TRANSMITTAL NOTICE - INDIAN HEALTH MANUAL TN 94-13

BACKGROUND:

This transmittal notice is forwarding Indian Health Manual (IHM) Part 1, Chapter 9, entitled Occupational Safety and Health Program." Relevant Indian Health Service (IHS) Circular issuances include: "Diagnostic X-Ray Radiation Protection (IHS Circular No. 91-12, 12/17/91), Bloodborne Pathogen Exposure Policy" (IHS Circular No. 92-4, 5/15/92), and "Tuberculin Testing Program IHS Personnel-Policy" (IHS Circular No. 92-14, 9/23/92).

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MATERIAL TRANSMITTED:

The IHM Part 1, Chapter 9, entitled "Occupational Safety and Health Program"
Pages 1 through 34
Manual Appendixes l-9-A through l-9-F
Manual Exhibits l-9-A and l-9-B
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MATERIAL SUPERSEDED:

The original Part 1, Chapter 8, entitled "Federal Employees Health and Safety Program," and Chapter 9, entitled "Occupational Health and Safety Management Program," are incorporated together as one chapter that this transmittal notice is forwarding. The IHS Circular 92-7, "Occupational Safety and Health Committee" is also superseded by the new chapter 9.

MANUAL MAINTENANCE:

File this chapter in the IHM at Part 1, behind the tab labeled "Chapter 9." Pen and ink change the tab to reflect the new chapter name, "Occupational Safety. and Health Program."

Record and file the Transmittal Notice number on the checklist in the Transmittal Notice book.

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Chapter 9 - Occupational Safety and Health Program

CHAPTER 9
OCCUPATIONAL SAFETY AND HEALTH PROGRAM

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l-9.1 INTRODUCTION

This chapter is published to define the Occupational Safety and Health (OSH) Program for the Indian Health Service (IHS). It is not intended to be all-inclusive but is designed to serve as a general outline for carrying out the OSH program. In all cases, the provisions set-forth in this chapter shall meet or exceed the minimum requirements for OSH programs as set forth in Title 29 Code of Federal Regulations (CFR), Part 1960, entitled "Basic Program Elements for Federal Employee OSH Programs and Related Matters;" Section 19 of the Occupational Safety and Health Act; and Executive Order 12196, dated Feb. 26, 1980. While not specifically mentioned in the OSH related regulations, executive orders, program guidance, etc., it is in the Agency and in the public interest to afford the same safe conditions to visitors, patients, contractors, and others present in IHS facilities. Where applicable to OSH program matters, the appropriate section of Part 1960 is referenced.

This chapter prescribes IHS policy with respect to:

A. Conducting safety programs for all IHS operations, installations, and construction activities; applying safety standards to all operations; and training IHS employees in safe practices.

B. Ensuring a safe environment for all IHS patients, employees, and visitors. Policy shall also apply to those locations operated under contract where IHS employees have been assigned under Intergovernmental Personnel Act or similar arrangements.

C. Investigating, reporting, and summarizing injuries, occupational diseases, and property damage within IHS for managerial information, program guidance, and to meet Occupational Safety and Health Administration (OSHA) requirements and, where appropriate, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and Health Care Financing Administration standards.

(1-9.1 continued)

D. Providing health care for IHS employees related to occupational illness and injury,, return to duty policies, light duty programs, and all other administrative responsibilities related to the Federal Employee Compensation Act (FECA).

E. Medical Surveillance programs for IHS employees.

F. Assignment of responsibilities for the foregoing activities.

The Indian Health Manual, (IHM) Part 1, Chapter 6, entitled "Program Administration," Section l-6.4, contains Incident Report for HSA-123. Incident Report form HSA-123 is superseded in IHS facilities by IHS Incident Report form IHS-516. This form will be used to report any incident of injury or occupational illness. If additional documentation is required, the HSA-123 may be attached to the IHS' Incident Report. Due to the sensitive nature of adverse events in medical care requiring documentation, the facility director should work with an experienced physician or nurse practitioner as well as the safety officer to determine which incidents should be reviewed by the OSH Committee and which incidents should be reviewed by the Pharmacy and Therapeutics, Risk Management, or other named committees charged with quality assurance. Recording procedures, standards and codes, claims and compensation procedures, useful references, and other information applicable to this chapter are found in the Manual Appendixes and Manual Exhibits.

l-9.2 POLICY

The Director, IHS, reaffirms and supports the policy of the President of the United States to conserve manpower and material to the maximum degree possible through the application of a comprehensive, effective, and continuous OSH program in accordance With Executive Order 12196.

(l-9.2 continued)

Consistent with the established intent of the President and Congress, every level of management in the IHS is responsible for the prevention of occupational injuries, occupational diseases, and property damage.

The IHS shall also strive to provide a safe and healthful environment for patients, employees, contractors and visitors.

The following are safe practices:

A. Risking of Life.

No person is expected to risk his/her life in the performance of any job. In the event that a life threatening condition develops, the OSH officer, supervisor or designee is authorized to immediately terminate the activity until such time that the hazard is abated.

B. Mandatory Use of Seat Belts and Child Restraint Devices.

All government vehicle operators and all IHS employees riding in Government or private vehicles on Government business must use seat belts. Government vehicle operators shall require all passengers to be properly restrained. Passengers under 40 pounds or under 5 years of age shall be restrained in approved child/infant restraint devices.

C. Safe Working Methods.

Proper work methods and procedures will be required to ensure that personnel will not be exposed to serious injury or health hazards. All employees shall be provided on-the-job training in the correct and safe method(s) of performing their assignments. Additionally, it is IHS policy that all government motor vehicle operators are required to possess a current state drivers license.

(l-9.2 continued)

D. Physical Fitness and Suitable Equipment.

Employees will be assigned only to those jobs they are physically qualified to perform safely and will be provided with appropriate equipment to safely carry out their job assignments. It is the employee's responsibility to be fully aware of the physical requirements of the job as per the position description for that job. If an employee is injured or becomes unable to meet the physical demands of a particular job, the personnel system requirements and procedures (Civil Service or Commissioned Corps) covering the employee are to be followed. Pre-employment and fitness for duty physical examinations will be provided by the IHS service unit or designated health care providers.

E. Working Conditions.

When unsafe or unhealthful working conditions exist, appropriate engineering controls, changes in work practices, or appropriate personal protective equipment will be used to minimize occupational injury or illness. The use of engineering controls shall be first considered for all hazardous operations. Where engineering controls are not possible, administrative controls or changes in work practices shall be used; e.g., there shall be a permitting and monitoring program for potentially hazardous confined spaces, as defined in 29 CFR 1910.146. Where hazards remain, personal protective clothing and equipment (PPCE) must be used by all personnel engaged in hazardous operations. PPCE shall be provided if determined by the supervisor to be necessary and in the best interest of the Government. Questions on the need for or types of protective equipment shall be referred to the OSH committee.

(l-9.2E continued)

(1) Indian Health Service Furnished Items

Protective equipment not normally owned by workers in non-hazardous occupations will be furnished without cost to the individual. Examples of personnel protective equipment include: respirators, safety eye wear, hearing protection, helmets, and clothing impervious to blood and other body fluids or chemicals (e.g., aprons, special gloves, and steel-toed footwear).

Video display terminals shall be equipped with anti-glare screens, if needed, and shall be located within work stations designed for optimal ergonomic considerations.

(2) Employee Furnished Items.

Personal protective apparel or equipment that is readily adaptable to private use will not ordinarily be furnished. Examples are coveralls, ordinary gloves, and work shoes.

F. Union Representation.

A representative of employees shall be given an opportunity to accompany safety personnel during the evaluation of any work place.

l-9.3 GOALS

Goals of the IHS OSH Program and supplement 29 CFR Part 1960 are to:

A. Ensure safe and healthful working conditions for federal employees.

B. Establish and maintain an effective and comprehensive OSH program.

(l-9.3 continued)

C. Promote specific opportunities for employee participation in the operation of the agency safety and health program.

D. Prevent or minimize the number of occupationally related illnesses and injuries among IHS personnel.

E. Decrease the amount of time lost from duty and workers' compensation claims due to occupational illness and injury.

F. Prevent or minimize the number of injuries and illnesses of patients, consultants, employees of private contractors, visitors, other members of the public and personnel detailed or assigned to IHS operations.

G. Prevent or minimize the number of incidents involving property damage.

l-9.4 DEFINITIONS

The following definitions will be used throughout this chapter.

A. Employee. Any person employed or otherwise permitted or required to work by IHS. This includes full and part time workers who are salaried or volunteers.

B. Employee Medical File (EMF). The employee health record, distinct from a general medical record, is described further in Manual Appendix 1-9-F, Page 1 of 16. It should include some baseline and all surveillance data, including annual tuberculosis skin testing, and required and recommended immunizations or documentation of their refusal.

(l-9.4 continued)

c. Emplovee Health (EH) Specialist. A nurse, physician, or other health care provider with clinical and administrative duties outlined below (see Section l-9.10C.3). This individual will work with the OSH Officer, Office of Workers' Compensation Program case manager and the Servicing Personnel Office (SPO) as a multidisciplinary management team coordinating all occupational health and safety activities.

D. Hazard Surveillance Team. Persons assigned by the health facility administration to identify hazards or deficits in staff knowledge and practice in health and safety.

E. IHS Facility. Any facility operated, either owned or leased by the Agency, for the purpose of fulfilling the Agency mission.

F. Imminent Danger. Any condition or practice in any workplace which is such that a hazard exists which could reasonably be expected to cause death or serious physical harm immediately or before the presence of such danger can be eliminated through normal procedures.

G. Incident. An incident is any event or chain of events, which results in property damage, injury, or illness to any person(s) or interrupts, interferes or has the potential to interfere with the orderly progress of work or for which a tort claim may be possible.

Catesories of Incidents: IniurY/Illness/Fatality.

(1) Injury - A wound or other condition of the body caused by external force, including stress or strain. The injury is identifiable as to time and place of occurrence and member or function of the body affected, and is caused by a specific event or incident or series of events or incidents within a single day or work shift.

(l-9.4G continued)

(2) Illness/Disease - Physiological harm or loss of capacity produced by systemic infection; continued or repeated stress or strain; exposure to toxins, poisons, or fumes; or other continued and repeated exposures to conditions of the work environment over a long period of time.

(3) Fatality:- Death resulting from an injury or illness/disease.

(4) Lost Time Case - See definition, below.

(5) Catastrophe - An incident resulting in three or more Agency and/or non-Agency people being hospitalized for inpatient care.'

Reportable Incident - All incidents regardless of cause, consequence, damage, or location shall be reported to the immediate supervisor on duty. An Incident Report Form IHS-516 (Manual Exhibit 1-9-A), shall be completed and routed through normal channels to the local OSH officer. For a description of the "Log of Federal Occupational Injuries and Illnesses," see definition "R" below.

