AGD TOOLKIT FOR MINIMIZING POTENTIAL COVID-19 LIABILITY IN THE DENTAL PRACTICE

OSHA's Inspection Procedures for COVID-10 Emergency Temporary Standard

PROTECTING YOUR STAFF, YOUR PATIENTS AND YOUR PRACTICE FROM COVID-19

Staying abreast of the latest evidence-based guidance and information is the best way to protect everyone. Be aware that guidance relevant to mitigating factors related to COVID-19 is issued by multiple federal agencies, as well as by different regulatory agencies at the state level.

While this toolkit focuses on matters relating to the Occupational Health and Safety Administration's (OSHA) COVID-19 Emergency Temporary Standard (ETS), the Academy of General Dentistry (AGD) recommends that you also monitor information from the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA) and others.

Is Your Practice Covered by the COVID-19 Healthcare Emergency Temporary Standard (ETS)?

Before you continue reading, AGD suggests that you determine whether your practice is covered by the COVID-19 Healthcare ETS.

Refer to OSHA's resource "Is your workplace covered by the COVID-19 Healthcare ETS?" for confirmation regarding whether or not your practice is covered under the ETS.

√ Small employers, like dental practices, with 10 or fewer employees on the date the ETS was published in the Federal Register are not required to comply with the recordkeeping provisions.

√ Generally speaking, dental practices that provide ambulatory care in outpatient settings are likely considered subject to the ETS.

√ It may be possible to claim an exception to the ETS by carefully and consistently prescreening everyone entering who enters the facility, including:
- patients
- patients' family members/companions attending appointments
- contractors, vendors, delivery personnel
- family members/associates of staff members who may visit the practice

√ Pre-screening patients for symptoms of COVID-19 is a vital precaution to help in preventing anyone with COVID-19 symptoms or who tests positive for SARS-CoV-2 out of the practice.

- Reschedule any patient with SARS-CoV-2 or COVID-19 symptoms so their treatment is provided after their symptoms have subsided.
- Consult the AGD's Return-to-Work Guidance for more information on the proper procedures for screening patients and team members for SARS-CoV-2 symptoms.
- If patients ask why your office continues to prescreen patients when their other healthcare providers have stopped doing so, let them know that prescreening is just one of many activities you and your team engage in to ensure everyone's safety.
  - o Gently reiterate that keeping COVID-19 symptomatic or positive patients and visitors out of the practice not only keeps patients safe, but it's also an added layer of protection to help protect their families as well as your staff members and their families.

A BRIEF HISTORY OF THE EMERGENCY TEMPORARY STANDARD (ETS)

The Occupational Exposure to COVID-19; Emergency Temporary Standard (ETS) went into effect immediately upon publication in the Federal Register on June 21, 2021. Since then, entities throughout the country that provide healthcare, like dental practices, have had to take swift action to protect their employees from what the agency called "grave danger due to exposure to toxic substances or agents determined to be toxic or physically harmful or to new hazards." [1]

On June 28, 2021, the U.S. Department of Labor's (DOL) Occupational Safety and Health Administration (OSHA) released its Inspection Procedures for the COVID-19 Emergency Temporary Standard. The 67-page document "establishes inspection procedures and enforcement policies for the COVID-19 ETS" and requires states to "have accessible enforcement policies and procedures in place which are at least as effective as those" in the agency's notice.

The ETS was developed in response to a Presidential Executive Order (EO) issued by President Biden in January 2021. According to information in the Inspection Procedures directive, nearly 500,000 healthcare workers have contracted COVID-19 since the pandemic was declared in March 2020 and more than 1,600 healthcare workers have succumbed to the disease. In response to the EO, OSHA assessed current workplace protective measures and determined that more could be done to prevent occupational exposures to SARSCoV-2 and the spread of the COVID-19 and decrease the number of Americans dying from the illness.

