

Staff Directive - Enforcement Procedures and Scheduling for Occupational Exposure to H1N1 Influenza

PESH Instruction - October 8, 2009. Corrections on August 24, 2009 directive

SUBJECT: Enforcement Procedures and Scheduling for Occupational Exposure to H1N1 Influenza

A. Purpose. This instruction provides uniform inspection procedures and guidelines to be followed when conducting inspections and issuing citations under Section 27-(a)(3)(a) of the PESH Act and pertinent standards for employees who are occupationally exposed to H1N1 Influenza.

B. Scope. This instruction applies PESH-wide.

C. References.

1. PESH Instruction The Revised Field Operations Manual (FOM) January 2007.
2. OSHA Instruction CPL 2-2.20B, CH-3, August 22, 1994. Occupational Safety and Health Administration Technical Manual Chapter No. 7.
3. OSHA Instruction, ADM 1-31, the IMIS Enforcement Data Processing Manual.
4. OSHA Instruction ADM 1-32, Enforcement User Skills Manual (for those Area Offices still using the NCR system).
5. Guidance on Preparing Workplaces for an Influenza Pandemic. OSHA Publication 3327-05R, (2009)
6. Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers. OSHA Publication 3328-05, (2007)
7. Workplace Preparation. PandemicFlu.gov.
8. CDC Interim Guidance for Homeless and Emergency Shelters on the Novel Influenza A (H1N1) Virus June 16, 2009 1:30 PM ET
9. CDC Interim Guidance for Correctional and Detention Facilities on Novel Influenza A (H1N1) Virus May 24, 2009 6:00 PM ET

10. CDC Interim Guidance for Infection Control for Care of Patients with Confirmed or Suspected Novel Influenza A (H1N1) Virus Infection in a Healthcare Setting May 13, 2009 7:00 PM ET
11. CDC General Business and Workplace Guidance for the Prevention of Novel Influenza A (H1N1) Flu in Workers May 30, 2009, 4:00 PM ET
12. CDC Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients with Confirmed or Suspected Swine-Origin Influenza A (H1N1) Infection May 11, 2009 8:30 PM ET
13. CDC Interim Recommendations for Facemask and Respirator Use to Reduce Novel Influenza A (H1N1) Virus Transmission May 27, 2009 6:30 PM ET
14. CDC Update on School (K – 12) and Child Care Programs: Interim CDC Guidance in Response to Human Infections with the Novel Influenza A (H1N1) Virus May 22, 2009, 2:30 PM ET
15. Interim CDC Guidance for Institutions of Higher Education and Post-secondary Educational Institutions in Response to Human Infections with Novel Influenza A (H1N1) Virus May 11, 2009 6:30 PM ET
- 16 Interim Guidance for Cleaning Crew for a Truck Cab when the Driver or Helper is Visibly Ill during an Influenza Pandemic
- 17 Interim Guidance for Passenger Railcar (Transit Vehicle) Cleaning When a Passenger or Crewmember is Visibly Ill During an Influenza Pandemic
- 18 Interim Guidance for Cleaning Transit Stations During an Influenza Pandemic

D. Action. PESH Managers and Supervisors shall use this instruction to ensure uniformity when performing inspections for occupational exposures to H1N1 influenza. The Director of the Division of Safety and Health shall provide support as necessary to assist the Managers and Supervisors in enforcing this directive.

E. Background. Influenza A (H1N1) is a new strain of virus originally referred to as Swine Flu. It has been determined that this virus is quite different from the virus that causes Swine Flu and for that reason is referred to as "Novel H1N1

virus". H1N1 was detected in April 2009 in Mexico, and has since spread internationally. The virus is spread from person to person in what appears to be much the same way as the regular seasonal flu. Workers must be protected against contact, droplet, and airborne transmission routes in order to be fully protected. Currently there is no vaccine for the H1N1 virus and its severity is unknown.

The World Health Organization (WHO) has created a six-phase progressive approach to determine if a pandemic is underway. Phase's 1–3 correlate with preparedness, including capacity development and response planning activities, while Phases 4–6 clearly signal the need for response and mitigation efforts. On June 11, 2009, the World Health Organization (WHO) signaled that a global pandemic of novel influenza A (H1N1) was underway by raising the worldwide pandemic alert level to Phase 6. This action was a reflection of the spread of the new H1N1 virus, not the severity of illness caused by the virus. At the time, more than 70 countries had reported cases of novel influenza A (H1N1) infection and there were ongoing community level outbreaks of novel H1N1 in multiple parts of the world.