H. Inspection. A comprehensive survey of all or part of a workplace in order to detect safety and health hazards. An inspection may also be conducted as part of an investigation of a complaint regarding a specific hazard or conditions in a specific location within a workplace.

I. Lost Time Case. A nonfatal employee injury (traumatic) that causes disability for work beyond the day or shift it occurred, or a nonfatal employee illness/disease (occupational) that causes disability at any time.

No Lost Time Case. A nonfatal employee injury or illness/disease that does not meet the definition of Lost Time Case.

(l-9.4 continued)

J. Motor Vehicle. Any mechanically or electrically powered vehicle designed primarily for either the conveyance of passengers or material.

K. Occupational Disease. A debilitating condition caused by environmental factors, the exposure to which is peculiar to a particular process, duty, or occupation and to which an employee is not ordinarily subjected or exposed outside of or away from such employment.

"Occupational disease or illness means a condition produced in the work environment over a period longer than a single workday or shift by such factors as systemic infection; continued or repeated stress or strain, or exposure to hazardous poisons, fumes, noise, particulate, or radiation, or other continued or repeated conditions or factors of the work environment." [20 CFR l.B (16), pg. 12]

L. Occupational Injury. Any injury suffered by a person which arises out of and in the course of his/her employment.

"Injury means a wound or condition of the body induced by accident or trauma, and includes a disease or illness proximately caused by the employment for which benefits are provided under the FECA. The term "injury" includes damage to or destruction of medical braces, artificial limbs, and other prosthetic devices which shall be replaced or repaired; except eyeglasses and hearing aids shall not be replaced, repaired or otherwise compensated for unless the damage or destruction is incident to personal injury requiring medical service." (20 CFR l.B (15), pg. 12).

M. The OSH Officer. An IHS service unit staff member who is authorized in writing and qualified by training and experience to carry out comprehensive duties in safety management and occupational health.

(l-9.4M continued)

The IHS recommends a team approach in managing the OSH program. Therefore, the responsibilities for occupational safety officer and EH specialist should be assigned to different individuals.

N. Office of Workers' Compensation Prosram-Case Manager (OWCP-CM). The IHS staff member collaterally designated by the service unit director (SUD) as the on-site personnel office liaison of the local employee or claimant to the Area office SPO. The OWCP-CM is authorized to consult with the EH specialist and OSH officer for the resolution of day-to-day occupational safety and health issues, especially in regard to environmental concerns identified at the time of an employee's illness or injury.

0. Patient. A person receiving or about to receive medical care in a medical facility or in transit via Government owned, Government personnel operated, or contract operated vehicle for the purpose of seeking medical care.

P. Property Damage. Includes damage to IHS-owned, rented, or leased property, damage in any amount by anyone to privately owned property used on official business; or damage to any private property by IHS employee(s) while on official business.

Q. Public. Any member of the community at large. An employee of the Department of Health and Human Service (HHS) may have the same status as a member of the public in connection with claims against the Government. When property owned by an employee is damaged by the act of another employee or is damaged while the employee's property is on Government property, the Government may be liable.

(l-9.4 continued)

R. Record of the Incident. A11 incidents will be recorded and coded for statistical evaluation purposes on the Incident Report Form (IHS-516). The OSH officer shall maintain a log of all occupational injuries and illnesses at each facility. The "Log of Federal Occupational Injuries and Illnesses" shall be used within six days after receiving information, to record all occupational injuries and illnesses. [see Manual Exhibit 1-9-A, page 1 of 1, for an example of the log.] All civilian Federal employees are covered by FECA. Thus all civilian Federal occupational injury or illness must be recorded on the appropriate CA forms [see Manual Appendix 1-9-A, page 6 of 6] to 'be eligible for continuation of pay or compensation. Supervisors are responsible for ensuring that the required compensation forms are properly completed, and forwarded in accordance with appropriate procedure.

S. Safety Review. An evaluation of a safety management program that involves the assessment of systems that detect,monitor,document, and abate hazards in the workplace.

T. SPO. Is the servicing personnel office for your official duty station assigned the responsibility to receive and review claims as the OWCP-CM for the employees of that Area or service unit.

u. Visitor Injury. An injury that, occurs to a member of the general public while in an IHS facility or on IHS property.

V. Workplace. The physical location where the Agency's work or operations are performed.

l-9.5 OTHER FEDERAL LAWS

A. FECA. In 1916 FECA was passed to provide compensation benefits to United States (U.S.)

(l-9.5A continued)

civilian employees who suffer injury, occupational disease, , or death as a result of their employment. Commissioned Officers of the U.S. Public Health Service are not covered under FECA. The IHM Part 1, Chapter 8, entitled "Managing the Workers' Compensation Program," deals with FECA in greater detail.

8. Federal Tort Claims Act (FTCA). Claims for property damage or personal injury due to negligence, wrongful act, or omission of IHS employees acting within the scope of their employment are covered by FTCA (see: 28 U.S.C. 2671-2680). The Act does not relieve employees, while acting within the scope of their work, of personal liability for negligence contributing to an incident. Each supervisor should become familiar with Chapter PHS 4-00 and 4-35 of the General Administration Manual. Procedures outlined in Chapter PHS 4-30 should be implemented promptly. In addition, the IHS may be held liable for damage to and loss of private property, for personal injury or death due to negligence of IHS employees, and for loss of personal property due to incidents involving any person authorized to enter upon or occupy IHS property.

l-9.6 ESTABLISHMENT OF PROGRAMS

In order to discharge the foregoing policy and responsibilities, a comprehensive OSH program will be established for all IHS Area offices, district offices, service units, field offices, Public Law (P.L.) 93-638 Contract Health Care facilities, and other installations. Skills that are necessary to implement a comprehensive OSH program include safety, industrial hygiene, occupational health nursing, and occupational medicine. Conscientious efforts to improve injury prevention and loss management through periodic evaluations and

(l-9.6 continued)

education are an integral part of the IHS OSH program. Employees shall receive a safety orientation within 30 days of hire on general safety rules and any special precautions to 'cover local conditions or unusual circumstances pertaining to their particular type of work or place of employment. Such training shall include information on the Agency OSH program with emphasis on the employee's rights and responsibilities. Inpatients shall receive appropriate safety instructions from the nursing staff (e.g. exit location, emergency call buttons, bed rail use, or other safety issues) during the hospital stay as soon after admission as possible.

l-9.7 MINIMUM PROGRAM ELEMENTS

The minimum OSH program for the IHS shall include the following elements:

A. Surveys, as required by 29 CFR 1960.25, of all workplaces. Reports prescribing recommendations for corrective action, and followup surveys to ensure that appropriate actions were taken. Refer to Manual Appendix l-9-E for a model "Hazard Surveillance Program."

B. Technical assistance, from any competent source, on OSH problems to establish acceptable procedures, work methods, and personal protective equipment, thus integrating sound OSH principles into operational instructions and processes. This includes but is not limited to support documents and consultations from the National Institute of Occupational Safety and Health, Federal Occupational Health program, American Hospital Association, and JCAHO.

C. Development, promotion, and distribution of educational materials and activities designed for patients, employees, and the general public.

D. Establishment and maintenance of active OSH committees;

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E. Employee safety and health orientation and training.

F. Development and implementation of OSH policies and procedures applicable to local operations.

G. Reporting and analysis of injuries, occupational diseases, and property damage incidents.

H. Plan review of new construction, repairs, or improvements for compliance with applicable safety codes and standards (i.e., The National Fire Protection Association and JCAHO).

l-9.8 BEPORTING, INVESTIGATION. AND ANALYSIS

The supervisor, department head, or OSH officer shall investigate, report, and analyze all incidents which are identify, including all incidents having potential for injury, illness, or property damage. The objective of reporting and analysis is to develop information and procedures essential to the maintenance and improvement of the OSH program throughout the IHS. This includes the identification of unsafe and unhealthful working conditions. (See Manual Appendix l-9-A for Forms, Procedures, and Standard Format.)

A. General Procedures.

(1) The OSH officer shall maintain a written or computerized record of the causes of occupational injuries, occupational diseases, and property damage incidents.

(2) Each IHS facility shall maintain a system to investigate and evaluate incidents involving non-occupationally affected individuals (i.e., patients, visitors, contractors).

(3) The facility OSH committee shall receive information to initiate and support corrective or preventive action.

(l-9.8A continued)

(4) The OSH officer shall provide statistical information to evaluate the effectiveness of the program. The OSH officer shall post the "Log of Federal Occupational Injuries and Illnesses" for a minimum of thirty days, no later than 45 days after the close of the fiscal or calendar year at each work establishment, as required in 29 CFR 1960.67.

(5) The OSH officer shall provide management with information with which to evaluate the effectiveness of the IHS program.

(6) The department head or supervisor shall provide prompt and factual information regarding occupational injuries/diseases and property damage or allegations thereof.

B. Incident Investigation;

(1) All incidents shall be investigated and the cause(s) identified.

(2) In addition to assisting the supervisor as appropriate, the local OSH officer shall review all incident reports. Narrative reports may be forwarded on to the facility safety committee for further discussion and recommended actions.

(3) When the possibility of an incident resulting in a property damage claim against the government is identified, then a claims investigation shall be conducted in accordance with Section 20A, Part 4, Chapter 4-30, HHS General Administration Manual. Claims will be addressed through the designated property management official in the servicing Area Office and forwarded to the PHS Claims Officer.

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(4) When an incident occurs that results in a claim against the government, it is the responsibility of the facility director to ensure that corrective action has been taken to remedy the situation, and avoid further injury or illness. A report of the corrective action taken and disposition of the case will be forwarded to the facility director, with a copy to the OSH officer.

c. Safeguarding Iniury Information.

(1) Incident reports prepared in accordance with these procedures are for the improvement of the safety program throughout the IHS. Every effort should be made to ensure their security for future reference against loss or destruction. All reports and related information shall be retained within the Agency for a period of at least 5 years following the end of the calendar year in which the incident occurred.

(2) Disclosure of this information should be in accordance with the Privacy Act procedures for IHS employees.

l-9.9 SCOPE OF RESPONSIBILITY

OSH responsibility is a joint obligation of every employee in the IHS.

A* Program Responsibility.

Program managers in the Headquarters, Area offices, district offices, SUDs, and Tribal health directors are responsible for the protection of patients, visitors, employees, and property under their jurisdiction and for ensuring that all phases of this program are adequately implemented within their

(l-9.9A continued)

operations. Full support is required as the success of the OSH program is directly associated with support from all management levels.

It is imperative that program managers realize that virtually all of the IHS OSH officers, EH specialists, and OWCP-CM assume these responsibilities in a collateral duty capacity and that the time necessary to conduct the activities pursuant to this policy must be made available. Additionally, it is the Area Director's responsibility to ensure that appropriate training is available to all OSH personnel to enable them to undertake their OSH responsibilities.