Issued considered by OSHA in creating the ETS included:

- COVID-19 inspection and violation history
- Worker complaints
- Hazard Alert Letters (HALs) issued
- Stakeholder petitions calling for the agency to issue an ETS

The review determined that specific requirements beyond the general duty clause would control COVID-19 hazards in the healthcare industry and improve worker protections. The resulting ETS calls for covered healthcare employers to develop and implement COVID-19 plans that identify and control COVID-19 hazards in the workplace. Employers' COVID-19 plans must address – and implement – steps to reduce transmission of COVID-19 in the workplace. Some of those steps include:

- Patient and Non-employee Screening and Management Requirements
- Standard and Transmission-based precautions
- Controls for Aerosol-Generating Procedures
- Physical Distancing
- Physical Barriers

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1 OSHA Standards Development

- Personal Protective Equipment (PPE)
- Cleaning and Disinfection
- Ventilation
- Employee Health Screening and Medical Management
- Vaccination
- Training
- Anti-retaliation
- Recordkeeping
- Reporting

Among the resources supporting the ETS is the COVID-19 Healthcare Worksite Checklist & Employee Job Hazard Analysis/The OSHA COVID-19 Healthcare Worksite Checklist: The 11-page resource offers an easy-to-follow checklist that will support covered healthcare employers in implementing worker protections from COVID-19 in compliance with the OSHA COVID-19 Healthcare Emergency Temporary Standard (ETS). Major topics covered include:

- Getting Started
- Physical Distancing in your Workplace
- Ventilation in Your Workplace
- Cleaning and Disinfection in Your Workplace
- Personal Protective Equipment (PPE) in Your Workplace
- Implementing a COVID-19 Training Program

FACTORS INFLUENCING HEALTHCARE WORKERS' POTENTIAL EXPOSURE TO COVID-19

Exposure to COVID-19 can occur anywhere, within and outside of the healthcare workplace. Within the healthcare environment, exposure may depend on many factors, including:

- The physical environment of the workplace
- The type of work activity
- The health and vaccination status of the worker
- The ability of workers to wear facemasks
- The ability of worker to abide by current CDC guidelines
- The need for close contact (within six feet for a cumulative total of 15 minutes or more over a 24-hour period) with any person, including those known to have or suspected of having COVID-19, and those who may be infected with—and able to spread—SARS-CoV-2 without knowing it.

Healthcare workers' risks of contracting COVID-19 can also be impacted by the conditions in communities where employees live and work, activities outside of the workplace, and individual health conditions.

PRIORITIZING INSPECTIONS THROUGH THE NATIONAL EMPHASIS PROGRAM (NEP) FOR COVID-19

The January 2021 Presidential Executive Order on Protecting Worker Health and Safety also called for the development and implementation of a National Emphasis Program (NEP) for COVID-19; that program went into effect March 12, 2021, called for OSHA to prioritize COVID-19-related inspections involving deaths or multiple hospitalizations due to occupational exposures to COVID-19. It also includes elements to ensure that workers are protected from retaliation. The NEP, which is subject to updates and revisions, is expected to be in place for one year, unless it's otherwise canceled or extended.

DIRECTIVE ON INSPECTION AND ENFORCEMENT PROCEDURES

OSHA has developed a comprehensive guide outlining how to conduct field inspections and the uniform enforcement of the ETS when addressing workplace exposures to SARS-CoV-2, the virus that causes COVID-19 disease. Those inspection procedures are effective for at least 12 months from the effective date of the ETS (June 21, 2022) unless the ETS is canceled or extended.

While this Checklist is intended to help guide you through the necessary steps to help protect your staff, and your practice, in the event of an audit, it is not meant to be legal advice; you may want to consider talking with a qualified compliance advisor as you develop or update the protocols in place in your practice.

That type of consultation may also be beneficial since it's possible that your state may have adopted enforcement policies that are different but at least as effective as those in the federal standard.

