EBP Inquiries and Responses received and answered by the DNH Triage team.

Inquiry #1

Is this QSO saying we have to use EBP for ALL residents with catheters, even if they do not have an MDRO? If that is true, then the part about "homelike" really isn't accurate right? Every single resident with a catheter has to have a staff person come in with a gown, etc.

Response

Current national standards recommend the use of EBP for all residents with an indwelling catheter regardless of their MDRO infection or colonization status, therefore facilities are expected to employ EBP for these residents as part of their infection prevention and control program as required in 42 CFR §483.80. Staff must employ EBP for residents with indwelling catheters when performing high-contact resident care activities. PPE for enhanced barrier precautions may not need to be donned prior to entering the resident's room. For example, staff entering the resident's room to answer a call light, converse with a resident, or provide medications who do not engage in a high-contact resident care activity would likely not need to employ EBP while interacting with the resident.

Inquiry #2

Upon reviewing the attached QSO, our team has identified several questions and would appreciate further guidance on the following:

1. Is this a recommendation or requirement. Can you please clarify?
2. Do the same requirements apply to hospice patients as enhanced precautions during end of life may be difficult for residents and staff?
3. If this is a requirement, not recommendation, would history of MRDO alone, constitute enhanced precautions? If so, are we as a facility required to further test and confirm colonization?
4. Is there a time limit on the history of MRDO?
5. We as a facility take great pride in our infection control protocols and feel that we have great processes in place to mitigate harm and our current practices prove to be effective. So, do we need to change policies to adapt to these recommendations?
6. Based on the QSO, most/ many referrals we receive from the hospital fall under either or criteria listed under the guidance section. This would significantly increase the amount of PPE and staff resources the facility uses to provide care. Per our Medical Director, not all should be on enhanced precautions. Would we then defer to our Medical Director?

Response

As you know, the Federal long-term care requirements require that nursing homes establish an infection prevention and control program (IPCP) that must include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases which follows accepted national standards. The CDC has published national standards for the use of enhanced barrier precaution (EBP)

use in nursing homes, therefore all CMS certified nursing facilities and skilled nursing facilities must implement EBP that align with national standards and in accordance with requirements in 42 CFR §483.80. Failure to incorporate and implement EBP as part of its' IPCP that aligns with national standards would not meet Federal requirements. As a reminder, all Federal requirements apply to all residents in a CMS-certified facility.

The CDC addresses questions regarding how long enhanced barrier precautions should be applied on their Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes webpage, please see the section Application and duration of Enhanced Barrier Precautions. Below is a FAQ that relates directly to your question:

18. May nursing homes stop using Enhanced Barrier Precautions if we screen the infected or colonized resident and they test negative for the novel or targeted MDRO?
Residents colonized with a novel or targeted MDRO are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. Because MDRO colonization is typically prolonged and follow-up testing to determine clearance may yield false negatives, CDC does not recommend routine retesting of residents with a history of colonization or infection with a MDRO or discontinuation of Enhanced Barrier Precautions after a subsequent negative test.

Inquiry #3

We've been getting a lot of questions from facilities regarding whether a gown and gloves must be worn when therapists are helping residents on EBP ambulate in the hallway (i.e., not in the therapy gym). Could you please advise?

Response

Per the guidance in QSO-24-08-NH, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. This means, if the therapist anticipates prolonged close physical contact while assisting the resident who meets the criteria for EBP with ambulation, they should employ EBP.

Inquiry #4

After reading through the recent enhanced barrier precaution guidelines, my team and I have several questions below. I'm hopeful they can be answered as we work to communicate these changes. Thank you!

1. If someone who requires EBP is transferred from bed to wheelchair by staff and is now being wheeled to another location outside the room, are staff required to continue wearing EBP outside the room after the transfer? Or can they remove the EBP after the transfer and wheel the resident to another location without EBP.
2. Do all staff who walk with residents with wounds or indwelling devises have to wear EPB outside of the room? ex. therapists, family/visitors?
3. Indwelling devises: if somebody has a central line, catheter, feeding tube, ostomy or drain and a staff is NOT performing any sort of devise care or use of those devises (for example therapy) would they still be required to wear EBP?
4. Do therapists have to wear EBP for the entire duration of working with someone with a wound or indwelling devise while in the therapy gym (regardless of if someone is being transferred or working on mobility)?
5. What about private duty caregivers?
6. What about family/loved ones?
7. What is an appropriate way to communicate if someone requires EBP? Signage? Iso bins outside the room?
8. What constitutes someone wearing a mask as part of EBP? It notes potential of "spray" would that include all catheters, IVs, tubes?
9. If a wound is covered and contained do staff need to wear EBP when performing other direct care activities or therapy?