'B. Staff Involved in OSH Management.

Each designated OSH officer, EH specialist, and OWCP-CM is responsible within his/her area of jurisdiction and expertise for each of the components listed below. The committee chairperson provides overall direction of the OSH program. Areas that are primarily the responsibility of an individual committee member are suggested below and further elaborated on in l-9.10 C (2), (3), (4), and l-9.10 D of this chapter.

(1) Committee leadership. The committee chairperson provides overall direction of the occupational safety and health program.

(2) Reports. The OSH officer will accumulate and review reports of injuries, occupational diseases, and property damage for presentation and discussion in OSH committee meetings.

(3) Technical contributions. The OSH officer, EH specialist, and OWCP-cm jointly will provide technical expertise from their respective disciplines in investigating and reporting occupational injuries and illnesses. The local

(l-9.9B(3) continued)

committee will work through the Area SPO for direct interaction with outside authorities, such as the Department of Labor.

(4) Incident follow-up. The OSH officer will initiate follow-up corrective action regarding reported incidents, or may delegate parts of this task, when appropriate.

(5) Incident data. The OWCP-CM will maintain local case files, and process and summarize data on all incidents to meet the requirements of this policy. Another locally designated individual may be appointed by the SUD (e.g., a representative of the safety, risk management, or quality improvement staff) to assume all or part of these responsibilities. This designee or the OWCP-CM should always be available to report on these data to the appropriate investigating authorities.

(6) Reports on actions. The OWCP-CM will provide results of investigations and corrective actions to the Area and/or IHS Claims Officer, when appropriate.

(7) The OSH committee member training The EH specialist and OSH officer have joint responsibility to provide or acquire health and safety training for personnel within their jurisdiction. In addition to development and implementation of relevant and effective personnel training, regular assessment of knowledge and practice of the principles presented in OSH training must be conducted. All staff in the management of OSH programs shall receive appropriate initial and continuing education necessary to perform their duties.

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(8) Committee liaison. Primarily the OSH officer will serve as a liaison between the occupational safety and health committee and the respective program managers.

(9) Health services. The EH specialist will provide or coordinate appropriate health care and medical surveillance for Federal employees. By definition, this is a primary duty of the EH specialist.

(10) FECA claims and case followup. The EH specialist will outline work task and duty hour/time limitations in the management of each FECA claim. The EH specialist is responsible for recommending to the OWCP-CM all activity restrictions, light duty designation, and workplace reentry activities on a case-by-case basis. The EH specialist may arrive at these recommendations for convalescent time periods, either independently or in collaboration with the employee's personal healthcare provider. The recommendations should be mutually agreed upon by the EH specialist and OWCP-CM.

Also see Section l-9.10 C of this chapter for specific duties of local OSH staff.

Supervisors.

Each Supervisor is responsible for:

(1) Prevention of injuries to patients and employees under his/her supervision and to patients or visitors on the premises, as well as for the protection of property under his/her administrative control.

(2) Ensuring that all incidents meeting the criteria stated in the definition section of this chapter that occur or are discovered in his/her area of

(l-9.9(3(2) continued)

responsibility or involve employees in his/her organization are investigated and reported. The supervisor's responsibilities include reporting all incidents to the OSH Officer through prescribed reporting channels and taking corrective action or advising higher authority of the need for such action when the required action is beyond his/her scope of authority or ability to perform.

Supervisors will investigate all circumstances related to each claim, will secure written statements from witnesses, if any, and will controvert continuation of pay whenever the circumstances warrant controversion. (See The IHM, Part 1, Chapter 8, entitled "Workers' Compensation Program.")

(3) Complying with and enforcing all applicable OSH standards, rules, and regulations and the orders issued by competent authority pertaining to the activities immediately under his/her jurisdiction.

(4) Reporting to the property officer, if applicable, incidents where property is damaged (including motor vehicles) in accordance with property board-of-survey procedures in the IHM, Part 5, Chapter 12, entitled "Personal Property Management Manual."

(5) Counseling employees on their FECA rights and responsibilities; preparing all necessary Office of Workers' Compensation Program forms in accordance with the IHM Part 1, Chapter 8, entitled "Workers Compensation Program" before reviewing and forwarding for SPO action on all OWCP claims forms. In consultation with the EH specialist or other clinicians, arrange for light duty assignments and participate in improved FECA management and monitoring programs.

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(6) Notifying employees of the results of monitoring, testing, or safety inspections that were conducted in the work area.

(7) Developing safe work practices based on a job safety analysis.

(8) Instructing employees under his/her supervision in the procedures to be followed, including use and distribution of reports, when reporting incidents.

(9) Providing each new employee with a job-specific or department-specific safety orientation.

D. Employees.

The OSH is an integral part of every job and requires the effort and support of every person involved. Each employee is expected to comply with all OSH standards, rules, regulations, and orders issued under the Act that apply to his/her own actions and conduct on the job. Each employee is responsible for keeping his/her equipment in safe working condition, maintaining good housekeeping in the specific work areas, and remaining alert to injury-producing situations. All employees are responsible for reporting all potential injury hazards to their supervisor and correcting them promptly, if possible. Employees (including both part/full-time civilians and members of the commissioned corps) are responsible for reporting to their supervisors all incidents, no matter how slight.

Employees are also responsible for immediately advising their supervisors of on-the-job injuries; for filing FECA claims and providing medical reports within prescribed deadlines; for returning to regular duties as soon as they are able; for exploring and accepting appropriate light duty assignments; for reporting

(l-9.9D continued)

medical evaluations, when directed, and for reporting for rehabilitative therapy or vocational rehabilitation counseling and training as directed. Under normal circumstances, an initial FECA claim form must be submitted within 3 workdays following an injury.

l-9.10 MANAGEMENT RESPONSIBILITIES

A. Headquarters - IHS.

The Institutional Environmental Health Officer, Environmental Health Services Branch, Division of Environmental Health, shall serve as the IHS OSH Manager. This individual is responsible for administration of the IHS OSH Program. At periodic intervals, Area operations will be evaluated by the OSH Manager to determine the general effectiveness of the overall occupational safety and health program. Technical assistance will be available to Area/Program Offices for establishing effective OSH programs. The IHS OSH Manager will coordinate the reporting activities, consolidate the annual IHS OSH Report, and recommend system changes, when necessary.

Headquarters staff must carefully review both the annual OWCP billings (final billings from the fiscal year 2 years earlier) and periodic quarterly OWCP billings (furnished quarterly on current year cases currently being paid by OWCP) to ascertain whether each FECA case listed is actually IHS responsibility or whether it should be reassigned to another agency.

B. Area/Program Offices.

The IHS Area Director (AD) has the authority and responsibility for developing and implementing the Area OSH program and designating an Area OSH officer/manager to discharge this responsibility. It is required that an individual qualified by previous

(l-9.10B continued)

OSH training or experience be selected. The OSH officer functions as principal advisor to the AD on safety and occupational health matters and as consultant and technical advisor to the SUD, health directors, administrative officers, and facility OSH officers.

An employee health specialist shall also be appointed. This individual's duties will depend on the number of employees and location of the office. See Section l-9.10C.3 of this chapter for a list of potential duties.

An Area OSH Committee shall be appointed to assist the Area OSH officer in reviewing safety inspections and reports, setting Area policy, discussing and evaluating any special problems, and recommending corrective action or program modification. The Area OSH program shall address the following:

(1) Each Area shall make the necessary modifications to Headquarters policy to meet local conditions.

(2) Each Area shall conduct management control reviews of service unit OSH programs. Area personnel should not conduct detailed inspections of individual institutions, with the exception of highly specialized surveys, e.g., radiation protection or industrial hygiene, for which Area personnel have the necessary expertise,

Area staff should determine the presence or absence of the necessary programs for hazard recognition, evaluation, and control at each service unit.

(3) Each Area shall provide or arrange for field staff training. If the local OSH staff are untrained to do one or more of the required tasks (e.g., hazard recognition, data

(l-9.10B(3) continued)

evaluation, and control), the Area must identify this need and take appropriate action, (e.g., provide or arrange for training).

(4) Area OSH personnel must function as a part of an Area team to monitor service unit compliance with OSH program requirements. This team may be composed of facility management, nursing, laboratory service, pharmacy, quality assurance, biomedical engineering, and top management. This team should provide a liaison function between service units and the AD.

The ADs are also responsible for monitoring and controlling all personnel management aspects of the FECA program. Each AD will:

a. Publish guidelines defining personnel management responsibilities of managers and supervisors in establishing light duty assignment programs.

b. Establish procedures to insure cooperation in the exchange of data and injury/illness investigative results on a routine basis between the FECA program management and OSH program management.

C. Ensure that the SPO seek second medical opinions; request investigations of suspected waste, fraud and abuse; approve separations from HHS rolls of permanently, totally disabled FECA recipients, and monitor recovery status of former Area/service unit employees receiving FECA compensation.

(5) Each AD will establish a system for periodic review of all FECA cases for which the IHS is billed but where the recipient is no longer on HHS rolls.

(l-9.10B(5) continued)

a. The AD will arrange for on-site reviews of the case file at the appropriate OWCP district office.

b. Where it appears that a new medical report might reveal partial recovery sufficient to allow a light duty or alternative work assignment, the AD will authorize the appropriate service unit OWCP-CM to request the OWCP district office to arrange for a fitness-for-duty physical. If qualified, the EH specialist may perform this assessment.

C. Any report of partial recovery will be returned to the SPO for renewed action to consult with the SUD on joint efforts to attempt to locate appropriate light-duty or alternative work assignments for which rehiring would be offered to the employee.

C. Service Units, Hospitals, Clinics, Field Health Stations.

(1) Designation of OSH officer, EH specialist and OSH Committee.

The SUDs are responsible for the local OSH program and shall designate qualified individuals to serve as the OSH officer and EH specialist for the purpose of carrying out the requirements outlined in this chapter. The SUD will ensure that the OSH team's professional qualifications are maintained through specialty training and other forms of continuing education offered at least annually.

Program managers shall also designate additional responsible individuals to serve on the local OSH committee. Membership of the OSH committee shall 'include the following: clinical services, e.g., a nursing representative; support

(l-9.1OC(l) continued)

services, e.g., a facilities management representative;' the SUD or administrative officer; the OSH officer; EH specialist; and the OWCP-CM. If available, representation from the local bargaining unit is required, and representation from the environmental health function is encouraged. The size of the committee will be determined by the size of the activity, but in no case consist of less than three members.