POSSIBLE INSPECTION TRIGGERS CO

√ While an inspection could happen for any reason or for no reason at all, some common triggers include:
- Worker complaints
- Referrals from other agencies
- An employer's report of a death or hospitalization or
- Selection of the work site under OSHA's COVID-19 nep, which targets industries with high worker-infection rates.

HOW THE COMPLIANCE SAFETY AND HEALTH OFFICER (CSHO)[2] PREPARES FOR AN AUDIT

The Directive is intended to provide instructions and guidance to Area Offices and compliance safety and health officers (CSHOs) to assist them in the enforcement of the ETS. OSHA's Field Operations Manual (FOM) details Inspection Procedures outlining all aspects of the activity. Guidance provided to inspectors notes that:

√ Effective inspections require judgment in the identification, evaluation, and documentation of safety and health conditions and practices.

√ Inspections can vary considerably in scope and detail depending on the circumstances of each case.

√ CSHOs should prepare for each inspection by:
- Reviewing the business' inspection history, including being aware of any previous citations since that information could be used to document an employer's previous awareness of a hazard.
- Determining whether the business is a participant in any cooperative programs, since that type of participation can affect the scope of the inspection and even whether or not it can be conducted.
- Requesting a copy of any written certification regarding any previous hazard assessment(s).
  - o If a written hazard assessment is not available, the person who signed the certification should advise the CSHO to describe all potential workplace hazards so the CSHO can select appropriate protective equipment for the visit.
  - o Absent a hazard assessment, the CSHO should select protective equipment in accordance with potential hazards in the workplace.
  - o The CSHO should conduct a pre-inspection evaluation for potential exposure to chemicals and, before entering any hazardous area, the CSHO should identify those work areas, processes, or tasks that require respiratory protection. If appropriate, the CSHO should wear a respirator and be in full compliance with OSHA's Respiratory Protection Standard (§1910.134 and CPL 02-02-054).
  - o The CSHO must comply with all employer safety and health rules and practices at the location being inspected and should not enter any area where special entrance restrictions apply until the required precautions have been taken.

2 OSHA Issues Inspection Guidelines for Virus Health-Care Rule

ADVANCE NOTICE OF INSPECTIONS

√ Worksites typically are not given advance notice of an inspection on the basis that prior knowledge could provide employers the opportunity to alter or remedy conditions in the workplace.

WHAT MAY TAKE PLACE DURING AN INSPECTION

√ While it's preferred that inspections be done in-person and on-site, it's possible that they may be done remotely to protect OSHA staff.

√ Expect any inspection to begin with an opening conference during which the OSHA Compliance Safety and Health Officer (CSHO) will meet with those team members responsible for managing the business' workplace safety plans and programs. The inspector may also opt to speak with employee representatives.

√ During an audit, the CSHO may ask for information about – or even proof of – such details as:
- The qualifications of your in-house safety official, including his/her professional knowledge and background/training in infection control principles and practices.
  - o Be aware that employees are not required to speak with OSHA inspectors during the opening conference.
    - Make certain that any individual meeting with the CSHO is fully prepared – or even overly prepared – for the meeting: that training and education could minimize the possible you're your representative might share – or over share – information that could have an impact on the outcome of the audit.
- Personnel/Human Resources records relating to staff illnesses, including whether employees who missed work because of COVID-19 received pay and benefits from the practice.

√ Anticipate that, during the inspection, the CSHO will observe staff to ensure:
- proper use of the appropriate personal protective equipment (PPE).
- adherence to appropriate physical distancing measures.

√ Inspectors may not photograph patients.

√ Workplace ventilation system may or may not be inspected since most inspectors are unlikely to have been fully trained in evaluating those systems, which also may be difficult to access.

√ The current understanding is that inspectors have some leeway in terms of evaluating compliance with requirements to screen patients for COVID-19 and for determine employees' vaccination status.
- COVID-19 screening protocols may allow for patients and non-employees to self-monitor their temperatures, complete a health survey, or use an online monitoring systems through which they can self-report any possible symptoms of COVID-19 or exposures before entering the facility.

