NEWSLETTER

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

香港危重病學護士協會有限公司
Hong Kong Association of Critical Care Nurses Ltd.

Message from the President

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LEUNG Fung Yee
President
HKACCN

Dear Members,

Time flies. It is a great pleasure to celebrate the 19th Anniversary of the Hong Kong Association of Critical Care Nurses. I would like to cordially invite all of you to join our Annual Dinner on 11th November this year. It is a joyful event which we are longing for meeting old friends, new members, and colleagues from different ICUs, public and private, to enjoy and share. Most gratefully, we thank our advisers, honorary guests and supporters for their unfailing support to us over the years.

In daily practice, we are faced with tremendous pressure from the increasing demands from our critically ill patients and expectations from the community. HKACCN is always on your side to fortify your competence and invigorate your pursuit of providing the highest standard of care. We provide ample training programmes to fulfill nurses' learning needs at all levels. In addition, we provide professional advice and support to members at any time when needed. Here, I call for solidarity and your invaluable support to frontline colleagues during this turbulent times and working environment.

Critical care nurses are not working alone and neither is HKACCN. During the past year, we have strengthened relationship with other professional organizations. We have celebrated the 2016 International Nurses' Day jointly with the HK College of Nursing, HK Nurses General Union, and the Nurses Branch of HK Chinese Civil Servants' Association. A history-making forum for five generations of nurses was organized where we have rich sharing of nursing professional issues mingled with beautiful live music.

2016 國際護士節 - 音樂唱談夜 之
「五代同台話今天，群策互融建明天」

Furthermore, the 7th International Infection Control Conference was successfully held in collaboration with the HK Infection Control Nurse Association on 2-3 July 2016. We had good interchange of knowledge and networking with renowned overseas and local speakers.

On 27 November 2016, we are soon going to have the Annual Scientific Meeting organized by the HK Society of Critical Care Medicine. HKACCN is a supporting organization and three speakers nominated by our Association will have oral presentations at the Critical Care Nursing Seminar. Surely, an event not to be missed! And look forward to seeking you there! Thank you.

Needs of ICU patients, not necessarily "high tech": The wet hair washing procedure for patients in ICU

CHEUNG, S. F. (and associates)
APN
Department of Anaesthesia and ICU
Prince of Wales Hospital

Introduction

Cleanliness has been described as a preventive medicine that it avoids the spread of ill health and supports good health (Smith, 2007). For the long-term hospitalised patients, hair washing can improve their hygiene as well as self-esteem.

However, hair washing in bed can be a difficult and complicated task for critical ill patients due to the movement of their heads and necks are restricted

by many invasive lines and tubes. Hair washing is basic nursing care for patients but it is not considered as a high priority in ICU due to the risk of interfering the airway during manipulation of patient's head. A safe, simple and comfortable way of hair washing, in particular the wet type, is necessary for patients in ICU.

Objectives

The objectives of promoting hair washing for ICU patients are,

i) to enhance nurses' awareness on hair hygiene of ICU patients;
ii) to reduce the risk of cross infection between patients with clearer hair after washing;
iii) to improve the efficiency in removing blood clots and glass fragments of trauma patients; and
iv) to promote patient comfort and satisfaction through the revised wet hair washing procedure.

Methods

i) Explain the procedure of wet hair washing to nurses in the briefing section with a training kit, which includes a Powerpoint presentation and a quick reference guide; and through a demonstration with a real patient.
ii) Receive feedback from nurses and revise the procedure accordingly.
iii) Collect questionnaires that evaluate satisfaction of the recruited patients and ICU nurses about the wet hair washing procedure.

Results

A total of 57 questionnaires from patients who had received the hair washing, and 60 questionnaires from ICU nurses who performed the procedure were received. The satisfaction levels were evaluated in terms of a Likert Scale of 1 – 5 (1 = 'very unsatisfactory' ..... 5 = 'very satisfactory'). Results of the analysis are provided in Table 1.

Conclusion

Both ICU patients and nurses agreed that the wet hair washing with the use of disposable and sterile items were able to promote patient's comfort and improve their hair hygiene.

References

Smith, V. (2007). *Clean: A history of personal hygiene and purity.* Oxford: Oxford University Press.

