Washington State Department of Health
DOH 420-446

Enhanced Barrier Precautions (EBP)
Frequently Asked Questions (FAQ)

Diagnosing multidrug-resistant organisms (MDROs) & implementing enhanced barrier precautions (EBP)

1) **Can we get a link of the targeted MRDO's in Washington? Carbapenemase producing organisms, Candida Auris (not yet identified), VRSA.**
Carbapenemase producing organisms, Candida Auris (not yet identified), VRSA, pan resistant organisms. The DOH MDRO Response Checklist shares organisms that are considered targeted MDROs.

2) **Can you please clarify what it means for a patient to be colonized with MDRO's? Do they have MDRO chronically or is more temporary?**
Colonization with an MDRO can be short term or long term. Risk factors for colonization with the targeted MDROs include chronic illness, long healthcare stays, indwelling devices, and antibiotics. Many of these risk factors are long term and, in general, we believe that colonization with a targeted MDRO should be considered lifelong, except in rare circumstances. Expert guidance in Duration of contact precautions for acute care settings by SHEA gives a rationale for recommendations.

3) **We have residents that have been here 50 years or more and others for a few decades as well. A 15-year-old MDRO diagnosis; asymptomatic - can we clear this through testing?**
If not on antibiotics, no indwelling devices, and not a targeted MDRO, very likely yes. Suggest consulting with your LHJ or HAI Program for specific guidance.

4) **What if they had an MDRO 10 years ago do they need to be on EBP?**
Suggest consulting with your LHJ or HAI Program for specific guidance. If not a targeted MDRO, the answer is likely yes.

5) **Are the labs going to notify the facility when result shows there is a specimen considered to be a MDRO?**
Lab results go to the submitter. Alert values are telephoned if the positive culture is from a sterile site like blood or cerebrospinal fluid, otherwise you will have to look for the results. If the culture was sent by the previous facility; you will only get the information if they tell you or you know to ask for the results.

6) **Does this only apply to patients with history of MDRO or any patient with wounds and indwelling devices?**
EBP is recommended for 1) a patient with specific MDROs when contact precautions do not apply, and 2) for patients with wounds or indwelling devices. In other words, every resident with a wound or indwelling device should be on EBP, even if there are no residents in your facility

who are known to have an MDRO. Residents with targeted MDROs should be on EBP. Your facility medical director, IP and other experts must review the list of other potential MDROs like MRSA, VRE, ESBL, etc., and decide which warrant EBP, then write a policy that explains the approach and rationale.

7) **Are EBP to be implemented for the person with colonization or indwelling device, or is every resident on the unit required to be on EBP? A sign over every bed? Sign on entrance to the unit?**
No, not every resident on the unit. EBP is recommended for 1) a patient with specific MDROs when contact precautions do not apply, and 2) for patients with wounds or indwelling devices.

8) **What if there are no residents with MDROs in the building? Do residents with indwelling devices still have to be on EBP?**
Yes, anyone with a wound or indwelling device should be on EBP.

9) **Do I have to place a nares-positive resident on EBP (NO wounds, indwelling device)?**
Residents with targeted MDROS should be on EBP. Your facility medical director, IP and other experts must review the list of other potential MDROs like MRSA, VRE, ESBL, etc., and decide which warrant EBP, then write a policy that explains the approach and rationale.

10) **In WA, 20-30% of our residents are colonized with ESBL+ gram negative rods. If these colonized residents have no wound or indwelling devices, are they to be maintained on EBP? For the entire duration of residency?**
Residents with targeted MDROS (**Carbapenemase producing organisms, Candida Auris** (not yet identified)**, VRSA)** should be on EBP. Your facility medical director, IP and other experts must review the list of other potential MDROs like MRSA, VRE, ESBL, etc., and decide which warrant EBP, then write a policy that explains the approach and rationale.

11) **When should nursing home staff use Contact Precautions versus Enhanced Barrier Precautions for a resident with a MDRO?**
Contact Precautions are recommended if the resident has an infection with an MDRO, acute diarrhea, draining wounds, or other sites of secretions or excretions that are unable to be covered or contained or for a limited period of time during a suspected or confirmed MDRO outbreak investigation. If none of those criteria are met and the resident does not have another indication for Contact Precautions (See Question 5), then Enhanced Barrier Precautions could be used, unless otherwise directed by public health authorities. Refer to your facility policy regarding which MDROs warrant EBP.

