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Vision statement
The voice for excellence in Canadian Critical Care Nursing

Mission statement
The CACCN is a non-profit, specialty organization dedicated to maintaining and enhancing the quality of patient- and family-centred care by meeting educational needs of critical care nurses.

Engages and empowers nurses through education and networking to advocate for the critical care nurse.

Develops current and evidence-informed standards of critical care nursing practice.

Identifies professional and political issues and provides a strong unified national voice through our partnerships.

Facilitates learning opportunities to achieve Canadian Nurses Association's certification in critical care.

Values and beliefs statement
Our core values and beliefs are:

- Excellence and Leadership
  - Collaboration and partnership
  - Pursuing excellence in education, research, and practice

- Dignity and Humanity
  - Respectful, healing and humane critical care environments
  - Combining compassion and technology to advocate and promote excellence

- Integrity and Honesty
  - Respectful, healing and humane critical care environments
  - Combining compassion and technology to advocate and promote excellence

Philosophy statement
Critical care nursing is a specialty that exists to care for patients who are experiencing life-threatening health crises within a patient/family-centred model of care. Nursing the critically ill patient is continuous and intensive, aided by technology. Critical care nurses require advanced problem solving abilities using specialized knowledge regarding the human response to critical illness.

The critical care nurse works collaboratively within the interprofessional team, and is responsible for coordinating patient care using each member's unique talents and scope of practice to meet patient and family needs. Each patient has the right to receive care based on his/her personal preferences. The critically ill patient must be cared for with an appreciation of his or her wholeness, integrity, and relation to family and environment. Critical care nurses plan, coordinate and implement care with the health care team to meet the physical, psychosocial, cultural and spiritual needs of the patient and family. The critical care nurse must balance the need for the highly technological environment with the need for safety, privacy, dignity and comfort.

Critical care nurses are at the forefront of critical care science and technology. Lifelong learning and the spirit of enquiry are essential for the critical care nurse to enhance professional competencies and to advance nursing practice. The critical care nurse's ability to make sound clinical nursing judgments is based on a solid foundation of knowledge and experience.

Pathways to success: Five pillars
1. Leadership:
   - Lead collaborative teams in critical care interprofessional initiatives
   - Develop, revise and evaluate CACCN Standards of Care and Position Statements
   - Develop a political advocacy plan

2. Education:
   - Provision of excellence in education
   - Advocate for critical care certification

3. Communication & Partnership:
   - Networking with our critical care colleagues
   - Enhancement and expansion of communication with our members

4. Research:
   - Encouraging, supporting, facilitating to advance the field of critical care

5. Membership:
   - Strive for a steady and continued increase in CACCN membership
The provision of high-quality evidence-based care is the overarching goal for every critical care nurse. As the most consistent and immediate group of providers, nurses are perfectly positioned to directly impact patient, hospital and system outcomes in critical illness. The nursing perspective is key in the recognition of opportunities for quality improvement, mitigation of vulnerabilities associated with critical illness and to the success of solution building and the implementation of improvements. It is essential that critical care nurses across all domains of practice (frontline, leadership, research and education) embrace quality improvement and prepare themselves to collaborate with our care partners to advance the collective understanding and delivery of best evidence-based care.

This past fall, CACCN was privileged to represent Canadian critical care nurses in a number of national initiatives for improving quality care for critically ill Canadians. Some of these activities were population specific; for example, the Canadian Blood Services Deceased Donations Advisory Committee. This interprofessional group provides advice on deceased donation clinical policy and leading practices for the advancement of deceased donation in Canada. The work of this group impacts care provided to potential organ and tissue donors in Canada, as well as the education, support and tools developed for providers caring for potential organ and tissue donors and their families. Our partnership with this group has also resulted in the development of our CACCN Deceased Organ and Tissue Donation position statement approved in January 2015 (see page 9), and an ongoing partnership for organ donation education of critical care nurses across Canada.

Similarly, we have contributed the perspective of Canadian pediatric critical care nurses to the work of the pediatric donation after cardiac death guideline development group. We remain actively involved in this interprofessional best practice guideline development for this unique population of children and families.

CACCN has also continued to contribute nursing expertise to the development of the Withdrawal of Life Sustaining Therapy guidelines working group in this past year and is nearing the completion of the nursing component of the Ebola Virus Disease guidelines. We, along with our partner organizations, recognize the importance of crafting tools and best practice recommendations that are reflective of the strengths and expertise that exist across the scope of multidisciplinary health care teams.

A recent opportunity for nursing input was extended through our relationship with the Canadian Critical Care Trials Group. Under the leadership of Dr. Paul Herbert, a nation-wide quality research initiative was launched in October 2014. A group representative from all critical care disciplines, community interest groups and policy makers was convened to look specifically at designing a national agenda for critical care quality research. This work includes evaluating the degree to which critically ill patients receive safe, effective, timely, equitable and sustainable patient-centred care. CACCN was at the table for the inaugural meeting of this exciting project and will continue to contribute the expertise and voice of nursing to the planning and execution of this important work.

It is clear that the Canadian critical care nurse lens is recognized as important to the advancement of quality critical care. Nurses impact at the level of the individual patient, unit and organization, and we will strive to remain positioned as full partners in national priority setting and policy development.

With this recognition we have enjoyed increasing opportunities to act and, as such, have accepted the associated accountabilities and responsibilities of this leadership. On behalf of the Board of Directors, I would like to express our gratitude to all the CACCN member volunteers who have contributed to these and other emerging initiatives. Your generosity of time, expertise and commitment to positive action is most appreciated and a credit to our organization. “Together we can” continue to answer the call for improved, efficient and effective critical care service for critically ill Canadians.

On behalf of the association and the National Board of Directors, I would also like to take this opportunity to extend our deepest thanks and appreciation to Directors Ruth Trinier and Marie Edwards, who are completing their terms on the Board this spring:

**Ruth Trinier**

Ruth joined the National Board of Directors in 2009 and quickly become a strong voice for the frontline clinical care nurse and for the specialty of pediatric critical care nursing. Prior to joining the Board, Ruth was a contributor to the CACCN Standards for Critical Care Nursing Practice (4th ed.), which has become a guiding document for nursing jurisdictions and critical care associations worldwide.

Ruth has served on the Board as the Director of Awards and Corporate Sponsorship and this past term as the CACCN National Treasurer. Ruth has also played a key role in developing and piloting the Paediatric Critical Care Certification preparation workshop that was delivered at Dynamics in Halifax in 2013, and again in a pilot test of web-based education in 2014.

*continued on page 6...*
Marie Edwards

Marie joined the board in 2013. She took on the portfolio of Director Publications and Research, contributing her impressive scholarly experience and skill to advance our engagement with and support of critical care nursing research. Marie has carried on the work of others to grow partnerships with researchers investigating phenomena important to critical care nursing practice across the country. As a long-time member of the CACCN Journal Editorial Review Board, Marie has also contributed to enhancing our publication and was instrumental in advocating for an update to the journal title (see below). Marie will continue to contribute to CACCN as the Chair for the 2015 Dynamics of Critical Care Conference being held in Winnipeg, Manitoba.

Although we are sad to see their tenure come to a close, we would like to wish Ruth and Marie all the best in the future and are grateful for their important contributions to our association. We are confident that both Ruth and Marie will continue to be active in CACCN and that our privilege of working alongside them, although shifting, is not at an end. Thank you both for your efforts and generous donation of time and expertise.

Karen Dryden-Palmer, MN, RN
President

CACCN journal: Name revision

Following discussions over the past year, the CACCN National Board of Directors voted in January 2015 to change the title of our journal from Dynamics: Journal of the Canadian Association of Critical Care Nurses to The Canadian Journal of Critical Care Nursing.

Background

• When the journal was first introduced in 1984, the title was Canadian Critical Care Nursing Journal
• In 1990, the name changed to Official Journal of the Canadian Association of Critical Care Nurses.
• In 2000, it became Dynamics: The Official Journal of the Canadian Association of Critical Care Nurses.
• The title of the journal was revised in 2011 to Dynamics: Journal of the Canadian Association of Critical Care Nurses when the redesign of the journal was implemented.
• The idea to change the title of the journal was first brought forward at the annual Chapter Connections Day in 2013, as it was noted the journal name reflects the title of CACCN’s annual conference, Dynamics of Critical Care, and does not adequately reflect the title of the association.
• The Board of Directors and our chapter leadership felt the title of the journal should clearly reflect the connection between the association and the journal.

The title of the journal has been changed to The Canadian Journal of Critical Care Nursing* and has been implemented with the Spring 2015 journal edition (Volume 26, Number 1, Spring 2015).

Sincerely,

Karen Dryden-Palmer
President
Renée Chauvin
Vice President
Marie Edwards
Director, Publications/Research

*DynamICS 2015

Bridging the Nation with Compassion, Imagination and Innovation

September 27–29, 2015
RBC Convention Centre, Winnipeg, MB

Dynamics 2015 conference flyer/brochure: The Summer Abstract Edition (May 2015) of the CJCNCN will include a colour flyer providing information on the Dynamics 2015 conference, accommodations and travel. The full colour electronic brochure and online registration will be available on the CACCN website at www.caccn.ca by June 1, 2015.
CACCN Editorial Review Board

Franco Carnevale, PhD, RN
My background in critical care has been primarily pediatric. I’ve worked in various roles in pediatric critical care nursing for more than 35 years. This included more than 20 years as nurse manager of the Pediatric ICU at the Montreal Children’s Hospital. Currently, I’m a professor at the Ingram School of Nursing at McGill University in Montreal. I’m also an Associate Member of Pediatric Critical Care at the Montreal Children’s Hospital and a Clinical Ethics Consultant at Le Phare, Enfants et Familles (a community centre for pediatric hospice and respite care). My primary research interests focus on ethical problems in pediatrics. I’m the founder and principal investigator for Views On Interdisciplinary Childhood Ethics (VOICE), a McGill-based international initiative to advance knowledge and practices relating to ethical concerns in childhood. I have served on the Editorial Review Board since the beginning of the journal—about 30 years.

Marie Edwards, PhD, RN
I completed the Intensive Care Nursing Program at the Health Sciences Centre in Winnipeg in 1982 and worked in the Surgical Intensive Care Unit there. I am a graduate of the Nursing PhD Program and Collaborative Program in Bioethics at the University of Toronto, and work as an associate professor with the College of Nursing, Faculty of Health Sciences at the University of Manitoba. I teach in the area of clinical ethics and my research interests include moral distress, nurses’ roles in conflict in the ICU, and end-of-life care. I am completing a two-year term on the Board of Directors for CACCN, as the Director responsible for Publications and Research. I am also the Chair of the Planning Committee for Dynamics 2015, which will be held in Winnipeg, MB. I have been on the Editorial Review Board for our journal since 2008.

Debbie Fraser, MN, RNC
I am an Associate Professor and the Director of the Nurse Practitioner program in the Faculty of Health Disciplines at Athabasca University. I also have an appointment in the Department of Pediatrics, Faculty of Medicine and the Faculty of Nursing at the University of Manitoba. I work clinically in the NICU at St. Boniface General Hospital and am the Editor-in-Chief of Neonatal Network: The Journal for Neonatal Nursing. I love to write and have edited two neonatal nursing textbooks and more than 70 book chapters and peer-reviewed articles on topics related to high-risk newborns. I am the Manitoba coordinator of EPIQ, a CIHR-funded quality improvement initiative directed at improving care of infants born at less than 30 weeks gestation. I was very honoured this year to be awarded the Canadian Nurses’ Association Order of Merit for Nursing Education.

Sandra Goldsworthy, PhD, MSc, RN, CNCC(C), CMSN(C)
I have been on the Dynamics editorial board for seven years. I have been a critical care nurse for 28 years and have served in a variety of capacities for CACCN (local executive, newsletter editor, Dynamics planning committee). I received my BScN from Lakehead University, my Master’s of Science from Queen’s University, and I just completed my PhD in Nursing at the University of British Columbia. I hold two national certifications, one in critical care and the other in medical-surgical nursing. I am currently a nursing professor in the BScN program and critical care. I have had the opportunity to sit on several international and national advisory boards including the International Simulation Advisory Board for vSim virtual simulations. I am the co-editor or author of seven textbooks including: Medical Surgical Nursing in Canada, ‘Simulation Simplified: A practical guide for nurse educators’, 'Simulation Simplified: Student lab manual for critical care nursing' and Compact Clinical Guide to Mechanical Ventilation: Foundations of Practice for Critical Care Nurses. I have presented locally, nationally and internationally on critical care topics and simulation. My research is focused in the areas of critical care nurse retention and the use of simulation and technology in education and at the bedside.

Martha Mackay, PhD, RN, CCN(C)
I am a clinician-scientist, dividing my time between the roles of Clinical Nurse Specialist (CNS) in cardiology at St. Paul’s Hospital Heart Centre and Clinical Assistant Professor at the UBC School of Nursing. I have practised for more than 30 years in critical care and cardiac nursing, with the past 18 as a CNS. My initial nursing education was at George Brown College in Toronto, and I’ve since earned a BSN, MSN and PhD at UBC. My clinical role focuses on improving the care of acute coronary syndromes and myocardial infarction patients. In 2012, I led the development of nursing decision support tools for Emergency Cardiac Care, which are used by all RNs in British Columbia. I hold two national certifications, one in critical care and the other in medical-surgical nursing. My background in critical care has been primarily pediatric. I’ve worked in various roles in pediatric critical care nursing for more than 35 years. This included more than 20 years as nurse manager of the Pediatric ICU at the Montreal Children’s Hospital. Currently, I’m a professor at the Ingram School of Nursing at McGill University in Montreal. I’m also an Associate Member of Pediatric Critical Care at the Montreal Children’s Hospital and a Clinical Ethics Consultant at Le Phare, Enfants et Familles (a community centre for pediatric hospice and respite care). My primary research interests focus on ethical problems in pediatrics. I’m the founder and principal investigator for Views On Interdisciplinary Childhood Ethics (VOICE), a McGill-based international initiative to advance knowledge and practices relating to ethical concerns in childhood. I have served on the Editorial Review Board since the beginning of the journal—about 30 years.

