Operational & Leadership Lessons Learned

Treating the First EVD Patient Diagnosed in the US

Presented to the American Hospital Association
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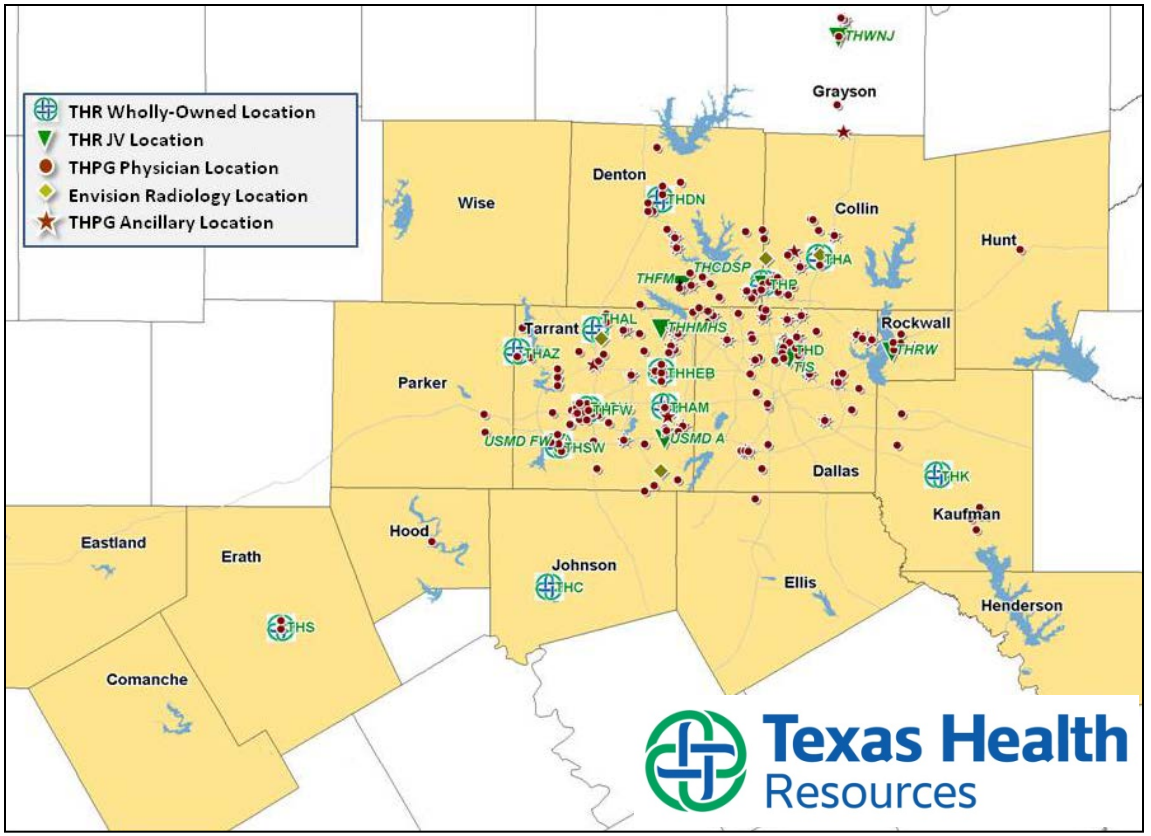
Texas Health Resources®

Texas Health Resources is the market-leading health system in North Texas

- **Texas Health Resources is one of the largest faith-based, nonprofit health care delivery systems in the United States and the largest in North Texas in terms of patients served. The system's primary service area consists of 16 counties in north central Texas, home to more than 6.8 million people.**

  - More than 20,500 employees of wholly-owned facilities plus 2,100 employees of consolidated joint ventures
  - 24 acute care, transitional, rehabilitation and short-stay hospitals that are owned, operated, joint-ventured or affiliated with Texas Health Resources
    - 16 acute-care hospitals
    - 6 short-stay hospitals
    - 1 transitional care hospital
    - 1 rehabilitation hospital
  - 68 outpatient facilities and more than 250 other community access points
  - More than 3,800 licensed hospital beds

