Notes of 1st Meeting of Task Group on SARS
held on 18 March 2003 5:00 p.m. in Rm 902, Block S, QEH

Present :

Dr. Lawrence LAI	CCE / HCE		(Chairman)
Ms. Alice TSO	GM (N)		
Dr. C.T. HUNG	COS	Anaesthesia	
Dr. Patrick LI	COS	Medicine	
Dr. James HWANG	COS	Surgery	
Dr. H.F. HO	COS	A&E	
Dr. Thomas MOK	Consultant	RMD	
Dr. Grace CHAN	Consultant	Paediatrics	
Dr. Johnny CHAN	SMO	Medicine	
Dr. M.P. LEE	Assoc. Consultant	Medicine	
Ms. Judy WONG	DOM	Medicine	
Ms. L.K. WONG	DOM	A&E	
Ms. Helen TANG	SHM	P.A.	
Ms. Clara YIP	NM	I.C.T.	
Ms. Gloria CHEUNG	Manager	C.Q.I. Unit	(Secretary)

Absent with Apologies :

Dr. Dominic TSANG	Consultant	Pathology
Dr. K.Y. LAI	Consultant	Medicine

Confirmation of Minutes of last Meeting

Action

1. The Chairman explained that the meeting was called to identify and to introduce operational measures for tackling SARS in the hospital. References were made upon the latest documents on case definition from HAHO, SARS Registry Form and Guideline from Department of Health.

2. The proposed terms of reference and membership were endorsed.

3. The overall situation was reviewed.

   3.1 The latest information showed that over 100 suspected cases were reported in the territories, and many cases were in PWH. In QEH, there were 1 confirmed SARS case, and 3 ARS suspected cases (1 HO, 2 RNs). Owing to the high incidents in PWH, the AED of PWH would be closed for 3 days as from 19 March 2003.

   3.2 The daily incident monitoring to HA was maintained via Infection Control Team.

   3.3 Contact tracing of the index case was carried out by Department of Health.

3.4 Infection Control measure promulgated for ARS and SARS incidents was droplet precaution with emphasis on use of mask and hand washing. When performing nasopharyngeal aspiration, staff had to wear mask and goggle.

4. Contingency Measures were decided as follows :

4.1 Suspected cases from AED would be admitted to B8 for cohort. The bed arrangement for SARS and ARS cases would be as follows : — AED Med.

Ward B8	Suspected Cases / Cohort	33 Beds
Ward A11	High risk case	14 Beds
Ward D6	ICU Care	12 Beds

4.2 In view of the need for isolation facilities, tight bed situation in Medical wards and possible increase admission after the closing down of AED in PWH, a contingency ward of 20 Beds would be opened (tentatively Saturday, 22 March 2003). More convalesant beds in KH and BH would be sourced and the support from RMD would be invited. — GM (N) Med. Secretary / RMD

4.3 To conserve resources for current situation, clinical departments would be advised to reduce non-urgent clinical activities including elective admission, SOPD attendance. — HCE

4.4 The supply of ribavirin in hospital would be ensured. — HCE

4.5 Staff would be reminded to comply to the droplet precaution. The use of mask for staff and visitors would be advised. — ICT

4.6 Staff Clinic should consider XRC for high risk staff or staff with upper respiratory symptoms. — ICT

5. Communication enhancements would include :

5.1 The internal communication would be stepped up through daily staff forum and announcement in the Intranet. The daily forum would focus on QEH situation, working guideline and practical information. Staff would be advised to contact ICT or Dr. Johnny Chan / Dr. M.P. Lee for query on SARS and ARS. — SHM (PA) / ICT / Dr. Johnny Chan / Dr. M.P. Lee

5.2 The external communication would be in line with HAHO. — SHM (PA)

5.3 The I.C.T. would daily provide the cases to the Task Group. — ICT

5.4 For preventing the spread of infection and accidental contact, it was necessary to limit the number of visitors. Ward notice to the public and visitors on visiting hour and no. of visitors would be issued in both Chinese and English. — SHM (PA)

5.5 Four clinical management guidelines, two from HA, 1 from Department of Medicine and 1 from AED, had been put onto the Intranet for staff information and guidance. The Paediatrics Department had also formulated similar checklist for clinical staff and patient relatives.

