香港護士管理局
The Nursing Council of Hong Kong

優良護理實務指引

Guides to Good Nursing Practice

2017 年 9 月修訂
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序言

為提供與護理專業有關的當代道德及主要關注事宜，及作為優良護理實務的指引，香港護士管理局（下稱「管理局」）於 2006 至 2008 年間首次出版以八項護理程序為專題的一系列《優良護理實務指引》（下稱「《指引》」）。

其後，管理局於 2017 年更新上述《指引》的內容，並加入有關臨牀督導的《指引》。截至 2017 年 9 月，管理局共出版以下指引：

(1) 臨牀督導
(2) 促進健康
(3) 健康評估
(4) 感染控制
(5) 施用藥物
(6) 知情同意
(7) 身體約束
(8) 晚期照顧
(9) 護理記錄

《指引》提出各專題的定義，重點指出相關專題的關注點，提供優良護理實務行為的準則，及列出護士的責任。各專題的《指引》涵蓋序言、原則和護士的責任，以協助護士運用其專業知識及判斷，務求令服務對象獲得最大利益。

《指引》摘要出有關專題的一般性原則去達至優良護理實務。《指引》不可能詳盡無遺包含護士可能遇到的所有情況，亦不旨在就護士執行相關護理職責時可能出現的各種事宜或問題提供處理方法。然而，本《指引》會作為管理局在考慮紀律個案時的參考文件。

Guides to Good Nursing Practice

Preamble

To provide nurses with contemporary ethical issues and major concerns in relation to the profession, and serve as the guidelines to good nursing practices, the Nursing Council of Hong Kong ("the Council") first published a series of "Guides to Good Nursing Practice" ("the Guides") on eight domains between 2006 and 2008.

Subsequently, the Council updated the content of the Guides and devised the Guides on Clinical Supervision in 2017. As at September 2017, the Council has published the following guides:

(1) Clinical Supervision;
(2) Health Promotion;
(3) Health Assessment;
(4) Infection Control;
(5) Administration of Medication;
(6) Informed Consent;
(7) Physical Restraint;
(8) End-of-life Care; and
(9) Nursing Documentation.

The Guides aim to give definitions of issues, highlight the related concerns, provide the criteria to good practice and list out the responsibilities of the nurse. The Guides contain the Preamble, Principles and Responsibilities of a Nurse for each domain to assist nurses in the application of professional expertise and judgement in the best interest of their clients.

They outline the broad principles to guide good nursing practice. The Guides are by no means exhaustive or covering every situation that nurses may encounter, and do not deal with all possible issues that may arise during the course of the relevant nursing practice. However, the Guides serve as a reference document for the Council in considering disciplinary cases.

Nurses should provide the nursing care and perform their duties based on the clinical assessment of individual client and their professional clinical judgement. To respond to the changing needs of patients and the public in Hong Kong, and the development in medical science and technology, nurses should continuously update their nursing knowledge and skill.

The Council will review the Guides from time to time with a view to updating the content and adding new domains as and when appropriate by making reference to international practices, local peer opinion and development of the profession, legal requirements, public expectations and moral obligations. Nurses are recommended to visit the Council's website at www.nchk.org.hk regularly for the Council's latest publications and guidelines for nurses.

護士應按個別服務對象的臨牀評估及其專業臨牀判斷提供護理及執行其職務。為回應病人及社會不斷轉變的需要及醫療科技的發展，護士亦應持續進修其護理知識及技能。

管理局將不時參考國際慣例、本地同業意見及護理專業的發展、法律規定、公眾期望及道德原則，檢討《指引》的內容，並適時更新有關內容及增加新的專題。管理局建議護士定期瀏覽管理局網頁 www.nchk.org.hk 閱覽管理局最新出版的刊物及指引。

香港護士管理局專業發展委員會制定

優良護理實務指引
臨牀督導

序言

臨牀督導是一個正規的專業支援及學習程序，以確保安全及有責任的護理實踐。它涉及督導員和被督導者之間的合作關係。一般而言，督導者是一位合資格的護士（以下稱為「護士督導員」），而被督導者是一位正被督導的護士，但不限於：正接受護理課程（例如登記或註冊前護理課程）的護士學生，或一位新合資格的護士。本指引目的是建立與臨牀督導相關的原則，當中不擬詳列護士督導員可能遇到的所有情況。更確切地說，本指引旨在協助護士督導員提供安全及有效的護理服務。

相關機構應提供一個內部系統，包括但不限於支持實施臨牀督導的相關指引。

原則

以優良的實務方式進行臨牀督導，護士督導員宜：

1. 適時提供適當的督導以致被督導的護士能安全和有效地提供護理服務；
2. 確保及改善標準和質素，以達致服務使用者的需求；
3. 接受並承擔自己個人的責任；以及
4. 實踐終身學習，以提升知識及能力，加強個人和專業成長。

護士的責任

1. *了解本地政策、指引和實務守則*
   護士督導員應遵守本地／相關機構有關臨牀督導的指引、程序和規則，並確保遵從建議的程序。

2. *在提供臨牀督導之前評估被督導者的資格、需要和能力*
   在提供臨牀督導之前，護士督導員應同時評估被督導者的需要以及醫療情況。此外，亦應評估環境是否有利於執行臨牀督導。護士督導員應在委派職務之前查核和確認被督導者的能力。

Guide to Good Nursing Practice
Clinical Supervision

Preamble

Clinical supervision is a formal process of professional support and learning to ensure safe and accountable practice in nursing. It involves partnership between a supervisor and a supervisee. In general, the supervisor is a qualified nurse (hereafter known as nurse-supervisor) while the supervisee is a nurse being supervised including, but not limited to, a nurse learner undergoing a nursing programme (e.g. pre-enrollment/ pre-registration) or a newly qualified nurse. The purpose of this Guide is to establish principles relating to clinical supervision. It is not intended to cover every situation that nurse-supervisors may encounter. Rather, the Guide sets out principles to assist nurse-supervisors in providing safe and effective nursing care/service delivery.

Organisation should provide a local system including, but not limited to, the relevant guidelines to support the implementation of clinical supervision.

Principles

For good practice in clinical supervision, the nurse-supervisor is advised to:

1. provide appropriate and timely supervision to enable supervisee deliver safe and effective nursing care / service delivery;
2. ensure and improve standard and quality in meeting service users' needs;
3. assume and accept responsibility for his/her own practice; and
4. enable lifelong learning to enhance knowledge and competence for personal and professional growth.

Responsibilities of the nurse

1. *Understanding local policies, guidelines and clinical practices*
   A nurse-supervisor should follow local guidelines, procedures and protocols on clinical supervision and ensure that the recommended procedures are adhered.

2. *Assessing supervisee's competence, needs and ability before providing clinical supervision*
   A nurse-supervisor should assess the needs of the supervisee as well as that of the health care situation before providing clinical supervision. In addition, the conduciveness of the environment for conducting clinical supervision should also be assessed. The nurse-supervisor should check and determine supervisee's competence before assigning responsibilities.

