U.S. Department of Labor

Assistant Secretary for
Occupational Safety and Health
Washington, D.C. 20210

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MEMORANDUM FOR: REGIONAL ADMINISTRATORS
STATE DESIGNEES

FROM: DOROTHY DOUGHERTY
Deputy Assistant Secretary

SUBJECT: Inspection Guidance for Inpatient Healthcare Settings

This memorandum establishes guidance for inspections conducted in inpatient healthcare settings, North American Industry Classification System (NAICS) Major Groups 622 (hospitals) and 623 (nursing and residential care facilities). All such inspections, programmed and unprogrammed, will cover the focus hazards included in the recently-concluded National Emphasis Program - Nursing and Residential Care Facilities, CPL 03-00-016 (NH-NEP):

- Musculoskeletal disorders (MSDs) relating to patient or resident handling,
- Workplace violence (WPV),
- Bloodborne pathogens (BBP),
- Tuberculosis (TB), and
- Slips, trips and falls (STFs).

These focus hazards will be addressed in addition to other hazards that may be the subject of the inspection or brought to the attention of the compliance officer during the inspection. The goal of this policy is to significantly reduce overexposures to these hazards through a combination of enforcement, compliance assistance, and outreach.

Background: The U.S. Department of Labor's Bureau of Labor Statistics (BLS) and OSHA's inspection history with the NH NEP have shown that inpatient healthcare settings consistently have exposures to the safety and health hazards noted above.

For example, with regard to MSDs, between April 5, 2012 and April 5, 2015, OSHA conducted 1,100 inspections of nursing and residential care facilities under the NH-NEP. Ergonomic stressors were evaluated in 596 of these inspections, which generated 192 ergonomic hazard alert letters (EHALs) to employers and 11 citations of OSHA's general duty clause for hazardous ergonomic conditions. Additional information on the incidence of MSDs and the other focus hazards is provided in Attachment 1.

Scope: This guidance applies to all Federal OSHA inspections, programmed and unprogrammed, conducted in NAICS Major Groups 622XXX (hospitals) and 623XXX (nursing and residential care facilities).

Regions may determine that a Regional or Local Emphasis Program is justified after reviewing relevant data (e.g. , review of the number of sites in the region) and as considerations of other resources demands. The guidance in this memorandum should be included in any Regional or Local Emphasis Programs developed to inspect facilities in the aforementioned NAICS.

State Plan Impact: Because these hazards are nationwide, State Plans are expected to follow the guidance provided in this memorandum. State Plans may have an existing State Emphasis Program (SEP), or, similar to OSHA's Regions, determine that an SEP is warranted after reviewing relevant state data. State Plans must code inspections conducted in accordance with this guidance as noted below ("OSHA Information System").

Other Hazards: In addition to the focus hazards listed above, and hazards that may be the subject of the programmed or unprogrammed inspection, other hazards that may be encountered in inpatient healthcare settings include, but are not limited to:

- Exposure to multi-drug resistant organisms (MDROs), such as Methicillin-resistant Staphylococcus aureus (MRSA).
- Exposures to hazardous chemicals, such as sanitizers, disinfectants, anesthetic gases, and hazardous drugs.

As detailed in the FOM (OSHA Instruction CPL 02-00-159), when such additional hazards come to the attention of the compliance officer, the scope of the inspection may be expanded to include those hazards.

Inspection Procedures: Inspections shall follow the guidance in the FOM, directives, or State Plan equivalent policies relevant to the focus hazards and other hazards encountered, with the addition of the specific guidance provided in Attachment 2. Sample Alleged Violation Descriptions (AVDs) for MSD and MRSA exposures may be found in Attachment 3.

Recordkeeping issues must be handled in accordance with OSHA Instructions, CPL 02-00-135, Recordkeeping Policies and Procedures Manual, and CPL 02-02-069, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, other relevant field guidance, or State Plan equivalent policies. A partial walkthrough shall be conducted and workers shall be interviewed in order to verify injury and illness records. Compliance officers shall follow current OSHA procedures regarding privacy of patient and resident medical records.

