For Information

LegCo Panel on Health Services

Guideline for reporting outbreaks drawn up between the Centre for Health Protection (CHP), the Hospital Authority (HA) and the Developmental Disability Unit (DDU) of the Paediatrics Department of the Caritas Medical Centre (CMC)

Purpose

This paper introduces the guidelines drawn up by the Centre for Health Protection (CHP), the Hospital Authority (HA) and the Developmental Disability Unit (DDU) of the Paediatrics Department of the Caritas Medical Centre (CMC) in reporting outbreaks of infectious diseases.

Background

2. At the Special Health Services Panel Meeting on 17 November 2004, Members requested the Administration to provide details concerning the above-mentioned guidelines.

The Guidelines

3. Early recognition, rapid initiation of control measures and effective communication are important elements in the control of outbreaks. Taking into account lessons learnt from the SARS outbreak, the CHP has worked closely with HA in drawing up an outbreak reporting mechanism. The mechanism came into operation in June 2004, with the Central Notification Office (CENO) of the CHP acting as the first and single point of contact in CHP for receiving notifications of statutory diseases and outbreak reports from public hospitals. Public hospitals also send reports of the outbreak simultaneously to the Central Committee on Infectious Diseases (CCID)* of the HA.

4. The reporting mechanism provides Hospital Chief Executives with clear guidance in reporting statutory notifiable diseases, non-statutory notifiable

---

* The Central Committee on Infectious Diseases is set up under HA Head Office to develop and promulgate policy on infectious disease arrangement and infection control practice throughout HA.

diseases, outbreak situations etc. The mechanism also identifies the diseases which require immediate notification to the CENO and the CCID of the HA. HA circular detailing the reporting mechanism is at Appendix 1.

5. To complement the reporting mechanism, HA has also promulgated a Response Plan for Infectious Disease Outbreaks (Appendix 2), which provides further guidance for headquarters staff and all HA hospitals on the notification and response actions required during different levels of disease outbreaks. The Plan sets out criteria to determine an outbreak situation, and stipulates different levels of HA's response actions depending on significance of the infection, risk of hospital spread, availability of existing knowledge and guidance to treatment control, and potential threat to the community, etc. According to the Response Plan, Head Office of HA and Surveillance & Epidemiology Branch of the CHP require to be notified of abnormal patterns of infectious disease inside the hospital system.

6. Using the HA Response Plan as a basic framework, each HA hospital has devised their own local management guidelines on infectious diseases to tie in with the reporting requirements, taking into account individual hospital's needs and conditions. As far as outbreak reporting is concerned, each hospital has taken into the baseline disease pattern of their different wards, definition of the baseline cases etc in drawing up the management guidelines.

7. At the DDU of CMC, local management guideline on infectious disease in DDU (Appendix 3) has been refined and implemented since June 2004 by its Infection Control Team (ICT) which provides guidance to staff on the management approaches under various scenarios.

8. This paper is for Members' information.

Health, Welfare and Food Bureau
3 December 2004

Ref : HA 752/10/38 XXI

16 July 2004

Hospital Authority Head Office
Operations Circular No. 6/2004

Reporting Mechanism for Notifiable Diseases and other Communicable Diseases

(This circular should be circulated and read by all HCEs, medical and nursing staff
It promulgates the inclusion of Japanese Encephalitis as a Notifiable Disease.
Annexes 1, 2 and 3b are updated.
It supersedes Hospital Authority Head Office Operations Circular No.5 /04)

With immediate effect, the Centre for Health Protection (CHP) operates a single contact point, the Central Notification Office (CENO) for reporting of notifiable diseases and outbreaks. Copies of these report forms are required to be sent to the CENO of CHP **and** to HAHO via the Central Committee on infectious Diseases Secretariat (CCID) through either fax or email for follow up action. The details of telephone, fax, email address, and emergency pagers are as following:

Reporting Channels	Telephone (Office hours)	Fax	E-mail address	Emergency call after office hr (pager)
CCID secretariat, HAHO	23007187	28815848	HA CCID Secretariat haccid@ha.org.hk	71163328 call 1333
CHP Central Notification Office (CENO)	24772772	24772770	ceno_chpweb@dh.gov.hk	71163300 call 9179

2. At present, medical staff are required to report notifiable diseases in accordance with the Quarantine and Prevention of Disease Ordinance. A list of the notifiable diseases is at Annex 1. **Form 1** (Annex 3a) (in the case of tuberculosis) and **Form 2** (Annex 3b) (in the case of notifiable disease other than TB) is to be used as appropriate.