CHECKLIST FOR MINIMIZING POTENTIAL LIABILITY IN THE DENTAL PRACTICE

OSHA's inspection procedures for the COVID-19 emergency temporary standard

This checklist was designed to provide some tips and information that may help protect your practice during a COVID-19 ETS inspection; it is not intended as legal advice. While content is based on OSHA's 67-page Directive on inspections and enforcement, some information, such as definitions, is not included in this resource and the sequencing of other information has been restructured in order to better support you and your colleagues in complying with the ETS. The Academy of General Dentistry urges anyone consulting this resources to also read the complete source document, which is available via the above hyperlink.

☐ DETERMINE WHETHER YOUR PRACTICE IS COVERED BY THE COVID-19 HEALTHCARE ETS:

√ It may be possible to claim an exception to the ETS by carefully and consistently prescreening everyone entering who enters the facility, including:
- Patients
- Patients' family members/companions attending appointments
- contractors, vendors, delivery personnel
- Family members/associates of staff members who may visit the practice

√ Pre-screening patients for symptoms of COVID-19 is a vital precaution to help in preventing anyone with COVID-19 symptoms or who tests positive for SARS-CoV-2 out of the practice.
- Reschedule any patient with SARS-CoV-2 or COVID-19 symptoms so their treatment is provided after their symptoms have subsided.
- Consult the AGD's Return-to-Work Guidance for more information on the proper procedures for screening patients and team members for SARS-CoV-2 symptoms.
- If patients ask why your office continues to prescreen patients when their other healthcare providers have stopped doing so, let them know that prescreening is just one of many activities you and your team engage in to ensure everyone's safety.
  - o Gently reiterate that keeping COVID-19 symptomatic or positive patients and visitors out of the practice not only keeps patients safe, but it's also an added layer of protection to help protect their families as well as your staff members and their families too.

√ Refer to OSHA's resource "Is your workplace covered by the COVID-19 Healthcare ETS?" for confirmation regarding whether or not your practice is covered under the ETS.
- Small employers, like dental practices, with 10 or fewer employees on the date the ETS was published in the Federal Register are not required to comply with the recordkeeping provisions.
- Generally speaking, dental practices that provide ambulatory care in outpatient settings are likely considered subject to the ETS.

☐ ETS COMPLIANCE FOR PRACTICES WITH FEWER THAN 10 EMPLOYEES IS RELATIVELY SIMPLE:

√ You are not required to establish a COVID-19 log of all employee instances of COVID-19, regardless of the location of exposure (on vs. off the job).

√ You must report any COVID-19 fatality to OSHA within eight hours of learning that it has occurred.

√ You must report any work-related COVID-19 in-patient hospitalization to OSHA within 24 hours of learning about the case.

☐ ETS COMPLIANCE FOR PRACTICES WITH 10 OR MORE EMPLOYEES INVOLVES:

√ Establishing a COVID-19 log of all employee instances of COVID-19 without regard to occupational exposure and following requirements to make records available to all employees.

√ Notifying OSHA of any COVID-19 fatality within eight hours of learning about it.

√ Reporting any work-related COVID-19 in-patient hospitalization to OSHA within 24 hours of learning about the case.

☐ DETERMINE WHETHER YOUR PRACTICE IS REQUIRED TO HAVE A COVID-19 PLAN: [(D. COVID-19 PLAN/29 CFR § 1910.502(C)]

√ Practices that had more than 10 employees on June 21, 2021, the date the ETS went into effect, must have a written COVID-19 Plan.

