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INSIDE

RELIAS MEDIA

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Avoid Legal Pitfalls in Peer Review Process With Bylaws, HCQIA Standards

The peer review process can be a legal mine field, with missteps exposing the hospital and health system to allegations that result in significant liability. Reduce that risk by knowing the common mistakes and using best practices to keep the review above reproach.

Liability risks can come in the form of patients suing the hospital for failing to properly credential and monitor caregivers, or from caregivers who allege the peer review process is unfair or inaccurate.

Hospital privilege decisions can entangle healthcare entities in malpractice litigation. Even though hospitals do not practice medicine, they do provide staff and facilities, notes **Richard A. Lovich**, JD, managing partner with Stephenson, Acquisto & Colman, in Burbank, CA.

Although the granting of privileges and ongoing reviews of performance are conducted technically not by hospitals but by clinical staff, hospital boards have the legal responsibility to ensure the reviews and privileging are adequate. They can be hospitals can be held liable for shortcomings in the peer review process if they result in delivering professional services below the standard of care, he says.

Twenty-eight states currently recognize the tort of "negligent credentialing," Lovich says. The basis for liability under this theory is the failure of the hospital to adequately vet, supervise, oversee, and evaluate healthcare practitioners in granting privileges. States that do not specifically recognize this tort under that name still provide a basis for holding the hospital liable within this context, he says.

For example, California, in a 1982 appellate court decision, (*Elam v. College Park Hospital*, 132 Cal.App.3d 332 [Court of Appeal of California, Fourth District, Division One, May 27, 1982]) reinforced and clarified the ability of a wronged patient to hold not only the caregiver but the hospital responsible for substandard care. The peer review process can play a large role

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in the hospital's potential liability in this regard, Lovich explains. When hospitals do not employ physicians directly, the traditional bases for vicarious liability, agency liability, or respondeat superior (the employer is held liable for employee actions committed in the course and scope of the employment) are unavailable, Lovich says.

"However, as illustrated in the *Elam* case, if a hospital fails to adequately investigate and evaluate physicians for privileges or fails to monitor their competence, it can be held liable in negligence if such failure is the proximate cause of injury to the patient," Lovich explains. "The hospital's responsibility is potentially very broad. Many states, through statute and regulation, define the scope of the responsibility well beyond the duty to vet, monitor, and reach the level of requiring the hospital to ensure the competence of the medical care provided, whether by employees or independent contractor physicians."

Liability rests on the hospital's independent duty to ensure such care, he adds.

Federal Laws Apply

This duty also is recognized federally. 42 C.F.R. Section 482.12 provides that hospitals participating in Medicare and Medicaid must have "an effective governing body legally responsible for the conduct of the hospitals and institution" and that this body must "be responsible for services furnished in the hospital whether or not they are furnished under contracts ... [and] must ensure that the services are provided in a safe and effective manner." The lack of effective peer-to-peer evaluation can be the basis for liability in this context, Lovich explains.

"Hospitals may also face legal action where a denial of privileges is challenged by the physician involved. The standard of review for the sufficiency of a vetting and evaluative process when a physician is challenging the denial of privileges depends on the type of facility involved," he says.

"If the facility is a governmental facility, the concepts of due process are applied, as the dictates of due process are guaranteed whenever a governmental entity acts," Lovich explains. "Nongovernmental entities, however, do not have a due process obligation ... they do have to meet a lower standard in their reviews."

In the nongovernmental context, this standard is whether a fair procedure was conducted, Lovich says. A fair procedure would be assessed as providing notice of the issues and a fair opportunity to be heard. The fairness of the process usually comes up when a physician challenges a denial of privileges, he notes.

However, the quality of the inquiry would be an issue in the context of a patient suit for damages; thus, it could be relevant beyond a physician action, Lovich says. "A common scenario where peer-to-

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peer credentialing decisions could be placed under scrutiny would be within the context of a malpractice action against a physician. The hospital could be brought in as a defendant, not as vicariously liable for the actions of the physician, but under its own alleged negligence for allowing the physician to practice at the facility despite actual or constructive knowledge, through historical acts of incompetence, or the lack of competence," Lovich explains. "If the patient can show that the hospital knew, or through the exercise of reasonable care should have known, of the incompetence of the physician, liability can attach."

