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Occupational Safety and Health Administration
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MEMORANDUM FOR: REGIONAL ADMINISTRATORS
STATE PLAN DESIGNEES

THROUGH: AMANDA EDENS
Deputy Assistant Secretary

FROM: PATRICK J. KAPUST, Acting Director
Directorate of Enforcement Programs

SUBJECT: Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19)

This Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19) provides new instructions and guidance to Area Offices and Compliance Safety and Health Officers (CSHOs) for handling COVID-19-related complaints, referrals, and severe illness reports. On the date this memorandum is issued, the previous memorandum on this topic.[1] will be rescinded, and this new Updated Interim Enforcement Response Plan will go into and remain in effect until further notice. This guidance is intended to be time-limited to the current COVID-19 public health crisis. Please frequently check OSHA's webpage at *www.osha.gov/coronavirus* for updates.

OSHA's priority is to use its resources to eliminate and control workplace exposures to SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), the cause of COVID-19, and to provide OSHA enforcement personnel with the protections necessary to allow them to safely perform inspections. Most workplaces within the scope of OSHA's authority have been affected by the COVID-19 pandemic. Some workplaces have maintained operations throughout the pandemic, while others have not. OSHA's mission is to assure safe and healthful working conditions for working men and women.

OSHA's enforcement of workplace safety and health requirements will reduce the risk of workplace transmissions of SARS-CoV-2. The agency's updated Response Plan prioritizes enforcement and focuses on employers that are not making good faith efforts to protect workers.

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[1] OSHA Memorandum, *Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19)*, May 19, 2020, www.osha.gov/memos/2020-05-19/updated-interim-enforcement-response-plan-coronavirus-disease-2019-covid-19.

The following summarizes OSHA's updated strategy:

- OSHA will continue to implement the U.S. Department of Labor's (DOL) COVID-19 Workplace Safety Plan to reduce the risk of COVID-19 transmission to OSHA CSHOs during inspections.[2]
- Pursuant to the March 12, 2021, National Emphasis Program (NEP) for COVID-19, DIR 2021-01 (CPL-03), OSHA will prioritize COVID-19-related inspections involving deaths or multiple hospitalizations due to occupational exposures to COVID-19. In addition, this NEP will include the added focus of ensuring that workers are protected from retaliation.
- Where practical, OSHA will perform on-site workplace inspections:
    - OSHA's goal is to identify exposures to COVID-19 hazards, ensure that appropriate control measures are implemented, and address violations of OSHA standards and the General Duty Clause.
    - OSHA will at times use phone and video conferencing, in lieu of face-to-face employee interviews, to reduce potential exposures to CSHOs. In instances where it is necessary and safe to do so, in-person interviews shall be conducted.
    - OSHA will also minimize in-person meetings with employers and encourage employers to provide documents and other data electronically to CSHOs.
    - In all instances, Area Directors (AD) will ensure that CSHOs are prepared and equipped with the appropriate precautions and personal protective equipment (PPE) when performing on-site inspections related to COVID-19 and throughout the pandemic.
    - To the extent possible, all inspections should be conducted in a manner to achieve expeditious issuance of COVID-19-related citations and abatement.
- In cases where on-site inspections cannot safely be performed *(e.g.*, if the only available CSHO has reported a medical contraindication), the AD will approve remote-only inspections that may be conducted safely.
- Inspections conducted entirely remotely will be documented and coded N-10-COVID-19 REMOTE.

Note: CSHOs who believe they may have been exposed to SARS-CoV-2 during an inspection must immediately report the potential exposure to their supervisor and/or AD.

The Office of Occupational Medicine and Nursing (OOMN) will provide assistance to ADs and CSHOs and serve as a liaison with relevant public health authorities. OOMN can also facilitate Medical Access Orders (MAOs) necessary to obtain worker medical records from employers and healthcare providers.

All enforcement and compliance assistance activities must be appropriately coded to allow for tracking and program review. This includes COVID-19 activity, which should continue to be

[2] *See* www.dol.gov/sites/dolgov/files/general/plans/2021-covid-19-workplace-safety-plan.

coded in the OSHA Information System (OIS), in accordance with the COVID-19 NEP, DIR 2021-01 (CPL-03).

Attached is specific inspection and citation guidance for potentially applicable OSHA standards and the General Duty Clause, including new guidance related to the COVID-19 NEP. This guidance is being provided to the OSHA-approved State Plans for informational purposes only. If you have any questions regarding this policy, please contact the Office of Health Enforcement at (202) 693-2190.

Attachments

cc: DCSP
DTSEM
DSG

Attachment 1

Specific Guidance for COVID-19 Enforcement

I. Workplace Risk Levels:

To prioritize OSHA enforcement activities during the Coronavirus Disease 2019 (COVID-19) pandemic, the following guidance is provided to help CSHOs identify workplaces and job tasks with a risk-based potential for COVID-19 exposures. The risk of worker exposures to SARS-CoV-2, the virus that causes COVID-19, depends on numerous factors, including: the extent of community transmission; the type of work activity; the ability of workers to wear face coverings and appropriate personal protective equipment (PPE); the extent to which the employer follows OSHA standards and current guidelines from OSHA and the Centers for Disease Control and Prevention (CDC); and the need to work in *close contact* with other people, hereafter defined as within 6 feet for a total of 15 minutes or more over a 24-hour period, per the CDC.[3] Potential for worker exposures could also depend on medical or other measures present to control the impact of the virus and the implementation of those measures. For example, vaccinations are becoming increasingly available to certain groups of workers and others in the general population. Information on classifying risk of worker exposure is available on the Hazard Recognition page on OSHA's COVID-19 website. OSHA has also prepared guidance that employers should use for planning purposes - *Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace*.

- Jobs with *higher potential for exposure* are those with tasks that expose workers to known or suspected sources of SARS-CoV-2. The CDC has reported that COVID-19 is a highly infectious disease with potential for airborne spread, most commonly through respiratory droplets and particles produced when an infected person exhales, talks, vocalizes, sneezes, or coughs. Thus, there is a higher potential for exposures at any workplace with high-population-density work environments, particularly where work is performed in poorly ventilated and enclosed spaces and workers are in close contact with others. Workplaces with higher potential for exposure include, but are not limited to, hospitals, emergency response settings, nursing homes and assisted living, laboratories, morgues, schools, businesses, manufacturing, meat, poultry, and other food processing, and some high-volume retail settings. Aerosol-generating procedures and operations, in particular, present a very high risk of exposure to workers. In healthcare, aerosol-generating procedures for which additional engineering controls, administrative controls, and PPE may be necessary include, but are not limited to, bronchoscopy, sputum induction, nebulizer therapy, endotracheal intubation and extubation, open suctioning of airways, cardiopulmonary resuscitation and autopsies.
- Jobs with *lower potential for exposure* to SARS-CoV-2 are those that do not require close contact with others. Workers in this category have minimal occupational contact with the public and other coworkers. Remote workers or office workers who

[3] *See* www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.

do not have frequent close contact with coworkers, customers, or the public are in this category.