3. *適當地提供臨牀督導*

護士督導員應在確認被督導者的專業知識、需要和能力後，才將職務委派給被督導者，並提供臨牀督導。護士督導員應支援被督導者，並使他／她的臨牀技巧和專業實踐得以達致服務使用者的需求。同樣，護士督導員應在臨牀督導中為被督導者提供心理及實務性的支援。此外，護士督導員應建立一個安全，並具有可與被督導者建立信任及有建設性之雙向溝通的督導環境。護士督導員應根據服務使用者的潛在風險評估保持緊密督導，以防止被督導者進行不安全的行為。

4. *評估及正確記錄被督導者的進展*

護士督導員應監察和評估被督導者的表現，並根據被督導者的進度和共同目標，提供適時的反映和適當的跟進。護士督導員亦應準確記錄被督導者的進度和學習結果。

5. *報告被督導者的表現*

護士督導員應把被督導者的表現報告給予合適的人員。特別對於表現不理想的被督導者，該報告應包括補救行動及跟進工作。

6. *保持臨牀督導的專業知識和技巧*

護士督導員應該維持其專業知識，並鼓勵被督導者維持他們的專業知識。此外，護士督導員亦應該保持他／她在臨牀督導實踐上的技巧。

7. *確保被督導者的理解和遵循*

護士督導員應提醒被督導者積極提高自己的能力，在任何時候均確保服務對象的安全。護士督導員亦應鼓勵及支持被督導者主動接觸相關護士督導員作臨牀督導，在需要時尋求支援和建議，並在有任何疑問時尋求說明。

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3. *Providing clinical supervision appropriately*

A nurse-supervisor should only assign responsibilities to supervisee and provide clinical supervision after confirming supervisee's competence, needs and ability. The nurse-supervisor should support the supervisee in developing his/her clinical skills and professional practice in response to service user needs. In clinical supervision, psychological and practical support to the supervisee should be provided by the nurse-supervisor. In addition, the nurse-supervisor should establish a safe supervisory environment where trust is maintained and a constructive two-way feedback process is practiced with the supervisee. Based on the assessed potential risk to client, the nurse-supervisor should maintain close supervision to prevent supervisee from performing unsafe practice.

4. *Evaluating supervisee's progress with proper documentation*

A nurse-supervisor should monitor and evaluate supervisee's performance and provide timely feedback and appropriate follow-up according to the supervisee's progress and agreed targets. The nurse-supervisor should also maintain accurate documentation and records of the supervisee's progress and learning outcomes.

5. *Reporting supervisee's performance*

A nurse-supervisor should report supervisee's performance to the appropriate party. In particular, for supervisee with suboptimal performance, the report should also include remedial actions and follow-up.

6. *Upkeeping professional knowledge and skills of clinical supervision*

A nurse-supervisor should upkeep his/her professional knowledge and encourage supervisee to do the same. In addition, the nurse-supervisor should upkeep his/her skills and practice of clinical supervision.

7. *Ensuring supervisee's understanding and compliance*

A nurse-supervisor should remind supervisee to enhance his/her own practice and ensure the safety of the client at all times. The nurse-supervisor should encourage and support supervisee to proactively approach the relevant supervisor for clinical supervision, ask for help and advice whenever necessary, and seek clarification whenever in doubt.

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優良護理實務指引
促進健康

序言

健康指「身心和社交方面均在完好狀態，而並非單指沒有患病或身體並不虛弱」。健康是讓人在個人層面活得充實、在社會及經濟層面展現生產力的資源。此外，健康也是基本人權(世界衞生組織，2016 年)。然而，個人、家庭、社羣和整體市民的健康取決於多種因素，包括居所、食物、教育、社會保障、衞生與社會服務、收入、就業和對人權的尊重程度。人們應享有獲取服務和資源的機會、資訊和權利，以便增強控制這些影響健康的因素的能力，藉實際行動鞏固自己和家人的健康。促進健康和預防疾病的活動是維持和改善個人、家庭、羣體和社羣健康的重要一環。護士既屬醫護團隊中主要的一員，在推動促進健康及相關活動方面，他們更要擔當重要角色。

促進健康的工作是一項進程，可增強人們控制各種影響健康的因素的能力，從而改善健康。為使促進健康的行動得以持續，各方的參與尤為重要。

促進健康的目標可藉下列三個基本策略來達成：

1. 倡導：締造健康所需的必要條件；
2. 增強能力：增強全民的能力，協助他們達到最佳健康狀態；以及
3. 平衡：平衡社會各方在追求健康方面不同的關注點。

推行上述策略有賴下列五大優先行動範疇的推展：

1. 制訂與健康有關的公共政策；
2. 締造有利健康的環境；
3. 加強促進健康的社區行動；
4. 發展個人促進健康的技能；以及
5. 調整健康服務的發展方向。

[《渥太華憲章》(1986 年)]

因此，促進健康的工作不僅涵蓋旨在加強個人技能的行動，也涵蓋指向改善社會、環境和經濟狀況的行動，從而促進公眾和個人健康。此外，促進

Guide to Good Nursing Practice
Health Promotion

Preamble

Health is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity". It is a resource that permits people to lead an individually, socially and economically productive life. Moreover, it is a fundamental human right (World Health Organization, 2016). Nevertheless, the health of an individual, a family, a community and a population-at-large is determined by many factors, including shelter, food, education, social security, health and social services, income, employment and respect for human rights. People should be given opportunities, knowledge and access to services and resources so that they are enabled to have better control over these health determinants and to build their own health as well as the health of their families by their own actions. Central to the maintenance or improvement of health of individuals, families, groups and communities are health promotion and disease prevention activities. As a key member of the healthcare team, a nurse has an important role to play in health promotion and related activities.

Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion actions.

Health promotion is to be achieved through three basic strategies:

1. advocacy - to create essential conditions for health;
2. enabling - to enable all people to achieve their full health potentials; and
3. mediating - to mediate between the different interests in society in the pursuit of health.

These strategies are to be supported by five priority action areas:

1. build healthy public policy;
2. create supportive environments for health;
3. strengthen community actions for health;
4. develop personal skills; and
5. re-orient health services.

[Ottawa Charter (1986)]

Hence, health promotion embraces not only actions directed at strengthening the skills and capabilities of individuals, but also those directed towards changing social, environmental and economic conditions so as to influence public and individual health. It encompasses political and social interventions designed to change policies and services as well as to promote social responsibility for health.

健康的工作也包括對政治和社會狀況作出干預，以完善相關政策及服務，並加強社會對健康的承擔。

原則

為以優良的實務方式推行促進健康的工作，護士宜：

1. 在不同醫護環境和社會中，把促進健康納入整體護理實務工作的一部分；
2. 通過賦權，促使個人、家庭和社區建立所需能力，以便更能控制各項決定健康的因素；
3. 與其他專業和界別合作，促進社區健康；
4. 評估促進健康的活動的成效，致力精益求精；
5. 參與並協助發展以實證為本的促進健康的工作；以及
6. 倡導個人、家庭和社區健康，並參與制訂促進全民健康的公共健康政策。

護士的責任

1. *評估健康需要以促進健康*

   護士應評估服務對象的健康需要，為他們提供資訊及指導，以助他們在人生各個階段改善健康和照顧自己，並應付急性或慢性疾病和傷患。

2. *提升促進健康方面的能力*

   護士應持續進修，以提升有關促進健康工作的專門技能。護士在推行這方面工作時，也應採取多種不同策略，協助服務對象增強能力，從而掌握個人健康，並選擇健康的生活方式。

3. *在跨界別合作中擔當主要角色*

   護理界認同跨界別合作有助推行促進健康的工作，因此在不同環境工作的護士均應與相關各方通力合作，推行促進健康的策略。

4. *應對多種影響健康的因素*

   護士在多個不同場所(包括學校、工作間、醫院和社區)和社會層面，均在促進健康方面擔當重要角色。護士藉加強服務對象對各種影響健康因素的認識，以及指導他們明白自己有責任控制這些因素，可協助排除促進健康方面的障礙。

Principles

For good practice in health promotion, a nurse is advised to:

1. incorporate health promotion as an integral part of nursing practice in different health care settings and the community;
2. facilitate and empower individuals, families and communities to increase control over the determinants of health through capacity building strategies;
3. collaborate with other disciplines and sectors to promote the health of the community;
4. evaluate the outcome of health promotion activities and pursue continuous improvement;
5. participate in and contribute to the development of evidence-based practice in health promotion; and
6. advocate individuals, families and communities, and contribute to the formulation of public health policies for promoting health of the population-at-large.

Responsibilities of a nurse

1. *Assessing health needs for health promotion*

   A nurse should assess the health needs of individuals and provide them with information and education, so as to enable them to promote health and assume self-care at different stages of their lives and to cope with acute/chronic illnesses and injuries.

