

4-15-2024 Weekly Clinical Update

There are so many questions about the newest QSO letter related to implementation of the Enhanced Barrier Precautions. Everyone has a little different challenge with the guidance. Hopefully, most of you are getting the same information from the LTC National Infection Prevention Forum.

First, many have had questions about “Resident Rights” to refuse EBP. There have also been some physicians that have written orders to never implement EBP on his/her residents. Dr. David Gifford, the Chief Medical Officer for AHCA answered that question. The question was: “Are families or residents allowed to refuse EBP?” and Dr. Gifford’s answer was: “We asked CMS this question. They said no; since the EBP is based in part on protecting the staff from spreading MDRO to others. While residents have a right to refuse care, they do not consider EBP as care that can be refused just like other safety practice that they cannot refuse. If they are placed in contact precautions in isolation they can't refuse that.”

One other contributor in Florida to that string of questions brought up a great suggestion. “When they (CMS) very first came out in 2019, the families were our hardest obstacle to overcome. The corporate Medical Director and myself (corporate IP) crafted a letter with an explanation and the CDC information at the time - we signed it, and then the facility IP and ED signed it. We also held town meetings prior to implementation, where we would be on video, and the facility staff present. The greatest anxiety was the fact that we were treating them “differently” and they have done nothing to be treated that way. It just took lots and lots of conversation and education to get them comfortable - and then COVID hit and it was really the least of our worries. However, that being said, we now need to start at square 1 for a different reason. There is a true PPE fatigue out there. I really recommend an informative letter, a CDC handout and then have town hall meetings or family/resident council meetings. Ask your Medical Director to be present. This is new to them as well as us, therefore, there is going to be that lack of understanding the why. Once they get the why, it's easier for them to understand. It truly protects their loved ones.” This seems like an excellent strategy to help residents and family member feel better about the new requirements.

One contributor had a survey at the facility on the first day of implementation of EBP. He had an “opportunity” to discuss the implementation with the surveyor and it was explained: “Resident rights and dignity are always to be respected when it doesn't impact the safety of the building. In the case of EBP the value of the safety of the building and the group supersedes the individual right of the resident. She also mentioned that EBP will be a focus of future surveys starting on 04/01/2024. So expect them to be standing outside of your EBP rooms or in the hallways with a clipboard like a pollster in a mall watching the staff. They will be asking for that policy and procedure and your copies of surveillance and education on implementation.”

Also creating a lot of confusion is exactly what is a “chronic wound”. The QSO letter discusses pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. Dr. Gifford also stepped into the discussion on this frequently asked question. His explanation was: “I want to step into this discussion about surgical wounds and the comments about “chronic wounds”. The use of chronic wounds by CDC in the FAQs as an example was not meant to say that only chronic

wounds trigger EBP. It's the characteristic of the wound that matters. Wounds that are likely to serve as a reservoir for MDRO colonization or a portal for infection are what matters. New post-op surgical wounds that are well approximated that may or may not require a dressing do NOT trigger EBP per CDC's comments in this thread and in our discussions with CDC. However, an open surgical wound such as a new open post-op surgical wound that is being allowed to granulate or a surgical wound that has recently dehisced would trigger. A surgical wound with a drain would trigger as it has an indwelling device. CDC guidance allows some clinical judgement of individual providers as it's not possible to list all the different situations. There is concern in everyone's comments on how CMS and State surveyors will second guess providers clinical judgement. CMS and state surveyors will look to your P&P on how you are making clinical decisions, so make sure you give yourself some flexibility and that you document in the resident's record why you have decided to or not to trigger EBP for the situations that are not specifically mentioned in CMS or CDC material."

There are many, many more questions that will come up as CMS starts surveying to the guidance. Let us know your questions.