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Martha Mackay, PhD, RN, CCN(C)
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I have received salary awards from the Canadian Institutes of Health Research, Cardiac Services BC, and the Heart & Stroke Foundation of Canada. I currently hold a Michael Smith Foundation for Health Research Scholar Award. My research focuses on the sociodemographic and behavioural influences on cardiac health, such as sex/gender, ethnicity and depression. I am investigating how these factors affect symptoms, treatment-seeking behaviour and care received among acute coronary syndrome patients, and developing interventions to improve gaps where they are identified.

Paula Price, PhD, RN

I am an Associate Professor in the Advanced Studies in Critical Care Nursing program at Mount Royal University, Calgary, Alberta. I have been working in critical care nursing practice and education for the past 30 years. I have been the Editor for Dynamics for almost 20 years and The Canadian Journal of Cardiovascular Nursing for about eight years. I have been a member of CACCN since 1985. My MN and PhD are both in cardiovascular critical care nursing. My area of research has been in the area of effects of nursing interventions on patients.

Judy Rashotte, PhD, RN

Although I officially retired from my full-time position as the Director, Nursing Research & Knowledge Transfer Consultant, at the Children's Hospital of Eastern Ontario (CHEO) in April 2014, I remain engaged in nursing research as a Director of Nursing Research at CHEO on a casual basis, and in my positions as an adjunct professor with the School of Nursing, University of Ottawa and Scientist, in the Evidence to Practice Research Program, CHEO Research Institute. My clinical background includes neonatal, pediatric and adult critical care nursing. In addition, I have held a variety of positions in education and administration associated with critical care. I have been a member of the Editorial Review Board for this journal since 1994. My research interests include qualitative research methods, nurses’ clinical decision-making, knowledge translation, the impact of technology on nursing practice, and the moral practice of nursing.

Mae Squires, PhD, RN

I graduated from Queen's University with both my Baccalaureate and Master’s in Science (Nursing) degrees and my PhD in nursing from Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto. I have worked full time in a variety of nursing leadership positions from clinical nurse, nurse educator, and nurse manager, to director in an acute tertiary care facility, and now as the Associate Dean of the School of Baccalaureate Nursing at St. Lawrence College, Kingston, Ontario. My research interest revolves around patient safety, the quality of nursing work environment and nursing leadership. In addition to working in the hospital sector, I have also taught for a variety of nursing programs, am a reviewer for several journals and, since 2008, have been on the editorial board of Dynamics. I have been acknowledged as Subject Matter Expert for the Critical Care Services Ontario of the Ministry of Health and Long-Term Care of Ontario and currently I am the co-chair of the Provincial Critical Care Nursing Committee.

Share your knowledge and critical care experiences...

The Canadian Journal of Critical Care Nursing is an international, peer-reviewed journal focusing on critical care nursing practice, administration, education and research. We are interested in publishing articles by nurses who are looking to share their evidence-based practices, research, quality management/improvement initiatives, and case studies.

The Canadian Journal of Critical Care Nursing is published four times annually (Spring, Summer, Fall and Winter) and is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, the International Nursing Index, MEDLINE and RNdex Top 100. This means that many nurses nationally and internationally will have access to your article.

Share your knowledge by submitting a manuscript to The Canadian Journal of Critical Care Nursing. Paula Price, Editor, and the Editorial Review Board are available to assist you with the development of your manuscript for publication.

Manuscripts should be submitted via email to Paula Price, Editor, pprice@mtroyal.ca, with a copy to CACCN National Office at caccn@caccn.ca or via facsimile to 519-649-1458.

For more information regarding The Canadian Journal of Critical Care Nursing, please visit “Publications” on the CACC website at www.caccn.ca.
The CACCN develops position statements to provide summaries of CACCN views on issues pertaining to critical care nurses and their nursing practice. Critical Care Nurses from across the country participate in the creation of the position statements. CACCN position statements are reviewed at a minimum of every five years to ensure applicability to practice. The following statement was approved by the CACCN National Board of Directors on January 13, 2015. Please visit www.caccn.ca to view all CACCN position statements.

Position Statement

Deceased Organ and Tissue Donation

Introduction

Critical care nurses play a key role in creating and maintaining a transparent, safe and supportive environment of care. Critical care nurses provide expert physical and emotional care to patients and families who may potentially donate organs and tissues, as well as playing a central role in the care of patients and families who may receive donated organs and tissues. As such, nurses are uniquely situated to act as facilitators of the organ donation process and to provide essential support throughout the experience. Critical care nurses are health care professionals that patients and their families look to for support and information related to organ and tissue donation. CACCN believes that, as critical care nurses, we play a pivotal role in the future of donation in Canada.

Statement

The Canadian Association of Critical Care Nurses (CACCN) acknowledges that there is a disparity in Canada between the number of Canadians waiting for an organ transplant and the number of organs donated. The CACCN believes that all eligible persons have a right to choose to donate their organs and/or tissues. The CACCN further believes it is important that critical care nurses understand the physical, emotional, organizational and legislative process associated with organ and tissue donation in Canada. Critical care nurses forge unique relationships with patients and family members providing them the opportunity to explore and advocate for pursuing donation wishes at end of life.

Background

In Canada, many thousands of adults and children are on the waiting list for organ and tissue donations (Canadian Institute for Health Information, 2012). One person dies every 1.5 days while on the wait list (Canadian Institute for Health Information, 2012). Canada’s demand for organs for transplantation is predicted to increase 152% by 2020 (Baxter & Smerdon, 2000).

Organ and tissue donation is a life-saving and life-enhancing procedure for medically suitable patients and their families. In Canada, there are two mechanisms by which an individual can be identified as an organ donor at the end of their life: donation after neurological determination of death (NDD), and donation after cardiocirculatory death (DCD). Tissue donation is possible in both end-of-life contexts.

The CACCN endorses the following responsibilities of the critical care nurse, critical care nursing units and organizations in providing care to potential organ and tissue donation candidates.

Responsibilities of the critical care nurse

- Advocate for organ and tissue donation options as an essential component of end-of-life care.
- Support and participate in the organ and tissue donation process in accordance with Canadian and provincial legislation and hospital policy.
- Identify potential organ and tissue donors.
- Activate the appropriate resources and process for exploring options with the patient and family in a timely manner.
- Collaborate with donation specialists and interdisciplinary team members throughout the donation process.
- Facilitate end-of-life care discussions that respect and support patient and family decisions.
- Provide support and information through the donation decision-making process.
- Maintain ethical practice at all times (CNA, 2008; CACCN, 2009).
- Provide for the patient’s and family’s social, cultural, religious and/or spiritual needs.
- Access support and other resources as needed (e.g., social worker, spiritual leader).
- Maintain current knowledge and skills related to the organ and tissue donation process.
- Provide informational, emotional and process support to colleagues and peers engaged in the donation process with patient and family members.
- Protect and respect donor anonymity and family confidentiality in accordance with current Canadian and provincial/territorial legislation and the applicable nursing code of ethics (CNA, 2008; Storch, Rodney, & Starzomski, 2004).

Expectations of critical care nursing units/organizations

- Integrate Accreditation Canada’s Organ and Tissue Donation Standards for Deceased Donors into unit-based policies and practices.
- Integrate organ and tissue donation options as the standard of care at end of life.
• Ensure identification mechanisms and processes are in place so all eligible patients and families are provided the option of organ and tissue donation.
• Support organ and tissue donation education for critical care nurses.
• Facilitate a culture of care where the patient’s and family’s unique cultural, spiritual, and social needs can be identified and addressed.
• Evaluate the process and outcomes of organ donation services to ensure continuous quality improvement.

Approved by the CACCN Board of Directors, January 13, 2015.


Permission to reproduce statement is granted. Please acknowledge the Canadian Association of Critical Care Nurses (CACCN).

Glossary
• Donation after Cardiocirculatory Death (DCD): Patients who do not fulfill neurological criteria for death or for whom continuing medical care may be considered futile. When there has been an agreement between families and the health care team to withdraw life-sustaining therapy and prior to withdrawal, consent for organ donation is requested. Death is anticipated to occur imminently upon withdrawal of life-sustaining therapy (Canadian Council for Donation and Transplantation [CCDT], 2005; Kootstra, Daemen, & Oomen, 1995).
• Family: “A group of individuals who are bound by strong emotional ties, a sense of belonging, and a passion for being involved in one another’s lives” (Wright & Leahey, 2013, p. 54). Family includes appointed substitute decision-makers.
• Neurological Determination of Death (NDD): The irreversible loss of the capacity for consciousness combined with the irreversible loss of all brain stem functions, including the capacity to breathe (CCDT, 2003).

Acknowledgements
The CACCN National Board of Directors would like to express appreciation to the following members for their contribution to the Deceased Organ and Tissue Donation Position Statement:

Committee Chair: Kirk Dawe, MN, NP, RN
Committee Members: Wendy D. Sherry, MN, RN, Kim Bowman, MEd, BScN, RN

CACCN National Board of Directors and the CACCN Organ Donation Position Statement Committee would like to acknowledge the assistance and support of Janice Bietel, MScN, RN, CNCC(C), CNNI(C), Jane Chambers-Evans, MSc A, MSc, Sam Shemie, MD, Karen Dryden-Palmer, MN, RN, CACCN President, the Canadian Blood Services and the CBS Deceased Donation Advisory Committee.

REFERENCES

Bibliography
March 1: Dynamics Planning Committee 2016 application deadline
March 3–5: BOD F2F Meeting, Toronto, ON
April 18: CNA Certification Examination
June 1: Dynamics 2015 conference brochure/online registration available
June 1: Brenda Morgan Leadership Excellence Award deadline
June 1: Spacelabs Healthcare Innovative Project Award deadline
June 1: Cardinal Health “Chasing Excellence” Award deadline
June 1: BBraun “Sharing Expertise” Award deadline

Awards available to CACCN members
Criteria for awards are published on pages 25–34 of this issue of Canadian Journal of Critical Care Nursing.

CACCN Facebook Page
Visit us on Facebook for updated information!

Follow us on Twitter:
@CACCN1

What’s new at www.caccn.ca?

CACCN Members Only!
- Start or join a discussion! The CACCN Members Only Discussion Forum is available to share information and meet nurses from coast to coast.
Dynamics 2016 Conference Planning Committee—Call for Participation

Dynamics 2016 will be held September 25–27, 2016, at the Delta Prince Edward in Charlottetown, Prince Edward Island. CACCN members from the New Brunswick Chapter/Eastern Region interested in working on the conference planning committee should submit a completed application form, together with a resume/CV to the CACCN National Office by March 1, 2015.

Please note, while any member may apply for the committee, consideration will be given to those who are New Brunswick Chapter (NB and PE) or Eastern Region (NB, NL, NS and PE) members. Planning Committee selection will take place in March 2015.

For further information on this exciting opportunity, please visit: www.caccn.ca/Dynamics 2016 for the Planning Committee Application submission and FAQs information.

Automatic renewal FAQs... CACCN membership

What is Automatic Renewal?
The new CACCN “Automatic Renewal” feature allows for automatic renewal of your membership on its expiry date if you pay via credit card. You will no longer have to worry about remembering to renew! Following the completion of your membership application, CACCN will charge membership dues to your credit card. Following this, CACCN will automatically charge your credit card at the selected membership interval (i.e., every one or two years). After each renewal, CACCN will send your membership card and receipt via mail. With this worry-free feature, your membership benefits will continue without interruption!

How do I sign up?
Signing up for automatic renewal is very easy!
• Members who complete their membership online are automatically included in the Automatic Renewal Program.
• If sending your membership using the printed membership/renewal form and a CREDIT CARD, the membership will be processed via the online system and “automatic renewal” implemented.
• On your next renewal date, depending on the membership term selected (one or two years), CACCN will renew your membership using the credit card information provided.
• If your credit card information or expiry date changes, be sure to let CACCN know by emailing caccn@caccn.ca or calling 1-866-477-9077 / 519-649-5284.

How does it all work?
Provided you continue to meet membership criteria (active or associate), your automatic renewal participation will continue until you choose to cancel your membership or opt out of the program. If there is a change in CACCN membership dues prior to automatic renewal, the newly determined fees will be applied. Any change in membership dues will be communicated well in advance of implementation.

Does CACCN store my credit card information?
No, CACCN does not store your credit card information in our database nor in any record held at National Office. All credit card information is explicitly stored with the credit card processing company Eigen Developments. Eigen Developments meets and exceeds all industry standards in ensuring the financial safety of our members. CACCN will maintain a record of those participating in the program via membership number and contact information.

Can automatic renewal be cancelled?
CACCN provides notification to members of the impending auto renewal of membership approximately forty-five (45) days prior to the renewal date via Canada Post and also provides notification via email. Refunds of payment will not be issued for auto renewal of membership fees if the member has not contacted CACCN National Office prior to the membership expiry date to cancel automatic renewal.

Cancellation of automatic renewal may be completed by submitting a written request to CACCN National Office at least fifteen (15) days prior to your membership expiry date: CACCN, P.O. Box 25322, London, ON N6C 6B1; via email to caccn@caccn.ca; or via fax to 519-649-1458.