Bibliographies

Anonymous (n.d.). Personal hygiene: Hair care. In Health NetCafe: Online caregivers' resources 2008-2016. Available: http://www.healthnetcafe.com/content/day-to-day_care/personal_hygiene/hair_care.html

Workflow of Wet Hair Washing Procedure in ICU

Prepare a trolley with sterile set & disposable plastic bag.

Withhold feeding & lie patient flat.

Place a plastic bag under patient's head.

Adjust the height of bed until the plastic bag reaches The base of the bucket.

Tilt the head of bed down to 10-15 degree to allow drainage of wasted water into the plastic bag.

Apply shampoo, massage & rinse with warm water.

Tie a knot on the top of plastic bag.

Drain dirty water to the sewage system directly.

Patients (n = 57)	**Mean**	**Nurses** (n = 60)	**Mean**
Duration of the procedure is appropriate	4.28		
Neck is comfortable during the procedure	4.42		
Feeling comfortable after the procedure	4.8	Promotion of patient's comfort	4.55
Improvement of hair hygiene after the procedure	4.7	Improvement of patient's hair hygiene after the procedure	4.5
		Usefulness of the procedure	4.6
		Ease of the procedure	3.8
		Minimal risk of tracheostomy dislodgement	3.6
		Risk reduction of cross infection among ICU patients with the use of disposable and sterile items for hair washing	4.25

Table 1 Results of the evaluation of satisfaction

Anonymous (n.d.). NHS hair washing method – On a real person. YouTube April 2015. Available: https://www.youtube.com/watch?v=DG5LhTzm24I

Morris, K. (n.d.). How to wash a patient's hair in bed. eHow 1999-2016. Available: http://www.ehow.com/how_8111814_wash-patients-hair-bed.html#ixzz310VZqTWO

Family Conference in ICU

WONG, Siu Fung
RN, ICU
Pamela Youde Nethersole Eastern Hospital

Background

Since 2014, health care team in the ICU of Pamela Youde Nethersole Eastern Hospital (PYNEH) has conducted a family satisfaction survey to collect families' satisfaction about ICU care and medical decision-making process. According to the results, some families expressed their expectation to have more clinician-family communications and higher participation in the decision making process.

Family conference is one of the best practices to improve quality of communication among families and medical professions in ICU (Curtis & White, 2008) and to increase family satisfaction (Huffines, Johnsone & Naranjo, 2013). Therefore, the family conference has been introduced to improve clinician-family communication. Family conference is a protocol driven, formal and purposeful meeting between families and designated medical professions. The first and second phases of family conference were commenced on 15th April, and 1st Oct 2015 respectively.

Objectives

The objectives of this project were to improve families and medical professions communication, to establish a better rapport with family, and to increase family satisfaction.

Project Team

A project team composing of seven members was set up to implement this project. Wide consultation about the workflow and interview record was performed with ICU doctors and the senior nurse management team. The project received great support from the ICU director.

Methods

Population

There were 3 inclusion criteria for patients who,

1. had a relative/s or significant other/s;
2. had severe clinical conditions and were not ready for discharge (as defined by ICU physicians); and
3. have stayed in ICU for at least 96 hours (a timing when it is more feasible to identify patient needs and family structure).

Participants

Participants of family conference included the patient's family (key persons of contact and significant others), an ICU physician and a case nurse / primary nurse. In some cases, a doctor from the parent team / specialty would also be invited if necessary.

Time and Venue

Family conference was scheduled on Monday to Friday (non-public holidays), with intended duration of 30 minutes. It depended on the availability of participants. A comfortable interview room was arranged to ensure family privacy and comfort.

The Structural Flow

Nurses spent significantly more time with the patients and played an important role in a successful, smooth and effective family conference. Team members contributed in the family conference in the following aspects.

Preparation

Before the conference, a case nurse or a primary nurse acted as a liaison person who took an active role on case selection; identifying the family structure, concerns and needs; and setting the conference goals.

During the Conference - Information and Evaluation

At the beginning of conference, the nurse made an introduction of the purpose and flow to the family.

An ICU physician presented overall clinical picture and plans of the patient. A physician from the parent team (if present) explained specialized clinical information and other plans such as indications of possible operation, disease progress, and prognosis.

After the explanations and updates, the nurse evaluated family's understanding. Additional explanation would be given if necessary. The nurse also identified, from verbal and non-verbal cues, and addressed family's emotions. Finally, a summary of the meeting was made by the nurse or the physician.

