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October 1, 2012

New Mexico Occupational Health and Safety Bureau (OHSB) Directive 13-08

Subject: Local Emphasis Program (LEP) for Hospitals, Nursing and Residential Care Facilities (NAICS 622110, 62311 and 623311).

A. Purpose: This notice establishes an LEP for Health and Safety Hazards Associated with Hospitals, Nursing and Residential Care Facilities (NAICS 622110, 62311 and 623311).

B. Scope: This notice applies to the State of New Mexico OHSB.

C. References: The following documents are referenced in or applicable to this instruction.

1. New Mexico Field Operations Manual
2. OSHA Instruction ADM 1-1.38, August 28, 2003, The IMIS Enforcement Data Processing *Manual for use with the NCR, and subsequent changes.*
3. OSHA Instruction CPL 2-0.102.A, November 10, 1999, Procedures for Approval of Local Emphasis Programs (LEP).
4. OSHA Instruction CPL 2-00-051, February 23, 2005, Exemptions and Limitations Under the Appropriations Act, with current Appendix A.

D. Cancellation: This notice does not cancel any notice.

E. Expiration: This notice expires on September 30, 2013.

F. Action: OHSB Compliance, Compliance Assistance, and Consultation personnel will ensure that the procedures contained in this notice are followed.

G. Background: OHSB is initiating this LEP to address high injury and illness rates in New Mexico hospital, nursing and residential care industries that are anticipated to continue experiencing high employment growth rates and high injury and illness rates.

Information obtained from the New Mexico Department of Workforce Solutions has projected employment growth between 2007 and 2017 for personal care to be 29.4% and healthcare support growth to be over 20%.

Information obtained from the Bureau of Labor Statistics reveals that both the total recordable cases (TRC) and recordable cases with days away, restricted, or transferred (DART) rates are higher than the average for all industries. The TRC for Hospitals (NAICS 622) in 2009 was 6.7 compared with the total rate of 4.8. The TRC for Nursing and residential Care Facilities (NAICS 623) in 2009 was 9.0 compared with the average rate of 4.8. This trend has continued into 2011 with TRC rates for NAICS 622 at 6.0 and for NAICS 623 at 6.9 in New Mexico, compared to the average rate of 3.5 for all industries in the state.

This directive was initially issued in 2012 to include the hazards of ergonomics, bloodborne pathogens (BBP) and slips, trips and falls. OHSB has added the hazards of workplace violence, chemical hazards, and non-BBP multi-drug resistant organisms (MRDOs).

H. Compliance Procedures:

In FY 2013, the OHSB will conduct approximately ten (10) inspections at healthcare facilities classified by the NAICS codes 622 and 623 including at least one from the public sector.

1. An establishment list of employers to inspect will be created from the listing of hospitals provided by the New Mexico Hospital Association. A listing of employers in the nursing and residential care industry will be created using InfoUSA. These two lists will be used for assignments of programmed inspections.
2. Any fixed site establishment that has received a substantially complete inspection since October 1, 2009, will be deleted from the FY 2013 inspection cycle.
3. The list will be consecutively numbered and a random numbers table applied. The inspection cycle for FY 2013 will consist of the first ten (10) randomly selected establishments. If a public facility is not among the 5 selected the process will be repeated to insure a public facility is chosen for inspection. Additional randomly selected establishments may be added to the list if an establishment is out of business or cannot otherwise be inspected. Comprehensive inspections will be conducted of all establishments selected.
4. OHSB reserves the right to re-inspect any establishment that has a fatality or catastrophe, receives a complaint or referral at any time during the period covered by this notice.
5. The normal procedures described in the New Mexico Field Operation Manual will be used to conduct the inspection. In addition the following guidelines will be followed for the special emphasis on ergonomic, bloodborne pathogen, and slips, trips, and falls issues.

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

        i. Program Management
            - Is there a system for hazard identification and analysis?

- Who has responsibility and authority for compliance with the system?
- Have employees provided input in the development of the lifting, transferring, or repositioning procedures?
- Is there a system for monitoring compliance with the policies and procedures and for following up on deficiencies?
- Have there been recent changes in the policies or procedures and what effect have the changes had on injuries and illnesses?

ii. Program Implementation

- How is resident mobility determined?
- What is the decision logic for using lift, transfer, or repositioning devices?
- Who decides how to lift, transfer, or preposition residents?
- Is there an adequate quantity and variety of appropriate lift, transfer, or repositioning devices available?
- Is there an adequate number of slings available of varying sizes?
- Are the policies and procedures appropriate to eliminate or reduce exposure to the manual lifting, transferring, or repositioning hazards at the establishment?

iii. Employee Training

- Have employees been trained in the recognition of hazards associated with manual resident lifting, transferring, or repositioning?
- Have employees been trained in the establishment's process for abating these hazards?
- Can employees demonstrate competency in performing lifting, transferring, or repositioning using the assistive devices?

iv. Citation Issuance

The General Duty Clause, Section 50.9.5 of the Act may be used if the employer did not furnish a place of employment which was free from recognized hazards that were likely to cause serious physical harm to employees who were required to perform lifting tasks resulting in stressors that have caused or were likely to cause musculoskeletal disorders (MSDs). Consider the following language:

> "Evaluation of the task of manually handling residents indicates that employees are exposed to a hazard which 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, herniated disks, and various shoulder injuries.
>
> OHSB has determined that one method of addressing these stressors is to implement a no manual lift 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."