Punitive Damages Possible

If the negative information was known, but ignored (e.g., a physician brings in significant revenue to the hospital, and the reviewing body ignores negative information to perpetuate the stream of business), then punitive damages may be imposed, Lovich says. He points out that punitive damages are not insurable.

Allegations of negligent credentialing could lead to other problems, too. All of a hospital's contracts and financial dealings with the target physician could be compelled to be produced to allow the complaining patient to evaluate the possibility of an ulterior motive on the part of the hospital in "looking the other way" in making credentialing decisions, Lovich explains.

Further, a suit based on negligent credentialing would render hospital policies related to the process of credentialing subject to discovery. If a hospital fails to follow its own procedures, Lovich says that may add to the evidence of inadequate oversight and can affect a jury's evaluation of the steps taken in a particular case, as well as the hospital's credibility and competence.

"Complicating a hospital's ability to adequately meet this responsibility is the qualified privilege attached to peer-to-peer review information exchanges," Lovich says. "For example, if a physician was denied privileges at hospital A after a peer-to-peer review, and applies for privileges at Hospital B, Hospital B may not have the benefit of reviewing the information that was used in the Hospital A's decision."

Some States Protect Disclosure

To promote candor in the peer-to-peer review process, many states render such information privileged and not subject to discovery, Lovich says. While not absolute, the privilege can hamper investigations and at the least slow down the process, he says.

The privilege protection covers information used by medical staff governance committees in making recommendations and covers only information related to quality of care. Other information, as well as information developed or used by hospital administrative governance committees, is not subject to the privilege, he explains.

Also, the restriction in many states renders the information nondiscoverable but not inadmissible at trial. That means if the information is obtained from other sources, it could be used, Lovich adds.

Know State Laws

Most states provide protection from liability in connection with peer review activities. It is important to know how one's own state laws apply, says **Stephanie Winer Schreiber**, JD, shareholder with Buchanan Ingersoll & Rooney in Pittsburgh.

For example, Pennsylvania provides that "no person providing information to any review organizations shall be held, by reason of providing such information, to have violated any criminal law, or to be civilly liable under any law unless an exception applies." (63 P.S. §425.3. Immunity from liability) Exceptions where liability could attach are where the

information provided is unrelated to the duties and functions of the review organization or where such information is false and the person providing such information knew or had reason to believe that the information was false.

"This immunity extends to individuals who are members or employees of review organizations, or who furnish professional counsel or services to such review organizations, unless the action taken was motivated by malice toward any person affected by such action," Schreiber says.

In Pennsylvania, she notes the records of a review committee are confidential and are not subject to discovery. Further, those records cannot be introduced into evidence in any civil suit against a healthcare provider that arise from matters that are within the scope of such a committee.

Still, this confidentiality obligation does not apply to documents or records from other original sources, Schreiber explains. This is the case even if such material was presented to a review committee.

Failure to maintain the confidentiality of the documents could constitute a waiver of the peer review privilege. Thus, this could subject the hospital and reviewers to liability, she says.

Other states provide protection from liability, but the degree of protection can vary.

HCQIA Provides Protection

The federal Health Care Quality Improvement Act of 1986 (HCQIA) also provides limited qualified immunity for persons participating in peer review activities. However, it does not extend to discrimination claims nor federal- or state-initiated antitrust claims, Schreiber says. Nonetheless, it is necessary for a hospital to follow medical staff bylaws that provide for a fair process. This allows an organization to maintain the immunity provided for in HCQIA.

"Professional review activities are generally deemed to be reasonable if the action was taken in the belief that it was in the furtherance of quality healthcare, and that the determination was made following a reasonable effort to obtain the facts," Schreiber says.

