



Saskatchewan Chapter of the Canadian Association of Critical Care Nurses

President's Message- Angela Kubiak RN, BSN

*Issue 4
Fall 2008*

**Special Points
of Interest in
this Issue**

**Get involved
with the
Chapter!!!**

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With the changing of the season to fall, the leaves changing colors and falling to the ground, vegetables being harvested from the gardens and the flowers dying, the Saskatchewan Chapter is also changing over some new leaves. We as a chapter are gearing up to apply what we have learned from Chapter Connections Day in Montreal, along with information gathered from the Dynamics conference. We are planning over the next year to make this strong and vibrant chapter even stronger by making concrete policies and procedures, holding more fun fundraising events and connecting more with our rural members.

I would like to take this opportunity to official announce our new and improved national website which showcases each individual provincial chapters section. The Saskatchewan Chapter's website is updated frequently and lists upcoming events and conferences. So feel free to visit it at www.caccn.ca. One other improvement that is up and running is that of the Saskatchewan Chapter's web mail. Any member can email the chapter at any time with suggestions or concerns at Saskatchewan@caccn.ca. Thanks once again!!!!

Publishing Message- Shelley Anderson RN, BSN

One of the exciting things we were able to do this year was to have the opportunity to send two Saskatchewan Chapter members fully funded to Montreal for the Dynamics 2008 conference. In order to receive funding, members were asked to write to the executive describing why they wanted to attend Dynamics 2008 and how it would affect their practice. We were happy to have selected Suzanne Stewart from Yorkton and Brenda Brehon from Saskatoon. In addition to attending the presentations, Saskatchewan Chapter attendees were required to provide a synopsis of a session that they found particularly interesting. Following, you will read about these session highlights in the hopes that you will find them informative and interesting and maybe consider attending Dynamics 2009 Navigating the Future: Sail the River of Knowledge in Fredericton, New Brunswick September 27-29, 2009.

Synopsis of CACCN Dynamics 2008 Sessions

Firstly and foremost I would like to thank the chapter for the financing made available to myself to attend this 25th anniversary conference. I do appreciate it greatly. Secondly, to see so many youth in attendance gives a person hope that critical care nurses will be around for a long time and at least when I may have to access the health care system in this country and province, there will be someone to care for me.

The conference definitely used their theme of "Past, Present and Future". From Suzanne Gordon speaking on the crisis in healthcare globally, to educational sessions on the present tools one may need and finally, bringing it all back home (as presented by, Sioban Nelson) for the future of nursing.

All of the seminars that I attended had relevance to my facility and unit in Yorkton.

Suzanne Stewart
Liaison Sk. Chapter CACCN
Yorkton, Sask.

Sunday Sept. 28th, 2008

The opening speaker was Suzanne Gordon: **Collective Advocacy: Engaging in Political Action to Protect Patients and the Nursing Profession**

Suzanne Gordon is an award-winning journalist and author/editor of 12 books. She has written for The New York Times, Los Angeles Times, Philadelphia Inquirer, Washington Post, American Prospect, Atlantic Monthly, Toronto Globe and Mail, Toronto Star and many other publications. She is currently co-editing a series of books for Cornell University Press on the Culture and Politics of Health Care Work.

Gordon is a popular lecturer and past commentator for CBS Radio and Public Radio International's "Marketplace" program.

*She is Visiting Professor at the University of Maryland School of Nursing and Assistant, Adjunct Professor at the University of California, San Francisco School of Nursing. She has also co-authored, with Lisa Hayes, a play entitled **Bedside Manners** that deals with nurse/doctor relationship.*

She spoke about the serious crisis in nursing and around the world. That we need to put \$'s where it is needed, recruitment. We need to speak to families/public to explain what needs to be done for healthcare. Advocacy is our biggest role and that there are barriers, i.e. doctors, administration, public to name a few. The social net is slowly being stripped away by governments, by \$'s decreasing and going to the wrong sources.

