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21 January, 2004

By Fax and mail

Miss Flora TAI,
Clerk to Select Committee.

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 24.12.2003. Enclosed please find my submission on :

Performance and accountability of the management of KE Cluster and UCH in the handling of the SARS outbreak.

Thank you for your attention.

Yours sincerely,

Dr. C.Y. Tse
Hospital Chief Executive

Enc.

CYT/sn

Performance and accountability of the management of KE Cluster and UCH in the handling of the SARS outbreak

The KE Cluster, which consists of 2 acute hospitals (United Christian Hospital and Tseung Kwan O Hospital) and 1 subacute hospital (Haven of Hope Hospital), had been in alert since the issue of the memo on severe CAP from Dr. S.H. Liu of HAHO on 12 February 2003. To prepare for surge capacity, less urgent elective admissions were deferred since mid-March. The admissions of CAP cases/suspected SARS cases were monitored.

During the SARS crisis, the KE Cluster SARS Management Committee was responsible for overseeing the management of SARS within KE Cluster. The Committee was chaired by CCE(KEC). CCE related the decisions and instructions of the HAHO SARS Round Up Meetings to the Committee. With the rapid influx of cases, wards were deployed within short notice to do SARS work. Deployment of manpower from non-medical departments to help the SARS work was also done with good co-operation and commitment from the staff.

The sudden surge in the SARS cases posed a great demand on our resources. The following was done to solve the issue:

- Less urgent elective cases were deferred from 17 March 2003.
- After the outbreak of staff infection in ward 12A, female medical admissions and male medical admissions were stopped from 2 April 2003 and 6 April 2003 respectively till 14 April 2003.
- A total of seven seriously ill SARS cases were transferred to other hospitals from 13 April 2003 to alleviate the demand on ICU beds.

Adequate communication was essential during the crisis period, and the hospital paid much effort to this. Feedbacks from staff were encouraged. In addition to the normal channels of communication, many HCE forums were held and "Update and SARS" were issued regularly.

Training, monitoring and raising and alertness of our staff in infection control was emphasized. A total of 148 training sessions (with over 6000 attendances) were held. The main themes included:

- What is atypical pneumonia
- Clinical features and management of SARS
- Infection control measures for SARS
- Use of PPE
- Special infection control precautions for SARS for supporting staff
- Work process re-design for SARS

The HAHO infection control guidelines were followed, with local adaptation to suit local situations. The wards were divided into ultra-high risk, high risk and moderate risk areas with the appropriate infection control policies. Work practice was re-designed to minimize infection risk. Appropriate personal protective equipments were provided in line with HAHO guidelines. The ward environment was improved steadily as we progressed, including the installation of exhaust fans and modification of one operating room into negative pressure.

Unfortunately there was an outbreak in ward 12A (a general medical ward) around the end of March 2003. On analysis, 2 primary cases and 1 secondary case were the likely index cases that caused the infection among the staff. One of them presented with fever and loin pain, one with mental confusion, and the third was a terminal Ca lung patient with little fever. Because SARS was not initially suspected, no extra precaution was taken when caring for these patients. The 12A outbreak was among the first incidents that HA came across patients later confirmed to have SARS presenting without respiratory symptoms, pneumonia or high fever. When the outbreak was noted, the issue was promptly reported to HAHO and Department of Health (DH). After that, HAHO decided that all in-patients should wear surgical masks, and the no visitor policy was to be implemented. We learned painfully from the 12A incident. Infection control measures for the general wards were stepped up. Infection control training was reinforced, and alertness to unsuspected cases was emphasized.

The following sets out the work done in UCH :

(a) Early Phase (10-23 March 2003):

All along, UCH has been admitting sporadic cases of atypical pneumonia with no contact history. Admission of 12 such cases within 1 day was reported to HAHO on 15 March, and the cases were cohorted in a special ward. The hospital started to defer less urgent elective cases from 17 March, to prepare for any sudden surge in admissions.

(b) Peak Phase (24 March to 6 April 2003):

On 24 March, the 1st case from Amoy Gardens was admitted. On 25 March till midnight, 3 families from Amoy Gardens were admitted. The outbreak was immediately reported to HAHO and DH on 26 March at 8:30 am. The plan of HA at that stage was to convert Princess Margaret Hospital (PMH) into a SARS hospital to admit all cases in Hong Kong. However, before PMH began to take all cases from 29 March, UCH had admitted over 100 cases from the community outbreak. During the peak of the crisis in early April 2003, UCH had around 150 cases of SARS in the wards.

Unfortunately, from 31 March, our staff got infected. To cope with the crisis situation, with the help of the other clusters, female medical admissions were stopped from 2 April, and all medical admissions were stopped from 6 April. Our Accident & Emergency (A&E) service never stopped.

(c) Plateau Phase (7-20 April 2003):

Because of the large number of cases requiring ICU care, a total of seven seriously ill cases were transferred to other hospitals from 13 April. Convalescent cases were transferred to WTSH. Medical admissions were resumed from 14 April. With the decreasing number of SARS cases in the hospital, admission of a proportion of SARS cases was resumed on 20 April 2003.

(d) Resolution Phase (21 April and go on):

There were no more staff infections from 20 April 2003. UCH resumed the admission of all SARS cases from 28 April 2003. Non-urgent elective services were also resumed steadily.

In total, UCH had managed 194 admissions of clinical SARS (total 186 patients).

TKOH has been admitting SARS patients from mid-March 2003. Some were family clusters from the community. A total of 58 clinical SARS cases have been managed there. Deployment from non-medical departments was done and wards were designated for SARS work (SARS ICU, SARS ward, triage wards). Staff morale remained high in TKOH, and 2 staff got infected in TKOH.

Our staff performed very well during the crisis, with great commitment, professionalism and team work. Other than the unfortunate outbreak at ward 12A, staff infection rate was low. With our emphasis on communication, staff complaints were few. With our emphasis on total patient care, complaints from patients or families were few.

By Dr. C. Y. Tse, CCE(KEC)
20 January 2004