130048

HA Review Panel on SARS Outbreak

Notes of Focus Group Discussion

Date	Title
9.7.03	Patient Group
10.7.03	Patient Group
12.7.03	Staff infected with SARS
12.7.03	Doctors Group
12.7.03	Nurses Group
12.7.03	Allied Health Professional Group
14.7.03	Supporting Staff Group
14.7.03	Administrative, Supervisory, Clerical & General Group
11.7.03	Notes of Meeting of the Hospital Authority Review Panel and Frontline staff of Princess Margaret Hospital on SARS Outbreak
11.7.03	Notes of Meeting of the Hospital Authority Review Panel and Frontline staff of Prince of Wales Hospital on SARS Outbreak
11.7.03	Notes of Meeting of the Hospital Authority Review Panel and Princess Margaret Hospital Management on SARS Outbreak
11.7.03	Notes of Meeting of the Hospital Authority Review Panel and of Prince of Wales Hospital Management on SARS Outbreak

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and a Patient Focus Group
held on Wednesday 9 July 2003 at 6:30 p.m.
in the Function Room, 2/F, HA Building, 147B Argyle Street, Kowloon

Present:

Review Panel Members

Mr Ronald ARCULLI Panel Chairman

Mr Clifton CHIU

Dr C H LEONG

Mrs Virginia MONG

Prof Peter YUEN

Patient Focus Group Members

[redacted] (Patient of Pamela Youde Nethersole Eastern Hospital)

[redacted] (Patient of Queen Mary Hospital)

[redacted] (Patient of Pamela Youde Nethersole Eastern Hospital, accompanied by husband who was also a SARS patient of Pamela Youde Nethersole Eastern Hospital)

[redacted] (Patient of Tuen Mun Hospital)

[redacted] (Patient of Tuen Mun Hospital, accompanied by his wife, a healthcare worker)

[redacted] (Patient of United Christian Hospital, later transferred to Wong Tai Sin Hospital)

[redacted] (Patient of Prince of Wales Hospital)

[redacted] (Patient of Kwong Wah Hospital)

[redacted] (Patient of Princess Margaret Hospital)

[redacted] (Patient of Queen Elizabeth Hospital)

[redacted] (Patient of Princess Margaret Hospital, later transferred to Wong Tai Sin Hospital)

In attendance:

Dr Billy HUNG Moderator

Mrs Helen POON Secretary

Opening remarks

Mr Ronald ARCULLI welcomed members of the patient focus group to the meeting. He explained that the purpose of this informal meeting was to collect views of the SARS patients on the Hospital Authority's (HA) management of the disease and see what improvements could be made in preparation for future outbreaks.

2. Dr C H LEONG also thanked members for their attendance and encouraged them to give frank input to the panel.

3. Dr Billy HUNG informed members of the ground rules for the meeting and invited them to express their views freely.

Discussions

4. After giving a brief account on how they got admitted and their hospital stay, at Dr Hung's invitation, members of the patient focus group made the following comments and suggestions on HA's management of the SARS epidemic:

Communication between healthcare workers and patients

(a) Communication between doctors and patients were in general regarded inadequate although actual experience differed among individuals. According to members' feedback, United Christian Hospital had done very well in communication with patients but for Wong Tai Sin and Princess Margaret Hospitals, patients rarely had chance to talk to the doctors. Doctors very often only communicated with patients through the nurses.

(b) Healthcare workers often declined to disclose to the patients' families the patients' progress on ground of personal data privacy. Under this particular circumstance where no visiting was allowed, special consideration should be given so that the patients' families could be updated on patient's progress.

Support from healthcare workers

(a) Healthcare workers were very supportive and caring. Apart from clinical care, some also provided psychological support to patients through words of encouragement which could have positive effect on patients' recovery. The healthcare workers of Queen Mary Hospital even gave their patients the feeling of a home.

(b) Members in general regarded that the healthcare workers had done their very best. They served patients selflessly. For Prince of Wales Hospital, the sick healthcare workers even helped in the light duty work of the ward and taught the other patients on infection control. The member of focus group from Queen Mary Hospital, despite the death of her husband from SARS, pointed out that the healthcare workers had done very well and no one should be held accountable as no one had experience on managing such a disease and no one knew what should be done.

(c) Because of insufficient manpower, the workload of the healthcare workers had been very heavy. This could sometimes lead to lapses in their daily work. An example given was in the administration of drugs. A member of the focus group from Pamela Youde Nethersole Eastern Hospital recalled that she had once not been given any drug in the drug dispensing process in the ward while another member from Prince of Wales Hospital pointed that she had once been given double dose of the drug.

(d) Special support should be provided to the elderly patients to address their emotions and sentiments as they might have difficulties in communication, might not be able to read and might not have mobile phones for contact with their families.

Infection control

(a) The wards were too congested particularly at the early stage of the disease. This could cause cross infection.

(b) Patients of Prince of Wales Hospital were allowed to walk around the wards and this might cause cross infection even if the beds were spaced out.

(c) Those nursing staff newly deployed to SARS wards were not familiar with the use of personal protective equipment and they should be given more training.

(d) Patients on admission should be briefed on infection control measures, what should be done and what should not be done.

(e) Both suspected and confirmed SARS patients were accommodated in the same ward in Princess Margaret Hospital and Tuen Mun Hospital. This arrangement should be improved.

(f) The arrangement of Kwong Wah Hospital where only 3 patients were accommodated in a ward was good.

Treatment process

(a) There was a general feeling that patients had not been adequately explained on the treatment and updated on the progress of their disease though individual hospitals such as Queen Elizabeth Hospital and Kwong Wah Hospital seemed to have done better in this aspect. Members of the focus group felt that it was very important for them as patients to be updated on the progress of their illness.

(b) As a number of recovering patients were suffering from psychological problems, stronger psychological treatment support should be provided to them.

Ward facilities

(a) Toilet and showering facilities in Queen Elizabeth Hospital and Tuen Mun Hospital were not sufficient. For Queen Elizabeth Hospital, only 2 toilet cubicles were available for sharing among about 20 patients of the same ward. There was no showering facility in the male ward and the male SARS patients had to go to the female ward for showers. One could only take a shower in 3.5 days. The hygiene of the toilets was poor and the toilet keeper had a difficult job in keeping the toilets clean.

(b) The medical equipment of Queen Elizabeth Hospital and Tuen Mun Hospital was too old and very often not functioning properly.

(c) As there was no visiting and there was not much facility in the ward, television was suggested to be provided to wards. This was particularly needed for elderly patients who could not read and might not have mobile phones.

(d) Ward supplies in Queen Elizabeth Hospital were inadequate. According to a member of the group from this hospital, a nurse in charge of a ward accommodating nearly 20 patients was only given $1,800 to man the whole ward. However, ward supplies in Queen Mary Hospital were regarded sufficient. According to the member of the group from Queen Mary Hospital, she was supplied with what she needed.

Visiting policy

(a) The 'no visiting' policy was quite unanimously accepted by both the patients and their families but special care should be provided to the elderly patients for their emotional and physical needs.

Hospital administration

(a) The charging policy for SARS patients was not clear. A member of the group, also suffering from heart problem, indicated that she had paid over $40,000 for her stay in Pamela Youde Nethersole Eastern Hospital but was subsequently informed by her doctor during a follow-up consultation that inpatient stay for SARS patients should be free. The question of whether a patient who was subsequently confirmed 'not SARS' would need to pay was also raised.

Health insurance

(a) In view of the minimal charge that was being imposed on public on the use of public healthcare services, the general public should take out their own health insurance policy in the long run. However, in view of the economic climate, this arrangement should not be implemented in the coming 2 years.

Other comments raised

(a) A member of the group, who was a volunteer of the Auxiliary Medical Service, was not satisfied with the Department of Health's arrangement of treating his infection as being community acquired. According to him, he got infected when he helped in the operation of moving residents of the Amoy Gardens to isolation camps. He did not have sufficient personal protective equipment and there was no training, briefing for him on the use of such equipment prior to the operation. As the work of the Auxiliary Medical Service was assigned by the Department of Health, his infection should be classified as healthcare worker infection.

Concluding remarks

5. Mr ARCULLI thanked members of the group for their valuable input and sharing. He assured that their views would be taken into consideration in the Review Panel's report which would be completed in September. Meanwhile, members having further feedback could forward it to the Review Panel through written submissions.

6. The meeting ended at 8:30 pm.

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and a Patient Focus Group
held on Thursday 10 July 2003 at 6:30 p.m.
in the Function Room, 2/F, HA Building, 147B Argyle Street, Kowloon

Present :

Review Panel Members

Mr Ronald ARCULLI — Panel Chairman

Mr Clifton CHIU

Prof Peter YUEN

Patient Focus Group Members

Two daughters of [redacted] (A deceased patient of United Christian Hospital)

[redacted] (Patient of Tuen Mun Hospital)

Son and daughter of [redacted] (A deceased patient of Tai Po Hospital)

[redacted] (Patient of Queen Mary Hospital)

[redacted] (Patient of Prince of Wales Hospital)

[redacted] (Patient of Alice Ho Miu Ling Nethersole Hospital) and her friend [redacted]

[redacted] (Patient of Kwong Wah Hospital)

[redacted] (Patient of Kwong Wah Hospital)

In attendance :

Dr Billy HUNG — Moderator

Mr Stephen MA — Secretary

Opening remarks

Mr Ronald ARCULLI welcomed members of the patient focus group to the meeting and expressed sympathy with their painful experience during the SARS outbreak. He explained that the purpose of this informal meeting was to collect the views of SARS patients on the Hospital Authority's (HA) management of the disease with a view to helping the organisation improve its services and facilities in preparation for future outbreaks.

2. Dr Billy HUNG informed members of the ground rules for the meeting and invited them to share their SARS experience with each other and to

express their views on the issues of treatment process, infection control, support from healthcare workers, ward environment and facilities, visiting arrangements, contact with relatives/friends, institutional problems of HA/hospitals, and etc.

Discussions

3. At Dr Hung's invitation, members of the patient focus group made the following comments and suggestions on the Government and HA's management of the SARS outbreak:

The treatment process

(a) Patients were required to take repeated blood tests during the treatment process, making them feel very uncomfortable.

(b) The dosage of drugs administered to patients seemed to be too heavy, producing many side effects during their rehabilitation process.

(c) The existing treatment regimens for SARS were too invasive. More research would be required to develop better treatment methods for the disease.

(d) Explanations on the treatment process provided by doctors were generally adequate, with alternative treatment methods and side effects of the drugs explained to patients.

