I. PURPOSE
The mission of MCG Health, Inc. (MCGHI) is to improve the health of the people of Augusta and the surrounding area by providing cost-effective, quality health and hospital services. Consistent with this mission, the governing body, medical staff and administration have established and provide ongoing support for the Safety Program described in this plan.

The purpose of the Safety and Security Management Plan is to define the Safety and Security Program. The Safety Management Program is designed to reduce the risk of injury of patients, staff, and visitors. The Security Management Plan is used to reduce the risk of personal injury and property loss.

II. SCOPE
The Security department operated on a 24/7 basis at the main campus. Services provided include, but were not limited to: Escorts, patrol, incident reporting, visitor identification, CCTV, access control and response to hospital codes. MCGHI's Security Department maintained a staff of 44.8 (including parking officers) during 2009.

Security at the main campus was staffed 24/7 and maintained a 24 hour emergency dispatch center. Security equipment used and/or available included: portable radios, golf carts, motor vehicles, electronic card access, delayed egress locks and CCTV equipment.

Safety is operated Monday thru Friday during business hours with on call staff available after hours.

The Safety and Security Management Plan included processes and monitors to minimize safety and security risks to staff, patients and visitors. Emphasis was placed on maintaining compliance with all regulatory requirements and the National Patient Safety Goals. The plan applies to all MCGHI Facilities and workforce members.

III. FUNDAMENTALS
A. Safety
1. Department heads and managers need appropriate information and training to develop an understanding of safe working conditions and safe work practices within their area of responsibility.
2. Safe working conditions and practices are established by using knowledge of safety principles to educate staff, design appropriate work environments, purchase appropriate equipment and supplies, and monitor the implementation of the processes and policies.

3. Safety is dynamic. Regular evaluation of the environment for work practices and hazards is required to maintain a current relevant safety program. The program should change as needed to respond to identified risks, hazards and regulatory compliance issues.

B. Security
1. A visible security presence in the hospital helps reduce crime and increase feelings of security by patients, visitors, and staff.

2. Assessment of risks to identify potential problems is key to reducing crime, injury, and other incidents.

3. Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.

4. Training hospital staff is critical to their performance. Staffs are trained to recognize and report either potential or actual incidents to ensure a timely response. Staffs in sensitive areas are trained about the protective measures designed for those areas and their responsibilities to assist in protection of patients, visitors, staff and property.

5. Violence in the workplace is a growing problem in healthcare. It is necessary to develop a program to address workplace violence.

IV. OBJECTIVES

A. The CEO will designate a Safety Officer.
1. The position description will be current.
2. Will reflect the responsibilities and expectations for the position.

B. Individuals assigned to respond to immediate threats to life and health will receive appropriate training for his/her role.
1. Staff assigned to this role will have the necessary resources to accomplish the tasks.

C. Initial risk assessments are conducted for:
1. Buildings, and grounds
2. Equipment
3. Staff activity
4. Patient care areas
5. Staff work environment

Additional risk assessments are conducted when substantive changes involving these issues occur.

D. Environmental Rounds will include:
   1. All areas of the hospital
   2. Affiliated medical practices
   3. Clinics.

The program includes the facilities, equipment; and all support areas at least annually, and all patient care areas at least semi-annually. Also included are annual inspections of the campus grounds and the facilities.

E. All new employees will receive training about the Safety and Security Programs, including the role of the Safety Department and what types of incidents Security Department staff can respond. The training will cover how to report incidents and obtain assistance in an emergency. Training for staff in designated sensitive areas is addressed during this training.

F. All departments have access to copies of current organization wide safety and security policies and procedures.
   a. Procedures have been evaluated within the past three years and/or as new procedures or needs arise.
   b. Security policies and procedures are established and maintained to direct staff performance when responding to security incidents.

G. There will be processes for follow-up to product safety recalls. Summary reports of recalls and hazard alerts are to be forwarded to the Safety Committee.

H. Regular monitoring and evaluation of the effect of the tobacco free policy and process will be reported to the Safety Committee. Where necessary, additional monitoring of the processes designed to correct identified problems or violations will occur.

I. Meaningful, measurable Safety and Security performance measures will be developed and monitored on a periodic basis. Sub-standard performance will be corrected in a timely fashion.

J. Security will be provided to:
1. Appropriate and timely action is taken to prevent crime, injury, or property loss.
2. Response is provided for emergencies and requests for assistance in a timely fashion.
3. Crime, fire, injury, or other incidents are reported and documented.
4. Communication is maintained externally with local, state, or federal law enforcement and other civil authorities.
5. Internal communications for emergency occurrences are provided as needed.
6. Control vehicle movement on hospital grounds, including parking and access to the Emergency Department.
7. Timely response to reports of violent activity or requests for assistance is provided, in restraining violent or aggressive patients or visitors.
8. Timely response to requests for escort, keys and door openings, or other routine requests for assistance is provided.

