North Carolina Department of Labor
Occupational Safety and Health Division

Raleigh, North Carolina

Field Information System Operational Procedure Notice 132D

Subject: Special Emphasis Program for Long Term Care Facilities.

A. **Purpose and Scope.**

This OPN describes the NCDOL Occupational Safety and Health Division - Special Emphasis Program (SEP) for all inspections of Long Term Care (LTC) Facilities in NAICS 623000 (NAICS 623110 - Nursing Care Facilities; 623210 - Residential Mental Retardation Facilities; 623220 - Residential Mental Health and Substance Abuse Facilities; 623311 - Continuing Care Retirement Communities; 623312 – Homes for the Elderly; and 623990 – Other Residential Care Facilities.)

The SEP has a primary focus on the major hazards prevalent in LTC facilities, specifically, ergonomic stressors relating to resident handling; exposure to blood and other potentially infectious materials; exposure to tuberculosis; slips, trips, and falls; and workplace violence. However, 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. Note that 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.

B. **Special Emphasis Program History.**

In August 1996, USDOL OSHA implemented a seven state nursing home initiative to address hazards in the LTC industry. This federal initiative was terminated on February 10, 1998. All enforcement policies for the initiative were replaced by a National Emphasis Program (NEP) on nursing and personal care facilities and were addressed by CPL 2 (02-03). The NEP ended on September 30, 2003 and nursing homes were returned to the Site Specific Targeting (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 Occupational Safety and Health Division included the SEP for LTC facilities in the Strategic Management Plan for 2004 – 2008 and will continue it for the 2009 – 2013 Strategic Management Plan.

C. **Background.**

Long Term Care facilities had one of the highest injury and illness rates 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 experienced an average LWDII rate of 7.9, despite the availability of feasible controls that 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). In addition, LTC workers had the potential for exposure to blood borne pathogens and tuberculosis.

Between 1998 and 2008, there have been significant reductions in the number of injuries in the LTC industry. However, the industry's rates are still double those of the average employer nationwide. Therefore, LTC remains an SEP in the state's Strategic Management Plan.

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 (bloodborne pathogens; tuberculosis; ergonomics; slips, trips and falls; and workplace violence) and any apparent violations observed during the inspection. The scope of programmed LTC inspections will be comprehensive and will always include these elements.

1. Privacy.

   a. Resident Privacy and Medical Records:

      i. Respect for resident privacy must be a priority during each inspection. Under no circumstances may a Compliance Safety and Health Officer enter resident rooms or other areas where resident privacy could be compromised without the consent of the resident or their next-of-kin or guardian.

ii. In evaluating resident handling or other hazards do **not** review any resident records that include personally identifiable health information, including diagnoses, laboratory test results, etc., provided by the employer without the consent of the resident or their next-of-kin.

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. Employee 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 FOM Chapters III, XIII, and XVI.

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 02-00-135, Recordkeeping Policies and Procedures Manual, CPL 02-02-069 (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.

Ergonomic evaluations, as they relate to risk factors associated with resident handling, shall be conducted in accordance with the FOM instructions in Chapter XVII – Ergonomics Inspection Procedures. Using those guidelines helps to identify case outcomes as early as possible in the inspection process in order to conserve department resources.

Evaluations will begin with a determination of the extent of resident handling, its hazards, and the manner in which the hazards are addressed. Then the CSHO will assess the establishment incidence and severity rates, determine whether the rates are increasing or decreasing over a three-year period, and evaluate whether the establishment has implemented a process to address these conditions in a manner that 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.
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 ergonomic disorders are identified and treated early to prevent the occurrence of more serious problems.
ii. Whether this process includes restricted or accommodated work assignments.

Citation Guidance: 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 refer to the FOM in Chapter XVII – Ergonomics Inspection Procedures and other OSHA reference documents prior to proceeding with citation or hazard alert letter issuance.

4. Slips, Trips, and Falls.

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 that 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 (BBP).

In order to conduct inspections and prepare citations for occupational exposure to blood and other potentially infectious materials (OPIM), CSHOs should refer to OSHA Instruction CPL 02-02-069 (CPL 2-2.69), Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens. In addition, outreach and educational materials for employers are available at www.nclabor.com and www.osha.gov.

6. Tuberculosis (TB).

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 02-00-106 (CPL 2.106), Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis.

