North Carolina Department of Labor
Division of Occupational Safety and Health

Raleigh, North Carolina

Field Information System Operational Procedure Notice 132A

Subject: Special Emphasis Program for Long Term Care Facilities.

A. Purpose and Scope.

This OPN describes implementation of an SEP for all inspections of Long Term Care (LTC) Facilities (NAICS 623110, Nursing Care Facilities; 623210, Residential Mental Retardation Facilities; and 623311, Continuing Care Retirement Communities.)

B. Special Emphasis Program History.

In August 1996, USDOL OSHA implemented a seven state nursing home initiative to address hazards and "protect workers in one of the nation's fastest growing industries" (OSHA News Release, August 8, 1996). This initiative was terminated by John B. Miles, Director, Compliance Programs, on February 10, 1998. All enforcement policies for the initiative were subsequently superseded and replaced by the Site Specific Targeting (SST) Inspection Plan (April, 1999) and a National Emphasis Program (NEP) on nursing and personal care facilities was begun. In April 2002, Nursing and Personal Care Facilities were removed from the SST Plan and were addressed by CPL 2 (02-03). The NEP on SIC 805 was ended on September 30, 2003 and nursing homes were returned to the SST Inspection Plan.

The NCDOL had similar strategic plan goals (from 1999 - 2003) and an SEP focused on LTC facilities. The inspection procedures contained in the federal directive were implemented with state-specific changes. While federal OSHA discontinued their NEP, The NCDOL included LTC in the 2004 - 2008 strategic plan. This document specifies the state specific inspection procedures to be used during current LTC facility inspections.

C. Background.

Long term care (LTC) facilities had one of the highest rates of injury and illness among industries for which nationwide lost workday injury and illness (LWDII) rates were calculated for calendar year 2000 (CY 2000). According to data from the Bureau of Labor Statistics (BLS), the national average LWDII rate for private industry for CY 2000 was 3.0. LTC facilities (employers within SIC codes 8051, 8052, and 8059) experienced an average LWDII rate of 7.9, despite the availability of feasible controls which had been identified to address hazards within this industry.

CY 2000 data from BLS indicated that overexertion and injuries from slips, trips, and falls accounted for a high percentage of total nonfatal occupational injury and illness cases with days away from work in LTC facilities. Taken together, these accounted for 72% of all cases involving days away from work (53.4% from overexertion and 18.6% from slips, trips, and falls).

OSHA enforcement data (from the IMIS) indicated that the most frequently cited standard in LTC facilities was 29 CFR 1910.1030, the Bloodborne Pathogens (BBP) Standard. Employees working in LTC facilities had been identified by the Centers for Disease Control and Prevention (CDC) as having a high incidence of exposure to Tuberculosis (TB).

Workplace violence was recognized as a hazard in LTC Facilities. In the year 2000, BLS data recorded 3,702 occupational injuries and illnesses involving days away from work in LTC Facilities that were attributable to violence inflicted on staff. During the period from 1992-2000, there were 29 homicides in this industry from violence toward staff.

The efforts set forth herein are designed to meet the NCDOL Division of Occupational Safety and Health Strategic Management Plan, October 1, 2003 - September 30, 2008, goals and Strategic Plan (2004-2008) goals in addressing the requirements of Government Performance and Results Act (GPRA), as this industry group was identified in NCDOL 2003 - 2008 Strategic Plan Goal 1.4. Under this Strategic Plan, NCDOL committed to reducing the number of worker injuries, illnesses, and fatalities by 15% in industries characterized by high-hazard workplaces. This goal is to be achieved by focusing state-wide attention and resources on the most prevalent types of workplace injuries and illnesses and the most hazardous workplaces.

This SEP focuses primarily on the hazards prevalent in LTC facilities, specifically, ergonomic stressors relating to resident handling; exposure to blood and other potentially infectious materials; exposure to tuberculosis; and slips, trips, and falls. As detailed in the Field Operations Manual (FOM), when the CSHO becomes aware of additional hazards, the scope of the inspection will be expanded to include those hazards. This SEP addresses only enforcement-related procedures. Voluntary guidelines published by OSHA will not be used as a basis for citations issued under this SEP.

