



Manitoba Chapter

CACCN Manitoba Chapter Newsletter



Spring 2011

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Greetings from the Manitoba Chapter CACCN Executive

Hello everyone and welcome to all new and returning members. It's hard to believe that Spring is just around the corner. The Manitoba Chapter Executive has had another busy and productive year.

Back in June 2010, the Executive met to formulate a plan for the upcoming year. We reviewed our list of goals and objectives and developed plans to increase recruitment and retention of members, We also planned education sessions to

provide our critical care nurses with opportunities for professional development.

A number of educational events were offered including a session on heart sounds with Dr. Morris and "Bugs, Drugs, and I See U" with Dr. Ariano. These sessions drew staff from various areas and even from Gillam and Thompson via TeleHealth. Watch for other education sessions to come in the Spring and Fall of this year.

In addition to planning educational opportunities, the committee continued to develop and use the web site to support becoming "green".

MARK YOUR CALENDARS for our annual Manitoba Chapter CACCN Critical Care Conference, "Edge of Excellence 2011" to be held on May 9th at the Norwood Hotel. Come and mingle with your fellow critical care nurses while enjoying a variety of topics and tasty food.

The day will begin with our AGM where we will be hearing from our current executive followed by the election of the 2011-2012 Chapter Executive.

Positions up for election include:

President
 Vice President
 Secretary
 Treasurer
 Programs Co-Chair
 Publicity/Newsletter

Please see website for position descriptions and nomination forms. If you have any questions about any of the roles please contact anyone on the executive. Consider your colleagues for nomination to serve on this rewarding executive.

The AGM will also include the presentation of the "Critical Care Nurse of the Year" award.

CACCN Executive:

Lissa Currie (President)
 Tannis Sidloski (Vice-President)
 Rhonda Matheson (Secretary)
 Andre Dube (Treasurer)
 Stacey Ross (Programs)
 Ashleigh Shearer (Programs)
 Jennifer Fulcher (Membership)
 Sara Unrau (Publicity/Newsletter)
 Joy Mintenko (Member at Large)



NOTICE OF MEETING AND CALL FOR NOMINATIONS

Notice is hereby given by the CACCN Manitoba Chapter President, to all members, that the Annual General Meeting of the Chapter will be held on Monday, **May 9, 2011** from **0730 – 0830, at the Norwood Hotel**, 112 Marion St., Winnipeg, Manitoba. This will be a general Chapter meeting where all members are welcome to attend. The purpose of this meeting is to review annual activities of the Chapter, accept committee reports, discuss Chapter business, elect Executive Officers for 2011/12, and present the Manitoba Chapter Critical Care Nurse of the Year Award(s).

Duties for 2010/11 Executive will begin in June for a term as outlined in the Constitution and Bylaws. Please refer to the website for job descriptions www.caccn.ca.

NOMINATION PROCEDURE

Members are invited to submit nominations of members to serve in these positions. Nominations can be emailed to Lissa Currie, President, at lcurrie@sbgh.mb.ca. In order to ensure timely receipt of any nominations, the due date for nominations is April 10, 2011.

Nominations will also be accepted from the floor at the AGM. Once there has been a reasonable opportunity to nominate, it will be announced that nominations are closed. Voting may be performed by secret ballot or by a show of hands. The chief scrutineer presents the results to the president, who will in turn announce the results to the general membership.

MANITOBA CHAPTER - CANADIAN ASSOCIATION OF CRITICAL CARE NURSES ELECTION OF ASSOCIATION EXECUTIVE OFFICERS NOMINATION FORM

I, _____ A MEMBER IN GOOD STANDING WITH THE
C.A.C.C.N., DO HEREBY NOMINATE _____
FOR THE POSITION OF _____

Signature of nominator

Signature of nominee

Membership number

Membership number

VOTING

If members are unable to attend the annual general meeting but wish to have a vote cast, a proxy form may be completed and given to a member who will be in attendance at the meeting.

