IN THIS ISSUE:

16  Critical care nurses’ decisions regarding physical restraints in two Canadian ICUs: A prospective observational study

23  Safety implications of the dose change alert function in smart infusion pumps on the administration of high-alert medications
Vision statement
All critical care nurses provide the highest standard of patient- and family-centred care through an engaging, vibrant, education- and research-driven specialized community.

Mission statement
We engage and inform Canadian critical care nurses through education and networking, and provide a strong, unified national identity.

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
  - Accountability and the courage to speak for our beliefs
  - Promoting open and honest relationships

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

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

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Critical thinking

The community of the Canadian Association of Critical Care Nurses is one of many communities to which Canadian Critical Care Nurses may belong. Every critical care nurse contributes formally and informally to groups, teams and communities of all shapes, sizes and purpose. You may belong to local practice interest group, a scheduling team, an inter professional project team, a national committee, a professional organization, a continuing education class, or maybe even a network of recognition like our Critical Care Certified nurse community.

In this past year, the board of directors has taken on the task of building CACCN’s future road map and the idea of growing a community for critical care nurses has been prominent in our thoughts. What exactly is a vibrant community for critical care nurses? What is it about that community that supports achieving our mission of an engaged and informed critical care nurse? How can we design and nurture a community to meet the needs of our members that is focused on the challenges of the complex work we do for critically ill Canadians?

CACCN is a highly successful organization. We deliver quality educational products to our members; we advise on national issues concerning critical care, we contribute to advancing science via our funding awards and publications. Yes, we could be satisfied with all of this good work. However, we have not been content to rest and instead we are choosing more. ‘Together We Can’ achieve more and the path to success is tapping the remarkable potential of our members and chapters leaders.

Since the beginning of my time as your president, it was clear to me that we are all eager for an organization that will aim higher, an organization that will ‘Be the Change’ leading the way for Canada. The amazing response on the ‘Together We Can’ theme board at Dynamics provided strong evidence of the great commitment we have to collectively improve safety, create supportive work environments, ensure access to resources in practice, and achieve better patient, team and system outcomes. As an organization we agree that we need to aspire beyond what we have accomplished in the past.

We all desire a community that provides a place of belonging for every critical care nurse, one that creates a platform for mutual growth and knowledge generation in our specialty. We need a space where individual members are brought together to build something beyond what they could have imagined achieving alone. To realize this vision we will need to build a community that is reflective of the values of critical care nursing practice and the ideals of our association: collaboration, strength-based solution building that is fully grounded in the practice of critical care nursing.

In the 1990s the concept of communities of shared learning emerged. These were called ‘communities of practice’. This concept has become popular in learning and understanding change and progress amongst professionals. Lave and Wenger, who first explored these groups, defined a community of practice as ‘a system of relationships between people, activities, and the world; developing with time, and in relation to other tangential and overlapping communities of practice’ (1991, p. 98). Communities of practice are delineated by mutual engagement, shared relationships and joint enterprise (Roberts, 2006). This is the type of community what we want for CACCN members; a strong infrastructure that will serve as the foundation for the next phase of our journey as an organization.

With this in mind, the governance structure for the activities of the national board have been redesigned and are committee-based in order to embrace this concept of a community of practice. These committees will continue our proud history of service to critical care nurses and will allow for better focus on CACCN’s priorities for meeting the challenges of our future.

Members will have an essential responsibility in this new structure. Key to the success of each of these committees will be the level of engagement of our members. Working collaboratively each committee will connect with our partner organizations, regional leadership, the academic community and employers to advance our mission. Members will need to be aware of the shared purpose and be motivated to contribute and to be actively involved. Each of us must put ourselves into the picture, express interest and act on it. ‘Together we can’ can then find our mutual position and define our critical care nursing ‘community of practice’.
The focus for each of the committees is directly linked with a key element of our mission and vision. The committees include: Member Relations, Partner Relations, Professional Development, Communications, Finance and the Conference Committees. A call was issued at the end of October 2015 for committee member participation and leadership.

Many of these communities of critical care intersect and overlap in ways that are catalyzing and will optimize our function and our success. Committees are chaired by a National Director and populated with members interested in advancing the goals of the association in the domains of that specific committee. Work within each committee will inform, and be informed by, the other committees via the Board of Directors. Engagement is the central element for our success. Individual members can take part in community activities at all levels; lead, share the work or contribute one’s voice to create the vision and drive actions of central importance for critical care nursing. It is an excellent opportunity to have your voice heard and to share your skills and expertise in a national forum.

Full member engagement in our future requires imagination on the part of each of us. We are required to see ourselves as part of the whole and to see our community as part of something larger and valuable. We will look beyond a single solution or individual perspective and build a mutual vision of what is possible. This will not be an easy task. Leadership and the voice of membership are the essential ingredients to build that mutual understanding and to be effective beyond CACCN’s boundaries and sustained beyond our own relationships. As nurses we have developed a practical understanding of how teamwork can impact outcomes for our patients and we now apply that same approach to this work.

I invite you to review the President’s Report in the 2014–2015 CACCN Annual Report and visit our web site for further information on our strategic plan and each of the committees. Please feel free to contact myself, Christine Halfkenny-Zellas, Chief Operating Officer or any of the committee chairs at anytime to share your interest in becoming involved in this exciting work.

Respectfully
Karen Dryden-Palmer
President

REFERENCES


**Congratulations to the following CACCN members on successfully attaining or renewing their Certified Nurse in Critical Care—Canada (CNCC(C)) and Certified Nurse in Critical Care—Pediatrics Canada (CNCCP(C)) Designation in April 2015.**

### CNCC(C) Initial Certification

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Certification Update Specialty Nursing Examination—
Critical Care Nursing, Canadian Nurses Association (CNA)

CNA has announced changes to the certification program. Join the growing network of more than 18,000 CNA-certified RNs at the leading edge of health care. Being CNA certified shows that you’re committed to an advanced standard of professional competence and have a comprehensive understanding of your nursing specialty. Become CNA certified! Show that you Care to Be the Best.

Registration and Exam Information
• The next CNA certification exams will be offered September 19 to October 7, 2016.
• The online application process to apply for the 2016 exams will be open April 11 to July 1, 2016.

Visit Get Certified at: www.nurseone.ca/en/certification

Looking for study resources? CACCN offers a Certification Study Guide to CACCN Members in the Members Only area!
Chapter Connections Day 2015

Chapter Connections Day is always a special one-day meeting the day before Dynamics begins when Chapter Presidents meet with the Board of Directors. It is a great day for sharing information and getting to know the issues the chapters and the board are facing. This year it was held on September 26, 2015, at the Delta Hotel in Winnipeg and I was pleased I was also able to attend.

President Karen Dryden-Palmer welcomed everyone and reviewed the agenda for the day. Then Director Lara Parker led the group with a fun warm-up exercise.

Each member of the Board of Directors reviewed their annual reports for 2014–2015 and gave updates. President Karen Dryden-Palmer spoke about her theme as president: Together We Can. She reported that last year the board worked to advance the strategic plan, sustained working relationships with partners, and provided educational products to members.

Lara Parker reported that the membership on April 1, 2015, was 1,314. There are no student members. Certifications: initial 67, renew 21 (adult) and initial 3, renew 6 (pediatric). Treasurer Rob Mazur reported that CACCN is in a solid financial position with a balanced budget. Barb Fagan reported that CACCN lost two sponsors, but the organization paid for those two awards. All awards are awarded this year. There is also a new award—Sage Poster Bursary. Work will begin soon on revising the Editorial Awards. The name of the journal changed to The Canadian Journal of Critical Care Nursing and the next Dynamics will be in Charlottetown, PEI and the following year in Toronto. Saskatoon is under review for 2018. The board is considering revising the schedule to Halifax, Toronto and Calgary.

The BOD shared its guiding principles when meeting:
• Say what needs to be said. No outside negative conversations.
• Create an environment that is respectful, open, and safe.
• Unified decisions and support each other.
• All are equal.
• Trust in people's ability to do their role.
• When given a role, come prepared and ask for help if needed.
• No judgment.

The new structure of the BOD was presented. There are no longer directors with portfolios on the BOD. Rather, the structure has changed to committees based on the mission statement. Terms of reference have been developed for each committee and each committee chair briefly reviewed her/his committee's purpose.
• Finance – Rob Mazur
• Member relations – Lara Parker
• Partner relations – Kathy Bouwmeester
• Professional development – Barb Fagan
• Communications – Renée Chauvin
• Dynamics – Carla MacDonald

There was open discussion and feedback from the chapter presidents.

The group broke into working groups to discuss each committee in more depth. We were asked to consider what the expectations of the committee were, factors that will impact/influence the work, and how will the committee move forward. There was excellent discussion and many ideas were generated. The chapter presidents reported they were excited to see this change in structure and it might allow them to have more access to the BOD. There will be a call out to the membership for volunteer members for each of these committees. What a great way for you to get involved with your association and colleagues from across the country.

The afternoon was spent with several chapter presidents sharing some of their expertise. The topics were nuts and bolts of chapter leadership, AGM 101, how to hold an education event, and engaging stakeholders (experiences of the Montréal Chapter).

For more information on the discussion, please contact your chapter president. These topics would all make for interesting education sessions.

The last discussion item was about certification. There is a lot of confusion between the roles of CACCN versus CNA. CNA is concerned about decreased numbers in some specialties (especially peds critical care). CACCN’s role is supportive. We do not drive the exam. We review the exam, but are not necessarily item writers. CACCN is a member of the Canadian Network of Nursing Specialties of CNA. There is no certification this year, as the exams are going online. Registration for writing the exam in 2016 will be in April 2016 with exam writing in the fall of 2016.

The day was fun, productive, engaging and thought provoking. As breaks, we were led through several fun exercises periodically.

Paula Price, PhD, RN
Editor, The Canadian Journal of Critical Care Nursing

CACCN chapter executive, back row: Meighan McColl, Greater Edmonton Chapter; Alison Rowlands, President, London Regional Chapter; Natalie Betanzo, President, Vancouver Island Chapter; Ingrid Daley, President, Toronto Chapter; Vena Camenzuli, President, British Columbia Chapter; Amber Eason, Vice President, Nova Scotia Chapter. Front row: Mélanie Gauthier, President, Montréal Chapter; Sara Unrau, President, Manitoba Chapter; Melissa Redlich, President, Southern Alberta Chapter
CACCN Chapters

CACCN’s newest chapter!
The CACCN Board of Directors is delighted to welcome our newest chapter to CACCN: The Newfoundland/Labrador Chapter. The Newfoundland/Labrador Chapter Executive includes:
President: Starlene Lundrigan
Vice President: Patricia Rodgers
Secretary: Brandy Ramstad
Treasurer: Ashley Hunt

Chapter Webpage: www.caccn.ca/en/chapters/newfoundland_and_labrador_chapter
Chapter Email: newfoundland@caccn.ca
Congratulations and welcome to the executive of the Newfoundland/Labrador Chapter. We wish you well!

