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

Vol. 19, No. 1, Nov 2018

LEUNG Fung Yee
President
HKACCN

Dear Members,

I am pleased to provide a report of the activities of Hong Kong Association of Critical Care Nurses (HKACCN) for the year 2017-2018. With the establishment of a new board of directors at our last AGM, we managed to organize a strategic workshop to identify our way forward to develop our Association and contribute to promoting critical care nursing in Hong Kong.

HKACCN Strategic Workshop held on 8 Jan 2018

With an aim to strengthen the collaboration between ICUs in public and private hospitals, we paid a professional visit to the Gleneagles Hong Kong Hospital. We have good sharing of experience and exchange of views in critical care nursing practices. In addition, we learned about the new setup of ICU environment and the related advanced technology. We sincerely thank the management team of Gleneagles Hospital for arranging the visit for our members and provide us a platform to share and network.

Visit to Gleneagles Hong Kong Hospital on 26 May 2018

Sharing and exchange of ideas in critical care practices

Quality and safe care is our prime goal in daily care. We are delighted to have organized a seminar on “Safety Line: Addressing Clinical Challenges with Extra-luminal & Intra-luminal Contamination” in August 2018. Mr Joseph Hommes from USA has given us an enlightening talk on care of intravenous lines and shared with us the effective techniques in maintaining the line clean and free from contamination. Participants were keen to enhance their competency in line care.

Critical Care Seminar with demonstration held on 30 August 2018

Safety is not only related to our work place, but also the office of our Association. The Administrative Committee successfully conducted a fire safety drill in Oct 2018. Use of fire extinguisher and routes for fire escape were demonstrated. We thank Mr Kan Siu Kuen, Chairperson of Administrative Committee, for his effort in leading his team to organize the drill for us.

Fire safety drill conducted on 5 Oct 2018

Last but not the least; I am pleased to report that HKACCN has maintained good financial position. Its financial stability provides a good flexibility for us to upgrade our equipment in training and also refurbish our office which provides a good environment for all training programmes to be conducted in our office. We would like to thank Ms LI Yuen and Ms CHIU Yeung Lin, Treasurers, for their stringent control and wise use of budget. We are also grateful to the Administrative Committee in providing good housekeeping of our office, the Professional Development Committee's effort and commitment in organizing high quality training programmes; and of course, your support to our Association to make us success in maintaining HKACCN as an excellent professional organization in the critical care arena.

ICU Patient Diary

NG Nga Ting, RN
Intensive Care Unit
Princess Margaret Hospital

Background

Staying in a place with discordant alarms, waking up on and off with tubes and lines all over the body, feeling painful and being physically fragile…it is easily imaginable that the stay in ICU can be a physically and emotionally stressful event for most patients. Studies reveal that one third of ICU survivors experienced anxiety and some psychological aftermath during the first year of recovery (Nikayin et al., 2016). More significantly, it is suggested that 14% to 59% of patients developed post-traumatic stress disorder (PTSD) after ICU treatment (Wu et al., 2018). Survivors from ICU frequently described their experience as 'nightmares, incomplete memories, fear, and disillusionment'. Furthermore, the use of sedatives such as benzodiazepines, duration of mechanical ventilation, awareness of painful procedures, sense of helplessness, loss of control and imminent threat of death; are common risk factors to PTSD after ICU treatment (Egerod and Christensen, 2009; Ullman et al., 2015). Without adequate attention and proper treatment, the symptoms might even contribute to mental health problem such as anxiety disorder and post-ICU depression.

Patient diary, in many countries, was explored in order to help restoring patients' factual memories and promoting their psychological wellbeing throughout the stay in ICU. The concept of patient diaries arose in Denmark in the 1980s and has widely been spread among developed countries. Daily entries are made by ICU nurses on the events that the patients undergo, their current status and descriptions of situations and surroundings in which the patients might recognize. Several studies show that diaries can help ICU patients experience a sense of coherence and filling their memory slots by adding daily factual entries (Ewens et al., 2014; Engstrom et al., 2009; Taylor et al., 2017). By reading the diary, patients might also be able to distinguish between reality and delusion, helping them to determine whether some memories are misinterpreted. Furthermore, research shows that the diary can reduce the occurrence of PTSD, depression, and anxiety related to critical illness and intensive care (Egerod & Christensen, 2009; Jones et al., 2010; Nydahl et al., 2014).

Objectives

The concept of patient diary was introduced and implemented in the ICU of Princess Margaret Hospital (PMH) in 2016 with the following objectives:

- to introduce and promote the use of patient diaries;
- to enhance coherent memories for critically ill patients;
- to promote psychological wellbeing of ICU survivors; and
- to enhance therapeutic relationship between ICU nurses and patients.

