The Challenges in Development of Effective Nurse Clinics

Ms. KONG Lim Lim, Irene
Nurse Consultant (Renal)  KWC

Ms. Elaine LEUNG
Nurse Consultant (Diabetes)  HKWC

Ms. Li Miu Ling
Nurse Consultant (Urology)  NTWC

Mr. LING Wai Man
Nurse Consultant (Oncology)  HKEC

Ms. WONG Yee Man, Rebecca
Nurse Consultant (Diabetes)  NTEC
Rundown

• Presentation
  – Introduction of Nurse Clinics
  – Triage & Early Intervention: Surgical Stream
  – Triage & Early Intervention: Medical Stream
  – Service Model: Patient Empowerment
  – Service Evaluation: Quantitative
  – Service Evaluation: Qualitative

• Open Discussions

• Round Up
Introduction of Nurse Clinics

Rebecca Wong

Nurse Consultant (Diabetes)
NTEC
Key Milestones for the Development of Nurse Clinics

1990’s - Patient care clinics were run by nurses in specific areas

2000 - Implementation of Nurse Clinics & Approved Operation Guidelines for Nurse Clinics

2003 - Conducted a Consultancy Study on Examinations of Best Practice of HA Nurse Clinics

Dec 2006 - Guidelines on Accreditation on HA Nurse Clinics approved by COC(N)

May 2008 - First batch of Nurse Clinics being awarded for 5-year Accreditation
Nurse Specialist Pilot Scheme
1991
Specialized Patient Care Clinics
Key Milestones for the Development of Nurse Clinics

1990’s - Patient care clinics were run by nurses in specific areas

2000 - Implementation of Nurse Clinics & Approved Operation Guidelines for Nurse Clinics

2003 - Conducted a Consultancy Study on Examinations of Best Practice of HA Nurse Clinics

Dec 2006 – Guidelines on Accreditation on HA Nurse Clinics approved by COC(N)

May 2008 – First batch of Nurse Clinics being awarded for 5-year Accreditation
Definition

- A formalized and structured health care delivery mode
- Nurse should demonstrate advanced nursing competence
- Support by a multidisciplinary team and can make referrals
- Employment of a holistic approach
- Key interventions are nursing therapeutics
- Key outcome measures
Establishing a definition for a nurse-led clinic: structure, process, and outcome

Frances K.Y. Wong PhD RN
Professor, School of Nursing, The Hong Kong Polytechnic University, Kowloon, Hong Kong, China

Loretta C.Y. Chung PhD RN
Assistant Professor, School of Nursing, The Hong Kong Polytechnic University, Kowloon, Hong Kong, China

Accepted for publication 30 May 2005

Correspondence:
Frances K.Y. Wong,
School of Nursing,
The Hong Kong Polytechnic University,
Kowloon,
Hong Kong,
China.
E-mail: bswong@inet.polyu.edu.hk

Establishing a definition for a nurse-led clinic: structure, process, and outcome
Aim. This paper reports a study to define a nurse-led clinic by exploring the domains of structure, process and outcome.
Background. Nurse clinics have been introduced as a measure to support intermediate care after the acute phase of disease. Previous studies have been mainly des-
1990's - Patient care clinics were run by nurses in specific areas

2000 - Implementation of Nurse Clinics & Approved Operation Guidelines for Nurse Clinics

2003 - Conducted a Consultancy Study on Examinations of Best Practice of HA Nurse Clinics

Dec 2006 – Guidelines on Accreditation on HA Nurse Clinics approved by COC(N)

May 2008 – First batch of Nurse Clinics being awarded for 5-year Accreditation
Objectives

• To provide continuity of care

• To improve quality of care and clinical outcomes

• To improve access to care through advanced health assessment and service triage

• To strengthen nurse clinical leadership
Who?