K. Access to the grounds, buildings, and sensitive areas will be limited by enforcement of staff and visitor identification policies and by participating in the design of processes to minimize unauthorized access.

L. The documentation system for security incidents is managed and used to provide appropriate reports to leadership and the Safety Committee. Security department activity, including investigations; routine patrol activity; special and routine requests for assistance; and other activities are appropriately documented. Identification of problems, failures, and user errors that require attention and action are quarterly reported to the Safety Committee.

M. Performance improvement opportunities are documented and forwarded to appropriate individuals.

N. An annual evaluation of the scope, objectives, performance, and effectiveness of the program will be performed. The evaluation will be documented.

V. Process of the Safety and Security Plan

A. **EC.01.01.01** The organization plans activities to minimize risks in the environment of care.

1. **01.01.01.01** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and
disseminate summaries of actions and results. (See also EC.04.01.01, EP 1)

The Director of Safety and Security is designated to coordinate the development, implementation, and monitoring of the safety management activities. The Safety Director's job is defined by a job description, and the CEO, or designee of the CEO, evaluates the performance of the Safety Director.

The Director reviews changes in law, regulation, and standards of safety, assess the need to make changes to equipment, procedures, training, and perform other activities essential to implement the EC Programs. The Safety Director is also responsible for conducting risk assessments and for coordinating the annual review the safety program.

2. 01.01.01.02 Leaders identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten to damage equipment or buildings. (See also LD.04.04.05, EP 5)

The Chief Executive Officer of MCGHI has identified an individual(s) who is/are responsible for intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings.

This process is detailed in the Immediate Threat Policy. This policy defines the chain of command in situations posing an immediate threat to the life or health of patients, staff, physicians, visitors, or the risk of major damage to buildings or property. The objective of the Immediate Threat Policy is to identify and respond to an immediate threat situation before an injury or loss occurs.

The Chief Executive Officer has delegated this authority to the Safety Director, and the Nursing Supervisor on duty. These individuals are empowered to immediately intervene and take appropriate action to mitigate the effects of such situations. Such delegation of authority enables the organization to take swift and decisive action to implement the policy twenty-four hours a day / seven days a week. The immediate threat Policy is signed by the Chief Executive Officer, revised when necessary, and reviewed at least every three years.

3. 01.01.01.03 the hospital has a written plan for managing the following: The environmental safety of everyone who enters the hospital’s facilities. (See also EC.04.01.01, EP 15)
4. 01.01.01.05 the hospital has a written plan for managing the following: The security of everyone who enters the hospital's facilities. (See also EC.04.01.01, EP 15)

MCGHI has developed and maintains a written management plan describing the processes it implements to effectively manage the safety and security of staff, visitors, and patients. This plan includes emergencies affecting the facility, patients, staff, and visitors. The plan is evaluated annually, and changed as necessary, based on changes in conditions, regulations, standards, and identified needs.

B EC.02.01.01 The organization manages safety and security risks.

1. 02.01.01.01 the hospital identifies safety and security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. (See also EC.04.01.01, EP 14; LD.04.04.05, EPs 7, 8, and 10)

The Director of Safety and Security manages the Safety Risk Assessment process.

The organization conducts an initial proactive risk assessment to evaluate the potential of adverse impacts of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and other visitors. Further risk assessments would be conducted when major changes to the organization occur.

The goal of performing risk assessments is to reduce the likelihood of future incidents or other negative experiences that have the potential to result in an injury, an accident, or other loss to patients, staff, or hospital assets.

The Safety Director, Director of Facility Services, individual department heads and other key members of the Safety Committee perform the risk assessments.
MCGHI conducts proactive risk assessments to evaluate the potential for adverse impact on the security of patients, staff, and other people coming to the organization’s facilities. Among the elements that are evaluated is the potential for workplace violence. The Risk Assessment is used to evaluate current programs, and help identify new programs and activities to better protect the patients, staff, and the organization.

2. 02.01.01.03 the hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

Safety and security risks identified during facility tours are corrected at the time of identification. Risks identified through monitoring processes are corrected as the risk is identified. If immediate correction is not possible, a corrective plan is developed. Planned corrections are monitored by the appropriate official and a status report is delivered to the Safety Committee.

3. 02.01.01.05 the hospital maintains all grounds and equipment.

The Director of Facility Services is responsible for managing the hospital grounds and external equipment maintenance process.

