

HEALTHCARE SAFETY LEADER



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Hazardous waste

Ensure compliance with EPA rule: Ban all sewerage of hazardous waste drugs

By A.J. Plunkett (aplunkett@decisionhealth.com)

Review and update policies on the disposal of pharmaceuticals to prohibit the flushing of any drugs into the sewers. Experts say that may be the best way to ensure compliance with a new EPA regulation banning the sewerage of hazardous waste pharmaceuticals that went into effect August 21.

The policy update also may help ease requirements on frontline staffers, who will no longer have to keep track of what they can and can't flush down the drain. And it may even help you stay on the good side of federal regulators, who are encouraging the no-sewerage of any drug as a best practice to protect water resources.

The August 21 ban on the sewerage of hazardous waste pharmaceuticals is the first deadline set out in new EPA regulations published in a February final rule. That rule overall sets up a new category, Subpart P, under the federal Resource Conservation and Recovery Act (RCRA).

The ban is the only part of the rule that goes into effect at all healthcare facilities across the United States and its territories without exception. That's because the EPA is declaring the ban under the authority set out by the federal Hazardous and Solid Waste Amendments (HSWA).

Other parts of the *final rule*, officially known as the "Management Standards for Hazardous Waste Pharmaceuticals & Amendment to the P075 Listing for Nicotine," are under RCRA and must be approved in each state or territory that has its own RCRA-authorized program (more on that in a bit).

No-sewerage ban more stringent

The sewerage ban is one of the more stringent changes outlined in the rule. The EPA only has the authority to ban flushing of those drugs deemed to be hazardous waste, as outlined under RCRA regulation, notes **Wade Scheel**, director of governmental affairs for Stericycle Environmental Solutions.

However, in the preamble to the final rule, the EPA "clearly makes it known" its position on sewerage of all drugs, he says.

That preamble states: “We note that although our RCRA statutory authority limits us to apply the prohibition on sewerage narrowly to pharmaceuticals that are RCRA hazardous wastes, EPA strongly recommends as a best management practice to not sewer any waste pharmaceutical (i.e., hazardous or non-hazardous) from any source or location.” The EPA even goes on to ask households to do the same.

The concern is that public sewer and water systems were not designed to filter out the complex chemical and biological elements found in many of today’s drugs, even if those drugs are not technically considered hazardous waste, says Scheel.

Pharmaceuticals can have a significant impact on the environment, according to **Michael Ganio, PharmD, MS, BCPS, FASHP**, director of pharmacy practice and quality with the American Society of Health-System Pharmacists, more commonly known as the ASHP.

“Studies have shown that non-hazardous-waste drugs that are disposed of down the drain can be found in water supplies and in lakes and streams, so a best practice is not to dispose of any pharmaceuticals down the drain,” says Ganio.

Because of such impacts, many larger health systems and healthcare facilities have already abandoned the practice of sewerage, notes Scheel.

Smaller facilities should pay special attention

While the new federal ban may not have a major impact on those larger hospitals and healthcare facilities, smaller organizations, especially in rural areas, will have to ensure policies are in place to adhere to the prohibition.

The main problem will be identifying which pharmaceuticals are considered hazardous waste under RCRA and which are not, and then training staff to know the difference, says Scheel.

Having staff make those decisions while also providing care can be an onerous demand, he notes. To help them out and ensure compliance, create a “make-it-easy button” for them and prohibit the flushing of all pharmaceuticals, recommends Scheel.

Facilities that do not want to follow that recommendation will need to inventory the pharmaceuticals disposed of on-site and update their disposal policies to identify which drugs are considered hazardous waste under RCRA, then prohibit those drugs from being sewerage.

“The sewerage ban applies to hazardous pharmaceutical waste, commonly referred to as P- and U-listed waste. The lists contain drugs that are considered toxic, reactive, corrosive, or ignitable. The lists are not updated frequently, and institutions should have systems in place to ensure the proper disposal of P- and U-listed waste,” says Ganio.

A variety of commercial services, including Stericycle and Waste Management, maintain databases to identify pharmaceuticals considered hazardous upon disposal, as well as those considered hazardous to staff under the USP <800> standards that go into effect December 1, and the long-standing protections against hazardous substances required by OSHA. Some of those pharmaceuticals fall into all categories, while others are in only one, say experts ([ECL 12/31/18](#)).

Training should be at least annual

Anyone potentially handling and disposing of the pharmaceuticals that are included in the EPA rule will need to be trained on the no-sewerage ban.

Training should occur now or upon hire, says Scheel. And a best practice would be refresher training at least once a year, he says. Although the EPA regulation does not require documentation of training, having documentation will help show compliance, he adds.

“Hospitals and health systems should train all staff who handle hazardous pharmaceutical waste on proper disposal,” says Ganio. “The new rule is an update to an existing rule regulating hazardous pharmaceutical waste, so hospitals and health systems should already have training, policies, and procedures in place to ensure staff are disposing of hazardous pharmaceutical waste correctly.”

“It’s also important to note that not all sections of the new rule are immediately effective and will depend on state EPA adoption of some provisions. For example, the sewerage ban is effective on August 21 nationwide, but other provisions in the new rule have to be adopted by state EPAs. Hospitals and health systems should check with their state EPA to determine if and when those parts of the new rule will be adopted,” says Ganio.

Other deadlines later for most

As noted, the sewerage ban is promulgated under the HSWA. The rest of the rule—which the EPA says reduces overlapping regulations from the DEA and FDA; tries to clarify how RCRA applies to reverse distribution and reverse logistics operations; and pro-

vides some regulatory relief to healthcare facilities that are regulated as large quantity generators by easing up on packaging of some nicotine replacement therapies— is under RCRA.

So by law, states or territories with their own RCRA-authorized programs have until July 1, 2021 to adopt the elements of the new rule—unless they also need to get legislative approval to do so, in which case those states have until July 1, 2022.

