Hospital Authority
Communication Kit –
Coronavirus disease 2019 (COVID-19)
Formerly named Novel Coronavirus (nCoV)
Version 7.16
24 Nov 2021

Prepared by Chief Infection Control Officer (CICO) Office
<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Major changes</th>
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<td>- Enhanced Laboratory Surveillance for COVID-19</td>
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<td>- Tier 8b Enhanced screening scheme for COVID-19 for patients attending day services</td>
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<td>- Placement plan for confirmed cases with SARS-CoV-2 VOC / VOI (Deleted a sentence “VOC according to the World Health Organization”)</td>
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<td>- Aerosol-generating Procedures (AGPs)</td>
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<td>- Regular testing for high-exposure staff at HKICC</td>
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<td>- Enhanced Measures</td>
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<tr>
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<td>- Summary table of special visiting arrangement</td>
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<td>- Case Referral</td>
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Global situation of COVID-19

- Globally, as of 6:45pm CEST, 23 Nov 2021, there have been 257,469,528 confirmed cases of COVID-19, including 5,158,211 deaths, reported to WHO.
- As of 21 Nov 2021, a total of 7,408,870,760 vaccine doses have been administered.

Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 14 November 2021**

Source:
Hong Kong situation of COVID-19
(as of 23 Nov 2021)

- Since 31 December 2019, the Centre for Health Protection (CHP) of the Department of Health has recorded a total 12411 cases of COVID-19, including 213 fatal cases.


Note: The case classification may be subject to changes when there is new information available.
### Hong Kong situation of COVID-19

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Hong Kong situation of COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2020</td>
<td>Initial cases recorded in January 2020 were mostly imported or imported related cases.</td>
</tr>
</tbody>
</table>
| Feb 2020   | - Clusters were observed in the local community involving large meal gatherings and other gatherings in February.  
- COVID-19 is rapidly spreading worldwide. Active community transmission are occurring in overseas countries. |
| Mar 2020   | - Further enhancement on the surveillance at clinics of Private Medical Practitioners has been implemented since 12 March 2020.  
- There was an upsurge in number of COVID-19 cases in Hong Kong from mid-March to late March, which was mainly due to marked increase in imported cases especially returnees from overseas countries.  
- Clusters of locally acquired infections have been reported in public venues/recreational premises since mid-March, including large outbreaks in bars/pubs and karaoke. |
| Apr 2020   | The number of cases has been decreasing gradually since early April. |
| Jul 2020   | There has been marked upsurge of cases since early July, with a sharp increase in locally-acquired infections. Outbreaks are occurring in different settings such as local restaurants, residential care homes for elderly, schools, residential buildings etc. While the majority of cases reside in Kowloon East areas, Wong Tai Sin in particular, cases were being reported in various districts in Hong Kong. The source of infection could not be identified in many of the cases. It is evident that there is diffuse and silent transmissions ongoing in the community. |
| Aug & Sep 2020 | While the daily number of COVID-19 cases has shown a decrease in August and September from the peak level (of over 100 cases per day) in late July, local cases of unknown sources/links were still being reported from time to time, and with further cases being identified through contact tracing. |
| Oct 2020   | Since early October, the number of new cases started to show an increase again, particularly locally-acquired infection. |
| Feb & Mar 2021 | A number of large clusters involving food premises and fitness centres were reported from late February to mid-March. While the daily number of COVID-19 cases has shown a decrease since late March, local cases of unknown sources/links were still being reported from time to time, and with further cases being identified through contact tracing. |
Coronavirus disease 2019 (COVID-19)

• COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019.

• Coronaviruses are
  – enveloped RNA virus;
  – large family of viruses which may cause illness in animals or humans.
  – In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

• The causative agent for COVID-19 is “severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 virus)”.
People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness.

People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Sore throat
- Congestion or runny nose
- New loss of taste or smell
- Nausea or vomiting
- Diarrhea
- Headache
- Fatigue
- Muscle or body aches

Source:
Radiological findings

- Initial imaging with chest radiograph (CXR) and computed tomography (CT) may be normal in COVID-19.

- Disease severity and timing of imaging appear to impact on the rates of normal baseline imaging.
  - In non-severe disease, up to 18% of patients have a normal initial CXR or CT, but only 3% in severe disease.
  - In a series of 121 symptomatic patients, a normal CT was found in 56% of patients scanned within 2 days of symptom onset, whereas normal scans were observed in only 9% and 4% of patients if imaged 3–5 days or 6–12 days from symptoms, respectively. Therefore, radiographic abnormalities are almost certain to be present on CT following 6 days of symptoms.

Source:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138157/
Radiological findings

• When imaging is abnormal, there are some common features:
  
  – CXR typically shows patchy or diffuse asymmetric airspace opacities, similar to other causes of coronavirus pneumonias.
  
  – The most common initial CT findings of COVID-19 pneumonia are bilateral, subpleural ground-glass opacity (GGO), ill-defined margins, and a slight right lower lobe predilection.

• With increased time between symptom onset and imaging, the pattern of radiological findings progresses from focal unilateral abnormality to diffuse bilateral opacities with evolution to consolidation, reticulation, and mixed pattern disease involving more lung segments.

• “Crazy-paving” pattern and the “atoll” sign is also reported with greater time from symptom onset.

Sources:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138157/
COVID-19: The Novel Coronavirus 2019
Route of transmission

• Predominant Modes of Transmission of COVID-19
  1. **Respiratory droplet** is the major route of transmission, similar to other coronaviruses.
  2. **Contact** is another important route of transmission.
     • Direct contact transmission occurs with direct physical contact between two persons, with viral particles passed by touching contaminated skin or mucosal surfaces.
     • Indirect contact transmission occurs when the person touches contaminated environmental surface or object and then touch his or her eyes or nose. Indirect contact transmission is also termed ‘fomite’ transmission.
  3. **Short-range airborne transmission in poorly ventilated enclosed environment**

• Aerosol-generating procedures (AGPs) are known to produce SARS-CoV-2-laden infective aerosols associated with airborne transmission, thus airborne precautions should be adopted when these procedures are carried out in healthcare settings as far as possible.

Source:
Risk factors for Severe Disease and Death

• Older age, smoking and underlying non-communicable diseases (NCDs), such as diabetes, hypertension, cardiac disease, chronic lung disease and cancer, have been reported as risk factors for severe disease and death.

• Multivariable analyses have confirmed older age, higher sequential organ failure assessment (SOFA) score* and D-dimer > 1 μg/L on admission were associated with higher mortality

* The SOFA score ranges from 0 to 24 and includes points related to six organ systems: respiratory (hypoxaemia defined by low PaO2/FiO2); coagulation (low platelets); liver (high bilirubin); cardiovascular (hypotension); central nervous system (low level of consciousness defined by Glasgow Coma Scale); and renal (low urine output or high creatinine).

Source:
### WHO – Working definitions of SARS-CoV-2 Variants of Interest and Variants of Concern

- All viruses, including SARS-CoV-2, the virus that causes COVID-19, change over time. Most changes have little to no impact on the virus’ properties. However, some changes may affect the virus’s properties, such as how easily it spreads, the associated disease severity, or the performance of vaccines, therapeutic medicines, diagnostic tools, or other public health and social measures.

- WHO and its international networks of experts are monitoring changes to the virus so that if significant amino acid substitutions are identified, we can inform countries and the public about any changes that may be needed to respond to the variant, and prevent its spread. Globally, systems have been established and are being strengthened to detect “signals” of potential VOIs or VOCs and assess these based on the risk posed to global public health. National authorities may choose to designate other variants of local interest/concern. Working definitions for SARS-CoV-2 variants of interest and variants of concern from WHO are as follows:

| SARS-CoV-2 Variant of Interest (VOI) | A SARS-CoV-2 variant:
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<td>• with genetic changes that are predicted or known to affect virus characteristics such as transmissibility, disease severity, immune escape, diagnostic or therapeutic escape; AND</td>
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<tr>
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<td>• Identified to cause significant community transmission or multiple COVID-19 clusters, in multiple countries with increasing relative prevalence alongside increasing number of cases over time, or other apparent epidemiological impacts to suggest an emerging risk to global public health.</td>
</tr>
</tbody>
</table>

| SARS-CoV-2 Variant of Concern (VOC) | A SARS-CoV-2 variant that meets the definition of a VOI and, through a comparative assessment, has been demonstrated to be associated with one or more of the following changes at a degree of global public health significance:
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<tr>
<td></td>
<td>• Increase in transmissibility or detrimental change in COVID-19 epidemiology; OR</td>
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<td></td>
<td>• Increase in virulence or change in clinical disease presentation; OR</td>
</tr>
<tr>
<td></td>
<td>• Decrease in effectiveness of public health and social measures or available diagnostics, vaccines, therapeutics.</td>
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</table>

Source:
### WHO - SARS-CoV-2 Variants of Interest (VOI) and Variants of Concern (VOC)

#### VOC (10 Nov 2021)

<table>
<thead>
<tr>
<th>WHO label</th>
<th>Pango lineage*</th>
<th>GISAID clade</th>
<th>Nextstrain clade</th>
<th>Additional amino acid changes monitored</th>
<th>Earliest documented samples</th>
<th>Date of designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha</td>
<td>B.1.1.7</td>
<td>GRY</td>
<td>20I (V1)</td>
<td>+S:484K, +S:452R</td>
<td>United Kingdom, Sep-2020</td>
<td>18-Dec-2020</td>
</tr>
<tr>
<td>Gamma</td>
<td>P.1</td>
<td>GR/501Y.V3</td>
<td>20J (V3)</td>
<td>+S:681H</td>
<td>Brazil, Nov-2020</td>
<td>11-Jan-2021</td>
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</tbody>
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*Includes all descendent lineages. See the [cov-lineages.org](https://cov-lineages.org) and the [Pango network](https://www.pango.net) websites for further details.

* only found in a subset of sequences

#### VOI (22 Sep 2021)

<table>
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<th>WHO label</th>
<th>Pango lineage*</th>
<th>GISAID clade</th>
<th>Nextstrain clade</th>
<th>Earliest documented samples</th>
<th>Date of designation</th>
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<tbody>
<tr>
<td>Lambda</td>
<td>C.37</td>
<td>GR/452O.V1</td>
<td>21G</td>
<td>Peru, Dec-2020</td>
<td>14-Jun-2021</td>
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<tr>
<td>Mu</td>
<td>B.1.621</td>
<td>GH</td>
<td>21H</td>
<td>Colombia, Jan-2021</td>
<td>30-Aug-2021</td>
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*includes all descendent lineages. The full list of Pango lineages can be found here: [https://cov-lineages.org/lineage_list.html](https://cov-lineages.org/lineage_list.html); for FAQ, visit: [https://www.pango.net/faqs/](https://www.pango.net/faqs/)

### Table 2: Summary of phenotypic impacts* of Variants of Concern

<table>
<thead>
<tr>
<th>WHO label</th>
<th>Alpha</th>
<th>Beta</th>
<th>Gamma</th>
<th>Delta</th>
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<tbody>
<tr>
<td><strong>Transmissibility</strong></td>
<td>Increased transmissibility$^4$</td>
<td>Increased transmissibility$^5,6$</td>
<td>Increased transmissibility$^6,7$</td>
<td>Increased transmissibility$^6,8,9$</td>
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<tr>
<td><strong>Disease severity</strong></td>
<td>Possible increased risk of hospitalization$^{10,11}$, possible increased risk of severe disease and death$^{12,13}$</td>
<td>Possible increased risk of hospitalization$^{11}$, possible increased in-hospital mortality$^{14}$</td>
<td>Possible increased risk of hospitalization$^{11}$, possible increased risk of severe disease$^{15}$</td>
<td>Possible increased risk of hospitalization$^{16,17}$</td>
</tr>
<tr>
<td><strong>Risk of reinfection</strong></td>
<td>Neutralizing activity retained$^{18}$, risk of reinfection remains similar$^{19}$</td>
<td>Reduction in neutralizing activity reported; T cell response elicited by D614G virus remains effective$^{20}$</td>
<td>Moderate reduction in neutralizing activity reported$^{21}$</td>
<td>Reduction in neutralizing activity reported$^{22-24}$</td>
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<tr>
<td><strong>Impacts on diagnostics</strong></td>
<td>Limited impact – S gene target failure (SGTF), no impact on overall result from multiple target RT-PCR; No impact on Ag RDTs observed$^{25}$</td>
<td>No impact on RT-PCR or Ag RDTs observed$^{24}$</td>
<td>None reported to date</td>
<td>No impact on RT-PCR or Ag RDTs$^{26}$ observed</td>
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*Generalized findings as compared to previously/co-circulating variants. Based on emerging evidence, including non-peer-reviewed preprint articles and reports, all subject to ongoing investigation and revision.

## WHO - SARS-CoV-2 Variants of Concern (VOC)

### Table 3. Summary of vaccine performance against Variants of Concern

<table>
<thead>
<tr>
<th>WHO Emergency Use Listing (EUL) Qualified Vaccines</th>
<th>Vaccines without WHO EUL*</th>
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<tbody>
<tr>
<td>AstraZeneca-Vacczen-Sir Cummings</td>
<td>Sinovac-CoronaVac</td>
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<tr>
<td>Bharat-Covax</td>
<td>Anhui ZL-Recombinant</td>
</tr>
<tr>
<td>Janssen-Ad26.COV2.S</td>
<td>Gamaleya-Sputnik V</td>
</tr>
<tr>
<td>Moderna-mRNA-1273</td>
<td>Novavax-Covavax</td>
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<tr>
<td>Moderna-mRNA-1273/Pfizer-Biontech</td>
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<tr>
<td>Pfizer-Biontech-Comirnaty</td>
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#### Alpha

**Summary of VE**
- Severe disease: $\rightarrow_2$
- Symptomatic disease: $\leftarrow_2$ to $\downarrow_4$
- Infection: $\rightarrow_2$
- Neutralization: $\rightarrow_2$ to $\downarrow_4$

**Protection retained against severe disease**

#### Beta

**Summary of VE**
- Severe disease: $\rightarrow_3$
- Symptomatic disease: $\leftarrow_2$, $\rightarrow_1$
- Infection: $\rightarrow_2$
- Neutralization: $\rightarrow_2$ to $\downarrow_4$

**Protection retained against severe disease**; **reduced protection against symptomatic disease**; **limited evidence**

#### Gamma

**Summary of VE**
- Severe disease: $\leftarrow_1$
- Symptomatic disease: $\leftarrow_1$
- Infection: $\leftarrow_1$
- Neutralization: $\leftarrow_1$ to $\downarrow_4$

**Unclear impact**; **very limited evidence**

#### Delta

**Summary of VE**
- Severe disease: $\rightarrow_3$
- Symptomatic disease: $\downarrow_2$
- Infection: $\rightarrow_2$
- Neutralization: $\rightarrow_2$

**Protection retained against severe disease**; **possible reduced protection against symptomatic disease and infection**; **limited evidence**

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Risk assessment in Hong Kong

- 25 Jan 2020
  - HA announced the activation of **Emergency Response Level** in public hospitals to tie in with the Government raising the response level from “Serious” to “Emergency” in response to the latest situation of Novel Coronavirus.