3. Other important communicable disease that CHP has requested HA hospitals to report are stipulated in Annex 2. Hospital staff are requested to use the **Clinical Record Form** (Annex 3c). In case of suspected case of biological attacks (bio-terriorism), the **Notification Form for Suspected Cases of Biological Attacks** (Annex 3d) should be used. All reports received by HAHO CCID Secretariat will be acknowledged and the respective hospital infection control officers will be informed.

4. For cases of an outbreak setting, templates for reporting and updating the incidents and patient information are attached at Annex 3 e-f for your easy reference. For guidance on outbreak management, please refer to HA Response Plan on Infectious Disease

Outbreaks which is also available at the HA intranet and internet websites. They can be downloaded from the "Infectious Diseases and Infection Control" webpage of the HA intranet (http://ha.home).

5. The infectious diseases outlined in Annex 1 and Annex 2 (**in bold and italic**) require immediate action. In this regard, hospital staff should alert CENO **and** CCID via telephone call (during office hours) or pager call (during non-office hours emergency) for immediately and follow-up with fax or email reports.

6. For suspected food poisoning cases, please follow the instruction in accordance with the Department of Health Standing Circular no 15/2000. Notification of food poisoning should be made promptly on clinical diagnosis and should not await the results of laboratory investigation. The telephone and fax numbers of Duty Room of Food & Environmental Hygiene Department is attached in Annex 4.

7. A Statement of Purpose (both English and Chinese version) has been prepared (in Annex 5) and hospitals are advised to make available of this document to patients.

8. If you have any enquiries on this Circular, please contact the undersigned at 2300 6456 or Mr Clement Che, Secretary, CCID, at 2300 6932 for clarification.

(Dr S H Liu)
for Chief Executive
Hospital Authority

First Version: 3 Oct 03
Revision no 1: 14 June 04

Hospital Authority's Response Plan for Infectious Disease Outbreaks

- Introduction
- Preparedness for outbreaks
- Surveillance and notification mechanism
- Definition of outbreak
- General framework for response to outbreaks of infectious diseases
- Checklist on HA response
- Standing down

Go to Chinese Version

Return to SARS Webpage Index

Hospital Authority's Response Plan for Infectious Disease Outbreaks

Legends List

HA	*Hospital Authority*
DH	*Department of Health*
CHP	*Centre for Health Protection*
SEB	*Surveillance and Epidemiology Branch*
ICB	*Infection Control Branch*
CCID	*Central Committee on infection Disease*

A. Introduction

The Hospital Authority (HA)'s response plan for infectious disease outbreaks covers the contingency response taken by the HA in the event of a major outbreak of infectious disease, including Severe Acute Respiratory Syndrome (SARS).

B. Preparedness for outbreaks

2. Hospitals are required to assess local hazards and risks which have potential detrimental effects on normal service provisions, and to integrate emergency response arrangements into the hospital's day-to-day working structures and processes. Having a mechanism to prevent and control hospital-acquired infections and preparedness for infectious disease outbreaks form part of the quality standards in Section 3 of the HA's Annual Plan which hospitals need to comply with. Corporate efforts in promoting such quality standards and internal audits on the level of compliance are carried out as part and parcel of the HA's Annual Plan and audit plans.

3. A work plan in preparation for resurgence of SARS (Attachment 1) and respiratory pathogens with high infectivity has been prepared.

C. Surveillance and notification mechanism

4. There is in place a surveillance and notification mechanism for infectious diseases between the *Centre of Health Protection (CHP)* and the HA:

   4.1 Statutory requirement to report on Notifiable Diseases

   4.2 Enhanced surveillance for SARS in post SARS period (Attachment 2);

   4.3 Ongoing surveillance of nosocomial infections by the hospital infection control teams;

   4.4 Mechanism of hospital infection control teams to inform *the Central Notification Office of the Surveillance & Epidemiology Branch (SEB) of CHP and the HAHO Central Committee on Infectious Diseases Secretariat (CCID) on notifiable diseases and unusual trend of other infectious diseases under surveillance.*

   4.5 *When the* followings *are* detected by *CHP's* surveillance system, *CHP* will alert HA for dissemination of information and augmenting surveillance in the public hospital system:

   4.5.1 Unusual pattern of clusters in the community, private hospitals or institutions.

   4.5.2 When *CHP* is alerted on a patient confirmed or suspected to have infectious disease coming back to Hong Kong and intends to arrange for medical assessment and treatment at public hospitals.