D. Definitions.

Days Away, Restricted, or Transferred (DART) Rate: This case rate includes injuries and illnesses involving days away from work, restricted work activity, and transfers to another job. It is calculated using the formula (N ÷ EH) x (200,000) where N is the number of cases involving days away and/or restricted work activity, and/or job transfer; EH is the total number of hours worked by all employees during the calendar year; and 200,000 is the base number of hours for 100 full-time equivalent employees.

For example: Workers of an establishment including management, temporary, and leased workers worked 645,089 hours at this worksite. There were 22 injury and illness cases involving days away and/or restricted work activity and/or job transfer from the OSHA-300 Log (total of column H plus column I). The DART rate would be (22 ÷ 645,089) x (200,000) = 6.8.

E. Program Procedures.

LTC assignments will be generated through accidents, complaints, referrals, SST and general schedule criteria. The assignments will have priority based upon instructions in the FOM.

F. Inspection Procedures.

Inspections initiated under this SEP will be scheduled and conducted in accordance with provisions of the FOM, except as noted below. Unprogrammed inspections will be expanded to cover the elements of a LTC inspection (BBP, TB, Ergo and slips, trips and falls).

1. Privacy.

   a. Residents' Privacy and Medical Records:

      i. Respect for residents' privacy must be a priority during each inspection.

      ii. In evaluating resident handling or other hazards (e.g., BBP, tuberculosis) Do NOT review any resident records that include personally identifiable health information, including diagnoses, laboratory test results, etc., provided by the employer.

      iii. Evaluations of workplace health and safety issues in this SEP may involve assessment of resident handling. Resident handling activities may take place in resident rooms, restrooms, shower and bathing areas or other areas where the privacy of residents could be compromised. Documenting resident handling activities by videotaping or photography requires the resident's informed, written consent. Family members or guardians may give consent for those residents who are incapable of giving informed consent (see Appendix A).

   b. Employees' Medical Records:

      i. If employee medical records are needed that are not specifically required by an OSHA standard (e.g., the results of medical examinations, laboratory tests, medical opinions, diagnoses, first aid records, reports from physicians or other health care providers), they must be obtained and kept in accordance with 29 CFR 1910.1020 - Access to Employee Exposure and Medical Records.

      ii. Health and Human Services' Standards for Privacy of Individually Identifiable Health Information 45 CFR 164.512 (b)(1)(v), state that an employer (or its health care provider) can disclose and use confidential employee health information when conducting or evaluating workplace medical surveillance; or to evaluate whether an employee has a work-related illness or injury; or to comply with OSHA requirements under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose.

2. Recordkeeping.

   Recordkeeping issues must be handled in accordance with OSHA Instruction CPL 2-0.131, Recordkeeping Policies and Procedures Manual, CPL 2-2.69 - *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*, or other relevant field guidance. For LTC assignments coming from an SST listing, a partial walkthrough may be conducted to confirm and verify the injury and illness experience. Any serious violations that are observed in the vicinity or brought to the attention of the CSHO must be investigated and may be cited.

3. Ergonomic Risk Factors Relating to Resident Handling.

This section provides guidance for conducting inspections in accordance with this SEP as it relates to ergonomic risk factors associated with resident handling. These inspections shall be conducted in accordance with the FOM instructions intended to identify case outcomes as early as possible in the inspection process, allowing resources to be allocated efficiently.

Establishment Evaluation: Inspections of resident handling risk factors will begin with an initial process designed to determine the extent of resident handling hazards and the manner in which they are addressed. This will be accomplished by an assessment of establishment incidence and severity rates, whether such rates are increasing or decreasing over a three year period, and whether the establishment has implemented a process to address these conditions in a manner which can be expected to have a useful effect. When assessing an employer's efforts to address these conditions, the CSHO should evaluate program elements, such as the following:

a. Program Management.

i. Whether there is a system for hazard identification and analysis.
ii. With whom the responsibility and authority for compliance with this system resides.
iii. Whether employees have input in the development of the establishment's lifting procedures.
iv. Whether there is a system for monitoring compliance with the establishment's policies and procedures and following up on deficiencies.
v. If there have been recent changes in policies/procedures and what effect they have had (positive or negative) on injuries and illnesses.

b. Program Implementation.

