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Performance & Accountability of the Infection Control Committee / Infection Control Team in Kwong Wah Hospital in the Handling of the SARS Outbreak

I Surveillance of severe community acquired pneumonia (SCAP) and severe acute respiratory syndrome (SARS) cases. The following were done:-

1) Starting February 12th 2003, SCAP cases requiring assisted ventilation or Intensive Care Unit (ICU) / High Dependency Unit (HDU) care and SARS reported by fax and later through computer to Hospital Authority SARS centre.
2) Denotification of cases found to have alternative diagnosis.
3) Daily update (by phone to SARS centre and through Clinical Management System (CMS)) regarding the number of new cases, whether patients were Health care workers or not, change of patients' status (ie in ICU / on ventilator / discharged / death etc).
4) All reported cases monitored to ensure patients were isolated according to prevailing Hospital Authority Head Office guidelines.

II Information Dissemination

All fact sheets, FAQ on management of SCAP, guidelines on management of SARS, subsequent updates and revisions disseminated through e-mails to all Kwong Wah Hospital (KWH) staff and posted on KWH website.

III Training & Education

1) A total of 21 talks on atypical pneumonia, SCAP, SARS and infection control precautions given to all hospital staff starting from 10th March 2003 onwards.
2) 14 briefings were given to individual departments, 3 sessions given to contractor staff and 1 given to old aged home operators.
3) 16 demonstration sessions on the use of personal protective equipment (PPE) were given in various wards.
4) Compact discs - on use of PPE and infection control measures made and distributed to all wards.

IV Liaison

Liaised with infection control link nurses, clinicians, health care workers from wards, allied health staff, administrators and engineering staff to solve problems and give advice on infection control measures.

V Specimens

Staff were reminded about appropriate specimens (nasopharyngeal aspirate (NPA), clotted blood etc) to be taken and sent promptly to Department of Health, Public Health Laboratory Centre (DH, PHLC) and Queen Mary Hospital (QMH) Microbiology Laboratories.

Special messengerial service was arranged to send specimens to PHLC, DH when that laboratory was opened on Sundays and Public Holidays.

Positive coronavirus polymerase chain reaction (PCR) results received by KWH Microbiology laboratory from DH / QMH Microbiology Laboratories were promptly faxed back to wards concerned.

VI Hospital Chief Executive Daily Lunch Briefings

This commenced from 18th March 2003 and was attended by senior clinical, nursing, administrative, allied health staff; infection control team members, representatives from KWH Doctors' and Nurses' Association and interested front line staff.

Staff were brought up-to-date with regards to patient information, cluster operation, PPE supplies, infection control etc. Staff concerns / problems / issues on various aspects were aired and dealt with.

VII Infection Control Enforcement Network

This was formed in KWH to help reinforce existing infection control measures and to have infection control briefings and updates in the respective work places.

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