新界西·醫院聯網
New Territories West Cluster

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Miss Flora TAI
Clerk to Select Committee
Legislative Council
Legislative Council Building
8 Jackson Road
Central
Hong Kong

Dear Miss TAI,

Information for Preparation of Written Submission Requested by Select Committee On the Performance and Accountability of the Management of NTWC and TMH In the Handling of SARS Outbreak
By CCE, NTWC / HCE, TMH

The management of SARS in New Territories West Cluster (NTWC) could be divided into 3 main phases. In the first phase from early March to early April, Tuen Mun Hospital (TMH) of NTWC handled sporadic SARS cases resided in the Tuen Mun and Yuen Long districts, and also rendered support to North District Hospital and Alice Ho Miu Ling Nethersole Hospital of New Territories East Cluster for non-SARS emergency patients. In the second phase from mid April to late April, NTWC provided support to Kowloon West Cluster and received SARS cases referred from Yan Chai Hospital and the designated medical clinics of Department of Health (DH) in addition to local cases. In the third phase, NTWC focused on handling of local SARS cases in the cluster and management of accumulated remaining SARS patients.

The specific scenario relating to SARS had set the playing field from the start. Hong Kong, as well as the world did not have knowledge of this disease. Although we believed that the causative agent was likely to be a virus, we did not know what organism we were dealing with at the initial stage. We have little knowledge on the route of its transmission, there was no effective means of absolute protection and we did not know what drugs would be effective to cure the infection. Even after the identification of the corona virus as the causative agent, there was no quick and accurate way of ensuring the diagnosis. Diagnosis mainly relied on clinical features. The atypical / cryptic presentation of this disease in some patients posed further difficulties in patient diagnosis.

As part of the Hospital Authority Executive Team, I was a member within the command structure in Head Office in fighting the SARS battle. Through close communication and daily meetings, I was aware of the up-to-date development and respective strategies in handling the crisis. As the outbreak affected different clusters at different stages, there had been close collaboration and mutual support among clusters through central coordination. Updated information and developed strategies were then immediately passed and implemented in the NTWC.

To tally with the Head Office command structure, a cluster infrastructure on crisis management had been set up in mid March to steer, plan, monitor and manage the SARS crisis in NTWC. The members included Chief Cluster Executive, Service Directors / Hospital Chief Executives of cluster hospitals, Cluster General Managers, Heads of key clinical specialties and departments, and Consultant Microbiologist / Chairman of Infection Control Committee.

Cluster contingency measures were formulated in mid-March, and it was frequently reviewed to keep in pace with the changing environment at different phases. These measures covered all important operational aspects, including surveillance and information flow, patient isolation and cohorting, service re-organization, manpower deployment, supplies and infection control precautions, staff support, accommodation and showering facilities. Within the framework, individual hospitals, departments had formulated local measures to fit the local context.

NTWC had been constantly reviewing the service provision throughout the whole SARS period to ensure adequate resources deployment to manage SARS patients, maintenance of emergency and essential services and ensured support to other clusters as required.

Before the crisis, infection control was coordinated centrally by the infection control committee and infection control team. Infection control link-nurse system in ward areas had been established since 2002. With the SARS crisis, the Infection Control Team for SARS was significantly strengthened by mobilization of experienced staff from other disciplines within the cluster.

One of the main roles of the Infection Control Team was on tracing hospital contacts. This specific function was setup in early April to minimize risk of hospital outbreak and assist in hospital outbreak control. The team worked closely with the New Territories West Regional Office of DH in contact tracing and following up discharged cases.

Guidelines of HAHO had been timely disseminated among staff through emails and printed copies. Cluster guidelines, covering infection control, clinical and operational issues, were developed and reviewed periodically. SARS webpage under the NTWC website was set up on mid-March, after which all related guidelines and information were posted there for easy access by staff. A collection of SARS information was also made available in the Infection Control Resource Centre set up in May.

The cluster had put much emphasis on training to ensure our staff can carry out proper infection control practices and to get prepared for staff deployment across services. Thus, different training programs were formulated. In fact, infection control training was an ongoing emphasis in hospital practice. Various regular infection control training programs were provided to our hospital staff round the year. Droplet precautions, proper hand-washing and prevention of cross infection etc were frequent review topics.

