

Hong Kong Association of Critical Care Nurses Limited (HKACCN Ltd)

Vol. 11, No. 2, Dec 2010

President's Message

LEUNG Fung Yee
President
HKACCN

Dear Members,

Stepping into the fourteenth year, Hong Kong Association of Critical Care Nurses (HKACCN) has served more than one thousand members, both ICU or non-ICU, locally or regionally from neighborhood countries. Our objectives have not changed since day one: to promote the standards of critical care nursing practice through education, collaboration and research. Time flies. In the blink of an eye, it has been already one year after our last annual dinner.

Today, I have much pleasure to invite you to participate in the fourteenth annual dinner on 2nd December 2010 to celebrate our achievements and mission achieved.

In the past years, I have witnessed HKACCN achieved a lot. We have created numerous learning opportunities to our members, participated in community work, co-organized international conferences with other organizations and strived to lay foundation stone for the establishment of the College of Critical Care Nursing (CCCN). With great encouragement from our supporters, we have successfully established a grant for members to conduct nursing research and projects, which will benefit critically ill patients and promote critical care nursing. I believe it is through nursing research to excel our practices and bring our profession to the highest standard of critical care.

I would like to take this opportunity to express my heartfelt gratitude and appreciation to all Directors, staff and supporters. Without their tremendous support and help, HKACCN would not be able to sustain its current momentum. We learn, we serve and grow.



The HKACCN team participated in the World Health Day 2010

Message from the Editor

CHIANG Chung Lim Vico
Chief Editor
HKACCN

It has been three years since the incorporation of HKACCN in 2007. Time flies as usual and I wish that you are all well and managing effectively with the ever coming new challenges in our professional careers and lives! In particular, our great collaborative team maneuver to setting up our critical care nursing college under the coming new professional body of Hong Kong Academy of Nursing is a very important one.

In this issue of our Newsletter, Dr Esther Wong described her work on developing the set of clinical practice competencies for APN (CC), which is one of the very important milestones for the development of advanced nursing practice in the specialty of critical care nursing. Ms Rainbow Lee and her colleagues shared with us their interesting project and results on investigating the teamwork and patient safety culture among three ICUs in Hong Kong. Beyond doubt, best quality in patient care and patient safety are ones of our key concerns regarding critical care nursing. In the remaining part of this issue, Ms Wong Sui Ching and her team shared with us their hand wash visual cue program, which had innovatively promoted hand hygienic practice in ICU. Last but not the least, details of our coming programs in 2011 are enlisted for your information and participation.

I wish you all enjoy reading this new issue of the HKACCN Newsletter

**Best Wishes to the
14th year of
the HKACCN!**



The Birth of a Competency Framework for Advanced Practice Nurses (Critical Care)

WONG Yee Hing Esther
Honorary President &
Chairperson, Administrative Committee,
HKACCN

What is "competence" in nursing? What is an advanced practice nurse (APN)?

Alexander and Runciman (2003) asserted that,

Competence is the major determinant of performance. There is general agreement in nursing that “competence” reflects knowledge, understanding & judgment; a range of skills cognitive, technical or psychomotor and interpersonal; and a range of personal attributes and attitudes.

Hind (1995) expressed that, when carrying out a specific job, competencies were valuable to describe the expected activities of the profession. Furthermore, nursing competencies are used to describe general nursing practice, specialized roles (such as disaster nursing) and specialty practice. International Council of Nurses (ICN) (1997) defined an advanced practice nurse / nurse practitioner (APN/NP) as “a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice” (see <http://www.icn-apnetwork.org/>).

Background

- The Hong Kong Nursing Council has published a set of competency framework for registered nurses (RNs) in general stream (RN – G) but none for any nursing specialties.
- The Hospital Authority, the biggest employer of nurses in Hong Kong, has formulated two sets of competency frameworks, one for registered nurses (RNs) and the other for advanced practice nurses (APNs) seven years ago for nurses practicing general nursing.
- In 2009, the Education and Accreditation Subcommittee of Hong Kong Academy of Nursing Preparatory Committee (HKANPC) developed a generic set of competency framework which stated what were expected of nurses at the advanced practice level.
- Up to August 2010, none of the available competency sets was dedicated to advanced practice nurse working in the critical care (CC) areas.

