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Patient safety

ECRI to take over critical online resource of evidence-based guidelines

As promised, the Agency for Healthcare Research and Quality (AHRQ) has shut down its operation of the National Guidelines Clearinghouse (NGC). But on July 17, a day after the site went dark, ECRI Institute announced it will take over sponsorship of the clearinghouse sometime this fall.

As *Inside the Joint Commission* reported in April, AHRQ shut down both the NGC and the National Quality Measures Clearinghouse on July 16 when federal funding to operate the two critical online databases ran out (*IJC 4/30/18*).

*(see **Patient safety**, p. 6)*

Infection control

CMS again spotlights control of *Legionella* with revision to surveyors' memo

Be prepared for renewed interest in your water management program and especially how it is designed to prevent the spread of *Legionella* infection. CMS just updated its memo from last year on requirements to reduce the risk of Legionnaire's disease, in part to clarify expectations for hospitals and nursing homes (NH).

Also be prepared for questions about how well you manage the risk of *Legionella* to appear on infection control worksheets used by some CMS surveyors.

*(see **Legionella**, p. 7)*

Infection control

Review your water management plan against newly revised CMS memo

Review your water management plan against a revised CMS letter to surveyors on expectations to reduce risk of *Legionella* and update against the specific expectations outlined in QSO 17-30-Hospitals/CAHs/NHs.

The memo to the Quality, Survey and Oversight (QSO) group, issued July 6, is a revision of a June 2017 letter to surveyors under the since-renamed Survey & Certification (S&C) group.

The main changes are to emphasize that hospitals and other facilities should now have a stated water management plan and that testing is not necessarily required (*more on the memo, see p. 1*). Although rewritten in sections, the memo still points to the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) standard released in 2015 — ANSI/ASHRAE Standard 188-2015 "Legionellosis: Risk Management for Building Water Systems" — as the main industry guideline for the prevention of *Legionella*. The memo also advices facilities to again consult the CDC's toolkit, released in 2017, on implementing the ASHRAE standard.

Highlight water plan under utilities

The utilities management already required by accrediting organizations such as The Joint Commission (TJC) should include a water management plan that encompasses prevention of waterborne infections such as *Legionella*.

Clearly mark your water management program under your utilities management plan and includes the specifics outlined in the revised memo, advises **Jennifer Cowel**, president of Patton Healthcare Consulting. That includes ensuring you:

- **Complete a hospital-wide water safety risk assessment.** "You could also consider adding Legionella to your HVA [hazard vulnerability assessment] if it is not part already," notes Cowel.
- **Review the ASHRAE standards and CDC toolkit on water management when updating your utility plan.** Remember that these were both referenced in the memo, Cowel emphasizes.
- **Define and document your planned testing protocols.** Include the acceptable ranges for those measures, advises Cowel. "Also, document the specific actions that the hospital will take if limits are exceeded."

Testing not necessarily required

Note that the QSO memo now states that CMS does not require regular, and often expensive, testing for *Legionella* or other opportunistic waterborne

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pathogens, notes **Ernest E. Allen**, a patient safety executive with The Doctor's Company in Ohio.

That doesn't mean no testing at all.

"Testing for chlorine levels that are high enough to help prevent *Legionella* and other pathogen growth should be performed on a regular basis," recommends Allen. That includes "regular testing from different locations in the hospital. For example, the Ohio Department of Health recommends 0.5-1 ppm of chlorine level at the fixture when the faucet is opened, at both hot- and cold-water faucet locations in varied locations of the hospital."

Beware if your facility, as do many hospitals, contracts out water management, Allen advises. "The hospital should check to see if the long list — 18 bullet points — of system components and devices listed in the letter are included in their program," says Allen.

He adds that for hospitals with LTC units or nursing homes, the revised letter also notes that CMS surveyors and accrediting organizations will review the LTC facility's risk assessment and testing protocols. The memo also says that surveyors "will not cite the facility based on the specific risk assessment or testing protocols in place."