Additionally, a hospital could lose immunity protections under HCQIA if a hospital fails to substantially meet the data bank reporting requirements, and such noncompliance is not corrected, Schreiber cautions.

"This is not just a theoretical risk. Claims come from physicians, who are either not granted privileges, have privileges revoked, or who face disciplinary action," she says. "Claims also come from third parties who allege that the hospital engaged in negligent credentialing by allowing a physician to have clinical privileges at the hospital and/or to retain such clinical privileges at the hospital. I believe we will see an increase in both types of cases brought against hospitals."

Claims often arise when a healthcare practitioner believes the peer review process was unfair, Schreiber says. This tends to occur in cases in which one caregiver is held accountable for actions, but others who engage in the same conduct are not, she says. Additionally, claims often arise when members of a review committee report a conflict of interest and could benefit financially if action is taken against a competitor, she says. In third-party claims, an injured person alleges the hospital failed to engage in a comprehensive peer process, waived requirements (i.e., the number of required procedures), and/or failed to oversee the caregiver's practice in the hospital, Schreiber explains.

Facilities should create comprehensive, well-written medical staff bylaws and follow the procedures closely, Schreiber advises. Unfortunately, hospitals and medical staffs often fail to review and update their medical staff bylaws regularly. Still, even facilities with proper policies may fail to follow them.

"Hospitals should make sure that the number of cases that are included in a review are sufficient for peer review activities, and that the persons doing the review are qualified to make appropriate determinations," Schreiber says. "Additionally, hospitals often fail to apply the requirements consistently for all applicable [caregivers]."

Suing to Prevent NPDB Report

Those facing disciplinary action may sue to prevent a report to the federal National Practitioner Data Bank (NPDB) and/or state licensing authorities because the ramifications can be so serious, says **Kathy H. Butler**, JD, an officer with Greensfelder, Hemker & Gale in St. Louis.

The NPDB was created by the HCQIA to protect good faith peer review activities. To receive the HCQIA protections, hospitals that credential caregivers must query when those caregivers apply or reapply to the medical staff.

When a hospital conducts peer review that results in disciplinary action against a healthcare provider, the most common complaints are the actions were not in good faith

or were prompted by an improper motive, Butler says. One may claim someone involved in the process is acting for anticompetitive reasons or in a discriminatory manner. Another common challenge is the process used to evaluate the issues prompting the peer review, or the subsequent hearing process, were inadequate or unfair.

Other risks that may arise out of peer review processes come from the identification of problems that may suggest the hospital's noncompliance with Medicare Conditions of Participation, accreditation standards, hospital licensure requirements, and potentially state and federal reimbursement requirements. Medical necessity failures and false claims can implicate both the provider and the hospital, Butler notes.

Must Follow Standards for Protection

State and federal laws enacted to protect peer review processes and participants from liability often include standards that must be followed to obtain immunity from liability, Butler explains. The HCQIA provides peer review participants with qualified immunity from antitrust and business tort claims — if participants follow the procedural protections outlined in the law.

"The defined process is presumed to be fair. The law also allows other procedures, which are fair under the circumstances, but the fairness of a different process would have to be defended," Butler notes. "The HCQIA, however, does not provide immunity for federal civil rights claims. States often have their own peer review laws that may also provide certain protections from claims."

The most common oversight or error leading to litigation in peer review is not following the HCQIA process or other fair process that is set forth in the medical staff bylaws, Butler says.

That leaves the healthcare entity and the peer review participants in a position to have to defend claims that otherwise might have been dismissed, she says.

"Having economic competitors of the physician being evaluated in decision-making positions within the process also creates risks. Although, in smaller hospitals, avoiding this is often a challenge," she acknowledges.

Butler notes that since the HCQIA's enactment, there has been a fair amount of case law involving claims challenging peer review actions. Most hospitals have enacted processes to ensure fairness; the trend in claims favors the hospital or healthcare entity because they can prove the process was fair.

"Unfortunately, the HCQIA does not prevent a physician from filing a claim. In many cases, some discovery is required before a claim can be dismissed," Butler adds.