- OSHA's website includes a COVID-19 Plan Template that can be downloaded and customized for any practice. Issues covered in the Template include:
  - o Purpose and Scope
  - o Roles and Responsibilities to include the identification of a COVID-19 Safety Coordinator
  - o Hazard Assessment and Worker Protections*
  - o Monitoring Effectiveness
  - o Coordination with Other Employers
  - o Entering Residences (likely not relevant to most dental practices)
  - o Signature and Plan Availability

*OSHA's Template provides comprehensive details relating to the identification, execution and tracking of information relating to Hazard Assessment and Worker Protections including:

- Patient Screening and Management
- Standard and Transmission-Based Precautions
- Personal Protective Equipment (PPE)
- Aerosol-generating procedures (AGPs) on a person with suspected or confirmed COVID-19
- Physical Distancing
- Physical Barriers
- Cleaning and Disinfection
- Ventilation
- Health Screening and Medical Management
- Vaccination
- Training
- Anti-Retaliation

- Requirements implemented at no cost to employees
- Recordkeeping
- Reporting

Employers seeking to be exempt from providing certain controls (such as facemasks, physical distancing and physical barriers) in a well-defined area of the workplace on the basis that employees are fully vaccinated, must have COVID-19 Plans that detail policies and procedures to determine workers' vaccination status.

Those policies and procedures can be part of, or separate from, any written COVID-19 response or part of the Human Resources systems.

√ Consult OSHA's guidance on Hazard Recognition and Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace for more information. Additional Guidance by Topic available from the agency addresses such topics as:
- Face Coverings
- Hand Hygiene
- Respiratory Protection

☐ CONTINUE TO PERFORM SCREENING AND MANAGEMENT OF ANY – AND ALL – NON-EMPLOYEES WHO ENTER THE PRACTICE. [E. PATIENT / NON-EMPLOYEE SCREENING AND MANAGEMENT/29 CFR § 1910.502(D)]

√ Patient screening and management is required in any location where direct patient care (as defined in the standard) is provided and they must be detailed in the COVID-19 Plan. A few examples of these types of activities include:
- Limiting the number of entrances to the facility.
- Screening patients, residents and non-employees for symptoms of COVID-19.
- Following CDC's COVID-19 Infection Prevention and Control Recommendations.

√ Anyone entering the facility must be screened for COVID19 symptoms: this includes patients, patient companions, delivery people, maintenance personnel, vendors, and all other visiting non-personnel.

√ Screening methods may be flexible and can:
- Include in person or self-monitoring temperature or health surveys, upon arrival
- Require hand hygiene at screening stations
- Mandate the use of source control (such as face coverings) in accordance with CDC's Infection Prevention and Control Recommendations if in person screening is performed
- Include an electronic monitoring system, such as an automated telephone or online system, that requires non-employees to self-report symptoms or exposures (e.g., absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days), prior to arrival at the facility.

☐ CONTINUE TO FOLLOW ALL STANDARD AND TRANSMISSION-BASED PRECAUTIONS. [F. STANDARD AND TRANSMISSION-BASED PRECAUTIONS/29 CFR § 1910.502(E)]

√ Healthcare employers must develop and implement policies and procedures in compliance with the Standard and Transmission-Based Precautions detailed in the CDC's 2007 Guidelines for Isolation Precautions.

☐ USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE). [G. PERSONAL PROTECTIVE EQUIPMENT/29 CFR § 1910.502(F)]

√ Covered healthcare employers should provide and ensure the use of PPE, such as facemasks, goggles, and gowns.
- Facemasks can be provided by either the employer or the employee.
  - o While employers are not required to reimburse employees for costs associated with providing their own facemasks, an inspector may ask if and how the employer makes certain that employee provided facemasks comply with relevant requirements.
- CSHOs should be expected to determine whether the use of facemasks is required and may ask employers to provide a sample facemask for examination.
  - o In practices where employees are allowed to use their own facemasks, CSHOs should ensure that they meet the required specifications and employees should change facemasks at least daily. They should also be replaced if they become soiled or damaged.
  - o Face shields worn over facemasks to protect them from becoming wet, soiled or damaged should be cleaned at least daily and be without any damage, cracks or voids.
- Employers must provide the appropriate and compliant respiratory protective any time that aerosol-generating procedures are performed on a patient who is suspected or confirmed to be COVID-19 positive.