   4.5.3 When *CHP* is *alerted* on occurrence of an unusual outbreak in neighbouring areas.

D. Definition of outbreak

5. In general, the term outbreak is used for a situation when diseases or health events occur at a greater frequency than normally expected in a specified period and place[1].

6. To define the term in a more measurable fashion, an outbreak can be one of the following:

   6.1 The occurrence of a greater number of cases or events than would normally occur in the same place when compared to the same duration in the past years.

   6.2 A cluster of cases of the same disease occurs which can be linked to the same exposure.

   6.3. A single case of a disease that has rarely if ever occurred before.

E. General framework for response to infectious diseases outbreaks

7. The general framework of response to infectious disease outbreaks in the HA is in three tiers. The response actually starts with watchfulness and surveillance of abnormal patterns of infections, which should be a part of our everyday risk management culture in the practice of medicine. When an abnormal pattern of infectious disease is discerned, there should be a swift assessment by the hospital infection control team on the significance of the infection, risk of hospital spread, availability of existing knowledge and guidance to treatment and control, and potential threat to the community, so that the hospital can take appropriate actions to manage and control the outbreak. When it is considered that the outbreak poses a significance risk to the hospital system and requires a coordinated response, our system should define the risk and initiate contingency response with a clear command structure: our 3 tiered green,

yellow, red alerts and responses. The 3-tiered alert & response system thus have three essential elements attached: Risk level, Response and Command.

8. The HA's response plan is a generic plan designed for infectious diseases including SARS, and the three levels of response correspond to the potential impact of the outbreak to the hospital system and the community. Below is a table on the HA's 3-tiered response to infectious disease outbreaks and the Governments Alert and Response for combating SARS:_

HA's response for infectious disease outbreaks	Government Alert and Response for SARS Alert
Tier-one response (Green Alert) Hospital alerts to an abnormal pattern of infectious disease in the community or inside the hospital system and when there are existing guidelines and knowledge on treatment and control, and local action is judged to be adequate.	
Tier-two response (Yellow Alert) An abnormal pattern of infectious disease which may have territory-wide implications, or require a HA-wide response, e.g. laboratory-confirmed SARS outside Hong Kong.	<u>Alert</u> a) Laboratory-confirmed SARS case outside Hong Kong.
Tier-three response (Red Alert) The infectious disease outbreak has widespread or prolonged territory-wide implications, e.g. SARS Alert and re-emergence of SARS.	<u>Alert</u> b) SARS alert in Hong Kong. <u>Response level 1</u> When there is one or more laboratory-confirmed SARS case(s) in Hong Kong. <u>Response level 2</u> When there are signs of local transmission of SARS.

9. Descriptions of each level of response in HA are as follows:

9.1 <u>Tier One Response (Green Alert)</u>

9.1.1 Definition: an abnormal pattern of infectious disease in the community or inside the hospital system and where there are and when there are existing guidelines and knowledge on treatment and control, and local action is judged to be adequate.

9.1.2 The hospital infection control team should assess the potential of transmission of the infectious disease in hospital setting. For any outbreak with transmission in health care setting, the hospital should conduct an investigation on the outbreak, identify the source of infection, and step up local measures, such as isolation of the patients, augmenting infection control, staff training and monitoring as appropriate for controlling the outbreak. A room with the necessary communication means may be designated as the incident control room to facilitate data collection and dissemination of information.

9.1.3 The Cluster Chief Executive (CCE) or the designated Hospital Chief Executive (HCE) will be in command for the response.

9.1.4 *CCID* should be notified for alerting other hospitals to heighten preparedness and awareness.

9.1.5 *The SEB of CHP* should be notified. *CHP's* involvement in investigation and control will be as appropriate to the situation.

