For information

SWD Review Report on Measures to Prevent the Spread of SARS in Elderly Homes

Purpose

This paper recapitulates the involvement of the Social Welfare Department (SWD) in preventing the spread of SARS in residential care homes for the elderly (RCHEs), reviews the various measures undertaken and suggests areas for improvement.

Background

2. In the midst of the SARS outbreak in Hong Kong, as both the licensing authority and the Department responsible for promoting the care and welfare of elders, SWD is extremely concerned about infection of elderly residents in RCHEs because –

(a) RCHEs in Hong Kong are providing long term care for elders particularly those suffering from frailty. These elders are frequent visitors to hospitals and clinics and are thus exposed to a higher risk of infection;

(b) RCHEs in Hong Kong are operating under considerable space constraints, particularly amongst private homes not operating in purpose-built premises, and the risks of cross infection amongst residents and staff are relatively higher; and

(c) With over 50 000 elders accommodated in RCHEs, any massive closure of homes resulting from a major SARS outbreak would give rise to problems of finding alternative accommodation.

Overview of RCHEs in Hong Kong

3. Hong Kong's population is ageing. There has been an increasing demand for residential care places for elders. At the moment, RCHEs providing care and attention up to the nursing home level come under the social welfare system[1] whereas more frail elders requiring infirmary care are looked after in infirmaries under the Hospital Authority (HA). In view of the shortage of infirmary places, a considerable portion of elders waitlisted for admission into hospital infirmaries are residing in RCHEs. They receive special care in Infirmary Units set up in care and attention homes or through extra funding made available to the homes in the form of Infirmary Supplements.

4. RCHEs in Hong Kong are operated by NGOs and the private sector. The majority of NGO homes are operating subsidised services with Government subventions while some are running non-subvented homes on a self-financing basis. As at June 2003, there were a total of about 70 500 places (roughly 21 500 subsidized; 3 100 self-financing and 45 900 private places of which about 5 800 have been purchased by the Government).

5. In general, subvented RCHEs are situated in purpose-built premises or public housing estates with more spacious environment (about 20 sq. meters per resident) and charging heavily subsidised fees. Private RCHEs are mostly located in commercial or residential buildings charging a fee at market rate with varying standards. To safeguard the operation and standards of elderly homes in Hong Kong, a statutory licensing scheme of control was implemented in 1996. All RCHEs have to comply with the requirements laid down in the Residential Care Homes (Elderly Persons) Ordinance, its subsidiary regulations and the Code of Practice for Residential Care Homes (Elderly Persons) regarding aspects like location, design, structure, safety measures, staffing, fire precautions, space (6.5 sq. meters for each resident) and care standard. Under this legislation and in accordance with the Prevention of the Spread of Infectious Diseases Regulation, Cap. 141, subsidiary legislation B, RCHEs are required to notify SWD and a medical practitioner or a medical officer of the Department of Health or the Hospital Authority in the event of any staff or resident suffering or suspected to be suffering from an infectious disease.

6. Apart from licensing requirements, subvented RCHEs and private homes participating in the Government's Bought place Scheme/Enhanced Bought Place Scheme are additionally subject to more stringent requirements in terms of space, staffing levels, service quality standards and service performance, etc.

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[1] Under the social welfare system, RCHEs are categorized into homes for the aged, care and attention homes and nursing homes. In recent years, the focus is to promote care at home and in the community. Since 1 January 2003, SWD has ceased new admissions into homes for the aged and has referred elders with little or no care needs to other support services.

Summary of SARS infections in RCHEs

7. Locally, 1 755 SARS cases were reported as at 19 June 2003, including 323 elders aged 65 and above (18.4%). 72 SARS cases were reported among residents of 51 RCHEs, of whom 57 died (79%). A total of 11 staff working in RCHEs had contracted SARS although some of them were known to have contracted the disease from elsewhere.

8. There has been a general mis-perception that private RCHEs are more prone to SARS infections because of their operating constraints in terms of the physical environment, staff, etc. However, an analysis of the 72 SARS elderly residents shows otherwise. As illustrated at **Annex 1**, the proportions of homes with confirmed SARS elders are 15.2% for subvented, 5.3% for self-financing and 4.7% for private RCHEs. Analysed in terms of the number of residents, the percentage of elders in private homes who had contracted SARS was also the lowest, 0.11% compared to 0.17%, for subvented homes.

Brief Account of Actions taken by SWD

9. In respect of preventing the spread of SARS in RCHEs, SWD has undertaken a series of actions during the SARS outbreak. These actions may be grouped and discussed under the following headings.

Precautionary Measures

Actions Taken

10. To ensure that all the 700 plus RCHEs are well acquainted with the preventive measures to be adopted, SWD has issued six sets of guidelines for reference and compliance by homes during the period from mid March to early July. These guidelines have evolved from the more generic advice to measures specific to homes and have been developed in collaboration with DH.