After Conference

An interview record (Table 1) was completed after the conference. The nurse acted as an advocate, who carried out follow-up actions such as making referrals to clinical psychologist, medical social workers, and more importantly, to ensure continuity of care to both the family and patient.

Results

1st Phase

Before the pilot period of family conference, briefing sessions were provided to ICU nurses and physician. Afterwards, a one-month pilot period commenced in 15th April to 15th May in 2016. A total

Table 1 Interview Record of the Family Conference

Family Conference in PYNEH ICU

Aim: To promote communication with family members on patient care in ICU

Interview Record

Patient's Name: _____ **Ward:** *B10/D10 **Bed No.:** _____

Conference Date: _____ **Time:** _____ **Venue:** *B10 / D10 Interview Room

No. of Conference: *1st/2nd/3rd/4th/5th/_____

Interviewers (Rank/ specialty): _____

Interviewees (relationship with patient) _____

Identify Key person(s) with a symbol *:

Preparation: Set goals	☐ Update conditions and treatment plan Miscellaneous if any: ☐ Procedure Plan ☐ Discharge Plan ☐ Comfort care ☐ Others : _____
1. *Introduce the flow of conference*	By ☐ Doctor ☐ Nurse
2. *Explore family attitude towards patient's disease*	☐ Concerned ☐ Positive ☐ Confident ☐ Doubtful ☐ Fear ☐ Others: _____
3. *Give information* - *Diagnosis* - *Conditions & Progress* - *Current Treatment* - *Prognosis* - *Treatment Options*	☐ Yes ☐ No, please specify: _____ ☐ Remarks (if any): _____
4. *Evaluate family understanding* - Did family show understanding?	☐ Yes ☐ No, remarks: _____
5. *Identify family's emotions*	☐ Calm ☐ Appreciative ☐ Aggressive ☐ Denying ☐ Anxious ☐ Angry ☐ Grief ☐ Other: _____
6. *Summary of conference*	By ☐ Doctor ☐ Nurse
7. *Provide time for Q&A*	☐ Yes ☐ No, remakes: _____
8. *Achieve goal(s)*	☐ Yes ☐ No, remarks: _____
9. *Date and time of next conference (if any)*	Date: _____ Time: _____
10. *Total time for the conference (mins)*	_____ mins
11. *Remarks (if any)* *(e.g. need to refer other specialties, allied health parties or chaplaincy?)*	☐ No ☐ Yes Please specify: _____

*Please circle the appropriate items ☑ for appropriate items

of 10 family conferences were held, involving the families of six ICU patients.

Each family was invited to complete a questionnaire, which was about satisfaction about the family conference, after the first conference. The questionnaire consisted of several questions, aiming to collect family's levels of satisfaction and opinions about the family conference. Overall, positive results were obtained from the families. All of the families agreed that interviewers had provided explanation in a comprehensive manner that they could understand. Eighty percent of the families agreed that the interviewers were able to provide them a complete picture of a patient's current condition, progress, and the rationales of treatments.

2nd Phase

After the pilot period, 12 more family conferences were held within six months, and eight of them were joint-speciality conferences. All of these families expressed their gratitude and appreciation for being invited to join the family conference. There were more physicians and nurses other than the project members participated in the conferences.

The Way Forward

In order to promote family conference in ICU, some future plans have been designed, such as motivating nurses' involvement, activating case recruitment by shift in-charge and increasing ICU doctor's participation. Outcome measurements will be continued by various ways such as monitoring the rating and comments of family satisfaction survey.

Conclusion

Family conference is an evidence-based practice to improve communication among family and health care professions. Essential components of the communication are included and guided by a structural flow. The development of family conference warrants empiric efforts and collaboration of the interdisciplinary team, and more research can enhance the practice in this area of the patient and family care in ICU.