b. Bloodborne Pathogens

The inspection procedures to be used are described in CPL 02-02-069. Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens. The Compliance Officer should evaluate the employer's written Exposure Control Plan by assessing the implementation of appropriate engineering and work practice controls. Areas to be evaluated include:

i. Determine which procedures require the use of a sharp medical device and whether the employer has evaluated, selected, and is using sharps with engineered sharps injury protection and needless system.
ii. 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.
iii. Determine whether non-managerial employees participated in the selection of safer devices.
iv. Determine if a safer device would compromise safety of the outcome of a medical practice.
v. Ensure that work practices and personal protective equipment are in place.
vi. Assess whether regulated waste disposal is performed properly.
vii. Evaluate the availability of hand washing or skin cleansing facilities.
viii. 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.
ix. Ensure that the employer has chosen an EPA-approved disinfectant to clean contaminated work surfaces.
x. Determine that the employer has made available (within 10 working days of initial assignment) the hepatitis B virus vaccination series to all employees with occupational exposure to blood and other potentially infectious materials.
xi. Ensure that employees who have contact with residents or blood and are at ongoing risk for percutaneous injuries are offered an antibody test, in accordance with the U.S. Public Health Service Guidelines.
xii. Ensure that adequate procedures are in place for post-exposure evaluation.
xiii. Ensure that appropriate warning labels and signs are present.
xiv. Determine whether employees receive training in accordance with the standard.
xv. Citation Issuance. If the employer is in violation of the Bloodborne Pathogens Standard, the employer will be cited in accordance with CPL 02-02-069.

c. Slips, Trips, and Falls

The following guidance should be used for recognizing these types of hazards:

i. Evaluate the general work environments and document hazards likely to cause slips, trips, and falls such as:
    - Slippery or wet floors
    - Uneven floors
    - Cluttered or obstructed work areas
    - Poorly maintained walkways, broken equipment
    - Inadequate lighting

ii. Note any policies, procedures, and or engineering controls used to deal with wet surfaces.

iii. Citing. Where hazards are noted, the Compliance Officer should cite use subparts D and J of 29 CFR 1910.

d. Workplace Violence.

Workplace violence (WPV) is a recognized hazard in nursing and residential care facilities. NIOSH defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents, CPL 02-01-052, adopted by OHSB on September 20, 2011, establishes enforcement policies and provides uniform procedures which apply when conducting inspections in response to incidents of workplace violence. OSHA Instruction, CPL 02-01-052, 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.

i. Citation Guidance. In accordance with the FOM's general guidance on general duty citations, citations should focus on the specific hazard employees are exposed to, not the events that caused the incident or the lack of a particular abatement method. The OSHA workplace violence directive also contains sample language for hazard alert letters.

e. Other Hazards.

As detailed in the FOM, when additional hazards come to the attention of the compliance officer, the scope of the inspection may be expanded to include those hazards. Although unprotected occupational exposures to MRSA and other 22 multi-drug resistant organisms or exposure to hazardous chemicals (i.e., hazard communication) are not included in the target hazards under this NEP, if these or other hazards become known during the course of an inspection conducted under this NEP, they should be investigated.

i. Methicillin-resistant *Staphylococcus aureus* (MRSA) and other multi-drug resistant organisms (MDROs). Nursing and residential care facilities are among the settings at increased risk of potential transmission of MRSA and other MDROs. Compliance officers are expected to investigate situations where it is determined during inspections conducted under this NEP that employees are not protected from potential transmission of MDROs such as MRSA. Refer to the FOM and other OHSB or 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 *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings,*

2007. Appendix E 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.

ii. Hazard Communication. Employee exposures to hazardous chemicals, such as sanitizers, disinfectants, and hazardous drugs may be encountered in nursing and residential care facilities. 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 Material Safety Data Sheets (MSDSs).

I. Compliance Assistance Procedures

The Compliance Assistance Specialists should conduct a minimum of two activities per year such as:

1. Meetings with industry associations to discuss potential alliances;
2. Conduction outreach activities at annual conventions for industry associations;
3. Developing and distributing outreach materials and publications;
4. Developing materials to include on the OHSB web page;
5. Conducting informational presentations in collaboration with industry associations; and,
6. Conducting formal presentations and training.

J. Consultation Procedures

The OHSB Consultants will conduct a minimum of five activities per year such as:

1. Assigning a high priority to consultation requests from healthcare facilities;
2. Conducting consultation visits;
3. Participating in industry association conventions to solicit consultation requests and to distribute outreach materials;
4. Creating and distributing mailings explaining compliance section focus on healthcare and availability of resources to include compliance assistance and consultation services;
5. Distributing electronically developed outreach materials;
6. Conducting formal training and presentations as requested.

K. IMIS Recording:

Information pertaining to this healthcare initiative shall be recorded in the IMIS following current instructions in the IMIS manual. The identifier code will be "NURSING".

1. The identifier "NURSING" will be recorded in item 25c on the OSHA-1 form for all LEP inspections.
2. The appropriate strategic plan code "NURSING" will also be coded in block 25f of the OSHA-1, to link with the strategic plan.

L. Evaluation:

An evaluation of the effectiveness of this local emphasis program will be conducted at the end of each fiscal year. An evaluation report will be written and submitted to the Bureau Chief within 30 days of the end of each fiscal year. Elements to be considered in the evaluation include:

1. Effectiveness of the Local Emphasis Program targeting system;
2. Number of establishments and/or operations inspected under the program;
3. Number of establishments and/or operations that appeared to be in violation of OHSB standards and/or general duty requirement of the OHS Act;
4. Number of employees removed from risk;
5. Number of hazards abated;
6. Number of activities conducted by Compliance Assistance; and,
7. Number of activities conducted by the Consultation section.

By and Under the Authority of

Robert Genoway
Acting Chief, Occupational Health and Safety Bureau