6. Monitoring and surveillance would be :

6.1 ICT the monitoring would continue role to evaluate the SARS situation. — ICT

6.2 The health status of staff exposed to SARS would be monitored. Surveillance template for sick staff would be sent to COSs for data collection to track staffing level and trend of disease pattern. — Secretary

7. Other issues discussed :

7.1 ICU had tightened the infection control measures. The issue of pregnant staff working in ICU was discussed. It was recommended that all staff working in ICU should observe full compliance to recommended infection control measures.

7.2 The use of N95 mask would be reserved for high risk cases. To ensure the effectiveness of the mask, appropriate method of wearing the mask should be observed.

7.3 In view of the closing down of AED of PWH. The contingency management in AED would be reviewed closely.

8. The date of next meeting would be 24 March 2003, 5 pm Rm 902.

9. The meeting ended at 8:40 pm.

080258

Notes of 2nd Meeting of Task Group on SARS
held on 24 March 2003 5:00 p.m. in Rm 902, Block S, QEH

Present :

Dr. Lawrence LAI	CCE / HCE		(Chairman)
Ms. Alice TSO	GM (N)		
Ms. Susanna KO	Proxy GM (PSS)		
Dr. C.T. HUNG	DHCE / COS	Anaesthesiology	
Dr. Patrick LI	COS	Medicine	
Dr. James HWANG	COS	Surgery	
Dr. H.F. HO	COS	A&E	
Dr. Thomas MOK	Consultant	RMD	
Dr. Grace CHAN	Consultant	Paediatrics	
Dr. Johnny CHAN	SMO	Medicine	
Dr. M.P. LEE	Assoc. Consultant	Medicine	
Ms. Judy WONG	DOM	Medicine	
Ms. L.K. WONG	DOM	A&E	
Ms. Helen TANG	SHM	P.A.	
Ms. Clara YIP	NM	I.C.T.	
Ms. Gloria CHEUNG	Manager	C.Q.I. Unit	(Secretary)

Absent with Apologies :

Dr. Dominic TSANG	Consultant	Pathology
Dr. K.Y. LAI	Consultant	Medicine

Discussion:

1.	In view of the increasing spread of SARS, the meeting would plan on the contingency measures for anticipated demand in the hospital.	Action
2.	According to HA's direction, clinical departments would reduce non-urgent clinical activities and SOPD services to conserve resources for the situation.	COSs
3.	Contingency measures in AED.	
3.1	For the anticipated soaring attendance, additional manpower support would be required on:	
3.1.1	Phlebotomists & nurses	CND
3.1.2	Family medicine physicians	Med.
3.2	Additional clinic would be set up for attendance with SARS symptom.	AED
3.3	Clinic location for cases with SARS symptoms and the follow-up clinic in G1 Ward would be rearranged. ACC would be contacted for venue support.	DHCE
3.4	Triage flowchart for SARS cases would be prepared.	AED

3.5	HAHO would be informed of the referral from GOPD.	HCE
3.6	More patient education information would be issued.	SHM (PA)
3.7	The respiratory team of QEH would follow-up AED suspected SARS cases together with staff contact in B8.	Med.
4.	Contingency measures for in-patient service.	
4.1	KH would provide 40 convalescent beds for medical patients.	HCE
4.2	A10 Ward would be reserved for filtered-out cases from B8.	Med.
4.3	Intensive Care areas :	Med.
4.3.1	To increase 4 beds in D6 and 3 beds in G9.	DHCE
4.3.2	In case D6 were full, the use of PACU would be considered.	
4.4	A11, B8, D6, G9 and all admission wards were considered to be high risk and dirty areas.	
4.5	Paediatrics had prepared the SARS checklist which was similar to adult patient management. This would be communicated within the department.	Paed.
4.6	Paediatrics would plan contingency measure similar to adult wards. Tentatively B2 Day Ward would be used for case cohort.	
4.7	HRCT Scan for close contact should be considered.	DR&I
4.8	Infection control guideline would be regularly updated and could be accessed from HA website.	
4.9	A coordinating group on SARS would be formed and would meet daily at 10 am. The Group aimed at monitoring the situation and contingency measures in hospital, and coordinating reporting to HAHO.	DHCE Dr. D. Tsang
5.	Infection Control measures.	
5.1	Disinfection of environment (public areas and clinical areas) using sodium hypochloride solution was recommended.	SHM (SS) DOMs DMs
5.2	Masks would be provided to patients and visitors, especially for high risk cases.	
5.3	Notice to patient about the requirement for wearing mask and gown would be issued.	SHM (PA)
5.4	The supply of isolation gowns, filter masks and N95 masks would be ensured. All staff were advised to wear mask. Gowns were to be worn for high risk cases and in dirty areas. The fund for various isolation facilities would not be borne by clinical departments.	HCE
5.5	Infection control associates of each ward would be activated to ensure good infection control practice.	ICT