In order to provide advocacy we need manageable workloads, manageable work hours, our own health, and we need the public to understand the relationship between nurse's workload and outcomes.

She stated that the proof of positive outcomes comes from nurse/patient ratios, as seen in California and now in Victoria, Australia. They have brought back nurses who were inactive to the workforce, reduced burnout, increased job satisfaction and reduced job turnover.

The advocacy depends on voice, image, and the way that nurses present themselves. They are seen as virtuous workers and not being advocates, they need a new image since they've lost their caps!

The first session I attended was with Dr. Tom Ahrens:

**“Non invasive cardiac output measurements” presented by Tom Ahrens DNS RN CCNS
FAAN(part I & II).**

At present in Yorkton our current practice of monitoring respiration is looking at the rate of respirations and pulse oximetry. He spoke about the non invasive tool of capnography to measure respirations.

Capnography is the monitoring of the concentration or partial pressure of carbon dioxide (CO₂) in the respiratory gasses. Its main development has been as a monitoring tool for use during anesthesia and intensive care. It is usually presented as a graph of expiratory CO₂ plotted against time, or, less commonly, but more usefully, expired volume. The plot may also show the inspired CO₂, which is of interest when re-breathing systems are being used.

The capnogram is a direct monitor of the inhaled and exhaled concentration or partial pressure of CO₂, and an indirect monitor of the CO₂ partial pressure in the arterial blood. Capnography provides information about CO₂ production, pulmonary perfusion, alveolar ventilation, respiratory patterns, and elimination of CO₂ from the anaesthesia breathing circuit and ventilator. It is increasingly being used to verify and monitor the position of an endotracheal tube. The American Heart Association (AHA) affirmed the importance of using capnography to verify tube placement in their 2005 CPR and ECG Guidelines.

The AHA also notes in their new guidelines that capnography, which indirectly measures cardiac output, can also be used to monitor the effectiveness of CPR and as an early indication of return of spontaneous circulation (ROSC). Capnography, because it provides a breath by breath measurement of a patient's ventilation, can quickly reveal a worsening trend in a patient's condition.

Dr. Ahrens then spoke about cardiac function. Current practice: blood pressure, urine output, LOC and heart rate. **What should we be doing for cardiac function and blood volume?** We should be measuring stroke volume, peak velocity/flow time, and StO₂/ScvO₂/lactate.

How? By using Triple lumen Oximetry – it expands ability to assess tissue oxygenation and has the potential to improve patient outcomes. Two measures of tissue oxygenation are Lactate levels as an indicator of Hypoxia and StO₂ (the new vital sign) monitoring by spectrophotometry (measures tissue O₂).

The new non invasive Cardiac Output measurements can be done by Doppler monitoring, i.e. esophageal doppler, and an external doppler and anyone can do it. Non invasive doppler measurement of blood flow, allows both left and right heart measurement. Dr. Ahrens showed us some of his study results to reflect the necessity to change our ways of measurements from the past and go forward to the future.

http://www6.medical.philips.com/CMSMedia/hemo_1/ (This site will give you hemodynamic monitoring)

http://books.google.ca/books?id=XIg44tQTXzoC&pg=PR5&lpg=PR5&dq=tom+ahrensX&oi=book_result&resnum=4&ct=result

(This site will give you the essentials of oxygenation)

Dr. Tom Ahrens, RN, DNS, CCRN, CS

Biography



Dr. Ahrens is a noted authority in critical care, specializing in hemodynamics, pulmonary and tissue oxygenation. He is a practicing clinical nurse specialist with 24 years experience.

&source=web&ots=vII4btDSPM&sig=cKk9wB21HjRi5G5tEz1hRmeTp5E&hl=en&sa= Author of four books, *Hemodynamic Waveform Analysis* is considered by many to be one of the finest clinical guides to the topic and *Essentials of Oxygenation* was selected as an American Journal of Nursing Book of the Year. The primary author on over 50 papers, he currently is on the editorial board of American Journal of Critical Care and the Journal of Cardiovascular Nursing. He was awarded a 1999 Society of Critical Care Medicine "Presidential Citation" and an AACN 1999 research abstract award for his work on sedation. Dr. Ahrens is currently active in research on end of life management, predicting survival during cardiopulmonary arrests, the use of technology and the value expert clinicians play in improving patient

outcome while controlling costs.