Challenge May Be Aggressive

Hospitals may face legal challenges from caregivers with competence or conduct problems but cannot acknowledge their deficiencies or correct their behavior so they can continue practicing safely, Butler observes. Some will take an aggressive litigation position, hoping a litigation-wary professional review committee (and, ultimately, the hospital) will agree to a sanction that will not require a report. Others may really believe the process was not warranted or was otherwise unfair.

"My experience has been that many hospitals and medical staffs are diligent in their professional review activities, and provide the physician in question with every opportunity to address the issues raised. In the end, they will take the steps they believe are appropriate to address the issue at hand and to protect patients, even if that results in a report against the physician," Butler reports.

There have been cases in which someone files state and federal court claims to enjoin a hospital from making a legally required report to the NPDB or state licensing board. Others have sued to remove reports that have been filed, Butler

says. Generally, these claims are unsuccessful. In addition to the HCQIA, state laws also may address these liability issues. Certain states have instituted a "rule of nonreview" in these types of actions.

For example, in Missouri, if a hospital follows the process outlined in its medical staff bylaws, a state court will not second-guess the ultimate action taken by the hospital's board, Butler explains. The state court will evaluate only whether the hospital followed its own process.

"These types of laws have the effect of discouraging disgruntled physicians from pursuing expensive litigation to challenge in cases where a fair process as outlined in the medical staff bylaws was followed," Butler says. ■

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Investigate Thoroughly, Follow HCQIA Standards in Disciplinary Process

Once an allegation is made against a healthcare practitioner that will require peer review, it is important to conduct a thorough and impartial investigation, says **Kathy H. Butler**, JD, an officer with Greensfelder, Hemker & Gale in St. Louis.

The caregiver should be informed of the issues of concern in writing during the investigation process and provided the opportunity to respond to the concerns of the professional review bodies. Where appropriate, outside experts can be helpful in objectively evaluating clinical issues. Hospitals should adhere to the standards set forth under the HCQIA.

"If a professional review body proposes discipline that will adversely affect a [caregiver's] clinical privileges or medical staff membership, most hospitals and medical staffs have adopted the standards and processes set forth in HCQIA," Butler notes. "[This] ensure[s] the hospital and those who participate in the peer review process get the benefit of the legal protections afforded by the HCQIA."

What follows is a summary of the HCQIA standards:

• The accused must be provided with notice of the professional review action proposed, the reasons for the proposed action, that the accused has the right to request a hearing (and the time limit for making the request) and a summary of rights in the hearing;

• If a hearing is requested timely, the accused must be notified of the place, time, and date of the hearing and a list of witnesses (if any) expected to testify at the hearing on behalf of the professional review body;

• The hearing must be held before an arbitrator mutually acceptable to the healthcare entity and the accused, a hearing officer who is appointed by the entity and who is not in direct economic competition with the healthcare practitioner involved, or a panel of individuals who are appointed by the entity and are not in direct economic competition with the accused;

• At the hearing, the accused has the right to be represented by an attorney or other person of his or her choice; to have a record made of the proceedings; to call, examine, and cross-examine witnesses; to present evidence the hearing officer determines to be relevant; and to submit a written statement at the close of the hearing;

• After the hearing is complete, the accused can receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendation, and can receive a written decision of the healthcare entity, including a statement explaining the decision.

Generally, it is important to follow these standards prior to the finalization of any discipline decision. However, these procedures will not apply in situations where an immediate suspension or restriction of clinical privileges is determined to be necessary to protect against an imminent danger to the health of any individual. In those cases, immediate action is permitted, subject to subsequent notice, hearing, or other adequate procedures.

For more information about the HCQIA, please read the full text at: https://bit.ly/2MEe0yq. ■

Hospital Fires Doctor for Verbal Attack During Peer Review

In an unusual case illustrating the potential legal exposure associated with the process, a hospital fired a physician reviewer for "verbally attacking" a colleague at a peer review meeting. The fired doctor sued.

