

NEWSLETTER

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

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Reactivating the BLS and ACLS Training in 2008

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The BLS and ACLS training programs of the HKACCN has ceased for some time because of two reasons. Firstly, our association has shifted from simply an association to a company limited; this provides our association better legal protection. Secondly, our association has spent a considerable amount of time to move under another official training centre of the American Heart Association (AHA), which covers the training needs of even bigger areas including Hong Kong, Macau and the whole China. This new partnership provides a better chance for our association to promote critical care and resuscitation techniques through training to a much larger population.

The Laerdal China has recently been designated as an official training centre under the AHA to run official BLS and ACLS programs all over Hong Kong, Macau, and China. Furthermore, it has become a partner with the HKACCN to run Life Support Programs. In November 2007, two directors (council members) of the HKACCN, David CHAN and Danny KONG, were sent to Chengdu (成都) to attend a "Training Centre Faculty (TC Faculty)" training program specifically organized for China. This training was a joint program between the Ministry of Health (China), Chinese Medical Association and the AHA. It was the first of its kind in our country. Both of them are now certified TC Faculty who are qualified with the capacity to train and certify local ACLS Instructors. We are honored to have our two directors being TC Faculties of the AHA. In the long run, this qualification will largely facilitate the development of BLS and ACLS training in Hong Kong, Macau and China.

In early 2008, HKACCN will offer BLS and ACLS provider courses again and the training will be held in Laerdal Training Center at Shatin. To celebrate our new partnership and to enable more healthcare professionals to obtain the life support qualifications, HKACCN has decided to reduce the course fee. You are very welcome to join us to achieve your provider qualifications or to be recertified. Please visit our website: <http://www.medicine.org.hk/hkaccn> for this remarkable reduct-



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ion. The 2008 BLS and ACLS training schedule will come out soon. Please keep closely an eye on our posters.

Patriots and the Professionals

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During World War I, a senior nurse in Chicago commented that, "We all possess an inborn patriotism, and that the nurse is not lacking in this is shown by the manner in which she responds to her country's call" (Hall, 1918). Clearly if Hall was still alive and for now, her statement must have included male nurses in the profession. Anyhow for patriotism, we generally think of it in time of war when a clear devotion of life for every citizen is required by the country. But our National Day in October also reminds us our patriotic spirit and thoughts. If patriotism was inborn, would there be any differences for health care professionals or nurses to actualize their patriotic attitude?

Schwirian (1998) defined profession as,

a prestigious occupation with a high degree of identification among the members that requires a lengthy and rigorous education in an intellectually demanding and theoretically based course of study; that engages in rigorous self-regulation and control; that holds authority over clients; and that puts service to society above simple self-interest (p.6).

I would argue that patriotism is compatible with the spirit of professionalism because as Schwirian put it in the last part of his definition: "and that puts service to society above self-interest" (an altruistic value is inherited in professionalism). Altruism may appear outdated in our secular society but this value actually underpins an extension of the professional "service to society above self-interest" to the national level, i.e. the devotion as a patriot to our country. There is a mission for the professionals to render service to the *country* above self-interest.

Hoffman (2006), from her careful examination of the contemporary social-economic-political contexts of China, concluded that a "patriotic professionalism" had emerged. She argued that even the recent governmental rationalities had promoted autonomous decisions of the young professionals in the free job markets, these professionals remained

framed within the notions of social responsibility and patriotism. Would our new and young professional nurses be attributed by the same value, either taught or “inborn” (perhaps through the socialization process in the life span)? With optimism, the new “3 + 3 + 4” education structure being prepared in Hong Kong should be able to cultivate more the broadening knowledge and skills for young professional nurses to become a fully responsible and rightful citizen with a patriotic attitude.

If we are patriotic as individual citizens who are ready to serve the very best for our country, being professional nurses will make no difference for this value (but only to contribute more with the specific professional knowledge and skills nurses have, at war or in peace). Nevertheless, the right attitude may be an individual attribute or the responsibility for each citizen to develop over time with good efforts and in appropriate objective circumstances. Therefore, while we are celebrating our National Day in October 2007 and thereafter, let us continue to reflect on our role as a health care professional in relation to the patriotic devotion to our country. To this end, the position of HKACCN is clear for its consistent best commitment to service the needs of critical care nursing professionals in the motherland.