- 30 Jan 2020
  - World Health Organization (WHO) declared the novel coronavirus outbreak a Public Health Emergency of International Concern (PHEIC)

- 11 Feb 2020
  - WHO has named the disease COVID-19, short for “coronavirus disease 2019”.

- 11 March 2020
  - WHO officially declared COVID-19 a pandemic.
Enhanced Measures

- Universal masking in ALL HA hospitals and clinics
  - Each inpatient would be provided with 1 mask per day unless it is damaged or soiled.
  - Patients and accompanying persons attending AEDs and outpatients clinics are advised to bring their own masks.
  - Disposable medical/surgical mask is preferred. Mask with an exhalation valve or vent is not acceptable.

- ILI Segregation Areas at AEDs

- Full personal protective equipment (PPE) i.e. N95 respirator, goggles / face shield, isolation gown & disposable gloves for aerosol-generating procedures (AGPs).
Enhanced Measures

- Enhanced ventilation at A&E, GOPC & SOPC waiting areas
  - Completed the widest opening of the fresh air dampers in the air handling equipment in the waiting areas of AEDs, GOPCs and SOPCs to achieve higher fresh air rate with improved air dilution; and
  - Completed wheeling in mobile HEPA units to augment the total air change rates in A&E waiting areas where necessary.

Example:
HEPA unit is placed at QEH AED
Enhanced Measures

- **Isolation facilities utilization**
  - Isolation beds available: ~1 200 first-tier isolation beds, ~1 000 beds in Community Treatment Facility, ~800 beds in The North Lantau Hospital Hong Kong Infection Control Centre (HKICC)
  - Daily monitoring of utilization
  - Re-designate the use to meet surge admission if necessary

- **PPE 90-day stockpile**
  - Daily monitoring of usage
  - A two-tier communication mechanism for the supply of PPE, laundry and linen.

- **Alcohol-based hand rub (ABHR)**
  - 3 months additional backup stock

- **ECMO machine utilization**
  - ECMO referral network
  - Daily monitoring of usage
## Cluster coordinator for the supply of PPE, laundry and linen

### Two-Tier Helpline for the supply issues of PPE and Laundry and Linen

<table>
<thead>
<tr>
<th>PPE</th>
<th>1st call</th>
<th>2nd call</th>
<th>3rd call</th>
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<tbody>
<tr>
<td><strong>Tier 1: Cluster</strong></td>
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<tr>
<td><strong>HKEC</strong></td>
<td>Ms Ada Hui (6463 7056)</td>
<td>Mr Stephen Li (6460 0713)</td>
<td>Ms Jolie Cheung (6460 0664)</td>
</tr>
<tr>
<td><strong>HKWC</strong></td>
<td>Mr Eric Cheung (9234 9145)</td>
<td>Mr Danny Kwok (6131 6194)</td>
<td>Ms Winnie Yip (9100 6880)</td>
</tr>
<tr>
<td><strong>KCC</strong></td>
<td>Mr Billy Tse (9416 2790)</td>
<td>Ms Elsa CHU (9167 8064)</td>
<td>Ms May Chan (9122 0377)</td>
</tr>
<tr>
<td><strong>KEC</strong></td>
<td>Mr Jeff Poon (5215 3393)</td>
<td>Mr Daniel Tong (6155 0066)</td>
<td>Mr Terence Cham (6899 0738)</td>
</tr>
<tr>
<td><strong>KWC</strong></td>
<td>Mr Timothy Chan (6461 1059)</td>
<td>Ms Sarah Wong (6461 0832)</td>
<td>Ms Lina Yung (6461 0880)</td>
</tr>
<tr>
<td><strong>NTEC</strong></td>
<td>Mr Peter Chow (5145 7824)</td>
<td>Mr Daniel Au (9804 8334)</td>
<td>Ms Esther Law (6296 9905)</td>
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<tr>
<td><strong>NTWC</strong></td>
<td>Mr William Chan (9554 7309)</td>
<td>Mr Kent Chan (9088 9728)</td>
<td>Mr Stephen Lam (9140 9627)</td>
</tr>
<tr>
<td><strong>Tier 2: HAHO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ms Amelia Lee (6892 1203)</td>
<td>Mr Antony Lui (6293 7207)</td>
<td>Mr Benjamin Lee (9011 2766)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laundry and Linen</th>
<th>1st call</th>
<th>2nd call</th>
<th>3rd call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1: Cluster</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HKEC</strong></td>
<td>Mr Chau Lee (6460 1303)</td>
<td>Ms Karen Lee (6460 0709)</td>
<td>Ms Julie Li (6460 0686)</td>
</tr>
<tr>
<td><strong>HKWC</strong></td>
<td>Mr Peter Ho (9198 7812)</td>
<td>Ms Candy Wang (9219 8961)</td>
<td>Ms Winnie Yip (9100 6880)</td>
</tr>
<tr>
<td><strong>KCC</strong></td>
<td>Mr Billie Mak (9643 2007)</td>
<td>Ms. Athena Kwan (9411 4377)</td>
<td>Ms Miscelle Kwok (9810 8028)</td>
</tr>
<tr>
<td><strong>KEC</strong></td>
<td>Ms Pinky Chan (9108 8763)</td>
<td>Ms Sandy Szeto (9036 7160)</td>
<td>Mr Terence Cham (6899 0738)</td>
</tr>
<tr>
<td><strong>KWC</strong></td>
<td>Mr Paul Lam (9648 2434)</td>
<td>Ms Dorian Ha (9209 9759)</td>
<td>Mr Raymond Ho (6626 8311)</td>
</tr>
<tr>
<td><strong>NTEC</strong></td>
<td>Mr Wayne Yip (9133 3723)</td>
<td>Ms Bonnie Chan (9081 1625)</td>
<td>Ms Zenobia Shum (9670 0870)</td>
</tr>
<tr>
<td><strong>NTWC</strong></td>
<td>Ms Candy Chan (5728 5828)</td>
<td>Ms Kathy Ip (9507 5756)</td>
<td>Mr Kevin Chan (9356 6669)</td>
</tr>
<tr>
<td><strong>Tier 2: HAHO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ms Alice Lee (6381 6960)</td>
<td>Mr Benedict Fu (9227 5800)</td>
<td>Mr Benjamin Lee (9011 2766)</td>
</tr>
</tbody>
</table>

Enhanced Measures

- Respirator fit test program
  - Hospital Infection Control Teams have revisited and offered the N95 respirator fit test program to all healthcare workers, in particular for those who work in high risk area.

- Pregnant staff
  - All pregnant staff should not be deployed into the high risk areas as stipulated in the Human Resources Circular (No.13/2013).

Enhanced Measures

- Blood donation arrangement
  The HA Blood Transfusion Service (BTS) Expert Panel on Blood and Blood Products Safety has reviewed the blood donation arrangement.

  1. Member of public who has recently visited a place with active community transmission of COVID-19 should be deferred from blood donation for 28 days from the date of departure.
     - Areas with active community transmission are available from CHP's webpage and will be updated from time to time: https://www.chp.gov.hk/files/pdf/statistics_of_the_cases_novel_coronavirus_infection_en.pdf

  2. Members of public who had close contact with a confirmed case of COVID-19 while that patient was symptomatic should be deferred from blood donation for 28 days

  3. Members of public with confirmed COVID-19 will be deferred for 180 days after complete recovery
Enhanced Measures

- Visiting to wards
  - Temporarily SUSPENDED in general.
  - Special visiting arrangement has been implemented in acute / specialist hospitals since 18 Aug 2021. (Refer to slide 25)

- Volunteer service
  - Temporarily SUSPENDED

- Clinical attachment (including research activities)
  - Temporarily SUSPENDED in general and gradually resumed after risk assessment

Updated on 24 Nov 2021
# Summary table of special visiting arrangement

<table>
<thead>
<tr>
<th></th>
<th>Phase 1-4</th>
<th>Phase 5</th>
<th>Phase 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective date</td>
<td>21/4/2021</td>
<td>18/8/2021</td>
<td>26/11/2021</td>
</tr>
<tr>
<td>Clinical settings</td>
<td>Hospitals / Units with Non-acute Settings</td>
<td>Acute / Specialist Hospitals</td>
<td>Child &amp; Adolescent Psychiatric</td>
</tr>
<tr>
<td>Criteria for visit</td>
<td>In-patient</td>
<td>Allow visit after 1st week of hospitalization*</td>
<td>Allow visit after cohort period in Psychiatric Admission Unit</td>
</tr>
<tr>
<td>By appointment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Electronic health declaration form</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Allowed session per week</td>
<td>1-2</td>
<td>1-2</td>
<td>1-2</td>
</tr>
<tr>
<td>Duration per visit (hour)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No. of visitors per visit</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Exchange of visitors</td>
<td>Not allowed</td>
<td>Not allowed</td>
<td>Not allowed</td>
</tr>
<tr>
<td>COVID-19 test requirement</td>
<td>Nucleic acid test</td>
<td>Allowed</td>
<td>Only allow visit for those who are completed two-dose COVID-19 vaccinations for 14 days</td>
</tr>
<tr>
<td></td>
<td>Rapid antigen test</td>
<td>Not allowed</td>
<td>Only allow visit for those who are completed two-dose COVID-19 vaccinations for 14 days</td>
</tr>
<tr>
<td>Completed COVID-19 vaccinations for 14 days</td>
<td>Exempted from test</td>
<td>Only allow visit for those who are completed two-dose COVID-19 vaccinations for 14 days</td>
<td>Only allow visit for those who are completed two-dose COVID-19 vaccinations for 14 days</td>
</tr>
</tbody>
</table>

Remark:
* For patient with high physical dependence, visitors who completed two-dose COVID-19 vaccinations for 14 days could make early appointment if situations allowed

Added on 24 Nov 2021
Guidance for Compassionate Visit of Inpatients

• Under Emergency Response Level, compassionate visit should be made as an exceptional arrangement in HA hospitals, with a view to address the essentiality of visitation for humanity and patient care in specific circumstances*. It is reminded that the frequency of visit should be minimized as far as possible.

# Paediatrics admission; emergency admission; patients in critical conditions upon admission; when patients having deteriorating health conditions; after surgery (Humanistic needs other than the listed reference situations may also be considered by local hospitals on a case-by-case basis)

<table>
<thead>
<tr>
<th>Guidance for compassionate visit of inpatients</th>
<th>Testing of visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>in general healthcare setting</td>
<td>Visitors are advised to undergo a COVID-19 nucleic acid test in private laboratories or community test services recognized by the government before the scheduled visit.</td>
</tr>
<tr>
<td>(Should be reinforced on a case-by-case basis after risk assessment)</td>
<td>✓ With effect from 1 Sep 2021, all visitors (including one off; repeated and regular visits) are required to provide a nucleic acid test results within 72 hours (from specimen collection time) on the day of visit</td>
</tr>
<tr>
<td>1. Visitors should check body temperature and screen for signs and symptoms of COVID-19 → No entry of those with signs or symptoms</td>
<td>✓ For urgent circumstances under compassionate visit (such as end-of-life visit), in case COVID-19 nucleic acid test is not available, visitors should provide a valid negative result of a rapid antigen test instead. The test should be performed within 24 hours before the visit or right after the visit if advance test is not feasible</td>
</tr>
<tr>
<td>2. Visitors should complete hospital visit record with contact information</td>
<td>✓ Testing arrangement for visitors who have completed a COVID-19 vaccination course* could be waived with effect from 21 Jun 2021, if they are able to present a valid vaccination record.</td>
</tr>
<tr>
<td>3. Visitors should put on a surgical mask and practice hand hygiene before and after the visit</td>
<td></td>
</tr>
<tr>
<td>4. Patients should put on a surgical mask if not contraindicated</td>
<td></td>
</tr>
<tr>
<td>5. Visit should be scheduled in advance</td>
<td></td>
</tr>
<tr>
<td>6. In general, the visit is limited to 1 hour, exchange of visitors is allowed in the meantime but limited to no more than two visitors at per session.</td>
<td></td>
</tr>
<tr>
<td>7. No more than 2 visitors per visit</td>
<td></td>
</tr>
<tr>
<td>8. No eating and drinking during the visit</td>
<td></td>
</tr>
</tbody>
</table>

* Completion of a COVID-19 vaccination course in general means having two doses of COVID-19 vaccine at least 14 days before the visit. For persons previously infected with COVID-19, a record of one dose of COVID-19 vaccines would be considered as completed the vaccination course.
Special Arrangement for the Request for Compassionate Visit of End-of-life patients from relatives under “Quarantine Order”  
(CCIDER’s important message on 29 Dec 2020)

Upon receiving the request form referred by DH for compassionate visit from confinees during their quarantine period, HA will coordinate the visit arrangement after risk assessment.

HO MICC and anchor points of hospitals will be notified in parallel by DH for the arrangement of compassionate visit for such group of visitors.

The part to be completed by HA staff

1. Compassionate In-patient Visitation by Relatives under Quarantine Order:  
   http://qsdportal/iec/Website/IEC%20Webpage/COVID-19/Compassionate%20visit%20v12_%20EOL%20visit%20for%20relatives%20under%20QO%2020201224.pdf

2. Request form for Compassionate In-patient Visitation by Relatives under Quarantine Order:  
   http://qsdportal/iec/Website/IEC%20Webpage/COVID-19/Request%20Form%20for%20Compassionate%20In-patient%20Visitiation%20by%20Relatives%20under%20Quarantine%20Order.pdf
Additional Infection Control Measures for Compassionate Visit of End-of-life patients from relatives under “Quarantine Order”

(CCIDER’s important message on 29 Dec 2020)

- Visitors to maintain social distancing and avoid physical contact with patient
- Hospital staff to arrange a designated route from entry to the site for visitation + vice versa
- In general, the visit is limited to 30 minutes, ≤2 confinees** per visit as approved by the Department of Health
- Hospital to arrange disinfection of the patient’s immediate environment after the visit

**2 confinees must be linked with the same index case
Enhanced Measures
(CCIDER’s important message on 11 Dec 2020)

➢ Recommendation from home leave patients /patients with activities outside hospitals

• Home leave and activities outside hospitals (such as visiting convenience store and smoking) should be minimised as far as possible.