Revised September 2014
Atrial electrogram interpretation improves after an innovative education program

By Julie L. Preston, BN(Hons), Crit Care Cert, MED, RN, Judy Currey, BN(Hons), Grad Cert Higher Ed, Grad Cert Sc(App Stats), Crit Care Cert, PhD, RN, Julie Considine, RM, BN, Grad Dip Nurs(Acute Care), Grad Cert Higher Ed, PhD, RN

Abstract

Background: To avoid adverse patient outcomes from inappropriate treatment, it is recommended that an atrial electrogram (AEG) be recorded whenever atrial arrhythmias develop in patients after cardiac surgery. However, AEGs are not commonly performed because nurses lack knowledge about differentiating atrial rhythms on AEGs.

Objective: To investigate whether completing a novel online evidence-based education program on interpreting AEGs would improve critical care nurses’ AEG interpretation.

Background: Cardiac surgery is among the most common surgical procedures performed worldwide (Ledoux & Luikart, 2010). A well known complication of cardiac surgery is atrial arrhythmias (Ledoux & Luikart, 2010). Approximately 30% of post-cardiac surgical patients develop new onset atrial fibrillation (Ledoux & Luikart, 2010) leading to complications such as hemodynamic instability, stroke and added health costs (Hogue, Creswell, Guterman, & Fleisher, 2005).

The surface 12-lead ECG is considered the gold standard tool for interpreting arrhythmias (Jackson, 2010). However, many atrial arrhythmias may mimic one another on a 12-lead ECG due to the distance of electrodes from the heart (Kern, McRae, & Funk, 2007), prominent atrial or ventricular electrophysiological activity (Ellis, 1998; Knight, Michaud, Strickberger, & Morady, 1999) or rapid ventricular responses (Conti & Ware, 2002). Inaccurate cardiac rhythm interpretation has been linked to adverse patient outcomes such as unnecessary initiation of anticoagulants and antiarrhythmic drugs (Bogun et al., 2004). Therefore, it is imperative that nurses, who monitor these patients for post-operative complications such as arrhythmias, interpret them accurately.

To overcome the known limitations of the surface 12-lead ECG, an atrial electrogram (AEG) recording and interpretation are recommended whenever a post-cardiac surgical patient develops an atrial arrhythmia (Drew et al., 2004). An AEG is recorded simultaneously with the surface ECG using temporary atrial epicardial pacing wires, which are routinely inserted during cardiac surgery. These wires are used predominately for pacing the atria to treat bradycardia (Ledoux & Luikart, 2010). However, they can also be connected to a bedside monitor or 12-lead ECG machine to record an AEG, which is similar to an intracardiac ECG for rhythm interpretation (Waldo, Ross, & Kaiser, 1971).

Although this nurse-initiated procedure is easy and quick to perform, the resultant cardiac rhythm must be interpreted correctly. Research has established that obtaining an AEG, although an evidence-based practice, is not commonly performed (Miller & Drew, 2007). One reason for the lack of AEG use may be nurses’ inability to accurately interpret AEGs due to a lack of knowledge (Miller & Drew, 2007). Providing timely education to nurses who work shifts has always posed a challenge. One strategy to maximize educational participation for shift-working nurses is online education programs, which offer learning opportunities at convenient times (Bromley, 2010).

Purpose

The primary aim of this study was to determine the effect of an online education program on the accuracy of nurses’ AEG interpretation. A secondary outcome was to establish the usefulness of the online education program. Assessment of learner satisfaction with the online education program was beyond the scope of this study.

Methods

Design

We employed a one group, time series, quasi-experimental design. The study was approved by Human Research Ethics Review Committees and all participants provided written informed consent prior to participation.

Sample and setting. This study was conducted in two Metropolitan Melbourne intensive care units (ICUs). One ICU was in a government-funded university tertiary referral hospital with 45 beds and a patient profile consisting of cardiac surgery and specialties such as heart and lung transplantation, mechanical cardiac assist devices, and adult trauma. The second ICU was in a major privately funded hospital with 15 beds and a patient profile consisting of elective post-surgical admissions primarily after coronary artery bypass grafting and valve replacements or repair.

Purpose sampling was used to recruit 61 registered nurses who had specialized critical care qualifications either from a university or a post-registration critical care certificate. Nurses

Methods: Specialized critical care nurses were taught about obtaining and interpreting atrial rhythms on AEGs using a 42-minute online mini-movie. AEG interpretation was assessed pre and two and eight weeks post-intervention.

Results: AEG interpretation increased two weeks post intervention and was retained at eight weeks. Some participants used their newly acquired knowledge to interpret arrhythmias that were not taught during the education program.

Conclusion: Accurate interpretation of AEGs is an easy skill for specialized critical care nurses to learn via an online education program.

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participants in this study were volunteers with at least six months cardiac surgical intensive care experience after completing their postgraduate qualification. In Australia, registered nurses complete a three-year baccalaureate degree in order to obtain specialized critical care qualifications. Specialization involves completion of at least one year of postgraduate study at a university coupled with clinical assessments. This cohort was chosen because post-cardiac surgical patients in ICU must be nursed by appropriately qualified and experienced nurses in order to manage and interpret patient information from the cardiac monitor, mechanical ventilation and cardiovascular support. There were no policies or procedures in either ICU for obtaining or interpreting AEGs. Therefore, the need to obtain and interpret AEGs in these clinical areas would be determined by individual nurses.

Procedures. Nurses who met the inclusion criteria were invited to participate in the study. Participants were required to complete four components of the study: a pre-test questionnaire, an online education program and two post-test questionnaires, two and eight weeks after completing the education program.

Instruments. Two questionnaires were developed by the researcher, as there were no previously validated data collection tools suitable for use in this study. Content and face validity were established by two critical care nurses not participating in the study and two post-doctorate nurse researchers who reviewed the questionnaires for clarity, content and question order.

The pre-test questionnaire elicited demographic data including clinical experience and experience with AEGs. Six case studies for rhythm interpretation were also included. A bank of 27 de-identified case studies was obtained in order to allocate these case studies. The bank contained sinus rhythm (SR) \((n = 10, 37\%)\), SR with a first degree atrioventricular (AV) block \((n = 1, 4\%)\), sinus tachycardia (ST) \((n = 2, 8\%)\), atrial fibrillation (AF) \((n = 4, 15\%)\), atrial flutter (AFL) \((n = 6, 22\%)\), AF with ventricular pacing \((n = 2, 8\%)\) and ST with 2:1 AV block \((n = 2, 8\%)\). Three experts (an electrophysiologist, a cardiac surgical nurse educator and a cardiac pacemaker rhythm specialist) assessed each 12-lead ECG and AEG for tracing quality and clarity and interpreted each rhythm. Inter-rater reliability was established at 100% for each case.

Each case study contained clinical background information such as the patient’s operative procedure, cardiopulmonary bypass time, past history, pre-operative rhythm, 12-lead ECG and corresponding AEG. Each participant was allocated six different case studies. The sequencing of the case studies was not in order of complexity in an effort to prevent interpretation of the rhythm by a process of elimination. Participants were instructed to read the patient information, and then interpret the cardiac rhythm on the 12-lead ECG and corresponding AEG.

The second questionnaire was administered two and eight weeks after the participant accessed the education program. Participants were asked if they had recorded or interpreted an AEG, attended an education session or read information on AEGs since beginning the study. Another six different case studies were allocated and the cardiac rhythm interpretation process was replicated from the pre-test questionnaire. Thus, each participant received 18 different case studies and no participant received the exact same case studies. Answers were treated in a binary manner (accurate or inaccurate), thus the maximum score was six for each set.

Education program. The education program was a 42-minute asynchronous narrated PowerPoint presentation converted to a mini-movie using iSpring software (iSpringSolutions, 2010). The education program included information about how to safely obtain an AEG and accurately interpret SR, ST, AF, AFL and AV blocks (first, second and third degree) from AEGs. This program was developed by the primary author who is an experienced educator and piloted by two peers who had no previous AEG education. After minor changes arising from the piloting process, the program was uploaded to a university’s password-protected learning management system website enabling the researcher to track and manage participant access. Email or text messages were sent to participants to encourage active participation and provide progress updates during the study (Gerber, Stolley, Thompson, Sharp, & Fitzgibbon, 2009). To meet the study aims, participants were required to complete the pretest questionnaire, access the online education program and complete the two post-test questionnaires (at weeks two and eight).

Data analysis. Data were analyzed using SPSS 20 (SPSS, Inc., Chicago, IL). Descriptive statistics (frequencies and percentages) were used to summarize study data. Scores for the accurate interpretation of cardiac rhythms on the AEGs across the three timeframes of the study were analyzed using the Wilcoxon Signed Rank Test. The Mann-Whitney U test was used to analyze differences in accurate AEG cardiac rhythm interpretation between groups based on demographic characteristics. Effect size was also calculated (Pallant, 2011).

Results
Of the 61 nurses who initially consented to participate in the study, 29 completed all study requirements: pretest questionnaire, the online education program and two posttest questionnaires. The response rate of 47.5% resulted in 174 AEGs being interpreted at each timeframe culminating in a total of 522 AEG interpretations for the entire study. Characteristics of the sample and potential relationships with accurate AEG interpretation scores pre-intervention are outlined in Table 1.

The majority of the sample (59%) was Grade 2 registered nurses. In Australia this indicates that participants were mainly bedside clinical nurses who had not yet taken on other duties such as an education portfolio or in-charge shifts. The majority of participants had postgraduate critical care qualifications obtained from a university (after 1995) and were from the larger ICU. Approximately half (52%) were aware that AEGs could be recorded. However, the majority had never recorded (73%), interpreted (76%), or read information (93%) on AEGs prior to the study.

Some characteristics were associated with differences in the number of correctly interpreted cardiac rhythms on AEGs pre-intervention and reached statistical significance. The first was between those who had a hospital versus university
postgraduate critical care qualification \( (U = 30.5, n_1 = 6, n_2 = 23, p = .03, r = .04, \text{two tailed}) \). The second difference noted was between those working in the larger versus the smaller hospital \( (U = 44, n_1 = 10, n_2 = 19, p = .02, r = .45, p = .02, \text{two tailed}) \). These differences were not maintained for the study’s duration.

The primary outcome, accurate AEG interpretation, significantly increased from baseline \( (T_0) \) to two weeks post-intervention \( (T_1) \) \( (p = 0.008) \). However, there were no significant differences in accurate interpretation of AEG accuracy scores between two weeks and eight weeks post intervention \( (p =

### Table 1: Participant demographic characteristics and pre-intervention AEG interpretation results across groups

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>( n )</th>
<th>( % )</th>
<th>( T_0 ) Score \text{ Medn} \text{ (0-6)}</th>
<th>IQR</th>
<th>Statistic</th>
<th>Effect size ( (r) )</th>
<th>( p )</th>
</tr>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>14</td>
<td>3</td>
<td>0.5, 5,5</td>
<td>43.5</td>
<td>-0.42</td>
<td>0.07</td>
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<td>Female</td>
<td>14</td>
<td>25</td>
<td>5</td>
<td>4, 5</td>
<td></td>
<td>0.67</td>
<td>0.67</td>
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<td>Age range 25–52 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>( M ) 33 years, SD 7.3</td>
<td>13</td>
<td>45</td>
<td>5</td>
<td>4, 5</td>
<td></td>
<td>0.74</td>
<td>0.14</td>
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<td>32 years or less</td>
<td>16</td>
<td>55</td>
<td>5</td>
<td>0.5, 5</td>
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<td>0.46</td>
<td>0.46</td>
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<tr>
<td>33 years or more</td>
<td></td>
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<td></td>
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<tr>
<td>Years working in ICU</td>
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<td>Range 1–17 years</td>
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<td>4 or less years</td>
<td>15</td>
<td>51</td>
<td>5</td>
<td>4, 5</td>
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<td>0.73</td>
<td>0.15</td>
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<td>5 or more years</td>
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<td>9</td>
<td>4.5</td>
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<td>0.16</td>
<td>0.16</td>
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<td>Hours worked per week</td>
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<tr>
<td>40 hours</td>
<td>9</td>
<td>31</td>
<td>4</td>
<td>1, 5</td>
<td></td>
<td>-0.83*</td>
<td>0.15</td>
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<tr>
<td>25–39 hours</td>
<td>13</td>
<td>44</td>
<td>5</td>
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<td>8–24 hours</td>
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<td>24</td>
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<td></td>
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<td>Grade 2(^a)</td>
<td>17</td>
<td>59</td>
<td>4</td>
<td>4, 5</td>
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<td>0.99</td>
<td>0.02</td>
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<td>CNS/ANUM/TL(^c)</td>
<td>12</td>
<td>41</td>
<td>5</td>
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<td>0.91</td>
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<tr>
<td>Hospital certificate</td>
<td>6</td>
<td>23</td>
<td>2.5</td>
<td>0, 4</td>
<td></td>
<td>0.30</td>
<td>0.04</td>
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<tr>
<td>University</td>
<td>23</td>
<td>79</td>
<td>5</td>
<td>4, 5</td>
<td></td>
<td>0.03*</td>
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<td>Highest education level</td>
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<td>1</td>
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<td>0, 5</td>
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<td>0.45</td>
<td>0.02*</td>
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<td>Honours</td>
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<td>14</td>
<td>5</td>
<td>4, 6</td>
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<tr>
<td>Postgraduate certificate</td>
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<tr>
<td>Postgraduate diploma</td>
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<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Privately funded hospital</td>
<td>10</td>
<td>34</td>
<td>3.5</td>
<td>0.5, 5</td>
<td></td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Government/university hospital</td>
<td>19</td>
<td>65</td>
<td>5</td>
<td>4, 6</td>
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<tr>
<td>Aware of AEG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>15</td>
<td>52</td>
<td>5</td>
<td>2, 5</td>
<td></td>
<td>0.16</td>
<td>0.93</td>
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<tr>
<td>No</td>
<td>14</td>
<td>48</td>
<td>4.5</td>
<td>4, 5</td>
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<tr>
<td>Frequency recorded AEG pre study</td>
<td></td>
<td></td>
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<td></td>
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<td>Never</td>
<td>21</td>
<td>72</td>
<td>5</td>
<td>3, 5</td>
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<td>0.04</td>
<td>0.82</td>
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<td>Once - 6 monthly</td>
<td>8</td>
<td>27</td>
<td>5</td>
<td>2, 5, 5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Frequency interpreted AEG pre study</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>22</td>
<td>76</td>
<td>4</td>
<td>1, 5</td>
<td></td>
<td>0.24</td>
<td>0.19</td>
</tr>
<tr>
<td>Once - 6 monthly</td>
<td>7</td>
<td>24</td>
<td>5</td>
<td>5, 5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Frequency read information on</td>
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<td>recording or interpreting AEGs</td>
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<tr>
<td>Never</td>
<td>27</td>
<td>93</td>
<td>2</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once – 6 monthly</td>
<td>2</td>
<td>7</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Note: \(^a\)Due to small sample group, size comparisons were made between full-time and part-time; \(^b\)Grade 2 = bedside clinical nurse; \(^c\)CNS = Clinical Nurse Specialist, ANUM = Associate Nurse Unit Manager, TL = Team Leader; NA = No analysis; AEG = atrial electrocardiogram, ICU = Intensive Care Unit; *Statistical significance not maintained for study’s duration.

