COVID-19

CBP Guidance for Leadership, Medical Officers, and Supervisors

September 25, 2020

U.S. Customs and Border Protection

As COVID-19 continues to spread throughout the Homeland, the concentration of community spread will vary from state, county, and city. To avoid illness and slow the spread, please continue to practice good hand hygiene, cover your cough with your elbow, practice social distancing, and when job duties allow, telework whenever possible. In addition, employees' personal risk factors should be taken into account to reduce their risk of exposure.

State and local public health officials in affected regions may further close schools and institute other containment and mitigation measures to slow the spread. CBP employees should monitor all state and local public health direction; however, local shelter-in-place orders do not apply to CBP mission-critical employees for work-related activities.

This package of guidance is to help CBP workforce management ensure mission continuity during a complex, novel, and evolving pandemic. Please use this guidance in conjunction with the CBP Job Hazard Analysis (JHA) and other relevant guidance documents available on the COVID-19 Resource page. All employees should continue to follow all guidance from their component leadership. For further questions or clarification, contact the CBP COVID-19 Emergency Operations Center (EOC) at (202) 325-2228 or CBPHQEOC@cbp.dhs.gov.

The following guidance is included:

- Exposure Documentation Guidance/Exposure Risk Assessment (Contact Tracing)
- Exposure Decision Tree for Supervisors
- Exposure Guidance for Mission-Critical Personnel
- Reporting Guidance for Supervisors
- Return to Work Guidance for Employees
- Cleaning Guidance for Management
- Cloth Face Coverings
- Guidance for Maximum Use of N95 Respirators
- Path to Protection: Considering the Full Range of Workplace Controls

This guidance was originally issued by the Management Office of the Chief Human Capital Officer (OCHCO) Workforce Health and Safety Division (WHS) and has been adapted to apply to the CBP workforce. CBP employees will need to remain flexible as the entire Nation recovers from this crisis. The Management OCHCO WHS will continue to monitor Center for Disease Control and Prevention (CDC) COVID-19 guidance and update Department guidance as the situation evolves.

GLOSSARY

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ACTIVE MONITORING	Local public health authorities actively monitor close contact cases in the affected community/ locale. Involves daily telephone, text, or in-person inquiries about fever or other symptoms for 14 days following the last known exposure to a person with confirmed COVID-19.
CONFIRMED CASE	An employee who has received a positive result from a diagnostic/ viral COVID-19 test.
CONTACT	**Direct Contact:** Direct physical contact with an infectious person or infectious secretions (e.g., cough, sneeze). **Close Contact:** Being within approximately 6 feet of an infectious person. **Limited Close Contact:** Less than approximately 15 minutes of close contact. **Extended Close Contact:** More than approximately 15 minutes of close contact. **Casual Contact:** Being in general proximity beyond 6 feet of an infectious person.
EXPOSURE	**High-Risk Exposure:** Extended (more than 15 minutes) close (less than 6 feet) or direct contact with symptomatic person with suspected or known COVID-19 without personal protective equipment (PPE). **Medium-Risk Exposure:** Limited (less than 15 minutes) close contact (less than 6 feet) without PPE or extended close or direct contact with PPE OR extended time in enclosed space with suspected or confirmed (symptomatic or asymptomatic) COVID-19 case. **Low-Risk Exposure:** Casual contact (greater than 6 feet) with or without PPE or secondhand contact with a suspected or confirmed (symptomatic or asymptomatic) COVID-19 case.
FACE COVERING	Face coverings are intended to keep the wearer from spreading respiratory secretions to others when talking, sneezing, or coughing. Cloth face coverings are not surgical masks or N95 respirators and are not considered PPE. Face coverings protect others, not the wearer.
FACE MASK	Face masks are often referred to as "surgical masks" or "procedure masks." Food and Drug Administration (FDA)-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated.
ILLNESS SEVERITY	**Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging. **Moderate Illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging (x-ray, CT scan, etc.) and a saturation of oxygen (SpO_2) ≥94 percent on room air at sea level. The employee may go to a hospital/urgent care for evaluation, but they are *not admitted*. **Severe Illness:** An employee that has been admitted to the hospital for COVID-19-related complications. The CDC's definition: Individuals who have respiratory frequency >30 breaths per minute, SpO_2 <94 percent on room air at sea level (or, for patients with chronic hypoxemia, a decrease from a baseline of >3 percent), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO_2/FiO_2) <300 mmHg, or lung infiltrates >50 percent. **Critical Illness:** An employee that is *transferred to the Intensive Care Unit (ICU)* for COVID-19-related complications. The CDC's definition: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
ISOLATION	The separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease. Isolation for public health purposes may be voluntary or compelled by federal, state, or local public health order. **In home/quarters isolation:** Saying home or in quarters; separating yourself from other people (i.e., trying not to be in the same room as other people at the same time; asking friends and family not to visit unless necessary). **In hospital isolation:** When you are ill and receiving medical care, you may be placed in a specialized room designed to separate you from other patients and visitors while decreasing risk of spread.
LOCAL/ PUBLIC HEALTH AUTHORITY	An agency or authority of the U.S. Government, a state, a territory, a political subdivision of a state or territory, or an Indian tribe that is responsible for public health matters as part of its official mandate has quarantine authority. Examples are state and local public health departments and the CDC.
PUBLIC HEALTH ORDERS	Legally enforceable directives issued under the authority of a relevant federal, state, or local entity that, when applied to a person or group, may place restrictions on the activities undertaken by that person or group, potentially including movement restrictions or a requirement for monitoring by a public health authority, for the purposes of protecting the public's health. Federal, state, or local public health orders may be issued to enforce isolation, quarantine, or conditional release. The local public health department may issue a public health order to prevent people from leaving a local area, their home, or require monitoring to protect the public's health.

