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

On March 20, 2024, the Centers for Medicare and Medicaid Services (CMS) issued QSO-24-08-NH, providing guidance for State Survey Agencies (SSAs) and long-term care facilities (LTCFs) on the use of EBP to align with nationally accepted standards. This guidance is incorporated into F880 Infection Prevention and Control and was effective April 1, 2024.

Below are many of the frequently asked questions received from AHCA members with associated answers based on the QSO, information available on the CDC website and responses from CMS and the CDC received via emails or posted on association community message boards.

Question	Answer
Are staff required to glove/gown every time they enter the room for a resident on EBP?	PPE for EBP 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.[1]
Are facilities required to place gloves/gowns outside the door for every resident on EBP?	Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. **Discretion may be used in the placement of supplies which may include placement near or outside the resident's room.**[1]
Are staff required to glove/gown for all ADL care for residents on EBP?	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 (does not include shorter-lasting wounds such as skin breaks or tears covered with an adhesive bandage or similar dressing or surgical wounds (unless there are complications or delayed healing). 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

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	when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility.[1]
Are gloves/gowns used for EBP required to be disposed of in red bags?	You should refer to local and state regulations regarding disposal of medical waste. The OSHA Bloodborne Pathogen Standard uses the term "regulated waste" to refer to the following categories of waste which require special handling, at a minimum: liquid or semi-liquid blood or other potentially infectious materials (OPIM); contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; pathological and microbiological wastes containing blood or OPIM. Based on this definition, 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. Facilities should remember to have an appropriate disposal container available in the resident room to allow for removal of PPE inside the room. However, local or state regulations may be more restrictive than this federal standard, so you should refer to those when making decisions.[2]
Are EBP required for persons colonized with any/all MDROs?	The recommendations outlined in the QSO include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, *in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.* MDROs targeted by the CDC include: • Pan-resistant organisms, • Carbapenemase-producing carbapenem-resistant Enterobacterales, • Carbapenemase-producing carbapenem-resistant *Pseudomonas*, • Carbapenemase-producing carbapenem-resistant *Acinetobacter baumannii*, and • *Candida auris1* On their website, the CDC also notes additional epidemiologically important MDROs may include, but are not limited to: • Methicillin-resistant *Staphylococcus aureus (MRSA)*, • ESBL-producing Enterobacterales,

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	• Vancomycin-resistant *Enterococci (VRE)*, • Multidrug-resistant *Pseudomonas aeruginosa*, • Drug-resistant *Streptococcus pneumoniae*[2] ***It is important to speak with your local or state health department to ask about those above and other important MDROs that may need to be included as well.***
Should therapy staff don gloves/gown when ambulating residents in the hallway when the resident requires contact guard assistance or higher?	The CDC does not have a strict definition of "close physical contact". However, they emphasize this as prolonged physical contact which typically occurs during the bundling of care (such as during am/pm care). The CDC notes that FAQ 21 and 26 may be a helpful resource for you. Additionally, while PPE use is generally discouraged in hallways, in some situations like this example where there is a safety concern removing PPE prior to existing the room (or if there is continued prolonged physical contact outside of the room), it might be appropriate for the therapist to continue wearing PPE, particularly if the resident requires full assist and high contact continues for the duration. Alternatively, if there is minimal contact with the resident during the one-person physical assist (transfer) and ambulation, and this is not part of bundled care, the physical therapist or staff would not necessarily need to wear a gown and gloves during this interaction.[3]
A resident is admitted to the nursing home with a new surgical wound that is covered with an intact surgical dressing. Current orders are to not remove the dressing until the first post-op visit. Is EBP required upon admission?	No, EBP would not typically be indicated for a new surgical wound. The intent of EBP is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period and this generally includes residents with chronic wounds and not those with only shorter-lasting wounds.[2]
For residents who are placed on EBP, what AAMI level gowns should the facility use?	There is not a specific gown level for EBP. The selected gown really depends on the tasks being performed and the level of fluid resistance needed.[4]