II. Complaints, Referrals, Rapid Response Investigations (RRIs), and Programmed Inspections:

To protect the health and safety of workers from SARS-CoV-2, Area Offices (AOs) will continue to prioritize inspections of COVID-19-related fatalities, multiple hospitalizations, and other unprogrammed activities alleging potential employee exposures to COVID-19-related hazards. Additionally, OSHA will implement programmed inspections targeting those industries where OSHA has previously identified increased enforcement activity, and/or establishments with elevated rates of respiratory illnesses in CY 2020, pursuant to the COVID-19 NEP, DIR 2021-01 (CPL-03). Complaint(s) or referral(s) for any general industry, agriculture, maritime, or construction operation alleging potential exposures to SARS-CoV-2 should be handled in accordance with the general procedures in the OSHA Field Operations Manual (FOM) Chapter 9, *Complaint and Referral Processing*. OSHA will perform, to the extent possible, on-site inspections for formal complaints, hospitalizations, and fatalities, as outlined in the FOM. Where appropriate, phone and video conferencing may be used instead of face-to-face interviews and meetings, to reduce potential for CSHO exposures.

- Per the COVID-19 NEP, the highest priority should be given to fatality inspections related to COVID-19 and then to other unprogrammed inspections alleging employee exposure to COVID-19 related hazards. AOs may schedule follow-up inspections related to COVID-19 hazards to meet the goals of the NEP where unprogrammed activities have decreased enough to allow them to do so. In areas where both unprogrammed and follow-up COVID-19-related inspections do not enable offices to meet the goals of the NEP to reduce worker exposures to SARS-CoV-2, programmed inspections may take priority over follow-up inspections.
- Sites selected for programmed inspections shall be inspected using either on-site or a combination of on-site and remote methods.
- Fatality events potentially related to COVID-19 will be prioritized for inspection using either on-site inspections or a combination of on-site and remote methods, except in cases where an on-site inspection cannot be conducted safely.
- Formal complaints alleging hazardous work conditions/activities where employees have a high frequency of close contact exposures, *e.g.*, complaints alleging SARS-CoV-2 hazards in healthcare and other workplaces with higher risk jobs, should be investigated using either on-site inspections or a combination of on-site and remote methods, except in cases where an on-site inspection cannot be performed safely:
    - Area Directors (ADs) may use discretion in prioritizing resources when determining whether to modify FOM instructions by notifying the employer of the alleged hazard(s) or violation(s) by telephone, fax, email, or by letter, in lieu of an immediate on-site presence.
- Other formal complaints alleging SARS-CoV-2 exposure, where employees are engaged in jobs with lower potential for exposure to SARS-CoV-2 (*e.g.*, workers who

do not regularly have close contact with others), may not warrant an on-site inspection, depending on whether non-formal investigative procedures can sufficiently address the alleged hazards.

- Non-formal complaints and employer referrals related to COVID-19 exposures will be investigated using non-formal inquiry processing, in accordance with the FOM, and other established procedures (*e.g.*, rapid response investigations (RRI)). Refer to procedures in the OSHA Memorandum on RRIs, dated March 4, 2016, for further information on RRI investigations.
    - In all phone/fax correspondences, AOs will direct employers to publicly-available guidance documents on protective measures, *e.g.*, CDC's website and OSHA's COVID-19 webpage at www.osha.gov/coronavirus.
    - Inadequate responses to a phone/fax investigation should be considered justification for an inspection in accordance with the FOM. See Attachment 2 for a sample letter for employers.
- Where an on-site inspection is warranted but cannot be performed safely (*e.g.*, if the only available CSHO has reported a medical contraindication), AOs will document the unsafe condition(s) preventing an on-site inspection and, with AD approval, follow the alternate inspection process (*e.g.*, remote-only inspection) that can be done safely. Remote-only inspections may be conducted with AD's approval to assure that SARS-CoV-2 hazards alleged in complaints, referrals, fatality reports, etc., are expeditiously investigated and abatement can be timely implemented (and, per the NEP, a portion of these will be re-inspected on site as follow-up, to ensure that compliance has occurred).
    - Entirely remote COVID-19 inspections shall be coded with the specific code, **N-10-COVID-19 REMOTE**.

  Note: the COVID-19 NEP includes guidance for follow-up inspections, and ADs may include any prior remote-only inspection for follow-up.
- In circumstances where the AD determines resources are insufficient to allow on-site inspection of hazards ordinarily warranting inspection, the Regional Administrator can approve investigation of these cases through an RRI in order to identify any hazards, provide abatement assistance, and confirm abatement.
- Workers fearing consequences for requesting inspections, complaining of COVID-19 exposure, or reporting illnesses may be covered under one or more whistleblower statutes. Inform them of their protections from retaliation and refer them to www.whistleblowers.gov for more information, including how to file a retaliation complaint. If the worker is alleging retaliation, the AO must submit a referral to the Regional Whistleblower Protection Program.

OSHA will forward complaint information deemed appropriate to other federal, state, and local authorities with concurrent interests, as applicable.

III. Inspection Scope, Scheduling, and Procedures:

- Inspection Planning and Compliance Safety and Health Officer (CSHO) Training. Facilities identified in Section I above as having job tasks with a higher potential for COVID-19 exposures, such as hospitals, emergency medical centers, and high-population density workplaces, may be identified for on-site inspections in response to COVID-19-related complaints/referrals and employer-reported illnesses.

  ADs or Assistant ADs shall continue using experienced CSHOs to perform COVID-19-related inspections in workplaces with higher potential for exposure, and shall continue to ensure less experienced CSHOs are paired with them as they gain the required experience and gain knowledge of CDC and OSHA's guidance. In addition to on-the-job training, new CSHOs shall be trained through available course work, such as offered by the OSHA Training Institute (OTI), *e.g.*, OSHA #2341 – Biohazards; OSHA #3360 – Healthcare), and archived webinars related to COVID-19 (OTI #0158 – Interim Response Plan; OTI #0161 – SHMS CSHO Safety; OTI #0162 – NIOSH Protecting Workers). Additionally, a new webinar is planned for the COVID-19 NEP and this updated Response Plan and it will be archived for future use.

  CSHOs shall be made aware of the individual characteristics and underlying conditions that, according to the CDC, increase risk for developing severe illness and complications from COVID-19. Note, however, that absence of these risk factors does not eliminate one's risk of severe illness and complications. These risk factors include (but are not limited to):

  - Being 65 years of age or older;
  - Being on immunosuppressive drug therapy or otherwise being immunosuppressed;
  - Having a history of smoking; or
  - Having any of the following medical conditions: cardiovascular disease, asthma or other pulmonary disease, renal failure, liver disease, cancer, obesity, or diabetes.

  CSHOs shall be provided with appropriate respiratory protection (*e.g.*, N95s, half half-mask elastomeric respirator) and the necessary sanitation equipment and supplies, including decontamination supplies (*e.g.*, ordinary bleach wipes) for cleaning any equipment and materials brought on site. CSHOs should dispose of used, disposable PPE and decontamination waste at the inspection site. Reusable PPE (*e.g.*, respirator facepiece) and other equipment should be cleaned on site or bagged and cleaned later. See CSHO Protection section below for further guidance.