5.6 Deep cleansing for wards with infectious case (e.g. G6) would be highly supported. SHM (SS)

5.7 Toilet cleansing with sodium hypochloride solution was recommended. Regular patrolling for compliance would be required. SHM (SS)

5.8 The use of ventolin nebulizer should be avoided. Spacer would be an alternative.

6. Staff Support

6.1 Staff counselling by clinical psychologist had been introduced.

6.2 Spot Award of HAHO would be promoted.

6.3 Staff re-deployment from stressful areas would be explored.

6.4 Comfortable room temperature in clinical areas would be explored with EMSD, in relation to the increased air change. SHM (SS)

7. Other suggestions

7.1 The availability of diagnostic test was deemed urgently necessary.

7.2 Staff with case contact or with increasing worry would be followed up in B8, when necessary. They might contact either Dr. Johnny Chan, Dr. M.P. Lee or Dr. Thomas Mok.

7.3 The advice from HAHO on seeking AED attendance by staff of other hospitals or clinics would be sought.

7.4 As informed, disposable masks could be purchased from QEH Seven Eleven Convenience Store.

7.5 Surgical-side would provide help to medical-side. Volunteer support from other departments within hospital was anticipated.

7.6 RMD would provide more help to AED and Dept. of Medicine. Respiratory physicians had been scheduled in daily round.

7.7 Counselling service was deemed necessary for relieving staff stress.

8. The date of next meeting would be within this week.

9. The meeting ended at 7:50 pm.

Notes of 3rd Meeting of Task Group on SARS
held on 28 March 2003 3:00 p.m. in Rm 202A, Block S, QEH

Present :

Dr. Lawrence LAI	CCE / HCE		(Chairman)
Dr. Y.C. CHOI	HCE	Kowloon Hospital	
Dr. Tseuk Tsan	HCE	Buddhist Hospital	
Ms. Alice TSO	GM (N)		
Ms. Leslie AU YEUNG	GM (BSS)		
Dr. James HWANG	COS	Surgery	
Dr. Patrick LI	COS	Medicine	
Dr. C.T. HUNG	DHCE / COS	Anaesthesiology	
Dr. H.C. YU	COS	ENT	
Dr. W.H. LEE	COS	Paediatrics	
Dr. Susan CHAN	COS	DR&I	
Dr. Y.C. SO	COS	O&T	
Dr. C.K. LAW	COS	Clinical Oncology	
Dr. H.K. WONG	COS	O&G	
Dr. H.F. HO	COS	A&E	
Dr. K.F. WONG	COS	Pathology	
Dr. K.Y. LAI	Clinical Director	ICU	
Dr. Grace CHAN	Consultant	Paediatrics	
Dr. H.M. CHIU	Consultant	Neurosurgery	
Dr. C.C. MA	Consultant	CTS	
Dr. Johnny CHAN	SMO	Medicine	
Ms. Judy WONG	DOM	Medicine	
Ms. L.K. WONG	DOM	A&E	
Ms. Helen TANG	SHM	P.A.	
Ms. Clara YIP	NM	I.C.T.	
Ms. Gloria CHEUNG	Manager	C.Q.I. Unit	(Secretary)

Absent with Apologies :

Dr. Thomas MOK	Consultant	RMD
Dr. Dominic TSANG	Consultant	Pathology
Dr. M.P. LEE	Assoc. Consultant	Medicine

Discussion:

Action

1. Upon the close down of AED in PWH and PMH, increase in AED attendance and hospital admission was expected. With the long length of stay of SARS cases, it was necessary to refocus the cluster service.

