

**OREGON OCCUPATIONAL SAFETY AND HEALTH DIVISION  
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**

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**PROGRAM DIRECTIVE**

Program Directive: A-284  
Issued: December 15, 2011  
Revised: November 27, 2017

**SUBJECT:** Local Emphasis Program (LEP): Hospitals and nursing and residential care facilities

**AFFECTED  
STANDARDS/  
DIRECTIVES:**

OAR 437 Division 1, General Administrative Rules

[Oregon OSHA Program Directive A-215: Tuberculosis: Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis](#)

[Oregon OSHA Program Directive A-267: Safety of Health Care Employees](#)

[Oregon OSHA Program Directive A-283: Workplace Violence Incidents – Enforcement Procedures for Investigating or Inspecting](#)

**PURPOSE:** This instruction describes policies and procedures for enforcement efforts to reduce occupational illness and injury in hospitals and nursing and residential care facilities in NAICS 622 Hospitals, 6231 Nursing Care Facilities, 6232 Residential Mental Retardation, Mental Health and Substance Abuse Facilities, 6233 Community Care Facilities for the Elderly, and 6239 Other Residential Care Facilities that are on the A or B tier of the Safety and Health scheduling lists.

**EXPIRATION:** This directive is effective immediately and will remain in effect until canceled or superseded.

**BACKGROUND:** Hospitals and nursing and residential care facilities continue to have one of the highest rates of injury and illness among industries for which nationwide days away, restricted work activity and job transfer (DART) injury, and illness rates were calculated for Calendar Year 2013. According to data from the Bureau of Labor Statistic (BLS), the national average DART rate for private industry for CY 2013 was 1.7 and 2.2 in Oregon. Hospitals and nursing and residential care facilities (employers within NAICS 622, 6231, 6232 and 6233) experienced average DART

rates of 6.4, 5.0, 3.7, and 4.3, respectively, despite the availability of feasible controls, which have been identified to address hazards within this industry. *Note: BLS data for NAICS 6233 contains data for establishments that fall within NAICS 623311, and for NAICS 623312 (i.e., assisted-living facilities without onsite nursing care facilities). Data separating the two sectors is currently unavailable.*

The rate in Oregon for NAICS 623 is 4.1 and for NAICS 622 is 3.8, based on the Oregon Occupational Injury and Illness Survey Table and Appendices, Calendar year 2013, published December 2014. The total recordable case incident rate was 7.2 and 7.5 for NAICS 623 and 622 respectively. Data specific to 6231, 6232, and 6233 for Oregon is unpublished.

The hazards prevalent in hospitals and nursing and residential care facilities that are the cause of the majority of these injuries are ergonomics related risk factors associated with resident handling (excessive exertion, working in awkward postures, and repetitive work tasks); exposure to infectious disease, including blood and other potentially infectious materials (OPIM) covered under the Bloodborne Pathogens rule, tuberculosis, and methicillin-resistant staphylococcus aureus; and slips, trips, and falls. Calendar Year (CY) 2013 national data from BLS indicate that overexertion and injuries from slips, trips, and falls account for a high percentage of total nonfatal occupational injury and illness cases reported in nursing and residential care facilities.

As an example, together these account for 72.3% of all reported cases within NAICS 6231 for CY 2013 (40.7% from overexertion and 25.6% from slips, trips, and falls). In Oregon, overexertion and repetitive motion injuries account for 57% with slips, trips, and falls accounting for 17.2% for a total of 74.2% of the cases in NAICS 623. For NAICS 622 overexertion and repetitive motion injuries account for 64.3% , slips, trips and falls account for 14.4% for a total of 78.7% of the cases.

Oregon OSHA enforcement data indicates that the most frequently cited standards in hospitals are 1910.1030 Bloodborne Pathogens, 1910.1001 asbestos, 1910.1048 Formaldehyde, 1910.134 (OAR 002-0134) PPE including respirators and OAR 001-0765 Safety Committees. For nursing and residential care facilities they are [OAR 437-001-0765 Safety Committees and Safety Meetings](#), [1910.303-305 Electrical](#), [OAR 437-002-0134 Personal Protective Equipment](#), [1910.134 Respiratory Protection](#), [1910.1200 Hazard Communication](#) and [1910.1030 Bloodborne Pathogens](#).

Additionally, employees working in nursing and residential care facilities have been identified by the Centers for Disease Control and Prevention

(CDC) as being among the occupational groups with the highest risk for exposure to Tuberculosis (TB) due to the case rate of disease among persons  $\geq 65$  years of age. In CY 2013, for example, the CDC reported an overall TB case rate of 3.0 per 100,000 people across all age groups. The corresponding case rate for persons  $\geq 65$  years of age was 4.9 per 100,000 in 2013. The overall rate for Oregon was 1.9 per 100,000 in 2013 with 27.4% of the cases in those  $\geq 65$ . [1, CDC]

Workplace violence is another recognized hazard in hospitals and nursing and residential care facilities. In 2013, there were 51 accepted disabling claims related to assaults by person in NAICS 622 and 97 assaults for workers in nursing and residential care facilities in NAICS 623.

