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IN THIS ISSUE

- ◆ **Legionnaires' outbreak**
3 patients die in N.J. hospital 1
- ◆ **Scoring system deconstructed**
Former JC associate director explains 4
- ◆ **Ask Jack**
2009 EC standard on monitoring 6
- ◆ **DNV Healthcare**
New accreditor chipping away 6
- ◆ **Holiday hazards**
Watch for combustible decorations 7
- ◆ **Life Safety CSI**
How many violations can you find? 8
- ◆ **In the electronic version**
Answer to Life Safety CSI 9

Questions or comments?
Contact Editor JoAnn Blake
at 301-287-2673
or at jblake@decisionhealth.com



3 patients in N.J. hospital die after Legionnaires' outbreak

Three patients among the eight recently diagnosed with Legionnaires' disease at Saint Peter's University Hospital in New Brunswick, N.J., became the latest victims of *Legionella*-related outbreaks in hospitals.

Hospital-acquired Legionnaires' disease continues to occur despite efforts to minimize *Legionella* colonization of building water systems, says Janet E. Stout, Ph.D., director of the Special Pathogens Laboratory in Pittsburgh, Penn., and nationally known Legionnaires' disease expert.

"These outbreaks are not as uncommon as many believe and actually are increasing in hospitals where the mortality rate is much higher – around 30 percent," she says. Hospital buildings house complex water systems, and many people in hospitals already have illnesses that increase their risk for *Legionella* infection.

In fact, there has been a spike in the incidence of legionellosis in the U.S. since 2003, with most cases reported in the eastern part of the U.S., according to a 2008 study by the Infectious Diseases Society of America. The New York City Health Department alone recorded 180 cases of Legionnaire's disease in 2006 and 120 cases in 2005.

Nationally, the number of reported legionellosis cases jumped by 70 percent from 1,310 cases in 2002 to 2,223 cases in 2003, with an increase of more than 2,000 cases per year from 2003-2005, according to the Centers for Disease Control and Prevention (CDC). Legionellosis includes Legionnaires' disease and Pontiac fever, a milder illness caused by the same bacterium.

All the patients who tested positive for Legionnaires' disease at Saint Peter's, a 478-bed teaching hospital, had been admitted to an oncology wing from late August through September,

Inside:
**New TJC
scoring
system
explained**

...see page 4

according to an Associated Press report. The first patient to test positive died Sept. 11, the second on Sept. 22 and the third patient on Oct. 3. As of Nov. 3, there had been no additional deaths related to the outbreak, says hospital spokesperson Michelle Lazzarotti, who declined further comment.

Stout says she can't share specifics about Saint Peter's Hospital case, but "it's probable that the patients were exposed to the *Legionella* bacteria via the hospital's drinking water."

According to local published reports, hospital officials discovered from water system records that from late August to early September, the level of chlorine in water circulating to the area where the infected patients were housed had dropped below the norm of .3 parts per million to .1 parts per million.

Legionella bacteria, which cause the disease, are more likely to make people sick who are smokers, older than 65 years, have lung disease or a weak immune system. Each year between 8,000 and 18,000 people in the U.S. are hospitalized with Legionnaires' disease, a type of pneumonia, according to the CDC.

Found naturally in the environment, the bacteria usually live in water and grow best in warm water, such as the kind found in hydrotherapy pools, cooling towers, hot water tanks, large plumbing systems, or the air-conditioning systems of large buildings.

People can get Legionnaires' disease when they breathe in a mist or vapor that has been contaminated with the bacteria. The disease, named

in 1976 when an outbreak occurred at a Philadelphia convention of the American Legion, is not spread from person to person.

Bringing *Legionella* under control

Hospitals often use guidance documents to help in preventing Legionnaires' disease; however, a consensus opinion for prevention of this disease doesn't exist, says Stout. That's because the role of environmental monitoring in determining the risk for hospital-acquired Legionnaires' disease continues to be debated and the guidance varies as to when and how to perform disinfection of a water system, she says.