11. The first general guideline on Respiratory Tract Infection was issued on **13 March** (before the first home resident contracted SARS was reported). An expanded and tailor-made guideline for residential institutions was prepared by the Department and cleared by DH on **25 March** to stipulate the necessary precautionary measures in different situations to combat SARS. These guidelines were revised for issue on 4 **April** to highlight, inter alia, the extension of the isolation period from seven to ten days in line with the incubation period of the disease as advised by the health authority. Alongside with more SARS case being reported in RCHEs, operators had asked for more detailed guidelines. On **16 April**, a RCHE-specific guideline named "Guidelines on the Prevention of the Spreading of Atypical Pneumonia in Residential Care Homes for the Elderly" was promulgated; this has included the do's and don'ts and details of cohorting measures. To meet home operators' request for more detailed professional advice on the requirements, wearing and disposal of PPEs as

well as circumstances under which full protective gear should be worn, particularly for addressing their care staff's concern, SWD and DH jointly revised and expanded the aforesaid guideline on **10 June**. Posters and leaflets on the precautionary measures for staff, residents and visitors were also distributed. In addition, with the help of NGOs, videos showing how staff should put on these protective gear were produced but a long time has taken for the concerned departments, i.e. DH and HA, to clear these educational materials. As a result, these videos were only distributed to RCHEs on 25 June 2003. With the removal of Hong Kong from the list of SARS affected areas on 23 June, the two departments joined hands to review the situation and produce the latest guideline named "Guidelines on Respiratory Tract Infection Prevention in Residential Care Homes for the Elderly" of **2 July** to provide health advice on basic and universal precautionary measures with the lifting of the cohorting arrangement.

12. To ensure that guidelines are followed and the necessary precautionary measures are adopted, SWD mounted concerns visits to all the 741 RCHEs in Hong Kong in the week commencing 28 April 2003. DH assisted us in the drawing up of checklists to facilitate assessment. Gift packs of protective gear and materials were delivered to the homes. An analysis of the assessments made and observed during those visits is at **Annex 2**. This shows that the majority of homes' awareness of the need for stepped up environmental and personal hygiene was generally high and precautions were adequate. Based on these observations, SWD had followed up on several areas, such as sourcing for protective gears subsequently distributed to homes with the support of two major donations from charitable organisations and identifying 27 homes with inadequate knowledge and referring these to DH for priority health care infection control training.

Observations and Suggestions

13. At the early outbreak of SARS and apparently with limited knowledge on the disease and tight manpower in DH, it has been difficult for SWD to obtain timely and detailed medical advice from DH in the drawing up of detailed guidelines for reference by RCHEs. Feedback from RCHE operators suggests that they would require clarification or medical advice related to the guidelines but it was not always easy to obtain that from a ready source (the DH hotline was extremely busy during the initial period). Some operators had expressed difficulties in following all the advice in the guidelines such as those in respect of cohorting arrangement and changing of PPE whenever personal care duties were involved for different elders.

14. In sum, our collaboration with DH in the preparation and updating of guidelines had been mostly smooth, especially in the latter period. However, in general, it appears that the authorities were reactive (that is, responding to home operators' concerns as the outbreak of the disease evolved), rather than anticipatory. This may be explained by the lack of full understanding of the disease. There is a need to produce a properly consolidated operating manual for RCHE staff to deal with infectious diseases and appropriate training and skills upgrading of the staff

concerned.

Surveillance and Notification

Actions Taken

15. To prevent the spread of communicable diseases, timely notification and promp/ advice is essential. In the case of RCHEs, it is important for home operators to be told in the first instance if their residents admitted into hospitals were suspected or confirmed to have SARS so that the necessary measures, particularly in respect of isolation, could be put in place without delay Ever since 23 March 2003, SWD and DH had worked on daily checking and sharing of information on RCHEs with home staff/residents suspected/confirmed to contract SARS. This took the form of RCHEs reporting to SWD as required under the licensing condition, or to DHof an elder suspected SARS admitted into hospital, and SWD would then forward all essential particulars of the affected home and the home staff/residents to DH. DH would then conduct investigation, contact tracing, render necessary medical advice to home and return the confirmed list of RCHEs with suspected/confirmed SARS cases for LORCHE's follow-up advice, support and monitoring of these affected RCHEs during the surveillance period.

16. RCHEs with suspected SARS residents or staff understandably expected immediate medical advice from DH. During the early stage of the SARS outbreak, such advice was not always timely received as perceived by home operators, thereby leading to prolonged anxiety among RCHE staff in sorting out the proper isolation arrangements. Home operators also encountered difficulties in reaching the regional offices of DH for advice.

17. The situation was much improved since mid-April. Close liaison was maintained amongst SWD, DH and the RCHEs under medical surveillance to provide to the latter the necessary advice and support.

18. SWD's communication with and flow of information from the HA was comparatively less scheduled and lower in frequency. HA also furnished a list of suspected/confirmed SARS cases in RCHEs to SWD though on a less regular interval, varying from daily to weekly. SWD would then cross check with the lists from DH and collate the information amongst concerned parties upon detecting different information contained therein. In so doing, we had to ensure that while RCHEs received accurate information in respect of their homes, they would not have to operate under unnecessary stress and panic.