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吉林之旅

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在2007年8月9日，我們應吉林大學吉林省護理學會及香港護士教育基金會的邀請，一行三人包括會長黃綺馨，麥慧玲及黃玉瓊在上午11時15分飛往北京，轉機去吉林省的長春市，在晚上7時50分到達。我們在第二天及第三天與吉林大學醫院的護士分享。吉林大學的校園及醫院遍佈在長春，佔地很大，有青翠草地，可供師生們休息。學生

人數約10萬人，每年也有多位的護士會到日本，韓國，香港及加拿大等地方學習。這二天課程包含的範圍廣泛，有ICU的基本護理，感染控制2005年的急救指引，專業發展，循証護理應用等等。他們的學習氣氛很好，會堂上下兩層共有約500位護士參與。這次講課的安排十分緊密，我們除了在會場分享外，還被安排到吉林大學四院及五院講課，好讓不能到會場的護士也能與我們有交流的機會。而我們在吉林這幾天剛巧也是他們護理技能比賽的時間，我們都看到他們忙碌及認真處事的一面。



開幕典禮中的各主禮嘉賓 (右一：宋麗華主任)



在吉林大學中的半個演講廳

兩天課程完畢後，宋麗華主任為我們安排了在市內及長白山旅遊，我們參觀了偽滿清皇宮，出產中國第一部電影的長春電影城，及第一汽車廠(第一部中國轎車生產的工廠)及長白山。長白山風景優美，遊客甚多，在不同的時段，不同的長白山地段會開放供人遊覽。雖然這次不能深入出產人參的地區，我們亦有機會購買到鮮人參，而天池的宏偉，亦儘入眼簾，可惜天池水怪在我們參觀前一天正出現過，我們沒有目睹。



長白山天池

HKACCN在2008年上半年度會去重慶分享，有興趣參與的會員可致電HKACCN(28612972)與我們聯絡。

Electrical Impedance Tomography (EIT) – a new device for respiratory monitoring in ICU

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Chairman, PDC
HKACCN

What is EIT

Electrical Impedance Tomography (EIT) is a non-invasive device designed for monitoring and quantifying the distribution of ventilation and lung volume changes during mechanical ventilation. Many studies concluded that EIT implicates the potential to emerge as a useful bedside monitoring tool (Frerichs, Dargaville, Dudykevych, & Rimensberger, 2003; Victorino et al, 2004, Hinz et al, 2005, Odenstedt, 2005). Such device is now being put on trial in one of the ICUs in Hong Kong.

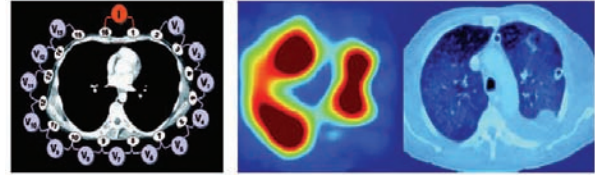
Mechanism

It is well-known that the bioelectric properties of lung tissue are affected by the air content. Therefore, any changes in lung volumes due to ventilation result in changes of the thoracic impedance (conductance of electrical impulse through the lungs). Conventionally, CXR & CT scans are used to provide regional information of the lungs. Electrical Impedance Tomography can provide functional images of the thorax with a fairly low spatial but very high temporal resolution on a breath-by-breath basis.

Equipment Set-up

To monitor thoracic impedance changes, a number of electrolytes are placed around the patient's chest wall (including anterior & posterior part of the chest). Tiny electrical currents are sent out from these electrodes through the thorax. Thoracic imp-

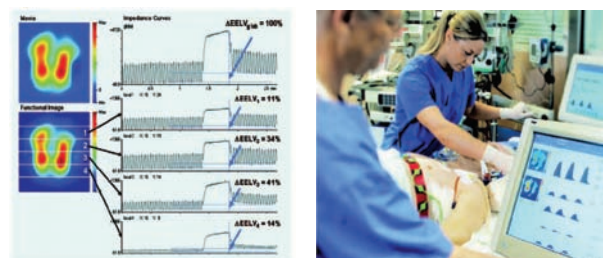
edance will differ in different regions of the lungs due to changes in lung volumes and ventilation. The resulting voltages are measured and recorded. The procedures are non-invasive and have no known hazards or adverse effects associated with it. These advantages allow EIT to serve as a continuous respiratory monitoring for ICU patients at the bedside.