The case of *Yedidag v. Roswell Clinic Corp* (2015 BL 42307 [Supreme Court of New Mexico, Feb. 19, 2015]) offers lessons for hospitals, says **Katharine Van Tassel**, JD, visiting professor at The Law-Medicine Center in the School of Law at Case Western Reserve University in Cleveland.

A hospital fired a doctor for "verbally attacking" a colleague during a peer review meeting. The alleged attack included sharp questions about a colleague's removal of one malignant tumor from a patient's colon, instead of two.

The hospital considered these questions as "unprofessional conduct" that justified the termination. However, the Supreme Court of New Mexico strongly disagreed. In this case, the judges held that a physician, under a state's peer review confidentiality statute, may sue a hospital that fired him or her based on his or her actions as a reviewer during a peer review proceeding against a colleague, she explains.

The court decided that the questions were privileged. Further, the judges ruled the hospital did not have the right to use those questions or any other confidential peer review information as a reason for termination. The court affirmed the jury's verdict, obligating the hospital to pay the plaintiff compensatory and punitive damages.

"This decision makes sense," Van Tassel offers. "The confidentiality provisions contained in peer review laws are intended to encourage physicians to take part in the process. Without the confidentiality provisions, doctors would be reluctant to participate or wouldn't be entirely forthcoming in their testimony for fear that they would be shunned by their peers, or even sued, for testifying or making adverse recommendations against other doctors."

Aggressive questioning is appropriate, especially in cases involving patient deaths or doctors who appear to be withholding information, Van Tassel says.

"The take-home message is that a hospital should not take an employment action against a physician based on what happened in peer review," she says. ■

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Patient Safety Act Offers Peer Review Protections

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) offers substantial legal protections to hospitals investigating medical errors, but one must understand the law to attain its full benefits. If one proceeds carefully, much information gathered can be protected from the prying eyes of plaintiffs' attorneys.

The PSQIA was the federal government's response to *To Err is Human: Building a Safer Health System*, the groundbreaking 1999 report by the Institute of Medicine (IOM) that increased the awareness of medical errors.[1] The IOM report estimated that 100,000 people die each year because of medical harm that could have been prevented.

The purpose of the PSQIA was to improve the quality of patient care by encouraging confidential review and reporting of adverse patient events, notes **Amy L. Blaisdell**, JD, an officer with Greensfelder in St. Louis.

To facilitate this objective, the PSQIA created a federal peer review privilege and more sweeping evidentiary protections for materials used therein than typically is available under state law.

Understanding the protections afforded by the PSQIA is important for several reasons, Blaisdell says.

First, the PSQIA substantially limits the risk that providers and healthcare systems were exposed to under state peer review statutes.

Historically, efforts to study patient safety events were subject to the risk that the information would be sought in discovery in provider disciplinary hearings, medical malpractice cases, and other legal proceedings.

"The PSQIA created a uniform layer of national protection on top of state law. Peer review professionals can fully investigate and share information regarding medical errors without being subject to discovery in connection with a federal, state, or local civil, criminal, or administrative proceeding," Blaisdell says. "Specifically, the act protects data, reports, records, memorandum, analyses, and written and oral statements that are compiled and submitted to a Patient Safety Organization [PSO] or developed by a PSO in order to conduct patient safety activities."

This work product is called Patient Safety Work Product (PSWP).

Helps Provide Uniform Approach

Second, the uniform, national protections that PSQIA created help alleviate the risk that healthcare systems in multiple states will be subject to varying state laws and enable providers to develop a consistent approach for their patient safety activities, Blaisdell says.

Third, the PSQIA allows providers to aggregate data. This helps providers receive the benefit of learning from others' mistakes. It also allows healthcare systems that report their patient safety activities to PSOs to engage more freely in discussions about adverse patient events to prevent them, Blaisdell says.

The PSQIA creates PSOs to collect, aggregate, and analyze information that healthcare providers submit confidentially. PSOs include all organizations that collect and analyze PSWP. Providers receive feedback on how to improve patient safety and quality of care.

Peer review professionals should determine whether their organization can qualify as a PSO before counting on the protections afforded by the PSQIA, Blaisdell suggests.