\(U\) = Statistic, \(n_1\) = Sample 1, \(n_2\) = Sample 2, \(r\) = Effect size, \(p\) = Probability.
0.98), indicating that there was no significant improvement in accurate AEG interpretation from two weeks post intervention to eight weeks post intervention. Overall, the number of accurate interpretations for all cardiac rhythms tested improved from 64% \((n = 174)\) pre intervention to 89% \((n = 174)\) eight weeks post intervention (Table 2).

The frequency of actual cardiac rhythms interpreted on AEGs by participants across the study's duration is shown in Table 2. The number of correctly interpreted AEGs increased for the cardiac rhythms of SR, ST, AF, and AFL. The most frequently incorrect AEG interpretation was for SR with 1°AV block and ST with a 2:1 AV block. There was a variation in the number of different cardiac rhythms given to participants at the baseline and two post-intervention assessments. For example, the number of infrequently occurring or more complex rhythms such as ST with a 2:1 AV block increased two weeks after the intervention from 12 to 20. Conversely, the number of sinus rhythm AEGs given to participants to interpret was reduced from 76 to 53 (see Table 2). The education program was accessed once by all participants and it remained available throughout all non-assessment periods. As the study’s aim was to investigate nurses’ ability to interpret AEGs, data were not analyzed in terms of nurses’ ability to recognize a specific rhythm repeatedly. However, the frequency of rhythms interpreted is shown in Table 2 to illustrate the variation in actual cardiac rhythms received by participants over the study period.

Some uncontrolled variables may have had an impact on the results, such as participants engaging in other learning activities, so information about these was sought after the education intervention. All participants reported not to have attended any other education session regarding AEGs. The majority of participants \((T_1: n = 26, 90%; T_2: n = 27, 92%)\) reported that they did not read any education material on AEGs during the study. Some participants indicated they had recorded an AEG during the study \((T_1: n = 1, 3%; T_2: n = 7, 28%)\). Those who did not record an AEG cited reasons such as there were no atrial pacing wires insitu \((T_1: n = 11, 50%; T_2: n = 10, 77%)\), no arrhythmias were detected \((T_1: n = 6, 27%; T_2: n = 2, 15%)\), or AEGs were not standard practice \((T_1: n = 5, 21%; T_2: n = 1, 8%)\). One participant reported that he/she recorded an AEG when he/she was unsure of the cardiac rhythm displayed on the bedside monitor. Following interpretation of the AEG, treatment was changed based on his/her rhythm interpretation.

### Discussion

Specialized critical care nurses are able to accurately interpret cardiac rhythms on AEGs. Prior to the education program, 64% of cardiac rhythms on AEGs were correctly interpreted. This result is not surprising given these participants had prior cardiac rhythm interpretation knowledge and skills in interpreting 12-lead ECGs that are easily translated to AEG interpretation. A statistically significant improvement in accurate AEG interpretation two weeks post intervention occurred despite participants receiving more difficult and less-common cardiac rhythms by chance. This favourable result may be explained by the short timeframe between AEG-specific knowledge acquisition and assessment. No statistically significant improvement in accurate AEG interpretation scores was found from two to eight weeks following the intervention, indicating knowledge was maintained, and that AEG interpretative accuracy neither improved nor deteriorated over this time. This result may have occurred because more frequently occurring and, thus, more familiar cardiac rhythms were analyzed by participants at eight weeks post test. Alternatively, there may have been a ceiling effect whereby nurses with high levels of AEG knowledge exhibit lesser increases in knowledge acquisition than nurses with poor AEG knowledge.

The overall result that accurate AEG interpretations improved after an education program is consistent with results reported by McRae, Chan and Imperial-Perez (2010) who tested nurses’ AEG interpretation in combination with 12-lead ECG analysis following a 30-minute education program. The combination of results from both studies suggests interpreting AEGs is quick and easy for nurses to learn and that this skill can be achieved after a short, well-designed education program. The ease with which this can occur raises the issue of why the recommendation by Drew et al. (2004) that nurses obtain an AEG whenever a post-operative cardiac surgical patient develops an atrial arrhythmia is not frequently performed (Miller & Drew, 2007).

<table>
<thead>
<tr>
<th>Cardiac rhythm</th>
<th>T₁ Baseline (n)</th>
<th>T₂ 2 weeks post-intervention (n)</th>
<th>T₂ 8 weeks post-intervention (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinus rhythm</td>
<td>61/76</td>
<td>48/53</td>
<td>94/97</td>
</tr>
<tr>
<td>Sinus rhythm with a 1°AV block</td>
<td>3/8</td>
<td>10/10</td>
<td>3/5</td>
</tr>
<tr>
<td>Sinus tachycardia</td>
<td>12/14</td>
<td>15/15</td>
<td>6/6</td>
</tr>
<tr>
<td>Sinus tachycardia with 2:1 AV block</td>
<td>1/12</td>
<td>16/20</td>
<td>2/3</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>16/26</td>
<td>26/32</td>
<td>13/14</td>
</tr>
<tr>
<td>Atrial fibrillation with ventricular pacing</td>
<td>8/14</td>
<td>15/15</td>
<td>7/9</td>
</tr>
<tr>
<td>Atrial flutter</td>
<td>10/24</td>
<td>22/29</td>
<td>30/40</td>
</tr>
<tr>
<td>Total score at end of each timeframe</td>
<td>111/174</td>
<td>152/174</td>
<td>155/174</td>
</tr>
</tbody>
</table>

\(^a\text{AV} = \text{atrioventricular}\)

Numerator = number of rhythms on AEG interpreted correctly
Denominator = number of AEGs for the specific rhythm given to all participants to interpret
One reason may be that nurses do not have the confidence to initiate the investigation or do not see performing AEGs and rhythm interpretation as their responsibility (Miller & Drew, 2007). Teaching nurses this skill places responsibility for accurate rhythm identification via AEGs firmly in their domain and provides a foundation for performing it when clinically indicated. Indeed, it is expected that nurses can interpret cardiac rhythms on a monitor, so the same expectations should be applied to AEGs post cardiac surgery.

A number of cardiac rhythms were not interpreted accurately 100% of the time despite these being taught during the education program. However, one rare rhythm, ST with 2:1 AV block, was not included in the education program; yet some participants were able to interpret this correctly at all three timeframes (T0 n = 1, 8%, T1 n = 16, 84%, T2 n = 2, 66%). This result differs from McRae et al’s (2010) study in which participants showed no improvement with AEG interpretation in rhythms that were not taught during the education program. McRae et al’s (2010) result may have occurred because only 81% of participants had attended a formal course on interpreting cardiac arrhythmias, whereas all participants in this study had a formal critical care qualification that included approximately 20 hours devoted to 12-lead ECG analysis.

Despite the primary results suggesting AEG interpretation is easy to learn, not all participants achieved an accuracy score of 100% at the two post-intervention timeframes. This result may have occurred for a number of reasons. First, no supplementary clinical cues such as blood pressure and skin colour were provided. Further, clinical cues in case studies were not presented in the manner in which nurses are traditionally familiar (being able to visualize a patient), but rather, as text information on paper (Elstein, Shulman, & Sprafka, 1978). Second, these participants may have a preferred learning style that did not completely match the asynchronous teaching method used in this study (Quinn & Hughes, 2007). Finally, feedback is known to improve learning, in this case accurate interpretation (Croskerry, 2000), however, no participant took up the offer of feedback about his/her results. In order for nurses to further improve or remain at a highly accurate level of AEG interpretation, holding follow-up sessions to provide feedback about learning is recommended.

One unexpected result was that some participants reported they had self-initiated recording and interpreting cardiac rhythms from an AEG in clinical practice after the education program (T1 n = 1, 3%; T2 n = 8, 24%). This is particularly noteworthy given that there was no guidance in the form of a protocol, procedure or direction from senior staff for recording or interpreting AEGs in the study settings. The process of translating evidence-based practice guidelines and in turn, their uptake into clinical practice is known to take up to 20 years (Sussman, Valente, Rohrbach, Skara, & Pentz, 2006). One reason given for this delay is the need for education (Black, Schorr, & Levy, 2012). Continuing education is a convenient way for nurses to increase knowledge and skills (Skees, 2010). Results from this study indicate that interpreting AEGs was used in practice by nearly a third of participants after attending just one continuing education session.

A likely barrier to implementing AEGs in practice is the lack of protocols regarding indications and recording procedures (Miller & Drew, 2007). This is supported by Sinuff et al. (2013) whose systematic review of 119 investigations revealed that implementation of evidence-based guidelines in ICU was more likely when protocols were provided. Despite nearly one third of participants recording and interpreting AEGs, more nurses may have recorded and interpreted an AEG if a written protocol or procedure had been available in either ICU. Protocols may now be written because analyzing and synthesizing research, which is one of the barriers to implementing evidence-based practice (Rickbeil & Simones, 2012) has been performed and information relating to recording and interpreting AEGs is readily available in a respected cardiac nursing textbook (Ledoux & Luikart, 2010). However, further education on recording and interpreting AEGs may be required for all nurses caring for post-operative cardiac surgical patients.

**Limitations**

A number of limitations are associated with this study. First, only 29 of 61 initial participants completed all stages of the study. Participants who failed to complete all requirements of the study did not indicate high participant burden, or other reasons for their non-completion. However, although there were only 29 participants from two hospital sites, 522 AEGs in total were interpreted to meet the research aims and inform the conclusions. Second, participants were self-selected, as informed consent was a requirement of study participation. It is unknown whether the characteristics of nurses who did and did not participate were different. Third, the timing of the assessment of knowledge retention was limited to eight weeks, therefore, no claims regarding long-term knowledge retention or ongoing practice changes are made. Finally, there was a lack of individual feedback to participants to further improve their learning and accurate AEG interpretation. Although feedback was offered, no participants took this up. The unanticipated high pre-education AEG interpretation scores, combined with nearly one third of nurses recording AEGs prior to this study, suggests nurses had no expectations to initiate AEGs in practice. In hindsight, asking participants to rate their confidence in AEGs and tracking this over time may have been useful.

**Conclusion**

Cardiac arrhythmias are a common post-cardiac surgical complication. Inaccurate interpretation of post-operative atrial arrhythmias that mimic other arrhythmias on the surface 12-lead ECG can potentially lead to the commencement of inappropriate therapy and adverse patient outcomes. Thus, only an accurate interpretation of an AEG offers a precise interpretation of a postoperative cardiac surgical atrial arrhythmia leading to targeted treatment.

Results from this study indicated nurses’ AEG interpretations improved significantly after a short education program. This result suggests that interpreting cardiac rhythms from AEGs is an easy skill for nurses to learn and can be taught in a very short period of time. Further, nearly one third of nurses translated this newly acquired knowledge to clinical practice.
RECENTS


A social construction of the development of ICU nursing in Canada, 1960 to 2002

By Brandi Vanderspank-Wright PhD, RN, CNCC(C), Frances Fothergill Bourbonnais PhD, RN, Cynthia Toman, PhD, Christine McPherson PhD, RN

Abstract

**Background:** The early 1960s marked the opening of intensive care units (ICUs) in several hospitals across Canada. From the beginning, registered nurses constituted the largest body of health care providers in the ICU environment and they were the central provider of hands-on care to patients and families. From a historical perspective, however, a limited body of knowledge exists specific to the development of ICU nursing in Canada.

**Purpose:** In this study we explored the development of ICU nursing in Canada from 1960 to 2002 using a social history approach that emphasized the creation of an historical account from the perspective of the everyday experiences of ICU nurses.

**Method:** A social history approach was used. Primary sources included oral history interviews, documents and records, published professional literature between 1960 and 2002, as well as photographs. The study received ethics approval from the research ethics boards at the University of Ottawa (for conducting oral history interviews), as well as Queen's University (for access to archives at the Kingston General Hospital).

**Results:** The findings of this study provide a perspective on how ICU nurses learned and created new knowledge, as well as the establishment of an ICU nursing identity at both the individual and national levels.