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Clinical Application

By using the EIT as a respiratory monitoring device, accurate information of the regional distribution of ventilation (which largely affects capability of the lungs to exchange gases) can be detected. Therefore, EIT can be used to guide directions of many clinical and therapeutic measures, including adjustment of ventilator settings, recruitment maneuvers, optimizing PEEP settings, patient positioning, lung suctioning and thoracentesis. The EIT data can also be linked with the PV loop values from ventilator to determine regional compliance of the lungs. Regional inflection points can then be identified, and this can guide clinicians to design ventilatory strategies more precisely, with the goal of avoiding regional lung injury. Electrical Impedance Tomography can also help to determine the cause of increase in end-expiratory lung volume (EELV), whether it is due to re-opening of the collapsed lungs or over-distension. Last but not least, EIT can help to determine lung perfusion, thus providing information about the ventilation-perfusion (V/Q) matching.



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Conclusion

Despite the limitations (e.g. time required in setting up the device, and training to interpret the EIT data), EIT may help clinicians to optimize the ventilator settings more appropriately with the goal of achieving a better gaseous exchange. It may also contribute to a reduction of ventilator-induced lung injury.

* **References (available upon request)**

危重症監護病房重症病人褥瘡的發病率

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重症病人是發生褥瘡的高危族群 (Carlson, Kemp & Shott, 1999; Theaker, Mannan, Ives & Soni, 2000; Boyle & Green, 2001; Keller, Wille, Ramshorst & Werken, 2002)。預防性護理必須將重點放在減低高危族群新褥瘡的發病率，而不是所有的病患。普遍認為很多引起褥瘡的風險因素都與重症病人所患疾病的嚴重程度有密切的聯繫。Braden 評分一直被用於對褥瘡高危病人進行評估，然而有關這項評分在危重症監護病房 (ICU) 的利用和價值的研究仍然空白。

目的

1. 確定 ICU 內重症病人發生褥瘡的有效高危因素，
2. 評估 Braden 評分對重症病人褥瘡風險的預測效果，和
3. 探索當其他風險因素被控制時，Braden 評分和急性生理學和慢性健康狀態 (APACHE II) 評分系統的關係。

方法

1. 設計與方法

這是一項回顧性佇列研究。首先，羅季斯回歸分析法 (logistic regression) 被用於確定有意義的導致褥瘡的風險因素。第二步，計算一個簡單的線性回歸分析法 (simple linear regression) 研究 Braden score 是否可以用於預測褥瘡發生。最後利用皮爾遜相關性分析 (Pearson's correlation) 探索 Braden 評分和 APACHE II 評分系統的關係。

2. 研究樣本

於 2005 年 8 月至 2006 年 2 月間在 ICU 接受治療，並且滿足以下標準的病人被確

定為這項研究的研究樣本：

- 年滿 18 歲及以上的成年人
- 被 ICU 接受時沒有褥瘡
- 至少在 ICU 住院治療 72 小時

符合以下標準的病人將被排除在該項研究以：

- 在 ICU 住院治療少於 72 小時
- 確診為腦死亡和需要生命支援

這項研究已經通過九龍西聯網臨床研究倫理委員會審核。因為只有病人的住院紀錄被閱讀而不會暴露參加病人的個人身份，所以研究人員不需要取得病人的知情同意。

3. 工具

急性生理學和慢性健康狀態評分 (Acute Physiology and Chronic Health Evaluation II Score)

APACHE II 系統建立於 1985 年，一直用於重症疾病的嚴重程度和結果預測工具。上升的 APACHE II 分數反映疾病嚴重程度的加劇和醫院死亡的風險提高。

Braden Scale 評分

這項評分是美國發明用於評估褥瘡風險的工具。當由註冊護士使用這項評分的時候，它被認為是一個相當可靠的工具。

資料收集表格

資料收集表格是研究小組根據已經發表的，被確認為危重症病人發生褥瘡的必要風險因素 (Batson, Adam, Hall & Quirke, 1993; Birtuhistle, 1994; Theaker et al, 2000) 制定而成。資料收集表格用於輸入從住院紀錄裏提取的資料以便於處理和編輯。資料包括年齡、APACHE II 評分、Braden 評分、住院長度、以及住院期間的有關生理症狀和藥物使用情況。