However, it warns that more guidance is expected in the future. — *A.J. Plunkett* (*aplunkett@h3.group*)

Resources

- CMS memo, July 6, 2018, QSO-17-30- Hospitals/CAHs/NHs, "Requirement to Reduce *Legionella* Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD): *https://tinyurl.com/QSO-17-30-revised*
- ANSI/ASHRAE 188 "Legionellosis: Risk Management for Building Water Systems" (2015): *https://www.tinyurl.com/or26ebt*
- CDC *Legionella* toolkit: "Developing a water management program to reduce *Legionella* growth and spread in buildings" (2017): *https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html*

Workplace violence

Protect your staff from sexual harassment by patients, vendors

Most employers are required by Title VII of the Civil Rights Act and state law to guard against and respond to claims that an employee was sexually harassed by a coworker or manager (*IJC 2/19/18*). But employers also can be liable for sexual harassment of an employee by non-employees, such as sales representatives, patients or referral sources.

Non-employee sexual harassment, also called third-party sexual harassment, is common, says attorney **Sarah Carlins** with Houston Harbaugh in Pittsburgh. The employer can be liable for acts of a non-employee if the employer knew about the conduct and failed to take immediate and appropriate corrective action.

For example, Southwest Virginia Community Health System paid $30,000 to settle an Equal Employment Opportunity Commission (EEOC) sexual harassment suit brought by a female receptionist at one of its clinics. She had complained to her supervisor that a male patient was sexually harassing her, but no action was taken to stop the abuse. The health system also had to conduct training on sexual harassment prevention, post a notice about the settlement, provide a copy of its sexual harassment policy to all employees and report new complaints to the EEOC.

The EEOC also has filed a lawsuit against Home Instead, a California home care provider that failed to take action and refused to reassign a home care worker who had reported being sexually harassed by a client.

Remember also that accreditors are watching how you are protecting your workforce. The Joint Commission earlier this year issued a Sentinel Event Alert to bring awareness to physical and verbal harassment of staff (*IJC 4/30/18*).

Physician offices, home care or other settings in which employees are in close working proximity with patients and others, and in which the setting is often more intimate and personal, may be especially vulnerable to sexual misconduct claims, including third-party ones. Patients and referral sources wield considerable power because they bring in revenue, says attorney **Audrey Mross** with Munck Wilson Mandala in Dallas. "It's about power."

Of course, it's harder to take corrective action against the harasser when he or she is a third party because a provider doesn't have the power to directly discipline and/or fire that person, points out Mross. But the employer still has a legal obligation to provide a safe environment for its employees.

"This is a developing area. We'll see more people emboldened and comfortable speaking out. People are re-evaluating the behavior they've received," Mross says. — *Marla Durben Hirsch* (*ijc_editors@decisionhealth.com*)

Resources

- Southwest Virginia Community Health System Inc. settlement: *www.eeoc.gov/eeoc/newsroom/release/10-23-13b.cfm*
- EEOC lawsuit against Home Instead: *www1.eeoc.gov//eeoc/newsroom/release/7-25-17c.cfm?renderforprint=1*

Workplace violence

8 ways to prevent, respond to harassment of staff by outsiders

Your staff members have a right to be protected from sexual harassment by outsiders, not just those who are also employed by your facility (*more, p. 3*). To meet your obligations as an employer, take these eight steps:

1. Include third-party sexual harassment in your training and policies. Employees need to know that any such harassment is prohibited and how to report it, says attorney **Sarah Carlins** with Houston Harbaugh in Pittsburgh.

2. Consider making reporting mandatory. Employees need to know that they have an obligation to report third-party sexual harassment the same way as they would report sexual harassment by someone who works for the provider, according to attorney **Adam Shestak**, also with Houston Harbaugh in Pittsburgh. "If there's an obligation to report, the employer can respond to the complaint and avoid liability," he says.

3. Make it clear that mandatory reporting extends to bystanders. Victims don't always report about themselves, notes attorney **Jon Hyman** with Meyers, Roman, Friedberg & Lewis in Cleveland. "Empower all employees to complain about harassment whether or not they're the target. This is the best weapon to find out if harassment is happening. Then the employer can do something about it," Hyman says.

4. Investigate an incident as soon as possible after you learn about it. Follow the process your organization has for complaints against a coworker or manager. Don't forget to document what you did and what you found, says attorney **Rick Hackman** with Saxton & Stump in Lancaster, Pa.