(e) The treatment process seemed not very effective in the early stage of the outbreak. Some patients might have died because of the side effects of the high doses of medication administered.

(f) The accuracy of the diagnostic tests was questionable. Two of the patients in the group were first diagnosed as non-SARS and refused to be admitted to hospital. They were later confirmed to have contracted SARS.

Infection control

(a) Post-discharge advice given to recovered patients should be enhanced to help them take the necessary infection precautionary measures at home and in the community.

(b) The healthcare workers of Tai Po Hospital did not wear full protective gears in late April; just wearing masks while handling suspected SARS patients.

(c) Tai Po Hospital had not taken the necessary precautions in preventing cross infection, e.g., not informing relatives that the patient had contracted SARS, still allowing them to visit the patient when he was confirmed to have contracted SARS, and putting the patient's body in a busy hallway for a long time when he was certified dead.

(d) Five members in a family were suspected to have contracted SARS through cross infection in United Christian Hospital, indicating that its infection control measures were far from being effective.

(e) Patients in different stages of the disease were accommodated in the same ward with no proper isolation, increasing the possibility of cross infection. Suspected and fever patients were sometimes housed in the same ward together with the confirmed SARS patients.

(f) Intubations were sometimes performed in open wards in Tuen Mun Hospital before transferring the patient to the Intensive Care Unit, exposing the healthcare workers and patients in the same ward to the danger of being infected.

(g) The frequent transfer of patients between wards during their period of hospitalisation would increase the chance of cross infection.

(h) The segregation of patients in Queen Mary Hospital was done very well, with suspected, fever, SARS and recovering patients accommodated in different wards on the same floor.

Support from healthcare workers

(a) Doctors and nurses were generally very supportive, serving patients selflessly and providing them with both physical and psychological support despite their heavy workload. The healthcare workers of Prince of Wales Hospital, Queen Mary Hospital and Wong Tai Sin Hospital were particularly caring.

(b) Some healthcare workers of Kwong Wah Hospital were slow in responding to the needs of patients and kept a distance from patients for fear of being infected. This would give patients an impression that they were being discriminated.

(c) The healthcare workers of public hospitals should be given credits for helping so many patients recovered from SARS.

(d) HA should provide maximum protection to its dedicated healthcare workers, including reducing their work hours, improving the shift arrangements and providing them with adequate protective gears.

Ward environment and facilities

(a) The air-conditioning system of Prince of Wales Hospital was shut down for some time, making the ward environment very uncomfortable for patients.

(b) The Government should seriously consider using its reserves to build an infectious diseases hospital to better prepare Hong Kong for future epidemics, rather than admitting patients to a large number of hospitals.

(c) The isolation facilities in public hospitals were inadequate. SARS patients were accommodated in open wards and there were no designated SARS wards in some hospitals. More isolation rooms with separate toilet facilities should be built in public hospitals.

(d) The bathing and toilet facilities of Kwong Wah Hospital would need to be improved.

Visiting arrangements

(a) The visiting arrangements were acceptable given the highly infectious nature of the disease. Patients were able to contact their relatives and friends through telephone and video links.

Contacts with relatives/friends

(a) More psychological support should be provided to patients and their relatives to help them get through the painful treatment and recovery process.

(b) In view of the heavy workload of doctors, more administrative support should be provided to them in communicating the patients' conditions to relatives and friends.

(c) The contact tracing work of the Department of Health was not coordinated very well. Different staff members of the Department contacted patients repeatedly at different times to obtain the same kind of information.

Institutional problems of HA and hospitals

(a) There was an impression that some hospitals did not have adequate resources to purchase protective gears. There was also a need to strengthen the administrative and logistic support provided to doctors and nurses.

(b) The low level of vigilance on part of the authorities concerned was an important factor contributing to the spread of SARS in Hong Kong. For instance, Prince of Wales Hospital should be closed in the early stage of the outbreak to control spread of the disease among healthcare workers, patients and visitors.

Concluding remarks

4. Mr Arculli thanked the focus group members for sharing their SARS experience with the Review Panel and assured them that their views would be

taken into consideration in formulating the Panel's conclusions. He explained that the Review Panel was an independent body with a majority of external members to review HA's management of the SARS outbreak in order to enhance its capability of handling possible outbreaks in future. The Panel would complete its work in the coming weeks and report its findings and recommendations to the HA Board in early September 2003. He also encouraged members to send in written submissions to the Panel after the meeting, if deemed necessary.

5. The meeting ended at 8:45 p.m.

Hospital Authority
PFG\NOTES
11 July 2003
SM/mw

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and the Special Patient Focus Group
held on Thursday 12 July 2003 at 2:00 p.m.
in the Function Room, 2/F, HA Building, 147B Argyle Street, Kowloon

Present:

Review Panel Members

Mr Ronald ARCULLI	Panel Chairman
Dr George BO-LINN	
Dr Jonathan BOYCE	
Prof Peter YUEN	
Mr Clifton CHIU	
Mrs Virginia MONG	

Special Patient Group Members

[redacted]	[redacted], UCH
[redacted]	[redacted], AHNH
[redacted]	[redacted], PMH
[redacted]	[redacted], UCH
[redacted]	[redacted], PMH
[redacted]	[redacted], PMH
[redacted]	[redacted], PWH

In attendance:

Dr Billy HUNG	Moderator
Mr Paul HUI	Secretary
Mr Rob BURNS	

Opening remarks

1. Mr Ronald ARCULLI thanked members of the special patient group for attending the meeting. Staff members were encouraged to comment on the treatment and care received, psychological and emotion impact after the tremor and any suggestions for improvement in future.

2. Dr Billy HUNG then proceeded by inviting members to tell the panel how they contracted SARS and to comment on what measures that the Hospital Authority could have taken to prevent their mishap.

Preventive Measures

3. [redacted] considered that the Hospital Authority could have prepared her staff better by enhancing their knowledge on infection control. She commented that majority of the staff lacked the aptitude and knowledge of infection control. She contracted SARS in the ICU ward when PMH began to take in SARS patients from other hospitals in late March. The number of ICU beds increased from 13 to over 40

in a few days. Although they were equipped with adequate protective clothing, the sudden surge of workload was too much to handle. She suspected that she was infected as a result of over exhaustion.

4. Echoing [redacted]s comment, [redacted] said that the Hospital Authority should have alerted all staff the severity of the disease immediately after the outbreak at PWH. At the same time, the Authority should have acquired and distributed sufficient protective materials to hospital staff and issued instructions on infection control. It was a pity that hospital staff was not fully protected at the initial stage. The protective materials only arrived later in batches. He also considered that the ventilation system in the ICU ward was incapable to handle so many infectious cases at the same time. As a result, many of his colleagues contracted SARS when performing intubations on patients.

5. [redacted] informed the panel that she worked in the Medical ward in AHNH and fell sick in early April. She agreed that protective materials were inadequate at the initiate stage. Staff in the general wards was only protected with surgical masks. Majority of the staff did not know how to put on the protective gear properly. Delay in the return of the laboratory results of the suspected cases had also contributed to the high percentage of staff in the medical ward to be infected by SARS patients.

6. [redacted] was the [redacted] of the Medical ward in UCH and contracted SARS in early April. She commented that the main problem was insufficient information about the new corona virus. When UCH began to take in the Amoy Gardens patients, there was confusion and lack of co-ordination between departments in the hospital. Despite the large number of Amoy patients admitted, the AED continued to accept new patients. The workload was too overwhelming and could not be handled. She also agreed that protective materials were insufficient at the initial stage. Medical wards had to surrender their stock of protective gear for use by colleagues in the cohort wards. 16 of her staff got infected by the cryptic patients.

7. [redacted] summarised the incidence as a result of (1) the sudden increase in the viral load, (2) presentation of cryptic cases distorted by other symptoms and (3) insufficient protective gear at the initial stage. To prevent recurrence of their mishap and protecting staff from future outbreak of communicable disease, [redacted] suggested that Hospital Authority should adopt a "Step Down" approach in the distribution of protection gears. Her suggestion was shared by other staff members at the meeting.

8. [redacted] said that he was one of the staff contracted SARS in Ward 8A of PWH. He said that the main reason for so many staff contracted SARS at work was their ignorance of the infectivity of the disease. Most of his colleagues were infected when performing resuscitation / intubation procedures on SARS patients. Another contributing factor was the ineffectiveness of the ventilation system in ICU wards. The overcrowded condition of the wards had also facilitated cross infection among patients. The delay in containing the disease in PWH and cancelling the visiting hours had contributed to the spread of the disease to the community. There was also insufficient communication between hospitals. Experience at PWH could have been shared with other hospitals and would have minimised the chances of fellow colleagues contracting SARS. He agreed that it was necessary to have specialised infectious disease wards within each hospital for communicable disease and preventing cross infection.

9. On the question whether the hospital had installed proper protocol for intubation, [redacted] replied that there was no time to follow the protocol when the patient was in a critical condition and must be intubated immediately.

Treatment and Care

10. All staff members agreed that they had received good medical care during their hospital stay and the hospital management had been very supportive.

11. [redacted] informed the panel that staff patients were put in isolation wards and had received good medical care and support from fellow colleagues.

12. [redacted] was admitted into TMH when she fell sick. Although she had received good medical care, she noticed that the standard of patient care provided by the hospitals varied.

Post-SARS arrangement

13. [redacted] informed the panel that the hospital management had been very understanding and supportive. She was given enough time for recovery and was also transferred to a less demanding post. The hospital had also provided sufficient counselling and convalescent rehabilitation. She commented that the Hospital Authority could consider using traditional Chinese medicine as part of the treatment regimen for recovering patients.

14. [redacted] commented that the hospitals were stepping down their precautionary procedures too rapidly. He worried that there might be chances for the disease to hit again as the problem of cryptic cases had not yet been resolved. He also felt that it was not advisable to put SARS patients of different degree of severity in the same ward. This would endanger the less severe patients.

15. [redacted] considered that the only solution for preventing recurrence of the mishap was to increase staff manpower and to ease the workload.

16. When asked whether more accessibility by friends and relatives during their hospital stay would provide more psychological and emotional support, [redacted] considered that it was adequate to communicate with her family over the phone. She said that the disease was too contagious and she could not risk infecting her family. Her views were shared by other staff members.

Psychological and emotional changes

17. [redacted] said that he worried about the side effect and complications after receiving high-dosed Steroid treatment. Many patients had had severe problems or even permanent damage to their lungs. He suggested that the Hospital Authority, when considering applications for compensation, should consider each case separately depending on the severity of the damage.