To be in line with the international trend and local practice in the development of advanced nursing practice in critical care, and after reviewing the appropriate sets, Hong Kong Association of Critical Care Nurses (HKACCN) opined that the unique requirements expected of a critical care nurse were not explicitly mapped out in the generic set because the views of serving critical care nurses in the field were not sought.

Why a competency Framework for APN (CC) was required?

We had a shared vision that a consensus-based competency framework unique to APNs working in critical care area would achieve three purposes,

1. to enable APNs to address fully the different concerns and challenges in critical care nursing practice,
2. to provide APNs with the expected standards of patient care and preferred attributes, thus facilitating them to deliver care that will achieve optimal patient outcomes, and
3. to generate core contents of the framework that will serve as the basis for developing university curriculum at a Master’s level.

Hence, a working group consisting of clinical experts and academic experts in the field was formed to examine the issue in 2009.

How was the competency Framework developed?

The process integrated qualitative and quantitative research methods. It involved the following four phases with the triangulation approach.

Phase 1 – Group and Individual interview: Initial phase

Ten APNs (6.6% of APN (CC) in 2009) were interviewed. With their input and references made to a) the Synergy model of the American Association of Critical-Care Nurses, b) the Disaster Competency Framework published by the World Health Organization and International Council of Nurses and c) practice of APNs overseas, the initial draft of the competency framework for APN (CC) was developed which comprises six domains, altogether 78 Items.

Phase 2 – Survey and data analysis: Preparatory phase to enable wider internal consultation

Two sets of questionnaires were developed and through convenience sampling, they were completed by 50 APNs (33% of APNs in 2009) and 84 RNs (14% serving critical care nurses in 2009). The framework underwent content validity and reliability testing in order to be fully acceptable for use by the critical care nurses working in different institutions.

Phase 3 – The external review phase (Delphi Technique): External review phase to secure expert consensus

A panel consisting of 15 international experts was invited to assess the relevance (including disaster nursing) and comprehensiveness of the framework for APNs in two stages. Based on the comments from experts, the contents of the framework were further revised, a total of 72 Items were left (please visit www.medicines.org.hk/hkaccn for details). They were 1) managing clients with complex health conditions (from 19 – >15 Items); 2) enhancing therapeutic nurse-client relationships (from 10 – >11 Items); 3) demonstrating effective leadership and teamwork (from 13 – >15 Items); 4) enhancing patient safety, quality assurance and improvement (from 15 – >13 items); 5) managing and negotiating innovative and effective approaches to care

delivery (from 20 – >16 Items); and 6) enhancing professional and personal attributes of general and advanced practice (from 1 – >2 Item).

Phase 4 – Group and individual interviews: Subsequent interviews for further exploration.

Thirty nurses were interviewed in late 2009 and early 2010. Attention was focused upon challenges of critical care nurses; disaster experience and preparedness; and suggestions for future training of the APN (CC). The perceived challenges of critical care nurses at advanced practice level nowadays are 1) shortage of nurses – the problem was aggravated by frequent turnover of nurses and the highly sophisticated technical systems, the changing pattern of diseases coupling with medical and pharmaceutical advances leading to new models of care as well as the co-morbidities of the aged; 2) being a knowledgeable and competent critical care nurse is not at all easy; 3) clinical reasoning capability is crucial to everyday decision making; 4) nursing leadership is essential in leading professional practice and maintaining standards of care; 5) poor staff morale due to poor promotion prospect and low job satisfaction; 6) high customer expectation in nursing care due to knowledge explosion; 7) having a good collaborative relationship with interdisciplinary teams; 8) potential risk of contracting infectious diseases; 9) customer mandate for culturally competent care is not so prominent in Hong Kong; however we are required to vary practices according to contextual and cultural influences, and 10) lack of disaster-related knowledge. In other words, nurses have to be competent in order to face challenges ahead of them. The Framework not only embraces a full range of skills, which are the generic features of advanced nursing practice, but also the requisite elements to enable APN (CC) to face challenges. They are clinical skills with the use of sound clinical knowledge in practice; critical thinking; clinical judgment; decision making skills; coaching and mentoring skills; research skills; changing practice skills; and clinical/ professional leadership.

