



IAFF
CANADIAN POLICY & GUIDELINES MANUAL
FOR COVID-19

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International Association of Fire Fighters 1750 New York Avenue, N.W. Washington, DC 20006

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About This Policy Manual

The IAFF encourages every affiliate to work in cooperation with their fire/emergency medical services (EMS) department to develop an overall COVID-19 program designed to minimize exposure and promote a safe and healthy workforce.

Any program should be positive — not punitive — and require participation by all uniformed and non-uniformed personnel (including administration personnel) once implemented, allowing for age, gender and position in the department to be reasonable and equitable for all participants.

COVID-19 programs should include the following key points:

- Confidentiality
- Provide education on prevention, testing and vaccines.
- Promote adequate personal protective equipment (PPE) on and off duty.
- Be a commitment by labor and management
 - Develop a holistic wellness approach that includes medical evaluation, physical wellness and behavioral health
 - The program should be long term and, where possible, available to retirees.

Disclaimer

This COVID-19 policy document will evolve as new research becomes available. The IAFF will continue to work with our partners and federal agencies to update our online resources to provide our members with the most up-to-date guidance to ensure their health and safety. We recommend that affiliates review their policy at regular intervals to ensure it contains the most up-to-date information.

Purpose

This document is provided to affiliate leaders to assist your local and fire/EMS department in developing a comprehensive policy. While this document includes a variety of recommendations, you and your department should comply with local and provincial health department regulations in customizing this document to meet the needs of your membership, your department and the community you serve.

Note that many of the recommendations throughout this document are from the U.S. Centers for Disease Control and Prevention (CDC). The IAFF considers that COVID-19-specific operational and safety guidance issued by U.S. agencies — such as the CDC — are generally applicable and useful in Canadian settings. In addition to recommendations from the CDC, IAFF Canadian locals should follow all applicable guidance and recommendations from the Public Health Agency of Canada and local, provincial and federal health authorities.

As an affiliate leader, we encourage you to work closely with your fire administration to construct a policy everyone can promote, embrace and practice throughout this pandemic. The information can also be adapted to develop similar policies and guidelines for future infectious diseases.

Because COVID-19 is a highly contagious respiratory illness that is constantly changing and mutating, it's important to update this policy in accordance with the recommended changes from the CDC and the World Health Organization (WHO). Membership should be notified when updates are made.

The protective measures and guidelines in this document will help all fire/EMS department personnel ensure a safe and healthy workplace while maintaining the highest service levels possible to the communities you serve.

IAFF Partners

The IAFF has consulted with a network of subject matter experts focused in the medical, occupational health, behavioral health, EMS and PPE fields to create evidence-based guidelines and best practices for protecting members and their families during the COVID-19 pandemic.

Our partnership with Johns Hopkins University's Bloomberg School of Public Health in Baltimore, Maryland — which sets healthcare standards in patient care, research and education — provides the IAFF with technical medical guidance and assists in developing educational materials, identifying speakers for educational seminars and offering technical assistance. This partnership allows the IAFF to consult with these physicians daily as they assist in developing the most up-to-date, evidence-based information and guidance on COVID-19.

Additionally, the IAFF collaborates with the National Institute for Occupational Safety and Health (NIOSH) and other subject matter experts on standards and requirements for personal protective equipment. The IAFF has been in direct contact with representatives from both the CDC and NIOSH regarding our guidance.

Resources

Centers for Disease Control and Prevention (CDC)

The CDC is the leading U.S. federal agency addressing the health, safety and security threats, both foreign and in the U.S., affecting the American people. The IAFF uses the CDC for the most up-to-date information and guidance of COVID-19 to support communities in combatting diseases and promoting a healthy nation. The CDC also leads the charge on protocols on returning to work, prevention measures and quarantine/isolation that directly impact our members.

World Health Organization (WHO)

The WHO is an international organization that brings together more than 150 countries (including the United States and Canada) and works worldwide to promote health, keep the world safe and serve vulnerable populations. The WHO was the first organization to classify COVID-19 as a pandemic and has the capabilities to keep a pulse on infectious diseases that are occurring worldwide. In addition, the WHO brings together medical doctors, public health specialists, scientists and epidemiologists, as well as experts in the fields of health statistics, economics and emergency relief to address global concerns.

Fire Service Joint Labor Management Wellness Fitness Initiative (WFI)

The WFI includes subject matter experts, physicians, nurses and other medical professionals who collaborate to ensure that uniformed personnel are healthy and can work safely and effectively throughout their careers and enjoy a healthy retirement. Recommendations from the WFI Task Force are incorporated in NFPA 1500, *Standard on Fire Department Occupational Safety, Health, and Wellness Program*, NFPA 1581, *Standard on Fire Department Infection Control Program*, NFPA 1582, *Standard on Comprehensive Occupational Medical Program for Fire Departments*, and NFPA 1583, *Standard on Health-Related Fitness Programs for Fire Department Members*.

IAFF Coronavirus Toolkit

The IAFF uses information from the CDC, WHO, the WFI and our partnership with Johns Hopkins to ensure we are providing our members with the most accurate and up-to-date information. As various organizations update their guidance or recommendations, the IAFF vets the information, updates our online resources and disseminates the information. Our goal is to ensure our members stay safe and healthy on the job.

Education

Educating members is one of the most important components of any COVID-19 program. Ongoing education about COVID-19 should be encouraged and accepted at all levels of the department and local, including the fire chief and local president.

The fire chief, local president or safety committee member, human resources director, workers' compensation and health department representative, medical director, peer support coordinator, EAP representative and department occupational health physician should be involved in providing education opportunities for uniformed and non-uniformed fire/EMS personnel.

Additionally, affiliate leaders, the fire administration and the membership should be made aware of available resources, including the IAFF online [coronavirus resource](#) the [CDC website](#) and the [WHO website](#).

Canadian affiliates should also refer to online resources and updates from your respective provincial health ministries and local health authorities: [provincial and territorial resources for COVID-19](#).

Education program should include:

- In-person (following necessary prevention precautions) or virtual video conferencing to allow for questions and answers
- A brief in-person or video message from the fire chief and local president
- Overview of the COVID-19 pandemic
- Transmission and prevention of COVID-19
 - Social distancing, wearing a face covering, screening for signs and symptoms with temperature check, wearing appropriate PPE, getting vaccinated
- Exposure and exposure reporting
 - Reporting protocols
 - Quarantine and isolation
 - Testing (PCR versus serologic)
 - Identify 24-hour exposure designated officer (DO)
 - Workers' compensation claims
 - Leave considerations while in quarantine — personal leave versus administrative leave
 - Return-to-work protocols
 - Role of department occupational health physician
 - Vaccination information and when/where to get the vaccine
- Behavioural health information and resources (handouts, EAP, clinicians, etc.)
 - Work with human resources, insurance carriers, etc., to access available clinicians to assist members and their families
 - **IAFF Center of Excellence for Behavioral Health Treatment and Recovery**

*Refer to [10 Things Your Local Should Be Doing for COVID-19 Response](#) on the IAFF website to assist in developing training curriculum.