CSHOs are encouraged to contact the Directorate of Technical Support and Emergency Management's Office of Occupational Medicine and Nursing (OOMN) to obtain a Medical Access Order, if necessary, early in the inspection process. OSHA Directive CPL 02-02-072, Rules of Agency practice and Procedure Concerning OSHA Access to Employee Medical Records provides guidance when there is a need to gain access to such personally identifiable employee medical information

Outreach, Compliance Assistance, and Training: The National Office has developed additional information, such as compliance assistance tools to support outreach, and training of compliance safety and health officers (CSHOs) and compliance assistance specialists (CAS), to address technical issues related to the focused hazards, including ergonomics and evaluation of MSD recordkeeping procedures. In 2014, OSHA published a new educational web resource with extensive materials to help hospitals prevent worker injuries, assess workplace safety needs, enhance safe patient handling programs and implement comprehensive safety and health management systems. This new resource contains a suite of guidance products, including fact sheets, self-assessments, and industry-recognized best practices, and is available at http://www.osha.gov/dsg/hospitals/. OSHA conducted additional outreach efforts in 2014 by sending out thousands of letters, with enclosed fact sheets, to hospitals across the country, which provided tools to assist them in their efforts to reduce worker exposure to hazards that are prevalent within this industry.

Furthermore, OSHA has well-established webpages, such as Safety and Health Topics webpages for Nursing Homes and Personal Care Facilities (http://www.osha.gov/SLTC/nursinghome/index.html) and Healthcare (http://www.osha.gov/SLTC/healthcarefacilities/index.html). The Agency published the brochure, Safe Patient Handling: Preventing Musculoskeletal Disorders in Nursing Homes (https://www.osha.gov/Publications/OSHA3708.pdf*), in 2014. These and additional references may be found in Attachment 4.

OSHA Information System: For all inspections meeting the definitions of this guidance (for NAICS Codes 622 and 623), code in OIS "N-03-Nursing-Hosp" for either Federal or State Plan enforcement activity. Coding for ergonomic enforcement activity must also be consistent with existing field guidance for OIS coding.

This policy is effective as of the date of this memorandum. This memorandum also cancels OSHA Memorandum, Expiration of the Nursing Home NEP, Effective April 5, 2015, dated April 2, 2015, and it cancels OSHA Instruction, CPL 03-00-016. If you have questions, please contact Dionne Williams at (202) 693-2140 or williams.dionne@dol.gov.

Attachments

cc: Directorate of Cooperative and State Programs

Attachments were edited on 08/18/15 with minor corrections and updated references

Attachment 1

Background on Focus Hazards in Inpatient Healthcare Settings

General. Inpatient healthcare settings have some of the highest rates of injury and illness among industries for which nationwide injury and illness rates were calculated for Calendar Year 2013 (CY 2013). In 2013, U.S. hospitals recorded 244,800 work-related injuries and illnesses, a total case rate of 6.4 work-related injuries and illnesses for every 100 full-time employees, almost twice as high as the rate for private industry as a whole (3.3 per 100 full-time employees for all U.S. industries). Additionally, of these recorded cases in hospitals, 57,680 cases resulted in lost workdays. [12, BLS].

Nursing homes and personal care facilities continue to have one of the highest rates of injury and illness among industries for which lost workday injury and illness (LWDII) rates are calculated. According to data from the BLS, in 2013 one in five reported nonfatal occupational injuries occurred among workers in the health care and social assistance industry, the highest number of such injuries reported for all private industries. [16, CDC]. BLS reported the national average days away, restricted work activity and job transfer (DART) rate for private industry for CY 2013 was 1.7 per 100 full-time employees. Hospitals, nursing and residential care facilities, i.e. , employers within NAICS 622 and 623, experienced average DART rates of 2.6 and 4.5, respectively, despite the availability of feasible controls to address the hazards that account for these high rates. This compares to a DART of 2.2 for construction workers in the private sector. General medical and surgical hospitals (NAICS codes 6221), Psychiatric and substance abuse hospitals (6222); and Specialty, except psychiatric and substance abuse facilities (6223) experienced average DART rates of 2.5, 3.8, 3.1, respectively, and nursing and residential care facilities (NAICS 6231, 6232, 6233, and 6239) had rates of 5.0, 3.7, 4.3, and 3.4, respectively. [12, BLS].