9.2 Tier Two Response (Yellow Alert)

9.2.1 *Definition: An* abnormal pattern of infectious disease which may have territory-wide implications, or require an HA-wide response in:

- providing central coordination in data collection and interpretation of the epidemiological pattern.
- refining clinical management or infection control guidelines.
- mounting a territory-wide response in service management and resource deployment.

Example: report of SARS outside Hong Kong.

9.2.2 CCID *will be alerted by SEB or Hospital ICT.*

9.2.3 The Chairman of the CCID *and ICB Head* should in consultation with the *designated* Director in HAHO activate HA's response plan at an appropriate level. At tier two response, the Chairman of the CCID/ *designated* Director will be in command for the response.

9.2.4 At the local level, the CCE or the designated HCE of the hospital should liaise with *SEB* on investigation and control. At the central level, Chairman of CCID should liaise with *SEB* Consultant (Community Medicine) *and ICB Head* on the overall response.

9.2.5 HA Central Command *Committee* will be activated and will serve the following functions:

- overseeing the overall HA response.
- coordinating expertise in mounting a response involving relevant specialist groups, nursing, pharmacy, public affairs, information technology, business support and human resources colleagues.
- communication hub for collection and dissemination of information.
- maintaining liaison with *CHP* and other relevant Government departments.
- when necessary, the Chairman of the CCID will designate room 502S of HA Head Office Building as the Data Management Centre to facilitate data collection and dissemination of

information.

9.2.6 The Chairman of the CCID will keep the Directorate informed of the actions taken, progress of the outbreak and seek directions on major decisions. When the outbreak has widespread territory-wide implications, the Chief Executive of the HA (CE) / Directors / Cluster Chief Executives (CCEs) will be directly involved in the command and control of the outbreak as in Tier Three response. *A room with the necessary communication means may be designated as the incident control room to facilitate data collection and dissemination of information at hospital level.*

9.3 Tier Three Response (Red Alert)

9.3.1 *Definition*: The infectious disease outbreak has widespread or prolonged territory-wide implications, such as the following:

- there are major impacts on HA service.
- there is a need for major central policy directions in HA.
- substantial cross cluster mobilisation of patients and staff are required.

Example: SARS Alert[2] and re-emergence of SARS *in HK.*

9.3.2 Higher-level inter-departmental response will be required and the Government may activate the Inter-departmental Action Coordinating Committee.

9.3.3 The Chief Executive of HA (CE) will be in direct command for the *overall* response.

9.3.4 In addition to the liaison as in the first and second response tiers, HA and *CHP* will maintain close liaison at high-level command.

9.3.5 When tier three response is activated, the CE will:

- activate the HA Central Command Committee for the outbreak e.g. SARS. Membership include CE, Directors, CCEs and involvement of the relevant experts.
- formulate a deputising plan on key posts (i.e. CE,CCE).
- steer the overall HA response.
- liaise with the Secretary for Health, Welfare and Food, *the Director of Health and the Controller of CHP*
- represent the HA in the Government's higher level Committees.
- involve the HA Chairman and HA Board on major decisions and keep the HA Board and Hospital Governing Committee (HGC) informed on progress of the outbreak and the ability of the HA to respond.
- designate the Data Management Centre if not already designated. A roster should be prepared for manning of the Data Management Centre. Additional staff will be pooled in on

a need basis.

- activate the Business Support Sub-command Centre to coordinate procurement and distribution of supplies that are in high demand and to collect feedbacks on supplies and distribution of stocks.
- initiate discussions with private hospitals and practitioners on provision of medical services and mutual support.

9.3.6 In a major disaster situation, there will be a need for strategic command to effect prompt and decisive response. There will need to be a mechanism to mobilise resources (supplies and manpower) in an efficient manner to ensure that the corporate interest and the health of the population is protected.

9.3.7 The CE could declare, when the situation warrants, a state of "emergency operation mode for disaster". Under such operation mode, the CE will effect deployment of supplies and manpower across clusters directly when necessary. Similarly, the CCE will effect deployment of supplies and manpower across hospitals and departments when necessary.