2. *Building capacity in health promotion*

   A nurse should acquire specialised skills and competence in health promotion through continuous learning and adopt various health promotion strategies that help individuals to build capacity in controlling their own health and in making healthy life choices.

3. *Acting as a key player in intersectoral collaboration*

   Nurses working in diverse settings should contribute to the implementation of health promotion strategies in partnership with other interested parties, as the nursing sector acknowledges that intersectoral collaboration may contribute to health promotion.

4. *Tackling multiple health determinants*

   A nurse has an important role to play in promoting health in a wide range of settings, including schools, workplaces, hospitals and local communities, as well as at the broad societal level. By raising the awareness of individuals of the various changing determinants of health and their responsibilities in controlling them, a nurse may help remove obstacles to health promotion.

5. *評估促進健康的活動的成效*
護士應在促進健康的活動的初步策劃階段制訂策略，以便按適當情況評估活動的成效和健康效益，這方面對日後持續改進相關活動十分重要。

6. *為個人、家庭和社羣進行倡導工作*
護士應提倡社區發展和社會參與，並爭取修改公共及社會政策，以促進全民健康。

7. *掌握有關促進健康的最新知識*
護士應透過不同途徑，例如參與研究有關促進健康的資訊及計劃的項目，發放研究結果的消息，為實證為本的實務工作發展建立科研資料庫，藉此掌握有關促進健康的最新知識。

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5. *Evaluating health promotion activities*
A nurse should include strategies in his/her initial planning for health promotion activities for evaluation of their effectiveness and health outcome as appropriate. This is important for the continuous improvement of future activities.

6. *Advocating for individuals, families and communities*
A nurse should advocate community development and social involvement and lobby for changes in public and social policies conducive to promoting the health of the population-at-large.

7. *Upkeeping knowledge of health promotion*
A nurse should upkeep his/her knowledge of health promotion by such ways as conducting research on both health promotion information and programmes and disseminating research findings to build a scientific database for the development of evidence-based practice.

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優良護理實務指引
健康評估

序言

健康評估是一項有系統、審慎和互動的工作，護士在過程中運用批判性思維來蒐集資料，並加以核實、分析和整合，以判斷服務對象本身以及其家屬的健康狀況和成長歷程，以及對社區的影響。健康評估可以鑑定服務對象本身現在和將來的護理需要。護士應根據健康評估的資料從而按優次提供恰當的護理程序。準確而深入的健康評估可反映出護士的專業知識和技能。

原則

為以優良的實務方式進行健康評估，護士宜：

1. 在所有醫護環境就服務對象的護理方案和介入治療，及時進行準確的健康評估；
2. 考慮服務對象的生理、心理、社交及靈性健康、文化及環境因素，以及其服務對象的成長狀況；
3. 就服務對象的健康狀況及對健康問題和介入治療的反應，進行資料蒐集、記錄和評估；
4. 把健康評估所得的資料與其他醫護人員溝通，以協力為服務對象提供治療和持續護理；以及
5. 確保服務對象的資料保密。

護士的責任

1. *了解本地有關健康評估的政策和實務守則*

   護士應遵守本地有關健康評估的政策和實務守則，在進行健康評估前必先取得服務對象同意。

2. *進行全面和合適的健康評估*

   護士負責為其職責範圍內對每名服務對象進行健康評估。護士應因應服務對象的需要定期進行重點評估，並隨時準備進行進階重點健康評估。

Guide to Good Nursing Practice
Health Assessment

Preamble

Health assessment is a systematic, deliberative and interactive process in which a nurse employs critical thinking to collect, validate, analyse and synthesise the collected information in order to make judgment about the health status and life processes of a client as well as his/her family members and communities. It can be used to identify the current and future client care needs. The nurse should prioritize appropriate intervention according to the health assessment information. An accurate and thorough health assessment also reflects the knowledge and skills of a professional nurse.

Principles

For good practice in health assessment, a nurse is advised to:

1. conduct accurate and timely health assessment for nursing care and intervention on the client in all healthcare settings;
2. take into account the client's physical, psychosocial, social and spiritual health, cultural and environmental factors as well as the client's developmental status;
3. carry out data collection, documentation and evaluation of the client's health status and responses to health problems and interventions;
4. communicate information collected from health assessment to other healthcare professionals for collaborative management of the client and continuity of care; and
5. keep client's confidentiality.

Responsibilities of a nurse

1. *Understanding local policies and practices on health assessment*

   A nurse should follow local policies and practices on health assessment and obtain the client's consent prior to health assessment.

2. *Conducting comprehensive and appropriate health assessment*

   A nurse is responsible for carrying out health assessment on every client under his/her care. A nurse should regularly conduct focused assessment in response to the client's needs and prepare himself/herself to conduct advanced and focused health assessment.

3. *確保健康評估的資料準確無誤*
為蒐集服務對象的資料，會採用多種技巧和方法，例如查詢病歷、進行體格檢驗，以及翻查服務對象的病歷記錄和診斷測試結果。護士應根據所得的資料加以推論，從而作出適當和可靠的臨牀判斷。

4. *記錄健康評估的資料*
護士應記錄健康評估結果、分析所得的資料、評估服務對象對健康問題和介入治療的反應，以及按適當情況向服務對象提供意見。

5. *建立跨專業溝通渠道*
護士應藉健康評估來鑑定服務對象的問題，並與其他專業醫護人員溝通，以協力為服務對象提供治療和持續護理。

6. *確保健康評估的資料保密*
護士應採取適當的貯存和保管措施，保障服務對象的私隱，以及確保健康評估的資料安全保密。

7. *掌握最新的健康評估知識*
護士應增進有關健康評估的專門知識、技巧和能力，並在進行健康評估時，照顧、尊重和關懷每名服務對象。護士也應在其護理職業生涯中不斷提升為服務對象的健康評估能力。

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3. *Ensuring accuracy of health assessment information*
Various techniques and tools, such as history taking, physical examination, reviewing the client's records and diagnostic test results, are used to obtain the client's information. A nurse should draw inferences from the data collected in order to make appropriate and sound clinical judgment.

4. *Documenting health assessment information*
A nurse should document the results of health assessment, analyse the data collected, evaluate the client's responses to health problems and interventions, and provide feedback to the client as appropriate.

5. *Establishing interdisciplinary communication channel*
A nurse should identify the client's problems through health assessment and communicate with other healthcare professionals for collaborative management of the client and continuity of care.

6. *Keeping confidentiality of health assessment information*
A nurse should safeguard the privacy, security and confidentiality of assessment information through appropriate storage and custody measures.

7. *Upkeeping knowledge of health assessment*
A nurse should acquire specialised knowledge, skills and competence in health assessment and demonstrate care, respect and concern for each client when conducting health assessment. A nurse should also continuously advance his/her competence in health assessment throughout his/her nursing career.

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優良護理實務指引
感染控制

序言

儘管科學與醫學昌明，取得重大發展，但疾病感染依然是主要的公共衞生議題。傳染病使人們的患病率大大增加，因此減低整體市民的生產力、增加醫療成本，以及降低個別市民的生活質素。

醫院感染控制工作始於 1800 年代中期，當時，塞麥爾維斯(Semmelweis)和南丁格爾(Nightingale)初次在醫院推行環境衞生和個人衞生管理措施。2003 年 3 月，嚴重急性呼吸系統綜合症爆發，出現了威脅性命的感染病例，事件凸顯了衞生當局有需要在所有醫護環境推行有效的感染控制措施，以及加強醫護人員這方面工作的能力。1980 年代中期，耐藥性金黃葡萄球菌爆發引起公眾廣泛關注，自此以後，感染控制成為本港一門正式學科。

醫護環境感染，不論出現在家居、日間醫療機構、院舍還是醫院的護理環境，也是現代醫學一項重大考驗。醫護環境感染不但引致高昂的醫療費用，也延長病人的留醫時間和增加死亡率。感染防控工作是為病人提供安全護理環境的基本要素，也是所有在不同臨牀環境工作的醫護人員的要務。感染防控措施旨在保障高危人士免在社區和醫護環境受到感染，而保持個人衞生則是感染防控的基本原則。

護士既身為前線護理人員，也就是執行感染防控工作的理想人選，而這方面的工作是優質護理服務的重要一環。

原則

為以優良的實務方式執行感染控制工作，護士宜：

1. 治療感染症狀，以清除感染源頭，並進行消毒程序，以保持環境和設備衞生；
2. 遵從妥當的潔手和消毒程序，並採取適當的隔離措施，以防傳染病蔓延；以及
3. 確保攝取足夠營養，並按需要服用預防性抗生素或接種疫苗，以增強身體抵抗力。

Guide to Good Nursing Practice
Infection Control

Preamble

Despite significant advances in science and medicine, infection still remains a major public health issue. Infectious diseases significantly increase the morbidity of individuals, thereby decreasing the productivity of the population, increasing healthcare costs and adversely affecting the quality of life of individuals.