The first step in controlling *Legionella* is knowing you have the problem in your hospital, says Stout. She recommends testing the water system for the organism and performing a culture.

Hospital water systems that add copper and silver, or chlorine dioxide to kill *Legionella* have been used successfully to disinfect water in hot-water distribution systems, says Stout, a research professor at the University of Pittsburgh.

Methods typically used to control *Legionella* are super chlorination (which can eat away at the piping if too much chlorine is used) and raising the temperature of the water system to kill the bacteria. But these are short-term solutions that will clear the problem up for a week or two, according to J. Glenn Morris, director of epidemiology and preventive medicine at the University of Maryland Medical Center (UMMC).

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EDITOR: JoAnn Blake; 301-287-2673; Fax: 301-287-2157;
jblake@decisionhealth.com

PUBLISHER: Wendy Johnson; 301-287-2386; wjohnson@decisionhealth.com

VICE PRESIDENT: Corinne Kuypers-Denlinger; 301-287-2363;
cdenlinger@decisionhealth.com

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UMMC uses a water decontamination system to control waterborne pathogenic bacteria. The method takes positively-charged copper and silver ions and places them into the water directly, creating an environment in which pathogens can't survive. The ions also can penetrate biofilm that typically collects inside piping, explains Morris.

Water temperature, cleaning and recordkeeping

OSHA recommends maintaining sump water at a low temperature (20 degrees C, 68 degrees F) to control *Legionella* growth. Other OSHA pointers include:

1. Clean and disinfect cooling towers quarterly or at least twice a year if the unit is not used year round. Any system that has been out of service for an extended period should be cleaned and disinfected. New systems require cleaning and disinfecting because construction material residue can collect and contribute to *Legionella* growth.
2. Inspect equipment monthly. Drain and clean quarterly or at least twice a year if the unit is not used year round. Treat circulating water for control of microorganisms, scale and corrosion. Include systematic use of biocides and rust inhibitors. Monthly microbiologic analysis is needed to ensure control of biological contamination.
3. Document operations and maintenance in a log book. List dates of inspections, cleaning, water-quality test results, outbreak investigations and maintenance. Maintain an up-to-date description of the operating system. Develop written procedures for proper operation and maintenance of the system that indicate the corrosion inhibitors

and antifoaming agents. Written records of biocide or chlorine use should be readily available.

The OSHA Legionella Chapter 7, however, is a non-enforceable standard, and it has not been validated scientifically, says Stout.

Tactics not proven effective

The following strategies should *not* be used to control *Legionella*, says Stout.

- Removing and disinfecting showerheads and aerators. Studies have found that descaling, disinfection and/or replacement of faucets and showerheads does not minimize *Legionella* colonization in hospitals.
- Routine maintenance of hospital water systems. "This is just paying lip service to the problem," says Stout. "Studies have refuted the assumption that average, routine maintenance helps minimize *Legionella* colonization."
- Maintaining a hot water storage temperature of 140 degrees F. While many guidelines recommend that hot water tanks be set to 140 degrees and the circulating hot water temperature be set to 124 degrees, one study showed that sites remained heavily colonized despite higher recirculation temperatures, says Stout.

Legionella in hospital water systems and the risk it poses to hospitalized patients is a serious problem that has received far too little attention, says Stout. The passive nature of the disease system leads to underreporting of cases, according to a 2008 article in the journal Clinical Infectious Diseases, suggesting that more than three-quarters of cases are currently undiagnosed or unreported. ♦--JoAnn Blake

HAC Candidate	Medicare Data (FY 2007)	CC/MCC (ICD-9-CM Code)	Selected Evidence-Based Guidelines
Legionnaires' disease	<ul style="list-style-type: none"> • 351 cases • \$86,014 per hospital stay 	482.84	http://www.legionella.org http://www.cdc.gov/ncidod/dbmd/diseaseinfo/legionellosis_g.htm

From the Federal Register, April 30, 2008

Note: Physicians often diagnose Legionnaires' cases as "pneumonia."