In 2008, there was a requirement to report all assaults in hospitals, ambulatory surgical centers, and hospital operated home health care services to Oregon OSHA. In almost all cases, the 1061 assaults recorded were from patient assaults. [Legislative report on collected data from 2008](#). While this data is specific to hospitals, outpatient surgical centers and homecare, and does not include nursing homes, it is indicative of the type of assaults expected in nursing and residential care facilities. NIOSH has found that there is a 72% reduction in assaults in a safe patient handling environment in long-term care. <http://www.cdc.gov/niosh/docs/2006-117/pdfs/2006-117.pdf>

**PROCEDURES:** See Appendix C for inspection questions

**A. Privacy**

1. Inpatient/Resident privacy.
  - a. Respect for patient/residents' privacy must be a priority during any inspection.
  - b. In evaluating patient/resident handling or other hazards (BBP, tuberculosis) DO NOT review any resident records that include personally identifiable health information, including diagnoses, laboratory test results, etc., provided by the employer.
  - c. Evaluations of workplace health and safety issues may involve assessment of patient/resident handling. Patient/resident handling activities may take place in patient or resident rooms, restrooms, shower and bathing areas or other areas where the privacy of patients or residents could be compromised. This might also occur during diagnostic imaging, emergency room activities, perioperative services, rehab and other treatment areas. Documenting handling activities by videotaping or photography requires informed written consent. Family members or guardians

may give consent for those who are incapable of giving informed consent (Appendix A).

2. Employee Medical Records.

- a. If employee medical records are needed that are not specifically required by an Oregon OSHA standard (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 according to requirements in 1910.1020 *Access to Employee Exposure and Medical Records*. Refer to [PD A-266, Oregon OSHA Access to Employee Medical Records](#) for information and guidance.
- b. Health and Human Services' Standards for Privacy of Individually Identifiable Health Information 45 CFR 164.512 (b)(1)(i), provides that protected health information may be disclosed to a public health authority that has the authority to collect such information to prevent or control disease and injury, or to be used in public health investigations (Oregon OSHA inspection activities to determine compliance with safety and health regulations).

3. Recordkeeping. Recordkeeping issues must be handled in accordance with OAR 437-001-0700 and Oregon OSHA [PD A-249, Recordkeeping Policies and Procedures Manual](#), [PD A-154, Bloodborne Pathogens](#), and [PD A-267, Safety of Health Care Employees](#) or other relevant field guidance.

**B. Risk Factors Relating to Resident Handling**

This section provides guidance for conducting inspections as it relates to ergonomic risk factors associated with resident handling.

1. 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 (such as a safe resident handling program) to address these hazards in an effective manner. Ask the employer and employees to describe the type and frequency of manual handling tasks that are performed. Inquire specifically about locations such as diagnostic imaging, emergency rooms, recovery room for example. This information will help determine if direct-care staff is being exposed to the hazard of manually handling patients/residents.

*Note: If there is indication from injury records or employer or employee interviews that other sources of musculoskeletal injuries exist (MSDs related to office work, laundry, kitchen, or maintenance duties), the compliance officer should include the identified work area and affected employees in the assessment. When assessing an employer's efforts to address these hazards, the compliance officer should evaluate program elements, such as the following:*

a. Program Management

- Is there a system for hazard identification and analysis? Who has the responsibility and authority for compliance with this system?
- Are there written procedures for lifting, transferring, and repositioning patients or residents using assistive equipment?
- Have employees provided input in the development of the establishment's safe lifting, transferring, or repositioning procedures.
- Is there a system for monitoring compliance with the establishment's policies and procedures and following up on deficiencies?
- Have there been recent changes in policies/procedures and if so what effect those changes have had (positive or negative) on injuries and illnesses?

b. Program Implementation.

- How is patient/resident mobility determined?
- What is the decision logic for using lift, transfer, or repositioning devices, and how often and under what circumstances does manual lifting, transferring, or repositioning occur?
- Who decides how to lift, transfer, or reposition patients or residents and how is that communicated?
- What is the decision logic for selecting and purchasing lift, transfer or repositioning devices, including the extent of employee involvement in the selection process?
- Are there adequate engineering controls in place (lift, transfer, or repositioning devices)?
- Is there an adequate quantity and variety of appropriate lifting, transferring, or repositioning assistive devices available and operational? A single lift assist device is not appropriate in all circumstances. Manual pump or crank devices may create additional hazards.
- Are there adequate numbers of slings, a variety of appropriate slings and in a variety of sizes specific for the assistive devices (such as but not limited to slip sheets, transfer devices,

repositioning devices) available within close proximity and maintained in a sanitary condition?

- Is there a preventative maintenance and inspection schedule for the lift, transfer and repositioning devices (including wheels, slings, boom, and hooks)?
- Are the policies and procedures appropriate to eliminate or reduce exposure to the manual lifting, transferring, or repositioning hazards at the establishment?

c. Employee Training.

- Are employees providing bedside care (nursing and therapy) trained in the recognition of hazards associated with manual patient or resident lifting and handling tasks, including, transferring, or repositioning, early reporting of injuries, and the establishment's process for abating those hazards? Are other employees adequately trained such as transporters, lift teams, and imaging staff?
- Are the employees providing bedside care (nursing and therapy) able to demonstrate competency in performing the lift, transfer, or repositioning using an appropriate device?
- Is staff that provides direct care to patients or residents competent in knowing when to modify lifting, transferring, or repositioning procedures using equipment?
- Does staff know how to select and replace appropriate foot wear to reduce slip, trips and fall hazards? Does training include how to recognize wear patterns and other indicators signifying need for replacement?