Background

The early 1960s marked the opening of intensive care units (ICUs) in several hospitals across Canada. ICUs offered a defined space and place where critically ill patients could receive constant nursing care and where the necessary equipment and technology were readily available (Fairman & Lynaugh, 1998). From the beginning, registered nurses constituted the largest body of health care providers in the ICU environment and they were the central provider of hands-on care to patients and families. From a historical perspective, however, a limited body of knowledge exists specific to the development of ICU nursing in Canada. There has been very little exploration or understanding of how ICU nursing became an area of recognized specialty nursing practice in Canada.

Purpose

The development of ICU nursing in Canada was studied from 1960 to 2002 using a social history approach that emphasized the creation of a historical account from the perspective of the everyday experiences of ICU nurses. Berger and Luckmann’s (1966) Social Construction of Reality framework, facilitated an exploration and understanding of ICU nursing as a social process centred on relationships—particularly the relationships among ICU nurses themselves.

Methods

A social history approach was used for this study. Primary sources (first-hand accounts) included oral history interviews, documents and records, professional literature published during the period, and photographs. In total, 25 oral histories were conducted. The sample reflects nurses’ experiences from 41 hospitals across Canada including community and larger academic centres. Sampling was purposive and relied on key informants and subsequent snowball sampling. Analysis of the interview data used a thematic approach and the identified themes were corroborated throughout the analysis process with other primary and secondary sources, as a means of establishing methodological rigour from a historical perspective. Archival sources from hospitals and organizations included annual general reports, meeting minutes, and newsletters. Published professional literature included the Canadian Nurse (as Canada’s longest standing nursing publication since 1904) and articles from the Canadian Association of Critical Care Nurses (available from 1984 onward). Archival and personal photographs were also incorporated. The study received ethics approval from the research ethics boards at the University of Ottawa (for conducting oral history interviews), as well as Queen’s University (for access to archives at the Kingston General Hospital).

The social construction of reality

The incorporation of the Social Construction of Reality (Berger & Luckmann, 1966) framework emphasized that the development of ICU nursing was a social process that was not linear but, rather, iterative in nature and changed over time. Concepts incorporated from this framework include objective and subjective realities, which helped to emphasize that the early cohorts of ICU nurses experienced a practice reality that had little formalized structure or routine. Aspects of nursing practice may have been transferable from their experiences on the wards or in training, but ICU nursing from a Canadian perspective, had yet to be defined by a particular structure (what Berger and Luckmann [1966] described as an objective reality). ICU nurses played an important role in the establishment of a structured reality where routines and nursing practices in ICU were discernible and easily distinguishable from other practice areas.
Findings

Early intensive care units

The reformed image of the hospital in the early-to-mid twentieth century was successful in positioning these institutions as the primary place of care for the sick (Gagan, 1989; Wishart, 2001). Canadian historians like Toman have argued that the proliferation of medical technology within hospitals was partially responsible for hospitals becoming a major place of employment for nurses during the 1950s and-1960s (Toman, 2005; Toman, 2006). She argues that nurses enabled this proliferation since “[p]hysicians generally introduced new technologies and were responsible for them until the volume of treatments increased or became burdensome to the medical staff” at which point the work was delegated to the nursing staff (Toman, 2005, p. 97). With a patient population that was becoming more complex and a proliferation of new and more technologically advanced treatments, other solutions needed to be put in place for patients who were more critically ill. Caring for critically ill patients on the wards posed a risk to patient safety (e.g., due to high nurse-to-patient ratios), and early strategies to minimize risk, like moving the sickest patients closer to the nursing station, were only partially effective (Fairman & Lynaugh, 1998).

Unlike the emergence of ICUs in the United States, which began in the early 1950s, Canadian ICUs opened somewhat later in the early to mid-1960s. These ICUs were often make-shift areas where wards or other large rooms were converted and subdivided into smaller spaces (Fairman & Lynaugh, 1998). Fothergill Bourbonnais likened the early structure of ICUs to modern day post-anesthetic care units (recovery rooms) where patient care areas were partitioned off by curtains and offered relatively little privacy (F. Fothergill Bourbonnais, personal communication, September 30, 2011). She added that many of the ICUs where she worked at the beginning of her career were often removed from the rest of the hospital and often had little natural light, making it difficult to distinguish night from day.

Archival records of the Kingston General Hospital (KGH), which evidence from this current study suggests was one of the first ICUs in Canada, provided a glimpse into some of the initial discussions and decisions about the development of an ICU.1

By 1959, discussion had begun regarding the establishment of an Acute Treatment Area for surgical patients. According to the records of the Medical Conference Committee (MCC) at KGH, the Acute Treatment Area would group acutely ill patients into one area rather than leave them scattered throughout the facility while also “concentrate[ing] nursing and other skilled personnel” into such an area. The MCC noted that “[t]he Nursing Staff will require to be adequate [in number] and on a twenty-four-hour basis.” (Bingham, 1959, April 15). It was also anticipated that the area would be a “very valuable source of training for young nurses, students and, indeed, [doctors].” (Bingham, 1959, April 15).

According to the committee minutes of 15 September 1959, Bingham (Chair of the Acute Treatment Area Committee), suggested “a study should be made of the best means of using the available nurses at our disposal at the present time,” since he felt it advisable that the Intensive Treatment Area2 be opened as soon as possible (Bingham, 1959, September 15). Bingham visited the Rhode Island Hospital (in Providence, Rhode Island) in 1959 to tour their unit for the treatment of seriously ill surgical patients. On return, he wrote to the Chair of the KGH MCC remarking that, “All with whom I came in contact spoke most enthusiastically about it. The nurses felt that it reduced, to a very substantial degree, the nursing stress in the general wards, eliminating a good deal of running about with intravenouses, Levine suction tubes, etc. They felt intensely interested in the area and there was a real esprit de corps and pride in their work.” (Bingham, 1959, October 8). In summary, he noted the advantages of the unit to include expert care being available on a constant basis, and a decreased pressure on other areas of the hospital. He remarked: “I feel that it would be an act of folly for us not to establish such a unit in this hospital.” (Bingham, 1959, October 8).

The early days of the 1960s: Developing ICU nursing knowledge

The success of these newly formed ICUs ultimately depended on the creation of a group of highly skilled nurses to provide care to critically ill patients and their families. Basic nurse training focused on a foundational set of skills and knowledge required for general practice, and would prove insufficient for the care of critically ill patients. For early ICU nurses in Canada, there were limited numbers of textbooks, courses and formalized educational resources. Essentially, they found themselves in an area of nursing practice where expectations had yet to be established and where they were thrust into a practice reality with minimal structure. Initially, ICU nurses built on previous nursing experiences (like general duty nursing on medical-surgical units or their days as students), but they also relied heavily on one another and their shared experiences at the ICU bedside. Nurses coming to this new environment quickly recognized and acknowledged their need for a more advanced understanding of anatomy, physiology and treatment regimens (S. Anderson, personal communication, January 23, 2013; F. Fothergill Bourbonnais, personal communication, September 30, 2011; R. Pollock, personal communication, September 7, 2011). With few formal opportunities available to them, their learning was largely self-driven and acquired, often through trial and error, at the bedside. Together they learned from each other and with each other through the provision of hands-on care. For example, Pollock described an early experience of interpreting cardiac rhythms:

“We’d spend our night…working with strips and playing with strips…just playing with them and discussing…I can remember…being embarrassed because I had to call [the doctor] in the middle of the night and say… ‘I’m seeing...

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1 An employment advertisement for Registered Nurses in the Intensive Care Unit at the Kingston General Hospital was published in a 1961 volume of The Canadian Nurse. This advertisement appeared to be the first of its kind.

2 The name would change several times in the KGH records, from acute treatment area, to intensive treatment area and eventually to intensive care unit.
something I don't like on the monitor. I don't know what it is, but I don't like it and the patient's not doing well.' And it was V-Tach' (R. Pollock, personal communication, September 7, 2011).

Similarly, McBain recalled, “All we knew was if there was a straight line [on the cardiac monitor] to call for help!” (M. McBain, personal communication, January 23, 2013).

From early on, two things became clear. First, nurses for these units would require a high level of motivation to learn and acquire new knowledge in order to provide good patient care. Second, the practice environment was always changing—new procedures and changes in patient populations were constant and nurses would need strategies to keep up. The need for new knowledge prompted early ICU nurses to identify what they needed to know and how they would teach each other, which, ultimately, set the stage for a structured ICU nursing practice reality. Parks, for example, recalled the tremendous effort she made to gather and disseminate literature for the pediatric ICU nursing staff at Toronto’s Hospital for Sick Children. Parks’ early efforts resulted in a series of 12 educational manuals for the unit (that were in use until the 1980s). Parks also (unknowingly) demonstrated the benefits of simulation long before it had become a routine aspect of nursing education. She recalled:

“Somebody gave me a toddler-size doll, and what I did was drill holes in it and put tubes up and set it up so she was intubated and had a balloon for lungs, and I was then able to teach them about intubation and ventilation…I put in an arterial line and a catheter and an NG feeding tube— as much as I could.” (D. Parks, personal communication, April 19, 2013)

She noted that the use of the doll facilitated the acquisition of knowledge and hands-on skills that could be learned away from the bedside, and then transferred back to patient care (D. Parks, personal communication, April 19, 2013).

The 1970s: Formalized learning and changes in nursing education

The 1970s proved to be a significant period of change, particularly related to the development of more formalized educational strategies. From a broader Canadian perspective, according to historian Kirkwood (2005), significant pedagogical shifts had taken place in nursing education with a move away from basic nursing education/training being taught primarily in hospital schools towards the preparation of nurses in colleges and universities (1970s and 1980s). A graduate workforce replaced the predominantly student workforce (Toman, 2006). This change in nursing education influenced the way nursing students acquired hands-on nursing experience and resulted in less time spent at the bedside.

Strategies to support new nurses were implemented into hospital settings. Initially, emphasis was placed on hospital-based orientations and, later, unit-based orientations. Discussion regarding the purpose and benefits of formalized hospital orientation had begun to surface in the Canadian Nurse in the 1960s and by the early to mid-1970s many of this study’s participants recalled having had an orientation. Evidence suggested that orientation programs (like hospital orientations) had a positive impact on new employees’ satisfaction, easing their anxieties and promoting a better transition into their new work experience/role (Buller & McDonald, 1962). Over time, study participants referred to more formalized ICU orientations from the early 1970s onward. Other learning strategies were linked with orientations and hiring “new to ICU” nurses, including the tendency to try and assign these new nurses to patients who were generally more stable, such as patients who required chronic ventilation. This strategy was coupled with ensuring new nurses had access to more experienced ICU nurses. Having a more experienced nurse in close proximity was pivotal, as they provided the support, the knowledge and the “know how” to ensure patient safety, as well as transitioning the new nurse into providing safe, competent care. However, while assigning new nurses to more stable patients was the ideal, participants like van den Berg noted that it was not always possible, especially when taking into account the unpredictability of patients with critical illness (R. van den Berg, personal communication, January 9, 2012).

The development of knowledge and skills needed to care for increasingly complex patients required continuing education, as well. Post argued that, “No professional nurse can function well or for long without continuing to learn. A nurse who graduated five years ago and has not studied in her field is out of date” (Post, 1969, pp. 29–30). By the mid-1970s, continuing education was becoming standard for staff nurses on the wards and in specialty units like the ICU. The majority of participants in this study recalled in-service education and workshops as the most common and frequently accessed form of continuing education. However, this type of education, although the most common, was also problematic for several reasons, but mainly because ICU nurses were the primary caregivers for patients and families. Their position at the bedside restricted their flexibility to leave the unit during the day to attend these educational sessions (J. Elliott, personal communication, September 15, 2011). Information and new knowledge from in-services were often disseminated among ICU nurses by their colleagues who had been able to take advantage of the continuing education opportunity. In-service education sessions were often attended by nurses on their own time, further indicating their commitment to learning and to enhancing patient care.

The closing of hospital schools of nursing and a shift to colleges and universities in the 1970s resulted in less experiential learning at the bedside for students. As Kirkwood (2005) noted, even prior to this change in nursing education, it had already become apparent within hospital training schools that junior students did not have the necessary skills to care for more complex patients. By the late 1970s, there were several innovative experiments to supplement nursing education and clinical experience, as well as ensure nurses’ knowledge and skills were adequate to care for an increasingly complex patient population. These include preceptorships, specialty conferences, and formalized ICU nursing courses.

Preceptorship programs were established to link theory and practice and to provide adequate clinical exposure, initially for
nursing students. Preceptorship involved a student nurse working alongside an experienced staff nurse for a designated period of time. ICUs were one of the first clinical practice areas to trial a preceptorship model of education. For example, in 1978, the British Columbia Institute of Technology began a preceptorship project. Taylor and Zabowski (1982) explained that the model was mutually beneficial, as the student worked side by side with an experienced nurse, and the nurse (or preceptor) identified the experience as educationally stimulating, and felt a sense of accomplishment through the sharing of nursing knowledge and an opportunity to sharpen his or her own skills and clinical thinking. The preceptorship model fit extremely well with ICU nursing education because learning in the ICU had always included at a minimum, a pairing or “buddy system”—a new nurse working alongside a more experienced nurse.