But if you are not in a state or territory with your own RCRA program, you were subject to all parts of the final rule as of August 21. That includes Iowa and Alaska, all the U.S. territories except Guam, and Indian Country.

Effective Dates & State Adoption EPA Management of Hazardous Waste Pharmaceuticals, 2019 final rule			
	Less Stringent	More Stringent	
	Nicotine Exemption	Sewer Ban	Subpart P
Non-authorized states (IA, AK), territories, & Indian Country	August 21, 2019*	August 21, 2019*	August 21, 2019*
Authorized states & territories, no legislative session required	<ul style="list-style-type: none"> Effective when state adopts State adoption not required 	August 21, 2019*	<ul style="list-style-type: none"> Effective when state adopts July 1, 2021⁺
Authorized States & territories, legislative session required	<ul style="list-style-type: none"> Effective when state adopts State adoption not required 	August 21, 2019*	<ul style="list-style-type: none"> Effective when state adopts July 1, 2022⁺

*effective date +state adoption deadline

Source: EPA

Healthcare facilities in all other states and territories should keep a close eye on what is adopted, experts have said. Federal law requires RCRA-authorized programs to adopt anything that is more stringent, but those programs do not have to adopt anything less strict—for instance, the exemption on throwing away over-the-counter nicotine-patch wrappers or warfarin blister packs.

Kentucky, New Jersey, and Pennsylvania have already indicated they will adopt the rule in its entirety, noted **Charlotte A. Smith, RPh, MS**, a senior regulatory advisor and founder of PharmEcology Services, now a part of WM Sustainability Services, during a recent webinar for HCPro.

Like the EPA and the other experts, Smith is a fan of healthcare facilities prohibiting the flushing of all drugs, regardless of whether they are hazardous waste or not.

She also co-authored *Managing Pharmaceutical Waste: A 10-Step Blueprint for Healthcare Facilities in the United States*, developed in 2006 and revised in 2008 for the EPA. In the final rule, the federal agency recommends hospitals and other healthcare providers use the blueprint as a continuing resource for best practices.

The blueprint can be found at <https://practicegreen-health.org/sites/default/files/upload-files/pharmwaste-blueprint.pdf>. Information on the webinar can be found at <https://hcmarketplace.com/breaking-new-ground>. ■

Hazardous waste

What constitutes healthcare facility? EPA offers definitions for new rule

by A.J. Plunkett (aplunkett@decisionhealth.com)

In February, the EPA published a long-awaited *final rule* on the management of hazardous waste pharmaceuticals that creates a new section, Subpart P, under the federal Resource Conservation and Recovery Act (RCRA).

The first deadline, the ban on sewerage of all hazardous waste pharmaceuticals, was effective as of August 21 (see article on p. 1). Other sections of the rule will go into effect as states adopt and revise their own EPA-approved RCRA programs (see chart on p. 3).

All hospitals fall under the EPA rule. But what about physicians’ offices or other off-campus facilities that may be part of a health system, but not the hospital itself?

Here’s how federal officials define a healthcare facility for the purposes of enforcing RCRA’s new Subpart P, according to an EPA-sponsored webinar in April:

“Healthcare Facility means any person that is lawfully authorized to (1) Provide preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, and counseling, service, assessment or procedure with respect to the physical or mental condition, or functional status, of a human or animal or that affects the structure or function of the human or animal body; or

(2) Distribute, sell, or dispense pharmaceuticals, including over-the-counter pharmaceuticals, dietary supplements, homeopathic drugs, or prescription pharmaceuticals”

“Healthcare Facility includes, but is not limited to:

- Wholesale distributors
- Third-party logistics providers (3PLs) that serve as forward distributors
- Military medical logistics facilities
- Hospitals
- Psychiatric hospitals
- Ambulatory surgical centers
- Health clinics
- Physicians’ offices
- Optical and dental providers
- Chiropractors
- Long-term care facilities
- Ambulance services
- Pharmacies
- Long-term care pharmacies
- Mail-order pharmacies
- Retailers of pharmaceuticals
- Veterinary clinics & hospitals.”

And what, you ask, constitutes a long-term care facility? According to the EPA:

“Long-term Care Facility means

- A licensed entity that provides assistance with activities of daily living, including managing and administering pharmaceuticals to one or more individuals at the facility

“Long-term Care Facility includes, but is not limited to:

- Hospice facilities
- Nursing facilities
- Skilled nursing facilities
- Nursing and skilled nursing care portions of continuing care retirement communities

“A Long-Term Care Facility does NOT include:

- Group homes
- Independent living communities
- Assisted living facilities
- Independent and assisted living portions of continuing care retirement communities.” ■

Fact Sheet

NAICS Codes of Healthcare Facilities and Reverse Distributors Potentially Affected by the Hazardous Waste Pharmaceutical Rule

This table from the U.S. Environmental Protection Agency (EPA) provides a guide for identifying entities that might be affected by the 2019 Hazardous Waste Pharmaceutical Rule regulations at 40 CFR266, Subpart P. The table lists examples of the types of entities the EPA knows could potentially be affected, although other types of entities not listed may also be affected. (**Note:** To determine whether your entity, company, business, organization, etc., is affected, you should examine the applicability criteria of the rule.)