5. Recognize your obligation to investigate even if the victim doesn't want you to. Sometimes the victim is reluctant to press the issue or fears retaliation. If that occurs, you can tone down the investigation, but you still are legally obligated to investigate the alleged harassment, and you should document that the complainant was uncooperative, says Hackman. "That way, you have a defense if six months later the employee files a complaint with the EEOC and says you didn't do anything," Hackman explains.

6. Take remedial action to stop the harassment if you find that it has occurred. This will vary depending on the circumstances, and you may need to take more than one step. For instance, it may be enough to tell the third party that such behavior won't be tolerated and must stop, says attorney **Audrey Mross** with Munck Wilson Mandala in Dallas. If that initial conversation doesn't do the trick, you may need to warn the harasser that he/she is no longer welcome if it continues. If the harasser is a vendor or delivery person, you may have to tell that person's employer to no longer send the individual to your facility. You might make operational changes so that the victim doesn't have to interact with the harasser. In extreme cases, you may need to cut ties with the harasser, the harasser's employer or both.

7. Report back to the complainant. You need not provide details, but you do need to let the complainant (and employee, if it differs) know that an investigation occurred, the general action taken and that any problems down the road need to be reported, says Hackman. This is not only a courtesy but will also reduce the likelihood that the victim will feel ignored and file a complaint with the EEOC.

8. Discuss the change and other alternatives with the employee if your response to the sexual harassment is to take the employee out of contact with the harasser, such as reassigning or moving the employee. Make sure the employee is OK with the change. Otherwise the change could be considered a discriminatory change to the terms and conditions of employment, says attorney **Beth Schroeder** with Raines Feldman in Los Angeles. "You have to end the harassment and make sure that the employee's career is not harmed," she explains. — *Marla Durben Hirsch* (*ijc_editors@decisionhealth.com*)

Infection control

Bouffant hat vs. skull cap may be debate but hospital policy is rule

As the medical world awaits the next pronouncement on skull caps, remember two things: Ensure your staff is following your hospital's stated policy and know that CMS surveyors sometimes do check what head gear people wear in surgical suites.

In the last 18 months, hospitals have been cited by CMS surveyors under Conditions of Participation regarding surgical services or infection control when staff was spotted wearing a skull cap, but almost always for not following the hospital's stated policy. Sometimes that staffer was also wearing a bouffant cover but not so that it sufficiently covered hair, according to deficiency reports on HospitalInspections.org.

Earlier this year, the Association of periOperative Registered Nurses (AORN) said it will revise its *Guideline for Surgical Attire*, an often-referenced best practice, to readdress the continuing debate over skull caps vs. bouffant caps in surgery (*IJC 5/14/18*).

Guidelines stand for nowr

Lisa Spruce, DNP, RN, CNS-CP, CNOR, ACNS, ACNP, FAAN, director of evidence-based perioperative practice for AORN, says the organization will still recommend complete hair coverage in that revised guideline, but "there's not going to be a recommendation on which head covering."

As for the coverage of ears, AORN is "probably going to come out in our new guideline and say the ears don't need to be covered," notes Spruce, because the task force feels the research focusing on its necessity has been inconclusive. "However," she says, "our guideline stands as is until it's revised."

It is significant that AORN will likely be changing its stance. As the world's largest professional association for perioperative nurses, it is a tone-setter for issues affecting all healthcare workers who enter the OR.

The study that seems to have ended this battle was led by **Troy Markel**, MD, assistant professor of surgery at Indiana University, who examined the effectiveness of disposable bouffant hats and skull caps as well as newly laundered cloth skull caps in preventing airborne contamination.

Not only did Markel and his peers observe no significant differences between the disposable bouffant hats and the disposable skull caps "with regard to particle or actively sampled microbial contamination," they also determined that the disposable bouffant hats had greater permeability, penetration, and greater microbial shed compared to both disposable and cloth skull caps.

Thus, the researchers concluded last October that disposable bouffant hats "should not be considered superior to skull caps in preventing airborne contamination in the operating room."

That study made the strongest case to date in the contentious debate over OR headwear.

AORN says position misstated

Several years ago, AORN began, depending on who you ask, either promoting the use of bouffant hats among surgical staff or advocating for skull caps to be banned. The organization encouraged full coverage of the ears in the OR, one of the reasons why AORN favored bouffant hats.