Would you like to help support future growth and direction of the CACCN? Wondering how you do that? Participate in your local chapter. Local chapters provide education days, networking, journal clubs, and so much more. Take the next step, and consider joining the local chapter executive! Your voice is vital!

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Image of a poster: "The Critical Care Team is Important Because..."
Image of a poster: "Intensive Care Week - Join Now!"
Compassion, Imagination, and Innovation: Dynamics 2015

From September 27-29, delegates gathered in Winnipeg, Manitoba, the heart of the continent and city of rivers, for the Canadian Association of Critical Care Nurses’ annual conference, Dynamics 2015. The theme of the conference was Bridging the Nation with Compassion, Imagination, and Innovation. From the lively opening to the closing ceremonies, opportunities abounded for critical care nurses to learn, share stories, debate ideas, and have some fun with colleagues from across the country and beyond. Delegates experienced three full days of informative, challenging, and thought-provoking presentations and posters flowing out of research studies, quality improvement projects, reviews of the literature, first-hand experiences, or changes to our legislative landscape.

The conference opened with the Norman Chief Memorial Dancers, who provided delegates with a sampling of their energetic and entertaining traditional Métis dancing and music, including the Red River Jig. Spokesperson for the dancers and member of the Manitoba Legislative Assembly, the Honourable Kevin Chief, acknowledged the important work nurses engage in every day and the power nurses have to make a difference. The lively dancers set the stage for the keynote speaker, Kristin Millar, to tell her story of critical illness and receiving a heart transplant in a presentation entitled “This Heart Loves to Dance”. Kristin spoke of the compassion of various members of the health care team throughout her journey to wellness and of the significance of innovation, as she was a pioneer in receiving the LVAD in Manitoba.

Day two of the conference began with a plenary session from Brenda Morgan, a well-respected leader in critical care nursing in Canada. Brenda reminded delegates of the compassion and imagination needed to care for patients and families in critical care settings, skilfully weaving stories from her practice throughout the presentation to illustrate this message. Brenda also provided examples of innovations in practice that grew out of nurses’ observations, ultimately leading to improvements in patient care through imagination and determination.

Quality end-of-life care was a thread evident throughout the conference. On day three, participants on a plenary panel on enhancing end-of-life care in the intensive care unit (ICU) spoke to delegates about programs for families after the death of a loved one in ICU and the use of tools such as G.R.A.C.E (as described in the literature by Joan Halifax) to enhance care, or the pause (as described in the literature by Jonathan Bartels) to acknowledge death in the unit. In a moving presentation, panellist John Bond spoke about the death of his wife, Sharon, in ICU, about simple acts of kindness extended to his family by staff members, and about opportunities lost due to lack of information or being asked to leave the room at a pivotal moment in care. At a sunrise session on day three, lawyer Elaine Borg, from the Canadian Nurses Protective Society, discussed the recent Supreme Court decision in the Carter v. Canada (Attorney General) case on physician-assisted death and possible implications of the decision for nurses.

Experts from across North America presented at luncheon sessions on a range of topics, including advanced hemodynamic monitoring, physician-assisted suicide, the tort of negligence, and infection prevention and control. Clareen Wienczek, President-Elect of the American Association of Critical-Care Nurses, in a luncheon session entitled “Focus the Flame: Attention to Excellence”, encouraged delegates to be fearless, to enquire, to be resilient, and to engage in order to achieve excellence in practice. Dr. Joyce Black, in a luncheon session sponsored by Sage Products, provided delegates with cutting-edge information on pressure ulcer prevention and treatment. Experts were also brought in by sponsors for a number of concurrent sessions. Nestlé Health Science sponsored speaker Judy King, who presented on the role of adequate nutrition in positive outcomes for patients in ICU. The Canadian Blood Services, Organ and Tissue Donation and Transplantation, sponsored a series of presentations featuring Dr. Jennifer Hancock, Dr. Matthew Weiss, Dr. Adrian Robertson, and Amber Appleby, Associate Director, Deceased Donation and Transplantation on topics including identification and referral of deceased donors, organ donation after circulatory death, the ICU nurses’ role in deceased donation, and conversations with families at end of life. BBraun Medical of Canada sponsored a presentation featuring Timothy Kavanagh on using two-way wireless communication in smart pumps to improve patient outcomes.

No Dynamics conference would be complete without social events. The poster reception, sponsored by the Canadian Intensive Care Foundation, was a fabulous opportunity to review poster content and interact with poster authors. The Sunday “Social”, sponsored by Spacelabs Healthcare, provided delegates an opportunity to network and enjoy the experience of a Winnipeg tradition. And the annual dinner, “Rock the ’Peg” with the Danny Kramer Dance Band, created an opportunity to showcase the inner rock star in all of us. CACCN recognized the continued educational support of GE Healthcare for the Dynamics conference at the annual dinner.

The closing speaker for Dynamics 2015 was Stephanie Staples, a Manitoba entrepreneur and motivational speaker. She reminded delegates of the importance of self-care, particularly given the work nurses do and the environments critical care nurses work within. A lasting image of this session was the large group of people who moved themselves to the corner of the room set aside for those who were dissatisfied with aspects of their life and wanted to work towards positive changes. It was a great reminder of the need for self-compassion in nursing and life, and Stephanie outlined a number of imaginative ways for people to care for themselves.

A conference of this size benefits greatly from the generosity of sponsors. Thank you to sponsors BBraun Medical of Canada, BD Medical, Canadian Blood Services, Canadian Intensive Care Foundation, GE Healthcare, Nestlé Health Science, Sage Products, and Spacelabs Healthcare for their support. The Canadian Nurses
Protective Society supported Elaine Borg to present, and we are grateful for their generosity. Thank you also to the exhibitors who made the exhibit hall a place of innovation and ideas. The ongoing support of our exhibitors is greatly appreciated and helps to make Dynamics the success it is year after year.

Putting a conference together requires hours of work by a planning committee for many months prior to the event and late nights and early mornings during the event. This year’s planning committee was deep in experience and enthusiasm, including a former Dynamics chair and skilled chapter executive members and critical care nurses with years of experience planning local conferences. Thank you to Christine Halkenny-Zellas, the Chief Operating Officer of CACCN, and conference planner extraordinaire, Karen Dryden-Palmer, our liaison to the board of CACCN, and the eight critical care nurses who worked tirelessly to make this conference a success:

- Tara Carson
- Lissa Currie
- James Danell
- Cathy Ferguson
- Joy Mintenko
- Colleen Shepard
- Tannis Sidloski
- Rhonda Thorkelson
- Lori Wakefield

These individuals care deeply about critical care nursing and quality care for patients and family members, exhibited many impressive talents, and were a joy to work with.

Dynamics is a reminder of all that critical care nursing can be: filled with compassion, imagination, and innovation. Thank you to the keynote and plenary speakers and panellists, session and poster presenters, sponsors, exhibitors, CACCN board members, delegates, staff of the Winnipeg RBC Convention Centre, Global Exposition Services, Canadian Event Production Services, and the staff at the Delta Winnipeg for making Dynamics 2015 a great conference. Thank you also to Renée Chauvin and Colleen Shepard for their creativity and humour in the closing ceremony report from the “roving reporters”. And finally, a special thank you to the members of the planning committee for their commitment, hard work, and sense of humour. Everyone is invited to Prince Edward Island for some eastern hospitality as we gather next year for Dynamics 2016!

Respectfully submitted
Marie Edwards, PhD, RN
Dynamics 2015 Conference Chair

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**Dynamics 2015 Sponsors/Exhibitors**

The CACCN Board of Directors and the Dynamics 2015 Planning Committee wish to sincerely thank the following for their contributions to Dynamics 2015. The ability to provide quality programming during the Dynamics of Critical Care Conference depends upon the support of our sponsoring and exhibiting companies:

- 3M Canada
- Alberta Health Services
- ArjoHuntleigh Canada
- Bard Canada
- Baxter Fluid Systems/Renal
- BBraun of Canada
- BD Medical
- Canadian Hospital Specialties
- Canadian Virtual Hospice
- ConvaTec Canada
- Dale Medical Products
- Dermasciences
- Draeger Medical Canada
- Edwards Lifesciences
- Fraser Health
- GE Healthcare
- Hill Rom Canada
- Hospira
- HoverTech
- Kanatan Aski (M Arcentales)
- Interior Health
- McArthur Medical Sales
- Meditek
- Millenium Multi Medical
- Nestle Health Science Canada
- Nova Scotia Health Authority
- Northern Health
- Omega Laboratories
- Philips Healthcare
- Physio-Control
- Providence Health Care
- Sage Products
- School of Nursing, University of Ottawa
- Spacelabs Healthcare
- Stryker
- Vernacare
- Zoll Medical

Special thank you to the Premier’s Office, Province of Manitoba, for the provincial pins distributed to all attendees.
Awards presented at Dynamics 2015—Winnipeg, MB

The CACCN Awards Ceremony was held on September 28, 2015, to honour and recognize the accomplishments and achievements of our CACCN colleagues.

Sponsored Awards

BBraun Sharing Expertise Award

• Joanne Baird, Grand Falls Windsor, NL
  Nominated by Glenda Roy
  “...It has been a privilege for me to say, I also had the opportunity to be trained and introduced to the fast-paced and advanced critical care nursing under this phenomenal individual who is also a brilliant and dedicated nurse and humanitarian...”

Renée Chauvin, CACCN Vice-President, Tim Kavanaugh, BBraun Medical Representative, Joanne Baird, Recipient and Karen Dryden-Palmer, CACCN President

Draeger Medical Canada Chapter of the Year

• Montréal Chapter, Montréal, QC
  Total points for 2014-2015 = 1,880 points
  210 hours of member education
  20 hours critical care specialty promotion
  14 members published in peer review journals
  15 members – CACCN committees
  11 members – CNA initial/renewal certification

Renée Chauvin, CACCN Vice-President, Tim Kavanaugh, BBraun Medical Representative, Joanne Baird, Recipient and Karen Dryden-Palmer, CACCN President

Sage Products Poster Bursary – Dynamics 2015

• Nicola Farrow, Beth Linseman, Erica Chadwick, Orest Kornetsky, Rowena Odejar and Patricia Storey, Toronto, ON
  Poster - Safe Travels: Keeping Critical Care Patients Safe During Intra-hospital and Inter-hospital Transports

L-R: Nicola Farrow, Recipient, and Nathan McHugh, Sage Products Representative

• Kyoung-Eun Moon, Soo-jin Oh, Yooun-joong Jung, Yeon-Hwa Chung, Sun-ju Lee and Soon-hang Lee, Seoul, Korea
  Poster - Risk Factors for the occurrence of delirium in Surgical Intensive Care Unit Patients

Kyoung-Eun Moon, Recipient, and Nathan McHugh, Sage Products Representative

• Jacqueline Torrance, Susan Dunford, Janice Ross, Christina Murphy, Margaret Cameron and Catherine Kerr, Peterborough, ON
  Poster - Getting to Zero: Daily Universal Chlorhexidine Bathing in the ICU