Transmission of novel influenza A (H1N1) is being studied as part of the ongoing outbreak investigation, but limited data available indicate that this virus is transmitted in ways similar to other influenza viruses. Seasonal human influenza viruses are thought to spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes near a susceptible person). Transmission via large-particle droplets requires close contact between source and recipient persons because droplets do not remain suspended in the air and generally travel only a short distance (< 6 feet). Contact with contaminated surfaces is another possible source of transmission as is transmission via droplet nuclei (also called "airborne" transmission). Because data on the transmission of novel H1N1 viruses are limited, the potential for ocular, conjunctiva, or gastrointestinal infection is unclear. Since this is a novel influenza A virus in humans, transmission from infected persons to close contacts might be common. All respiratory secretions and bodily fluids (diarrheal stool) of novel influenza A (H1N1) cases should be considered potentially infectious. Workers must be protected against contact, droplet, and airborne transmission routes in order to be fully protected

The following settings pose a potential occupational exposure including but not limited to:

- Healthcare
- Correctional and Detention facilities
- Homeless and Emergency Shelters and 9-1-1 personnel
- Emergency Medical Transportation Services
- Lab workers
- Educational setting e.g. Child care, Schools, Colleges and Universities

- Transportation workers in these settings who are in frequent close contact with these individuals
- As well as employers whose employees are required to work in higher risk workplaces (such as those listed above) or in workplaces that require frequent close contact between employees or with the general public.

The employer's obligations are those set forth in the Occupational Safety and Health Act (OSH Act) of 1970.

F. Inspection Scheduling and Scope

1. The evaluation of occupational exposure to H1N1 shall be conducted in response to employee complaints regarding H1N1, related fatality/catastrophes, or as part of all industrial hygiene inspections conducted in workplaces where the CDC has identified workers as having a greater incidence of H1N1 infection than in the general population. The degree of risk of occupational exposure of a worker to H1N1 will vary based on a number of factors discussed in detail by OSHA and the CDC. These workplaces have been the subject of advisories issued by the CDC which provide recommendations for the control of H1N1. Specifically, these workplaces are as follows:

- a. Health Care Facilities
- b. Correctional Institutions
- c. Educational Settings
- d. Homeless Shelters

G. Inspection Procedures. The procedure given in the FOM, Chapter III, shall be followed except as modified in the following sections:

1. Health care facilities generally have internal infection control and employee health programs. This function may be performed by a team or individual. Upon entry, the CSHO shall request the presence of the infection control director and employee occupational health professional responsible for occupational health hazard control. Other individuals who will be responsible for providing records pertinent to the inspection may include: training director, facilities engineer, director of nursing, etc. In non-health care settings contact should be made with management and request made for plans and pertinent records.

2. The CSHO shall establish whether or not the county has had a suspect or confirmed H1N1 case within the previous year from the opening conference to determine coverage under the OSH Act. This determination may be based upon information obtained from NYS Department of Health or the specific county health department.

3. The CSHO shall verify implementation of the employer's plans for H1N1 protection through employee interviews and direct observation where feasible. Professional judgment shall be used to identify which areas of a facility must be inspected during the walkthrough (e.g., emergency rooms, respiratory therapy areas, bronchoscopy suites, and morgue). After review of the facility plans for worker H1N1 protection, employee interviews combined with an inspection of appropriate areas of the facility shall be used to determine compliance. See appendix A.

4. The CSHO should ascertain if the employer has done a risk assessment to determine the level of employee exposure. We will be using Guidance on Preparing Workplaces for an Influenza Pandemic. OSHA Publication 3327-05R, (2009) to determine levels of risk and appropriate control measures along with CDC interim guidance documents.

- **Lower Exposure Risk** - workplace does not require employees to have frequent contact with employees and the general public.
- **Medium Exposure Risk** -workplaces require frequent close contact between employees or with the general public.
- **Very High or High Exposure Risk**-workplace requires your employees to have contact with people that are known or suspected to be infected.