(2) Responsibilities and Duties of OSH Officers

OSH officers will function as staff advisors to program managers in safety and health matters. Their activities include:

a. Conducting, monitoring, and evaluating safety and health programs; facility safety inspections/surveys; internal and external drills; and informing the SUD/administrative officer and OSH Committee of the results of such programs and activities.

b. Consulting with or assisting supervisors in preparing and maintaining safety manuals and other OSH publications for local information and accreditation purposes.

c. Ensuring that reports are submitted promptly and accurately.

d. Consulting with or assisting supervisors in conducting job safety analyses of operations, consulting in, or developing safe working procedures, and requiring the correction of unsafe conditions.

e. Coordinating all OSH programs to whatever extent necessary to ensure accomplishment of objectives.

(l-9.10C(2) continued)

f. Providing for, or conducting and evaluating, appropriate safety educational efforts. This may be accomplished by using bulletin boards, contests, awards, news releases, etc.

g. Maintaining current information, reports, regulations, and safety files.

h. Conducting studies that may be required to provide accurate and timely information of safety problems for which supervisors require assistance and guidance.

i. Contributing to the successful operation of the safety committees by maintaining records and followup on committee recommendations where appropriate.

j. Consulting with supervisors on obtaining and maintaining personal protective equipment.

k. Monitoring the regular inspection and testing, by department/branch staff, of safety equipment to ensure compliance with existing standards and required inspection and testing frequencies.

1. Reviewing plans and specifications of construction repairs and improvements for compliance with Life Safety and other applicable standards and codes.

m. Coordinating and promoting staff OSH orientation and training, in conjunction with clinic personnel.

n. Consulting with other IHS OSH program personnel, as necessary.

(l-9.10C(2) continued)

0. Performing other OSH duties, as necessary.

(3) Responsibilities of EH Specialists:

a. Providing emergency evaluation and first treatment of injury or illness.

b. Providing definitive treatment or referral for occupationally-acquired illness or injury (NOTE: All employees who are seeking care for an on-the-job injury should be seen by a clinician, if available, before being referred to a private doctor).

C. In conjunction with SPO, ensuring that OWCP forms are appropriately filled out, and following up on employees who are referred for treatment of occupational injury or illness.

d. In conjunction with SPO, recommending light duty, if medically indicated, and coordinating early return to duty.

e. Ensuring that all occupational health medical records are maintained as described in Manual Appendix l-9-F "Employee Medical File System."

Any medical record generated as a result of treatment for occupational illness or injury, as well as medical surveillance information, will be maintained in a separate medical record entitled "Employee Health Medical Record" or "Employee Medical File (EMF) ." The information in an employee's medical record is kept in strict confidence, however, a copy of his/her record can be obtained by the employee or by his/her representative designated in writing.

(l-9.10C(3)e continued)

NOTE: The OSHA representatives may also examine and/or copy medical records or medical information from the medical record which may bear directly on exposure to toxic materials or harmful physical agents.

f. Arrange for or conduct annual surveillance examinations for employees, as necessary.

D. Functions of the OSH Committee.

The OSH committee chairman or OSH officer, shall intervene whenever conditions are identified that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings.

(1) Headquarters.

The Committee shall comply with the requirements for committee function listed in 29 CFR 1960.37, with the exception that the Committee Chairperson will be appointed by the Director, IHS.

The membership of the Committee shall, at minimum, consist of the following:

Director, Division of Facilities Management (DFM), OEHE
IHS OSH Manager, Division of Environmental Health, OEHE
Director, Division of Management Policy, OAM
Risk Manager, OHP
Representative, Division of Nursing, OHP
Representative, Pharmacy Services, OHP
Representative, Dental Services, OHP
Director of Medical Imaging, OHP
Representative, Biomedical Engineering, DFM, OEHE
Representative, Office of Human Resources
Representative, Division of Resources Management, OAM

(l-9.10D(l) continued)

Representative, Office of Planning, Evaluation, and Legislation
Representative, Office of Tribal Activities
Representative, Office of Information Resources Management
Representative for the Federal employees bargaining unit(s)

Each committee member shall designate an alternate to ensure representation at meetings.

The Headquarters OSH Committee shall meet at least annually.

Similar committees shall be established at IHS Headquarters West, Albuquerque, New Mexico, and the Clinical Support Center, Phoenix, Arizona. Information shall be exchanged between the Headquarters East and other Headquarters committees.

Committee minutes or other special reports shall be shared with the IHS Director, Associate Directors, Area Directors, and Division Directors.

(2) Area and Service Unit Committees.

a. The membership of Area committees should be similar to that of Headquarters. Service unit committees should be structured as defined in JCAHO standards, with the exception that membership must include a representative of the local bargaining unit, if present.

b. Committees shall meet periodically, at least quarterly, or at a prescribed frequency as outlined by a review authority (i.e. JCAHO) to:

(l-9.10D(2)b continued)

(i) Review the results of hazard surveys.

(ii) Develop, maintain, and review epidemiological information relative to incident occurrences, internal/external disaster drills, and reports.

(iii) Discuss special problems.

(iv) Recommend corrective action and followup, as appropriate.

C. Other responsibilities of the Committees include:

(i) Reviewing procedures for evaluations, recording, reporting, and developing educational programs in the interest of OSH.

(ii) Developing or assisting in developing safety policies and procedures.

(iii) Requesting inspection, by competent individuals, of special equipment or systems to ensure that proper safety protection is provided, maintained, and used.

(iv) Soliciting and reviewing employee suggestions for improving OSH.

(VI Requesting assistance of qualified persons concerning special problems, such as radiological safety, fire protection, hazardous materials, ventilation, elevator, boiler, and emergency power concerns.

(vi) Reviewing OWCP claims to ensure appropriateness of case handling, followup, and return to duty.

(l-9.10 continued)

E. Servicing Personnel Offices.

(1) Each SPO will be responsible for monitoring and controlling all personnel administrative aspects of FECA provisions as they relate to employees of the service unit including:

a. Establishing an FECA case monitoring file for each case forwarded to the SPO by a supervisor, health unit medical officer, safety officer, or other OSH program officials.

b. Informing supervisors that an initial FECA claim submitted by an employee or prepared by the supervisor must be forwarded to the SPO within 5 workdays following the injury.

C. Review the claim for completeness and accuracy before forwarding it to the Area office and the OWCP district office.

(2) The SPO will assist supervisors in the controversion of apparently non-meritorious claims.

(3) The SPO will assist in the development of a light duty assignment program and coordinate finding light duty assignments.

(4) The SPO will counsel supervisors to advise all employees receiving FECA benefits that physician's reports certifying continued disability are required:

a. Once every 2 weeks after the initial 45 day period of an FECA claim.

b. Less than once every 2 weeks only when authorized by the OWCP district office.

(l-9.10E continued)

(5) The SPO will monitor each currently active FECA case and consult with the supervisor biweekly regarding:

a. Light duty or alternative work assignments in the supervisor's area of responsibility.

b. Grounds for seeking second medical opinion.

c. Grounds for seeking an investigation of possible fraudulent claims.

d. To insure that claims forms protecting the employee's entitlement are being completed and forwarded to the SPO in a timely manner.

(6) The SPOs are responsible for counselling a permanently injured employee whom OWCP has determined to be unable to perform the critical elements of the regular position and who is eligible for either an annuity under civil service retirement or long term compensation from OWCP.

l-9.11 INCIDENT ACCOUNTABILITY

A. Incidents involving employees while on detail to other organizations are reported by and charged to the activity to which the employee is detailed.

B. Commissioned Corps and civilian personnel on temporary tour of duty to other Federal agencies will report all occupational injuries and illnesses to their parent organization and will be included in OSH surveillance system of that organization.

C. Incidents involving employees while visiting another activity for official purposes (on official travel) are to be reported and charged to the activity

(l-9.11C continued)

carrying the injured employee on its payroll. Property damage will be reported through the activity that owns, leases, or otherwise manages the property.

D. Employees injured while in a permanent change of station status will be reported by the gaining activity and charged to its injury surveillance.

1-9.12 SUPERVISOR'S RESPONSIBILITY ON CLAIMS FOR COMPENSATION

A. The OSH Program, supervisors, and safety officers should be aware of the information regarding Claims for Damage or Injury, and Penalties for Supervisors Added to the Compensation Act, which can be found in Manual Appendix l-9-C.

Each supervisor must see that prompt treatment is given to employees and that required compensation forms for civilian employees (see the IHM, Part 1, Chapter 8) are properly completed and forwarded in accordance with established procedures.

8. Allegations of Reprisal.

It is the policy of the IHS that no employee will be subject to restraint, interference, coercion, discrimination, or reprisal for filing a report of unsafe or unhealthy working conditions or because of other participation in OSH activities.

FORMS, PROCEDURES, AND STANDARD FORMAT FOR MESSAGES AND INCIDENT REPORTS

A. Incident Reportins - General. (See IHM, Part 1, Chapter 9, Section l-9.4 for definitions)

Please note: A manual of instructions for incident reporting will be prepared separately.

(1) All incidents shall be reported using the IHS Incident Report form (IHS-516). The report will be initiated by the employee or the supervisor having jurisdiction over the operation or function experiencing any incident involving patients, IHS personnel, visitors to IHS facilities including contractors, the general public, or property. The Incident Report will then be submitted 6 days after receiving information on an incident to designated Safety Officers as follows:

a. The original report is forwarded to and maintained by the Local OSH Officer for a minimum of 5 years. A copy of all completed forms will be forwarded to and maintained by the Area OSH Officer at the Area Office.

b. The originating facility OSH Officer will provide consecutive (beginning with number 001) case numbers for all incidents at each reporting facility, on October 1st of each fiscal year. The employee injury and illness incidents will be used to compile the "Log of Federal Occupational Injuries and Illnesses."

C. The IHS Headquarters OSH Manager will not be sent copies of incident reports. Records will be maintained at the local facility. Software generated reports will be used to supply the IHS OSH Manager with required reports on an annual basis. The only exception is the message report and followup reports for serious incidents, which are submitted as soon as possible (see Manual Appendix 1-9-A, Part B.). Fully completed copies of all related forms and information will be sent to the IHS OSH Manager.

(2) In the, event Federal employees other than IHS personnel are injured during the course of their employment on or near INS property, an original Incident Report will be prepared and forwarded to the supervisor of the agency at which the injured person is employed. These cases are not to be included as part of the IHS incident experience.

B. Serious Incidents, Iniuries, and Illnesses.

All serious incidents are to be reported to the IHS Headquarters OSH Manager within 8 hours. Serious occupational incidents must be reported within 8 hours to the OSHA Office of Federal Agency Programs. Non-occupational incidents are to be reported to IHS Headquarters as well but not to OSHA.

Serious incidents include:

(1) Any incident which is fatal to one or more persons.

(2) Injuries requiring hospitalization to 3 or more employees. Also injuries to 5 or more persons, including non-Federal employees, patients, the general public, and Federal contractors in a single incident resulting in provision of first-aid treatments.

(3) Any occupational illness that results in death.