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QUARANTINE	Separation, at home, of a person or group of people reasonably believed to have been exposed to a communicable disease but not yet symptomatic, from others who have not been so exposed, to prevent the possible spread of the communicable disease.
RESPIRATOR (N95)	A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/National Institute for Occupational Safety and Health (NIOSH), including those intended for use in healthcare.
SELF-OBSERVATION	Individuals stay alert for developing signs and symptoms during the self-observation period. If symptoms develop during this time, check temperature, self-isolate, limit contact with others, and seek medical advice by telephone or local public health department to determine if a medical evaluation is needed. Continue social distancing as directed.
SELF-MONITORING	People should monitor themselves for fever by taking their temperatures twice daily and remain alert for cough or difficulty breathing. • Take temperature twice daily and record. • Make note of any changes in how you feel (particularly if you start to have trouble breathing). • Keep your health care provider's contact information handy. • If your condition worsens, consult with a medical provider. A self-monitoring worksheet is available on the CBP COVID-19 Resource page under the Employee Guidance section.
SIGNS AND SYMPTOMS	The common symptoms, which may appear in some combination within 2-14 days after exposure to the virus, are cough, shortness of breath or difficulty breathing, fever (100.4°F [38°C] or higher), chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell.
SOCIAL DISTANCING	Remaining out of congregate settings, avoiding mass gatherings, and maintaining distance (approximately 6 feet or 2 meters) from others when possible. • Telework and teleconferences are an acceptable alternative. • Workspace modifications for business transactions (glass barriers, moving workspace for added distance, etc.). • School closure (proactive or reactive). • Workplace closure including closure of "non-essential" businesses and social services. • Cancellation of mass gathering events. • Voluntary isolation of contacts. • Voluntary quarantine of contacts.
TESTING	**Diagnostic Testing (Viral/PCR/Antigen):** Test requiring a respiratory specimen (nasal or throat swab) that measures the amount of COVID-19 virus in an individual. The **viral/PCR** and **antigen** tests are currently the only accepted methods to confirm an active COVID-19 infection in an individual. **Antibody Testing (Serology/Ab):** Test that measures COVID-19 antibody levels after an exposure/ infection. A positive result does not necessarily indicate that the individual has an active COVID-19 infection, only that they have been exposed and may have developed immunity. A negative test does not necessarily rule out an active infection. A diagnostic test will be required to determine if the individual has an active infection. Any positive antibody test will be treated as a presumed positive case until a diagnostic test confirms if there is/ is not an active infection.

EXPOSURE DOCUMENTATION GUIDANCE

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FOR EMPLOYEES

1. Notify supervisor.
   - For **potential** exposure* situations, coordinate with supervisor to document on CBP-502 in the Safety Incident Reporting Tool (SIRT) as appropriate. Create a record of potential exposure* to assist with future claims process related to potential symptoms,* health complications, or positive COVID-19 viral/diagnostic test* results.
   - For **confirmed** exposure* situations as a result of **positive viral/diagnostic COVID-19 test,*** ensure CBP-502 has been completed in SIRT and initiate CA-1 as appropriate in eCOMP (or CA-2 only if directed by the Office of Workers' Compensation Programs (OWCP)). Gather and submit appropriate documentation (i.e., COVID-19 test results, medical paperwork, memos, reports of investigation) to supervisor or local injury compensation coordinator for processing with OWCP once your claim is filed.
2. Per COVID-19 guidance, self-monitor,* quarantine,* or isolate* as appropriate.
3. CA-1 must be submitted within 30 days of the date of exposure to be eligible for continuation pay for 45 days.