The field of hospital infection control started in the middle of the 1800s when Semmelweis and Nightingale introduced sanitation and hygienic practices to hospitals. The emergence of life-threatening infections during the outbreak of Severe Acute Respiratory Syndrome ("SARS") in March 2003 has highlighted the need for implementing effective infection control measures in all healthcare settings and capacity building for healthcare workers. Infection control has become a formal discipline in Hong Kong since mid-1980s because of public concern over the methicillin-resistant *Staphylococcus aureus* ("MRSA") outbreak.

Healthcare-associated infections ("HAIs"), whether acquired during home, ambulatory, institutional or hospital care, constitute one of the greatest challenges of modern medicine. HAIs have shown to be expensive as they extend clients' stay and increase mortality. The prevention and control of infection is fundamental to the provision of a safe environment for clients and forms an integral part of the practice of all healthcare workers in any clinical setting. Infection prevention and control measures are aimed at protecting vulnerable individuals from acquiring an infection in the community and various healthcare settings. Hygiene is the basic principle of infection prevention and control.

Nurses, as frontline caregivers, are ideally placed to practise infection prevention and control which is an integral part of quality client care.

Principles

For good practice in infection control, a nurse is advised to:

1. remove sources of infection by treating infection symptoms and carry out decontamination procedures to maintain the hygiene of the environment and equipment;
2. prevent transmission of infections by adopting proper hand hygiene practices, aseptic procedures and appropriate isolation precautions; and
3. enhance body resistance by ensuring adequate nutrition as well as receiving appropriate antibiotic prophylaxis or vaccination.

護士的責任

1. *了解本地有關感染控制的政策和實務守則*
   護士應了解和遵守本地有關感染控制的政策和實務守則。

2. *評估感染風險*
   護士在不同工作環境提供護理服務時，均應評估傳染病蔓延的潛在或實際風險。

3. *減低感染傳播風險*
   護士應採取所需措施，減低服務對象、自己和相關各方受感染的風險，這些措施包括：
   a) 備存自己最新的防疫注射記錄；
   b) 在提供護理服務時採取適當的預防措施；
   c) 遵從適用的潔手指引／常規程序；
   d) 使用合適的個人防護裝備；
   e) 在服務對象、自己或相關各方暴露於感染風險時，作出匯報、採取介入措施和提供適當護理；以及
   f) 及時為受感染的服務對象提供適當的檢查、治療及護理。

4. *監察和匯報感染防控實務守則的執行情況*
   護士應按照當前的通報機制，呈報出現集體症狀但不屬傳染病的異常情況。為有效預防感染，護士應與相關方面協力監測感染防控情況，以及監察相關人員有否遵從感染控制政策和實務守則。

5. *為服務對象提供指導*
   護士應就個人及環境衞生和感染防控措施，為服務對象及其家屬提供指導。

6. *使感染防控措施維持高水平*
   護士應主動識別適當資源，使感染防控措施維持高水平。

7. *掌握有關感染控制的最新知識*
   護士應掌握有關感染防控措施的最新知識。

Responsibilities of a nurse

1. *Understanding local policies and practices on infection control*
   A nurse should understand and comply with local policies and practices on infection control.

2. *Assessing risk of infection*
   A nurse should assess the risk of potential or actual transmission of infectious diseases during care delivery in all settings.

3. *Reducing risk of infection transmission*
   A nurse should take necessary actions to reduce the risk of clients, himself/herself and relevant parties of contracting infection. These include:
   a) keeping an updated immunisation record of himself/herself;
   b) adopting appropriate precautions during caring practices;
   c) adhering to appropriate hand hygiene guidelines/protocols;
   d) using appropriate personal protective equipment;
   e) reporting, intervening and providing appropriate care when clients, himself/herself or relevant parties are exposed to risk of infection; and
   f) providing the infected clients with timely and appropriate investigation, treatment and care.

4. *Monitoring and reporting infection control and prevention practices*
   A nurse should report abnormal clustering of symptoms other than infectious diseases in accordance with the prevailing reporting system. To effectively prevent infections, nurses should collaborate with relevant parties in surveillance for prevention and control of infection and monitor the compliance of infection control policies and practices.

5. *Providing education to clients*
   A nurse should educate clients and their family members about personal and environmental hygiene as well as prevention and control of infection.

6. *Upkeeping standards of infection prevention and control measures*
   A nurse should proactively identify appropriate resources to upkeep the standards of infection prevention and control measures.

7. *Upkeeping knowledge of infection control*
   A nurse should upkeep his/her knowledge of infection prevention and control.

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優良護理實務指引
施用藥物

序言

藥物是為診斷、治療、紓緩症狀或預防疾病而施用的物質。施用藥物的程序複雜，過程涵蓋初步評估和給予藥物，以至蒐集重要資料供日後評估服務對象的反應、適當記錄，以及在有需要時與醫護團隊成員溝通以作跟進。本指引旨在就施用藥物制訂相關原則，當中不擬詳列護士可能遇到的所有情況，而只會載列各項原則，協助護士運用專業知識，作出專業判斷，以保障服務對象的最佳利益。

原則

為以優良的實務方式施用藥物，護士宜：

1. 確保在所有工作環境均以安全和有效的方式施用藥物；以及
2. 因應實際情況作出專業判斷和運用所需知識及技能。

護士的責任

1. *了解本地有關施用藥物的政策和實務守則*

   護士應遵守本地有關施用藥物的政策、程序和常規，並確保藥物由適當並獲授權的人士處方。

2. *在施用藥物前評估病人狀況*

   護士應按病人已知的藥物過敏資料複查獲處方的藥物，並了解有關藥物的療效、劑量、副作用、注意事項和禁忌。此外，護士也應按照病人目前的臨牀狀況，考慮是否適宜為他／她施用有關藥物。

3. *為病人正確施用藥物*

   護士應先核實病人身分，並在確保藥物正確，用藥劑量、時間和途徑一切無誤後，才為病人施用藥物。護士如在病人用藥過程中有任何懷疑，應暫停施用藥物，並採取適當的跟進行動。

4. *確保妥善使用用藥裝置和棄置剩餘的藥物及裝置*

   護士應了解用藥裝置的操作方法，以及使用該等裝置可能出現失誤所致的風險。護士也應確保妥善棄置剩餘的藥物及裝置。

Guide to Good Nursing Practice
Administration of Medication

Preamble

A medication is a substance administered for the diagnosis, treatment, mitigation or prevention of diseases. Administration of medication is a complex process from the initial assessment and administration of medication to the collection of essential information for subsequent evaluation of client's responses, appropriate documentation and follow-up communication with the healthcare team as necessary. The purpose of this Guide is to establish principles in respect of the administration of medication. It is not intended to cover every situation that nurses may encounter, but instead, it sets out principles to assist nurses in the application of professional expertise and judgement in the best interests of their clients.