• Advanced practice nurse or equivalent level or higher with advanced academic and clinical experience

• Able to diagnosis and manage most common and many chronic diseases

• Independently and/or interdependently with other health care team members for at least 80% of his/her work
Main Functions of the Nurse Clinics

• Health assessment
• Patient education and counselling
• Treatment compliance and symptoms control monitoring
• Nursing consultation to in-patients and out-patients
• Appropriate advanced nursing interventions
• Appropriate referrals and care coordination
Key Outcome Measures

- Symptoms control
- Prevention of complications
- Patient satisfaction
- Practice outcomes
Total 145 accredited nurse clinics

- HKE region → 22
- HKW region → 16
- KC region → 17
- KE region → 14
- KW region → 21
- NTE region → 33
- NTW region → 22

(* Accreditation is underway for one additional nurse clinic.*)
For more information, visit HA internet:

ha.home

→ Nurses

→ Accreditation of HA Nurse Clinics
The efficacious and effectiveness of Urology Nurse-led Triage Clinics in NTWC

Li Miu Ling
Nurse Consultant (Urology)
NTWC
Traditional Work Flow of Urology Out-Patients’ Journey in NTWC

Non-life-threatening urology problem:

1st attend to URO OPD after referral screening

Waiting time: ~6.5 years

Follow up by Urologist in 6 months or 1 year

+/- medication / investigation

Refer to urology nurse in 3 to 6 months

for behavioural therapy / CIC
Urology Nurse-led Triage Clinics in NTWC

Patients’ Referrals to Urology Out-patient clinic

- Referrals screening by Urologist

General URO clinic

- Nurse-led LUTS clinic
  - FU by Urology nurse for behavioural empowerment, +/- CIC etc.

- Nurse-led Stone Triage & Care clinic
  - Triage by Urology nurse then FU by Urologist
  - FU by Urology nurse for small stone < 4 mm

- Nurse-led Prostate Triage & Care clinic
  - Triage by Urology nurse then results reviewed by Urologist
  - Refer to Prostate clinic

- Nurse-led Andrology clinic
  - Triage by Urology nurse then FU by Urologist
  - FU by Urology nurse for effectiveness of medication

- Nurse-led Ketamine Bladder Syndrome clinic
  - FU by Urology nurse for Psychosocial counseling and progress monitoring

- Nurse-led Haematuria & Care clinic
  - Triage by Urology nurse then flexible cystoscopy by Urologist

~ 2400/6000 new referral letters screened and referred to Urology Nurse-led clinics per year since 2012

General URO clinic

- Nurse-led LUTS clinic
  - FU by Urology nurse for behavioural empowerment, +/- CIC etc.

- Nurse-led Stone Triage & Care clinic
  - Triage by Urology nurse then FU by Urologist
  - FU by Urology nurse for small stone < 4 mm

- Nurse-led Prostate Triage & Care clinic
  - Triage by Urology nurse then results reviewed by Urologist
  - Refer to Prostate clinic

- Nurse-led Andrology clinic
  - Triage by Urology nurse then FU by Urologist
  - FU by Urology nurse for effectiveness of medication

- Nurse-led Ketamine Bladder Syndrome clinic
  - FU by Urology nurse for Psychosocial counseling and progress monitoring

- Nurse-led Haematuria & Care clinic
  - Triage by Urology nurse then flexible cystoscopy by Urologist

~ 2400/6000 new referral letters screened and referred to Urology Nurse-led clinics per year since 2012
Work Flow of Patients’ Journey in LUTS

Traditional

1st Attend URO OPD after referral screening (waiting time: ~6.5 years)

Follow up Urologist: +/- medication; +/- investigation

3-6 months

Refer to nurse for Behavioural therapy

6 or 12 months

New

1st attend Nurse-led LUTS clinic (waiting time: ~6-9 months after referral screening)
   Behavioural therapy was started at 1st visit

If doubt; consult / refer to Urologist

FU in nurse clinic in 3/12; 6/12 to monitor the progress.

Patients may need to wait ~7.5 years for behavioural therapy.
Advanced Skills in Urology Nurse-led Clinics

Ultrasound machine

Urodynamic machine
Simple Non-invasive Behavioural Modification Therapy for Patients’ Empowerment Program

Components of Behavioral Treatment

- Pelvic floor Muscle training / Biofeedback / Electrode Stimulation
- Education
- Toileting / Bowel Habit programs
- Positive reinforcement
- Lifestyle Changes Fluid & Diet management
- Bladder Training with urge suppression strategies
Therapeutic Management in Urology Nurse-led Clinics

- Clean intermittent catheterization / self urethral dilatation
- Urethral catheterization
- Caverject injection
Number of Patients Attended in Nurse-led Clinics

Attendance of Urology Nurse-led clinics

2012 vs 2013

- Prostate
- Stone
- LUTS
- Ketamine
- Andrology
Incidentally abnormal finding by advanced skill in Urology Nurse-led clinics 2012/13

2 cases with severe bilateral hydronephrosis and hydroureter with urgent admission