2. The support from KH and BH would be enlisted to provide more convalescent beds. — HCEs (KH, BH)

3. HA contingency plan on hospital service reorganization was as follows:
   - All SARS admitted to PMH
   - KWH convalescent patients to BH
   - PMH obstetric patients to QEH
   - K.W. Cluster TB and Chest patient to KH
   - UCH paediatric patients to QEH
   - KW Cluster head injury convalescent patient to KH
   - PMH trauma patients to KWH
   - PMH non-trauma patients to CMC and YCH
   - UCH neurosurgical patient to QEH

4.	The Task Group for SARS was set up deciding and for coordinating contingency plan in KCC. Members support to the Group's decision was invited.	HCEs / COSs
5.	The strategy for handling the SRS situation would be :	
	5.1 Conservation of manpower and resources.	COSs
	5.1.1 To reduce non-urgent service and elective admission in all departments.	
	5.1.2 To reduce SOP activities.	
	5.2 Setting up A10 Ward with 20 beds for step-down care.	Med.
	5.3 Managing work volume upon service rearrangement of PMH :	
	5.3.1 Reducing own workload to help other, except for cancer care or urgent surgery.	COSs
	5.3.2 Not confining AED admissions to one hospital within the cluster.	HCEs
	5.3.3 Transferring expertise at intra cluster level.	
	5.4 Reinforcement on infection control practices :	
	5.4.1 Availability of infection control policy and guideline in hospitals of the cluster.	HCEs
	5.4.2 Appropriate allocation and use of infection control facilities, namely masks, protective gowns, O.T. gowns, chlorhexidine alcohol hand-rub and handwashing facilities.	HCEs
	5.4.3 Mandatory infection control training workshops for all staff.	GM (N)
	5.4.4 Mobilisation of infection control associates in wards to ensure good infection control practice.	GM (N)
	5.4.5 Recruiting 5 surgical colleagues to HAHO for promoting infection control.	DHCE
	5.5 Providing session for experience sharing and case studies.	CCE
	5.6 Coordination on public information and enquiry by HA and DH.	
	5.7 Centralisation of SARS incident reporting through Infection Control Team in the hospital.	ICT
	5.8 Strengthening more support to AED.	
6.	The transfer of suspected SRS cases to KH should be avoided. Alternatively the patient should at least stay in QEH over 7 days. Early return to community care should be considered.	COSs
7.	Staff members of the cluster were welcomed to participate in the seminars and forums of QEH.	HCEs
8.	The NEATS for Geriatric Day Hospital service had to be suspended so as to ensure the capacity for transference of SRS cases to PMH.	GM (BSS)
9.	Meeting ended at 4:50 pm.	
10.	Date of next meeting would be announced in due course.	

Notes of 4th Meeting of Task Group on SARS
Held on 8 April 2003 5:00p.m. in Room 202A, Block S, QEH

Present :

Dr. Lawrence LAI	CCE / HCE		(Chairman)
Dr. Y.C. CHOI	HCE	Kowloon Hospital	
Dr. CHEUK Tsan	HCE	Buddhist Hospital	
Dr. C.K. LIN	HCE	BTS	
Dr. C.T. HUNG	DHCE / COS	Anaesthesiology	
Ms. Alice TSO	GM (N)		
Ms. Leslie AU YEUNG	GM (BSS)		
Dr. James HWANG	COS	Surgery	
Dr. Patrick LI	COS	Medicine	
Dr. W.H. LEE	COS	Paediatrics	
Dr. Susan CHAN	COS	DR&I	
Dr. Y.C. SO	COS	O&T	
Dr. C.K. LAW	COS	Clinical Oncology	
Dr. H.K. WONG	COS	O&G	
Dr. H.F. HO	COS	A&E	
Dr. K.F. WONG	COS	Pathology	
Dr. YIP Ka Chee	COS	Psychiatry	
Dr. K.K. HO	COS	CTS	
Dr. N.M. LAM	(Proxy COS)	Eye Hospital	
Dr. H.L. CHAN	Consultant (Proxy COS)	ENT	
Dr. F.C. CHEUNG	Consultant (Proxy COS)	Neurosurgery	
Dr. Grace CHAN	Consultant	Paediatrics	
Dr. W.Y. SHEN	Consultant	O&T	
Dr. K.Y. LAI	Clinical Director	ICU	
Dr. Thomas MOK	Consultant	RMD	
Dr. M.P. LEE	Assoc. Consultant	Medicine	
Ms. Judy WONG	DOM	Medicine	
Ms. L.K. WONG	DOM	A&E	
Ms. Helen TANG	SHM	P.A.	
Ms. Annie WONG	SNM	Commissioning	
Ms. Clara YIP	NM	I.C.T.	
Ms. Gloria CHEUNG	Manager	C.Q.I. Unit	(Secretary)

Absent with Apologies :

Dr. Dominic TSANG	Consultant	Pathology
Dr. Johnny CHAN	SMO	Medicine

Discussion :

Action

1. The CCE presented an overview on existing SARS situation in Hong Kong and world-wide. He expressed the need for command and control in combating the SARS epidemics. Strategies for this battle included communication, identification and isolation of SARS patients, staff protection, supplies and facilities, as well as service rearrangement, staff deployment and rotation.

