Transformational Leadership: Advocacy and Influence

TL5 Nurse Leaders lead effectively through change.

TL5a: Provide one example, with supporting evidence, of the strategies used by nurse leaders to successfully guide nurses through unplanned change.

Introduction

Ebola Viral Disease (EVD) is a very serious illness caused by one of the five species of the Filoviridae virus. The virus is naturally harbored in Pteropodidae bats, a family of fruit bats that live in tropical and sub tropical areas. The bats act as reservoirs of the virus that infects wild animals in the surrounding geographic area but are not always infected themselves. The disease spreads to other animals and humans through direct contact with blood, body fluids, or organs of an infected animal. Human to human transmission also occurs via direct contact with blood and body fluids of an infected individual, as well as from inanimate objects that are contaminated with infected body fluids. EVD is characterized by sudden onset of fever, fatigue, muscle pain, weakness, and severe headache. These signs are followed by abdominal pain, diarrhea, vomiting, rash, and in some cases, internal and external bleeding. Impaired renal and hepatic function can also occur. According to the World Health Organization (WHO, 2016), the disease carries a mortality rate of approximately 50%.

In mid-March of 2014, the first cases of the most recent outbreak of EVD were reported in the West African countries of Guinea, Sierra Leone, and Liberia. This outbreak was considered the largest since EVD was initially reported in 1976, in that there were more reported cases and more deaths. It was also considered a more complex outbreak, eventually defined as an epidemic, since it spread beyond remote areas to urban areas. Between March and July of 2014, the number of cases and related deaths increased exponentially, but the outbreak was contained to West Africa (WHO, 2016).

In early August 2014, two American missionary aid workers who were caring for victims in the affected area developed EVD and were evacuated to the United States (US) for treatment. Confirmation of the disease in these individuals put EVD on the radar screen of most Americans. At the same time, the hospital that treated them became the test case and guide for how to treat those infected with EVD and how to prevent the spread of the extremely contagious disease to those caring for them in the American medical setting. On August 7, 2014, a “Public Health Emergency of International Concern” was declared by the WHO. On September 4, 2014, a third American, a physician aid worker was diagnosed with EVD and evacuated from West Africa to a different US facility for treatment.

On September 26, 2014, the WHO described the EVD epidemic as “the most severe acute public health emergency seen in modern times” and went on to state that “Never before in recorded history has a biosafety level four pathogen infected so many people so quickly, over such a broad geographical area, for so long.” Two days later, an
American man who had recently returned to the US from West Africa was diagnosed with EVD. This was the first case of EVD diagnosed in the US and the index case of travel-associated EVD in the US. He received intensive care for 10 days before he succumbed to the disease. On October 10, 2014, a nurse who cared for the patient was diagnosed with EVD and became the first case of transmission to a health care worker in the US. Another nurse who also cared for the now deceased patient was found to have EVD on October 15, 2014 (CDC, 2014).

Throughout this time period, the EVD epidemic was constantly being monitored at Massachusetts General Hospital (MGH). Decisions were being made for how to identify and manage potential cases, as well as maintain healthcare worker safety in the care of these patients. By mid-October, the Emergency Department (ED), Medical Intensive Care Unit (MICU), and Pediatric Intensive Care Unit (PICU) were identified as the units that would care for patients with known and suspected EVD. Leadership of these units contacted the hospitals that had cared for the patients in the US, and they and their care teams began to consider the impact on their units. It was recognized that the EVD situation was dynamic and that there was an urgent need for an institutional response plan that was comprehensive and protective. There was also a need for a formal and streamlined communication plan to manage the rapidly changing information and recommendations.

**MGH Organizational Preparation for EVD Patients**

The MGH senior executive leaders elected to utilize the existing Hospital Incident Command System (HICS) disaster response system as the format for addressing this issue. On October 21, 2014, the first meeting of the institution-wide EVD HICS was held. At that meeting, Jeanette Ives Erickson, RN, DNP, FAAN, NEA-BC, Senior Vice President for Nursing & Patient Care Services and Chief Nurse, who served as Incident Commander for this group, and Robert Seger, Executive Director for Emergency Medicine Administration appointed chiefs for four areas of focus: Logistics, Planning, Finance and Operations. Nurse Leader Kevin Whitney, RN, DNP, NEA-BC, Associate Chief Nurse (ACN) for Surgical, Neuroscience, and Orthopedic Nursing, was given the responsibility of Operations Chief for the MGH EVD response (attachment TL5a.a). According to the EVD HCIS, in the role of Operations Chief, Whitney was responsible for “developing and implementing strategies to carry out the priorities established by the Incident Commander... and will organize, assign, and assess the impact to patient care.” This role also provided oversight to four major areas of focus: Ambulatory Care, Ancillary Services, Psychological Support, and Medical Care. The Medical Care area encompassed medical and nursing care in the three units that had been designated as locations for placement of Ebola patients, as well as the Nursing Supervisors. Nurse Leader Theresa Gallivan, RN, MS, NEA-BC, ACN for Medicine, the Heart Center, and Emergency Nursing was assigned responsibility for these areas (attachment TL5a.a).
MGH Nurse Leaders to Guide Staff in Nursing and Patient Care Services

Whitney and Gallivan recognized the enormity of their responsibilities and realized that, in order to lead and guide their nursing colleagues efficiently and productively through this unplanned change, they would need to rely on unit-based leadership and other leaders to address key needs.