18. Mr Ronald ARCULLI advised members to protect their interest by recording and making proper document of their conditions. These documentation would be useful when making claims.

Communication and Publicity

19. [redacted] commented that the government had not distributed enough information to educate the public about the disease. There was not enough publicity on the work done by the Hospital Authority. She considered that the Hospital Authority should play a more leading role and enhance its public image when facing another outbreak of communicable disease in future.

20. There being no further items for discussion, the Chairman thanked staff members for their comments and suggestions. He also commended their bravery and dedication at work. The meeting adjourned at 3:35 PM

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and a Doctor Focus Group
held on Saturday 12 July, 2003 at 8:30 am
in the Function Room, 2/F, HA Building, 147B Argyle Street, Kowloon

Present: Review Panel Members

Mr Ronald ARCULLI Panel Chairman

Mr Jonathan BOYCE

Mr George BO-LINN

Mr Clifton CHIU

Dr C H LEONG (He joined the meeting at around 9:15 am)

Mrs Virginia MONG

Prof Peter YUEN

Doctor Focus Group Members

Dr AU YEUNG Tung Wai (Senior Medical Officer, Tuen Mun Hospital)

Dr CHAN Kin Sang (Chief of Service (Pulmonary & Palliative Care), Haven of Hope Hospital)

Dr CHAN Wai Ling (Medical Officer, Alice Ho Miu Ling Nethersole Hospital)

Dr CHAU Tai Nin (Medical Officer, Princess Margaret Hospital)

Dr James HO (Medical Officer, Queen Mary Hospital)

Dr LEUNG Ka Lau (Senior Medical Officer, Prince of Wales Hospital)

Dr MOK Yun Wing (Consultant, Kowloon Hospital)

DR C K NG (Medical Officer, Queen Elizabeth Hospital)

Dr SO Kit Ying (Medical Officer, Alice Ho Miu Ling Nethersole Hospital)

Dr WONG Tak Cheung (Chief of Service (Medicine), Tseung Kwan O Hospital)

Dr WUN Yiu Chung (Senior Medical Officer, Tuen Mun Hospital)

Dr YAM Man Ching (Senior Medical Officer, Prince of Wales Hospital)

In attendance: Mr CHEUNG Chor Yung — Moderator

Mr Rob Burns

Mrs Helen Poon — Secretary

Opening remarks

Mr Ronald ARCULLI welcomed members of the doctor focus group to the meeting. He introduced members of the review panel to the group and invited group members to express their views freely on the Hospital Authority's (HA) management of the SARS outbreak. He added that views collected would help the organization to improve its services and facilities in preparation for future outbreaks.

2. Mr CHEUNG Chor-young explained to members the ground rules of the meeting and invited them to share their views and opinions in a concrete way on major issues in the management of the epidemic:

Discussion

3. At Mr Cheung's invitation, members of the doctor focus group made the following comments and suggestions on the Government and HA's management of the SARS outbreak:

Overall management

(a) Both the Government and HA had under-estimated the seriousness of the situation at the outset. They just hoped that luck would come and the outbreak would die down by itself. No action was taken at the start: hospitals were not closed, visiting was not stopped, masks were not worn in order not to invoke fear in the community. This attitude must be changed in the management of future outbreaks.

(b) The management deliberately played down infection in the community at the early stage. Though there were 37 patients infected from the community on 16 March, they were not reported in the press release which only included the number of healthcare workers infected.

(c) The infection curve of Hong Kong was longer than that of the neighbouring areas such as Beijing and Singapore. This was due to its accident and emergency admission policy where excessive patient load for a hospital was not diverted to other hospitals. As a sudden large increase of patients at a hospital could increase the risk of staff infection, which could in turn lead to infection in the community, patient load beyond a hospital or cluster's capacity should be diverted to hospitals of the other clusters. However, the management was not flexible enough in managing the patient flow. When Princess Margaret Hospital was overloaded with patients, there was no mechanism to stop admission to the hospital.

(d) There should be contingency plan for future outbreaks. Capacity of each hospital and logistics of the patient flow should be carefully worked out.

Staff management

(a) There was a general feeling that there was not enough support from the management to the frontline in the fight against the epidemic. Seniors had not been caring enough to their juniors and there were complaints that the infected staff were not visited by their supervisors. Provision of personal protective equipment was also not adequate.

(b) Upon being designated as the SARS hospital, Princess Margaret Hospital had to clear its wards and admit hundreds of patients in a very short time. With no additional manpower, staff had to work under immense pressure and the patient load was beyond what they could cope. The problem was reflected to the management but not much improvement was made. With the number of healthcare workers in the Intensive Care Unit coming down and the increasing number of intensive care wards being opened, there were not enough intensive care nurses and doctors to man the Intensive Care Unit of the hospital although staff from different disciplines including Obstetrics & Gynaecology, Psychiatry, etc, were later deployed to the hospital's Intensive Care Unit.

(c) Not enough psychological support was offered to staff who had to work under immense pressure and fear and could not go home for fear of cross infection to family members.

(d) Training for staff was in general not adequate and forceful enough. Volunteers getting into the Intensive Care Unit started work only after 1 lesson of training. Some of them were surgeons, some were psychiatrists and some pathologists. Insufficient training made them very vulnerable to infection.

(e) Appropriate staff should be assigned to appropriate work. In managing SARS, respiratory specialists should take the leading role. However, it was known that in some hospitals, the work was not led by respiratory specialists. Some seniors in respiratory medicine even took leave during the war time period. This had set very bad examples for others and Head Office should play a coordinating role and set out policies to address such issues.

Infection Control

(a) The management should conduct investigation into every single case of staff infection as even the infected staff themselves might not know the cause of infection. Such investigation could only be conducted with the support of the necessary data which could only be obtained with the management's authority.

(b) There should be a systematic way to capture information on staff infection in future. As for the past infections, review might have to be done based on memories as there had not been standardized way of capturing such information. Even so, review on staff infection would be useful.

(c) There had been no central guidelines on infection control. When Princess Margaret Hospital started to admit patients, the hospital staff there had to find their own way to get a copy of the Prince of Wales Hospital guidelines themselves. When guidelines were available, they differed among experts. Different guidelines were issued, sometimes through the Cluster Chief Executives and sometimes through the Infection Control Officers, causing confusion amongst staff. Besides, the guidelines were only put on the intranet. This would only be helpful to those people using computers. As infection control measures should be made known to all frontline staff including ward attendants

who did not use the computers, communicating the guidelines mainly through the intranet would create compliance problem.

(d) There should be central policy on infection control to be complied by all hospitals which could be modified at hospital level to suit local situations. The system of accountability was very important in the effective implementation of infection control policy. Each hospital should appoint one subject officer to be held accountable for the infection control system in the hospital.

(e) To improve infection control, staff awareness on the need and measures for infection control would need to be raised.

(f) It was noted that 9 acute hospitals would be funded for modification works to improve their infection control facilities. As there were altogether 14 hospitals admitting SARS patients, that only 9 hospitals were funded for such modification work was unfair to the rest of the hospitals.

Personal protective equipment

(a) HA had not been offering adequate protection to its staff. Since there was little scientific evidence on what was needed with regard to personal protective equipment at the beginning, the highest protection should be provided to staff. When more information was known about what was actually needed, staff could then gear down. However, the management had done the opposite. Only low grade protection was provided at the beginning and staff were then asked to gear up. The management's response to the actual situation was always slow.

(b) There was no guideline on personal protective equipment and staff did not know what to do. A single guideline on the basic standard should be set for hospitals, allowing fine adjustments by hospitals to suit local situations.

(c) There was not enough supply for personal protective equipment. Protective gowns had to be reused and there was no additional supply even after continuous requests. The issue was raised at the staff forum but no improvement was made.

Communication between management and staff

(a) Top management held meetings on daily basis. Information was then disseminated through minutes, memos and emails. The management did not spare their time to go down to the wards to see what was actually happening.

(b) There were not enough channels for the frontline to reflect their views to the management and administration. A more effective communication network would need to be established. That the frontline staff had to complain to the media reflected badly on the Authority in its communication with staff.

Visiting policy

(a) The 'no visiting' policy should have been announced and implemented earlier. The issue of visiting had created a lot of conflicts between healthcare workers and visitors.

Role of Head Office

(a) In times of crisis, there should be strong central control to over-ride different interests amongst clusters. This mechanism should be worked out by Head Office.

(b) Head Office should have a central coordinating role in manpower deployment and in matching people to work. In the SARS outbreak, this function was not properly performed.

Other comments

(a) A member of the focus group, who had got infected, reported that the information contained in the statement on how she got infected for submission to the Labour Department for report of injury on duty was not correct. According to her, she had not been contacted by the writer of the statement and did not know where he got the information. As this was outside the purview of the panel, this member was advised to contact the HA Chairman direct if needed.

Concluding remarks

4. Mr Ronald ARCULLI thanked members of the group for their valuable input and sharing. Members having further feedback could forward it to the review panel through written submissions.

5. There meeting ended at 10:30 am.

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and a Nurses Focus Group
held on Saturday 12 July 2003 at 10:30 a.m.
in Room 204S, 2/F, HA Building, 147B Argyle Street, Kowloon

Present : Review Panel Members

Mr Ronald ARCULLI, GBS, JP Panel Chairman

Dr Jonathon BOYCE

Dr George BO-LIN

Mr Clifton CHIU

Dr C H LEONG, GBS, JP

Mrs Virginia MONG

Professor Peter YUEN

Nurses Focus Group Members

Ms Angela LAM
Nursing Officer, Caritas Medical Centre

Mr LUI Hing-pui, Michael
Enrolled Nurse, Kwong Wah Hospital

Mr Peter H WONG
Nursing Officer, Princess Margaret Hospital

Mr Danny KONG
Nurse Specialist, Princess Margaret Hospital

Mr LO Wai-kit
Registered Nurse, A&E, Prince of Wales Hospital

Ms CHENG Hang-kam
Ward Manager, Pamela Youde Nethersole Eastern Hospital

Mr CHAN Kong-yeung
Nursing Officer, Queen Elizabeth Hospital

Miss Cecilia SO
Nursing Officer, Queen Mary Hospital

Miss SIU Kwai-fung, Betty
Ward Manager, Tseung Kwan O Hospital

Mr Hilton LING
Department Operations Manager, Tuen Mun Hospital

Mr Poon Tak-fai, William
Senior Nursing Officer, United Christian Hospital

Miss CHOW Pik-chi, Peggy
Deputy Ward Manager, Wong Tai Sin Hospital

In attendance	:	Dr Billy HUNG	Moderator
		Mr Rob Burns	
		Miss Constance CHEN	Secretary

Opening Remarks

Mr Ronald Arculli welcomed members of the nurses focus group to the meeting. He explained that the purpose of this meeting was to listen to views and experience of frontline staff with a view to helping the Hospital Authority's (HA) management improve its services and facilities in preparation for handling future epidemics. He invited members to freely express their views, comments and suggestions for improvement.