In 2016, the American College of Surgeons (ACS), who see the skull cap as "symbolic of the surgical profession," came out and said skull caps "may be worn when close to the totality of hair is covered by it and when only a limited amount of hair on the nape of the neck or modest sideburns remains uncovered." Executive director **David Hoyt**, MD, FACS, stated that its new guideline for appropriate attire was "based on professionalism, common sense, decorum, and the available evidence."

As **Priya Nori**, MD, medical director of the antibiotic stewardship program at the Montefiore Health System and associate professor at Einstein School of Medicine, puts it, they were ticked.

"Surgeons said, 'Where's the evidence? We've been doing this for generations,'" says Nori.

Last year, surgeons from the University of Buffalo and Kaleida Health also challenged AORN's stance with a study published in *Neurosurgery*, arguing that according to research, wearing bouffant hats in the OR didn't influence surgical site infection rates for Class 1 cases.

Lead researcher **Kevin Gibbons**, MD, senior associate dean for clinical affairs with the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo, said last year, "The result of this interpretation resulted in hospitals around the country being cited by outside reviewers for poor infection-control practice if anyone in the OR was seen wearing a surgical cap."

AORN fired back, saying "there were too many assumptions in that study." But the organization also claimed the researchers "repeatedly misrepresented the AORN recommendation throughout the article" and later issued a statement to correct "misrepresentation" and "misinformation" of its position, noting that "there is no recommendation that bouffant caps should be worn."

New evidence cited

By doing the latter, AORN appeared to be softening its stance, though the organization notes that its current

Guideline for Surgical Attire, revised in 2014, does not explicitly recommend bouffant caps. AORN will revise its guideline again in 2019 following the study from Markel and his peers that found that the requirement for ear coverage is not supported by sufficient evidence.

"It was the first, if only, [study] that I have seen that looked at the effectiveness of those types of hats as far as whether they were doing what they were designed to do," says Spruce, speaking on behalf of AORN. "I think it just sparked everybody's interest and opened up this discussion."

AORN and others felt the evidence was enough to revisit the controversy and, according to Spruce, ACS assembled the task force, which included the Council on Surgical and Perioperative Safety, the American Society of Anesthesiologists, the Association for Professionals in Infection Control and Epidemiology, the Association of Surgical Technologists, and The Joint Commission.

The task force released a joint statement in May that said, in part, "evidence-based recommendations on surgical attire developed for perioperative policies and procedures are best created collaboratively, with a multi-disciplinary team representing surgery, anesthesia, nursing, and infection prevention."

Spruce says AORN had already decided "that it was time to revise that guideline" but "it was valuable" to hear the thoughts among that multidisciplinary group. She adds, "The perioperative setting has always been a team environment and we've always promoted that, so we want the teams to come together and agree on issues that are important to patient safety."

Convene your stakeholders

AORN's *Guideline for Surgical Attire* will be reviewed by AORN's advisory board, which includes representatives from organizations that formed the task force, plus the Society for Healthcare Epidemiology of America (SHEA), the International Association of Healthcare Central Service Material Management, and the American Association of Nurse Anesthetists. That revised guideline is expected to be ready in April 2019.

In the meantime, Spruce recommends that healthcare organizations "convene all of the relevant stakeholders"— an all-inclusive, interdisciplinary team — "to discuss their current facility policy and either confirm that it's going to stay the same until the guideline comes out or go ahead and institute changes based on the consensus of [the task force]."

She notes that The Joint Commission was part of the consensus, so allowing the use of skull caps "should be fine."

However, **Steven A. MacArthur,** a senior consultant with The Greeley Company in Danvers, Massachusetts, believes that healthcare organizations should proceed with caution.

"Until CMS provides some relief or guidance or recapitulation relative to the skull cap issue, you have to go by what has been documented in the process, which is in this case, 'Thou shalt not wear skull caps as the only protection,'" says MacArthur. "Until CMS tells their surveyors not to chase this, then … they are increasing their vulnerability relative to the survey process." — *Matt Vensel* (*mvensel@hcpro.com*)

Resource

- Task force joint statement on surgical attire: *https://tinyurl.com/OR-attire-joint-statement*

Patient safety

(continued from p. 1)

For more than two decades, hospitals, clinicians and others in health care have used the two clearinghouses to find vetted, evidence-based information on which to set policy, create clinical treatment plans and objectively measure quality outcomes.

