and asymptomatic transmission), the importance of hand hygiene to reduce the risk of spreading COVID–19 infections, ways to reduce the risk of spreading COVID–19 through the proper covering of the nose and mouth, the signs and symptoms of the disease, risk factors for severe illness, and when to seek medical attention;
- Employer-specific policies and procedures on patient screening and management;
- Tasks and situations in the workplace that could result in COVID–19 infection;

- Workplace-specific policies and procedures to prevent the spread of COVID–19 that are applicable to the employee's duties (e.g., policies on Standard and Transmission-Based Precautions, physical distancing, physical barriers, ventilation, aerosol generating procedures);
- Employer-specific multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace;
- Employer-specific policies and procedures for PPE worn, including:
    - When PPE is required for protection against COVID–19;
    - Limitations of PPE for protection against COVID–19;
    - How to properly don, doff, and properly use PPE;
    - How to properly care for, store, clean, maintain, and dispose of PPE; and
    - Any modifications to donning, doffing, cleaning, storage, maintenance, and disposal procedures needed to address COVID–19 when PPE is worn to address workplace hazards other than COVID–19;
- Workplace-specific policies and procedures for cleaning and disinfection;
- Employer-specific policies and procedures on health screening and medical management;
- Available sick leave policies, any COVID–19-related benefits to which the employee may be entitled under applicable federal, state, or local laws, and other supportive policies and practices (e.g., telework, flexible hours);
- The identity of the safety coordinator(s) specified in the COVID–19 plan;
- The requirements of this section; and
- How the employee can obtain copies of this section and any employer specific policies and procedures developed under this section, including the employer's written COVID–19 plan

Additional training will be provided by the supervisor regarding specific tasks. If changes are made to this plan or to job-specific protocols additional training will be provided. Any employee that does not demonstrate knowledge, understanding or skill implementing this plan will be required to attend additional training.

If, at any time during or after the training, personnel have questions about this program, they can contact their COVID-19 Safety Coordinator(s) named above.

Contractors

This plan, as it applies to the OSHA ETS, should be shared with affected contractors. Contractors are expected to comply with this plan. Employer-specific multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace must be established. These

agreements will specify that contractors must comply with the NIH Safety Guidance and COVID-19 Safety Plan for Working Onsite During the Coronavirus Pandemic and must share their company COVID-19 Safety Plans to the extent they impact expectations of NIH and other contract personnel at the affected site.

Anti-Retaliation

It is the policy of the NIH that no one at the NIH shall be discharged or discriminated against for exercising their rights under the OSHA ETS or for engaging in actions required by the ETS or any other applicable federal standard.

Appendix IX – OSHA ETS Areas of Responsibility

COVID-19 Plan

Location	DOHS	Clinical Center Hospital Epidemiology	NIH DFRS	Acquisition/ Contracting	ORF	Contractors
Carline	X					
Building 10 Patient Care		X				
Contractors				X		X
NIH Emergency Services	X					

Patient Screening and Management

Building 10 All Areas		X				
Carline	N/A					
Asymptomatic Testing Sites	X					
Fire and Rescue Operations			X			

Standard and Transmission-based Precautions

Clinical Center - Patient Care		X		X		
Clinical Center - Hospital Support Services - ORF	X			X		
Clinical Center - Hospital Support Services - ORS	X			X		
Clinical Center - Hospital Support Services - Non-OD		X		X		
Carline	X					
Fire and Rescue Operations			X			

Personal Protective Equipment

Location	DOHS	Clinical Center Hospital Epidemiology	NIH DFRS	Acquisition/ Contracting	ORF	Contractors
Clinical Center - Patient Care		X				
Clinical Center - Hospital Support Services - ORF	X					
Clinical Center - Hospital Support Services - ORS	X					
Clinical Center - Hospital Support Services - Non-OD		X				
Carline	X					
Fire and Rescue Operations			X			

Aerosol Generating Procedures

Clinical Center - Patient Care		X				
Carline	X					
Fire and Rescue Operations			X			

Physical Distancing

Clinical Center - Patient Care		X				
Clinical Center - Hospital Support Services - ORF	X					
Clinical Center - Hospital Support Services - ORS	X					
Clinical Center - Hospital Support Services - Non-OD		X				
Carline	X					
Fire and Rescue Operations			X			

Physical Barriers

Location	DOHS	Clinical Center Hospital Epidemiology	NIH DFRS	Acquisition/ Contracting	ORF	Contractors
Clinical Center - Patient Care		X				
Other	X					
Fire and Rescue Operations	X				X	

Cleaning and Disinfection

Clinical Center - Patient Care		X				
Clinical Center - Hospital Support Services - ORF	X					
Clinical Center - Hospital Support Services - ORS	X					
Clinical Center - Hospital Support Services - Non-OD		X				
Fire and Rescue Operations			X			
Carline	X					

Ventilation

All areas					X	

Health-Screening and Management

Clinical Center - Patient Care		X				
Clinical Center - Hospital Support Services - ORF	X					
Clinical Center - Hospital Support Services - ORS	X					
Clinical Center - Hospital Support Services - Non-OD		X				

Carline	X					
Fire and Rescue Operations			X			

Vaccination

Location	DOHS	Clinical Center Hospital Epidemiology	NIH DFRS	Acquisition/ Contracting	ORF	Contractors
All areas	X					

Training

Clinical Center - Patient Care		X				
Clinical Center - Hospital Support Services - ORF	X					
Clinical Center - Hospital Support Services - ORS	X					
Clinical Center - Hospital Support Services - Non-OD		X				
Carline	X					
Fire and Rescue Operations	X		X			

Recordkeeping

Clinical Center Staff	X					
Clinical Center - ORF	X					
Clinical Center - ORS	X					
Clinical Center - Contractors	X					
Fire and Rescue Operations	X					

Reporting

All areas	X					