4. 程式 (Procedures)

當研究人員取得醫院對解除病人紀錄的批准之後，開始招募符合樣本標準的研究物件。研究人員利用資料收集表格收集相關資料。根據以往的發表文獻，21 項風險因素被確定，包括年齡、ICU 住院長度數、糖尿病、高血

壓和外周血管疾病的過往史、排泄控制能力、活動能力、血管活性藥物的使用、營養狀況、白蛋白水平、血紅蛋白水平、APACHE II 評分、Braden 評分。這 21 個因素在病人進入 ICU 的首 72 小時第一次評估，然後是 ICU 住院期間的每個星期一、三、五。儘管 Braden 分數每天都會紀錄，但只有平均分數會被用於資料分析。發生褥瘡的患者會與在第一次記錄入床前的 Braden Scale 分數平均值對比。

結果

1. 褥瘡高危病人的描述性分析

這項研究共對 111 位病人進行了研究。其中男性 64 (56%)，女性 47 (42%)。年齡跨度從 20 歲至 92 歲，平均年齡 62.2 (SD = 17.4)。ICU 平均住院時間為 11 天 (SD = 10.8)，範圍由 3 到 57 天不等。23 個褥瘡發病案例佔研究期間所有樣本的 21%。褥瘡發病風險因素的特徵歸納如表 1 所示。

表 1：人口統計特徵和褥瘡發生風險因素

| 研究參與者 n = 111 | 褥瘡發生次數(%) | |
|--------------------|-------------|------------|
| | Yes: n = 23 | No: n = 88 |
| 年齡(年) | | |
| 20 - 39 | 3 (13) | 14 (15.9) |
| 40 - 59 | 6 (26.1) | 22 (25) |
| 60 - 79 | 13 (56.5) | 39 (44.3) |
| 80 - 99 | 1 (4.4) | 13 (14.8) |
| 性別 | | |
| 男 | 16 (69.6) | 48 (54.5) |
| 女 | 7 (30.4) | 40 (45.5) |
| ICU 住院長度(天) | | |
| LOS ≤ 11 (Mean) | 9 (39.1) | 66 (75) |
| LOS > 11 (Mean) | 14 (60.9) | 22 (25) |
| 過往史 | | |
| 糖尿病史 | 8 (34.8) | 17 (19.3) |
| 高血壓史 | 13 (56.5) | 34 (38.6) |
| 外周血管疾病史 | 3 (13) | 3 (3.4) |
| 吸煙史 | 3 (13) | 21 (23.9) |

表 1 (續)：人口統計特徵和褥瘡發生風險因素

| 研究參與者 n = 111 | 褥瘡發生次數(%) | |
|-----------------------|-------------|------------|
| | Yes: n = 23 | No: n = 88 |
| 排泄功能 | | |
| 大便失禁 | 9 (39.1) | 9 (10.2) |
| 小便失禁 | 0 (0) | 1 (1.1) |
| 活動能力 | | |
| 禁止翻轉 | 0 (0) | 8 (9.1) |
| 使用身體綁帶限制活動 | 11 (47.8) | 31 (35.2) |
| 血管活性藥物使用 | | |
| 去甲腎上腺素 | 15 (65.2) | 27 (30.7) |
| 腎上腺素 | 0 | 0 |
| 多巴酚丁胺 | 3 (13) | 8 (9.1) |
| 多巴酚 | 0 | 0 |
| 類固醇 | 12 (52.2) | 16 (18.2) |
| 營養狀況 | | |
| 減少營養吸收 | 6 (26.1) | 49 (55.7) |
| 白蛋白質水平 | 17 (73.9) | 6 (6.8) |
| 血紅蛋白水平 | 13 (56.5) | 10 (11.4) |
| Braden Score | | |
| 嚴重 (<= 9) | 3 (13) | 6 (6.8) |
| 高危 (10 - 12) | 11 (47.8) | 15 (17) |
| 中度 (13 - 14) | 7 (30.4) | 31 (35.2) |
| 輕微 (15 - 18) | 2 (8.7) | 33 (37.5) |
| 無 (> 18) | 0 | 3 (3.4) |
| APACHE II | | |
| APACHE II ≤ 21 (mean) | 9 (39.1) | 48 (54.5) |
| APACHE II > 21 (mean) | 14 (60.9) | 40 (45.5) |