Companies at the conference were displaying the tools needed. Some of these were:

<http://www.edwards.com/Products/MinInvasive/>

<http://www.masimo.com/index.htm>

<http://www.sentec.ch>

<http://www.usa.philips.com/index.page>

Microstream® CO2 Extension for capnography with the Multi-Measurement Server from Philips medical. Microstream CO2 is an innovative, advanced technology for side stream capnography. The Microstream CO2 Extension is designed to work with the Multi-Measurement Server and provide real-time waveform and numeric values for CO2.

The Microstream CO2 Extension is a lightweight, rugged, plug-and-play unit that easily attaches to the IntelliVue and M3/M4 patient monitors.

During transport, the unit stores patient demographics and up to eight hours of patient trend data as well. An advance in capnography.

Microstream capnography may be used with intubated or non-intubated patients. It offers significant advantages over traditional side stream capnography:

- Very low sample flow rate of 50ml/min
- Fast response time
- Crisp waveform
- Exceptional moisture handling with an integrated water separation filter in each connector and a patented multi-port airway adapter design
- No cross-sensitivity to other gases, such as anaesthetic agents

- Quick warm-up time
- No routine calibration required

The Microstream CO₂ Extension has one port for CO₂. And second port that can be used for invasive pressure or temperature is available as an option.

A powerful combination

The combination of the MMS and Microstream CO₂ Extension provides all of these measurements in one compact unit:

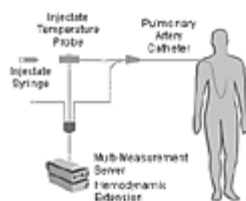
- ECG
- Respiration
- SpO₂
- Blood pressure (invasive and non-invasive)
- Temperature
- CO₂

The Hemodynamic Extension is designed to work with the Philips Multi-Measurement Server and supports cardiac output monitoring from a right heart catheter.

The Hemodynamic Extension is a lightweight, rugged, plug-and-play unit that slides directly on top of the Multi-Measurement Server and travels easily with a patient. At the bedside, the Multi-Measurement Server/Hemodynamic Extension combination can be connected to Intellivue Patient Monitors.

During transport, the unit stores patient demographics and up to eight hours of patient trend data, as well as calibration and measurement settings.

Traditional right heart thermodilution



Right heart thermodilution is the gold standard in hemodynamic monitoring. The Hemodynamic Extension displays the thermodilution curve and the following numerics:

- Cardiac output

- Cardiac index
- Blood temperature

It has four ports for cardiac output, temperature, invasive pressure, and invasive pressure/temperature.

The combination of the Multi-Measurement Server and Hemodynamic Extension provides all of these measurements in one compact unit:

- ECG
- Respiration
- SpO2
- 1 port for non-invasive blood pressure
- 1 port for invasive pressure
- 1 port for temperature
- 2 ports that can be used for invasive pressure or temperature
- Cardiac output

To end this report, I found him easy to listen to and he gave me encouragement to go after the non invasive forms of monitoring for our patients. If we are to go forward with unsafe staffing levels and doing more with less, working with other less knowledgeable health providers, I believe we need tools such as those described to free our hands for other duties, as a Registered Nurse, and to show that these methods are not only cost effective but, highly accurate.

The next speaker was Dr. Elizabeth Peter: *Critical Care Nurses and Moral Distress*

http://www.nursing.utoronto.ca/staff/Faculty_Bios/Elizabeth_Peter.htm

She spoke about the moral distress and factors contributing to CC nurses when one knows the right thing to do, but institutional constraints make it nearly impossible to do the right thing. Factors: lack of staff, policy that doesn't fit practice, conflicts with hierarchical systems, lack of support services, conflicting goals within teams, overly aggressive/futile medical care and prolonged proximity to tragedy.