• If home leave is considered necessary, special advice on infection control measures should be given to patients prior to their home leave arrangement.

• Upon the return of patients, risk assessment should be performed on their corresponding placement or test arrangement.
Enhanced Measures
(CCIDER’s important message on 23 Aug 2021)

➢ For Non-HA workers entering “restricted in-patient areas”
  • “Restricted in-patient area” is defined as in-patients areas not freely accessible to public (e.g. Wards, OT, Endoscopy Suite, CCL etc.)
  • “Entering” is defined as “stay for over 30 minutes”
  • In view of the emerging threat of the Delta variant, with effect from 1 Sep 2021, all non-HA workers entering HA’s “restricted in-patient areas” must follow the following requirement:
    • Received two doses of COVID-19 vaccination for 14 days; OR
    • Has undertaken a PCR test within two weeks
Reinforcement on Infection Control Measures

1. Provide surgical masks to patients if necessary
2. Ensure the availability of alcohol-based hand rub (ABHR) at convenient locations (e.g. ward entrance, lobby and corridors)
3. Disposal of masks in lidded rubbish bins
4. Posters / signage at ward entrance and lobby
5. Compliance of universal masking (e.g. conduct site inspection)
6. Full PPE for AGPs to avoid super spreading event (e.g. conduct refresher training or drill exercises)
7. Arrange temperature screening in wards, AEDs, GOPCs and SOPCs (health advice should be given to visitors with fever and respiratory illness)
Reinforcement on infection control measures for staff during meal time
(CCIDER’s important message on 14 Aug 2020)

1. Staggering meal times to avoid crowding
2. Limit number of persons each table (No more than 4 persons each table*)
3. Tables 1.5m apart or effectively partitioned or sit on one direction to avoid face to face, if operationally feasible
4. Avoid talking while eating
5. Put on mask immediately after meal
6. Provide alcohol-based handrub solution for hand hygiene before and after meal
7. Consider provision of disinfectant wipe for cleaning/ disinfecting the tables before/ after each use

Staff are strongly advised to seek medical attention immediately if have COVID-19 symptoms.

* For dine-in services in hospital canteens, catering operators, with the agreement of respective clusters, are allowed to adopt the Type B Mode of Operation according to the requirement of Cap. 599F Prevention and Control of Disease (Requirements and Directions) (Business and Premises) Regulation, allowing a maximum of four persons per table. Colleagues are required to scan the “LeaveHomeSafe” QR code or complete the record form before entering the restaurants. A number of hospital canteens will gradually adopt this arrangement if operationally feasible. Please refer to the announcement of respective clusters. Besides, the dining facilities of all hospital canteens are still only available for staff, and visitors could only order takeaways.
Staff Vaccination

• To reduce the impacts of COVID-19 on public health and society, vaccines against COVID-19 is considered an important public health tool for containing the pandemic in the medium and long term by increasing the population immunity against SARS-CoV-2.

• Healthcare workers regularly have contact with severely ill patients who have the highest levels of virus / have contact with the most vulnerable patients who have the weakest immune systems.

• Healthcare workers are encouraged to get vaccinated early to protect yourselves, your family and patients.

• Participation in the COVID-19 Vaccination Programme is entirely voluntary and you could choose which vaccine to take.
Case Reporting & Notification
Case Reporting Criteria (Revised by CHP on 28 Apr 2020)

Coronavirus disease 2019 (COVID-19) (2019冠狀病毒病)

<table>
<thead>
<tr>
<th>Clinical criteria</th>
<th>Epidemiological criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presented with</td>
<td>Either one of the following conditions within 14 days BEFORE ONSET OF SYMPTOM:</td>
</tr>
<tr>
<td>1. Fever*</td>
<td>1. With travel history to a place with active community transmission of COVID-19#</td>
</tr>
<tr>
<td>OR</td>
<td>OR</td>
</tr>
<tr>
<td>2. acute respiratory illness, OR</td>
<td>2. Had close contact with a confirmed case of COVID-19.</td>
</tr>
<tr>
<td>3. pneumonia</td>
<td></td>
</tr>
</tbody>
</table>

*Except fever due to a known etiology not related to respiratory infections

Notification

- The disease caused by COVID-19 was first listed as a statutorily notifiable disease with the name “Severe Respiratory Disease associated with a Novel Infectious Agent” under the Prevention and Control of Disease Ordinance (Cap 599) on 8 January 2020.

- Under the amendments on 28 April 2020, "Severe Respiratory Disease associated with a Novel Infectious Agent" has been renamed as "coronavirus disease 2019 (COVID-19)".

- Clinicians should report any suspected case to CENO and HAHO via NDORS/eNID.

- For cases admitted to ICU or died, please call MCO of CHP at 71163300-9179 immediately.
Laboratory Investigation & Specimen Transport
Laboratory Investigation

Respiratory specimen for RT-PCR of SARS-CoV-2
Lower respiratory tract (always preferred)
• Sputum
• Tracheal Aspirate (TA) (if intubated)
• Bronchoalveolar Lavage (BAL) (if bronchoscopy)
OR
Upper respiratory tract #
• Nasopharyngeal Flocked Swabs (NPFS) or Nasopharyngeal Aspirate (NPA) [pooled with Throat Swab in Viral Transport Medium (TM)]

Cluster lab for SARS-CoV-2 PCR tests
• Two or more rounds will be provided, depending on the service demand and lab capacity

If preliminary result for RT-PCR of SARS-CoV-2 is positive

Specimen should be re-tested and sent to PHLSB for confirmation*
1. Specimen requirement for respiratory samples
   • Original specimen (undiluted) should be sent to PHLSB for confirmation
2. Cut-off time of specimen arrival:
   (a) Weekdays
      • Test will be performed during office hours, with prior arrangement
   (b) Weekend
      • Prior notice is required, please call on duty Consultant beforehand
      The arrangement on Public holidays will be confirmed with PHLSB.

Stool specimen for RT-PCR of SARS-CoV-2
(for NDORS cases)
• For patient fulfilling reporting criteria who presents with diarrhea, stool can be sent to PHLSB for RT-PCR for SARS-CoV-2 testing.

PHLSB

# The Scientific Committee on Emerging and Zoonotic Diseases (SCEZD) does not object to the use of deep throat saliva as an alternative respiratory specimen to NPS for diagnosis as well as eradication screen.
* For confirmed positive cases, please send acute serum sample (upon diagnosis or earlier sample if available) and convalescent sample (upon discharge). No routine baseline serum sample is required.
• SHS for additional specimen transportation during Saturdays, Sundays, and Public Holidays is included under winter surge programmes.
## Inpatients - Enhanced Laboratory Surveillance for COVID-19

<table>
<thead>
<tr>
<th>Tier</th>
<th>Inclusion Criteria</th>
<th>Notification</th>
<th>Pre-test of SARS-CoV-2</th>
<th>Negative screening of SARS-CoV-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CHP’s reporting criteria of <a href="https://cdis.chp.gov.hk/CDIS_CENO_ONLINE/disease.html">Coronavirus disease 2019 (COVID-19)</a> under Cap 599</td>
<td>NDORS/eNID</td>
<td>Airborne Infection Isolation Room (AIIR) as far as possible / Surveillance ward</td>
<td>General wards with 1 metre spacing between patients</td>
</tr>
</tbody>
</table>
| 2    | Enhanced Laboratory Surveillance *(i) Any pneumonia case irrespective of their travel history:*  
|      | ▪ requiring ICU care; or  
|      | ▪ occurring in clusters; or  
|      | ▪ who is a healthcare worker. | --- | Surveillance ward as far as possible | --- |
| 3    | Extended Laboratory Surveillance *(i) Any inpatients with pneumonia other than Tier 2; or  
(ii) Any inpatients presented with ILI symptoms (e.g. fever or cough or sore throat); or  
(iii) Any inpatients presented with new loss of taste/ smell, shortness of breath or gastrointestinal symptoms | --- | Surveillance ward as far as possible | --- |

**Actions required:**

1. A specimen should be taken for cases fulfilling the above inclusion criteria and sent to cluster laboratory for RT-PCR for SARS-CoV-2.
2. Cases with positive results of novel coronavirus (SARS-CoV-2) should be isolated in airborne infection isolation room (AIIR) and reported to NDORS immediately.
3. Repeat SARS-CoV-2 testing for patients with COVID-19 compatible symptoms / chest infection, who are tested negative upon admission screening within 2 days after admission screening.
   a) Lower respiratory tract specimen (e.g. sputum) is preferable. DTS or NPS is acceptable if sputum could not be saved.
   b) In order to ease the demand on surveillance wards, repeated testing could be done in general wards after the patients are tested negative to SARS-CoV-2 in their first test and transferred to general wards upon clinical assessment. It is reiterated that the additional test should not affect the clinical management, placement or discharge of the patients.
Management of Suspected Cases

In view of the increasing number of both confirmed and suspected cases, the following two arrangements have been agreed after the joint risk assessment with CHP:

1. Admission of suspected cases
   • Suspected cases (excluding close contacts from Quarantine Centre (QC)) could be arranged in AIIR with adequate distancing of at least 1 metre while awaiting test result.
   • If AIIR are exhausted, these cases can be admitted to surveillance wards as the fallback.
   • This temporary measure remains effective until further review.

2. Management of test negative cases from quarantine centre (QC)
   • Test negative case from QC who is clinically stable and waiting for transferal back to QC can be admitted to non-AIIR with the following IC measures adopted:
     • Adequate distancing of at least 1 metre
     • Adopt universal masking
Management of patients with positive serology result done in private sector or over-the-counter

(CCIDER’s important message on 1 Jun 2020)

Regarding managing cases who presented with positive serology result done in private sector or over-the-counter and attended public hospitals, the following arrangement is agreed by CHP:

• **For symptomatic patients**, they will be managed as suspected cases of COVID-19, i.e. Triage & Test at AED if available or admit for a test;

• **For asymptomatic patients**, they will be offered deep throat saliva collection under the Tier 4 Enhanced Laboratory Surveillance.
**Management of Hospital Admission of Patients under Quarantine and Medical Surveillance**

*(CCIDER’s important message on 11 Dec 2020)*

<table>
<thead>
<tr>
<th>Admission of passengers</th>
<th>Pre-test of SARS-CoV-2</th>
<th>Tested negative for SARS-CoV-2</th>
<th>Tested positive for SARS-CoV-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Quarantine Centre</td>
<td>AIIR</td>
<td>AIIR as far as possible / Surveillance ward</td>
<td>Surveillance ward / Side room</td>
</tr>
<tr>
<td>Under Hotel Quarantine</td>
<td>AIIR as far as possible / Surveillance ward</td>
<td></td>
<td>Surveillance ward / Side room as far as possible</td>
</tr>
<tr>
<td>Under Home Quarantine</td>
<td>AIIR as far as possible / Surveillance ward</td>
<td></td>
<td>General ward with 1 metre spacing between patients*</td>
</tr>
<tr>
<td>Under Medical Surveillance</td>
<td>Surveillance ward as far as possible</td>
<td></td>
<td>Managed as general patient</td>
</tr>
</tbody>
</table>

*If test for SARS-CoV-2 is required, side room or corner bed should be considered for patient placement.*

Patient spacing and ventilation consideration for surveillance ward or cubicle:

- 1-metre spacing between patients
- A minimum of total 6 ACH for existing setting
- Additional portable HEPA filter(s) to augment total ACH
- Deploy ward cubicles of relatively closest to air handling unit return to enhance airflow effectiveness
- Deploy ward with air handling unit exhaust out to ambient having 3-metre away from fresh air intake or neighbour passage.

- Final setting will depend on actual site layout and corresponding installed ventilation system
- ICT should work with respective hospital/cluster FM where necessary
Release from Isolation for **Suspected** case

Revised principle to be considered (*NOT applicable to probable case*):

Patient tested RT-PCR negative for **SARS-CoV-2 UNLESS** patient has strong epidemiological link OR worsening clinical conditions

NOTE: No isolation order will be issued for routine suspected cases and they can be discharged/off isolation once the above criteria is fulfilled.
Exit screening for hospitalised patients under DH quarantine order

- To facilitate the arrangement of exit screening for these confinees, HA would offer a SARS-CoV-2 testing (deep throat saliva (DTS) or nasopharyngeal swab) within day 10 to day 12 of the quarantine period of patients during their hospital stay, starting from 9 September 2020.

- DH will send a request form together with the information required and a blank reply slip to HA upon patient admission as attached.

- The reply slip should be completed by ward and faxed to QC together with the patient’s laboratory report, if available.
Discharge Arrangement for Patients under Quarantine

1. Patients from Quarantine Centre (QC)
   – Call QC Medical Post (QCMP) for transportation arrangement at Tel: 21252600
   OR
   – Arrange hospital transportation according to hospital workflow

2. Patients from Home Quarantine
   – Self-arranged transport to home / hotel
   – Health advices such as wear a surgical mask and maintain social distancing

For health quarantine arrangements, please refer to CHP’s webpage: https://www.chp.gov.hk/en/index.html
Available specimen:
1. Bronchoalveolar Lavage
2. NPA + Throat swab
3. NPS + Throat swab
4. Sputum
5. Stool
6. Tracheal aspirate
7. Throat saliva
8. NPS, NPA
Added “Any inpatients presented with new loss of taste/ smell, shortness of breath or gastrointestinal symptoms”
The criteria for requesting the SARS-CoV-2 antibody test in HA is revised as below:

- Asymptomatic or 7 days after symptom onset AND RT-PCR test for SARS-CoV-2 with CT value 33 AND the test is ordered for pre-discharge screening. (CCIDER’s important message on 8 Apr 2021)

Added the information page on past infection and vaccination history for “Baseline serology test”.

GCRS test information page is updated on 27 Jul 2021 18:31
Specimen Transport

• All specimens are required to be sent via hospital courier services to HA laboratories, PHLSB and QMH laboratories to suit the local lab workflow.

• Clusters are advised to explore the available couriers services to support the delivery of the specimens. In case of any difficulties encountered, clusters could contact networked clusters or HO BSSD in accordance with the Response Plan of Business Support Services in Handling Major Incidents for coordination of cross-cluster support for transporting specimens.
  – First priority: hospital courier service
  – Second priority: contract out service is acceptable
Enhanced Laboratory Surveillance (Tier 4) for Coronavirus Disease (COVID-19) – in A&E and GOPC out-patients

Inclusion criteria*
A&E or GOPC out-patients:
Smart enough to understand the technique of “Deep Throat Saliva” collection (adult and paediatric patients)
AND
(i) with Fever and Respiratory symptoms; OR
(ii) mild Chest Infection; OR
(iii) Fever or respiratory symptoms subject to clinical assessment of physician in charge; OR
(iv) Gastrointestinal symptoms, new loss of taste/smell or shortness of breath

*The purpose of the surveillance scheme is to enhance catchment of potential coronavirus disease 2019 in the society. There is no guarantee that 100% of all patients fulfilling the above criteria will be recruited for the scheme.