The document was endorsed by HKACCN on 2 November 2010 and put into practice with immediate effect. Core contents would be identified for master's curriculum development in due course.

Implications

1. Regular assessment of clinical practice competencies would be crucial to effective functioning of a critical care nurse.
2. APN (CC) should be properly and strategically prepared.
3. Competency-based performance appraisal system would help to measure the performance of APN in a "SMART" (specific, measurable, achievable, realistic, and timely) manner on an annual basis to ensure consistency in critical care practice.
4. The nursing workforce could be strengthened at time of nursing shortage through staff

recruitment, recognition, retention, and practice reinforcement based on the standard of clinical practice competencies.

Acknowledgments

I would like to take this opportunity to thank the local expert group, who participated actively in the interviews in Phase 1 & 4, and in the survey in Phase 2 for their effort and time spent. Their comments were invaluable. The international panel had an important impact on the work. Their expert opinions were instrumental in refining the contents of the framework.

Reference

- Alexander, M.F., & Runciman, P.J. (2003) *ICN Framework of Competencies for the Generalist Nurse: Report of the Development Process and Consultation*. Jean-Marteau, Geneva (Switzerland), CH-1201.
- Hird, V. (1995). *Nursing competencies: the artistry of nursing*. Available 7 July 2007 from CIAP Online Anytime: <http://www.ciap.health.nsw.gov.au/hospolic/stvincents/1995/a05.html>

Teamwork and Patient Safety Attitude in Hong Kong ICU Doctors and Nurses

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²Intensive Care Unit, North District Hospital, HA

³Intensive Care Unit, Prince Wales Hospital, HA

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Background

Safety and quality are the highest priorities for hospitals in Hong Kong. More efforts have been made each year by the Hospital Authority (HA) to improve patient safety culture. Through the sentinel event reporting system (Advanced Incident Reporting System – AIRS), the development of a safety culture has been signified since 2006. In the past two years, the number of medication incidents reported through AIRS has dropped by 13% (Solomon, 2010). Hospital Authority particularly put a strong focus on patient safety in high-risk areas such as Intensive Care Units (ICU). Working groups were formed to address this concern. In order to align with the safety goals, evaluation of the safety and teamwork attitudes among ICU health care professionals is paramount. Therefore, a research team composed of three different ICUs in the same cluster was formed in 2008 and it initiated this study to survey the situation of teamwork and safety attitudes among ICU doctors and nurses.

Purposes

- To examine the perceptions of doctors and nurses between ICU and within ICU about teamwork and patient safety attitudes

- To investigate the relationship between teamwork and patient safety attitudes of ICU doctors and nurses

Method

Design

A cross-sectional survey of doctors and nurses in three intensive care units of Hong Kong hospitals with different sizes, levels of care, and staff-to-patient ratios.

Instrument

A modification of the Safety Attitudes Questionnaire developed by Sexton and colleagues in 2006 was used for this study (Table 1).

Table 1 Teamwork and Patient Safety Attitudes Questionnaire	
Part A: Demographic data	
Part B: Answer the following statements by selecting one of the following descriptors, "Strongly Disagree"; "Disagree"; "Neutral"; "Agree"; "Strongly Agree".	
1.	I would feel safe being treated here as a patient.
2.	This unit is putting effort to ensure patient safety.
3.	In this ICU, it is difficult to discuss errors.
4.	All the staff in my ICU take responsibility for patient safety.
5.	I am encouraged by my colleagues to discuss any patient safety issue.
6.	In this ICU, it is easy to share learning points from the errors.
7.	I know the proper channels to direct questions regarding patient safety in this ICU.
8.	I know how to report errors that happen in this ICU.
9.	Patient safety is constantly reinforced as a priority in this ICU.
10.	Information obtained through incident reports is used to make patient care safer in this ICU.
11.	Nurse input on patient safety is well recognized in this ICU.
12.	Staff input is utilized by this ICU for decision making.
13.	This ICU encourages teamwork among its staff.
14.	In this ICU, I find it difficult to speak up if I perceive a problem with patient care.
15.	Disagreements in this ICU are resolved basing on what is the best for the patient.
16.	I have the support I need from other staff to care for the patients.
17.	It is easy for staff in this ICU to ask questions when there is something that they do not understand.
18.	The doctors and nurses here work together as a well-coordinated team.
19.	Interactions in this ICU are collegial (equal level), rather than hierarchical (ranking).
20.	Important issues are communicated well at shift changes.
Part C: Answer the following statements by selecting one of the following descriptors, "Very unsatisfactory"; "Unsatisfactory"; "Neutral"; "Satisfactory"; "Very Satisfactory".	
1.	Please indicate your overall impression of the collaboration and communication that you have experienced in this ICU with ICU doctors.
2.	Please indicate your overall impression of the collaboration and communication that you have experienced in this ICU with ICU nurses.
Part D: Incident reporting in ICU	
Part E: Recommendation	