Prevention

All department personnel should practice and enforce preventive measures while on duty and don the applicable PPE when treating suspected or confirmed COVID-19 patients.

Illness prevention techniques:

- Cover nose and mouth with a sleeve or tissue when sneezing or coughing. Turn head away from others when sneezing or coughing. Dispose of used tissues immediately.
- If sick, stay home; if you become sick while at work, notify your immediate supervisor and go home (follow your protocols when calling in sick or requesting to go home on sick leave).
- Keep hands away from eyes, nose and mouth.

Prevention measures include:

Facemask/face coverings

- The IAFF strongly recommends wearing a facemask to prevent transmission of COVID-19 — not only for your protection but the protection of your brothers and sisters and immediate family members.
- On-duty best practices include wearing a medical mask (cloth mask if there is a shortage of medical masks) while on duty in the fire station and when in public, as well as when riding in fire apparatus together.
- It is also recommended that members wear a medical mask (or cloth mask) while off duty, especially in circumstances where social distancing cannot be maintained or when using mass transit. Medical masks should be disposed of after each use, and cloth facemasks should be laundered frequently.
- When on EMS calls, properly don and doff the appropriate PPE while treating Persons Under Investigation or confirmed COVID-19 patients to include N95 or higher respirator, gloves, impervious gown, goggles or full-face shield.

Social Distancing

Maintain a physical separation of two (2) metres from others to reduce the chance of spreading COVID-19. Refrain from shaking hands and eliminate non-essential meetings/gatherings (use virtual platforms to communicate whenever possible).

Physical distancing protocols for all personnel:

- Maintain physical distancing during shift change, meetings and meals to minimize contact between individuals and groups.
 - Hold morning briefings in areas where everyone can socially distance. For example, apparatus bay, outside if weather is cooperative, dayroom or larger room, etc.
 - Find ways to eat meals at varying times or use multiple rooms.
 - Maintain a distance of two (2) metres while watching television and during downtime. Consider additional televisions and furniture in other areas.
 - Look for creative alternatives while maintaining two (2) metres between each bunk in sleeping quarters, including physical barriers (such as partitions) or designating other areas as additional bunkrooms.

- Due to asymptomatic transmission, consider sleeping and using a Continuous positive airway pressure (CPAP) in a separate bedroom during this public health emergency. This advice is consistent with American Academy of Sleep Medicine recommendations.
- Ensure ventilation systems have been recently serviced and correct HEPA filters are installed. Ensure the ventilation system is operating on maximum air exchange during overnight hours.
- Restrict training activities to company evolutions that can be completed in isolation of other agencies and limit personal contact.
- Restrict fitness activities to ensure that no more than two individuals are in the gym at one time while maintaining a distance of at least two (2) metres. Members not engaging in aerobic exercises (e.g., treadmill, elliptical) should wear a facemask.

The station captain, in cooperation with a union representative, should determine how best to practice social distancing throughout the station. A high level of compliance can slow the spread of disease.

Daily self-assessments for COVID-19 signs and symptoms to include temperature checks twice daily.

All fire fighters/EMS personnel should be vigilant about symptom monitoring twice daily, including temperature checks (both on shift and off shift) to identify symptoms early and prevent exposures. Follow these recommendations whether or not you have been exposed to a positive COVID-19 patient.

- If you are sick or have a fever — stay home. Follow your department protocols when reporting sick
- Review the IAFF [video on symptom monitoring](#)
- Follow the IAFF [COVID-19 Self-Screening Guidelines](#)

Hand hygiene

One of the most effective ways to minimize the risk of infection is good hand hygiene. Wash hands with soap and warm water for at least 20 seconds or use waterless, alcohol-based hand sanitizers. These should be located throughout the station, as well as all apparatus and support vehicles. Proper hand washing helps prevent the transfer of the virus from the hands to other parts of the body, particularly the eyes, nose and mouth or to other surfaces you touch.

All fire/EMS personnel should wash their hands frequently; before eating, drinking or touching your face; after removing PPE and gloves; and once you return to the fire station from emergency and non-emergency duties.

Decontaminating the station, equipment and apparatus

Frequent and regular cleaning of the work environment and station are the responsibility of all fire/EMS personnel.

- Telephones, computers, keyboards, doorknobs/handles and computer mice are particularly susceptible and should be cleaned using disinfectant wipes or an EPA-approved disinfectant to kill the COVID-19 virus.

Enhanced and frequent cleaning of the fire station is as an additional preventative measure. In addition to the general cleaning, follow the schedule below for station cleaning:

- **Shift change** — wipe down all high-contact areas, including countertops, doorknobs, workstations, handles and fire apparatus surfaces.

- **Mid-day** or prior to preparing meals — wipe down all high-contact areas in food preparation and eating areas.
- **Prior to going to bed** — wipe down all high-contact areas, including countertops, doorknobs, workstations, handles and fire apparatus surfaces; clear bedding and wash or take bedding home.

Washrooms and locker rooms should be disinfected daily and as needed; fitness equipment should be disinfected daily and after each use; kitchen towels and dishcloths should be changed daily and laundered. Remove mattress covers and wash all personal bedding at end of shift.

The cleaning of fire stations and apparatus outlined above is to be considered the minimum required frequency and extent. Ongoing monitoring and maintenance in addition to the above should continue.

Station Best Practices

These additional station best practices will help reduce the risk of transmission of COVID-19:

When reporting for duty, use the designated fire fighter entrance (rear door of the station), perform self-screening protocols, wash your hands and disinfect your cell phone.

- Do not handle other members' turnout gear at shift change.
- Do not handle other members' uniforms or fitness clothing.
- Do not leave uniforms hanging in the gym and washroom areas.
- Increase the frequency of uniform changes and laundering.
- Shower at the end of your shift to ensure you go home to your loved ones safe and clean.

Off Duty

Members who are off duty are reminded to be vigilant at all times and practice all preventive measures outlined above.

If you are exposed to someone on your scheduled time off who tests positive for COVID-19, you could be infected with the virus. If you are exposed off duty, contact your DO and follow the exposure reporting chapter of this document.

Vaccines

The IAFF strongly recommends all members be vaccinated against COVID-19 for their own protection and the protection of their brothers and sisters, family members, friends and communities.

As fire fighters and medical emergency personnel who work in confined and uncontrolled environments while treating or transporting patients or interacting with the public, members are at a greater risk of contracting COVID-19. It is critical that members are vaccinated to maintain their readiness to respond to COVID-19 and other emergencies.

Refer to the **IAFF Coronavirus Toolkit** to learn more about COVID-19 vaccines as safe and effective for protecting yourself and others and slowing the spread of the disease.

Educate

Educating your members and their families about the importance of getting the COVID-19 vaccine is paramount. When a new vaccine becomes available, it is important to promote confidence, communication and the importance of getting the COVID-19 vaccine, which can help support confidence among fire/EMS personnel.