2. He called for collaboration from hospitals and institutions within the Cluster to fight against SARS. He explained that this Task Group would steer the overall initiatives in the cluster. HCEs COSs

3. To cater for the increase in SARS admission, accumulated suspected and confirmed SARS cases and to manage undiagnosed SARS cases in general wards, a contingency plan was proposed for members' view. The assumption for the plan was that QEH would receive 10% of the 3,000 SARS cases as projected by HA, and 15% of the patient would need ICU care. HCE COSs

4. Contingency plan for discussion :

4.1 Stage 1

4.1.1 Option 1

To vacate 1 medical and 1 surgical admission ward to cater 80 cohort beds :

- H2 and A1 would be surgical admission wards
- E4, E5, E6, E7, G5 & G6 would be medical admission wards
- E4, E6, G5 & G6 would be cohort/fever wards

There would be 182 beds, including 80 cohort, 42 SARS, 20 ICU, 20 step-down and 20 discharge beds. Bed situation would be improved if 40 beds in KH were fully utilisated.

4.1.2 Option 2

To vacate 2 wards (i.e. E4 and G5) from surgical stream for medical emergency admission wards. The bed no. would be similar to Option 1.

4.1.3 Option 3

To allow liberal medical overflow to Surgical and O&T wards

4.2 Stage 2

To vacate G3 and H4 for case cohort and to convert A10 to SARS ward. Cases for step-down care would be sent to KH. This would make 120 beds for SARS admission.

5. Feedback on contingency plan was as follows:

5.1 Attention had to be paid in maintaining Eye and ENT Consultation Rooms in H2 and H4 respectively.

5.2 Obstetric admission in QEH was on the rise.

5.3 If the situation persisted for a long time, back-up for ICU and trauma care would be required.

5.4 QEH had to provide a suppressed reasonable general service.

5.5 E4 ward could be a possible extension for ICU area.

5.6 QEH had to maintain overall hospital service, in addition to service for SARS admission.

6. Staff Deployment and Training :

6.1 In managing the tight manpower situation in QEH, with the deployment of medical and nursing staff to ICU PMH and the new function areas in QEH, staff deployment within the hospital would be needed for AED, ICU and Respiratory Team. Support had already been received from Departments of Anaesthesiology, Surgery and O&T, RMH (KH) and Medical Team (BH).

6.2 Nursing deployment would be on staff skill mix and redeployment within Dept. of Medicine. It was noted that frequent rotation would affect staff expertise and might not prevent burnt-out.

6.3 Medical deployment from different specialties would initially be within QEH and later on within the Cluster. Cross-cluster deployment would be based on COC decision. This could be a training opportunity for staff skill.

6.4 The initial deployment period would be 12 weeks. Deployed staff would rotate in 2 batches consecutively, and each batch would last 6 weeks.

6.5 Each department would deploy 30% medical staff i.e. 15% for each batch. Names of staff would be sent to Dr. C.T. HUNG before 12th April. — COS

6.6 Refresher medical training would be arranged for the deployed staff. — DHCE

7. Members were invited to give feedback before 10 April on the two papers 'Guidelines for managing unprotected exposure to SARS patients' and 'Guideline for managing staff exposure to SARS patients'. — HCEs / COSs

8. Rapid Test for PCR would not be available in QEH before the end of April. For the time being, Rapid Test had to be sent to Dept. of Health or HKU. — COSs

9. The meeting ended at 7:45 p.m.

10. The date of next meeting would be announced in due course.

Notes of 5th Meeting of Task Group on SARS
Held on 24 April 2003 4:00p.m. in Room 202A, Block S, QEH

Present :

