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OSHA NATIONAL EMPHASIS PROGRAM
COVID-19
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Background

In response to President Biden's January 21, 2021 Executive Order (Presidential Executive Order on Protecting Worker Health and Safety, January 21, 2021), OSHA launched a National Emphasis Program (NEP) on March 12, 2021 that contains policies and procedures designed to reduce or eliminate worker exposures to the virus SARS-CoV-2 that causes the disease COVID-19. The NEP is effective on March 12, 2021 and will remain effective for no more than 12 months, unless canceled or extended. On the same day, OSHA also updated its Interim Enforcement Response Plan concerning workplace inspections.

The NEP contains many useful references to interim orders, memoranda, and other pertinent documents on COVID-19 that have been compiled over the last several months. See the NEP at the following:

https://www.osha.gov/news/newsreleases/national/03122021

The Executive Order can be viewed at:

https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-protecting-worker-health-and-safety/

The goal of reducing exposures will be met, according to OSHA's NEP, by:

- *targeting industries* and worksites where employees may have a high frequency of close contact exposures;
- *outreach to employers;* and
- *compliance assistance.*

OSHA decided not to issue an Emergency Temporary Standard (ETS) for COVID-19 at this time; the NEP is *not* a new standard. OSHA will enforce the NEP by citing various standards or regulations already in place such as respiratory protection, PPE, sanitation, bloodborne pathogens, hazard communication, etc. OSHA broke no new ground on new standards or regulations for COVID. In the event that OSHA issues an ETS pursuant to the January 21, 2021 Executive Order, OSHA's citation guidance will be updated.

Targeting Industries

Each OSHA Region will target for special ("programmed") NEP inspections at least 5 percent of its total inspection goal. Countrywide, this is a total of approximately 1,600 inspections. If spread out over 50 States, this amounts to about 32 facilities per State. In addition, OSHA will continue to conduct routine ("unprogrammed") inspections as they have been doing at workplaces where employees have a high frequency of close contact exposures as well as referrals or complaints. OSHA expects the majority of the overall inspections will continue to occur in general industry, particularly in healthcare, including facilities previously inspected for COVID-19 hazards. The highest priority will be given to inspections involving fatalities or multiple hospitalizations related to COVID-19.

The NEP contains several appendices. Appendix A contains various Tables of industries that will be targeted in a group where OSHA data shows the highest number of workers thought to be exposed. Table 1 contains Primary industries including healthcare and long-term nursing care facilities. Table 2 is Secondary non-healthcare industries including meat processors, supermarkets, restaurants, correctional facilities, etc. Appendix B contains additional Secondary industries for targeting. This is a group of essential workers from non-healthcare facilities who are likely to have close contact exposures.

Outreach

OSHA will provide outreach about the NEP using press releases, announcements, letters to the public, seminars, and communications to media outlets, its stakeholders, and existing alliances.

Compliance Assistance

In the NEP, OSHA refers to its OSHA Guidance document, *Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace*, Jan. 29, 2021. In addition, OSHA refers employers to the OSHA Memorandum, *Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19)*, also published March 12, 2021, the same day as the NEP was published. Finally, OSHA refers employers to its On-Site Consultation Programs.

Inspections

The attached Appendix contains information on OSHA inspection procedures that was largely taken from the OSHA Memorandum, *Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19)*, March 12, 2021. The Memorandum can be found at:

https://www.osha.gov/memos/2021-03-12/updated-interim-enforcement-response-plan-coronavirus-disease-2019-covid-19

APPENDIX – OSHA INSPECTION PROCEDURES

During COVID-19 inspections, OSHA will:

- Determine whether the employer has a written safety and health plan that includes contingency planning for emergencies and natural disasters, such as the current pandemic.
- Review the facility's procedures for hazard assessment and protocols for PPE use.
- Determine whether the employer has implemented measures to facilitate physical distancing and to ensure the use of face coverings by employees, customers and the public.
- Review relevant information, such as medical records related to worker exposure incident(s), OSHA-required recordkeeping, and any other pertinent information. This includes determining whether any employees have contracted COVID-19, have been hospitalized as a result of COVID-19, or have been placed on precautionary removal/isolation.
- Review the respiratory protection program and any modified respirator policies related to COVID-19, e.g., policies modified during anticipated shortages of respirators, such as recommended by the CDC or the FDA for healthcare employers and assess compliance where 29 CFR 1910.134 applies.
- Review employee training records, including any records of training related to COVID-19 exposure prevention or in preparation for a pandemic, if available.
- Review documentation of provisions made by the employer to obtain and provide appropriate and adequate supplies of PPE.
- For healthcare facilities, determine if the facility has airborne infection isolation rooms/areas, and gather information about the employer's use of air pressure monitoring systems and any periodic testing procedures. For testing procedures of isolation rooms, refer to the OSHA Directive, CPL 02-02-078, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, June 30, 2015, Appendix B, Testing Methods for Airborne Infection Isolation Rooms, at

