香港社會服務聯會
The Hong Kong Council of Social Service

Submission No.
050/050E

By fax and email

June 30, 2003

Secretariat,
SARS Expert Committee
Room 1808,
Murray Building,
Garden Road, Central,
Hong Kong,
(Fax : 3150-6930)

Dear Sir/Madam,

Paper on SARS experience and suggested improvements

Enclosed please find our submission to the Expert Committee for consideration.

Please feel free to call me at 2864 2929 if you need any other information.

Yours sincerely,

Christine M.S. Fang
Chief Executive

c.c. The Hon Bernard Chan, Chairperson, HKCSS

Encl. 1. Submission (English version)
2. Submission (Chinese version)

凝聚力量 United for a Better Society

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THE HONG KONG COUNCIL OF SOCIAL SERVICE

Paper on SARS experience and suggested improvements

Background

Since the outbreak of SARS, the death toll of older persons and people with chronic illness has been exceptionally high. Coupled with the fact that these people were frequent visitors to hospitals, agencies providing elderly and rehabilitation services were very cautious in stepping up their protective measures according to the spread of the epidemics in the past few months.

Among all social services, Residential Care Homes for the Elderly (RCHEs) are regarded as the most easily transmitted locality of the disease. According to our survey conducted in mid-May, the death rate of older persons known to service agencies suffering from SARS was 60%. The rate was even higher for those elderly residents in RCHEs, which was as high as 85%. Such findings resembled the WHO figures reported on May 8, 2003, pointing out that the death toll for elderly people was over 50%. The death rate for elderly residents suffering from SARS was again similar to the one released by the Department of Health on June 14, 2003, announcing that the death rate for RCHE residents had reached 80% ! In this respect, how to strengthen the collaboration between hospitals and elderly services, as well as reducing the infection rate of older persons should be the review foci of the Government and Hospital Authority.

Besides, Government kept on announcing death toll involving the chronically ill has aroused fear among older persons and the chronically ill patients. The overwhelming mass media report that older persons and the chronically ill patients were source of infection had exerted great stress on them. A local research has pointed out that 70% of the chronically ill patients interviewed were worried about being infected and transmitting the disease to their family members. Due to such fear, about 30% of these patients had avoided going to hospitals for medical consultation[1] and thus affecting their eventual health. Thus, how to reduce the fear of the chronically ill and to prevent them from

[1] Research on "The impact of SARS on chronically ill patients" .Community Rehabilitation Network, Hong Kong Society for Rehabilitation (2003).

being infected should be another focus of the review.

Difficulties encountered by social service agencies in the SARS epidemic and the proposed solutions

Faced with this sudden and highly infectious disease , elderly service agencies had gone through some difficult times. Nonetheless, there were also some precious experiences gained after overcoming such difficulties. The following are some of the difficulties met and suggested improvements. Some of them also applied to rehabilitation service units :

1. **Older persons being infected in hospitals**
   The findings from our survey reflected that majority (60%) of the infected older persons got the disease during their hospitalization for other illnesses. Some of them were called back to the hospital after discharge as contact cases with confirmed SARS patients during the hospitalization period and sadly were later also confirmed the disease. Thus, we are very concerned about the isolation measures and the safety of the elders receiving treatment in the hospitals. Reducing the need of hospitalization during the SARS period is a common concern of us all.

Suggestions :

1.1 Improve the isolation measures within hospitals and prevent older persons and chronically ill patients from being infected;

1.2 Reduce the need of elders being hospitalized by continuing the "One Home One Doctor" scheme. Instead of sending the elders to hospitals, doctors would outreach to all elderly homes to provide consultation, treatment and medications.

2. **Arrangement of "follow-up consultation"**
   Similar to chronically ill patients, a research[2] jointly conducted by the Hong Kong Polytechnic University and a social service agency, also found that

[2] A research jointly conducted by the Hong Kong Polytechnic University Applied Social Studies and the SKH Lady MacLehose Centre. (May 20, 2003).

older persons had suspended their follow-up treatment due to fear of being infected. This would cause adverse effect on their health. Besides, different arrangements in different hospital clinics were reported at the SARS period and this had caused confusion to the elders, the chronically ill and their care-givers.