Dr. Lawrence LAI	CCE / HCE		(Chairman)
Dr. Y.C. CHOI	HCE	Kowloon Hospital	
Dr. CHEUK Tsan	HCE	Buddhist Hospital	
Dr. C.T. HUNG	DHCE / COS	Anaesthesiology	
Ms. Leslie AU YEUNG	GM (BSS)		
Ms. Rebecca NG	Proxy GMN		
Dr. James HWANG	COS	Surgery	
Dr. Patrick LI	COS	Medicine	
Dr. W.H. LEE	COS	Paediatrics	
Dr. Susan CHAN	COS	DR&I	
Dr. Y.C. SO	COS	O&T	
Dr. William FU	Consultant (Proxy COS)	Clinical Oncology	
Dr. H.K. WONG	COS	O&G	
Dr. YIP Sai Hung	Consultant (Proxy COS)	A&E	
Dr. K.F. WONG	COS	Pathology	
Dr. YIP Ka Chee	COS	Psychiatry	
Dr. K.K. HO	COS	CTS	
Dr. N.M. LAM	(Proxy COS)	Eye Hospital	
Dr. H.C. YU	COS	ENT	
Dr. Samuel LEUNG	COS	Neurosurgery	
Dr. Grace CHAN	Consultant	Paediatrics	
Dr. W.Y. SHEN	Consultant	O&T	
Dr. K.Y. LAI	Clinical Director	ICU	
Dr. Thomas MOK	Consultant	RMD	
Dr. M.P. LEE	Assoc. Consultant	Medicine	
Ms. Judy WONG	DOM	Medicine	
Ms. L.K. WONG	DOM	A&E	
Ms. Helen TANG	SHM	P.A.	
Ms. Annie WONG	SNM	Commissioning	
Ms. Grace CHENG	NM	CND	
Ms. Gloria CHEUNG	Manager	C.Q.I. Unit	(Secretary)

Absent with Apologies :

Dr. Dominic TSANG	Consultant	Pathology
Dr. Johnny CHAN	SMO	Medicine
Ms. Clara YIP	NM	I.C.T.

Discussion : **Action**

1. The notes of last meeting was confirmed with no amendment.

Overall Situation

2. The management and political issues of the SARS epidemics were reviewed. In spite of decreasing new cases, problems might arise from discrepancy of expectation and what could be done, clinical governance, system defects in ward ventilation and beds spacing, as well as hospital culture and staff attitude towards infection control.

Action

3. For preventing the above issues, the help of departments' heads was solicited in communicating with staff on current situation, reducing staff grievance and harnessing their support. Staff should be also reminded of vigilance for infection control. — Department Heads

Use of PPE

4. The standard PPE included N95 mask, cap, goggles, gown and gloves.The level of personal protective equipment (PPE) required was controversial, whether 100% protection or adopting standard protection. The discussion was focused on Air-mate Respirator, Stryker T4 Respirator and Barrier-man overall. Samples of these PPE were tried by members present. It was deemed necessary to direct the message to department staff with photographs of these items through email or demonstration. — DHCE

5. Concerning self-purchase PPE, staff had to be reminded of the principle that the purchased item should not be substandard. They should have the knowledge of correctly using the item and the item could not endanger the health of other staff. P100 mask was one of those items not recommended for general use except in ICU where all staff were using the item. — Departments

6. For enhancing better staff protection

   6.1 Aerodynamic calculation for negative pressurised operating rooms in D2 (Room 7 and Room 8) with existing laminar flow would be made to ensure balanced pressure within the operating theatre. — DHCE

   6.2 The Safety Controllers (Infection Control) would help cross-inspection and sharing out of good practice. — GM (N)

7. The supply of PPE had been consistent and adequate. For appropriate use, the KCC Command Centre would be responsible for any related enquiry. All staff had to be on the alert for proper infection control practice, in view of hidden SARS in Non-SARS wards. — DHCE Departments

Bed Arrangement for SARS

8. The contingency plan for further bed allocation for SARS was proposed.

	QEH Adult		**Paed**		**KH**
SARS Wards	A11 A10 B8	14 27 24	A9	20	32
ICU	D6/B6/G9	23	B2	2	
Cohort SARS Wards	G6 G5	27 27	B2D	4	
		142		**26**	**32**
				Total	**200**

		Action
	By May there would be one more ward in KH to receive convalescent patients from G5. In case of any community outbreak, further bed allocation would be sourced from neurosurgical wards and orthopaedic wards.	KH DHCE
9.	The ward setting in G5 and G6 would serve as reference for future isolation ward.	DHCE
10.	For facilitating better infection control facilities in high risk wards, the ward MO room would be relocated to allow a gowning room in ward, and a staff toilet would be converted to a shower room.	DHCE GM (BSS)
11.	Manpower deployment would be carried out after 28 April. Each round of staff rotation would be 4 weeks for medical staff and 6 weeks for nursing staff.	Departments