Subjects

A number of 209 ICU doctors and nurses were included in this study.

Results

There were 209 questionnaires distributed to three ICU, and a total of 135 returned (134 were valid). The overall response rate was 64.11% (Table 2).

Table 2 Respond rates of the survey

Unit	Response Rates								
	Respondents			Doctors			Nurses		
	Rec. (n)	Adm (n)	%	Rec. (n)	Adm (n)	%	Rec. (n)	Adm (n)	%
A	71	104	68.27	5	10**	50.00	66	94	70.21
B	53	69	76.81	7	11	63.64	46	58	79.31
C	10	36	27.78	1	4	25.00	9	32	28.13
All	134*	209	64.11	13	25	52.00	121	184	65.76

* One subject was excluded because of over 50% of missing items.

** Only full time, core ICU staff were administrated the questionnaire.

There was no significant difference of perceptions of teamwork and patient safety attitudes of medical and nursing staff among the three studied ICUs (Table 3).

Table 3 Perceptions of teamwork and patient safety attitudes of medical and nursing staff among the three studied ICUs

	Mean Score		Percent Favorable %	
	Safety	Teamwork	Safety	Teamwork
Unit A	69.86	63.63	38.03	14.08
Unit B	68.87	63.00	32.08	22.64
Unit C	68.51	65.00	40.00	10.00
P value ^{a, b}	0.836	0.921	0.978	0.269

^a ANOVA comparing mean scores of nurses and doctors

^b χ^2 -Square comparing percent favorable of nurses and doctors

Doctors in ICU A showed both significant differences regarding teamwork and patient safety attitudes ($p=0.014$; 0.018 respectively), who rated more positively than nurses working in the same clinical setting (Table 4).

A highly statistically significant association between patient safety attitude and teamwork was found from the Spearman rho statistics with $r_s(134) = 0.61$, $p=0.000$ (Table 5).

Table 4 Differences in patient safety attitudes and teamwork between doctors and nurses across the three studied ICU

	Mean Score		Percent favourable %	
	Safety	Teamwork	Safety	Teamwork
Unit A				
Doctor	79.50	76.50	60.00	40.00
Nurse	69.13	62.65	36.40	12.12
<i>P</i> value ^{a, b}	0.018*	0.014*	0.049**	0.125
Unit B				
Doctor	67.15	63.93	28.57	28.57
Nurse	69.29	63.21	32.61	21.74
<i>P</i> value ^{a, b}	0.493	0.887	0.656	0.569
Unit C				
Doctor	80.00	85.00	100.0	100.0
Nurse	67.22	62.28	33.33	0.00
<i>P</i> value ^{a, b}	0.137	0.017*	0.046**	-

* Statistically significant

^a ANOVA comparing mean scores of nurses and doctors

^b χ -Square comparing percent favorable of nurses and doctors

Table 5 Relationship of teamwork and patient safety attitude

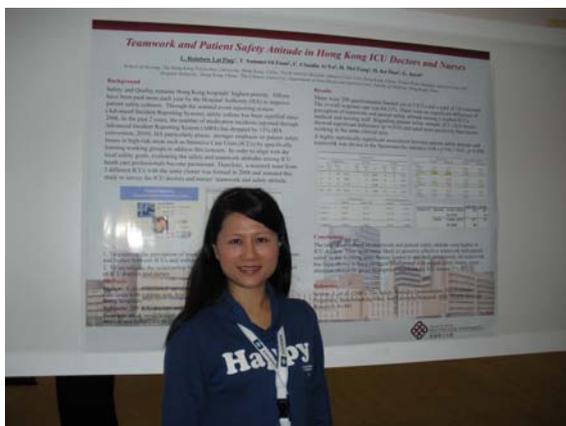
		dimension1		
		Mean	Std. Deviation	N
dimension0	safety climate	3.6963	.36365	134
	Teamwork	3.4627	.41106	134