2. Dr Billy Hung explained the ground rules for the meeting. It was noted that some members of this focus group were representatives of staff associations or unions whilst some were individual members nominated by their respective hospitals. Members of the focus group expressed their wish for the review to be conducted in an open and independent manner. Mr Arculli shared this view and assured the focus group that the Review Panel would fully note all their views and comments.

Discussions

3. At Dr Hung's invitation, members of the nurses focus group made the following comments and suggestions on various aspects of SARS management:

Communication

(a) At the early stage of the outbreak, internal communication within hospital was a bit slow. Staff of A&E of Prince of Wales Hospital first learned of the large number of staff infected from the newspapers or television programme. Frontline staff received instructions that all staff members were required to wear masks about 4 or 5 days later. Infection control measures were carried out in the affected wards but precautionary measures were not taken immediately in other wards.

(b) The HA Head Office had not issued any formal Operation, Administration or HR Circular on operational guidelines during the SARS crisis, e.g. on leave arrangement, manpower deployment, etc.

(c) Infection control guidelines were promulgated in the intranet website and disseminated through e-mails. Many frontline staff did not have e-mail facility or access to the intranet and most supporting staff did not have the language proficiency or the time to read and digest the guidelines. The department or ward managers had to screen the information received through e-mail and print them out for the frontline staff everyday. The middle managers were under a lot of pressure as they had to shoulder this additional workload and some of them were being criticized for selectively summarizing and reproducing information obtained from various sources when frontline staff compared information and spotted variations in the infection control checklists adopted in different hospitals and/or departments. Better coordination by HA Head Office is required in this respect.

(d) There was proliferation of information, with guidelines promulgated by HA Head Office, hospital and department management at the same time, causing confusion to frontline staff. Different hospitals and departments had different practices in infection control. Better co-ordination and leadership was required.

(e) The newsletter "Battling SARS Update" provided information on various practices in different hospitals. The information could be better organized.

(f) The confusion in communication of information at the initial stage of the outbreak was understandable as SARS was a new disease and its characteristics and ways of infection unknown. The management should learn from experience.

(g) Sharing of information amongst hospitals could be improved. Kwong Wah Hospital received and treated one of the earliest SARS case. Before this case, the SARS experience in Guangdong province was already mentioned in the newspapers. The relevant experience could have been shared amongst HA hospitals. Experience of Prince of Wales Hospital in treating SARS patients could also have been shared with other hospitals. The fact that some staff learned of the SARS experience from newspapers and posted the relevant clippings in the ward for reference by other colleagues reflected that the management could have improved internal sharing of information.

(h) Many instructions on SARS management e.g. those on manpower redeployment and allocation of resources, were given by the hospital management verbally, not followed up by any formal written guidelines. Verbal instructions were also changed from time to time, giving staff the impression that the management formulated their guidelines based on their own subjective knowledge.

(i) Staff of Prince of Wales Hospital had reflected to the HK Chinese Civil Servants' Association that staff working in wards adjacent to Ward 8A were not aware of the massive infection in Ward 8A until 2 or 3 days later.

(j) In the middle stage of the SARS crisis, hospital management had made efforts to enhance communication with staff by organising briefing sessions and forums. However, frontline and supporting staff were on shift duty and might not be able to attend these forums. The problems of frontline staff might not be reflected to the management.

(k) Wong Tai Sin Hospital received advice from the cluster management on 27 March 2003 that the hospital would start to receive SARS patients on a full scale. Due to the short notice, a briefing session was immediately arranged for all staff. More advance notice would be appreciated so that hospital staff could be better prepared psychologically.

(l) In Caritas Medical Centre, the Hospital Chief Executive and Chiefs of Service issued messages on updated information on SARS to all staff every day. The department heads summarized the information received from e-mails for all frontline staff.

(m) In United Christian Hospital, the Hospital Chief Executive disseminated updated SARS information to staff through e-mail and hard copies everyday.

Infection Control – Measures, Supplies, Training & Psychological Support

(a) At the early stage of the outbreak, the importance of infection control was not given enough emphasis.

(b) There were different opinions on infection control. Some experts advocated the importance of hand washing whilst some clinicians considered that more should be done.

(c) SARS being a new and highly contagious disease, conventional infection control measures were considered inadequate. When increasing number of staff got infected, frontline staff had doubts on whether surgical masks could provide adequate protection. The senior staff or experts should be able to set a role model and demonstrate to frontline staff that the PPEs they advocated were adequate.

(d) In practical ward environment, some infection control measures were hard to follow, e.g. many hospitals did not have shower facility conveniently located near the wards and the busy schedule of ward staff also made is difficult for them to take shower after every procedure.

(e) Link nurse system was implemented in most hospitals, but ward staff had to be alert and remind each other to follow infection control measures all the time, e.g. washing hands.

(f) Some doctors appeared unhappy when being reminded to wash hands by nurses.

(g) In Tuen Mun Hospital, there was a coaching team, which visited and inspected the SARS wards and rectified errors in infection control on-site.

(h) In Wong Tai Sin Hospital, compulsory infection control training was provided to all staff. The training session was videotaped and shown to all staff who could not attend the training session. Counselling was provided by the social workers and hotline service was available to answer staff queries. Supplies of PPE were arranged by the cluster management and were at times insufficient to meet the hospital's needs. The hospital supplies section always informed the ward in advance and arranged to borrow PPEs from Kwong Wah Hospital to meet urgent need. It was suggested that quantity of PPEs required should not be based on patient ratio but on number of high risks procedures performed and on need basis.

(i) Some nurses transferred to work in the SARS ward did not have ICU background and training. The nurse i/c in ICU had to pay special attention to and coach these nurses.

(j) In some hospitals, fit tests for N95 were conducted. However, the sizes required were not always available. The situation had now improved and more models and sizes were available.

(k) Infection control training should be provided to all healthcare workers including those working in non-ward areas.

(l) A night nurse had reflected to the HK Chinese Civil Servants Association that nurses worked under pressure and constant threat of infection during the SARS period and they had to talk to each other to relieve their stress and sometimes wept in front of each other. They would appreciate it if someone from the hospital management could talk to them directly and listen to their problems.

(m) The SARS experience in Pamela Youde Nethersole Hospital was manageable. The hospital management reacted quickly in response to the changing situation. An infection control team was set up and daily feedback sheet was provided for frontline staff to reflect problems to the management. Staff concerns raised were quickly addressed. Training in the use of equipment was provided and issues of ward environment addressed. During the peak period, supply of N95 was not sufficient and the masks had to be re-used. The situation had improved.

(n) Princess Margaret Hospital handled over 600 patients during the peak period, with over 130 in intensive care. After an increasing number of staff got infected, the hospital could hardly cope with the workload and nurses were redeployed from other hospitals to help out. The hospital management had tried their best to obtain the necessary PPE and equipment.

Manpower and Staffing Issues

(a) Healthcare workers in Tuen Mun Hospital were redeployed to work in the SARS ward based on the result of drawing lots. This is not a good basis for staff redeployment as this easily gives rise to frustration and staff may question its fairness. A better basis for manpower redeployment should be worked out.

(b) Staff redeployed to work in SARS ward did not know how long they had to stay there and looked for job rotation. However, frequent staff rotation would increase the risks of infection. Some frontline staff did not understand this management concern as it was not properly communicated to them.

(c) Before the setting up of HA, nurses were redeployed to various clinical specialties after their graduation to help them gain exposure in different clinical areas and were given some management autonomy after working for several years. Under the new management structure of HA, a nurse could stay in a particular specialty for 10 to 12 years. The lack of a spectrum of clinical and management experience made it difficult for the nurses to face changes during the SARS crisis when required to take care of patients transferred from other wards or redeployed to work in SARS ward.

(d) Since the setting up of HA, the number of doctors and hospital management staff had increased but the number of nurses had not increased in proportion to the increase in patients and service demand. Fortunately, the voluntary early retirement programme had not been implemented for nurses and the experienced nurses were still working in HA during the SARS crisis.

(e) In view of the necessary gown-up and gown-down procedures and stress of handling SARS patients, the shift hours for nurses working in SARS wards should be shortened.

(f) In view of the special circumstances of SARS, the staffing requirement for SARS ward is different from other wards. A manpower indicator for SARS ward should be worked out in due course.

(g) The staff and management of HA should have the courage to admit mistakes, learn from the SARS experience and work as a team in making improvements.

Concluding Remarks

4. Mr Arculli thanked the focus group members for sharing their views and experience. He appreciated the hard work and contributions of HA staff during the SARS crisis and asked the focus group members to convey his message to all frontline colleagues.

5. The meeting ended at 11:45 a.m.

Hospital Authority
NFG\NOTES
11 November 2003

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and Allied Health Professionals
held on Saturday 12 July 2003 at 11:50 a.m.
in the Function Room, 2/F, HA Building, 147B Argyle Street, Kowloon

Present : Review Panel Members

Mr Ronald ARCULLI, GBS, OBE, JP Panel Chairman

Dr Jonathon BOYCE

Dr George BO-LIN

Mr Clifton CHIU

Mrs Virginia MONG

Professor Peter YUEN

Allied Health Professional Group Members

Mr Ray LEE
Clinical Psychologist, Alice Ho Miu Ling Nethersole Hospital

Ms Frances LOUISE
SOT, Alice Ho Miu Ling Nethersole Hospital

Mr CHIA Chi Keung, Luke
Orth I, Caritas Medical Centre

Dr Kitty WU
Clinical Psychologist, Caritas Medical Centre

Miss Florence LEE
MSW DM, Kwong Wah Hospital

Miss FU Tak Yan
PTII, Queen Elizabeth Hospital

Mr LAW Kwok Sing
Rad II, Queen Mary Hospital

Mr CHAN Hung Tat
Rad I, Ruttonjee Hospital

Mr LONG Fuk Cheong
Senior Medical Technologist, Yan Chai Hospital

		Ms May JUNG Dietitian, United Christian Hospital	
In attendance	:	Dr Billy HUNG	Moderator
		Mr Rob BURNS	
		Mr YU Hung Loon	(Secretary)

Opening Remarks

Mr. Ronald ARCULLI welcomed members of the Allied Health Professionals Group to the meeting and urged them to speak out freely and frankly their views on Hospital Authority's handling of the recent SARS outbreak.