Any Other Business

12.	Encashment of leave would be applicable only for the maintenance of normal service. The granting would be up to department management's discretion.	Department Heads
13.	In case of contingency, O.T. nurses would be deployed to ICU.	
14.	Rapid Test for PCR would be available in QEH as from 23 April and would be provided to health care worker as start. The turn-around time for real time PCR would be shorter.	Dept. of Pathology
15.	Temperature taking for visitor was advisable but not mandatory. Hospital staff should attend staff clinic or AED whenever feeling unwell.	Wards to note
16.	CCE concluded that the current epidemics was a battle and the battle front was changing. It was necessary to avoid disintegration among staff and breakage in system. The SARS might linger for 3-6 months. The prime goal would be zero infection rate in staff. Better communication with staff would not only be required among middle management but also for all frontline. Vigilance and sustenance on infection control practices would be required.	Departments
17.	The date of next meeting would be announced in due course.	
18.	The meeting ended at 8:10 pm.	

080269

Notes of 6th Meeting of Task Group on SARS
Held on 16 May 2003 5:00p.m. in Room 202A, Block S, QEH

Present :

Dr. Lawrence LAI	CCE / HCE		(Chairman)
Dr. CHEUK Tsan	HCE	Buddhist Hospital	
Mr. S.Y. KWAN	GM (N) prox HCE	Kowloon Hospital	
Dr. C.T. HUNG	DHCE / COS	Anaesthesiology	
Ms. Leslie AU YEUNG	GM (BSS)		
Ms. Alice TSO	GM (N)		
Dr. Derrick AU	COS	Rehab. (Kowloon Hospital)	
Dr. YIP Ka Chee	COS	Psychiatry	
Dr. James HWANG	COS	Surgery	
Dr. Patrick LI	COS	Medicine	
Dr. W.H. LEE	COS	Paediatrics	
Dr. Susan CHAN	COS	DR&I	
Dr. Y.C. SO	COS	O&T	
Dr. C.K. LAW	COS	Clinical Oncology	
Dr. H.K. WONG	COS	O&G	
Dr. H.F. HO	COS	A&E	
Dr. K.F. WONG	COS	Pathology	
Dr. K.K. HO	COS	CTS	
Dr. N.M. LAM	(Proxy COS)	Eye Hospital	
Dr. H.C. YU	COS	ENT	
Dr. Samuel LEUNG	COS	Neurosurgery	
Dr. Grace CHAN	Consultant	Paediatrics	
Dr. W.Y. SHEN	Consultant	O&T	
Dr. M.P. LEE	Assoc. Consultant	Medicine	
Ms. Judy WONG	DOM	Medicine	
Ms. L.K. WONG	DOM	A&E	
Ms. Annie WONG	SNM	Commissioning	
Ms. Gloria CHEUNG	Manager	C.Q.I. Unit	(Secretary)

Absent with Apologies :

Dr. Dominic TSANG	Consultant	Pathology
Dr. K.Y. LAI	Clinical Director	ICU
Dr. Thomas MOK	Consultant	RMD
Dr. Johnny CHAN	SMO	Medicine
Ms. Helen TANG	SHM	P.A.
Ms. Clara YIP	NM	I.C.T.

Discussion :

Action

1. Review of current situation :
   - 1.1 No SARS admission was recorded in recent weeks. PMH would reopen for general service in July while PWH might still require some support on medical admissions.
   - 1.2 Occasional breakthrough infections of SARS in staff could be due to :
     - 1.2.1 inadequate awareness for "hidden" SARS patients.
     - 1.2.2 unreported sickness of SARS in staff.
     - 1.2.3 inappropriate use and disposal of personal protective equipment and gear such as Barrier-man which led to recontamination.

1.3 Overcrowding and narrow bed spacing would render prevention of cross infection difficult.

1.4 About 125 clinical SARS patients had been admitted to QEH. Successful management of these patients was achieved through reduced non-emergency in-patient activities and admissions, so as to focus resources to tackle the SARS outbreak.

1.5 The lessons learnt from this epidemics were :
- 1.5.1 need for contingency planning for SARS outbreak.
- 1.5.2 efficient manpower deployment.
- 1.5.3 reducing overcrowding.
- 1.5.4 better risk stratification and identification of infectious patients.
- 1.5.5 facilities and environmental improvement for the treatment of infectious patients.