References

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Using prone position ventilation for critically ill patients with severe acute respiratory distress syndrome (ARDS) in ICU: An outcome review

Rowlina LEUNG
NC, ICU
Queen Elizabeth Hospital

Background

Acute Respiratory Distress Syndrome (ARDS) is a complex condition affecting critically ill patients, resulting from direct or indirect lung injuries. It can cause pulmonary congestion, reduced aerated lung volumes and decreased pulmonary compliance, ultimately resulting in severe hypoxemia. ARDS is associated with increased mortality and morbidity rates, as well as increased costs of care (Powers, 2011). Recently, prone positioning has been proposed as a potential option for treatment of acute lung injury and ARDS in ICU of Hospital Authority hospital. A recent meta-analysis of current literature (Beitler et al., 2014) found that prone positioning reduced mortality from ARDS with the low tidal volume lung protective ventilation strategies. Gattinoni & Pietro (2010) raised two major points,1) the therapy seemed to improve systemic oxygenation, especially in hypoxemic patients, and 2) in particular when lung heterogeneity is the greatest in severe ARDS patients, the therapy appeared to provide about a 10% survival benefit. Prone positioning is a viable, inexpensive therapy for the treatment of severe ARDS. This maneuver consistently improves systemic oxygenation in 70% to 80% of patients with ARDS.

There are potential risks or complications for the procedure of prone positioning that can occur to both the patient and health care worker. Notable complications may include unplanned extubation, lines pulled, and tubes kinked for the patients; and back or other injuries of the staff. The risk of developing pressure ulcers is ever-present, as the patient is immobile and the pressure exerted on bony prominences may be prolonged. Nurses should be aware of the potential complications in all patient populations to anticipate and prevent these occurrences. Extended prone position ventilation is the most beneficial when administered 18 to 20 hours daily (Powers, 2011). The procedure is safe and effective in ARDS patients when performed by trained staff under an established protocol. Thus, a standardized protocol was constructed and an education program for prone positioning was conducted to all nurses in an ICU. Nurses experienced the use of prone positioning are able to provide safe therapeutic intervention to the patients. Purposes of the project are to review the outcomes of prone positioning, and identify areas for improvement in preventive strategies for the potential complications related to nursing care of

ARDS patients in ICU.

Objectives

The objectives of this overview are, 1) to assess possible outcome benefits of prone positioning in patients with moderate and severe hypoxemia who are affected by ARDS, and 2) to identify the major complications during prone positioning.

Methods

The project involved the prospective investigation of a sample of critically ill patients with ARDS from the ICU at QEH during the period of Dec 2015 to Apr 2016. Patients were recruited under the inclusive and exclusive criteria in the established protocol (QEH ICU protocol, 2015). According to the protocol, patients with severe hypoxemia or ARDS successfully recruited were placed in the prone position for at least 12-16hours per day. Prone positioning was applied manually and patient's heads were placed a silicon headrest and pillows. Mechanical ventilation support for the patients was set with a lung protective strategy, i.e. tidal volume targeting at 6ml/kg predicted body weight, and maintenance of the plateau pressure <30cmH_2O. Data regarding demographics, Acute Physiology and Chronic Health Evaluation II & IV(APACHE II & IV), length of stay (LOS) in ICU, ICU mortality rate per 100 patient treated, and the outcomes (alive or death) were collected to evaluate the severity of illness and the benefits from the prone positioning (Table 1). Adverse events related to positioning of patients from the supine to the prone position or vice versa (e.g. displacement of tubes and lines), or those associated with remaining in the prone position (e.g., need for increased sedation or vasopressor support, pre- and post-prone arterial blood gas, vital signs and mechanical ventilation settings adjustment) were recorded on a daily basis (Table 2).

Table 1 Demographic characteristics of subjects

Characteristics (n=11)	Values
Age (mean), range (years)	(35), 22 -70
BMI [a] range	17-18 - 33.39
Gender	
Male	5
Female	6
Causes induced ARDS	
H1N1Pneumonia	4
Flu A pneumonia	1
Severe CAP	2
Respiratory Failure	2
HAP	1
Acute interstitial lung, PE	1
APACHE II [b]	13-34
APACHE IV [c]	40-139
Duration of prone position (mean),range (hrs)	(14), 4-36
Length of stay (LOS) in ICU	1.13 -116.51
ICU mortality rate per 100 patient treated	6.45 -14.77
Alive / Death	7/ 4

Abbreviations:
BMI [a], Body mass index. Normal weight = 18.5-24.9. Underweight = < 18.5, Overweight = 25-29.9, Obesity = BMI of 30 or greater
APACHE II [b], Acute Physiology and Chronic Health Eva luation II, severity of disease classification system and applied written 24hours of admission, most widely used in ICU mortality predicted score, an integer score from 0 to 71, higher scores correspond to more severe disease and a higher risk of death
APACHE IV [c], using ICU day 1 inform ation a multivariate logistic regression procedure to estimate the probability of hospital death