2. Occupational Health Management. Is there a process to ensure that work related disorders are identified and treated early to prevent the occurrence of more serious problems and whether this process includes restricted or accommodated work assignments?

Citation Guidance: Where hazards are noted, the CSHO should cite the appropriate standard.

**The General Duty Clause, [ORS 654.010](#):** 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 that included, but were not limited to awkward postures, overexertion, and repetitive movements that have caused or were likely to cause musculoskeletal disorders (MSDs).

[OAR 437-001-0760\(1\)\(c\)](#) Every employer shall be responsible for providing the health hazard control measures necessary to protect the

employees' health from harmful or hazardous conditions and for maintaining such control measures in good working order and in use.

*Alleged Violation Descriptions (AVD) must be adapted to the specific circumstances noted in each inspection. The AVD below is an example for some circumstances*

(LOCATION)(DESCRIBE THE TASK) Evaluation of the task of manually handling nursing home residents indicates that employees, including nursing assistants, are exposed to a hazard that is causing or likely to cause MSDs. 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.

Oregon OSHA has determined that one method of addressing these risk factors is to implement and administer a safe patient/resident handling and mobility policy for transferring and lifting of non-weight bearing and partial weight bearing patients/residents. This necessitates the use of mechanical lift assist and transfer devices.

**C. Slips, Trips, and Falls**

This section provides general guidance related to these types of hazards when conducting inspections in hospitals and nursing and residential care facilities.

1. Evaluate the general work environments (i.e., dietary, hallways, laundry, shower/bathing areas, rehab areas with pools or whirlpools, EVS equipment areas, laboratories, operating rooms, patient/resident rooms, points of access, and egress).

*Note: In reference to points of access and egress. Division 2/E (Exits and Exit Routes), 437-002-0041(c) requirement: Exits must open from the inside without keys, tools or special knowledge. Devices that lock only from the outside are acceptable. There must be nothing on an exit door that could hinder its use during an emergency.*

*However, a note was placed in the rule that allows the following: You may lock or block an exit door from the inside in a mental, penal, or correctional institution, if supervisory personnel are continuously on duty and a plan exists to remove occupants during an emergency.*

Document hazards likely to cause slips, trips, and falls such as:

- a. Slippery or wet floors; uneven floor surfaces; cluttered or obstructed work areas/passageways; poorly maintained walkways; broken equipment; or inadequate lighting.
  - b. Unguarded floor openings and holes.
  - c. Damaged, inadequate, or poorly lit stairways, and clutter or storage on stairways.
  - d. Elevated work surfaces, which do not have standard guardrails.
  - e. Inadequate aisles for moving patients or residents.
  - f. Use of ladders and stools.
  - g. Power cords in patient/resident rooms and other areas.
2. Note any policies, procedures and/or engineering controls that address wet surfaces. These would include but are not limited to ensuring spills are reported and immediately cleaned up, posting sign/barriers alerting employees to wet floors, mopping one side of the hall at a time, passageways/aisles kept clear of clutter and use of appropriate footwear. Where appropriate, evaluate the use of non-skid surfaces and products designed to enhance surface friction.

Citation Guidance: Where hazards are noted, the CSHO should cite the applicable standard from Division 2, Subdivisions D and J and other applicable standards related to slips, trips, and falls.

If employees are exposed to falling hazards while performing various tasks including maintenance for elevated surfaces, then Oregon OSHA's [PD A-197](#), *Fall Protection: General Industry*, should be reviewed to determine the applicability of [1910.23\(c\)\(1\)](#), [c\)\(3\)](#) and [1910.140](#).

#### **D. Bloodborne Pathogens**

This section describes procedures for conducting inspections and preparing citations for occupational exposure to blood and other potentially infectious materials (OPIM) in nursing and residential care facilities. This is not an exhaustive list. For further detailed guidance, refer to Oregon OSHA's [PD A-154](#), *Bloodborne Pathogens*. In addition, outreach and educational materials are available on the Internet and other references are provided in Appendix B to this document.

1. Evaluate the employer's written Exposure Control Plan (ECP).
2. Assess the implementation of appropriate engineering and work practice controls.



- a. Determine which procedures require the use of a sharp medical device (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 and needleless systems.
  - b. Confirm that all tasks involving sharps have been evaluated for the implementation of safer devices. For example, determine whether the employer has implemented a policy requiring use of safety engineered needles for pre-filled syringes and single-use safety engineered blood tube holders.
  - c. Determine whether the selection of safer devices was based on feedback from non-managerial employees responsible for patient/resident medical care.
  - d. 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.
  - e. Ensure that the evaluation process is documented in the employer's ECP: [Part 1](#) and [Part 2](#).
3. Ensure that proper work practices and personal protective equipment are in place.
  4. Assess whether regulated waste disposal is performed properly.
  5. Evaluate and document the availability of hand-washing facilities. If immediate access to hand-washing facilities is not feasible, ascertain whether skin cleansers (alcohol gels) are used.
  6. Assess the use of appropriate personal protective equipment (masks, eye protection, face shields, gowns and disposable gloves, including latex free gloves where appropriate).
  7. 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.
  8. Ensure that the employer has chosen an EPA-approved appropriate disinfectant to clean contaminated work surfaces.
  9. Determine if the employer has made available to all employees with occupational exposure to blood and OPIM the hepatitis B virus (HBV) vaccination series within 10 working days of initial assignment.
  10. Ensure that healthcare workers who have ongoing contact with patients or blood and have an ongoing risk for injuries with contaminated sharp instruments and needlesticks, are offered an

antibody test post vaccination, in accordance with the U.S. Public Health Service Guidelines.