12) **Can colonized patient's shed intermittently, so would a single clearance test be sufficient?**
It depends on the MDRO and what your facility policy is for clearing residents. For targeted MDROs, EBP are recommended for life. The rare exception is if risk factors for long term carriage (including chronic illness, long healthcare stays, indwelling devices, and antibiotic therapy) have resolved. We recommend that facilities consult with public health about ending EBP for a resident with a targeted MDRO.

13) **In SNS facilities our short-term residents come to us with indwelling devices, chronic wounds, or surgical incisions. At any one time we can have up to 20 residents that meet these criteria +**

residents on Quarantine and other TBP. Our concern is the more precautions we have in place the compliance tends to go down due to burden placed on the caregiver to don and doff the PPE. This also tends to take away the home like setting we try to create. What advice can you provide to encourage compliance when we have a high number on Precautions?
Signage on door with exact PPE needed and for what activities will help keep staff aware. Educate your staff on the rationale for precautions, audit performance. In general, PPE would only be used in a resident's room so implementing EBP should not impact the home like setting. Regarding EBP in resident's room, our understanding of healthcare transmission of organisms is evolving and EBP are a response. It will be important to explain to families and residents that you are starting to use EBP and that it is to protect the person you are caring for as well as other residents in the building.

14) **Since EBP is not recommended in Assisted Living, but is recommended in SNF, when a facility has multiple levels of care, do you recommend dividing the facility by level (EBP on SNF units, but not in AL units) or do you recommend utilizing consistent precautions in the whole facility? Thinking about how that might impact staff confusion.**
Each facility will have to decide what is best for them, however, EBP would not be required in the AL.

15) **Why will this not be recommended in hospitals? Do you anticipate that EBP will be expanded to adult family homes/group homes in the future?**
At this time, CDC has not recommended implementation of Enhanced Barrier Precautions in other healthcare settings; however, the evaluation for broader application of EBP to others healthcare settings is ongoing. The high-contact resident care activities described in the guidance were chosen based on hundreds of observations of care in nursing homes that evaluated the potential for antibiotic-resistant bacteria to contaminate the hands and clothing of healthcare personnel. In general, hospitals implement CP for the short time that patients are in the hospital.

16) **Is C. diff considered to be a "novel" MDRO?**
C. diff is not a novel MDRO. EBP is not intended for use in acute care or long-term acute care hospitals and does not replace existing guidance regarding use of Contact Precautions for other pathogens (e.g., Clostridioides difficile, norovirus) in nursing homes.

17) **Who will be assisting with obtaining the PPE (gowns, masks, gloves)? We are already experiencing supply/cost issues.**
We are interested in hearing more about your supply chain issues. Please email us at hai@doh.wa.gov and provide as much detail as possible about the shortages you are experiencing.

Regulation

18) **When does EBP need to be implemented? When will this become a regulation as opposed to the current recommendation? A lot of centers have not adapted EBP. Does this mean that RCS will be surveying on EBP?**

EPB must be implemented now. Enhanced Barrier Precautions is a CDC recommendation/guidance for reducing the spread of multi drug resistant organisms. Facilities are expected to follow CDC IPC standards. **§ 483.80 Infection control F880.** The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: **§483.80(a)(1)** A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to **§483.70(e)** and following accepted national standards.

19) **Where should it be documented that education to residents has been provided?**
I recommend a note in the Progress notes. When you begin to implement EBP, send a letter to all current residents and their families (template here: https://www.cdc.gov/hai/pdfs/containment/Letter-Nursing-Home-Residents-Families-Friends-508.pdf) and announce it at resident meetings.

Wound care

20) **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. 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 status ulcers.

See FAQ Question: https://www.cdc.gov/hai/containment/faqs.html

21) **So, a resident with a wound on the heel/foot is on Enhanced Precautions per CDC guidelines. Even there is no drainage but still there is dressing on, resident able to participate in all activities. Do you still require the Precaution sign on the door with supplies at the door?**
Pressure ulcers are included in the list of wounds, per CDC.