One case with mass over LUQ detected by bedside USG with urgent admission and confirmed by CT was pancreatic tumour

One case with huge cystic lesion urgent refer to Gynae. and confirmed ovarian tumour

Urology appointment advanced

Significant hydronephrosis ~8%

? bladder mass 0.4%

Chronic Retention of Urine ~2.6%

Severe pelvic organ prolapse 0.1%

Uterine fibroid

hydronephrosis
Outcomes of Urology Nurse-led service implemented

Reduced the urology SOPD waiting time for non-life-threatening Diseases: from 6.5 years to less than one year

Reduced E-admission of AROU cases to acute surgical ward by 44% (280/632)

Decrease LOS before & after major operation by transiting patient from hospital care to clinic setting thro’ patient & relatives’ empowerment: ~ 2-5 days (post-op radical cystectomy with continent diversion)

Reduced unplanned admission and re-admission: ~ 2-4 cases/month

Decrease hospital-acquired infection e.g. CAUTI thro’ staff knowledge promotion and decrease indwelling urethral catheter by promoting CIC or SPC

Lengthen Urological cancer patients’ follow up by urologist: from every 3 months to 6 months
Pre-consultation Triage Nurse Clinic for New Diabetes Referrals

Elaine Leung

Nurse Consultant (Diabetes)
HKWC
Extend Scope of Service: Before Doctor Consultation

Early assessment & management for newly referred DM patient

Objectives:

– Incorporated risk stratification to ensure high risk patients have timely access to specialist care

– Minimize the risk of deterioration in condition while awaiting new case appointment

– A proactive response to an expected increase in service need
A Case Sharing

Inadequate information in most referrals!
Protocol Driven & Structured Program

Visit 1
- Baseline assessment
- Blood Ix
- DM education
- Infection screening
- Complication assessment
- Foot assessment
- Dietician assessment
- FU planning
  - New case
  - Admission
  - Other clinic FU
  - DM centre visit 2

Visit 2
- Review Ix results
- Assess progress
- Modification of Rx
- FU planning
  - New case
  - Admission
  - Other clinic FU
  - DM centre visit 3

Visit 3
- Assess progress
- Modification of Rx
- FU planning
  - New case
  - Admission
  - Other clinic FU
Evaluation

- Total number of cases referred: 151 (01/02/2009 – 31/7/2009)
- DM nurse waiting time: $5.39 \pm 3.14$ weeks
- Number of DM nurse visit: $2.03 \pm 1.23$ sessions
Evaluation

Adjustment of treatment

No 44%
Yes 56%

19.2 % started insulin therapy
Evaluation

Referral to other specialties

- Eye: 14%
- Eye & clinical admission: 5%
- Clinical admission: 3%
- Chest clinic (Tuberculosis): 1%
- No: 77%

Early detection and intervention of DM related complications
<table>
<thead>
<tr>
<th></th>
<th>Before Programme</th>
<th>After Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glycaemic Level</td>
<td>9.72%</td>
<td>8.16%</td>
</tr>
<tr>
<td>HbA1c Level</td>
<td>(p = &lt; 0.001)</td>
<td></td>
</tr>
</tbody>
</table>

Glycaemic Improvement
Before Doctor Consultation

After Programme
Before Programme

HbA1c Level
Pre-consultation Triage Clinic for New Diabetes Referrals

Works together with other programs, the new referral waiting time of DM clinic of QMH has been decreased

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>(in weeks)</td>
<td>31</td>
<td>25</td>
<td>17</td>
<td>18</td>
</tr>
</tbody>
</table>
Patient Empowerment Model

Irene Kong
Nurse Consultant (Renal)
KWC
**Patient Empowerment Model**

**Outcomes**
- Maximized functional capacities & physical performance and/or changes in health status
- Developed / Modified independent health-promoting behaviors
- Improved and/or maintained patients’ quality of life particularly family functioning via optimal adjustment to living with the disease
- Enhanced the acceptance of diseases.
- Improved patients’ satisfaction of care
- Improved patients’ confidence – feeling to be in control of their illness
- Reduced unplanned hospitalization.

