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Written Submission to LegCo

Tai Po Hospital is one of the 7 hospitals in the New Territories East Cluster. One of her major roles is to provide convalescent support to the acute medical units in the cluster.

Clinical Departments of Tai Po Hospital were first alerted of the pneumonia cases in Guangzhou, as well as the surveillance and management on severe community acquired pneumonia (SCAP) dated 13.2.2003 and 15.2.2003. Briefing on infection control measures commenced in late February 2003.

In view of the outbreak of atypical pneumonia in PWH, infection control precautions were again emphasized, PPE provisions were upgraded and patients / staff surveillance was enhanced as from 14.3.2003.

As from 15.03.2003, cohorting of suspected patients with contact history and upgraded droplet isolation of patients with suspected symptoms commenced.

IC training / briefing started on 27.2.2003. Physiotherapy Gymnasium and Occupational Therapy sessions had been suspended since 1.4.2003. Also, clinical departments had been requested to review procedures to minimise patient contacts.

Ventilation of all medical wards was improved as from 14.3.2003. Additional shower facilities were provided on 26.3.2003 and cleansing became more frequent in all wards on 28.3.2003. All medical wards were designated high risk areas as from 31.3.2003.

Updates of the latest IC guidelines / information were disseminated to all staff through emails, department briefings, briefing on shift hand-over, notice boards etc. To further strengthen communication with front-line staff, meetings with department heads and staff forum started on 18.3.2003.

A staff hotline was set up on 9.4.2003. Responses from hospital management to staff concern were posted up on the Hospital SARS Notice Board.

TPH had discouraged visiting to patients and had restricted visits to potential SARS cases since 15.3.2003, and had prohibited visiting to wards with recent occurrence of SARS infection since 2.4.2003. Patients and visitors had been provided with masks since mid March 2003. Since 1.4.2003, visitors had also been given precautionary advice during their visits to TPH and to watch out for and report to DH any suspicious symptoms. All discharged patients were also given precautionary advice on discharge and to watch out for

and report to DH any suspicious symptoms. Volunteer services in patient areas had been suspended since 17.3.2003.

TPH stepped up the screening procedures before admitting patients from acute medical units of other hospitals within the cluster. After admission, patient surveillance was enhanced.

Starting early April 2003, Department of M&G had held daily meetings to update staff on infection control information / guidelines, conduct surveillance on suspicious cases, and to deliberate on any additional infection control measures. Lectures on SARS were conducted for clinical staff to enhance and share knowledge .

In view of the recognition of TPH outbreak in 3 wards on 22.4.2003, daily Department Heads meetings were held to monitor and keep everybody updated on the situation, and to discuss/decide on further infection control / administrative support measures. Hospital wide prohibition of visiting was implemented on the same day. A contact tracing team was formed for contact tracing.

When SARS outbreak in a ward was confirmed, a series of outbreak measures were carried out.

(1) Closing the ward to admission, discharge and visiting

(2) Restriction of movement of patients between cubicles

(3) Close monitoring of patients' conditions, tracing index patients

(4) Liaison with Department of Health for contact tracing

(5) Follow up with patients discharged within 10 days prior to outbreak

The index patients involved in Tai Po Hospital SARS outbreak were cryptic patients.

All staff in TPH had done their best in the SARS battle. The TPH team spirit and team work shone in the difficult times. I must express my deepest gratitude for their dedication, courage and selflessness.

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