Surviving flood and contamination: How teamwork kept our diabetes centre afloat

Sara Da Costa, Joy Williams

Although we have been trained to deal with many emergencies that happen in hospitals, we were untrained and unprepared for the one that befell our diabetes centre. The amount of damage and risk required immediate action and evacuation, and subsequent strategic planning and service review. This article will focus on the decisions and actions that were taken, and the effects on staff, patients and services; and lessons learned will be shared.

Article points

1. Disasters require both an emergency response and strategic planning to manage them.
2. Networks helped us to overcome difficulties and bypass bureaucracy.
3. Everybody worked together to problem solve so patients were not disadvantaged with cancelled appointments.

Key words

- Teamwork
- Networks

Emergencies and incidents come in many different forms in the hospital setting; what started as a trickle of water from an overhead pipe rapidly became a deluge of sewage flooding into our diabetes centre. The flood was due to a failure of the foul waste pipe in the void above the education room. Sewage had backed up to this point from a blockage in the pipes within the hospital. Once the trickle became a stream, we found a bucket and emergency bleeped our maintenance team who came running. As they arrived, sewage flooded through the ceiling into the education room. The sewage was prevented from escaping to all rooms in the diabetes centre by heavy-duty water extractors. Some sewage came out from the education room into the central patient waiting area, at a time when clinics were running. This necessitated the evacuation of patients to a safe clinical location to continue their consultations.

Not all staff members were able to escape contamination, so we immediately needed to reduce the infection risk to patients and ourselves. Simultaneously, we had to salvage uncontaminated equipment and leave the scene as soon as possible. However, we had to leave the area as safe and secure as possible because there were patient files and data that we could not gain access to and remove.

Strategic planning

The following day, the diabetes team met in a local coffee shop to discuss the extent of the damage, the effects on the service, and how best to use our resources to meet our commitments over the next month. We discussed a number of issues:

- Health and safety. Limiting or stopping

Sara Da Costa is Nurse Consultant in Diabetes, Worthing and Visiting Fellow, University of Brighton. Joy Williams is Senior Diabetes Nurse, Worthing & Southlands Hospitals NHS Trust.

Page points

1. We had to relocate all clinics, and meet and greet patients, escorting them to the new venues.
2. We had to decide which aspects of the service we could safely run, reduce or discontinue.
3. Group education sessions and all clinics continued but in various new locations.
4. Planning strategically and making decisions based on safety and available resources is only one of the key components of coping with disasters such as the flood.

access to the diabetes centre. We found that patients still tried to get in to obtain diaries, despite biohazard notices and furniture in the way!

- We had to find space for clinics and to work in, and accommodation for essential items that could be salvaged safely.
- We had to relocate all clinics, and meet and greet patients, escorting them to the new venues.
- We had to decide which aspects of the service we could safely run, reduce or discontinue. Patient safety and reducing clinical risk was the main priority immediately following the flood. Decisions had to be made strategically in order that we would continue to meet targets, and communicate these decisions to the rest of the hospital and primary care.
- We stopped using the patient telephone helpline because we could not access patients' files so would have had to advise treatment changes without all of the information, and we could not record interventions in line with the Nursing and Midwifery Council recommendations (2007). In addition, we did not have a private area to make telephone calls so confidentiality would have been a problem. A message on the helpline asked users to contact their practice nurse or GP if in difficulty. We updated the message in order to inform patients when we would be opening again.
- We kept our own caseloads of patients we needed to contact regularly and we telephoned them, rather than asking them to phone us as we had no direct telephone line.
- We could visit wards and maintain primary care clinics so these were continued.
- Group education sessions and all clinics continued but in various new locations, for example the surgical pre-assessment area and the management suite.
- We were running a Level 3 degree module in diabetes, validated by the University of Brighton. This we continued, but in an alternative venue.
- We had to interview candidates for a diabetes specialist nurse post on the day following the flood. Fortunately, most paperwork was rescued and we were able to let all candidates know of the change of venue.

How did staff cope?

Planning strategically and making decisions based on safety and available resources is only one of the key components of coping with disasters such as the flood. Staff members are another, equally important, part of the process, so it was important to assess their feelings. Most described feeling shocked, disoriented, stressed, and "homeless". They were unhappy at "hot desking", frustrated at not having easy access to items that are needed to provide basic diabetes care (pen needles, leaflets, contact details, and so on), and the extra time needed to find each item.

In the authors' opinion, the worst things were being separated, the smell and the feeling of everything being contaminated. Staff could not be contacted by phone, so we obtained one bleep, but it was difficult to find one another and communication was heavily disrupted. We had no computers, so, therefore, had no access to email, and were worried that we might be missing important messages. We no longer felt in control of the diabetes service.

We realised that we had taken the convenience of working in a purpose-built centre, and the benefits of our co-location, for granted. Having worked hard over the past 3 years to develop an effective integrated service across the primary–secondary care interface, we found it difficult to communicate when we did not have a base from which to work.

