HEALTHCARE SAFETY LEADER

Hazardous waste

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

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Review and update policies on the disposal of pharmaceuticals to prohibit the ushing of any drugs into the sewers. Exper1.1 (r)-23.1 (131 (l 2 0.1 (l o)9280.1 (l1<14.8 (p.541.C /S91.1 (10.

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That preamble states: “We note that although our RCRA statutory authority limits us to apply the prohibition on sewering 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 lter 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 signi cant impact on the environment, according to [illegible] D [illegible], 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 sewering, 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 ushing 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 sewered.

“The sewering 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 (*C 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-sewering 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 sewering 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.

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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 nal rule as of August 21. That includes Iowa and Alaska, all the U.S. territories except Guam, and Indian Country.

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"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' of ces
- 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

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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 de ciency report led 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 of cer 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 of cers 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 of cers with rearms, but rather list considerations for discussion in developing a policy. (*C 3/11/19*)

CEWs are among an array of control devices often employed by security of cers, 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 [illegible] 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 of cers up to hospitals. However, CMS is clear in the [illegible], Appendix A (SOMA), which contains interpretive guidelines for the enforcement of Medicare *C* [illegible], that weapons are not to be used for restraint.

"CMS does not consider the use of weapons in the application of restraint or secl.4 (h)9.9 (sp)3.7 (i)15.4.5 0 0 10.50 Tc 0 Tw 10 (ea8 (v)25.7 (e)11.1 (r)38H(p)-6 (o)3. s)-3.78 2

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:

- Of cers 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 of cers 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 dif cult balance, MacArthur says. A hospital's policy may require, for instance, that a security of cer 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 signi cantly 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 of cers accidentally break a patient's leg because the patient wasn't educated in restraint—he zigged 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 [illegible], 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, A ', 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 restraintadrseyuse of wesrt tlpolace

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simply arm hospital security of cers. Firearms or Tasers, whether carried by of cers 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 of cers 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

B A. . (@ .)

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 originally published in 2012 in C (a precursor to). Now retired from healthcare management, Burney spent years in facilities management, including a stint as executive director of planning, design, and construction in the of ce of the vice chancellor of the University of Mississippi Medical Center in Jackson, Mississippi.

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E-size O2 cylinders

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
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Back to school

Teach employees safety rules by following the rules of the classroom

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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 dif cult workload, and lling 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 ll 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 rst things schoolchildren learn when they come 5 0 0 10.74 (h)9.9 s 2cos ig3-22.6 oombi8 >>BDC BT10(n t)-5lfsroour fac

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