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Should therapy staff don gloves/gown when ambulating residents in the hallway when the resident requires contact guard assistance or higher? A Physical Therapist (PT) enters a resident room to help the resident to therapy who is currently on EBP. PT assists the resident with a transfer and then walking from the room to the therapy gym using a gait belt and hands on assistance. Normally, the therapist would remove PPE prior to entering the hallway, but if they do, they will need to let go of the resident leading to a safety issue due to impaired balance. In this scenario, would it be realistic and appropriate according to guidance NOT to have the therapist wear the PPE at all or continue to wear the gloves/gown through the hallway to the therapy gym until it is more appropriate to remove?	There may be times when the facility has to use clinical judgement when determining whether to apply EBP. While PPE use is generally discouraged in hallways, in this situation, it might be appropriate for the therapist to continue wearing the PPE, particularly if the resident requires full assist to get to the therapy gym and they will be providing high-contact care in the therapy gym. Alternatively, if there is minimal contact with the resident during the one-person physical assist (transfer) and this is not part of bundled care, the physical therapist would not necessarily need to wear a gown and gloves during this brief interaction and therefore, would not need to doff the gown and gloves while using a gait belt to enter the hallway.[4]
A resident has a long-standing g-tube for enteral nutrition/medication administration. Outside of ADL care, the nurse needs to access the g-tube for medication administration and to hook up overnight feeding. During these sessions when no other care is provided (e.g., ADL care, suctioning), are gloves/gowns required?	The presence of an indwelling medical device is a major risk factor for being colonized with or acquiring a MDRO. Therefore, the safest practice would be to wear a gown and gloves for any care (e.g., dressing changes) 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 involves 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.[2]

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A resident tested positive for a targeted MDRO two years ago. Recently, the resident went to the hospital and returned. Repeat tests no longer show the presence of a targeted MDRO. Would this resident no longer require EBP?	Residents colonized with a novel or targeted MDRO are intended to remain on EBP 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.[2]
Are nursing homes able to use cloth gowns on a routine basis for persons on EBP? This would be single use (i.e., wear once and then launder), following manufacturer guidance as applicable for maintenance.	Yes, reusable isolation gowns are acceptable if they are appropriately laundered after each use.[4]
For residents who trigger EBP are there any special handling or washing of linens when it's triggered for: • Wounds or indwelling devices only? • Colonization or infection with target organisms? • Colonization or infection with epidemiologic important organisms?	No. There are no special handling or washing requirements for linens beyond what they should already have in place to protect staff handling used linens.[4] The CDC outlines the best practices for handling of linens on their website, including use of PPE by laundry staff. • Always wear reusable rubber gloves before handling soiled linen (e.g., bed sheets, towels, curtains). • Never carry soiled linen against the body. Always place it in the designated container. • Carefully roll up soiled linen to prevent contamination of the air, surfaces, and cleaning staff. Do not shake linen. • If there is any solid excrement on the linen, such as feces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet/latrine before putting linen in the designated container. • Place soiled linen into a clearly labeled, leak-proof container (e.g., bag, bucket) in the patient care area. Do not transport soiled linen by hand outside the specific patient care area from where it was removed. • Reprocess (i.e., clean and disinfect) the designated container for soiled linen after each use. • If reusable linen bags are used inside the designated container, do not overfill them, tie them securely, and launder after each use. ○ Soiled linen bags can be laundered with the soiled linen they contained.

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	It is recommended to review the full information available on the CDC website regarding the handling of linens. AHCA also has tips for meeting the linen requirements under F880 available for members.
May PPE utilized for EBP be stored inside of the resident's room?	Storage of PPE for the use of EBP ONLY within the room is acceptable as long as the facility can avoid contamination and it is not used for other residents.[5]
Does EBP need to be implemented for a resident with an ostomy?	Per Standard Precautions, PPE (e.g., gloves) would be indicated for staff helping a resident change an ostomy bag. However, the CDC does not consider an ostomy to be a chronic wound and does not consider it an indication for EBP.[4]

Additional resources:

Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities

Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | HAI | CDC.

QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes

[1]QSO-24-08-NH Enhanced Barrier Precautions in Nursing Homes, page 4

[2]Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes

[3]Posted by AAPACN on Community Message Board 4/26/24

[4]Email response from the Centers for Disease Control and Prevention (CDC)

[5]Email response from the Centers for Medicare and Medicaid Services (CMS)