The Director of Facility Services is responsible for scheduling and performing maintenance of hospital grounds and external equipment. Engineering staff makes regular rounds of various areas to observe and correct the current condition and safety of hospital grounds and external equipment.

Hospital grounds include lawns, shrubs and trees, sidewalks, roadways, parking lots, lighting, signage, fences, etc. Some external equipment, such as the oxygen storage facility, has established protocols for inspection, testing, or preventive maintenance.

4. 02.01.01.07 the hospital identifies individuals entering its facilities.

The Director of Safety and Security coordinates the identification program with the Vice President of Human Resources and all supervisory personnel manage enforcement of the identification program.

MCGHI maintains policies for identification. All personnel are required to display an identification badge on their upper body while on duty. Identification badges are to be displayed picture side out. Personnel who fail to display identification badges are counseled individually by their department head. Identification badges are removed from personnel upon termination.
Visitors and patients are not normally expected to have identification. Visitors to some specific units are requested to have identification, or to be recognized by staff in Labor and Delivery; Newborn Nursery, Behavioral Health. The Security Officers assist in enforcement of visitor identification policies. After-hours temporary I.D. badges are issued by security to visitors in the Children's Medical Center.

Where not previously provided, patient identification is provided at the nursing unit during the admitting process. If a patient wristband is damaged, the wristband is replaced by the nursing staff. Patient identification is not removed upon discharge. Patients are instructed to remove the identification band at home.

The Purchasing Department provides vendor and contractor identification. Identification badges are controlled and stored in a secure area.

5. 02.01.01.08 the hospital controls access to and from areas it identifies as security sensitive.

The Director of Safety and Security works with leadership to identify security sensitive areas.

The following areas are currently designated as sensitive areas:

1. Psychiatry (In/Out Adult and Child)
2. Business Office (e.g. Cashier)
3. Emergency Department
4. Human Resources
5. Newborn Nursery
6. Labor and Delivery
7. Pharmacy
8. OR
9. ICU's

Personnel are reminded during their annual in-service about those areas of the facility that have been designated as sensitive. Personnel assigned to work in sensitive areas receive department level continuing education on an annual basis that focuses on special precautions or responses that pertain to their area.

6. 02.01.01.09 the hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.

MCGHI has designed and implemented security procedures that address the precautions for preventing, and the plans for handling of an infant or child abduction as applicable. Selected areas are provided with access control, and with alarm systems to assist staff in becoming aware of a
possible potential for the abduction of an infant, or child. Staff receives ongoing training and drills to maintain their awareness. Parents and other designated visitors are also informed of the precautions and their role in those precautions.

A Code Pink is announced over the internal page system, as well to selected radio pagers. Designated staff responds to doors and specified areas to observe for person with children or packages, and call Security if such cases occur. Other staffs check designated areas, and respond to the unit involved to document information, and provide support to the parents.

The plan is tested quarterly and the responses documented, evaluated, critiqued, and as appropriate corrective activity, additional training, or program improvements are made.

7. 02.01.01.10 when a security incident occurs, the hospital follows its identified procedures.

Security procedures are followed. Incident reports are prepared by officers, reviewed by the Security Manager, and reported to the Director of Safety and Security.

8. 02.01.01.11 the hospital responds to product notices and recalls. (See also MM.05.01.17, EPs 1-4)

The organization ensures responses to product safety recalls by appropriate organization representatives. Materials Management manages the process, receiving reports from manufacturers and vendors, and distributing the information to those departments using or managing the products. They document the follow-up, and report the results to the Safety Committee on a periodic basis. Critical recalls or alerts are brought to the attention of the Safety Committee.

C. EC.02.01.03 The organization prohibits smoking except in specific circumstances.

1. 02.01.03.01 the hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined.

MCGHI became a tobacco-free environment in November 2007. Tobacco use is prohibited in all buildings and on all MCGHI grounds.

2. 02.01.03.04 if the hospital decides that patients may smoke in specific circumstances, it designates smoking areas that are physically separate from care, treatment, and service areas. (See also EC.02.03.01, EP 2)
Not applicable. MCGHI buildings and campus is a tobacco free environment.

3. 02.01.03.06 the hospital takes action to maintain compliance with its smoking policy.

Security monitors the campus for compliance with the campus tobacco free policy. Monitoring results are reported to the Security Manager. The Security Manager shares the monitoring results with the Safety Committee.

D. EC.02.06.01 The organization establishes and maintains a safe, functional environment.

1. 02.06.01.01 Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment and services provided.

During EOC rounds space needs, safety and suitability for care, treatment, and services are verified.

2. 02.06.01.04 the hospital provides space for recreation and social interaction for patients who remain in the care of the hospital for more than 30 days.