FOR SUPERVISORS

1. Notify leadership and contact local health authorities* (if necessary).
2. Complete CBP-502 in SIRT.
3. Complete CA-1 in eCOMP (if necessary).
4. Offer Employee Assistance Program (EAP) assistance.
5. Initiate Significant Incident Report/Evolving Situational Report (SIR/ESR) (if necessary).

EXPOSURE RISK ASSESSMENT (CONTACT TRACING)

Identify personnel exposed to the suspected or confirmed case* for a period of 48 hours prior to the identification of the suspected or confirmed case.*

Contact tracing refers to the identification and management of persons with potential exposure* to a known or suspected case of an infectious disease (such as COVID-19). Formal contact tracing is a public health function, conducted by state/local health authorities* or the CDC.

CBP should facilitate/assist/support public health authorities* with contact tracing efforts in general and specifically related to COVID-19.

From a CBP perspective, as a law enforcement agency, CBP conducts Exposure Risk Assessment and Management, which is similar to public health contact tracing and can be conducted as an adjunct to public health contact tracing.

1. **Review schedule: Identify personnel exposed to the suspected or confirmed case* for a period of 48 hours prior to the identification of the suspected or confirmed case.*** People, locations and equipment the impacted employee or person(s) in custody came into contact* with.
2. **Review detention log: Identify person exposed to the suspected or confirmed case* for a period of 48 hours prior to the identification of the suspected or confirmed case.*** CBP personnel, contract employees, and person(s) in custody.
3. **Determine exposure* risk level per the Exposure Decision Tree for Supervisors.**
4. **Take appropriate steps per the Exposure Decision Tree for Supervisors,** include persons in custody – with isolation* or quarantine* in custody or at home.
5. **Contact and advise others who came into contact* with person(s) in custody.** Contracted security guards who conduct transports for ICE-ERO (G4S), Enforcement and Removal Office (ERO), Processing/Transportation agents, and CBP Attachés as necessary.
6. **Identify, clean, and sanitize assigned equipment/locations per CBP/Occupational Safety and Health (OSH), General Services Administration (GSA), and Office of Facilities and Asset Management (OFAM) guidance.**
7. **Report as required per the Reporting Guidance for Supervisors.**
8. **See the CBP COVID-19 Resource page for exposure risk assessment FAQs and a risk assessment worksheet (under the Supervisor Guidance section).**

* See Glossary for definition.

EXPOSURE DECISION TREE FOR SUPERVISORS

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HAS THE EMPLOYEE, OR PERSON(S) IN CUSTODY, BEEN EXPOSED TO A SUSPECTED[1] OR CONFIRMED COVID-19 CASE?

YES

NO

HIGH RISK[2]

Extended (more than 15 minutes) close (less than 6 feet) or direct contact with a person with suspected or known (symptomatic or asymptomatic) COVID-19 without PPE.[3]

MEDIUM RISK[2]

Limited (less than 15 minutes) close contact (less than 6 feet) without PPE, extended close or direct contact with PPE, or extended time in enclosed space with suspected or confirmed (symptomatic or asymptomatic) COVID-19 case.[3]

LOW RISK

Casual contact (greater than 6 feet) with or without PPE or secondhand contact with a suspected or confirmed (symptomatic or asymptomatic) COVID-19 case.[3]

NO KNOWN RISK

Have employee continue to come to work as appropriate and self-observe. If symptoms* develop, have employee isolate.* Offer appropriate flexibility (e.g., sick leave, telework). Employee should consult medical provider and follow Return to Work Guidance.

IS EMPLOYEE SYMPTOMATIC?

NO

Have the employee self-quarantine* and self-monitor* for 14 days beginning with the last date of close contact* with the known or suspected symptomatic* COVID-19 case.* Employee can telework if able; if not, offer appropriate leave (e.g., weather and safety leave or other applicable processes[4]). If symptoms* develop, employee should consult medical provider; use sick leave. If no symptoms after 14 days, employee can return to work.

IS EMPLOYEE SYMPTOMATIC?

YES

Have the employee stop work activities and isolate.* Offer appropriate flexibility (e.g., sick leave, telework if able, or other). Have employee or person in custody wear a face covering,* contact medical provider, and follow Return to Work Guidance.

NO

If the employee is mission critical, consider utilization of Mission-Critical Guidance. Otherwise, have employee self-quarantine* and self-monitor* for 14 days from last exposure (weather and safety leave or other applicable processes[4]). Employee can telework if able. If symptoms* develop, provide sick leave, and have employee isolate* and consult medical provider and follow Return to Work Guidance.

IS EMPLOYEE SYMPTOMATIC?

YES

Have the employee stop work activities and isolate.* Offer appropriate flexibility (e.g., sick leave, telework if able). Have employee or person in custody wear a face covering,* contact medical provider, and follow Return to Work Guidance.