Building trust or confidence in the vaccine is critical to a department's effective vaccine program. Provide clear, complete and accurate messages about COVID-19 vaccines, and take visible action to build trust.

- Communicate transparently about the process for approving and making recommendations for monitoring the safety of distributing and administering COVID-19 vaccines, including data handling.
- Provide regular updates.
- Outline the benefits and safety of the vaccination and how it can protect from severe illness or even death.
- Address common side effects and why side effects occur. This can alleviate fear about unintended consequences of getting a new vaccine.
- Address concerns regarding the effectiveness of vaccines. The rapid development of COVID-19 vaccines has raised questions, but explaining the process will give members a better understanding.
- Proactively address and mitigate the spread of harmful misinformation via social media platforms, other members and trusted messengers. These comments are often made out of fear. It is important to cite science to demonstrate these claims are not true
- Continue to practice preventive measures. Current guidelines from the CDC promote the continued use of preventative measures. Highlight that these recommendations are designed to prevent the spread of the virus if the vaccinated individual is a carrier.

Leadership

The IAFF has urged federal, state, provincial and local governments to include fire fighters in Tier 1a for vaccine distribution, as well as encouraged affiliate leaders to contact their respective governor to ensure priority access to vaccines.

In December 2020, the Canadian government cited fire fighters in a COVID-19 vaccine guidance as workers “who are needed to maintain services essential for the functioning of society.” Subsequently, decisions about vaccine prioritization have been left to provincial and local health authorities. The IAFF recommends advocating for fire fighter vaccine prioritization with those authorities based on the following points:

- In a December 2020 guidance on COVID-19 vaccine prioritization, the government of Canada identified fire fighters as workers who are needed to maintain services essential for the functioning of society.

- If a significant number of fire fighters in your department are unavailable for duty due to infection or isolation, fire vehicles will have to be taken out of service and serious public safety lapses may result.
- Reduced personnel availability due to infections and isolations puts more stress on the entire workforce, which contributes to fire fighter burnout and excessive overtime costs.
- Fire fighters can't work from home like other workers.
- Fire fighters need to be on the frontlines, not infected or in isolation and unavailable to help people when they need it most.
- Fire fighters may be required to come into close contact with members of the public in the course of their duties.

Note: Optional point below if applicable or suitable for use in your jurisdiction:

- Fire fighters are frontline medical responders who have direct contact with patients and should be included in the same vaccine priority group as other healthcare workers.

The Fire Service Joint Labor/Management Wellness-Fitness Initiative (WFI) states, "Uniformed personnel must receive or provide documentation of having received vaccinations." The IAFF and the International Association of Fire Chiefs (IAFC) collectively embrace and promote this initiative, and continue to advocate, educate and recommend the COVID-19 vaccine for our members.

Declining Vaccines

The IAFF recognizes that under some circumstances, including sincere religious objections or a bona fide medical reason, fire fighters may object to being vaccinated. These members may be able to obtain an exemption or reasonable accommodation from their fire departments. The IAFF recommends the following guidelines from the NFPA 1581 Standard:

- 4.5.2.5* Members who choose to decline immunizations offered by the department shall be required to sign a written declination.
- 4.5.2.5(a) Members who decline immunizations should be counseled by the fire department physician. If the member persists in refusing vaccination, a signed written declination is required.
 - 4.5.2.5.1 The declination shall become part of the member's confidential health database.
 - 4.5.2.5.2 Members shall be allowed to recant a declination at any time and receive the offered immunizations.

In the event a provincial or local government or fire department mandates that members be vaccinated, and a member declines, he or she may be subject to penalization of workers' compensation, disability or **Memorial Grant Program** coverage. An exemption or preferred accommodation may be difficult to obtain through a lawsuit as employers are only required to offer a reasonable (not preferred) accommodation and will have little difficulty demonstrating that providing an exemption to a COVID-19 vaccination would cause an undue hardship given that public health and safety are at risk.

Vaccine Distribution

The IAFF supports enlisting fire fighters/EMS personnel for vaccine distribution. Note: this may be more applicable to Canadian members who are paramedics, for example, in integrated fire-EMS departments). If Canadian IAFF members are enlisted to assist with vaccine distribution, the following conditions should be met:

- Authorization by provincial or local medical directors to provide immunizations.
- Compensation at overtime rates as this would be in addition to regular shift work.

- Assigning members to provide immunizations does not impact the department's staffing levels for responding to emergencies and performing other duties.
- Coverage under workers' compensation and disability remains.
- Personnel have been vaccinated.
- Proper training and education in vaccine handling, tracking and administration.
- Proper personal protective equipment (PPE) is provided for vaccine distribution.
- A safe environment to distribute the vaccine (avoid the fire station as a vaccination site).

Refer to **IAFF Talking Points on Vaccination**

Behavioural Health and Physical Wellness

Behavioural Health

An area most often overlooked is members' behavioural health. Affiliate leaders are encouraged to ensure peer support teams, Employee Assistance Program (EAP) representatives and clinicians are available as resources.

- Ensure your peer support team members and contact information is posted at each fire station and work location (9-1-1 call center, apparatus shop, headquarters, etc.), and remind members these resources are available to assist them and their families.
- Refer to the IAFF **Coronavirus Toolkit** for information on behavioural health, including the **IAFF Guide to Managing Coronavirus Anxiety** and **What to Expect in Quarantine**.
- The IAFF offers online recovery meetings for alcohol or substance abuse problems as alternatives to in-person meetings. Learn more at www.iaff.org/behavioral-health/#online-recovery-meetings.
- Many healthcare insurance carriers are offering telemental health to subscribers. Work with your department or city human resource director regarding telemental health services available for members and their families.

Physical Wellness

The IAFF strongly encourages including your department's Peer Fitness Trainers (PFT) in ensuring physical wellness during COVID-19. PFTs can also provide daily, weekly or bi-weekly resources for members and their families to use on and off duty.

Additional resources:

- **Physical Activities FAQs**
- **Successful Exercise at Home**
- Refer to the **IAFF Coronavirus Toolkit** for more information.

Communications

The fire/EMS DO should be the primary contact on all COVID-19 communications and coordinate with all divisions, local emergency management, local public health authority and all personnel to ensure everyone is kept informed with the most up-to-date information.

Responsibilities

In addition, below are the general duties and responsibilities for officers and fire fighters/EMS personnel:

Officer responsibilities include:

- Ensuring the health and safety of all workers under their direct supervision.
- Ensuring all staff have appropriate and fitted PPE.
- Ensuring members are adequately trained to identify and minimize the risk of exposure.
- Enforcing, upholding and adhering to the policies of the department and the recommendations in this document.
- Submitting a PPE replacement form when needed.
- Sending employees who are ill or displaying symptoms of illness home.
- Reporting all possible exposures.

