Long-Term Care Survey Alert

SURVEY & CLINICAL NEWS TO USE

CMS has corrected an error in survey guidance for F441 specifying the strength of a disinfectant bleach solution.

The previous guidance stated that "cleaning equipment used for residents with C. difficile with a 1:10 dilution of sodium hypochlorite (**one part water to nine parts bleach**) will also reduce the spread of the organism." The corrected version says "nine parts water to one part bleach." The incorrect information from the CMS guidance was printed in the Long-Term Care Survey Alert article,

"Get Up to Speed Fast With the New Infection Control Guidance" in Vol. 11, No. 10, which will be corrected in the online version.

In addition, CMS has made minor changes to the examples for Severity Level 4.

CMS has rescinded Transmittal 54, dated Nov. 30, 2009, and replaced it with Transmittal 55 (Dec. 2, 2009), which includes the corrections.

If you're using Negative Pressure Wound Therapy (NPWT) devices (i.e., wound vacs), be aware of a new preliminary public health warning from the U.S. Food and Drug Administration. The "FDA has received reports of six deaths and 77 injuries associated with NPWT systems over the past two years," the agency reports in a Nov. 13 health notice. Most of the deaths and serious injuries related to NPWT systems occurred in the home or in long-term care facilities, the FDA says.

Bleeding represented the most serious wound vac-related complication, which was associated with six deaths and 17 injuries, according to the FDA. "Extensive bleeding occurred in patients with blood vessel grafts in the leg, breastbone and groin wounds, those receiving medication for blood clots, and during removal of dressings attached to the tissues. Patients with bleeding required emergency room visits and/or hospitalization and were treated with surgery and blood transfusions," states a report on the FDAWeb site.

Twenty-seven reports involved "worsening infection from original open infected wounds or from pieces of dressing that remained in the wound," the FDA reports. And "32 reports noted injury from foam dressing pieces and foam sticking to tissues or clinging to the wound." Most of the afflicted patients required surgery, antibiotics, and hospitalization.

Read the warnings at www.fda.gov/MedicalDevices/Safety/AlertsandNotices/PublicHealthNotifications.