NAICS Code	Description of NAICS Code
4242	Drug Wholesalers
44511	Supermarkets and Other Grocery (except Convenience) Stores
44611	Pharmacies and Drug Stores
452311	Warehouse Clubs and Supercenters
54194	Veterinary Services
6211	Physicians’ Offices
6212	Dentists’ Offices
6213	Other Health Practitioners (e.g., Chiropractors)
6214	Outpatient Care Centers
6219	Other Ambulatory Healthcare Services
622	Hospitals
6231	Nursing Care Facilities (e.g., assisted-living facilities, nursing homes)
623311	Continuing Care Retirement Communities (e.g., assisted-living facilities with on-site nursing facilities)
Various NAICS	Reverse Distributors

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Security

Use of Tasers and other control weapons remains debate in hospitals

By A.J. Plunkett (aplunkett@decisionhealth.com)

Carefully review whether you want to allow security officers to carry conducted-electrical weapons (CEW) such as Taser® devices on your facility grounds. If you choose to allow them, ensure a high level of training in both when and how to use the weapons, in compliance with your hospital’s weapons policy and with CMS’ restraint and seclusion requirements.

Also be aware that CMS has cited hospitals for the improper use of such weapons, including a Pennsylvania hospital who faced immediate jeopardy (IJ) after a

guard used a CEW in an attempt to control a patient earlier this year who was “becoming verbally and physically aggressive.”

The hospital was able to have the IJ removed the same day as the complaint investigation by banning the weapons from the premises, according to the CMS deficiency report filed after an investigation in April.

In a June incident that took place in a South Carolina hospital, a patient was able to take a CEW away from a private security officer during an altercation and used the weapon on a nurse. That patient was later charged with assault.

When and how to arm security guards or off-duty police officers working in hospitals has long been debated, with little resolution—especially with the ongoing concern about workplace violence and active shooter incidents.

Repeated questions to the International Association for Healthcare Security and Safety (IAHSS) led the group to approve new guidelines in January. However, the guidelines don’t encourage or discourage arming officers with firearms, but rather list considerations for discussion in developing a policy. ([ECL 3/11/19](#))

CEWs are among an array of control devices often employed by security officers, such as handcuffs, pepper spray, and batons. “There is heated debate presently regarding these tools and whether they have any place in the healthcare setting,” notes **Sarah Henkel** in the introduction to the position paper “Violence in Healthcare and the Use of Handcuffs,” published in 2018 by the IAHSS Foundation.

Hospitals cited for improper use of CEWs

While CMS has cited hospitals for incidents involving CEWs and other such control tactics, it leaves the decision on arming officers up to hospitals. However, CMS is clear in the *State Operations Manual*, Appendix A (SOMA), which contains interpretive guidelines for the enforcement of Medicare *Conditions of Participation*, that weapons are not to be used for restraint.

“CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term ‘weapon’ includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and

Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion,” states the SOMA.

The arming of hospital security officers varies across the country, notes **Ernest E. Allen, ARM, CSP, CPHRM, CHFM**, a former Joint Commission surveyor and now a patient safety consultant for The Doctor’s Company in Ohio.

“In general, many of the large medical centers often have their own police security force, with officers licensed by the state with full arrest authority. This is very helpful as the officers respond much quicker than the city police department, and helps deter wrongful arrest or detention lawsuits. Most of those private medical center security/police officers are equipped with firearms and Tasers,” says Allen.

“Medium size hospitals with security staff often do not carry firearms, but it varies considerably depending on the location, with urban locations more likely to have officers with firearms and sometimes Tasers.”

“Small hospitals with security officers are almost never equipped with firearms or Tasers and rely on the response of the local police or sheriff department. A few small hospitals may hire off-duty police to provide coverage on weekends when the ED is busy,” notes Allen, “and those officers would be armed.”

What are the concerns?

Overall, liability would be less for hospitals if security officers are not issued firearms or Tasers, he says. But there is a need to protect employees as well as others from out-of-control patients or visitors.

Healthcare employees face a much higher risk of a workplace injury, with the ED being the prominent location, notes Allen. “That is why most hospitals have a security office or officer stationed adjacent to the ED entrance. And EDs have lockdown capability to prevent unauthorized people from entering.”

Hospitals face competing concerns when considering arming officers, notes **Steven A. MacArthur**, senior compliance consultant with The Greeley Company in Danvers, Massachusetts.

“The fact of the matter is that once you introduce weapons into the equation, it increases the potential for

something bad to happen, and while bad things may not happen often, I guess it comes down to weighing the risks,” says MacArthur.

“That said, CMS says no weapons on patients unless it is for a forensic/laws enforcement reason, so the risk is compounded from a compliance standpoint.” Anytime it does happen, the hospital can expect a visit from CMS, warns MacArthur.

“There are potentially all sorts of liability issues when you ‘weaponize’ your security force,” he says. Those include making sure:

- Officers are competent to use the weapons they are provided
- There are very clear rules of engagement and use-of-force elements in the hospital policy
- That security officers know how to “safe” their weapons

There may also be legal concerns about providing a safe workplace, he notes.

Protect patient rights

But providing security while protecting patient rights is also a difficult balance, MacArthur says. A hospital’s policy may require, for instance, that a security officer secure any weapons before helping to restrain a patient, he says. But incidents escalate quickly.

“The big piece of this is that any time you do the laying on of hands, it is a time of significantly increased risk to everyone involved; restraint education, inclusive of practicing takedowns and holds, is an important way to minimize the risk to the extent possible, but it is never a risk-free endeavor,” says MacArthur. “I’ve had very experienced officers accidentally break a patient’s leg because the patient wasn’t educated in restraint—he zipped when he should have zagged, and the next thing you know he’s screaming. It’s always easy to Monday

morning quarterback when something goes wrong, and there are plenty of folks willing to do just that.”

“Even with the best education and practice, things can go sideways, so they have to set up to minimize the risk.”

For more on what to consider with the use of CEWs in hospitals, see the Q&A on p. 7 with healthcare security expert **Lisa Terry, CHPA, CPP**, vice president, vertical markets – healthcare, for security consultant Allied Universal in Charlotte, North Carolina. ■

CMS clear on use of weapons as restraint: Don’t

CMS clearly states its position on the use of weapons on patients. It can be found within the interpretive guidelines for surveyors outlining patient’s rights expectations as a Medicare Condition of Participation, under A-Tag A-0154 of the State Operations Manual, [Appendix A](#).