Fire fighter/EMS and administrative staff responsibilities include:

- Taking all reasonable measures to protect their health and safety.
- Performing their work in accordance with established safe work procedures.
- Wearing appropriate PPE when required.
- Reporting any potential exposure to your supervisor.
- Do not report to work if you are ill or experiencing COVID 19 symptoms.
- Go home if you become sick or begin experiencing symptoms (follow your department's SOP or policy regarding sick leave).
- Adhere to the policies of the department and follow the direction of their supervisor.
- Follow self-monitoring and self-isolation recommendations.

Personal Protective Equipment

Ensure all members are provided with the proper personal protective equipment (PPE) to respond to calls involving confirmed cases and Persons Under Investigation (PUI) for COVID-19.

Minimum PPE required:

- NIOSH-approved N95 or higher respirator
- Eye protection
- Gloves
- Disposable impervious gowns

Additional PPE to be considered:

- Powered Air Purifying Respirators (PAPRs)
- Air Purifying Respirators (APRs)
- Red bio-hazard bags
- Tyvek/Tychem coveralls
- Booties
- Hand sanitizer (minimum 60% alcohol)
- Face shields

Decontamination

Decontaminating Turnout Gear, Station Wear and Equipment

Review the IAFF [donning and doffing video](#) on how to handle contaminated PPE after treating a patient. Immediately upon doffing PPE, hand sanitizer or soap and water should be applied, followed by cleaning any exposed skin using soap and water.

Follow these guidelines:

Turnout gear and station wear

- Use of structural fire fighter PPE for patient encounters should be a last resort. In case of an incidental exposure, refer to Recommended Guidelines for Selection, Care and Cleaning/Sanitization of Structural Fire Fighting Personal Protective Clothing, which provides the proper care, cleaning and sanitization of structural fire fighter PPE.
- If turnout gear or station uniform are visibly contaminated by bodily fluid, place it in a biohazard bag at the scene and wash it following prescribed laundry procedures. Chlorinated bleach should not be used with any fire fighter protective clothing. Fire departments should follow the decontamination guidelines in [National Fire Protection Association \(NFPA\) 1851, Standard on Selection, Care, and Maintenance of Structural Fire Fighting Protective Ensembles](#).

Equipment

- Dispose of disposable respirator, respirator filters, gloves and other disposable equipment/supplies used at the scene as bio-hazardous waste.
- Non-disposable respirators should be cleaned and disinfected in accordance with the manufacturer's recommendation.
- See the Health Canada's [List of Disinfectants with Evidence for Use Against COVID-19](#).
 - When researching products on the EPA website, note that the answer to the emerging viral pathogen claim questions is no. This is NOT a concern. Per the EPA, "All products on this list meet EPA's criteria for use against SARS-CoV-2, including those marked as No in this column." The emerging viral pathogen claim has to do with whether the virus is standard/old/well-known or emerging, not how hard it is to kill.
- Find more information about infection control against COVID-19 [here](#) under the section, **Cleaning EMS Transport Vehicles After Transporting a PUI or Patient with Confirmed COVID-19**.

Decontaminating the EMS Transport Unit and the Station

UV-C lights have been used for many years in ambulances for disinfection. It is important to note that this should not be the only means of disinfection. UV-C lights will disinfect surfaces (this is a surface technique and will not penetrate fabrics) on which there is direct access for the appropriate period of time (time is related to energy of the UV-C lamps). This affects surfaces that are at an angle to the lights or are shadowed by other surfaces. UV light disinfection appears to be effective against coronavirus. Efficacy, however, is highly variable and related to the placement of the lights, light intensity, contact times, surface type, etc.

The benefits of UV-C include effectiveness on flat surfaces at 90-degree angles (walls, floors, ceilings, etc.). Personnel are not required to enter the contamination zone. The limitations are that the power decreases over distance (light must be close enough to surface); if the surfaces are not flat, it may not decontaminate the shadowed areas.

Perform an appropriate decontamination before using UV-C light. These steps include:

1. If the material to be decontaminated is considered airborne, all doors to the ambulance should be left open to allow for any airborne particles to settle or exhaust. The time required for one complete air exchange in a standard size ambulance using passive ventilation (low wind conditions) is approximately 10 minutes or six air changes per hour (ACH). This correlates to 90% efficiency in 23 minutes, 99% efficiency in 46 minutes and 99.9% efficiency in 69 minutes.
2. Clean all soiled surfaces.
3. Disinfect contaminated surfaces with a chemical disinfectant (preferably applied using an electrostatic sprayer for complete coverage).
4. Follow up with UV-C disinfection, if desired, prior to returning to service.

It is equally important to decontaminate surfaces that are frequently touched to prevent the spread of COVID-19. Properly decontaminate all equipment and frequently touched office supplies to include apparatus, equipment, stations, phones, desks, computer keyboards, doorknobs, tables and other contact surfaces using an **Health Canada-approved disinfectant**. Areas frequently touched should be decontaminated several times per day, especially at shift-changes.

Exposures

Exposures to COVID-19 vary based on several factors. The IAFF defines exposure as high-risk exposures and low-risk exposures.

- **High-Risk Exposure** — A member has a prolonged close contact exposure with a PUI or confirmed COVID-19 patient and was not wearing a respirator or the member performed a high-risk procedure — such as intubation, CPAP or nebulizer treatments **without** the full required PPE, including a fluid resistant gown, gloves, goggles and a N95 or higher respirator. The CDC now defines a close contact as exposure within 6 feet of an infected individual for a total of 15 minutes or longer over a 24-hour period. Health Canada defines a close/high-risk contact as:
 - Healthcare workers who provide direct physical care to a case or a laboratory worker handling COVID-19 specimens **without** consistent and appropriate use of recommended PPE and infection prevention and control practices.
 - Anyone who lives with a case, has **direct** physical contact with a case or is exposed to infectious body fluids, including the case's caregiver, intimate partner, child receiving care from the case, etc.
 - Anyone who has shared an indoor space (e.g., same room) with a case for a prolonged period of time, including closed spaces, crowded places or settings where close interactions may occur (e.g., social gatherings, workplaces) **without adhering to appropriate individual-level and setting-specific risk mitigation measures**.
 - Anyone who has a close-range conversation with a case or has been in settings where a case engaged in singing, shouting or heavy breathing (e.g., exercise) **without adhering to appropriate individual-level and setting-specific risk mitigation measures**.
- **Low-Risk Exposure** — A member has a brief or prolonged interaction with a PUI or COVID-19 patient and wore the recommended PPE, donned and doffed the PPE correctly, properly decontaminated all reusable equipment and contact surfaces in vehicles, and washed hands and exposed skin with soap and warm water. Additional personnel not within a 6-foot radius of the patient but engaged on scene should also be considered a low-risk exposure.

ALL POTENTIAL EXPOSURES SHOULD BE DOCUMENTED ACCORDING TO YOUR DEPARTMENT'S EXPOSURE CONTROL PLAN and/or this COVID-19 Policy Manual.