Suggestions :

2.1 During the epidemic, change all follow-up consultations from the Specialist Out-patient Clinics (S.O.P.C.) to the General Out-patient Clinics (G.O.P.C.) as the latter were located in the community instead of hospitals. If space is a problem, local hospitals may discuss with the District Elderly Community Centres, Neighbourhood Elderly Centres or other social service centers to set up temporary mobile clinics in these centres. Besides, Hospital Authority could also network with the GPs, allowing the elders and chronically ill patients to seek consultation and medication there. Nonetheless, the consultation fee should be the same as that of the Authority and the medicines prescribed by the GPs should not be restricted.

3. Communication mechanism

Like family members of older individuals, front-line workers of elderly services also have very close contacts with the frail elders while providing care, like bathing, lifting and transfer, change of diapers, etc. Such elderly services include RCHEs, Integrated Home Care services/ Enhanced Home and Community Care Services and Day Care Centres for the Elderly. These front-line workers often have to provide care to a few elders simultaneously. There is always a potential risk that they could become agents transmitting the virus from one elder to another, especially when their clients are frail and immobile. Thus, it is very important that these service units be informed whenever any one of their clients had been suspected or confirmed being infected by SARS, so that the unit in-charge could take precautionary measures such as stepping up infection control measures or asked the concerned worker to take home leave.

Nonetheless, these service units had difficulty in getting information

whether their clients were infected or not in the initial stage. Their contact with the ward nurse was to no avail due to privacy reasons. The situation was somehow improved later after the intervention of the Department of Health, in which the Elderly Visiting Health Teams would inform the RCHEs as soon as they knew of respective residents' progress. For community services, a temporary communication channel was also established with the assistance of [redacted] of Hospital Authority.

Suggestions :

3.1 To set up clear mutual communication mechanism between hospitals and elderly service units and to establish protocol which ensure that hospital staffs would inform relevant elderly service units or case managers once an older person was suspected or confirmed being infected by SARS. To facilitate better communications of hospital staffs with the service units, we are planning to design a card for all the elderly clients under the care of NGOs.

3.2 The Community Geriatric Assessment Teams have been working with the RCHEs for many years and established close links with them. Their linkage with all the elderly service units could be strengthened for SARS communication.

3.3 In the long run, IT solutions should be explored to develop an Information system where hospitals and elderly services providing Long Term Care can easily exchange information. Eldercare is often multi-facet and transdisciplinary that involves different care providers. Making use of the Internet, care providers can update and check the most updated status of the client on a real time on line basis and thus, facilitating communication among all stakeholders and improving care of our clients.

4. **Isolation arrangement for discharged patients**

Due to their frailty, residents of elderly homes often have to go in and out of hospitals. Common examples were those C.O.A.D. sufferers who cannot use nebulizers during the SARS period. In recent years, subvented elderly homes had been maximizing their spatial use by adding beds under the Enhanced Productivity Program (EPP). Coupled with their long-standing high occupancy (constantly over 95%), many of these elderly homes faced great difficulties in providing individual isolation rooms for their residents

discharged from hospitals.

In the middle of the epidemic, discharged elders could be transferred to the Helping Hand Holiday Centre for isolation before going back to the Elderly Home. Such arrangement is worth supported as the Centre can provide single room to the elders. However, since the Centre is designed mainly for healthy elders, there is insufficient care staff to cater for care of frail elders.

Suggestions :

4.1 Hospitals should closely observe their aged in-patients and discharge them back to the elderly homes ONLY when isolation has been completed and that they are confirmed of non-infectious. Besides, the hospitals should also liaise with the elderly home on a discharge date and avoid sending too many patients back to one home, especially when a particular home has already had a few elders requiring isolation.

4.2 Government should also study the length of the incubation period of SARS in elderly patients. The original 10-day period seems not quite applicable to older individuals. Some of our elderly homes reported having residents returning to the facility, after a 10-days "cooling down" isolation in the hospital, with confirmed SARS on the 12th or 13th day, 2-3 days after discharge. The whole facility was then put on medical surveillance, again causing unnecessary stress and burden to all residents and staff. It seems that a longer period is suggested for older persons for the "cooling down" effect in the hospital prior to their discharge back to the facility, say 14 days as suggested by the HK Geriatric Society.

4.3 Government may also consider injecting temporary care staffs in the Helping Hand Holiday Centre during epidemic so that they can provide individual room isolation for the frails elders as well.