Each member present (or represented by proxy) shall be entitled to one vote on each matter of business brought before the general membership. Proxy votes must be registered with the secretary of the Manitoba Chapter prior to commencement of the meeting. All members shall be entitled to vote and must present their membership card upon request, as proof of active membership.

Voting shall be by a show of hands unless otherwise directed by the residing officer. The residing officer of the meeting shall appoint two or more members of the general membership to act as scrutineers. The scrutineers shall arrange for the holding of any vote, shall distribute, collect and count ballots if used, and shall report the results. Any decision made, as a result of a vote at a meeting shall take effect at the conclusion of the meeting if it is consistent with the National Association's bylaw.

Please refer to the website www.caccn.ca for the PROXY FORM.

Call for Nominations

Manitoba Chapter Critical Care Nurse of the Year Award

Background:

Since 1990, the Manitoba Chapter CACCN has presented the Critical Care Nurse of the Year Award to a local Chapter member who consistently exemplifies critical care nursing excellence. This award recognizes chapter member(s) who promote critical care nursing, exhibit professionalism, and demonstrate proficiency in critical care. Extraordinary nurses and their accomplishments should not be taken for granted! The selection will be made by the Manitoba Chapter Executive, Awards Sub-Committee. The award consists of a commemorative plaque and honorarium presented at the Annual General Meeting on May 9, 2011. The nomination deadline is **April 9, 2011**.

Eligibility:

1. Must be a member in good standing of the Manitoba Chapter CACCN.

2. A Critical Care Nurse working in Pediatric, Neonatal or Adult Critical Care.
3. A Critical Care Nurse working at the bedside or in management, research, administration or education.

Ineligibility:

1. A member of the Executive of the Manitoba Chapter - CACCN.
2. A past recipient of less than 3 years.

Information Required for Nomination:

1. A completed nominee form found below.
2. A write up (minimum: 250 words) describing why the nominee should receive the award. This should include a specific example in at least one of the following areas:
 - Promotion of critical care nursing in Manitoba
 - Exhibits a high degree of professionalism
 - Demonstration of proficiency in critical care

Submission Deadline – April 9, 2011

Nominee Information:

Name: _____

Address: _____ Postal Code: _____

Telephone (Home): _____ (Work): _____

Employer: _____

Nominated by: (print name/signature)

1. _____

2. _____

Certification by Nominee:

I, _____ have read the information contained herein and certify it to be accurate.

I hereby allow my name to stand for nomination of the Manitoba Chapter Critical Care Nurse of the Year Award.

Mail to: Awards Committee

Manitoba Chapter CACCN

Box 2236

Winnipeg, Manitoba R3C 3R5

Winnipeg Critical Care Nursing Education Program Graduating Class of September 2011

Congratulations to the WCCNEP Graduating Class of September 2011

The Winnipeg Critical Care Nursing Education Program (WCCNEP) is proud to celebrate the success of these deserving and hard working nurses. This is the seventh graduating class of the WCCNEP.



These nurses completed the 14 weeks of Theory and Clinical, and went on to complete the Specialized Orientation portion of the program at the units and sites where they have taken positions throughout the region. The rewards and benefits of the WCCNEP are many, including the advanced knowledge these nurses have obtained to assist them in caring for the critically ill patient. Graduation ceremonies were held on February 18, 2011 with Betty Lou Rock acting as master of ceremonies.

We wish them success in their critical care nursing careers.

Remember – **YOU** are our best ambassadors to recruit, so please encourage your nursing friends to consider the program.

