

Virginia Department of Health Frequently Asked Questions About Implementing Enhanced Barrier Precautions

The following questions and answers are for nursing homes and public health partners to support implementation of Enhanced Barrier Precautions in nursing homes, according to the current (July 2022) [CDC guidance](#)

1. Are Enhanced Barrier Precautions (EBP) a recommendation or regulatory requirement?

EBP are an [evidence-based recommendation from the Centers for Disease Control and Prevention](#) (CDC) based on available evidence that shows that EBP are an effective infection control intervention for preventing multidrug-resistant organism (MDRO) transmission in nursing homes. EBP (gown and gloves during high-contact resident care activities) should be used, in addition to Standard Precautions, when Contact Precautions do not apply for residents known to be colonized or infected with an MDRO as well as for residents at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Though it is not currently part of the regulatory requirements, VDH is aware that there are discussions between CDC and the Centers for Medicare and Medicaid Services (CMS). It is unknown if or when EBP will be incorporated into regulatory guidance.

2. If we start implementing EBP in our facility and staff are still learning, will we get “tagged” at this time?

At this time, the VDH Office of Licensure and Certification is not surveying to the implementation of Enhanced Barrier Precautions.

3. How would EBP affect reimbursement or coding of isolation precautions being observed in the MDS (Minimum Data Set)?

Unfortunately, the VDH Office of Licensure and Certification cannot comment on coding as it relates to reimbursement. For coding of isolation precautions, please refer to MDS, Chapter 3, Special Treatments, Procedures, and Programs.

4. What is the expectation for how soon these changes should be implemented?

It is recommended that they should be implemented as soon as possible to protect the health and well-being of residents by reducing the transmission of multidrug-resistant organisms.

5. How is “wound” defined? Our facility considers open blisters and infected in-grown hair follicles as being wounds in addition to things like surgical sites, pressure ulcers, etc.

In the context of Enhanced Barrier Precautions, CDC defines wounds as any skin opening requiring a dressing, such as chronic wounds (e.g., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers). This does not include shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-Aid or similar dressing.

6. How does CDC define multidrug-resistant organisms (MDROs) and to which MDROs does EBP apply?

CDC defines [MDROs](#) (multidrug-resistant or drug-resistant) as bacteria that are resistant to one or more classes of antimicrobial agents. The MDROs that are applicable for the use of EBP should be based on local epidemiology and, at a minimum, resistant organisms [targeted](#) by CDC and other epidemiologically important MDROs.

Examples of MDROs targeted by CDC include:

- Pan-resistant organisms
- Carbapenemase-producing carbapenem-resistant Enterobacterales
- Carbapenemase-producing carbapenem-resistant *Pseudomonas* spp.
- Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*
- *Candida auris*

Additional epidemiologically important MDROs may include, but are not limited to:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Extended spectrum beta-lactamase (ESBL)-producing organisms
- Vancomycin-resistant Enterococci (VRE)
- Multidrug-resistant *Pseudomonas aeruginosa*
- Drug-resistant *Streptococcus pneumoniae*

7. Do I need to include EBP in my infection prevention and control (IPC) program plan and risk assessment?

If your facility will be using EBP, it is recommended that EBP be included as part of your facility's IPC's program, similar to how Standard Precautions and Transmission-based Precautions are addressed in the risk assessment and plan, as well as in any relevant policies or procedures. Staff should also receive education on EBP prior to implementation.

8. What is the expectation for determining prior infection status in these residents, as our facility only keeps files on site for one year?

Residents that had a prior infection with a MDRO may be persistently colonized with the same MDRO for multiple years. We recommend that, to the extent possible, the facility maintains a complete history of MDRO infection or colonization. As part of the infection prevention program's surveillance program, this should be included in the facility's intake procedures to identify potentially infectious persons at the time of admission. If the facility has an electronic medical record, we suggest participating in the [Emergency Department Care Coordination Program](#) to receive alerts about the history of key MDROs.