The guidelines also state that inappropriate use of restraint and seclusion is a condition-level deficiency. Such deficiencies could result in an immediate jeopardy ruling that could threaten a hospital’s ability to bill Medicare.

In addition, the guidelines make clear that hospital leadership holds the ultimate responsibility for restraint and seclusion deficiencies.

According to A-0154:

- “CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term “weapon” includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. If a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff, or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement.
- “The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by this rule. The use of such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital’s patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer’s prisoner).”



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– AJ Plunkett, Editor
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Security

Q&A: Understand the risks and benefits of arming security

In June, a patient in a South Carolina emergency room was charged with assault after a security guard had his Taser® taken away during an altercation. The conductive-energy weapon was then used on a nurse.

The issue of arming security officers in healthcare is complicated, and we asked longtime security consultant **Lisa Terry, CHPA, CPP**, vice president, vertical markets – healthcare, for Allied Universal in Charlotte, North Carolina, for help in sorting out concerns.

Terry co-authored a *special report*, “Defensive Weapons and Equipment In Healthcare,” for ODS Security (now Allied Universal) in 2016.

The following Q&A has been lightly edited for clarity:

Q: Once a hospital has made a decision to allow weapons for security officers—whether they are private contractors, hospital employees or local police officers (on duty or off)—how do you ensure those weapons (firearms or other weapons such as Tasers, pepper spray, batons, etc.) are secure at all times?

A: Understanding both the risks and benefits of “armed” security professionals is critical when considering allowing the presence of firearms or other defensive equipment, including conducted energy weapons (Tasers), into the healthcare environment. Decisions must be made on facts, trends, foreseeable risks, and the unique challenges of each hospital. A thorough review and risk assessment should be conducted before this critical decision is made.

Once the decision is made, a comprehensive and well-thought-out plan should begin. This plan should include the development of very detailed policies and procedures. Careful consideration of legal requirements and regulatory expectations should drive the policies. The requirement that officers utilize appropriate safety retention level holsters (level two or three) as well as the presence of a safe location to secure a firearm or a conducted energy weapon (Taser) are important facets of any defensive equipment program. There are certain situations/locations in which an officer should avoid bringing a firearm or a conducted energy weapon (Taser). Thus, the establishment of a robust training program with continuous oversight is essential in facilitating those policies and procedures.

Q: Presumably there is some level of training associated with arming officers—how often should organizations require the training? What competencies are required? Who should do that training (for instance, local law enforcement if they agree to, or a private security training operation)?

A: There are individual state requirements regarding competencies and the certification of the instructors. The maximum amount of training required should be completed. I would recommend that consideration be given to utilizing a certified instructor with the additional knowledge and capability to conduct the training in a manner which takes into account the unique healthcare environment (regulatory requirements to include CMS, specific medical and safety precautions, etc.). In my opinion, this is an important conversation that the healthcare administrator and the security leader should have with the instructor prior to scheduling the first class.

The course outline may include a portion dedicated to the unique healthcare environment.

Q: If security is provided by a contractor, what should be in that contract to ensure that training is being done, and being done to the hospital’s requirements?

A: The value of continued and improved training cannot be overemphasized. This training should be viewed as a priority investment and worth added cost which may be incurred. In addition to the specific state-mandated certification requirements, I recommend that supplementary defensive weapons training (firearms or conducted energy weapons—Tasers) be implemented on a quarterly or semiannual basis. The training should be competency based. Officers must demonstrate competency in each phase of the training process before being allowed to continue on to the next phase. Competency-based training focuses on what is learned rather than simply measuring what is taught.

The hospital should be specific in the contract as to their expectations of training (amount, type, etc.). However, the contractor will no doubt be specific on charges for this training due to staffing during the training, etc. There is significant value associated with this ongoing training for the officers. It is important that the contractor provide a value proposition that appropriately meets the needs of the hospital to this end.

Q: What kind of training should non-security personnel go through? For instance, do you train ER staff on what to do if they realize a patient has just gotten a hold of a weapon?

A: In my opinion, a hospital should provide active assailant/active shooter training for their non-security personnel on an ongoing basis. This type of training can be customized for each department as necessary to include the unique situations most prevalent to that area.

Q: In reading CMS reports and media reports over the last few years of times when Tasers have been involved in incidents at a hospital, it's almost always been at an emergency room, involving an out-of-control patient that needs to be restrained. CMS has specific restrictions on restraint. Should all security officers go through that training? And what about the use of weapons in those instances?

A: If there is an expectation by the hospital that a security officer participates as a member of the “healthcare team” and assists in restraining an “out of control” patient, it is recommended that the security officer be provided the same training as the other “healthcare team” members in terms of the CMS *Conditions of Participation*. These expectations should be specific and be made very clear by the hospital administration to the security director (or placed in the contract for the security provider) to ensure that appropriate training is conducted, procedures developed, etc.

It is difficult for me to generalize past incidents in which a Taser has been used involving an “out of control” patient in the emergency department. I do believe that when possible, the best option is for officers to secure their weapons before conducting a “one-on-one” with a behavioral health patient. However, there are exigent situations that may preclude that option.

Q: Some of the incidents have involved an officer who was trying to scare a patient into submission. The affidavit sample (recommended in the ODS special report) says that officers will affirm they won't do that—how can you ensure that?

A: There are no guarantees, but steps can be taken with special care to eliminate candidates who are physically or psychologically unfit to carry a weapon.

Consideration may be given to adding the psychological assessment and the integrity testing components to the selection process for armed officers. There are

reputable and affordable companies with online products which provide these services. However, continued training and appropriate supervision remains the key to an effective program.

Q: The affidavit says in times when a patient is being restrained, you should take the clip out of your weapon—is the same thing true for Tasers?