Actions required
1) Doctor recognizes a suitable case and invite the patient to the scheme.
2) Explain the scheme to the patient and provide the information leaflets:
   i. Information sheet for collection of early morning deep throat saliva (Annex I)
   ii. General health advice information leaflet (Annex II)
3) Doctor orders "Throat Saliva – SARS-CoV-2 PCR in GCRS"
4) Provide a specimen bottle and 2 specimen bags for the patient to go home to collect early morning “Deep Throat Saliva”.
5) Remind patient to register or verify the mobile number at the registration counter for receiving SMS on negative results notification. The number should be entered at PMI/PAS “other phone number”.
6) Return the specimen in the morning on the same day of collection. Please refer to the general advice for A&E and GOPC staff upon receiving patients’ specimens. (Annex III)
7) The specimen collection and transport workflow will follow existing mechanism that have been agreed at cluster level.
8) The specimen should be sent to Public Health Laboratory Service Branch of CHP for RT-PCR for COVID-19. Specify “Enhanced laboratory surveillance for COVID-19” on the laboratory request form.
9) For patients with positive results, DH Medical Control Officer (MCO) will inform the patient directly for admission to hospital. After admission, hospital will report the case to eNID.
10) For patients with negative results, they will receive a standard SMS:
   「閣下最近於醫院管理局的深喉唾液檢測結果呈陰性反應。」

As PHLSB is going to support testing service of COVID-19 for asymptomatic persons under the Compulsory Quarantine of Persons Arriving at Hong Kong from Foreign Places Regulation (Cap. 599E), HA laboratories will start providing SARS-CoV-2 RT-PCR testing for 4th Tier ELS with effect from 26 March 2020 00:00hrs until further notice.
Effective from 1 Dec 2020, 18:30:
1) “Compulsory Testing Cap. 599J” is added for Tier 4 request.
2) Reason for the test “Others please specify in clinical information” under Tier-4 DTS test has been removed
Triage and Test (T&T) service in AED
(CCIDER’s important message on 31 Mar 2020)

- For the early decision of discharge/admission of suspected cases in 1st tier surveillance, patients could have NPS and throat swab collected in AIIR for RT-PCR (SARS-CoV-2) and then wait in a designated area while pending test results.
- In case of AIIR exhaustion/no AIIR available at AED, NPS and throat swab could be collected in an adequately ventilated single room with at least 6 ACH and the use of portable HEPA filter unit e.g. IQ Air. The PPE standard remains the same for NPS taking in either AIIR or non-AIIR.
- The patient recruiting criteria are as follows:

<table>
<thead>
<tr>
<th>Patient recruiting criteria</th>
<th>Patients who are clinically stable with</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Mild symptoms; AND</td>
</tr>
<tr>
<td></td>
<td>♦ No need on oxygen therapy</td>
</tr>
</tbody>
</table>

Added on 24 Apr 2020
Triage and Test (T&T) service in AED

(CCIDER’s important message on 31 Mar 2020)

The designated areas for patients waiting for test results need to fulfill below requirements:

• Make reference to surveillance ward standards
• Adequate distancing of > 1m apart
• Universal masking
• Unilateral sitting
• Minimize eating and drinking
• Minimize patient movement and gathering
• Good ventilation
• Adequate cleansing
Tier 8a Admission Screening for asymptomatic inpatients

- In view of the evolving situation and catchment of occult COVID-19 patients in general hospital setting, it is recommended to extend the availability of COVID-19 test under tier 8a admission screening to inpatients of all clinical specialties, with effect from 9 September 2020 until further notice.

- Subject to operational feasibility, hospitals are encouraged to perform COVID-19 tests for newly admitted inpatients. By nature of sentinel surveillance, the tier 8a admission screening test is an additional measure for COVID-19 vigilance and the clinical management of patients participating in the scheme should not be affected.

- Clinicians could request for SARS-CoV-2 PCR tests via the Generic Clinical Request “(Tier 8a) Admission screening for asymptomatic inpatients” in the proforma.

- As the latest scope of admission screening will cover patients among vulnerable groups and epidemiological high risk groups, the memo titled “Admission screening for Coronavirus Disease 2019 (COVID-19) in vulnerable groups and epidemiological high risk groups” effective from 15 July 2020 will be obsoleted with effect from 9 September 2020.
**Tier 8b Enhanced screening scheme for COVID-19 for patients attending day services**

- HA has been extending the scope of sentinel screening scheme\(^\text{^A}\) in response to the COVID-19 situation to facilitate early case detection, clinical management and public health intervention. On 14 Sep 2021, CCIDER reviewed the local situation of COVID-19 with zero local case, **the criteria of Tier 8b ELS will be updated with effective from 27 Sep 2021:**

**Actions required**

1) Beside patients who have completed a COVID-19 vaccination course\(^*\), all day patients **attending Day Care Centres / Day Services** are strongly recommended to receive SARS-CoV-2 PCR testing\(^\#\) **within 72 hours prior to the appointment**, or on a weekly basis for those have regular appointments.

- Patients who will stay in Day Care Centres / Day Services **for less than 4 hours and maintain good compliance with recommended infection control measures**, including mask wearing at all times, could be exempted from the test requirement, except the following groups:
  A. Patients with regular day service appointments
  B. Vulnerable patient groups
    i. Renal patients attending haemodialysis (HD) centres
    ii. Patients attending day centres for chemotherapy or radiotherapy
    iii. Patients attending Geriatric Day Hospitals (GDH)
    iv. Patients attending Psychiatric Day Hospital (PDH)
  C. Patients undergoing day surgeries or procedures where mask wearing is not applicable (e.g. bronchoscopy)

2) Clinicians could request the SARS-CoV-2 PCR test via the Generic Clinical Request System (GCRS) (Annex I). The provision of DTS bottle and information sheet on deep throat saliva collection to patient should tie in existing workflow.

3) The specimen should then be sent to cluster laboratories for SARS-CoV-2 RT-PCR test according to the prevailing mechanism.

4) Infection Control Officer (ICO) will inform the physician in-charge of the day service centres for any positive results of COVID-19 and advise on follow-up investigation accordingly.

5) **No routine meal time would be allowed; snack could be offered if indicated.**

6) **Upkeep usual infection control measures including:**
   i. Separate patients by partitions / curtains;
   ii. Maintain adequate social distancing;
   iii. Advise patients to wear surgical mask and carry out frequent hand hygiene during their visit;
   iv. Sit in one direction to avoid face-to-face contact;
   v. No talking during eating or drinking.

7) **Symptomatic cases** should be managed and tested in **airborne infection isolation rooms (AIIR) or surveillance wards.**

---

\(^\text{^A}\) By nature of the sentinel surveillance, the test is an additional measure for COVID-19 vigilance and the clinical management of patients participating in the scheme should not be affected.

\(^*\) Completion of a COVID-19 vaccination course in general means having two doses of COVID-19 vaccine at least 14 days before the visit. For persons previously infected with COVID-19, a record of one dose of COVID-19 vaccines would be considered as completed the vaccination course.

\(^\#\) Either performed by HA, private laboratories or community test services recognized by the government
Tier 8a & 8b GCRS Request & Test Information Page for Deep Throat Saliva for SARS-CoV-2 PCR

Choose “Throat saliva” specimen

1. Choose “Throat saliva” from the specimen list.
2. Select “Throat Saliva, SARS-CoV-2 PCR”.
3. Choose the relevant reason for the test:
   - vii. (Tier 8a) Admission screening for asymptomatic inpatients
   - vii. (Tier 8b) Screening for asymptomatic patients attending day services
Information Sheet on Deep Throat Saliva Collection

For in-patients (updated in Sep 2020):

- No food or drink, mouthwash and brushing teeth within 2 hours before specimen collection

For out-patients (updated in Oct 2020):

- No food or drink, mouthwash and brushing teeth within 2 hours before specimen collection
- Please collect the deep throat saliva in a well-ventilated place, and keep a distance of at least 2-metre from other people

Hospital Authority
In-patient Information Sheet on Deep Throat Saliva Collection

Hospital Authority
Patient Information Sheet on Deep Throat Saliva Collection

Infection control advice to outpatients awaiting test result for COVID-19
給等候2019冠狀病毒病測試結果的非留院人士之感染控制建議

Annex II

Preamble
This advice applies to patients seen at outpatient settings (GOPCs and AEDs) with fever and mild respiratory symptoms without epidemiological links of COVID-19. This group of patients does not require admission to hospital and can return to their place of residence while waiting for test result of COVID-19 (deep throat saliva specimen).

Advice for patients leaving the clinic
(a) As you are having respiratory infection symptoms, please continue to wear a surgical mask after clinic attendance.
(b) Please return home to take a rest as soon as possible and avoid going out.
(c) Always maintain hand hygiene.

Advice for patients at home
(a) Please stay in your residence for rest and refrain close contacts with other household members as far as possible before symptoms resolved.
(b) Avoid sharing of personal items and meals with other household members.
(c) Perform hand hygiene frequently and observe cough etiquette.
(d) Stay in a well-ventilated single room as far as possible. Household members should preferably stay in a separate room.
(e) Ensure that shared spaces are well ventilated by keeping windows open.
(f) Limit the number of caretakers of the patient. Wear a mask when caring the patient and perform hand hygiene frequently.
(g) Clean and disinfect the home environment daily with 1 in 99 diluted household bleach (mixing 10 ml of bleach containing 5.25% sodium hypochlorite with 990 ml of water), leave for 15-30 minutes and then rinse with water.

Proper use of toilet
(a) Close toilet lid before flushing to minimize spread of germs
(b) Always wash your hands with liquid soap and water after toileting.
## Enhanced Laboratory Surveillance (ELS)

<table>
<thead>
<tr>
<th>HA</th>
<th>Tier 1</th>
<th><strong>Notifiable cases</strong> fulfilling CHP’s reporting criteria tested by HA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>HA’s temporary test centres at AWE [Suspended on 19 Apr 2020 noon] and NLTH [Suspended on 5 Apr 2020 20:00]</td>
</tr>
<tr>
<td>Tier 2</td>
<td><strong>Inpatients</strong>: pneumonia cases irrespective of travel history requiring ICU care; or occurring in clusters; or who are healthcare workers</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td><strong>3A: inpatients</strong> with pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>3B: inpatients</strong> with influenza-like illness symptoms, new loss of taste/ smell, shortness of breath, or gastrointestinal symptoms</td>
<td></td>
</tr>
<tr>
<td>Tier 4</td>
<td><strong>A&amp;E or GOPC outpatients</strong> (clinically stable and do not require hospital admission): adult and paediatric outpatients with fever or respiratory symptoms or new loss of taste/ smell, shortness of breath, or gastrointestinal symptoms subject to clinical assessment</td>
<td></td>
</tr>
</tbody>
</table>

**DH Tier 5**

**For private clinics:**

| 5A | Testing available at clinics of sentinel private medical practitioners for patients presenting with (i) fever or respiratory symptoms; OR (ii) mild chest infection. |
| 5B | All private clinics and hospitals |

**Tier 6**

**For asymptomatic inbound travelers:**

- Since 20 April 2020, an extra specimen container would be provided to asymptomatic inbound travelers for collection of sample on Day 12 of the 14-day quarantine for 2nd rounding of testing.

**DH Tier 7**

**For persons with higher risk of exposure**

| 7A | New admission to Castle Peak Bay Immigration Centre |
| 7B | HKIA staff |
| 7C | Staff at RCHEs, RCHDs and nursing homes |
| 7D | Chinese Medicine Clinics and Training and Research Centres for persons with a higher risk of exposure to their job |
| 7E | Members of Kwai Tsing District Health Centre with a higher risk of exposure to the infection in their job |
| 7F | Frontline workers of bus companies |
| 7G | Others, including distribution by Haven of Hope Christian Service |
| 7H | People who perceived themselves to have higher risk of exposure and experience mild discomfort |

**HA Tier 8**

**For high risk patients:**

| 8A | Admission screening for asymptomatic inpatients **(to inpatients of all clinical specialties, with effect from 9 Sep 2020)** |
| 8B | Day patients before attending day services **(strongly recommended)** |

Addresses of deep throat saliva specimen collection points:

http://qsdportal/ieC/Website/IEC9Webpage/COVID-19/Address%20of%20deep%20throat%20saliva%20specimen%20collection%20points.pdf
Staff Vaccination in lieu of Regular Testing Arrangement for All HA Staff (full-time and part-time)

- Preventing patients and colleagues from COVID-19 infection has been our common goal since the pandemic outbreak. To go in line with this goal, all HA staff members, full time and part time, should receive COVID-19 vaccination.

- For HA employees who are unfit to receive COVID-19 vaccination with valid medical consideration:
  - From 1 Sep 2021 onwards, all HA staff who have not received the first dose of vaccine are required to undergo PCR test for COVID-19 using combined nasal and throat swabs (CNTS) on a biweekly basis at Community Testing Centres (CTCs) outside working hours at their own expenses.
  - Staff who have valid medical consideration certified by a registered medical practitioner (not including a registered Chinese medicine practitioner for this purpose) as unfit to receive vaccination can claim for reimbursement of the expenses of PCR test performed.
  - The verification of valid medical consideration and reimbursement arrangement of biweekly PCR test using combined nasal and throat swabs (CNTS) at CTCs are subject to HR’s announcement.
  - To dovetail the Government on tightening the VRT arrangement, the testing requirement will be tightened from biweekly to weekly basis with effect from 22 Nov 2021.
Regular testing for high-exposure staff at HKICC

(CCIDER’s important message on 26 Oct 2021)

• To further minimise the risks of high exposure groups, **staff working in the North Lantau Hospital Hong Kong Infection Control Centre (HKICC)** will have to undergo PCR tests for COVID-19 using combined nasal and throat swabs (CNTS) every three days.

• The HKICC has already set up testing stations to implement the relevant arrangements.
Clinical Management
Placement of local cases and imported cases
(CCIDER’s important message on 12 Jul 2021)

• In response to the emergence of SARS-CoV-2 variants of concern (VOCs) or variants of interest (VOIs), both globally and locally, HA is currently adopting a more stringent approach to isolate individual imported cases in airborne infection isolation room (AIIR) until discharge.