2. Dr. Billy HUNG informed members of the ground rules for the meeting. He stressed that this was a fact finding meeting and as such no names would be mentioned unless specifically requested. He then invited members to express their views on the communication aspect of HA's management of SARS. (Two letters, containing comments from Hong Kong Occupational Therapy Association and Hong Kong Clinical Psychologists Association respectively were also tabled at the meeting).

Items Discussed

3. A member pointed out that during the early stage of SARS outbreak, the X-ray Department of PWH faced a serious problem of staff shortage when quite a number of the staff who had been in contact with a suspected SARS patient were forced to take leave in compliance with the 14 days wash out period as required by the hospital management. However, as far as he could gather this information was not released to similar departments of the same cluster. He suggested that in future when unprecedented or unknown situation arose, problems encountered and measures taken should be released to all frontline departments as lessons learnt or at least for experience sharing. The relevant managers could use e-mail as a means of expeditious communication. As far as he knew, this means of communication had not been put to full use during the current outbreak.

4. Another member shared the view and pointed out that there were virtually no cross-hospital communication especially at the middle management and frontline level. The hospital management did try its very best to relay messages from HAHO to its staff through daily meetings, etc, but the communication flow from bottom or frontline upward was poor. The situation might improve if more middle managers were allowed to assist the top management in the decision process.

5. One member echoed the view that transparency was low and not enough information on the disease had been disseminated, especially during the early stage of the outbreak. Many frontline staff were worried about PPEs and their supply. Sometimes hospital management had to wait for guideline from HAHO before issue of PPEs or in addressing other staff concern. This might handicap a prompt response. Staff were also given little psychological support, as a result many had to resort to the media, e.g, radio programmes and newspapers to voice out their concern in the hope

that they might be speedily addressed. To illustrate the lack of bottom to top communication channel, he pointed out that in the past there was a Central Consultative Committee for frontline staff to voice out their sentiments but after the outbreak of SARS no more CCCs were held since 25 March. Staff were thus further deprived of a channel to express their views. Mr. Billy HUNG added that management and resources were two very important issues which would be discussed later and meantime the meeting would concentrate on matters on communication.

6. A member pointed out that during a crisis staff might have both psychological and emotional need and these should not be regarded as irrational or unreasonable. She suggested that clinical psychologists should be involved at an early stage in the top management level to make recommendation on how to address the psychological needs of staff and patients in times of crisis.

7. A member was of the view that there was a big communication gap not only from bottom to top but also from top to bottom. As an example, he said that during the early stage of the crisis, although HAHO had assured adequate supply of PPEs to all hospitals, some middle managers held up some of the supply for fear of future supply shortage, and as a result the frontline staff had to purchase PPEs themselves. This was most undesirable.

8. A members said that in early March, staff learnt from the media that pregnant women were most prone to get infected, but there was no guideline on this aspect from HAHO, and the granting of no pay leave to pregnant staff was left to the discretion of individual managers. It was understandable that middle managers had to rely on guidelines especially at the early stage of this new disease but she hoped this situation could improve in future.

9. On the issue of guidelines, a member pointed out that there was a time where there were too many guidelines originating from HAHO, Clusters and hospitals, especially at the early stage of the outbreak, causing great confusion to the frontline staff. For those frontline staff on shift duty they might even miss some of the guidelines and thus were more confused. The situation was so bad that at a certain stage local management had to ask its staff to pay attention only to the guidelines issued by the top hospital management.

10. A member opined that guidelines should not be too rigid but instead should allow minor modifications to fit different physical situations, such as nature of work of staff, hospital environment, etc. In enforcing strict adherence to HAHO guidelines the local management must be very careful to address staff sentiments at the same time otherwise it might ruin the trust between the staff and the management.

11. Although Mr. Billy HUNG reminded that time was running short the Panel Chairman considered that in view of the diversity of work and the impact of the issue on other topics, there was a need to spend more time on the guideline issue.

12. A Panel member opined that central guidelines were corporate directions and therefore should be followed by all hospitals. Individual desire and preference of staff should not affect corporate guidelines, otherwise there would be different

protocols in a ward. It might even cause confusion on the use of PPEs among the staff in the same ward.

13. One staff member stressed that it was not a question of compliance with the guidelines, but the corporation should treat its staff as reasonable and rational beings and as such respect and take heed to their individual psychological needs and sentiments by allowing modifications to suit actual situations.

14. Another Panel member agreed that for a new disease with constantly new developments the guidelines at the beginning must understandably be arbitrary and modifications could and should be made as time went on.

15. The Chairman considered it difficult to strike a balance between strict adherence to guidelines and psychological need of individual staff. However, he was of the view that if clear and simple guidelines could be issued they should be strictly followed as far as possible.

16. Another member responded that actual site visits to the wards and training were very important factors in the formulation of guidelines. If the guidelines were impractical, they would eventually be disregarded by the local wards and units.

17. A Panel member suggested that each hospital could designate an officer who was empowered to make minor variations depending on local situations to the guidelines issued by the HAHO, which had to be clear and simple in the first place. Other members suggested that more flexibility should be allowed for different professionals in different working locations to design their own guidelines to fit their particular needs.

18. In view of the time limit the Chairman called the meeting to an end at 1:25 pm. He praised the staff for their courage, devotion and dedication shown during the outbreak. He informed members that the conduction of the meeting was geared at the best way to elicit frank comments and views and he believed that the meeting had discussed in great detail some of the key issues. He assured all members present that they were welcome to approach the Panel through arrangement with the Panel Secretary for further discussion and expression of their views.

Notes of Meeting between the Hospital Authority Review Panel on SARS Outbreak and a Supporting Staff Focus Group held on Monday 14 July 2003 at 8:30 a.m. in the Function Room, 2/F, HA Building, 147B Argyle Street, Kowloon

Present :

Review Panel Members

Mr Ronald ARCULLI Panel Chairman

Mr Clifton CHIU

Mrs Virginia MONG

Prof Peter YUEN

Supporting Staff Focus Group Members

Miss LAM Lai-fong, Workman
(Princess Margaret Hospital)

Mr LAM Wai-seng, Workman
(Prince of Wales Hospital)

Miss LEE Wong-chuen, Workman
(Pamela Youde Nethersole Eastern Hospital)

Mr LEUNG Shou-ki, Health Care Assistant (Wong Tai Sin Hospital)

Miss LI Shui-yi, Health Care Assistant
(Princess Margaret Hospital)

Mr TANG Tak-ho, Ward Attendant
(Tuen Mun Hospital)

Miss TONG Ying-wah, Health Care Assistant
(United Christian Hospital)

Mr YU Po-kwan, Patient Transfer Assistant (Princess Margaret Hospital)

In attendance :	Mr CHEUNG Chor-yung	Moderator
	Ms Joanne LEUNG	Secretary

Opening remarks

Mr Ronald ARCULLI welcomed members of the support staff focus group to the meeting and introduced the composition of Review Panel. The purpose of these meetings with patients and various disciplines of staff was to listen to the views of those who had direct experience in the incident. Their views together with the facts collected would facilitate a thorough review on the Hospital Authority's (HA) management of the disease and to enable HA better prepared for future outbreaks.

2. Mr CHEUNG Chor-yung asked for members' consent for the discussions to be taped and members agreed. He invited members to speak freely and frankly about what they encountered and issues they wished the Panel to know in their respective posts during the outbreak, and in their opinions, what could be done for future improvement. Members should not feel inhibited if they had views different from the others.

Discussions

3. At Mr CHEUNG's invitation, members of the supporting staff focus group made the following comments and suggestions:

Infection Control

(a) When staff were deployed to work in other areas such as the ICU in late March, they were not clearly briefed beforehand. They just told to report for duty and followed nurses' instructions. Everything happened so abruptly and quickly. Panic and chaos prevailed and no one seemed to be responsible for overall control. Staff likened the situation as working in hell as they knew there was no cure for the disease. Some of them used self-purchased PPE for ease of mind. When the situation was reflected to the management a couple of days later, staff began to receive concrete guidelines from above and sufficient supply of PPE was ensured. Infection control measures were gradually in place. In Princess Margaret Hospital, PPE supply was quite adequate.

(b) The vigilance of linen staff had been low as they needed not go into wards. As a standard practice even before SARS happened, they needed to put on PPE such as masks, gloves and goggles for handling dirty linen. In mid-March workmen in the laundry of Prince of Wales Hospital as usual received linen in red bags denoting high risk. But since then the linen came in unusually large volume. They did not know the reason. They were told to soak the linen in water with bleaching agent added (1:49) for half an hour first but without being informed what exactly was going on. Their supervisor did tell them to wear full sets of PPE. When the large volume of linen kept pouring in and stacked in heaps, they had to seek the help of outside contractors. But washed linen was not returned in a timely manner. They needed to keep reminding the contractors to return the clean linen which included the working clothes for healthcare workers themselves. Work was hectic. Later staff were briefed every day after 5 p.m. informing them to alter some of the work procedures, such as using hot water over 80 degrees and washing hands frequently.

(c) In some old-styled laundries such as Chai Wan Laundry where ventilation was poor, although ventilation works had been done in recent years, the availability of PPE such as N95 masks served little practical purpose because of the high temperature there, and the wearing of protective gowns would mean being steamed up. The distribution of PPE might just be wasteful. Members suggested it would be far more practical if sterilization could be thoroughly done on dirty linen in wards before sending it to the laundry and special caution was exercised during the delivery process to ensure safety of staff. There were also not enough carts for delivering linen in some hospitals and the same cart would be used to transport dirty and then clean linen at different times.

(d) Cross infection control measures were inadequate for patient transfer workers when a whole batch of staff would board an ambulance to transfer SARS patients with stable conditions to Wong Tai Sin Hospital for rehabilitation. Staff worried they would be infected. Fear and confusion prevailed at the time. Supervisors sometimes queried them for cleaning the ambulance too often and asked them to do one more round of delivery instead. Although the PPE of a hospital might be sufficient, people in the middle management might hold up the stock, e.g. a N95 mask would have to be used for a month. After views were reflected, patient transfer arrangement was improved with less staff boarding the ambulance

and PPE supply was enhanced. Gradually more guidelines and instructions began to reach the staff via the Infection Control Team.

(e) Members suggested that although SARS had subsided, all staff should be given a set of PPE for their own retention for use at any time as the situation warranted, as some patients might have cryptic presentations and they were constantly exposed to such threat.