Members who experience a **high-risk exposure** should notify their DO or health department's point of contact immediately in accordance with the exposure control plan and be placed in quarantine for 14 days, as well as get a COVID-19 test if they show signs or symptoms. If asymptomatic for 14 days, they should return to work. If they become symptomatic, they should be isolated and tested for COVID-19, remain in isolation for 10 days from onset of symptoms, and follow the physician's treatment plan. Once isolation is lifted by the physician, the employee can return to work. **(Refer to Quarantine, Isolation and Administrative Protocols Chapters).**

Members who experience a **low-risk exposure** should return to work and self-monitor for signs and symptoms, including taking their temperature and recording it twice a day. If members become symptomatic or test for COVID-19, they should be isolated for a period of 14 days from the onset of symptoms and follow the physician's treatment plan. Once isolation is lifted by the physician, the employee can return to work.

Some individuals are asymptomatic; they are infected with the COVID-19 disease but are not exhibiting symptoms. These individuals can still spread the disease to others, so it is important to screen for signs and symptoms to detect if you may be infected. Meanwhile, members should be practicing prevention measures, including social distancing, wearing face coverings, hand washing and self-assessments with temperature checks twice daily. Below are the signs and symptoms of COVID-19 to monitor:

- Fever > **99.9 degrees F** or > **37.7 degrees C** (temperature should be checked twice a day at the start of the shift and middle of the shift duration)
- Cough
- Sore throat
- Difficulty breathing/shortness of breath
- Muscle aches/headache
- Loss of taste and smell
- Vomiting
- Diarrhea

Exposure Reporting

- The department, in cooperation with the local, should have a DO available to members 24 hours/seven days a week for exposure reporting.
- If not previously established, the department and the local should designate a minimum of two DOs, such as department personnel, who are available 24/7 and have an understanding of infectious diseases, including safety officers, infection control and prevention officers, etc.
- The DO's name and 24-hour contact information should be posted and made available to every member of the department and local at every work location. Consider creating laminated wallet cards for each member.
- Department personnel suspecting or confirming a potential COVID-19 exposure must notify the DO immediately or as soon as feasible (after transporting the patient to the hospital, leaving the private residence, etc.)
 - The apparatus with the affected personnel should remain out of service until contact is made with the DO and further direction is provided. **NOTE** — Personnel who assess/transport a suspected/confirmed COVID-19 patient and are in full PPE — N95 respirator or higher, gloves, eye protection and gown — are deemed a low-risk exposure and should be reported as such. The DO will guide you further on next steps. (e.g., exposure documentation, deconning the apparatus, equipment, laundering your work uniforms)
 - Document exposure according to the department's exposure control plan and cooperate with the DO to ensure COVID-19 does not spread through the department.

Point of Contact Role and Responsibilities

Relationships are important, and a DO for infectious disease is important for staying ahead of any emerging infectious disease and to ensure relationships with hospitals and healthcare facilities are established.

Hospitals and health facilities

- The DO is strongly encouraged to meet with all area medical facility infection control practitioners (ICP) to establish those relationships and obtain the pertinent contact information (e.g., mobile phone number, email addresses) to ensure 24-hour access and assistance.
- Additionally, the DO should be familiar with applicable provincial laws regarding first responders' right to know the infectious disease status of an individual with whom they have come into contact in the course of their duties, and whether they may apply to COVID-19. According to IAFF Canada Legal Counsel:

- Ontario was first to enact a Mandatory Blood Testing Act that applies to listed communicable diseases. Currently, only HIV and Hepatitis B and C are listed.
- In Alberta, the Mandatory Testing and Disclosure Act allows for mandatory testing where a fire fighter has come into contact with a bodily substance of another person. The Act covers communicable diseases prescribed by regulation. To date, the only communicable diseases listed are HIV and Hepatitis B and C.
- Nova Scotia also has a Mandatory Testing and Disclosure Act. It applies where a fire fighter may have come into contact with a bodily substance of another person and might be infected with a microorganism or pathogen that causes a communicable disease listed in the regulations. Only HIV and Hepatitis B and C are listed in the regulations.
- Saskatchewan has a Mandatory Testing and Disclosure (Bodily Substances Act). It has similar provisions to the Nova Scotia legislation, including the same list of communicable diseases in the regulations.
- To date, a COVID-19 infection is not included as a communicable disease whereby forced mandatory testing can be required.
- There are non-statutory requirements to, at minimum, report to an emergency services worker, such as a fire fighter, where there has been suspected contact with a communicable disease. For instance, in Ontario, an infectious disease protocol established in 2018 is published by the Ministry of Health. In part, the protocol is intended to ensure that emergency service workers, such as fire fighters, are notified by the medical officer of health in the event that they may have been exposed to an infectious disease. In British Columbia, “Protocol for Protecting Emergency Responders from Communicable Disease” is similar.
- For assistance in determining applicable provincial laws governing infectious diseases and the right to know, contact the IAFF Canadian Office at (613) 567-8988 or canada@iaff.org.
- The DO should exchange contact information with area medical facility ICPs to ensure the ICPs know who to contact when there is a previously unsuspected patient who is now positive for COVID-19 that your department personnel previously treated and/or transported.
- In addition to establishing relationships with area medical facility ICPs, the DO should build relationships and obtain contact information from public ambulance services, third-party and private EMS transport services points of contact who handle their agency’s COVID-19 program, if applicable, to your jurisdiction. **For exposure reporting and exposure follow-up to be successful, the DO must be communicating with area medical facility ICPs and third party or private EMS transport services DOs early and often.**

Local Jurisdictions and Health Departments

- The DO should establish relationships with jurisdictions providing and accepting mutual aid emergency services and obtain contact information for area jurisdictions’ DOs to include health departments from another county or province.
 - The DO should not wait until an event occurs before taking action. Build and establish those relationships early. The DO may also consider establishing a relationship with area law enforcement agencies (local police department, provincial police, RCMP, etc.)
 - The DO should share this policy manual with other mutual aid jurisdictions to ensure exposed members’ best interests are always a priority — not an afterthought.
- The DO should also establish a relationship with a POC from local health authorities. After the DO receives notification from a medical facility’s ICP, the DO has the duty to advise, protect and give next steps in a timely manner to members who are potentially exposed. It is incumbent on the DO to have a 24/7-hour POC with the local health agency. Mobile phone numbers and email addresses should be exchanged to ensure constant communication.

- The DO should make sure the health department POC is familiar health officials with right to know laws, if applicable, as well as area medical facility ICPs and, if applicable, third party or private EMS transport services DOs.
- Frequent and ongoing in-person or virtual meetings are recommended with the DO, medical facility ICPs, third party or private EMS transport services DOs and local and provincial health POCs for any updates or to review a previous exposure.