Fothergill Bourbonnais recalled the development of a consolidation experience in 1981 for all fourth-year students in the baccalaureate program at the University of Ottawa. Students selected an area to complete their final clinical experience, structured as a preceptorship program. The experience lasted six weeks full time and later became eight weeks. A small number of fourth-year students went to the ICU and, soon after, others could choose the emergency department or the post-anesthesia care unit, as well. Fothergill Bourbonnais said, “Because of my background [as a critical care nurse]… we organized it so that a [small] group of students could go to intensive care. And, at the time, we developed the consolidation experience, we knew that we had to have certain criteria [for student selection]” for those going to ICU (F. Fothergill Bourbonnais, personal communication, September 30, 2011). The specific criteria, she explained, included high academic standing and references from previous clinical instructors that indicated critical thinking and independence, among other traits. Preceptorship, as Burrows recalled, “was a great opportunity to learn.” (M. Burrows, personal communication, August 31, 2011). She explained that learning from senior staff, as role models, played an integral role in becoming more comfortable in one’s self, as a developing professional.

The 1980s—Practice changes and moving towards a national ICU nursing identity

Along with the introduction of preceptorship experiences in ICUs, significant progress began to take place for intensive care nursing education from a national perspective. By the early 1980s, ICU conferences and courses had become common across the country. Evidence suggests that early programs, like the Intensive Care Nursing Program at the Winnipeg General Hospital (WGH), which began in 1966, were instrumental in the dissemination of critical care nursing knowledge across the country. Participants like Dyna and Stutsky noted that students came from across Canada, as well as internationally to participate in the Winnipeg course (A. Dyna, personal communication, October 27, 2011; B. Stutsky, personal communication, October 26, 2011). Importantly, the course included a formal, structured “buddying” experience with an experienced nurse, reinforcing that an essential part of learning for ICU nurses was from, and with, each other (Health Sciences Centre, no date). Evidence also indicates that ICU nurses actively promoted their own continuing education by developing these courses and organizing conferences (Canadian Nurses Association, 1967; Winnipeg General Hospital, 1969; Weick, 1989, May 8; M. Burrows, personal communication, August 31, 2011.)

Towards a national identity. The 1980s marked another important development in the history of intensive care nursing in Canada. The American Association of Critical Care Nurses (AACN) had been in existence since 1969 and had within its structure an educational mandate for nursing (Fairman & Lynaugh, 1998). Prior to 1975, it is likely that Canadian ICU nurses relied to a certain extent on the AACN for educational support. However, by the mid-1970s a national grassroots movement was taking place within Canadian ICU nursing. The movement resulted in the establishment of a Canadian Chapter of the AACN in Toronto in 1975 and other associations like the Niagara Association of Critical Care Nurses in 1979. At the Toronto Chapter’s executive meeting on April 20, 1983, the group decided to leave the AACN and form a Canadian association. Meeting minutes suggest that experience with the AACN had provided “structure, guidance, and credibility” to the fledgling Canadian group (Toronto Chapter of the AACN, 1983, April 20). According to Zanin (1984), “a need for autonomy and credibility” prompted the split and the AACN gave full support. The Toronto Chapter became the National Society of Critical Care Nurses (NSCCN) with individual chapters in London, Windsor, and Vancouver (Mahon, 2008). The Niagara Association changed its name to the Canadian Association of Critical Care Nurses under which new chapters formed in Niagara, Waterloo Regional, Hamilton, Ottawa, and Alberta (Mahon, 2008).

By 1985, a merger of the NSCCN and the Canadian Association of Critical Care Nurses (formerly the Niagara group) marked the foundation of what is now referred to collectively as the Canadian Association of Critical Care Nurses (CACCN). Mahon (2008) suggested that the merger reflected a “true spirit of unity” (p. 6) in that the name was incorporated from the CACCN and the official logo was that of the Toronto-based NSCCN. The merger of these two groups brought the total CACCN membership to more than 700 in 1984 (Zanin, 1984).

The formation of the CACCN provided opportunity to build on educational initiatives previously offered by the individual associations and chapters. In 1984, for example, the NSCCN sponsored a “Dynamics of Critical Care Conference” held September 26–28 in Toronto. It was advertised at a national level in the newly established Canadian Critical Care Nursing Journal. In the years following, annual conferences held by the

3 The official publication of the association would change names several times: Canadian Critical Care Nursing Journal (1984 to 1990); The Official Journal of the Canadian Association of Critical Care Nurses (1990 to 1999); Dynamics: The Official Journal of the Canadian Association of Critical Care Nurses (2000 to 2010); and Dynamics: Journal of the Canadian Association of Critical Care Nurses (2011 to the present). (C. Halikenny-Zellas, personal communication, August 12, 2013).
Standards clearly claimed critical care nursing as:

its “Standards for Critical Care Nursing Practice,” which under-
1986, p. 7). By 1992, the CACCN published the first edition of
accepted as “credible and attainable by practitioners” (Whitely,
& Scherer, 1987; Whitely, 1986). The Standards Committee,
chairied by Whitely, provided an avenue by which a committee of
practitioners could begin to develop standards that would be
accepted as “credible and attainable by practitioners” (Whitely,
1986, p. 7). By 1992, the CACCN published the first edition of
its “Standards for Critical Care Nursing Practice,” which under-
Standards clearly claimed critical care nursing as:

A profession which exists to care for clients who are experi-
cencing life-threatening health crises. Nursing the critically
ill client is continuous and intensive. Critical care nurs-
requires a careful decision-making process, founded
upon a sound knowledge base and the ability to assess,
intervene, and evaluate. Aided by sophisticated technol-
y and advanced knowledge, critical care nurses aim to
assist clients to achieve and maintain an optimum level of
functioning or a peaceful death (Canadian Association of
Critical Care Nurses, 1992, p. 3).

Within the Social Construction of Reality framework, the
establishment of these standards for critical care nursing prac-
tice marked the institutionalization of ICU nursing in Canada.
Years of history, shared experiences, specialty knowledge, and
clinical practice culminated in a set of national standards. The
standards provided a structure and framework for critical care
nursing practice in Canada—subsequently shaping practice
realities (objective realities), the knowledge required, and the
expectations for working with patients, families and each other.
The “Standards for Critical Care Nursing Practice” were also
pivotal in CACCN’s application to the Canadian Nurses’
Association Specialty Certification Program. In 1993, the
CACCN, in collaboration with a working group of critical
care nurses from across the country, identified initial compe-
tencies for certification in critical care. The CACCN submitted
the “Specialty Designation Proposal for Critical Care Nursing”
to the Canadian Nurses Association (Canadian Association of
Critical Care Nurses, 1993). It was intended to be “the basis to
create a critical care certification exam” (Morgan, 1999, p. 10).
The initial exam blueprint was completed in 1994 and, until the
year 2000, included a pediatric component (Canadian Nurses
Association, 1994). A separate pediatric exam was developed
subsequently in 2003 (Canadian Association of Critical Care
Nurses, 1999). Critical care nursing was formally established as
an area of specialty practice in 1995.

Over the course of the CACCN’s existence it worked dili-
gently towards becoming the voice of critical care nursing
in Canada. The “Dynamics” conferences and the evolving
journal enabled the identification of pertinent Canadian
critical care issues over time. An analysis, for example, of
the topics of the yearly “Dynamics” conferences reveals the
growth of the association, as well as strengthening the voice
of Canadian critical care nurses. Initially, conference pro-
grams included many presentations from physicians rather
than nurses (similar to the early years of the Winnipeg ICU
nursing program). Over time, however, physician presence at
these conferences (as presenters) diminished and ICU nurses,
including those in formal leadership and educational roles, as
well as front-line nurses, formed the body of presenters. From
an initial focus on highly technical discussions, presentations
expanded to highlight the broader ethical and societal issues
that impacted critical care nurses. For example, discussions
began to reflect the toll on nurses of trying to provide care to
critically ill patients and families when little regard was given
for their own emotional needs (Gervaise & Howard, 1984).
Through conferences and a national publication, front-line
nurses found opportunity to voice their experiences from
their individual ICUs.

Summary

Over a period of approximately 40 years, nursing in Canadian
ICUs grew from individual nurses who worked in ICUs, to a
recognized specialty nursing practice area with formalized stan-
dards and competencies. Over time, nurses began to recognize
themselves as critical care nurses rather than simply nurses who
worked in critical care. As a critical mass of ICU nurses devel-
oped in Canada, they sought a national identity that, ultimately,
became the Canadian Association of Critical Care Nurses. This
study provides a beginning exploration of ICU nursing from a
Canadian perspective and serves as a starting point, from a
historical perspective, to further explore ICU nursing educa-
tion and knowledge development, the role of technology in this
milieu of care, as well as the socialization and identity forma-
tion of ICU nurses themselves.

The findings of this study provide a perspective on how ICU
nurses learned and created new knowledge, as well as the estab-
ishment of an ICU nursing identity at both individual and
national levels.

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The Draeger Medical Canada Inc. “Chapter of the Year” Award

The Draeger Medical Canada Inc. “Chapter of the Year” Award is presented to recognize the effort, contributions and dedication of a CACCN Chapter in carrying out the purposes and goals of the association.

The Chapter of the Year criteria is founded on the CACCN Mission Statement and recognizes the activities of the Chapter with specific emphasis on service to members and promotion of the specialty of Critical Care Nursing including, but not limited to publications, presentations, and certification activities.

Note: this award application process is complementary to the Annual Chapter Report. We recommend completion of the Annual Chapter Report prior to proceeding with calculating the Chapter of the Year score.

Award funds available: $500.00
Recognition plaque

Submission deadline: May 31 annually
Application process: Mandatory submission for all Chapters

Criteria for the award program
• Eligible chapter activities for the period of April 1 to March 31 each year
• The chapter awarded the most points will be the successful recipient of the Chapter of the Year Award
• In the case of a tie, CACCN BOD will determine the final recipient of the award
• The successful chapter will be announced at Chapter Connections Day
• Plaque and cheque will be presented at the annual awards ceremony at Dynamics by the Chapter of the Year recipients for the previous year.

Conditions for the award program
• All chapters of CACCN are eligible for Chapter of the Year Award
• Chapters who have not submitted their annual report and quarterly financials by the required deadline quarterly/annually to National Office will not be eligible for the award
• Chapters will be responsible for ensuring that National Office receives all required documentation to be considered for the award
• Points will be awarded for only chapter activities that have been validated with supporting documentation
• The successful Chapter will be announced at the annual CACCN Awards Ceremony and in CACCN publications
• All Chapter reports/and individual chapter scores will be available for review at Chapter Connections Day/Dynamics.

Points system
Points are accumulated in each of six activity categories:

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<th>Section</th>
<th>Category</th>
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<tr>
<td>1</td>
<td>Member education</td>
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<td>2</td>
<td>Promotion of critical care specialty</td>
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<tr>
<td>3</td>
<td>New member recruitment</td>
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<td>4</td>
<td>Sustained membership</td>
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<td>5</td>
<td>Academic activity</td>
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<tr>
<td>6</td>
<td>Certification activity</td>
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</tbody>
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Instructions:
1. Complete the Chapter Annual Report
2. Gather validation documents for each of the categories of activities in the past year
3. Calculate scores for sections 1 thru 6
4. Add section scores for total Chapter of the Year score
5. Submit the application with documentation to CACCN National Office by May 31 annually

Section instructions
Section 1: Member education
• Any educational event coordinated and hosted by the local chapter is eligible
• The total number of hours for an educational session are considered (excluding meal breaks and social events)
• Concurrent sessions are not cumulatively totaled. It is presumed that the session participants would be split between the concurrent session, therefore hours of education for participant is not altered
• For example: an eight-hour educational day that includes six concurrent sessions would be counted as eight hours for a total of 6 CL hours
• Please contact CACCN head office if your delivery model is different than reflected in this section
• Suggested validation documents:
  • Brochure, advertising or pamphlet
  • Copy of agenda (including hours of education)
  • Attendee numbers
  • Evaluation forms or report from each event

Formula:
• To create the member education score, the total number of hours of education hours provided in the year is divided by the total number of Chapter members, this number is then multiplied by 1,000 in order to establish a score that is not dependent on the size of the individual chapter.

Total hours of education offered in the year
Total number of Chapter members x 1000 = member education

Example:
Chapter A
• Donation after Cardiac Death educational meeting – 3 hours
• Total Chapter Membership number 26
• 3 hours divided by 26 members = 0.115 multiplied by 1000 = 115
• therefore the membership education innovation score is 115
Chapter B
• Neuro education and bioethics education session offered
• Total education hours – 28 hours
• Membership number 310
• Formula: 28 hours divided by 310 members = 0.090 multiplied by 1000 = 90
• Therefore, the member membership education score is 90

Section 2: Promotion of critical care specialty
Total hours of any public or community service event coordinated and hosted by the local chapter is eligible.
• Concurrent sessions are calculated as per member education hours. For example: an eight-hour event that includes six concurrent sessions would be counted as eight hours.
• Eligible event must be clearly indicated as sponsored/hosted by CACCN. Event examples: participating in blood pressure clinics, teaching CPR to the public, participation in health fairs.

Validation documents:
• Documents to identify event as CACCN sponsored
  • For example, submitting a letter from the receiving group or a picture of the event, etc.

Formula:
To create the Promotion of Critical Care Specialty score, the total number of hours of promotional event hours provided in the year is divided by the total number of Chapter members. This number is then multiplied by 1,000 in order to establish a score that is not dependent on the size of the individual chapter.

Total new members
Total number of chapter members x 100 = percentage of new members

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Points</th>
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<tr>
<td>01–10%</td>
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<td>51–60%</td>
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<td>11–20%</td>
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<td>41–50%</td>
<td>50</td>
<td>91–100%</td>
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</tbody>
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Chapter A
• Total number of new members 23
• Total number of chapter members 110
• Formula: 23 new members divided by 110 members = 0.209 multiplied by 100 = 20.9 % - rounded up to 21%
• 21% corresponds with the 21-30% level on the chart therefore 30 points will be awarded.