Training

(a) Hitherto for supporting staff in wards, there had been insufficient training for them. At the early stage, staff resorted to their own means of protection in order to safeguard themselves. Guidelines only came up later to facilitate their learning.

(b) Training for contract staff, especially those working in wards, was very inadequate. They were seldom released to attend training for operational reasons. Just at $6,000 on contract terms, HA seemed to be satisfied with anyone willing to work in wards and little training would be provided. Not equipped with proper infection control knowledge, and without a sense of belonging, many of them resigned during the outbreak for fear of losing their lives.

(c) Training for staff in the middle management such as nurses and foremen, needed to be stepped up for effective communication with the supporting staff and enhanced infection control knowledge.

(d) In some hospitals, staff needed to stay behind after work to receive compulsory training, in some other hospitals, staff had training 2-3 times since the SARS outbreak. Members generally felt that HA had stepped down staff training activities in recent years.

Communication

(a) The culture of "nothing will go wrong if you do nothing" was prevalent in the management. They would provide little information and explanation. As such, they had a tendency of not initiating anything until there were guidelines from above and the central management. However, once certain guidelines were promulgated, they would expect the staff to comply fully with them without perceiving the actual difficulties involved. Even when the staff had

done a great job, they would seldom express appreciation and just took it for granted.

(b) Communication between the supporting staff and their supervisors was inadequate and there was no clear and detailed explanation given. Staff were often just told to go right-away and do the job, follow what the others did, or just to be careful and use PPE as far as possible, the rest would have to be taken care by themselves .

(c) Staff often received messages and information from the radio and TV instead of from their own hospital. Internal information flow within a hospital was inadequate. For example for workers responsible for receiving patients in wards, if prior information about the sorts of patients to be admitted could be provided, they could get psychologically and materially prepared so as to work more effectively. In the course of work, everything seemed to be in a hurry and on the move, and there was little time for them to think and ponder.

Staff establishment

(a) A difference in the mentality of contract and permanent staff was noted. During the outbreak, some of the contract staff resigned in view of the great danger because they did not want to risk their lives. For permanent staff, they had a greater sense of belonging and commitment to their work, and thus would stand fast at their posts. Permanent terms of employment would give rise to manpower stability. Knowledge and skills needed to be accumulated. If there was another outbreak in future, trained permanent staff would be better equipped to handle it and danger might be kept down. For contract staff with employment for one year only, training had to be repeatedly organized for them. When there was an outbreak, they might not have the experience to handle such an incident and this would lead to greater danger.

Work support and environment

(a) Of the 6 HA staff died from SARS, 50% were HCAs. There was a small number of irresponsible nurses who did not do their duty well. For unknown reasons such as fear, laziness, being busy with other work or whatsoever, they would leave the ward after giving instructions and let HCAs handle the high-risk procedures alone such as wrapping up of dead bodies

and feeding patients after just being extubated. HCAs should work under guidance and with assistance in some of the high-risk procedures. Such phenomenon existed before SARS happened and SARS exemplified the problem. But it should be pointed out that this was only limited to a small number of nurses.

(b) When wearing PPE to perform work (mostly manual work) in wards, staff would become wet through soon, not to mention those working in old-typed laundries. But at the same time for patients' comfort, the temperature of the air-conditioners in wards could not be set too low.

(c) Dirty linen bags in wards were inadequate and staff had to constantly ask for replenishment.

(d) Lockers originally intended for staff use were relocated to quarters provided for staff working in SARS areas. The requests for quarters of some of the staff were not met.

Staff sentiments

(a) Panic and fear struck the staff at the early stage and they all resorted to their own means of protection. However, in the performance of work at the forefront, members witnessed that their fellow workers were generally very dedicated. Many of them worked on Sundays without complaint (with compensation leave) and tried to avoid creating extra workload for other healthcare workers. Albeit there was confusion at times, team spirit among their fellow workers was notable.

(b) Staff cooperation was also notable in the ICU of UCH. Deployed workers were adequately briefed and supervised. Training on PPE, work instructions and quarters were provided. PPE was especially sufficient for workers in the ICU and so the staff there maintained a high level of vigilance. HCAs worked under the guidance of nurses and the situation was not that disorderly.

Concluding remarks

4. Mr Arculli thanked the focus group members and their fellow colleagues for their unreserved contribution and exceptional act of devotion during the outbreak. Members had provided useful inputs to the Panel and he undertook to convey their views to the Board.

5. The meeting ended at 10:12 a.m.

Hospital Authority
15 July 2003

Notes of Meeting between
the Hospital Authority Review Panel on SARS Outbreak
and Administrative, Supervisory, Clerical & General Focus Group
held on Monday 14 July 2003 at 10:20 a.m.
in Room 204, 2/F, HA Building, 147B Argyle Street, Kowloon

Present : Review Panel Members

Mr Ronald ARCULLI Panel Chairman

Mr Clifton CHIU

Ms Virginia MONG

Prof Peter YUEN

Administrative, Supervisory, Clerical & General Focus Group Members

Mr CHEUNG Chun-wai
Supplies Assistant
Queen Elizabeth Hospital

Mr Sherwood KWOK
Senior Hospital Administrator (Supporting Services)
Princess Margaret Hospital

Mr Aven LEE
Hospital Administrator (Facility Management)
Prince of Wales Hospital

Mr Benjamin LEE (General Manager (Administrative Services)
Tuen Mun Hospital

Ms Fion LEE
Senior Hospital Administrator (General & Patient Services)
Pamela Youde Nethersole Eastern Hospital

Mr LEE Lop-man
Senior Hospital Foreman
Queen Mary Hospital

Ms MAK Yim-lan
Ward Steward
Queen Elizabeth Hospital

Mr Desmond NG
Cluster General Manager
(Business Support Service & Capital Works)

Queen Mary Hospital
Mr Kevin WONG
Senior Manager (Human Resources)
Queen Elizabeth Hospital

Absent with : apologies
Mrs Grace LEUNG
General Manager (Administrative Services)
United Christian Hospital

In attendance :
Dr Billy HUNG (Moderator)

Mrs Cecilia LAM (Secretary)

Manager (Board & Committees) 2

Opening Remarks

Mr Ronald ARCULLI welcomed members of the Administrative, Supervisory, Clerical & General focus group to the meeting. He explained the purpose of this informal meeting was to collect comments on HA's management of the disease with a view to helping the organization improve its services and facilities in preparation for future outbreaks.

2. Dr Billy HUNG informed members of the ground rules for the meeting and invited them to share their views on HA's management of SARS with reference to the Terms of Reference of the Review Panel, in particular management of hospital services in terms of internal and external communication, supplies and materials management, and human resources management.

Discussions

3. At Dr Hung's invitation, members of the Administrative, Supervisory, Clerical and General focus group made the following comments and suggestions on HA's management of the SARS outbreak:

Internal Communication

(a) During the initial period of outbreak, internal communication among HA hospitals was not satisfactory, particularly in terms of personal protective equipment (PPE). In early April 2003, when staff of Queen Mary Hospital (QMH) saw that the staff of Prince of Wales Hospital (PWH) were equipped with whole set of PPE, including the

"Barrier-man" jumpsuit, they immediately requested for similar equipment to be provided. Insufficient internal communication was seen on this issue as it was known through unofficial channel that the "Barrier-man" jumpsuit was only used on a trial basis. After some of QMH's doctors had tried wearing the "Barrier-man" jumpsuit themselves, they realized that it did not serve the purpose of protection. In fact, there was greater chances of infecting themselves as well as others when the "Barrier-man" was taken off. Dr Seto, head of infection control at QMH, issued circulars to all staff daily on proper infection control measures, including the danger of wearing too much PPE. There was sufficient PPE but there was no clear information on the proper use of PPE among HA hospitals during the initial period of SARS outbreak.

(b) Dissemination of SARS related information at Princess Margaret Hospital (PMH) varied at different stages of SARS outbreak. The communication process improved gradually and Battling SARS Update information was conveyed to staff through channels such as Hospital Chief Executive's forum. Middle managers received a lot of SARS related information while some staff of large clinical departments such as the Department of Medicine still did not seem to be fully updated on the latest information. Internal communication among HA hospitals was much improved after the issue of "Battling SARS Update".

(c) HA Head Office did not coordinate with hospitals on issue of common standards on PPE. Clusters had their own practices.

(d) Due to lack of understanding of wearing proper PPE for different procedures, some staff would be upset when they were informed to step down their PPE such as to discontinue the wearing of "Barrier-man".

(e) It was much faster for individual clusters in updating their PPE and infection control standards than reaching a common consensus among all clusters on these issues.

(f) There were no common standards on ward environment even now. It would be better to have clear common guidelines on the important aspects of SARS such as ventilation, PPE, infections control and treatment protocols before future outbreaks as staff would feel that they would be properly protected.

(g) On learning that PWH's staff had "Barrier-man" protection, the first reaction of some colleagues at Queen Elizabeth

Hospital was to ask for provision. However, after some of the colleagues had actually worn it at work, they found it too hot and impractical. Various PPE items were provided to staff such as goggles but they became misty after wearing them for a long time. Wiping misty goggles would pose higher risk of infection. It would be better if tests could be done to ensure that certain PPE items were suitable before including them in the guidelines.

(h) There should be better communication with cluster eg Clusters were still not certain or whether cost for PPE after SARS would be from the central or hospital budget.

(i) Internal communication should be improved as guidelines from management level did not quite get down to the working level. The views of low-ranking staff should also be adopted as they were the ones experiencing the actual working situations. Cooperation among staff of different wards should be improved as better coordination would be beneficial to patient service and staff morale.

(j) The more channels to facilitate internal staff communication, the better. At PYNEH, minutes of SARS related meetings would be issued to all department managers and relevant extracts would be posted onto the hospital's homepage to keep staff updated on the latest situation. PPE coordinators and infection control patrol teams collection views from staff without revealing their identity help in internal communication.

(k) Some of line managers had done well in internal communication on PPE and infection control during the SARS outbreak. Their achievement should be recognised.

(l) As internal communication improved day by day, the number of staff attending the daily forum in QEH decreased because they had already received a lot of information through various channels. In future outbreaks, communication should be more proactive right at the beginning and throughout the whole period.

External communication

(a) As SARS outbreak impacted upon everyone at that time, media naturally put top priority and great resources on reporting all SARS related information. As SARS was an unknown disease at that time, medical experts did not have common views on the sources of infection and treatment protocols. As various media reported different HA's experts' views, the public found it confusing. The external

communication could have been better if HA Head Office could be proactive to coordinate with all medical experts and come to a common understanding on some of the aspects that would be issued to the media.