(4) Property damage of $25,000 or more.

(5) All aircraft incidents reportable to the National Transportation Safety Board (NTSB) per Federal aviation regulations.

(6) Radiation overexposure that could result in a disabling injury

(7) Biological exposure **or** unintentional release of biological substances where the public may be exposed.

A message, report will be sent immediately, via FAX or electronic mail, to the IHS OSH Manager who will notify the PHS Safety Officer and OSHA within 8 hours of any serious incident. The message must address at least the following information:

(1) Names of individuals involved.

(2) Number of fatalities and/or injuries and illnesses and their extent.

(3) Establishment name, time, date, location, type of incident, and kind of operation conducted at the incident site.

(4) Actions taken by the IHS to investigate the incident and whether OSHA assistance is needed.

Appropriate incident report forms will be prepared and forwarded to Headquarters through normal channels as soon as possible. Completed copies of all available information (forms or other) will be sent to the IHS OSH Manager as soon as the information is available.

C. Damage by Members of the Public. If property damage (meeting definition l-9.4.P) is accomplished by a member of the public (non-IHS personnel), an investigating officer (usually the supervisor of the affected department, an employee of the affected department, or the local OSH officer) shall be designated and through normal channels shall submit an Incident Report (IHS Form-516). If employee property is damaged, (e.g. vandalism), the employee is to be given the information for filing a claim against the government to recover the loss or cost of damages.

D. Specific Types of Incidents.

Special procedures and report forms required are listed below:

(1) Aircraft Incident. All aircraft incidents shall be investigated using the Incident Report and will require the submittal of a message report to the IHS OSH Manager.

(2) Motor Vehicle Incidents. Motor vehicle incidents are to be investigated and reported promptly to IHS and GSA. Tort claims often result from motor vehicle incidents (see Section l-9.5 of this chapter); therefore, all incidents must be properly and completely documented (see Section l-9.8 of this chapter). Safety Officers and Investigating Officers shall become familiar with the Personal Property Management Manual, Chapter 6-200, Motor Vehicle Management, and the General Administration Manual Chapter PHS 4-30-10 A.l.b., A.2, and 4-30-47, A, B, and C. The operator of the vehicle shall submit a completed Incident Report through the normal channels to the local OSH Officer. Operators of Government vehicles or their supervisors will also notify GSA Fleet Management and complete the following as required by GSA:

a. Data Bearing Upon Scope of Employment of Motor Vehicle Operator, Optional Form-26.

b. Statement of Witness, Standard Form-94, shall be completed in all cases where witnesses are available.

C. Operators Report on a Motor Vehicle Accident, SF-91.

d. Investigation Report of Motor Vehicle Accident, SF-91A.

e. Form HHS-342 - Report of Survey. In instances where property is damaged, including motor vehicles, 'the supervisor must also report the property damage to the Property Officer in accordance with Property Boards of Survey procedures in IHM, Part 5, Chapter 12, Personal Property Management.

NOTE : In addition, all applicable State and local investigation/reporting forms should be completed within prescribed timeframes.

E, Safety Review.

A review of all workplaces including offices will be completed annually by the local hazard surveillance team. The survey results shall be entered into the facility safety tracking system. See Manual Exhibit l-9-C, "Model Hazard Surveillance Program, I for an example of a safety tracking system.

F. Annual Report of the Safety Management Program.

An annual report describing the previous fiscal year's OSH program will be prepared by each Area and submitted to the Headquarters OSH Manager by January 1st. Format and report requirements will be provided by the Department of Health and Human Services. The Area OSH Officer, shall provide a format for the annual reporting of safety activities to the service units and contract facilities at which Federal employees are stationed.

G. Los of Occupational Injuries and Illnesses.

Each establishment 'is required to keep a log of occupational injuries and illnesses. This log should be completed 6 days after information about the incident has been received. Also, yearly totals of all injuries, illnesses, and fatalities must be posted within 45 days from the end of the fiscal year and shall remain posted for 30 days.

H. Medical Records. Record of treatment, examination, exposure, and any other occupational medical and related records that are filed in the employee medical file. The purpose of occupational health medical records,. as described in Manual' Appendix 1-9-F, is to provide a complete record of employee health care for both medical and legal purposes. If an employee receives any medical attention, a medical record must be generated. The information will be kept in the employee's medical record in a separate section entitled "Employee Medical File" or "Employee Health Medical Record."

I. FECA Claims.

All incidents that result in an injury or illness to an IHS employee covered by FECA shall be reported as set forth in 20 CFR Parts l-25. Forms to be maintained at each IHS site for this purpose include:

Manual Appendix l-9-A

CA-l: Federal Employee's Notice of 'Traumatic Injury and Claim for Continuation of Pay/Compensation.

CA-2: Notice of Occupational Disease and Claim for Compensation

CA-2a: Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation

CA-3: Report of Termination of Disability and/or Payment

CA-5: 'Claim for Compensation by Widow,' Widower and/or Children

CA-5b: Claim for Compensation by Parents, Brothers, Sisters, Grandparents or Grandchildren

CA-6: Official Superior's Report of Employee's Death

CA-7: Claim for Compensation Due to Traumatic Injury or Occupational Disease

CA-8: Claim for Continuing Compensation on Account of Disability

CA-12: Claim for Continuance of Compensation

CA-16: Authorization of Examination and/or Treatment

CA-17: Duty Status Report

CA-20: Attending Physician's Report

CA-20b: Attending Physician's Supplemental Report

Refer to Indian Health Manual, Part 1, Chapter 8, Managing the Workers' *Compensation* Program for more information on FECA claims.

A. STANDARDS AND CODES.

Standards, guidelines,, and codes important in OSH include, but are not limited to:

(1) Applicable National Fire Protection Association (NFPA) Codes. The more important ones are:
NFPA - 99 STANDARD FOR HEALTH CARE FACILITIES
NFPA - 101 LIFE SAFETY CODE
NFPA - 70 NATIONAL ELECTRIC CODE

(2) Applicable Nuclear Regulatory Commission Standards

(3) Applicable Occupational Safety and Health Act provisions 29 CFR Part 1910, 1926 and 1960

(4) National Institute of Occupational Safety and Health (NIOSH) Guidelines for Health Care Workers, 1988

(5) Applicable Standards of the Joint Commission on the Accreditation of Healthcare Organizations

(6) Applicable Regulations and Guidance from the FDA Center for Devices and Radiological Health (CDRH)

(7) Uniform Building Code

(8) Applicable IHS infection control or safety policies

(9). National Standard Plumbing Code

(10) Applicable EPA regulations

(11) Boiler Construction Code of American Society of Mechani.cal Engineers (ASME)

(12) The IHM, Part 3, Chapter 21, "Medical Imaging Program"

(13) American Conference of Governmental Industrial Hygienists (ACGIH) Threshold Limit Values (TLVs)

(14) Applicable Department of Health and Human Services (HHS) Injury Compensation Program references of HHS Instruction 810-l):

a. 5 USC 8101, et seq.
b. 20 CFR 10.1 through 10.624
c. The IHM Part 1, Chapter 8, "Managing the Workers' Compensation Program"

A. CLAIM FOR DAMAGE OR INJURY (SF-95).

Any valid Claim for Damage or Injury (SF-95) and subsequent written material concerning the claim shall be se&directly to the IHS Claims Officer by the Area Property Management Branch. Employees as well as members of the public; may submit claims if their personal property is damaged while on the premises of a Government installation.

Tribal facilities under contract with the IHS, as per P.L. 93-638, have been extended coverage under the Federal Tort Claims Act (FTCA). This is fully described in Indian Self-Determination Memorandum No. 92-l. The FTCA states that a person covered by the FTCA is not personally liable for any negligent act committed while in the scope of employment under the contract. The injured party's remedy is restricted to filing a claim against the appropriate U.S. Government Agency pursuant to the FTCA. The employee is not subject to suit.

B. Penalties for Supervisors Added to Compensation Act.

Supervisors are reminded of the seriousness of failing to report incidents of injured employees as required. Under the regulations for administering the Federal Employees' Compensation Act, an immediate superior is required to make a prompt report through established agency channels to the Office of Worker Compensation Programs for every injury which: (1) is likely to result in any medical charge against the Compensation Fund; (2) is likely to result in any disability for work beyond the shift in which the injury occurs; (3) appears likely to require prolonged treatment, result in future disability, or result in any permanent disability, loss of use of a member of the body, serious disfigurement, etc.; or (4)results in immediate death, or is likely to result in death.

(1) Public Law 86-767 (18 U.S. Code 1922) includes an amendment to the Act by the 86th Congress that makes supervisors liable to a fine of not more than $500, or imprisonment of not more than 1 year, or both, if convicted of:

a. Willfully failing, neglecting, or refusing to make a report of any of the above.

b. Knowingly filing a false report.

c. Inducing, compelling, or directing an-injured employee to forego filing of any **claim** for compensation of other benefits provided for under the Act, extension or application of it.

d. Willfully retaining any notice, report, claim or paper which is required to be filed under the ***Act,*** extension, application or other regulations promulgated under it.

(2) The supervisor must see that prompt treatment is given the employee and that required compensation forms for civilian employees (CA-l, CA-2, etc.) are properly completed in duplicate and forwarded in accordance with established procedure.

USEFUL REFERENCES AND ASSOCIATIONS

American Hospital Association, (AHA)
840 North Lake Shore Drive
Chicago, Illinois 60611

Federal Safety Council (FSC)
Railway Labor-Building
First and D Streets, N.W.
Washington, DC 20210:

American Standard Association.
10 East 40th Street
New York, New York l0038

National Board of Fire Underwriters (NBFU)
85 John Street
New York, New York 10038

National Institutes of Standards and Technology (NIST)
Gaithersburg, Maryland 20760

National Safety Council (NSC)
425 North Michigan Avenue
Chicago, Illinois ,60611

OSHA Training Institute
1555 Times Drive
Des Plaine,; Ill 60018
(708) 297-4913

American Society of Mechanical Engineers (ASME)
29 West 39th Street
New York New York. 10016:‘.

National Fire Protection Association (NFPA)
60 Batterymarch Park Street
Quincy, MA 02169
(617) 770-3000
.

Joint Commission on Accreditation, of Healthcare Organizations (JCAHO)
Headquarters and Conference Center
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
(708) 916-5600

MODEL HAZARD SURVEILLANCE PROGRAM.

Each IHS facility shall have written policy and procedures describing the hazard surveillance program. -The following model program may be adapted for local use.

A. Backsround.

The Indian Health Service, the Joint Commission on Accreditation of Healthcare Organizations, and the Occupational Safety and Health Administration require the establishment of a system to identify, investigate, track, and correct conditions potentially hazardous to patients, visitors, employees, or the building. The system must also assess employee knowledge of the facility's safety and health policies and procedures.