  NOTE: Where inspections require coordination with other federal agencies, such as the U.S Department of Agriculture (USDA), the Centers for Medicare & Medicaid Services (CMS), or local and state health departments, AOs shall contact the regional or local offices of these agencies to determine potential involvement of external authorities and coordinate efforts to maximize efficiencies and maintain controls. Regional Offices should notify the Office of Federal Agency Programs in the National Office, as needed.

- Inspection Procedures. Inspection procedures in FOM Chapter 3 shall be followed, except as modified below. CSHOs should also consult OSHA directives, appendices, and other references cited in this instruction for further guidance.
    - Opening Conference. Inspections shall be conducted in a manner to assure the safety of CSHOs and all personnel they come in close contact with in the course of their inspections. CSHOs shall observe all appropriate precautions for physical distancing, PPE use, and hygiene. When on site, CSHOs will take additional precautions, as necessary, such as requesting to conduct opening conferences in a designated, uncontaminated administrative area or outdoors, and always wearing face coverings and necessary PPE. As appropriate, CSHOs should speak to the safety director, infection control director, and/or the person responsible for implementing COVID-19 protections or occupational health hazard control. Other individuals responsible for providing records pertinent to the inspection should also be included in the opening conference or interviewed early in the inspection (*e.g.*, facility administrator, training director, facilities engineer, director of nursing, human resources). Also, employee representatives, *e.g.*, union officials, may accompany CSHOs during the inspection (*see also,* FOM, Chapter 3, describing CSHO authority to ensure fair and orderly inspections).

      NOTE: CSHOs should direct employers to the OSHA Guidance, Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace, and/or other industry-specific guidance deemed appropriate.
    - Program and Document Review. Prior to conducting a walkaround inspection, CSHOs shall take the following steps as appropriate to the facility:
        - 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. This is particularly important for large facilities, business operations, and institutions. For example, in healthcare, government, and schools, a pandemic plan should be established, as recommended by the CDC.[4] If this plan is a part of another emergency preparedness plan, the review does not need to be expanded to the entire emergency preparedness plan (*i.e.*, a limited review addressing issues related to exposure to the COVID-19 virus would be adequate). The evaluation of an employer's pandemic plan may be based upon other written programs, and in hospitals, a review of the infection control plan.[5]
        - Review the facility's procedures for hazard assessment and protocols for PPE use.
        - Determine whether the employer has implemented measures to facilitate physical distancing (*e.g.*, barriers or administrative measures to encourage

[4] For hospitals, *see* www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.
[5] *See* CDC's *Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*, www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.

6-foot 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 or documentation deemed appropriate by the CSHO. 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.

  Note: CSHOs in need of an OOMN consultation are encouraged to use the online OOMN consultation request form. Also, for accessing medical records, CSHOs are encouraged to use the online Medical Access Order (MAO) Request Application. For assistance with the above services, contact OOMN at (202) 693-2323. Consider issuing a subpoena for medical records to compel production of the records by employers.

- 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 U.S. Food and Drug Administration (FDA) for healthcare employers, and assess compliance where 29 CFR § 1910.134 applies. *See also*, discussion of equipment shortages, below. Also, if shortages are anticipated or experienced, document the employer's efforts to address these.

- 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.

Additional Steps Specific to Healthcare Facilities:

- Where appropriate, 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.[6] Review any procedures for assigning patients to those rooms/areas and procedures used to limit access to those rooms/areas to employees who are trained and adequately outfitted with PPE.

  NOTE: For testing procedures of isolation rooms, CSHOs should refer to the OSHA Directive, CPL 02-02-078, Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis, June 30, 2015,

[6] *Airborne Infection Isolation Room (AIIR):* A room designed to maintain Airborne Infection Isolation (AII). AIIRs are single-occupancy patient-care rooms used to isolate persons with suspected or confirmed infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually spread from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIIRs should be maintained under negative pressure (so that air flows under the door gap into the room), at an air flow rate of 6–12 air changes per hour, and there should be direct exhaust of air from the room to the outside of the building or recirculation of air through a high-efficiency particulate air (HEPA) filter.

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, CSHOs and supervisors or 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

[7] CDC, *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, at: www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.

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.

- CSHO Protection. ADs and Assistant Area Directors will ensure that CSHOs performing COVID-19-related inspections are familiar with the most recent CDC guidelines and OSHA's guidance, including general information, as well as industry-specific information, and trained as mentioned above. Supervisors and CSHOs should also review ADM 04-00-003, OSHA Safety and Health Management System (SHMS), including Chapter 8, *Personal Protective Equipment*, and Chapter 19, *Bloodborne Pathogens*.[8] Consultation with the Regional Office is encouraged prior to beginning such inspections.

  The Agency is working to make sure every CSHO will have access to COVID-19 testing, as necessary, to conduct on-site inspections safely. The Agency and Department are also working to make sure vaccinations for COVID-19 are available as soon as possible. CSHOs are also encouraged to take the annual influenza vaccine.

  ADs and Assistant Area Directors must ensure that appropriate PPE is available for CSHOs conducting on-site activities. CSHOs should determine from the employer where donning, doffing, and decontamination can be done, as well as the location of additional PPE (if available) and decontamination waste disposal facilities, in preparation for the walkaround. CSHOs must also be equipped with appropriate respiratory protection, goggles or face shields, disposable gloves, and disposable gowns or coveralls of appropriate size. CSHOs must also ask employers if there are any facility-imposed PPE requirements and adhere to those PPE requirements during the inspection.

  The **minimum levels of respiratory protection** for CSHOs are a fit-tested half-mask elastomeric respirator with at least an N95-rated filter or a fit-tested, NIOSH-approved, disposable, filtering facepiece respirator (FFR), such as an N95, since they have an assigned protection factor (APF) of 10. A fit-tested half-mask elastomeric respirator with at least an N95-rated filter is preferred as minimum protection for use in healthcare settings. CSHOs shall have met all other applicable requirements, per OSHA Instruction, CPL 02-02-054, *Respiratory Protection Program Guidelines*, July 14, 2000, at www.osha.gov/enforcement/directives/cpl-02-02-054, and OSHA Instruction, ADM 04-00-003, *OSHA Safety and Health Management System*, May 6, 2020, at www.osha.gov/enforcement/directives/adm-04-00-003.

[8] *See* www.osha.gov/enforcement/directives/adm-04-00-003.

In cases where an FFR is being used, CSHOs should also have available their elastomeric respirator with appropriate filter cartridges for any anticipated exposures during an inspection that may not be adequately protected by an N95 FFR (*e.g.*, any toxic gases/vapors or any particulates where the maximum use concentration would exceed an APF of 10).

Additional PPE, such as gloves, goggles or face shields, gowns or coveralls shall be worn, as necessary, when CSHOs expect to be in areas of higher potential exposure during the inspection (*e.g.*, laboratory or patient areas), or when required by the employer.

In accordance with the Presidential Executive Order on Protecting the Federal Workforce and Requiring Mask-Wearing, January 20, 2021, all on-duty or on-site Federal employees, such as CSHOs, in Federal buildings and on Federal lands are required to wear face coverings (*i.e.*, cloth face coverings or surgical masks), maintain physical distance, and adhere to other public health measures, as provided in CDC guidelines. This also applies to CSHOs performing on-duty activities outside of Federal buildings, such as performing on-site inspections.