Finally, CC nurses are the key to negotiating the tensions between biotechnology and hope, as they have the knowledge, experience, place and voice within the family/healthcare team and society.

A panel discussion took place at the end of the first day, with Dr. Tom Ahrens, http://www6.medical.philips.com/CMSMedia/hemo_1/; Dr. Louise Rose,

http://www.nursing.utoronto.ca/staff/Faculty_Bios/Louise_Rose.htm; Annette Bourgault,
<http://www.classmates.com/directory/public/memberprofile/list.htm?regId=416754281>;
<http://ncp.aspenjournals.org/cgi/content/abstract/18/5/398>; Brenda Morgan,
http://23072.vws.magma.ca/centennial/documents/Morgan_e.pdf.

They are all specialists in their field and just reiterated Best Practices in Critical Care. It was very informative.

Monday Sept. 29th

Dr. Franco Carnevale was the keynote speaker on, “**What is a Good Nurse Supposed to do?**”

He talked about nurse advocacy and cited the cases of the pediatric deaths from cardiac surgery, in the Winnipeg Children’s Hospital there were 12 deaths. He testified as an expert witness, as to what “good nurses do”. You can access his profile and information at:

<http://www.mcgill.ca/crcf/people/members/fcarnevale/>.

The next session I attended was: **Part 1 & 2 of Case Studies in ECG Monitoring by Dr. Barbara Drew.**

The syllabus she provided gave opportunity to listen rather than write. Her access can come via:

http://www.gehealthcare.com/usen/education/patient_mon_systems/barbaraj.html.

There is even a video.

The lunchtime speakers were 2 women from the Canadian Armed Forces, who have spent time over in Afghanistan in their critical care units. Their names were: Capt. Amelie Proulx BSN CCNO; and Capt. Annie Tetreault BSN CCNO. They spoke about what it is like to work in 50 plus degrees in their hospital. At the end of their presentation there wasn’t a dry eye in the room. If you ever had any doubts as to how difficult it is for them, don’t. I hope everyone learned that these nurses would definitely have more to complain about in their specialty than anyone else in a Canadian facility or agency. They were inspiring.

The last session for the day was: **Power of One with Kathleen Vollman.**

<http://www.vollman.com/>.

About impacting patient outcomes by returning to the basics. It is in the syllabus that was handed out and is a good self read (which is attached).

The CACCN annual meeting followed this I did not attend.

Then the banquet that evening, which was spectacular.

Tuesday Sept.30

Keynote speaker:

Sioban Nelson: Bringing it all back home: Science, Technical Skill and Nursing Practice.

http://www.nursing.utoronto.ca/staff/Faculty_Bios/Sioban_Nelson.htm.

<http://www.amazon.ca/Complexities-Care-Nursing-Reconsidered/dp/0801473225>.

<http://books.google.ca/books?id=BBBE6OIC7gcC&pg=PA175&lpg=PA175&dq=sioban+nelson&source=web&ots=wUjxgZfVAC&sig=b99CO35Cgm1->

[K4FR0AqfD5ruHek&hl=en&sa=X&oi=book_result&resnum=8&ct=result](http://books.google.ca/books?id=BBBE6OIC7gcC&pg=PA175&lpg=PA175&dq=sioban+nelson&source=web&ots=wUjxgZfVAC&sig=b99CO35Cgm1-K4FR0AqfD5ruHek&hl=en&sa=X&oi=book_result&resnum=8&ct=result).

She spoke on the nursing knowledge, skill and value of experience; theory versus practice; tension between service and education sector; training versus education debate. Spoke on the anxieties regarding the organization of nursing education. Finally nurses need to be advocates for

their patients and their practices. What do you say about your work to colleagues, public, patients? Why is it important? Funding, cuts, new models of care? What is code green?

http://books.google.ca/books?hl=en&id=YUiaMX5l3KQC&dq=weinberg+code+green&printsec=frontcover&source=web&ots=Z0OnLjverW&sig=N_dwEH4fQZtjZPjfMDXgguwXgLc&sa=X&oi=book_result&resnum=1&ct=result.

http://www.nursingadvocacy.org/media/books/code_green.html.