Criteria for a PSO

Generally, Blaisdell says there are four steps that must be met to qualify as a PSO. First, the organization must be the type of entity that can establish a PSO. A wide range of entities can form PSOs.

These can include public or private entities, for-profit or nonprofit entities, provider entities, hospital chains, and other entities that establish special components.

The organization must certify that it has established procedures needed to perform eight patient safety activities specified in the PSQIA, Blaisdell explains. This includes establishing policies and procedures to ensure patient safety activities are executed properly.

The organization also must certify that it will comply with seven additional criteria specified in the Patient Safety Rule. The additional criteria focus on the mission and activities of the PSO, the qualification of the PSO's workforce, reporting to the Secretary of Health and Human Services, and the purposes for which PSWP will be used, Blaisdell says.

Finally, the organization must confirm it meets the requirements to be listed as PSO.

"Even if an organization cannot establish its own PSO, it can nevertheless engage in patient safety activities, create PSWP, and report information to another PSO," Blaisdell says. "As such, the organization can achieve the goal of improving patient safety, while also maximizing the protection under federal law."

The primary pitfall is the belief that the work begins and ends with establishing a PSO or participating in one. That is only the starting

point, Blaisdell cautions. As with developing any policy, the practice is only as strong as its implementation and use. Another pitfall is the failure to educate providers about the existence and scope of the PSO, along with their obligations, Blaisdell says. Education is critical because the PSQIA prohibits providers from disclosing PSWP, absent a specific exception.

Furthermore, the PSO can only achieve its purpose (improving patient safety) by controlling the quality of input and output from the system, she says.

There also may be the opportunity to "stack" these protections with those afforded by state law.

"In general, providers and healthcare systems want to access the broadest protections available to them, which will generally be the protections available under the federal act. However, [they] should never ignore the protections that are available under state law," she says.

"They should ensure that they understand the extent to which state laws provide different protections from the federal law," Blaisdell continues. "Once they have done so, they should establish a uniform process through which all patient safety activities are conducted. This makes clear that the process is intended to be conducted under the broadest confidentiality protections available under the act and state law."

Organizations that establish or participate in PSOs should create a PSO and PSWP policy, which explains that the purpose of the PSO is to improve patient safety in accordance with the PSQIA's requirements and applicable state law, Blaisdell says.

At a minimum, Blaisdell says the policy should meet these requirements:

- Define patient safety activities and PSWP in accordance with the PSQIA;
- Outline the practice for reporting of patient safety information to the PSO;
- Make clear that all patient safety activities are subject to the policy;
- Stress that the maximum available confidentiality protections under the PSQIA and state law are intended to apply.

Understand What Is Not Protected

It is important to understand what is not protected as PSWP, says **Bruce D. Lamb**, JD, shareholder with Gunster in Tampa, FL. The PSQIA specifically excludes information prepared for purposes other than reporting to the PSO to improve patient safety.

"That would include patient records and anything prepared for mandatory reporting to a state agency," Lamb says.

"This puts the facility in a quandary because it may have obligations to analyze events for multiple reasons," Lamb continues. "For example, there may be obligations to do so to retain accreditation by The Joint Commission. Most states have some type of obligation to report to them."

Those reports would not be protected under the PSQIA as PSWP, but they typically are more limited in scope than what would be reported to the PSO, Lamb notes. That information usually covers what practitioner was involved, the nature of the incident, when it occurred, and whether any corrective action was taken. A report to the PSO often is more in-depth, Lamb adds. When the PSQIA was enacted, healthcare leaders were unsure if they needed to run two separate systems of analysis to preserve patient safety privileges.

Since then, the government has provided more guidance. Hospitals can run only one investigation and pull out the documents that must be reported to regulators or accreditation bodies.

"Then, you can continue with your process to look for corrective action plans and other information, putting that in your report to the PSO. That information then will be protected as patient safety work product," Lamb explains.

Many healthcare leaders do not understand the protections afforded by the PSQIA, Lamb says.