The Journey of Implementation

Pilot Project
Patient diary was designed in a fold-up card format consisting two parts: the journal and the solicitude from ICU staff and was subsequently promulgated within the unit. During the introductory phase, a pilot project of patient diary was implemented. Nine subjects were recruited based on the inclusion criteria as: being able to read Chinese and communicable, and preferably obstetric or gynecological patients with a relative shorter ICU length of stay (usually within 1 to 7 days). Survivors of post cardiac arrest and trauma who had higher chance of developing PTSD were included as well. The use of patient diary was explained to all nursing staff. Nurses were educated to record patients' remarkable events during their stay in ICU. Wordings should be simple, personalized with medical jargons avoided. The entries of events should be brief and easily understandable. Nurses, doctors, physiotherapists, occupational therapists, dietitians and even patient's family members were encouraged to write some words on the solicitude part of the diary. The diary was given to the patient or his/her family members upon discharge from the ICU. Photo taking was optional and performed with the patient's agreement.

Full implementation
In September 2018, the use of patient diary was extended to all patients. Blank diaries with patient's names are made available at patient's folders on the second day of ICU admission. Primary nurses and case nurses are responsible to enter the significant events such as intubation and ambulation the first time…etc. All ICU staff are invited to make diary entries. Family members and staff are also welcomed to write encouraging words. Upon patient discharge, the respective diaries will be given to them that serves as a "gift and blessing".

Encouraging Feedback

An increasing number of thank you cards and letters were received, which included those with the implementation of the patient diary.

The Way Forward

Patient diary is a simple and caring act in promoting ICU patients' psychological wellness. It is challenging to measure and analyze the project outcomes as the feedback is currently in qualitative format. Several follow-up actions should be performed for project improvement. Firstly, a satisfaction rating scale could be developed for outcome evaluation. For instance, the scale subjects could be used immediate to patient discharge from ICU and comparing with a time at post-discharge follow-up to evaluate the acceptability of patient diary. Moreover, qualitative feedback such as feelings in reading the diary, and the most appropriate content and area for improvement could be obtained through in-depth interviews. By understanding patients' concern, the diary could be refined in accordance to their needs and maximizing the therapeutic effect.

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Evidence-based Practice of Nursing Care for Critically Ill Patients to Minimize the Risk of Exposure Keratopathy: 2-year Experience in the ICU of United Christian Hospital

HUI Chi Ming, RN
Intensive Care Unit
United Christian Hospital

Introduction

A paralyzed or semi-comatose patient on mechanical ventilation carries multiple risk factors to develop exposure keratopathy. A randomized controlled study in Hong Kong identified the prophylactic effect of polyethylene covers in preventing exposure keratopathy of the mechanically ventilated and critically ill patient (So et al., 2008). Base on the results of this study, evidence-based practice (EBP) of eye care has been applied to minimize the risk of exposure keratopathy.


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Objectives

The objective is to minimize the risk of exposure keratopathy through the implementation of an EBP eye care intervention for mechanically ventilated patient in the ICU of United Christian Hospital (UCH).

Methods

The EBP of eye care has been implemented when referred by the case nurse since June 2016 in UCH ICU, targeting ventilated patients on neuro-muscular blocking agent (NMBA), on prone position ventilation, with impaired eyelid closure, or being semi-comatose with incomplete eyelids closure. A survey over 2 years was conducted to assess and evaluate the clinical outcomes after implementation. Five identical briefing sessions about the intervention were conducted before implementation in order to enhancing nurses' knowledge and awareness on evidence-based eye care in ICU. The briefing sessions mainly addressed how to provide nursing care using a silicone adhesive tape (6cm length x 5cm width) as the prophylactic measure to cover patient's eye. The tape assists in maintaining complete eyelids closure, and provides a barrier against tear film evaporation to prevent corneal desiccation. All patients were assessed with no sign of exposure keratopathy at the beginning, and the interventions were applied by case nurses every 8 hours. Eye assessment was performed for any signs and symptoms of exposure keratopathy with normal saline eye swabbing, and changing of the silicone adhesive tape when necessary. If signs of exposure keratopathy were detected, the patients would be further assessed by ICU doctor for the appropriate management.

Results

Of the 73 recruited patients, 47 patients (64%) were on NMBA, 10 with impaired eyelid closure, 10 were semi-comatose with incomplete eyelid closure, three were on prone position ventilation, and the remaining three were referred by an ophthalmologist. Sixty-six patients (90%) did not experience any exposure keratopathy. Seven patients (10%) developed chemosis, and two of them died within 17 hours after ICU admission because of their critically ill conditions; other three of them died after 79 – 314 hours of the eye care intervention. The average hour of implementing the evidence-based eye care intervention for each patient was 58. And the main reason to cease such eye care was discontinuation of NMBA (65%). The other reasons were death of patient (20%) due to their medical conditions, or return of blinking (15%).