**Patient Attributes**
- Individualized knowledge acquisition
- Receptive to education
- Active participation
- Motivation
- Adaptability
- Commitment
- Capability

**Therapeutic Nursing Interventions**

Knowledge & Skills to be transferred (individualized):
- Information giving related to treatment
- Decision-making and problem solving skills - Patient and relatives’ participation in the plan of care
- Adaptation skills: Give information to enhance patient’s compliance. Promote adaptation and rehabilitation

**Patient Education and Care**
- Symptoms control
- Prevention of complications
- Patient / family’s satisfaction of care
- Supportive counselling
- Formulate plan of care

**Patient Care Pathway**

- 3 core components of the care pathway
  1. Health improvement plan with multi-disciplinary team and patient involvement
  2. Patient education & teaching materials e.g. education class, patient teaching package CD/VCD, brochure.
  3. Patient self-management

Patient Care Pathway developed by multi-disciplinary team

3 core components of the care pathway

1. Health improvement plan with multi-disciplinary team and patient involvement
2. Patient education & teaching materials e.g. education class, patient teaching package CD/VCD, brochure
3. Patient self-management
Patient Empowerment Model

**Therapeutic Nursing Interventions**

Knowledge & Skills to be transferred (individualized):

- Information giving related to treatment
- Decision-making and problem solving skills - Patient and relatives’ participation in the plan of care
- Adaptation skills: Give information to enhance patient’s compliance. Promote adaptation and rehabilitation

**Patient Education and Care**

- Symptoms control
- Prevention of complications
- Patient / family’s satisfaction of care
- Supportive counselling
- Formulate plan of care
Patient Empowerment Model

Patient Attributes

• Individualized knowledge acquisition
• Receptive to education
• Active participation
• Motivation
• Adaptability
• Commitment
• Capability
Patient Empowerment Model

Outcomes

• Maximized functional capacities & physical performance and/or changes in health status
• Developed / Modified independent health-promoting behaviors
• Improved and / or maintained patients’ quality of life particularly family functioning via optimal adjustment to living with the disease
• Enhanced the acceptance of diseases
• Improved patients’ satisfaction of care
• Improved patients’ confidence, feeling to be in control of their illness
• Reduced unplanned hospitalization
A Randomized Study to Evaluate the Effectiveness of a Nurse Clinic Led by Nurse Consultant in High Risk Type 2 Diabetic Patients

Rebecca Wong
Nurse Consultant (Diabetes)
NTEC
Background

Public Hospitals in HK, diabetes is presented in:

• 15% of patients in medical clinics
• 30% of patients with heart disease or stroke
• 40% of patients on dialysis

Background

• Optimal control of risk factors reduced risks of micro- and macrovascular complications.
• However, the rates of attaining metabolic targets remained poor.
• < 5% type 2 DM patients were at goal for all three cardio-metabolic risk factors of blood pressures (BP) <130/80 mmHg, low density-lipoprotein cholesterol (LDL-C) <2.6 mmol/l, and glycemia (HbA1c<7%).

Hypothesis

In type 2 diabetic patients with or at high risk for cardiovascular disease receiving collaborative care (CC) led by diabetes nurse consultant and regular telephone reminders improved cardio-metabolic control and cognitive-psychological-behavioral measures compared to usual care (UC).
Study Design

Patients from Cardiac & Specialist Medical Clinic

Eligible patients randomized

Comprehensive complication assessment

Collaborative Care Protocol (CC)
- NC follow up: 5 times/year
- DR. follow up: 2 times/year
- Phone reminder: 3 times/year by HCA
- Liaise with endocrinologist if major medical problems

Usual Clinic-based Care (UC)
- Usual follow up at medical clinics
- Frequency of Dr. follow up according to their decisions
- +/- DM nurse / dietitian follow up
- Treatment targets not reinforced by protocol

Assessment at 1 year
Nurse Clinic

- Education & Counseling
- Treatment
- Health assessment & Laboratory investigation

Very high risk Patient

Health Care Assistant

Phone Reminder

Visit NC

Refer to Endocrinologist if has major Med problem

Nurse Consultant
Clinical Outcomes

Primary endpoints:

• Metabolic changes in HbA1c, Blood Pressure & Lipid

• The percentage of patients attaining the treatment targets was as defined:
  - HbA1c <7%
  - BP <130/80 mmHg
  - LDL-C <2.6 mmol/L
Clinical Outcomes

Secondary endpoints:

• Changes in body weight
• Cognitive-psychological-behavioral scores by using validated instruments
Validated Instruments

- Depression Anxiety and Stress Scale (DASS21)
- Diabetes Empowerment Scale (C-DES)
- Summary of Diabetes Self Care Activities (SDSCA)
- General Health Questionnaire (GHQ-12)
- Diabetes Knowledge scale
- Heart Disease Fact Questionnaire
Results