F. Checklist on HA response

10. Management and progress of outbreak should be properly documented. The followings are checklists of HA's response to infectious disease outbreaks:

10.1 Collection and dissemination of epidemiological information

10.1.1 Establishing case definition and reviewing the notification procedures in collaboration with *CHP*;

10.1.2 Ensuring data are efficiently collected e.g. activation of the eSARS Registry (for SARS Alert and SARS), or establishing other database where appropriate;

10.1.3 Monitoring the progress and outcomes of patients;

10.1.4 Projecting the trend of the outbreak and possible implications to service (e.g. hospitalization rates, demand on intensive cares, human resources requirement); and

10.1.5 Dissemination of information in an efficient manner to *CHP*, the private sector and other key stakeholders.

10.2 Infection control and outbreak management

10.2.1 At present, hospitals will maintain a heightened state of alertness and preparation for SARS and other possible respiratory outbreaks in accordance with the HA guidelines for the "post SARS" phase. Once there is evidence of resurgence of SARS in Hong Kong, the full infection control guidelines for SARS, including use of enhanced Personal Protective Equipment and restriction of visiting on SARS will be put back in force.

Infection control guidelines upgraded to SARS level:

- For SARS Alert: in affected hospital(s)

- A single case of *confirmed* SARS: in all hospitals

10.2.2 A more detailed plan on investigation and control of outbreak is in Attachment 3 [3]

10.2.3 The hospital's infection control team will investigate the outbreak and report to the *CCID & CHP*. When necessary, the hospital infection control team should evolve into a hospital outbreak control team. The hospital outbreak control team will be headed by the CCE or the designated HCE. Representative from *CHP* will be member of the team. Hospitals should build and identify a pool of professionals with knowledge on outbreak investigation and control to provide assistance to the hospital infection control team. For hospitals without the appropriate expertise, the CCE should assist deployment.

10.2.4 When necessary, the HAHO will collaborate with *CHP* and relevant specialists and deploy a central outbreak control team to assist the hospital to ensure:

- the source of the infection is promptly identified and controlled.
- containment measures are in place to prevent further spread of infection.
- necessary changes to prevent the recurrence of the problems are identified and implemented.
- the lessons learnt are rapidly shared with other hospitals.

10.2.5 Patients and the inpatient contacts will be isolated in appropriate areas in accordance with the mode of spread and risk stratification.

10.2.6 Measures to prevent spread of the disease inside hospital and in the community will be assessed and implemented as appropriate.

10.2.7 The infection control measures should balance infection control, practicality, sustainability and service implications.

10.2.8 Measures which have major service implications should be brought to the appropriate authority for decision making:

- stopping admission to ± discharge from ward(s): by CCE.
- stopping admission ± discharge in a hospital, or closure of A&E Department: by CE.

10.2.9 If there is a need to invoke the "Prevention of the spread of Infectious Diseases Regulations" to isolate patients in the hospital or the community, *DH* should be involved on policy and logistics.

10.2.10 With evidence collected and experience accumulated in outbreak investigation, the outbreak control teams should provide ongoing feedbacks to hospital management and HAHO for initiation of:

- augmentation of infection control guidelines.
- augmentation of staff training targeted to address areas of deficiencies.

- environmental improvements.

10.2.11 If control of the outbreak involves specific measures such as a vaccination programme or use of prophylaxis, the CCID will promptly advise on a policy, and the extent of the coverage.

10.3 Decanting and mobilisation of patients

10.3.1 Depending on the mode of spread, appropriate measures to isolate/ place patients in cohorting areas will be instituted. Taking SARS as an example, there will be a staged response in mobilisation of hospitals to take in confirmed and suspected patients:

Stage		Hospital		Patient Intake	Total Patient Intake
1	1st 50 cases	Designated hospital	PMH	50	50
2	Local cluster	Designated hospital in clusters	TMH, AHNH, UCH/QEH, PMH/KWH, QMH/PYNEH (50 each)	50 x 5 = 250	300
3		Major hospitals in clusters	PMH/KWH, UCH/QEH, QMH/PYNEH, PWH (50 each)	50 x 4 = 200	500
4		Other cluster hospitals	TKOH (25), CMC (50), RH (25), NDH (25)	125	625
5	Cases over 625	Individual hospitals to increase intake up to 100	All acute major hospitals	Up to 100 for each hospital	> 625

Note: 1. For outbreaks which involve primarily paediatric patient groups, the mobilisation will be fine-tuned in accordance with the plan for staged mobilisation of paediatric hospital units.