23 例褥瘡紀錄 Braden 分數少於或等於 9 - 15。高危組病人 (分數為 10 - 12) 顯示最高的褥瘡流行率為 47.8% (11)。

這研究共紀錄 111 位元病人的 ICU 住院長度，羅季斯回歸性分析顯示住院長度是有顯著性的發生褥瘡的風險因素 (p < 0.001)。平均住院時間為 11 天。在 23 例褥瘡案例中，14 (60.9%) 例發生在住院 11 天之後。18 位元病人記錄有大便失禁，而他們褥瘡發生案有 9 例 (50%，p = 0.002，顯

示這個結果是有顯著性的，見表 2。

表 2：導致褥瘡的顯著性風險因素

| 風險因素 | 分數 | df | Sig. |
|---------------|--------|----|------|
| Braden 評分 | 12.615 | 1 | .000 |
| ICU住院 長度 | 27.766 | 1 | .000 |
| 大便失禁 | 10.024 | 1 | .002 |
| 去甲腎上腺素的 使用 | 5.239 | 1 | .022 |
| 類固醇的使用 | 13.062 | 1 | .000 |
| 低血清白蛋白 | 7.454 | 1 | .006 |
| 潮濕和排汗 | 4.184 | 1 | .041 |
| 減少營養 吸收 | 6.471 | 1 | .011 |

在 111 位病人中 105 位接受血清白蛋白水平檢查。結果表明血清白蛋白水平低於 24g/dl 是褥瘡風險的一個指示 (Theaker et al, 2000)。而血清白蛋白低於 24g/dl 的病人中褥瘡流行律為 73.9% (17)，而白蛋白高於 24g/dl 的病人中流行律祇為 6.8% (6)。

血管活性藥物 (去甲腎上腺素) 和類固醇也在預測褥瘡產生方面具有顯著性的結果。他們的流行率分別為 65.2% 和 53.3%。

濕潤和減少營養吸收都在褥瘡產生的羅季斯回歸分析中具有顯著性的風險因素。顯著性水平分別為 $p = 0.04$ 和 $p = 0.01$ 。

2. 具有顯著性的褥瘡風險因素

對於樣本發生褥瘡風險因素的研究結果顯示，以下 8 個風險因素是具有統計學顯著性的 (表 2)。

3. Braden 評分作為褥瘡的預測值之一

線性回歸方程計算成立 $F(1,109) = 14.96$ 和 $p = 0.000$ 。所以 Braden 評分在預測褥瘡產生中是具有統計學顯著性的。

4. Braden 評分和 APACHE II 評分的關係

皮爾遜相關係數計算結果為 $r(109) = -0.55$, $p <$

0.001 。而這個結果是具有顯著性的負向關係，也就是說 APACHE II 評分越高的病人所得的 Braden 評分越低 (高風險)。

結論

被研究的 ICU 裏褥瘡流行率是 21%。過往有關 ICU 病人的研究顯示出不同的褥瘡流行率的差異性，範圍為 14% 至 41% (Weststrate & Bruining, 1996; Theaker et al, 2000; Keller et al, 2002)。在本次研究中，以下的顯著性風險因素被確定為會提高褥瘡產生的可能性：Braden Scale 評分、ICU 住院長度、血清白蛋白低於 24g/dl、大便失禁、去甲腎上腺素注射、類固醇的使用、潮濕和減少營養吸收。

危重症病人的整體活動和運動能力全面受限，使得他們在床上主動更換姿勢的能力下降，從而導致皮膚接受強化壓力的風險增加。因此，長時間在 ICU 住院會使病人傾向於產生褥瘡的高風險。無論什麼原因引起的低血清白蛋白水平都會造成間質水腫而破壞向外周組織提供氧氣和營養的通道，使得外周組織對壓力和揚棄的耐受性減弱。減少營養吸收會改變身體新陳代謝。新陳代謝改變後，以喪失皮下組織的負氮平衡會使皮膚過度接觸骨突部位和影響傷口癒合。尤其多發於重大創傷、燒傷、膿毒症和大型手術術後 (Keller et al, 2002)。此類問題有被放大的可能性，因為本研究中的 ICU 是主要創傷中心負責接收所在區域的全部創傷病人。大便失禁會引起皮膚潮濕，不可避免的使皮膚的天然保護層退化從而破壞皮膚的完整性。血管活性藥物，如去甲腎上腺素會引起血管收縮，降低外周組織灌注和毛細血管血流，也會因為間質水腫的產生而進一步受損。Braden Scale 評分作為確定病人是否面對褥瘡產生風險的評估工具是本次研究裏一個強而有效的預測指數。此外，也許毫不意外的發現作為身體紊亂和慢性病健康評估工具的 APACHE II 在本研究中和 Braden Scale 的評分是有顯著相關性的 ($r = -0.55$, $p < 0.001$)。