A: Exceptions occur, as in the case of an emergency where there is no time, but it is a recognized best practice for the officer who is the “contact” officer (making contact with the patient) to not have his/her conducted energy weapon (Taser) on his/her person. He/she should have secured it prior to making contact with the patient.

If possible, there should be a secondary officer who is still in possession of the conducted energy weapon (Taser) who is not in direct contact with the patient who could utilize the weapon in the event an emergency.

Q: In your experience, how often is the use of firearms or other weapons in a hospital setting connected to poor training, lack of resources or overtired officers (either someone pulling extra duty or shifts that have been extended)? This question goes to resources, which are of course limited everywhere but especially at hospitals.

A: Every situation provides an opportunity for analysis and identification of areas for improvement to strengthen the program. For example, officers may have properly utilized force when they deployed their conducted energy weapons (Tasers) on various occasions in defense of another individual's life. However, as the debriefs and root cause analyses were conducted, opportunities for improving the training and program oversight were determined.

Q: Training, adequate staffing—all of this takes resources. For the financially strapped hospital or for the compliance officer who's trying to argue for more resources for training or personnel, what advice could you offer? What arguments do you focus on—to track incidents and provide a quality report? Present the C-suite with risk assessments?

A: Risk assessments are a good first start. Risk avoidance is a good argument for ongoing and enhanced training and oversight. Hospitals can be violent places. The answer to changing that unfortunate fact is not to

simply arm hospital security officers. Firearms or Tasers, whether carried by officers protecting the hospital or brought into it by others seeking to do harm, are only part of the equation. Investing in non-violent crisis de-escalation training for the security team as well as other staff members is good response. It is imperative that the entire healthcare organization work as one unit in the management of violent patients and potentially violent situations, regardless of improvements in security systems and the presence of security personnel. Seamless integration of these officers into the patient- and family-centered care environment is critical to the ongoing safety and security of everyone. ■

Life safety

Time to remind staff about the fire dangers with decorations

By A.J. Plunkett (aplunkett@decisionhealth.com)

It's October, so it's about time to dust off the Scrooge costume for Halloween. Remind hospital staff about what they can and cannot do with decorations during the upcoming holidays.

If you have a written policy, this might be a good time to break it out and send it around. Maybe stop to say hello at a nursing station, with a smile and a copy of the policy in hand.

If you don't already have a policy, consider these tips from **Chris Burney**, originally published in 2012 in *Environment of Care Leader* (a precursor to *Healthcare Safety Leader*). Now retired from healthcare management, Burney spent years in facilities management, including a stint as executive director of planning, design, and construction in the office of the vice chancellor of the University of Mississippi Medical Center in Jackson, Mississippi.



Questions Comments & Ideas

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What does the NFPA say about decorations?

Here's a summary of what the NFPA 2012-101 Life Safety Code® (LSC) says about combustible decorations.

They must:

- Be flame retardant or treated with approved flame-retardant coating that is listed and labeled for application to the material to which it is applied.
- Meet the requirements under NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.
- Exhibit a heat release rate not exceeding 100 kW, when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20kW ignition source.
- Decorations such as photographs, paintings, and other art must be attached directly to walls, ceiling, and non-fire-rated doors so as not to interfere with the operation or latching of the door; and when used inside a room or smoke compartment space, the decorations cannot take up more than:
 - 20% of space in an area not protected throughout by an approved sprinkler system, or
 - 30% of space in an area protected by a supervised automatic sprinkler system, or
 - 50% of space inside patient sleeping rooms with no more than four persons that is protected by an approved, supervised automatic sprinkler system. And any of those sprinkler systems have to be in accordance with Section 9.7 of the LSC.
- An explanatory note in the LSC Annex says that the “percentage of decorations should be measured against the area of any wall or ceiling, not the aggregate total of walls, ceilings, and doors. The door is considered part of the wall. The decorations must be located such that they do not interfere with the operation of any door, sprinkler, smoke detector, or any other life safety equipment. Other art might include hanging objects or three-dimensional items.”
- Decorations such as photographs and paintings must be in such limited quantities that hazard of fire development or spread is not present.

For the exact language, consult the NFPA codes themselves.

Every year, Burney would bring out what he calls his “Humbug Policy.” Yours should have elements of the same:

- **Prohibit any combustible decoration unless it's fire retardant.** If the decoration is fire retardant or resistant, it must say so on an attached label or on the packaging in which it came. Keep the box or labeling nearby—if a surveyor asks whether a decoration is flame retardant, you have to be able to prove it.
- **Allow exceptions as long as they meet Life Safety Code® (LSC) requirements.** The LSC allows for decorations but sets limits on how many, what kind, and where (see a summary above). For instance, never decorate doors or fire safety equipment.

- **Keep decorations separate from possible ignition sources.** Don't mix combustibles with those holiday lights.
- **Don't allow open flames of any kind.**
- **Prohibit flammable materials.** That includes sprays such as artificial snow, or decorations like crepe paper in any quantity.
- **Don't allow artificial trees** unless they are labeled or otherwise documented to be flame retardant or flame resistant.
- **Make it clear that trees or large decorations** can't be placed in hallways or obstruct doors.
- **Have the hospital's electrical or safety department** approve lights or other electrical equipment for use. Electricals must be for indoor use only, and they must be UL or FM approved.
- **Don't allow staff to hang decorations from the ceiling.** They can obstruct safety signs. Also note that decorations CANNOT be strung from fire sprinkler heads.
- **Make it clear** that all decorations must be removed by a certain date. And state that date.
- **Clarify that decorations cannot be stored** in the department where they are used. The hospital's facilities staff should oversee storage. ■

Life safety

Ask the expert: Can smoke compartments be removed from plans

By Brad Keyes, CHSP (www.keyslifesafety.com)

Q: Section 19.3.7 of the 2012 Life Safety Code® (LSC) discusses smoke compartments in facilities that have greater than 30 sleeping beds per floor or building. If your facility is under 30 beds but greater than 22,500 square feet, are smoke compartments required? Or can they be removed on the life safety plans?