11. Investigate procedures implemented for post-exposure evaluation and follow-up following an exposure incident. An occupational exposure incident is an employee's exposure to or contact with blood or OPIM through broken skin, through the eyes, nose, or mouth, or by means of a wound such as a needlestick with a contaminated needle.
  - a. Determine if establishment-specific post-exposure protocols are in place (i.e., where and when to report immediately after an exposure incident, procedures for staff coverage while employee seeks medical evaluation, and source patient testing) as recommended by current U.S. Public Health Service Guidelines.
  - b. 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. The evaluating health-care professional must be provided with: a copy of the Bloodborne Pathogens standard; a description of the exposed employee's duties relating to the exposure incident; documentation of the exposure routes and circumstances under which the exposure occurred; the results of the source individual's blood testing if available; and all medical records relevant to the appropriate treatment, including the vaccination status of the exposed employee ((f)(4) of the standard.)
  - c. Ensure that information provided to the employer following an exposure incident is limited to those elements defined in paragraph (f)(5) of the standard.
12. Observe whether appropriate warning labels and signs are present.
13. Determine whether employees receive training in accordance with the standard, including having an opportunity to have questions addressed by the individual conducting the training session.
14. Evaluate the employer's Sharps Injury Log (Note: An employer may use the OSHA 300, as long as the type and brand of the device causing the sharps injury is entered on the Log, records are maintained in a way that segregates sharps injuries from other types of work-related injuries and illnesses, or allows sharps injuries to be easily separated, and personal identifiers are removed from the log. However, CSHOs may suggest that employers simply use a separate sharps-injury log). A sample log is available on the Oregon OSHA website. Note that in Oregon the log must be kept regardless of other recordkeeping exemptions, OAR 437-002-1035 Oregon Rule for Sharps Injury Log.

15. Determine whether the log includes the required fields.
16. Ensure that employee's names are not on the log, but that a case or report number indicates an exposure incident.
17. 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 PD A-154, *Bloodborne Pathogens*.

**E. Tuberculosis (TB)**

This section provides guidance for conducting inspections and preparing citations for the occupational exposure to Tuberculosis specific to nursing and residential care facilities. This is not an exhaustive list. For further detailed guidance, refer to Oregon OSHA [PD A-215, Tuberculosis](#).

1. 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, PD A-215, Tuberculosis.
2. Determine whether the establishment has procedures in place to promptly isolate and manage the care of a patient or resident with suspected or confirmed TB, including a negative pressure isolation room, respiratory protection program, and other abatement procedures, or procedure for transferring these patients or residents to an appropriate healthcare setting.
3. Determine whether the establishment offers tuberculin skin tests for employees responsible for patient or resident care, specifically those described in [PD A-215, Tuberculosis](#).

Citation Guidance: The CSHO should refer to [PD A-215, Tuberculosis](#) for enforcement procedures including citation guidance for:

- Respiratory Protection (Note: All respiratory protection citations must be cited under 1910.134 – Respiratory Protection)
- Accident prevention signs, 1910.145.
- Access to employee medical records, 1910.1020.
- Recordkeeping, 437-001-0700.

**F. Methicillin-resistant Staphylococcus aureus (MRSA), Norovirus, other multi-drug resistant organisms (MDROs), and other infectious diseases**

Hospitals and nursing and residential care facilities are among the settings at increased risk of potential transmission of MRSA, Norovirus, MDROs, and other infectious diseases. CSHOs are expected to investigate situations where it is determined during inspections that employees are not protected from potential disease transmission. This section provides guidance for preparing citations for the occupational exposure to MRSA, Norovirus, and other infectious diseases specific to nursing and residential care facilities.

Citation Guidance: Use the General Duty Clause ORS 654.010 when issuing citations for violations that do not follow CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007. Examples listed below recommend standard precautions and contact precautions to reduce or eliminate exposure to MRSA, MDROs, and Norovirus.

Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since Norovirus can be aerosolized from these bodily substances. Abatement would include disinfection of surfaces, hand washing, cohorting of patients, use of appropriate PPE, and appropriate device and laundry handling as described in the CDC guidelines mentioned above (standard and transmission-based precautions). Waterless hand-cleaners are ineffective against most diarrhea-causing pathogens.

**Rule violation examples: Where hazards are noted, the CSHO should cite the applicable standard.**

1. General Duty Clause: ORS 654.010 - 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 exposed to communicable diseases without adequate protection.

Variable language: Employees were exposed to drug-resistant infections while providing care to patients or residents with infections such as, but not limited to, Methicillin-Resistant Staphylococcus aureus (MRSA). Condition observed on \_\_\_\_\_.

