8(e)

Q. *Terms of reference, names and post titles of members, and minutes or any other records of meetings of: Task Force on Infection Control on SARS*

The Taskforce on Infection Control was a daily informal meeting and as such did not have a formal terms of reference and no minutes taken. - **H95**

Membership is at Attachment a

The areas under this Taskforce's monitoring included:

i) Expert Group on Infection Control (minutes at Attachment b) - **H96**
ii) Hotlines
iii) Hospital inspection / audit
iv) Chinese Medicine (membership, TOR & minutes of the Chinese Medicine Expert Panel & Chinese Medicine Advisory / Expert panel at ci, ii & iii) - **H97**

Attachment 1

080521

Notes of the 1st Meeting of the Expert Group on Infection Control for SARS held on 3 May 2003 at 11am in Room 519N, HAHO

Present

Dr W M KO, D(PS&PA) — Chairman
Dr William HO, CE
Dr Hong FUNG, NTEC CCE
Dr Beatrice CHENG SEM (PS) 3
Ms H S LAM, YCH ICN/ICO(Path)
Mr PW LEE, CP
Dr S H LIU, SEM (PS)1
Dr H W LIU, Cons (CE)
Dr S F LUI, NTEC SD(QA&RM)
Prof Joseph Malik PEIRIS, MIC,HKU
Dr W H SETO, HKWC CD(Q & RM)
Ms Margaret TAY, EM (PS) 6
Dr W K TO, YCH, SMO (Path)
Dr N C TSANG QEH Con (Path)
Prof Ignatius YU, COM & FM, CUHK
Mr PL YUEN EM (EM)
Dr Raymond YUNG, HKEC CPA CSC
Ms Assunta LEE, HOPS&PA M(SD)2 (Notes taking)

Absent with Apologies

Dr Paul CHAN, MIC, CUHK
Dr S T LAI, PMH Con (Med & Geri)

Action By

I. Briefing on Task Force on Infection Control for SARS

1. Dr WM Ko said that the Task Force on Infection for SARS composed of the Expert Group and a team of staff from the HAHO including Dr SH Liu, Dr HW Liu, Dr Beatrice Cheng, Ms Margaret Tay, Dr KM Choy and Mr Michael Ho. The Expert Group would serve as the brain of the Task Force, and would be setting standards and formulating guidelines for implementation. Dr H Fung would participate in the Group as

the supplies of PPE were crucial in implementing infection control.

2. Individual hospitals were having their own infection audit teams but there was no central coordination. Dr HW Liu would be working with a professional independent team composing of volunteers from the PDA, senior surgeons and nurses. They would form small independent audit teams and visit hospitals to collect feedback. The feedback would be channeled back to the Expert Group, Directors' meeting and the CCEs after analysis. In addition, there was a 24-hour SARS hotline for staff to address their enquiry.

3. The outbreak of SARS and the cause of staff infection would also be studied.

II. Audit of Infection Control

4. There would be 3 types of audit as follows:
   - Hospital's internal audit
   - Independent Audit Team centrally coordinated
   - GIA

5. They were of different nature and purposes. The hospital internal audit would have a more operational duty and they would be for enforcing the local implementation of guidelines. Independent audit team was centrally coordinated where they would have a more independent observation. The GIA would have more focus on the management process. It was important to have proper documentation to protect the organization and the staff. Members were requested to provide input to Dr HW Liu the latest by Monday so that he could finalize the standard audit form to be used by the independent audit team. *All to note*

6. A briefing had been conducted to the independent audit team. There would be about 3-5 volunteers to in a small audit team per hospital and they would visit the hospitals in a biweekly cycle except when the individual hospitals had just carried out their

own audit within 1-2 weeks. The audit team would only collect information except for those very obvious problem would they give immediate advice. Subsequent analysis would be carried out by Mr Michael Ho and the feedback would be given to the CCEs, Directors' meeting and the Expert Group. The process could commence in the middle of the following week.

III. Standard Provision of PPE

7. CE said that there were extreme and diversified views and whether those views were due to supplies or communication problems, they might lead to fear of staff. The Chairman, Dr C H Leong was of the view that a standard should be set for high and other areas with which one could differentiate what was within or beyond the HA standard despite the diversified views of the staff.