Information about the WCCNEP can be found on the WRHA website at:
www.wrha.mb.ca/prog/criticalcare

Please join us in congratulating this group of nurses on completing the WCCNEP:

Roy Almero	Shauna Eggerston	Zofia Rejewski
Paul Ballesteros	Wendy Gibson	Tasha Molinski
Brent Becker	Manuela Grumazescu	Sally Pavao-Harder
Camille Boucher	Adam Grycko	Corinne Pearce
Stephanie Burge	Brent Kellas	Laura Ross
Kristian Burns	Gahmeng Khuu	Krystyna Saja
Marjorie Chody	Erika Hiller	Jeanne San Miguel
Sara Coleman	Natasha Macsymach	Eileen Scharfenberg
Jocelyne Durand	Lindsay Martin	Jennifer Vincent
Alexandra DeGuzman	Tammy McLachlan	Monica Whiteway
Kevin Eckert		



CACCN Manitoba Chapter would like to recognize

**Adam Grycko
Jeanne San Miguel
Stephanie Burge**

on the receipt of the CACCN Manitoba Chapter Recognition Award!

Shock Recognition and Management in the Critical Care Unit

By Tricia Garrioch

Manitoba Chapter CACCN Education Funding Recipient

I had the privilege of attending Dynamics 2010 in Edmonton in September: "The Power of Critical Care". The many speakers at these conferences are always diverse and this fall's session was no exception. There were expert bedside Critical Care Nurses, Nurse Leaders, Physicians, Nurse Educator's and as a guest speaker the Captain of the Canada's National Women's Hockey Team. It was a difficult choice when the time came to submit this entry for the CACCN Manitoba Chapter Newsletter highlighting just one presentation.

Brenda Lynn Morgan is a Clinical Nurse Specialist in the Critical Care Trauma Center at the Victoria Hospital in London's Health Sciences Center who has presented on many occasions for CACCN. Brenda has been an integral part of CACCN for many years. Brenda is a speaker who brings her topic to life. This year Brenda went back to basics with her topic, Shock. The following is a summary discussion on her presentation:

Shock: Recognition and Management in the Critical Care Unit

The discussion began with Oxygen balance. This balance can only be achieved when the oxygen reaching the tissues is adequate to provide the oxygen needed in the tissues. When an imbalance occurs, shock is the result. Shock is divided into three types, hypovolemic, cardiogenic and distributive.

Hypovolemic shock occurs when there is a decreased cardiac output, decreased CVP and a decreased PWP. This may be as a result of hemorrhage, external volume losses such as diarrhea, or internal volume losses due to third spacing.

Cardiogenic shock occurs when there is a decreased cardiac output and either a decrease or increase in SVR, CVP and PWP. This may be as a result of a myocardial infarction, an arrhythmia, a pericardial effusion creating a mechanical obstruction or obstruction due to a pulmonary embolus or a tension pneumothorax.

In distributive shock you can have either an increased or decreased cardiac output with a decreased SVR and a low or normal CVP, PWP. This can be vasodilatory such as in sepsis.

Reasons for hypoxia may be a decreased cardiac output, hypoxemia, anemia, a change in hemoglobin affinity for oxygen. Other reasons for oxygen imbalance may be thyroid storm or massive edema. These conditions impair cellular extraction of oxygen resulting in the demand exceeding the oxygen delivery.

Shock can be broken into three phases. The first phase, sometimes known as pre shock or compensated, is where the heart, lung and brain are preserved. In the second phase of shock, there is dysfunction of the heart, lung and brain. In the final phase called MODS where there is lactic acidosis and multi-organ failure.

As the body attempts to compensate, there is initially a sympathetic response. This includes increased heart rate, increased cardiac output, increased respirations, increased perfusion pressure, decreased SVR to vital organs. The goal is preservation of priority organs.

In the first step of compensation, the body attempts to increase oxygen delivery by increasing cardiac output (HR X SV). In this first stage of compensation, you still have adequate oxygen content and oxygen saturation of hemoglobin. Oxygen extraction is normally 20 to 25% at the tissue level.

In the second step of compensation, cardiac output is inadequate and tissue extraction increasing to greater than 25%. This occurs when oxygen saturation drops below ~70% and increase cardiac output is inadequate to normalize lactic acidosis.