Response

Pushing a resident in a wheelchair is not considered a high-contact resident care activity therefore, EBP would not be indicated in this circumstance. As a reminder, there are very few circumstances in which staff should employ the use of gowns while transporting a resident in the facility, in fact it should be very rare. The guidance states "In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility." This means, if staff anticipates prolonged close physical contact while assisting the resident with ambulation or another high-contact care activity they should employ EBP, regardless of the location.

Current national standards recommend the use of EBP for all residents with an indwelling catheter regardless of their MDRO infection or colonization status, therefore facilities are expected to employ EBP for these residents as part of their infection prevention and control program as required in 42 CFR §483.80. Staff must employ EBP for residents with indwelling medical devices (e.g., indwelling catheter) or a chronic wound, when performing any high-contact resident care activities, if contact precautions do

not apply. PPE for enhanced barrier precautions may not need to be donned prior to entering the resident's room. For example, staff entering the resident's room to answer a call light, converse with a resident, or provide medications who do not engage in a high-contact resident care activity would likely not need to employ EBP while interacting with the resident. It is the high-contact care activities that necessitate the need to employ EBP, medical device care is only one high-contact care activity that requires EBP use.

Facilities have discretion on how to communicate to staff which residents require the use of EBP. CMS supports facilities in using creative (e.g., subtle) ways to alert staff when EBP use is necessary to help maintain a home-like environment, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. How the facility communicates if someone requires EBP is a matter of facility policy. Similar to when transmission-based precautions are implemented, facilities should educate residents (to the degree possible/consistent with the resident's capacity) and their representatives or visitors on the use of enhanced-barrier precautions. Private duty caregivers who are providing care to only one resident would be considered a visitor.

Please see the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) [https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html] webpage as well as their Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes [https://www.cdc.gov/hai/containment/faqs.html] webpage, which provides additional clarifications on EBP.

Inquiry #5

I am being asked by LTCF's whether or not it is now mandatory or if they will be cited for failing to use EBP. They have found that staff are easily confused on when to use EBP/ CP, so have opted to use only full contact precautions in their facility, even when a resident could potentially be cared for with EBP (e.g., contained wound with no draining) by definitions laid out in the QSO. Please advise what is or is not mandatory and we shall pass the information on.

Response

Thank you for your question regarding whether the implementation of enhanced barrier precautions in nursing homes is a requirement that facilities MUST implement. As you know, the Federal long-term care requirements require that nursing homes establish an infection prevention and control program (IPCP) that must include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases which follows accepted national standards. The CDC is a national standard for Enhanced Barrier Precautions.

On March 20, 2024, CMS posted memo QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) today to the CMS Policy & Memos to States and CMS Locations webpage. The memo provides guidance for State Survey Agencies and long-term care facilities on the use of enhanced barrier precautions to align with nationally accepted

standards. The memo goes into effective April 1, 2024. Updated survey tools will be available in the LTCSP software for surveys beginning on April 1, 2024. As stated in the memo “Surveyors will evaluate the use of EBP when reviewing sampled residents for whom EBP are indicated and focus their evaluation of EBP use as it relates to CDC-targeted MDROs.”

The memo explains the negative impact on a resident’s quality of life and psychosocial well-being when they are restricted to their rooms when contact precautions are in place. EBP use does not restrict residents to their rooms or limit their participation in activities, so residents do not experience social isolation or other negative impacts. Failure to implement EBP in accordance with national standards may be considered noncompliance.

Inquiry #6

“Infected or colonized with a non-CDC targeted MDRO without a wound, indwelling medical device, or secretions or excretions that are unable to be
covered or contained” – it is at the discretion of the facility to use EBP.
The non-CDC targeted MDRO refers to these, right?
Additional epidemiologically important MDROs may include, but are not limited to:
* Methicillin-resistant Staphylococcus aureus (MRSA),
* ESBL-producing Enterobacterales,
* Vancomycin-resistant Enterococci (VRE),
* Multidrug-resistant Pseudomonas aeruginosa,
* Drug-resistant Streptococcus pneumoniae

Response

If the resident has an infection or is colonized with a non-CDC targeted MDRO and does NOT have a wound, indwelling medical device or secretions/excretions that cannot be contained/covered, then the facility has the discretion on whether to implement EBP for the resident.
Non-CDC targeted MDRO refers to any MDRO not identified by the CDC as "targeted." The epidemiologically important MDROs you referenced are examples of non-CDC targeted MDROs but is not an all-inclusive list. Facilities have discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by the CDC. Facilities should have policies regarding the use of EBP in these situations.