Observations and Suggestions

19. Based on the above experience and feedback from RCHEs, there is clearly room for improving the notification arrangements to ensure that homes are told of the status of their elderly residents in the first possible opportunity. Instead of individual

homes trying to approach individual HA hospitals or regional offices of DH for information, there is a case for building up a more coherent information flow amongst the parties concerned.

Assistance to RCHEs under cohorting

Action-s Taken

20. For RCHEs placed under active medical surveillance because they had a confirmed or suspected SARS resident/staff, SWD would provide DH with the essential home information retrieved from LORCHE to facilitate the latter to map out cohorting arrangements, e.g. the identification of "high risk" and "low risk" areas and residents to be isolated for close observation. Where the operator of the RCHE under active surveillance reported to have physical and staffing constraints in providing cohorting arrangement, DH's advice would be sought on feasible alternatives such as temporarily utilizing appropriate functional room or reserving vacant beds in designated and well-ventilated corner. Upon a referral mechanism developed between SWD and DH, the VHTs of DH would render on site health education and training to care staff in the home.

21. There had been requests from RCHEs under active surveillance that SWD should find alternative cohorting facilities outside of their home and provide relief staff to the homes concerned. These requests posed practical problems. Instead, we had assisted by liaising with retraining institutes and the Labour Department to help promote the recruitment of new/relief health workers and care workers. The Department had also frozen or slowed down admission of new residents to subsidized RCHEs to enable spare space for cohorting arrangements.

Observations and Suggestions

22. We consider it rather unrealistic for affected RCHEs to transfer their elderly residents who have to be isolated or put under observation to another facility. Many of these elders are frail and have low mobility and are incapable of self care. *In situ* cohorting seems to be the only practical arrangement. In a way, in this outbreak of SARS, we were fortunate that the number of homes affected was small and many of them could look to their sister homes for support in terms of decanting some "clean" elders so as to make room for cohorting in the affected home and redeploying care staff. Also, at the time of the outbreak, the majority of private homes were not fully occupied (less than 70%). As for NGO homes, they are generally better provided for in terms of accommodation and the slow-down admission had somewhat eased the problem.

23. However, looking ahead, RCHEs should be better provided in terms of space and better equipped with facilities for isolation, e.g. with self-contained rooms with toilet/bathing facilities. SWD is prepared to support the needed renovation to create the isolation facilities in NGO homes through capital grants from the Lotteries Fund. As for private homes with inherent physical constraints which make effective cohorting difficult, SWD would have to explore other possibilities and welcome pertinent advice from experts.

Reduced Admissions into Hospitals

Actions Taken

24. Noting that many elderly residents had acquired SARS during hospitalization, it was agreed by all parties concerned that efforts should be stepped up to provide outreaching medical support to RCHEs. SWD had explored with HA the options of strengthening the homes' VMO or HA enhancing its CGAT coverage. As a result, and since the primary objective is to reduce hospital admission, it was agreed that any enhanced medical support to RCHEs should be aligned with CGAT. Since mid-May, HA has implemented the Honorary VMO system as supported by CGAT to strengthen home-based medical support to RCHEs. Feedback from home operators on the scheme was mostly favourable but some RCHEs that had not yet benefited from the scheme have expressed grievances.

Observations and Suggestions

25. Prior to the SARS outbreak, only 80% of RCHEs were covered by CGAT. Individual RCHEs have entered into separate arrangements with HA hospitals to provide medical coverage such as in the form of tele-medicine. Such initiatives are useful in reducing elders' visits to hospitals and clinics and are cost-effective to both the home and the hospital. We believe that in furtherance of the objective of "hospital without walls" advocated by the HA and the concept of "ageing in place", we should facilitate more such collaborations between HA hospitals and RCHEs on

a district or cluster level.

Prevention against Cross Infection

Actions Taken

26. While homes with SARS affected elders had to go through the necessary cohorting arrangements, similar practices were put in place for elders discharged from hospitals, irrespective of whether they were SARS patients. There were two different situations. First, planning for elderly patients originated from RCHEs to return to the RCHEs concerned and secondly, elders living in the community who had difficulty in returning home because their family members were not ready to receive them for care. While SWD's Medical Social Workers (MSW) are charged to assist in discharge planning, they experienced difficulty in obtaining from the medical team in hospital timely information on the patients' status. On one occasion, one elderly non-SARS patient whom upon discharge SWD had arranged to undergo respite in an NGO home was subsequently found to be infected with SARS.