### Abatement

Feasible means of abatement include:

- a. Provide training on all routes of transmission of infections and transmission-based precautions, the proper personal protective equipment to be used, and infection control practices to be used.
- b. Ensure that employee on-going notification is timely and up-to-date regarding the status of any patient or resident with infection, prior to beginning care assignments for every shift.
- c. Cohorting patients.
- d. Use of administrative controls outlined in the CDC Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007, such as limiting access to patients with MRSA infections by non-essential personnel.
- e. Provision of hand protection (i.e. gloves) and other necessary PPE to protect from exposure.
  - Personal protective equipment, 437-002-0134. See standard and transmission based precautions described in CDC guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007.
  - Specifications for Accident Prevention Signs and Tags standard, 1910.145.

### **G. Workplace violence**

See [Program Directive A-283: Workplace Violence Incidents – Enforcement Procedures for Investigating or Inspecting](#)

### **H. Accident investigations and workplace inspections**

1. Determine if accident investigations were performed for lost time injuries. The employer is required to investigate every lost time injury to determine the means that will be taken to prevent recurrence. If the employer did not investigate all lost time injuries, cite OAR 437-001-0760(3)(a).
2. Determine if corrective measures or safeguards indicated by the investigations of lost time injuries were implemented. If they were not implemented, cite OAR 437-001-0760(3)(a).
3. Determine if there are workplace inspections performed by personnel who are not on the safety committee.

- a. If there are such inspections, determine if the person who performs them is qualified. If he or she is not qualified, cite OAR 437-001-0760(7)(a).
- b. Determine if any defective equipment or unsafe conditions found by such inspections was replaced or repaired or remedied promptly. If defective equipment or unsafe conditions were not promptly corrected, cite OAR 437-001-0760(7)(a).

**I. Safety committee and safety meeting rules**

- 1. Training of safety committee members.
  - a. Determine if safety committee members received training on hazard identification in the workplace. If they did not, cite OAR 437-001-0765(4).
  - b. Determine if safety committee members received training on principles regarding effective accident and incident investigations. If they did not, cite OAR 437-001-0765(4)
- 2. Determine if the safety committee worked with management to establish procedures for investigating all safety-related incidents including injury accidents, illnesses and deaths. If the committee did not work with management to establish such procedures, cite OAR 437-001-0765(8).
- 3. Procedures for work place inspections established by the safety committee.
  - a. Determine if workplace inspections are conducted at least quarterly. If not, cite OAR 437-001-0765(7).
  - b. Determine if the safety committee established procedures for the review of all safety and health inspection reports. If not, cite OAR 437-001-0765(8).
  - c. Determine if the safety committee recommended to the employer how to eliminate hazards and unsafe work practices in the workplace. If not, cite OAR 437-001-0765(8).
- 4. Determine if the safety committee made written recommendations to improve the employer's accident and illness prevention plan where applicable. If not, cite OAR 437-001-0765(8).

5. Determine if the safety committee evaluated the employer's accountability system and made recommendations to implement supervisor and employee accountability for safety and health. If not, cite OAR 437-001-0765(8).
6. Determine if the safety committee established a reasonable time limit for the employer to respond in writing to safety committee recommendations. If not, cite OAR 437-001-0765(6).

**J. Self-insured and Group Self-Insured rules**

1. Determine if the employer implemented a written occupational health and safety loss prevention program for each establishment. If not, cite OAR 437-001-1055.
2. Determine if the employer provided for a loss prevention effort within the normal functions of the business for prevention or reduction of health and safety injuries and illnesses. If not, cite OAR 437-001-1055(1).
3. Determine if the employer informed its managers and locations of the availability and the process for requesting loss-prevention services. If not, cite OAR 437-001-1055(2).
4. Determine if the employer implemented a loss prevention effort for each of its locations that identifies and controls all reasonably discoverable occupational safety and health hazards. If not, cite OAR 437-001-1060.
5. Determine if the loss prevention effort included at least the following:
  - a. Information addressing management's commitment to health and safety. If not, cite OAR 437-001-1060(1).
  - b. An accountability system for employer and employees. If not, cite OAR 437-001-1060(2).
  - c. Training practices and follow-up. If not, cite OAR 437-001-1060(3).
  - d. A system for hazard assessment and control. If not, cite OAR 437-001-1060(4).
  - e. A system for investigating all recordable occupational injuries and illnesses that includes corrective action and written findings. If not, cite OAR 437-001-1060(5).





**APPENDIX A**

**Release and Consent**

I hereby consent and release to Oregon OSHA, the right to use my picture and sound videotaped or photographed during an inspection of \_\_\_\_\_(name of facility) 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 Patient or Resident

\_\_\_\_\_  
Date

In the event that there has been a medical or legal determination that a patient or resident cannot give informed consent to be videotaped or photographed, use the following:

On behalf of \_\_\_\_\_(name of patient or resident), I hereby grant to Oregon OSHA, the right stated above.

