Infection Prevention During a Water Outage

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Conflict of Interest Statement:

The author certifies that he has no real or perceived conflicts of interest that relate to this presentation.

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Overview:

- Holzer notified of water outage impacting the city of Gallipolis June 2, 2014 at 8:30 am
    - Holzer immediately converts to water storage tank use, and turns off supply line from city
- Boil water advisory issued at June 2, 2014 at 11:33 and water is considered unsafe for consumption (non-potable)

Day 1:

- Water conservation efforts are announced
  - Poor compliance
  - Severity of issue not fully realized
  - Incident command team not yet formed
  - Communication between local, regional and state entities inconsistent
    - Potable versus non-potable water and it's uses

Day 2:

- Holzer Gallipolis water supply tank at low levels for continued hospital boiler operation on June 3, 2014 at 7:30 am
- Decision made to contact Fire Departments to transport water (shock process)
  - Initially the local health department approved the transported water for all use (potable)
  - Ohio Department of Health rescinded approval and stated all water transported by Fire Department was non-potable

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Water Statistics

7 Fire Departments

4 evenings of shuttling

1839 miles driven

427,150 gallons shuttled


KEEP BACK 500ft.
TEXAS
FIRE/RESCUE

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The Problem:

- Non-potable water was added to our closed system: how to safely continue operations???
  - Hand Hygiene
  - Bathing
  - Surgical Cases
  - Decontamination/Sterilization
  - Drinking Water
  - Environmental cleaning

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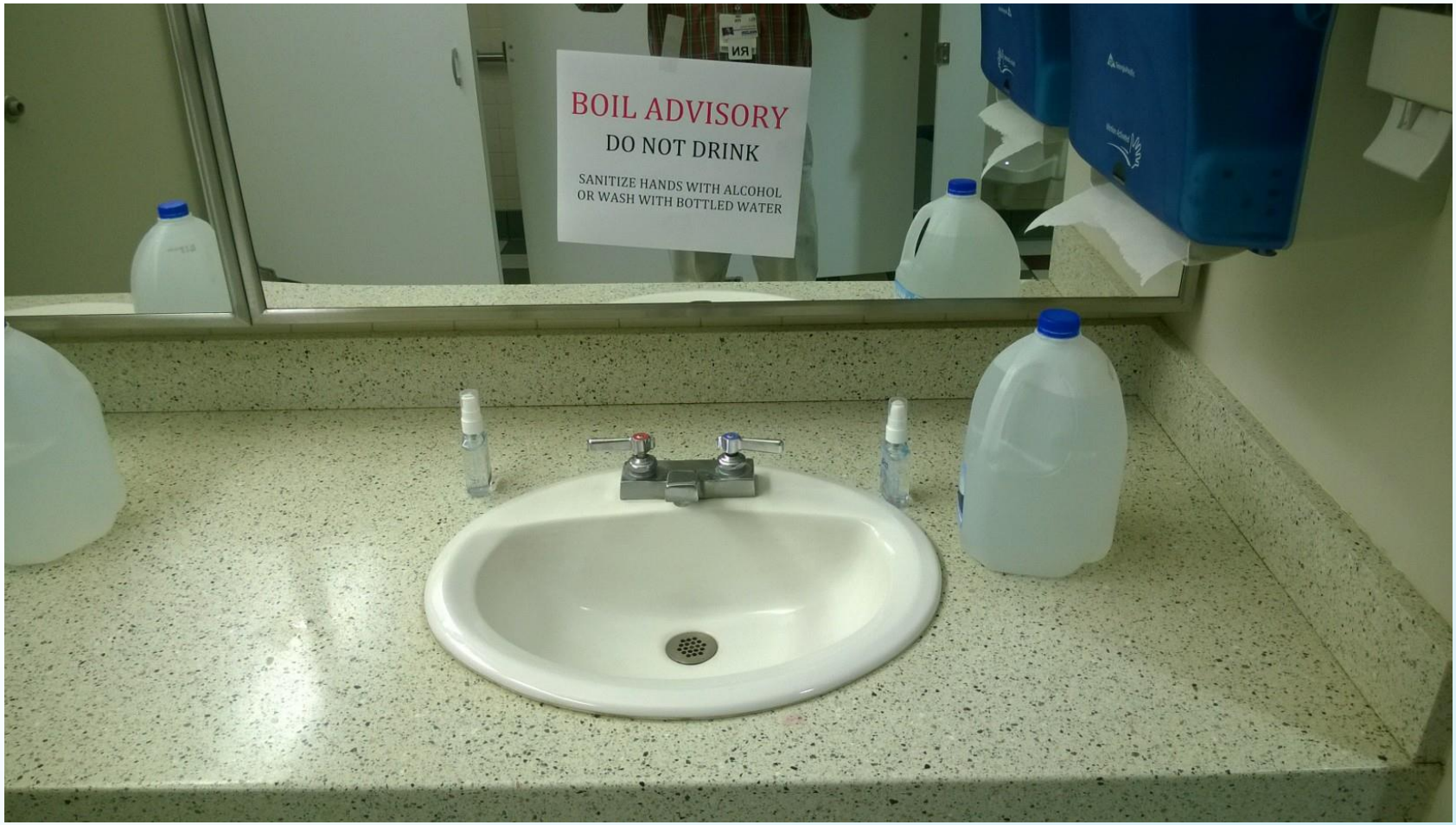
Hand Hygiene:



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Bathing:

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Surgical Cases:

Initially all cases were completed using sterile product

- Not viable for long term use
- Any non-emergent case were rescheduled to an alternate system Operating Room (OR)
- Gallipolis OR team on call with 2 sets of instruments available for emergent cases

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Decontamination/Sterilization

Centers for Disease Control (CDC) states non-potable water unsafe for use in decontamination/sterilization.

- All contaminated instruments transported to alternate sites for processing.
- Efforts coordinated so a minimum of one back up set was always at the Gallipolis site for an emergent case.

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Drinking Water

Bottled water proved to all patients and staff. Some issues that arose:

- Distribution
- Supply
- Theft
- Requests from employees for family members/friends/community

Environmental Cleaning:

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What we learned:

- Initiate the IC process early
- Communicate constantly
- Involve front line staff
  - They better understand the challenges and have great input/feedback!
- Don’t be afraid to ask for help
- Have a copy of this document!!!
  - http://www.cdc.gov/healthywater/pdf/emergency/emergency-water-supply-planning-guide.pdf

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What we learned:

- Better Understanding of Water Shuttle Capabilities
- Investigation and Coordination of dual sources of water.

Outcomes:

Coordination of services resulted in:

- Minimal impact on overall operations.
  - Being a healthcare system enabled us to continue to provide care to our community
- Zero increase in Healthcare Associated Infections
  - Increased monitoring for 90 days post event

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Questions?

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