4.4 Besides, Government should also study and review the spatial requirement for an Elderly Home. This SARS epidemic showed that Elderly Homes, operating in a group living environment and providing care to hundreds of frail elders, have the highest risk of cross infection if the environment is too crowded. From our survey, there are cases suspected being infected by their fellow inmates.

5. Response to staff request of self-isolation

- Like hospital staffs, workers providing care to the elders requiring isolation also worried about transmitting the virus to their family members. Some of them preferred staying out during the surveillance or SARS period. Yet, the Homes did not have enough spaces to cater for their accommodation needs.

Suggestion :

5.1 Allowing elderly service workers to use the accommodation provided for hospital staffs free of charge as well.

6. Drain on resources

During the SARS period, elderly service agencies had to purchase large quantity of protective gears to carry out the isolation requirements. Some of the Homes even had to renovate their activity rooms for the purpose of isolation. Alongside with the inflated price of the protective gears in the SARS period, agencies had shouldered enormous financial pressures. For instance, a 200-person Home had spent around $ $150,000 to $200,000 throughout the epidemic, whereas an Integrated Home Care Team serving around 100 cases had spent around $10,000 to $15000 , depending on the severity of infection in their service area.

Suggestion :

6.1 Similar to the support to hospitals, the Government should inject additional resources to the elderly service agencies for them to purchase protective gears and other expenses incurred by stepping up isolation for the discharged patients.

7. Public Education to reduce discrimination

We received numerous reports of discrimination of the general public against service units with suspected or confirmed SARS clients. We were told that neighbours had requested an Elderly Home under surveillance to close all their doors and windows. The Home's staffs were also rejected by the nearby grocery stalls that used to supply goods to them. Some home-helpers were also facing similar stigmatization. They were not

welcomed by other customers when they had lunch outside wearing their uniform. In actual fact, these elderly service front-line workers should be complimented instead of being stigmatized. Like hospital professionals, they kept on doing their job and providing care to the older persons, as well as families under home confinement throughout the epidemic.

Besides, most of the Elderly Homes had controlled visitors to the Home in order to prevent spreading the disease to the frail elders. They would, however, maintain close contacts with the family members and encourage them to call the elders. Most of the family members were supportive to such measure, but some of them were still dissatisfied, thus adding much care burden to the staff who were already facing additional workload in implementing infection control measures within their work settings.

Suggestion :

7.1 More public education to increase the public's understanding of the epidemic and the role and contribution of elderly healthcare workers in combating the disease is essential. The Government should also advise the public not to visit Elderly Homes during the high transmission period to avoid spreading the virus to the vulnerable elderly residents.

Last but not least, we sincerely hope that different sectors can closely collaborate and better prepare for the probable return of the epidemic in the coming fall. Likewise, all social service agencies would continue to stand firm and respond fast to combat the epidemic.

END

June 30, 2003

香港社會服務聯會

處理非典型肺炎的經驗及建議改善的方法

背景

自非典型肺炎爆發以來，長者與長期病患者的死亡率一直偏高，加上他們需要經常進出醫院，故各安老服務及復康機構均嚴陣以待，按疫症的發展而不斷提升防禦工作。

在眾多的服務當中，安老院舍可說是最受影響。本會曾於五月中發出問卷，向安老服務機構收集了一些數據，發現感染非典型肺炎的長者死亡率達百分之六十，安老院的長者感染非典型肺炎後，死亡率更高達百分之八十五。這些數據與官方數字十分接近，世界衛生組織於五月八日曾經指出感染非典型肺炎的長者死亡率超過百分之五十；而衛生署亦於六月十四日公佈，安老院個案的死亡率接近百分之八十！所以，如何加強與安老服務的配合及減少長者受感染的機會，應是政府及醫管局檢討的一個重點。

另一方面，由於政府公佈非典型肺炎的死亡數字時，會一併指出死者是否長期病患者，再加上不少報導指出長期病患者可能是某些連環感染個案的源頭病人，令長期病患者在非典型肺炎疫症期間感到很大的憂慮及壓力，有調查指出約七成被訪長期病患者擔心受感染或將疾病傳染家人，約三成病人更因避免到醫院而更改覆診日期[1]。所以，如何減低長期病患者的憂慮及感染非典型肺炎的機會，亦應是檢討的另一重點。