(b) HA Head Office had an expert panel advising on various issues during SARS outbreak but there was no common consensus on those issues such as PPE. Some staff therefore aired their grievances through media. Actually it was important to take care of the staff's emotional conditions at that time. It was acceptable to have common minimal standards on the important issues and allow variations among hospitals as situations were not the same. For example, surgeons at Pamela Youde Nethersole Eastern Hospital (PYNEH) had worn "Stryker T-4" overall protective clothing despite expert did not agree on such a need.

Infection control

(a) Infection control standards varied among HA's hospitals. Hospitals such as QMH had implemented more advanced infection control measures as they had infection control expertise. There were updates or changes to infection control measures but there were no updated standardized infection control measures among HA hospitals.

(b) There were different standards in ventilation even now, for example, Hepa filters were used in all hospitals except Hong Kong West Cluster.

Supplies and materials management

(a) After HA Head Office had taken over the procurement of PPE, there was very short notice on delivery of PPE items, making it difficult for deployment of staff and allocation of storage space. As manpower had been reduced to a bare minimum, the supplies and materials management staff of Kowloon Central Cluster had gone through a very difficult time. There was concern on whether additional manpower support would be provided at future outbreaks.

(b) After HA Head Office had taken over the procurement of PPE, Business Support Services had set up a SARS control centre with 7 sub-centres coordinating the procurement and supply of PPE for 7 clusters. As there was a global surge of demand for PPE items, delivery of goods was made to hospitals without advance notice whenever stocks were available. Hospitals had problem in arranging manpower to receive the stock and allocate storage.

(c) The good practice of delivering PPE supplies outside, instead of inside the wards, in hospitals such as QMH and PMH should be shared by other hospitals as this would minimize the delivery staff's risks of infection as well as lessen their workload. Such good practices should be disseminated through internal communication channels such as "Battling SARS Update 抗炎日訊 ".

(d) The Cluster Chief Executive of Hong Kong West cluster was kept informed of daily utilization, stock level and supply status of various PPE items. Standards of provision of various items for various categories of staff according to job nature had been agreed with section heads and appropriate demand for PPE was projected accordingly. As the front-line staff were assured of sufficient supply of PPE, they would not worry about its shortage. This would help allay fear and worry of some staff on shortage of PPE supply. As a result, they might not need to convey their grievances through the media.

(e) There should be standardized guidelines on PPE for staff performing different procedures to reduce discontent among staff due to different practices of ward managers.

Human resources

(a) There should be additional manpower support for supplies and materials management during future outbreaks as the implementation of total solution initiative had reduced staff to a bare minimum of 8 persons handling all the procurement and supply work for the whole Kowloon Central Cluster.

(b) Before SARS outbreak, temporary workers of PWH protested against their contract not being renewed. During SARS outbreak, some contractors' workers resigned for fear of getting infected as they did not have a sense of belonging to the hospital.

(c) Focus had mostly been on professional training and development of professional staff such as doctors and nurses. More resources should be allocated to training on organizational development and alignment of core values with those of the corporate values of HA.

(d) Human resources managers had not been able to play a strategic role in hospital management.

Closing remarks

4. Mr Arculli thanked the focus group members for their experience during the SARS outbreak and assured them that their views would be taken into consideration in formulating the Panel's conclusions. He explained that the Panel would complete its work in the coming weeks and report its findings and recommendations to the HA Board in early September 2003.

5. The meeting ended at 12 noon.

Hospital Authority
CL/mw

Notes of Meeting of the
Hospital Authority Review Panel and Frontline staff of
Princess Margaret Hospital on SARS Outbreak
held on 11 July 2003 at 11:00 a.m. in the Conference Room of Princess Margaret Hospital

Present:	Mr Ronald ARCULLI, GBS, OBE, JP	Chairman	) Review Panel
	Mr Clifton CHIU	Members	)
	Dr George BO-LINN		)
	Dr Jonathan BOYCE		)
	Mrs. Virginia MONG		)
Absent with apologies:	Dr C H LEONG, GBS, OBE, JP		)
	Professor Peter YUEN		)
Present:	Dr LAW Chun-bong		) Frontline Staff of
	Dr LEUNG Chi-wai		) Princess Margaret
	Dr HUI Yim-wo		) Hospital
	Dr CHOI King-wing		)
	Dr CHIU Ming-chee		)
	Dr LIU Pak-ling		)
	Dr CHOW Kam-ming		)
	Mr Philip CHOI,		)
	Ms Betty LAM		)
	Mr Danny TONG		)
	Ms Pamela CHAN		)
	Mr Andrew WONG,		)
	Ms Sandy HO		)
	Ms LI Hoi-fung		)
	Ms SIU Suet-mei		)
	Ms FOK Miu-chi		)
	Ms LI Tsz-ping		)
	Ms WONG Chau-man		)
In attendance:	Mr. Banny Wong (Secretary)		

Opening Remarks

Mr. Arculli welcomed staff members of the Princess Margaret Hospital (PMH) to the meeting and expressed heartfelt appreciation for their selfless contribution during the SARS outbreak. He explained that the purpose of the hospital visit was to collect information on how the hospital managed the SARS outbreak with a view to help Hospital Authority to improve its services and facilities to tackle similar future outbreak.

Discussions

2. At Mr. Arculli's invitation, staff members of the PMH made the following comments and shared their experience during the SARS outbreak.

Designated Hospital for SARS

(a) PMH was not ready to be the designated centre for all suspected SARS cases referred by Department of Health (DH). Before March 26, PMH was able to take care of its SARS patients in its isolation wards and negative pressurized ICU units. However, after PMH became the SARS referral centre of DH, the hospital experienced shortage of facilities and manpower to cater for the sudden surge of patients.

(b) The ICU facilities were not able to expand to meet sudden increase in demand for services. There was inadequate time to deploy experienced and qualified nurse, set up equipment and tighten up the infection control measures. Owing to inadequate ICU facilities, the SARS patients were admitted to general wards though they were highly infectious, thus increasing the possibility of cross infection.

The Treatment Process

(a) The management has exerted pressure to influence the physicians to start early use of steroid in treating patients. Some doctors felt that their professional autonomy was affected to some extent.

(b) Different kinds of treatment methods had not been sufficiently explored and considered. Some physiotherapists considered that some patients could be given instructions on breathing exercise and intubations might not be necessarily. The allied health staff should be suitably consulted in the treatment of SARS patients.

(c) Hospital Authority was not proactive in rehabilitation services. Some patients complained to the radio broadcast about the lack of support in rehabilitation services. The whole team of physiotherapists was transferred out of Wong Tai Sin Hospital in which many in-patients were there waiting for their rehabilitation services.

Infection Control

(a) At the early stage of SARS outbreak, nursing and allied health staff were not aware of the infection control procedures against SARS. They complained that Hospital Authority and the hospital management had not provided them with information on correct infection control procedures against SARS. They had to turn to their colleagues and friends in other hospitals to learn about the protection and precautionaries measures.

(b) PMH staff pursed precautionary information through e-mails, ex-colleagues and friends of other departments and hospitals since they did not receive sufficient information from hospital management.

(c) The protection guidelines issued by Hospital Authority were not clear and kept changing, for instance, the gown-up and gown-down procedures were revised repeatedly and staff felt confused.

(d) Some staff were not fully aware of the risk at the early stage of the break and felt the risk was over exaggerated. As a result, they had not protected themselves and others adequately. Until the mass outbreak in Alloy Garden, those staff were suddenly aware of

the crisis and were frustrated. Hospital Authority should have improved communication of the disease to staff concerned and provided them with the correct information.

Personal Protective Equipment

(a) Staff were provided with sufficient personal protective equipment (PPE), viz. gown, mask and goggles.

(b) However, some of the staff had no knowledge on how to use PPE correctly e.g. goggles, facial masks. They were confused on which particular types of masks could provide sufficient protection.

(c) Staff were satisfied that the hospital management allowed them to use their own PPE.

Dissemination of Information

(a) Staff were disappointed that communication was not effective. They did not receive instructions and guidelines about SARS from Hospital Authority as expected. The guidelines received kept changing and were difficult to trace.

(b) Since SARS was a highly contagious disease with a lot of unknowns, staff had to work under stress and experienced severe emotional challenge. However, Hospital Authority could not provide adequate emotional support in time.

Concluding Remarks

3. Mr. Arculli thanked the hospital staff for their efforts in fighting the SARS and their contribution to Hong Kong. He welcomed the staff to contact the Review Panel if there was further information or comment.

4. The meeting ended at 11:40 a.m.

Hospital Authority
Hospital Visit Notes
15 July 2003

Notes of Meeting of the
Hospital Authority Review Panel and Frontline staff of
Prince of Wales Hospital on SARS Outbreak
held on 11 July 2003 at 1:20 p.m. in the Conference Room of Prince of Wales Hospital

Present:	Mr Ronald ARCULLI, GBS, OBE, JP	Chairman	) Review Panel
	Mr. Clifton CHIU	Members	)
	Dr George BO-LINN		)
	Dr Jonathan BOYCE		)
Absent with apologies:	Dr C H LEONG, GBS, OBE, JP		)
	Mrs Virginia MONG		)
	Professor Peter YUEN		)
Present:	Dr Yam Man Ching		) Frontline Staff of
	Dr Vincent Wong		) Prince of
	Tam Man Yee		) Wales Hospital
	Dr Tam Lai Shan		)
	Dr Justin Wu		)
	Dr Li Wah		)
	Mak Kin Shing		)
	Ms Lam Yan Ha		)
	Ms Alana Nip		)
	Kwok Ho		)
	Celestina Luk		)
	Ms Dora Lam		)
	Ms Ma Sau Lai		)
In attendance:	Mr Banny Wong (Secretary)		

Opening Remarks

Mr. Ronald Arculli welcomed staff members of the Prince of Wales Hospital (PWH) to the meeting and expressed his appreciation for their selfless contributions and hard work during the SARS outbreak.

Discussion

2. At Mr. Arculli's invitation, the staff members of various disciplines made the following comments and suggestions on the Hospital Authority management of SARS outbreak:

Infection Control

(a) Some PWH staff were seconded to Tuen Mun Hospital (TMH) and Princess Margaret Hospital (PMH). They were surprised that the hospital staff were not aware of the infection control procedures and had no correct information about protection. For instance, they did intubations in the open wards which were not allowed in PWH.

