THE K3 GROUP

3705 Arctic Blvd. #353
Anchorage, AK 99503-5774
Phone (907) 312-5535

Email: info@thek3group.com
www.thek3group.com

DRAFT COVID-19 PROCEDURES						
The K3 Group						
Version 1.9						
Mar 24, 2020						

Version 1.9 updates:

Alaska Health Mandate 010 guidance updated under PREPARATION

Timing of tracing of close contacts under DOCUMENTATION and QUARANTINE updated to 24 hours before the onset of symptoms or 14 days before a positive test sample was obtained.

COVID-19 PROCEDURES

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Note: these are draft guidelines only, developed in conjunction with industry stakeholders in order to assist companies in developing their own internal procedures related to the evolving pandemic. This is not intended as a standard of care or as an industry standard and does not constitute independent legal or regulatory authority or mandate.

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PURPOSE

These procedures are intended to provide medical guidance to remote camps utilizing guidance provided by the Center for Disease Control (CDC) to control the spread of COVID-19 in remote camps calling upon the United States and to mitigate the risk of potential fines for failure to report COVID-19 symptomatic cases.

These procedures can also be applied as a best practice at camps engaged in international commerce. For camps in international territories, many countries around the world have implemented their own protocols which could include an extended quarantine period for the camp employees depending upon the last place traveled, the travel history of the employee and employees living in the camp, and may include travel and/or employee change restrictions. Employees are advised to check with their supervisor seven (7) days prior to travel to your camp location to check and complete a health screen prior to departure.

COVID-19 is now classified as a global pandemic, as declared by the World Health Organization. In order to assist in containing the spread of COVID-19 to the extent possible, employees, other than those leaving for scheduled time off, should be restricted to the camp while on shift unless in emergency.

In the event employees must leave the camp, they should be expected to follow social distancing and other mitigation strategies and wash hands before returning to the camp as well as wear a cloth face mask.[1]

PREPARATION

Employee Time Off:

Attempt to minimize employee change outs as much as possible. The goal is to keep healthy employees healthy. For any joining employees, strongly consider a 14 day quarantine period prior to arrival with home symptom screening.

Be aware that the State of Alaska has mandated quarantine for 14 days whether resident, worker, or visitor. Oil ad Gas and Mining is considered part of the critical infrastructure and for workers to enter Alaska, a plan or protocol outlining how you will avoid the spread of COVID-19 is required to be submitted.[2]

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[1] https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf
[2] https://content.govdelivery.com/bulletins/gd/AKDHSS-282d20b

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Isolation or Quarantine Rooms:

Identify which rooms will be used for isolation, ideally it should be an airborne isolation room. If this is not one available, it should be a private room with a bathroom. If this is not available, designate rooms that will house only sick employees. A separate bathroom should be designated for sick employees.

Additionally, identify which rooms will be used to quarantine employees with close contact exposure to a suspected COVID-19 case if necessary. Identify what the minimum safe staffing requirements are for a camp in case of a widespread isolation or quarantine. This will be determined by the Contracting company. K3 will follow the guidelines set forth and implement them accordingly.

PPE:

Ensure adequate PPE, N95 or cloth face mask, disposable medical gloves, eye protection such as goggles or disposable face shields that cover the front and sides of face) is available at each camp location. The quantity recommended is at the discretion of the operating faciluty. Operators should have contingency plans for rapid resupply during outbreaks.

Have disposal plans in place. https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

If N95 masks or surgical masks are not available, the CDC has issued the following guidance:

In settings where facemasks are not available, health care providers might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect health care provider is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.[3]

If N95 masks or surgical face masks are not available, but a higher level industrial respirator, such as a half-face or full-face mask with a HEPA filter cartridge is available, this may be an acceptable alternative if an OSHA respiratory protection program is in place, the employee has been fit tested for the specific respirator, and a sanitizing and cleaning program is in place.

[3] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

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Movement in Camp:

All camps should be prepared to send individual meals to sick employee and clean dishes separately. Eliminate buffet style dining: staff will serve food as employees pass through the line instead of having each employee touch the serving utensils. Staff should practice *meticulous* hand and cough hygiene and should consider masking while serving food. Some considerations include:

- Self-service utensils – to reduce the opportunity for items to be touched by multiple people, set up trays with utensils on them and hand them out;
- Use of single use cups/plates/etc;
- Aggressive sanitizing of push button/lever beverage dispensers, condiments, etc. – areas that people may be touching during the meal service; or use single use condiments/drinks;
- Stagger meal breaks to reduce the number of people in the kitchen/dining area at one time or reducing the seating capacity in the dining area so people are spaced farther apart;
- Ensure people wash, sanitize, and wear single-use gloves on their hands on the way to the kitchen/dining area.