- Safety Practices during On-Site Inspections. CSHOs shall inspect facilities in a manner that minimizes or prevents risk of exposure (for example, view employee work tasks through an observation window). CSHOs shall avoid potential exposure to suspected or confirmed COVID-19-positive persons (*e.g.*, quarantined workers, patients, residents). For example, in a hospital, it is not generally necessary for CSHOs to enter patient rooms or airborne isolations areas. CSHOs shall **not** enter AIIRs or rooms occupied by COVID-19 patients to evaluate compliance. If CSHOs must enter a vacant AIIR or patient room, sufficient time must lapse (to allow for proper clearance of potentially infectious aerosols) before entering. (For information on clearance rates under differing ventilation conditions within healthcare settings, see www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1). Additionally, CSHOs may consult the Salt Lake Technical Center (SLTC) for assistance in evaluating the adequacy of control measures. Prior to entering a recently vacated AIIR or patient area that has not been adequately purged, a CSHO must discuss the need for entry with the AD.

  As mentioned above, under circumstances where CSHOs need to test a room's ventilation or air flow (*e.g.*, rooms where aerosol-generating procedures are performed), CSHOs shall, at a minimum, wear an N95 FFR or a half-mask negative-pressure respirator with at least an N95 filter, goggles, and disposable gloves. If CSHOs wear full-face, negative- or positive-pressure respirators, those respirators take the place of goggles for the purposes of providing eye protection.

  As appropriate to the inspection, CSHOs shall conduct private interviews with affected employees in uncontaminated areas or remotely. CSHOs should practice physical distancing (maintaining at least 6 feet of distance) and wear face coverings while conducting in-person interviews with employees.

Another option is conducting the interview by voice call, or better, video phone, even while still on site. Interviews shall **not** take place in a room or area where high-hazard procedures such as bronchoscopy, sputum induction, certain dental procedures in high-transmission communities, lab procedures, mortuary procedures, etc., are being or recently have been conducted.

CSHOs must wash their hands with soap and water after each inspection or use hand sanitizers with at least 60% alcohol if handwashing facilities are not immediately available. Also, prior to leaving the site, CSHOs will decontaminate supplies and equipment using bleach wipes or other approved disinfectant wipes,[9] and dispose of all used, disposable PPE and decontamination waste on site, or bag and clean later. CSHOs are also encouraged to wash their hands during the course of the walkaround, such as when leaving areas and after touching surfaces. CSHOs should always wash hands after removing gloves or other PPE. CSHOs should practice contamination reduction techniques, *i.e.*, limiting surface touching, and avoiding secondary or subsequent contact, especially with their faces when donning and doffing PPE or face coverings.

- Applicable OSHA Standards. Several OSHA standards may apply, depending on the circumstances of the case. In the event that OSHA issues an emergency temporary standard (ETS), pursuant to the Presidential Executive Order on Protecting Worker Health and Safety, January 21, 2021, citation guidance will be updated. CSHOs must rely on the specific facts and findings of each case for determining applicability of OSHA standards. The list of general industry standards applicable to infectious diseases, such as COVID-19, include the following (*see also*, corresponding standards for other industries, as applicable to the inspection):

  - 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

[9] *See,* U.S. Environmental Protection Agency (EPA), List N: Disinfectants for Use Against SARS-CoV-2: www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2.

standard will apply to facilities where COVID-19 vaccinations are being administered by employees covered by OSHA.

- Observation of hazards. Where no violations of OSHA standards, regulations, or the general duty clause are observed or documented, CSHOs shall complete the walkaround portions of the inspection and immediately leave the facility.
- Citation Guidance. The above list of applicable standards is not exhaustive, and depending on the specific work task, setting, and exposure to other biological or chemical agents, additional OSHA requirements may apply (*e.g.*, 29 CFR § 1910.133, 29 CFR § 1910.138, 29 CFR § 1910.1200). Violations of OSHA standards cited under this inspection guidance will normally be classified as serious.
- General Duty Clause If deficiencies not addressed by OSHA standards or regulations are discovered in the employer's preparedness for controlling occupational exposure risk for SARS-CoV-2, and guidance is available (*e.g.*, CDC), follow the FOM guidance for obtaining evidence of a potential general duty clause violation, including the four required elements: (1) The employer failed to keep the workplace free of a hazard to which employees of that employer were exposed; (2) The hazard was recognized; (3) The hazard was causing or was likely to cause death or serious physical harm; and, (4) There was a feasible and useful method to correct the hazard.

  Unless the investigative evidence establishes *all four* of the above elements, the AO should issue a hazard alert letter (HAL) recommending the implementation of protective measures that address SARS-CoV-2 hazards. For example, if there is no evidence that an employee was potentially exposed to the virus in the workplace, then the first element is not met. See Attachment 3 for two sample HALs addressed to a hospital facility and a meat processing establishment. Additional example HALs are available on the OSHA intranet.

  Note: In the event that OSHA issues an ETS, violations under the ETS will take precedence over general duty clause citations.
- 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.
- Citation Review. In all cases where the AD determines that a condition exists warranting issuance of a 5(a)(1) violation, or a notice of a violation of § 1960.8(a) to a federal agency, for an occupational exposure to SARS-CoV-2, the proposed citation shall be reviewed with the Regional Administrator and the National Office **prior to** issuance. In general duty clause cases, the Regional Offices shall also consult with their Regional Solicitor. See

Attachment 4 for a sample alleged violation description (AVD). Additional internal resources relating to COVID-19 are also available on the OSHA intranet.

Additionally, per the NEP, when COVID-19-related citations or HALs are issued to an establishment for a corporation that has more than one location engaged in the same or similar operations, CSHOs will consult with the AD to send a letter to the corporate entity. The letter should inform them of the COVID-19 observed hazard(s), share the copy of the citation or HAL and recommend they conduct a hazard assessment and abate any COVID-19 hazards in their other establishment(s). A sample letter for this is included in the NEP, Appendix E.

- **Additional Guidance for Certain OSHA Standards.**
    - 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.[10] 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*, www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.

  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.[11] 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

[10] Currently exempt are offices of physicians, outpatient care centers, and medical and diagnostic laboratories. For the full list, see Appendix A to 29 CFR Part 1904, Subpart B, at: www.osha.gov/laws-regs/regulations/standardnumber/1904/1904SubpartBAppA.

[11] *See* www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy.

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.

- 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.

IV. Coding and Point of Contact.

All activity, specifically enforcement and compliance assistance, will be appropriately coded in the OSHA Information System (OIS) to allow for tracking and program review. As explained in the COVID-19 NEP, all enforcement activities related to that Directive shall be coded with the specific NEP code, **COVID-19**. The additional codes listed in the NEP shall continue to be used for remote inspections, inspections where enforcement discretion was used (*i.e.*, abatement deferred), and related event codes for violations and hazard alert letters (HALs). If you have any questions regarding these procedures, please contact the Office of Health Enforcement at (202) 693-2190.