Jacqueline Torrance, Recipient, and Nathan McHugh, Sage Products Representative
Spacelabs Innovative Project Award
• Teddie Tanguay and the Royal Alexandra Rapid Response Team, Edmonton, AB
Rapid Response Team

Bob Brooks, Spacelabs Healthcare (centre) with Royal Alexandra Rapid Response Team Members Eugene Mondor, Heather Colaco, Lesley LaPierre and Meighan McColl (absent: Teddie Tanguay)

• Karen Webb-Anderson, Marlene Ash and Pamela Hughes, Halifax, NS
The Implementation of a Novel Nursing Role and the use of Simple Data to Effect Positive Change

Bob Brooks, Spacelabs Healthcare (centre) with recipients Karen Webb-Anderson, Pamela Hughes and Marlene Ash

CACCN Awards

Brenda Morgan Leadership Excellence Award
• Pamela Cybulski, Alliston, ON
Nominated by Shirley Marr
“…Pam promotes daily excellence in nursing and works with nursing to develop critical thinking skills. Pam leads our code blue committee at the hospital and in this she shines as an advocate for patient care in those worst moments. She has advocated for equipment, training on an ongoing basis as well as a quality review of code blue so we can always be looking at improvement…”

Karen Dryden-Palmer, CACCN President, Pam Cybulski, Recipient, Brenda Morgan, Life Member, and Renée Chauvin, CACCN Vice-President

Canadian Intensive Care Week Spotlight Challenge Award
• Kaitlin Ames and Andrea McCormick, CCU and PICU, Hospital for Sick Children

Renée Chauvin, CACCN Vice-President, Karen Dryden-Palmer, CACCN President, and Kaitlin Ames, Recipient

Certification - CNCC(C) and CNCCP(C) Draw Prize Recipients 2015
• Adult Initial Certification
Shelley Dolbeck, RN, CNCC(C), Winnipeg, MB
Kristie Dirks, RN, CNCC(C), Legal, AB
Nichole N. Tao, BN, RN, CNCC(C), Winnipeg, MB

• Adult Certification Renewal
Michel Doré, Quebec City, QC
Clarice Watt, Timmins, ON

• Pediatric Initial Certification
Stacey Conway, RN, CNCCP(C), Prince George, BC
Lindsay Ingram, RN, CNCCP(C), Toronto, ON

• Pediatric Certification Renewal
Beverly D. Fletcher, RN, CNCCP(C), Bedford, NS

Chasing Excellence Award
• Pamela Hughes, Halifax, NS
Nominated by Karen Webb-Anderson
“…Pam exemplifies excellence in Critical Care Nursing at so many levels: in acute bedside nursing, as acting Charge Nurse, on the Quality and Patient Safety Committee and as a colleague. I have witnessed Pam in several emergency situations at the bedside, where she excels. She is astute, calm, cool and collected. She is able to problem-solve at a rapid pace during critical situations and has kept many a potentially chaotic bedside situation under control…”

Renée Chauvin, CACCN Vice-President, Pamela Hughes, Recipient, and Karen Dryden-Palmer, CACCN President
Editorial Awards
• Elaine Doucette, Tieghan Killackey, Danielle Brandys, Annie Coulter, Meghan Daoust, Joanna Lynsdale, Emma Millson Taylor, Fannie Pinsonneault and Eric Shamy-Smith, Montréal, QC

First Place: L-R: Paula Price, CJCCN Editor and Elaine Doucette, Recipient

• Myriam Breau and Ann Rhéaume, Irishtown, NB
No Photo Available

Educational Award
• Fall 2014—Sarah Crowe, Vancouver, BC
Educational Program—Post-Masters Nurse Practitioner Diploma, University of Toronto
No Photo Available

• Winter 2015—Myriam Breau, Irishtown, NB
Educational Program—PhD of Health Sciences Research Université de Sherbrooke
No Photo Available

Life Member Award
• Paula Price, Calgary, AB
Nominated by Ruth Trinier
“…Paula has dedicated a lifetime to ensuring the Canadian Association of Critical Care Nurses, is an organization with a high-quality peer reviewed “Official Journal”…Paula has consistently performed to a high standard. Paula has demonstrated exemplary leadership. Paula role models excellence in many ways, including demonstrating personal leadership, accountability and integrity. She has consistently demonstrated a strong work ethic. As the journal editor, Paula has worked collaboratively as an integral and invaluable member leading a large Editorial Review board. She is irreplaceable. She encourages us, mentors us, and provides a role model for us as to how to lead with dignity, excellence, compassion and humanity…”

Life Member Award
Renée Chauvin, CACCN Vice-President, Karen Dryden-Palmer, CACCN President, and Kathleen Przybyl, Recipient

Research Grant
• Craig Dale, Toronto, ON
Predictors and prevalence of difficulty accessing the mouth as a result of oral hygiene barriers in critically ill adults: An observational study

Renée Chauvin, CACCN Vice-President, Ingrid Daley, CACCN Toronto Chapter President, accepting on behalf of Craig Dale, Recipient, and Karen Dryden-Palmer, CACCN President

Dynamics 2015 Awards
Dynamics 2015 Poster Awards
• Delegates Choice Award
Kathleen Przybyl, Lansing, IL
Nursing Respite Room: Naps Aren’t Just for Kids!
First Place Poster Award
Kathleen Przybyl, Lansing, IL
Nursing Respite Room: Naps Aren’t Just for Kids!

Second Place Poster Award
Jacqueline Torrance, Susan Dunford, Janice Ross, Christina Murphy, Margaret Cameron and Catherine Kerr, Peterborough, ON
Getting to Zero: Daily Universal Chlorhexidine Bathing in the ICU

Congratulations to all award recipients!
Thank you for the continued support of our sponsors BBraun Medical Canada, Draeger Medical Canada, Sage Products and Spacelabs Healthcare!

Future sites of Dynamics conferences
Dynamics 2016: September 25–27, 2016, Charlottetown, PE
Dynamics 2017: September 24–26, 2017, Toronto, ON
Dynamics 2018: September 23–25, 2018, Saskatoon, SK
Critical care nurses’ decisions regarding physical restraints in two Canadian ICUs: A prospective observational study

BY ELENA LUK, BScN(Hons), RN, CNCC(C), MN (student), LISA BURRY, PharmD, SHAGHAYEGH REZAIE, MD, SANGEETA MEHTA, MD, AND LOUISE ROSE, PhD, RN

Abstract

Background: Legislation, guidelines and accreditation standards call for the minimization of physical restraints, yet their use remains common in intensive care units (ICUs) both in Canada and internationally. In Canada, physical restraints are prescribed by physicians. However, assessment of their need, application, and removal are primarily the responsibility of ICU nurses.

Objectives: We sought to describe Canadian ICU nurses’ decision-making and practices of physical restraint application and discontinuation, as well as alternative measures attempted prior to their use for critically ill adults.

Methods: We conducted a prospective, observational study in two medical-surgical ICUs (tertiary academic and large community teaching hospital) of physical restraint use.

Results: We collected physical restraint data from the medical records of 141 patients from October 2011 to September 2012. Most restrained patients were mechanically ventilated (n = 118, 84%). Of the 247 reasons for restraint application identified for these 141 patients, agitation (n = 107, 43%), restlessness (n = 42, 17%) and use as a precautionary measure (n = 42, 17%) were the most commonly documented. Of the 167 behaviours observed and documented by nurses as indicative of agitation, pulling at the endotracheal tube or other lines/tubes (n = 111, 66%) was most commonly cited. Nurses documented the use of various strategies as an alternative to physical restraint prior to their use for 46 (33%) patients. Of the 96 alternative strategies attempted, communication comprising reorientation and reminders was the most frequently documented (n = 26, 27%). Nurses reported having considered removing restraints during their shift for 61 (43%) patients. The criterion most commonly deemed essential for restraint removal was a calm patient (51 of the 104 reasons listed, 49%).

Conclusions: Our study suggests that patient behaviour indicative of agitation was the most common reason for physical restraint application. Use as a precautionary measure and in situations where nurses’ ability to be present at the bedside was reduced, as well as the limited use of alternative measures prior to physical restraint suggest restraint minimization may not be optimal.

Critically ill patients require technologically complex therapies and continuous monitoring to sustain life. Physical restraints may be used to promote patient safety including prevention of device removal, prevent self-harm and harm to others, and to avoid chemical restraint. However, in contrast to these perceived benefits, physical restraints have been associated with multiple adverse outcomes in the intensive care unit (ICU), including injury to restrained limbs, device removal despite restraint, delirium, post-traumatic stress symptoms, and prolonged ICU length of stay (Chang, Wang, & Chao, 2008; Demir, 2007; Hatchett, Langley, & Schmollgruber, 2010; Jones et al., 2007; Mion, Minnick, Leipzig, Catrambone, & Johnson, 2007; Stafseth, Solms, & Bredal, 2011; Van Rompaey et al., 2009). Furthermore, physical restraints are argued by some to compromise patients’ rights (Akansel, 2007), generating ethical distress for healthcare professionals.

Despite uncertainty over the ability of physical restraints to maintain patient safety, as well as the potential for undesirable psychological patient outcomes and ethical concerns, physical restraint use is common in ICUs of many countries with prevalence ranging from 0% to 100% (Benbenbishy, Adam, & Endacott, 2010). Physical restraints are considered unacceptable and, therefore, are not used in some regions such as the United Kingdom and Scandinavia (Bray et al., 2004; Egerod, 2009; Samuelson, 2011; Stafseth et al., 2011), with chemical restraint more prevalent as an acceptable alternative (Bray et al., 2004; Maccioli et al., 2003). Conversely, physical restraint use is well documented in North America, many European countries, the Middle East, Asia, and Africa (Akansel, 2007; Benbenbishy et al., 2010; De Jonghe et al., 2013; Hatchett et al., 2010; Kandeel & Attia, 2013; Kim & Park, 2010; Krüger, Mayer, Haaster, & Meyer, 2010; Martin & Mathiesen, 2005; Mehta et al., 2012).

In Canadian ICUs, recent reports indicate the prevalence of physical restraint use ranges from 53% to 79% (Luk et al., 2014; Mehta et al., 2012; Wen, Mauceri, Smith, & Wilson, 2008), despite various professional guidelines (College of Nurses of Ontario, 2009), provincial legislation (Government of Ontario, 2001), and national accreditation standards recommending restraint minimization (Accreditation Canada, 2013). In Ontario, the Patient Restraints Minimization Act (Bill 85) states that hospitals and other facilities are prohibited from restraining patients except in special circumstances including prevention of serious bodily harm to self and others. Although a written physician order is required for restraint use in many parts of the world (Maccioli et al., 2003) including...
Canada (Government of Ontario, 2001), international data suggest needs assessment, application and discontinuation of physical restraints are predominantly performed by ICU nurses (Al-Khaled, Zaharan, & El-Soussi, 2011; Cho et al., 2006; Choi & Song, 2003; De Jonghe et al., 2013; Demir, 2007; Eser, Khoshid, & Hakverdioglu, 2007). To our knowledge, no data describe nurses’ decisions regarding physical restraint use in Canadian ICUs, including nurses’ reasons for restraint application and alternative methods employed to minimize restraint use.