  www.osha.gov/enforcement/directives/cpl-02-02-078

Review procedures in place for transferring patients to other facilities in healthcare settings where appropriate isolation rooms/areas are unavailable or inoperable. Also, review procedures for accepting COVID-19 patients transferring from other facilities. Establish the numbers and placements, i.e., room assignments or designated area (cohorting) assignments, of confirmed and suspected COVID-19 patients under isolation at the time of inspection. Establish the pattern of placements for confirmed and suspected COVID-19 patients in the preceding 30 days. Determine whether the workplace has handled specimens or evaluated, cared for, or treated suspected or confirmed COVID-19 patients. This should include a review of laboratory procedures for handling specimens and procedures for decontamination of surfaces. Determine and document whether the employer has considered or implemented a hierarchy of controls for worker protection, i.e., engineering controls, administrative controls, work practices, or PPE (including a respiratory protection program). Such documentation can be in the form of written plans and procedures, photos, work orders, or design specifications.

NOTE 1: The CDC currently recommends that healthcare personnel (HCP) who are providing direct care of patients with known or suspected COVID-19 implement robust infection control procedures, which they should already have in place for other airborne infectious diseases like tuberculosis. These include engineering controls (e.g., AIIRs), administrative controls (e.g.,

cohorting patients, designated HCP), work practices (e.g., handwashing, disinfecting surfaces), and appropriate use of PPE, such as gloves, face shields or other eye protection, and gowns.[7]

NOTE 2: Several tools are publicly available to offer employers assistance in developing preparedness plans. The CDC has developed checklists for various industries and for different types of settings. The national public service campaign, Ready.gov, provides toolkits and emergency planning resources for businesses. These resources are listed in Attachment 5.

Walkaround. Based on information from the program and document review and interviews, Compliance Safety and Health Offices (CSHOs) and supervisors or Area Directors (ADs) should determine what areas of a facility will be inspected (e.g., emergency rooms, respiratory therapy areas, bronchoscopy suites, and morgue in a hospital; kill floor, meat packing floor, locker room in a meat processing facility; assembly line in a manufacturing plant). In healthcare settings, CSHOs should not enter patient rooms or treatment areas while high-hazard procedures are being conducted. Photographs or videotaping where practical should be used for case documentation, such as recording smoke-tube testing of air flows inside or outside an airborne infection isolation room (AIIR). However, under no circumstances shall CSHOs photograph or take video of patients, and CSHOs must take all necessary precautions to assure and protect patient confidentiality. Throughout their engagement with facilities treating a significant number of COVID-19 patients, CSHOs should avoid interference with the facilities' ongoing medical services.

Applicable OSHA Standards. Several OSHA standards may apply, depending on the circumstances of the case. The list of general industry standards applicable to infectious diseases, such as COVID-19 include the following:
29 CFR Part 1904, Recording and Reporting Occupational Injuries and Illness.
29 CFR 1910.132, General Requirements-Personal Protective Equipment.
29 CFR 1910.134, Respiratory Protection.
29 CFR 1910.141, Sanitation.
29 CFR 1910.145, Specification for Accident Prevention Signs and Tags.
29 CFR 1910.1020, Access to Employee Exposure and Medical Records.
Section 5(a)(1), General Duty Clause of the OSH Act.

NOTE: OSHA's Bloodborne Pathogens (BBP) standard (29 CFR 1910.1030) applies to occupational exposure to human blood and other potentially infectious materials that typically do not include respiratory secretions that may contain SARS-CoV-2 (unless visible blood is present). However, the provisions of the standard offer a framework that may help control some sources of the virus, including exposures to body fluids (e.g., respiratory secretions) not covered by the standard. Additionally, the BBP standard will apply to facilities where COVID-19 vaccinations are being administered by employees covered by OSHA.

Use of CDC recommendations. The current CDC guidance should be consulted in assessing potential workplace hazards and to evaluate the adequacy of an employer's protective measures for workers. Where the protective measures implemented by an employer are not as protective as those recommended by the CDC, the CSHO should consider whether employees are exposed to a recognized hazard and whether there are feasible means to abate that hazard.

Access to employee medical and exposure records. For general guidance, CSHOs should refer to CPL 02-02-072, Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records, August 22, 2007, at www.osha.gov/enforcement/directives/cpl-02-

02-072. CSHOs are encouraged to consult with OOMN for guidance if they have any questions when reviewing medical records and for obtaining MAOs, as necessary.

A record concerning an employee's work-related exposure to SARS-CoV-2 is an employee exposure record under 29 CFR § 1910.1020(c)(5). A record of COVID-19 medical test results, medical evaluations, or medical treatment is considered an employee medical record within the meaning of 29 CFR § 1910.1020(c)(6). Medical records are to be handled in accordance with the procedures set forth at 29 CFR § 1913.10, Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records.