Chapter B
• Total number of new members – 12
• Total number of chapter members 38
• Formula: 12 new members divided by 38 members = 0.315 multiplied by 100 = 31.5 % - rounded up to 32%
• 32% corresponds with the 31-40% level therefore 40 points will be awarded.

Section 4: Sustained members
• Calculated based on the percentage of renewing members up to March 31 of the award year
• Any member with a membership lapse of less than 12 months or more will be considered a renewed member
• i.e., a membership expired April 2013 and is renewed February 2014. This member would be considered a renewing member as the renewal is within 12 months of the expiry
• i.e., a membership expires April 2013 and is renewed June 2014. This member would be considered a new member as the “renewal” is over 12 months of the expiry
• Use the Membership Recruitment/Retention spreadsheet from the CACCN national office to obtain the number of new members
Formula:
To create the sustained members score, the total number of renewed members is divided by the total number of chapter members as of March 31 of the award year. This number is then multiplied by 100 to give you the percentage of sustained members. The points awarded are noted on the chart based on the percentage of new members.

Total new members
Total number of chapter members x 100 = percentage of new members

<table>
<thead>
<tr>
<th>Percentage</th>
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<td>71–80%</td>
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<td>31–40%</td>
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<td>81–90%</td>
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<tr>
<td>41–50%</td>
<td>25</td>
<td>91–100%</td>
<td>50</td>
</tr>
</tbody>
</table>

Example:
Chapter A
- Chapter A renewed 70 members this past year
- They have 250 total chapter members
- 70 divided by 250 = 0.28 multiplied by 100 = 28%
- 28% corresponds with the 21–30% category therefore 15 points are awarded

Section 5: Academic activity
- This section accounts for the activity of each chapter related to contribution to the science and specialty of critical care nursing. This can include publications and presentations in local, national and international journals, and presentation delivered by chapter members.
- Participation in national position statements, standards work and other committees is also scored.

Formula
Publications
- Points will be calculated for chapter members who have contributed articles to:
  - The chapter newsletter
  - Canadian Journal of Critical Care Nursing (excluding the Summer Abstract Journal)
  - Any other peer reviewed journal where the author is affiliated with CACCN
- Chapters are responsible for providing:
  - list of member contributions, together with a copy of the chapter newsletter
  - list of member contributions to the journal or publication (full reference)

Each article = 25 points

Presentations
- Points will be calculated for chapter members who have contributed presentations at local, provincial and national CACCN activities
- Points will be awarded only once for the presentation, regardless of the number of times/venues, at which it is presented
- Chapters are responsible for providing:
  - list of member contributions, together with a copy of the brochure or flyer listing the chapter member as a presenter.
  - Each Presentation = 25 points

Committee work
- Points will be calculated for chapter members who have contributed to committee work on behalf of CACCN at the local, provincial and national CACCN activities
- Points will be awarded only once for each member on each committee, regardless of the number of meetings or level of participation of the member
- Chapters are responsible for providing: list of member contributions.

Total points from all three areas:

Example
Chapter A
- An article was published by a member in the chapter’s newsletter = 25 points
- One article from a chapter member was published in Canadian Journal of Critical Care Nursing = 25 points
- One chapter member presented at the local education day = 25 points
- Three members presented separate presentations at a Dynamics conference = 75 points
- Total points = 150

Section 6: Critical care certification—CNCC(C) and CNCC(P)
- Points will be calculated for chapter members who have successfully completed and/or renewed the CNA Certification Examination in the award year
- Validation of certification status of submitted members will be obtained via the Canadian Nurses Association

Formula initial certification
To create the certification score, the total number of certified members of the chapter in the award year is divided by the total number of chapter members. This number is then multiplied by 100 to give you the percentage of certified members. Multiply this number by 10 to give you the number of points awarded.

\[
\text{Number of members certified/renewed} \times \frac{100}{\text{Total number of chapter members}} \times 10 = \text{Points awarded}
\]

Example
Chapter A
- Initial certification = 3 members
- 250 chapter members
- 3 divided by 250 = 0.012 multiplied by 100 = 1.2%
- multiplied by 10 = 12 points

Formula renewal certification
To create the renewal certification score, the total number of renewed certifications of the chapter in the award year is divided by the total number of chapter members. This number is then multiplied by 100 to give you the percentage of certified members. Multiply this number by 5 to give you the number of points awarded.

\[
\text{Number of members certified/renewed} \times \frac{100}{\text{Total number of chapter members}} \times 5 = \text{Points awarded}
\]

Example
Chapter A
- Initial certification = 3 members
- 250 chapter members
- 3 divided by 250 = 0.012 multiplied by 100 = 1.2%
- multiplied by 10 = 12 points

Each member = 5 points
Number of members renewed  
Total number of chapter members x 100 = Percentage  
5 points for each percentage of the total number of chapter members who are new certifications in the award year.

Percentage x 5 = certification points

Example

Chapter A
- Renewed certification = 11 members
- 250 chapter members
- 11 divided by 250 = 0.044 multiplied by 100 = 4.4%
- multiplied by 5 = 22 points
- Add initial certification total with renewal total for points awarded in certification category
- Initial certification points + renewal certification points = total certification score for chapter
- Example Chapter A: 12 + 22= 34 certification points

Submission: Tally the points from all categories on the calculation form, complete the application form and forward all to National Office with supporting documentation.

Draeger Medical Canada and the CACCN Board of Directors look forward to receiving your application. Good luck in your endeavours!

The CACCN Board of Directors & Draeger Medical Canada retain the right to amend the award criteria

Criteria Revisions: October 2014
CACCN Document: Award Criteria Revised March 2011
Form Design Revision Date: January 2011

The Draeger Medical Canada Inc. Chapter of the Year Award

CACCN Research Grant

The CACCN research grant has been established to provide funds to support the research activities of a CACCN member that are relevant to the practice of critical care nursing. A grant will be awarded yearly to the investigator of a research study that directly relates to the practice of critical care nursing.

Award funds available: $2,500.00

Deadline for submission: February 15

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or mail to: CACCN, PO Box 25322, London, ON N6C 6B1. Mailed applications must be postmarked on or before February 15.

Eligibility:
The principal investigator must:
- Be a member of CACCN in good standing for a minimum of one year
- Note: where a student is submitting the research grant application and is ineligible to act as the principal investigator, the student must be a member of CACCN in good standing for a minimum of one year
- Be licensed to practise nursing in Canada
- Conduct the research in Canada

Additional requirements:
- Publish an article related to the research study in Canadian Journal of Critical Care Nursing
- CACCN members enrolled in a graduate nursing program may also apply
- Members of the CACCN board of directors and the awards committee are not eligible.

Budget and financial administration:
- Funds are to be issued to support research expenses
- Funds must be utilized within 12 months from the date of award notification.

Review process:
- Each proposal will be reviewed by a research review committee
- Its recommendations are subject to approval by the board of directors of CACCN
- Proposals are reviewed for potential contribution to the practice of critical care nursing, feasibility, clarity and relevance
- The recipient of the research grant will be notified in writing.

Terms and conditions of the award:
- The research is to be initiated within six months of receipt of the grant
- Any changes to the study timelines require notification in writing to the board of directors of CACCN
- All publications and presentations arising from the research study must acknowledge CACCN
- A final report is to be submitted to the board of directors of CACCN within three months of the termination date of the grant
- The research study is to be submitted to the Canadian Journal of Critical Care Nursing for review and possible publication.

Application requirements:
- A completed application form
- A grant proposal not in excess of five single-spaced pages exclusive of appendices and application form
- Appendices should be limited to essential information, e.g., consent form, instruments, budget
- A letter of support from the sponsoring agency (hospital, clinical program) or thesis chairperson/advisor (university faculty of nursing)
- Evidence of approval from an established institutional ethical review board for research involving human subjects and/or access to confidential records. Refer to CNA publication Ethical Guidelines for Nursing Research Involving Human Subjects
- A brief curriculum vitae for the principal investigator and co-investigator(s) describing educational and critical care nursing background, CACCN participation, and research experience. An outline of their specific research responsibilities
- Proof of CACCN active membership and Canadian citizenship
- Facility approval for commencement of study.

CACCN Research Grant Application located at http://www.caccn.ca/en/awards/index.html or via CACCN National Office at caccn@caccn.ca.

The CACCN Board of Directors retains the right to amend the award criteria.
The Editorial Awards
The Editorial Awards will be presented to the authors of two written papers in *Canadian Journal of Critical Care Nursing* which demonstrate the achievement of excellence in the area of critical care nursing.

**Award funds available:** $1,250.00 total
- $750.00 award will be given to the author(s) of the best article
- $500.00 award will be given to the author(s) of the runner-up article
- It is expected that the award funds will be used for professional development
- More specifically, the funds must be used by the recipient within 12 months following the announcement of the winners, or within a reasonable time, to cover and/or allay costs incurred while attending critical care nursing-related educational courses, seminars, workshops, conferences or special programs or projects approved by the CACCN, and to further one’s career development in the area of critical care nursing.

**Deadline for submission:** Fall, Winter and Spring Journal manuscripts annually.

Send *manuscripts for publication* to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or mail to: CACCN, PO Box 25322, London, ON N6C 6B1

**Eligibility**
- The author is an active member of the Canadian Association of Critical Care Nurses (minimum of one year)
- Should there be more than one author, at least one has to be an active member of the Canadian Association of Critical Care Nurses (minimum of one year)
- The author(s) is prepared to present the paper at Dynamics of Critical Care Conference (optional)
- The paper contains original work, not previously published by the author(s)
- Members of the CACCN board of directors, awards committee or editorial committee of *Canadian Journal of Critical Care Nursing* are excluded from participation in these awards.

**Criteria for evaluation**
- The topic is approached from a nursing perspective
- The paper demonstrates relevance to critical care nursing
- The content is readily applicable to critical care nursing
- The topic contains information or ideas that are current, innovative, unique and/or visionary
- The author was not the recipient of the award in the previous year.

**Style**
- The paper is written according to the established guidelines for writing a manuscript for *Canadian Journal of Critical Care Nursing*
- For the *Canadian Journal of Critical Care Nursing* manuscript submission guidelines, please refer to the CACCN Information for Authors at [http://www.caccn.ca/en/publications/dynamics/authors.html](http://www.caccn.ca/en/publications/dynamics/authors.html)

**Selection**
- The papers are selected by blind review by the awards committee in conjunction with the CACCN board of directors.
- The awards committee reserves the right to withhold the awards if no papers meet the criteria.

**Presentation**
The awards are presented by representatives of the sponsoring company or companies at the Dynamics of Critical Care Conference.

*The CACCN Board of Directors retains the right to amend the award criteria.*

The Spacelabs Innovative Project Award
The Spacelabs Innovative Project Award will be presented to a group of critical care nurses who develop a project that will enhance their professional development.

**Award funds available:** $1,500.00 total
- $1,000.00 will be granted to the Award winner
- $500.00 will be granted for the runner up
- A discretionary decision by the review committee may be made, for the award to be divided between two equally deserving submissions for the sum of $750.00 each.

**Deadline for submission:** June 1 each year

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1.

**Do you have a unique idea?**

**Award criteria:**
- The primary contact person for the project must be a CACCN member in good standing for a minimum of one year
- Applications will be judged according to the following criteria:
  - the number of nurses who will benefit from the project
  - the uniqueness of the project
  - the relevance to critical care nursing
  - consistency with current research/evidence
  - ethics
  - feasibility
  - timeliness
  - impact on quality improvement.
- If the applicant(s) are previous recipients of this award, there must be a one-year lapse before submitting an application
- Members of the CACCN board of directors and the awards committee are not eligible.

**Award requirements:**
- Within one year, the winning group of nurses is expected to publish a report that outlines their project in *Canadian Journal of Critical Care Nursing*.

*The CACCN Board of Directors and Spacelabs Healthcare retain the right to amend the award criteria.*
**CACCN Educational Awards**

The CACCN Educational Awards have been established to provide funds ($1,000.00 each) to assist critical care nurses to attend continuing education programs at the baccalaureate, masters and doctorate levels.

**Award funds available:** Two awards - $1,000.00

**Deadline for submission:** January 31 and September 1

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or

Mail to: CACCN, P.O. Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before January 31 or September 1

**Eligibility criteria**

The applicant must:

- be an active member of the Canadian Association of Critical Care Nurses for a minimum of one (1) year
- be accepted to an accredited continuing education program relevant to the practice, administration, teaching and research of critical care nursing
- not have been the recipient of this award in the past two years.

**Application process**

- submit a completed CACCN Educational Award application including all required documentation. Submit a letter of reference from his/her current employer
- incomplete applications will not be considered
- presentations considered for merit points are those that are not prepared as part of your regular employment role/responsibilities — oral and poster presentations will be considered.

**Selection process**

- CACCN reserves the right to withhold the award if no candidate meets the criteria.
- The successful candidate will be notified via email and regular mail.
- The successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September).
- The successful candidates name/photograph will be published in *The Canadian Journal of Critical Care Nursing* (Winter edition).
- Current members of the National Board of Directors are not eligible.

*The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.*

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**CACCN Recruitment and Retention Awards**

The Canadian Association of Critical Care Nurses Recruitment and Retention Awards were established to recognize chapters for their outstanding achievements with respect to recruiting and retaining membership.

**Award funds available:**

- Full Dynamics Conference Tuition Coupons
- Partial Dynamics Conference Tuition Coupons

**Deadline:** Fiscal year end – March 31

The CACCN Office will track chapter recruitment and retention for the fiscal year.

Chapters will receive a copy of the Recruitment and Retention Report annually in April with coupon allotment noted.

Coupons will be issued electronically to all chapters.