Patients from Cardiac & Specialist Medical Clinics
N= 242

Eligible patients randomized

Collaborative Care (CC)
N= 120

Usual Care (UC)
N=122

Death : 2
Loss to follow : 13

Death : 3
Loss to follow : 11

At completion of study
N = 106

At completion of study
N= 109
# Clinical Characteristics at Baseline of the 242 Patients

<table>
<thead>
<tr>
<th>Clinical parameters</th>
<th>Total patients (n=242)</th>
<th>Cases (n=120)</th>
<th>Control (n=122)</th>
<th>p-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>61.8 ± 9.3</td>
<td>61.8 ± 9.1</td>
<td>61.8 ± 9.5</td>
<td>0.958</td>
</tr>
<tr>
<td>Men, n (%)</td>
<td>146 (60.3)</td>
<td>68 (56.7)</td>
<td>78 (63.9)</td>
<td>0.293</td>
</tr>
<tr>
<td>Duration of DM</td>
<td>13.02 ± 8.117</td>
<td>13.0 ± 8.04</td>
<td>13.04 ± 8.225</td>
<td>0.928</td>
</tr>
<tr>
<td>BMI, kg/m2</td>
<td>25.9 ± 4.0</td>
<td>25.8 ± 3.8</td>
<td>26.0 ± 4.2</td>
<td>0.697</td>
</tr>
<tr>
<td>S BP</td>
<td>136.8 ± 18.5</td>
<td>138 ± 18.4</td>
<td>135.5 ± 18.6</td>
<td>0.296</td>
</tr>
<tr>
<td>D BP</td>
<td>77.4 ± 10</td>
<td>78 ± 10</td>
<td>77 ± 9.8</td>
<td>0.360</td>
</tr>
<tr>
<td>Fasting blood Sugar</td>
<td>9.6 ± 3</td>
<td>9.5 ± 3.3</td>
<td>9.7 ± 2.7</td>
<td>0.560</td>
</tr>
<tr>
<td>HbA1c</td>
<td><strong>9.3 ± 1.4</strong></td>
<td><strong>9.5 ± 1.5</strong></td>
<td><strong>9.1±1.1</strong></td>
<td><strong>0.026</strong></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>4.6 ± 1.1</td>
<td>4.7 ± 1.2</td>
<td>4.6 ± 1</td>
<td>0.389</td>
</tr>
<tr>
<td>HDL</td>
<td>1.1±0.3</td>
<td>1.1±0.3</td>
<td>1.1±0.3</td>
<td>0.944</td>
</tr>
<tr>
<td>LDL</td>
<td>2.5 ± 0.9</td>
<td>2.5 ± 0.9</td>
<td>2.5 ± 0.9</td>
<td>0.991</td>
</tr>
<tr>
<td>Triglyceride</td>
<td>2.2±1.8</td>
<td>2.3 ± 2.1</td>
<td>2.1±1.4</td>
<td>0.588</td>
</tr>
</tbody>
</table>
**Clinical Characteristics at Baseline of the 242 Patients**

<table>
<thead>
<tr>
<th></th>
<th>Total n=242</th>
<th>CC n=120</th>
<th>UC n=122</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insulin Therapy</strong></td>
<td>114 (47.11%)</td>
<td>62 (51.67%)</td>
<td>52 (42.62%)</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td>33 (13.64%)</td>
<td>17 (14.17%)</td>
<td>16 (13.11%)</td>
</tr>
<tr>
<td><strong>CHD</strong></td>
<td>72 (29.75%)</td>
<td>30 (25%)</td>
<td>42 (34.43%)</td>
</tr>
<tr>
<td><strong>MI</strong></td>
<td>24 (9.92%)</td>
<td>12 (10%)</td>
<td>12 (9.84%)</td>
</tr>
<tr>
<td><strong>Cardiac failure</strong></td>
<td>22 (9.09%)</td>
<td>11 (9.17%)</td>
<td>11 (9.02%)</td>
</tr>
<tr>
<td><strong>Coronary Intervention</strong></td>
<td>61 (25.21%)</td>
<td>23 (19.17%)</td>
<td>38 (31.15%)</td>
</tr>
<tr>
<td><strong>Renal impairment</strong></td>
<td>131 (54.13)</td>
<td>61 (46.56%)</td>
<td>70 (53.44%)</td>
</tr>
<tr>
<td><strong>Renal failure</strong></td>
<td>20 (8.27%)</td>
<td>10 (8.33%)</td>
<td>10 (8.20%)</td>
</tr>
<tr>
<td><strong>DM retinopathy</strong></td>
<td>36 (14.88%)</td>
<td>24 (18.33%)</td>
<td>14 (11.48%)</td>
</tr>
<tr>
<td><strong>LEA</strong></td>
<td>1 (0.41%)</td>
<td>0</td>
<td>1 (0.82%)</td>
</tr>
</tbody>
</table>
### Results between Collaborative Care (CC) & Usual Care (UC)