This is evident in the many court cases in which parties contest whether particular information is protected as PSWP and the hospital is deemed to have stumbled with its processes.

"There is a lot of inconsistency and variability in the outcomes, with courts ordering that the material be turned over to a plaintiff, and others concluding that it is protected," Lamb explains. "It's not very well understood, and it's an evolving area of the law." ■

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Continuous Visible Lighting Disinfection May Offer Benefits

The University of New Mexico (UNM) Comprehensive Cancer Center recently replaced traditional light bulbs in its operating rooms with antibacterial LEDs for a visible-light continuous environmental disinfection (CED) system.

Research suggests the fixtures can continuously kill harmful bacteria on high-risk surfaces, which should be an improvement over intermittent cleaning, explains **Stewart Livsie**, manager of maintenance and construction at UNM Comprehensive Cancer Center.

Another common option, ultraviolet (UV) lighting, is not safe for human exposure and can only sanitize spaces once patients and staff leave the room, Livsie says. The germicidal properties of UV light are well-established. Many healthcare organizations use it to destroy microorganisms, but the usefulness of visible violet-blue 405 nm light has been recognized only recently for addressing environmental contamination.

The commonly used light disinfection method uses the UV-C (250 nm) wavelength to kill pathogens by causing photodegradation of DNA. That same process is harmful to humans. Hospitals are limited to using UV light disinfection to clean rooms and equipment without exposing people to the light. Usually, these UV devices are used when rooms are cleaned between patients or on a regular schedule, Livsie explains.

Not Harmful to People

UV also can degrade some plastics and other materials. The visible light disinfection systems kill pathogens through a different process and are not harmful to humans, meaning they can be employed in ways that provide visible-light CED in which people will be exposed to the light, Livsie says.

The visible light requires longer to disinfect surfaces than the UV light. Still, because the UNM Comprehensive Cancer Center is the state's only National Cancer Institute-certified facility, leaders try to stay on the cutting edge of technology, Livsie says.

THE RESEARCH BEHIND THE DISINFECTION TECHNIQUE MAKES LEADERS OPTIMISTIC THAT THEY WILL SEE SUBSTANTIAL REDUCTIONS IN COLONY COUNTS.

"Our patients make up the most immunocompromised population. Whatever we can do to try to keep them safe is a priority for us," he says. "I was at a healthcare design conference where a big focus was on how to use the built environment to help patients and facilitate quality improvement. This was one of the strategies that was presented ... this one [CED] seemed to be most advantageous to us from our infection control personnel's perspective."

Part of OR Renovation

Most pathogens that concerned leaders at the UNM Comprehensive Cancer Center are contact transmissible. They were attracted to a technological solution that promised continuous surface cleaning of surfaces.

As part of a service line change, the cancer center was bringing in interventional radiologists to help with port placements and similar needs. Thus, the center needed to renovate its operating rooms. The surgical suites had not been updated since they were built in 2009. The cancer center was ready to make structural improvements in addition to accommodating the interventional radiologists.

UNM Comprehensive Cancer Center decided to replace the old fluorescent light fixtures with LED lighting because it provides better light quality and is more energy efficient. "As we were doing that project, it seemed kind of a no-brainer to use the visible light continuous disinfection LEDs because this was the most critical area in our facility," Livsie reports. "Even if it didn't work for disinfection, we'd still have LED lights in our operating facility. We really didn't feel like we had anything to lose by trying it."

The cancer center is still piloting CED, so there are no data yet to show effectiveness. However, Livsie says the research behind the disinfection technique makes leaders optimistic that they will see substantial reductions in colony counts. "We're going to keep our environmental services processes

exactly the same. We're not changing anything there," he says. "This is more of a belt-and-suspenders type of approach. We will be doing everything we've always done to control infections. But we also have this lighting system that is working to kill bugs and germs any time the lights are on, and everywhere the light touches a surface."