Injury/Illness Records. CSHOs should review the employer's injury and illness records to identify any workers with recorded illnesses or symptoms associated with exposure(s) to persons with suspected or confirmed COVID-19 or other sources of SARS-CoV-2.

For purposes of OSHA injury and illness recordkeeping, cases of COVID-19 are not considered a common cold or seasonal flu. The work-relatedness exception for the common cold or flu at 29 CFR § 1904.5(b)(2)(viii) does not apply to these cases. Note that OSHA had been exercising enforcement discretion for the recording of COVID-19 cases, in certain circumstances. As transmission and prevention of COVID-19 infection have become better understood, employers should have an increased ability to determine whether an employee's COVID-19 illness is likely work-related, e.g., if the employee while on the job has frequent, close contact with the general public in a locality with ongoing community transmission and there is no alternative explanation. OSHA provided guidance for all employers. See OSHA Memorandum, Revised Enforcement Guidance for Recording Cases of 2019 Coronavirus Disease (COVID-19) on OSHA Injury and Illness Logs, issued on May 19, 2020

www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19

Employers are responsible for recording cases of COVID-19 if all of the following requirements are met:
The case is a confirmed case of COVID-19, as defined by the CDC;
The case is work-related, as defined by 29 CFR § 1904.5; and
The case involves one or more of the recording criteria set forth in 29 CFR § 1904.7 (e.g., medical treatment, days away from work).
NOTE: Several types of facilities in the healthcare industry are partially exempt from recordkeeping requirements under 29 CFR Part 1904 and are, therefore, not expected to maintain OSHA 300 logs. CSHOs should rely on interviews and other records reviewed during the investigation at these facilities. Although facilities in these industries are exempt from maintaining OSHA 300 logs, they are not exempt from the reporting requirements under 29 CFR 1904.39(a)(1) or 29 CFR 1904.39(a)(2).

Respiratory Protection Standard. For general guidance, CSHOs should refer to CPL 02-00-158, Inspection Procedures for the Respiratory Protection Standard, June 26, 2014, at

www.osha.gov/enforcement/directives/cpl-02-00-158

During an inspection, CSHOs will evaluate whether workers, are using proper respiratory protection when necessary.

Appropriate respiratory protection is required for all healthcare personnel providing direct care for patients with suspected or confirmed cases of COVID-19. For additional guidance, see COVID-19 Hospital Preparedness Assessment Tool,

https://www.cdc.gov/coronavirus/2019-ncov/global-covid-19/emergency-preparedness-assessment-tool.html

Equipment Shortages. As supplies of health and safety equipment have increased to meet the high demands of the early and peak stages of the pandemic, shortages are becoming less of a barrier to compliance. Only a temporary increase in demand for equipment, such as N95 FFRs, should cause an employer to anticipate a periodic limitation on their availability. For healthcare and emergency response, employers in such settings have been advised to follow the CDC's strategies for optimizing their supplies of respirators. These strategies may also be useful to non-healthcare employers anticipating temporary shortages of respirators. The CDC strategies are also intended to be time-limited and applicable only to certain circumstances described in the guidance.

As an alternative to using multiple N95 FFRs, many healthcare employers have switched critical staff to wearing NIOSH-approved, non-disposable, elastomeric respirators or powered air-purifying respirators (PAPRs) to reduce the demand for N95 FFRs. See also, OSHA memorandum, Temporary Enforcement Guidance – Tight-Fitting Powered Air Purifying Respirators (PAPRs) Used During the Coronavirus Disease 2019 (COVID-19) Pandemic, October 2, 2020. See:

https://www.osha.gov/memos/2020-10-02/temporary-enforcement-guidance-tight-fitting-powered-air-purifying-respirators

Enforcement Discretion. In view of periodic equipment shortages and limitations during the COVID-19 pandemic, OSHA has provided specific enforcement discretion procedures, as described in several Enforcement Memoranda, for CSHOs enforcing OSHA standards, such as the Respiratory Protection standard, 29 CFR 1910.134. OSHA has not waived compliance with any of its requirements, and any enforcement discretion is intended to be time-limited and applicable on a case-by-case basis. Where respirators or associated supplies and services are readily available, enforcement discretion will not be exercised.

When considering citations, CSHOs should evaluate whether the employer made good faith efforts to comply with applicable OSHA standards and, in situations where compliance was not possible during the pandemic, to ensure that employees were not exposed to hazards from tasks, processes, or equipment for which they were not adequately trained. As part of assessing whether an employer engaged in good faith compliance efforts, CSHOs should determine whether the employer thoroughly explored alternative options to comply with the applicable standard(s), such as the use of virtual training or remote communication strategies, or efforts to obtain alternate respiratory protection devices (e.g., N95 respirators) when supplies were depleted.