3M Canada Ad
Pain in the Neck
use 4-colour film from last issue
What an honour! Addressing you for the first time as president of this critical care nursing association, I feel several emotions—thrilled that I have this opportunity to develop in a new way; afraid that the abilities I possess could not possibly be equal to the task; and obliged to encourage you, the members of CACCN, to learn more about me and become involved in our association to ensure that we continue to grow in the way that you want.

My involvement in critical care nursing has been centered in the nursing care of children and their families since 1982. I have changed and grown as a critical care nurse just as I have observed the nursing profession grow and change. What significant changes have I observed in critical care nursing within the last 20 years? Advanced monitoring of children has progressed from an unusual occurrence to a common necessity. Nurses are no longer subtle, behind-the-scene providers of health care but are active, front-line professionals demanding changes that will enhance the care they provide. Children and families who used to be guests in “our place” are now knowledgeable consumers challenging the system to meet their needs.

What do I think of these changes? In my view, they are necessary contributions to maintain and improve the quality of health care. So keep the changes happening! And while I haven’t been here to observe all the changes, CACCN has advanced as well. Brenda Morgan, currently a director and a former president, can identify huge changes in our association. “I think our association has moved during the past 20 years from a neophyte stage of initial development as an organization, through a period of restoring financial solvency and association maintenance, to our current focus on professional advancement with a vision for where we want critical care nursing to be in the future.”

The members of the board of directors met in April in London, Ontario for our annual spring face-to-face meeting. The focus of this two-day meeting was to explore strategies that would assist our association to meet the objectives defined by our five-year strategic plan (CACCN, 2000). This visionary document outlines activities to achieve three major goals: membership enhancement, advancement of critical care practice, and partnership development. We would like to share these strategies with you and look forward to responding to your feedback.

**Membership Enhancement:** The growth and development of our association is directly dependent upon the quality, diversity and size of CACCN’s membership. Recruitment of new members and retention of existing members is of utmost importance to the board of directors. After successfully meeting the five per cent increase in membership targeted for 1999/2000, we are aggressively aiming for a 10% increase in membership next year. Major strategies for achievement of this goal will be: increasing the number of communication boards distributed to Canadian hospitals as well as striving to provide regularly updated materials of relevance to Canadian critical care nurses; targeting communication to critical care nurses who are not currently members of CACCN; and promoting and marketing the work of critical care nurses nationally by developing a brochure and poster that capture the essence of critical care nursing.

**Advancement of critical care practice:** CACCN is devoted to ensuring that care given to critically ill patients and families is based on the best evidence available and that this care is delivered by nurses who have the corresponding education. Excellence in educational activities provided by the 11 CACCN chapters across Canada is acknowledged and is supported. Our scientific, peer-reviewed journal will continuously be assessed for quality. The new nursing research

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**A Vision Statement for the CACCN**

CACCN is seeking your input in the creation of a new vision statement for the association. Do you and/or your colleagues have phrases/keywords/ideas that would help CACCN create a vision statement that succinctly depicts the nature of critical care nursing? Please forward your thoughts to the CACCN national office by July 1.

**e-mail:** caccn@caccn.ca,  
**phone:** (519) 652-1989,  
**fax:** (519) 652-5545

Be sure to include your name and contact information. We thank you in advance for your assistance and creative suggestions!
utilization committee will launch its plan to contribute to excellence in practice. In addition, a number of initiatives will be introduced or continued in an effort to encourage ongoing certification for critical care nurses. Over the next year, CACCN will publish our position statement on withholding and withdrawing life support, and will begin the development of two additional statements, including: advanced practice nursing roles and organ donation in critical care. In addition, work will begin on a discussion paper on the recruitment and retention of critical care nurses.

**Partnership development:** As with many of life’s important activities, relationships are crucial to successful outcomes. We are working towards enhancing our relationships with the Canadian Nurses Association, the Canadian Critical Care Society and the Canadian Intensive Care Foundation, the Kidney Foundation of Canada, the Heart and Stroke Association of Canada and the National Committee on Organ Donation. A review of our corporate contribution program is also underway, as we seek new opportunities to collaborate effectively.