		safety climate		Teamwork
Spearman's rho	safety climate	Correlation Coefficient	1.000	.606**
		Sig. (2-tailed)	.	.000
	Teamwork	Correlation Coefficient	.606**	1.000
		Sig. (2-tailed)	.000	.

** Correlation is significant at 0.01 level (2-tailed)

Conclusions

The rate of agreement on teamwork and patient safety attitude were higher in ICU doctors. They were more likely to perceive effective teamwork and patient safety in the working area. Nurses tended to rate both items lower. As teamwork has been shown to have a strong relationship with patient safety issues, more attention should be given to improve teamwork for ICU nurses.



Ms Rainbow Lee in the 23rd ESCIM Annual Congress 2010

Reference

Solomon, S. (2010). From P4P to VMV. *Hospital*

Authority Convention 2010 (Keynote Address). Hong Kong: Hospital Authority.

Sexton, J. B., Helmreich, R. L., Neilands, T. B., Rowan, K., Vella, K., Boyden, J. ... Thomas, E. J. (2006). The Safety Attitudes Questionnaire: Psychometric properties, benchmarking data, and emerging research. *BMC Health Services Research*, 6 (44), doi:10.1186/1472-6963-6-44

Visual Cue on Hand Hygiene Practices Program in TMH ICU

WONG Sui Ching (APN, ICU); KOO C K (Director, ICU); TANG K S (AC, ICU); MAK C M (DOM, ICU); CHAU L S (NS, ICU); LEE W M (RN, ICU); Si Y Y (RN, ICU); Wong S W (RN, ICU); Pang C Y (RN, ICU); MOK W Y (RN, ICU) - Tuen Mun Hospital

Introduction

It is well recognized that hand hygiene (HH) is the most important factor in reducing and preventing healthcare associated infections (HAI). All staff within healthcare settings must recognize the importance and should perform it effectively and timely. However, the compliance rate has generally been low and poorly sustained.

Objectives

In order to improve the HH compliance, and promote the five right moments for hand hygiene and usage of alcoholic hand rub, we implemented a “visual cue on hand hygiene practices” program in our Intensive Care Unit (ICU) in April 2009.

Methodology

A questionnaire survey on the usage of alcoholic hand rub and the first hand hygiene audit were performed simultaneously in April of 2009. The target groups were ICU health care workers (HCW) including doctors, nurses, general service assistants (GSA), and allied healthcare workers. The sample size was about 200 staff members. After the survey, hand hygiene education and briefing regarding the “visual cue on hand hygiene practices” program were introduced by the program taskforce groups through education talks, briefing sessions and e-mail communication. Subsequently A4 sized posters of “hand rub visual

Visual Cue Poster in A4 Size

Hand Rub Before & After Patient Contact
接觸病人前/後, 請消毒雙手!



cue" were designed and produced. These visual cues were attached to each bedside rail and foot end of each bed. Two months in August 2009 after the implementation of "hand rub visual cues", a second hand hygiene audit was performed.

Placement of Visual Cue Poster



Results

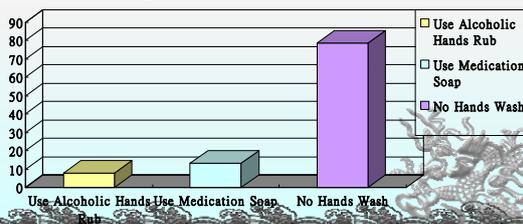
The result of "visual cue on hand hygiene practices" program indicated that the compliance of hand hygiene before approaching patients increased from 21.3% to 39.7%. The compliance of hand hygiene after approaching patients also increased from 81% to 98.5%. Moreover, staff using the hand rub before and after approaching patients have increased from 10% to 25%. These findings suggested that the visual cue might increase the staff's awareness of hand hygiene.