2. Suspected patients refer to patients fulfilling criteria as defined and promulgated by HAHO. For SARS, the criteria for transfer to designated hospitals will be:

- Patients with positive laboratory findings for SARS-CoV ,
- Index patients for SARS Alerts,
- The cluster of patients related to the index who fulfill the WHO clinical case definition.

3. The above are for reference only. The actual mobilisation in a particular outbreak will be subject to situational assessment coordinated by HAHO.

10.3.2 The HAHO will ensure that:

- Decanting is coordinated.
- support to the receiving hospitals, including supplies and manpower is provided.
- the need for implementing the plans for arranging additional isolation facilities is assessed at end of stage 1, and will liaise with the relevant departments to put the plan into action if there is a need for additional facilities in stage 2/3 as appropriate; and
- directions on service reprioritisation e.g. reducing other elective services, are given.

10.3.3 Each hospital cluster should establish a contingency plan for service reprioritisation which will be put into action when:

- there is an indication that the outbreak may have significant impact to hospital services.
- there is evidence that services have been overloaded.

10.3.4 The cluster plan for reprioritisation should cover inter-hospital and inter-specialty service reorganisation.

10.3.5 Designated hospitals need to prepare for receipt of patients. The plan should cover:

- plans for reduction of non-urgent elective operations, especially operations that may potentially require ICU support.
- plans for reduction of elective admissions.
- plans for re-designation of wards less likely to be involved, such as surgical, orthopaedic and gynaecological wards.
- staff deployment plan to provide assistance to the areas likely to be stressed.

10.3.6 Other hospitals in the cluster should similarly reorganise service to support the service reorganisation.

10.3.7 HAHO should in consultation with the relevant specialists, promulgate appropriate criteria on diversion to designated hospitals. The actual mobilisation plan will be subject to assessment bearing in mind:

- capacity of the hospitals.
- level of protection/ isolation required.
- need to preserve expertise.
- stage of development of the outbreak.

10.4 Human Resources

10.4.1 Service reprioritisation and service reorganisation should aim to reduce the need for deployment of staff.

10.4.2 Each hospital cluster should develop a plan for cluster based training and mobilisation plan for clinical area likely to be stressed, such as: intensive care or respiratory care.

10.4.3 A plan for deployment of staff if volunteers cannot meet service needs should be in place in the cluster. Staff are expected to comply, unless satisfactory reasons are provided. Staff deployment will be in the following sequence:

- staff with expertise and experience on the required specialist skills.
- staff trained in the field or a closely related field.
- staff of a less affected specialty.

10.4.4 All staff deployed must first receive training on infection control and orientation of relevance to the local setting before they are put to full duties.

10.4.5 There should be equitable chances for deployment across all ranks under the same principles, unless there are demonstrable overriding essential needs in other clinical areas.

10.4.6 The policy on leave and relief related to the deployment will be centrally determined by the HAHO taking into consideration the situational assessment of the outbreak.

10.4.7 If the outbreak involves a large number of staff, the HAHO in consultation with the staff clinics *in-charges* will implement the appropriate procedures to augment cases identification, health *counseling* and education.

10.5 Ensuring adequate supplies of drugs, consumables and equipment

10.5.1 The HAHO will make arrangements to ensure adequate stock of drugs, consumables and equipment for responding to the outbreak.

10.5.2 If the outbreak is likely to require additional stock, HAHO Chief Pharmacist and the Business Support Services will assess whether procurement and distribution should be centralised. If

there is a likely shortage and the outbreak involves multiple hospitals, there will be central coordination in arranging supplies.

10.5.3 A system on distribution and collection of feedbacks should be in place in HAHO, clusters, hospitals and frontline work units to ensure adequate supplies.

10.6 Clinical Management

10.6.1 Where applicable, the contingency plan for each of the clinical specialties across hospitals, as advised by the respective Specialty Coordinating Committees should be put into action.

10.6.2 Cluster based support in specific clinical areas e.g. respiratory care, intensive care and infectious disease management will be mobilised to support the receiving hospitals when appropriate. If there is a need, HAHO will arrange cross cluster mobilisation.