Patients in the hospital for 30 days or more have access to supervised recreational and social interaction facilities.

3. 02.06.01.05 for swing beds used for long term care in hospitals: The hospital provides storage space to meet resident needs.

Not applicable.

4. 02.06.01.06 when the hospital provides care for more than 30 days, it provides outside areas for patient use, suitable to the patient's age, physical or mental condition, or other factors.

Not applicable.

5. 02.06.01.11 Lighting is suitable for care, treatment, and services.

During EOC rounds, lighting is checked to verify appropriateness for care, treatment, and services provided in the area.
6. **02.06.01.13** The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided.

Ventilation, temperature, and humidity levels throughout the hospital are monitored. These conditions have established thresholds; conditions are maintained accordingly. Staff are able to report problems related to ventilation, temperature, and humidity; complaints are investigated and corrected, if warranted.

7. **02.06.01.18** Interior spaces accommodate the use of equipment, such as wheelchairs, necessary to the activities of daily living.

Spaces are designed to comply with applicable rules, regulations, and laws concerned with accommodations for equipment (such as wheelchairs). Staffs are encouraged to report problems with this issue.

8. **02.06.01.20** Areas used by patients are clean and free of offensive odors.

Unusual odors and other air quality concerns are reported to the Safety Manager. Concerns are investigated; if corrections are needed, the corrections are completed as soon as possible.

9. **02.06.01.23** The hospital provides emergency access to all locked and occupied spaces.

Security has access to all locked spaces; occupied spaces where emergency egress are in compliance by having locks overridden by emergency alarm systems; also, a security officer is dispatched to all emergency alarms.

10. **02.06.01.26** The hospital keeps furnishings and equipment safe and in good repair.

Furnishings and equipment are inspected and checked during environmental tours. Problem items are tagged for repair or removed from service.

**E. Standard EC.02.06.05** The organization manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.

1. **02.06.05.01** When planning for new, altered, or renovated space, the hospital uses one of the following design criteria:
- State rules and regulations

When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria. (See also EC.02.05.01, EP 1).

The hospital employs an architect to orchestrate requirements for new, altered, and/or renovated spaces. The architect uses state rules and regulations, nationally recognized design and construction guidelines, and The Joint Commission design and construction resources.

2. 02.06.05.02 when planning for demolition, construction, or renovation, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services.

Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.

The facility has a comprehensive risk assessment policy and program focusing on preconstruction issues. Risk assessments are performed by a team comprised of members from Safety, Facility Services, Infection Control, clinical staff, architect, and contractors.

3. 02.06.05.03 the hospital takes action based on its assessment to minimize risks during demolition, construction, or renovation.

Plans to minimize the impact of construction are developed using the risk assessment. Periodic inspections of construction areas are performed to monitor compliance with plan requirements.

F. Standard EC.03.01.01 Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

1. 03.03.01.01 Staff and licensed independent practitioners can describe or demonstrate methods for eliminating and minimizing physical risks in the environment of care. (See also HR.01.04.01, EP 1)
Life Safety and EOC rounds are regularly conducted. As part of the inspection, staffs are quizzed about safety, risks, and EOC processes. Feedback (positive and/or negative) is provided to area supervision.

2. 03.03.01.02 Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident. (See also HR.01.04.01, EP 1)

EOC rounds are conducted on a regular basis. Staffs are questioned about EOC issues and incidents. Descriptions or demonstrations of the EOC reporting process and/or corrective actions indicate understanding of processes.

3. 03.03.01.03 Staff and licensed independent practitioners can describe or demonstrate how to report environment of care risks. (See also HR.01.04.01, EP 1)

EOC rounds are conducted on a regular basis. Descriptions or demonstrations on reporting EOC risks by staffs are part of the inspection process. In addition, annual mandatory training programs describe how to report EOC incidents and risks; training programs encourage staff to correct EOC problems as part of this process.

G. Standard EC.04.01.01 The organization collects information to monitor conditions in the environment.

1. 04.01.01.01 The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:

- Injuries to patients or others within the hospital’s facilities
- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- Security incidents involving patients, staff, or others within its facilities
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors
Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

Processes to monitor incidents, occurrences, and problems relative to the EOC are provided. Staffs have been identified to investigate, resolve, record, and report these incidents, occurrences, and problems to the Safety Committee. Staff positions for this process are:

- Injuries to patients or others: Risk Management
- Occupational illness and staff injury: Employee Health
- Damage to property or property of others: Security Manager
- Security incidents (patients, staff, visitors): Security Manager
- Haz Mat wastes, spills and exposures: Safety Manager
- Fire safety problems, deficiencies or failures: Safety Manager
- Medical or laboratory equipment issues: BioMed
- Utility systems problems, failures or user errors: Facility Services

2. 04.01.01.03 Based on its process(es), the hospital reports and investigates the following: Injuries to patients or others in the hospital's facilities. (See also EC.04.01.03, EP 1; LD.04.04.05, EP 11)

Risk Management investigates accidents involving patients and visitors.