(b) Unfortunately, the valuable experiences of PWH staff were not effectively communicated to the staff of other hospitals. Some of the health care workers repeated the mistakes already committed by PWH.

(c) It was a mistake to overload the PMH with SARS patients. As about 20-30% of SARS patient required intubation, the maximum number of SARS patients that PMH could handle was only around 500. PMH did not have sufficient ICU equipment and manpower to take care of its SARS patients.

(d) Furthermore, the reinforcement of staff did not perform effectively. They did not receive sufficient infection control and ICU training. They were vulnerable to contact SARS due to inexperience and lack of knowledge.

Ward Environmental and Facilities

(a) It was inappropriate to accommodate SARS patients and suspected patients together in the open ward which would be vulnerable to cross infection. However, it was unavoidable, as there were not enough isolation wards in the hospital.

(b) Even though 24 rooms in private ward in Block 10E and 11E of PWH were available, the hospital management failed to make use of them as isolation facilities.

Personal Protection Equipment and Supplies

(a) There were sufficient Personal Protection Equipment (PPE) and infectious control supplies available to ward. However, the ward staff had to go through cumbersome procedures to justify their requests.

(b) Furthermore, the delivery frequency of stock was reduced after Hospital Authority outsourced the relevant supplies services to contractor. The ward staff had to spare space to store the monthly supplies and caused inconvenience to their work.

The Way Forward

PWH staff felt that the Review Panel should find out the reasons of the high mortality rate. They also proposed the following points for consider by Hospital Authority.

(a) Improve the communication among Hospital Authority and the hospitals. Infection control information and protection procedure should be clearly disseminated.

(b) Expand facilities like isolation wards and negative pressurized wards.

(c) Improve the overcrowded situation in the ward.

(d) Department of Health should impose strict quarantine procedure to control the outbreak of SARS.

Concluding Remarks

3. Mr. Arculli thanked the staff Prince of Wales Hospital for their valuable comment and information given at the meeting. The Review Panel would take into account of their views and they were welcome to forward further comment, if available to the Panel. It was hoped that the review would enhance Hospital Authority management ability in facing the future possible outbreak.

4. The meeting ended at 2:10 p.m.

Hospital Authority
Hospital visits
15 July 2003

Notes of Meeting of the
Hospital Authority Review Panel and
Princess Margaret Hospital Management on SARS Outbreak
held on 11 July 2003 at 9:45 a.m. in the Conference Room of Princess Margaret Hospital

Present:	Mr Ronald ARCULLI, GBS, OBE, JP	Chairman	) Review Panel
	Mr. Clifton CHIU	Members	)
	Dr George BO-LINN		)
	Dr Jonathan BOYCE		)
	Mrs. Virginia MONG		)
Absent with apologies:	Dr C H LEONG, GBS, OBE, JP		)
	Professor Peter YUEN		).
Present:	Dr Lily CHIU		) Princess Margaret
	Ms Adela LAI		) Hospital
	Ms Nancy CHOW		) Management
	Ms Charlene KONG		)
	Dr CHOW Chun-bong		)
	Dr TONG Kwok-lung		)
	Dr CHIU Man-chun		)
	Dr Tom Buckley		)
	Dr NG Tak-keung		)
	Dr Albert LIT		)
	Dr SO Man-kit		)
	Mr Philip CHOI		)
In attendance:	Mr Banny Wong (Secretary)		

Opening Remarks

Mr. Ronald Arculli explained that the purpose of hospital visit to Princess Margaret Hospital Management was to collect information and review the work the Hospital Authority and its hospitals in respect of SARS outbreak. The main objective was to help the organization to improve its services and facilities in preparation for similar crisis in future.

Discussion

1. At Mr. Arculli's invitation, the panel members and the hospital management discussed the issues raised by the Panel. The information and comments of the hospital management were provided as follows-

Designated Hospital for SARS

(a) Towards the end of March, the Department of Health (DH) requested Princess Margaret Hospital (PMH) to be as a designated centre to receive all suspected SARS patient referred by DH. The hospital was also requested to provide information on the number of beds available for suspected SARS patients.

(b) The hospital management envisaged that it was chosen as the SARS referral centre by DH because the hospital had six fellows in infection control specialty and solid experience in infectious disease.

(c) PMH sought Hospital Authority's directive regarding DH's proposal. An urgent meeting was immediately held in Hospital Authority to deliberate the proposal. Simultaneously, PMH mobilized other hospitals in its cluster for supporting services and reorganized its resources to meet the urgent demand of SARS cases.

(d) Hospital management admitted that the sudden increase of cases inevitably exerted pressure on the hospital though PMH had in fact already received SARS patients.

(e) The hospital management commented that the condition would be better managed if PMH was given sufficient time, for example, one week for preparing the hospital for the surge on the number of SARS patients. In fact, sufficient time was required for the decanting of non-SARS patients from PMH to other hospitals. Besides, the hospital would need more time on contact tracing and arranged early quarantine as well as seeking additional ICU facilities and manpower support.

(f) When questioned by the Review Panel why more hospitals could not be designated as SARS referral centres, the hospital management remarked that every hospital was under pressure during the SARS crisis especially for ICU facilities and manpower. PMH had to negotiate for ICU support from hospitals of other clusters.

Infection Control

(a) PMH was aware of the need for infection control. There were medical forums for doctors to discuss treatment guidelines. Senior Medical Officers were appointed as coordinators for infection control and to enforce procedures. Seminars on gown-up and gown-down were conducted. The training targets covered different level of staff, including medical, nursing, health care related and general frontline staff. VCDs on training were also distributed by Hospital Authority Head Office (HAHO).

(b) In deployment of frontline supporting staff, the hospital management deliberately posted the experienced and well-trained staff to the high risk areas like fever and cohort wards while the less experienced staff were deployed to general wards with lesser chance of infection.

Personal Protective Equipment

(a) The expert team in HAHO was responsible for assessing the provision and effectiveness of the Personal Protective Equipment (PPE) while another HAHO team had to secure the continuous supply of PPE. The hospital had no problem in the supply of PPE to the hospital staff.

(b) Hospital staff were given the right to use their own PPE while they could access to PPE supplied by the hospital.

Concluding remarks

3. Mr. Arculli thanked the hospital management for sharing their views in fighting the SARS and their comments would be helpful for the Review Panel to understand and analyze the overall situation of Hospital Authority during the SARS crisis.

4. The meeting ended at 10:45 a.m.

Hospital Authority
Hospital Visits
15 July 2003

Notes of Meeting of the
Hospital Authority Review Panel and
Prince of Wales Hospital Management on SARS Outbreak
held on 11 July 2003 at 12:10 p.m. in the Conference Room of Prince of Wales Hospital

Present:	Mr Ronald ARCULLI, GBS, OBE, JP	Chairman	) Review Panel
	Mr. Clifton CHIU	Members	)
	Dr George BO-LINN		)
	Dr Jonathan BOYCE		)
Absent with apologies:	Dr C H LEONG, GBS, OBE, JP		)
	Mrs Virginia MONG		)
	Professor Peter YUEN		)
Present:	Dr Fung Hong		) Prince of
	Dr Philip Li		) Wales Hospital
	Dr S F Lui		) Management
	Dr William Wong		)
	Dr Susanna Lo		)
	Prof Gavin Joynt		)
	Dr C B Leung		)
	Dr K C Wong		)
	Ms Lily Chung		)
	Ms Elizabeth Mok		)
	Prof Peter Cameron		)
	Ms Sammei Tam		)
	Mr Albert NG		)
	Mr Stones Wong		)
	Ms Winnie Cheng		)
In attendance:	Mr. Banny Wong (Secretary)		

Opening Remarks

Mr. Ronald Arculli briefed the hospital management that the purpose of hospital visit was to collect information and review the work of Hospital Authority and its hospitals in respect of SARS crisis. It was hoped that the review would help Hospital Authority to improve its services and facilities to prepare for the possible outbreak in future.

Discussion

2. At Mr. Arculli's invitation, the panel members and the hospital management of Prince of Wales Hospital (PWH) discussed the issues raised by the Panel. The information and comments of the hospital management were provided as follows-

Infection Control

(a) The hospital management had daily meeting with the Chief of Services, senior hospital

staff and the Chairman of PWH Doctor Association. The meeting focused on different areas including the clinical management of SARS, microbiology study and operational measures.

(b) The hospital disseminated the infection control information through the hospital cluster's intranet website. Staff of PWH, Hospital Governing Committee and staff of other hospitals can access the latest SARS's information.

(c) The hospital also tightened up the control on hospital visitors and the quarantine procedures in the hospital.

(d) PWH kept close liaison with Hospital Authority and proposal to close down the hospital was considered. However, the cessation of the hospital operation would affect other hospitals and impose heavy workload to them. Inevitably, Accident and Emergency Service and some other services were suspended for a short period due to insufficient manpower.

Coordination with Department of Health

(a) On March 11, the hospital management informed Hospital Authority and Department of Health's (DH) Regional Office about the outbreak in PWH. Community Physician of Regional Office was invited to set up a station in PWH to monitor the situation.

(b) DH stationed a team and set up a disease control centre in PWH. It was agreed with DH that PWH should be responsible for contact tracing of in-patients and medical students while DH would be responsible for the rest.

(c) On March 22, the hospital gained the cooperation from DH and successfully merged the database of contact tracing which was very useful to prevent the spread of the disease.

Effective use of Personal Protection Equipment

(a) The hospital management analyzed the appropriate use of Personal Protection Equipment (PPE) and the correct way of using them. With the application of the infection control procedure and the right use of PPE, there was significant decrease in staff infection in PWH.

(b) As the above information was also useful to other hospitals, PWH sent out its staff to help out other hospitals to improve their infection control measures and the use of PPE.

Vigilance on Noticeable Disease

(a) Regarding the coordination of vigilance on infectious disease at hospital level, cluster management would coordinate with all its hospitals for all noticeable disease. If the hospitals had reason to suspect the existence of a case of infectious disease, they would inform the cluster management of the details about suspected infectious disease.

(b) Furthermore, DH would rely on its disease surveillance system to keep vigilance on infectious disease. Both general practitioners and outpatient clinics had to follow the

reporting procedure of suspected case. However it would not be effective if the case number was small in the preliminary outbreak since it could not trigger the surveillance system.

Concluding Remarks

3. Mr Arculli thanked the hospital management for sharing their SARS experience with the Review Panel and hoped the review of Hospital Authority's management of the SARS outbreak would enhance Hospital Authority's capability in handling possible outbreaks in future.

4. The meeting ended at 1:20 p.m.

Hospital Authority
Hospital visits
15 July 2003