i. How resident mobility is determined.
ii. What decisions are made for using lift assist devices, and under what circumstances manual lifts occur.
iii. With whom does the decision on how to lift patients reside.
iv. Whether there is an adequate quantity and variety of appropriate lift assist devices available and operational. Note that no single lift assist device is appropriate in all circumstances. Manual pump devices may create additional hazards.
v. Whether there are an adequate number of slings for lift assist devices, double handled gait belts, or other transfer assist devices (such as but not limited to slip sheets, pivot transfer devices) available and maintained in a sanitary condition.
vi. Whether the policies and procedures are appropriate to reduce exposure to the lifting hazards at the establishment.

c. Employee Training.

i. Whether employees have been trained in the recognition of hazards associated with resident handling.
ii. Whether there is early reporting of injuries.
iii. Whether management has an effective process for abating those hazards.

d. Occupational Health Management.

i. Whether processes are established to ensure that disorders are identified and treated early to prevent the occurrence of more serious problems.
ii. Whether this process includes restricted or accommodated work assignments.

After evaluating the facility's incidence and severity rates and the extent of the employer's program, a decision will be made as to the need to continue the ergonomic portion of the inspection. Where there is a need to address these issues, the CSHO will follow NCDOL instructions in determining whether to send an ergonomic hazard alert letter, other communication, or issue citations.

Citation Guidance: Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance.

4. Slips, Trips, and Falls.

This section provides general guidance related to these types of hazards when conducting inspections in a LTC facility.

a. Evaluate the general work environments (i.e., kitchen, hallways, laundry, bathing areas, and egress) and document hazards likely to cause slips, trips, and falls such as but not limited to:

i. Slippery or wet floors; uneven floor surfaces; cluttered or obstructed work areas/ passageways; poorly maintained walkways; broken equipment; or inadequate lighting (especially for night shift).
ii. Unguarded floor openings and holes.
iii. Damaged or inadequate stairs and/or stairways.
iv. Elevated work surfaces which do not have standard guardrails.
v. Inadequate aisles for moving residents.

b. Note any policies, procedures and/or engineering controls used to deal with wet surfaces. These would include but are not limited to ensuring spills are reported and immediately cleaned up, posting signs/barriers alerting employees to wet floors, passageways/aisles kept clear of clutter, and using appropriate footgear. Where appropriate, evaluate the use of no-skid waxes or other types of coated surfaces designed to enhance surface friction.

Citation Guidance: Where hazards are noted, the CSHO should cite the applicable standard (subparts D and J of 29 CFR 1910). If employees are exposed to falling hazards

while performing various tasks including maintenance from elevated surfaces, then determine the applicability of 29 CFR 1910.23(c)(1), (c)(3) and 1910.132(a).

5. Bloodborne Pathogens.

This section describes procedures for conducting inspections and preparing citations for occupational exposure to blood and other potentially infectious materials (OPIM) in LTC Facilities. For further detailed guidance, CSHOs should refer to OSHA Instruction CPL 2-2.69, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*. In addition, outreach and educational materials are available on the Internet.

a. Evaluate the employer's written Exposure Control Plan (ECP).

b. Assess the implementation of appropriate engineering and work practice controls.

i. Determine which procedures require the use of a sharp medical device (e.g., use of a syringe for the administration of insulin) and determine whether the employer has evaluated, selected, and is using sharps with engineered sharps injury protection (SESIPs) and needleless systems.
ii. Confirm that all tasks involving sharps have been evaluated for the implementation of safer devices.
iii. Determine whether the selection of safer devices was based on feedback from non-managerial employees responsible for resident medical care and documented in the plan.
iv. If a safer device is not being used, determine if the use of a safer device would compromise patient safety or the outcome of a medical procedure.
v. Ensure that this information is documented in the employer's ECP.

c. Ensure that proper work practices and personal protective equipment are in place.

d. Assess whether regulated waste disposal is properly handled within the facility.

e. Evaluate and document the availability of hand washing facilities. If immediate access to hand washing facilities is not feasible, ascertain whether skin cleansers are used (e.g., alcohol gels).

f. Assess the use of appropriate personal protective equipment (e.g., masks, eye protection, face shields, gowns and disposable gloves, including latex free gloves, as appropriate).

