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醫院管理局
HOSPITAL AUTHORITY

群策群力為病人・優質醫護滿意林
Quality Patient-Centred Care Through Teamwork

Central Nursing Division,
Tai Po Hospital, 9 Chuen On Road, Tai Po.

14 April, 2004

By fax: 22482011
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Ms Flora TAI
Clerk to Select Committee
Legislative Council.

Dear Ms 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 dated 6 April 2004. I submit herewith the followings:

1. Written statement in respond to the questions in Appendix IV.
2. Professional qualification and experience.

Regards.

Yours sincerely,

LI Yuk Lin Helena
General Manager (Nursing)
Tai PO Hospital

Appendix 4

Please respond to the following questions in your written statement –

1. Were you concerned about the preparedness and capability of Tai Po Hospital (TPH) when 14 patients were transferred from ward E1 of Alice Ho Miu Ling Nethersole Hospital (AHNH) to TPH for SARS contact cohort on 3 April 2003? If not, why not? If yes, why were you concerned? Was your view sought before a decision was made to divert these patients from AHNH to TPH? If yes, what was your view? When and by whom were your view sought? Did you raise your concern? If yes, what was the response?

- TPH, being one of the hospitals in the NTEC, has all along providing convalescent support to AHNH. The proposal to transfer the 14 patients from Ward E1 of AHNH to TPH was initiated by the AHNH hospital management on 1.4.03. On 3.4.03, the proposal to transfer the 14 patients of Ward E1 of AHNH to TPH was endorsed by Deputizing CCE with the presence of senior management from AHNH and TPH, including myself. The 14 patients were to be cohorted in Ward 3AR of TPH. Appropriate infection control (IC) measures were taken to prepare for receiving these patients in TPH. TPH was capable of receiving these patients.

2. 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?

- Yes. All 14 patients were placed in the same ward (Ward 3AR). None of these 14 patients developed suspicious SARS symptoms when Ward 3AR was closed on 15 April 2003. However, two of them developed suspicious SARS symptoms subsequently on 25.4. 03. They were not index patients.

3. Whether training and guidelines on infection control had been given to nurses in TPH? If yes, what were the training and guidelines given? Was the nursing manpower adequate at that time? If not, had you sought any help within the Cluster or from other hospitals?

- A series of infection control training/briefing for hospital staff was started on 27.2.03 covering various topics such as PPE, infection control practices etc. New Territories East Cluster & Hospital Authority IC guidelines were disseminated to staff through various means including email, department head meetings, department meetings, staff forums, hospital SARS notice board, Infection Control Board in each ward/unit and by shift hand over briefing etc. The nursing manpower was adequate.

4. Did the healthcare workers (HCWs) who attended the index patient of Ward 3DR and the

index patient of Ward 4DR (who were both admitted on 11 April 2003) and the index patient of Ward 4BR (who was admitted on 14 April 2003) take any infection control measures? If not, why not? If yes, what were these measures? Whether any HCWs in TPH were infected by these index patients? If yes, what was the reason and how was the HCW infected?

- HCWs of Ward 3DR, Ward 4DR and Ward 4BR were required to put on N95 masks, gloves, gowns and eye protection equipment (when performing high risk procedures). They were also to perform handwashing before and after patient care.
- 3 HCWs were infected with SARS.

Staff	Ward	SARS Symptoms	Cause of infection
1	4BR	Fever on 17.4.03 Suspected SARS on 21.4.03	Unknown
2	4DR	Fever on 20.4.03 Suspected SARS on 21.4.03	Unknown
3	4DR	Fever and suspected SARS on 23.4.03	Unknown

END