The CSHO should then review what controls the employer has put in place for Work Practice and Engineering Controls; Administrative Controls; and Personal Protective Equipment assessment.

H. Compliance Officer Protection

1. PESH Managers or supervisors or associate industrial hygienists shall ensure that CSHOs performing H1N1 related inspections are familiar with the OSHA planning for influenza pandemic and CDC Interim Guidance, terminology, and are adequately trained through either course work or field/work experience in health care settings.

2. CSHOs shall not enter occupied respiratory isolation [AIIR airborne infection isolation room)] rooms to evaluate compliance unless, in their determination, entry is required to document a violation. Prior to entry CSHOs will discuss the need for entry with the supervisor. Photographs or videotaping where practical shall be used for case documentation. Under no circumstances shall photographing or videotaping of patients be done. CSHO's must take all necessary precautions to assure and protect patient confidentiality.

3. CSHOs shall exercise professional judgment and extreme caution when engaging in activities that may involve potential exposure to H1N1.

CSHOs normally shall establish the existence of hazards and adequacy of work practices through employee interviews and shall observe them in a manner which prevents exposure (e.g., through an observation window where available).

4. On rare occasions when entry into potentially hazardous areas is judged necessary (e.g., where the CSHO determines that direct observation of a high hazard procedure is necessary), the CSHO shall be properly equipped as required by the facility, this directive, and following consultation with their supervisor. Since CSHOs' respiratory protection is used in more than one type of industry they shall use their negative pressure elastomeric face piece respirators equipped with N-95 filters as the minimum level of respiratory protection.

5. If an isolation room is occupied by a patient with confirmed or suspect H1N1 or has not been adequately purged when a smoke-trail test is performed, then the CSHO should assume that the isolation room is not under negative pressure. Under such circumstances CSHOs shall wear a negative pressure N95 respirator when performing air tests or if entry into the room is determined to be necessary.

I. Citation Policy. Relevant chapters of the FOM shall be followed when preparing and issuing citations for hazards related to H1N1.

1. The following requirements apply when citing hazards found in target workplaces. Employers must comply with the provisions of these requirements whenever an employee may be occupationally exposed to H1N1:

- Section 27-a(3)(a) -- General Duty Clause
- 29 CFR 1910.134 -- Respiratory Protection
- 29 CFR 1910.132 -- Personal Protective Equipment
- 29 CFR 1910.141-- Sanitation
- 29 CFR 1910.145 -- Accident Prevention Signs and Tags
- 29CFR 1910.1020 -- Access to Employee Exposure and Medical Records
- Part 801 -- Recording and Reporting Occupational Injuries & Illness

J. Violations. All elements in this section must be addressed to ensure adequate protection of employees from H1N1 hazards. Violations of these PESH requirements will normally be classified as serious.

1. General Duty Clause - Section 27-a(3)(a). Section 27-a(3)(a) provides: "Each employer shall furnish to each of its employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to its employees."

a. Section 27-a(3)(a) citations must meet the requirements outlined in the FOM, and shall be issued only when there is no standard that applies to the particular hazard. The hazard, not the absence of a particular means of abatement, is the basis for a general duty clause citation. All applicable abatement methods identified as correcting the same hazard shall be issued under a single 27-(a)(3)(a) citation.

b. Recognition, for purposes of citing section 27-a(3)(a), is shown by the CDC Interim Guidance for the types of exposures detailed below because the CDC is an acknowledged body of experts familiar with the hazard along with the guidance given by OSHA in Guidance on Preparing Workplaces for an Influenza Pandemic **OSHA Publication 3327-05R, (2009)**

c. Citations shall be issued to employers with employees working in one of the workplaces where the CDC has identified workers as having a higher incidence of H1N1 infection than the general population, or in a workplace classified at a medium, high or very high exposure when the employees are not provided appropriate protection **and** who have exposure as defined in (1) or (2) below:

(1). Exposure to the exhaled air of an individual with suspected or confirmed H1N1, or

Note: A suspected case is one in which the facility has identified an individual as having symptoms consistent with H1N1. The symptoms of novel H1N1 flu virus in people are similar to the symptoms of seasonal flu and include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and fatigue. A significant number of people who have been infected with this virus also have reported diarrhea and vomiting.