Former JC associate director explains new scoring system and “criticality”

Starting in 2009, Joint Commission surveyors will cite all findings that lack full compliance as a Requirement for Improvement (RFI), which will require resolution through an Evidence of Standards Compliance (ESC) submission, said Dean Samet, former associate director of the Joint Commission.

The timeline for completing the ESC submission will depend on the “criticality” of findings and immediacy of risk, he explained to more than 200 attendees at the EC Summit in Las Vegas, held Oct. 20-22.

In moving away from the “threshold-based” decision process, the Joint Commission will focus on a decision process based on timely compliance with specific groups of standards, said Samet, who is now director of regulatory compliance services at Smith Seckman Reid, Inc. of Nashville, Tenn.

The key criterion for the new scoring system will be the “criticality” of the findings – the immediacy of the impact of noncompliance on quality care and patient safety rather than the number of noncompliant standards and EPs (*see ECL 6/9/08*).

The report the surveyors leave on site after the survey will be renamed the “Summary of Survey

Findings Report.” It will not include the potential accreditation decision. Instead, the official survey report will be posted on the organization’s secure Joint Commission Connect site typically within two days after survey unless the Joint Commission’s central office review is required. The final accreditation decision will be made after TJC receives and approves the organization’s ESC.

After an onsite Joint Commission survey, health care organizations receiving any RFIs can clarify their findings for each standard within 10 business days after the final decision report has been published. “This is for organizations that can demonstrate evidence previously not available to surveyors reflecting full compliance at the time of survey,” said Samet. After TJC’s review, if any or all of the findings remain valid, the organization must submit the ESC to detail the actions it took to bring itself into full compliance with the standard.

Below are specifics regarding the scoring system:

Tier categories

- Tier 1) Immediate Threat to Life
- Tier 2) Situational Decision Rules
- Tier 3) Direct Impact Requirements
- Tier 4) Indirect Impact Requirements

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Immediate Threat to Life (ITL)

Definition: Situations identified at survey that have or potentially may have a serious adverse effect on patient health and safety. For example: 1) inoperable fire alarm or pump without fire watch or ILSM (Interim Life Safety Measures); 2) emergency generator down for extended periods without backup; 3) lack of master alarms for med gas systems.

Result: The Joint Commission president issues an expedited Preliminary Denial of Accreditation decision, which remains in effect until the implementation of corrective action is validated through an on-site survey. Once resolved, the organization's status would change to Conditional Accreditation until a follow-up survey is conducted in 4 to 6 months to assess the organization's sustained implementation of appropriate corrective actions.

Situational Decision Rules (SDR)

Definition: Situations in which an accreditation decision of Preliminary Denial of Accreditation is recommended to the Accreditation Committee.

Example: Failure to implement corrective action in response to identified life-safety deficiencies.

Result: The organization must demonstrate resolution through the Evidence of Standards Compliance (ESC) process within 45 days followed by an on-site survey conducted to validate implementation of corrective action.

Direct Impact Requirements (DIR)

Definition: Implementation-based requirements

Example: Requirements where noncompliance is likely to create an "immediate risk" to patient safety or quality of care.

Result: All noncompliant EPs must be addressed through the ESC process within 45 days. The organization's accreditation decision is pending submission of ESC within the 45-day time frame. Failure to resolve noncompliance would lead to progressively more adverse accreditation decisions.

Indirect Impact Requirements (IIR)

Definition: Planning or evaluation-based requirements

Example: Requirements where failure to resolve compliance issues "increase risk" to patient safety or quality of care over time.

Result: All noncompliant EPs must be addressed through the ESC process within 60 days. The organization's accreditation decision is pending submission of ESC within the 60-day time frame. Failure to resolve noncompliance would lead to progressively more adverse accreditation decisions.

Disputed survey findings during survey

If you feel a surveyor has mistakenly cited you for a life safety code or environment of care standards issue, the first thing to do is, said Samet: Get out the Life Safety Code or your accreditation

Quick ABCs of scoring

There will be no more category "B" scoring and no more supplemental recommendations in 2009.