27. In a separate development, in order to release more space in hospitals to deal with SARS patients, SWD had assisted in the transfer of HA's infirm patients to NGO homes. The first batch of 83 patients transferred from Tai Po Hospital was completed within two days. Collaboration with HA was smooth despite extra efforts required in liaising with the RCHEs over the detailed arrangement. Complication however arose when a staff of the Tai Po Hospital was confirmed to have contracted SARS and the question of whether the infirm patients transferred from Tai Po Hospital were SARS free arose. DH's VHTs were inclined to advise these RCHEs to send these infirm patients back to hospitals due to their high risk origin. This had caused confusion and worries among staff of RCHEs. The rate of re-admission of these infirm elders to hospitals was thus as high as 20% during the initial stage of transfer. The situation improved subsequently with the strengthening of support from CGATs and enhanced communication amongst relevant stakeholders, including the sharing of patients' medical conditions prior to their transfer in subsequent batches, e.g. their chest x-ray and blood tests results, etc.

Observations and Suggestions

28. As mentioned earlier, there were already inadequate isolation facilities in RCHEs to cope with the need during medical surveillance. It would therefore be a double burden for RCHEs, especially those operating under physical constraints, to cope with the added cohort requirements for discharged elders whose SARS clinical picture was unclear. As majority of elderly residents contracted SARS acquired the disease in hospital, RCHEs were particularly concerned about cross infection in their homes arising from an infected discharged elderly patient. From the RCHEs' perspective, the solution lies in hospitals providing an extended convalescent care to such elderly patients.

Social Welfare Department
July 2003

Annex 1

SARS Infections in Different Types of Elderly Homes

	RCHEs			Nursing Home (Subsidized)	Total
	Subsidized (Note)	**Self-financing**	**Private**		
(a) No. of Homes as at June 2003	138	38	577	6	759
(b) No. of beds as at June 2003	19,913	3,056	45,934	1,553	70,456
(c) No. of residents as at June 2003	19,316	2,261	31,671	1,506	54,754
(d) No. of homes with confirmed SARS residents (%=d/a)	21 (15.22%)	2 (5.26%)	27 (4.68%)	1 (16.67%)	51 (6.72%)
(e) No. of residents contracted with SARS (%=e/c)	33 (0.17%)	3 (0.13%)	35 (0.11%)	1 (0.07%)	72 (0.13%)
(f) No. of inhouse staff contracted with SARS	7	0	4	0	11

Note: Including Government, subvented and contract homes but excluding purchased places from private homes.

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Annex 2

Analysis of Data Collected during Concern Visits in respect of Preventing the Spread of SARS in RCHEs

(A) Environmental hygiene needed to be improved:

There are a total of 35 assessment areas comprising five aspects (cleanliness, air ventilation, smell, pest control and condition of pipes) of environmental hygiene to be assessed against each of the seven functional areas (bedroom, living room, bathroom/toilet, nursing/treatment room, activity room, kitchen and cleaning room) in each RCHE.

Table 1: No. of assessment areas that need to be improved (有待改善) in each RCHE

No. of assessment areas needed to be improved [Note 1]	No. (%) of home
0	648 (88.2)
1-6	72 (9.8)
>=7	15 (2.0)
Total	735 (100)

Table 2: No. (%) of RCHE with environmental hygiene of all four functional areas [Note 2] including bedroom, living room, bathroom/toilet and kitchen, being rated satisfactory (滿意) or acceptable (可接受) in respect of each aspect:

Aspects of environmental hygiene	No. (%) of RCHE (Total = 735)
1. Cleanliness (清潔)	702 (95.5%)
2. Air ventilation (空氣流通)	712 (96.9%)
3. Smell (氣味)	727 (98.9%)
4. Pest control (防治蟲蟻)	711 (96.7%)
5. Condition of pipes (渠管及沖水暢通)	715 (97.3%)

Note 1: The majority of 648 RCHEs (88.2%) have no assessment areas that need to be improved whereas those RCHEs found in the low end of the analysis i.e. with more areas needed for improvement as presented in Figures 1 to 5 below would warrant further assistance and close monitoring to strive for continuous improvement.

Note 2: The nursing/treatment room (護士房/治療室), activity room (活動房) and cleansing room (洗衣房) are excluded in Figures 1 to 5 since about 10% of the RCHE

do not have at least one of these functional areas. Therefore, only bedroom (寢室), living room (客廳/走廊), bathroom/toilet (浴室/廁所) and kitchen (廚房), i.e. a total of four functional areas, are included.