Restrict access into the camp accommodation areas – keep doors locked to restrict unnecessary employee or visitor movement through camp.

Post hand and cough hygiene posters throughout camp.

Supplies:

Camps should have appropriate diagnostic supplies including stethoscopes, blood pressure cuffs, pulse oximeters, and thermometers.

Ensure adequate supplies for cleaning, sanitizing, and disinfecting, including PPE and bags for disposal. Have alcohol-based hand sanitizer (at least 60-70%) ready for use upon entry into common areas, in the kitchen, gym, and throughout the camp. Have disposable tissues and waste bins available throughout the camp.

Camps should consider carrying Point-Of-Care influenza tests. Camps should have sterile viral transport media and sterile swabs to collect nasopharyngeal and nasal specimens if COVID-19 is suspected. These specimens must also be refrigerated for up to 72 hours after collection, or frozen.

Camps should carry appropriate medications and pharmaceutical supplies, based on the level of training of medical responders at site, which may include:

- Antipyretics such as acetaminophen;
- Oseltamivir;
- Oral hydration salts;

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- IV fluids and IV administration supplies;
- Oxygen and oxygen administration supplies;
- Airway interventions including oral and/or nasopharyngeal airways;
- Advanced airway support interventions;
- A selection of antibiotics, oral and IV, to treat bacterial respiratory infections and sepsis.

EDUCATION OF EMPLOYEE

Ensure your employees are aware of the[4]:

- Global risk of COVID-19 during international travel;
- Signs and symptoms that may indicate a sick traveler has COVID-19;
- Requirement for the camp's medical unit to report a traveler with suspected or known COVID-19 to CDC;
- Importance of not working while sick with fever or acute respiratory symptoms.

The company should also review their sick leave polices and communicate them to employees. CDC recommends that employees who self-report or appear to have fever or acute respiratory symptoms (such as cough or shortness of breath) be immediately evaluated.

Reassure employees that COVID-19 is not thought to spread via airborne transmission. It is thought to spread via droplet transmission, mainly from person-to-person, between persons who are in close contact with one another (within about 6 feet), or through respiratory droplets produced when an infected person coughs or sneezes.[5]

These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

Reassure employees that COVID-19 is unlikely to be spread through ventilation systems. Droplets are too large to be airborne for a prolonged period of time and quickly settle out of air.

employee should be advised to frequently wash hands with soap and water, use alcohol-based hand sanitizer, mask if coughing or sneezing, and not touch their faces.

[4] https://www.cdc.gov/quarantine/recommendations.html

[5] https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fabout%2Ftransmission.html

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A video to share with employees to help understand how to recognize and prevent COVID-19 spread, is here this is for vessel's however does discuss small spaces and is relevant: https://vimeo.com/398986642 and https://www.youtube.com/watch?v=DCdxsnRF1Fk

IDENTIFICATION

Procedure to identify employee with suspected COVID-19[6]

Screen employee for:

1. Have you experienced any difficulty breathing, shortness of breath, or symptoms of acute respiratory illness in the last 72 hours?[7]
2. Have you experienced a fever (100.4° F [38° C] or greater using an oral thermometer) within the last 72 hours? (A forehead (temporal) scanner is usually 0.5°F (0.3°C) to 1°F (0.6°C) lower than an oral temperature.)[8]
3. Have you experienced signs of a fever such as chills, aches & pains, etc. within the last 72 hours?
4. Have you traveled within the past 14 days to an affected area as identified by the CDC? https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
   Travel to an area with documented COVID-19 infections in a jurisdiction with known community transmission may contribute to an epidemiologic risk assessment to inform testing decisions. Obtain a detailed travel history and cross reference with the CDC website for a risk assessment.[9] Refer to the CDC website for US areas with community mitigation plans for US cities and regions considered high risk.
   https://www.cdc.gov/coronavirus/2019-ncov/community/index.html
5. Have you had contact within 14 days of symptom onset with a lab confirmed **or suspected** COVID-19 case patient? (contact defined as being within 6 feet of a COVID-19 case for a prolonged period of time (10 minutes) or having direct contact with infectious secretions of a COVID-19 case).[10]

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[6] https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html
https://www.who.int/publications-detail/operational-considerations-for-managing-covid-19-cases-outbreak

[7] *Difficulty breathing or shortness of breath means the person is*

- *unable to move enough air into or out of the lungs, or can do so only with an unusually great effort*
- *gasping for air,*
- *feeling "short of breath," or unable to "catch" his/her breath*
- *breathing too fast or shallowly, or using muscles of stomach, chest or neck to breathe (especially for children).*

[8] https://www.cigna.com/individuals-families/health-wellness/hw/medical-topics/fever-temperatures-tw9223

[9] https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

[10] The International Chamber of Shipping defines close contact as: https://safety4sea.com/ics-issues-new-guidance-about-seafarers-protection-amid-coronavirus/

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Action:

If an employee screens "yes" to any of the symptom questions (1-3), place a surgical mask on if tolerated.