The three-year CPL 03-00-016, National Emphasis Program - Nursing and Residential Care Facilities, (NAICS 623110, 623210, 623311) (NH-NEP), completed in April 2015, addressed the same primary hazards of MSDs, WPV, BBP, TB and STFs. [6, OSHA]. As of April 5, 2015, both a qualitative and quantitative review of the data yielded from those inspections conducted, indicated the need for the Agency to continue its efforts to materially reduce or eliminate worker exposure to these focus hazards in residential care facilities.

Between April 5, 2012, and April 5, 2015, OSHA conducted 1,100 inspections (approximately 75% of which were programmed) of nursing and residential care facilities under the previous NH-NEP. Ergonomic stressors were evaluated in 596 of these inspections, which generated 192 ergonomic hazard alert letters (EHALs) to employers, and 11 citations of OSHA's general duty clause for hazardous ergonomic conditions.

According to the Centers for Disease Control and Prevention (CDC), as published in the Morbidity and Mortality Weekly Report (MMWR) Vol.64/No.15, the National Institute for Occupational Safety and Health (NIOSH), with collaborating partners, created the Occupational Health Safety Network (OHSN) to collect detailed injury data to help target prevention efforts. Their data covered 112 U.S. facilities, which reported 10,680 OSHA-recordable injuries from January 1, 2012-September 30, 2014: patient handling and movement (4,674 injuries); slips, trips, and falls (3,972 injuries); and workplace violence (2,034 injuries). Overall incidence rates of OSHA-recordable injuries (average worker-months = 125,041) per 10,000 worker-months for patient handling, slips, trips and falls, and workplace violence were 11.3, 9.6, and 4.9, respectively. [16, CDC].

MSDs and Overexertion. BLS data for CY 2013 demonstrates that almost half (44 percent) of all reported injuries within the healthcare industry (NAICS 622 and 623) were attributed to overexertion-related incidents. In comparison, that rate equates to almost one and a half times the total MSD rate (33 percent) for all reported injuries for all industries. [13, BLS] [14, BLS]. Nurses and nursing assistants each accounted for a substantial share of this total. In 2013, orderlies, nursing assistants, and personal care aides continued to have some of the highest MSD rates of all occupations. MSD cases accounted for 53 percent of total reported cases that occurred to nursing assistants in 2013. Additional BLS data for CY 2013 provided further evidence of the prevalence of MSD rates for private industry nursing assistants (202.4), which were almost six times higher than the average MSD rates reported for all private industry workers (33.5). [15, BLS]

Workplace Violence (WPV). NIOSH defines WPV as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. [20, NIOSH]. WPV is a recognized hazard in hospitals and nursing and residential care facilities. Violence accounted for 4 percent of the cases in the private sector in 2013, with a rate of 4.2 cases per 10,000 full-time workers. In the health care and social assistance sector, 13 percent of the injuries and illnesses were the result of violence, and the rate increased for the second year in a row to 16.2 cases per 10,000 full-time workers, up from 15.1 in 2012. Fifteen percent of the days-away-from-work cases for nursing assistants were the result of violence. Less than 10 percent of the overall private sector days-away-from-work cases were the result of violence. [10, OSHA]. In 2013, BLS data reported that days-away-from-work cases were caused by approximately 14,440 assaults by persons in hospitals and nursing and residential care facilities. Hospitals reported approximately 5,660 assaults and nursing and residential care facilities reported approximately 8,780 assaults. [14, BLS]. OSHA Instruction CPL 02-01-052, Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents, provides inspection guidance for unprogrammed and programmed inspections at worksites that are in industries with high incidences of workplace violence, such as healthcare facilities. Other sectors in the healthcare industry have WPV concerns as well. For general information on WPV in healthcare and social services, see OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, located at: www.osha.gov/Publications/osha3148.pdf*.