9. How would donning/doffing work (what are the expectations) for physical and occupational therapists working out-of-room with residents, e.g., PT needing to retrieve an exercise ball from across the therapy room gym?

PPE should be donned at the beginning of the resident's session if the therapist is going to be performing transfers or conducting high contact activities with the resident. Prior to beginning the therapy session and donning PPE, all necessary equipment and supplies should be gathered so they are easily accessible and the therapist does not have to leave the resident during the session.

- If the therapist must leave the resident's direct area to retrieve items during the therapy session, the best practice would be to fully doff PPE, perform hand hygiene, and then retrieve the therapy equipment. Upon return, hand hygiene should be performed, PPE donned, and then the therapy session can be resumed.

The PPE should **ONLY** be worn while working with that resident during his or her therapy session and not between multiple residents. At the completion of the therapy session or if having to assist other residents, ensure PPE is doffed correctly and hand hygiene is performed. Thoroughly clean and disinfect the area the resident was in including any equipment or therapy items used during the session.

10. While on EBP, does the resident's door need to remain closed?

Unlike precautions for residents with infections spread by respiratory droplets or airborne pathogens where the door to the room is recommended to be kept closed to limit transmission, EBP is only used to prevent transmission during high-contact resident care activities. There is no explicit recommendation for a resident's door to remain closed if they are on EBP. Appropriate signage should be in place to communicate to anyone entering the room about what PPE is necessary and when.

11. Should we use dedicated medical equipment (e.g., vital signs machine) for a resident on EBP?

Unlike Contact Precautions which include placement in a private room and dedicated medical equipment, EBP does not require that medical equipment be dedicated. This is because the focus of EBP is limiting transmission with wearing PPE during the high-contact resident care activities. Medical equipment may be dedicated, if supplies allow. If equipment is shared, healthcare personnel should clean and disinfect equipment following Standard Precautions and according to manufacturer's instructions prior to use on another resident.

12. Do residents with tube feeding require EBP?

A feeding tube is an example of an indwelling medical device that is an indication for EBP, so yes, EBP would be recommended during its care and use. In the CDC's EBP [FAQ](#), they address specific considerations for PPE use when limited physical contact is occurring (e.g., passing medications through the feeding tube).

13. If a resident is colonized with an MDRO, how long do they stay on EBP?

For a resident with an MDRO infection or colonization, assuming that Contact Precautions do not apply (e.g., resident has an MDRO wound infection that can't be covered/contained), EBP would be indicated for the duration of the resident's admission.

14. If a resident has a long-term Foley catheter, how long do they stay on EBP?

Enhanced barrier precautions are recommended for residents with indwelling medical devices (such as long-term Foley catheters) as long as the device remains in place, if the resident is on EBP solely because of the presence of the indwelling medical device.. This is because devices are risk factors that place these residents at higher risk for carrying or acquiring a multidrug-resistant organism and many residents colonized with an MDRO are asymptomatic or not presently known to be colonized.

15. Does the trash can inside the room of a resident on EBP need to be a biohazard container or is a regular trash can appropriate?

Most PPE used during resident care, including care of residents placed in Enhanced Barrier or Transmission-Based Precautions, would not fall into the category of regulated medical waste requiring disposal in a biohazard bag, and could be discarded as routine non-infectious waste in a regular trash can. You should refer to local and state regulations regarding disposal of medical waste and the OSHA Bloodborne Pathogen Standard. Additional information on waste management is shared in CDC's EBP FAQ.

16. Do I need to use EBP when accessing a dialysis port?

Use of EBP with accessing a dialysis port would be based on the type of dialysis access device in place. If an indwelling medical device is used (e.g., central venous catheter or peritoneal catheter), EBP is recommended during high-contact resident care activities such as device care or use (e.g., accessing the catheter).

To view additional frequently asked questions from CDC about the implementation of EBP, go to: <https://www.cdc.gov/hai/containment/faqs.html>