Attachment 2

Sample Employer Letter for COVID-19 Complaint

Area Offices may use this sample letter for non-formal inquiry processing of complaints and referrals, in accordance with the FOM, and other established procedures (*e.g.*, rapid response investigations (RRI). The sample correspondence, below, directs employers to publicly-available guidance documents on protective measures, *e.g.*, CDC's website and OSHA's COVID-19 webpage. Bracketed and/or italicized comments are for OSHA compliance use only and should be removed when appropriately completed with the case-specific information.

RE: OSHA Complaint No. [ ]

Dear Employer:

On **[Date]**, the Occupational Safety and Health Administration (OSHA) received notification of alleged workplace hazard(s) at your worksite concerning **[Potential illness:** *an employee exhibiting signs and symptoms of respiratory illness, such as, fever, cough, and/or shortness of breath, possibly indicating infection by SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), which is the virus causing the current coronavirus disease 2019 (COVID-19) pandemic.***] or [PPE shortage:** *employees not provided with adequate personal protective equipment (PPE), such as respiratory protection, gloves, and gowns*.**]** The specific nature of the complaint is as follows:

<< ENTER COMPLAINT INFORMATION >>

OSHA does not intend to conduct an on-site inspection in response to the subject complaint at this time. However, because allegations of violations and/or hazards have been made, we request that you immediately investigate the alleged conditions and make any necessary corrections or modifications. Please advise me in writing, no later than [**Date Response Due]**, of the results of your investigation. You must provide supporting documentation of your findings. This includes any applicable measurements or monitoring results; photographs/video that you believe would be helpful; and a description of any corrective action you have taken or are in the process of taking, including documentation of the corrected condition.

In addition, OSHA is aware that the current pandemic has created an increased demand for some protective equipment, limiting availability for use in protecting workers from exposure to the virus. If this situation has prevented you from furnishing protective equipment to your employees, you should provide documentation of the efforts you have made to obtain that equipment. Please feel free to contact the office at **[AO phone]** if you have any questions or concerns. [**If the complaint is at a CMS certified facility add the following:** We are also advising you that OSHA will notify the Centers for Medicare & Medicaid Services (CMS) of substantiated complaints for their consideration].

This letter is not a citation or a notification of proposed penalty which, according to the Occupational Safety and Health Act, may be issued only after an inspection or investigation of the workplace. It is our goal to assure that hazards are promptly identified and eliminated. Please take immediate corrective action where needed. Depending on the specific circumstances

at your worksite, several OSHA requirements may apply to the alleged hazards at your worksite, including:

- 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.

OSHA's Bloodborne Pathogens 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. This standard applies to facilities administering vaccinations for COVID-19.

Information about these and other OSHA requirements can be found on OSHA's website at www.osha.gov/laws-regs.

If we do not receive a response from you by [Date Response Due] indicating that appropriate action has been taken or that no hazard exists and why, an OSHA inspection may be conducted. An inspection may include a review of the following: injury and illness records, hazard communication, personal protective equipment, emergency action or response, bloodborne pathogens, confined space entry, lockout/tagout, and related safety and health issues. Please also be aware that OSHA conducts random inspections to verify that corrective actions asserted by the employer have actually been taken.

OSHA's website, www.osha.gov, offers a wide range of safety and health-related guidance in response to the needs of the working public, both employers and employees. The following guidance may help employers prevent and address workplace exposures to pathogens that cause acute respiratory illnesses, including COVID-19 illness. The guidance includes descriptions of the relevant hazards, how to identify the hazards, and appropriate control measures. Additional resources are provided that address these supply issues and contain industry-specific guidance.

1. For OSHA's latest information and guidance on the COVID-19 pandemic, please refer to OSHA's COVID-19 Safety and Health Topics Page, located at www.osha.gov/coronavirus.
2. Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace, located at www.osha.gov/coronavirus/safework
3. [Add additional links, as needed, for industry specific guidance, such as one or more of those listed in Attachment 5.]

The Centers for Disease Control and Prevention (CDC) also maintains a website that provides information for employers concerned about COVID-19 infections in the workplace. The CDC has provided specific guidance for businesses and employers at the following CDC webpage,

which is updated regularly: www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.

1. For general information and guidance on the COVID-19 pandemic, please refer to the CDC's main topic webpage at www.cdc.gov/coronavirus/2019-ncov.
2. Resources for businesses and employers, www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.
3. [Add additional links, as needed, for industry specific guidance, such as one or more of those listed in Attachment 5.]

The CDC is recommending employers take the following steps to prevent the spread of COVID-19:

- **Plan for infectious disease outbreaks in the workplace**
- **Assess workplace hazards and determine what controls or PPE are needed for specific job duties**
- **Consider improving engineering controls, including the building ventilation system**
- **Ensure employees wear face coverings in accordance with CDC and OSHA guidance, as well as any state or local requirements**
- **Actively encourage sick employees to stay home**
- **Consider conducting daily in-person or virtual health checks**
- **Accommodate employees through physical distancing or telework**
- **Emphasize respiratory etiquette and hand hygiene by all employees**
- **Perform routine environmental cleaning**

You are requested to post a copy of this letter where it will be readily accessible for review by all of your employees, and to return a copy of the signed Certificate of Posting (attached) to this office. In addition, you are requested to provide a copy of this letter and your response to a representative of any recognized employee union or safety committee that exist at your facility. Failure to do this may result in an on-site inspection. The complainant has been furnished a copy of this letter and will be advised of your response. Section 11(c) of the Occupational Safety and Health Act provides protection for employees against retaliation because of their involvement in protected safety and health related activity.

If you have questions regarding this issue, you may contact me at the address in the letterhead. I appreciate your personal support and interest in the safety and health of your employees.

Sincerely,
Area Director

Attachment **[Certificate of Posting not included in this sample letter]**

Attachment 3

Sample Hazard Alert Letters for a COVID-19 Inspection

NOTE: The two letters below are examples of the type of letter that may be appropriate in some circumstances. It must be adapted to the specific circumstances noted in the relevant inspection. If the employer has implemented, or is in the process of implementing, efforts to address hazardous conditions, those efforts should be recognized and encouraged, if appropriate. Bracketed and/or italicized comments are for OSHA compliance use only and should be removed when appropriately completed with the case-specific information.

Sample Letter 1.

Dear **Hospital** Employer:

An inspection and evaluation of your workplace at (location) on (date) disclosed the following workplace conditions which raise concerns about the potential for employee illness(es) related to exposure to SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), which is the virus causing coronavirus disease 2019 (COVID-19).

[Include a general description of the working conditions at issue and the nature of OSHA's concerns for settings classified as medium risk and settings classified as having potential for ongoing transmission for SARS-CoV-2 virus. Address, as applicable, any lack of feasible engineering controls, lack of PPE, inappropriate PPE, etc.

For example:

Employees performing cough induction procedures on suspected or confirmed COVID-19 patients were not provided suitable respirators for use while doing these procedures.]

At this time, OSHA has determined that conditions in your workplace are not in violation of Section 5(a)(1), the general duty clause of the Occupational Safety and Health Act and no citation will be issued.