Bloodborne Pathogens (BBP) and Tuberculosis (TB). OSHA enforcement data from the OIS indicate that one of the most frequently cited standards in nursing and residential care facilities is 29 CFR 1910.1030, the Bloodborne Pathogens Standard. Additionally, employees working in nursing and residential care facilities have been identified by the CDC as being among the occupational groups with the highest risk for exposure to TB due to the case rate of disease among persons 65 years of age. In CY 2013, for example, the CDC reported an overall TB case rate of 3.0 per 100,000 persons across all age groups. The corresponding case rate for persons 65 years of age was 4.9 per 100,000 in CY 2013. [17, CDC].

Slips, Trips, and Falls (STFs). Injuries from STFs were also among the nonfatal occupational injury and illness cases reported in nursing and residential care facilities. Taken together, overexertion together with slips, trips, and falls accounted for 68.6% of all reported cases with days away from work within NAICS 622 and 623 for CY 2013 [14, BLS].

Other Hazards. Hazards other than those selected for focus in this initiative are likely to exist in inpatient healthcare settings. For example, a commonly recognized hazard in these settings is exposure to multi-drug resistant organisms (MDROs), such as methicillin-resistant Staphylococcus aureus (MRSA). The CDC has identified healthcare settings, such as hospitals and nursing care facilities, among those at increased risk for colonization with MRSA, and recommends that employers institute standard precautions and contact precautions to protect workers who must provide care and services to residents or patients colonized with MRSA or other MDROs.

Employee exposures to hazardous chemicals, such as sanitizers, disinfectants, anesthetic gases, and hazardous drugs (e.g. , antineoplastic drugs), are also among the other hazards that are commonly encountered in inpatient healthcare facilities. A recent article in the American Journal of Infection Control notes that, in addition to environmental service workers, many other healthcare workers routinely use cleaning and disinfecting products. These chemicals are both irritants and sensitizers, causing a variety of adverse health effects, including eye irritation, irritant and allergic contact dermatitis, upper and lower respiratory symptoms, work-related asthma and chronic bronchitis. Note: Some cleaning and disinfecting chemicals are known to be mutagens, carcinogens and reproductive toxins. The article reviews knowledge gaps and research priorities and calls for a more integrated approach to both occupational illness prevention and infection control. [Quinn 21].

Attachment 2

Inspection Procedures for Focus Hazards and Other Hazards in Inpatient Healthcare Settings

1. **Ergonomics: MSD Risk Factors Relating to Patient/Resident Handling.**

   This section provides guidance for conducting inspections in workplaces in NAICS Codes 622 and 623 as they relate to risk factors for musculoskeletal disorders (MSDs) associated with patient/resident handling. These inspections shall be conducted in accordance with the FOM, and other relevant OSHA reference documents.

   A. **Establishment Evaluation.** Inspections of MSD risk factors will begin with an initial determination of the extent of patient/resident handling hazards and the manner in which they are or are not addressed. This will be accomplished by an assessment of establishment incidence and severity rates and whether the establishment has implemented a process to address these hazards in an effective manner.

      CSHOs should ask for the maximum census of patients/residents permitted and the current census during the inspection. Additionally, CSHOs should inquire about the degree of ambulation of the patients/residents, as this information may provide some indication of the level of assistance given to patients/residents or the degree of hazards that may be present.

      Note: If there is indication from injury records, or from employer or employee interviews that other sources of ergonomics-related injuries exist (e.g. , MSDs related to office work, laundry, kitchen, or maintenance duties), the compliance officer must include the identified work area and affected employees in the assessment.