**Purpose**

The purpose of our study was to describe: reasons for physical restraint application, alternative measures attempted, if any, prior to physical restraint application, and reasons for restraint discontinuation.

**Methods**

We conducted a prospective observational study of physical restraint application and discontinuation from October 2011 to September 2012. The study was approved by the research ethics boards of each participating hospital, which waived the need for informed consent from either patients or nurses due to the observational nature of the study. Provision by nurses of data on restraint application that was not available from the medical record was voluntary.

**Setting and study population**

We conducted the study in two adult medical-surgical ICUs in Toronto, Canada. One ICU (16 beds) was in a university-affiliated hospital and the other (15 beds) a large community teaching hospital. Both hospitals had least restraint policies addressing both physical and chemical restraint in place for the study duration. These policies mandated a physician order for physical restraint with further orders required every 24 hours if the need for physical restraint persisted. Least restraint policies also stipulated a minimum of hourly assessment and documentation of physical, psychological and emotional health, response to, and ongoing need for physical restraint. In both ICUs, sedation protocols were not in place; in general, sedation was titrated using the Sedation-Agitation Scale (Riker, Picard, & Fraser, 1999) based on a specific order tailored to individual needs of patients. The study population included patients physically restrained during their ICU stay and the bedside nurses providing care. There were no exclusion criteria. Research personnel identified restrained patients and the nurses providing care twice daily, morning and late afternoon, Monday to Friday.

**Data collection**

Using a standardized case report form, research personnel collected data on restraint use from the medical record and bedside nurses caring for the patient on the first calendar day of restraint application. We did not collect data for these patients on reasons for restraint reapplication. Data we collected included reasons for restraint application, restraint type, alternative measures employed to avoid restraint use, and potential indications for restraint discontinuation. Lists of potential reasons for restraint application were generated from previous studies documenting physical restraint use (Benbenbishty et al., 2010; Choi & Song, 2003; Turgay, Sari, & Genc, 2009) to facilitate data collection using tick boxes, as opposed to documenting free-text responses from the medical record and/or the bedside nurse. We identified all reasons for restraint application for each eligible patient. As a priori we anticipated agitation would be a frequent indication for restraint, we either recorded the documented Sedation-Agitation Scale (SAS) score (Riker et al., 1999) or, if not available, we asked nurses to quantify agitation using this score to ensure consistency in their description of agitated behaviours. For example, an SAS score of 7 indicated that a patient was dangerously agitated and displayed any of the following behaviours: pulling at the endotracheal tube (ETT), catheters, tubes, or lines, climbing over bed rails, striking staff, and thrashing side to side. We defined restlessness as anxious or apprehensive, but movements not aggressive or vigorous.

Tick box options for potential alternative measures to physical restraint included frequent communication with patient; involvement of relatives or friends with care; assessment and management of potential causes of agitation; administration of sedatives, analgesics, or anti-psychotics; cognitive stimulation; and ambulation of the patient. A second case report form was used to document reasons for restraint discontinuation on the day this occurred. Patient demographic data collected from the medical record included age, gender, Acute Physiology and Chronic Health Evaluation (APACHE) II score (Knaus, Draper, Wagner, & Zimmerman, 1985), mechanical ventilation status (yes/no), airway type (ETT or tracheostomy), reason for hospital and ICU admission, and previous health history.

**Data analysis**

Continuous variables (e.g., demographic characteristics) were summarized using means and standard deviations (SD) or medians and interquartile ranges (IQR) depending on data distribution. Categorical variables (e.g., type of physical restraint used, reason for physical restraint application/discontinuation) were summarized using frequencies and proportions. Missing data were not computed. All analyses were performed using SPSS 22.0 (IBM, Armonk, NY, USA) or Excel 2013 (Microsoft, Redmond, WA, USA).

**Results**

**Patient demographics**

We collected data on restraint use for 141 patients, 71 in ICU 1 and 70 in ICU 2. Mean patient age was 63 (SD 18) years and 80 (57%) were male (see Table 1). Respiratory failure was the most frequent reason for ICU admission (n = 68, 48%), and the median ICU length of stay was 6.9 (IQR 4.7–9.8) days. Most patients were mechanically ventilated during restraint application (n = 118, 84%).

**Patterns of restraint use**

Mean restraint duration captured for 109 (77%) patients was 1.8 (SD 1.0) days. The time of discontinuation was not documented for the remaining 32 patients. Most patients were restrained using wrist restraints (n = 128, 91%). Four-point (all four limbs) restraints (n = 6, 4%) and unilateral wrist-ankle and wrist-mitten restraint combinations were used infrequently (n = 3, 2%).

*continued on page 19...*
### Table 1: Patient demographics (N = 141)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD)</td>
<td>63 (18)</td>
</tr>
<tr>
<td>Male gender</td>
<td>80 (58)</td>
</tr>
<tr>
<td>APACHE II score, mean (SD)</td>
<td>20.8 (8)</td>
</tr>
<tr>
<td>Mechanical ventilation</td>
<td>118 (87)</td>
</tr>
<tr>
<td>Airway type (n = 108)</td>
<td></td>
</tr>
<tr>
<td>Endotracheal tube</td>
<td>97 (90)</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>11 (10)</td>
</tr>
<tr>
<td>Admission type (n = 123)</td>
<td></td>
</tr>
<tr>
<td>Elective surgery</td>
<td>20 (16)</td>
</tr>
<tr>
<td>Non-elective surgery</td>
<td>12 (10)</td>
</tr>
<tr>
<td>Medical</td>
<td>88 (72)</td>
</tr>
<tr>
<td>Trauma</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Reason for ICU admission (n = 124)</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>68 (55)</td>
</tr>
<tr>
<td>Sepsis</td>
<td>19 (15)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>13 (10)</td>
</tr>
<tr>
<td>Neurologic</td>
<td>10 (8)</td>
</tr>
<tr>
<td>Metabolic</td>
<td>4 (3)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Other†</td>
<td>7 (5)</td>
</tr>
<tr>
<td>Previous history</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>13 (9)</td>
</tr>
<tr>
<td>Bipolar disease</td>
<td>12 (8)</td>
</tr>
<tr>
<td>Stroke</td>
<td>11 (8)</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>8 (6)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>7 (5)</td>
</tr>
<tr>
<td>Dementia</td>
<td>6 (4)</td>
</tr>
<tr>
<td>Delirium</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Visually impaired</td>
<td>8 (6)</td>
</tr>
<tr>
<td>Hearing impaired</td>
<td>5 (4)</td>
</tr>
</tbody>
</table>

†Genitourinary, Hematologic, and other

### Table 2: Reasons for restraint application

<table>
<thead>
<tr>
<th>Reasons for applicationa (N = 247)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agitation</td>
<td>107 (43)</td>
</tr>
<tr>
<td>Behaviours indicative of agitationb (n = 167)</td>
<td></td>
</tr>
<tr>
<td>Pulling at ETT</td>
<td>54 (32)</td>
</tr>
<tr>
<td>Pulling at lines/tubes</td>
<td>57 (34)</td>
</tr>
<tr>
<td>Climbing over bed rails</td>
<td>21 (12)</td>
</tr>
<tr>
<td>Thrashing</td>
<td>19 (11)</td>
</tr>
<tr>
<td>Striking staff</td>
<td>16 (10)</td>
</tr>
<tr>
<td>Precautionary measure</td>
<td>42 (17)</td>
</tr>
<tr>
<td>Restlessness</td>
<td>42 (17)</td>
</tr>
<tr>
<td>Altered mentation</td>
<td>22 (9)</td>
</tr>
<tr>
<td>Suggested by another team member</td>
<td>13 (5)</td>
</tr>
<tr>
<td>Delirium</td>
<td>7 (3)</td>
</tr>
<tr>
<td>Isolation</td>
<td>6 (2)</td>
</tr>
<tr>
<td>Procedure</td>
<td>6 (2)</td>
</tr>
<tr>
<td>Going on break</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

ETT: endotracheal tube

a nurses indicated more than one reason for 141 patients

b nurses indicated more than one behaviour for 107 patients

### Table 3: Alternative measures prior to restraint application

<table>
<thead>
<tr>
<th>Alternative measures (N = 96)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication including reorientation</td>
<td>26 (27)</td>
</tr>
<tr>
<td>Sedation</td>
<td>20 (21)</td>
</tr>
<tr>
<td>Assessment/management of potential causes of agitation</td>
<td>19 (20)</td>
</tr>
<tr>
<td>Analgesia</td>
<td>17 (18)</td>
</tr>
<tr>
<td>Involvement of family/friends</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Cognitive stimulation</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Patient ambulation</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

Data provided for 46 patients who received alternative measures. Please note more than one alternative measure could be identified for an individual patient.
Restraint type was not documented for 4 (3%) patients. In most cases (n = 117, 83%) restraints were applied on the preceding night shift. For 106 (75%) patients, the reasons for restraint application were provided during shift handover. Sixteen per cent of nurses applied restraints on the day shift of data collection.

We documented 247 reasons for application of restraints. Agitation (n = 107, 43%), restlessness (n = 42, 17%) and restraining as a precautionary measure to prevent accidental device removal and maintain patient safety (n = 42, 17%) were the most common reasons for restraint application (see Table 2). Of the 107 patients identified as agitated, 94 had a documented SAS score. Of these, 37 (35%) exhibited dangerous agitation (SAS score of 7), 16 (15%) were very agitated (SAS score of 6), and 41 (38%) were agitated (SAS score of 5) (not reported for 13 patients). Of the 167 behaviours observed by nurses as indicative of agitation, pulling at the ETT and other lines or tubes (n = 111, 66%) was the most common.

Nurses reported that alternative measures were considered prior to physical restraint application for 46 (33%) patients. For 10 (22%) of these 46 patients, after consideration, alternative measures were not attempted because nurses believed the patient’s immediate safety was at risk. Alternatives to physical restraint are shown in Table 3, with communication comprising reorientation and reminders being the most frequent (n = 26, 27%). Chemical restraint was used for 20 (21%) patients.

For 61 (43%) patients, nurses reported having considered removing restraints during their shift. The criterion most commonly deemed essential for restraint removal was a calm patient (51 of the 104 reasons listed, 49%) (see Table 4). Nurses did not consider restraint removal if their patient remained agitated and exhibited associated behaviours (Table 5). Reasons

---

**Table 4: Criteria nurses considered needed for restraint discontinuation**

<table>
<thead>
<tr>
<th>Criteria (N = 104)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is calm</td>
<td>51 (49)</td>
</tr>
<tr>
<td>Timeframe</td>
<td></td>
</tr>
<tr>
<td>&gt; 2 hrs</td>
<td>21 (41)</td>
</tr>
<tr>
<td>&gt; 1 hr to 2 hrs</td>
<td>17 (33)</td>
</tr>
<tr>
<td>30 min to 1 hr</td>
<td>9 (18)</td>
</tr>
<tr>
<td>Family/friend is present at bedside</td>
<td>20 (19)</td>
</tr>
<tr>
<td>Patient is sedated</td>
<td>16 (15)</td>
</tr>
<tr>
<td>Patient is extubated</td>
<td>13 (12)</td>
</tr>
<tr>
<td>Patient is unrousable</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Patient is paralyzed</td>
<td>1 (2)</td>
</tr>
</tbody>
</table>

Data provided for 61 patients for whom nurses considered the possibility of restraint removal. Please note more than one criteria could be identified for an individual patient.