For members treating a PUI of COVID-19:

- The DO should immediately notify the receiving facility's emergency room charge nurse and infection control practitioner (ICP).
- This COVID-19 Policy Manual should include how each applicable party (DO, medical facility ICP, third party or private EMS transport services DO and health department POC/official) is responsible for contact tracing when a member has been confirmed positive for COVID-19).
- It is particularly important for the health department POC/official to assist the DO with contact tracing for members who are COVID-19 positive and have potentially exposed shift/station members. The health department POC/official should assist the department DO with contact tracing with any potential family members that have been exposed.
- The DO is further responsible for notifying the fire administration of the occurrences and the number of members (or family members) potentially exposed and requiring quarantine or isolation.
- When confirmation occurs that members are positive for COVID-19 or were exposed to someone positive for the virus, coordination between the DO, the health department POC/official, the positive members, their immediate supervisor and the battalion chief should occur early in the process.
- The affected members should be relieved of duty and the DO should provide next steps, e.g., quarantine, testing.
- The affected members should complete an exposure report any time a suspected or confirmed exposure to a positive COVID-19 patient has occurred.
- For personal tracking download the **National Fire Operations Reporting System (NFORS) Exposure Mobile App**.
 - **NFORS app poster for printing**
 - **NFORS app sample video**
 - Exposure reporting is required as soon as possible after the potential/confirmed exposure occurred.
 - Exposure reports should be saved in accordance with local or provincial regulations.

Quarantine

QUARANTINE is defined as the restriction and separation on the movement of people that is intended to prevent the spread of disease. It is often used in connection to disease and illness, preventing the movement of those who may have been exposed to a communicable disease (e.g., COVID-19), **but do not have a confirmed medical diagnosis.**

Members are required to quarantine when there is a **high-risk exposure** as defined in the Exposures section of this document. Quarantine is typically for 14 days. However, the DO, the fire administration, a local representative and the health agency POC/official can establish a quarantine policy of 10 days due to the size of the department, taking into

consideration the impact on safe staffing. Establish the policy early — do not wait until a situation occurs.

The DO, the fire administration, a local representative and the health department POC/official should determine best practices regarding quarantine, including locations/facilities (fire station (not preferred), area hotel or personal residence).

- For hotel discount offers, check the IAFF online coronavirus resources. Confirm with the hotel to ensure offers are active.
- Regardless of where the quarantine is established, members in quarantine are required to do the following:
 - If quarantining at home with family members, it is critical that members practice social distancing and hand hygiene, wear a facemask and monitor for symptoms consistently.
 - Use the following links to assist with recording and understanding the signs/symptoms of the COVID-19 infection:
 - **Post-Exposure/Quarantine Symptom Monitoring Tracker**
 - **COVID-19 Self-Screening Guidelines**
 - **COVID-19 Prevent the Spread Flyer**
- The DO or health department POC/official should check in on affected members at least once daily.
- The department's peer support coordinator or EAP representative, in cooperation with the DO, should also check in on the affected members and families.
 - The department's peer support coordinator or EAP representative should provide the affected members and families with the various behavioral health links accessible on the IAFF inline coronavirus resource under Behavioral Health Resources.

If, at any time, the affected members develop the signs/symptoms as outlined on the Quarantine Monitoring Tracker, such as fever, coughing, shortness of breath, etc., they are required to notify the DO immediately; in turn, the DO is to notify the health department POC/official of the changes and to consider COVID-19 testing.

If testing of the now-symptomatic members is determined by the health department POC/official, the DO should notify the symptomatic members about where they should report for COVID-19 testing. An acceptable timeframe for newly symptomatic members to be tested is within 24 hours of the reported adverse changes.

- Typically, results of RT-PCR COVID-19 test results are available within 24 to 72 hours. The health department POC/official is responsible for notifying the affected members and the DO of the results.
- If the results are positive, the affected members are moved to isolation. Refer to the Isolation chapter for further direction and instruction.
- If the results are negative, the affected members should remain in quarantine until the 10 or 14 days are completed and symptoms have subsided.
- Prior to having the affected members return to work after completing quarantine, consider meeting with your department occupational health physician for any additional follow up.

Isolation

ISOLATION is defined as separating those with a contagious disease from people who are not sick or infected. Those who test positive or are symptomatic should be placed in isolation.

Similar to quarantine, the DO, the fire administration, a local representative and the health department POC/official should determine best practices regarding isolation, including locations/facilities (fire station (not preferred), area hotel or personal residence).

- For hotel discount offers, check the IAFF online coronavirus resources. Confirm with the hotel to ensure offers are current.

If affected members decide to isolate at home, the DO should educate the affected members about the importance of not coming in contact with any family members, particularly those with pre-existing conditions (elderly, respiratory ailments, cancer, etc.).

- The DO or health department POC/official are encouraged to check in on the affected member(s) at least daily.
 - The DO should notify the department's peer support team coordinator or EAP representative to contact the affected member(s) at least daily or as agreed on by all parties.
 - The affected member(s) should remain in isolation in accordance with the Return-to-Work Protocol (see Administrative Protocols chapter)
 - Behavioral health assistance should continue with the affected member(s) and family members until directed otherwise.
 - The DO should continue coordinating with the health department POC/official or the department's occupational health physician.
 - The respective department and local should coordinate with the health department POC/official and department's occupational health physician when and how the affected member(s) should return to full duty, follow up regarding any family members and how the affected member(s) will be tracked and followed as they return to full duty.
 - For example, does the department's occupational health physician want to conduct a modified fitness for duty, with the concurrence of the fire administration and the local (affiliate leaders may want to consider this additional procedure for the membership)?

Testing

Testing is an important component for determining whether an individual has COVID-19. This information will determine if a member remains on-duty

Types of Tests

COVID-19 tests fall under two broad categories — diagnostic and antibody (serologic) tests — are available.

Diagnostic tests diagnose an active infection and include:

- **Molecular tests**, which detect the virus's genetic material in the human body. RT-PCR is the most common type of test in this category and remains the most accurate and reliable test for COVID-19 infection.

- **Antigen tests**, which detect specific proteins on the surface of the virus.

Both tests are typically nasal or throat swab, but the major difference is that antigen tests are commonly rapid diagnostic tests. While rapid tests may be more desired, they can be more unreliable than the molecular RT-PCR test. Negative antigen tests should be confirmed with the molecular RT-PCR test.

Antibody (serologic) tests identify if you've had an infection and include:

- Antibody (serologic)_blood tests that inform whether an individual has been exposed to or has some level of immunity to the virus.

Since the body takes time — from a few days to several weeks — to make antibodies, serologic testing is not useful for identifying those who currently have and may be infectious with the virus. In addition, accuracy of detection is not as high. Thus, more research is necessary to determine the accuracy and medical application of antibody (serologic) test results for COVID-19 management decisions.

The IAFF supports the recommendation from the U.S. FDA that results from serologic testing alone should not be used to diagnose or exclude COVID-19 infection or to inform infection status. For return-to-work decisions, the only acceptable testing regimens are RT-PCR tests or antigen tests. Contact your local or provincial health authority for more information about COVID-19 testing.

Point of Care Testing Protocols

Accurate testing of affected members from a high-risk exposure should be tested two to eight days post exposure for the highest potential for infectivity to COVID-19. Testing earlier than two days may result in a false negative with the affected members subsequently becoming symptomatic later with the COVID-19 virus.