社會服務機構在疫症爆發時面對的困難和建議的解決方法

面對這一場突如其來且傳染性極高的疫症，安老服務單位當中遇到了不少的困難，亦累積了不少的寶貴經驗。以下是一些曾經遇到的困難和建議的改善方法，部分亦適用於復康服務：

1. 長者入住醫院後受到感染

   從本會收集的數據顯示，大部份(60%)的長者是在入住醫院後感染非典型肺炎。曾經有不少個案是因其他原因入住醫院，但在出院後不久，便收到醫院的電話，告之因長者入住的房間發現有人感染，故需要再入院觀察，而長者其後亦不幸証實受到感染。因此，我們十分關注長者在入住醫院後的安全，並希望盡量減低長者進出醫院的需要。

[1] 香港復康會社區復康網絡〔2003 年〕，*「非典型肺炎對長期病患者影響」調查報告*。

建議：

1.1 改善醫院內的隔離措施，避免長者及長期病患者在病房內受其他人感染；

1.2 延續現時的「一院舍一醫生」計劃，派出醫生到所有的安老院爲長者診症及開藥，減少長者需要入院的機會；

2. 覆診安排

除了長期病患者之外，根據理工大學和一間社會服務機構進行的調查[2]，不少長者在疫潮期間亦因害怕受到感染而暫停覆診，令人憂慮他們的病情會因此而惡化。此外，不同醫院在疫症期間有不同的覆診安排，令長者、長期病患者和家人難以配合。

建議：

2.1 在疫症爆發時，將所有的覆診由專科門診改爲設在社區的普通科門診進行。如地方不敷應用，可與長者地區中心、長者鄰舍中心或其他服務中心商討借用地方，並派出醫護人員到中心，設立社區的臨時流動診所；亦可考慮與私家醫生聯繫， 讓社區的長者及長期病患者到區內的私家診所覆診或取藥，但收費須與醫管局相同，且不要限制私家醫生可以爲長者處方的葯物。

3. 通報機制

除長者的家人外，不少的安老服務前線工作人員亦須爲長者提供有親密接觸的照顧，例如：洗澡、扶抱、更換尿片等。這些服務包括安老院舍、家務助理 / 家居護理隊、長者日間護理中心等。由於這些前線工作員往往需要同時照顧多位長者，故此若有長者被懷疑或証實患上非典型肺炎，單位便需要作出相應的安排， 例如增加防禦措施或安排員工自我隔離， 避免把病毒傳給其他的長者。

然而，服務單位在疫潮初期難以獲悉長者是否受到感染，即使知道長者入住的病房後，向病房的護理人員查詢時，亦遭他們以病人的私隱爲由拒絕透露。後期在我們向衛生署及醫管局反映後，情況大爲改善。衛生署長者外展隊會盡快通知安老院， 家居照顧隊亦在醫管局[redacted]的協助下， 獲悉長者是否受到感染， 惟後者的安排屬暫時性。

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[2] 調查由理工大學應用社會科學及聖公會麥理浩夫人中心聯合進行，並於 2003 年 5 月 20 日公佈。

建議：

3.1 醫院與各安老服務單位建立清晰的互相通報機制， 並制定指引(protocol)，確保醫院護理人員在知道長者懷疑或證實受感染時， 必須通知有關之服務單位/個案經理，以便作出相應的安排。爲方便醫院知悉爲長者提供服務的機構資料，本會正計劃爲所有接受非政府機構的安老服務使用者設計一張統一的資料卡，以茲識別。

3.2 除此之外，「社區長者評估隊伍」(Community Geriatric Assessment Team) 與安老院舍已有多年的合作，故亦可考慮善用這些隊伍作爲醫院與安老服務單位在疫症溝通方面的橋樑。

3.3 長遠來說，應考慮利用資訊科技發展一套醫院與安老服務可以互相交換資訊的軟件，並以互聯網的平台，讓不同的護理員以最簡單和快捷的方法在互聯網上更新及查閱長者的情況。介時，醫院的護理人員便不用花時間通知安老服務單位，而安老服務同工亦只需上網查閱長者的最新進展，便可知道長者到了那一間病房、做了那些檢查和是否受到感染等等。

