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醫院管理局
HOSPITAL AUTHORITY

Tai Po Hospital, 9 Chuen On Road, Tai Po, NT
[Tel: 2607 6188 Fax: 2664 6986]

耳目聯力醫病人·質量醫護新世代
Quality Patient-Centred Care Through Teamwork

13 April 2004

Clerk to Select Committee
Legislative Council
HKSAR

Attn: Miss Flora TAI
(Fax: 2248 2011)

Dear Miss TAI,

Select Committee to inquire into the handling of the Severe Acute Respiratory Syndrome outbreak by the Government and the Hospital Authority

I refer to your letter of 2 April 2004.

I submit herewith

(1) my response to Appendix IV of your letter; and
(2) my Resume.

Yours sincerely,

(Dr TUNG Sau-ying)
Hospital Chief Executive
Tai Po Hospital

Encl

SYT/ws

Appendix IV

Please respond to the following questions in your written statement -

1. **At the meeting on Management of Atypical Pneumonia Incidence of the New Territories East (NTE) Cluster held on 27 March 2003, it was considered that Tai Po Hospital (TPH) might be used for admission of suspected atypical pneumonia cases since it had isolation facility. Had the capability of TPH in terms of its facilities and manpower to perform such task been assessed at that meeting? What preparation work had you done subsequently? Had you informed your staff of the plan?**

➢ The 27 March 2003 NTEC Management of Atypical Pneumonia meeting asked TPH to consider the feasibility of admitting SARS patients into its isolation ward. TPH then discussed the feasibility internally and decided that the following key areas of preparation had to be undertaken :-

(a) environment improvement;
(b) additional manpower;
(c) patient routing and segregations;
(d) staff preparedness;
(e) PPE provision; and
(f) enhancement of staff amenities.

Staff of TPH were informed through departmental meetings and staff forums.

2. **Had improvement measures been made to the isolation facilities and ventilation systems in TPH to prevent infection and cross-infection among healthcare workers (HCWs) and patients? If not, why not? If so, what were the measures?**

➢ The followings improvements were made to the isolation ward prior to the in-take of SARS patients :-

(1) Positive pressure ante-room in front portion of the ward.
(2) Installation of additional exhaust fans.
(3) Installation of high efficiency filters at exhaust ducts.
(4) One empty ward adjacent to the SARS ward was converted to provide staff amenities.

3. **14 patients from Ward E1 of Alice Ho Miu Ling Nethersole Hospital (AHNH) were transferred to TPH for SARS contact cohort on 3 April 2003. What was the policy of transfer at that time? Were all these 14 patients admitted to TPH at the same time? If not, what was their respective time of admission? What were the patients' conditions upon their admission to TPH?**

➢ TPH has all along been providing convalescent support to AHNH. The 14 patients from ward E1, AHNH were transferred to TPH in one block on 3 April 2003, to allow AHNH to arrange terminal cleansing to ward E1. On admission, they were medically stable.

4. **How many SARS patients had been transferred to TPH before 21 April 2003?**

➢ NIL

5. **Were the three index patients of Ward 4DR, Ward 4BR and Ward 3DR transferred from other hospitals? If yes, what was the policy of transfer at that time? If not, were they admitted on referral from the Accident and Emergency Department?**

➢ The 3 cryptic index patients were transferred from AHNH for convalescence.

6. **Were there any guidelines for cohorting? Had consideration been given to placing these 14 patients in the same ward having regard to the incubation period of SARS? If not, why not? In which ward(s) were these patients placed? Did any of these patients turn out to be SARS patients? If yes, how many and when?**

➢ TPH followed NTEC's guidelines and cohorted all 14 patients in 1 ward since 3 April 2003. When this ward was closed on 15 April 2003, none of these patients developed SARS symptoms. Two of these patients developed suspicious symptoms subsequently on 25 April 2003. These patients were not index patients.

7. **How many HCWs in TPH at that time had training in infectious disease or respiratory medicine? What training and guidelines on infection control had been given to HCWs in TPH?**

➢ 2 doctors and 4 nurses had specialist training in respiratory medicine at that time. In addition, there were 4 Hong Kong Academy of Medicine fellows in Advanced Internal Medicine who had training and experience in respiratory medicine. HCWs in TPH were given both NTEC and HAHO guidelines. Training had also been given.

8. **How many staff members in TPH were infected with SARS? When did they develop SARS symptoms? Do you know the cause of infection? Please provide the names of the staff members in TPH who were infected with SARS and the ward he/she was working at the time of infection.**

➢ 3 staff members in TPH were infected with SARS:

Name	Working Ward	SARS Symptoms	Cause of Infection
WONG [redacted]	4BR	Fever on 17.4.03 Suspected SARS on 21.4.03	Unknown
[redacted] CHENG [redacted]	4DR	Fever on 20.4.03 Suspected SARS on 21.4.03	Unknown
IP [redacted]	4DR	Fever and suspected SARS on 23.4.03	Unknown

9. **At the Meeting on Management of Atypical Pneumonia Incidence of the NTE Cluster held on 9 April 2003, when the plan to handle SARS cases was discussed, it was planned to admit about 180 cases to AHNH and about 60 cases to TPH. What was the basis for this plan for TPH to handle 60 SARS cases? Had you expressed any views on this plan? What were the facilities and manpower of TPH at that time?**

➢ The 9 April 2003 NTEC Management of Atypical Pneumonia meeting's discussion was based on bed capacity. TPH subsequently reassessed the situation. As it had a psychiatric unit but no ICU set up, the option of TPH admitting SARS patients based on bed capacity was not pursued subsequently.

10. **Please provide in tabular form the respective dates of admission of all the SARS patients handled by TPH, the wards they were placed at the time of infection and their causes of infection if known.**

➢ Please see attached appendix.

- END -

Appendix

SARS Patients Handled by TPH

Patient	Date of Transferred in	Ward	Cause of Infection
1	21/4	4CR	Unknown
2	21/4	4CR	Unknown
3	21/4	4CR	Unknown
4	21/4	4CR	Unknown
5	21/4	4CR	Unknown
6	21/4	4CR	Unknown
7	21/4	4CR	Unknown
8	22/4	4CR	Unknown
9	22/4	4CR	Unknown
10	22/4	4CR	Unknown
11	22/4	4CR	Unknown
12	22/4	4CR	Unknown
13	22/4	4CR	Unknown
14	23/4	4CR	Unknown
15	23/4	4CR	Unknown
16	23/4	4CR	Unknown
17	23/4	4CR	Unknown
18	23/4	4CR	Unknown
19	23/4	4CR	Unknown
20	23/4	4CR	Unknown
21	23/4	4CR	Unknown
22	24/4	4CR	Unknown
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24	24/4	4CR	Unknown
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26	25/4	4CR	Unknown
27	25/4	4CR	Unknown
28	24/4	4CR	Unknown
29	24/4	4CR	Unknown
30	26/4	4CR	Unknown
31	26/4	4CR	Unknown
32	27/4	4CR	Unknown
33	28/4	4CR	Unknown
34	28/4	4CR	Unknown
35	28/4	4CR	Unknown
36	28/4	4CR	Unknown
37	28/4	4CR	Unknown
38	28/4	4CR	Unknown
39	29/4	4CR	Unknown
40	30/4	4CR	Unknown
41	1/5	4CR	Unknown
42	2/5	4CR	Unknown
43	2/5	4CR	Unknown
44	2/5	4CR	Unknown
45	3/5	4CR	Unknown
46	9/5	4CR	Unknown
47	10/5	4CR	Unknown
48	10/5	4CR	Unknown