2. Hospital normalizing arrangement after SARS

2.1 Decommissioning of SARS cohort wards
- 2.1.1 A10 convalescent ward would be decommissioned by next Monday.
- 2.1.2 SARS patients in B6 ICU would be transferred to D6 ICU. B6 ICU would serve as general ICU after deep cleansing.
- 2.1.3 B8 would admit suspected SARS patients.
- 2.1.4 A11 would be for clinical SARS patients.
- 2.1.5 G5 and G6 would continue as "fever" wards.
- 2.1.6 Two wards in KH would be designated for step-down care for patients from G5 and G6.

2.2 Deployed staff would return to original departments/wards.

2.3 Normal hospital services could not be resumed within a short period as the ICU support was still compromised, but clinical departments should prepare for returning to normal activities, e.g. surgical services. — Departments to note

3. Enhanced requirement for isolation facilities

3.1 HA would advocate rightsizing of in-patient beds in hospitals.

3.2 More ambulatory care and day procedures would be advocated as the preferred future mode of hospital service delivery.

3.3 HA would explore the options of designating hospital in each cluster for admission of infectious disease patient or setting up infectious disease wards in each hospital.

3.4 Optimal bed spacing of 6.5m²/bed would be targeted. This would infer that the bed state in each QEH ward might have to be reduced.

3.5 Hospital ventilation system would be enhanced with more wards to be equipped with negative pressure.

3.6 The service area in AED would have to be increased to allow space for segregation of fever cases from general cases.

3.7 The feasibility of allowing AED nurses to initiate XRC would be explored to facilitate early diagnosing of SARS. — AED

3.8 The capability of admitting infectious disease in QEH would be enhanced with risk stratification :

a. setting up infectious disease wards with a total of 50 beds.
b. designated cubicle or side room for cohorting patients with the same suspected infectious disease in individual wards.

3.9 Enhanced design of infectious disease (fever) wards would include infection control features like gowning room and showering facilities. A10 would be converted to infection disease ward with facilities similar or better than A11.

3.10 An integrated admission wards system of 10 admission wards would be explored, each with 32 beds, to cater for 130-150 admissions per day.

3.11 Ward G5 and G6 would continue to serve as "fever" wards.

4. Staff Deployment

4.1 Difficulties in staff deployment were encountered during the SARS epidemics. This suggested the need for future contingency plan on staff deployment.

4.2 Deployment of medical staff should be planned with training and skill transfer prior to deployment. — DHCE

4.3 For nursing staff, deployment raised the issue of generalization and specialisation of nursing work force. Under the existing system of departmentalization, nurses were developed in specialty care rather than general care. Deployment to other clinical departments would be fraught with difficulty because of differences in nursing competency. It was proposed that the management of nursing staff be centralized to facilitate professional training and development by rotating among different specialties in the first 5 to 6 years before settling in one specialty for further development. Clinical departments could then have core nursing staff with specific skill. Under such arrangement, nurses would have a broad-based experience and be capable of working in different settings. — GM (N)

5. Emergency shower facilities

Showering and changing facilities in 'F' Block would be opened for staff with unprotected exposure to SARS patients. Departments were requested to render these facilities to hospital management. — Departments to note

(Post meeting Notes : Shower facilities were identified at AED and A11 Ward for emergency use.)

6. High flow oxygen administering

HAHO had recently promulgated the QMH incident of staff acquiring SARS because of over aerosolisation generated from high flow oxygen. Hospital oxygen guideline was accordingly issued to ensure proper precaution with the use of high flow oxygen, i.e. simple mask and nasal cannula for 1l - 6l / min flow of oxygen, non-breathing bag mask for 6l - 10l / min oxygen of flow. Venturi mask should only be used when patient was oxygen sensitive and be placed close to exhaust fan. BiPAP should be avoided (HA guideline). — Departments to note

7. Staff body temperature checking — All Staff to note
All staff should be encouraged, though not mandatory, to self-check body temperature before work to detect unaware feverish condition. A clinical thermometer would be issued to every staff.

8. Standard PPE — Departments to note
HAHO had released the list of standard basic PPE today. The use of face shield was recommended to avoid splashing. N95 mask could be changed daily. For high risk procedure, more and better PPE could be adopted, such as N100 mask and Airmate respirator. Staff should seek advice from Infection Control Team or KCC Command Centre on SARS concerning the use of self purchased PPE to ensure the appropriateness and knowledge of usage as well as to avoid any hazard to other people. Staff sentiment of using PPE should be addressed when giving advice.

9. Dr. K.F. Wong advised members to repeat laboratory test upon receiving abnormal serology test results for SARS. — Departments to note

10. The date of next meeting would be announced in due course.

11. The meeting ended at 8:30 p.m.