NEW CDC HOSPITAL EBOLA GUIDELINES FALL SHORT OF WHO GUIDANCE ON PERSONNEL FLOW

I'm either a lone voice in the wilderness or just another angry old man shouting at clouds on this, but, to me, the issue of personnel flow inside a facility treating a patient for Ebola is critical. Texas Health Presbyterian Dallas got that issue terribly wrong in the case of Thomas Duncan, and now, although they provide very good guidance on the issue of personal protective equipment and its use, new guidelines just released by CDC sadly fall short of correcting the problem I have highlighted.

The issue is simple and can even be explained on a semantic level. If a patient is being treated in an isolation ward, that isolation should apply not only to the patient but also to the staff caring for the patient. As I explained previously, National Nurses United complained that health care workers at Texas Health Presbyterian Dallas treated Duncan and then continued "taking care of other patients".

Allowing care providers to go back to treating the general patient population after caring for an isolated patient is in direct contradiction to one of the basic recommendations by WHO in a document (pdf) providing guidance for treatment of hemorrhagic fever (HF, includes Ebola):

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

By exclusively assigning personnel to care of the isolated patient, then the isolation is more complete.

The new CDC guidelines, released on Monday, offer updated recommendations on the types of personal protective equipment (PPE) to be used and how it is to be used. The guidelines also stress the importance of training on effective PPE use prior to beginning treatment of an Ebola patient. Unfortunately, though, the guidelines still leave open the possibility of health care workers moving between the isolation area and the general patient population.

In the preparations before treatment of an Ebola patient commences, the guidelines state:

> Identify critical patient care functions and essential healthcare workers for care of Ebola patients, for collection of laboratory specimens, and for management of the environment and waste ahead of time.

And then once treatment begins, we have this:

> Identify and isolate the Ebola patient in a single patient room with a closed door and a private bathroom as soon as possible.
>
> Limit the number of healthcare workers who come into contact with the Ebola patient (e.g., avoid short shifts), and restrict non-essential personnel and visitors from the patient care area.

So the facility is advised to identify the “essential” workers who will provide care to an Ebola patient and to limit the number of personnel coming into contact with the patient. And even though the patient is to be in an isolated room, the guidelines still fall short of the WHO measure of calling for the Ebola treatment staff to be exclusively assigned. Precautions for safely removing the PPE are described, but once removed, the workers presumably are free to go back to mixing with the general patient population. Hospitals are cautioned against allowing large numbers of care

providers into the room and to avoid “short shifts”, but there still is no recommendation for workers to be exclusively assigned to the isolation area.

The first thing that comes to mind in this regard is to question whether the CDC recommendations fall short of the WHO call for exclusive assignment in order to allow US hospitals avoid the perceived expense of dedicating a handful of personnel to treatment of a single patient. Is the ever-constant push to reduce personnel costs responsible for this difference between CDC and WHO guidelines? In the US healthcare system, it appears once again that MBA’s can carry more weight than MD’s on critical issues.