However, in the interest of workplace safety and health, we recommend that you voluntarily implement the following recommended to eliminate or materially reduce your employees' exposure to the hazards described above in *[WORK AREA(S)]*.

These steps are based on the guidelines of the Centers for Disease Control and Prevention (CDC), which are listed at the end of this letter [*NOTE: Use only the items on the list that are appropriate for the hazards relevant to the particular inspection*]:

1. Engineering Controls: Engineering controls are the first line of defense in worker protection. Therefore, employers should provide appropriate engineering controls, where feasible, and should train their employees in the use of those controls to ensure the protection of employees providing care to suspected or confirmed COVID-19 patients. The following are recommended controls:
    a) Use Airborne Infection Isolation Rooms (AIIRs) to reduce the spread of SARS-CoV-2 virus when performing aerosol-generating procedures such as:

- Bronchoscopy
- Sputum induction
- Endotracheal intubation and extubation
- Open suctioning of airway
- Cardiopulmonary resuscitation
- Autopsies

b) Air from AIIRs should be exhausted directly outside whenever possible, and never into areas where workers or visitors congregate or pass through (*e.g.*, break areas, walkways); best practice incorporates high-efficiency particulate air (HEPA) filtration of this exhausted air.

c) If AIIRs are not available, increase air changes and avoid unfiltered recirculation of the room air or utilize negative pressure patient enclosure devices (*e.g.*, tents or booths).

d) Where air must be recirculated, use HEPA filtration.

e) Use ultraviolet germicidal irradiation (UVGI) devices only in addition to HEPA filtration.

f) Filtration systems should be on maintenance schedules, and labeled and disposed of properly.

2. Administrative Controls: Managing the transmission of infectious diseases such as COVID-19 relies heavily on the implementation of administrative controls and good work practices. Preparedness should involve planning for the implementation of administrative controls and good work practices to protect affected employees. The following are recommended controls:

a) Develop measures to support expeditious triage and isolation (or cohorting) of suspected or confirmed COVID-19 patients to minimize unprotected employee exposure.

b) Limit the number of persons entering isolation rooms to the minimum number necessary for patient care and support.

c) Dedicate patient-care equipment for suspected or confirmed COVID-19 patients.

d) Ensure use of appropriate Biosafety Level 2 or 3 practices and equipment in laboratory facilities that handle specimens from suspected or confirmed COVID-19 patients to reduce the spread of SARS-CoV-2 virus to laboratory workers.

e) Limit patient transport when possible and appropriate (*e.g.*, do portable chest films at the bedside instead of transporting the patient to the Radiology department).

f) Post signs on the entrances to AIIRs or affected procedure rooms to communicate the entry requirements necessary for worker protection.

g) If tolerated, place facemasks on suspected or confirmed COVID-19 patients to reduce employees' exposure.

h) Consider offering enhanced medical surveillance and screening to workers who

perform the riskiest tasks or activities.

i) Provide cleaning supplies, and where directed by the CDC, disposable disinfectant wipes or equivalent supplies, so commonly-touched surfaces are cleaned or disinfected by employees after use. For disinfection, use products that meet EPA's criteria for use against COVID-19, diluted household bleach solutions, or alcohol solutions with at least 60% ethyl or 70% isopropyl alcohol and are appropriate for the surface. Follow manufacturer's directions for use.

3. Personal Protective Equipment. Perform a workplace hazard assessment as required by 29 CFR § 1910.132(d) to determine the tasks that necessitate the use of personal protective equipment (PPE) such as face masks, gloves, goggles, and respirators.

   a) Provide gloves made of latex, vinyl, nitrile, or other synthetic materials, as appropriate, when there is contact with body fluids, including respiratory secretions.

   b) Assure that employees wear appropriate protective clothing (*e.g.*, an isolation gown) when it is anticipated that clothes or a uniform may get soiled with body fluids, including respiratory secretions.

   c) Use eye and face protection if sprays or splatters of infectious material are likely. Goggles and a half-face respirator, or a full-face respirator, should be worn while performing aerosol-generating procedures. Use of a full face shield in front of a respirator may also prevent bulk contamination of the respirator.

   d) If employees are using respiratory protection, establish, implement, and maintain a written respiratory protection program as required by 29 CFR § 1910.134(c). *[The following are specific to respiratory protection use:]*

      - Use National Institute for Occupational Safety and Health (NIOSH)-certified respirators that are N95 or higher. When both fluid protection (*e.g.*, blood splashes) and respiratory protection are needed, use a surgical N95 respirator that has been certified by NIOSH and cleared by the Food and Drug Administration (FDA).
      - Consider NIOSH-certified elastomeric respirators (*e.g.*, cartridge respirators) for essential workers who may have to decontaminate and reuse respirators in the event that there is a shortage of disposable respirators.
      - Consider NIOSH-certified powered air-purifying respirators (PAPRs) for circumstances (possibly bronchoscopy or autopsy on persons with suspected or confirmed COVID-19 disease and selected laboratory procedures) for which a level of respiratory protection that exceeds the minimum level provided by an N95 disposable respirator is necessary. Loose-fitting hooded PAPRs have the additional advantage of not requiring fit testing.

      NOTE: See also OSHA's website at www.osha.gov/coronavirus for certain temporary enforcement policies for this Respiratory Protection standard if

anticipating shortages of equipment during the COVID-19 pandemic.

4. Training and Information: Provide training, education, and informational materials about the risk of SARS-CoV-2 exposure associated with workers' job tasks and activities.
    a) Whenever PPE is required, explain why it is being used. Educate and train employees about the protective clothing and equipment appropriate to their current duties and the duties they may be asked to assume when others are absent.
    b) Explain how to use basic hygiene (*e.g.*, hand washing, covering mouth and nose with a tissue when coughing or sneezing) and physical distancing precautions that will be implemented and why they are effective.
    c) Ensure materials are easily understood and available in the appropriate language and educational level for all workers.
    d) Post signs asking workers, customers, and the general public to follow basic hygiene practices.
    e) All employees should be trained on the operation of control methods used, so that in the event of any malfunction, they are aware and can summon the appropriate authorities.
    f) Whenever administrative controls are implemented, explain why the controls are being implemented. All employees affected should be trained on the specifics of the controls, including, for example, how they protect workers, and the benefits of the controls, as well as detecting malfunctions, if applicable.

For OSHA's latest information and guidance on the COVID-19 pandemic, please refer to OSHA's COVID-19 Safety and Health Topics page, located at www.osha.gov/coronavirus.

1. Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace, located at www.osha.gov/coronavirus/safework.

The CDC also maintains a website that provides information for employers concerned with COVID-19 infections in the workplace. The CDC has provided specific guidance for businesses and employers at the following CDC webpage, which is updated regularly: www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.

1. For general information and guidance on the COVID-19 pandemic, please refer to the CDC's main topic webpage at www.cdc.gov/coronavirus/2019-ncov.
2. Strategies for conserving/optimizing the supply of respirators:
    a. www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-supply-strategies.html#ppe-respiratory-protection.
    b. www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.
    c. www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.
3. Hospital Preparedness Assessment Tool, www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist. Also, for Infection Control Guidance, www.cdc.gov/oralhealth/infectioncontrol/statement-COVID.