22) **What about a resident with a draining wound? What about a resident who is colonized with an MDRO and has a draining wound? Is EBP appropriate?**
Contact Precautions are appropriate. See CDC FAQ:
https://www.cdc.gov/hai/containment/faqs.html

23) **I have a vent unit in my SNF. Every resident on the unit has an UNDRESSED wound (ostomy?).**
All residents with an indwelling device (trach tube, ET tube) using a ventilator should be on EBP.

Tube Feeding

24) **Can you clarify what PPE would be required to administer meds through a feeding tube?**
According to the CDC EBP guidance (https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html) EBP are recommended for "care and use" of a feeding tube. The safest practice would be to wear a gown and gloves for any care or use (e.g., injecting or infusing medications or tube feeds) of the indwelling medical device. It may be acceptable to use gloves, alone, for some uses of a medical device that involve only limited physical contact between the healthcare worker and the resident (e.g., passing medications through a feeding tube). This is only appropriate if the activity is not bundled together with other high-contact care activities and there is no evidence of ongoing transmission in the facility. Facilities should define these limited contact activities in their policies and procedures and educate healthcare personnel to ensure consistent application of Enhanced Barrier Precautions.

25) **50% of our residents have tube feedings, so then all of them need to be on EBP for life? 50% of our residents have tube feedings, so then all of them need to be on EBP for life?**
That is the recommendation from CDC.

Activities of Daily Living (ALDs) & Therapy

26) **Are gowns and gloves recommended for Enhanced Barrier Precautions when transferring a resident from a wheelchair to chair in the dayroom or dining room?**
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. Enhanced Barrier Precautions is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high-contact activity, such as part of morning or evening care. This extended contact with the resident and their environment increases the risk of MDRO spreading to staff hands and clothes. Outside the resident's rooms, Enhanced Barrier Precautions should be followed when performing transfers and 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 activities.

27) **To clarify the single item assistance portion: if I ONLY help a resident brush their teeth, I don't need to be wearing gown and glove; if I help them brush their teeth AND brush their hair, I do?**
Here is the FAQ from CDC: What activities are included under "providing hygiene"?

Providing hygiene refers to practices such as brushing teeth, combing hair, and shaving. Many of the high-contact resident care activities listed in the guidance are commonly bundled as part of morning and evening care for the resident rather than occurring as multiple isolated interactions with the resident throughout the day. Isolated combing of a resident's hair that is not otherwise bundled with other high-contact resident care activities would not generally necessitate use of a gown and gloves."

28) **What about feeding a resident in the dining room? Does this require EBP? Why is oral care considered "high risk" but feeding a resident is not?**
Brushing teeth often causes sprays and splashes. In general, feeding a resident does not.

29) **You said that therapy would need to wear PPE...so is there a time period that contact is made that makes it High Contact vs not? Can one facility call it HC and one doesn't?**
The facility should have a policy that addresses this question. In general, if staff are having close body contact between their clothing and the residents, that is high risk for potential spread of organisms from contaminated clothing. The policy should have a rationale for when and why EBP are used, staff should be trained on the policy be able to show it to a surveyor.

30) **Can you please clarify, how should rehab staff handle the EBP? For example, if they are walking a resident down the hallway should they be in PPE? Gown and gloves? Since it is prolonged close contact.**
The facility should have a policy that addresses this question. In general, if staff are having close body contact between their clothing and the residents, that is high risk for potential spread of organisms from contaminated clothing. On the other hand, the facility can encourage care that involves close contact to occur in the gym or resident's room to avoid needing to use gown and gloves in public spaces.

Resident Rights and Dignity

31) **Is walking a resident requiring contact guard assist down the hall with gown and gloves, or wearing a gown and gloves during therapy (prolonged exposure) be a dignity issue?**

With the new psychosocial severity outcome guide being used in surveys, how would you address this being a dignity issue and potential harm for dignity of a resident who is living in a LTC facility? If this is causing a resident to be embarrassed, and the resident is a "reasonable person"-would the facility receive a citation for this?

Our understanding of healthcare transmission of organisms is evolving and EBP are a response. It will be important to explain to families and residents that you are starting to use EBP and that it is to protect the person you are caring for as well as other residents in the building. When you begin to implement EBP, send a letter to all current residents and their families (template here: https://www.cdc.gov/hai/pdfs/containment/Letter-Nursing-Home-Residents-Families-Friends-508.pdf) and announce it at resident meetings.