If an employee screens "yes" to BOTH the any of the symptom questions (1-3) and an epidemiological risk factor questions (4 or 5), **place a surgical mask on employee if tolerated and isolate per the ISOLATION protocol.**

Evaluating provider to don appropriate PPE and begin to document who has exposure to employee from this point forward.

If available, obtain a rapid influenza swab. If positive, and no other reason to suspect COVID-19, treat employee as an influenza case, not a COVID-19 case.

If an employee screens "yes" to fever and respiratory symptoms, but does not clearly have an exposure that would qualify for a COVID-19 suspect case, recommend isolation for 72 hours AFTER

- Has stayed in the same room with a suspect/confirmed COVID-19 case;
- Has had close contact within one foot of and was in a closed environment with a suspect/confirmed COVID-19 case (for employees this may include sharing a room);
- Participated in common activities in camp;
- Participated in the same immediate traveling group;
- Dined at the same table (for employees this may include working together in the same area);
- Is a housekeeper who cleaned the room;
- Is a staff member who delivered food to the room;
- Is a medical support worker or other person providing direct care for a COVID-19 suspect or confirmed case.

The WHO defines close contacts (high-risk exposure) as: https://www.who.int/publications-detail/operational-considerations-for-managing-covid-19-cases-outbreak

- Stayed in the same room as a suspected or confirmed COVID-19 case;
- Had close contact (within 1 ft.) or were in a closed environment with a suspected or confirmed COVID-19 case –
- For employees, this may include participating in common activities in camp, being a member of a group traveling together, dining at the same table, working in the same area as the suspected or confirmed COVID-19 case, for example, housekeepers who cleaned the room or kitchen staff who delivered food to the room
- Healthcare worker or another person who provided care for a suspected or confirmed COVID-19 case..

The European Center for Disease Prevention and Control defines close contact for case surveillance as: https://www.fhi.no/en/op/novel-coronavirus-facts-advice/advice-to-health-personnel/definitions-of-probable-and-confirmed-cases-of-coronavirus-covid-19-and-con/

- A person living in the same household as a COVID-19 case;
- A person having had direct physical contact with a COVID-19 case (e.g. shaking hands);
- A person having unprotected direct contact with infectious secretions of a COVID-19 case (e.g. being coughed on, touching used paper tissues with a bare hand);
- A person having had face-to-face contact with a COVID-19 case within 2 ft. and > 15 minutes;
- A person who was in a closed environment (e.g. classroom, meeting room, hospital waiting room, etc.) with a COVID-19 case for 15 minutes or more and at a distance of less than 2 ft.;
- A healthcare worker (HCW) or other person providing direct care for a COVID-19 case, or laboratory workers handling specimens from a COVID-19 case without recommended personal protective equipment (PPE) or with a possible breach of PPE;
- A contact in an aircraft sitting within two seats (in any direction) of the COVID-19 case, travel companions or persons providing care, and employee serving in the section of the aircraft where the index case was seated (if severity of symptoms or movement of the case indicate more extensive exposure, passengers seated in the entire section or all passengers on the aircraft may be considered close contacts).

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the fever ends without the use of fever-reducing medications AND an improvement in initial symptoms (i.e. cough, shortness of breath) before returning to work.[11]

Additional Recommendations:

Screen employee daily for:

- New signs of fever, cough or shortness of breath
- If there is a respiratory illness identified in camp, take temperature at least daily of each employee

Contact tracing information for departing employee should be maintained for at least one month (name, phone number, home address, email). They should be provided with information on whom to contact if they develop fever, cough or shortness of breath in the following 14 days.

ISOLATION

Isolation separates sick people with a contagious disease from people who are not sick.

Procedure to isolate employee with suspected COVID-19[12]

If an employee is identified as a potential COVID-19 case, immediately ask them to wear a facemask (a surgical/cloth mask, not N-95) if tolerated.

Place the employee in a private room with the door closed, ideally an airborne infection isolation room if available. Place a label on the door indicating no one is to enter the room without proper PPE. This room should have separate toilet and bathing facilities.