8. The meeting discussed on the use of standard PPE for the following setting:

- High risk area and other clinical areas
- Convalescent wards
- Psychiatric wards

<u>Standard Provision of PPE for High Risk Areas</u>

9. The standard personal protection equipment (PPE) for high risk areas was discussed which included the following:

- Cap
- Goggles
- Disposable N95 mask/ surgical mask
- Full-faced shield
- Working clothes for hospitals
- Protective gown
- Gloves

The high risk areas were defined as SARS wards, ICU, A&E, Admission/ Fever/Triage ward, wards for special aerosol procedures eg Bronchoscopy. The boundary for high risk areas could be more specifically defined depending on the physical

layout of the wards.

(i) Cap

Staff should be capped all the time

(ii) Goggles

Suitable protection eye wear should be put on all the time. The staff should wear a face shield and for special procedures eg intubation a goggle should be worn.

Dr H Fung said that the face shield could be manufactured locally and the production line could be set up once the quantity was confirmed and it could take place the following week.

(iii) Mask

It was proven that the transmission of SARS was mainly due to droplets which was >0.5μm. A surgical / N95 mask had to be worn. The meeting discussed on the use of various models of masks regarding the efficiency and practicality. It was crucial that there must not have faceseal leak of the masks in the high risk areas. N100 model was useful for industrial purposes but not needed in the SARS management. The use of N95 and surgical masks was discussed and the meeting concluded the followings:

- Face shield being a must item
- N95 must fit the individual staff with no faceseal leak. Fit check must be carried out beforehand. Fit test could also be carried out if considered necessary.
- Fit check should also be carried out as and when necessary because the mask could be displaced after certain procedures
- N95 must be disposed immediately after use if being used without protection of face shield ie naked N95. However, if covered, N95 could be reused in the same area but staff must not leave the high risk areas putting on the same N95. It would be dangerous if staff wearing the same N95 from the high risk areas to other places of the hospital.
- N95 had to be worn for high risk procedures eg intubation and

it had to be disposed immediately after the procedure. When N95 got wet or soiled, it had to be disposed immediately.

- Models of masks should be standardized within HA. The standard models found to be useful were N95 1860S, N95 1860, 9210 and Technol (Duck beak).

Surgical mask was recommended for other areas but the above would apply when admitting new patients, carrying out high risk procedures and carrying out procedures having close contact with patients.

(iv) Full-face Shied

Full-face shield would be manufactured locally and it would be an universal item for staff at high risk areas.

(v) Working Clothes for Hospitals

Staff could continue wearing hospital uniform but they had to get changed before going home.

(vi) Protective Gown

- The gown should be of adequate length to provide protection
- The quality of the gown should provide sufficient protection to staff from having fluid getting through it
- Quality of gown
  - White one no good
  - Yellow one, water repellant
  - New blue ones the best, more water resistant
- Use the new blue ones in the high risk areas and continue to use the yellow ones until the stock was exhausted

(vii) Gloves

- Double gloves not necessary
- If double gloves were used, staff must wash hands when changing the gloves
- Must wear gloves for patient procedures & must remove gloves and wash hands after patient procedures
- Staff might also wear gloves all the time if preferred but must wash hand when changing gloves

PPE for Other Areas

10. It was considered not necessary to have full application of the above to all other areas. Mask and eye protection were considered necessary as PPE for other areas. However when admitting new patients, carrying out high risk procedures and having close contact with patients, the application of full gear PPE for high risk areas should be in place. Apart from PPE items for mask and eye protection, other PPE items would also be made available for staff who preferred to have them.

11. Other PPE

(i) Stryker and Air-mate

There was a recent controversy on the effectiveness of Sryker therefore pending further review, recommendation could not be made then. No special recommendation had yet been set for Air-mate.

(ii) BarrierMan

The barrierMan provided total coverage which had a better physical protection to staff however staff might not like it. Prof Ignatius Yu said that if the infection control procedures had been carried out properly then the risk would be very much reduced and there might not have a need to have total body coverage. Dr WM Ko said that the current barrierMan gear was not water resistant and there was perspiration problem, and the procedures to gown and ungown were clumsy. Hence there would be a separate design with two pieces (upper and trouser part) which provided adequate coverage for the body. New material would also be used which could allow perspiration. To conclude, there would have a better design barrierMan with better material to provide better protection.

(iii) Shoe Cover

Shoe cover was considered not necessary but staff should change to another pair of shoes before going home

12. It was resolved that the convalescent and psychiatric wards would

be included under the category of Other Areas and the provision of PPE would be the same.