3. 04.01.01.04 Based on its process(es), the hospital reports and investigates the following: Occupational illnesses and staff injuries. (See also EC.04.01.03, EP 1; LD.04.04.05, EP 11)

Employee Health investigates occupational illnesses and injuries to staff.

4. 04.01.01.05 Based on its process(es), the hospital reports and investigates the following: Incidents of damage to its property or the property of others. (See also EC.04.01.03, EP 1; LD.04.04.05, EP 11)
Damaged property reports and investigations are conducted by facility security and the MCG Campus Police Department.

5. **04.01.01.06** Based on its process(es), the hospital reports and investigates the following: Security incidents involving patients, staff, or others within its facilities. (See also EC.04.01.03, EP 1; LD.04.04.05, EP 11)

The Security Department receives reports and investigates security incidents involving patients, visitors, and staff.

6. **04.01.01.12** the hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. (See also EC.04.01.03, EP 1)

Environmental tours are performed on a semi-annual basis in patient care areas and areas where patients may gather or visit. Problems found during the tour are corrected, with inspection staff present. Results of the tours are provided to the Safety Committee. Trends (if any) are identified and follow-up performed to verify resolution.

7. **04.01.01.13** the hospital conducts annual environmental tours in non-patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate risks in the environment. (See also EC.04.01.03, EP 1)

Environmental tours are performed annually in non-patient care areas. Problems found during the tour are corrected, with inspection staff present. Results of the tours are provided to the Safety Committee. Trends (if any) are identified and follow-up performed to verify resolution.

8. **04.01.01.14** the hospital uses its tours to identify environmental deficiencies, hazards, and unsafe practices. (See also EC.02.01.01, EP 1; EC.04.01.03, EP 1)

Problems found during the environmental tours are corrected, with inspection staff present. Results of the tours are provided to the Safety Committee. Trends (if any) are identified and follow-up performed to verify resolution.

9. **04.01.01.15** every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan’s objectives, scope, performance, and
effectiveness. (See also EC.01.01.01, EPs 3-8; EC.04.01.03, EP 1)

All EOC management plans are annually reviewed. The review covers the plans objectives, scope, performance, and effectiveness. Reviewed plans are evaluated by the Safety Committee.

H. **Standard EC.04.01.03** The organization analyzes identified environment of care issues.

1. **04.01.03.01** Representatives from clinical, administrative, and support services participate in the analysis of environment of care data. (See also EC.04.01.01, EPs 3-6 and 8-15; EC.04.01.05, EP 3)

Representatives from clinical, administrative, and support services compose the membership of the Safety Committee. The Safety Committee assist with analysis of data generated from EOC rounds, observations, and performance improvement (PI) projects.

2. **04.01.03.02** The hospital uses the results of data analysis to identify opportunities to improve the environment of care. (See also EC.04.01.05, EP 1)

Analysis of EOC data assists with rapidly identifying trends (both positive and negative) in the EOC. Deficits in the EOC require creating an action plan for correction. These action plans are monitored by responsible staff and the Safety Committee.

3. **04.01.03.03** Annually, representatives from clinical, administrative, and support services recommend to leaders one or more priority performance improvement activities for the environment of care.

The Safety Committee recommends performance improvement (PI) projects. When approved, the project is defined, developed, implemented, and monitored by the Safety Committee.

I. **Standard EC.04.01.05** The organization improves its environment of care.

1. **04.01.05.01** The hospital takes action on the identified opportunities to improve the environment of care. (See also EC.04.01.03, EP 2)
As opportunities are identified, the opportunity is acted upon. Reports summarizing the status are provided at Safety Committee meetings.

2. 04.01.05.02 the hospital evaluates changes to determine if they resulted in improvements in the environment of care.

Reports summarizing the status are provided at Safety Committee meetings.

3. 04.01.05.03 the hospital reports performance improvement results to those responsible for analyzing environment of care issues. (See also EC.04.01.03, EP 1; EM.03.01.03, EP 16)

PI projects are implemented by various staffs and departments. When the project is complete, a report is delivered to the Safety Committee. After approval, PI project results are reported to hospital administration.

CC: Safety Committee (Reviewed & Approved-)
     JCC to Board (Reviewed & Approved-)