Principles

For good practice in administration of medication, a nurse is advised to:

1. ensure the safe and effective administration of medication in all practice settings; and
2. exercise professional judgement and apply necessary knowledge and skills in the context of the situation.

Responsibilities of a nurse

1. *Understanding local policies and practices on administration of medication*

   A nurse should follow local policies, procedures and protocols on administration of medication and ensure that the medication is prescribed by the appropriate authority.

2. *Assessing client's conditions before administering medication*

   A nurse should check the prescribed medication against the client's known allergies and understand the therapeutic uses, dosage, side effects, precautions and contraindications of the medication. In addition, a nurse should consider the appropriateness of administering the medication having regard to the client's current clinical conditions.

3. *Administering medication to clients correctly*

   A nurse should only administer the medication after confirming the client's identity and ensuring that it is the right medication administered at the right dose, at the right time and in the right route. If a nurse has any doubt during the course of medication administration, he/she should withhold the medication and take appropriate follow-up actions.

4. *Ensuring proper use of medication administration devices and disposal of residual medication and devices*

   A nurse should understand the way of using medication administration devices and the risk of possible errors arising from the use of such devices. A nurse should also ensure that residual medication and devices are disposed of properly.

5. *評估病人進展並作妥善記錄*
護士應觀察藥物對病人的療效和副作用、提供合適的護理，以及備存準確的文件記錄。

6. *依照本地政策及相關條例確保恰當處理和保管藥物*
護士應確保恰當處理和保管藥物。至於危險藥物，應依照香港法例第 134 章《危險藥物條例》的規定處理和施用。

7. *為病人及其照顧者提供指導*
護士應視乎需要，指導病人及／或其照顧者認識所施用的藥物和用藥裝置的正確操作方法。

8. *匯報藥物事故*
護士應記錄藥物事故和不良藥物反應，並向其督導人員作出相應匯報。

9. *掌握最新的藥物知識*
護士應掌握最新的藥物知識。

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5. *Evaluating client's progress with proper documentation*
A nurse should observe the therapeutic effects and side-effects of the medication experienced by the client. A nurse should also provide appropriate nursing care and maintain accurate documentation and records.

6. *Ensuring proper handling and safe custody of medication in accordance with local policies and relevant ordinances*
A nurse should ensure proper handling and safe custody of medication. For dangerous drugs, they should be handled and administered to the client in accordance with the Dangerous Drugs Ordinance, Chapter 134 of the Laws of Hong Kong.

7. *Educating the client and his/her caregivers*
A nurse should educate the client and/or his/her caregivers about the medication administered and the proper operation of the medication administration devices as necessary.

8. *Reporting medication incidents*
A nurse should document medication incidents and adverse medication reactions and report them to his/her supervisor accordingly.

9. *Upkeeping knowledge of medication*
A nurse should upkeep his/her knowledge of contemporary medication.

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優良護理實務指引
知情同意

序言

徵求知情同意是醫護團隊成員與服務對象之間溝通的過程，最終徵得服務對象授權或同意進行特定的介入措施／治療程序，並非單單請服務對象簽署同意書。

尊重每名服務對象按照個人意願作出決定的權利，是護士應遵守的基本道德原則，而在法律上，每名服務對象也有權決定其身體在治療過程中可以和不可以接受哪些程序。因此，護士在提供護理或進行治療程序時，在法律和道德上均有責任徵得服務對象的知情同意。未徵得同意而提供護理或進行治療，可能構成民事或刑事法律責任。

原則

在徵求服務對象的知情同意時，護士宜：

1. 尊重服務對象有權就如何管理自己的健康作出決定；
2. 確定服務對象在精神上是否有能力給予同意；
3. 及時為服務對象提供充足而適當的資料；
4. 確保服務對象在自願和不受威迫的情況下給予同意；
5. 尊重服務對象有權隨時拒絕給予同意或撤回已給予的同意；
6. 注意如符合服務對象或公眾的最佳利益，在下列情況下，可未徵得同意而進行醫學檢查／治療：
   6.1 根據普通法為服務對象(例如失去知覺的成人或尚有知覺但沒有能力給予同意的人士)提供緊急治療；以及
7. 知悉妥善備存記錄是整個徵得同意過程的重要一環。

護士的責任

1. *了解本地有關知情同意的政策、實務守則和法定要求*
   護士應遵守本地有關徵求知情同意的政策、實務守則和法定要求。

Guide to Good Nursing Practice
Informed Consent

Preamble

Obtaining an informed consent is a process of communication between a client and a member of the healthcare team that results in the client's authorisation or agreement to undergo a specific intervention/procedure. It is more than simply getting a client to sign a consent form.

Respecting the right of every client to self-determination is a basic ethical principle that every nurse should observe. It is also a legal right of every client to decide what can and cannot be done to his/her own body in the treatment process. Therefore, when providing nursing care or treatment, a nurse has legal and ethical obligations to obtain an informed consent from the client. Care or treatment without consent may amount to civil or criminal liability.

Principles

In obtaining an informed consent from the client, a nurse is advised to:

1. respect the client's right to make decisions about the management of his/her own health;
2. determine the client's mental competency to give consent;
3. provide sufficient information for the client in a timely and appropriate manner;
4. ensure that the client gives the consent voluntarily and is not under any duress;
5. respect the client's right to refuse or withdraw the consent to treatment anytime;
6. be aware that medical examination/treatment may be done without consent under the following situation if it is in the best interests of the client or the public:
   6.1 provision of emergency treatment under the common laws on, for example, an unconscious adult client or a conscious client who is incapable of giving consent; and
7. understand that proper documentation is an integral part of the whole consent process.

Responsibilities of a nurse

1. *Understanding local policies, practices and statutory requirements on informed consent*
   A nurse should follow local policies, practices and statutory requirements in obtaining an informed consent.

2. *提供適切資料以徵求知情同意*

護士應就下列各項提供充足而適切服務對象情況的資料，以徵求知情同意：

- 服務對象病況的性質；
- 介入／治療程序的詳情、效益、潛在風險和併發症；
- 在建議的介入／治療程序以外其他可行的替代方案；以及
- 不進行介入／治療程序可引致的後果。

3. *採用適當形式的知情同意*

3.1 默示同意

護士可單憑服務對象願意前來接受介入／治療程序並在過程中表現合作這點，視病人默示同意接受治療。該等介入／治療程序包括量度體溫、檢查、觸診、叩診和聽診等簡單的程序以至抽血這類入侵性程序。

3.2 書面同意

如上述具體資料顯示服務對象須接受若干需予特別關注的治療／介入程序，而考慮到程序的複雜程度、風險或後果，護士應先徵求服務對象給予書面同意或確認其書面同意有效，其後護士或臨牀專業人員(例如醫生)方可進行該等程序。該等情況包括：

- 複雜的治療／介入程序；
- 高風險的治療／介入程序；
- 治療／介入程序可能對服務對象的就業、社交生活或個人生活帶來嚴重後果；或
- 服務對象須接受其他附加程序，例如輸血。

4. *保持有效溝通*

護士身為醫護團隊的成員，應按照服務對象的需要和意願提供所需資料。護士在作出說明時，應使用服務對象能理解的語言，並鼓勵病人及其親屬表達各種感受，坦然說出心中憂慮、恐懼、憤怒和焦慮。護士身為服務對象的代言者，應確保服務對象有足夠時間考慮選擇接受哪項治療。護士應利用資料單張(如有的話)，為服務對象提供個別治療程序的資料。資料單張應定期更新，並註明資料來源和修訂日期。

2. *Providing specific information to obtain informed consent*

A nurse should provide adequate information specific to the client as follows for obtaining an informed consent:

- the nature of the client's medical conditions;
- the description, benefits, possible risks and complications of the intervention/ procedure;
- the available alternatives to the proposed intervention/procedure; and
- the likely consequences if the intervention/procedure is not carried out.