13. Dr H W Liu would draw up guidelines for the provision of standard PPE in HA — *Dr H W Liu*

IV. Faecal transmission of SARS

14. It was difficult to disinfect excreta and use of Chlorine tablet to disinfect the faecal matter was not effective. Dr SF Lui and Dr NC Tsang were requested to draw up the guidelines for handling bedpan including the usage, transportation, disposal and treatment. — *Dr Lui* *Dr Tsang*

15. Used Diapers should be treated as clinical waste. Additional instruction should also be given to waste disposal contractor to ensure proper handling of SARS contaminated clinical waste. — *Dr M Y Cheng*

V. Temperature Check for Staff

16. It was important to prevent the introduction of SARS to hospitals via staff and visitors, and SARS to non-SARS ward by new patients. Checking of temperature was crucial as it was an important indicator.

17. In view of the recent outbreak of SARS in the non-SARS ward, it was important to study the cause and take appropriate action for prevention. Recently there had been a HCA who got infected in community while taking leave.

18. Dr WM Ko brought up the practice of Singapore, Toronto and Taiwan where checking the body temperature was an important element before reporting duty. In Toronto and Taiwan, the hospitals had restricted to only one entrance for each building. If there was any fever detected, staff would need to report to in-charge and refrain from work. Apart from staff, visitors were also required to have the body temperature checked.

19. Although some professionals in HA might not be of the view of checking body temperature daily as a routine, it was indeed an important indicator that needed to be considered. The meeting concluded that

- the professional staff should take the body temperature themselves before reporting duty
- the supporting staff would have their body temperature taken on their behalf before reporting duty

20. As for visitors, an apparatus using infra-red scanning for checking body temperature could be used. Mr LP Yuen showed two apparatus to the meeting in which one was a portable intra-red gun and the other one was an intra-red scan that could be fixed to the entrance of a ward or building. In order to avoid false negative, the equipment would be calibrated before used. The cost of the scan was around $200,000+. CE commented that the scan should be set up at the entrance of the areas where there was busy flow of the public and new patients eg A&E. The equipment should also be set up in convalescent and psychiatric hospitals to check the visitors. Mr PL Yuen would explore purchasing the equipment however he said that the supplies of the equipment might be tight as they were in demand. Dr WM Ko also said that each staff should be provided with a thermometer for checking body temperature. *Mr Yuen*

21. While all necessary procedures had been taken, the work culture would also need to be addressed as some of the staff were very conscientious and they would still come back to work despite that they had a fever. Staff should stop from going to work if they had a fever. Special attention should pay to the contract or temporary supporting staff group. *HR*

VI. Discharge Policy & Management of ward contact

22. The proposed protocols from DH on the procedures at the airport, border control points and ports for health declaration and temperature measurements and the criteria for referring passengers with suspected SARS symptoms were supported.

23. Some of the hospitals had separate SARS follow up clinic. Availability of SARS clinic in hospitals should be checked. It was suggested that the discharge policy for keeping the patients for 14 days at home should include institutions as well. Upon discharge, the institutionalized patients should be kept at the individual institution for 14 days. DH should be informed of the arrangement. The institution should be asked to identify the appropriate cohort facilities to accommodate the discharged patients. *Dr S H Liu*

VII. Outbreak Investigation

24. Ms Margaret Tay would be taking care of the SARS outbreak study. Any 2 or more people contracted with SARS in a non-SARS area would be treated as an outbreak and it had to be reported and the related information would be collected within a day.

25. Dr Beatrice Cheng would take care of the study on staff infection. She would carry out a retrospective study for all staff who had got infected and a prospective study for newly infected staff. Dr Ho Pak Leung had been assisting the outbreak and staff infection study.

VIII. Any Other Business

26. Function for the pneumatic tube connecting with SARS wards should be suspended to minimize opportunity for infection.

27. Members commented that the product titanium dioxide product from Green Earth Society would cause fogging and hence the product was not desirable.