   B. **Program Evaluation.** Compliance officers should evaluate program elements, such as the following:
      1. **Program Management**.
         - Is there a system for hazard identification and analysis?
         - Is there a system for development of strategies to address identified hazards?
         - Who has the responsibility and authority for administering this system?
         - What are the credentials or experience of the individual responsible for administering the program?
         - What input have employees provided in the development of the establishment's lifting, transferring, or repositioning procedures?

- Is there a system for monitoring compliance with the establishment's policies and procedures and following up on deficiencies?
- Are there records of recent changes in policies/procedures and an evaluation of the effect they have had (positive or negative) on resident handling injuries and illnesses?

2. **Program Implementation**.
   - How is patient/resident mobility determined and how is the mobility determination communicated to staff?
   - What is the decision logic for selection and use of lift, transfer, or repositioning devices?
   - When and under what circumstances may manual lift, transfer, or repositioning occur?
   - Who decides how to lift, transfer, or reposition patients/residents?
   - Is there is an adequate quantity and variety of appropriate lift, transfer, or reposition assistive devices available and operational? Note that no single lift assist device is appropriate in all circumstances. Manual pump or crank devices may create additional hazards.
   - Are there adequate numbers of supplies such as: slings, batteries, and charging stations for lifting devices? (Note: There should be a minimum of 1 sling per resident that needs the device and some extras to account for laundering and repair. There should be adequate numbers of batteries to accomplish all necessary lifts during a shift). There should be appropriate types and sizes of slings specific for all patients/residents.
   - Are there appropriate quantities and types of the assistive devices (such as, but not limited to slip sheets, mechanical lifts, sit-to-stand assists, walk assists, or air-hover transfer pads) available within close proximity and maintained in a usable and sanitary condition?
   - Are their policies and procedures appropriate to eliminate or reduce exposure to the manual lifting, transferring, or repositioning hazards at the establishment?
3. **Employee Training.**
   - Have employees (nursing and therapy) been trained in the recognition of ergonomic hazards associated with manual patient/resident lifting, transferring, or repositioning, the early reporting of injuries, and the establishment's process for abating those hazards?
   - Have the employees (nursing and therapy) been trained in proper techniques and procedures to avoid exposure to ergonomic risk factors and can they demonstrate competency in performing the lift, transfer, or repositioning task using the assistive device?

C. **Occupational Health Management.**

Is there a recognized process to ensure that work-related disorders are identified and treated early to prevent the development of more serious problems and 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 about the need to continue the ergonomic portion of the inspection. Where there is a need to address these issues, the AO will follow OSHA reference documents in determining whether to send an Ergonomic Hazard Alert Letter (EHAL), other communication, or issue citations. In all cases, the AO will notify the Regional Ergonomic Coordinator (REC) of the result of the inspection.

OSHA will contact all employers who receive an ergonomic hazard alert letter to determine whether the deficiencies identified in the letter have been addressed. Please refer to CPL 02-00-144, Ergonomic Hazard Alert Letter Follow-up Policy, for the process for contacting employers who received an ergonomic hazard alert letter. During this contact, OSHA may again provide information on available consultation and compliance assistance. In appropriate cases, OSHA will consider conducting another compliance inspection.

Some states (e.g. , California, Alaska, Minnesota, Washington, and Oregon) have existing regulations or codes that can be applied to ergonomics-related injuries. In these cases, State or local regulations may support the 5(a)(1) element of industry recognition.

D. **Citation Guidance.**

Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. When conditions indicate that a General Duty Clause citation relating to patient/resident handling may be warranted, the Area Office will contact the REC and collaborate with the Regional Solicitor (RSOL) on the case prior to issuing a citation. Attachment 3 is provided only as an example of the language that may be used in an Alleged Violation Description (AVD) for patient/resident handling-related incidents.