NO

Have the employee self-observe* for 14 days while continuing to come to work. Employee can telework if able. If symptoms* develop, have employee isolate,* consult medical provider, and follow Return to Work Guidance.

[1] If the source of the suspected exposure tests negative, then follow No Known Risk box guidance.

[2] Refer to Reporting Guidance for Supervisors for processes on how to report confirmed cases and medium- to high-risk exposure cases.

[3] Identify employees with exposure to symptomatic employee or person in custody 48 hours prior to employee or person in custody showing symptoms.

[4] Please reference your local human resources representative for appropriate leave designation.

* See Glossary for definition.

EXPOSURE GUIDANCE FOR MISSION-CRITICAL PERSONNEL

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WHAT IF A MISSION-CRITICAL EMPLOYEE IS EXPOSED* TO SUSPECTED OR CONFIRMED* COVID-19?

If the Employee:

- ☐ Performs mission-critical activities
- ☐ Has had a **medium-risk exposure*** in the last 14 days
- ☐ But has not had symptoms*

then the Employee:

- ☐ **CAN** continue mission-critical activities at DHS facilities
- ☐ **BUT** he or she **MUST** meet all listed requirements specified in this guidance

REQUIREMENTS CHECKLIST

Applies to the first 14 days after exposure.

- ☐ Practice social distancing.* Remain at least 6 feet, or two arm-lengths away, from others when possible.
- ☐ Prior to coming into work, verify that you do not have any symptoms.*
- ☐ Prior to leaving for work, you must take your temperature and it must be lower than 100.4ºF (38ºC) without fever-reducing medication. (If taking temperature by mouth, do not drink anything for 30 minutes prior to taking your temperature.) If you have a fever, do not go to work.
- ☐ When possible, avoid carpooling or taking public transportation to commute to and from work (e.g., bus, metro, train).
- ☐ Prior to entering the Department of Homeland Security (DHS) facility, a face mask* may be provided for voluntary use as appropriate.
- ☐ Prior to entering the DHS facility, sanitize your hands (e.g., hand sanitizer, hand wipes). As soon as possible, once in the facility, wash your hands with soap and water for at least 20 seconds.
- ☐ While in the DHS facility, limit your contacts and movement. Do not eat or socialize in the community kitchen, lounge, or cafeteria. If at all possible, exercise telework options.
- ☐ Prior to using communal bathrooms, sanitize your hands. Prior to leaving the restroom, wash your hands with soap and water and use a paper towel to open the door to leave the restroom.
- ☐ Prior to leaving the facility, put on your face mask* (if provided/ available) and wipe down your workstation (e.g., keyboard, monitor, mouse, desktop, phone, door knob, light fixtures) with disinfectant. Wash or sanitize your hands and leave the facility. Limit your contacts and avoid socializing in communal areas as you exit the facility.

IF YOU DEVELOP FLU-LIKE SYMPTOMS WHILE AT WORK:

- ☐ Put on face mask* (if available), stop work activities, and notify your supervisor.
- ☐ Prior to leaving, wipe down workstation, door knobs, and light switches with disinfectant.
- ☐ Limit your contacts and avoid socializing in communal areas as you exit facility.
- ☐ Wash or sanitize your hands and leave the facility.
- ☐ Go directly home, do not stop for errands on the way home, consult your medical provider, and follow the Return to Work Guidance. To prevent disease spread in your household, please follow the CDC Guidance for Implementing Home Care.
- ☐ Coordinate with supervisor to complete appropriate documentation.

* See Glossary for definition.

REPORTING GUIDANCE FOR SUPERVISORS

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Supervisors must report all confirmed* and suspected medium- to high-risk exposure* cases. The below guidance should be followed in addition to any component-specific reporting requirements.

Whether or not a specific employee or contractor has contracted COVID-19, the information pertaining to the individual must be treated as Sensitive Personally Identifiable Information (Sensitive PII) and as a confidential medical record. As a reminder, medical information about CBP personnel is protected and confidential pursuant to the *Privacy Act of 1974.* See HIPAA-related information on CBP's COVID-19 Resource page.

