Medical Leader	
Medical Expert	☐
Communicator	
Advocate	•
Scholar	
Professional	
Collaborator	•
Manager	•

Legionella In A Routine Test

2014 Day2 – Q6 (Choice)

A routine three-monthly Legionella screening swab taken from a shower head at a small, maternity and geriatric long stay institution run by your service in a rural service town unexpectedly returns a positive result. There are two obstetric bathrooms and the mothers who have used the affected shower since its last (clear) screening swab can be identified with certainty. There are only nine.

The showers in the geriatric unit did not return any positives, and like the obstetric showers, have never done so in the past.

You immediately restrict entry to both obstetric bathrooms as the plumbing and fixtures are of the same mature vintage in both and you want to be quite sure that no-one is put at risk. Midwives and mothers booked to deliver in the next few weeks are contacted individually and invited either to deliver at the base hospital about 45 minutes' drive away, or to deliver at the local unit but use a bathroom set aside for their use in the geriatric wing. You anticipate having the two bathrooms inspected and the plumbing treated to eliminate Legionellae in 2 – 3 weeks. There are only four local women who are likely to deliver within this time frame and as all have been contacted and enabled to rebook if they choose, you do not see the need for any media release.

However, in a small town news travels and the next you hear is from a well-known local MP, a woman who has a particular interest in women's and children's health issues. "How convenient" she has been quoted in the media as saying "what a perfect excuse for the (health service) to close this unit as a cost-cutting measure." The next election is about 6 months away.

You had ensured that the situation had been elevated to your CEO but needless to say he phones and tells you to "sort this out, and quickly".

How do you proceed?

Censor's Notes

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Issues to be addressed:

Patient safety: has any user of the bathroom been unwell? Include staff who may have assisted mothers in the bathroom, and the cleaners. Check hospital records, the local GPs, the local laboratories, and disease notifications for the period of concern. Why might this have happened? Check with your maintenance department and your infection control team, about the protocols for water storage, plumbing maintenance, infection control in relation to Legionella prevention, and compliance. What risk factors should you ask the plumbers to look for in particular? (water storage at 55°C, "dead legs" (blind loops to us), opportunities for soil contamination)Reputational concern: How will you respond to the media when they come to you for comment? How will you manage this MP, who is known to you?

What about the mothers who did use the shower, or were in the hospital over the time of concern? What about the users of the other obstetric bathroom? Are there concerns among clients of the geriatric long stay unit and their family members?

Cost of repairs, disinfection – budgetary impact of these costs and lost revenue from deliveries happening elsewhere. What are the contractual arrangements with the midwives who run the obstetric service, if they are not your own employees?

Next day or two:

Advise well child providers of the possible exposure of newborns and their mothers, and equally, advise staff, the local GPs, staff

Are there implications from this incident for your other smaller hospitals, and your base hospital as well?