080530

Notes of the 2nd Meeting of the Expert Group on Infection Control for SARS held on 10 May 2003 at 10am in Room 524N, HAHO

Present

Dr William HO, CE — Chairman
Dr W M KO, D (PS&PA)
Dr H FUNG, CCE NTE
Dr Derrick AU, KCC CC (MR)
Dr Beatrice CHENG SEM (PS) 3
Dr Daisy DAI, SEM (MSD)
Dr S T LAI, PMH Con (Med & Geri)
Ms H S LAM, YCH ICN/ICO(Path)
Mr P W LEE, CP
Dr Michael LI, HKEC SUR CSC
Dr H W LIU, Cons (CE)
Dr P L LIU, PMH SMO (SURG)
Dr S H LIU, SEM (PS)1
Dr H C MA, RHTSK HCE
Dr W H SETO, HKWC CD(Q & RM)
Ms Margaret TAY, EM (PS)6
Dr W K TO, YCH, SMO (Path)
Dr N C TSANG QEH Con (Path)
Mr Raymond WONG, SEM (BSS)
Prof Ignatius YU, COM & FM, CUHK
Dr Raymond YUNG, HKEC CPA CSC
Ms Assunta LEE, HOPS&PA M(SD)2 (Notes taking)

Absent with Apologies

Mr SW CHAN, UCHN DOM (CSSD & IC)
Dr CC LAU, PYNEH AED COS
Dr SF LUI, NTEC SD (QA&RM)
Prof Joseph Sriyal Malik PEIRIS, HKUMIC
Dr HY SO, AHNHAIO COS (AIO)
Prof John TAM, MIC, CUHK

Action By

1. **Confirmation of Notes of Meeting**

There was no comment received.

2. **Matters Arising**

2.1 Guidelines for Handling Bedpans

2.1.1 It was raised that the practice on pouring away excreta from bedpans should be cautious as it would cause splashing. Used bedpans should be put in the bedpans washer immediately after collection for disinfections. Hospitals should put up notice to advise patients /relatives not to flow other waste e.g. hand towel into the bedpan to avoid blockage of sewage.

2.2 SARS Follow Up Clinic

2.2.1 The arrangement of SARS clinics in hospitals was attached as Appendix I. SARS Follow Up clinics should be categorized as other clinical areas with the corresponding PPE unless they were located within a SARS ward. (Post-meeting notes : The precaution measures in SOPD/ ACC including SARS Follow Up clinics had been circulated to members for comment as per Appendix II)

3 **Standard Provision and Supply of PPE**

3.1 CE said that further to the discussion and views expressed by members at the previous meeting on the provision of PPE for SARS, there was a need to finalise the standard provision in HA. The meeting discussed the draft recommended PPE standard and provision on HA.

3.2 It was noted that there were variations among the hospitals. Some of the hospitals provided admission ward whereas some hospitals might have direct admission to SARS ward. Some of the hospitals might have two levels of categorising the risk for SARS while some hospitals might have three levels.

Action By

3.3 It was concluded that standard provision would still be based on high risk and other areas.

3.4 Standard Provision of PPE for High Risk Areas

3.4.1 The definition of high risk areas were the same as the discussion in the previous meeting i.e. SARS wards, ICU, A&E, Admission/ Fever/Triage ward, wards for special aerosol procedures eg Bronchoscopy. The boundary for high risk areas could be more specifically defined in individual hospitals depending on the physical layout of the wards / work place.

3.4.2 The meeting discussed the standard personal protection equipment (PPE) for high risk areas which would also apply to high risk procedures and procedures involving extensive and close patient contact and risk of exposure to body fluid / blood / secretion /excreta. The following items were discussed:

- Cap
- Goggles
- Disposable N95 mask/ surgical mask
- Full-faced shield
- Working clothes
- Protective gown
- Gloves
- Other PPEs as indicated

(i) Cap

- Staff were recommended to wear cap all the time but for having close patient contact and carrying out high risk / high contaminating procedures, wearing of caps would be mandatory.

(ii) Eye Shield /Goggles

- The meeting discussed on the mandatory provision of eye protection in all areas due to risk of mucosal entry. The majority considered that the provision of eye protection was a necessity to safeguard from the risk of contracting SARS however Dr Seto was of the view that eye protection need

Action By

not be a definite standard except with high risk procedures, and procedures having close contact with patients.

- The meeting concluded that eye protection eg eye shield was mandatory. When high risk procedures were being carried out, goggles would be mandatory. It was important to strike a balance between enforcing infection control and the bearing of risk.