ECRI Institute, a nonprofit patient safety organization in Plymouth Meeting, Pa., has worked for the federal government since NGC was established to develop and maintain the guidelines database. And after the funding was cut, ECRI worked behind the scenes to address concerns in the healthcare industry about the loss of such a critical resource.

The announcement July 17 confirmed that ECRI was ready to launch what it called an interim website this fall to allow continued access to the NGC information.

"ECRI Institute's team of highly trained guideline and measure experts are taking the lead to ensure the global healthcare community has access to guidelines," says **Karen M. Schoelles**, MD, SM, FACP, director, ECRI Institute-Penn Medicine Evidence-based Practice Center and director of ECRI's Health Technology Assessment Consulting Services.

ECRI's announcement promises that the "institute's new guideline resource will provide a centralized

repository of current, properly vetted evidence-based clinical practice guideline summaries and other information. An interim website will launch this fall, with many additional features planned for the near future."

"The initial site will enable users to search and retrieve ECRI's summarizations of clinical practice guidelines from hundreds of participating guideline developers, and will include unbiased evaluations on the rigor and transparency of guidelines against the National Academy of Medicine (formerly the Institute of Medicine) standards for trustworthiness," said the announcement.

The future phase of the ECRI site "will feature advanced search capabilities, support for guideline implementation and decision-making, and an enhanced user interface," says ECRI.

As for the quality measures database, that future is less certain. But ECRI is hopeful about that, as well.

"We will focus on guidelines first but do want to include quality measures in the future," Schoelles told IJC on Tuesday. "We will be providing tools for developing quality measures from guideline recommendations within the next year."

Resource

- ECRI Institute announcement: *www.ecri.org/guidelines*

Legionella

(continued from p. 1)

While the updated CMS memo to surveyors added no new expectations for hospitals or critical access hospitals (CAH), be aware it does add a specific statement that "facilities must have water management plans" as well as a new note that testing for waterborne pathogens is left "to the discretion of the provider," according to the letter to CMS' Quality, Safety and Oversight (QSO) group, formerly the Survey & Certification (S&C) group.

"The terms 'plans' and 'policies' are sometimes confusing to hospitals," warns **Kurt Patton**, the former director of accreditation services for The Joint Commission (TJC) and founder of Patton Healthcare Consulting, now in Naperville, Ill.

"TJC already requires a utilities management plan and water is a component of that. The unknown will be if CMS surveyors say they don't want to look at a utilities plan, they want to look at a water management plan," explains Patton. "At a minimum, I would suggest accredited hospitals have a table of contents and a subject header for 'Water Management Plan' inside their overall utilities plan."

Review your plan against memo

The memo, **QSO 17-30-Hospitals/CAHs/NHs**, was published July 6 and supersedes the former S&C 17-30-Hospitals/CAHs/NHs, issued in June 2017 (*ECL 6/19/17*), and it adds more specific expectations for long-term care (LTC) facilities.

"The memo is fairly prescriptive" in what it expects of facilities, notes **Jennifer Cowel**, president of Patton Healthcare Consulting and a former TJC director of service operations, adding that hospitals should include the specific items set out in the memo in the water management section of their utilities plan.

"The main difference in the revised July CMS letter is the note that *Legionella* or other opportunistic waterborne pathogen tests will not be required in the hospital management plan," says **Ernest E. Allen**, a former TJC life safety surveyor and now a patient safety executive with The Doctor's Company in Ohio. "*Legionella* tests are expensive and most hospitals only perform them after a patient is diagnosed with *Legionella*."

ANSI/ASHRAE still go-to standard

Some sections of the memo have been revised to move or edit information, including a reference to what CMS and other organizations consider to be the main industry standard on the management of *Legionella* released by the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) in 2015: **ANSI/ASHRAE Standard 188-2015** "Legionellosis: Risk Management for Building Water Systems."