---

**Table 5: Indications for restraint continuation**

<table>
<thead>
<tr>
<th>Indication (N = 98)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient remains agitated</td>
<td>42 (43)</td>
</tr>
<tr>
<td>Level of agitation</td>
<td></td>
</tr>
<tr>
<td>Agitated (SAS 5)</td>
<td>23 (55)</td>
</tr>
<tr>
<td>Very agitated (SAS 6)</td>
<td>6 (14)</td>
</tr>
<tr>
<td>Dangerously agitated (SAS 7)</td>
<td>7 (17)</td>
</tr>
<tr>
<td>Dangerous behaviours (n = 44)</td>
<td></td>
</tr>
<tr>
<td>Pulling ETT</td>
<td>12 (27)</td>
</tr>
<tr>
<td>Pulling lines/tubes</td>
<td>15 (34)</td>
</tr>
<tr>
<td>Climbing over bedrails</td>
<td>9 (20)</td>
</tr>
<tr>
<td>Thrashing</td>
<td>6 (14)</td>
</tr>
<tr>
<td>Striking staff</td>
<td>2 (5)</td>
</tr>
<tr>
<td>Patient remains restless</td>
<td>27 (28)</td>
</tr>
<tr>
<td>As a precautionary measure</td>
<td>16 (16)</td>
</tr>
<tr>
<td>Altered mentation</td>
<td>9 (9)</td>
</tr>
<tr>
<td>Patient remains delirious</td>
<td>4 (4)</td>
</tr>
</tbody>
</table>

Data provided for 60 patients perceived to continue to require physical restraint. Please note more than one indication could be identified for an individual patient.

---

**Table 6: Reasons for restraint discontinuation**

<table>
<thead>
<tr>
<th>Reasons (N = 75)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient was calm &amp; cooperative</td>
<td>56 (75)</td>
</tr>
<tr>
<td>Timeframe</td>
<td></td>
</tr>
<tr>
<td>&gt; 30 min to 1 hr</td>
<td>8 (14)</td>
</tr>
<tr>
<td>&gt; 1 hr to 2 hrs</td>
<td>10 (18)</td>
</tr>
<tr>
<td>&gt; 2 hrs</td>
<td>35 (63)</td>
</tr>
<tr>
<td>Family/friend present at bedside</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Patient died or was discharged</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Patient was unrousable</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Patient was sedated</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Patient was paralyzed</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Suggestion by another team member</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Completion of medical procedure</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Not reported</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

...continued from page 17
for restraint discontinuation were recorded for 81 (57%) patients with the most common being a calm and cooperative patient for greater than two hours (Table 6).

Discussion
In this two-centre, prospective, observational study, we found that agitation comprising dangerous behaviours such as pulling at the ETT and other medical devices, thrashing, and striking staff, was the most common reason for physical restraint application. Consideration of alternative measures to avoid physical restraint and manage these behaviours was not routine despite both hospitals having policies mandating restraint minimization. Use of restraints as a precautionary measure and in situations where nurses’ ability to be present at the bedside was reduced, such as patient isolation and staff breaks, also appears contrary to the goal of restraint minimization. Those nurses reporting alternative strategies prior to restraint application used communication for reorientation, assessed for potential causes of agitation, administered analgesics, and used chemical restraint. Patients who remained agitated continued to be restrained and, in most cases, nurses reported restraints were not discontinued until the patient was demonstrably calm and cooperative for two hours.

Previous work by our group has found the prevalence of physical restraints to range from 53% to 76% in Canadian ICUs (Luk et al., 2014; Mehta et al., 2012). This may reflect infrequent use of alternative measures to avoid physical restraint and their utilization as a precautionary measure, as demonstrated in our study. In a multicentre prospective, randomized, controlled trial of protocolized sedation versus protocolized sedation plus daily sedation interruption, more than 76% of the 430 patients were physically restrained at least once despite sedatives titrated to a SAS of 3-4. As such, patients were likely physically restrained even when comfortable, able to follow commands, and not agitated. This high prevalence and the practice patterns illustrated in our study suggest Canadian ICU nurses and physicians consider physical restraint an essential aspect of ICU management of ventilated patients despite professional guidelines, provincial legislation, and national accreditation standards recommending restraint minimization (Accreditation Canada, 2013; College of Nurses of Ontario, 2009; Government of Ontario, 2001). A similar perspective was found in a recent survey of restraint practices in 121 French ICUs (De Jonghe et al., 2013). This survey found that 82% of ICUs reported physical restraints were used at least once during mechanical ventilation in the majority of patients; 65% applied physical restraints for more than half the duration of mechanical ventilation; and 80% considered cessation of physical restraint use in mechanically ventilated patients to be impossible in France.

Conversely, other countries such as the U.K., Denmark, Norway, and Portugal report minimal to no physical restraint use in the ICU (Benbenbishy et al., 2010; Bray et al., 2004; Egerod, Albarran, Ring, & Blackwood, 2013; Martin & Mathisen, 2005). A higher nurse-to-patient ratio is one reason cited for this difference (Bray et al., 2004; Egerod et al., 2013; Martin & Mathisen, 2005). This rationale may be applicable to other European countries including France where nurse-to-patient ratios may be as high as 1:4 (Rose et al., 2011). In Canada, however, nurse ratios for ventilated patients are similar to those in the U.K. and Scandinavia (either 1:1 or 1:2) and ICUs are also staffed with respiratory therapists who manage ventilation and weaning.

Another potential reason for reported international differences in physical restraint practices is differences in the prevailing cultural and moral perspectives on their use both from a societal perspective and more locally within the ICU (Bray et al., 2004; Martin & Mathisen, 2005). Since nurses are the primary decision-makers when it comes to application of physical restraints, creating a culture to effect and sustain change, such as that required for restraint reduction, requires substantial buy-in from clinicians working at the bedside (Gershengorn, Kocher, & Factor, 2014).

Nurses’ attitudes, practices, and knowledge of the evidence base regarding physical restraints are strongly associated with their exposure to use in practice (i.e., experiential learning) and the prevailing workplace culture (Karlsson, Bucht, Eriksson, & Sandman, 2001). Egyptian researchers who examined factors influencing physical restraint use by 50 ICU nurses found only 8% had good knowledge of the evidence base regarding physical restraints (Al-Khaled et al., 2011). Improving knowledge of the evidence relating to restraints may reduce their use, as shown in a previous Canadian study that demonstrated increasing ICU nurses’ knowledge through a physical restraint learning plan resulted in a statistically significant decrease in restraint use after one year (Hurlock-Chorostecki & Kielb, 2006). Given the high prevalence of physical restraints in Canadian ICUs, and increasing evidence that restraint may cause harm (Chang et al., 2008; Evans, Wood, & Lambert, 2002; Hatchett et al., 2010; Jones et al., 2007), research is urgently needed that evaluates the effectiveness of innovative education strategies to reduce physical restraint use in the ICU.

Limitations
Our study has limitations. Restraints were applied on the previous shift for 84% of patients with the reason for restraint application not reported on handover for 24% of these patients. This may have led to under-reporting of alternative measures to avoid physical restraint. Reasons for restraint discontinuation were available for only 57% of patients, which may have resulted in an incorrect estimation of the duration of restraint and reasons for discontinuation.

Conclusion
Our study suggests behaviours indicative of agitation such as pulling at the ETT, lines and tubes, climbing over bed rails, thrashing and striking staff that may result in harm to the patient or to staff were the most common reasons for physical restraint application. Use as a precautionary measure and in situations where nurses’ ability to be present at the bedside was reduced, as well as the limited use of alternative measures prior to physical restraint suggest restraint minimization may not be optimal. Innovative strategies that focus on promoting understanding and knowledge translation of the current evidence regarding physical restraints are needed to decrease the frequency and duration of their use.
Funding
This study was funded by the Canadian Association of Critical Care Nurses (CACCN) through a grant sponsored by the Baxter Corporation.

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Phone: +1 416 978 3492

REFERENCES

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Safety implications of the dose change alert function in smart infusion pumps on the administration of high-alert medications

By Catherine Goulding, PharmD, and Mario Bedard, PharmD

Abstract

Background: Most intravenous medication errors occur during administration. Smart pumps can reduce the incidence of dose or rate errors using soft and hard limits. However, industry standard dose error reduction software misses errors that occur during titration. The dose change alert was developed to detect errors during titration.

Purpose: To evaluate the safety implications of the dose change alert in the SIGMA Spectrum Infusion System on the administration of high-alert medications at The Ottawa Hospital.

Method: This retrospective analysis included all titratable high-alert medication infusions administered between May 1 and October 31, 2014 (inclusive). Analysis of continuous quality improvement reports included drug library compliance, dose change alerts, soft limit confirmations and cancellations, and hard limit pull-back reports for each high-alert medication and care area.

Findings: Compliance with using the drug library was 96.8%. The percentage of dose change alert confirmations and cancellations within the soft limits were 48.1% and 1.9%, respectively. The titration of vasopressors resulted in the highest percentage (75%) of dose change alert confirmations. The titration of anticoagulants resulted in the highest percentage (12%) of dose change alert cancellations. Titration within the soft limits accounted for 65% of the alerts.

Conclusions: This study provided insight into the safety implications of the dose change alert on the titration of high-alert medications. Key-press errors during titration of high-alert medications can cause patient harm, even within the soft limits. Nurses can be involved in customizing the percentage dose change limit for individual drugs within each care area to provide an additional safety check during titration.

Key words: smart pump, high-alert, titration, dose error reduction software

Background

Any intravenous medications are classified as high-alert medications (Bates, 2007; Institute for Safe Medication Practices, 2014). Critically ill patients experience approximately 1.7 medical errors per day in the intensive care unit (Camire, Moyen, & Stelfox, 2009). Furthermore, medication errors account for 78% of serious medical errors (Camire et al., 2009). Most medication errors occur during the prescription (54%) and administration (46%), commonly due to the wrong infusion rate (40.1%) (Calabrese et al., 2001; Camire et al., 2009). Medication errors place a financial burden on the health care system through increased length of stay (Kaushal, Bates, Franz, Soukup, & Rothschild, 2007). To meet Accreditation Canada’s required organizational practices, institutions must standardize high-alert medications by implementing a comprehensive strategy for their management to enhance patient safety and reduce the possibility of harm (Accreditation Canada, 2014).