REPORTING CONFIRMED* COVID-19 DIAGNOSES

1. All cases of employees with confirmed* COVID-19 diagnoses are required to be reported to the SITROOM, using normal reporting procedures, and a Significant Incident Report (SIR) will be generated.
   - Employees with symptoms* or pending results do not require reporting until/if they receive a positive test result.
2. When reporting, the initial notification should include (1) presumed work exposure* or presumed home exposure* and (2) date of diagnosis.
3. The SIR will be categorized as: "Employee Issues-Employee Injury/Illness: Other" in the SIR module.
4. The SITROOM Call Summary will be categorized as: "Employee Issues-Employee Injury/Illness: COVID-19."
5. The SIR shall be updated for the following milestones:
   I. Admission to hospital,
   II. Change in prognosis (e.g., transfer to/from ICU, put on/taken off ventilator),
   III. Discharge from hospital or death,
   IV. Begin quarantine* or isolation,*
   V. Finish quarantine* or isolation,*
   VI. Recovery from illness as deemed by medical professional or per CBP/CDC Return to Work Guidance, AND
   VII. Return to work.
6. In addition to the SIR, the appropriate CBP Workforce Incident Tracking (WIT) system should be utilized for reporting suspected or known exposures* of COVID-19.

* See Glossary for definition.
Current guidance has changed and reporting is no longer required for Supervisor Directed Quarantine or Isolation.

RETURN TO WORK GUIDANCE FOR EMPLOYEES

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WHEN SHOULD AN EMPLOYEE WHO HAS RECOVERED FROM SUSPECTED OR CONFIRMED* COVID-19 RETURN TO WORK?

All employees with COVID-19 should consult their medical provider. **HOWEVER**, formal clearance from a medical provider or health department is not required to return to work if the below guidelines are followed. If employee meets CBP Return to Work parameters, but is advised by a medical provider to continue quarantine,* employee can take sick leave.

Any employee re-exposed within three months of recovery from COVID-19 does not need to quarantine; after three months, normal exposure guidance applies.

Return-to-work testing is no longer recommended by the CDC because, in the majority of cases, employees will continue to shed detectable virus up to three months, but they are no longer contagious after 10 days from the date of onset of symptoms.

PRIMARY RETURN TO WORK APPROACH (Recommended)

Personnel diagnosed with COVID-19, with or without a diagnostic laboratory test,* may return to work under the following circumstances:

☐ Personnel with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed since symptoms first appeared or you tested positive;
- At least 24 hours have passed since last fever without the use of fever-reducing medications; and
- Symptoms (e.g., cough, shortness of breath) have improved (symptoms do not need to be completely resolved/absent).

☐ Personnel with severe to critical illness or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed since symptoms first appeared;
- At least 24 hours have passed since last fever without the use of fever-reducing medications;
- Symptoms (e.g., cough, shortness of breath) have improved (symptoms do not need to be completely resolved/absent); and
- Consider consulting with infection control experts.

ALTERNATE RETURN TO WORK APPROACH

If you were directed to receive follow-up testing, return to work IF:

☐ No fever without the use of fever-reducing medications;

☐ Symptoms (e.g., cough, shortness of breath) have improved (symptoms do not need to be completely resolved/absent); AND

☐ You have had two negative diagnostic tests* more than 24 hours apart.

- If you have a positive follow-up diagnostic test,* use the Primary Return to Work Approach or, if necessary, use the Alternate Return to Work Approach.

RETURN TO WORK AFTER POSITIVE ANTIBODY TEST

Antibody testing* should not be used to determine return to work status.

If you have a positive antibody test*:

☐ Get a confirmatory diagnostic test* (this includes antigen testing).

- If positive, use the Primary Return to Work Approach.
- If negative and asymptomatic, you may return to work.

OR

☐ If a confirmatory diagnostic test* is not available, use the Primary Return to Work Approach.

A negative antibody test* does not necessarily rule out an active infection.

* See Glossary for definition.