The final step of compensation, anaerobic metabolism, occurs and lactic acid is produced. As the cardiac output increases and the tissue extraction of oxygen increases, the demand exceeds the supply and further worsens the anaerobic metabolism. The decrease in cardiac

output can be a result of ectopics, arrhythmias or slow heart rates. The end result is a decrease in oxygen saturation of hemoglobin.

Underlying treatment in shock is the basic formula: $CO = HR \times SV$

The first course of treatment is fluids to increase the preload. If this is inadequate, vasopressors may be added to increase blood pressure and inotropes for contractility. Drugs for hypotension may be vasoconstrictors.

In order to resolve shock, you must look at the H's and T's:

- H hypovolemic, hypoxia, hydrogen ions, hypokalemia, hyperkalemia, hypothermia, hypoglycemia
- T toxins, tablets, tamponade, tension pneumothorax, coronary or pulmonary thrombus, trauma

Shock is a situation we face daily in critical care and reviewing the basics provides an opportunity for us to reinforce previous learning and review our clinical practice.

Attending conferences like Dynamics leaves a delegate energized, motivated and empowered. It is a time to network with critical care colleagues from across the Nation, discover results of nursing research at other centers, view the latest in equipment and technologies, as well as renew old friendships and create new ones.

CACCN is "dedicated to maintaining and enhancing the quality of patient and family centered care by meeting educational needs of critical care nurses".

I would like to invite all critical care nurses to become involved locally or nationally with CACCN. Attend a chapter education session or join us at the next Dynamics in London, October 16-18, 2011 or better still come both.

Respectfully submitted by Trica Garrioch

This report was written as a summary from Brenda Morgan's presentation at Dynamics on September 19, 2010.

Dates to Remember

April 18, 2011

The Critical Eye . . . Focus On
"How Far We've Come . . . Where We are Going"
McPhillips Street Station
484 McPhillips Street
Registration Deadline: April 8, 2010
Contact: Louise Lemoine (204) 787-3699

May 9, 2011

CACCN, Manitoba Chapter
Edge of Excellence 2011
Norwood Hotel
112 Marion Ave
Pamphlet and registration to follow
Contact: Sara Unrau at sunrau@sbgh.mb.ca

For more information on CACCN events and deadlines go to www.caccn.ca

Spotlight on . . .

We have done a feature on Brandon ICU, Victoria ICU and Seven Oaks ICU and we would like to hear continue to hear from and about your ICUs and your experiences.

Send your story to sunrau@sbgh.mb.ca for the next newsletter!

Spotlight on Boundary Trails Health Centre ICU Winkler, Manitoba



Welcome to Boundary Trails Health Centre! BTHC is a 94 bed facility that provides quality acute care services to the communities of Winkler and Morden as well as a large surrounding area. The hospital is located between the two communities, at the intersection of Highway #3 & #14, and serves a population of 40,000 – 50,000. The community is rich with ethnic and cultural diversity.

Boundary Trails Health Centre ICU is a 4 bed unit adjacent to a 4 bed Observation Unit and a busy Emergency Department. The three departments are staffed by one collective group of nurses and allied staff. Nurses working in this ICU are challenged not only to look after a variety of medical, surgical and occasionally pediatric patients, but these same nurses also work in the ER and OU as well. Being one of only 2 ICUs in the largest rural RHA in Manitoba, BTHC ICU receives many patients transferred from other facilities throughout Central Region as well as the entire province.

In order to meet the challenges of looking after such a wide variety of patients, nurses are required to maintain current registration in Advanced Cardiac Life Support. It is also recommended that they maintain current TNCC and PALS. The hospital currently employs only one full time Respiratory Therapist, meaning that the ICU nurses must learn many RT duties as well. These duties include set up, and maintenance of the ventilator,

as well as monitoring and weaning of the ventilated patient.