4. 院友出院後之隔離

安老院的長者較爲體弱，不時需要送出醫院，尤其那些患有氣促的長者，不少因不能在疫症期間使用噴霧器而需要入院。加上資助院舍近年不斷因資源增值而增加床位，且入住率長期處於高水平， 實有困難同時爲多位長者安排獨立房間作隔離，要做到男女不同房間更是不容易。

在疫潮的中期，長者出院後可以到伸手助人協會的渡假中心暫住，待隔離期滿後才返回安老院。因該渡假中心可以提供獨立房間予長者，這個安排十分值得支持。然而，由於渡假中心本是爲健康長者而設，故甚少護理人員，因此，對大部份安老院的體弱長者便不適用。

建議：

4.1 醫院必須密切觀察長者的情況，確保他們有足夠時間的隔離和沒有受到感染後，才讓他們返回安老院。此外，醫院亦應與院舍互相協調長者出院的日期，避免同一時間有太多長者出院，尤其當該院已有多名長者需要接受隔離。

4.2 政府應研究長者在急症醫院出院後需要隔離的日子。現時的時段是 10 日，但我們的安老院曾有出院後的長者是在第十三日才發病，剛好是回到安老院後的第二天。整間院舍因此而不幸地再度需要封閉，對員工及其他院友做成打擊。事實上，老人科醫學會較早前亦憑藉他們的臨床經驗而建議長者出院後的隔離期應爲十四天。

4.3 政府亦可在仲手助人協會的渡假中心增加短期的護理人員，爲體弱的長者提供獨立房間的隔離。

4.4 政府應研究及重新檢視安老院的空間運用，例如預留有獨立洗手間和設有救命鐘的多用途房間，以便有需要時用作隔離房。是次疫症已反映出安老院舍作爲一個群居環境，且照顧數以百計的體弱長者。如環境過於擠迫，一旦發生如非典型肺炎的傳染病，便會有交义感染的危機。從我們收到的數據中，亦發現有患者是在院舍內被其他長者感染。

5. 回應員工自我隔離的訴求

負責照顧需要接受隔離的安老服務前線同工，亦與醫院的醫護人員一樣，憂慮會把病毒帶回家中，故希望自我隔離，但院舍缺乏足夠的地方讓他們作休息之用

建議：

5.1 開放各區供醫院員工作隔離的地方予安老服務同工免費使用。

6. 資源不足

在疫潮期間，安老服務機構需要購買大量的保護物資以應付大量的隔離安排；部份安老院更需要改裝活動室作隔離出院長者之用。加上保護物資在疫症初期的價格高漲，令機構在財政上增添了不少壓力。一間二百人的安老院在整個疫潮便花了約$15 萬至 20 萬購買大量的防炎保護物資; 一隊綜合家居護理隊則約$1 萬至$1.5 萬，實際費用須視乎其服務範圍是否在重災區。

建議：

6.1 政府應像支援醫院一般，向安老服務機構發放一筆額外的資源，讓各安老服務單位購買防炎保護物資及應付爲長者進行隔離而增加的支出。

7. 公眾教育　消除歧視

曾經有居民在獲悉鄰近的安老院有証實個案時，要求安老院把所有的門窗關上，商舖亦拒絕售賣東西予該安老院的員工。除安老院外，家務助理員亦因穿上制服外出用膳時，同桌的其他顧客選擇離開。事實上，這些安老服務的前線同工在疫症期間仍緊守崗位，爲長者及需要家居隔離的人士提供適切服務。因此，市民大眾不但不應歧視這些前線同工，更應向他們致敬。

此外，大部份安老院舍在疫症高峰期謝絕家人探訪，以保障院內體弱長者的安全。但他們仍會與家人保持聯絡，更鼓勵家人致電長者慰問。這項措施得到不少家人的支持，但仍有部份家人表示不滿。

建議：

7.1 政府宜多作宣傳和教育，讓公眾人士了解疫症的特性，不要歧視長者和他們的照顧者；更要呼籲家人在疫症高峰期暫不要到安老院探訪，以免不自覺地把病毒帶入院舍，感染體弱的長者。

最後，衷心盼望各個界別能通力合作，為可能在冬季出現的另一次疫症作出準備；所有的社會服務定必繼續緊守崗位，與大眾一起戰勝疫症。

完

二零零三年六月三十日