☐ PERFORMING AEROSOL-GENERATING PROCEDURES. [H. AEROSOL-GENERATING PROCEDURES/29 CFR § 1910.502(G)]

√ Aerosol-generating procedures have been determined to present a very high-risk for exposure to respiratory infections.
- Only those employees who are essential to providing the required patient care should be present during aerosol-generating procedures on suspected or confirmed COVID-19 patients.
- Inspectors should be expected to verify that all cleaning and disinfection procedures are performed in the room or area following aerosol-generating procedures on COVID-19 patients.
- It's recommended that dental practice postpone appointments for patients who are suspected or confirmed COVID-19 positive until such time as they are healthy.
- While the standard discusses the use of airborne infection isolation rooms, that type of facility is generally not available in most facilities provided dental treatment.

√ It's recommended that emergency treatments for patients who are COVID-19 positive should take place in a hospital setting, not the dental office.

☐ MAINTAINING PHYSICAL DISTANCING. [I. PHYSICAL DISTANCING/29 CFR § 1910.502(H)]

√ Employers are required to ensure that each employee is separated from all other people by at least six feet unless physical distancing is not feasible for a specific activity, such as providing direct patient care, which would be the case in most interactions that take place in the dental practice.

√ Systems to maintain physical distancing may include such activities as:
- Reducing the number of people, including visitors, in an area at one time.
- Providing visual cues like signs and floor markings, to indicate where people should stand or the preferred direction and path of travel in a specific location.
- Staggering arrival, departure, work, and break times.
- ensuring that designated eating and drinking areas have enough space to accommodate physical distancing or have been modified through the installation of appropriate physical barriers.
- Adjusting work processes or procedures, to allow greater distance between employees.

√ In situations where it's not possible to separate employees, employers should implement additional controls, such as physical barriers, source control, hand hygiene, and ventilation.

☐ MAINTAINING PHYSICAL BARRIERS. [J. PHYSICAL BARRIERS/29 CFR § 1910.502(I)]

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☐ MAINTAINING PHYSICAL BARRIERS. [J. PHYSICAL BARRIERS/29 CFR § 1910.502(I)]

√ While physical barriers are not required in direct patient care areas, they should be in place to protect employees at fixed workstations.
- Fixed work locations outside of direct patient care areas should have cleanable solid barriers unless the employer can prove providing that type of protection is not feasible.
- In situations where it's not possible to maintain physical distancing and physical barriers, employers should implement additional overlapping controls, including the use of facemasks or respirators, hand hygiene, source control, and ventilation.

☐ PROPER CLEANING AND DISINFECTING. [K. CLEANING AND DISINFECTING/29 CFR § 1910.502(J)]

√ High touch surfaces and equipment must be cleaned at least once a day in accordance with the manufacturers' instructions for application of cleaners. In healthcare settings, cleaning and disinfecting may be needed more frequently throughout the day. Examples of high touch surfaces include:
- Tables
- Doorknobs
- Light switches
- Countertops
- Handles
- Desks
- Phones
- Keyboards
- Toilets
- Faucets
- Sinks
- Touch screens

√ Workplaces must be cleaned and disinfected any time that a COVID-19 positive person has been in the facility within the previous 24 hours.

√ Employers must provide alcohol- based hand rub that is at least 60% alcohol or provide readily accessible hand washing facilities.

☐ PROPER VENTILATION. [L. VENTILATION/29 CFR § 1910.502(K)]

√ Employers who own or control buildings or structures with existing heating, ventilation, and air conditioning (HVAC) systems must comply with certain requirements for ventilation systems but are not required to install new HVAC systems, or airborne infection isolation rooms for healthcare, to replace or augment functioning systems. They must:
- Ensure that existing HVAC systems including in exam rooms are used in accordance with the HVAC manufacturers' instructions and specifications.
- Maximize outside air, use air filters rated MERV 13 or higher where required and compatible with HVAC systems.
- Maintain and replace filters.
- Ensure that intake ports are clear of debris.