Any staff entering the room should use Standard Precautions, Contact Precautions, and Airborne Precautions, and use eye protection such as goggles or a face shield. If N-95 masks are not available, a surgical/cloth mask may be considered an acceptable alternative at this time.[13]

Access to the room should be limited to personnel involved in direct care. Meals should be delivered to the room and dishes and utensils cleaned separately. Anyone with exposure to the employee should document the date and time of exposure, nature of exposure (close contact, same room, secretions), and PPE worn.

[11] https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/COVIDcasepositive.pdf
https://www.kingcounty.gov/depts/health/emergency-preparedness/preparing-yourself/pandemic-flu/businesses/returning-to-work.aspx

[12] https://www.cdc.gov/quarantine/recommendations.html

[13] https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html

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Meticulous hand hygiene MUST be performed immediately after doffing PPE.

- Maintain a distance of 6 feet from the sick person while interviewing, escorting, or providing other assistance.
- Keep interactions with sick people as brief as possible.
- Limit the number of people who interact with sick people. To the extent possible, have a single person give care and meals to the sick person.
- Avoid touching your eyes, nose, and mouth.
- **Wash your hands often with soap and water.** If soap and water are not available and if hands are not visibly soiled, use a hand sanitizer containing 60%-95% alcohol.
- Provide tissues and access to soap and water and ask the sick persons to:
    - Cover their mouth and nose with a tissue (or facemask) when coughing or sneezing.
    - Throw away used tissues immediately in a disposable container (e.g., plastic bag) or a washable trash can.
    - Wash their hands often with soap and water for 20 seconds. If soap and water are not available and hands are not visibly soiled, the sick person should use a hand sanitizer containing 60%-95% alcohol.
- If soap and water are not available and hands are not visibly soiled, the sick person should use a hand sanitizer containing 60%-95% alcohol.

Discontinuance of Isolation for employee not requiring care, can be considered, in conjunction with your telemedical advisory service, under the following conditions:[14]

• If you had a fever, 3 days after the fever ends without the use of fever-reducing medications AND you see an improvement in your initial symptoms (e.g. cough, shortness of breath);
• If you did not have a fever, 3 days after you see an improvement in your initial symptoms (e.g. cough, shortness of breath);
AND
• 7 days after symptom onset,
whichever is longer.

Note: discontinuance of isolation for a suspected COVID-19 case should be made on a case by case basis with your camp telemedical advisory service and does not remove the mandatory USCG reporting requirements.

[14] https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/COVIDcasepositive.pdf
https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html
https://www.kingcounty.gov/depts/health/emergency-preparedness/preparing-yourself/pandemic-flu/businesses/returning-to-work.aspx

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PROTECTION

Procedure to identify who will have exposure to a potential COVID-19 case, what PPE will be worn, and how PPE will be managed:[15]

Once a suspect COVID-19 case is identified and isolated, response team members should be identified who will be the primary contact with the isolated employee. This should be reduced to the absolute minimum number of people.

Proper PPE must be provided:[16]

- NIOSH-certified N95 mask or surgical mask;
- disposable long-sleeved gown;
- disposable medical gloves;
- eye protection such as goggles or disposable face shields that cover the front and sides of face.

For N-95 masks, an OSHA respiratory protection program and fit testing should be in place.

Designated responders must be trained in how to appropriately don and doff PPE: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

Designate a hand hygiene station for doffing of PPE as close to the exit of the room as possible. Hand washing with soap and water is preferred to hand sanitizer if possible.

A plan for collection and disposal of PPE must be in place.

The amount of PPE provided should be determined by the operator based on the number of employees, anticipated exposure, and availability of supplies.

ASSESSMENT

Procedure on assessing possible COVID-19 cases, camp diagnostic and treatment recommendations[17]

[15] https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
[16] https://www.cdc.gov/quarantine/recommendations.html
[17] https://www.cdc.gov/quarantine/recommendations.html

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When a potential COVID-19 case is identified, the isolated employee should be evaluated by the medical staff at camp, wearing appropriate PPE. Attempt to maintain a distance of 6 feet from the sick person while interviewing, escorting, or providing other assistance.

The following historical information should be gathered:

- List of the sick traveler's signs and symptoms, including onset dates. Symptom definitions are available here: https://www.cdc.gov/quarantine/definitions-signs-symptoms-conditions-ill-travelers.html
- The sick traveler's highest recorded temperature;
- The sick traveler's dates of travel;
- Contact with a confirmed or suspected COVID-19 case in the past two weeks;
- Countries visited two weeks prior to onset of symptoms;
- Past medical history;
- Medications taken including dose and frequency;
- Allergies and reactions;
- History of influenza vaccination and if childhood vaccination sequence completed.

The following physical exam information should be obtained:

- Complete vital signs including temperature, blood pressure, pulse, pulse oxygenation, respiratory rate;
- Mental status exam;
- Lung exam;
- Skin/perfusion exam;
- Any other relevant organ system exam based on presenting signs and symptoms.