Accreditation Canada recently issued a high-priority standard for smart pump technology (Accreditation Canada, 2014). The implementation of smart pump technology can reduce the incidence of errors in the administration of high-alert medications (Wilson & Sullivan, 2004). Critical care nurses and pharmacists can work collaboratively to ensure the medication library in smart pumps is customized to an organization’s patient population, intravenous protocols and order sets. The library can incorporate soft and hard rate limits, concentration confirmation alerts and clinical advisories. When soft limits are exceeded, the pump will alert the nurse that the rate is outside the commonly prescribed range for this medication. However, the nurse can still override the soft limits. When the nurse programs a value that exceeds a hard limit, the pump will alert the nurse to reprogram within the acceptable safe dosing range. Smart pumps configured with soft and hard limits have a greater impact in preventing dosing errors, as compared to those configured with only soft limits (Rothschild et al., 2005; Trbovich, Pinkney, Cafazzo & Easty, 2010).

The Institute for Safe Medication Practices medication safety assessment for hospitals found that almost half of the respondents indicated that they use smart pump technology throughout the organization to intercept and prevent errors due to misprogramming or miscalculation of doses or infusion rates (Institute for Safe Medication Practices, 2011). However, preventable errors associated with misprogramming of smart infusion pumps may still occur (Rothschild et al., 2005; Trbovich et al., 2010). Within the soft limits there is still the potential for error during titration. A controlled trial of smart infusion pumps found that 66% of medication errors occurred due to incorrect dosing of titratable medications in critically ill patients (Rothschild et al., 2005). Furthermore, if nurses are not programming medications within the medication library and compliance with the smart pump technology is poor, it is difficult to know if a programming error has occurred (Institute of Safe Medication Practices, 2011; Mansfield & Jarrett, 2013; Rothschild et al., 2005).
The SIGMA Spectrum Infusion System incorporates a single step dose or rate change alert to detect errors when changing a dose or rate. Even within the soft limits, the dose change alert will alert the nurse if the dose change exceeds the preconfigured change limit (percentage). Many facilities have analyzed the impact of soft and hard limits on initial programming in smart infusion pump technology and have documented the reduction in adverse medication event rates (Breland, 2010; Mansfield & Jarrett, 2013; Rothschild et al., 2005; Tribovich et al., 2010; Wilson & Sullivan, 2004). Currently, there is no study evaluating the effect of dose change alert on the titration of high-alert medications. Data collected from the infusion pump can drive practice change by identifying opportunities to enhance the use of high-alert medications and take action to promote patient safety.

Purpose
The purpose of this study was to evaluate the safety implications of the dose change alert on the administration of high-alert medications in a smart infusion pump.

Methods
Design
This study was a retrospective analysis of the data gathered from the SIGMA Spectrum Infusion System at The Ottawa Hospital. This hospital implemented 1,600 of these large volume pumps with a drug library consisting of 615 medications. Through the collaboration between nurses and pharmacists, the drug library was developed over a four-month period. Analysis included all titratable high-alert medication infusions administered in all care areas between May 1 and October 31, 2014 (inclusive). The study was performed with approval from the Research Ethics Board at The Ottawa Hospital.

Instruments
The SIGMA Spectrum Infusion System incorporates second generation dose error reduction software (DERS). When powered on, the pump automatically defaults into the DERS or drug library, allowing the nurse to complete programming in compliance with The Ottawa Hospital's clinical protocols and practices. If the nurse chooses to opt out of the drug library (non-compliant with the medication library) and into BASIC mode, the infusion will not be protected by DERS. The nurse is required to manually enter the concentration, dose mode and dose or rate without safety limits (soft and hard limits and dose change alerts). Within the drug library, nurses can search for the medication and concentration, and program the dose and rate within the safety limits. If a medication has multiple concentrations, once the nurse selects the desired concentration, a concentration alert will appear on the pump screen. The concentration confirmation alert is a brightly coloured visual alert that prompts the nurse to confirm that the medication label on the IV bag matches the concentration being programmed. Clinical advisories are a customized text box that appears on the pump screen after a medication and concentration are selected and prior to programming. For high-alert medications, the clinical advisory indicates that the nurse must have an independent double check for pump programming.

The drug library contains soft limits, which can be exceeded by the nurse, and hard limits, which cannot be exceeded by the nurse. Nurses are provided with education around the normal soft, hard and dose change limits through their collaboration with pharmacy in the drug library development process and attendance at clinical training classes. During pump programming, nurses are made aware of the normal dose limits for each medication in the drug library. When a nurse programs the pump to change the dose or rate, the programming screen clearly displays the soft limits before the change can be made. Both audible and brightly coloured visual alerts appear on the pump screen when soft, hard limits and dose change limits are attempted. When a nurse attempts to program a dose or rate outside the soft limits for a given medication, the soft limit alert appears on the pump screen. The nurse is required to confirm or cancel the dose or rate programmed. If the nurse confirms the soft limit alert, the infusion screen will display the medication name, dose and rate in red font. When a nurse attempts to program a dose or rate outside the hard limits for a given medication, the hard limit alert appears on the pump screen. The nurse will be required to pull back and program a dose below the hard limit value. When a nurse attempts to change the dose or rate more than the configured percentage change limit, the dose change alert appears on the pump screen. The nurse is required to confirm or cancel the dose or rate programmed. Dose change alert messaging indicates the difference between the current and desired dose.

Data collection
Titratable high-alert medications were identified using The Ottawa Hospital's high-alert medication list and categorized by therapeutic class (The Ottawa Hospital Safe Medication Practices Subcommittee, 2011). Soft and hard limits and the dose change percentage configured for each medication were obtained from the drug library software report. Continuous quality improvement (CQI) reports were obtained from wireless pump downloads. CQI reports included Drug Library Compliance, Dose Change Alert (confirmations and cancellations), Soft Limit Exceeded (confirmation and cancellations) and Hard Limit Attempted (pull backs).

The DERS Compliance report summarized the number of infusions started in the drug library or BASIC mode. The Dose Change Alert report summarized the incidence of dose change exceeded alerts (change confirmed and cancelled). The Soft Limit Exceeded report summarized the incidence of dose or rate soft limit exceeded alerts (soft limit confirmation and cancellation) for each care area and medication. The Hard Limit Attempted report summarized the incidence of dose or rate hard limit attempted alerts (hard limit pull backs) for each care area and medication. Report information included event name, date, time, device serial number, care area, medication and concentration, dose programmed or previous dose programmed. We combined the drug library compliance, dose change alert, soft limit and hard limit reports for each medication to identify those alerts confirmed, cancelled and pulled back during infusion. Only alerts during titration programming were captured.

Data analysis
The primary outcome was the percentage of dose change alert confirmations and cancellations during the titration of high-alert medications, within the soft limits. This was calculated based on...
the number of dose change alert confirmations and cancellations out of all infusion starts, respectively. The secondary outcomes were the percentage drug library compliance, percentage soft limit confirmations and cancellations, and the percentage of hard limit pull backs. The percentage of soft limit confirmations was calculated based on the number of soft limit confirmations and cancellations out of all infusion starts, respectively. Similarly for the hard limit, the number of pull backs out of all infusion starts.

Findings
The drug library at The Ottawa Hospital had a total of 615 medications across eight care areas, including anesthesia, birthing unit, critical care, medicine/surgery, neonatal, oncology, pediatrics, and training. From The Ottawa Hospital’s list of high-alert medications, 21 medications were identified in the drug library and were evaluated within six therapeutic classes: vasopressor, insulin, sedative, neuromuscular blocker (NMB), opioids and anticoagulants. The care area, therapeutic class, medication name, concentration, dose mode and rate limits for all high-alert medications were collected.

The neonatal care area did not contain high-alert medications. Although The Ottawa Hospital does not have a pediatric unit, pediatric patients may be treated in the emergency department prior to transfer to a local children’s hospital. The DERS Compliance report for the pediatric care area did not summarize any infusion starts for high-alert medications. The training care area was a copy of the critical care area and used for training purposes only. Therefore, the neonatal, pediatrics and training care areas were not analyzed. There was a total of three drug library updates during the six-month period. Changes did not impact the medications being evaluated.

Compliance, as defined as using the pre-programmed drug library for medications versus BASIC mode, was reported as 96.8%.

The dose change alert was configured to display on the pump screen when the dose or rate increase exceeded 101% for all medications, except those in anesthesia (configured to 500%). The percentage of dose change alert confirmations and cancellations within the soft limits were 48.1% and 1.9%, respectively (Figure 1). Critical care reported a higher percentage of dose change alert confirmations and cancellations (58% and 2%, respectively) than the hospital average (Figure 1). Anesthesia reported the lowest percentage of dose change alert confirmations and cancellations (1% and 0%, respectively) (Figure 1). The titration of vasopressors resulted in the highest percentage (75%) of dose change alert confirmations (Figure 2). The titration of anticoagulants resulted in the highest percentage (12%) of dose change alert cancellations (Figure 2).

![Figure 1: Rate Advisory by Care Area](https://via.placeholder.com/150)

![Figure 2: Rate Advisory by Therapeutic Class](https://via.placeholder.com/150)
The percentage of soft limit confirmation and cancellations were 20.8% and 2.3%, respectively, and the percentage of hard limit pull backs was 3.5% (Table 1).

Changing a dose or rate during an infusion (titration) within the soft limits accounted for 65% of the alerts recorded (Figure 3).

**Discussion**

The high rate of compliance (96.8%) with the drug library gave a strong platform to observe titration changes. Establishing a collaborative process to design, build and vet the drug library with pharmacy and nursing before implementation; defaulting nurses directly into the drug library when the pump is powered on; and making frequent wireless updates to the drug library post implementation explains the high rate of compliance. Traditional smart pumps make it easy for nurses to bypass the drug library or drug library implementation does not incorporate hard limits, making overrides more frequent (Breland, 2010; Mansfield & Jarrett, 2013; Rothschild et al., 2005; Trbovich et al., 2010; Wilson & Sullivan, 2004).

The dose change alert prompted nurses to confirm 48.1% and cancel 4% of the titrations within the soft limits for all high-alert medications in the drug library. As expected, the titration of high-alert medications in critical care resulted in the highest percentage of dose change alert confirmations, with vasopressors being the largest contributor. In critical care, the dose change alert notified the nurse when the dose or rate increase exceeded 101%. Vasopressors are indicated to increase arterial blood pressure to restore and maintain adequate tissue perfusion. Although a mean arterial blood pressure of 60 mmHg is a common end point for vasopressor titration, the specific blood pressure threshold below which perfusion is compromised and the ideal target for vasopressor titration is not known (Dellinger et al., 2013; Lamontagne et al., 2011; St-Arnaud et al., 2013). The approach to the titration of vasopressors may vary by indication. Recommendations in hemodynamic support of sepsis can vary with comorbidities (Lamontagne et al., 2011). The CQI reporting in critical care provided insight into medication programming issues and an opportunity to update the drug library to ensure it is clinically relevant. A multidisciplinary pumps team consisting of critical care nurses and pharmacists could make the decision to increase the dose change percentage for vasopressors in the critical care area. Since anesthesia is an area where significant dose or rate changes are made to infusions, the programmed limit for the dose change alert was defaulted to 500%. This could explain why the titration of high-alert medications in the anesthesia resulted in the lowest percentage of dose change alert conformations.