A typical assignment might include a STEMI patient post thrombolytics, an unstable post- op surgery patient, and a septic patient requiring inotropes, vasopressors and a ventilator. Staffing is adjusted based on the acuity in the department at any given time. One health care aide/ward clerk is available to assist, but works throughout Emergency, Observation and ICU. If a patient's condition requires more specialized care than we can provide, the ICU nurse may be required to accompany the patient in the ambulance during transfer to a tertiary care facility, in order to maintain a safe level of care. The ICU nurse is responsible for monitoring telemetry patients, attending Code Blue events, and responding to "Medical Emergency" calls.



BTHC actively takes part in initiatives to promote best practice care. They participate in the Safer Healthcare Now initiatives for improvements to AMI care, and the prevention of VAP and CLI. BTHC has a dedicated Critical Care Services Team within the facility and is also represented on a regional Critical Care/Medical Team. These teams work together to develop and improve policies and

procedures and to provide staff with the most current guidelines and information possible.

The quality, variety and unpredictability of our unit are what provide the challenging and exciting work environment that few nurses want to leave.

Ask The Expert

If you have a question,
chances are half your colleagues will have the same question!

Send us your questions and we will find the expert to answer.

Send any questions to sunrau@sbggh.mb.ca.

"Why Measure Gastric Residual Volumes? What do they tell us?"

By Sara Unrau, RN BN

Critical Care Clinical Educator

St. Boniface Hospital

Question:

Why do we measure gastric residual volumes and what does this really tell us about our patients? When do we need to stop tube feeds and how do we know whether or not the patient is tolerating their tube feeds?

These questions come up on a regular basis and there are always different answers.

The practice of measuring gastric residual volumes (GRV) has long been a measure of patient tolerance of gastric feeding. Is this practice based on sound science or just an accepted practice?

When measuring GRV there are numerous "pitfalls" that need to be considered. First of all, there is no consensus on the amount of GRV that is acceptable or that determines feeding intolerance (2005, McClave, et al).

Second, we need to consider the accuracy of measuring GRVs. Gravity plays a role in emptying of the stomach. Head of bed elevated greater than 30 degrees and placing the patient in the right lateral decubitus position will facilitate emptying of the stomach by gravity (2008, McClave and Parrish). Tube position in the stomach, tube

type and size, and size of the aspirating syringe can all affect the amount of GRV.

Third, what does a GRV tell you about your patient? A number alone will not provide very much information about your patient. Any small or large amount should be considered in the context of the specific patient's disease, medications, and electrolyte imbalances. What is a normal GRV? Think about this... On average the normally fed adult will generate approximately 188 ml/hour of endogenous salivary and gastric secretions.

Fourth, consider the research... A low GRV does not necessarily guarantee tolerance of gastric feeding and a single high GRV does not necessarily predict intolerance of gastric feeding (2005, McClave, et al). GRV by itself is not very sensitive as a marker for feeding tolerance, regurgitation or aspiration.

Where does this leave the practice of measuring GRVs?

The Winnipeg Regional Health Authority, in conjunction with dieticians of Manitoba and the Critical Care Program has recently released guidelines and recommendations on managing GRV (please refer to the charts on pages 9, 10, 11).