褥瘡的產生是多種因素造成的。本次研究強調了21個風險因素，本文未提到其他因素也很重要，例如手術時間、血液過濾、膿毒症和骨骼肌鬆弛藥。因此，有必要將來進一步在不同的ICU對這項推斷進行科學性的驗證。

* **References (available upon request)**

UPCOMING PROGRAMS

ECG Course for Beginners

This ECG course is designed to help frontline nurses understand basic ECG concepts and common arrhythmias. All nurses who show interest to ECG are welcome to join this course.

Date and Time:

1, 8, 15, 22 Nov 2007 (Thur) (6:30-9:30pm)

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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 attended all the sessions and passed the quiz

Program Fee :

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

Elementary Critical Care Nursing ECCN Series Module 3 (Reno-Neuro-Trauma Care)

Date and Time:

8 Oct – 26 Nov, 2007 (8 Mondays) (6:30-8:30 pm)

Venue :

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

Speakers :

Nurse Specialists and APNs from various critical care areas

Language medium :

Both English & Cantonese

Award :

Certificate will be issued for those who attended

all the sessions and passed the quiz (16 CNE points)

Program Fee :

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

Auscultation Workshop

This workshop is designed to help improving nurses' knowledge and skills in listening patients' heart sounds and lung sounds.



Date and Time:

19 Dec 2007 (Wed) (6:30-8:30 pm)

Venue :

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

Speaker :

Dr. CHAN Wai Ming, Consultant
AICU, Queen Mary Hospital

Language medium :

Cantonese (English handouts)

Award :

Attendance certificate will be issued to those who attended the workshop (2 CNE Points)

Program Fee :

HK 600 (Member), HK 900 (Non-member)

Critical Care Endocrinology

Date and Time:

14 Nov, 2007 (Wed) (6:30-8:30pm)

Venue :

Lecture Theatre, G/F, M Block,
Queen Elizabeth Hospital

Speakers:

Dr. So Hing Yu
Director, Intensive Care Unit
Prince of Wales Hospital

Language medium :

English & Cantonese (English handouts)

Award :

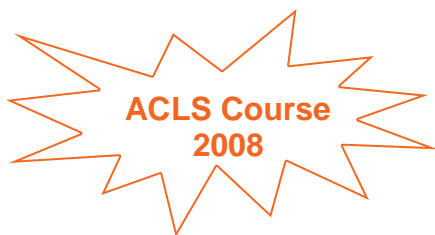
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Influencing Critical Care Nursing in Europe
Place: Florence, Italy

European federation of Critical Care Nursing associations (EfCCNa) and Italian Association of Critical Area Nurses (Aniarti)

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30 Oct - 2 Nov 2008

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Website:

<http://www.intensivecareasm.com.au/content/view/91/121/>

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ANZICS / ACCCN ASM 2007
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Website:

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

European Federation of Critical Care Nurses

(EfCCNa)

www.efccna.org

World Federation of Critical Care Nurses

(WFCCN)

www.wfccn.org

CONTRIBUTIONS TO THE NEWSLETTER

The HKACCN Newsletter is published quarterly. The editor welcomes articles reporting news and views relevant to critical care nursing. The following deadlines for submission of issues, news clips, short articles, and research briefs must be adhered to for 2006. Please email your contribution to:

Dr. Vico CHIANG at vchiang@hkucc.hku.hk

And

Mr. David CHAN at hkaccn@yahoo.com.hk

Article Preparation

Individual submission should be double-spaced and can be sent through emails. Accompanying photographs must be of good quality. The editor reserves the right to accept, modify, reject and/or check material to corroborate information.

Submission Deadlines

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