Networks

The benefits of having developed a network of people within the hospital became apparent following the flood. Networks are

an integral part of any organisation which can oil the wheels of action in bypassing bureaucracy (Handy, 1993). Several people were willing to come to our rescue with offers of a clinical room or a desk for us to use. We needed to work together to aid communication, but could not find anywhere permanent. There was no free area in the hospital suited to clinical use into which we could move while repair work was carried out at the diabetes centre. We managed to relocate clinics to various departments within the hospital, but keeping track of where they were was difficult for everyone involved as locations changed so frequently. Administration areas were problematic; again there was no spare office space. We were invited to share a couple of desks in a communal office, but with the number of staff coming and going it was deemed too disruptive to others working there, so we had to find a new temporary base. Eventually, through the networks, we were able to negotiate somewhere to set up properly.

The senior staff had to be proactive in obtaining the help and resources that were required to successfully continue to run the diabetes clinics. This was necessary as there were no hospital or clinical directors coming forward with solutions to the problem or sympathy. However, the concern shown by other hospital staff, and the help we received through the networks, was very much appreciated.

Repairing the damage

Any hopes of progressing quickly with repairs were dashed, as the problem turned out to be more extensive than just within the diabetes centre, although neighbouring departments were affected to a smaller scale as only one area or room was flooded. This meant that the maintenance team were overstretched and could not concentrate on our area alone.

Another concern was whether we would be able to replace items that were ruined by the flood quickly: the ordering process and procurement of goods is rarely speedy in a hospital setting.

The fabric of the building was the most urgent priority, and the maintenance team worked hard to repair the damage and replace all the necessary parts. Once the repairs were completed, a deep clean of the whole department was undertaken, followed by a complete re-flooring and redecoration of the centre and we were able to begin replacing the items that had been contaminated or damaged by the flood. It was decided that some items would not be replaced – for example older equipment such as a slide projector and a VCR unit. However, the trust fund allowed the replacement of all the items that it was felt were necessary.

Positive outcomes

Teamwork, and support for each other, was evident – despite the stress of the situation. We agreed to meet at 9am each day to discuss the day ahead and any other issues that arose from providing diabetes care outside of the normal clinic setting. Mohrman et al (1995) suggest that the way team members interact influences their ability to accomplish tasks, and this was certainly evident as we got to know each other a little better and, despite all of the difficulties, continued to provide high-quality care for the people with diabetes in the locality.

The combined contributions of all team members led to the effective delivery of good health care, in spite of the difficult circumstances. The benefit of having established networks was that many of our solutions came from external colleagues, who readily helped where they could.

We changed one of the original consulting rooms into a telephone triage room, and stored all files and protocols in there for easier access. This was because we realised that the telephone helpline generated a lot of noise, which was distracting to the staff working in the communal office. However, we had not had the opportunity, or need, to

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radically rethink how we managed this aspect of the diabetes service. The flood gave us the chance to think about this and several other aspects of how we provide and deliver our services. The administrative office in the centre is now much quieter, and staff are finding that they can get work done more quickly with less distraction.

We had all the centre flooring changed for easier cleaning and to remove all risk of contamination. Changing the flooring meant we had to move all of the filing cabinets and storage cupboards, so we had to decide what was to be kept and what was discarded. We also took this opportunity to relocate the furniture, allowing more effective utilisation of space. As a result, the working area is more spacious, brighter and a more pleasant place to work. In addition, stocks that are used frequently are more conveniently stored for easier access.

We felt that it was important to acknowledge the help and support that we received from the maintenance and housekeeping teams, and all of those people in our networks who had assisted us in our time of need, so on our return to the diabetes centre they were all invited for a celebratory party so we could show our appreciation.

Reflection

On reflection 6 months on, we now have a fully redecorated department, with improved use of space and stronger networks than before. We emphasised our commitment to patient care and safety throughout the period that the centre was closed– we did not cancel one outpatient appointment while the centre was unusable. Given the scale of the disruption and damage over the 3-week period the centre was closed, this is, we believe, a remarkable achievement.

Following the flood it has been necessary to put in some measures to prevent such a disaster occurring again. In an ideal world the sewage pipe would be redirected in order that if it ever burst again it would not affect any of the clinical rooms within the hospital. However, it was deemed that this would be too major an undertaking to be feasible. As the flood was found to be caused by a backing up of sewage behind a blockage of cleaning wipes and other items that had been flushed, the decision was taken that all cleaning wipes that are purchased from now on are now degradable in the macerator.

Conclusion

Without leadership of the initial evacuation and the subsequent strategic planning and teamwork, not only would we not have coped with such a traumatic event, but we would not have emerged at the end stronger and with distinct advantages. It would appear that this serious event was the catalyst for many changes and improvements, some of which had been considered, but not put into action, for all the usual reasons – staffing shortages, busyness, other priorities, and so on. Our workplace is now much more organised, and our challenge is to maintain and improve this. We will continue to develop our networks, enjoy our working environment, and hope that we have seen flooding and contamination for the last time! ■

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