g. Ensure that a program is in place for immediate and proper clean-up of spills, and disposal of contaminated materials, specifically for spills of blood or other body fluids.

h. Ensure that the employer has chosen an EPA-approved appropriate disinfectant to clean contaminated work surfaces.

i. Determine that the hepatitis B virus (HBV) vaccination series was made available to all employees with occupational exposure to blood and OPIM within 10 working days of initial assignment.

j. Ensure that healthcare workers who have contact with residents or blood and are at ongoing risk for percutaneous injuries are offered an antibody test, in accordance with the U.S. Public Health Service guidelines.

k. Investigate procedures implemented for post-exposure evaluation and follow-up following an exposure incident:

i. Determine if establishment-specific post-exposure protocols are in place (i.e., where and when to report immediately after an exposure incident).
ii. Determine if medical attention is immediately available, including administration of a rapid HIV test, as currently recommended by the U.S. Public Health Service guidelines.
iii. Ensure that information provided to the employer following an exposure incident is limited to those elements defined in paragraph (f)(5) of the standard.

l. Observe whether appropriate warning labels and signs are present.

m. Determine whether employees receive training in accordance with the standard.

n. Evaluate the employer's Sharps Injury Log. (Note: A sample log is available in CPL 2-2.69.)

o. Determine whether the log includes the required fields.

p. Ensure that employee's names are not on the log, but that a case or report number indicates an exposure incident.

q. Determine whether the employer uses the information on the Sharps Injury Log when reviewing and updating its ECP.

Citation Guidance: If an employer is in violation with the Bloodborne Pathogens Standard, the employer will be cited in accordance with CPL 2-2.69.

6. Tuberculosis (TB).

This section provides guidance for conducting inspections and preparing citations for the occupational exposure to Tuberculosis specific to LTC facilities. For further detailed guidance, CSHOs should refer to OSHA Instruction CPL 2.106, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis*.

a. Determine whether the establishment has had a suspected or confirmed TB case within the previous 6 months prior to the date of the opening conference. If not, do not proceed with this section of the inspection. If a case has been documented or suspected, proceed with inspection according to the guidance document, CPL 2.106, referenced above.

b. Determine whether the establishment has procedures in place to promptly isolate and manage the care of a resident with suspected or confirmed TB, including sending the resident to a facility with an isolation room and other abatement procedures.

c. Determine whether the establishment offers tuberculin skin tests for employees responsible for resident care, specifically those described in CPL 2.106, referenced above.

Citation Guidance: The CSHO should refer to CPL 2.106, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis (TB)* for enforcement procedures including citation guidance for:

a. Respiratory Protection 29 CFR 1910.134.
b. Accident prevention signs, 29 CFR 1910.145.
c. Access to employee medical records, 29 CFR 1910.1020.
d. Recordkeeping, 29 CFR 1904.

G Outreach.

The outreach efforts of Education, Training and Technical Assistance (ETTA) and the Consultative Services Bureau (CSB) will be in accordance with the goals set forth in the Division of Occupational Safety and Health Strategic Management Plan, October 1, 2003 - September 30, 2008. Training marketing mailings will be sent to all known employers in SIC 805X and NAICS 623XXX in order to provide outreach materials to all applicable employers.

H. Recording and Tracking.

1. For all unprogrammed inspections conducted in conjunction with a LTC Facilities SEP inspection, the OSHA-1 forms must be marked as "unprogrammed" in "Inspection Type" with the appropriate unprogrammed activity identified (accident, complaint, referral, etc).

2. For programmed inspections, the OSHA-1 forms must be marked as "programmed planned" in Inspection Type with the appropriate activity identified (SST, Health GS list, Safety GS list, etc).

3. Other Codes for the OSHA 1.

a. Mark the "National Emphasis" box with the value "NURSING".
b. Select 'Strategic Plan Activity' and enter the value "LONG TERM CARE FACILITIES".
c. OSHA 1 Optional Information, Item 42 codes, as follows:

Code	Information
S-16	General Duty Ergonomic Citation Issued
S-17	Ergonomic Hazard Alert Letter Issued
N-02-BLOOD	Blood Borne Pathogen Related Inspection
N-02-TB	TB Related Enforcement Inspection
N-03-UED	Upper Extremity Disorders
N-03-BACK	Back Disorders
N-03-ERGO-CIT	Nursing NEP Inspection - 5(a)(1) Ergo. Citation Issued
N-03-ERGO-LTR	Nursing NEP Inspection - Ergo Hazard Alert Letter Issued
N-03-OTHER	Other Ergonomic Disorders

I. Program Evaluation.

BLS data for NAICS 623XXX will be reviewed to determine the effectiveness of the program.