(iii) Mask

- N95/ surgical mask was mandatory. When high risk procedures were being carried out, N95 would be mandatory.
- The approved standardised models of masks within HA included N95 1860S, N95 1860, 9210 from 3M and Kimblery-Clark "Technol" 62126 (Duck beak).
- If a staff could not fit the above models, an alternative model could be used and the staff had to consult hospital ICN team to ensure that the mask could fit.
- It was crucial for staff to carry out fit check for N95 or Technol before use to ensure no face seal leak.
- Mask with exhalation valve was forbidden for use only in procedures where a clean field of operation was required.
- N95 should be disposed after use. However when N95 was needed to be reused, the following had to be fulfilled:
  - N95 covered and protected by a surgical mask or full face shield
  - Had not been exposed to gross contamination
  - Not wet
  - Free from visible soiling
  - Not being deformed
  - Used N95 stored in a single-use clean paper bag
  - Only allowed to be reused in the same area within a day
  - Naked N95 had to be treated as contaminated after use and had to be disposed. Wet or Soiled N95 had to be disposed immediately.

- It was commented that N100 model was not particularly superior to N95 but could be considered as an alternative if

Action By

staff could not fit with a N95 mask.

- CE said that as there were only 4% of staff that could not fit the approved mask models, they could be allowed to use alternative models but safety and efficacy factors had to apply. PMH shared that they would use P100 with addition of filters for staff that did not fit the approved models.

(iv) Full-face Shied

- Full-face shield was recommended. When high risk procedures were being carried out, full-face shield would be mandatory.

(v) Linen Gowns/Working Clothes for Hospitals

- Staff had to wear long sleeved linen gown /uniform and they had to get changed before going home.

(vi) Disposable Protective Gown

- Disposable protective gown was recommended. When high risk procedures were being carried out, disposable protective gown would be mandatory.
- The gown should be of adequate length to provide protection
- The level of water resistant/ repellent of the disposable gown had to be chosen to suit the type of procedures.

(vii) Gloves

- Double gloves not recommended
- If double gloves were used, staff had to change gloves when attending different patients and had to wash hands or use hand rub when changing the gloves. Washing gloves must not be considered the same as washing hand.
- Must wear gloves for patient procedures & must remove gloves and wash hands after patient procedures.
- Staff might also wear gloves all the time if preferred but must wash hand and change gloves when attending different patients.

3.5 Used PPE in a high risk area should be treated as contaminated items

Action By

and should not be taken to other areas. There should be designated areas for gowning down and removing /changing of PPE from high risk area to other areas.

3.6 Supporting staff transporting / carrying clinical waste should apply PPE as for high risk areas.

3.7 Tea-room in the ward should be defined as clean area and all potentially contaminated PPE had to be prohibited.

3.8 Staff e.g. Nurses who stationed in the ward could comply more easily while doctors who would need to move between wards and other clinical areas would have more practical difficulties however they should still follow the standard PPE provision.

3.9 For transporting SARS patients, the staff would be in full gear and Dr Seto said that in QMH a lift would be designated for the transportation and it would be disinfected right after the transportation before being used again by other people.

3.10 PPE for Other Areas

3.10.1 Surgical mask was mandatory and some forms of eye protection were strongly recommended at all times. It was considered not necessary to have full application of the above to all other areas. However when admitting new patients, carrying out high risk procedures and having close contact with patients, the application of full gear PPE for high risk areas should be in place. Apart from PPE items for mask and eye protection, other PPE items (disposable caps, N95 mask, gloves, visor, goggles, full-face shield, linen gown and disposable gown) would also be made available for staff who preferred to have them.

3.10.2 Staff should dispose the surgical mask when leaving a ward.

3.11 Other PPEs

Action By

3.11.1 Stryker and Air-mate

- The effectiveness of Stryker had yet to be reviewed pending the laboratory result. Air-mate would generate a positive pressure and could be useful for aerosol generating procedures.

3.11.2 BarrierMan

- The BarrierMan provided total coverage which had a better physical protection to staff however staff might not like it due to physical discomfort. Staff had to be careful when gowning down to avoid contamination and the process should take place in a designated area.
- BarrierMan was designed for industrial use in which there would have facilities for gowning down but hospitals did not possess the facilities. Therefore staff had to take extra care when gowning down to prevent cross infection.

3.11.3 Ebola

- It could be explored as an optional PPE.

3.11.4 Shoe Cover

- Shoe cover was considered not necessary but staff should change to another pair of shoes before going home.

3.12 Self-provided items:

3.12.1 Unless there was a very good reason, staff would not be prohibited from using personal PPE but they had to consult their hospital Infection Control team or occupational safety officer for advice on safety and efficacy before use. Items that are dangerous to the user or to others would not be allowed. It was important to educate staff that equipment failure could arise from improper usage, improper maintenance or from other unforeseen causes, and the hospital could not be held accountable if a staff choose to use a self-provided item against hospital advice.