**Another change**
The year 2000 marked the first time that the critical care certification examination focused on the care of adults only. While I have mixed feelings about this, I can appreciate that this is less stressful for nurses who work in either adult-specific or child-specific units. The Canadian Nurses Association has made a commitment to develop a pediatric critical care certification process. In accordance with our association’s mandate to be the voice for Canadian critical care nurses working with neonatal, pediatric and adult patients, CACCN is committed to working with CNA to develop a certification mechanism that reflects the specialized competencies of critical care nurses working with children of all ages. The board of directors will keep members informed of opportunities for participation with this initiative in the months ahead.

In closing this, my first Critical Thinking column, I would be remiss if I did not acknowledge my former board of director colleagues who, over the past two years, have blessed me with both valuable mentorship and inspiration, namely, Val Davies, Regina, Saskatchewan, Joyce Thomas, Winnipeg, Manitoba, and Petula Wong, Halifax, Nova Scotia. In addition, I would like to thank Gwynne MacDonald, current past-president, who has been and continues to be an enormous source of knowledge, support and guidance. A huge bouquet of recognition is deserved by Heather Reid, administrator of our national office, who keeps us informed, organized, motivated and consistently improves the quality of our work with her knowledge and expertise. Building on the momentum of the association, the commitment of the current board of directors (who are introduced in this issue), and the enthusiasm of our ever-growing membership, I am confident that CACCN will succeed in being “the voice of critical care nursing excellence” in new and exciting ways. I know I am looking forward to the challenge!

Rosella Jefferson, CACCN President

**References**
Dynamics...
so much to see... so little time!

Attending a Dynamics of Critical Care conference is an exciting and rewarding experience. Participants are eager to obtain quality information which will benefit them professionally and which will be valuable to their colleagues and institutions. The following ideas are suggested to help you prepare for attending a Dynamics conference.

Choosing sessions to attend:
1. Scan the abstracts to determine what is included in the presentation. This year, Dynamics of Critical Care 2000 is pleased to provide some of the concurrent session abstracts in this issue of the journal. You can peruse the abstracts prior to attending the conference, discuss the topics with your peers and plan your conference schedule in advance. When reading and discussing the abstracts, consider the following points to help you determine if the session will be of benefit to you:
   • is the purpose of the presentation clear to you?
   • is the issue / program / technique relevant to your practice setting?
   • could an issue in your practice setting be affected by creative and innovative suggestions that are to be presented?
   • will you obtain new knowledge that could promote quality care in your unit?
   • does the information provided help you promote patient safety, cost-effectiveness and/or replace myth with fact?
   • have you heard the presenter speak in the past and did you enjoy the speaker?
2. After you have read the abstracts, you may find that there is more than one presentation in a concurrent session which you would like to attend. In such cases, be creative! If you are attending with friends or colleagues, each of you could choose a different session and have fun sharing the new information. Don’t despair, however, if you are not able to do this, because this is a great time to network with nurses from other critical care settings across the country. Discuss sessions with your new acquaintances and share the wealth of knowledge. Remember that this provides an opportunity to ask other critical care nurses “how do you do it in your unit”.
3. Don’t forget to attend the poster presentations which provide state-of-the-art practice recommendations and innovative approaches to nursing care. As well, attending the brief oral overviews of the posters could be very helpful in extracting the posters’ key points. Both of these present you with the opportunity to gather new and exciting ideas.

Getting the most from the exhibit hall:
1. Talk to your colleagues before attending Dynamics to identify questions regarding products currently being used in your unit. Make a list of products that your unit is interested in purchasing.
2. Wear comfortable clothing and shoes, and don’t forget your Dynamics bag for all your collected information.
3. Take a moment to examine all the exhibits to determine the flavour of what exactly is available. Plan to return to the exhibits which most interest you.
4. Attend the exhibits which provide free information and samples.
5. Talk to others and find out what exhibits they enjoyed. Chances are they may have seen useful information that you may have missed.
6. If you are investigating new products for your unit, you should:
   • be aware of the company/ies that supply your institution
   • determine if the company has research to support its claim and ask to see the copies of the supporting research
   • ask the company representative to provide your unit with free samples to trial
   • determine what education can be included for staff regarding the product
   • inquire as to the contact name for the company representative