Unfortunately, I could not attend the rest of Tuesday, as my departure time was 1400 hours. Through all of this conference there was time to view new technologies, network and view the poster presentations.

I would encourage anyone to attend this conference and learn more from those that have the knowledge so that you too can spread the knowledge around to others.

This was definitely a conference about past, present and future endeavours in nursing.

My hope is that you all take time to look through the syllabuses and learn a little.

Suzanne Stewart

Withholding and Withdrawing Treatment:

Whose Decision is it?

The topic was presented by Marie Edward, RN, PhD, Faculty of Nursing of University of Manitoba. She states treatment or refusal of treatment has clear guidelines when done by a *capable* individual. But particular healthcare cases have become national news when substitute decision makers become involved and disagree with the medical decisions. One particular case was trying to seek approval for a DNR order and the other was to have a

DNR order removed from the chart. After the Manitoba Law Reform Commission reviewed these matters one important conclusion became evident. "Canadian Law does not clearly address end-of-life decision-making and there is much uncertainty regarding the respective rights and obligations of healthcare providers and patients" (MLRC, 2000, p. 18). It is a hazy area and affects outcomes of patients and the work of the healthcare team. The Canadian Critical Care Society position on withholding or withdrawal of life support stated

"When it is clear the treatment will not be effective and is not in accord with standard medical practice or norms the physician is not obliged to begin, continue, or maintain the treatment" (Rocker & Dunbar, 2000.p. S55). They continue to go on to say if there is a disagreement then intensive care should continue but further discussions should take place to result in "*consensus*". In very disagreeable situations they will need to use others for opinions, ethics committees, transfer of care, or mediation procedures.

The ongoing dilemma of who can make decisions for the patient's healthcare causes many questions, concerns, and observations such as:

1. Do doctors have the right to make decisions for the patient? After all they are not God.
2. Moral staff distress: anger, frustration, despair
3. Family distress: anger, fear, distrust (us vs. them), questioning-“what if they get it wrong?”
4. Ethics: personal beliefs and religion affect patient care and differ from healthcare views. The healthcare team does not KNOW the patient.

These circumstances have many implications on the intensive care nurse. After all it is the nurse who is first to recognize and begin conversations with the family. It is the nurse who is the constant in the whole equation. Every one of them must follow guidelines when conflict arises. They need to:

1. Be aware of such situations developing
2. Pay attention to distress/suspicion of family members. Build and maintain trusting relationships.
3. Share a role in preventing and/or addressing conflict by using good communication that is clear, honest, and consistent.
4. Share a role in conflict resolution by using help from others such as pastoral care, social work.
5. Create “moral space” so they can talk about the situation in debriefing sessions, managerial and colleague support. There should be a protocol developed to support staff and help them sort out their feelings and in a timely matter.
6. There is the question- should only staff comfortable with end of life decisions be taking care of a dying patient in order to support the patient and family?

The role of the intensive care nurse is of great importance. They are the ones the patient and family see at the bedside continually. To decrease distrust they could allow the family to participate more in patient care. All the staff should use the same consistent language and one that the family can understand. They need clear definitions and better terminology. Nurses need to be active in family conferences, not just the doctor. Talk to families to understand their fears, beliefs, and background. They can use resource staff specialties to assist in coming to an understanding. Every one should focus on care and dignity. Hopefully all these guidelines and suggestions can assist to a mutual decision of what direction is the best for the patient. But ultimately the question of “Whose decision is it?” in the matters of withholding or withdrawing treatment still does not have an answer.