• In view of the increasing number of VOCs or VOIs, and to facilitate more efficient and sustainable use of the isolation beds and manpower resources, the isolation policy for imported COVID-19 cases is updated, as endorsed by the Scientific Committee on Infection Control (SCIC) under CHP:

  ➢ Imported COVID-19 cases with the same SNP PCR profile pattern could be cohorted.
Placement plan for confirmed cases with SARS-CoV-2 VOC / VOI
(Endorsed in the 40th SCIC Meeting on isolation of VOC on 23 April 2021)

<table>
<thead>
<tr>
<th>N501Y PCR</th>
<th>E484K PCR</th>
<th>L452R PCR</th>
<th>Patient placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td>Cohort with other case with all targeted mutations negative</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td>Negative</td>
<td>Negative</td>
<td>Single room or cohort with other case with same PCR profile</td>
</tr>
<tr>
<td><strong>Positive</strong></td>
<td><strong>Positive</strong></td>
<td>Negative</td>
<td>Single room or cohort with other case with same PCR profile</td>
</tr>
<tr>
<td>Negative</td>
<td><strong>Positive</strong></td>
<td>Negative</td>
<td>Single room or cohort with other case with same PCR profile</td>
</tr>
<tr>
<td>Negative</td>
<td>Negative</td>
<td><strong>Positive</strong></td>
<td>Single room or cohort with other case with same PCR profile</td>
</tr>
</tbody>
</table>

**NOTE:** Any inconclusive SNP result should wait for confirmation by Sanger sequencing.
Baseline serology testing for confirmed cases
(CCIDER’s important message on 30 Apr 2021)

• In view of the potential breakthrough infection or re-infection, clinicians are advised to take a baseline serology test for all confirmed cases upon admission.

Added the information page on past infection and vaccination history for “Baseline serology test”.

GCRS test information page is updated on 27 Jul 2021 18:31
Clinical Management

• General Clinical Management
  – Monitor vital signs and organ functions, and recognize complication(s) early
  – Liaise with ICU early for intensive care if anticipate clinical deterioration
  – Provide supportive treatments
    • Monitor for any concomitant bacterial infections and start empirical antibiotics if necessary
    • β-lactam/β-lactamase inhibitor combination or 3rd generation cephalosporin +/- macrolide/doxycycline can be considered
    • Oxygen
    • IV fluid (conservative fluid management for severe respiratory failure)
    • Hemodynamic support
    • High-flow nasal oxygen (HFNO) may be considered in selected patients with hypoxemic respiratory failure. These patients should be closely monitored for clinical deterioration.
    • Mechanical ventilation with protective lung ventilation +/- consider ECMO for refractory respiratory failure
    • Renal replacement therapy (renal failure)
    • Consider proton pump inhibitors (PPI) for stress ulcer prophylaxis for prevention of GI bleeding per clinical judgment of ID physician/Intensivist for moderate to severe cases

  – Anticoagulation
    • In patients hospitalized with COVID-19, use pharmacological prophylaxis, such as low molecular weight heparin (such as enoxaparin 40mg Q24H subcutaneous, according to local and international standards, to prevent venous thromboembolism, when not contraindicated. For those with contraindications, consider mechanical prophylaxis (intermittent pneumatic compression devices)

Source: Interim Recommendation on Clinical Management of Adult Cases with Coronavirus Disease 2019 (COVID-19)
### Use of specific anti-COVID-19 treatments

The following table summarizes different available treatment regimens. These regimens are determined based on evidence extrapolated from research performed for other coronaviruses, expert opinion, non-randomized placebo controlled trials, case series and limited randomized placebo controlled trials on treatment of COVID19, as well as the availability of therapeutics in Hong Kong. This serves as an interim guidance and will be updated according to the availability of new evidence or drug availability.

<table>
<thead>
<tr>
<th>Setting and severity of illness</th>
<th>Antivirals</th>
<th>Anti-Inflammatory or Immuno-therapeutics</th>
<th>Anti-SARS-CoV-2 Antibody products</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild-to-moderate disease without need of suppl, oxygen</td>
<td>Can be considered for early onset disease (&lt;14 days symptom)</td>
<td>Suggest against use</td>
<td>Can be considered in high risk patients</td>
</tr>
<tr>
<td>Severe but non-critical disease (SaO2 &lt;94% on room air)</td>
<td>Can be considered for early onset disease (&lt;14 days symptom)</td>
<td>Suggest use</td>
<td>Suggest against routine use</td>
</tr>
<tr>
<td>Critical disease (e.g. in ICU needing HFNO, mechanical ventilation (MV), or septic shock, ECMO)</td>
<td>Can be considered for early onset disease (&lt;14 days symptom)</td>
<td>Can be considered as part of interferon-based regimens</td>
<td>Can be considered as part of interferon-based regimens</td>
</tr>
</tbody>
</table>

1. **Interferon beta-1b**
   - Can be considered for early onset disease (<14 days symptom)
   - Can be considered for early onset disease (<14 days symptom)
   - Can be considered for early onset disease (<14 days symptom)

2. **Remdesivir**
   - Can be considered in high risk patients
   - Suggest use
   - Suggest against routine use

3. **Ribavirin**
   - Can be considered as part of interferon-based regimens
   - Can be considered as part of interferon-based regimens
   - Can be considered as part of interferon-based regimens

4. **Lopinavir + ritonavir**
   - Can be considered as part of interferon-based regimens
   - Can be considered as part of interferon-based regimens
   - Can be considered as part of interferon-based regimens

#### Anti-Inflammatory or Immuno-therapeutics

<table>
<thead>
<tr>
<th>Corticosteroids</th>
<th>Suggest against use</th>
<th>Support use Dexamethasone 6mg QD or equivalent glucocorticoids</th>
<th>Recommend use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convalescent plasma</td>
<td>Suggest against use</td>
<td>Suggest against use</td>
<td>Can be considered at discretion of ID physicians/ ICU intensivist, or use in the context of a clinical trial</td>
</tr>
<tr>
<td>Tocilizumab</td>
<td>Suggest against routine use</td>
<td>Suggest use in addition to standard of care (steroid)</td>
<td>Suggest use in addition to standard of care (steroid)</td>
</tr>
<tr>
<td>Baricitinib + remdesivir + corticosteroids</td>
<td>Suggest against use</td>
<td>Suggest use at discretion of ID physicians/ ICU intensivist</td>
<td>NA</td>
</tr>
</tbody>
</table>

#### Anti-SARS-CoV-2 Antibody products

| Casirivimab + imdevimab | Can be considered in high risk patients at discretion of ID physicians | Suggest against use | Suggest against use |

Step Down Criteria to 2\textsuperscript{nd} Tier Isolation Facilities for Confirmed Cases

(CCIDER’s important message on 25 July 2020)

Inclusion criteria:

1. Improving clinical condition and diarrhea (if any) subsided; and

2. Patients with low grade fever are not absolutely contraindication but subject to clinical assessment of physician in-charge; and

3. Normal or improving trend of haematology and biochemistry blood tests profile; and

4. Not on oxygen therapy

Remarks:

- *Cycle threshold value (Ct value) is a consideration factor but not a mandatory criteria. A cut off value is not required.
- If the patient deteriorates clinically, readmission to AIIR should be considered.
Step Down Care for Confirmed Cases
(CCIDER’s important message on 31 Mar 2020)

Recommended PPE for Step-down Wards

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
<td>Y</td>
</tr>
<tr>
<td>Respiratory protection</td>
<td>N95</td>
</tr>
<tr>
<td>Eye protection</td>
<td>Goggles / face shield</td>
</tr>
<tr>
<td>Isolation gown*</td>
<td>AAMI level 1</td>
</tr>
<tr>
<td>Disposable gloves</td>
<td>Y</td>
</tr>
<tr>
<td>Hair cover</td>
<td>Optional</td>
</tr>
</tbody>
</table>

- N95 respirator, eye protection and gown may remain insitu between patients providing they are not soiled or damaged.
- Gloves should be changed between patients and adherence to the 5 moments of hand hygiene.
- *AAMI level 3 isolation gown can be considered when splashing is anticipated. Alternatively, a waterproof apron on top of the AAMI level 1 isolation gown is also acceptable.
Step Down Care for Confirmed Cases

( CCIDER’s important message on 31 Mar 2020)

Environment standards of negative pressure wards converted from general wards

1. Installation of exhaust fan / HEPA filter in cubicle
   - The exhaust fan / filter helps keep the cubicle under negative pressure with 12 air changes per hour non-recirculating. With clean to less clean inward air flow, the ventilation is designed to flow from corridor to cubicle, and exhaust to the outdoor. For the exhaust unit in close proximity to the air inlet duct, a HEPA filter which can capture 99.97% of 0.3-micron particles will be installed.

2. Additional door in ward
   - Additional door installed at the entrance of the ward creates a buffer zone which helps stabilise the negative pressure inside the ward.

3. Additional mobile air-conditioning unit
   - It helps the indoor cooling during summer if needed.
Transferal Criteria for Stepped Down Cases from Hospitals to AWE

- Age 16-65
- ADL independent
- No diarrhea
- Clinically improving
- Normal or improving trend of haematology and biochemistry blood tests profile (e.g. lymphocytes, LDH, CRP, ferritin, D-dimer, CK)
- No shortness of breath and Not on oxygen therapy
- Not on antiviral therapy/ insulin/ injection therapy/ infusion
- Normal CXR or CXR obviously improving (for patient with pneumonia)
- Afebrile or low grade fever (Temp ≤ 38 degree Celsius)

**Exclusion:** Pregnancy (2nd/3rd trimester), Chronic renal failure on HD/CAPD, on BiPAP/CPAP, active manic/psychotic manifestation
Updated Criteria for Releasing Confirmed COVID-19 Patients from Isolation with effect from 27 Oct 2021

(CCIDER’s important message on 26 Oct 2021)

**For symptomatic patients**
1. Afebrile for > 3 days; **AND**
2. Significant improvement in respiratory symptoms; **AND**
3. Significant improvement in lung infiltrates in chest imaging; **AND**
4. Fulfil the following laboratory criteria:
   - With two clinical specimens of the same type* (i.e. respiratory or stool) tested negative for nucleic acid of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by reverse transcription polymerase chain reaction (RT-PCR) taken at least 24 hours apart; **AND**
   - 10 days have passed since the onset of illness.

For patients who meet discharge criteria (1) to (3), but with persistent positive test of nucleic acid of SARS-CoV-2 for more than 4 weeks, it is recommended to conduct a comprehensive assessment of the infectivity through methods of antibody test, and viral culture, before hospital discharge.

**For patients who did not develop any COVID-19 compatible symptoms all along**
1. Fulfil the following laboratory criteria:
   - With two clinical specimens of the same type* (i.e. respiratory or stool) tested negative for nucleic acid of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by reverse transcription polymerase chain reaction (RT-PCR) taken at least 24 hours apart; **AND**
   - 10 days after the first positive RT-PCR test for SARS-CoV-2.

For patients with persistent positive test of nucleic acid of SARS-CoV-2 for more than 4 weeks, it is recommended to conduct a comprehensive assessment of the infectivity through methods of antibody test, and viral culture, before hospital discharge.

*For patients ever with stool specimen(s) tested positive, they should have two negative stool specimens collected 24 hours apart before release from isolation

Remark:
Patients fulfilling the discharge criteria will immediately be arranged by point-to-point transfer to designated isolation facilities to undergo 14-day isolation and health monitoring through close-loop management arrangement to ensure that they do not bring the virus into the community.

Streamline process of termination of isolation orders of COVID-19 patients

(CCIDER’s important message on 31 Dec 2020)

In order to facilitate the process of termination of isolation orders, CHP has reviewed the existing workflow and designated a fax number for handling termination of isolation order instead of telecommunication with MCO. The new workflow would be adopted with immediate effect.

Under the new workflow, ward staff should follow the below steps for the request of termination of isolation orders of COVID-19 patients:

1. Ward staff should fill in the request form with personal particulars of the patient (gum label with necessary information is acceptable).

2. Staff should fax the completed form, together with the discharge summary and relevant laboratory reports to CHP through the designated fax number as indicated in the request form in one go.

3. CHP would handle the request upon receiving the request, and fax the termination of isolation to the concerned ward afterwards via the fax number of the ward as provided in the completed form.

Should there be any concerns encountered during the process, staff could call MCO for further advice / assistance.

Request form for termination of isolation order for COVID-19 cases

For COVID-19 patients fulfilling the discharge criteria and fit for discharge, the attending physician could request for termination of isolation order by filling this form and fax to CHP (designated fax number: 2893 5350) with the following documents:

- Discharge summary
- Relevant laboratory reports (i.e. 2 consecutive negative PCR 24 hours apart OR IgG positive result)

CHP will arrange termination of isolation order upon receipt of request. There is no need to call MCO when making the request.

CHP’s case number: __________________________
Patient’s name: __________________________
Sex/Age: __________________________
HICD/passport number: __________________________
Hospital/ward: __________________________
Ward Fax no.: __________________________
Ward Tel no.: __________________________
Date: __________________________
Discharged COVID-19 patients who are retested positive
(CCIDER’s important message on 19 May 2020)

• As agreed by CHP, there is no need to readmit discharged COVID-19 patients due to retested positive results alone; the need of hospital admission should be determined by the clinical conditions of patients.

• If discharged patients developed respiratory symptoms again, attending medical staff should work up for alternative diagnoses according to clinical assessment.
Case Referral
Case Referral

- Cases fulfilled the reporting criteria should be isolated at local hospitals.

- Cases fulfilled the reporting criteria screened at Boundary Control Points will be admitted to catchment hospitals' isolation wards under the prevailing port health referral mechanism.