3.13 To address the differences among hospitals, it was resolved that there should have flexibility to the guidelines to allow the individuals in adopting their own practices. Hospitals should define the high risk

Action By

areas and other areas, and followed the standard provision of PPE accordingly.

3.14 The boundary of the high risk areas could be further worked out according their zoning. The zoning had to be effective which depended on the physical layout of the individual high risk areas

3.15 Guideline for Resuscitation in hospital had been sent out to members.

3.16 Dr Seto mentioned the importance of taking a shower right after contamination or high risk procedures.

3.17 Supply of PPE

3.17.1 Mr Raymond Wong informed the meeting of the estimated demand and the projected supply of mask and disposable gowns.

3.17.2 Thermometer for Staff

- Staff would be advised to pay attention to their health status by taking body temperature frequently and before going to work. Thermometers would be provided to staff on demand. A memo would be issued to hospitals once the thermometers for staff were ready.
- The sourcing of supplies of thermometers for HA staff was in progress.

(Post-meeting notes : About 30,000 thermometers had been delivered to hospitals via cluster BSS coordinators and overseas order was in progress.)

3.17.3 Infra-red Gun / Scan

- The requirement for psychiatric wards for infra-red guns was about 120. Convalescent wards preferred to have health check for visitors and infra-red guns for checking body temperature and the auditory scan thermometer were both preferred. The required number would be finalised after consolidating the request from hospitals.

Action By

4. Independent Audit of Infection Control

4.1 Standard checklist had been sent out by Dr HW LIU to hospitals. Some members expressed their concerns on having too frequent audit for the hospitals. It was important to ensure proper documentation and independent audit would be needed for hospitals as a protection for HA as an organisation. *Dr HW LIU*

4.2 Dr HW Liu would contact the hospitals to make the arrangement for the independent audit.

5. Any Other Business

5.1 The meeting considered the provision of additional period of leave for staff who were deployed to non SARS wards after working in SARS wards was not necessary as an infection control measure because the staff working in SARS ward had already been fully protected. The staff with full protection in SARS wards were not considered as close contacts of SARS patients.

5.2 A company promoted the use of ozone for sterilising the goggles after being used in SARS wards. The meeting considered that the current sterilisation practice was effective and there was no need for change.

5.3 Members moved to Room 509S for a demonstration on the use of infra-red scan and hand held infra-red gun for measuring body temperature set up by EMSD.

(Post Meeting Notes: The standard provision of PPE found in HA home should be taken as the lastest updated version which was drawn based on the discussion of guidelines from Expert Group and the directors' meeting and that should prevail the notes of the meeting.)

Appendix I

Availability of SARS Clinic

Cluster	Hospital	SARS Clinic A/V	No SARS Clinic	SARS Clinic separated from other clinic
HKE	CCH		X	
	PYNEH	✓		✓
	RHTSK		X	
	SJH		X	
	TWEH		X	
	WCH		X	
HKW	DKCH		X	
	FYKH		X	
	GH		X	
	MMRC		X	
	NLH		X	
	QMH	✓		✓
	TYH		–	
	TWH		X	
KCC	BH		X	
	BTS		X	
	HKE		X	
	KH		X	
	QEH	✓		✓
	RC		–	
KEC	HHH		X	
	TKOH		X	
	UCH	✓		✓
KWC	CMC	✓		✓
	KCH		X	
	KWH	✓		✓
	OLMH		X	
	PMH	✓		✓
	WTSH		X	
	YCH		X	
NTEC	AHNH	✓		✓
	BBH		–	
	NDH/ FH		X	
	PWH	✓		✓
	SH		X	
	SCH		X	
	TPH		X	
NTWC	CPH		X	
	POH		X	
	SLH		X	
	TMH	✓		✓

Appendix II

Interim SARS Precaution Measures in SOPD

1. Ventilation of the OPD patient waiting area should achieve at least 6 air changes per hour with sufficient fresh air intake, and preferably more depending on the person load and density.

2. To avoid overcrowding in the patient waiting areas, schedule patient appointment and remind patients to adhere to it.

3. Require all patients and accompanying persons to wear a surgical mask (or equivalent / superior model).

4. Universal surveillance of patients and accompanying persons by questionnaire. If it shows any suspicion of SARS, check body temperature and arrange immediate medical assessment, either in the OPD or to the AED.

5. Disinfect the environment at least twice daily or more frequently as indicated such as for patient lavatories.