Figure 1: No. of areas with cleanliness (清潔) needed to be improved

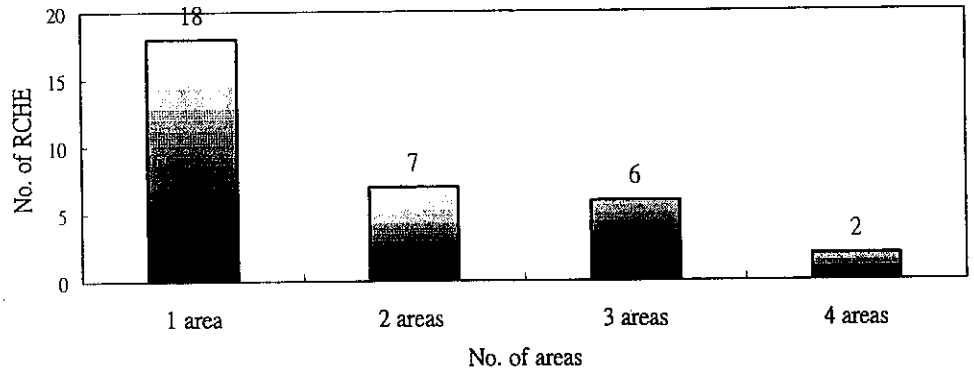


Figure 2: No. of areas with air ventilation (空氣流通) needed to be improved

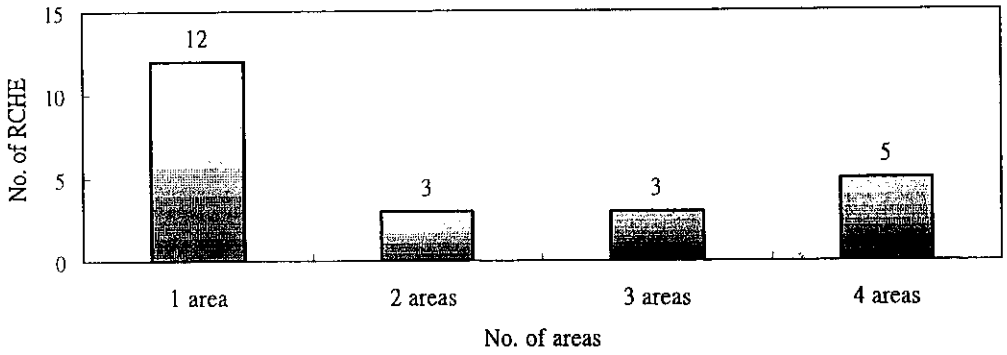


Figure 3: No. of areas with condition of smell (氣味) needed to be improved

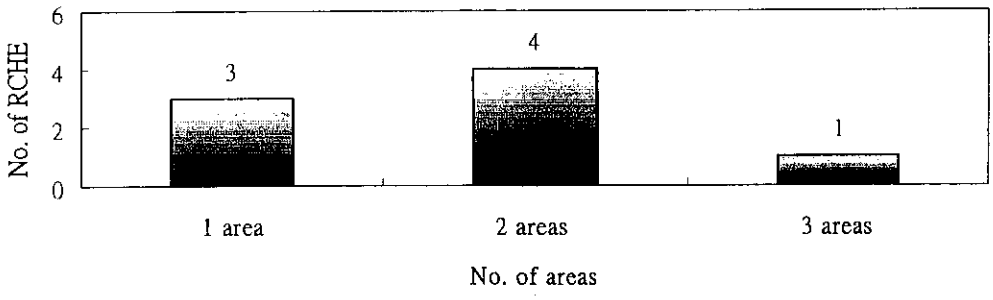


Figure 4: No. of areas with condition of pest control (防治蟲蟻) needed to be improved

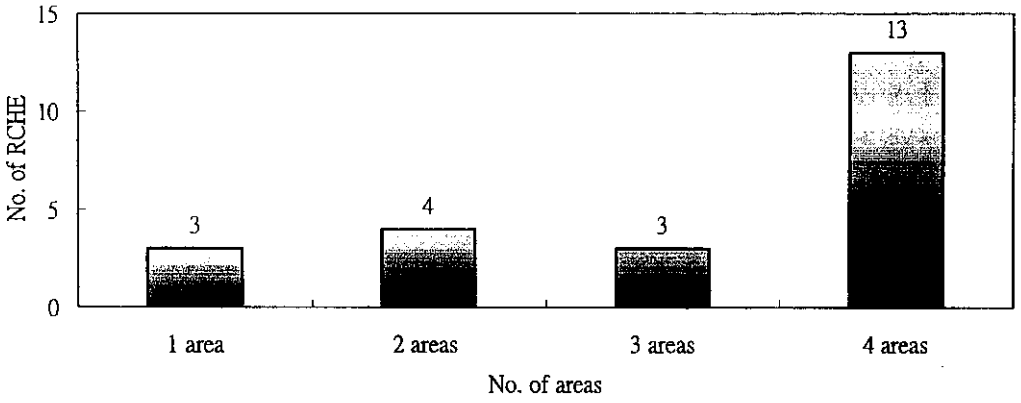
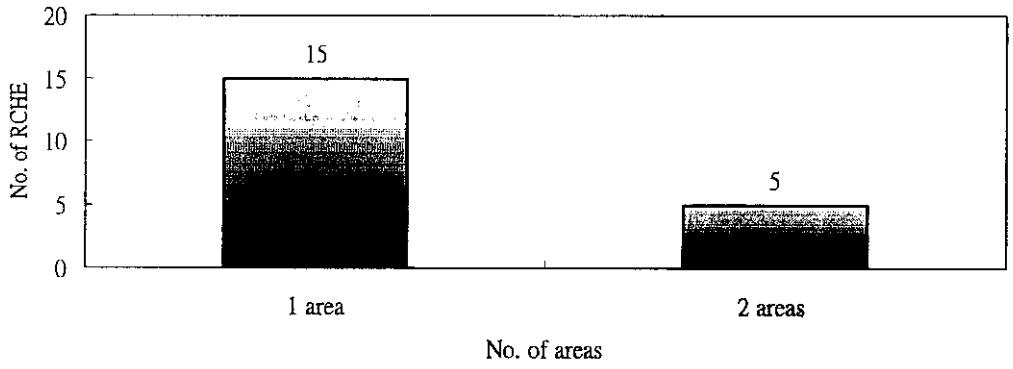