- All confirmed cases with SARS-CoV-2 should be isolated at HKICC or HA IDC. HOMICC will assist in the diversion when necessary.
Readiness of Isolation Beds

• Beds being used for receiving general medical patients or other purposes are convertible to isolation beds in 72 hours by phases if necessary

• Get prepared:
  1. Ventilation of isolation rooms
  2. Vacate beds
  3. Equipment
Referral of Infectious Diseases from Boundary Control Points to HA Hospitals (Version 29/7/2020)

### Compulsory Referral of Infectious Diseases from BCPs to HA Hospitals

1. For suspected *Novel Influenza A (including Avian Influenza), Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS), Cholera, Coronavirus Disease 2019 (COVID-19)*

<table>
<thead>
<tr>
<th>Boundary Control Point (BCP)</th>
<th>Referring Hospital</th>
<th>Cluster Coordinator &amp; Contact Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HK-Macau Ferry Terminal</td>
<td>Queen Mary Hospital</td>
<td>Ad&amp;E in charge, Tel: 2255 3700 (Back up: A&amp;E nursing staff, Tel: 2255 3007)</td>
</tr>
<tr>
<td>China HK Ferry Terminal</td>
<td>Queen Elizabeth Hospital</td>
<td>If aged below 18: Paed A9 MO via operator, Tel: 3506 8887 If aged 18 or above: Adult isolation ward in-charge, Tel: 3506 5124 Adult ICU on call via operator, Tel: 3506 8887</td>
</tr>
<tr>
<td>Ocean Terminal (海運碼頭)</td>
<td>Hong Kong Women’s Hospital</td>
<td>If aged below 18: Paed A9 MO via operator, Tel: 3506 8887 If aged 18 or above: Adult isolation ward in-charge, Tel: 3506 5124 Adult ICU on call via operator, Tel: 3506 8887</td>
</tr>
<tr>
<td>Hong Kong Railway Terminal BCP</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>West Kowloon Station</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Kai Tak Cruise Terminal</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Lo Wu BCP (羅湖管制站)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Lok Ma Chau Tunnel BCP</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Lok Ma Chau BCP (落馬洲管制站)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Shum Wan Koi Kuk BCP (沙頭角管制站)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Mun Kam To BCP (文錦渡管制站)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Hung Ying Wai BCP (元朗管制站)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Shenzhen Bay Port BCP</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Tuen Mun Terminal (屯門客運碼頭)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Shek Kung Stabling Sidings (石崗列車渡輪)</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Hong Kong International Airport</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
</tr>
<tr>
<td>Hong Kong – Zhuhai – Macao Bridge Hong Kong Port BCP</td>
<td>United Christian Hospital</td>
<td>A&amp;E Nursing staff in charge Tel: 9949 4125 (Back up: Dr. Kitty Fung, Tel: 5215 6456)</td>
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Please refer to the link for any update:
http://qsdportal/iec/Website/IEC%20Webpage/COVID-19/Compulsory%20Referral%20of%20Infectious%20Diseases%20from%20BCPs%20to%20HA%20Hospitals.pdf
<table>
<thead>
<tr>
<th>Cluster</th>
<th>Contact persons</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>HKEC</td>
<td>PYNEH On Call ICN (Adult and PAED)</td>
<td>2595 6111</td>
</tr>
<tr>
<td></td>
<td>RTSKH On call ICN (Adult)</td>
<td>2291 2000</td>
</tr>
<tr>
<td>HKWC</td>
<td>Dr. Ivan Hung (office hour 9am – 5pm) QMH A6 ward nurse in-charge (non-office hour) Pager 7306 9442 2255 5511/ 2255 1140</td>
<td></td>
</tr>
<tr>
<td>KEC</td>
<td>UCH A&amp;E nurse in-charge</td>
<td>3949 4125</td>
</tr>
<tr>
<td></td>
<td>Dr Kitty Fung (back up)</td>
<td>5215 6456</td>
</tr>
<tr>
<td>KWC</td>
<td>Haidc S12 - Adult case master ward</td>
<td>2990 3024</td>
</tr>
<tr>
<td></td>
<td>Haidc S8 – Paed Case master ward</td>
<td>2990 2950</td>
</tr>
<tr>
<td>KCC</td>
<td>QEH Adult isolation ward in-charge,</td>
<td>3506 5124</td>
</tr>
<tr>
<td></td>
<td>QEH Adult ICU on call via operator</td>
<td>3506 8887</td>
</tr>
<tr>
<td></td>
<td>QEH Paed A9 MO via operator</td>
<td>3506 8887</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Contact persons</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTEC (PWH)</td>
<td>Adult: Bed Coordinator of M&amp;T</td>
<td>5569 6308</td>
</tr>
<tr>
<td></td>
<td>Paed: Bed coordinator of General Paed</td>
<td>5569 9219</td>
</tr>
<tr>
<td>NTEC (AHNH)</td>
<td>Med: AED Nurse in charge Paed: D7 Nurse in charge</td>
<td>2689 2929 / 2689 2145 26893647</td>
</tr>
<tr>
<td>NTEC (NDH)</td>
<td>NDH AED Nurse in charge</td>
<td>2683 7230</td>
</tr>
<tr>
<td>NTWC</td>
<td>Adult: TMH B9 adult isolation ward i/c</td>
<td>2468 6757 / 2468 6758</td>
</tr>
<tr>
<td></td>
<td>Paed: TMH D5 Paed isolation ward i/c</td>
<td>2468 5729</td>
</tr>
</tbody>
</table>

Please refer to the link for any update:
- [http://qsdportal/iec/Website/IEC%20Webpage/List%20of%20HA%27s%20Cluster%20Coordinates.pdf](http://qsdportal/iec/Website/IEC%20Webpage/List%20of%20HA%27s%20Cluster%20Coordinates.pdf)
# List of Private Hospital Coordinators

(Updated as of 29 Jan 2020)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person(s)</th>
<th>Title</th>
<th>Contact Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canossa Hospital (Caritas)</td>
<td>Ms Wendy LAM</td>
<td>Nursing Officer, ICN</td>
<td>28255802/51127606</td>
<td><a href="mailto:wvhlam@canossahospital.org.hk">wvhlam@canossahospital.org.hk</a></td>
</tr>
<tr>
<td>Evangel Hospital</td>
<td>Dr Billy CHUI</td>
<td>Infection Control Officer/ Chief Medical Executive</td>
<td>27603447</td>
<td><a href="mailto:drchui@evanhosp.org.hk">drchui@evanhosp.org.hk</a></td>
</tr>
<tr>
<td>Gleneagles Hong Kong Hospital</td>
<td>Ms Clara KWOK</td>
<td>Nurse Manager, Infectious Prevention &amp; Control (IPC)</td>
<td>31539676</td>
<td><a href="mailto:clara_kwok@gleneagles.hk">clara_kwok@gleneagles.hk</a></td>
</tr>
<tr>
<td>Hong Kong Adventist Hospital-Stubbs Road</td>
<td>Ms Clara LEUNG</td>
<td>Director of Nursing</td>
<td>36518958</td>
<td><a href="mailto:clara.leung@hksah.org.hk">clara.leung@hksah.org.hk</a></td>
</tr>
<tr>
<td>Hong Kong Adventist Hospital-Tsuen Wan</td>
<td>Mr LEUNG Man Wai Andy</td>
<td>Nursing Officer- Infection Control</td>
<td>27756530/55063204</td>
<td><a href="mailto:andy.leung@twah.org.hk">andy.leung@twah.org.hk</a></td>
</tr>
<tr>
<td>Hong Kong Baptist Hospital</td>
<td>Dr Patrick LAU Pak Lun</td>
<td>ICO &amp; Chief of Service, Pathology Department</td>
<td>23398073</td>
<td><a href="mailto:patrickplau@hkbb.org.hk">patrickplau@hkbb.org.hk</a></td>
</tr>
<tr>
<td></td>
<td>Ms Cindy WONG Yim Yin</td>
<td>NO/ ICT</td>
<td>23398403</td>
<td><a href="mailto:yywong@hkbb.org.hk">yywong@hkbb.org.hk</a></td>
</tr>
<tr>
<td>Hong Kong Sanatorium &amp; Hospital</td>
<td>Dr Raymond W H YUNG</td>
<td>Deputy Medical Superintendent/ Infection Control Officer</td>
<td>23398925</td>
<td><a href="mailto:raymondyung@hksh.com">raymondyung@hksh.com</a></td>
</tr>
<tr>
<td>Matilda International Hospital</td>
<td>Dr Hans Schrader</td>
<td>Chief Medical Executive</td>
<td>28490700/28490715</td>
<td><a href="mailto:schrader@matilda.org">schrader@matilda.org</a></td>
</tr>
<tr>
<td></td>
<td>Ms Rajwinder Kaur</td>
<td>General Manager Clinical Operations</td>
<td>28490163</td>
<td><a href="mailto:rai@matilda.org">rai@matilda.org</a></td>
</tr>
<tr>
<td>Precious Blood Hospital (Caritas)</td>
<td>Ms CHENG Yee Man</td>
<td>Nursing Officer, ICN</td>
<td>39714403</td>
<td><a href="mailto:yeeman@pbbh.hk">yeeman@pbbh.hk</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:jcn@pbbh.hk">jcn@pbbh.hk</a></td>
</tr>
<tr>
<td>Shatin International Medical Centre Union Hospital</td>
<td>Dr YAN Ka Lok</td>
<td>ICO</td>
<td>26083351</td>
<td><a href="mailto:kyan@union.org">kyan@union.org</a></td>
</tr>
<tr>
<td></td>
<td>Mr LAI Kai Cheong Moiris</td>
<td>ICN</td>
<td>26083930</td>
<td><a href="mailto:moorisht@union.org">moorisht@union.org</a></td>
</tr>
<tr>
<td></td>
<td>Ms CHAN Sin Fong Ada</td>
<td>DICN</td>
<td>26083129</td>
<td><a href="mailto:adachan@union.org">adachan@union.org</a></td>
</tr>
<tr>
<td>St. Paul's Hospital</td>
<td>Ms Christina CHEUNG Woon Yee</td>
<td>Nursing Officer, ICN</td>
<td>28303768/28308605/92691713</td>
<td><a href="mailto:Christina_cheung@stpaul.org.hk">Christina_cheung@stpaul.org.hk</a></td>
</tr>
<tr>
<td>St. Teresa's Hospital</td>
<td>Ms KWOK Man Kee Maggie</td>
<td>ICN/ on- call supervisor</td>
<td>22003546/22003555</td>
<td><a href="mailto:kwokmk@sth.org.hk">kwokmk@sth.org.hk</a></td>
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</table>

Please refer to the link for any update:

- [http://qsdportal/iec/Website/IEC%20Webpage/Private%20Hospital%20ICN%20Contact.pdf](http://qsdportal/iec/Website/IEC%20Webpage/Private%20Hospital%20ICN%20Contact.pdf)
Infection Control Measures
Patient Isolation

1. Nurse in **Airborne Infection Isolation Room (AIIR)** (i.e. with negative pressure and at least 12 ACH) en-suite with toilet facility, in an isolation ward setting

2. Implement **Airborne, Droplet and Contact Precautions** in addition to Standard Precautions

3. PPE: N95 respirator, eye protection (goggles / face shield), isolation gown, gloves, and cap (optional) for aerosol-generating procedures (AGPs) and routine patient care
AED Triage – FTOCC Risk Assessment

Patient Arrives at hospital A&E registration

Fulfill FTOCC reporting criteria
- Fever
- Travel
- Occupational exposure
- Contact history
- Clustering phenomenon

Triage
Staff should wear minimum PPE:
Surgical mask, eye protection, gown, +/- gloves

No
Follow usual A&E procedure

Yes
Designated AIIR Assessment
Staff should wear PPE: N95 respirator, goggle / face shield, gown, gloves

Updated on 21 Jan 2020
# Recommended PPE under Emergency

Table 1b. Recommended PPE under Serious Response (S2) and Emergency Level

<table>
<thead>
<tr>
<th>Areas</th>
<th>Activities</th>
<th>Recommended PPE at Serious (S2) / Emergency Response Level</th>
</tr>
</thead>
</table>
| **High -risk patient areas** |                                                  | • N95 respirator  
• eye protection(e)  
• gown  
• gloves  
• cap (optional)  
*Surgical mask could be an alternative for triage stations based on nature of encounter upon risk assessment* |
| • triage stations of Out-patient Clinics and AEDs;  
• designated clinics and  
• Isolation rooms (including isolation rooms in ICU and AEDs) | Routine patient care  
And aerosol generating procedures (a,b) |                                                                                                                           |
| No patient contact (e.g. outside patient room) | No patient contact | • Surgical mask                                                                                                                                 |

| **Other patient areas** | Routine patient care  
Aerosol-generating procedures (a,c,f) | • Surgical mask, Standard Precautions +/- transmission based precautions  
*PPE for NIV: please refer to logistic flowchart for the initiation of Non-Invasive Ventilation (NIV) in HA hospitals* |
| No patient contact | No patient contact | • S2 Level: Surgical mask is required in patient areas  
• Emergency Level: Surgical mask is required in ALL areas |

| **Non patient areas** | No patient contact | • S2 Level: Surgical mask is required in patient areas  
• Emergency Level: Surgical mask is required in ALL areas |

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Updated on 26 Jan 2020
Personal Protective Equipment (PPE)

PPE at triage / fever room / fever consultation room / surveillance ward
- Eye visors / goggles / face shield
- Surgical mask / N95 respirator
- Isolation gown (AAMI level 1)*
- Disposable gloves as indicated.*
  *For example, when presence of skin lesions or contact with blood and body fluids

Recommended PPE for AGPs / suspected or confirmed COVID-19
- Face shield / goggles
- N95 respirator
- Isolation gown (AAMI level 1)*
- Disposable gloves

- AAMI level 3 isolation gown can be considered when splashing is anticipated. Alternatively, a waterproof apron on top of the AAMI level 1 isolation gown is also acceptable.
- Shoe covers are not recommended.
Follow standard precautions and transmission-based precautions at all time and use appropriate PPE as determined by risk assessment according to the procedure and suspected pathogen.

<table>
<thead>
<tr>
<th></th>
<th>AIIR for suspected / confirmed COVID-19</th>
<th>Triage station / fever room at GOPC</th>
<th>Surveillance ward / cubicle / side-room</th>
<th>Aerosol-generating procedures (AGPs)</th>
<th>Other wards</th>
<th>Other patient areas (e.g. general consultation room, renal unit, X-ray, PT etc.)</th>
<th>Other area with no direct patient contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand hygiene</strong></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Surgical mask</strong></td>
<td>N95</td>
<td>Surgical mask / N95</td>
<td>Surgical mask / N95</td>
<td>N95</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td><strong>N95 respirator</strong></td>
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<td></td>
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<tr>
<td><strong>Isolation gown</strong></td>
<td>AAMI level 1*</td>
<td>AAMI level 1*</td>
<td>AAMI level 1*</td>
<td>AAMI level 1*</td>
<td>Standard precautions +/- transmission based precautions</td>
<td>Standard precautions +/- transmission based precautions</td>
<td></td>
</tr>
<tr>
<td><strong>Disposable gloves</strong></td>
<td>Y</td>
<td>Risk assessment</td>
<td>Risk assessment</td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eye protection</strong></td>
<td>Goggles / face shield</td>
<td>Eye visor / goggles / face shield</td>
<td>Eye visor / goggles / face shield</td>
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<td>N</td>
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<tr>
<td><strong>Hair cover</strong></td>
<td>Optional</td>
<td>Optional</td>
<td>Optional</td>
<td>Optional</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- *AAMI level 3 isolation gown can be considered when splashing is anticipated. Alternatively, a waterproof apron on top of the AAMI level 1 isolation gown is also acceptable.
- Shoe covers are not recommended.
Reinforcement on PPE for oral hygiene/oral feedings in general wards
(CCIDER’s important message on 29 Dec 2020)

• To prevent infection by sprays of respiratory secretions, staff is advised to wear surgical mask, eye protection, disposable isolation gown (e.g. Polytex’s white isolation gown) and gloves for performing oral hygiene or oral feedings to patients.
  – Remove gloves and perform hand hygiene immediately after each procedure.
  – Change the gown if soiled or contaminated and remove it before leaving the cubicle/ room.
Prudent Use of Personal Protective Equipment (PPE)
(Consensus in the 11th ad hoc CCIDER meeting on 7 Feb 2020)

In view of the global tight supply of PPE, prudent use of PPE in accordance with HA’s infection control recommendation should be advocated.