7. Workplace Violence.

Through employee interviews and a review of OSHA 300 logs, Compliance Officers conducting inspections in long term care facilities should identify any instances that were the result of workplace violence to employees in these facilities. In accordance with the OSH Workplace Violence Memo dated 10/24/2011, OSHA directive CPL 02-01-052 will be used as guidance for determining the applicability of citing the General Duty Clause and any associated OSH standards for failure to establish a workplace violence prevention program.

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 Occupational Safety and Health Division Strategic Management Plan. Training marketing mailings will be sent to all known employers in NAICS 623XXX (formerly SIC 805X) 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 will be reviewed to determine the effectiveness of the program.

J. **Effective Date.**

OPN 132C 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
J. Edgar Geddie
SEP Team Leader

Signed on Original
Allen McNeely
Director

3/07/2012
Date of Signature

Appendix A: Resident Consent and Release

I hereby consent and release to the N.C. Department of Labor, Division of Occupational Safety and Health (OSH), the right to use my picture and sound being videotaped or photographed during an OSH 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 (OSH), 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: Resources

Title 29 Code of Federal Regulations Part 1904.

Title 29 Code of Federal Regulations Part 1910.

North Carolina Field Operations Manual

OSHA Notice 09-05 (CPL 02), Site-Specific Targeting 2009 (SST-09), July 20, 2009 (or most current revision).

OPN 124 – most current revision.

Occupational Injuries and Illnesses; Recording and Reporting Requirements, published in the Federal Register on January 19, 2001 (66 FR 5915) and following years.

OSHA Instruction CPL 02-00-135, Recordkeeping Policies and Procedures Manual (RKM), December 30, 2005 (or most current revision).

OSHA Instruction CPL 02-00-051, Enforcement and Limitations under the Appropriations Act (most current revision).

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.

OSHA Instruction CPL 02-00-106, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, February 9, 1996.

OSH Field Information System (FIS) Memorandum WPV 1, October 24, 2011. Subject: Workplace Violence Inspections.

OSHA Instruction CPL 02-02-069, 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).

45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy, Subpart E - Privacy of Individually Identifiable Health Information, Section 164.512.

13 NCAC 7A.0900, Access to Employee Medical Records, March 1, 2010.

Publications:

NIOSH, Musculoskeletal Disorders and Workplace Factors, 2nd printing, US DHHS, CDC, NIOSH Pub No. 97-141.

Back Injury Prevention Guide in the Health Care Industry for Health Care Providers, Cal OSHA (11/97).

NIOSH, Elements of Ergonomic Programs: A Primer based on Workplace Evaluations of Musculoskeletal Disorders, DHHS/NIOSH Pub. No. 97-117

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA publication # 3148.

Web links:

NIOSH Home Page
http://www.cdc.gov/niosh/homepage.html

OSHA Nursing Home E-Tool
http://www.osha.gov/SLTC/etools/nursinghome/index.html

OSHA Safety and Health Topics: Nursing Homes and Personal Care Facilities
http://www.osha.gov/SLTC/nursinghome/index.html

OSHA Safety and Health Topics: Tuberculosis
http://www.osha.gov/SLTC/tuberculosis/index.html

OSHA Safety and Health Topics: Workplace Violence
http://www.osha.gov/SLTC/workplaceviolence/index.html

Ergonomic Web links:

NIOSH Publication No. 2006-117: Safe Lifting and Movement of Nursing Home Residents
http://www.cdc.gov/niosh/docs/2006-117/

Best Practices for Nursing Homes
http://www.orosha.org/pdf/ergo/nursingbp.pdf

A Back Injury Prevention Guide for Health Care Providers
http://www.dir.ca.gov/dosh/dosh_publications/backinj.pdf

Safe Patient Handling in Washington State
http://www.washingtonsafepatienthandling.org/

Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in the Acute Care Setting
http://www.aohp.org/About/documents/GSBeyond.pdf

OSHA Safety and Health Topics: Ergonomics
http://www.osha.gov/SLTC/ergonomics/index.html

Guidelines for Nursing Homes, Ergonomics for the Prevention of Musculoskeletal Disorders
http://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html

NIOSH Ergonomics & Musculoskeletal Disorders Page
http://www.cdc.gov/niosh/topics/ergonomics/

VA Resource Guides (the following two links are part of the VA info)
http://www.visn8.med.va.gov/patientsafetycenter/resguide/

Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement (pt 1)
http://www.visn8.med.va.gov/patientsafetycenter/resguide/ErgoGuidePtOne.pdf

Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement (pt 2)
http://www.visn8.med.va.gov/patientsafetycenter/resguide/ErgoGuidePtTwo.pdf