B. Policy.

This policy establishes a facility based subcommittee to perform routine hazard surveillance for each hospital and health center.

C. Procedures.

(1) The team shall be composed of, at a minimum, representatives from environmental health, facility management, and nursing (particularly when evaluating patient care areas). One team member must be the safety officer, and representation from administration is encouraged.

(2) The scope of work shall include at a minimum: general safety, fire and life safety (e.g. egress, detectors, alarms, extinguishing systems, smoke and fire exits, internal and external disaster preparedness, etc.), electrical safety, lock-out/tag-out safety, vision safety, video display terminal (VDT) worksite environmental and ergonomic reviews, hearing conservation, confined spaces, hazardous materials and wastes management, and protection from occupational exposure to biological hazards, e.g., tuberculosis and bloodborne pathogens.

(3) Hazard surveillance surveys of patient care areas shall be conducted at least twice a year. Non-patient care areas shall be surveyed at least annually.

(4) Adverse safety and health conditions shall be referred to the safety or infection control committees for action.

a. Items will be assigned a code and entered into the appropriate facility tracking system.

b. Building deficiencies that are not safety or health hazards shall be tracked through the facility preventive maintenance system.

C. Conditions will be evaluated for their impact on health and safety. Recommendations will be based on the priority ranking. See section D. for the method of evaluating the relative seriousness of hazards.

d. The appropriate reference shall be cited when identifying hazardous conditions, e.g., a required exit obscured by file cabinets would be a violation of NFPA 101, 5-5.2.

(5) The safety or infection control committee will identify the department(s) responsible for correction and monitoring. All necessary documentation will be forwarded to the affected department for appropriate follow-up.

(6) All items will be tracked until corrected or resolved.

(7) Summaries of actions will be documented in committee minutes.

D. Survey Priority Setting.

Major Risk Management Factors.

Recommendations should be assigned a priority based on an assessment of risk Establishing levels of priority is a complex task, often requiring professional judgement. Attempts must be made to weigh risk factors analytically to determine the order of priority.

Applicable standards and regulations, along with professional judgement should be used in combining one factor from each of the above groups to achieve a priority value of A, B, or C.

These values represent high, medium, 'or low impact on health. or safety. Each of the above risk factors should not be assigned the same weight in determining the priority value. Obviously, risks that affect such factors as injury, litigation, or frequency of occurrence should be rated higher than cost. Cost is included to help in determining priority of correction if all other factors are equal. Also, it is often more difficult to determine which issues should be assigned a "moderate" priority than those which are perceived as "high" or "low" since these are often gray areas.

The following demonstrates some examples of the use of this system.

(1) Potential Severity of Injury or Illness.

a. Potentially, Fatal
b Potentially Disabling
c. Minor
d. None

(2) Relative Risk of Iniury/Illness Occurrence or Other Negative Outcome.

a.Continuously present
b. Frequently present
c. Occasionally present
d. Rarely present

(3) Cost of Correction.

a. No cost
b. Within operating budget
c. Minor capital improvement (Less than $200,000)
d. Major capital improvement (More than $200,000)

(4) Other Negative Outcomes.

a. Potential loss of JCAHO or other accreditation, major fine or litigation
b. Type I recommendation (Contingency), moderate risk of fine or litigation
JCAHO recommendation, low risk of fine or litigation
c. Minor recommendation, no risk of fine or litigation

Analysis of Factors.

Each situation,should be assigned a degree of hazard of "A - High," "B - Moderate, " or "C - Low." This ranking scheme roughly corresponds OSHA's hazard rating of "Imminent" "Severe," and "Less than Severe Some examples of analysis of factors are as follows:

Class A Recommendation - High Priority

Top priority = (l)a + (2)a. +(3)a. + (4)a.

Class B Rocommendation Moderate Priority

(1)c. or(4.)c. + (2)b or (2)c. + (3)a.

Class C Recommendation - Low Priority

(1)d. or (4)d. + (2)d. + (3)d.

Other Combinations = professional Judgement

E. Safetv Tracking Svstem,

Each OSH program shall establish a tracking system to ensure that identified hazards are appropriately addressed. following Safety Tracking System" log requires the following entries:

(1) Code.

Each hazard should be assigned a code by the local OSH officer to assist in tracking. Some structural hazards may require several years to abate. Therefore a coding system that includes the fiscal year plus three digits is recommended. For example, the first hazard identified in fiscal year 1994 would be coded as 94-001.

(2) Item/Issue.

Each hazardous condition should be described in sufficient detail for comprehension.

(3) Recommendation/Action.

Hazardous conditions should be assigned to a committee, e.g., OSH, Infection Control, or Quality Improvement, or to an individual. The committee or individual shall assign a priority, (e.g., A,B, or C) to the hazardous condition and develop a corrective action plan.

Recommendations may be the result of an interpretation or application of a code, standard, or guideline. The committee's or individual's interpretation may be questioned by the recipient of the report. This often occurs when a recommendation will require an expenditure of funds. The source of each recommendation should be clearly stated, including the specific number, section, paragraph, etc. The actual code citation should be used in framing the corrective action plan.

(4) Outcome.

The results of implementation , of the action plan shall be described. The individual assigned the responsibility to evaluate the results of the action plan shall determine the need to monitor (M) the situation or consider the situation closed (C). If the action plan is determined to be unsuccessful, the issue must be referred to a committee or an individual for reconsideration and development of a new action plan,

OCCUPATIONAL HEALTH RECORDS: THE EMPLOYEE MEDICAL FILE SYSTEM

A. APPLICABLITY

These instructions apply to employees at all 'Indian Health Service facilities.

B. DEFINITIONS

For the purposes of this exhibit, the following definitions are added to those already contained in Chapter 9.

(1) Employee Medical File System (EMFS). Agency's complete system composed of control procedures; implementing instructions; all automated, microfilm, and paper records on employee illnesses, accidents, injuries, and exposures; and other medical or health maintenance matters.

(2) EMFS Manager. Agencywide official who is assigned responsibility for management of the agency-wide EMFS. This may be a medical or allied health professional.

(3) Employee Medical File (EMF). A separate file folder (Standard Form 66-D or approved equivalent) that contains all relevant medical records designated for long-term retention, which accompanies the employee during his or her Federal career and is stored with the Official Personnel Folder/Merged Personnel Record Folder (referred to as the OPF) at the National Personnel Records Center (NPRC) after the employee's termination or retirement.

(4) Epidemiological Record. Contains statistical patient health and environmental sampling data, assembled and analyzed to enable conclusions to be drawn regarding occupational exposure of groups of workers. No personal identifiers are included in this composite data.

(5) Exposure Record. An individually identifiable record of radiation exposure or of exposure to an environmental health hazard, toxic substance, or harmful physical or biologic agent (as defined in OSHA documents, 29 CFR 1910.20 (c)(6) and (11)).

(6) Implementins Instructions. Refers to any form of internal Agency issuance that provides the guidance required by 5 CFR 293.503 and as described below in this exhibit.

(7) Non-occupational Patient Record. Refers to a record of medical treatment of examination, either inpatient or outpatient, maintained by a health care facility, which may for completeness or health maintenance of the employee be included in the EMF, e.g., records of voluntary employee physical exams, administration of allergy shots, or records of non work-related medical treatment or examination.

(8) Non-personal Record. Any Agency aggregate or statistical data resulting from studies covering groups of employees or resulting from studies of the worksite environment, e.g., data on employee accidents, health profiles, or exposure incidents.

NOTE : This record should not include any patient identifiers if it is to be reviewed outside of the occupational safety and health department.

(9) Occupational Illness/Accident/Injury Record. Certain forms (e-g., CA-20 or Agency developed form) that record an on-the job occupational 'illness, accident, or injury if medically related will be filed in the EMF. When a claim is filed with the Office of Worker's Compensation Programs (OWCP) the case papers physically retained at OWCP are not part of the EMFS, but any Agency retained file related to the Federal Employee Compensation Act (FECA) claim is considered as part of the employee's EMFS records.

(10) Occupational Medical and Related Record. A chronological, cumulative record, regardless of the form or process by which it is maintained (e.g., paper document, microfiche, etc.), of information about health status developed on an employee and related to employment, including personal and occupational health histories, exposure records, medical surveillance records, and records about occupational illnesses and diseases. Related records include the

opinions and written evaluations generated in the course of diagnosis and/or treatment by medical health care professionals and technicians or by industrial hygienists. For the purposes of this chapter supplement, the term "medical record" is deemed to mean treatment, exam, exposure, and occupational medical and re1ated records when they are properly filed in the EMFS/EMF:

(11) Occupational Safety and Health (OSH) and Office of Workers Compensation Programs (OWCP) Long-term Record. Those medical records defined in OSHA regulations (29 CFR 1910 and 1960) and designated for retention for the duration of employment plus 30 years and reports of occupational illness, accident, or exposure and related records, required to be completed under Agency or OWCP regulations (20 CFR l0), whether or not a FECA file is created.

C. IMPLEMENTING INSTRUCTIONS.

Internal Agency instructions on maintenance of the EMFS must be prepared with' joint, participation of IHS medical, health, safety, and personnel officers and should be reviewed by Privacy Act staff. Consultation with' Agency labor organizations must be afforded. The following instructions are suggested for standardizationof the EMFS.

(1) Overall Operation'. The medical records designated as part of the EMFS must be in a secure location identified to the EMFS manager and IHS Headquarters OSH staff. They are to be retrieved for inclusion of health or environmental data entry, and may require duplication of some documentation from the worker's general medical record in order to include information essential or useful for the employee's health and for OSH surveillance.

(2) Location. A description of where and under whose custody employee medical records will be physically maintained (e.g., in a section of the general medical records file room, dispensary, or personnel office; in custody of the EMFS manager or other responsible individuals) should also be provided in writing to the EMFS manager.

(3). General Guidance. The EMFS must be maintained in accordance with established retention schedules, and procedures to establish an EMF for an active employee must at a minimum include initiation of a file at the time of a first visit following issuance of this manual. For the majority of health care facility workers, this should require no more than 12 months, in the context of the currently required annual tuberculosis skin testing policy. When an employee transfers to another facility or agency, or leaves Federal service, the EMF may follow to the next agency with a move, retirement, or resignation. If there is no gaining agency, the EMF shall be transferred along with the employee's personnel file to the National Personnel Records Center (NPRC) or a regional Federal Records Center.

a. Disclosures.

Disclosures of EMFS records, both to individuals outside the IHS and to IHS officials, are restricted in order to protect personal privacy, particularly with regard to records of physician treatment or examination. These records generally should not be made available to non-medical personnel versus those medical reports that are properly provided to management for the purposes of making decisions affecting the employee. The confidentiality of the doctor-patient relationship is protected by the IHS Privacy Act. Routine use of the records, retention and disposal of the record, accessing of the record, and restricted accessing of the record by current and former employees and,other requesters; and amendments of the records are described in the EMFS system notice of the Office of Personnel Management, OPM/GOVT-10. Of note, routine uses of a record are permissive in nature, and the EMFS custodian is not required to make a disclosure or release the full record. If the custodians of the record have concerns about making a disclosure, they should consult with the EMFS manager, the IHS General Counsel, or other IHS responsible official.

b. Confidentiality.