At the October 30, 2014 meeting of the EVD HICS (attachment TL5a.b), Whitney and Gallivan reported that there was a sense of urgency to finalize a plan for personal protective equipment (PPE) training and communicate it to leadership of the units and support services that would encounter potential or actual Ebola patients. They recognized the time-sensitivity of initiating training for all direct care disciplines and role groups. Whitney and Gallivan also reported that training of 22 interdisciplinary staff members, who would be responsible for training others, was complete, and the planning process for the large scale training that needed to be done was underway. As CDC recommendations changed throughout the process (e.g., the type of recommended respirators) and the possibility of PPE supply shortages, a decision was made to briefly delay the start of training for other direct care providers. Seger verbalized the need for someone with clinical, administrative, and educational skills to lead the training effort from a central perspective. Monica Staples, RN, MSN, ACNS-BC, Clinical Nurse Specialist for General Medicine (White 10) and a member of the MGH Hazmat Team, was suggested as an expert nurse whose experience would make her a good candidate for this role. Whitney asked Gallivan to explore this recommendation as White 10 was part of Gallivan's span of control as ACN. She agreed to negotiate with Jennifer Mills, RN, MS, NE-BC, Nursing Director of White 10 to determine how Staples could be made available to serve in this role for the remainder of 2014.

Nurse Leaders Guide Personal Protective Equipment Training for Staff

At the November 6, 2014 meeting of the EVD HICS (attachment TL5a.c), Whitney and Gallivan reported that the plan for PPE training was complete and that Gallivan had been successful in making Staples completely available to coordinate all aspects of PPE training until the end of 2014. Both were essential to the preparation of nurses to manage this unanticipated and unplanned clinical change.

Staples embarked on putting a training plan in place that encompassed all shifts. The goal was to achieve a critical mass of staff that had completed PPE training within one week. Whitney and Gallivan worked with Nursing Directors for the ED, MICU, and PICU to ensure that staff would be able to attend training, and Staples provided updates regarding the training schedule that she shared with unit leadership via email. A sample of such a communication is found in (attachment TL5a.d). The comprehensive training package for all end-users consisted of an overview of EVD, care of patients with suspected or known infection, general concepts related to PPE, and a rigorous, observed practice of donning and doffing the protective equipment.
Through the ongoing support of Whitney and Gallivan, the interdisciplinary healthcare teams in the ED, PICU and MICU were trained by Staples and her faculty. An excerpt from the EVD PPE Training database showing the ED, PICU and MICU nursing staff that were trained between October 31, 2014 and December 23, 2014 is found in attachment TL5a.e.

The work of Whitney, Gallivan, and colleagues was put to the test on December 2, 2014 when the first patient with suspected EVD, technically referred to a “Person Under Investigation” (PUI) arrived at MGH. To the relief of all involved, the patient did not have EVD, but the opportunity to test all aspects of the plan proved to be very valuable. Whitney and colleagues met to collectively share their experiences, and they conducted a debriefing with the staff in the MICU, where the patient received care.

Ultimately, the plan was activated again on June 9, 2015 for another PUI who also did not have EVD. Although the plan has only been formally activated twice, it is regularly tested, exercised, and up-dated to ensure it remains current and that MGH is ready to manage another response to EVD or another highly pathogenic disease.

On June 12, 2015, the MGH, in partnership with the Massachusetts Department of Public Health (MA DPH), was designated as a special regional treatment center for the care and treatment of Ebola patients by the US Department of Health and Human Services (HHS). This designation included a monetary grant of $3.25 million to be used to support MGH’s and DPH’s ability to care for EVD patients from all over the world. The funding will be allocated over the course of five years.

Dr. Slavin communicated this news on June 30, 2015 in his monthly on-line newsletter, From the Desktop, which is posted the last day of every month.

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From: Broadcast MGH
Sent: Tuesday, June 30, 2015 2:19 PM
To: All User MGH
Subject: From the Desktop of Peter L. Slavin, MD

From the Desktop of . . .  
Peter L. Slavin, MD  
MGH President

June 2015

Mass General Highlights

Hospital Designated a Regional Treatment Center for Ebola

This month the MGH, in collaboration with the Massachusetts Department of Public Health, was selected by the U.S. Department of Health and Human Services to be one of nine designated regional treatment centers for patients with Ebola virus disease or other severe, highly infectious diseases. As part of this designation, the hospital will receive about $3.25 million over the course of the five-year project. The support comes from emergency funds approved by Congress to enhance preparedness in the wake of the 2014 Ebola epidemic in West Africa. As you know, planning and preparing for the possibility of an Ebola
patient at the MGH was a significant undertaking involving many departments and staff, and I thank all those who have worked hard to ensure that, if called upon, we can safely take excellent care of a patient who needs our help.

Whitney’s and Gallivan’s leadership, initially with the organizational response and then with ongoing work, prepared and guided nurses through a critical time of unplanned change and was instrumental in the designation of MGH as a regional treatment center.