3. *Adopting the appropriate type of informed consent*

3.1 Implied consent

A nurse may accept it as an indication of implied consent to an intervention/a procedure based on the mere fact that the client presents himself/herself to the nurse and cooperates in going through the intervention/procedure. The intervention/procedure may vary from simple ones, such as temperature taking, inspection, palpation, percussion and auscultation, to invasive ones, such as blood taking.

3.2 Written consent

A nurse should obtain a written consent or ensure the validity of the written consent before he/she or the clinical professional, such as doctor, carries out certain treatments/interventions which require particular attention due to their complexity, risks or consequences based on the aforesaid specific information. Such situations include those where:

- the treatment/intervention is complex;
- the treatment/intervention poses significant risks;
- the treatment/intervention might have significant consequences on the client's employment, social life or personal life; or
- the client has to receive other additional procedures, such as blood transfusion.

4. *Maintaining effective communication*

A nurse, as a member of the healthcare team, should provide information according to the client's needs and preferences. A nurse should explain by using a language that the client can understand and encourage the client and his/her relatives to express feelings and to talk about concerns, fear, anger and anxiety. As the client's advocate, a nurse should ensure that adequate time is given for the client to consider the choice of treatment. A nurse should use a fact sheet, where available, to provide information on particular procedures to the client. The fact sheet should be updated regularly and marked with sources and revision date.

5. *在徵求知情同意的過程中擔任見證人*

護士可自行擔任或請他人擔任見證人，而見證人須參與整個徵求知情同意過程，由作出說明起至簽署同意書止。見證人無須就醫護人員所提供的資料承擔法律責任，但須在有關人員徵得服務對象知情同意和服務對象簽署同意書的同時，於同意書上簽署。並非所有治療程序均須有見證人，惟在某些情況下(例如治療／程序甚為複雜或涉及重大風險)安排見證人參與徵求知情同意的過程，是優良的實務方式。

6. *記錄徵求同意的過程*

護士應妥善記錄徵求同意的過程，這是整個同意過程的重要一環。須予記錄的資料包括：

6.1 介入程序的適應症；
6.2 介入程序的說明；
6.3 不進行介入程序可引致什麼後果的說明；
6.4 進行介入程序後的計劃；
6.5 潛在風險；以及
6.6 服務對象對有關說明的回應。

7. *尊重服務對象有權拒絕給予同意或撤回已給予的同意*

護士應尊重服務對象有權隨時以任何理由，拒絕給予同意或撤回已給予的同意。護士在該等情況下，應記錄服務對象的決定。

8. *徵求未成年人士的知情同意*

給予同意是不受年齡限制的。18 歲以下的未成年人士如能完全明白建議的治療／介入程序，理解其後果、可能帶來的效益和潛在風險，也可給予同意。然而，在未成年人士給予同意時，宜讓家長參與有關過程，除非此舉不符合該名未成年人士的最佳利益，則作別論。如未成年人士沒有能力給予同意或沒有監護人，承擔家長責任的人士可給予同意。

9. *徵求精神上無行為能力人士的知情同意*

護士為精神上無行為能力的人士提供治療時，應參考香港法例第 136 章《精神健康條例》第 IVC 部的規定、釐清監護權狀況，以及在有需要時徵詢監護委員會的意見，以保障服務對象的利益。

5. *Acting as a witness of informed consent*

A nurse may act as a witness or engage a person to be a witness who has to engage in the entire process of informed consent, from the explanation-giving to the signing of the consent form. The witness has no legal responsibility for the information given but should sign the consent form at the same time as the person who obtains the informed consent and the client who signs the consent form. A witness is not mandatory for all procedures. However, it is a good practice to have a witness present in the process of obtaining informed consent when, for example, the treatment/procedure is complex or involves significant risks.

6. *Documenting the consent process*

A nurse must properly document the process of obtaining the consent, which is an integral part of the whole consent process. Information to be documented includes:

6.1 indication(s) of intervention;
6.2 explanation of the intervention/procedures and available alternatives;
6.3 explanation of the consequences if the intervention is not carried out;
6.4 post-intervention plan;
6.5 potential risks; and
6.6 the client's response to the explanation.

7. *Respecting the right to refuse or withdraw consent*

A nurse should respect the right of the client to refuse or withdraw the consent given at any time and on any ground and should document the decision of the client under such situations.

8. *Obtaining informed consent from minors*

A minor under 18 years of age can give a consent if he/she is able to fully understand the proposed treatment/intervention as well as its consequences, possible benefits and risks. Nevertheless, parental involvement is suggested when a minor gives a consent, unless it is not in the minor's best interests to do so. A person with parental responsibility may give a consent if a minor lacks the capacity or is not under guardianship.

9. *Obtaining informed consent from mentally incapacitated clients*

In providing treatment for a mentally incapacitated client, a nurse should make references to Part IVC of the Mental Health Ordinance, Chapter 136 of the Laws of Hong Kong, clarify the guardianship status and consult, if necessary, the Guardianship Board to protect the client's interests.

10. 掌握最新的知情同意知識

護士應掌握最新的知情同意知識。

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10. Upkeeping knowledge of informed consent

A nurse should upkeep his/her knowledge of informed consent.

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優良護理實務指引
身體約束

序言

身體約束泛指使用附加或貼近個人身體而不能輕易移除的裝置，用以減低該人隨意移動身體部位及／或正常接觸自己身體。我們得承認，當所有約束程度較低的處理方法均未能收效，有時最後不得已要使用約束物品，以防出現身體受傷的即時危險或保障服務對象或他人的安全。本指引旨在就護理實務工作中如何以安全和專業的方式使用約束物品，以及在使用約束物品時如何保障服務對象的最佳利益等方面提供參考。

原則

為以優良的實務方式使用身體約束，護士宜：

1. 盡量減少使用身體約束，並只在一切可行辦法均已用盡但未能收效的情況下，最後不得已才使用身體約束；
2. 使用約束程度最低的物品，並盡量縮短使用時間，以達到上文序言中所述的目的；
3. 為保障服務對象或他人的安全和福祉，並在符合他們最佳利益的情況下，才考慮使用身體約束；
4. 在決定使用身體約束前，考慮及遵從任職機構所制定的相關政策和指引；
5. 考慮道德方面的事宜，確保有實際需要使用身體約束，受約束服務對象的安全、舒適和尊嚴得以維持，以及其生理和心理社交需要均已獲得照顧；
6. 如建議使用約束物品，事先應告知服務對象及／或其家屬或監護人有關使用身體約束的需要、風險和好處，並在使用有關物品後，如適用，在合理可行範圍內盡快為他們進行事後講解；以及
7. 妥善記錄有關使用約束物品的資料，以供存檔和查核之用。

護士的責任

1. *了解本地有關約束物品的政策和實務守則*

   護士應遵守本地有關身體約束的政策和實務守則，並留意有關的權力依據。護士可徵詢醫護團隊其他成員的專業意見，以作有關決定的參考。

Guide to Good Nursing Practice
Physical Restraint

Preamble

Physical restraint refers to the use of any device attached to or adjacent to a person's body that cannot be easily removed by the person, and deliberately restricts a person's freedom of movement and/or prevents a person's normal access to his or her body. It is acknowledged that physical restraint would sometimes be necessary as a last resort to prevent imminent danger of physical harm or protect the safety of the client or others when less restrictive options of treatment have failed. This Guide serves as a reference on the safe and professional use of physical restraint in nursing practice as well as the ways to protect the best interests of the client in the application of physical restraint.

Principles

For good practice in using physical restraint, a nurse is advised to:

1. minimise the application of physical restraint and only use it as a last resort after all viable alternatives have been explored and have failed in the circumstances;
2. apply the least restrictive form of physical restraint over the shortest duration to achieve the purposes as mentioned in the preamble above;
3. consider physical restraint only for the sake of safety and well-being and when it is in the best interests of the client or others;
4. take account of legal considerations with regard to the source of authority of applying physical restraint and observe the policies and guidelines set out by the institution in which he/she is practising before making any decision on applying physical restraint;
5. take account of ethical considerations and ensure that there is a genuine need to apply physical restraint; the safety, comfort and dignity of the client on the restraint are maintained; and his/her physical and psychosocial needs are catered for;
6. inform the client and/or his/her family members or guardian of the needs, risks and benefits of physical restraint before the proposed application. After application, conduct a debriefing if indicated as soon as reasonably practicable; and
7. make proper documentation on the use of physical restraint for record and inspection purposes.