<table>
<thead>
<tr>
<th></th>
<th><strong>CC</strong></th>
<th><strong>UC</strong></th>
<th>Absolute difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>At completion</td>
<td>P value</td>
</tr>
<tr>
<td><strong>HbA1c (%)</strong></td>
<td>9.5 ± 1.5</td>
<td>7.9 ± 1.1</td>
<td>0.05</td>
</tr>
<tr>
<td><strong>SBP (mmHg)</strong></td>
<td>138 ± 18.4</td>
<td>135.2 ± 17.5</td>
<td>0.16</td>
</tr>
<tr>
<td><strong>LDL-C (mmol/L)</strong></td>
<td>2.5 ± 0.9</td>
<td>2.2 ± 0.7</td>
<td>0.05</td>
</tr>
</tbody>
</table>
Comparing at least 1% Reduction of HbA1c

Comparing at least 1% reduction of HbA1C from baseline between the two groups

CC group: 60%
UC group: 40%
Comparing Percentage of Patients’ HbA1c <7%

% patients’ HbA1C <7% between the two groups

- CC group: 20%
- UC group: 16%
The Change of HbA1c from Baseline between 2 Groups

-16 -14 -12 -10 -8 -6 -4 -2 0

(month3) (month6) (month9) (month12)

% reduction in A1c compared to baseline

CC group

UC group

* p<0.05
The Improvement of ABC Targets and Percentage Change Compare to Baseline in 2 Groups

* * p<0.05

minimal reduction in risk factors

A= HbA1c, B= Blood pressure, C = LDL-C
Comparing BW Reduction

Comparing % patients' BW reduction (<3%)

CC group: 16%
UC group: 6%
Results of Diabetic Knowledge and Level of Self Efficacy at Completion of Study

* $p < 0.05$
Summary of Results

- Greater improvement in ABC and body weight control
- Better knowledge in disease, efficacy and self care
- Decrease of anxiety level in CC group than UC group
Enhancement of Self Management/Empowerment of Patient: Qualitative Evaluation

Ling Wai-man
Nurse Consultant (Oncology)
HKEC
A Case Sharing

- Mr. Y, M/71, inoperable cholangiocarcinoma, for palliative chemotherapy.
- Accompanied by his wife & 2 daughters for the 1st Chemotherapy Nurse Clinic consultation.
- Everything alright except 5% drop in BW in 10 days.
Ask & Listen

• Patient had reduced his oral intake by half deliberately since knowing the diagnosis of cancer.

• His believes:
  “Good nutrition will nourish the cancer”
  “Diet control can starve the cancer to death”
Information Sharing

• Shared correct information using both the perspectives of Western & Chinese Medicine.
• At last, he agreed, & showed the willingness to follow my new suggestions.
• Thereafter, no more self starvation. BW showed a steady increase.
Key Points to Success

• Be sensitive
• Give time to listen & to understand patient’s value & belief
• Have good communication skills, including being culturally sensitive & relevant
• Give the correct information as appropriate

Respect & rapport → Successful empowerment → Behavioural change
Chemo Nurse Clinic (PYNEH)

- Help the cancer patients / family to effectively manage the potential treatment side effects & cope with the psychosocial stress.
- By means of high sensitivity, good communication skills & accurate information giving.

“High Touch”
**Patient Satisfaction Survey - 2013**

- **Mean score in the empowerment item:**

  - Trastuzumab Group: [Bar Chart]
  - Gemcitabine Group: [Bar Chart]
  - Capecitabine Group: [Bar Chart]

- **Written comments:**

  “每位護士對本人的關顧, 令我充滿勇氣去接受和完成整個療程”

  (The care by every nurse has given me the courage to accept and complete my whole course of treatment)
The Challenges in Development of Effective Nurse Clinics

Open Discussions