Figure 5: No. of areas with condition of pipes (渠管及冲水暢通) needed to be improved



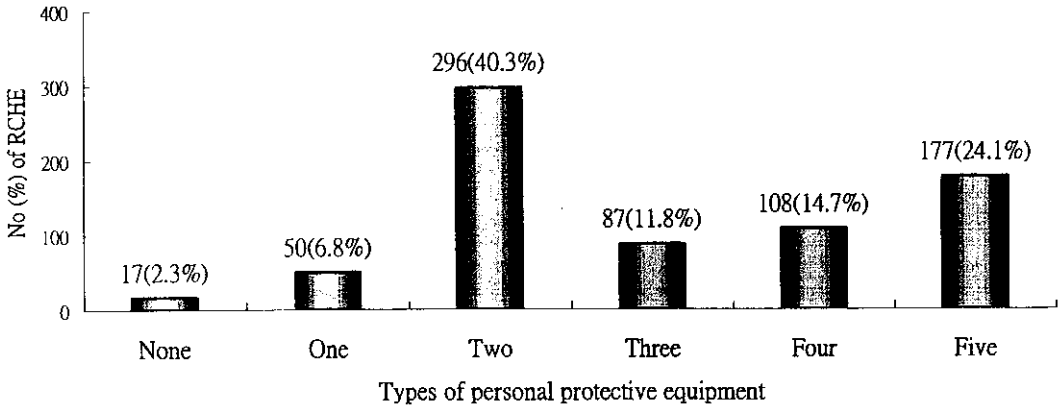
(B) Facility:

Table 3: Personal protective equipment (PPE) (保護衣物)

Items of PPE [Note 3]	No. (%) of homes that have this PPE	No. (%) of homes that did not have this PPE	Total No. (%)
1. Protective cap (保護帽)	298 (40.5)	437 (59.5)	735 (100)
2. Eye shield (眼罩)	204 (27.8)	531 (72.2)	735 (100)
3. Face mask (口罩)	706 (96.1)	29 (3.9)	735 (100)
4. Gown (保護袍)	345 (46.9)	390 (53.1)	735 (100)

5. Glove (膠手套)	667 (90.7)	68 (9.3)	735 (100)

Figure 6: Types of personal protective equipment in each RCHE



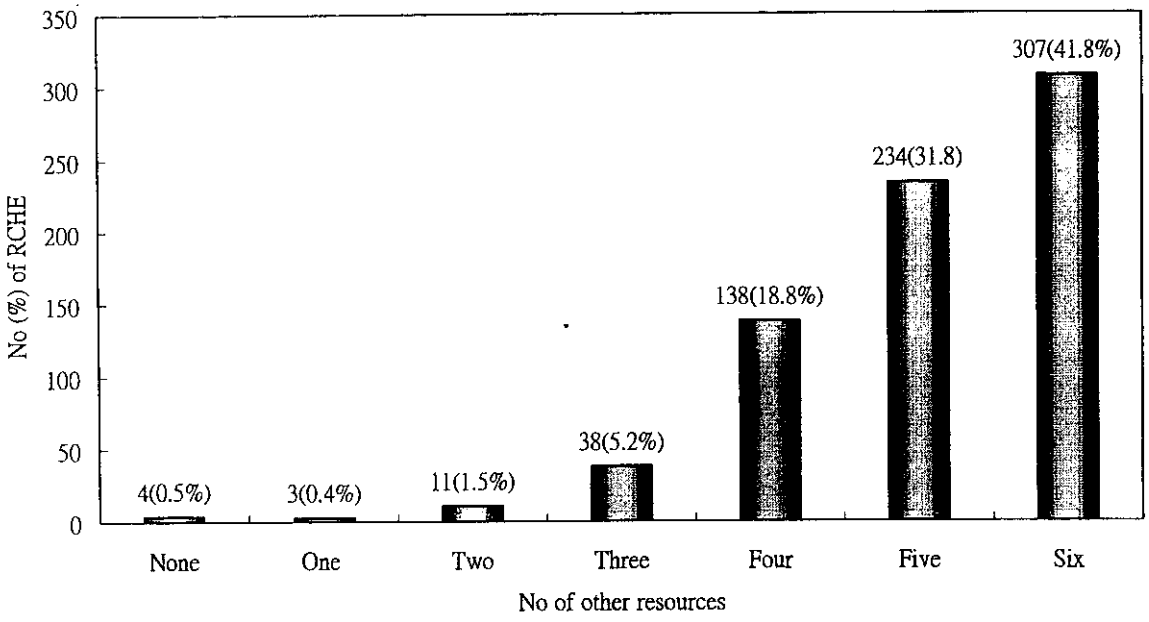
Note 3: Less satisfactory were the provision of eye shield, protective gown and protective cap constituting 27.8%, 40.5% and 46.9% of all RCHEs respectively. This may be attributed to the shortage or unavailability of such supplies in the local market at the early outbreak of SARS in March and the peak period in April.