Pre-visual Cue Hand Hygiene Audit

Hand hygiene practice before patient contact

- * Use alcoholic handrub 8% (15/188)
- * Use medicated soap 13.3% (25/188)
- * Use neither alcoholic handrub nor medicated soap 78.7% (148/188)

Conclusion: Only 21.3% of HCWs perform hand hygiene before patient contact

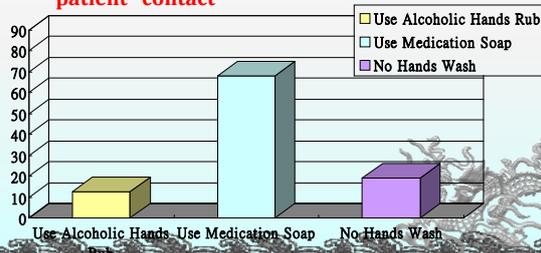


Pre-visual Cue Hand Hygiene Audit

Hand hygiene practice after patient contact

- * 12.8% HCWs use alcoholic handrub after patient contact
- * 68.1% HCWs use medicated soap after patient contact
- * 19.1% HCWs do not use either alcohol based HR or medicated soap after patient contact

Conclusion: Near 81% of HCWs perform hand hygiene after patient contact

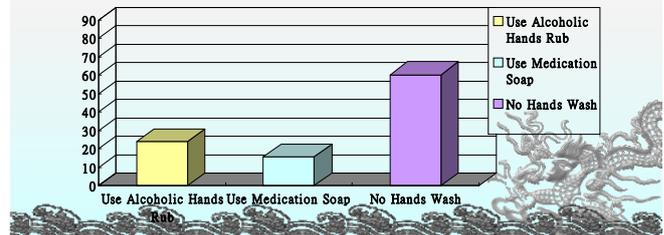


Post-visual Cue Hand Hygiene Audit

Hand hygiene practice before patient contact

- * Use alcoholic handrub 24% (49/204)
- * Use medicated soap 15.7% (32/204)
- * Use neither alcoholic handrub nor medicated soap 60.3% (123/204)

Conclusion: 39.7% of HCWs perform hand hygiene before patient contact

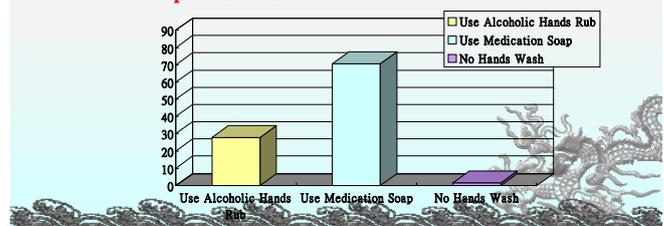


Post-visual cue hand hygiene audit

Hand hygiene practice after patient contact.

- * Use alcoholic handrub 27.9% (57/204)
- * Use medicated soap 70.6% (144/204)
- * Use neither alcoholic handrub nor medicated soap 1.5% (3/204)

Conclusion: 98.5% HCWs perform hand hygiene after patient contact



Limitations

Due to the limitation of time, the correlation between the hand hygiene compliance and nosocomial infection rate was not investigated in this program. Furthermore, it has been well recognized that being observed in practice could lead to false positive elevation of compliance rate.

Conclusions

World Health Organization (WHO) 2009 Guidelines on Hand Hygiene in Healthcare showed that most hand-hygiene intervention programs usually demonstrated the improvement in a short term. To sustain the improvement, regular evaluation of hand hygiene behavior and compliance with performance feedback to all staff were helpful. Therefore, the positive aspects of creating change to improve hand hygiene and reduce infection have to be stressed for staff. Regular nosocomial infection surveillance data which demonstrate the correlation of hand hygiene compliance and low nosocomial infection rate will be a motivating factor, encouraging staff to sustain their HH practice. Similar observational study can also be conducted as a part of an ongoing infection control audit program for our unit, providing regular feedback for staff to sustain their compliance.