- **More than 5,500 physicians with active staff privileges****
- **$4.06 billion in total operating revenue (FY 2014)**
- **$6.6 billion in total assets (FY 2014)**



*** Physicians on the medical staff practice independently and are not employees or agents of the hospital or Texas Health Resources.*

Incident Timeline and Review

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Mr. Duncan's First Visit

GROUND ZERO: September 25 – 26

- 100.1 temp, abdominal pain, dizziness, nausea, headache
- Patient reports recent travel to Africa. This information is noted in EMR but not verbally communicated to ED doctors by nurse; doctor captures different information in his intake history
- "Routine" lab work performed
- CT scan of head and abdomen performed
- Temperature increases to 103, but it is 101 when discharged
- Discharge diagnosis is sinusitis and abdominal pain

Mr. Duncan's Second Visit

FIRST DAY of INPATIENT CARE, September 28

- Immediate placement in ED negative flow isolation room
- Immediate contact made to Infection Preventionist who initiates full contact and droplet precautions
- First treating nurses and ED physician gowned, gloved and masked but without face shield
- ED physician examines patient within 20 minutes of arrival
- ED physician orders Ebola blood test right after exam
- All other patients within patient's ED pod transferred to other rooms
- Dallas County and CDC notified of patient's condition

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Mr. Duncan's Second Visit

DAYS TWO-ELEVEN, September 29 – October 8

- Patient transfer to guarded, otherwise evacuated ICU unit
- Initial PPE consists of double gown, cap, mask, face shield, double gloves and foot protection
- Nurses commence wearing Tyvek suits/PAPR on confirmation of EVD on 9/30; more protection than required by CDC guidelines
- CDC, Emory, THD doctors immediately discuss experimental drugs and convalescent serum
- Patient's blood type precludes donor match with available A/O blood types for convalescent serum
- Zmapp (experimental drug) is reported unavailable
- Decision to prescribe Brincidofovir obtained within 24 hours and administered twice
- Patient loses his battle with EVD on October 8

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Two MICU Nurses Test Positive

DAYS FOURTEEN – FORTY-ONE: October 11 – November 7

- October 11: First MICU nurse tests positive for EVD
- October 12: THD commences ED ambulance diversion
- October 14: Second MICU nurse tests positive
- October 15: Second nurse was transferred to Emory
- October 16: First nurse was transferred to NIH
- October 20: THD discontinues ambulance diversion
- October 21: Gov Perry designates UTMB-Galveston and the "old" Methodist Richardson campus as treatment centers
- October 25: First nurse returns home
- October 28: Second nurse returns home
- November 7: "All Clear": Epidemiologic surveillance discontinued for all exposed healthcare workers (HCW) and non-HCWs

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Operational Lessons

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Lessons Learned: Preparedness for the Novel Event

- Community hospitals are unlikely to have advance notice before receiving a patient diagnosed with an infectious disease
- ED processes must be designed to provide rapid, effective screening and isolation for the safety of patients and care teams
- Care teams must emphasize face-to-face dialogue to bolster team communications among nurse, doctor, and patient

Lessons Learned: Preparedness for the Novel Event

- Information development and dissemination is essential, but insufficient
- Training, simulation and reinforcement of the new processes, technologies and skill sets is required to insure readiness
- Need to do all of this without creating “preparedness fatigue” that leads to missing the commonplace (e.g., influenza)

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Lessons Learned: Availability of Data and the Illusion of Communication

- Data has to be presented ***where*** it can make a difference in the decision-making process of the caregivers
- The ***presence*** of data does not insure that the data has been seen or communicated
- ***How*** data is acquired is as important, if not more important, as ***that*** it was acquired

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Lessons Learned: Incident Command and Interagency Collaboration

- Incident command cannot be “one size fits all”
- No matter how good or bad the available consultative advice is, we still have to own the operations
- Administrative fatigue is as real as caregiver fatigue and must be accommodated
- Jurisdictional clarity is critical, but is hard to achieve for lots of reasons

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Leadership Lessons

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Leadership: Guiding Principles

Principle #1:

Leadership, especially in a crisis, begins with listening

Principle #2:

A leader has to be willing to do things differently in the face of unique circumstances

Principle #3:

You have to trust your leadership team and the judgment of others even when the stakes are extremely high

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