(2). Employee exposure without appropriate protection to a high hazard or cough producing procedure performed on an individual with suspected or confirmed H1N1 and which has the potential to generate infectious airborne droplet nuclei. Examples of high hazard procedures include aerosolized medication treatment, bronchoscopy, sputum induction, endotracheal intubation and suctioning procedures, emergency dental, endoscopic procedures, and autopsies.

d. If a citation under 27-a(3)(a) is justified, the citation, after setting forth the SAVE for section 27-a(3)(a), shall state:

Section 27-a(3)(a) of the PESH 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 exposed to the hazard of being infected with novel H1N1 flu through unprotected contact with [specify group such as patients, inmates, clients, etc.] who was/were confirmed or suspected to be infectious with novel H1N1 flu in that: [list deficiencies]

Reasonable and adequate abatement methods for reducing this hazard, as recommended by the CDC, include, but are not limited to: [list abatement methods].

e. The following are three examples of feasible and useful abatement methods, which must be implemented to abate the hazard. Deficiencies found in any category can result in the continued existence of a serious hazard and may, therefore, allow citation under 27-a(3)(a).

1. Early Identification of Patient/Client. The employer shall implement a protocol for the early identification of individuals with H1N1.

2. Worker Education and Training. Training and information to ensure employee knowledge of such issues as the mode of H1N1 transmission, its signs and symptoms, medical surveillance and therapy, and site specific protocols including the purpose and proper use of controls shall be provided to all current employees and to new workers upon hiring. Training should be repeated as needed.

Workers shall be trained to recognize, and report to a designated person, any patients or clients with symptoms suggestive of H1N1.

3. Work Practices and Engineering Controls. The use of each control measure must be based on its ability to abate the hazard.

[i]. Any patients who have a confirmed, probable, or suspected case of novel H1N1 and present for care at healthcare facilities should be placed directly into individual rooms and the door should be kept closed.

[ii]. For procedures that are likely to generate aerosols (e.g., bronchoscopy, elective intubation, suctioning, administering nebulized medications), an airborne infection isolation room (AIIR) with negative pressure air handling with 6 to 12 air changes per hour should be used. Air can be exhausted directly outside or be re-circulated after

filtration by a high efficiency particulate air (HEPA) filter. Facilities should monitor and document the proper negative-pressure function of AIIRs, including those in operating rooms, intensive care units, emergency departments, and procedure rooms.

Note: The employer must assure that AIIR isolation rooms are maintained under negative pressure. At a minimum, the employer must use nonirritating smoke trails or some other indicator to demonstrate that direction of airflow is from the corridor into the isolation/treatment room with the door closed. If an anteroom exists, direction of airflow must be demonstrated at the inner door between the isolation/treatment room and the anteroom.

[iii]. Air exhausted from AIIR isolation or treatment rooms must be exhausted directly outside and not re-circulated into the general ventilation system.

Note: The opening and closing of doors in an isolation or treatment room which is not equipped with an anteroom compromises the ability to maintain negative pressure in the room. For these rooms, the employer should utilize a combination of controls and practices to minimize spillage of contaminated air into the corridor. Recognized controls and practices include, but are not limited to: minimizing entry to the room; adjusting the hydraulic closer to slow the door movement and reduce displacement effects; adjusting doors to swing into the room where fire codes permit; avoiding placement of room exhaust intake near the door; etc.

[iv]. If high-hazard procedures are performed within AIIR isolation or treatment rooms without benefit of source control ventilation or local exhaust ventilation (e.g., hood, booth, tent, etc.), and droplets are released into the environment (e.g., coughing), then a purge time interval must be imposed during which personnel must use a respirator when entering the room.

[v]. Work Practice and Engineering Controls - Instruct employees to avoid close contact (within 6 feet) with other employees and the general public in order to avoid contact with large droplets from people talking, coughing or sneezing.

- **Respiratory Hygiene/Cough Etiquette**
- The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection.
 - [Cover your mouth and nose](#) with a tissue when you cough or sneeze.

- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use.
- [Cough or sneeze into your upper sleeve](#) if you don't have a tissue.;
- Perform hand hygiene (e.g., hand washing with soap and water, alcohol-based hand rub, or antiseptic handwash) after having contact with respiratory secretions and contaminated objects/materials.