During the titration of high-alert medications in the birthing unit, 10% of the dose change alerts were cancelled. Most of these cancellations were during the titration of anticoagulants and insulin. The administration of high-alert medications has become standardized with the use of dosing charts and order sets (Accreditation Canada, 2014). The physician orders for heparin specify to increase or decrease the rate by 150–250 units/h for the treatment of venous thrombosis and 100–150 units/h for the treatment of acute coronary syndrome or atrial fibrillation. Depending on the initial rate and the patient’s anti-Xa assay result, the rate of heparin would not increase more than 101%. Without the dose change alert function, the nurses would not be able to catch these near misses during the titration of heparin within the soft limits. The physician orders for insulin in the birthing unit specify to increase the rate by 0.5–1 unit/h for every 2 mmol/L increase in blood glucose. Depending on the initial rate and the patient’s blood glucose, the rate of insulin could increase between 50–700%. The dose change alert is based on a percentage increase or decrease. Lower initial rates may result in more dose change alerts than higher initial rates. For example, a nurse initiates an insulin infusion at 1.5 units/h. As per the physician’s order for insulin in the birthing unit, if the patient’s blood glucose was greater than 14 mmol/L, the dose of insulin could be titrated up to 4 units/h, resulting in a 167% dose change increase. The nurse would then confirm the dose change alert to go forward in infusing insulin at 4 units/h. This could explain the higher rate of dose change alert confirmations than cancellations for insulin. Key stroke errors such as decimal errors can still occur and result in fatal error no matter the initial starting rate (Rothschild et al., 2005). The CQI reporting in the birthing unit provided an opportunity for quality improvement and focus on appropriate clinical education.

Accreditation Canada promotes the use of smart pumps with dose limits and alerts to increase patient safety (Wilson &

**Table 1: Soft and hard limits by care area**

<table>
<thead>
<tr>
<th></th>
<th>Soft limit</th>
<th>Hard limit</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Confirmation (%)</td>
<td>Cancellation (%)</td>
</tr>
<tr>
<td>Oncology</td>
<td>35.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>MedSurg</td>
<td>28.5%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>24.4%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hospital</td>
<td>20.8%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>19.5%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Birthing Unit</td>
<td>10.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

**Figure 3: Alerts during Titration**
Sullivan, 2004). However, industry standard DERS misses potential titration errors (Rothschild et al., 2005; Trbovich et al., 2010). In addition, a controlled trial of smart infusion pumps found that 66% of medication errors occurred due to incorrect dosing of titratable medications in critically ill patients (Rothschild et al., 2005). During the infusion of high-alert medications at The Ottawa Hospital, changes in the dose or rate within the soft limits accounted for 65% of the alerts recorded. Many of the high-alert medications infused in critical care had a wide range between the lower and upper soft limits. Critical care had less soft limit confirmations and cancellations compared to the hospital average, suggesting that the majority of titration changes occurred within the soft limits. Critically ill patients are more likely to experience adverse events as they receive high-alert medications with a narrow therapeutic window. Therefore, the customization of the dose change alert by medication has an important role in potentially preventing medication errors.

Critical care nurses have a dynamic role in supporting the development of the drug library and customizing the soft, hard and dose change alert limits to their care area. It is not a smart pump unless nurses are compliant with inhibiting medications through the drug library and its safeguards. Critical care nurses also have a pivotal role in reviewing CQI reports to DERS compliance, provide insight into medication programming errors, identify an opportunity for quality improvement, and focus on appropriate clinical education and measure outcomes and success.

Several limitations were identified. A randomized control trial, although a preferable study design, could not be implemented because all 1,600 pumps were implemented in a short sequence at The Ottawa Hospital. Other pumps with DERS capabilities were not used at The Ottawa Hospital during the time of this study and data from the previous pump model were not sufficient enough to compare. Medication errors, patient outcomes and cost were not directly correlated with dose change alert, soft limit or hard limit alerts. The dose change alert report does not display the dose or rate the infusion was changed to, only the dose or rate the infusion was changed from. This feature has since been improved in the newer version of the pump software. These are opportunities for future research.

**Conclusion**

This study provided insight into the safety implications of the dose change alert on the titration of high-alert medications in the SIGMA Spectrum Infusion System at The Ottawa Hospital. Key-press errors during titration of high-alert medications can cause patient harm, even within the soft limits. Nurses can be involved in customizing the percentage dose change limit for individual drugs within each care area to provide an additional safety check during titration.

**About the authors**

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**Conflict of interest:** Catherine Goulding is a Medical Affairs Pharmacy Consultant at Baxter Corporation.

**REFERENCES**


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Current CACCN members are eligible to be entered into a quarterly draw to receive a complimentary one-year CACCN membership (value $75) for new members referred to CACCN.

Criteria:
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2. Applicable on NEW member applications only. A new member is one who has not been a CACCN member previously or has not been a CACCN member for a min of 12 months.
3. To qualify, your name must be included on the new member’s application form or included in the online application submission, as the “sponsor” or “person who recommended joining CACCN”.
4. Names cannot be entered into the draw if the sponsor/recommending information is not included when the member application is processed.
5. Members may be entered to win a complimentary membership for each referral received per quarter.

www.caccn.ca

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The Canadian Journal of Critical Care Nursing (CJCCN) is distributed to members of the CACCN, to individuals, and to institutions interested in critical care nursing. The editorial board invites submissions on any of the following: clinical, education, management, research and professional issues in critical care nursing. Critical care encompasses a diverse field of clinical situations, which are characterized by the nursing care of patients and their families with complex, acute and life-threatening biopsychosocial risk. While the patient’s problems are primarily physiologic in nature, the psychosocial impact of the health problem on the patient and family is of equal and sometimes lasting intensity. Articles on any aspect of critical care nursing are welcome.

The manuscripts are reviewed through a blind, peer review process.

Manuscripts submitted for publication must follow the following format:

1. **Title page with the following information:**
   - Author(s) name and credentials, position
   - Place of employment
   - If there is more than one author, the names should be listed in the order that they should appear in the published article
   - Indicate the primary person to contact and address for correspondence.

2. **A brief abstract of the article on a separate page.**

3. **Body of manuscript:**
   - Length: a maximum of 15 pages including tables, figures, and references
   - Format: double spaced, 1-inch margins on all sides. Pages should be numbered sequentially including tables, and figures.
     Prepare the manuscript in the style outlined in the American Psychological Association’s (APA) Publication Manual 6th Edition
   - Use only generic names for products and drugs
   - Tables, figures, illustrations and photographs must be submitted each on a separate page after the references
   - References: the author is responsible for ensuring that the work of other individuals is acknowledged accordingly. Direct or indirect quotes must be acknowledged according to APA guidelines
   - Permission to use copyrighted material must be obtained by the author and included as a letter from the original publisher when used in the manuscript.

4. **Copyright:**
   - Manuscripts submitted and published in Dynamics become the property of CACCN. Authors submitting to The Canadian Journal of Critical Care Nursing are asked to enclose a letter stating that the article has not been previously published and is not under consideration by another journal.

5. **Submission:**
   - Please submit the manuscript electronically as a Word attachment to the editorial office as printed in the journal. Accepted manuscripts are subject to copy editing.
   - All authors must declare any conflicts of interest and acknowledge that they have made substantial contributions to the work and/or contributed substantially to the manuscript at the time of acceptance.

Revised November 2011
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 are founded on the CACCN Mission Statement and recognize 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 that 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:
Section | Category
--- | ---
1 | Member education
2 | Promotion of critical care specialty
3 | New member recruitment
4 | Sustained membership
5 | Academic activity
6 | Certification activity

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 totalled. 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 six 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 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 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.

<table>
<thead>
<tr>
<th>Total hours of events offered</th>
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<tbody>
<tr>
<td>Total number of chapter members x 1000 = Promotion of Critical Care Specialty</td>
</tr>
</tbody>
</table>

Chapter A
• Total specialty promotion hours – 4 hours
• Membership number 38
• Formula: 4 hours divided by 38 members = 0.105 multiplied by 1000 = 105
• Therefore the Promotion of Critical Care Specialty score is 105

Chapter B
• Total specialty promotion hours – 2 hours
• Membership number 110
• Formula: 2 hours divided by 110 members = 0.018 multiplied by 1000 = 18
• Therefore the Promotion of Critical Care Specialty score is 18

Section 3: New Member Recruitment
• Calculated based on the percentage of new members recruited up to March 31 of the award year
• Any member with a membership lapse of 12 months or more will be considered a new member
  • i.e., a membership expires April 2011 and is renewed June 2012. This member would be considered a new member due to the lapse in membership of 14 months
• Use the Membership Recruitment/Retention spreadsheet from the CACCN national office to obtain the number of new members.

Formula:
To create the recruitment score, the total number of recruited 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 new members. The points awarded are noted on the chart based on the percentage of new members.

<table>
<thead>
<tr>
<th>Total new members</th>
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<tbody>
<tr>
<td>Total number of chapter members x 100 = percentage of new members</td>
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</table>

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Points</th>
<th>Percentage</th>
<th>Points</th>
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<tr>
<td>01–10%</td>
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<tr>
<td>31–40%</td>
<td>40</td>
<td>81–90%</td>
<td>90</td>
</tr>
<tr>
<td>41–50%</td>
<td>50</td>
<td>91–100%</td>
<td>100</td>
</tr>
</tbody>
</table>

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>
<th>Points</th>
<th>Percentage</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>01–10%</td>
<td>5</td>
<td>51–60%</td>
<td>30</td>
</tr>
<tr>
<td>11–20%</td>
<td>10</td>
<td>61–70%</td>
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<tr>
<td>21–30%</td>
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<td>31–40%</td>
<td>20</td>
<td>81–90%</td>
<td>45</td>
</tr>
<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.

Section 5: 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 a 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.

\[
\text{Percentage} \times 10 = \text{certification points}
\]

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.

\[
\text{Percentage} \times 5 = \text{certification points}
\]

Example  
*Chapter A*

- Initial certification = 3 members
- 250 chapter members
- 3 divided by 250 = 0.012 multiplied by 100 = 1.2%
- multiplied by 5 = 6 points
The principal investigator must:

Eligibility:

- 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

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.

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

• 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 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 the Canadian Journal of Critical Care Nursing.

The 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 candidate’s 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.
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 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

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 Canadian Journal of Critical Care Nursing • Canadian Association of Critical Care Nurses
• 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 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 supported by thorough assessments
  • 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 candidate’s 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
Certification Draws
Canadian Intensive Care Week “Spotlight” Challenge
The Canadian Association of Critical Care Nurses Canadian Intensive Care Week "Spotlight" Challenge award 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.