\_\_\_\_\_  
Signature of person authorized to give informed consent on resident's behalf

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## APPENDIX B

### Reference Material for Nursing Home Inspections

1. [Inspection Guidance for inpatient Healthcare Settings](#), June 25, 2015
2. [Safe Patient Handling Toolkit](#), Federal OSHA 2013.
3. [The National Institute for Occupational Safety and Health \(NIOSH\)](#) – information about statistics and injuries related to patient handling.
4. [NIOSH Science Blog](#)
5. [CPL 03-00-016](#), April 5, 2012 National Emphasis Program – Nursing and Residential Care Facilities
6. [\(OCHE\) Oregon Coalition for Health Care Ergonomics](#)
7. Centers for Disease Control and Prevention, [Reported Tuberculosis in the United States, 2013](#). Atlanta, GA: U.S. Department of Health and Human Services, CDC, October, 2014.
8. [NIOSH, Safe Lifting and Movement of Nursing Home Residents](#), USDHHS, CDC, NIOSH Pub No. 2006-117
9. [NIOSH, Musculoskeletal Disorders and Workplace Factors](#), 2<sup>nd</sup> printing, USDHHS, CDC, NIOSH Pub No. 97-141
10. America Nurses Association, [Nursing World](#)
11. [Back Injury Prevention Guide in the Health Care Industry for Health Care Providers](#), Oregon OSHA (11/00)
12. [NIOSH Safe Patient Handling Training for Schools of Nursing](#)
13. NIOSH, Elements of Ergonomic Programs: A Primer based on Workplace Evaluations of Musculoskeletal Disorders, DHHS/NIOSH Pub. No. 97-117 [Note: There are links on the Ergonomics Tech Links page to the NIOSH documents]
14. OSHA Publication OSHA 3148-04R 2015\*, [Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, 2015](#).
15. [CDC, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#)
16. Centers for Disease Control [Sharps Safety](#)

17. [NIOSH Information on Sharps](#)
18. [CDC, Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, 2011](#)
19. [Occupational Hazards in Long Term Care Nursing Home e-Tool](#)
20. “[Can it Happen Here](#)” publication by Oregon OSHA.
21. Centers for Disease Control and Prevention, [Slip, Trip, and Fall Prevention for Health Care Workers](#), DHHS (NIOSH) Publication Number 2011-123,
22. [Patient Handling Train for Schools of Nursing](#) (NIOSH)

## APPENDIX C

### Hospitals and nursing and residential care facilities inspection questions

This appendix provides examples of questions that can be used to evaluate hospitals and nursing, and residential care facilities. The list is not meant to be all inclusive.

When there is a need to evaluate patient/resident rooms, restrooms, and showers or bathing areas, resident privacy is of concern and must be respected. When documenting patient/resident handling activity using videotaping or photography, obtain written consent from patients, residents, family members, or guardians.

#### A. **Risk factors relating to patient/resident handling**

Assess establishment incidence and severity rates, whether the rates are increasing or decreasing over a three year period, and whether the establishment has implemented a process (such as a safe resident handling program) to address these hazards in an effective manner.

Describe the type and frequency of manual handling tasks that are performed. If there is indication that other sources of musculoskeletal injuries exist (*office work, laundry, kitchen, or maintenance*) include the identified work and affected employees in the assessment.

#### 1. **Program management**

Is there a system for hazard identification and analysis?

Who has the responsibility and authority for compliance with this system?

Are there written procedures for lifting, transferring, and repositioning patients or residents using assistive equipment? (Note: "Care plans" may be another source of information.)

Have employees provided input in the development of the establishment's safe lifting, transferring, or repositioning procedures?

Is there a system for monitoring compliance with the establishment's policies and procedures and for following up on deficiencies?

Have there been recent changes in policies/procedures and if so what effect have those changes had (positive or negative) on injuries and illnesses?

## 2. **Program implementation**

How is patient/resident mobility determined?

What is the decision logic for using lift, transfer, or repositioning devices, and how often and under what circumstances does manual lifting, transferring, or repositioning occur?

Who decides how to lift, transfer, or reposition patients or residents and how is that communicated? (If this information is in the care plan, is it being followed?)

What is the decision logic for selecting and purchasing lift, transfer or repositioning devices, including the extent of employee involvement in the selection process? The [US Department of Veterans Affairs](#) has guide, which provides an example of a safe patient handling program.

Are there adequate engineering controls in place (lift, transfer, or repositioning devices)? Do they have ceiling mounted lifts; portable lifts?

Is there is an adequate quantity and variety of appropriate lifting, transferring, or repositioning assistive devices available and operational? (*A single lift assist device is not appropriate in all circumstances. Manual pump or crank devices may create additional hazards.*)

Are there adequate numbers of slings, a variety of appropriate slings and in a variety of sizes specific for the assistive devices (slip sheets, transfer devices, repositioning devices) available within close proximity and maintained in a sanitary condition?

Is there a preventative maintenance and inspection schedule for the lift, transfer and repositioning devices (including wheels, slings, boom, and hooks)?

Are the policies and procedures appropriate to eliminate or reduce exposure to the manual lifting, transferring, or repositioning hazards at the establishment? (Is staffing adequate to allow caregivers time to use mechanical lift devices when needed?)

## 3. **Employee training**

Are employees who provide bedside care (nursing and physical therapy) trained in the recognition of hazards associated with manual patient/resident lifting and handling tasks, including, transferring, or repositioning, early reporting of injuries, and the establishment's process for abating those hazards?

Are the employees providing bedside care able to demonstrate competency in performing the lift, transfer, or repositioning using an appropriate device?

Is the staff that provides direct care to patients/residents, competent in their knowledge of when to modify lifting, transferring, or repositioning procedures/equipment?

Do staff know how to select and replace appropriate foot wear to reduce slip, trip and fall hazards?

Does training include how to recognize wear patterns on footwear and other indicators signifying the need for replacement?