The reference to the ASHRAE standard and the use of specific control measures is no longer in the section outline expectations for healthcare facilities, but moved to the memo's background section along with the mention of the CDC's toolkit on implementing the 2015 standard.

There is a new expectation added in the revision that facilities will "maintain compliance with other applicable Federal, State and local requirements," which is also a generic expectation of TJC and other accrediting organizations (AO).

The only entirely new section is devoted to expectations of surveyors and AOs when surveying LTC: "LTC

surveyors will expect that a water management plan (which includes a facility risk assessment and testing protocols) is available for review but will not cite the facility based on the specific risk assessment or testing protocols in use. Further LTC surveyor guidance and process will be communicated in an upcoming survey process computer software update. Until that occurs, please use this paragraph as guiding instructions," the CMS memo now states.

Legionella in draft IC worksheet

If your hospital also includes oversight of a nursing home or other long-term care facility, note that while the prevention of *Legionella* is not specifically stated in the CMS infection control worksheet for hospital surveyors, it is a part of the worksheet now in a draft pilot program for LTCs.

The worksheet is a push by CMS to improve infection control at LTCs. In a QSO memo issued in March, CMS said it was developing an online training course in infection prevention and control for nursing home staff, which was to include a section on water management.

The three-year IC pilot program began in 2015. Much like the draft worksheets tested out by CMS surveyors a few years ago in hospitals before being officially made public for use in 2014, the IC worksheet for LTC facilities is being used in pilot surveys in which CMS hospital surveys are paired with LTC facilities being surveyed, according to CMS information.

That worksheet includes a section that asks surveyors to check if the "Hospital has a water management program to reduce the risk of *Legionella* growth and spread," and includes a note to reference the CDC toolkit on *Legionella* "for key elements of a water management plan."

Although, as with the earlier draft worksheets, that worksheet is only being used as a guide for now, CMS has cited hospitals in the past for problems with *Legionella* management.

And whatever management plan you have, ensure that it is being followed.

CMS make take water temperature

In March, a hospital in Brooklyn, New York, was cited under CMS **Tag A-0749,** outlining responsibilities of the infection control officer, for failure "to ensure that water temperature was maintained at an acceptable range in accordance with generally accepted standards."

The citation came after a surveyor touring the hospital's Emergency Department found that the water in the Trauma/Critical section was cold — 70.3 degrees Fahrenheit — when measured by the supervisory plumber on staff. In addition, the water at two scrub sinks in two operating suites was measured at 51.9 degrees Fahrenheit.

The hospital's own policy stated, "The domestic hot water temperature will be maintained at 110 degrees Fahrenheit or less in all patient and staff areas. However, the facility's policy does not provide guidance on the temperature range for domestic hot water," according to the deficiency report, found on the Association of Health Care Journalists site HospitalInspections.org.

The report said that in a review of CDC recommendations, "When state regulations or codes do not allow hot water temperatures above the range of 105F-120F (40.6C-49C) for hospitals or 95F-110F (35C-43.3C) for nursing care facilities or when buildings cannot be retrofitted for thermostatic mixing valves, follow either of these alternative preventive measures to minimize the growth of *Legionella* spp. in water systems," according to the deficiency report.

Further, the report stated recommendations call for the facility to "Periodically increase the hot water temperature greater or equal to 150F at the point of use," or "alternatively, chlorinate the water and then flush it through the system," and to "maintain constant recirculation in hot-water distribution systems serving patient-care areas."

The deficiency report noted that it was the senior associate director of facilities operation and plumbers' supervisor who were questioned about the water management plan. (*For more on implementing the revised QSO memo, see p. 2.*) — *A.J. Plunkett* (*aplunkett@h3.group*)

Resources

- CMS memo, July 6, 2018, QSO-17-30- Hospitals/CAHs/NHs, "Requirement to Reduce *Legionella* Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD): *https://tinyurl.com/QSO-17-30-revised*
- ANSI/ASHRAE 188 "Legionellosis: Risk Management for Building Water Systems" (2015): *https://www.tinyurl.com/or26ebt*
- CDC *Legionella* toolkit: "Developing a water management program to reduce *Legionella* growth and spread in buildings" (2017): *https://www.cdc.gov/Legionella/maintenance/wmp-toolkit.html*