Table 2 Adverse effect or outcome of prone positioning

Adverse effect or outcome of prone positioning	No. of incidents		
Need for increase sedation/ muscle relaxants	3		
Transient desaturation	3		
Hypotension, arrhythmias, increased vasopresors	7		
Loss of venous access	0		
Displacement of endotracheal tube	0		
Displacement of thoracotomy tube	0		
Eye lid oedema	2		
Skin integrity	*Intact*	*Red*	*Score*
Forehead	8	1	2
Chin	2	4	4
Facial/ cheek	10	1	0
Upper chest	9	2	0
Lower abdomen	9	1	1

Outcome Review

From Dec 2015 to Jul 2016, 11 patients were recruited for the study project. Baseline characteristics of the study population are reported in Table 1. Patients with severe hypoxemia in this sample, independently of the assigned treatment, were characterized by great clinical severity and high mortality rates (5 out of 11 patients with high APACHE IV) (Table 1). Patients enrolled in the prone group were ventilated in the prone position for a mean of 14 hours. The main reason for not completing the 14-hour target for every recruited patient was related to hemodynamic instability (two patients). Table 2 reports the clinically relevant adverse effects observed during the study. A significantly greater proportion out of the 11 patients placed in prone position experienced episodes of hemodynamic instability and required increase vasopressor support (seven patients). Prone positioning might have promoted the lung-protective ventilation strategy and take advantage of the potential improvement in oxygenation and respiratory compliance. There were 7 out of 11 patients who demonstrated the improvement of oxygenation (Table 3), and 6 out of 11 patients improved in their dynamic lung compliance after prone positioning (Table 4). The other significant events observed were the impairment of skin integrity (redness and sore), especially in the areas of forehead (3 patients) and chin (8 patients), after the prone positioning (Table 2). There were lower incidents of skin impairment in upper chest and lower abdomen (2 patients respectively); and 2 patients had eyelid oedema. There was no incident of dislodgement of endotracheal tube and thoracotomy tube.

Key Findings

In those three patients (Case 3, 8 & 10) with severe hypoxia (with PaO_2 8.0 -10 kPa) (Table3), the benefits of prone positioning appeared to outweigh the potential risks (with better post prone P/F ratios of ARDS with mortality) (Table 3). The outcome of these patients indicated that there was improve-

ment in oxygenation and lung compliance after prone positioning (Table 3 & 4). Regardless of the methods used to position patients, several key care elements should be instituted to ensure patient safety.

Mortality rate of patients with ARDS remains high even with protective lung ventilation. Prone position has been found to improve oxygenation and decrease the P/F ratios of ARDS with mortality in patients with severe refractory hypoxemia in the

Table 3 Oxygenation status (PaO_2/ FiO_2 ratio) of pre- and post-prone positioning

Case	pH		PCO_2 (kPa)		PO_2 (kPa)		HCO_3 (mmol/L)		BE		SaO_2(%)		P/F Ratio*		Oxygenation improved
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Y / N
1	7.26	7.304	5.96	4.89	18.3	13.88	19.5	17.8	-7.3	-7.8	98	98	229	208	N
2	7.44	7.37	5.72	6.46	32.5	8.62	29.6	27.2	6	1.1	94	93	244	129	N
3	6.99	7.108	11.8	8.89	8.0	13.3	21.8	21.1	-8	-8	74	95	60	133	Y
4	6.85	6.92	10.89	11.78	11.2	13.2	14.5	18.4	-19	-14	--	--	105	132	Y
5	7.35	7.42	6.0	5.6	11.8	7.9	24.8	26.3	-1	1.5	96	91	127	66	N
6	7.27	7.69	7.68	9.47	12.4	9.7	26.9	20.5	0	-10	96	86	104	81	N
7	7.14	7.09	8.09	10.2	12.4	13.2	22.7	22.5	-6	-9	94	95	93	75	Y
8	7.09	6.90	8.73	7.68	8.2	13.0	20.0	11.5	-10	-21	98	98	62	87	Y
9	7.48	7.45	5.7	7.1	16.5	25.2	30.9	35.9	6.6	9.9	99	99	124	315	Y
10	7.0	6.79	7.0	8.4	10.0	19.4	12.6	9.8	-18.9	-25	86	86	75	208	Y
11	7.33	7.34	7.2	7.5	15.8	19.4	27.8	29.7	0.8	2.5	98	99	119	208	Y