10.6.3 The HAHO will support the clinicians on clinical management e.g. issuing protocols and guidelines. Where appropriate, HAHO will coordinate with the appropriate expert groups to make available reference on clinical management to guide practices in hospitals.

10.6.4 For outbreaks which warrant special research, assistance from relevant experts and academics will be solicited to consolidate efforts in preparing the appropriate research protocols in key areas to guide treatment. For infections with protocols prepared e.g. SARS, the HAHO will coordinate in carrying out the research in public hospitals.

10.6.5 For outbreaks involving elderly homes, the Community Geriatric Assessment Teams will enhance support to the Visiting Medical Officers of the Homes. *Surveillance will also be enhanced through our Accident and Emergency Departments* in collaboration with the *CHP* and *Elderly Health Services of DH.*

10.6.6 For specific infectious disease outbreak such as SARS, a number of General Out Patient Clinics will be designated as triage clinics to screen and follow up specific patient groups when necessary.

10.7 Communication

10.7.1 A situational communication plan appropriate to the outbreak for internal and external communication, to facilitate effective dissemination of information to and collection of feedbacks from key stakeholders, will be formulated, implemented and updated as the outbreak evolves with a view to engage public co-operation and avoid unnecessary panic.

10.7.2 Internal communication with HA staff regarding policy, strategy, operational details, infection control measures and communication tactics will be conducted via appropriate channels (*e.g.*, e-mail, Intranet, circulars; CE's letters to staff, staff forums, video conference, hospital visits) and ad hoc means like daily bulletin, staff hotline and video newsletter.

10.7.3 External communication with patients and relatives, patient groups and advocates, politicians, other interested parties and the general public regarding personal precautionary measures, nature of the disease, treatment outcome and control of the outbreak will be conducted. Channels include the three Regional Advisory Committees of HA, District Councils, Legislative Council, the mass media (regular press briefing/statements, briefings to editorial writers and columnists, radio & TV programs), public hotlines, *professional associations and the HA web page.*

10.7.4 Where appropriate, a dedicated communication group for the infectious disease outbreak should be set up by the Central Command Committee. The scope of work includes design of communication strategies and tactics, collection and analysis of external questions, opinion, complaints and suggestions through all channels.

10.7.5 Systematic collation and recording of events, plans, decisions and outcome of actions from all levels during a crisis situation will help in formulation of communication strategies, as well as assist in debriefing and any internal or external inquiries after the crisis.

10.7.6 Taking into consideration input from external and internal sources, the communication strategy (when, what, how, to whom and by whom) will be formulated and fine-tuned continuously. A team of spokespersons will be assigned to disseminate accurate and consistent information (in liaison with those of Health, Welfare and Food Bureau (HWFB), *DH, CHP* and other related Government departments).

10.7.7 Where appropriate, information on the outbreak and infection control measures will be shared with medical practitioners in the private sector to solicit their cooperation and support.

10.8 Liaison with CHP and other Government departments

10.8.1 At hospital level, there will be a close liaison with the *CHP* on case definition, patient notification, contact tracing and outbreak control. Hospital outbreak control team may be formed if appropriate, *with CHP representatives.*

10.8.2 HAHO will maintain close liaison with *CHP* on case definition, mechanism of notification, contact tracing and outbreak control. Central outbreak control team may be formed if appropriate, *with CHP representatives.*

10.8.3 HAHO will continue close communication with the appropriate government departments on outbreak control or other related matters and through formal command structures when established by the Government in major outbreaks.

10.9 Governance on HA's response to major outbreaks

Within the HA, hospital management and HA executives will discharge their duty of accountability to the HGCs and the HA Board. The following will be considered in the event of a major outbreak:

10.9.1 Timely alert and information to HA Chairman and Board Members, Hospital Governing Committee Chairmen and Members on major incidents, including the provision of line-to-take

messages and advice in case members of governance are approached by external parties.

10.9.2 Efficient information update to the Board on development and the ability of the HA to respond to the incident, which could be through: special updates with press release, news bulletin on intranet, special messages from the CE / Chairman, Chief Executive's progress reports to the Board.

10.9.3 Where necessary, the HA Chairman and Members may decide to hold extra-ordinary meetings or establish special task forces on specific areas of concern, and take part in the decision making process.

10.9.4 A designated Director in HAHO and a designated senior management staff at hospital level will be responsible for coordinating reports to the Board/HGC members.