Inquiry #7

I am requesting clarity on the covered and contained verbiage for wounds. If the wound is covered and contained and no MDRO is present is EBP needed?

Response

Yes, EBP would be indicated for a resident who has a wound in which is covered, and secretions are contained, and the resident is not known to have an MDRO infection or colonization. The fifth example provided in Table 1 in the memo applies to the example you provided. EBP are indicated to prevent the transmission of MDROs between staff and residents.

Inquiry #8

The March 20 memorandum mentions the use of EHB for any resident infected or colonized with a CDC targeted MDRO without a wound (also non-CDC targeted MDROs at the discretion of the facility). Is there a point after so many years when a resident with a distant history of MDRO, especially a targeted MDRO like CRE, would no longer be considered colonized if that MDRO has not presented since? Or are they just considered colonized for life & therefore expected to be on EBP for life in a long term care setting?

Response

The CDC addresses questions regarding how long enhanced barrier precautions should be applied on their Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes webpage, please see the section Application and duration of Enhanced Barrier Precautions. Below are two FAQs that related directly to your questions:

17. How long should a resident remain on Enhanced Barrier Precautions?
Enhanced Barrier Precautions are intended to be used for the duration of a resident's stay in a facility. A transition back to Standard Precautions, alone, might be appropriate for residents placed on Enhanced Barrier Precautions solely because of the presence of a wound or indwelling medical device when the wound heals or the device is removed.

18. May nursing homes stop using Enhanced Barrier Precautions if we screen the infected or colonized resident and they test negative for the novel or targeted MDRO?
Residents colonized with a novel or targeted MDRO are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. Because MDRO colonization is typically prolonged and follow-up testing to determine clearance may yield false negatives, CDC does not recommend routine retesting of residents with a history of colonization or infection with a MDRO or discontinuation of Enhanced Barrier Precautions after a subsequent negative test.

Inquiry #9

I'm the infection preventionist here at …. We are working on implementing the EBP here at our facility and just had a few questions that we needed clarified, if you would be able to help. I would appreciate any help you could provide. Thank you for your time. Have a great night!

1. Does staff have to wear the PPE (gown and gloves) in a residents room when feeding, if on EBP?

2. Does staff need to wear PPE (gown and gloves) in an EBP room when administering eye drops, insulin, or when checking a blood sugar or obtaining VS?
3. Is this guidance only applicable for the CDC targeted MDRO's (pan resistant organisms, CRE, CRP, candida auris) at this time, not the usual MDRO's (ex: MRSA, VRE, ESBL)?

Response

EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Feeding is not included in the list of high-contact care activities therefore, EBP are generally not indicated when feeding/assisting a resident to eat, unless it is coupled with another high-contact care activity.

The guidance in QSO-24-08-NH states "PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. For example, staff entering the resident's room to answer a call light, converse with a resident, or provide medications who do not engage in a high-contact resident care activity would likely not need to employ EBP while interacting with the resident."

EBP are indicated for residents with any of the following:

• Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or

• Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.

At a minimum, facilities must implement EBP for residents who meet his criteria. As indicated in Row 3 of Table 1 in QSO-24-08-NH, facilities have discretion in implementing EBP for residents infected or colonized with a non-CDC targeted MDRO, and who do not have a wound, indwelling medical device, or secretions or excretions that are unable to be covered or contained. Decisions regarding the use of EBP for these residents should be determined in consultation with public health authorities, on units or in facilities during the investigation of a suspected or confirmed MDRO outbreak, or when otherwise directed by public health authorities.

Inquiry #10

In the guidance on wounds, the QSO states, Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.
How is "chronic" defined? Is it how the RAI defines "Chronic" or non-healing?

It is futher stated in the QSO that EBP should be implemented when a resident:

Has a wound or indwelling medical device, and secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO or has a wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO.

Should it be all wounds other than skin tears or skin breaks? We may get a stage 2 that heals in a week. Do these count?

Response

CMS and the CDC describe chronic wounds as those wounds that are not short-lasting. Please see the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) and Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes webpages for additional information regarding the use of EBP when a resident has a wound.