CLEANING GUIDANCE FOR MANAGEMENT

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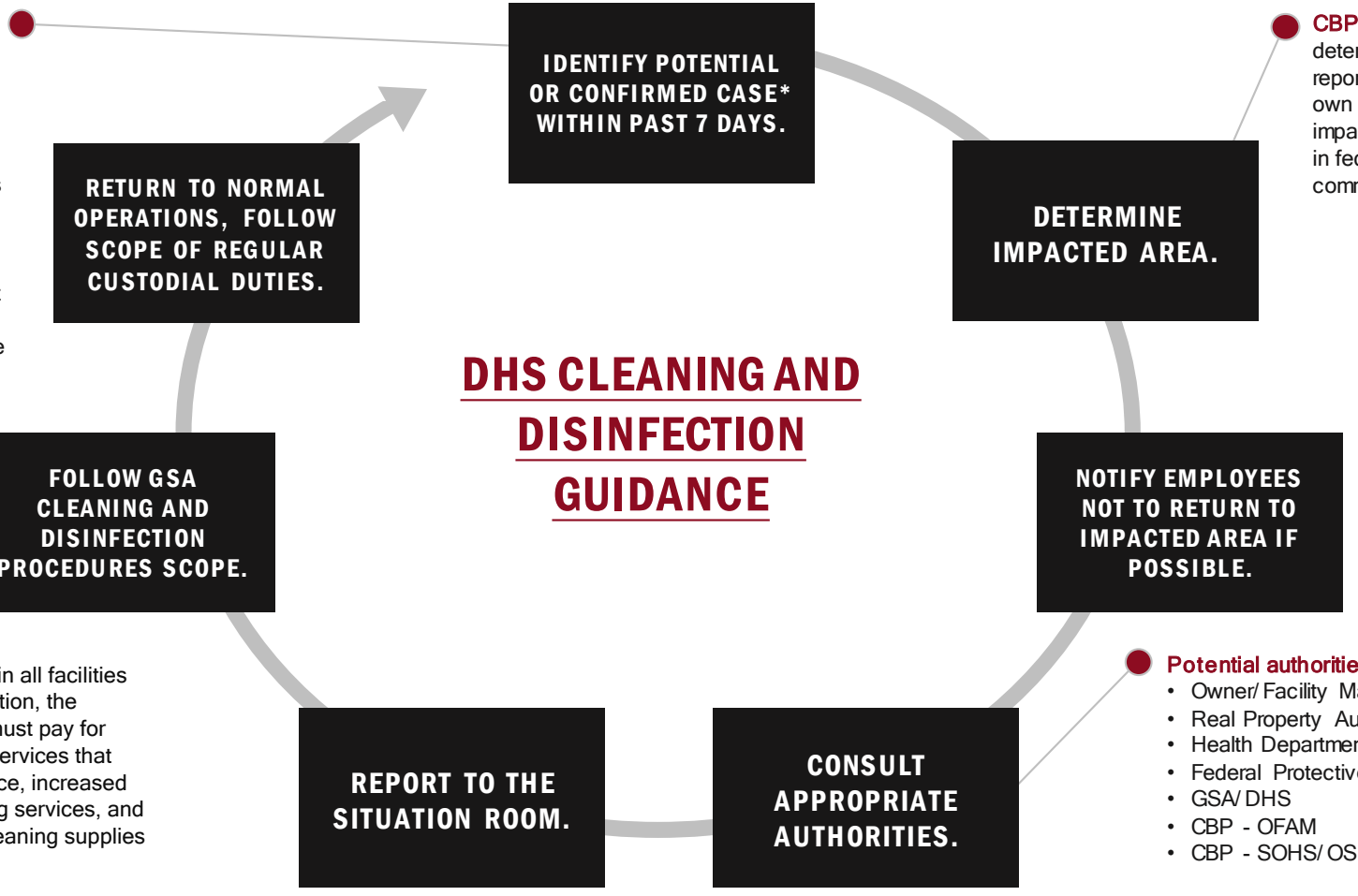
WHAT NEEDS TO BE DONE IF A SUSPECTED OR CONFIRMED* CASE OF COVID-19 ENTERS A CBP FACILITY?



Components must report to GSA potential and confirmed cases in federal buildings and GSA-leased commercial buildings as soon as they are identified. Potential and confirmed cases* in DHS direct leases should be communicated to the building owner.

CBP can only make determinations on the reporting status of their own employees to impacted workspaces in federal buildings and commercial leases.

For above-standard in all facilities under GSA's jurisdiction, the requesting agency must pay for additional cleaning services that exceed CDC guidance, increased frequency of cleaning services, and the use of special cleaning supplies and materials.

Potential authorities:

- Owner/ Facility Manager
- Real Property Authority
- Health Department (if applicable)
- Federal Protective Service
- GSA/ DHS
- CBP - OFAM
- CBP - SOHS/ OSH Division

This process flow is meant to apply to any CBP workspace that is currently operational and has experienced a potential or confirmed* exposure* incident but cannot account for every scenario. Please review the DHS Cleaning and Disinfection Guidance. The process does not account for determining mission criticality to remain open within an area of responsibility prior to an exposure* incident or decisions about limiting access to a building or having employees telework to slow the spread of COVID-19. The DHS Cleaning and Disinfection Guidance has additional communication examples to follow for notification of employees. Follow all DHS, GSA, and CBP policy. For vehicle cleaning and disinfection, reference the CBP JHA.

* See Glossary for definition.

CLOTH FACE COVERINGS

Cloth face coverings slow the spread of the virus by ***protecting others*** from those who may have the virus and don't know it (i.e., asymptomatic spread).

HOW TO WEAR THEM

They should fit snugly but comfortably against the side of your face, with your mouth and nose fully covered, secured with ties or ear loops. They should NOT restrict your breathing.

WHEN TO WEAR THEM

Face coverings should be worn when you have to be less than 6 feet away from someone, such as at the grocery checkout counter, when using public transportation, and any other situation where you cannot maintain social distancing.