√ It's also suggested that employers consider other measures to improve ventilation in accordance with CDC's Ventilation Guidance.

☐ EMPLOYEE HEALTH SCREENING AND MEDICAL MANAGEMENT. [M. EMPLOYEE HEALTH SCREENING AND MEDICAL MANAGEMENT/29 CFR § 1910.502(L)(1)(I)-(II)]

√ While employers must screen each employee before each workday and each shift, there is some flexibility in terms of the screening methods used. Those can include:
- In person screenings of employees by the employer
- Self-monitoring by employees before reporting to work by conducting temperature checks, completing employee questionnaires, or using electronic screening apps.

√ Employers who require COVID-19 tests must provide those to employees at no cost.

√ All screening records and test results must be securely maintained as employee medical records and in accordance with the appropriate regulations.

√ Employees must be required to notify the employer of a confirmed positive COVID-19 test, a diagnosis or reported suspicion of COVID-19 infection or of serious symptoms such as loss of taste, loss of smell, or when experiencing high fever (≥100.4° F) combined with an unexplained cough.
- That notification can be in the form of verbal communication, e-mail/text, voice mail, a written letter from the employee, a family member, and/or physician or other licensed health care provider.

√ Once notified, employers must advise all employees within 24 hours of becoming aware of any COVID-19 exposure in the workplace.
- They must also notify affected employers and employees who were not wearing respirators of their close contacts with a COVID-19 positive person and detail when the contact occurred and the location where the infected person was in the workplace.

√ Employers must immediately remove from the workplace any employee known to be COVID-19 positive or who has been advised by a licensed healthcare provider that they are suspected to have

COVID-19, are experiencing symptoms, or were in close contact in the workplace to a person who was found to be COVID-19 positive.

- Employees who have been medically removed from the workplace must stay away until the appropriate return to work criteria are met or until the employer provides a polymerase chain reaction (PCR) test at no cost to the employee.
- Employers are not required to remove any employee who has been fully vaccinated (i.e., 2 weeks or more following the final dose); or who recovered from COVID-19 within the past 3 months, if the employee is not COVID-19 positive and does not experience symptoms.

☐ VACCINATIONS. [N. VACCINATION/29 CFR § 1910.502(M)]

√ Employers are required to support COVID-19 vaccination for each employee through reasonable time off during work hours and paid leave (e.g., paid sick leave, administrative leave, etc.) for the full vaccination series (i.e., each required dose) and any side effects experienced following vaccination.

- The period of time for paid leave to get each dose of the vaccine is presumed to be up to four hours for each dose.
- The period of time for paid leave for any side effects of vaccination is up to 16 hours (or eight hours per dose).
- Employers are not required to grant time or paid leave to employees who opt to receive the vaccine outside of work hours.
- Employers are not required to reimburse employees for transportation costs associated with traveling to/from a vaccination site.

√ Employers can assess employees' vaccination status through various methods such as: by questioning individual workers and documenting their responses, maintaining copies of employees' vaccination cards, discussing vaccinations during a staff meeting, asking employees to produce other proof, such as a letter from a healthcare provider, etc.

√ Employers have the option of requiring vaccination as a condition of employment.

- Employees who opt to decline getting vaccinated are not required to sign a declination form.

☐ TRAINING. [O. TRAINING/29 CFR § 1910.502(N)]

√ Employees are a critical factor in reducing COVID-19 exposures since their adherence and use of work practices and controls limit exposure levels. It's therefore very important that employees are aware of the gravity associated with COVID-19 and specific workplace measures that have been implemented to reduce risk and provide protection.

- In addition to knowing what specific protective measures have been put in place, employees must be trained in the use of those measure so they can be properly implemented and provide protection against COVID-19.

√ Employers must provide training in a way that accommodates employees' language and literacy levels, including reasonable accommodation as required by the Americans with Disabilities Act if needed by an employee with a disability, at no cost to the employee.