FAQ #23 The guidance describes that "all residents with wounds" would meet the criteria for Enhanced Barrier Precautions. What is the definition of a "wound" in relation to this guidance? []

In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks, or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers.

Inquiry #11

To whom it may concern,

I am the SDC/Infection Preventionist at …. I have a question to clarify regarding QSO-24-08-NH, which was recently announced to be included in Survey audits. It is not a new concept and has been a policy of ours for some time. Reading this new Memorandum, https://www.cms.gov/files/document/qso-24-08-nh.pdf, I would like some clarification regarding "wounds".
Under "Guidance", wounds are described as the following:
"Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of Page 3 of 5 chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers."
Later, after Table 1 is a list of the high-contact care indications for using EBP, listed as the following:

“For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:

- Dressing
- Bathing/showering
- Transferring
- Providing hygiene
- Changing linens
- Changing briefs or assisting with toileting
- Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator
- Wound care: any skin opening requiring a dressing”

I am providing education to our staff regarding our current practices, and would like to be clear on the short-term skin conditions that can be covered by a small non-adherent contact dressing, band-aid, et cetera.

Might someone be able to clarify this for me? Is EBP intended to cover “any skin opening that requires a dressing”, or indeed “not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing.”?

Response

CMS and the CDC describe chronic wounds as those wounds that are not short-lasting, therefore a resident with a skin opening which requires a dressing, that is expected to heal in a short period of time, e.g., a skin tear, would not meet the criteria for EBP. Please see the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) and Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes webpages for additional information regarding the use of EBP when a resident has a wound.

FAQ #23 The guidance describes that “all residents with wounds” would meet the criteria for Enhanced Barrier Precautions. What is the definition of a “wound” in relation to this guidance?

In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks, or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers.

Inquiry #12

I am an Infection Control RN at a Long Term Care/Skilled facility. I have a question regarding the new EBP recommendations taking into effect April 1st.

Are these new EBP recommendations REQUIRED or per facility discretion. Does it need to be for every catheter or only for wounds with MDRO or catheter with known MDRO.

Response

As you know, the Federal long-term care requirements require that nursing homes establish an infection prevention and control program (IPCP) that must include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases which follows accepted national standards. The CDC has published national standards for the use of enhanced barrier precaution (EBP) use in nursing homes, therefore all CMS certified nursing facilities and skilled nursing facilities must implement EBP that align with national standards and in accordance with requirements in 42 CFR §483.80. Failure to incorporate and implement EBP as part of its' IPCP that aligns with national standards would not meet Federal requirements.

Current national standards recommend the use of EBP for all residents with an indwelling catheter regardless of their MDRO infection or colonization status, therefore facilities are expected to employ EBP for these residents as part of their infection prevention and control program as required in 42 CFR §483.80. Staff must employ EBP for residents with indwelling catheters when performing high-contact resident care activities.

Inquiry #13

I have a question in regard to Memo Ref: QSO-24-08-NH.
In the table provided within the memo, the Resident Status only indicates Contact or EBP for wound secretion/excretion that UNABLE to be covered or contained.
My question is, what precautions are indicated for wound secretions/excretions that are ABLE to be covered or contained?

Response

Thank you for your recent inquiry regarding the Federal infection control requirements.
Rows 2, 3, and 5 of Table 1 in QSO-24-08-NH depict scenarios in which the resident does not have a wound, an indwelling medical device, or secretions/excretions that cannot be contained.

- Row 2: Infected or colonized with a CDC-targeted MDRO **withou**t a wound, indwelling medical device or secretions or excretions that are unable to be covered or contained.
- Row 3: Infected or colonized with a non-CDC-targeted MDRO **without** a wound, indwelling medical device or secretions or excretions that are unable to be covered or contained.

- Row 5: Has a wound or indwelling medical device, **without** secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO.

Use guidance in the Row that corresponds with the resident's specific information/situation to determine whether contact or enhanced barrier precautions are indicated.

Inquiry #14

Good afternoon, we would like to have clarification and guidance on the use of EBP in therapy. If the Rehab gym space is limited or not deemed safe to ambulate due to lack of space, are Physical Therapists allowed to wear gown and gloves ambulating a patient that requires EBP and needed (high contact activities) in the hallway? Also, same issue when Physical therapist needed to do car transfers training with patient and caregiver outside of facility? Thank you.