Research on the effectiveness of the particular product used at UNM Comprehensive Cancer Center was performed largely in coastal regions, so Livsie and infection control leaders at the facility are curious to see if the drier air in New Mexico has any impact. Lower humidity tends to favor the growth of spores and some other pathogens, he notes.

"Any reduction will be good. The cost for the lights was less than what the cost of a traditional light fixture would have been. For me, there was really no risk in that sense," Livsie says. "If we start seeing that there is a significant reduction in colony counts, we will start looking at rolling these lights out to other critical areas of the facility, like the bone marrow and stem cell transplant unit and the infusion suite." ■

SOURCE

- **Stewart Livsie**, Manager, Maintenance and Construction, University of New Mexico Comprehensive Cancer Center, Albuquerque. Phone: (505) 272-4946.

Research Shows Effectiveness of Antibacterial LEDs

Research indicates visible-light continuous environmental disinfection (CED) can be effective in combatting microbial surface contamination and surgical site infections (SSIs).[1]

Investigators studied samples from 25 surfaces within two contiguous ORs sharing an air supply. The samples were obtained after manual cleaning on multiple days before and after a visible-light CED system installation in one OR.

SSIs were tracked in both ORs and a third OR at a distant site for one year prior to and one year after the implementation of the CED system. Researchers found an 81% reduction in total colony-forming units after the visible-light CED system installation in the OR, decreasing from 1.4% in the year prior to installation to 0.4% following installation. Also, there was a 49% reduction in the contiguous OR without the CED system.

"A visible-light CED system is a relatively novel disinfection technology that addresses some of the limitations posed by other supplemental no-touch environmental disinfection strategies in the OR, namely episodic disinfection, staffing, and lack of uniform disinfection," the researchers wrote.[1] "This study demonstrates that a visible-light CED system provides enhanced environmental disinfection beyond standard manual cleaning and that this optimized disinfection resulted in a significant reduction in SSIs for procedures performed in the visible-light CED system OR."

In other research, the New York State Department of Health Wadsworth Biodefense Laboratory studied 405 nm visible light for Vital Vio in Troy, NY. The company reports the CED system was successful in reducing methicillin-resistant *Staphylococcus aureus*, *Streptococcus pyogenes*, *Escherichia coli*, and *Clostridioides difficile* in liquid cultures. The unpublished study exposed the bacteria and spores to a range of intensities and durations, finding a 99% reduction compared to the control in the spores tested, and near-total reduction in the bacteria tested, according to the company. ■

REFERENCE

1. Murrell LJ, Hamilton EK, Johnson HB, Spencer M. Influence of a visible-light continuous environmental disinfection system on microbial contamination and surgical site infections in an orthopedic operating room. *Am J Infect Control* 2019;47:804-810.

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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CE QUESTIONS

1. **What is one way liability can attach to a hospital regarding its peer review process?**
   a. If the patient can show the hospital knew or should have known of the physician's incompetence
   b. If physicians collectively agree the peer review process is flawed
   c. If federal regulators determine the hospital does not conduct its peer review process in a way that gives the public access and the ability to contribute
   d. If the peer review activity causes a shortage of doctors in the community, and local authorities intervene

2. **When does the Health Care Quality Improvement Act of 1986 provide peer review participants with qualified immunity from antitrust and business tort claims?**
   a. When the participants follow the procedural protections outlined in the law
   b. Any time participants conduct peer review activities
   c. When participants make their proceedings open to the public
   d. When the subject of peer review confirms the process was fair

3. **What is necessary for information related to a medical error to be protected as Patient Safety Work Product (PSWP)?**
   a. It must be gathered within 30 days of the adverse event.
   b. It must be submitted to a federally recognized Patient Safety Organization.
   c. It must be declared PSWP by the CEO of the healthcare organization.
   d. It must be provided to the patient, even though it is inadmissible in court.

4. **What is a potential benefit of visible-light continuous environmental disinfection over conventional ultraviolet light disinfection?**
   a. It is substantially cheaper.
   b. Its use is not regulated by federal safety standards.
   c. It can be used around humans without harm.
   d. It is more selective in the type of pathogens that can be killed.