- Employees must be paid for time spent receiving training at the job location. Time spent traveling to be trained at an off-site facility must be paid by the employer who is also responsible for paying the actual travel costs.
- Training must be overseen or conducted by a person with knowledge about how the topic relates to the duties performed by the employee.
  - o Virtual or online training program must be of a format that allows employees to ask questions and get answers promptly.
  - o Video- or computer -based trainings may require the employer to make available a qualified trainer to address questions after the training, or to offer a telephone hotline where employees can ask questions.

- A few of the topics employees should be able to describe after training include describing tasks and situations where exposure could occur, how to don/dof PPE, and proper cleaning, disinfecting and storage procedures.

☐ ANTI-RETALIATION. [P. ANTI-RETALIATION/29 CFR § 1910.502(O)]

√ Under this provision, employers are:
- prohibited from firing or otherwise discriminating against any employee who exercises his/her right to these protections or who engages in actions required by this section.
- required to inform employees of their right to the protections detailed in this section of the standard.
  - o That notification can take many forms including, but not limited to, letting them know in writing, verbally during a staff meeting, or through other methods.
  - o It can provide separately or in conjunction with other required training.

☐ REQUIREMENTS AT NO COST. [Q. REQUIREMENTS AT NO COST/29 CFR § 1910.502(P)]

√ All costs relating to compliance with the implementation of the ETS are the responsibility of the employer and employees should not be required or asked to share in funding those expenses.
- This requirement extends to include both time and any other expenses necessary to perform required tasks.
- Employees are prohibited from requiring employees to incur out of pocket expenses to finance COVID-19-related:
  - o Training and/or training materials
  - o The purchase of protective equipment and devices
  - o The purchase of cleaning and/or disinfectant materials
  - o Vaccination

☐ RECORDKEEPING. [R. RECORDKEEPING/29 CFR § 1910.502(Q)]

√ Dental practices required to comply with the ETS (usually those with more than 10 employees) must:
- Maintain all (non-draft) versions of the COVID-19 plan and make that information readily available to staff
- Establish and maintain a COVID-19 log for at least as long as the ETS stays in effect.

☐ REPORTING TO OSHA. [S. REPORTING TO OSHA/29 CFR § 1910.502(R)(I)]

√ Employers operating under the standard must report any work-related COVID-19:
- fatality to OSHA within eight hours of learning about the fatality.
- inpatient hospitalization within 24 hours of learning about the hospitalization.
  - o According to OSHA, "in-patient hospitalization" is defined to mean a formal admission to the in-patient services of a hospital or clinic for care or treatment
  - o Treatment in an Emergency Room only is not reportable.
  - o The hospital or clinic is charged with determining whether an employee is formally admitted for "in-patient" service.
    - Treatment in an emergency room only is not reportable.

√ In the even that an employer notified OSHA of an employee's COVID-19 in-patient hospitalization within

the 24-hour period as required and the employee subsequently dies from the illness, the employer does not need to make an additional fatality report to OSHA, but must still record the fatality.

√ The employer is required to ensure that the appropriate instructions and procedures are in place so other individuals, such as managers, supervisors, company medical personnel, and other employees, who learn of an employee's death or in-patient hospitalization due to work-related COVID-19 are aware that the company must submit a report to OSHA.

√ The following information should be reported to OSHA following an employee's COVID-19 related death or in-patient hospitalization:
- The name of the practice
- The location of the work-related incident
- The time of the work-related incident
- The type of reportable event (fatality or inpatient hospitalization)
- The number of employees who died or were hospitalized
- The name(s) of the deceased or hospitalized employee(s)
- The employer's contact person and his/her phone number
- A brief description of the work-related incident.

√ Since some OSHA Area Office may be temporarily closed due to the pandemic, employers must report required events via the agency's 24-hour hotline at 1-800-321-6742 (OSHA) or by completing and submitting a Serious Event Reporting Online Form at the OSHA website.
- Reports may not by submitted by fax, email or voice mail left at the Area Office.