• **Use of PPE for serial patient encounters**
  – It is suggested extending the use of N95 respirator for multiple patients during serial patient encounters without removing or re-donning between encounters, which is recommended by the US Centre for Disease Control and Prevention (CDC), unless it is damaged or soiled. Same principle applies to eye protection.
  – Meanwhile, staff should change gloves, gowns and most importantly, practice hand hygiene between patient encounters. Touching the N95 respirator and eye protection should be avoided.

• **Eye Protection**
  – Eye protection with face shield should be reserved for handling of suspected/confirmed cases, or in anticipation of large amount of splashes of blood, body fluids, excretions or secretions (e.g. AGPs, trauma case, emergency room etc.).
  – For other patient care activities when eye protection is required, staff may consider wearing eye visor or reusable goggles.

**NOTE: Replace N95 respirator and eye protection when they are contaminated with patient’s respiratory secretions, blood or body fluid, or following use during high-risk AGPs i.e. CPR, emergency intubation and bronchoscopy)**
Use of non-surgical N95 respirator
(Consensus in the 19th ad hoc CCIDER meeting on 9 Apr 2020)

• N95 respirators can be divided into surgical and non-surgical N95 respirators (also called standard N95 respirator).

• Surgical N95 respirators have been evaluated for the fluid and flammability resistance and are intended for use by healthcare workers who need protection from both airborne and fluid hazards (e.g. splashes, sprays, or splatters of blood or body fluids) in healthcare settings.

• If a properly-fitted surgical N95 respirator could not be identified for a staff and non-surgical N95 respirator has to be used, adequate preventive control measures should be implemented to control the risk, including the proper use of face shield as a physical barrier to prevent contamination of blood or body fluid by potential splashes.

• For details, please refer to Annex I of HA Safety Manual (Chapter 5) - Infection Control
  http://ha.home/ho/ps/hasafetymanual_infectioncontrol.pdf
Reusable Goggles

Interim recommendations:

- Individual use is recommended.
- Follow the manufacturer’s recommendation and select the appropriate agents for decontamination.
- If the manufacturer’s instruction is not available, use disinfectant wipe (e.g. non-sterile alcohol wipe) for decontamination of goggles after use. Other decontamination method as advised by local infection control team is acceptable.
- If the goggles are visibly contaminated or soiled,
  1. Clean with detergent and water first
  2. Immerse in sodium hypochlorite solution 1,000 ppm for 10 minutes
  3. Rinse and store dry

Reference:
1. 將索帶扣上
面罩左、右兩面共4個扣位
2. 將索帶兩端扣上
3. 戴上面罩，將索帶拉緊至緊貼頭部
4. 完成如圖示
Face Shield (2) – Koln 3D Technology (Medical) Limited

2 sizes
(medium & large)
Face Shield (3) - Medicom (HA tender item)

Prioritize for use in airborne infection isolation rooms (AIIRs), and high-risk aerosol-generating procedures (AGPs) i.e. CPR, intubation, bronchoscopy
Aerosol-generating Procedures (AGPs)

AGP

Non-invasive ventilation (NIV)

Logistic flowchart for the initiation of NIV in AED

Logistic flowchart for the initiation of NIV in HA hospitals

AGP other than NIV
1. Endotracheal intubation and extubation
2. Cardiopulmonary resuscitation (CPR)
3. Bronchoscopy
4. Open suctioning of respiratory tract (including tracheostomy care)
5. Autopsy
6. High-frequency oscillatory ventilation
7. Nebulizer therapy
8. Sputum induction
9. Dental procedures with the use of spray generating equipment

Risk assessment

It is recommended to follow the WHO’s latest recommendations on COVID-19 and include the following dental procedures with the use of spray generating equipment in the list of AGPs. Therefore, healthcare workers should adopt airborne precautions, wear full PPE and perform the procedures in an adequately ventilated room.

- Procedures that use three-way air/water spray;
- Dental cleaning with ultrasonic scaler and polishing;
- Periodontal treatment with ultrasonic scaler;
- Any kind of dental preparation with high or low-speed hand-pieces;
- Direct and indirect restoration and polishing;
- Definitive cementation of crown or bridge;
- Mechanical endodontic treatment;
- Surgical tooth extraction and implant placement

Aerosol-generating Procedures (AGPs)

• All AGPs should be conducted under airborne precautions.

• In high risk patient areas, place patient in a negative pressure airborne infection isolation room (AIIR) before performing AGPs.

• In other patient areas, place patient in a well-ventilated area (e.g. at least minimum overall 6 air changes per hour (ACH) or use portable HEPA filter e.g. IQ Air if indicated) before performing AGPs.
Management of AGPs in general wards

(CCIDER’s important message on 14 Aug 2020)

• In general, AGP should be conducted under airborne precautions in Airborne Infection Isolation room (AIIR) or well ventilated areas.
• AGP should be minimised in general wards to protect both staff and patients.
• In case of any unavoidable AGP in general ward, the following measures should be adopted if feasible as advised by local experts:
  A.  *For management of AGP in one-off nature*
  B.  *For management of AGP or High flow oxygen therapy in continuous nature*
Management of AGPs in general wards (Cont’d)
(CCIDER’s important message on 14 Aug 2020)

A. *For management of AGP in one-off nature*

- Examples that may occur in general ward: Cardiopulmonary resuscitation (CPR) including chest compression; Bag-Valve-Mask (BVM) ventilation; Endotracheal intubation; Open suctioning of respiratory tract (including tracheostomy care)

(i) Perform AGP on patient within the below facility in ward if possible:
   - A designated room with door preferred
   - Negative pressure if available (otherwise with air ventilation of up to 6 air changes per hour (ACH))
   - If no designated room is available, design a corner cubicle with adequate spacing from other patients and staff in the ward

(ii) Assign trained staff for the procedure and the staff should wear full PPE during the procedure

(iii) Limit the number of staff in the room during the procedure

(iv) Clean and disinfect all high touch surface after the procedure, and allow time-out for the room if feasible
Management of AGPs in general wards (Cont’d)
(CCIDER’s important message on 14 Aug 2020)

B. For management of AGP or High flow oxygen therapy in continuous nature

- Examples that may occur in general ward: non-invasive ventilation (NIV); High flow oxygen therapy

(i) Centralize patients requiring continuous high risk AGP in a designated area if possible:
   - Enhanced respiratory isolation environment
     (adequate physical segregation with more than 1m apart; sufficient air exchange > 6 ACH and a door); or
   - Mobilize 1st tier or 2nd tier isolation facilities for the purpose

(ii) Assign trained and designated staff with full PPE for the management of AGP

(iii) Perform COVID-19 testing for all cases centralized in the designated area
   - For patients with negative test results, the patient may be kept in the enhanced respiratory isolation environment, or return to general ward based on clinical risk assessment and availability of facilities.
Logistic flowchart for the initiation of **NIV** in Accident and Emergency Department (AED)

[Reference from Communication kit for MERS]

**Is this patient indicated for NIV?**
- Yes
- No

**Any contraindications for NIV?**
- Yes
- No

**Suspected** a **or confirmed transmissible respiratory diseases that require isolation**
- No
- Yes

**Put on NIV in general clinical setting**

**FTOCC** b **or confirmed Airborne infections** c
- No
- Yes

**Check availability of **NIV bed**#**

#NIV bed refers to bed in a ward which is equipped with 6 ACH and beds are at least 3 feet apart. PPE: Surgical mask, eye protection, gown, gloves and cap (optional)

- Yes
- No

**Put on NIV**

**Consider intubation & mechanical ventilation or other alternative management plan**

**To AIIR / Resuscitation room**

PPE: N95 respirator, eye protection, gown, gloves and cap (optional)

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**Notes:**
- **a:** Suspected transmissible respiratory diseases: fever with features suggestive of respiratory tract infections (e.g. sneezing, purulent sputum etc) +/- radiological features of pneumonia
- **b:** FTOCC=Fever, Travel, Occupation, Cluster and Contact
- **c:** Disease requiring airborne precautions: such as avian flu, SARS or MERS-CoV, PTB, emerging respiratory viruses

**Added on 6 Jan 2020**

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Logistic Flowchart for the Initiation of Non-invasive Ventilation (NIV) in HA hospitals

[Reference from HA Infection Control Plan (MERS) Version 3.1 (Oct 2018)]

Acute Respiratory Failure deemed suitable for NIV

No

Consider alternative management plan

Suspected or confirmed transmissible respiratory diseases that require Airborne Infection Isolation (AII) with NIV (e.g. presence of clinical features\(^a\) + FTOCC\(^b\) for highly pathogenic infections \(^c\) or as advised by the CCIDER, airborne infections such as TB etc.)

No

NIV in non-AIIR areas (including Medical wards)

Yes

To Airborne Infection Isolation Room (AIIR) and put on NIV

High Clinical risk (e.g. radiological TB, strong epidemiological link with persistent fever): possible false –ve lab test

Low clinical risk: (e.g. Responded to empirical antibiotic treatment; Alternative diagnosis established)

Test(s) -ve

Continue AIIR + NIV + treatment

Test(s) +ve

Relevant Laboratory Investigations

\(a\): Fever + symptoms suggestive of respiratory tract infections (e.g. sneezing, purulent sputum etc) +/- radiological features of pneumonia

\(b\): FTOCC=Fe\(\text{e}\)ver, Travel, Occupation, Cluster and Contact

\(c\): Including Avian flu, SARS, MERS-CoV
Supplementary Notes for NIV
[Reference from Communication kit for MERS]

- All patients who have fulfilled the reporting criteria for novel influenza, MERS-CoV and SARS should have been isolated promptly in AIIR already;
- The “FTOCC” screening criteria applied in the flowchart above refers to cases with “Fever” and one or more of “T: travel to an affected areas during the incubation period”/”O”: occupational related/”C”: contact of a suspected/confirmed case/”C”: cluster of cases detected.
- “Relevant” laboratory investigations refer to tests ordered after clinical and epidemiological assessments
- The possibility of having insufficient AIIR if there is a large number of such patients (e.g. during epidemics and major outbreaks of novel infections) exists
- Manpower issue: increased nursing workload in the isolation areas with NIV cases
- Similar concerns for NIV exist in other aerosol generating procedures
- The flowchart should be read in parallel with the latest Respiratory Consensus Statement on NIV, which can be found in the Hong Kong Respiratory Medicine webpage: [http://hkts.com2.hk/site/HKTS/upload/editorfile/file/20171117/20171117192543_71234.pdf](http://hkts.com2.hk/site/HKTS/upload/editorfile/file/20171117/20171117192543_71234.pdf)
Nebulization
(Consensus in the 6th ad hoc CCIDER meeting on 24 Jan 2020)

• A nebulizer is a small device that can convert a drug from a solution into an aerosol form by means of a compressor / compressed gas source.

• Nebulization should be minimized to reduce the risk of nosocomial transmission and super-spreading event.

• Alternatives should be considered e.g. metered-dose inhaler, spacers, powder inhaler
Nebulization
(Consensus in the 6th ad hoc CCIDER meeting on 24 Jan 2020)

• Where these procedures are medically necessary, they should be undertaken in
  1. an airborne infection isolation room (AIIR)
     OR
  2. an adequately ventilated single room with at least 12 air changes per hour (ACH) and negative pressure differential with respect to the corridor
     OR
  3. an adequately ventilated single room with at least 6 (ACH) and use of portable HEPA filter unit e.g. IQ Air for direct removal of airborne contaminants.

• Only the minimum number of required staff should be present, and they should put on appropriate PPE i.e. N95 respirator, eye protection (goggle / face shield), isolation gown, disposable gloves and cap (optional).

• Entry and exit from the room should be minimized during the procedure.

• The room should be ventilated after the procedure, then cleaned and disinfected before being put back into use.

• Please refer to Table 1 for ACH and time required for airborne-contaminant removal by efficiency.
Nebulization
(Consensus in the 6th ad hoc CCIDER meeting on 24 Jan 2020)

Table 1. Air changes/hour (ACH) and time required for airborne-contaminant removal efficiencies of 99% and 99.9%

<table>
<thead>
<tr>
<th>ACH*</th>
<th>Time (mins.) required for removal 99% efficiency</th>
<th>Time (mins.) required for removal: 99.9% efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>138</td>
<td>207</td>
</tr>
<tr>
<td>4</td>
<td>69</td>
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<td>6</td>
<td>46</td>
<td>69</td>
</tr>
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<td>8</td>
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<td>10</td>
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<td>15</td>
<td>18</td>
<td>28</td>
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<tr>
<td>20</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>50</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

* Values apply to an empty room with no aerosol-generating source. With a person present and generating aerosol, this table would not apply. The times given assume perfect mixing of the air within the space. Removal times will be longer in rooms or areas with imperfect mixing or air stagnation. Caution should be exercised in using this table in such situations.

References:
1. UK PHE - Guidance Wuhan novel coronavirus (WN-CoV) infection prevention and control guidance for aerosol generating procedures
2. WHO - Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected, Interim Guidance
3. CDC - Guidelines for Environmental Infection Control in Health-Care Facilities
https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf
NPA, NPS & High Flow Oxygen

• Collection of Nasopharyngeal aspiration (NPA) and nasopharyngeal swab (NPS), and use of high flow oxygen (≥6L/min) are not considered as AGPs in international recommendations, but they are theoretically at risk of dispersal of infectious respiratory droplets, therefore with a more cautious approach, they should be performed in conditions as required for aerosol-generating procedures in high-risk patient areas.

• Other procedures should be assessed on discretion of hospital Infection Control Officers.
Special Consideration
(Consensus in the 4th ad hoc CCIDER meeting on 14 Jan)

- Respiratory care: open suctioning of respiratory tract and sputum induction in convalescent hospitals

  - Taking into consideration of long stay patients who have been undergone FTOCC risk assessment and hospitalized for more than 14 days, staff should wear a surgical mask / N95 respirator for open suctioning or sputum induction in accordance with Standard Precautions and Transmission-based Precautions (if indicated).