The first responsibility of the IHS is to protect the confidentiality of the records whenever possible. The mere receipt of a request for a record under one of the established routine uses is not, ordinarily, sufficient to warrant the release of all records on the employee. Scope of the request should be carefully examined and narrowed whenever feasible. Only the specific record sought or a portion of that record should be released, and, if appropriate, a report by competent IHS officials on the contents of the file should be furnished in lieu of the record itself. All routine disclosures should be recorded and retained for five years or the life of the record, whichever is longer.

c. Retention Schedule.

The retention schedule herein has been established by the NARA and is binding on Federal agencies. The IHS Records Management Officer should be consulted with any questions. Disposal of records shall be by shredding, burning, or erasure of disks or tapes.

Temporary medical records may be maintained as part of the EMFS, covered by the procedures of this chapter-exhibit and covered by the Office of Personnel Management's EMFS Privacy Act system notice. However, they are not to be placed in the EMF being sent when the employee transfers to another agency or when the EMF is sent to the NPRC. Temporary medical records most commonly refers to Drug Testing Records in other federal agencies; there is no Drug Testing Program of employees in the Indian Health Service, but this paragraph is included for completeness.

Medical records considered to be long-term records in the EMFS must be maintained for the duration of employment, plus 30 years. Therefore, upon separation from the employing Agency, the records either accompany the employee to a new assignment or are transferred to NPRC for disposal in accordance with the GRS #l.

d. Current Employee Access to Records.

All Federal agencies are required by Privacy Act regulations to make the initial decision on a current employee's request for access to his or her EMF. The IHS may establish any internal procedures that it chooses for processing such requests without imposing any condition beyond those contained in the regulations or guidance of the Office of Personnel Management (OPM). Furthermore, special accessing permitted by the Privacy Act for a physician or other person to receive the record, should only be made by the IHS EMFS manager or designated medical officer. If IHS withholds any records, the requester must be informed of his/her right to appeal the IHS decision in writing to the Office's Assistant Director for Workforce Information, 1900 E Street, NW, Washington, D.C. 20415.

e. Requests For Access to EMFS Records By Former Employees.

If IHS receives a request for access to EMFS records by a former employee, it must determine if the Agency still has any EMFS records, (e.g., temporary records not sent with the EMF, or the EMF itself). For any records still retained, the request will be processed the same as a request from a current employee. If IHS has retained temporary records after having sent the EMF to the next agency or to the NPRC, and those temporary records are still covered by the OPM Privacy Act for EMF system of records (i.e., still within the retention schedule), then the Agency will provide access. If the temporary records have been retained beyond the established retention schedule, since they are no longer covered by the OPM system of records, the Agency is responsible for issuing both the initial decision and for processing any appeal of a denial. A request for access to an EMF when the EMF has been sent to another employing agency will require the request to be referred to that agency. If the EMF has been sent to the NPRC, the request will be referred to the Office's St. Louis Office, OPM/EMF Access Unit, for appropriate action.

f. Amendment Requests.

As in the case of an access request, under the Office's Privacy Act regulations an agency makes the initial determination when a current employee requests amendment of an EMFS record (temporary or long-term). Any agency denial requires that the IHS inform the requester of his or her right to appeal the decision to the Office's Assistant Director of Workforce Information. Amendment requests from, former employees for long-term EMF records also will be referred to this office.

'3. Exempt Records.

Traditionally an individual has had the right to access his or her medical records. Therefore, the Office has claimed no. Privacy Act exemptions for records in the EMFS/EMF. Additionally, when an individual cannot name a physician to receive the records (e.g., because of economic or religious reasons), the IHS should consider giving the, records to an alternative responsible person named by the, individual, e.g., a spouse, parent, or clergy member.

h. Method of providing access to EMFS records

The IHS must provide the requester with either a copy (at no cost) of the record, or the right to personally review his/her own total EMFS/EMF contents. Any written designation of access of an employee's record must include, the specific identity of the representative and of the records to be provided.

D. ESTABLISMENT AND REVIEW OF EMPLOYEE MEDICAL FILES.

(1) Establishment.

When initially,implementing the EMFS IHS facilities need to establish an EMF only when there are medical records that are appropriate for filing in an EMF and only when the employee leaves the employing agency. At a facility's discretion, an EMF may be established when an

employee moves within the employing facility, e.g.; when the IHS decides to transfer that employee's medical records to a new servicing location. The IHS is authorized by OPM to require the establishment of an EMF when medical records exist for its current employees (or all new hires).

(2) Reviewing an EMF of a former Federal employee.

a. When the EMF is located in the NPRC, an agency may request the former employee's EMF with that individual's OPF only when the requesting agency has specific authority to do so, e.g, when determining if the applicant can meet specific medical standards identified for the position before being appointed. When there are no specific medical standards and the agency does not have the authority to require all applicants to undergo a physical examination prior to appointment, the agency must make its decision without reviewing the EMF. The IHS may not request the NPRC to forward the EMF to the IHS EMFS manager until an employee has been employed 30 days. This delay is designed to prevent unnecessary retrieval of an EMF, with the attendant potential for inappropriate or unnecessary disclosure of highly sensitive data.

b. When the EMF is located with a former employing agency, the need for the record from the most recent non-Federal employer should be clear before a request is sent to the last employing agency. The retrieved and transferred records should be placed into an EMF and forwarded to the EMFS manager designated by the requesting agency. Thereafter, the receiving agency will be responsible for maintaining both the records it received and any it may create for the employee.

(3) Reviewing the EMF of a current Federal employee.

When an agency is considering an employee of another agency for possible selection, it may review that employee's EMFS records only under the conditions described in paragraph B(1) of this section. In these

cases, the reviewing agency may wish to consider a written stipulation from the employing agency's EMFS manager that specific qualifications for the position can be met by the candidate. In all other cases, a general statement by the employing agency that there is no evidence of a, health condition that would prevent the candidate from performing the duties of the position should suffice.

(4) Reviewing an EMF for other than employment reasons.

If it becomes necessary (e.g., in matters before a judicial or quasi-judicial authority or for other legitimate agency reasons), an agency may retrieve an EMF from the NPRC or another agency. The request to NPRC will be made in accordance with any instructions issued by NARA.

Content of the Employee Medical File:

a. Applicant Medical Records.

Medical records pertaining to an applicant, including Drug Testing Records under Executive Order 12564, are part of the OPM/GOVT-5. Recruiting, Examining, and Placement system of records are not part of the EMFS. Only when an applicant is subsequently hired will those medical records created during the 'application for employment process be retained in the IHS-generated EMFS, and shall include:

(i) Forms, e.g., Standard Forms 88 and 93, Medical History and Physical Examination, submitted with job application or completed shortly after entrance on duty.

(ii) Records created/submitted when demonstrating that the applicant qualifies for appointment under special authorities regarding employment of the severely physically or mentally disabled.

(iii) Records that demonstrate that the applicant meets the medical standards identified in the Office's X-118 and X-118C handbooks.

b. Medical records created during **employment**.

Records created as a result of a condition-of employment or as a result of an on-the-job occurrence.

(i) Those resulting as a condition of employment

(a) Records necessary to demonstrate that the employee continues to **meet** the medical standards for the position, e.g., periodic hearing, sight, or physical examinations.

(b) Records to support placement of the employee in a light duty status or which lead to **some** other temporary accommodation made by an agency, e.g., a detail because of a medical condition.

(c) Records created under the agency's employee health monitoring programs.

(ii) Those arising as a result of an on-the-job occurrence are of two kinds.

Exposure records that include:

(a) Employee health surveillance records (e.g., regularly scheduled employee examinations, including audiograms, blood tests, and periodic readings of employee monitoring meters or badges).

(b) Records from emergency situations (e.g., toxic agent exposure requiring immediate examination).

(c) Industrial hygiene records documentation of exposure levels, including: physical, biological, chemical, and radiological workplace hazards.

(iii) Occupational illness or injury records, regardless of whether the person files a claim for compensation with the Office of Workers' Compensation Program (OWCP).

(a) When no compensation claim is filed, a record of the occupational illness or injury should be made part of that employee's EMF record, along with any record of treatment by agency staff or furnished by the employee's private physician.

(b) When a claim is filed with OWCP, the official copy of the claim file is maintained by OWCP, but the IHS maintains a duplicate claim file (FECA file) during the processing of the case and during the period that benefits are being received. The duplicate file may be retained at the service unit where the employee works, and at the Area or Headquarters facility where processing has been taking place. It is recommended that since the agency policy is to retain the agency FECA file for the duration of compensation, that the EMF also be retained. A notation is to be made in the employee's OPF that the EMF is being retained by the last employing agency. When compensation ceases and the FECA file and other EMF records are still subject to the 30-year retention schedule, a notation will be added to the EMF to indicate that the individual is off compensation and, if known, state whether the person is or is not capable of working. The EMF will then be sent to the NPRC for storage. If the FECA file and other EMF records are 30 or more years old, then the retention schedule for EMFS records has been met and the records may be disposed of in accordance with the agency's internal records schedule for EMFS records.

(5) Records created durins the separation. process.

Such records include termination medical examinations for those employees working in areas with hazardous materials as a documentation of medical status at the time 'of discharge. Records shall also be created for an agency-initiated separation, for an agency or employee initiated application for disability retirement, and when the employee dies in service. Records involved in a granted disability retirement or in a death would be those that are:

a. Relied upon in reaching a decision for the IHS to initiate a request for disability retirement.

b. Provided by the employee in connection with an application for disability retirement.

C.. Resulting when the employee dies in service.

NOTE: Although the OPM will retain copies of medical records received in connection with a disability retirement issue (whether or not it is granted) and in death-in-service situations, the IHS should also place copies of these records in the subject's EMF.

E. RECORDS GENERALLY EXCLUDED FROM THE EMPLOYEE MEDICAL FILE SYSTEM.

Records that are generally not considered part of the EMFS but may become part under certain conditions include:

(1) Emolovee assistance/counselins records.

These records relate to counseling on personal or on drug/alcohol abuse problems, when the employee formally enters into such a program. While such EAP files might include copies of medical records from the EMFS/EMF, inclusion of any counseling-related records in the EMFS or the EMF is not allowed due to the confidentiality mandates of the statutes establishing such programs. When the employee voluntarily seeks and accepts counseling or, upon the recommendation of management, enters into the IHS' counseling program, then he or she is considered to be formally entered into such a program. Otherwise, medical

records released,to these problem areas are considered to be part of the EMFS. Formalcounseling records may be included in the EMFS only when the employee consents.