Responsibilities of a Nurse

1. *Understanding local policies and practices on physical restraint*

   A nurse should follow local policies and practices on physical restraint and be aware of the source of authority. Expertise from other healthcare team members may be solicited as a reference to the decision.

2. *在使用身體約束前評估服務對象的狀況*

護士應評估是否有需要對服務對象使用身體約束。只有在服務對象或他人的安全和福祉受到威脅，而其他約束程度較低的可行辦法均已考慮或採用過但證實不足以應付有關情況、未能收效或不宜使用，在最後不得已的情況下，才使用身體約束。護士可考慮加強看守和監察、減少感官刺激、主動聆聽、協助服務對象以適當渠道轉化焦慮行為、應用鬆弛技術，以及允許親友陪伴等不同措施，這些都可能替代身體約束。此外，護士在使用身體約束前，應向能勝任的員工尋求所需協助，以保障相關各方(包括服務對象)的安全。

3. *建立溝通渠道*

護士在建議使用約束物品前，應告知服務對象及／或其家屬有關使用身體約束的需要、風險和好處；而在使用身體約束時，應向服務對象解釋使用原因和嘗試取得對方合作。護士在使用身體約束後，如適用，在合理可行範圍內盡快為服務對象及其家屬和員工進行事後解說。

4. *就使用身體約束作妥善記錄*

護士應使用合理、適當和約束程度最低的裝置來約束服務對象，並妥善繫穩有關裝置，以確保服務對象安全舒適。在使用身體約束時，應注意服務對象脆弱的身體部位。護士須具充分理據，才可使用適當力量及／或對服務對象的活動自由作適當限制。

護士應把受約束的服務對象安置在易於觀察的地方，並確保服務對象免受公眾注目，除非此安排並不切實可行，則作別論。護士在使用身體約束期間，應按服務對象的狀況，定時照顧其生理、心理和社交需要。護士應記錄有關使用身體約束的資料，包括但不限於使用原因，開始使用、隨後覆檢和移除約束的日期和時間，約束物品的種類，服務對象的狀況，所採取的預防措施，以及相關的觀察所得。

5. *盡量減少使用身體約束*

護士應探討可有其他介入程序、實務方法和替代措施，以盡量減少使用身體約束。此等方案包括全面評估服務對象的狀況、覆檢所提供的護理、改善護理環境、指導員工，以及與家屬和其他醫護專業人員加強合作等。

2. *Assessing client's conditions before application of physical restraint*

A nurse should assess the need to apply physical restraint. It should only be applied when the safety and well-being of the client or others is being threatened and as a last resort when other less restrictive viable alternatives have been considered, tried or proved to be insufficient, ineffective or inappropriate. Various potential alternative measures can be considered, such as additional supervision and observation, decreased sensory stimulation, active listening, appropriate outlets for anxious behaviour, relaxation techniques, companionship of a family member or friend, etc. Furthermore, a nurse should seek necessary assistance from competent staff before carrying out the restraint procedure to ensure the safety of all involved parties, including the client.

3. *Establishing communication channel*

A nurse should communicate with the client and/or his/her family members regarding the needs, risks and benefits of the proposed use of physical restraint prior to application, explain to the client the reason for applying physical restraint and attempt to enlist his/her cooperation when it is applied. If physical restraint is used, a nurse should debrief the client, his/her family members and staff as soon as reasonably practicable after application.

4. *Applying physical restraint with proper documentation*

A nurse should apply reasonable, appropriate and the least restrictive device to restrain the client. The device should be secured in a proper manner to ensure the client's safety and comfort. While restraining, a nurse should pay attention to the client's fragile body parts. Any force used and/or any restriction of the client's freedom of movement must be justifiable and appropriate.

A nurse should also arrange for the client under physical restraint to stay at a place which is easily observable and ensure that he/she is protected from public exposure unless it is not practicable or feasible to do so. A nurse should attend to the client's physical and psychosocial needs during restraint at regular intervals according to his/her conditions.

A nurse should document information on the use of physical restraint including, but not limited to, reasons for restraining; date and time of initial application, subsequent reviews and removal; type of restraint; the client's conditions; precautions taken; and related observations.

5. *Minimising the use of physical restraint*

A nurse should explore other interventions, practices and alternatives to minimise the use of physical restraint, such as comprehensive assessment of the client, review of the care provided, modification of the environment, education of staff, collaboration with family members and other healthcare professionals, etc.

6. *評估服務對象的進展*

護士應對受約束的服務對象進行密切和定期的觀察，尤須注意其安全、舒適度、尊嚴、私隱，以及身體和精神狀況。護士應定期或按照所屬機構既定的政策，覆檢身體約束的使用情況，並在覆檢結果顯示服務對象的狀況有所改善後，考慮盡早停用身體約束。

7. *掌握最新的身體約束知識*

護士應增進和掌握最新的身體約束知識和技能。

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6. *Evaluating client's progress*

A nurse should maintain close and regular observation of the client under physical restraint with particular attention to his/her safety, comfort, dignity, privacy as well as physical and mental conditions. A nurse should review the use of the restraint regularly or according to institutional policies and consider the earliest possible time to discontinue the use of the restraint once the conditions of the client have improved in the reviews.

7. *Upkeeping knowledge of physical restraint*

A nurse should acquire and upkeep knowledge and skills in contemporary physical restraint.

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優良護理實務指引
晚期照顧

序言

死亡是人生必經階段。對於病情屬於晚期、逐漸惡化或無法治癒且預期將於數天或數月內離世的病人，在醫護機構或社區為他們提供晚期照顧，是護理服務當中重要的一環。護士除關顧病人的生理、心理、社交和靈性狀況外，也應考慮文化範疇的事，並盡量改善病人家居和醫護機構的護理環境，讓病人可帶着尊嚴，安然離世。

原則

為以優良的實務方式提供晚期照顧，護士宜：

1. 尊重生命，並視臨終和死亡為人生必經階段；
2. 在護理病人以外，並會關顧其家屬和摯愛的需要；
3. 按以病人為本的方針，盡量令病人感覺舒適和身心安泰，維護他／她的尊嚴；
4. 在提供護理時，顧及生理、心理、社交、靈性和文化等不同範疇；
5. 讓病人自行就護理和晚期照顧事宜作出決定；以及
6. 在病人、家屬和醫護團隊之間作出協調，確保護理服務貫徹始終。

護士的責任

1. *評估病人需要和提供護理*

   護士應評估病人的痛楚和不適程度，並採取適當行動加以紓緩。護士也應尊重病人知悉和索取有關其病況、預後效果和護理方案資料的權利，並尊重其決定。此外，護士應該明白，病人放棄接受維持生命治療的決擇建基於對護士的信任，當中必須投入時間，給予充分資訊，坦誠相向，並以同理心回應。護士應確保病人參與評估維持生命治療方案的負擔、風險、效用和好處。

2. *擔當倡導者角色並促進病人與醫護團隊溝通*

   護士應與病人維持良好關係，致力有效溝通，以便了解其需要及所選擇的治療和護理方案。護士也應擔當倡導者的角色，促進病人與醫護團隊和家人的溝通，並把病人的選擇和意願轉達醫護團隊。病人自行決定和選擇的權利應予尊重，並應盡量配合。

香港護士管理局專業發展委員會制定

Guide to Good Nursing Practice
End-of-life Care

Preamble

Dying is inevitable in life's continuum. End-of-life care is an essential element of care provided in healthcare institutions or the community for clients with advanced, progressive or incurable conditions whose life expectancy is estimated to be within days or months. In addition to providing physical, psychological, social and spiritual care, a nurse should also consider cultural aspects and optimise the caring environment in the client's home and in the healthcare setting, so as to facilitate a dignified and peaceful closure to a client's life.