If indicated, based on medical staff assessment or consultation with medical advisory service, the following diagnostic testing may be recommended:

- Rapid influenza testing;
- Sterile viral transport media and sterile swabs to collect nasopharyngeal and nasal specimens if COVID-19 infection is suspected are recommended by the CDC. Samples must be refrigerated for up to 72 hours after collection or frozen. (https://www.cdc.gov/coronavirus/2019-ncov/lab/rt-pcr-detection-instructions.html)

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Treatment recommendations should be discussed with a camps's telemedical providers. Some treatments that may be recommended include:[18]

- Antipyretics such as acetaminophen;
- Oseltamivir;
- Oral rehydration salts;
- IV fluids and IV administration supplies;
- Oxygen and oxygen administration supplies;
- Airway interventions including oral and/or nasopharyngeal airways;
- Advanced airway support interventions;
- A selection of antibiotics, oral and IV, to treat bacterial respiratory infections and sepsis.

Frequent reassessments of the employee's medical status are recommended as symptoms can change rapidly.

COMMUNICATION AND REPORTING

Procedure on communicating possible COVID-19 cases with telemedical providers, medical providers, and regulatory authorities:

Telemedical providers:

All cases of suspected COVID-19 (based on criteria under IDENTIFICATION procedure), should be communicated with the camp's medical advisory service. A standard template to include the information on the ASSESSMENT procedure should be used for documentation.

Before arriving at a camp medical staff and telemedicine providers must discuss the removal of patients suspected of having COVID-19 with the CDC quarantine station having jurisdiction for the camp and with state and local health departments.[19]

Healthcare providers:

Medical providers will benefit from advanced notification of a potential COVID-19 patient. Information should be relayed to the provider by phone, fax or email before the affected employee is removed or flown out. The employee should wear a surgical mask during transport if possible.

[18] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
https://www.who.int/docs/default-source/coronaviruse/clinical-management-of-novel-cov.pdf?sfvrsn=bc7da517_2

[19] https://www.cdc.gov/quarantine/recommendations.html

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42 CFR 71.21 requires to immediately report any death or illness.

According to U.S. federal regulations, all deaths and ill persons displaying any of the following signs and symptoms must be reported to CDC:

A. Fever (has a measured temperature of 100.4 °F [38 °C] or greater; or feels warm to the touch; or gives a history of feeling feverish) **accompanied by one or more of the following**:
   - skin rash;
   - difficulty breathing or suspected or confirmed pneumonia;
   - persistent cough or cough with bloody sputum;
   - decreased consciousness or confusion of recent onset;
   - new unexplained bruising or bleeding (without previous injury);
   - persistent vomiting (other than sea sickness);
   - headache with stiff neck;

OR

B. Fever that has persisted for more than 48 hours;

OR

C. Acute gastroenteritis, which means either:
   - diarrhea, defined as three or more episodes of loose stools in a 24-hour period or what is above normal for the individual, or
   - vomiting accompanied by one or more of the following: one or more episodes of loose stools in a 24-hour period, abdominal cramps, headache, muscle aches, or fever (temperature of 100.4 °F [38 °C] or greater);

OR

D. Symptoms or other indications of communicable disease:
   through posting of a notice in the Federal Register (CDC will notify partners in applicable industries as well as posting on the CDC website).

DOCUMENTATION

Procedure on documenting potentially exposed contacts of a suspected COVID-19 patient[22]

[22] https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

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Once a potential case of COVID-19 is identified, there are two important areas of documentation:

- Identification of all potential exposures while the employee was experiencing symptoms
- Documentation of all personnel who have contact with employee after isolation is instituted

Once a potential case is identified, interview the employee to determine:

The time and date of onset of symptoms

From **24 hours before the symptoms began**, document all people who had close contact with the affected employee, defined as:

A. being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; (close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case)

OR

B. having direct contact with infectious secretions of a COVID-19 case; (e.g., being coughed on or shared utensils)

Document the name and contact information, time and date of contact, the nature of contact (close contact, in the same room) and the duration of contact.

High risk close contacts of suspected COVID-19 cases should be quarantined according to the QUARANTINE section of this document.

This includes any people that may have already left work site/camp.

Once an employee is isolated, maintain a log to document:

All personnel who enter the employee's room, the time and date, duration of exposure, type of PPE worn, nature of exposure (close contact, secretions, same room). Provide name and contact information as well.

Other documentation:

Daily logs of temperature and signs or symptoms including fever, cough or shortness of breath on all employees should be maintained and available for inspection.