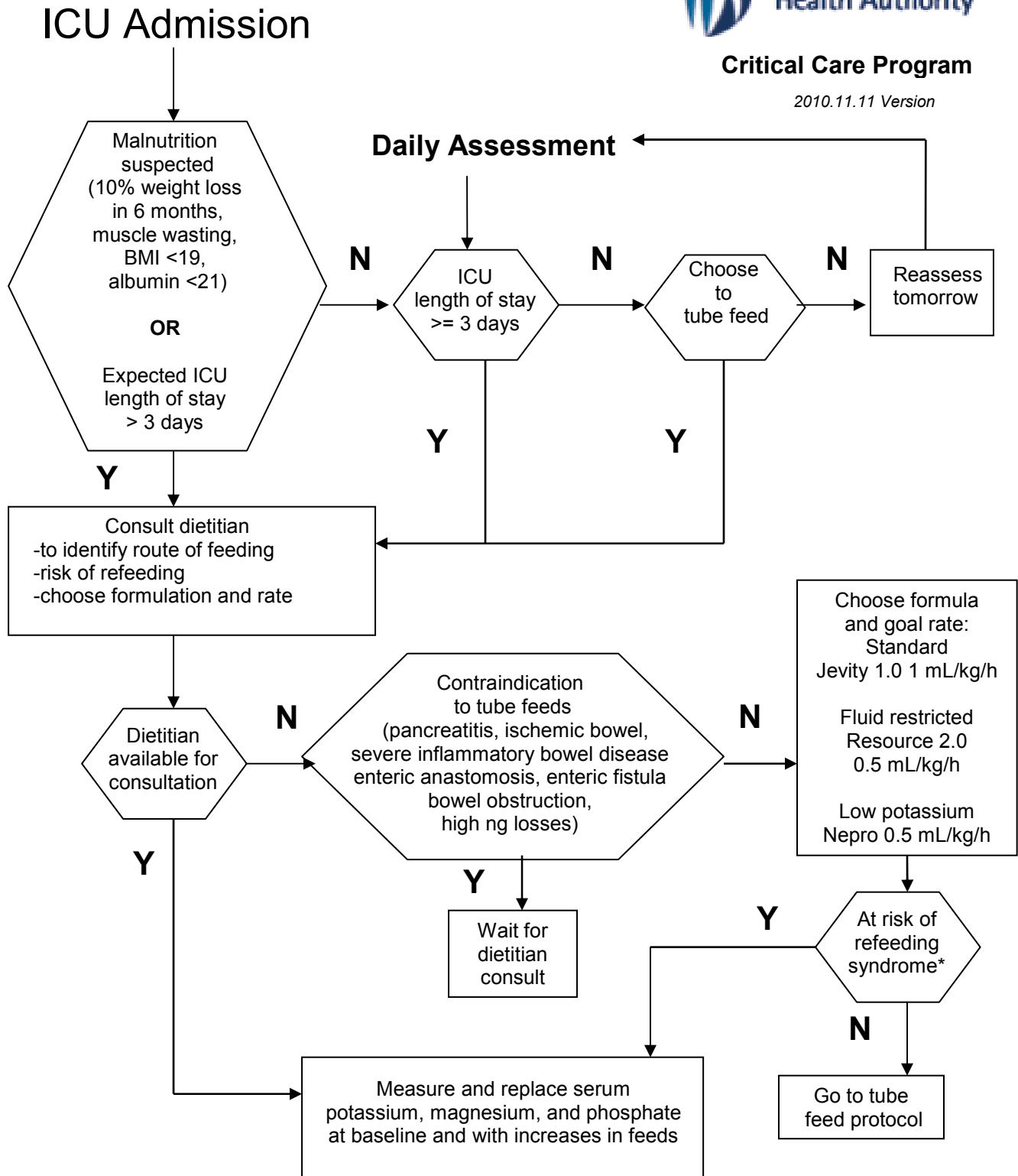
Nutrition for ICU Patients



Winnipeg Regional Health Authority

Critical Care Program

2010.11.11 Version



*Risk of refeeding syndrome if: NPO for > 7 days, >10% weight loss in 6 months, evidence of muscle wasting, body mass index <19 (BMI=weight(kg)/height(m)²), serum albumin <21g/L

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Gastric tube feeding



Critical Care Program

2010.11.11 Version

Begin gastric feeds

full strength
50mL/h or goal rate
whichever is less

Q4 h
assessment

Residual
volume
> 500 mL

Refeed residual volume
Hold tube feeds
Check residual volume in 4 h

Refeed residual volume
Restart tube feeds
at previous rate

Residual
volume
> 500 mL

Patient has
vomiting or
>3 large liquid stools/day or
significant
abdominal cramps