Limitations

The major limitation of this survey is the small sample size, and the lack of comparison with a control group.

Conclusion

The use of polyethylene covers in preventing exposure keratopathy of the mechanically ventilated and critically ill patient clinically appears to be promising, and warrants further translational studies of a larger scale.

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Tailor Making the ICU Handover Checklist for Better Continuity of Patient Care

CHAN Y. Y.[1], CHUNG K. W.[1], FAI, L. F.[2], LAU, Y. L. E.[2], TSANG, W. M.[1]

[1] RN, Intensive Care Unit, Tseung Kwan O Hospital
[2] RN, Intensive Care Unit. Ruttonjee Hospital

Introduction

Intensive care nurses face a load of challenges every shift. Since the patients who require intensive care usually have multi-organs involvement in their disease processes, the nursing care is complex and that sufficient and relevant handover is crucial. Poor clinical handover by nurses may contribute to unwanted consequences, or even harmful events to patients. From a managerial perspective, inconsistent, insufficient, and non-specific handover of information leads to inappropriate decision making and a mismatch between patient care demands and service efficiencies (Henderson, Caplan & Daniel, 2004). According to international experiences on patient quality of care, the absence of systems, training and handover protocols increased incidents and jeopardized patient safety; and the variability of clinical handover styles, duration, and content made the handover more challenging to convey consistent content and patient information (Nasarwanji, Badir & Gurses, 2016). A standardized approach of handover was proven to simplify clinical decision-making, as well as serving as a guideline for staff (Rycroft-Malone, Fontenla, Seers & Bick, 2009). As freestyle handover is the usual practice in our unit, we are inspired to unify the handover process with an easy-to-follow checklist to assure quality, quantity, and consistency of information, in particular during the Clinical Information System (CIS) innovation period.

The Handover Checklist

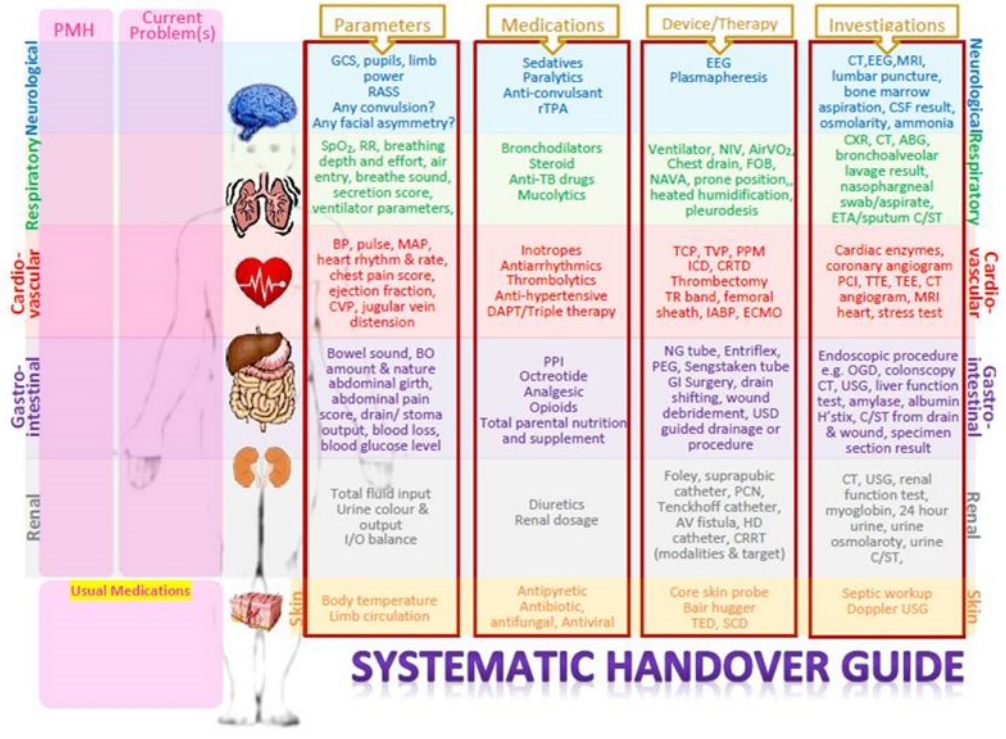
The Situation-Background-Assessment-Recommen-dation model (SBAR) is chosen as the central framework to develop our handover checklist because it is proven to promote effective exchange of information between professional; guide inform-

ation exchange with emphasis on situation facts; and lead to a more holistic process for communication by adding standardization to nurses' individualized assessment and subsequent recommendations (Stewart & Hand, 2017). The checklist starts with identifying problems; follows by gathering of background information regarding the specific problems and the relevant assessment; and subsequently assembling the recomm endations for the most appropriate targets and plans of care. Since the use of SBAR focuses on current information about the situations rather than overall background of patient's condition, we supplement a problem-oriented approach in order to assure that all the problems are addressed for the patient care. This also helps to prioritize the focuses of our nursing management.