Reference (Available upon request)

UPCOMING PROGRAMS

I) ECG Course for Beginners

Course Objectives:

- To enhance frontline nurses' knowledge on basic ECG concept and common arrhythmias.
- To promote the competence of frontline nurses in caring patients with common arrhythmias.

Target Group and Capacity:

All nurses; 36 per class

Duration:

Total 12 contact hours (2-hour lecture for 6 sessions)

Date and Time:

ECG 1 3 Mar – 7 Apr 11

ECG 2 5 May – 9 Jun 11

ECG 3 7 Jul – 11 Aug 11

ECG 4 1 Sep – 6 Oct 11

ECG 5 3 Nov – 8 Dec 11

6 Thursday evenings for each identical course, 6:30 - 8:30 pm

Venue:

HKACCN

Rm 501, 5/F Great Smart Tower,
230 Wan Chai Road, Hong Kong

Speakers:

Nursing experts from critical care areas

Language medium:

Both English & Cantonese

Award:

Certificate will be issued for those who have attended all the lectures and have passed the Quiz (12 CNE Points) (80% attendance is required)

Program Fee:

HK\$1200 (Member), HK\$1800 (Non-member)

II) Elementary Critical Care Nursing ECCN Series Module 1 – 3

This Elementary Critical Care Nursing (ECCN) Series is designed to enable frontline nurses to understand the basic concepts in the monitoring and management of critically ill patients in Critical Care Areas. It consists of 3 modules :

- Module 1: Respiratory Nursing (7 Mar – 9 May 11)
- Module 2: Cardiovascular Care (13 Jun – 1 Aug 11)
- Module 3: Reno-Neuro-Trauma Care (5 Sep – 24 Oct 11)

Target Group and Capacity:

All nurses; 36 per module

Duration of each Module:

8 Mondays evenings

(6:30 - 8:30 pm)

Venue:

HKACCN

Rm 501, 5/F Great Smart Tower,
230 Wan Chai Road, Hong Kong

Speakers:

Nurse experts from various critical care areas

Language medium:

English & Cantonese (with English Handouts)

Award:

A certificate of completion will be issued to those who have attended all the lectures and have passed the quiz (16 CNE Points) (80% attendance is required).

Program Fee (per module):

HK\$1600 (Member), HK\$2000 (Non-member)

III) Health Assessment Course

This Health Assessment Courses is designed to help frontline Nurses acquire knowledge about assessing health for critically ill patients.

Content:

- Principles of health assessment
- Health assessment on CVS, respiratory, neurological and GI system
- Nutritional, pain and trauma assessment
- Interpretation on laboratory findings, CXR, CT brain and echocardiogram

Target Group and Capacity:

All nurses; 36 per class

Date and Time:

HA 1 6 May – 24 Jun 11

HA 2 7 Oct – 25 Nov 11

8 Friday evenings for each identical course, 6:30 - 8:30 pm

Venue:

HKACCN

Rm 501, 5/F Great Smart Tower,
230 Wan Chai Road, Hong Kong

Speaker:

Nurse experts from various critical care areas

Language medium:

English & Cantonese (with English Handouts)

Award :

A certificate of completion will be issued to those who have attended all the lectures and have passed the quiz (16 CNE Points) (80% attendance is required).

Program Fee:

HK\$1600 (Member), HK\$2000(Non-member)

IV) Basic Life Support and Advanced Cardiac Life Support Courses

a) Basic Life Support (for Health Care Provider) (BLS – HCP) Course

This BSL – HCP Course is organized by the HKACCN Ltd. The HKACCN Ltd is an official AHA training site under Laerdal International Training Center (ITC), which is the ITO of AHA CPR and ECC Course in Hong Kong, China and Macau.