You may voluntarily provide this Area Office with progress reports on your efforts to address

COVID-19 hazards in your workplace. OSHA may return to your worksite to further examine the conditions noted above. Please note that Section 11(c) of the Occupational Safety and Health Act provides protection for employees against retaliation because of their involvement in protected safety and health related activity.

Enclosed is a list of available resources that may be of assistance to you in preventing work-related injuries and illnesses in your workplace. Additionally, general resources for compliance assistance are available at www.osha.gov/employers. If you have any questions, please feel free to call [name and phone number] at [address].

Sincerely,
Area Director

Sample Letter 2.

Dear **Meat Processing Establishment** Employer:

An inspection of your workplace at [FACILITY] on [DATE] disclosed the following conditions which raise concerns about the potential for employee illness(es) related to exposure to SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), which is the virus causing coronavirus disease 2019 (COVID-19):

[Include a general description of the working conditions at issue and the nature of OSHA's concerns for settings classified as having potential for transmission of SARS-CoV-2 virus. Address, as applicable, any lack of feasible engineering controls, lack of PPE, inappropriate PPE, etc.

For example:

Specifically, OSHA found [Company Name] was not tracking employees who had contracted COVID-19, thus putting other employees at risk.]

At this time, OSHA has determined that conditions in your workplace are not in violation of Section 5(a)(1), the general duty clause of the Occupational Safety and Health Act and no citation will be issued.

However, in the interest of workplace safety and health, we recommend that you voluntarily implement the following recommended steps to eliminate or materially reduce your employees' exposure to the hazards described above in *[WORK AREA(S)]*.

These steps are based on the guidelines of the Centers for Disease Control and Prevention (CDC), which are listed at the end of this letter *[NOTE: Use only the items on the list that are appropriate for the hazards relevant to the particular inspection.]*:

1. Engineering Controls: The use of barriers between work stations, in lunchrooms, in break areas, and in other common areas such as classrooms or conference rooms; Employees must be trained on the need to continue physical distancing even when outside of their immediate work areas/stations, the limitations of barriers, and the continued use of PPE.
2. Administrative Controls: Managing the transmission of infectious diseases such as COVID-19 relies heavily on the implementation of administrative controls and good work practices. Preparedness should involve planning for the implementation of administrative controls and good work practices to protect affected employees. The following are recommended administrative controls:
    a. Enhance employee notification practices to ensure not only persons potentially exposed to suspected and confirmed positive COVID-19 employees are notified, but also persons working in close proximity to employees calling in sick with symptoms identical/similar to COVID-19 symptoms and swiftly move those persons to quarantine.
    b. Strongly encourage employees to alert management if they had recent contact with a suspected or confirmed COVID-19 case. Stress the importance of this communication and ensure that they understand that there will not be any retaliation for reporting.

c. Ensure that employees and supervisors who may have worked in the vicinity of any individuals who have been confirmed as having COVID-19 are notified of their potential exposure. Conduct in-depth investigations to identify and notify all employees who may be suspected to have come in close contact with a confirmed COVID-19 co-worker, as well as those working in close proximity to employees calling in due to illness. Initiate a quarantine program to isolate any employee who has potential exposure to a COVID-19 positive individual, or persons who call in sick until their illness is determined.

d. Ensure employees understand the necessity to remain home when they are not feeling well for any reason or still experiencing some symptoms.

e. Provide cleaning supplies, and where directed by the CDC, disposable disinfectant wipes or equivalent supplies, so commonly-touched surfaces are cleaned or disinfected by employees after use. For disinfection, use products that meet EPA's criteria for use against COVID-19, diluted household bleach solutions, or alcohol solutions with at least 60% ethyl or 70% isopropyl alcohol and are appropriate for the surface. Follow manufacturer's directions for use.

3. Personal Protective Equipment. Perform a workplace hazard assessment as required by 29 CFR § 1910.132(d) to determine the tasks that necessitate the use of personal protective equipment (PPE) such as facemasks, gloves, goggles, and respirators.

   Ensure that employees replace facemasks if they become wet or contaminated. Disinfect reusable PPE after use (*e.g.*, face shields) and store in a clean, dry location.

For OSHA's latest information and guidance on the COVID-19 pandemic, please refer to OSHA's COVID-19 Safety and Health Topics page, located at www.osha.gov/coronavirus.

1. Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace, located at www.osha.gov/coronavirus/safework.
2. 9 Steps to Reducing Worker Exposure to COVID-19 in Meat, Poultry, and Pork Processing and Packaging Facilities, located at www.osha.gov/Publications/OSHA4050.
3. Meat and Poultry Processing Workers and Employers (COVID-19), Interim Guidance from CDC and OSHA, located at www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.

Additionally, the CDC maintains a website, which provides information for employers concerned with COVID-19 infections in the workplace. The CDC has provided specific guidance for businesses and employers at the following regularly updated CDC webpage: www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.

1. For general information and guidance on the COVID-19 pandemic, please refer to the CDC's main topic webpage at www.cdc.gov/coronavirus/2019-ncov.
2. COVID-19 Critical Infrastructure Sector Response Planning, located at www.cdc.gov/coronavirus/2019-ncov/community/critical-infrastructure-sectors.
2. Meat and Poultry Processing Facility Assessment Toolkit, located at www.cdc.gov/coronavirus/2019-ncov/php/meat-processing-assessment-tool.

3. Meat and Poultry Processing Facility Assessment Checklist, located at www.cdc.gov/coronavirus/2019-ncov/downloads/php/Meat-And-Poultry-Facility-Assessment-Tool.pdf.
4. Meat and Poultry Processing Tips for Employees (multiple languages), located at www.cdc.gov/coronavirus/2019-ncov/downloads/community/FS-MeatProcessing-EMPLOYEES.pdf.

To evaluate your efforts in reducing these hazards, please send me a letter detailing the actions you have taken, or plan to institute, to address our concerns within 30 days of the date of this document. We will review the response and determine if follow up is needed to evaluate any newly implemented controls, or other measures taken to address the hazards identified above.

Under OSHA's current investigation procedures, we may visit your work site within six months to examine the conditions noted above.

Enclosed is a list of available resources that may be of assistance to you in preventing work-related injuries and illnesses in your workplace. Additionally, general compliance assistance resources for employer are available at: www.osha.gov/employers.

We appreciate your attention to these areas of concern. If you have any questions, please feel free to call at *[phone number]*.

Sincerely,
Area Director

Attachment 4

Sample Alleged Violation Description (AVD) for Citing the General Duty Clause

This general alleged violation description (AVD) language below is presented as an example to assist Compliance Safety and Health Officers (CSHOs) in developing citations under the general duty clause, Section 5(a)(1), of the Occupational Safety and Health (OSH) Act. Citations should be drafted in consultation with the Regional Solicitor to reflect specific conditions found at establishments and to give notice to employers of the particular hazardous condition or practice cited.