*P/F Ratio**, PaO_2 / FiO_2: 200-300 mild ARDS with mortality 27%; 100 -200 moderate ARDS with mortality 32%; < 100 severe ARDS with mortality 45%

Table 4 Lung dynamic compliance status of pre- and post-prone positioning

Case	Peak inspiratory pressure (PIP)		Tidal volume (Vt)		Dynamic lung compliance (C_{dynam})*		Lung compliance Improved
	Pre	Post	Pre	Post	Pre	Post	Y / N
1	40	29	400	400	16.7	30.8	Y
2	26	27	420	360	38.2	30.0	N
3	46	32	360	400	12.0	21.2	Y
4	40	28	380	400	15.2	28.6	Y
5	34	33	420	390	26.3	21.7	N
6	30	31	400	400	26.7	25.0	N
7	31	31	360	33	27.7	25.4	N
8	37	36	280	270	12.7	15.0	Y
9	40	45	420	450	15.6	14.0	N
10	43	33	340	340	26.2	34.0	Y
11	34	37	400	400	21.0	23.5	Y

(C_{dynam})*, Dynamic lung compliance = Vt / (PIP - PEEP)

Skin Care

With the potential skin breakdowns caused by the prone devices and the major pressure points in prone positioning, nurses should assess the areas at risk frequently, with special focus on pressure areas on the chest, cheeks, chin, forehead and lower abdomen. Skin barriers, e.g. hydrocolloid or foam dressings, should be placed prophylactically under the forehead, cheeks, chin, upper chest, and nipples to prevent shear, friction and too much pressure. Use of heel lift devices or pillows may also be beneficial. If reddened areas are noted during skin assessment, repositioning or lifting of the areas for a few seconds at regular intervals during the prone position can relieve pressure.

Eye Lid Oedema

Patients in the prone position often experience dependent edema of the face (eyes, lips and tongue). Powers (2011) suggested that ice packs placed on the patient's face during the supine position had been found to be beneficial on these areas.

Conclusion

findings of this project (Table 3 & 4). Healthcare professionals who are capable in performing the procedure with proper techniques based on a standardized protocol for prone positioning, especially about the protection of pressure areas, can implement the therapy in a safe and effective manner.

References

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Positioning-with-ARDS.aspx
QEH (2015). ICU guideline on prone position for ARDS patients (KCC/QE/ICU/HDU/GL/0090).

UPCOMING PROGRAMS

COURSES (2016)

a. **Basic Life Support Provider Course:** 3 Dec
b. **ECG Course for Beginners:** 23, 30 Nov, & 7, 14, 21, 28 Dec
c. **ACLS Provider Course:** 26 - 27 Nov; or 17 - 18 Dec
d. **Elementary Critical Care Nursing (ECCCN) — Module 2 / Cardiovascular Nursing 2016:** 1 Nov- 20 Dec

ENQUIRIES for ALL COURSES:
Phone: 2861 2972
Email: hkaccn@hotmail.com.hk

For detailed information & application, visit
http://www.medicine.org.hk/hkaccn/activities.htm

CONFERENCES

7th EfCCNa Congress 2017
15 - 18 Feb 2017
Belfast, Northern Ireland
http://www.efccna.org/congress

Canadian Critical Care Conference
1 - 3 Mar 2017
Whistler, BC, Canada
http://www.canadiancriticalcare.ca/

USEFUL LINKS

International Nurses Day 2016
Theme: Nurses: A force for change: Improving health systems' resilience
http://www.icn.ch/publications/2016-nurses-a-force-for-change-improving-health-systems-resilience/

International Nurses Day 2017
Theme: Nurses: A voice to lead - Achieving the sustainable development goals
http://www.icn.ch/publications/2017-nursing-a-voice-to-lead-achieving-the-sustainable-development-goals/

Australian College of Critical Care Nurses (ACCCN)
http://www.acccn.com.au/

British Association of Critical Care Nurses (BACCN)
https://baccn.org/

Hong Kong Society of Critical Care Medicine (HKSCCM)
http://www.hksccm.org/

European federation of Critical Care Nursing association (EfCCNa)
http://www.efccna.org/

World Federation of Critical Care Nurses (WFCCN)
www.wfccn.org