2. **Workplace Violence.**

OSHA Instruction CPL 02-01-052, Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents, establishes agency enforcement policies and provides uniform procedures which apply when conducting inspections in response to incidents of workplace violence. This Instruction directs CSHOs, who conduct programmed inspections at worksites that are in industries with high incidence of workplace violence, such as health and residential care facilities, to investigate for the potential or existence of this hazard.

3. **Tuberculosis (TB).**

For further detailed guidance, CSHOs should refer to OSHA Instruction CPL 02-02-078, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis.

NOTE: CSHOs shall note the employer's compliance with current CDC Guidelines: Centers for Disease Control and Prevention (CDC), Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, MMWR December 30, 2005/ Vol. 54/ No. RR-17.*

4. **Bloodborne Pathogens.**

CSHOs should refer to OSHA Instruction CPL 02-02-069, Enforcement Procedures for Occupational Exposure to Bloodborne Pathogens.

5. **Slip, Trips, and Falls.**

If employees are exposed to hazards from falling while performing various tasks including maintenance from elevated surfaces, then OSHA Instruction STD 01-01-013, Fall Protection in General Industry, should be reviewed to determine the applicability of 29 CFR 1910.23(c)(1), 1910.23(c)(3) and 1910.132(a).

6. **Other Hazards.**

As detailed in the FOM, CPL 02-00-150,* when additional hazards come to the attention of the compliance officer, the scope of the inspection may be expanded to include those hazards. Although they are not included in the focus hazards for inspections conducted in inpatient healthcare settings in NAICS Codes 622 and 623, unprotected occupational exposures to multi-drug resistant organisms, or exposure to hazardous chemicals (i.e. , hazard communication) should be investigated if these or other hazards come to the attention of the compliance officer during the course of an inspection.

A. Methicillin-resistant Staphylococcus aureus (MRSA) and other multi-drug resistant organisms (MDROs).

Compliance officers are expected to investigate situations where it is determined during inspections conducted in such workplaces that employees are not protected from potential transmission of MDROs, such as MRSA.

Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. Recommendations for standard precautions and contact precautions to reduce or eliminate exposure to MRSA and other MDROs are outlined in CDC guidelines, including the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. [18, CDC] Attachment 3 contains information that is provided only as an example of language that may be used in an Alleged Violation Description (AVD) for unprotected occupational exposure to MRSA specific to nursing and residential care facilities.

NOTE: Violations of applicable OSHA standards (e.g. , PPE standards) must be documented in accordance with the FOM. In General Duty Clause citations the recognized hazard must be described in terms of the danger to which employees are exposed, e.g., the danger of being infected by MRSA, not the lack of a particular abatement method. Feasible abatement methods that are available and likely to correct the hazard must be identified.

B. Hazard Communication.

Employee exposures to hazardous chemicals, such as sanitizers, disinfectants, and hazardous drugs may be encountered in inpatient healthcare settings in NAICS Codes 622 and 623. Employers are required to implement a written program that meets the requirements of the Hazard Communication standard (HCS) to provide worker training, warning labels and access to Safety Data Sheets or SDSs (which replaced Material safety data sheets (MSDSs) under the HCS revised in 2012).

NOTE: Inspection and citation guidance are contained in OSHA Instruction, CPL 02-02-079, Inspection Procedures for the Hazard Communication Standard (HCS 2012).

Attachment 3

Sample AVDs

1. Sample 5(a)(1) AVD for Patient/Resident Handling Hazards:

NOTE: Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. The following is provided ONLY as an example of the language that may be used in an Alleged Violation Description (AVD) for resident handling-related incidents.

The General Duty Clause.

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause serious physical harm to employees, in that employees were required to perform lifting tasks resulting in stressors that have caused or were likely to cause musculoskeletal disorders (MSDs):
a). Location - Address:
On or about Date employees were exposed to _____ hazards which were causing or likely to cause _____ . Employees were required to transfer non-weight bearing and partial weight bearing residents manually by lifting or partially lifting them, exposing employees to lifting-related hazards resulting in injuries and disorders such as lumbar or back strain/sprain/pain, herniated/ruptured disk, injury to the L5/S1 disc, and various shoulder injuries.