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TRANSPORTATION

Procedure on transportation of suspected COVID-19 cases[23]

For the employees with suspected COVID-19:

A facemask should be worn by the patient for source control. If a nasal cannula is in place, a facemask should be worn over the nasal cannula. Alternatively, an oxygen mask can be used if clinically indicated. If the patient requires intubation, see below for additional precautions on the site above for aerosol-generating procedures.

If ambulance transportation is required

Local EMS should be notified that this is a potential COVID-19 case so that responders may use appropriate PPE and follow their protocols.

If private vehicle transportation is utilized

Anyone who will be driving an employee with suspected COVID-19 who will provide direct care (e.g., moving patients onto stretchers) should wear recommended PPE. After completing patient care and before entering a driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene **before** entering the driver's compartment. Windows should be down to allow for air exchange if possible.

All personnel should avoid touching their face while working.

The receiving healthcare facility should be notified that a patient with suspected COVID-19 is being brought in so that they may take appropriate infection control precautions.

QUARANTINE

Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick.

Procedure for quarantining employees exposed to a potential COVID-19 case[24]

[23] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html

[24] https://www.cdc.gov/quarantine/recommendations.html
https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html

THE K3 GROUP

3705 Arctic Blvd. #353
Anchorage, AK 99503-5774
Phone (907) 312-5535

Email: info@thek3group.com
www.thek3group.com

In Camp:

Contractors and employee who have had **high-risk exposures** to a person suspected of having COVID-19 should be quarantined in their rooms. All potentially exposed passengers, medical staff, and employees **self-monitor under supervision** of medical staff or telemedicine providers until 14 days after the last possible exposure.

A high-risk exposure could occur through close contact with the suspected case without PPE. Close contact is defined as:

A. being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; (close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case);

OR

B. having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

Self-monitoring with delegated supervision means, for employees, self-monitoring with oversight by your medical staff and telemedical provider in coordination with the health department of jurisdiction. Points of contact between the self-monitoring personnel, management, telemedical provider, local and state health departments with jurisdiction for the location where personnel will be during the self-monitoring period should be established. If personnel develop fever, cough, or difficulty breathing during the self-monitoring period, they should undergo medical assessment, isolation, treatment, reporting and transportation as per the other relevant sections of this document. Camp management and telemedical providers should remain in contact with personnel through the self-monitoring period to oversee self-monitoring activities.
If private rooms are not available, a room should be designated for the quarantine of exposed individuals.

If the volume of quarantined staff would pose a risk to the entire camp, it is recommended to work with your medical advisory service, CDC to determine the minimum necessary employees to operate safely.

IN CAMP:

The CDC has responsibility for determining if contacts of a suspected COVID-19 case should be quarantined and the camp operator may be required to operationally comply with the quarantine.

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Companies should have plans in place for locally housing employees if they are unable to travel home. The CDC would prefer not to quarantine cases in camp, but decisions are made on a case-by-case basis. If a small number of people have been exposed, it would be best to have the exposed employees stay away from the remaining employees and quarantine in place.

Companies should have plans in place to quickly replace quarantined employees so that the camp can be cleaned and returned to full operation.

First-degree contacts are defined as those that had close contact (defined above) with the suspected COVID-19 source patient from **24 hours before symptoms began or 14 days before the time a positive test sample was obtained**. All first-degree contacts should be quarantined for 14 days with twice daily symptom monitoring or until the source patient's COVID-19 test comes back negative. If the source patient's COVID-19 test is positive, all first-degree contacts should be quarantined with twice daily symptom checks for 14 days from the date the test was obtained.

If a first-degree contact has roommates, attempt to move the first-degree contact to a private room or a room with other first-degree contacts for quarantine. If the first-degree contact develops symptoms during the 14 day period, *second-degree contacts* should be quarantined for 14 days or until the first-degree contact's COVID-19 test result comes back negative. If the first-degree contact's test result is positive, the second-degree contacts should be quarantined for 14 days with twice daily symptom monitoring from the time the test was obtained.

Second-degree contacts are defined as people who had close contact with a first-degree contact who was not having symptoms from the time of contact with the source patient.

Note: discontinuance of quarantine for a suspected COVID-19 case should be made on a case by case basis with advice from a medical provider.

R & R LEAVE PRECAUTIONS

Aggressive infection control precautions, early identification of possible COVID-19 cases and isolation and quarantine procedures can help prevent the spread of COVID-19 in camp. Leaving camp will present a risk for exposure. Companies should limit the contact of employee with outside personnel as much as possible.