A: No, they cannot be removed, because section 4.6.12.2 of the 2012 LSC says existing life safety features shall not be removed or reduced where such feature is a requirement for new construction. New construction requires it, so you must maintain it for the life of the building.

ASC soiled utility room

Q: How does one handle a “soiled utility” room in an ambulatory surgery center (ASC)? If it is a small storage room without large volumes of flammable liquids but perhaps containing soiled linens, are there any special fire protection features which need to be included?

A: Soiled utility rooms in ASCs are treated differently than they are in hospitals and healthcare occupancies. Where chapters 18 and 19 specifically identify soiled utility rooms as hazardous areas for healthcare occupancies, chapters 20 and 21 do not for ambulatory healthcare occupancies (AHCO). But chapters 20 and 21 refer to chapters 38 and 39 for “Protection from Hazards” and they do identify “storage rooms” as a hazardous area that must comply with section 8.7. Section 8.7.1.1 requires the hazardous room (i.e., a soiled utility room in ASC) to be protected in one of the following two ways:

- Enclosing the room with one-hour fire-rated barriers, that would include a ¾-hour fire-rated door assembly that is self-closing and positive latching, or:
- Protect the room with sprinklers

Ambulatory suites

Q: Am I allowed to have a suite inside an area designated as an ambulatory occupancy? And for clarification, do suite boundary walls need to be one-hour fire rated?

A: Yes, you are permitted to have a suite in an AHCO. Look at section 20/21.2.4.3, which permits suites in an AHCO, but states that any suite over 2,500 square feet must have two remotely located doors from the suite. No, suite boundary walls are not necessarily required to be one-hour fire rated. They are required to be equal to the fire-resistive rating of the corridor walls. For new construction, corridor walls would be a minimum of one-hour fire-rated barriers, unless one of the following applies:

- Where exits are available from an open floor area
- Within a space occupied by a single tenant
- Within buildings that are fully protected with automatic sprinklers

For existing construction, there are no requirements for corridor walls, so there are no requirements for suite boundary walls.

E-size O2 cylinders

Q: Can E cylinders be stored in a closet where people hang their jackets, even if the cylinders are in an acceptable storage cart?

A: Yes, up to a certain number of E cylinders. Storage of compressed medical gases up to 300 cubic feet in accumulative quantity per smoke compartment is unregulated, other than the requirement in section 11.6.2.3 (11) of NFPA 99-2012 to properly secure the cylinders and to not store them in such a way that they obstruct the required egress. But once the accumulative total of stored gases exceeds 300 cubic feet per smoke compartment, then section 11.3.2 of NFPA 99-2012 regulates how they are stored. It states that:

- The cylinders must be in a designated room constructed with non-combustible or limited-combustible materials
- This room must have a door that can be secured against unauthorized entry
- Oxidizing gases cannot be stored with any flammable gas, liquid, or vapor
- Oxidizing gases must be separated from combustibles by 20 feet, or 5 feet if the room is sprinklered or enclosed in fire-rated cabinets

An E cylinder (which is 25.5 inches tall and 4.3 inches in diameter) contains 24 cubic feet of gas when full, so that means you could have up to 12 E cylinders in a single smoke compartment before you would have to comply with section 11.3.2 for storage.

Generator batteries

Q: I was reviewing the various regulatory requirements and came across the need for weekly visual inspections of the generators. At one campus, we have changed out the batteries to gel type. On the other campus, we still have wet cell type. Yes, we have a hydrometer and, within the weekly PM work order, it does state to check them. But we don't really use a form to capture that information. We called our contractor who provides the generator service and asked them to quote on gel batteries. They state that the manufacturer does not recommend sealed batteries because they can't be manually maintained and, because generator batteries are constantly in a state of being charged, the water could dry out and the batteries can explode. They also state that gel batteries for our particular engines will lose 200–300 cranking amps. I saw your Q&A section

on generator batteries and wondered, now that the accreditation organizations (AO) have adopted the 2012 version of NFPA 101, are there any formal decisions on the use of gel/sealed batteries?

A: There is no formal decision or interpretation from any national AHJ (that I know of) that prohibits maintenance-free batteries, or gel-type batteries, for generators. However, there are standards that say you must follow the manufacturer's recommendations regarding plant equipment maintenance and operations (see CMS *CFR* §482.41(d)(2)) and your AO's standards. In your case, it appears the manufacturer of your generator says you shouldn't use maintenance-free batteries. So, CMS and your AO could cite you for not following your manufacturer's recommendations. By the way, the requirement to test the generator battery electrolyte level is monthly, not weekly, according to NFPA 110-2010, section 8.3.7.1. But you still must document the monthly reading.

Fire/smoke barriers

Q: According to our life safety drawings, we have a barrier that is identified as a fire/smoke barrier. A surveyor from a recent accreditation survey said we cannot have a combination fire/smoke barrier and it has to be one or the other, not both. This is causing a disagreement among our staff on how we maintain the doors in these barriers. Where can I find the code reference regarding this issue?

A: What the surveyor said is not correct. Take a look at section 8.5.3 of the 2012 *LSC*, which says fire barriers may be used as smoke barriers provided they meet the requirements of section 8.5 for smoke barriers. To be sure, a smoke barrier does not qualify as a fire barrier because the doors in a smoke barrier are not required to be fire-rated and positive latching, but a fire barrier could be used as a smoke barrier provided it meets all of the requirements of a smoke barrier. Perhaps the surveyor was confused with the label "fire/smoke barrier" on the life safety drawing. This description is not clear, and the surveyor could have been commenting that a barrier should not be labeled as both. I always recommend to my clients to avoid a combination label that reads "fire/smoke barrier." ■

EDITOR'S NOTE:

Brad Keyes, CHSP, is founder of Keyes Life Safety Compliance. Follow Keyes' blog on life safety at www.keyeslifesafety.com for up to date information.