(2) Non-occupational Medical Patient records.

Such records can include those the IHS maintains or those maintained by a non-Federal treating physician, hospital (inpatient or outpatient), or health care facility (e.g., DOD or VA hospital or clinic). When the treatment or examination received by the employee is directly related to the position held (e.g., where regularly recurring physical examinations or examinations are part of the conditions for continued employment), is the result of an occupational illness or injury, is due to an exposure incident on the job, or is performed as a result of an IHS employee health monitoring program, then a copy of the record of treatment/examination should be made part of the EMFS/EMF at the time' treatment/examination occurs.

(3) The following records may be placed in an individual's EMF only when it is clear that the report covers a situation in which' that employee was involved.

a. Non-personal records'. These are records about working conditions or the work environment that contain no specific information about individual employees but were prepared from information about other unspecified employees. For example, a notation could be entered' into an employee's EMF regarding an indication for increased surveillance or special testing of this employee, such as uncertain recent work exposure to patients diagnosed with infectious tuberculosis or other dangerous communicable disease, after the diagnosis of occupational illness or injury in a coworker. This notation could be made either for a planned intervention involving the employee, or merely to evaluate need for intervention via an investigation-generated report. After the report is prepared the individual record may be destroyed or filed in another system.

b. Records on working conditions. Such records would be those that provide data about the work environment, e.g., quality of air, hazardous agents (chemical, physical, biological) in the work environment, or protective equipment utilizations and training.

F. RECORDS REQUIRING SPECIAL FILING PROCEDURES.

Classified Records. Such a record carries a defense classification, and would be declassified prior to transfer to an IHS EMFS.

(2) X-Ray Records. Some *X-ray* records will fit within the EMF while others do not, e.g., the Chest/Torso X-ray. The NPRC cannot accept an EMF with documents extending beyond the border of the folder nor will it accept boxed oversized X-rays. These X-rays, in cases where OSHA standards apply, must be retained at the service unit where originally interpreted for the duration of employment plus 30 years.

NOTE: Asbestos surveillance X-rays must be retained for the duration of employment **plus** 30 years. Most other X-rays, e.g., arm or leg, are usually recorded on film that fits within the border of the EMF and should be included in the EMF. When the oversized X-ray is required to be retained, the creating agency must retain it and include a notice in the *EMF* as to how a subsequent custodian of the EMF may obtain it. Should technology permit, and the OSHA standards allow, a microfiche copy of any X-ray may be placed in the EMF in lieu of the X-ray itself.

G. LOCATION OF EMPLOYEE MEDICAL FILE SYSTEM RECORDS AND EMPLOYEE MEDICAL FOLDERS.

(1) The physical location for retention of EMFS records or active EMFs is an IHS prerogative. Facilities should retain such sensitive data in a physically secure location apart from the main body of patient medical record; that is, the EMFs of a service unit or facility should be kept together in one cabinet or group of cabinets to ensure the integrity, privacy, and availability of the records for clinical use and regulatory and surveillance functions. Alternative sites include the location where employees receive occupational health clinical services (either on- or off-site), or office of the local EMFS manager, provided that the location is at least as secure as the general medical records department.

(2) EMFS records should not be located in the same office with the OPF in order to avoid inappropriate disclosure of the records. Only staff with essential occupational health duties are authorized to use the EMFS or any individual EMFs. Medical records that had been stored in an OPF prior to the advent of the EMFS should be removed from the OPF and placed in the EMF at the time of its activation.

H. OWNERSHIP OF THE EMPLOYEE MEDICAL FILE.

The EMF of each employee who is in a position subject to civil service rules and regulations is part of the records of the OPM, entrusted to the IHS. When the EMF also contains medical records created during employment in a position not subject to the IHS or OPM's civil service regulations, e.g., with the Postal Service, the EMF is then part of the records of both the OPM and the non-civil service employer.

I. TYPE OF FOLDER TO BE USED.

(1) When retiring an EMF to the NPRC, the IHS must use the folder prescribed by the OPM and available through the Federal Supply Service. This blue folder is identified as Standard Form 66-D, Employee Medical Folder. This is the only folder that will be accepted by the NPRC for storage of medical records.

(2) When IHS establishes an EMF on a current employee, it will be used to transfer medical records when necessary within the IHS, e.g., when an employee transfers to another service unit. When an EMF is not used for current employees, any folder or a sealed envelope may be used to retain or transfer the record. However, when transferring records to another agency, the prescribed EMF must be used.

(3) When the medical records of an employee fall under the jurisdiction of two agencies, e.g., the IHS and the US Postal Service, the prescribed EMF is to be used.

J. USE OF EXISTING EMPLOYEE MEDICAL FILES UPON TRANSFER OR REEMPLOYMENT.

It is the obligation of the gaining/appointing agency to locate and obtain any prior medical records for the new employee, either from the last employing agency or from the NPRC.

(Exception: any new employee who left his or her last agency on or prior to September 1, 1984.) Medical records for an employee transferring into an agency should be in the SF 66-D and IHS should continue to use it for storing any medical records created on the individual. If the medical records are not in the SF 66-D (e.g., in an envelope or other folder that 'has been identified as the EMF) the gaining agency should transfer those records to the SF 66-D.

K. STORAGE AND RETRIEVAL OF EMPLOYEE MEDICAL RECORDS AND EMPLOYEE MEDICAL FILES OF SEPARATED EMPLOYEES.

Over the years, agencies have stored medical records of separated employees in different locations; therefore, the procedures for obtaining medical records vary according to when and where they were stored. 'Before 1978, medical-records were sent to the. National Personnel Records Center. Between 1978 and August 1984, they were sent to either the NPRC or to one of the regional Federal Records Centers. In addition, some medical records (e.g., SF 88, SF 177, and CA-l and CA-20 forms) were filed (either interfiled or included in a separate envelope or agency-designated folder) in OPFs that were sent to the NPRC. Since August 1984, agencies have been required to consolidate the medical records of each separated employee in an EMF, SF 66-D, and to send the EMF to the gaining Federal agency.

Agency_____ Bureau_____ Establishment_____

Log of Federal Occupational Injuries and Illnesses

Case or File Number	Date of Injury or Onset of Illness	Employee's Name	Occupation	Department	Description of Injury/Illness and Body Part Affected	Injuries			Illness/ Diseases		
						Fatal Cases	Lost Time Cases	No Lost Time Cases	Fatal Cases	Lost Time Cases	No Lost Time Cases
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)

Totals (if used as annual in compliance with 20 CFR 1960.69(b))

SAFETY TRACKING SYSTEM

As of:

M = Monitor C = Closed

Code	Item/Issue	Recommendations/Actions	Outcome	M/C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service

INCIDENT REPORT

SSN NUMBER	DUTY STATION	DEPARTMENT
ADDRESS		
CITY	STATE	ZIP CODE
DATE OF REPORT	DATE OF INCIDENT	

TYPE OF INCIDENT			SEVERITY	DISABILITY	SERIOUS INCIDENT TYPE (Check one)
Initial ☐ Follow-up ☐	YES	NO	☐ 1. Fatal	☐ 1. Temporary	☐ 1. Fatal
1. Employee Injury	☐	☐	☐ 2. Hospitalized	☐ 2. Partial Permanent	☐ 2. More than 3 Injured
2. Patient Injury	☐	☐	☐ 3. Ambulatory	☐ 3. Full Permanent	☐ 3. Property damaged > $25,000.
3. Visitor Injury	☐	☐	☐ 4. No Treatment	☐ 4. None	☐ 4. Aircraft
4. Medical Device Injury	☐	☐			☐ 5. Radiation Release
5. Property Damage	☐	☐	LOST TIME (days)_____		☐ 6. Biological Release
6. Hazardous Condition	☐	☐			

EXAMINED BY PRIMARY CARE PROVIDER ☐ YES ☐ NO	MEDICAL EXPENSE INCURRED: ☐ YES ☐ NO	ESTIMATED COST: $_____
INVESTIGATION CONDUCTED BY:		PHONE NUMBER ( )

INDIVIDUAL INVOLVED

NAME		TORT POSSIBLE ☐ YES ☐ NO
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE
ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER ( )	TIME OF INCIDENT	

EMPLOYEE

JOB TITLE		OWCP FORM FILED ☐ YES ☐ NO
PERSONNEL STATUS - CO, GS, WG, TRIBAL, VOLUNTEER, OTHER		GRADE LEVEL / STEP
NUMBER OF DEPENDENTS (Spouse and Children under 18)	SUPERVISOR'S NAME	
WORK PHONE NUMBER ( )	SHIFT ONE, TWO, OR THREE ☐ 1 ☐ 2 ☐ 3	TIME ON DUTY BEFORE INCIDENT

PATIENT

DATE OF ADMISSION	DEPARTMENT	DEPARTMENT PHONE NUMBER ( )	CHART NUMBER
DIAGNOSIS ON ADMISSION			MEDICAL DEVICE RELATED ☐ YES ☐ NO
CONDITION BEFORE INCIDENT			
MEDICATIONS ADMINISTERED ☐ YES ☐ NO	TYPE OF MEDICATION		
COMMENTS			

VISITOR

PURPOSE OF VISIT

HHS-616
Rev. 6/94

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service

INCIDENT REPORT

PROPERTY

OWNER			PRIVATE PROPERTY ☐ YES ☐ NO
ADDRESS			
CITY		STATE	ZIPCODE
PROPERTY MANAGEMENT NOTIFIED ☐ YES ☐ NO	DATE	NATURE AND EXTENT OF DAMAGE	
ESTIMATED REPAIR / REPLACEMENT $	GOVERNMENT VEHICLE INVOLVED ☐ YES ☐ NO	REGISTRATION / TAG NUMBER	

NARRATIVE

Give a factual description of incident, location, and other important specifics [ie, body parts(s), other individual involved, etc.]

FACILITY NAME: _____ DEPARTMENT: _____

DESCRIPTION:

DIAGRAM OF INCIDENT

CODING SECTION

INCIDENT LOCATION CODE		DESCRIPTION	
OSHA TYPE CODE		HS TYPE CODE	
OHSA SOURCE CODE		CD NATURE CODE	
OCCUPATION CODE		CD EXTERNAL CAUSE CODE	
DWCP AGENCY CODE			
SIGNATURE AND TITLE OF REPORTING EMPLOYEE		DATE	PHONE ( )
SIGNATURE AND TITLE OF REVIEWING OFFICIAL		DATE	PHONE ( )
SIGNATURE AND TITLE OF CODING OFFICIAL		DATE	PHONE ( )

The information collected on this form is to be utilized in compliance with the Privacy Act of 1974

HHS-516 (BACK)
Rev. 6/94

U.S. GPO: 1994-378-057/80067