Regarding to the problem-based approach, a Systematic Handover Guide was provided as a reference for further elaboration of each problem identified. The problems are classified into the neurological, respiratory, cardiovascular, gastrointestinal, renal, and/or dermatological system/s first. And the specific parameters, medication, device/therapy, and investigations in each system are used as hints for staff to easily gather relevant and comprehensive background information concerning the problems identified for the planning of care.

Results

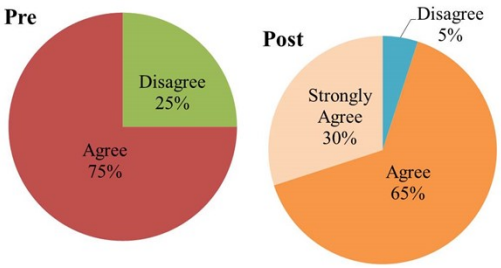
Data were collected before and after freestyle handover and the tailor-made checklist during han-



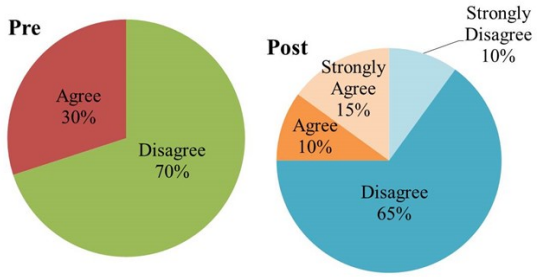
dover respectively for comparison. The questionnaire used was a modified Handover Evaluation Scale (HES) (O'Connell, Ockerby & Hawkins, 2014). Briefing sessions were conducted to all staff to introduce the project and checklist.

The result was encouraging because most of the colleagues were able to obtain more accurate, relevant, and sufficient information from handover with the tailor-made checklist. Results on the accuracy, relevancy, and sufficiency of information provided during handovers based on adherence to the checklist are illustrated as followed.

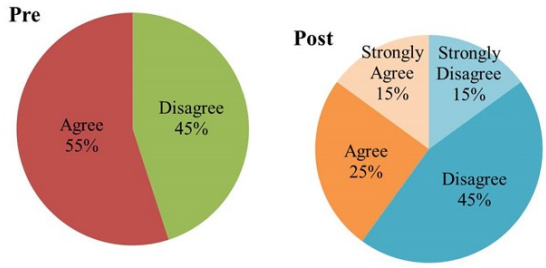
Item 11. The information that I receive is correct



Item 9. I am often given information that is not relevant to patient care.

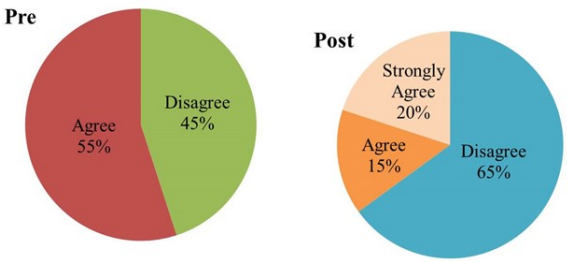


Item 15. I am provided with too much information that distracts me.

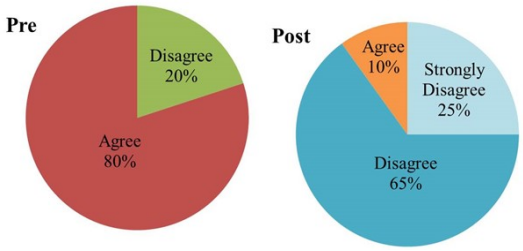


Some colleagues also expressed that they had spent less time for the overall handover process, and they did not even need to identify additional information. The time saved from more efficient handover allowed them to directly dedicate more activities of care to the patients.

Item 8. I find handover takes too much time.



Item12. I have to find out additional information about patients myself.



Psychologically, from some open-ended comments, colleagues expressed a sense of being less stressful to give handover as they were confident in presenting information with the established flow based on the use of the new checklist, and there was less missing information.

Conclusion

We found that use of the tailor-made, systematic, and problem-based checklist could enhance handover in ICU in a way that the receiving case nurses are able to obtain accurate, relevant, and sufficient information to continue the appropriate nursing care. It is promising towards the establishment of a standardized and institutionalized handover guideline for nurses working in ICU.

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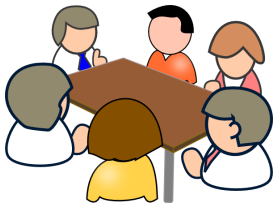

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