Employers also should consider installing physical barriers, such as clear plastic sneeze guards, to protect employees where possible (such as cashier stations).

Some organizations can expand internet, phone-based, drive-through window, or home delivery customer service strategies to minimize face-to-face contact.

Employer's pandemic planning should address the need for employees to remain home if sick and return in accordance with CDC guidelines

Remind employees to cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.

Provide employees with supplies for hand and surface hygiene.

Hand hygiene is absolutely essential and should be performed before and after patient care, and before donning and after removal of any ppe.

Perform hand hygiene (e.g., hand washing with soap and water, alcohol-based hand rub, or antiseptic handwash) frequently.

Clean your hands after coughing or sneezing or having contact with any respiratory secretions and contaminated objects/materials from others.

Use signs to keep customers informed about symptoms of the flu, and ask sick customers to minimize contact with your employees until they are well.

Your workplace may consider limiting access to customers and the general public, or ensuring that they can only enter certain areas of your workplace.

2. Personal Protective Equipment (PPE) – 29 CFR 1910.132 Employers must do a PPE assessment to determine what protection from H1N1 influenza is appropriate.

3. Respiratory Protection - 29 CFR 1910.134(a)(2). The standard provides in part:

"Respirators shall be provided by the employer when such equipment is necessary to protect the health of the employee. The employer shall provide the respirators which are applicable and suitable for the purpose intended. The employer shall be responsible for the establishment and maintenance of a respiratory protective program which shall include the requirements outlined in paragraph (c) of this section."

a. Requirements for a minimal acceptable program. Unless otherwise specified, "respirator" refers to an N95 or higher filtering face piece respirator certified by the CDC/National Institute for Occupational Safety and Health (NIOSH). A respirator is designed to protect the person wearing the respirator against breathing in very small particle aerosols that may contain viruses. A respirator that fits snugly on the face can filter out virus-containing small particle aerosols that can be generated by an infected person. The following respiratory protection measures must be addressed:

(i). Employees wear at a minimum an N-95 respirator certified under 42 CFR Part 84 Subpart K in the following circumstances:

Note: If a facility chooses to use disposable respirators as part of their respiratory protection program, their reuse by the same health care worker is permitted as long as the respirator maintains its structural and functional integrity and the filter material is not physically damaged or soiled. The facility must address the circumstances in which a disposable respirator will be considered to be contaminated and not available for reuse. Consideration should be given as to type of precautions being recommended - either contact and/or droplet precautions vs. airborne precautions.

(ii). The following sample language is provided for citations which are warranted under 1910.134(a)(2):

"The employer did not provide respirators which were applicable and suitable for the purpose intended, nor was a respiratory protection program established which included the requirements outlined in 29 CFR 1910.134(b):

[a] Employees were given a [surgical mask or list manufacturer/model number] respirator for protection against confirmed, probable, or suspected case of novel H1N1 when entering isolation rooms or performing high hazard procedures [including vehicular transporting if

applicable]. They shall use NIOSH approved respirators (N-95 or those certified under 42 CFR Part 84 Subpart K).

NIOSH approved respirators providing greater protection would also be acceptable.

(iii). When respiratory protection (including disposable respirators) is required, a complete respiratory protection program including fit testing, must be in place in accordance with 29 CFR 1910.134(c).

4. Access to employee medical and exposure records: 29CFR 1910.1020.

- a. A record concerning employee exposure to confirmed, probable, or suspected case of novel H1N1 is an employee exposure record within the meaning of 29 CFR 1910.1020.
- b. A record of medical evaluations and treatment are employee medical records within the meaning of 29 CFR 1910.1020.
- c. Procedures governing CSHO access to employee medical records are contained in 29 CFR 1913.10.

5. Sanitation: 29 CFR 1910.141

- a. [1910.141\(d\)](#) Washing facilities. Shall be provided in a sanitary condition, have running water and method to dry hands.
- b. If the employer does not provide a sanitary lavatory, issue [1910.141\(d\)\(1\)](#) General. Washing facilities shall be maintained in a sanitary condition.
- c. If an employer does not provide running water, issue [1910.141\(d\)\(2\)\(ii\)](#) Each lavatory shall be provided with hot and cold running water, or tepid running water.
- d. If an employer does not provide a cleaning agent, issue [1910.141\(d\)\(2\)\(iii\)](#) Hand soap or similar cleansing agents shall be provided.
- e. If an employer does not provide a way to dry after washing, issue [1910.141\(d\)\(2\)\(iv\)](#) Individual hand towels or sections thereof, of cloth or paper, warm air blowers or clean individual sections of

continuous cloth toweling, convenient to the lavatories, shall be provided.