"A" EPs: Policies or plans that either exist or don't exist, and are scored as "Yes" (2) or "No." (0)

"C" EPs: Score based on the number of times an organization does not meet EPs as determined during the survey.

Score 2 = satisfactory compliance

Score 1 = partial compliance

Score 0 = insufficient compliance

Be prepared to prove that you do what you say you do via:

- Minutes of meeting (for example, safety committee, emergency management committee)
- Documented risk assessments
- Records, logs, manifests
- Performance indicators, measures

standards manual and, together with the surveyor, review and discuss the applicable section(s) and specific requirements. It also may be necessary to call TJC's Standards Interpretation Group (with the surveyor) to obtain further clarification. Surveyors have an 800 number.

The HAS manual's The Accreditation Process chapter section "Feedback Sessions" states, "Surveyors will communicate their observations at daily briefings, if requested to do so by the organization. If the organization has additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI, the organization should supply that information to the surveyor(s) as soon as possible.

♦--JoAnn Blake

Ask Jack

2009 EC standard prompts questions over monitoring

Q: *The 2008 JC standards, under EC.8.10.7, state "Ventilation provides for acceptable levels of temperature and humidity and eliminates odors." The 2009 standards, EC.02.06.01, get a little more specific, requiring that we "maintain ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided."*

My question, specifically with regard to areas like OR suite: Is the Joint Commission saying we must monitor humidity, and maintain it at certain levels? If so, what levels, and who gets to decide? Has anyone ever gotten dinged on this?

A: The 2008 EC.8.10 EP7 applies to areas other than OR suite. Standard EC.7.10 EP16 applies to specially designed areas and lists ORs and requires pressure relationships, temperatures and humidity to be maintained. So there is nothing new in 2009

under EC.02.06.01. (It corresponds to EC.8.10 EP7 in 2008 and EC.05.01 EP13 in 2009 corresponds to EC.7.10 EP16 in 2008.) In addition, CMS under Conditions of Participation (COP A-0333) interpretive guidelines 482.41(c) also requires monitoring humidity in ORs. ♦--Jack L. Waisblat is vice president and senior regulatory compliance director at Smith Seckman Reid's Fort Lauderdale office.

DNV Healthcare chips away at TJC's hospital client base

It's been less than two months since the new hospital accreditor – DNV Healthcare Inc. – was approved by CMS, and already the company is starting to whittle away at the Joint Commission's customer base.

Since Sept. 25, when CMS announced it had granted DNV Healthcare deeming authority, the new hospital accreditor has surveyed at least two hospitals. Of those, Citizens Medical Center, a 344-bed acute care hospital in Victoria, Texas, has been accredited. Another, Hays Medical Center, a 194-bed regional referral center in Hays, Kansas, expects to be accredited for the Medicare Conditions of Participation after it gets back its survey results.

Hays Medical Center expects to discontinue its relationship with the Joint Commission after it receives accreditation, says Judith Purdy, director of Risk/Quality Management at the community hospital. There's also a strong possibility that Citizens Medical Center will sever its relationship with the Joint Commission, according to Caren Adamson, the hospital's assistant administrator.

One of the things that Cherie Brzozowski, Citizens quality management director, likes about working with DNV is that its standards are closely aligned with the Conditions of Participation, which means there's no need to compare differing interpretations or figure out which standard sets the bar higher.

Mike Meagher, director of pharmacy at West Shore Medical Center, a 45-bed acute care rural community hospital in Manistee, Mich., noted that the DNV surveyors takes such a low-key approach to interviewing that some of the time frontline staff

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don't realize they're being interrogated. "It's not a gotcha thing," he says.

Surveyors suggested that West Shore streamline recordkeeping, says Meagher, by developing a "one-stop" grid for all recordkeeping. Although they could find drug utilization studies, statistics gathered on patients, use of antibiotics and renal dosing, it would be helpful to have them all in one place, he says. They plan to compile all their information on one Excel document with tabs.