The DO, the local, the health department POC/official and the department's occupational health physician should determine when affected member are tested for COVID-19 and where testing is available (more than one location needs to be made available. Additionally, testing needs to be considered for members whose residence is 60 minutes or longer outside of the employed jurisdiction for convenient and reliable COVID-19 testing.

Once symptomatic members notify the DO that they are exhibiting symptoms, the DO should notify the health department POC/officials regarding the affected members' potential infection for COVID-19.

Testing for the affected members exhibiting signs and symptoms of COVID-19 infection should within 24 hours of notification to the DO and subsequently to the health department's POC/official. The affected members' family members should also be considered in the testing equation.

Detection of Viral RNA: RT-PCR Test

Tests that detect viral RNA levels can identify current infections and suggest infectivity and transmission risk for others. Currently, the most widely used RNA test on the market is the Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) for the detection of nucleic acid from SARS-CoV-2 in upper and lower respiratory specimens (such as nasal, nasopharyngeal or oropharyngeal swabs) collected from individuals suspected of COVID-19. **Negative results do not mean there is no COVID-19 infection and should not be used as the sole basis for patient management decisions.** The DO and the local should review the testing procedures when testing should occur and the available testing locations for affected members and applicable family members.

Multiple studies have identified false negative results in initial PCR tests, but it's not clear why this happens. Reasons may include stage of illness (days from initial exposure), lower amounts of virus in certain anatomic sites and in certain patients, and suboptimal sample collection methods. Overall, the FDA has asserted that FDA-authorized nucleic acid amplification tests for COVID-19 meeting emergency use authorization criteria are highly reliable. Thus, these tests are currently the gold standard.

Detection of Host Immune Response: Antibody Testing

Tests that identify host immune response are referred to as serological tests and are intended to be administered as simple blood tests. These tests can indicate whether an individual has been previously exposed to COVID-19. Antibody test results are important in detecting infections in individuals with few or no symptoms and have been used in conjunction with RT-PCR results in establishing a diagnosis or exclusion of COVID-19 infection. IgM and IgG are the two major antibodies assessed by serologic testing.

- IgM antibodies typically appear earlier within the course of infection — within days to about one week after the onset of symptoms. The antibodies can persist for a week to a few months.
- IgG antibodies develop later in the course of infection, typically appearing in the bloodstream around two weeks after infection and may last for months to several years.
- Those with IgM only or IgM and IgG antibodies are likely in an early stage of infection, even if they don't have any symptoms. Ideally, fire fighters with these markers should undergo quarantine, plus a reflex PCR test, to confirm infectivity.

Expanding testing for COVID-19 is a top priority; however, there is limited information on the significance of the presence of antibodies detected by serologic testing. While serologic tests may indicate that an individual has an immune response to COVID-19, much remains unknown about how long individuals with an immune response suggested by the presence of IgG or IgM antibodies could shed infectious virus.

Emergency Use Authorization (EUA)

During public health emergencies declared under Section 564 of the Federal Food, Drug and Cosmetic (FD&C) Act, the FDA is able to issue Emergency Use Authorizations (EUAs) when certain criteria are met that allow for the use and distribution of potentially life-saving medical products to diagnose, treat or prevent the disease, which can include diagnostic tests. EUAs are a shortcut in the FDA approval process that allows products to be used that have not gone through the full FDA approval process, which sometimes can take years.

According to the FDA, there is no FDA-approved or cleared test to diagnose or detect COVID-19. Therefore, the FDA has issued several EUAs for the use of new diagnostic tests to detect COVID-19 (review the [list of EUA-approved tests](#)).

The FDA has also evaluated the performances of the EUA serologic test. The performance of these tests is described by their sensitivity or their ability to identify those with antibodies (true positive rate) and their specificity or their ability to identify those without antibodies (true negative rate). See the [results](#).

Testing Positive

Members who test positive for COVID-19 or are exposed to someone who tested positive while off duty are required to notify the DO in accordance with the Exposure Reporting chapter of this document.

- The DO or the health department POC will provide information relating to testing, quarantine or isolation, family concerns and next steps. Members are responsible for making the notification as soon as possible upon testing positive or experiencing exposure to someone who has tested positive.
- The DO will make all the applicable notifications in accordance with the Exposure Reporting. One of those notifications will be to the peer support team coordinator or to the designated EAP representative to assist the affected member and family members with behavioral health concerns. Coordination between the affected member and the peer support team coordinator or EAP representative on the frequency communication will be determined early on (e.g., daily, every other day, etc.).

- The DO or health department's POC will be responsible for ensuring contact tracing is conducted in a timely manner in accordance with the Exposure Reporting chapter.
- Before affected members can return to duty, they must meet the criteria established in the Return-to-Work chapter of this policy manual. Additionally, the department may require a modified fitness for duty (physical) with the department's occupational health physician dependent of the severity (e.g., hospitalization, extended symptomatic issues, etc.) of symptoms resulting from the effects of COVID-19.
- Ensure documentation and exposure reporting

Contact Tracing

Contact tracing helps protect you, your department, your family and your community. In addition, contact tracing”

- Informs your members that they may have been exposed to COVID-19 and should monitor their health for signs and symptoms (e.g., fever, coughing, shortness of breath) of COVID-19.
- Assists members or family members who may have been exposed to someone who tested positive.
- Requires members to self-isolate if they have COVID-19 or self-quarantine if they have been in close contact with an infected person.

The DO and the health department's POC/official play an important role with contact tracing to further reduce the possibility of additional exposures or infections. The DO is responsible in establishing a policy on how and when contact tracing will be conducted. Training and guidance should come from the health department's POC/official to ensure it is being conducted in a timely and efficient manner with minimal impact to the affect members or their families.

- The DO is responsible for notifying the fire administration on the number of members affected (e.g., quarantine, testing) as contact tracing is conducted.
- The DO should ensure affected members being ordered to quarantine, test, etc., receive the necessary guidance and information on what to expect.
- The DO should follow up with the department's peer support team coordinator or EAP representative to assist members required to quarantine or isolate due to positive COVID-19 test results.
 - The DO should provide peer support assistance for affected family members as requested.

Testing in Skilled Nursing Homes

In the event that fire fighters with medical skills are asked to assist with COVID-19 testing in long-term care facilities or similar settings, it should be noted that these are hot zones and often the tasks are out of the scope of fire fighters' training or practice. This **testing guidance** on best practices includes how to safely perform testing for both the nursing home residents and fire fighters.

The San Antonio Fire Department has developed training videos to assist in developing guidelines for designing and safely performing testing at skilled nursing homes, as well as large-scale testing:

- **Nursing Homes: What to Expect**
- **Large-Scale Testing**

Administrative Protocols

It is extremely important for the DO, the fire administration, the local, and the human resources director/representative to establish protocols for when members are in quarantine for 10 or 14 days. Everyone needs to know which type of leave to use while in quarantine (e.g., personal leave [vacation or sick], administrative leave, COVID-19 leave). The affected members need to know which leave is required while in quarantine.

The policy established needs to be consistent for any affected members who are in quarantine, whether the affected members are in operations (in the field) or in an administrative position (in an office setting).