Stop tube feeds
consult MD
and dietitian

Increase tube feeds
by 25 mL/h
unless at goal or at
risk of refeeding

*In order to maintain Feeding Tube patency - flush feeding tube Q4h with 10 to 20 mL of water

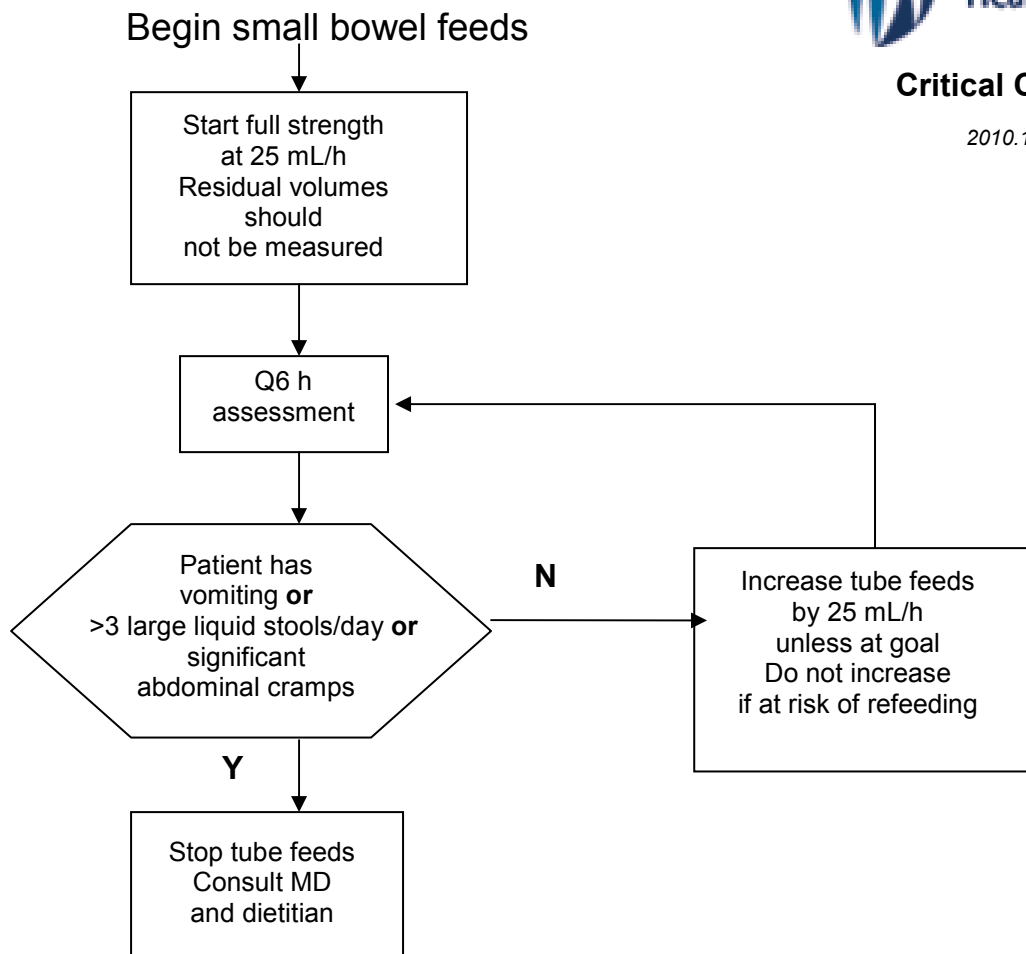
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Small bowel tube feeding



Critical Care Program

2010.11.11 Version



* In order to maintain Feeding Tube patency – flush feeding tube Q4h with 10 to 20 mL water

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Manitoba Chapter

CANADIAN ASSOCIATION OF CRITICAL CARE NURSES
Box 2236 Winnipeg, Manitoba R3C 3R5