G. Standing down

11. Control of the outbreak should be declared taking reference to the incubation period of the infection. Inputs from *CHP* should be consulted when appropriate. For tier two and three responses, the HAHO will declare standing down of HA's response taking into consideration control of the outbreak and the clinical needs of the patients. The HCE of involved hospitals will declare standing down of the hospitals' response taking into consideration control of the outbreak and the clinical needs of the patients under treatment in the hospital.

Footnote:

[1] Oxford Textbook of Public Health (4th ed) 2002 Page 530.

[2] The SARS Alert is an operational definition introduced by the WHO to ensure that appropriate infection control and public health measures are implemented until SARS has been ruled out as a cause of the atypical pneumonia or respiratory distress syndrome. Definition of a SARS Alert is -

- two or more health care workers in the same ward/unit fulfilling the clinical case definition of SARS and with onset of illness in the same 10-day period; or

- hospital acquired illness in three or more persons (health care workers and/or other hospital staff and/or patients and/or visitors) in the same ward/unit fulfilling the clinical case definition of SARS and with onset of illness in the same 10-day period.

[3] Adapted from Model Plan for the management of communicable disease outbreaks in Wales. Welsh Collaboration on Health and Environment, March 1995.

Management of Infectious Diseases (ID) in DDU

<table>
<tr><th>Condition / Situation</th><th>Fever Management</th><th>Gastro-enteritis (GE) Management</th><th>Rash Management</th></tr>
<tr><td>A kid with signs and symptoms in ward</td><td>A kid with first click of fever (rectal temperature ≥ 38 oC)
- continue to monitor temp (Q4H temp taking)
- no school
- standard precautions
- post-up a "fever" card at bedside to remind staff
If fever persist (2 episodes of fever with rectal temp ≥ 38 oC within 24 hours)
- count as fever case
- strengthen infection control (IC) practices, prefer to care in side room
- clinical management and investigation as decided by pediatrician</td><td>Handle excreta and vomitus with care
(refer to guidelines on handling excreta and vomitus)

A kid with GE (≥ 3 loose stool within 24 hours and/or with vomiting)
- no school
- monitor the situation
- assess dietary history
- prefer to care in side room
- standard precautions + contact precautions
- clinical management and investigation as decided by pediatrician</td><td>A kid with skin rash
- prefer to care in side room
- no school
- monitor for any viral infections
- standard precautions + droplet precautions
- clinical management and investigation as decided by pediatrician
- monitor the situation for one week</td></tr>
<tr><td rowspan="3">Cluster of cases</td><td>New onset of fever cases ≥ 3 cases in 24 hours or exceed the base line of fever cases in ward:</td><td>A cluster of GE cases (≥ 3 GE cases within 24 hours)</td><td>A cluster of cases with rash (≥ 3 cases with rash within one week):</td></tr>
<tr><td colspan="3">- inform ICT (ext. 7810/7951)
- enhance IC precautions: isolation / cohort the cases, droplet + contact precautions
- review cases
- case definition (define by ICT & clinical)
- continue close monitoring, and microbiological investigation is required</td></tr>
<tr><td></td><td>- investigation / assessment on dietary history</td><td></td></tr>
<tr><td rowspan="2">≥ 3 cases fulfilled the case definition</td><td>≥ 3 cases fulfilled the case definition within 24 hours or when judge significant by ICT:</td><td>≥ 3 cases fulfilled the case definition within 24 hours or when judge significant by ICT:</td><td>≥ 3 cases fulfilled the case definition within one week or when judge significant by ICT:</td></tr>
<tr><td colspan="3">- inform HCE
- prepare sitrep & epicurve
- consider initiation Hospital Outbreak Control Team (HOCT) by HCE & ICT
- freeze movement (patients & staff)
- cohort the contacts
- consider revise the visiting arrangement
- strengthen environment cleansing/disinfection
- health surveillance to the contacts
- communicate with Lok Yan School
- additional measures decided by HOCT
- outbreak report to CCID, CHP, CCE and relevant parties</td></tr>
</table>

*24 hrs defined as (0 a.m. to 23:59 a.m.)

** Inform ICT if any other abnormalities related to infections detected by nursing or medical staff

Prepared by Infection Control Team June 24, 2004