What's wrong with this picture?

Answers to last issue's Hospital Safety Forensics photo

By A.J. Plunkett (aplunkett@decisionhealth.com)

A stairwell may seem like unused space good for storage, but make it clear to staff that the stairs are for egress only.

No boxes can be stored in stairwells, says **Linda Gylland, MLS (ASCP) QLS**, a laboratory safety officer for Sanford Health in Fargo, North Dakota, who provided this photo. The evacuation route “must be clutter free,” she says.

Know that surveyors from CMS and all accrediting organizations will be inspecting your stairwells. CMS Life Safety surveyors are instructed in Appendix I of the *State Operations Manual* to complete a “room-by-room, floor-by-floor, walk through of the facility.”

That inspection must include, at a minimum, “one smoke barrier, including doors, on each floor or wing; all fire barriers; all hazardous areas including doors into the area; all exit stairs, doors, signs; resident room doors for condition, latching and fit in the door frame; the fire alarm system; the sprinkler system; the emergency power generator set; corridor walls; emergency lighting; and medical gas storage, if applicable.”

Surveyors from The Joint Commission would cite stairwell clutter under **LS.02.01.20, EP 14**, requiring hospitals to maintain the means of egress, including ensuring that exits, exit accesses, and exit discharges are “clear of obstructions or impediments to the public way.”

Surveyors from HFAP would cite the similar requirement under **Life Safety chapter 13.01.08**, Path of Egress Obstructions.

Hospitals are often cited for problems with storage in the path of egress. A hospital in Detroit was cited in January under the Life Safety K-tag **K-211**, Means of Egress, for having wheelchairs stored on a stairwell landing, according to a CMS deficiency report found on the Association of Health Care Journalists database at HospitalInspections.org.

In December, a hospital in New Jersey was cited under Medicare's physical environment Condition of Participation standard §482.41, under tag **A-0710** on Life Safety. The citation came after state surveyors found the following stored in two stairwells, on various landings:



Photo courtesy of Linda Gylland, MLS (ASCP) QLS

- Two rolling carts with empty biohazard containers
- One commercial display-style refrigerator
- Three rolling trash cans for shredded paper
- One empty linen cart
- One broken wheelchair
- Three rolling trash carts full of trash
- 14 boxes
- Two wooden and eight metal doors

While neither hospital faced immediate jeopardy problems, either easily could have, according to instructions to CMS surveyors in Appendix I:

“The guiding principles to determine immediate and serious threat make it clear that the threat to life is imminent and can be related to the health and safety of the residents/patients. Some examples of life threatening deficiencies are failure to maintain required fire protection systems in an operating condition, obstructed passageways that prevent egress in the event of an emergency, open stairways, missing tamper switch and water flow alarm in a sprinklered facility and unprotected wood frame construction which is not sprinklered.”

Do you have a photo that illustrates a Life Safety or Environment of Care problem? Please share it with us.

Send it to *Healthcare Safety Leader* Editor A.J. Plunkett at aplunkett@decisionhealth.com, and we will consider publishing it—anonymously if you choose—in an upcoming issue. ■

Back to school

Teach employees safety rules by following the rules of the classroom

By John Palmer (johnpalmer@palmereditorial.com)

At the beginning of each school year, teachers spend a month or more getting students into the swing of things by introducing them to new classroom rules and habits, assigning an increasingly difficult workload, and filling out paperwork to help assess them and keep them safe should something happen.

The healthcare industry can learn from our tireless educators.

As a healthcare safety professional, you should be thinking on the same level as a classroom teacher, because safety should never become stagnant—it should be a constant presence in your facility. And because employees come and go, you will always be teaching new staff the ways of your workplace.

There will always be paperwork to fill out, protocols to put into place, and assessments to conduct, all to ensure your workers are following the directives you've created to keep patients and employees safe. At worst, you should take a good, hard look at your safety game once a year to verify everything is running smoothly. Here, we've assembled some common rules of the classroom along with some ideas of how to apply them to your facility.

Don't run in the halls

This is one of the first things schoolchildren learn when they come to school. It's the old adage of haste makes waste: If you try to do something too quickly, you're likely to make a mistake.

Use this lesson to teach your workers to slow down in everything they do. It's a crucial tenet in practicing sharps safety, for instance. After giving an injection, slow down and be mindful regarding what happens to the syringe. Cap it properly, place it in a "neutral" zone so no one else will touch it, and make sure it goes into the proper disposal receptacle. The same lesson can be used to help prevent and respond to workplace violence. Experts suggest that healthcare workers should be comfortable with de-escalation tactics to help calm an anxious or angry person down. A worker's intervention could be the deciding factor that keeps a situation from getting out of control and leading to injury.

Put on your sneakers for gym class

The gym teacher is not going to allow Annie to play sports in her dress shoes. For one, her parents won't be happy if they get dirty. But more importantly, sneakers are grippy for a reason: so that when Annie runs after the kickball, she won't accidentally slip and hurt herself.

So why have so many adult healthcare workers failed to learn the lessons taught in the gym so many years ago? Slips, trips, and falls still cause the majority of injuries to healthcare workers in hospitals and medical facilities, and they usually occur because of improper footwear.

It's time to insist that your workers wear the right shoes for the healthcare workplace—grippy and closed-toe, and with a reinforced toe box if possible. And just like your coach didn't let you get in the game if you didn't bring your sneakers, make it a rule that if your workers don't show up dressed appropriately, they go home for the day. A couple of missed paychecks will convince them to take you seriously.