  - Hospital Infection Control Teams, with directives given by CCE, would work with different clinical departments for assessment.
Special Consideration
(Consensus in the 4th ad hoc CCIDER meeting on 14 Jan)

✱ Patient requiring high flow oxygen (≥ 6L/min)

- If an airborne infection isolation room (AIIR) is not available in high risk area such as A&E and GOPC, the patient should be arranged in an area with portable HEPA filter (e.g. IQ Air) and physical barrier.
Respiratory Protection Program for Healthcare Workers

• Before initial use of N95 respirator, fit test should be performed to select a suitable type, model and size of respirator for individual respirator user. Test results should be maintained according to local hospital protocol.

• Qualitative Fit Test (QLFT) and Quantitative Fit Test (QNFT)

• Maintain Fit Test results record
Positive Seal Check:
Place both hands completely over the respirator and exhale sharply. If air leaks around respirator edges, adjust the straps back along the sides of your head. Perform seal check again if an adjustment is made.

Negative Seal Check:
Place both hands completely over the respirator. Inhale sharply and the respirator will collapse slightly. If inward leakage of air is detected, the seal of the respirator is considered unsatisfactory. Reposition it by adjusting the straps. If you cannot achieve a proper seal, do not enter the contaminated area.

每次配戴N95呼吸器後，要做正壓及負壓密合檢查。
*Perform positive and negative seal check every time after wearing N95 respirator*
Repeat of N95 Respirator Fit Test

Under the following circumstances, retest of fit test should be done:

- A significant change on facial contour affecting the respirator fit
- A significant increase or decrease in weight (10%)
- Change in facial structure or scarring due to dental work, cosmetic surgery or accidents
- When no supply of appropriate model or size of respirator
- Any other condition that may interfere with face-piece sealing
Patient Care Equipment

1. Handle used/soiled patient-care equipment carefully to prevent skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environment.

2. Use disposable items when those items cannot be cleaned or disinfected properly.

3. Designate non-critical patient care equipment to the patients. If sharing is unavoidable, clean and disinfect with sodium hypochlorite solution 1,000 ppm after each patient use.

4. Respiratory therapy equipment require high-level disinfection. Central reprocessing is preferred based on local hospital policy. Well-packed contaminated items before transfer to prevent environmental contamination.
Environmental Control

1. Decontaminate the environment regularly and immediately when becomes visibly soiled.

2. Decontaminate patient environment, especially high-touch areas, at least once daily in general clinical areas.

3. Clean and disinfect with sodium hypochlorite solution 1,000 ppm twice daily in high risk areas with suspected and confirmed patients.

4. Perform terminal disinfection upon each patient discharge.

5. Strengthen cleaning schedule as advised by HICT.
Maintain drainage pipes properly and regularly

- To make sure the trap is not dry, pour about half a liter of water into each drain outlet (U-traps) e.g. once a week.

- For details, please refer to CHP. Make Sure the Trap is Not Dry: https://www.chp.gov.hk/files/pdf/make_sure_the_trap_is_not_dry.pdf

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Linen Handling

1. All linen should be classified as **infected linen**. Linen bag should be secured with “infected linen” tag with information of the origin.

2. **Avoid sorting** linens in patient-care areas.

3. Place linen into **water soluble bag**, then a **laundry bag** with minimal manipulation or agitation to avoid contamination of air, surfaces and persons.
Waste Management

• All wastes from suspected or confirmed patients are classified as **clinical waste**

  *Follow HA Operation Circular No. 14/2015 Implementation of Clinical Waste Management Plan (CWMP) for proper handling and disposal of clinical wastes*

• Use bedpan washer to clean and thermal disinfect the urinals and bedpans

• If bedpan washer is not available, please consider to use the **liner bag**. After use, the contents are to be solidified with high-absorbency gel and then discarded as **clinical waste**.

Example: Bedpan Liner
Cleaning of Spillage of blood, body fluids, or other potentially infectious materials

1. Clean the visible soils with disposable absorbent material and discard it into the appropriate waste bag

2. Mop the area with a cloth or paper towels wetted with sodium hypochlorite solution 10,000 ppm, leave for 10 minutes

3. Then rinse with water and allow the area to air dry

4. 70% alcohol can be used in metal surface if household bleach is contraindicated
Handling of Dead Body

1. Wear full PPE i.e. surgical respirator, eye protection (goggles or face shield), fluid resistant gown, disposable gloves for suspected / confirmed COVID-19 case during last offices.

2. Dead body under **Category 2**
   a) The dead body should be first placed in a robust and leak-proof transparent plastic bag of not less than 150 μm thick, which should be zippered closed. Pins are NOT to be used. The bagged body should be either wrapped with a mortuary sheet or placed in an opaque body bag.
   b) The outside of the body bag should be wiped with 1 in 4 diluted household bleach (mixing 1 part of 5.25% bleach with 4 parts of water) and allow to air dry.

3. Use YELLOW

   **Danger of Infection**
   In handling dead bodies, Standard Precautions are required. 處理屍體時要採取標準防護措施。

   **Category 2**
   In addition, the following precautions are also required: 此外，下列附加的預防措施亦必須採納:

<table>
<thead>
<tr>
<th>Bagging 入屍袋</th>
<th>Viewing in funeral parlour 墳儀館內瞻仰遺容</th>
<th>Embalming 防腐處理</th>
<th>Hygienic preparation in funeral parlour 墳儀館內裝身及化妝</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Must</strong> 必須</td>
<td><strong>Allowed</strong> 可以</td>
<td><strong>Not allowed</strong> 不可以</td>
<td><strong>Allowed</strong> with disposable gloves, water resistant gown / plastic apron over water repellent gown &amp; surgical mask 可以，但必須戴上用後即棄的手套、防水保護衣/防水保護衣外加防溼衣和外科口罩</td>
</tr>
</tbody>
</table>

Precautions for Handling and Disposal of Dead Bodies, 10th edition.
Patient Transport

1 Limit patient transport to essential purpose only
2 Wear appropriate PPE when handling patients
3 Provide surgical mask to patients during transportation if not contraindicated
4 Inform the receiving ward/ parties before patient transport to facilitate appropriate arrangement.
5 Inform the administration to prepare the designated route for transport. The involved area should be disinfected afterwards.
6 Disinfect transport vehicles after use
## Inter-hospital Transport Arrangement

<table>
<thead>
<tr>
<th>Patient</th>
<th>Service provider</th>
<th>Refer document below</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency inter-hospital patient transport</td>
<td>Fire Services Department (FSD) Ambulance</td>
<td>HAHO Operations Circular No. 5/2017: <strong>Calls for Ambulance Service provided by the Fire Services Department (FSD) for Emergency Inter-hospital Patient Transfer</strong></td>
</tr>
<tr>
<td>• Transport of patient with suspected or confirmed case</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other patient transport</td>
<td>Non-Emergency Ambulatory Transfer Services</td>
<td><strong>Infection Control Guideline for Non-Emergency Ambulatory Transfer Services (NEATS)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Staff Early Sickness Alert System (SESAS)

For early detection and control of potentially communicable infectious diseases / outbreaks

Staff Early Sickness Alert System (SESAS)
職員初期病徵預警系統

User Login (使用者登入)

- **Logon Name** (登入名稱):
- **Password** (密碼):
- **Domain Name** (組織名稱): CORP

- Save my "NT Domain" and "User Name" for next login

General inquiries (一般查詢):
- Infection Control Team (感染控制組)
- Email to HAIDC (電子郵件)

User Manual/使用者手冊
User Guidelines/使用者守則

Next information (下述資訊)

- **If you have any query**, please contact (if using Call Center) 2515-2555 OR input your query by clicking the following link (Business Support Desk):
- **Business Support Desk** (Business Support Desk):
  - http://weds.doik/1bsb/hotnet.ogrrn.asp

**News 職業消息**

- **HRM** is replaced by **Employee Number** during sickness reporting. In the interest of personal data privacy, HRM is no longer required for reporting sickness for colleagues not on the list of "My Team". For non-NT staff and in cases where the Employee Number is not available, the Employee Number field can be left blank and the system will generate a reference number for that purpose.

- For full notice, please visit [http://weds.doik/1bsb/hotnet.ogrrn.asp](http://weds.doik/1bsb/hotnet.ogrrn.asp)

- For any queries, please contact Hospital Infection Control Team or CICO Office.
Contact Tracing Management in Hospital

<table>
<thead>
<tr>
<th>Healthcare workers (HCWs)</th>
<th>Close contacts</th>
<th>Other contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCWs who had cared for the confirmed case without appropriate PPE for the procedures</td>
<td>-</td>
</tr>
<tr>
<td>In-patients in general wards*</td>
<td>1. In-patients who had face-to-face contact for &gt; 15 min with the confirmed case, regardless of surgical masks OR 2. In-patients who had stayed in the same cubicle for &gt; 2 hours of the confirmed case, regardless of surgical masks</td>
<td>-</td>
</tr>
<tr>
<td>Visitors</td>
<td>Visitors who had stayed in the same cubicle without surgical mask, for &gt; 15 min</td>
<td>Visitors who had stayed in the same cubicle for ≤ 15 min or had worn surgical mask</td>
</tr>
<tr>
<td>Quarantine</td>
<td>Quarantine for 14 days after last exposure</td>
<td>Not required</td>
</tr>
<tr>
<td>Medical surveillance</td>
<td>Follow by 14 days of medical surveillance</td>
<td>28 days after last exposure to the confirmed case</td>
</tr>
</tbody>
</table>

- All contacts who are symptomatic are managed as “probable cases”
- *Surveillance ward / cubicle is excluded.
- If doubt in particular case, discuss and consider the exposure situation with CHP
- Day 0: day of last exposure
Healthcare workers who had cared for the confirmed case without appropriate PPE for the procedures are classified as close contact.

In the same confined area, without any face-to-face interaction with the case

<table>
<thead>
<tr>
<th>Proper wearing of surgical mask</th>
<th>Cumulative contact time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case</td>
<td>Contact</td>
</tr>
<tr>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

With face-to-face interaction with the case

<table>
<thead>
<tr>
<th>Proper wearing of surgical mask</th>
<th>Cumulative contact time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case</td>
<td>Contact</td>
</tr>
<tr>
<td>+</td>
<td>+</td>
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<tr>
<td>+</td>
<td>-</td>
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<td>-</td>
<td>+</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Medical Surveillance for Contacts

1. Staff should conduct self-checking of body temperature before commencement of work

2. Wear surgical mask during the medical surveillance period, i.e. not only on duty

3. Hospital infection control team (HICT) communicates with staff on a daily basis and report HA Head Office Major Incident Control Centre (HO MICC) daily on the condition of the other contacts working / staying in the hospitals

4. If symptoms develop, staff should inform HICT for immediate isolation and laboratory testing ^

^ urgent RT-PCR test to rule out COVID-19, TAT 24 hours
CHP’s Hotline for Public Enquiry on Contact Tracing

• CHP has set up a hotline (2125 1122) for confirmed cases of novel coronavirus.

• AED staff could call the Medical Control Officer (MCO) of the Department of Health (DH) at pager: 7116 3300 call 9179 to verify contact list if necessary.
Risk Communication
Enhanced Measures

Risk communications

- **Internal:**
  - Designated webpage
  - Communication kit
  - Staff forums
  - HASLink Express
  - HA Touch
  - HR Apps
  - Coronavirus disease 2019 (COVID-19) Bulletin

- **External:**
  - Daily press release on no. of reported cases in the past 24 hours
  - Facebook
# Staff Enquiry Hotline (Updated on 21/5/2021)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Enquiry on Infection Control / COVID-19 testing</th>
<th>Non-Clinical Enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICT</td>
<td>Telephone</td>
</tr>
<tr>
<td>NTEC</td>
<td>PWH ICT</td>
<td>5569 9156</td>
</tr>
<tr>
<td></td>
<td>AHNH/TPH ICT</td>
<td>2607 6320</td>
</tr>
<tr>
<td></td>
<td>NDH ICT</td>
<td>2683 7718</td>
</tr>
<tr>
<td></td>
<td>SH/SCH/BBH ICT</td>
<td>3919 7657</td>
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<tr>
<td>NTWC</td>
<td>TMH ICT</td>
<td>2468 5423</td>
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<td></td>
<td>POH ICT</td>
<td>2486 8092</td>
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<td></td>
<td>TSWH ICT</td>
<td>5276 7126</td>
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<td>CPH/SLH ICT</td>
<td>2456 8991</td>
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<tr>
<td>KWC</td>
<td>PMH ICT</td>
<td>2990 1854</td>
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<tr>
<td></td>
<td>CMC ICT</td>
<td>3408 6210</td>
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<tr>
<td></td>
<td>YCH ICT</td>
<td>2417 8399</td>
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<tr>
<td></td>
<td>HLTH ICT</td>
<td>3467 7034</td>
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<tr>
<td></td>
<td>KCH ICT</td>
<td>2959 8044</td>
</tr>
<tr>
<td>KEC</td>
<td>UCH Dr. Kitty Fung</td>
<td>5215 6456</td>
</tr>
<tr>
<td></td>
<td>TKOH Dr. Sandy Chau</td>
<td>5215 6062</td>
</tr>
<tr>
<td>KCC</td>
<td>Dr. Cindy Tse</td>
<td>3517 2468</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pager 71128993-5234</td>
</tr>
<tr>
<td>HKEC</td>
<td>PYNEH ICT (PYNEH, WCH, SJH &amp; GOPCs)</td>
<td>2595 5129</td>
</tr>
<tr>
<td></td>
<td>RTSKH ICT</td>
<td>2291 1366</td>
</tr>
<tr>
<td></td>
<td>TWEH ICT</td>
<td>2162 6104</td>
</tr>
<tr>
<td>HKWC</td>
<td>Dr. Vincent Cheng Chi Chung</td>
<td>9789 0966</td>
</tr>
</tbody>
</table>
# Staff Enquiry

<table>
<thead>
<tr>
<th></th>
<th>E-mail</th>
<th>Contact phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Infection Control Officer (CICO) Team</td>
<td><a href="mailto:hocicoteam@ha.org.hk">hocicoteam@ha.org.hk</a></td>
<td>2300 7456</td>
</tr>
<tr>
<td>Infectious Disease Control Training Centre (IDCTC)</td>
<td><a href="mailto:idctc@ha.org.hk">idctc@ha.org.hk</a></td>
<td>2125 2920</td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td>2300 6575</td>
</tr>
</tbody>
</table>