Professional colleagues from other clusters were invited to seminars to share their experience in other clusters. Experts were invited to conduct clinical round and share experience with our clinicians. Clinical discussions were arranged, exchange of views and discussions among colleagues and other experts were encouraged.

Briefings on the disease and preventive measures had been conducted by Consultant Microbiologist at the open staff forums in all 4 cluster hospitals during the period between 18 – 28 March. The briefing was video-taped and broadcasted to gain a wider audience. Various infection control programs such as basic infection control training, training and demonstration on wearing of PPE etc., were organized. Tailor-made programs for specific groups of staff such as ward staff, phlebotomist, dietitians, speech therapist students, supporting staff, laundry workers etc were also arranged. To allow efficient knowledge and skill transfer and availability of on-site coaching and monitoring, train-the-trainer courses were also organized for supervisory staff. Besides, every healthcare staff was given an infection control training VCD produced by Hospital Authority Head Office. Individual departments had also arranged various briefings, discussion sessions and training to their department staff on specific areas.

At the initial stage of SARS, the Cluster Procurement and Materials Management Unit procured Personal Protective Equipment as advised by the cluster SARS command group and Infection Control Team and supported by the Head Office Business Support Services. Subsequently, Head Office Business Support Services assumed the central coordinator role in facilitating the supplies allocation to individual clusters. There was constant communication with frontline users on the supplies requirements and logistics. Other support services such as cleansing, waste disposal, transport, security, and laundry were also greatly enhanced. Additional quarters and changing facilities were made available for staff.

In response to the SARS crisis, a series of improvement works had been carried out in NTWC hospitals. The cluster had made early requests to Electrical & Mechanical Services Department (EMSD) to adjust the air exchange rate and fresh air change rate in wards. Installation of exhaust fans at high risk areas, other wards and departments had been arranged to further increase the air change rate and redirect air flow. Apart from ventilation improvement, NTWC also carried out other facilities and environmental improvements to cope with the demand arising from the crisis.

Communication, both internal and external, had been highly emphasized since the very beginning of the crisis aiming at gaining timely, effective, and bi-directional information flow. In terms of internal communication, the cluster utilized every possible means to facilitate communication. The cluster central command group met regularly, even daily, to manage the SARS crisis. Regular senior staff forums were conducted to provide a platform for discussions and communications. Multiple and frequent open forums for all NTWC staff were held to update staff on the situations and the operational arrangements. Multiple visits to staff in frontline areas and meetings with specific staff groups were conducted by cluster management.

Update on the responses and plans for the cluster and all related information and guidelines were posted to the SARS intranet webpage. Relevant messages, information and updates were communicated to staff instantly through emails and printed copies. Cluster Chief Executive also gave specific messages to staff for instant update. At the operational level, division heads, unit heads, and supervisors had actively communicated the update development with their staff.

For external communication, media enquiries were coordinated through Head Office. The update progress and responses of the SARS crisis were regularly reported to District Councils of Tuen Mun and Yuen Long.

Staff health and safety had all along been the priority of the cluster. Apart from providing our staff with adequate training, various measures to address the needs and concerns of staff were arranged. Counseling services were also established to provide assistance and support to staff. Senior management conducted regular ward rounds to facilitate communication. Working environment and conditions were periodically reviewed and improved.

Around late April 2003, TMH experienced a limited scale outbreak in one of the general wards. 3 staff working in C8 were reported sick and admitted. This was immediately regarded as a likely outbreak and urgent actions were taken to investigate the possible causes, prevent further spread of the infection and implement necessary improvement measures. At the conclusion of the outbreak in early June 2003, a total of 5 staff, 10 patients and 1 patient relative were confirmed as having clinical SARS. Upon recognition of the outbreak, TMH had taken prompt and effective actions to prevent further spread of the virus. ***With our effective contact tracing, there was no spread of the infection to the community.***

The new disease of SARS had caused a public health and multi-dimension crisis to Hong Kong. Faced with this outbreak in March, Hospital Authority together with other parties were able to completely eliminate the virus from Hong Kong within a short time period of 3 months. On the C8 outbreak in TMH, with the concerted efforts of all staff from all levels and other collaborating parties, the incident was contained within a limited scale and had not spread to the community.

Yours sincerely,

(Dr. Cheung Wai Lun)
Cluster Chief Executive, New Territories West Cluster,
/ Hospital Chief Executive, Tuen Mun Hospital,
Hospital Authority