Principles

For good practice in end-of-life care, a nurse is advised to:

1. respect life and regard dying and death as an integral part of life's continuum;
2. provide care for, in addition to the client, his/her family members and loved ones;
3. maximise the comfort and well-being of the client and preserve his/her dignity in a person-centred approach;
4. attend to physical, psychological, social, spiritual and cultural aspects in the provision of care;
5. enable the client to make his/her own care and end-of-life decisions; and
6. coordinate with the client, his/her family members and the healthcare team to ensure continuity of care.

Responsibilities of a nurse

1. *Assessing client's needs and providing care*

   A nurse should assess the client's pain and discomfort and take appropriate actions for alleviation. A nurse should also respect the client's right and decision to know and obtain information about his/her illness, prognosis and care options. In addition, a nurse should acknowledge that a decision to forgo life-sustaining treatment is built on trust and requires time, information, honesty and empathy. He/She should ensure that the client is involved in the evaluation of burdens, risks, efficacy and benefits of the life-sustaining treatment in question.

2. *Acting as advocate and facilitating communication with healthcare team*

   A nurse should maintain good relationship and effective communication with the client in order to understand his/her needs as well as choices in treatment and care options. A nurse should take up the role of an advocate to facilitate the client's communication with the healthcare team and his/her family members and to convey the client's choices and wishes to the healthcare team. The client's right of self-determination and choices should be respected and accommodated as far as possible.

Developed by the Professional Development Committee of
the Nursing Council of Hong Kong

3. *關顧臨終病人*

遺體處理對家人而言是莊嚴的事情。護士在處理遺體時，應尊重病人秉持的價值觀，當中須顧及不同信仰和習俗在文化和靈性範疇的差異。護士也應了解，臨終病人經歷人生最後階段，在情緒上會很受折磨。護士應協助病人及其家屬處理痛苦、哀傷和失落之情，並在有需要時轉介家屬接受專業的喪親支援服務。

4. *為同事提供支援*

護士為臨終病人提供護理服務後，應為醫護同事提供所需的支援。

5. *掌握最新的晚期照顧知識*

護士應掌握最新的晚期照顧知識。

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3. *Providing care to client at end stage of life*

Last office is a sacred family affair. When performing last office, a nurse should respect the values held by the client, taking into consideration the cultural and spiritual diversities in beliefs and customs. A nurse should appreciate that experiencing end stage of life is emotionally taxing for the client. A nurse should assist the client and his/her family members in coping with the suffering, grief and loss, and refer the family members to professional bereavement support if deemed necessary.

4. *Providing support to co-workers*

After the provision of care to the dying, a nurse should provide necessary support to co-workers.

5. *Upkeeping knowledge of end-of-life care*

A nurse should upkeep his/her knowledge of end-of-life care.

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優良護理實務指引
護理記錄

序言

護理記錄是臨牀記錄的重要部分，也是護士的基本職責。護士須按照法律規定，備存內容平衡的臨牀記錄。記錄是對所發生事情和事情發生時間的準確描述。因此，就病人的徵狀和醫護人員的觀察所得備存準確完整的記錄，是妥善診治病人的關鍵。護理記錄是說明曾為個別服務對象或某羣服務對象所提供護理或服務的手寫或電子記錄，這些記錄是不同專業的醫護人員溝通的基礎，而護士可根據護理記錄把觀察所得資料、決定、行動和護理成效告知其他醫護專業人員，以協力為病人提供協調和貫徹始終的護理服務。

原則

為以優良的實務方式備存護理記錄，護士宜：

1. 無論何時均在工作環境中遵守本地有關護理記錄的政策、程序和常規；
2. 確保護理記錄清晰、簡潔、準確、完整、客觀、容易閱讀和適時，以符合臨牀需要和法律規定；以及
3. 因應實際情況作出專業判斷和運用所需知識及技能。

護士的責任

1. *了解本地有關護理記錄的政策和實務守則*

   護士應遵守本地有關護理記錄的政策和實務守則。

2. *確保護理記錄準確及適時*

   護士應按時間順序記錄服務對象所有相關資料，註明日期和時間，並應以完整、準確、聚焦和適時的方式，匯報和記錄護理評估或觀察所得、為服務對象所提供的護理以及服務對象對護理的反應。護士也應經常為服務對象作全面而深入的記錄，特別當服務對象病情惡化、患急性疾病、屬高風險病人或有複雜的健康問題時，更應如此。

3. *對護理記錄作出妥善更正*

   如發現護理記錄需要作出更改，護士應適時修正。所有後補記項應附上備註，註明該記項的日期和時間，以及事情的實際資料。

香港護士管理局專業發展委員會制定

Guide to Good Nursing Practice
Nursing Documentation

Preamble

Nursing documentation is an integral part of clinical documentation and is a fundamental nursing responsibility. Nurses must balance clinical documentation with respect to legal imperatives. Documentation is an accurate account of what occurred and when it occurred. Therefore, an accurate and complete documentation of the client's symptoms and observations is critical to proper treatment and management. Nursing documentation is any written or electronically-generated record that describes the care or services provided to a particular client or group of clients. Documentation allows interdisciplinary communication through which nurses can share their observations, decisions, actions and outcomes of care with other healthcare professionals for coordinated, collaborative and harmonised nursing care.

Principles

For good practice in nursing documentation, a nurse is advised to:

1. follow local policies, procedures and protocols of documentation in practice settings at all times;
2. ensure clear, concise, accurate, complete, objective, legible and timely documentation to fulfil both clinical and legal imperatives; and
3. exercise professional judgment and apply necessary knowledge and skills in the context of the situation.

Responsibilities of a nurse

1. *Understanding local policies and practices on nursing documentation*

   A nurse should follow local policies and practices on nursing documentation.

2. *Ensuring accurate and timely nursing documentation*

   A nurse should document all relevant information about the client in chronological order with date and time, and should report and document nursing assessments or observations, the care provided for the client and the client's response to the care in a complete, accurate, focused and timely manner. A nurse should also carry out comprehensive, in-depth and frequent documentation, particularly when the client is deteriorating, acutely ill, of high risk or having complex health problems.

3. *Making corrections to nursing documentation properly*

   A nurse should correct any documentation error in a timely and forthright manner. Any late entry should include a remark indicating both date and time of the entry and the actual event.

Developed by the Professional Development Committee of
the Nursing Council of Hong Kong

4. *就護理記錄承擔責任*
護士應明白，他／她須就其個人為服務對象提供的護理所作的臨牀記錄負責。護士也應在臨牀記錄的每個記項和更正附上簽署，並註明所屬機構核准的職銜，以示自己該承擔責任。

5. *建立跨專業溝通渠道*
護士應把在提供護理服務期間與其他醫護人員曾交代的資料和關注事項持續記錄。

6. *把護理記錄保密*
護士應採取適當的貯存和保管措施，保障病人的私隱，以及確保臨牀記錄安全保密。

7. *掌握最新的護理記錄知識*
護士應增進和掌握最新的護理記錄知識和技能。

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4. *Taking accountability for nursing documentation*
A nurse should understand that he/she is accountable for documentation of a clinical record of the care he/she personally provides for the client. A nurse should also indicate his/her accountability by adding his/her signature and title as approved by his/her organisation to each entry and correction made on the clinical record.

5. *Establishing interdisciplinary communication channel*
A nurse should document information or concerns communicated with other healthcare providers during the care process on a continuous basis.

6. *Keeping confidentiality of nursing documentation*
A nurse should safeguard the privacy, security and confidentiality of clinical records through appropriate storage and custody measures.

7. *Upkeeping knowledge of nursing documentation*
A nurse should acquire and upkeep knowledge and skills in contemporary nursing documentation.

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