To prevent confusion about competing versions of old forms and policies, staff at Citizens Medical Center decided to ensure consistency by putting all policies and procedures on an internal intranet.

"With one source, you reduce the chances of someone not accessing the most current version," says Adamson. "It's up to us within the facility to control those documents." ♦--Sandra Yin [syin@decisionhealth.com]

Christmas decor may be hazardous to your holiday

With the holiday season approaching, facility managers often are faced with the question of whether to allow decorations such as electrical Christmas lights and live trees.

Be aware that the Life Safety Code, Chapter 19.7.5.4, warns combustible decorations are prohibited in any health care occupancy unless they are flame-retardant. An exception: Combustible decorations such as photographs and paintings in such limited quantities that a hazard of fire developing or spreading is not present, says Dean Samet, former associate director of the Joint Commission.

Examples of explosive or highly flammable decorations are Christmas trees, crepe paper decorations that are not effectively treated with flame retardant, plastic decorations, and real pine trees or branches. Decorations cannot be hung in such a way that they block exit signs or exit doors.

Only listed electrical lights and wiring can be used on natural or artificial combustible vegetation, natural or artificial Christmas trees and other similar vegetation, states NFPA 1, Uniform Fire Code, 2006, provision 10.14.5. Other provisions in the Code:

- Electrical lights are prohibited on metal artificial trees.
- Open flames such as candles, lanterns, kerosene heaters and gas-fired heaters should not be located on or near combustible vegetation, such as Christmas trees.
- Combustible vegetation and natural cut trees should not be located near heating vents or portable hearing devices.

The typical Christmas lights do not have a UL-rating that would include their use in a health care facility, according to Dan Chisholm, Sr., MGI Systems Inc., of Winter Park, Fla.

Here is a suggestion from Chisholm: Select one location within the facility that is common to everyone and then decorate for the holiday season. Man the area 24/7.

Consider the following precautions for the use of live trees in your facility, courtesy of *Holiday Decorations for Health Facilities*, South Dakota Department of Health:

- Live trees must be flocked with a fire retardant.
- A staff person must be designated to water the tree.
- Trees should be limited to one per building.
- Live trees may be in the building only between the dates of Dec. 8 and Jan. 1.
- The tree must be located in a room that can be closed off from corridors, that is, a dining room or lounge, and closely supervised by staff.
- The tree should be located near sprinkler heads or smoke detectors, if possible.
- No lights are allowed on flocked or metal trees. If lighting is desired, indirect flood lights may be used.
- Lights may be used on UL-listed plastic trees in accordance with manufacturer's directions. Lights on trees should be unplugged at night. All lights used on trees must be UL-listed. ♦--JoAnn Blake

What's wrong with this picture?

Life Safety CSI: How many potential snags can you identify?

Welcome to a regular feature of your *Environment of Care Leader* subscription. We provide a photo in every issue to help you flex your survey-readiness muscles.

Study the photo below, from Ernie Allen, to identify potential violations of Joint Commission standards and the Life Safety Code.

The “answers” to this photo appear on p. 9 of your electronic version of *Environment of Care Leader Online*. *ECL Online* is the e-mail version of this newsletter that's a free benefit to all subscribers. If you don't regularly receive it, send an email to customer@decisionhealth.com and put “Add my e-mail to my subscription” in the subject line.



Life Safety CSI: How many errors can you identify?

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Submit a photo! Want to share one of your own photos for a future “Life Safety CSI” feature? Send it to jblake@decisionhealth.com. We'll have a former surveyor or other accreditation expert review it for possible violations. ♦

Answer to Life Safety CSI

Storage room with boxes

These cardboard boxes shouldn't be stored directly on the floor, says Ernie Allen, former Joint Commission Life Safety surveyor. Where would you put them? And how about that door -- is it being held open? Tell us what you see. Send your observations to jblake@decisionhealth.com.