- Have a hand-sanitizer station at the exit, with tissues and a waste container;

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www.thek3group.com

- Do not allow non-essential personnel in camp, any communication should be done by phone or radio instead of in person if possible;
- Restrict employees from entering other employees rooms;
- Screen any personnel who comes to camp for fever, cough or shortness of breath in the prior 72 hours. If any symptoms present, deny boarding/travel;
- Wipe down rails, door handles, and surfaces frequently with disinfecting wipes.

Leaving camp for employee should be minimized as much as possible. For employees who do leave:

- Follow "social distancing" recommendations (stay at least 6 feet away from people), maintain good cough and hand hygiene, avoid groups of people;
- Wash hands with soap and water or use alcohol-based hand sanitizer frequently. Do not shake hands;
- Employee should be screened for fever, cough or shortness of breath on return to the camp and isolated if symptoms present.

SANITATION AND DISPOSAL

Procedure to clean, sanitize, and disinfect a camp and dispose of PPE[25]

In addition to routine cleaning and disinfection strategies, **camps may consider more frequent cleaning of commonly touched surfaces such as handrails, countertops, and doorknobs.**

The primary mode of COVID-19 virus transmission is believed to be through respiratory droplets that are spread from an infected person through coughing or sneezing to a susceptible close contact within about 6 feet. Therefore, widespread disinfection is unlikely to be effective.

CLEAN, SANITIZE, AND DISINFECT COMMON AREAS DAILY

Daily disinfection of surfaces that people touch frequently can help decrease the spread of germs. If illness has been identified in camp consider disinfecting surfaces multiple times per day.

Cleaning uses soap or detergent to remove dirt and debris from surfaces.

Sanitizing is meant to reduce, but not kill, the occurrence and growth of germs from surfaces.

[25] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html
https://www.kingcounty.gov/depts/health/communicable-diseases/disease-control/~/media/depts/health/homeless-health/healthcare-for-the-homeless/documents/cleaning-disinfection-guidelines-shelters.ashx
https://www.cdc.gov/quarantine/recommendations.html

THE K3 GROUP

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Disinfection uses a chemical to kill germs on surfaces that are likely to harbor germs.

Disinfectants work best on a clean surface and usually require a longer surface contact period (between 1 - 10 minutes) to work.

Surfaces that people touch a lot (door handles, railings, light switches, chairs, tables) and bathroom and kitchen surfaces should be cleaned, sanitized, and disinfected routinely.

SUPPLIES FOR CLEANING, SANITIZING, AND DISINFECTION

Ensure supplies are stocked and available for cleaning and disinfecting:

- Personal protective equipment: disposable gloves, eye protection, clothing that covers exposed skin, face mask;
- Properly labeled spray bottles & measuring cups;
- Scrubbing pads/cleaning brushes, paper towels, garbage bags.

HOW TO SELECT A SANITIZER AND/OR DISINFECTANT

Sanitizing and disinfecting cleaners and wipes are readily available and come in pre-mixed formulas such as kitchen or bathroom disinfectant as well as hospital-grade formulations. These products are effective for cleaning and sanitizing common surfaces. To select the best one for your camp, read the label for guidance.

Common types of disinfectants to choose from include:

- Bleach/sodium hypochlorite;
- Quaternary ammonias (ammonium chloride formulations);
- Accelerated hydrogen peroxides.

HOW TO USE "DISINFECTANT WIPES" EFFECTIVELY

To use wipes for disinfecting, use a "wipe, discard, wipe" technique. Wipe the surface to clean away dirt or debris, discard the wipe, and then wipe again with a fresh wipe and allow the surface to air dry.

STEPS FOR CLEANING, SANITIZING, AND DISINFECTING USING SPRAY SOLUTIONS

1. **Clean first:**
   Spray your surface with a cleaning solution. Wipe or rinse with water. Use a scrubbing pad or brush to remove debris. If using a disinfectant cleaner, follow the instructions on the product label for cleaning.
2. **Apply your Sanitizer/Disinfectant:**

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Wet the surface and leave solution on the surface for the recommended contact time, generally between 1 -10 minutes. Dry with a paper towel or let the surface air dry.

HOW TO MIX A BLEACH SOLUTION

- Identify the bleach/sodium hypochlorite % on the label and prepare your sanitizing or disinfecting solution based on the surface or area you are cleaning (see table below).
- Use cool water, not warm or hot water, for mixing.
- Mix fresh solutions for sanitizing and disinfecting. If using a spray bottle, mix daily, and if using a bucket with rags, make a new batch every 2-4 hours.
- Always add the bleach to the water.
- **Do not mix liquid bleach with other cleaning products.**

	To one gallon of water, add:	
	8.25% bleach/sodium hypochlorite	5.25% bleach/sodium hypochlorite
Sanitizing (100 PPM)	1 teaspoon	1 teaspoon
Disinfecting (600 PPM)*	2 tablespoons	¼ cup
Special disinfecting (5000 PPM): vomit, diarrhea, blood	1 cup	1 ½ cups

*Contact time: Wet for 10 minutes or as specified on the label when used as a disinfectant.