CACCN Life Member Award
CACCN Life Member status is awarded to individuals who have demonstrated sustained support and exceptional contributions to the Canadian Association of Critical Care Nurses and its Mission and Vision. Life members have contributed to the advancement of the art and science of critical care nursing through practice, education, research leadership and advocacy for the specialty.

This award is conferred by the Canadian Association of Critical Care Nurses.

As a Life Member, the recipient will be provided a complimentary annual CACCN membership. The recipient will retain CACCN voting privileges until such time as they actively retire from registered nursing and/or cease to hold an active practising nursing licence, at which time the complimentary membership will revert to an affiliate membership.

Awards available
• Award of choice
• Funding for travel, tuition and hotel accommodation to Dynamics to accept the award

Deadline for submission: June 1 annually

Send nominations 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

Eligibility criteria
• The candidate must be a CACCN member in good standing for a minimum of 10 years (with no lapse of membership)
• The candidate has contributed to the Mission and Vision of CACCN in two or more of the following ways:
  • Providing leadership in direct patient care practice, education, research and advocacy with a focus on critical care
  • Assuming CACCN leadership roles within the organization through national or chapter executive/project work or contributions to the Canadian Journal of Critical Care Nursing (editorial board, columnist)
  • Contributing to the advancement of the science of critical care nursing via evidence generation, education or quality assurance activities on behalf of the CACCN at local, regional and national levels
  • Demonstrating the values of CACCN in their practice
  • Acting as a resource/expert in a domain of critical care nursing (practice, education, research and leadership)
  • Advocating for the practice of critical care nursing at the regional, provincial or national level.

Exclusion criteria
• The candidate is not a member of CACCN
• The candidate does not hold a registered nursing licence
• Self-nominations will not be accepted
• Nominations of elected officers at the national or chapter level of the CACCN will not be accepted during an active term of office.
Nomination procedure
The primary nominator is required to provide the following for consideration:

- Candidate Personal Information:
  - Curriculum Vitae; or
  - Resume, or
  - Name
  - Address
  - Educational history
  - Employment history including number of years of practice
- Candidate's CACCN activities including:
  - Positions and terms of office with the CACCN (local and/or national)
  - Relevant contributions, for example committee work (local and/or national), guideline development, educational contributions certification exam support.

Nominators (two CACCN members) must each provide a written statement as the candidate's eligibility for a lifetime member award:

- Candidate statements cannot exceed one page
- The statement should highlight the impact the candidate has had on the growth of the association and the achievement of the association's mission
- The statement should also provide examples of outstanding contributions to CACCN and/or critical care nursing practice.

Consideration/selection

- Candidates must be nominated by a current CACCN Member
- Only candidates meeting the award criteria will be considered
- Selection shall be made by candidate review and Life time membership will be awarded by the National Board of Directors of the Canadian Association of Critical Care Nurses
- Successful recipients will be notified of their selection via email and regular mail
- Successful recipients will be:
  - announced at the Annual General Meeting (AGM)
  - acknowledged at the CACCN Awards ceremony at Dynamics of Critical Care
  - in the Canadian Journal of Critical Care Nursing (Winter); and
  - posting on the CACCN website.
- The award will be presented in person wherever possible
  - If the recipient is not in attendance at Dynamics, a National Board of Director or Chapter President will present the award in person
  - In circumstances where a personal presentation is not possible, the Chief Operating Officer shall mail the award to the recipient in a timely manner following the announcement
- The CACCN Board of Directors are not eligible to submit nominations
- The CACCN Board of Directors has the right to forego a designation in a given year
- The CACCN Board of Directors has the right to alter the award criteria as required.

Terms of Reference

- At the time of the award CACCN shall provide recipients with the following:
  - Complimentary CACCN Membership for life
  - A commemorative certificate
  - A commemorative gift (recipient's choice)
  - Dynamics Conference tuition for the day of the Awards ceremony
  - Travel expenses of up to $500 to be used to attend the Awards Ceremony at the Dynamics of Critical Care Conference; Travel expenses must be used in the year the award is presented
  - Hotel accommodation for two nights at the conference host hotel.

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

CACCN/Sage Products

Poster Bursary

The CACCN/Sage Products Poster Bursary provides a $500 award to eligible applicants to attend the Dynamics of Critical Care Conference to present a poster with a focus on the prevention of complications or deleterious impacts of critical illness hospitalization. Maximum of ten (10) recipients may be selected annually.

Award funds available: $500/each
Ten (10) bursaries available (annually)

Application year: Dynamics of Critical Care Conference Call for Abstracts (annually)

Deadline for submission: January 31 (annually)

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

Eligibility

- First/presenting poster author is an active CACCN member
- First-time poster submission to CACCN Dynamics conference
- Focus of the poster is on the prevention of complications or deleterious impacts of critical illness hospitalization for example (but not limited to): prevention of hospital acquired infection, including; pressure injury reduction; and early mobility)
- Completed CACCN/Sage Products Poster Bursary application
- Poster is reviewed through the abstract submission system and is accepted for presentation at CACCN’s Dynamics of Critical Care conference.
Note:
• No branding of the poster for Sage Products is required
• The poster does not need to address prevention using products provided by Sage Products.

Application process
• Applicants must submit a poster abstract online at www.caccn.ca as per the CACCN Dynamics abstract submission process by no later than 2359 ET – January 31 annually
• Applicants complete and submit the CACCN/Sage Products Poster Bursary application to CACCN National Office (caccn@caccn.ca) at the time of abstract submission or by no later than 2359 ET – January 31 annually
• The poster abstract will be blind reviewed according to CACCN’s abstract review policies
• Following review, eligible abstracts will be listed based on review scores
• The first ten (10) eligible abstracts with the highest review scores will receive a bursary of $500/each;

• Successful poster presenters will be notified via email and regular mail
• Acceptance of the Sage Products – CACCN Bursary indicates a commitment by the presenter to attend the Dynamics conference to present the poster
• A letter of acceptance must be signed by the recipient prior to the distribution of the funds
• CACCN/Sage Products Poster Bursary may only be used to offset conference expenses: registration, travel, accommodation, meals, poster preparation/printing, etc.
• CACCN/Sage Products Poster Bursary recipients will be acknowledged by CACCN and Sage Representatives at the CACCN Awards Ceremony
• Recipients are required to attend the CACCN awards ceremony and the Sage Products Exhibit Booth at the conference for photographs
• The successful applicant will forfeit the bursary if they fail to attend the Dynamics of Critical Care Conference, the CACCN Awards Ceremony and the Sage Products Booth.
Application for membership

Name: _____________________________________________________________
Address:  ___________________________________________________________

W (____) ____ - ________  H (____) ____ - ________  C (____) ____ - ________

Email:  _____________________________________________________________
Employer:  __________________________________________________________
Position:  ___________________________________________________________
Area of Employment:  _________________________________________________
Nursing Registration No.: _______________________ Province:  _____________
Chapter Affiliation (if known):  __________________________________________
CACCN Referral Name:  _______________________________________________

Please note, this application is for both National and Chapter membership

Type of membership: (Members/Associate Affiliates/Student Affiliates)

Membership fees: add GST/HST based on province of residence

☐ New Member  ☐ one year $75.00 + taxes  ☐ two years $140.00 + taxes
☐ Renewal  ☐ one year $75.00 + taxes  ☐ two years $140.00 + taxes

CACCN # _______________

☐ Student Member  ☐ one year $50.00 + taxes
☐ Affiliates  ☐ one year $75.00 + taxes

Are you a CNA/RNAO member?  ☐ Yes  ☐ No

Signature:  ______________________________________________________________

Date:  __________________________________________________________________

Visa/MasterCard: _________________________________ Expiry: _________________

Make cheque or money order payable to:
Canadian Association of Critical Care Nurses (CACCN)
Mail to: CACCN, P.O. Box 25322, London, ON N6C 6B1
Or send with Visa/MasterCard number, expiry date to: 519-649-1458

Continuous renewal: We have made it easier to maintain your membership. By providing a credit card number, your membership will automatically renew on the next membership expiry date, so you will no longer have the worry about remembering to renew! Depending on the month and type of membership selected (one or two years), one or two years later, CACCN will charge your credit card for membership dues based on your membership at the time of renewal. Following automatic renewal, CACCN will mail your membership card/receipt. For FAQs on Automatic Renewal, visit www.caccn.ca/JOINUS.

Email: caccn@caccn.ca, Website: www.caccn.ca

Why CACCN?
Vision: The voice for excellence in Canadian Critical Care Nursing

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.

Vision Statement
All critical care nurses provide the highest standard of patient and family centred care through an engaging, vibrant, education- and research-driven specialized community.

Mission Statement
We engage and inform Canadian critical care nurses through education and networking and provide a strong unified national identity.

Benefits of Membership
• A strong, unified voice for critical care nursing in Canada
• A subscription to the Canadian Journal of Critical Care Nursing
• CACCN Standards for Critical Care Nursing Practice (4th Ed.)
• Annual Report
• Position Statements
• Awards, Grants and Bursaries
• CNCC(C) Certification Study Guide
• Opportunities for nurses to present at local and national levels
• Educational opportunities to accumulate continuing learning hours
• Opportunities to network with peers
• Reduced tuition fees

Become a member of your professional association today!

Oct 2015
Communication Board
How to complete your Membership Application/Renewal with CACCN

- **New Members:** Online at [www.caccn.ca](http://www.caccn.ca) – select **JoinUs**
- **Renewals:** select **JoinUS/Renewals** – Sign in with your User Name and Password; Forget your user name and password? Select **Forgot Password** under the sign in boxes.
- **Fax** the membership form with credit card information (Visa/MasterCard) to 519-649-1458
- **Mail** membership form with a cheque, money order or credit card information to CACCN National Office

**CACCN Membership Information:**

- **Active member:** Any registered nurse, with an interest in critical care, who possesses a current and valid licence or certificate in the province, territory or country in which the registered nurse practises.
- **Affiliates:**
  - **Student:** Any student nurse in an accredited professional nursing program, who is **currently NOT licensed** as a registered nurse or graduate nurse. *If you hold a registered nursing license, affiliate-student application does not apply.*
  - **Associate:** Any person with an interest in critical care, who does not meet the requirements for an Active Member.

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Canadian Association of Critical Care Nurses
P. O. Box # 25322, London, ON, N6C 6B1
Toll Free: 1-866-477-9077 • Telephone: 519-649-5284 • Fax: 519-649-1458
Email: caccn@caccn.ca • Website: [www.caccn.ca](http://www.caccn.ca)
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“I can do my job at many different places, but I chose VCH for the team.”  **Michael P, VCH Critical Care Employee - VGH**

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- **Outstanding Career Move**

We are hiring Registered Nurses who have completed an advanced certificate program in Critical Care Nursing, or have a minimum of two (2) years’ recent critical care nursing experience.

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- Lions Gate Hospital, North Vancouver
- Sechelt Hospital
- Powell River General Hospital
- R. W. Large Memorial Hospital, Bella Bella
- Bella Coola General Hospital, Bella Coola

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