HOW TO REMOVE THEM

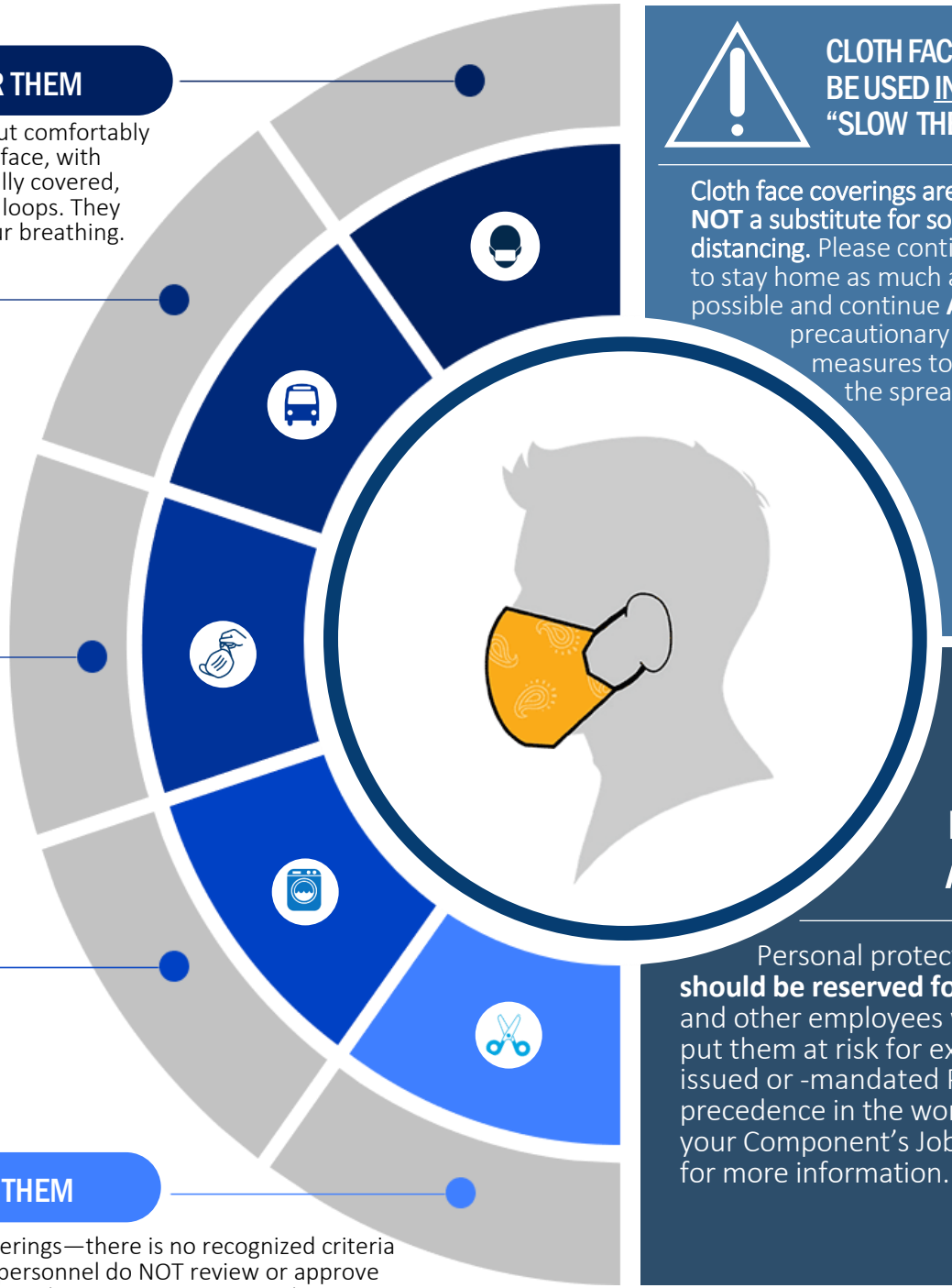
Be careful not to touch your eyes, nose, and mouth when removing face coverings. Wash your hands immediately after removing.

HOW TO WASH THEM

Face coverings should be routinely washed depending on the frequency of use. They should be able to be laundered and machine-dried without damage or change to shape. Also, be sure to store them in a clean container or paper bag.

HOW TO MAKE THEM

Anybody can make face coverings—there is no recognized criteria for making them. DHS OSH personnel do NOT review or approve them. Click here for CDC's step-by-step instructions on how to make your own.



CLOTH FACE COVERINGS SHOULD BE USED IN ADDITION TO EXISTING "SLOW THE SPREAD" GUIDELINES

Cloth face coverings are **NOT** a substitute for social distancing. Please continue to stay home as much as possible and continue **ALL** precautionary measures to slow the spread.