**Recruitment initiative**

This initiative will benefit the chapter if the following requirements are met:

- Minimum of 25% of membership is "NEW" between April 1 to March 31, the chapter will receive one (1) – *Dynamics of Critical Care Conference three-day early bird* tuition coupon
- Minimum of 33% of membership is “NEW” between April 1 to March 31, the chapter will receive one (1) – *Dynamics of Critical Care Conference three-day early bird* tuition coupon and one (1) – *Dynamics of Critical Care Conference partial* tuition coupon

Partial coupons are equal to one-day early bird members tuition.

**Retention initiative**

This initiative will benefit the chapter if the following requirements are met:

- If the chapter has greater than 80% renewal of its previous year’s members, the chapter will receive one (1)—*Dynamics of Critical Care Conference three-day early bird* tuition coupon and two (2)—*Dynamics of Critical Care Conference partial* tuition coupons
- If the chapter has greater than 70% renewal of its previous year’s members, the chapter will receive two (2)—*Dynamics of Critical Care Conference partial* tuition coupons
- If the chapter has greater than 60% renewal of its previous year’s members, the chapter will receive one (1)—*Dynamics of Critical Care Conference partial* tuition coupon

Partial coupons are equal to one-day early bird members tuition.

**Tuition coupon policy**

- Tuition coupons are for full or partial tuition
- Tuition coupons may only be used by active members of the Canadian Association of Critical Care Nurses
- Coupons are issued to chapters annually in May
- Coupons are valid on early bird tuition only
- Coupons must be redeemed by the early bird tuition deadline
Coupon codes may be used only once
Tuition coupon values are determined annually by the CACCN National Board of Directors
Coupons may not be used for dinner, tour, hotel or other conference activities
Coupons are not redeemable for cash
Tuition coupons cannot be carried over to the next fiscal year
Tuition coupons are non-transferable
Exceptions to this policy must be approved by the CACCN National Board of Directors

For additional information, please refer to the Canadian Association of Critical Care Nurses Tuition Coupon Policy.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

CACCN Document: Award Criteria
Content Revision Date: March 2014
Form Design Revision Date: January 2011
Content Revision Date: April 2008
Chapter Recruitment and Retention Awards

BBraun Sharing Expertise Award

The BBraun Sharing Expertise Award is a peer-nominated award and will be presented to an individual who exhibits stellar leadership and mentoring abilities in critical care.

The nominee for this award is an individual who supports, encourages, and teaches colleagues. The nominee must demonstrate a strong commitment to the practice of critical care nursing and the nursing profession. These qualities may be demonstrated by continuous learning, professional involvement, and a commitment to guiding novice nurses in critical care. It is not necessary for the candidate to be in a formal leadership or education role to qualify for this award.

The award funds may be used to attend educational programs or conferences related to critical care.

Award funds available: $1,000.00

Deadline for submission: June 1

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1.

Eligibility criteria

- The nominee must be an active CACCN member for a minimum of one (1) year
- The nominee must have a minimum of three (3) years of critical care nursing experience
- Preference is given to a nominee who has CNA Certification [CNCC(C) or CNCCP(C)]
- The nominee practises to the CACCN Standards of Critical Care Nursing Practice (4th ed., 2009)
- Each nomination must have the support of a critical care nursing colleague and the nominee's manager
- Members of the CACCN Board of Directors are not eligible for consideration of the BBraun Sharing Expertise Award.

Nomination process

- Three letters in support of the nominee are required and must be sent to the CACCN
- The nomination letter must provide information outlining the qualities of the nominee and the reasons the nominee should be selected for the award
- One letter of support must be written by a CACCN member
- The other two letters must include one written by the nominee's manager—must testify to the eligibility
- Incomplete nomination packages will not be considered

Selection process

- Each nomination will be reviewed by the CACCN Award Review Committee
- The awards committee reserves the right to withhold the award if no candidate meets the criteria
- The successful candidate will be notified by the CACCN Director of Awards and Corporate Sponsorship via email and regular mail
- The successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September)
- The successful candidate's name/photograph will be published in Canadian Journal of Critical Care Nursing (Winter edition)

The Board of Directors of the Canadian Association of Critical Care Nurses and BBraun Medical retain the right to amend the award criteria.

CACCN Document: Award Criteria
Content Revision Date: March 2014
Form Revision Date: April 2012
Form Design Revision Date: January 2011
Content Revision Date: January 2010
BBraun Sharing Expertise Award
The Brenda Morgan Leadership Excellence Award

The Brenda Morgan Leadership Excellence Award is a peer-nominated award. The award was established to recognize Brenda Morgan’s contribution and leadership to CACCN.

The Brenda Morgan Leadership Excellence Award will be presented to a nurse who, on a consistent basis, demonstrates outstanding performance in the area of leadership in critical care. This leadership may have been expressed as efforts toward clinical advances within an organization, or leadership in the profession of nursing in critical care. The results of the nominee’s leadership must have empowered people and/or organizations to significantly increase their performance capability in the field of critical care nursing.

The Brenda Morgan Leadership Excellence Award has been generously sponsored by the Canadian Association of Critical Care Nurses to recognize and honour a nurse who exemplifies excellence in leadership, in the specialty of Critical Care.

Award funds available: $1,000.00 plus award trophy

Deadline for submission: June 1

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1.

Eligibility criteria

Critical care nurses who are nominated for this award will have consistently demonstrated qualities of leadership and are considered a visionary and an innovator in order to advance the goals of critical care nursing.

The nominee must:

- be an active member of CACCN for a minimum of five (5) years
- have a minimum of five (5) years of critical care nursing experience
- be registered to practise nursing in Canada
- hold a valid adult or pediatric specialty in critical care certification from CNA (preferred)
- demonstrate leadership in the specialty of critical care
- engage others in the specialty of critical care nursing
- role model and facilitate professional self-development and lifelong learning
- exemplify the following qualities and values:
  - Innovation
  - Accountability
  - Visionary
  - Teamwork and Collaboration
  - Respect/Integrity
- contributes or has contributed to the Canadian Association of Critical Care Nurses at the regional and/or national levels.

Application process

- the application involves a nomination process
- submit two (2) letters describing how the nominee has met the requirements under the Eligibility Criteria:
  - Use as many examples as possible to highlight why the nominee should be considered for the award and what this nominee does that makes her/him outstanding
  - The nomination letters should be as detailed as possible, as the CACCN Award Committee depends on this information to select the award recipient from amongst many deserving candidates.

Selection process

- each nomination will be reviewed by the CACCN Director of Awards and Corporate Sponsorship and the CACCN Award Review Committee
- The Brenda Morgan Leadership Award Review Committee will consist of:
  - Two members of the Board of Directors
  - Brenda Morgan (when possible)
- the Awards Review Committee reserves the right to withhold the award if no candidate meets the eligibility criteria
- the successful candidate will be notified by the CACCN Director of Awards and Corporate Sponsorship via email and regular mail
- the successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September) conference
- the successful candidate’s name/photograph will be published in Canadian Journal of Critical Care Nursing (Winter edition).

Terms and conditions of the Award:

- the award recipient will be encouraged to write a reflective article for Canadian Journal of Critical Care Nursing sharing their accomplishments and describing their leadership experience
- the article should reflect on their passion for critical care nursing, their leadership qualities and how they used these effectively to achieve their outcome.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

CACCN Document: Award Criteria
Content Revision: March 2014
Form Design Revision Date: January 2011
Content Revision Date: January 2010

The Brenda Morgan Leadership Excellence Award
The CACCN “Chasing Excellence” Award

The CACCN “Chasing Excellence” Award is presented annually to a member of the Canadian Association of Critical Care Nurses who consistently demonstrates excellence in critical care nursing practice.

The CACCN Chasing Excellence Award is to be used by the recipient for continued professional or leadership development in critical care nursing.

**Award Funds Available:** $1,000.00

**Deadline for Submission:** June 1

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or Mail to: CACCN, P.O. Box # 25322, London, ON, N6C 6B1

Mailed applications must be postmarked on or before June 1.

The CACCN Chasing Excellence Award is a peer nominated award. The CACCN Chasing Excellence Award is awarded to a critical care nurse who:

- is an active member of the Canadian Association of Critical Care Nurses for a minimum of one (1) years
- has a primary role in direct patient care in critical care
- holds Canadian Nurses Association certification in critical care [CNCC(C) or CNCCP (C)] (preferred)
- consistently practises at an expert level as described by Benner (1984)
- **Expert practice** is exemplified by most or all of the following criteria:
  - participates in quality improvement and risk management to ensure a safe patient care environment
  - acts as a change agent to improve the quality of patient care when required
  - provides high quality patient care based on experience and evidence
  - effective clinical decision making based on experience and evidence
  - has developed a clinical knowledge base and readily integrates change and new learning to practice
  - is able to anticipate risks and changes in patient condition and intervene in a timely manner
  - sequences and manages rapid multiple therapies in response to a crisis (Benner, Hooper-Kyriakidis and Stannard, 1999)
  - integrates and coordinates daily patient care with other team members
  - advocates, and develops a plan of care that consistently considers the patient and family and ensures they receive the best care possible
  - provides education, support and comfort to patients and their families to help them cope with the trajectory of illness and injury, to recovery, palliation or death;
  - role models collaborative team skills within the inter-professional health care team
  - assumes a leadership role as dictated by the dynamically changing needs of the unit
  - is a role model to new staff and students
  - shares clinical wisdom as a preceptor to new staff and students
  - regularly participates in continuing education and professional development

**Nomination Process:**

- **Three** letters in support of the nominee must be sent to CACCN by the deadline
- One letter of support must be written by a CACCN member. A supporting letter from a **supervisor** such as a unit manager or team leader is also required.
- The nomination letters must describe three clinical examples outlining the nominee's clinical excellence and expertise
- Incomplete nomination packages will not be considered.

**Selection Process**

- each nomination will be reviewed by the Canadian Association of Critical Care Nurses Awards Review Committee
- The awards committee reserves the right to withhold the award if no candidate meets the criteria.
- The successful candidate will be notified by the CACCN Director of Awards and Corporate Sponsorship via email and regular mail.
- The successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September);
- The successful candidates name/photograph will be published in Canadian Journal of Critical Care Nursing (Winter edition);
- Current members of the National Board of Directors are not eligible.

*The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.*

**Reference**


*The CACCN “Chasing Excellence” Award*

Revision: January 2015
Content Revision: March 2014
Logo Revision: 2012
Form Design Revision Date: January 2011
CACCN Certification Draw

The Canadian Association of Critical Care Certification Draw was established to recognize members of the association who successfully certify or renew their certification in our specialty—Certified Nurse in Critical Care Canada [CNCC(C)] and Certified Nurse in Critical Care Pediatrics Canada [CNCCP(C)].

Award funds available: Eight prizes of $250.00 each

Deadline: September 1

Draw eligibility

To be eligible for the Canadian Association of Critical Care Nurses Certification Draw:
- the certified nurse must provide the Canadian Nurses Association (CNA) with permission to release their name and contact information to their nursing specialty, the Canadian Association of Critical Care Nurses
- the certified nurse must be an active member in good standing as of September 1 of the year in which the nurse certified or renewed their certification
  - i.e., certification in April 2013 = entered into draw September 2013.

Draw process

- The names of eight (8) nurses will be drawn, as follows:
  - Adult Initial Certification – three (3) recipients
  - Adult Certification Renewal – two (2) recipients
  - Pediatric Initial Certification – two (2) recipients
  - Pediatric Certification Renewal – one (1) recipient
- the awards are completed by a random blind draw of eligible members from each category
- the Canadian Association of Critical Care Nurses Certification Draw is held at the Board of Directors’ meeting prior to the Dynamics of Critical Care Conference annually in September
- the Board of Directors reserves the right to not award a prize or to draw additional names in another category, if there are no qualifying nurses in a specific category.

Notification

- recipients are recognized at the Canadian Association of Critical Care Nurses Award Ceremony (annually in September)
- names of the recipients are noted in Canadian Journal of Critical Care Nursing (Winter Edition)
- names of the recipients are noted on the Canadian Association of Critical Care Nurses website under Awards/Recognition
- recipients are notified and receive the award funds via the Canadian Association of Critical Care Nurses National Office (annually in October).

One never knows… next year… it could be YOU!

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

CACCN Document: Award Criteria
Content Revision Date: March 2014
Form Design Revision Date: January 2011

Canadian Intensive Care Week “Spotlight” Challenge

The Canadian Association of Critical Care Nurses Canadian Intensive Care Week “Spotlight” Challenge will be presented to a group of critical care nurses who develop an activity and/or event that will profile their local Critical Care Team during Canadian Intensive Care Week (annually in October/November).

Award funds available: $500.00 total

Deadline for submission: August 15

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1.

Award criteria

- the primary contact person must be an active member of the Canadian Association of Critical Care Nurses for a minimum of one (1) year
- a completed Canadian Association of Critical Care Nurses application form must be submitted.

Award requirements

- the event/activity must be held during Canadian Intensive Care Week
- following the event/activity, a report must be submitted for publication, with photographs*, for publication on the Canadian Association of Critical Care Nurses website and/or in Canadian Journal of Critical Care Nursing
- Canadian Association of Critical Care Nurses photographic consent forms must accompany all submitted photographs
- all submissions become the property of the Canadian Association of Critical Care Nurses and may be used in current/future publications (print and electronic).

Award review

- applications will be judged by blind review
- applications will be considered based on the following criteria:
  - increase the visibility of critical care services in your local community
  - uniqueness/creativity of the activity/event
  - relevance to the objectives of Canadian Intensive Care Week
  - feasibility of activity/event.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

Canadian Intensive Care Week “Spotlight” Challenge
Criteria Revision: March 2014
Criteria Revision: December 2013
Approved: March 2013
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