Table 4: Other resources (其他物品)

Item of Other Resources	No. (%) of homes that have this resource	No. (%) of homes that did not have this resource	Total No. (%)
1. Soap (梘液)	690 (93.9)	45 (6.1)	735 (100)
2. Towel (抹手紙) Note 4	402 (54.7)	333 (45.3)	735 (100)
3. Thermometer (探熱針+用後即棄針套)	617 (83.9)	118 (16.1)	735 (100)
4. Bleach (漂白水)	722 (98.2)	13 (1.8)	735 (100)
5. Rubbish bin with cover (有蓋垃圾桶)	668 (90.9)	67 (9.1)	735 (100)
6. Visitor record (探訪紀錄)	604 (82.2)	131 (17.8)	735 (100)

Note 4: Home operators explained that they would rather provide automatic heat air dryer or arrange each resident to use his/her own towel for hand drying instead of using disposal paper towel but meeting the same personal hygiene standard.

Figure 7: Types of other resources in each RCHE



(C) Preventive measures and knowledge (對預防非典型肺炎措施的認識及執行)

Table 5: Preventive measures done by RCHE

Items of Preventive Measures Performed by RCHEs in Combating SARS	No. (%) of homes that have this practice	No. (%) of homes that did not have this practice	Total No. (%)
1. 照顧院友前後用梘液洗手 Hand wash before and after taking care of residents	716 (97.4)	19 (2.6)	735 (100)
2. 照顧院友時適當地戴上口罩 Wear face mask when taking care of residents	660 (89.8)	75 (10.2)	735 (100)
3. 處理排泄物、血液、分泌物時有穿戴保護衣物 Wearing gown when handling blood, secretion, vomitus, faeces and urine **Note 5**	377 (51)	358 (49)	735 (100)
4. 定期有觀察院友的身體狀況及記錄在個人健康記錄表上 Periodical observation on residents' health condition and proper recording	699 (95.1)	36 (4.9)	735 (100)
5. 床與床之間有足夠的距離(1m) Bed space> 1m	554 (75.4)	181 (24.6)	735 (100)
6. 可安排獨立房間或人少清靜的地方供剛出院的院友暫居 Isolation room / area for residents discharged from hospital	616(83.8)	119(16.2)	735 (100)

Note 5: This relatively low percentage of not using protective gowns is consistent with the lack of such supply as tabulated in Table 3 above.

Figure 8: No. of preventive measures done by RCHE

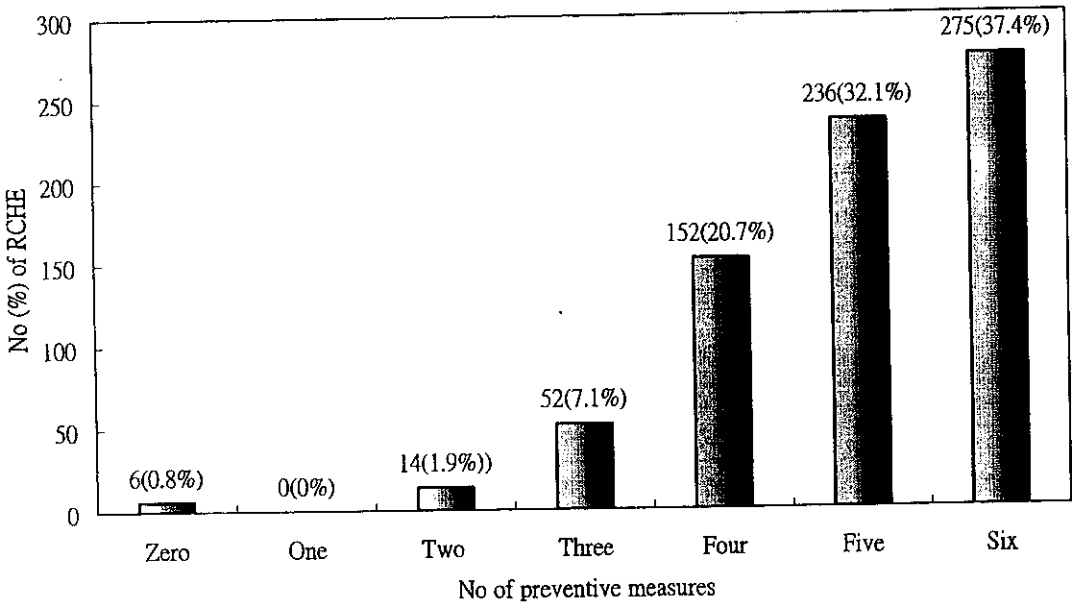


Table 6: Condition of bed space and isolation room /area in each RCHE (cross tabulation extracted from Item 5 and 6 in Table 5 above)