Content:

- CPR skills for all ages (adult, child, infant) according to AHA 2005 CPR Guidelines
- Ventilation with pocket mask and BVM
- Use of Automated External Defibrillator (AED)
- Foreign Body Airway Obstruction Management

Target Groups:

- Health care providers, such as nurses, doctors, paramedics, and ambulance personnel
- Nursing and medical students
- Other interested personnel

Date and Time:

8:30am – 1:00pm (a half-day program)

8 Jan; 12 Feb; 5 Mar; 2 Apr; 7 May; or 4 Jun 2011

Venue:

TSK A&E Training Centre / HKACCN office

Award:

AHA BLS Provider Card – valid for 2 years (4 CNE points; 2 – 7 CME points)

Program Fee:
HK\$400

b) Basic Life Support (for Health Care Provider) (BLS – HCP) Renewal Course

Date and Time:
8:30am – 12:30pm (a half-day program)
15 Jan; 12 Mar; or 14 May 2011

Venue:
TSK A&E Training Centre / HKACCN office

Award:
AHA BLS Provider Card – valid for 2 years (3 CNE points; 2 – 3 CME points)

Program Fee:
HK\$250

c) Advanced Cardiac Life Support (ACLS) Provider Course

This Advanced Cardiac Life Support (ACLS) Provider Course is organized by the HKACCN Ltd. The HKACCN Ltd is an official AHA training site under Laerdal International Training Center (ITC), which is the ITO of AHA CPR and ECC Course in Hong Kong, China and Macau.

Content:

- Adult CPR skills and use of AED (According to AHA 2005 CPR Guideline)
- Management of 10 core cases related to resuscitation including : Pulseless VT/VF, Asystole, PEA, bradycardia (Heart Block), Unstable Tachycardias, Stable Tachycardias, Respiratory Arrest, Acute Coronary Syndrome, and Acute Stroke.

Target Groups:

- Health care providers, such as nurses, doctors, paramedics, and ambulance personnel
- Nursing and medical students
- Other interested personnel

Date and Time :
8:30pm – 4:30pm (a 2-day program)
27 – 28 Jan; 26 – 27 Feb; 24 – 25 Mar; 23 – 24 Apr;
26 – 27 May; 25 – 26 Jun 2011

Venue :
TSK A&E Training Centre / HKACCN office

Award :
AHA ACLS Provider Card – valid for 2 years (13 CNE points; 5 – 13 CME points)

Program Fee :
HK\$1300

ENQUIRIES for ALL COURSES:

2861 2972 (Mr. Leo LAM)
Email: hkaccn@yahoo.com.hk



For detailed information and application form:
<http://www.medicine.org.hk/hkaccn/activities.htm>

(報名及繳費:填妥報名表格,連同劃線支票,親自遞交或郵寄至HKACCN Ltd.)

V) CCM Inter-hospital Grand Round

Joint program of HKACCN and HKSCCM, one evening on ad hoc basis (2 hours)

Award: CNE 2

Program Fee:
Free of charge (All are welcome)

Venue:
Lecture Theatre, M Block, QEH

Topics and dates to be announced (see <http://www.medicine.org.hk/hkaccn/activities.htm>)

CONFERENCE ANNOUNCEMENT

24 – 26 Mar 2011

4th EfCCNa Congress & FSAIO Spring Congress
Place: Copenhagen, Denmark
Website: <http://www.efccna2011.dk/>

20 – 21 May 2011

Critical Care Nursing Continuing Education 12th Annual Meeting ICE 2011
Place: Perth, Australia
Website: <http://www.accn.com.au/content/view/126/157/>

16 – 18 Oct 2011

Dynamics 2011 of the Canadian Association of Critical Care Nurses (CACCN): Critical Care Nursing Our Kaleidoscope
Place: London Convention Centre, Ontario
Website: http://www.caccn.ca/en/events/dynamics_2011.html

USEFUL LINKS

International Nurses Day 2010

Theme: Delivering Quality, Serving Communities:
Nurses Leading Care Innovations (IND Kit Download:
<http://www.icn.ch/indkit.htm>)

Australian Collage of Critical Care Nurses (ACCCN)

<http://www.acccn.com.au/>

Australian & New Zealand Intensive Care Society (ANZICS)

<http://www.anzics.com.au/>

British Association of Critical Care Nurses (BACCN)

<http://www.baccn.org.uk/>

Canadian Association of Critical Care Nurses (CACCN)

<http://www.caccn.ca/en/index.html>

European Federation of Critical Care Nurses (EfCCNa)

www.efccna.org

World Federation of Critical Care Nurses (WFCCN)

www.wfccn.org

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