Response

Current CDC recommendations include the use of EBP by therapy staff when in the resident's room or in the therapy gym, they do not include use of EBP in a hallway or other locations. Please see the CDC's Frequently Asked Questions (FAQs) webpage for additional information regarding the implementation of EBP, specifically FAQ #26:

> 26. **Is Physical or Occupational Therapy considered a "high contact" resident care activity?**
>
> Yes. Therapists should use gowns and gloves when working with residents on Enhanced Barrier Precautions in the therapy gym or in the resident's room if they anticipate close physical contact while assisting with transfers, mobility, or any high contact activity.

Inquiry #15

I did ask this on the CMS forum this afternoon but just asking for a written response as well.

Can you please provide guidance on whether Enhanced Barrier Precautions should be included with "Transmission Based Precautions" for completion of the Matrix CMS-802?

Response

Thank you for your recent inquiry regarding the Federal infection control requirements. The instructions for completing the transmission-based precautions item on the CMS Roster/Sample Matrix have not changed, and enhanced barrier precautions are not the same as transmission-based precautions and therefore should not be included when completing the matrix.

Inquiry #16

When it comes to determining who is placed in EBP due to MDRO's - how far back are you looking in a patient or resident's chart for MDRO?

Response

Thank you for your recent inquiry regarding the Federal infection control requirements. You should review any and all available medical records for a resident when evaluating a resident's MDRO status.

Inquiry #17

I have a quick question. Does these precautions only apply to staff working with residents or is it also for family and friends that come in and are in close contact with their loved one? I appreciate any clarification on this.

Response

Thank you for your recent inquiry regarding whether EBP use applies to family and friends visiting residents.
The CDC recommends education and frequent hand hygiene for visitors of residents for whom EBP are indicated. The CDC does not recommend the use of EBP for visitors.

Inquiry #18

Here are some questions I have for EBP:
1. If a resident with a catheter sits in a recliner in the lounge per their choice, does staff have to gown/glove in the lounge to transfer them?
2. Residents rights: if the resident requires EBP to protect them, can we provide education on risks/benefits and if they say I don't want staff to gown/glove for all these basic things because it is embarrassing or makes me feel bad or dirty or causes them distress, can we document that and careplan it? how then do we protect the rights and well being of the resident, their psychosocial well being?
3. Wondering how CMS or the federal government plans to increase reimbursement to cover the huge increase in cost for gowns and gloves. At some locations this will be 80 gowns per day for one resident.
4. If a resident with a feeding tube or catheter goes to therapy, or is ambulated in the hall will staff need to wear gown/gloves?

Response

The guidance in CMS memo QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms states "Note: In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Outside the resident's room, EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility." This means staff do not need to employ EBP when assisting a resident for whom EBP are indicated, to transfer in the lounge.

Nursing homes should educate the resident and/or their representatives and families on enhanced barrier precautions. The CDC provides resources for facilities to facilitate this education on their Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) webpage. Residents do not have the right to refuse staff donning PPE.

Regarding residents with a feeding tube or indwelling catheter, EBP are indicated when the therapist anticipates close physical contact while assisting with transfers, mobility, or any high contact activity in the resident's room or therapy gym, or when working with a resident on bathing/showering activities in a shared/common shower room. PPE is removed before exiting the resident's room, therapy gym, or shared/common shower room and should not be worn in the hallway, dining, or activity rooms, or in other areas of the facility.

We are unable to comment on Federal reimbursement for costs associated with PPE use.

Inquiry #19

I had a question regarding enhanced barrier precautions. Do EBP need to be used for residents with colostomies/illeostomies? And does EBP need to be used for residents with dialysis fistulas (not indwelling dialysis catheters)? I have received conflicting answers regarding these instances and would like a clear answer to give the team.

Response

Thank you for your recent inquiry regarding the Federal infection control requirements. EBP is not indicated for a resident who has a colostomy, ileostomy, or urostomy, as the intent of EBP focuses on wounds requiring dressings.

Dialysis fistulas (i.e. arteriovenous fistulas) are implanted under the resident's skin and does not require a dressing, therefore EBP are not indicated when performing high-contact care activities. Standard precautions always apply and should be employed when accessing the fistula and providing dialysis, and when providing other care based upon the principles of standard precautions.

Inquiry #20

How should a facility proceed with residents refusing EBP?

Response

For the health and safety of all residents, CMS requirements under §483.80 Infection Control, state that facilities must follow national standards. This includes implementation of enhanced barrier precautions, when indicated. We note that facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents, however residents do not have the right to refuse staff using PPE.