Abatement.

Feasible means of abatement include but are not limited to implementing a safe patient handling and movement policy for transferring and lifting of non-weight bearing and partial weight bearing residents. This necessitates the use of mechanical lift assist and transfer devices. Note: AVD must be adapted to the specific circumstances noted in each inspection. The AVD above is an example that will be appropriate in some circumstances.

2. Sample 5(a)(1) AVD for MRSA Exposure:

NOTE: Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. The following is provided ONLY as an example of the language that may be used in an Alleged Violation Description (AVD) for unprotected MRSA exposure.
General duty clause, Section 5(a)(1) - refer to the CDC guidelines: Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, which recommends standard precautions and contact precautions to reduce or eliminate exposure to MRSA. Abatement would include handwashing, cohorting of patients/residents, device and laundry handling.

The General Duty Clause.

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to communicable diseases:

a). Location - Address:
On or about Date employees were exposed to drug-resistant infections while providing care to residents with infections such as, but not limited to, Methicillin-Resistant Staphylococcus aureus (MRSA).

Abatement.

Feasible means of abatement include, but are not limited to: a) providing training on all routes of transmission of infections, the proper personal protective equipment to be used, and infection control practices to be utilized; b) notifying employees about status of any resident with infection prior to beginning care assignments for every shift; c) cohorting patients/residents; and d) using administrative controls, such as limiting access to patients/residents with MRSA infections by non-essential personnel.

Attachment 4

References

1. OSHA's Healthcare Safety and Health Topics webpage: http://www.osha.gov/SLTC/healthcarefacilities/index.html.
2. OSHA Worker Safety in Hospitals webpage: http://www.osha.gov/dsg/hospitals/index.html.
3. OSHA Nursing Homes and Personal Care Facilities Safety and Health Topics webpage: http://www.osha.gov/SLTC/nursinghome/index.html.
4. OSHA Nursing Home eTool: http://www.osha.gov/SLTC/etools/nursinghome/index.html.
5. OSHA Hospital eTool: http://www.osha.gov/SLTC/etools/hospital/index.html.
6. OSHA Instruction CPL 03-00-016*, National Emphasis Program - Nursing and Residential Care Facilities, (NAICS 623110, 623210, 623311), April 5, 2012.
7. OSHA Instruction CPL 02-01-052, Enforcement Procedures for Investigating Workplace Violence Incidents, September 8, 2011.
8. OSHA Instruction CPL 02-02-069, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, November 27, 2001.
9. OSHA Instruction CPL 02-00-144, Ergonomic Hazard Alert Letter Follow-up Policy, April 11, 2007.
10. OSHA Publication OSHA 3148-04R 2015*, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, 2015
11. 79 Federal Register 56129-56188, Occupational Injury and Illness Recording and Reporting Requirements--NAICS Update and Reporting Revisions; Final Rule, September 18, 2014.
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18. Centers for Disease Control and Prevention, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf * .
19. Centers for Disease Control and Prevention, Slip, Trip, and Fall Prevention for Health Care Workers, DHHS (NIOSH) Publication Number 2011–123, http://www.cdc.gov/niosh/docs/2011-123/pdfs/2011-123.pdf*.
20. NIOSH 2002, Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. Violence: Occupational Hazards in Hospitals, DHHS (NIOSH) Publication No. 2002-101, (2002). http://www.cdc.gov/niosh/docs/2002-101/. June 17, 2015.
21. Quinn MM, Henneberger PK et al. Cleaning and disinfecting environmental surfaces in health care: Toward an integrated framework for infection and occupational illness prevention. American Journal of Infection Control, 2015; 43:424-434. http://www.sciencedirect.com/science/article/pii/S0196655315000759.

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