## **B. Occupational health management**

Is there a process to ensure that work-related disorders are identified and treated early to prevent the occurrence of more serious problems and does this process include restricted or accommodated work assignments?

## **C. Slips, trips, & falls**

Evaluate the general work environments (*dietary, hallways, laundry, shower/bathing areas, patient/resident rooms, points of access, and egress*).

*Note: In reference to points of access and egress. Division 2/E (Exits and Exit Routes), 437-002-0041(c) Requirement: Exits must open from the inside without keys, tools or special knowledge. Devices that lock only from the outside are acceptable. There must be nothing on an exit door that could hinder its use during an emergency.*

*However, a note was placed in the rule that allows the following: You may lock or block an exit door from the inside in a mental, penal, or correctional institution, if supervisory personnel are continuously on duty and a plan exists to remove occupants during an emergency.*

Document hazards related but not limited to the following questions?

- Are floors slippery or wet? \_\_\_\_\_ Uneven? \_\_\_\_\_ Cluttered or obstructed? \_\_\_\_\_
- Are work areas/passageways/walkways/stairways maintained?
- Is there adequate lighting?
- Are there unguarded floor openings/holes?
- Are there missing guardrails?
- Are ladders and stools in good repair, and used correctly?
- Are cords kept out of the work area?

Note any policies, procedures and/or engineering controls that address wet surfaces. (*Ensure spills are reported/ immediately cleaned up, posting sign/barriers alerting employees to wet floors, and use of appropriate footgear. Evaluate use of non-skid surfaces/products that enhance surface friction.*)

**D. Bloodborne pathogens** (see [Program Directive A-154](#))

Review and evaluate the employer's written Exposure Control Plan (ECP).

Assess the implementation of appropriate engineering and work practice controls.

- Determine if sharp medical devices (syringes and lancets) are used and if employees who will use them have been trained in their use.
- Has the employer [evaluated](#), selected, and are they using sharps with engineered sharps injury protection and needleless systems?
- Have all tasks involving sharps been evaluated for the implementation of safer devices (*use of safety engineered needles for pre-filled syringes and single-use safety engineered blood tube holders*)?
- Is selection of safer devices based on input from employees responsible for resident medical care?
- 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.
- Is the evaluation process documented in the employer's ECP?

Are proper work practices and personal protective equipment in place?

Is regulated waste disposed of properly?

How available are hand-washing facilities? If immediate access is not feasible, are skin cleansers used (alcohol gels)?

Is appropriate personal protective equipment (masks, eye protection, face shields, gowns and disposable gloves, including latex-free gloves where appropriate) available?

What are the procedures for immediate and proper clean up of spills and disposal of contaminated materials (blood or other body fluids)?

Is an EPA-approved, appropriate disinfectant used to clean contaminated work surfaces?

Is the hepatitis B virus (HBV) vaccination series offered to workers within 10 working days of initial assignment?

Are workers, who have contact with patients, residents, or blood and are at an ongoing risk for percutaneous injuries, offered an antibody test (titer), post vaccination, in accordance with the U.S. Public Health Service Guidelines?

What are the procedures for post-exposure evaluation and follow-up after an exposure incident (*where and when to report immediately after an exposure incident, procedures for staff coverage while employee seeks medical evaluation, and source patient testing, as*

*recommended by current U.S. Public Health Service Guideline)?*

- Is medical attention immediately available, including administration of a rapid HIV test, as currently recommended by the U.S. Public Health Service Guidelines?
- Is the required information provided to the employee following an exposure?
  - Results of testing?
  - Are hep B vaccinations indicated?
  - Is further treatment required (HIV)?
- Is information provided to the employer, following an exposure incident, limited to the elements defined in paragraph (f)(5) of the standard?
  - Is hep B needed?
  - Did employee get hep B?
  - Did employee received results of evaluation?
  - Was employee notified of indication for further treatment?

Are appropriate warning labels and signs present (*biohazard*)?

Do employees get annual training for BBP and have an opportunity to have questions answered by the individual conducting the training session?

Do employees understand the difference between standard precautions and universal precautions?

Does the employer have a Sharps Injury Log? (*An employer may use the OSHA 300, if the type and brand of the device causing the sharps injury is entered on the log, records for sharps injuries are segregated from other types of injuries, or allows sharps injuries to be easily separated, and personal identifiers are removed from the log.*)

- Does the log include the required fields?
- Are employee names removed and a case or report number used to indicate an exposure incident?

Does the employer use information on the Sharps Injury Log when reviewing and updating its ECP?

**E. TUBERCULOSIS (TB)**

Has the establishment had a suspected or confirmed TB case within 6 months prior to the date of the opening conference?

Yes \_\_\_\_\_ No \_\_\_\_\_



If no, skip to section F

If yes, continue with the following questions.

Does the establishment have procedures in place to promptly isolate and manage the care of a patient or resident with suspected or confirmed TB, including a negative pressure isolation room, respiratory protection program, and other abatement procedures, and/or procedure for transferring these patients or residents to an appropriate healthcare setting?

Does the employer offer tuberculin skin tests for employees responsible for resident care?

