TEXAS HOSPITAL VIOLATED BASIC PRECAUTION IN WHO EBOLA PATIENT TREATMENT GUIDELINES

The incompetence of Texas Health Presbyterian Hospital Dallas is staggering. In following today's rapidly developing story of a second nurse at the hospital now testing positive for Ebola, this passage in the New York Times stands out, where the content of a statement released by National Nurses United is being discussed (emphasis added):

> The statement asserted that when Mr. Duncan arrived by ambulance with Ebola symptoms at the hospital's emergency room on Sept. 28, he "was left for several hours, not in isolation, in an area where other patients were present." At some point, it said, a nurse supervisor demanded that Mr. Duncan be moved to an isolation unit "but faced resistance from other hospital authorities."
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> The nurses who first interacted with Mr. Duncan wore ordinary gowns, three pairs of gloves with no taping around the wrists, and surgical masks with the option of a shield, the statement said.
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> "The gowns they were given still exposed their necks, the part closest to their face and mouth," the nurses said. "They also left exposed the majority of their heads and their scrubs from the knees down. Initially they were not even given surgical bootees nor were they advised the number of pairs of gloves to wear."
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> The statement said hospital officials allowed nurses who interacted with Mr.

> Duncan at a time when he was vomiting and had diarrhea to continue their normal duties, “taking care of other patients even though they had not had the proper personal protective equipment while providing care for Mr. Duncan that was later recommended by the C.D.C.”

From the context of both the New York Times article and the nurses’ statement, it seems most likely that this movement of nurses from treating Duncan to treating other patients took place during the period after Duncan was admitted to the hospital and before the positive test result for Ebola was known. However, from the nurses’ statement showing that at least some of the personnel on duty realized Duncan almost certainly had Ebola, proper isolation technique should have been initiated immediately.

And that movement of nurses from a patient who should have been in isolation back into the general patient population is a huge, and obvious, error. Consider this publication (pdf) put out in August by the World Health Organization, summarizing precautions to be taken in care of Ebola patients. The very first page of actual content, even before the section labeled “Introduction”, is a page with the heading “Key messages for infection prevention and control to be applied in health-care settings”. The page lists nine bullet points about dealing with ” hemorrhagic fever (HF) cases” (hemorrhagic fever diseases include Ebola). Here is the third entry on that list:

> Exclusively assign clinical and non-clinical personnel to HF patient care areas.

There really is no point in saying a patient is isolated if staff are freely moving back and forth between the isolation area and the general patient population. I’m wondering how long it will be until there is a whole new management team at Texas Health Resources, the parent firm

for the hospital.