6. Accident prevention signs and tags: 29 CFR 1910.145.

a. In accordance with 1910.145(f)(8), a warning shall be posted outside the Respiratory isolation or treatment room. 1910.145(f)(4) requires that a signal word (i.e. "STOP", "HALT", or "NO ADMITTANCE") or biological hazard symbol be presented as well as a major message (e.g., "special respiratory isolation", "Respiratory isolation", or AIIR isolation). A description of the necessary precautions, e.g., respirators must be donned before entering. Respiratory isolation rooms in an emergency department or a message referring one to the nursing station for instruction must also be posted.

b. The employer shall also use biological hazard tags on air transport components (e.g., fans, ducts, filters) which identify H1N1 hazards to employees associated with working on air systems that transport contaminated air.

c. The standard provides in part:

29 CFR 1910.145(e)(4): Biological hazard warning signs were not used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with viable hazardous agents:

Sample violation language:

(a) On or about [date], warning signs posted outside respiratory (Respiratory) isolation or treatment rooms did not state the entry requirement of wearing N-95 respirators.

Abatement Note: Warning signs must be posted on respiratory isolation or treatment rooms stating "pulmonary isolation", "respiratory isolation," or "AFB isolation." The sign must state specifically the precautions required to enter the room. Indicators on patient records or tags on corpses, printed in language or symbols easily recognized by employees are additional methods to achieve this purpose.

K. Recording in the IMIS. A H1N1-related inspection is any health inspection conducted to investigate the presence or alleged presence of H1N1 (i.e., a referral or complaint inspection).

1. When a H1N1-related inspection is conducted, complete the OSHA-1 as for any inspection and enter the code "N 02 H1N1" in Item 42, Optional Information. EXAMPLE:

Type	ID	Value
N	2	H1N1

2. When an OSHA-7 is completed and the complaint alleges the presence of H1N1 hazards, enter the code "N 02 H1N1" in Item 46, Optional Information.

3. When an OSHA-90 is completed and the referral alleges the presence of H1N1 hazards, enter the code "N 02 H1N1" in Item, 26, Optional Information.

L. Pre-citation Review. Citations proposed pursuant to this program shall be reviewed prior to issuance, by the Program Manager, DOSH Director and Counsel for consistency with these procedures.

Appendix A

1. Pandemic flu program-

Has the employer conducted a risk assessment to determine employee exposure to Novel H1N1 flu?

Has a program been created using the information gathered in the risk assessment?

Is there a person responsible for maintenance of the program and training of employees on the program?

Has the employer developed procedures for early identification/isolation of cases?

Does the employer have a schedule for cleaning or decontaminating workplaces?

2. Engineering control

Does the employer perform aerosol generating high risk procedures on suspect or confirmed N1N1 cases?

Does the facility have a negative pressure isolation room? If so, is it operable?

3. Personal protective equipment

Has a hazard assessment determined the need for personal protective equipment?

Has the personal protective equipment been provided (e.g. gloves, eye protection, gowns)?

Is personal protective equipment available in different sizes?

Have employees been trained on the proper use of personal protective equipment?

4. Training

What guidance is being given to workers who transport individuals who may be ill or exhibit symptoms of Novel H1N1?

Are employees aware of the signs and symptoms of Novel H1N1?

Are employees familiar with the employer's program?

Are employees aware of the personal protective equipment available?

Do employees know what to do if they suspect someone may have Novel H1N1 and who to report suspected cases to in the facility?

Do they know how to protect themselves from contracting Novel H1N1 and what to do if they have symptoms during the scheduled work time?

5. Respiratory Protection Program

Is there a respiratory protection program in place and has it been reviewed and updated to include Novel H1N1 risks/exposures?

Have employees been trained on the respiratory protection program?

Have employees been trained on the proper use, limitations, maintenance and care of the respiratory protection?
Have employees received medical evaluations and fit testing prior to respirator usage?