		Isolation room /area		
		Yes	**No**	**No. (%) of RCHE**
Bed space	**>=1 m**	479 (65.2%)	75 (10.2%)	554 (75.4)
	<1m	137 (18.6%)	44 (6.0%) Note 6	181 (24.6)
			Total No	735 (100)

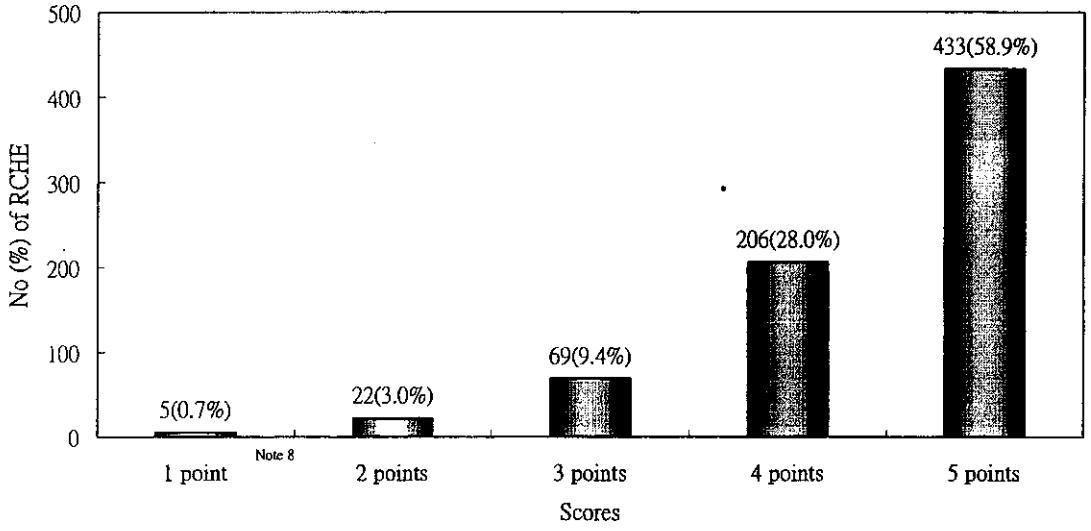
Note 6: Out of these 44 RCHEs observed to have insufficient bed distance of 1m and unavailability of isolation room/area, LORCHE inspectors cross-checked with track records and has confirmed that 16 of them required follow-up action. The Visiting Health Teams (VHTs) of the Department of Health (DH) has been requested to pay visits to advise and assist these homes to make improvement within the physical constraints as far as practicable.

Table 7: Infection control knowledge

Items of Infection Control Knowledge	No. (%) of homes with concerned staff providing correct answer	No. (%) of homes with concerned staff providing incorrect answer	Total No. (%)
1. 一個懷疑受感染的長者剛被收入醫院，護老者應盡快把懷疑受感染長者床位附近的院友調開，以策安全 When a suspected SARS patient has just been admitted to hospital, residents living besides him/her should be removed to other parts of the home to avoid infection.[Note 7]	570(77.6)	165(22.4)	735 (100)
2. 清潔血液或分泌物應用 1:49 的稀釋家用漂白水消毒 To use 1:49 bleach to clean blood or secretion	658(89.5)	77 (10.5)	735 (100)
3. 戴手套照顧院友可減免洗手次數 No need to wash hands frequently when wearing gloves in taking care of residents,	682 (92.8)	53 (7.2)	735 (100)
4. 當院舍曾有感染非典型肺炎的個案，便應盡快關閉窗門，免病毒散播 Once the home has a resident confirmed to contract SARS, all windows should be shut to avoid cross infection.	664 (90.3)	71 (9.7)	735 (100)
5. 盡量安排同一組職員照顧固定的長者，有助減低交叉感染的機會 Staff should be divided into designated teams to take care of specific groups of residents to avoid cross infection.	671 (91.3)	64 (8.7)	735 (100)

Note 7: A noticeable percentage of 22.4% of RCHEs got confused in removing or not removing elder residents in bed arrangement situated next to the affected elder resident. Some home operators explained that they could vacate a dormitory for isolation which is an acceptable arrangement. Some explained that it is due to the personal preference of elder residents and their family members for change of bed arrangement to avoid self-perceived cross infection irrespective of health advice.

Figure 9: Infection control knowledge of the representative from each RCHE



Note 8: One point for one question in Table 7 correctly answered. For the 27 homes scoring just one or two points, they have been referred to DH for priority training in health care and infection control.

Social Welfare Department
July 2003