**F. METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA), NOROVIRUS, OTHER MULTI-DRUG RESISTANT ORGANISMS (MDROs) & OTHER INFECTIOUS DISEASES**

How are employees protected from potential disease transmission? (*Limit access to patients with MRSA infections by non-essential personnel; provide hand protection, adequate PPE and signage.*)

**G. MISCELLANEOUS**

**Respiratory protection:** Evaluate the employer's respiratory protection program. See program directive [A-233, Respiratory Protection](#).

- Who is the program administrator?
- What job classifications use respirators?
- What types of respirators are used?
- Do they do fit testing?
- Who does the fit testing?
- Who does the annual training?

**Chemicals, health, and environmental hazards:**

**Anesthetic gases:** Are methods in place to control exposure to waste anesthetic gases? (Halogenated anesthetics are often administered in combination with nitrous oxide.) <http://www.cdc.gov/niosh/docs/2007-151/>

**Antineoplastics:** Are precautions taken to eliminate or reduce exposure as much as possible to antineoplastic agents such as cancer chemotherapy drugs and cytotoxic drugs?

What is the employer's handling and disposal process?

Is there a medical surveillance component?

<http://www.cdc.gov/niosh/topics/antineoplastic/>

**Sterilization:**

Is ethylene oxide used for sterilization?

<http://www.cdc.gov/niosh/topics/ethyleneoxide/>

Is formaldehyde or glutaraldehyde used as a disinfectant or a sterilant?

[http://www.cdc.gov/hicpac/Disinfection\\_Sterilization/7\\_0formaldehyde.html](http://www.cdc.gov/hicpac/Disinfection_Sterilization/7_0formaldehyde.html)

**Asbestos:** Has there been an asbestos survey done? Some hospitals may have tunnels that may contain asbestos.

**Indoor air quality:** Is there an indoor air quality program? (Look for water incursion in ceiling tiles.)

**Nuclear medicine/radiation:**

What are the radiation sources in the facility? (x-rays, drugs, implants, etc.)

Do they have a radiation control officer? What training have they had?

Is there an exposure monitoring program?

<https://www.osha.gov/SLTC/radiationionizing/>

**Noise:** Have noise exposures been evaluated? A hearing conservation program may be necessary for maintenance, groundkeepers, and laundry personnel. Do they have/use hearing protection?

**Air Ambulance:**

Does the employer have or use air ambulance services?

Where does the air ambulance land? Is access controlled?

Does staff accompany the patient?

**Workplace violence:**

Are program requirements for acute care and some home health environments in place as required by [ORS 654.414](#) (Duties of health care employer; security and safety assessment; assault prevention program; requirements)?

- [OSHA's guidelines for preventing workplace violence for healthcare and social service workers](#)
- [Oregon OSHA's guide to preventing aggression where you work](#)

**H. ACCIDENT INVESTIGATIONS AND WORKPLACE INSPECTIONS**

Are accident investigations performed for lost time injuries?

Are corrective measures or safeguards, indicated by the investigations, implemented?

Are workplace inspections performed by personnel who are not on the safety committee?

If so, is the person who performs them qualified?

Is defective equipment or any unsafe conditions, found by such inspections, replaced, repaired or remedied promptly?

**I. SAFETY COMMITTEE & SAFTY MEETING RULES**

What type of training is given to safety committee members (*hazard identification and principles regarding effective accident and incident investigations*)?

Does the safety committee work with management to establish procedures for investigating all safety-related incidents including injury accidents, illnesses and deaths?

Does the safety committee establish procedures for workplace inspections?

Are workplace inspections conducted at least quarterly?

Did the safety committee establish procedures for the review of all safety and health inspection reports?

Does the safety committee recommend to the employer how to eliminate hazards and unsafe work practices in the workplace?

Has the safety committee made written recommendations to improve the employer's accident and illness prevention plan?

Has the safety committee evaluated the employer's accountability system and made recommendations to implement supervisor and employee accountability for safety and health?

Has the safety committee established a reasonable time limit for the employer to respond, in writing, to safety committee recommendations?

**J. SELF-INSURED & GROUP SELF-INSURED RULES**

Has the employer implemented a written occupational health and safety loss prevention program for each establishment?

Has the employer provided for a loss prevention effort within the normal functions of the business for prevention or reduction of health and safety injuries and illnesses?

Has the employer informed its managers of the availability and the process for requesting loss-prevention services?

Has the employer implemented a loss prevention effort for each of its locations, which identifies and controls all reasonably discoverable occupational safety and health hazards? (See [April 4, 2012](#) interpretation letter.)

Does the loss prevention effort include at least the following:

- a. Information addressing management's commitment to health and safety? Y N

- b. An accountability system for the employer and employees? Y N
- c. Training practices and follow-up? Y N
- d. A system for hazard assessment and control? Y N
- e. A system for investigating all recordable occupational injuries and illnesses including corrective action and written findings? Y N
- f. A system for evaluating, obtaining and maintaining personal protective equipment? Y N
- g. Onsite, routine industrial hygiene and safety evaluations to find physical and chemical hazards in the workplace, and implement engineering or administrative controls? Y N
- h. Evaluation of workplace design, layout and operation, and assistance with job-site modifications utilizing an ergonomic approach? Y N
- i. A procedure in place to ensure employee involvement in the health and safety effort? Y N
- j. An annual evaluation of the employer's loss prevention activities based on the location's current needs? Y N

**Additional question for Group Self-Insured Employers**

- k. Are records documenting assistance provided to each member of the self-insured group? Y N