J. Effective Date.

OPN 132 is canceled. This OPN is effective on the date of signature. It will remain in effect until revised or canceled by the Director.

Signed on Original
Roseanne Morgan
Health Compliance Officer
LTC Team Leader

Signed on Original
Allen McNeely
Director

3/13/06
Date of Signature

Appendix A: Release and Consent

I hereby consent and release to the N.C. Department of Labor, Division of Occupational Safety and Health (OSHA), the right to use my picture and sound being videotaped or photographed during an OSHA inspection of _____ (name of facility) commenced on _____(date). I understand that this videotape or photograph will be used solely to document employee safety and health conditions at the facility, and may be used as evidence in legal proceedings related to those conditions.

_____ _____
Signature of Resident Date of Signature

In the event that there has been a medical or legal determination that a resident can not give informed consent to be videotaped or photographed, the following shall be used:

On behalf of _____ (name of resident), I hereby grant to the N.C. Department of Labor, Division of Occupational Safety and Health (OSHA), the right stated above.

_____
Printed name of person authorized to give informed consent on resident's behalf

_____ _____
Signature of Authorized Person Date of Signature

_____ _____
Signature of Witness Date of Signature

Appendix B: Supporting Documents

References:

1. Title 29 Code of Federal Regulations Part 1904.
2. Title 29 Code of Federal Regulations Part 1910.
3. North Carolina Field Operations Manual
4. OSHA Notice 04-02 (CPL 2), Site-Specific Targeting 2002 (SST-02), April 19, 2004 (or most current revision).
5. OPN 124 – most current revision.
6. Occupational Injuries and Illnesses; Recording and Reporting Requirements, published in the *Federal Register* on January 19, 2001 (66 FR 5915) and following years.
7. OSHA Instruction CPL 0-2.131, Recordkeeping Policies and Procedures Manual (RKM), January 1, 2002.
8. OSHA Instruction CPL 2-0.51J, Enforcement and Limitations under the Appropriations Act, May 28, 1998.
9. Bureau of Labor Statistics (BLS), Table 1. Incidence Rates of Nonfatal Occupational Injuries and Illnesses by Industry and Selected Case Types, 2000, and following years.
10. OSHA Instruction CPL 2.106, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, February 9, 1996.
11. OSHA Instruction CPL 2-2.69, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens Standard, 29 CFR 1910.1030, includes revisions mandated by the Needlestick Safety and Prevention Act (November 27, 2001).
12. 45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy, Subpart E - Privacy of Individually Identifiable Health Information, Section 164.512.

Publications:

1. NIOSH, Musculoskeletal Disorders and Workplace Factors, 2nd printing, US DHHS, CDC, NIOSH Pub No. 97-141.
2. Back Injury Prevention Guide in the Health Care Industry for Health Care Providers, Cal OSHA (11/97).
3. NIOSH, Elements of Ergonomic Programs: A Primer based on Workplace Evaluations of Musculoskeletal Disorders, DHHS/NIOSH Pub. No. 97-117
4. Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA publication # 3148.

Web links:

1. http://www.cdc.gov/niosh/homepage.html
2. http://www.cdc.gov/niosh/healthpg.html
3. http://www.cdc.gov/niosh/ergopage.html
4. http://www.dir.ca.gov/dosh/dosh_publications/backinj.pdf
5. http://www.osha.gov/SLTC/ergonomics/ergonomicreports_pub/index.html#80
6. http://www.osha.gov/SLTC/workplaceviolence/guideline.html
7. http://www.osha.gov/SLTC/workplaceviolence/index.html
8. http://www.osha.gov/SLTC/nursinghome/index.html
9. http://www.osha.gov/SLTC/nursinghome_ecat/index.html
10. http://www.osha.gov/SLTC/tuberculosis/index.html