

## THE EBOLA FILE

1. In violation of hospital policy, a nurse chooses not to wear two pairs of gloves when caring for a patient under investigation for suspected Ebola. The nurse argued that the extra glove made it hard to provide care.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

2. A doctor, being sprayed with blood from an infected patient, doffed his mask and gloves without first moving to the PPE removal area.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

3. A trained observer takes a photo of a suspected Ebola patient. He then shared it his 14 year-old daughter who then posted it on Instagram.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

4. Being in a bit of a panic now facing a real Ebola patient, a nurse forgot to disinfect her outer gloves with Alcohol-Based Hand Rub before proceeding to touch the patient.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

5. The hospital's patient safety officer, when doing an interview with a local newspaper, made the comment that "the Ebola scare has saved at our hospital given our dismal hand hygiene rate of 74% that has now increased to 93% with the awareness of the Ebola threat."

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
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6. An ICU nurse who claims hypersensitivity to infections decides not to show up for work during the seven days an Ebola patient is at the hospital. She notifies her supervisor three days into her absence.

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<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

7. Out of frustration, the Hospital President tells all managers that they have 90 days to get their hand hygiene rate above 90% in their respective departments. Two managers, upon review of outside observational data, have fallen short. One department is at 88%, the other at 67%.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

8. The family member of an Ebola patient overheard a nurse say, in reference to the Ebola patient, “he’s circling the drain, only a matter of time.” The nurse thought she was in a private area when she made the statement to a fellow nurse. Other nurses confirm that the “circling the drain” language is occasionally, if not routinely, used slang at this hospital.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

9. A manager from corporate communications removes a sign at the entrance of the hospital that speaks to Ebola precautions that should be taken by patients. He claims, given the low risk, that the sign unnecessarily scares patients.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

10. At one of our outpatient facilities, the entire group of nurses working triage has been found to not be asking patients whether they have lived in or travelled to a country with widespread Ebola.

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11. A doctor in the ED refused to enter the room of a healthcare provider who has just returned from providing aid in West Africa. While not showing signs of Ebola, the patient was bleeding from injuries suffered in an automobile accident.

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<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

12. A nurse manager, in setting up his area for a potential Ebola patient, refused to let his nurses go through “repeated” Ebola training as they have already demonstrated competency in Ebola-related infection control practices. This was in direct violation of the CDC “repeated training” standards adopted by the hospital.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

13. In the investigation of the above, it was found that the Chief Nursing Officer was aware that nurses were not going through the “repeated” training as required. Additionally, it appears she took no action to correct the omission.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

14. The hospital President directed that a report would not be filed with the state Department of Health concerning an employee who was in a high-risk country and was exhibiting a fever above 100.4 °F. He made this decision, against DoH requirements, because he believed there was little threat as two of the subject employee’s family members were already confirmed as having the flu before the employee’s symptoms appeared.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

15. Being in a bit of a rush facing an Ebola patient who was vomiting in the moment, the nurse, once donned, chose to give aid without allowing the Alcohol-Based Hand Rub to dry on her outer gloves.

<b>Duty Evaluated?</b>	Avoiding Harm	Procedural Rule	Outcome
<b>Action Taken?</b>	Do nothing/console	Coach	Disciplinary Action

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16. A physician under state-ordered quarantine is caught catching local movie. When it came to light, the physician said “I am a healthcare provider. I know when I am contagious. Those rules don’t apply to me.”

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17. In the rush to get a room set up for a person first suspected of Ebola, the hospital failed, per CDC guidelines to, to keep a log of persons entering the patient’s room. The investigation revealed the task was given to a charge nurse who left only three hours after the patient was transferred to her unit. She kept the log, but in the shift turnover, inadvertently failed to transfer that specific responsibility. The second charge nurse knew of the requirement but assumed it was being kept by the Quality Assurance person near the door, as she had personally suggested in the Ebola preparedness meetings.

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18. An ED attending misdiagnoses an Ebola patient. The patient was not at high risk for infection, and all signs suggested it was simply the flu.

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19. Three employees were caught in the medical record of a fellow employee, now patient, suspected of Ebola. None of these employees were on the patient’s care team.

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20. A hospital administrator, over the objections of several nurses, allowed an attending physician to visit his partner who was hospitalized under suspicion of Ebola. In review, the DoH stated publicly that the hospital made a mistake, as the partner was not “essential for the patient’s well being.”

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