Cleaning a camp after a suspected COVID-19 exposure

Cleaning recommendations are based on existing CDC infection control guidance for preventing COVID-19 from spreading to others in homes.

STEP 1: Restrict access to rooms used for isolation or quarantine for at least 2 hours after the sick person has left the room

Standard practice for pathogens spread by air (such as measles, tuberculosis) is to restrict people unprotected (for example, no respiratory protection) from entering a vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on clearance rates under differing ventilation conditions is available).

We don't yet know how long COVID-19 remains infectious in the air.

Note: these are draft guidelines only, developed in conjunction with industry stakeholders in order to assist companies in developing their own internal procedures related to the evolving pandemic. This is not intended as a standard of care or as an industry standard and does not constitute independent legal or regulatory authority or mandate.

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In the interim, it is reasonable to apply a similar time period before entering the sick person's room without respiratory protection as used for other pathogens spread by air (for example, measles, tuberculosis), **restrict access for two hours after the sick person has left the room.**

STEP 2: Clean surfaces infected by the respiratory secretions of a sick person suspected with COVID-19 (for example, in the sick person's living quarters or work area, and in isolation rooms) while wearing appropriate PPE and maintaining awareness of OSHA Bloodborne Pathogen Standard.

Use disinfectant products against COVID-19 with Environmental Protection Agency (EPA)-approved emerging viral pathogens claims. These products can be identified by the following claim:

- [Product name] has demonstrated effectiveness against viruses similar to COVID-19 on hard non-porous surfaces. Therefore, this product can be used against COVID-19 when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces.
    - Specific claims for "COVID-19" will not appear on the product or master label.
- More information about EPA-approved emerging viral pathogens claims can be found here: https://www.epa.gov/pesticide-registration/emerging-viral-pathogen-guidance-antimicrobial-pesticides
    - If there are no available EPA-registered products with an approved emerging viral pathogen claim for COVID-19, use products with label claims against human coronaviruses according to label instructions.
- This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to healthcare facilities, physicians, nurses, and public health officials, "1-800" consumer information services, social media sites and company websites (non-label related).
- **Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2. Refer to List N on the EPA website** (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use.
- **In addition to wearing disposable gloves during routine cleaning, wear disposable gowns when cleaning areas suspected to be contaminated by COVID-19**. Wear PPE compatible with the disinfectant products being used and approved for use in a camp. Remove carefully gloves and gowns to avoid cross-contamination and the surrounding area.

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Procedures for proper removal of gloves are reviewed here: https://www.cdc.gov/vhf/ebola/pdf/poster-how-to-remove-gloves.pdf

- A face shield or facemask and goggles should also be worn if splashes or sprays during cleaning are anticipated.
- Perform hand hygiene (https://www.cdc.gov/handwashing/when-how-handwashing.html) upon removing and disposing gloves by washing hands often with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60 to 95% alcohol.
- Clean all "high-touch" surfaces in the sick person's room (for example, counters, tabletops, doorknobs, light switches, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables) according to instructions described for the above EPA-registered product. Wear disposable gloves and gowns during cleaning activities.
- If visible contamination (for example, blood, respiratory secretions, or other body fluids) is present, the basic principles for blood or body substance spill management are outlined in the United States Occupational Safety and Health Administration (OSHA Bloodborne Pathogen Standard: https://www.osha.gov/SLTC/bloodbornepathogens/standards.html) CDC guidelines recommend removing bulk spill matter, cleaning the site, and then disinfecting the site with the above EPA-registered disinfectant. For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present, and wash according to the manufacturer's instructions. Clean and disinfect unremovable materials with products mentioned above and allow to air dry.

STEP 3: Launder soiled textiles, linens and dispose of PPE appropriately.

- When cleaning is completed, collect soiled textiles and linens in sturdy leak-proof containers; these can be laundered using conventional processes following your standard operating procedures.
- Follow standard operating procedures for containing and laundering used linen. Avoid shaking the linen.
- PPE should be removed and placed with other disposable items in sturdy, leak-proof (plastic) bags that are tied shut and not reopened. The bags of used PPE and disposable items can then be placed into the solid waste stream according to routine procedures. Follow your standard operating procedures for waste removal and treatment.
- No additional cleaning is needed for the camp's supply-and-return ventilation registers or filtration systems.
- No additional treatment of wastewater is needed.

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STEP 4: Clean and disinfect any reusable equipment that may have been exposed.

Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.