Economic Resources

Provinces across Canada are already feeling the financial impact of the pandemic as many municipalities face large budget shortfalls from losses in tax and other revenue. The administration may use this as justification for not taking the appropriate protective measures as they may be considered cost prohibitive. Be aware of legislation that will assist with and provide financial relief to offset the costs associated with responding to the pandemic while adequately protecting your members.

During a pandemic, legislation that may include assistance with paid sick leave, expanded family and medical leave and financial assistance to prevent layoffs are important to support.

Workers' Compensation

- Ensure your members complete the exposure reporting document as outlined in the Exposure Reporting chapter. Affiliate leaders should work with their province or leadership to see if COVID-19 infection is covered either under presumptive legislation or direct ministerial order.
- Work closely with your provincial association or provincial health and safety representatives to ensure exposure documentation is reported or recorded in accordance with the applicable requirements for compensability of the affected members' claims.
- Exposure reporting, along with favorable outcomes related to workers' compensability claims should be part of the educational component of this policy manual.
- Affiliate leaders, in cooperation with their provincial association or provincial health and safety representatives, should play an integral role to ensure the timing, wording and submission of the workers' compensation claim follows the current requirements.

Return to Work

- Return-to-work procedures need to be in accordance with applicable local or provincial health agency recommendations. While the health and safety of your members are paramount, returning affected members to work after quarantine or testing positive previously for COVID-19 can provide additional safe staffing and relieve the burden for other members working multiple consecutive shifts.
- The DO, the fire administration, a local representative, the health department's POC/official and the department's occupational health physician should establish and agree on a procedure for when and how affected members return to work.
- In Canada, return-to-work policies are generally set by respective provincial health authorities, in some cases with different criteria for different types of workers (for example, healthcare workers). Refer to your provincial association or the IAFF Canadian Office if you need assistance in determining applicable return-to-work guidelines in your jurisdiction.

The Policy

- Members who experience a **high-risk exposure** should notify their department in accordance with their exposure control plan, be placed in quarantine for 14 days and get a COVID-19 test if showing signs and symptoms. If asymptomatic for 14 days, members are eligible to return to work. If members test positive, they should be isolated and follow the guidance below for returning to work.
- If members are currently in isolation due to signs/symptoms of COVID-19 (e.g., fever, cough, shortness of breath) or have tested positive for the COVID-19 virus:
 - The CDC has updated **duration of isolation and precautions** guidance based on available data. The guidance indicates that persons with mild to moderate COVID-19 symptom may remain infectious for up to 10 days after symptom onset. Persons with more severe to critical illness or severe immunocompromise may remain infectious up to 20 days after symptom onset. Based on these findings, a test-based strategy is no longer recommended to discontinue isolation or precautions, unless the individual is immunocompromised.
- **Members may be cleared to return to work based on the following guidelines:**

1. Isolation and precautions can generally be discontinued:

- 10 days after symptom onset (refer to the **CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19** [interim guidance]. NOTE: Individuals with severe illness may produce the virus beyond 10 days, which may warrant extending the duration of isolation and precautions for up to 20 days after symptom onset. Consult with the department's occupational health physician and possibly infection control experts.
- With the absence of fever for at least 72 hours without the use of fever-reducing medications. The CDC recommends a 24-hour fever-free interval (without fever-reducing medications) before returning to work, while the IAFF recommends a 72-hour fever-free interval (without fever-reducing medications). This recommendation has been reviewed with input from medical professionals. There is no clear evidence that warrants a change to a shorter time interval.

2. For members who never develop symptoms, isolation and other precautions can be discontinued 10 days after the date of their first positive RT-PCR test.

NOTE: Serologic testing should not be used to establish the presence or absence of COVID-19 infection, and the results should not be used to determine if someone should discontinue isolation or precautions.

The DO, the fire administration, a local representative, the health department's POC/official and the department's occupational health physician should consider a modified fitness for duty examination before affected members return to work as affected members previously infected with COVID-19 with moderate to severe complications continue to experience respiratory distress, muscle-skeletal pain and cardiac dysrhythmia.

The department's occupational health physician should have frequent follow up with the affected members prior to and after returning to work.

- If affected members are unable to return to full duty due to ongoing complications from COVID-19, the fire administration, a local representative and the department's occupational health physician should determine if the affected members can work in an alternative duty capacity (e.g., office setting) or if they cannot return to duty at all. Additionally, the fire administration and local representative should determine which leave affected members are using if no duty is ordered by the department's occupational health physician (personal leave versus administrative leave).

- Regardless of the duty status, the DO should maintain frequent contact with the affected members for any needs or assistance (behavioral health, completing paperwork, etc.).
- The affected members are responsible for notifying the DO and the department's occupational health physician with any ongoing complications or new symptoms as a result of their previous COVID-19 infection.
- A copy of the Return-to-Work Flowchart should be included in this chapter to further assist with determining if affected members are returning to work.
 - **Return-to-Work Flowchart**

Confidentiality

Confidentiality and all applicable local, province and federal privacy laws should be strictly adhered to at all times regarding affected members' medical information.

Dispatch Protocols

A collaborative effort should be made with 9-1-1 call takers and dispatchers, the call center agency head, the fire administration, the DO, a local representative and the health department POC/official to aid in incorporating the questions below to pre-screen 9-1-1 calls for assistance for COVID-19.

Additionally, based on the pre-screening of COVID-19, information received from the 9-1-1 call center needs to be disseminated to the incoming emergency responders (your members) in a timely manner (prior to their arrival on the scene).

Recommendations for 9-1-1 Public Safety Answering Points (PSAPs)

- Municipalities and local EMS authorities should coordinate with provincial and local public health, PSAPs and other emergency call centers to determine the need for modified caller queries concerning COVID-19.
- Dispatch questions related to COVID-19 should be asked for all emergencies (police, fire and EMS).
- Modified caller queries should be closely coordinated with an EMS medical director and informed by local, provincial and federal public health authorities, including the city or county health department, provincial health department and the CDC.
- PSAPs or emergency medical dispatch (EMD) centers (as appropriate) should question callers and determine the possibility that calls concern a person who may have signs or symptoms and risk factors for COVID-19.
- Refer to **Guidance for Emergency Medical Services Systems and 9-1-1 Public Safety Answering Points (PSAPs) for COVID-19 in the United States**.

Questions Dispatch Centers Should Be Asking to Screen for COVID-19:

- What is the address of the emergency?
- What is the phone number you are calling from?
- Okay, tell me exactly what happened.
- How old is the patient?
- Is the patient awake?
- Is the patient breathing?
 - If the patient is awake and breathing, before proceeding to the chief complaint protocol, ask the three questions below:
 1. Is the patient short of breath?
 2. Does the patient have a fever?
 3. Does the patient have a cough?

If YES to two of the three questions, a pre-alert message should be sent to the responding crews informing them to don the appropriate PPE for COVID-19. The response configuration should be modified to minimize the number of first responders being exposed to a person under investigation. ■