> Section 5(a)(1) of the Occupational Safety and Health Act: 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 working in close proximity to each other and were exposed to SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), the cause of Coronavirus Disease 2019 (COVID-19).
>
> (a) (LOCATION) (DATE) (IDENTIFY SPECIFIC OPERATION/TASK(S) AND DEPARTMENTS, DESCRIBE CONDITIONS, INCLUDING EXPOSURE LEVELS) On or about [Date], the employer did not develop and implement timely and effective measures to mitigate the spread of SARS-CoV-2, the virus that causes COVID-19. Employees working [in the *emergency room staffed with 35 employees, on [DATE]: Three employees, a physician, nurse, and nursing assistant, were providing direct patient care – performing a routine endotracheal intubation procedure - to a patient who was previously confirmed to be infected with SARS-CoV-2.*
>
> The employer did not ensure that appropriate and available engineering controls were used to protect against infective respiratory droplets and aerosols, in that [*an available isolation room was not used for the procedure, thereby exposing adjacent unprotected*] workers to SARS-CoV-2.[12] These conditions allowed the perpetuation of an outbreak of COVID-19 at the facility. As of [Date], the employer had [number] total positive tests out of approximately [number] employees.
>
> Among other methods, feasible and acceptable means of abatement for this hazard include:
>
> 1) Erect an airborne infection isolation (AIIR) room with negative pressure that provides a minimum of 6 air exchanges, or 12 air exchanges (new construction or renovation), per hour.[13]
> 2) Erect physical barriers or partitions in triage areas to guide patients.

[12] Centers for Disease Control and Prevention (CDC), *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, at: www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.

[13] CDC Infection Control.

3) Install curtains separating patients in semi-private areas.
4) Install isolation tents or other portable containment structures that can serve as alternative patient-placement facilities when AIIRs are not available and/or examination room space is limited.
5) Training: All employees must be trained on the need for such controls and to be aware that when the controls are not operating efficiently they should not be used and the appropriate authorities should be contacted to correct the problems encountered.

Note: *COVID-19 inspections resulting in a proposed 5(a)(1) citation are considered novel cases. The Directorate of Enforcement Programs (DEP) and the Regional Solicitor's Office must be notified of all such proposed citations and federal agency Notices that relate to COVID-19 exposures.*

Attachment 5

Additional COVID-19-Related References

Please see the following references and web-links for Coronavirus Disease 2019 (COVID-19)-related guidance and technical information. For subsequent updates, continue to refer to OSHA's COVID-19 Safety and Health Topics page located at www.osha.gov/coronavirus.

U.S. Department of Labor (DOL) / OSHA Guidance:

- U.S. Department of Labor's (DOL) COVID-19 Workplace Safety Plan, February 2021, www.dol.gov/sites/dolgov/files/general/plans/2021-covid-19-workplace-safety-plan.
- OSHA Direction, National Emphasis Program (NEP) for COVID-19, DIR 2021-01 (CPL-03), March 12, 2021, www.osha.gov/enforcement/directives/dir-2021-01cpl-03.
- OSHA Guidance, *Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace*, January 29, 2021.
- Joint OSHA-CDC guidance: Manufacturing Workers and Employers.
- Joint OSHA-CDC guidance: Meat and poultry processing.
- OSHA Memorandum - *Discretion in Enforcement when Considering an Employer's Good Faith Efforts During the Coronavirus Disease 2019 (COVID-19) Pandemic*, April 16, 2020, www.osha.gov/memos/2020-04-16/discretion-enforcement-when-considering-employers-good-faith-efforts-during.
- OSHA Memorandum – *Revised Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19),* May 19, 2020, www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19.
- OSHA Memoranda Providing Enforcement Discretion for 29 CFR § 1910.134 - In view of the periodic shortages and limitations of respiratory protection, OSHA has provided specific enforcement discretion, www.osha.gov/coronavirus/standards#temp_enforcement_guidance.
- OSHA Respiratory Protection standard, 29 CFR § 1910.134:
  - www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134;
  - www.osha.gov/respiratory-protection.
- OSHA Personal Protective Equipment standard:
  - www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132;
  - www.osha.gov/personal-protective-equipment.
- OSHA Sanitation standard:
  - www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.141.

U.S. Department of Health and Human Services (HHS):

Centers for Disease Control and Prevention (CDC)/National Institute for Occupational Safety and Health (NIOSH)

- General COVID-19 information:

  www.cdc.gov/coronavirus/2019-ncov.

- Resources for businesses and employers:
  - www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers;
  - www.cdc.gov/coronavirus/2019-ncov/php/building-water-system;
  - www.cdc.gov/coronavirus/2019-ncov/community/clean-disinfect;
  - www.cdc.gov/coronavirus/2019-ncov/hcp/managing-workplace-fatigue.
- Strategies for conserving/optimizing supply of respirators:
  - www.cdc.gov/coronavirus/2019-ncov/community/conserving-respirator-supply;
  - www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-supply-strategies.html#ppe-respiratory-protection;
  - www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95;
  - www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.
- Hospital preparedness assessment tool:

  www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.
- PPE burn rate calculator: www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.
- Infection control guidance in healthcare settings:

  www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.
- Clearance rates of isolation rooms under differing ventilation conditions:

  www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.
- Infection control guidance in dental settings:

  www.cdc.gov/oralhealth/infectioncontrol/statement-COVID.
- Cleaning and disinfection for community facilities:

  www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.

Assistant Secretary for Preparedness and Response (ASPR)

- Strategic National Stockpile (SNS):

  www.phe.gov/about/sns.

For further questions or information about the SNS, contact sns.ops@cdc.gov.

Food and Drug Administration (FDA)

- FAQs on the EUAs for Non-NIOSH Approved Respirators During the COVID-19 Pandemic *(see* www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/faqs-euas-non-niosh-approved-respirators-during-covid-19-pandemic); and
- Considerations for Selecting Respirators for Your Health Care Facility (*see* www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/considerations-selecting-respirators-your-health-care-facility).

National Institutes of Health (NIH)/National Institute of Environmental Health Sciences (NIEHS)

- National Clearinghouse for Worker Safety and Health Training: tools.niehs.nih.gov/wetp.

Federal Emergency Management Agency (FEMA):

- Federal emergency for COVID-19: www.fema.gov/coronavirus.
- Guidance for frontline emergency responders: www.usfa.fema.gov/current_events/coronavirus.

Ready.gov

- Preparedness Planning for Your Business: www.ready.gov/business.

Environmental Protection Agency (EPA):

- Guidance on disinfectants, water, and wastewater: www.epa.gov/coronavirus.

Association for Professionals in Infection Control and Epidemiology (APIC):

- Guidance on infection control: www.apic.org.

American Dental Association (ADA):

- COVID-19 Safety and Clinical Resources: success.ada.org/en/practice-management/patients/safety-and-clinical.

American College of Surgeons:

- Covid-19 and Surgery: www.facs.org/covid-19.

ASTM:

- ASTM F3502-21, *Standard Specification for Barrier Face Coverings,* ASTM International, West Conshohocken, PA, 2021, www.astm.org.

American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE):

- ASHRAE Journal, vol. 62, no. 5, May 2020 – *Guidance for Building Operations During the COVID-19 Pandemic*:

  technologyportal.ashrae.org/journal/articledetail/2190.