Submitted by Brenda Brehon

One of the sessions that I found the most useful as a bedside nurse was developed around nosocomial infections, particularly VAP. It was brought to my attention that people are interested in this because it tends to get overlooked in ICU. Something as simple as basic hygiene gets put on the back burner as other patients are crashing, family is visiting or for goodness sakes "the heart is coming"... into the room next to you. The focus was going back to basics... performing simple oral care. In Canada VAP is responsible for 230 deaths per year, and all cases are estimated to cost over **\$46 million dollars**... so don't think twice about using too many sponges...The presenter also pointed out some do's and don'ts for oral care such as no more Glycerine swabs...we know about the stashes of glycerine on some wards ... but it is proven that glycerine swabs are harmful. The citric acid has no moisturizing capabilities, the glycerine actually absorbs water, and the swabs irritate the oral mucosa. She also showed research on instilling saline down the ET tube another no no... apparently it does not thin or liquefy secretions but may be increasing colonization. As far as VAP goes we know that immunosuppression, increasing gastric pH(withholding gastric feeding) contaminated equipment and immobility are some of the causes we attribute to, therefore we can no longer just blame it on the ET tube we must go back to basics and take part in the prevention. The other large part of the focus of this presenter was on positioning, really think about it, do we reach Q2H positioning? Make this a priority. One way I have practiced was to do oral care as one of the first and last things on my shift then everything else in between just seems natural plus I never trust that the other guy has or will do it before or after me. Believe it or not there are hospitals out there that have worked hard enough that the number of VAP cases was ZERO in two years... Think of all the money they saved on ICU days.

Brenda Blair

Futile Medical Care in the Intensive Care Unit

By: Angela Kubiak RN, BScN

Futile medical care is probably one of the most talked about type of care that is taking place in today's medical world. The idea around this type of care can be controversial and near and dear to the hearts of medical professionals, mostly the bedside nurse. Now futile medical care refers to the idea that in an incapacitating condition where there is no hope of improvement no further treatment be provided. Many arguments and issues have surfaced with providing this care and around whose decision is it. I am sure that all of us as bedside nurses have seen or been a part of this type of care.

While attending a session around this topic at Dynamics in Montreal, there was a case study presented that made me think seriously about my ethical and moral obligations as a nurse in providing the best care possible for my patients. It made me review certain situations that I as an intensive care nurse have seen where there were actions taken against the best interest of a patient, prolong death and even false hope provided to patient families insinuating that a positive outcome would be achieved. This made me question, what we as bedside nurses can do so that this doesn't happen to our patients.

As medical professionals we all know that not every patient that enters the healthcare system leaves the healthcare system at the end of life with dignity and respect. This would be

where futile medical care would and should be initiated. These decisions are particularly complex when physicians have less experience with these discussions, when families and providers disagree about benefits from treatment, and when cultural disparities are involved in misunderstandings. When every medical intervention provided fails to return the patient to their previous state or serves no purpose, the withdrawal of care or comfort care needs to be discussed. Maintaining patient dignity and the respect for them as human beings is the utmost important component of nursing.

As difficult as it may be, one must put aside their own feelings and thoughts and act according to the best interest of their patients with respect to informing and not providing false hope to a hopeless situation. Remember that personal dignity and respect is the utmost goal of patient care.

In the interest of length, more synopsis will be included in the next newsletter.



Get Involved with the Saskatchewan Chapter

Your local chapter is interested in providing services that meet your needs. Are there educational topics that you would like us to include at our next conference? Email us or better yet join us at one of our monthly executive meetings. Monthly meeting date, location and time will be sent to chapter members.

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Angela Kubiak

[Email Angela Kubiak](#)

Vice President

Sarah Sidebottom

[Email Sarah Sidebottom](#)

Treasurer

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[Email Marian Hutchinson](#)

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Maureen Sapara

[Email Maureen Sapara](#)

Education

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Fundraising

Tanis Cole

[Email Tanis Cole](#)

Publications

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[Email Shelley Anderson](#)

Members at Large

Justin Rae

[Email Justin Rae](#)

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registration forms
at
[CACCN National](#)

*The executive members of the Saskatchewan
CACCN Chapter wish you all safe and enjoyable
Holiday Season!!*