Never drink the chemicals under the sink

The classroom teacher keeps the bottles of hand soap and glue clearly labeled and stored under the sink or in the closet, out of reach. And just in case little Johnny happens to take a swig, the teacher knows what to do.

The same goes for the handling of hazardous chemicals in the facility, especially since you're dealing with stuff that can cause real problems—like cancer—from minimal exposures.

This is one more reminder to up your game on your facility's hazardous chemicals training. Take stock of all chemicals in the workplace, and make sure you and your staff know where the safety data sheets (SDS) are.

Teach everyone, especially the newbies, that the SDS is divided into 16 sections, each dedicated to various information about the chemical: firefighting, first aid, storage, hazards, and what to do in the event of exposure to the substance. In addition, the SDS system includes eight visual guides to workplace hazards, called pictograms; they consist of a black hazard symbol on a white background with a red border and are designed to be universally identifiable at a glance. The pictograms clearly identify hazards such as flames, carcinogens, corrosives, explosives, and environmental dangers.

SDSs make it much easier for your employees to identify the hazardous chemicals in your facility and

quickly deliver first aid should there be a worker exposure. And if you've got a Johnny on staff with his heart set on quaffing chemicals, maybe take the crew out for a few drinks after training.

Ask lots of questions

Students are trained from a young age to question authority and to be inquisitive—it's a major principle of the scientific method, which asks experimenters to come up with an essential question they want to answer.

The same should be taught to your new employees. Yes, it's your responsibility to make sure they know the rules of the road, but there will inevitably be a thing or two you don't cover. By inviting your employees to ask questions, you teach them that it's safe to ask about something they don't know.

Also, unlike the classroom, tattletales make for a safe environment in the healthcare facility. Create a culture where it's OK for workers to question each other, and if necessary, to report unsafe workplace behaviors and practices.

Fill out your forms clearly

At the beginning of every school year, students are asked to fill out contact information and to bring home permission slips and other forms to be filled out by parents. These forms are designed to keep students safe: They specify whom to contact in an emergency, any allergies a particular student has, and other important information—all kept at the teacher's fingertips, just in case.

So should be the case for your employees. You should have a file for every person who works in your facility filled with important contact and health information. In addition, the file should contain information about all training provided to the employee and signed documentation indicating his or her understanding of that training. Any information regarding disciplinary actions against the employee goes in here as well—if OSHA comes knocking, it will want to know where you keep this information.

Be quiet and exit quickly during fire drills

Kids test their teachers all the time, but the one thing kids don't mess with during school is the fire drill—and to a greater extent, the lockdown drill. When that loud alarm goes off, they stop what they're doing, get in line, and single-file themselves out the door.

Unfortunately, adverse events happen in medical facilities, whether it's a fire or a violent incident that requires the evacuation of the facility and a quick accounting of workers and patients.

You should be doing a monthly fire drill that tests your evacuation procedures and requires employees to meet at a predetermined location. And just like teachers take roll call once everyone is assembled at the evacuation point, you should have a checklist that keeps track of everyone in your workplace.

Don't eat your lunch at your desk

Teachers always make sure that snack time is in a designated area and that everything is put away neatly before the snacks come out. They also make sure to separate students with allergies to ensure food isn't cross-contaminated.

Seriously, if you have to be reminded that food and drink aren't allowed in areas of the healthcare facility that may come into contact with blood or other infectious materials, then you need to go back to school. Make sure there is a designated area for eating, with a sink to wash up, and never allow eating or chewing gum in patient treatment areas.

Make up your own rules

The most progressive and democratic of teachers sit their students down at the beginning of each school year and ask them what they think should be the most important rules for the classroom. This practice teaches students to take ownership of their classroom, and of the behaviors and actions that are appropriate within the four walls.

This could be the most important lesson you can take from the classroom. Allow your employees to take ownership of the environment in which they work. By showing that you trust them, you'll make them more likely to foster that positive safety culture. ■

EDITOR'S NOTE:

John Palmer is a freelance writer who has covered healthcare safety for numerous publications, including HCP's Medical Environment Update.

Correction

An article in the August issue of *Healthcare Safety Leader* incorrectly said that Keyes Life Safety Compliance was recently acquired by [Compliance One Group](#) in Kalamazoo, Michigan. Compliance One acquired only the Keyes website, <http://www.keyeslifesafety.com>.

The Hospital Safety Center is your resource center for the latest guidance from CMS, The Joint Commission, the HFAP and other accreditation organizations.

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Patient safety

Use these tools for falls prevention

By Brian Ward (bward@hcpro.com)

Every fall costs a hospital an average of \$14,056 in non-reimbursable expenses.

According to the Agency for Healthcare Research and Quality (AHRQ), between 700,000 and 1 million patients fall in the hospital each year. Sometimes fall injuries can be slight. But in 30%–35% of cases, these preventable events can result in broken bones, cuts, internal bleeding, concussions, or death.

Facilities have a long way to go before this problem is solved. Make sure to check your hospital's falls prevention program: Are staff following it? Are they reporting falls when they happen? How many falls do you have per year? How can your facility improve?

Here are some tools to review your program:

- AHRQ: Preventing Falls in [Hospitals: A Toolkit for Improving Quality of Care](#)

A roadmap to falls prevention from AHRQ. Goes over enlisting leadership support, assessing your facility, and development and improvement of your program.

- U.S. Department of Veterans Affairs: [Falls Notebook](#)

Downloadable Word®, Excel®, and PDF documents on post-falls huddles, falls prevention teams, and falls policies. Also has podcasts detailing the VA's position on falls prevention.

- *Patient Safety Monitor Journal*: [Case Study: Reducing Falls by Engaging Patients](#)

Case study on Brigham and Women's Hospital in Boston and how their "Fall TIPS" tool offers a tailored approach to falls prevention. ■

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