MAINTAIN SOCIAL DISTANCING

WASH YOUR HANDS

STAY HOME IF YOU FEEL SICK

FACE COVERINGS ARE NOT PPE

Personal protective equipment (PPE) **should be reserved for healthcare workers** and other employees whose occupations put them at risk for exposure. Employer-issued or -mandated PPE always takes precedence in the workplace. Please refer to your Component's Job Hazard Analysis (JHA) for more information.

Homeland Security

GUIDANCE FOR MAXIMIZING USE OF N95 RESPIRATORS

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HOW CAN I MANAGE MY LIMITED SUPPLY OF N95 RESPIRATORS*?

The COVID-19 pandemic in the United States is causing limited availability and expected delivery delays of filtering face piece respirators* (FFRs), including N95 respirators.* for CBP locations. Local management can employ reuse strategies to reduce respirator* usage and help combat supply shortages.

HOW TO MAXIMIZE USAGE

- During times of critical demand and limited supply, respirator* use should be extended as much as possible.
- There is no maximum number of shifts/days a respirator* can be worn. Generally, disposable respirators* can be used a minimum of eight hours of actual wear time (over several shifts/days).
- Respirator* may continue to be used over a period of multiple shifts/days by the same employee under the following conditions:
  - Replace anytime respirator* has been used around a known or suspected COVID-19 case.*
  - Replace when contaminated with blood, sputum, or when visibly soiled or dirty.
  - After use, store in a clean, breathable paper bag, labeled with employee's name and date or hang in a locker or other designated area where it will stay clean, away from the work environment.
  - Before each use, inspect straps and filter to ensure they are still in good condition.
  - Do not touch inside of respirator* without washing hands, using hand sanitizer, or a clean pair of gloves.

DONNING AND DOFFING

- Treat respirators* as though they are contaminated.
- Clean hands with soap and water or alcohol-based hand sanitizer before and after touching respirator.*
- Avoid touching inside of respirator.*
- Check components such as straps, nose bridge, and nose foam material for degradation.
- Use a pair of clean disposable gloves when donning and performing a user seal check.
- Perform a user seal check immediately after donning, if a successful user seal check cannot be performed, discard the respirator.*

Reuse of FFRs is only allowed in times of crisis-level supply shortages and under certain conditions. FFRs are normally disposed of whenever removed for breaks, other duties, or at the end of a shift. Reuse refers to wearing the respirator* for a period of work, taking it off (doffing), and later putting it on (donning) for another period. The time between doffing and donning can be just for breaks to allow for a whole shift of wear, or it can be several days - whether caused by work schedule, infrequent need, or for decontamination processes. When not in use, the respirator* will be stored in a secured location, in a breathable paper sack, labeled with the wearer's name. Reference: "DHS Guidance for Extended Use and Reuse of Filtering Facepiece Respirators (N95, etc.)" April 17, 2020.

* See Glossary for definition.

PATH TO PROTECTION: CONSIDERING THE FULL RANGE OF WORKPLACE CONTROLS

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Leaders must choose effective ways to control workplace hazards, like COVID-19, to protect and preserve the DHS workforce. The proven method used by safety and health experts to control hazards and reduce risk is to implement solutions following the Hierarchy of Controls. This method is a tool, along with workforce input, that can assist leaders in selecting and implementing hazard control methods in a progression from the broadest, organization-wide protective solutions to individual protective equipment. This can reduce reliance on PPE, especially when there are limited supplies. Contact your local OSH Division Safety and Health Specialist for additional guidance.

Organization Level → Individual Level

1 ELIMINATION

Physically remove the hazard

- Reduce operations to mission critical personnel
- Use engineering controls, administrative controls, then PPE to eliminate the hazard as much as possible

2 Engineering

Isolate the People from the Hazard

- Reconfigure workspaces to allow for social distancing.
- Consider use of barriers such as Plexiglas® where social distancing or workspace reconfiguration cannot be achieved.
- Adjust HVAC systems to increase outside air exchanges when necessary.
- Use designated entry and exit points to control the movement of personnel.
- Use negative pressure holding cells for symptomatic* persons.
- Use floor markings and other mechanisms to provide for social distancing.*

3 Administrative

Change the way People Work

- Substitute in-person meetings, training, formal interviews, and other functions with virtual technology.
- Establish social distancing policies.
- Use e-signatures in place of in-person, wet signatures.
- Post reduced elevator capacities.
- Establish cleaning and disinfecting policies
- Maximize the use of telework programs.

4 PPE

Protect the Person

- Allow voluntary use of respirators*/ surgical masks.*
- Provide mandatory PPE (N95, gloves) for tasks identified by JHA/Risk Assessment.
- Provide cleaning/ disinfection supplies
- Provide hand sanitizer and soap in break rooms.

* See Glossary for definition.