Socialize, network and have fun:
1. Attend the planned social activities, such as the CNCC(C) recognition reception, where you will meet critical care nurses from other provinces, the CACCN board of directors and the Dynamics planning committee members.
2. Experience first-hand the great cuisine, entertainment and hospitality of the region by participating in CACCN’s annual dinner event.
3. Attend a networking session...another great way to gather new ideas from other experts in critical care.
4. Plan some time to see the local sights, savour the delicious food...and shop ’til you drop!

Like most critical care nurses who attend Dynamics conferences, you will return home recharged and rejuvenated. Share your enthusiasm with peers and take a lead in facilitating change. Contact colleagues you met while at Dynamics for guidance and support. Your excitement can be very contagious. When your colleagues hear the new information and share in your excitement, they will want to attend Dynamics the following year. You can mentor your peers as an experienced Dynamics participant, and help your co-workers make their Dynamics experience even more worthwhile, relaxing and enjoyable!

Valerie Banfield, CACCN Secretary
The 2000-2001 CACCN Board of Directors

Rosella Jefferson, RN, MSN
Western Region, President

Rosella Jefferson has completed two years on the CACCN board of directors as a representative from the western region. With the portfolio of publications chair, Rosella has enjoyed the opportunity to learn more about our scientific, peer-reviewed journal and the dedicated professionals involved with its production. Rosella was appointed vice-president in October 1998 and became president effective April 1, 2000.

Rosella currently applies learning from her MSN program, which was completed at the University of British Columbia in 1998, in her position as clinical nurse specialist for the pediatric critical care program at Children’s & Women’s Health Centre of British Columbia. Rosella is involved with coordinating nursing care for children with complex critical illnesses, partnering with people from regional hospitals regarding meeting their pediatric critical care needs, and facilitating research-based practice and program changes in the PICU.

Rosella attributes her love of learning and teaching to the BScN program which she completed at McMaster University in 1979. She also loves progress and changes, and is excited about her role with this dynamic association for critical care nursing. Rosella asks that you keep her informed about issues important to you.

Lori Garchinski, RN, BSN, CNCC(C)
Western Region, Vice-President

Lori is pleased to be on the board of directors for CACCN national representing the western region. As she enters her second year with the board, she continues to be amazed at the work done by the association in representing and providing a voice for critical care nurses in this country. As we enter this new millennium, there are many challenges facing nursing as a profession and Lori believes that CACCN is taking an active role in meeting some of these challenges. Through the networking we are doing with other interest groups and medical counterparts, we continue to strive towards providing optimal patient care whether it is through creating position statements or certification standards for critical care nurses to incorporate in their daily care.

On a more personal note, Lori has enjoyed the challenge of critical care nursing for the last 11 years. She is currently in a new role as one of the clinical development educators for ICU in the Regina Health District. This has been a great opportunity for her to spread the message of how exciting critical care nursing can be. Lori is also the mother of three great children and with the tremendous support of her husband Neil and her colleagues at the Regina Health District ICUs, does her best to balance home and work life.

One of Lori’s greatest challenges lies ahead as she assumes the role of vice-president for CACCN. Lori is pleased to work with a talented group of critical care nurses on the board of directors and knows that Rosella Jefferson will guide our association with great insight and expertise. Lori welcomes your comments and questions, and looks forward to meeting many of you in the next few years. Finally, Lori encourages you to take an active role in your professional association whether it is provincially or nationally.

Gwynne MacDonald, RN, MN, CNCC(C)
Central Region, Past-President

Gwynne was appointed to the CACCN board of directors in April 1997, and has just completed a two-year term as president of CACCN. She is now past-president for one year. In addition to being a resource person for the president, Gwynne will continue to serve as CACCN’s research utilization committee’s chairperson, as well as the chairperson of Dynamics of Critical Care 2001 in Victoria, BC.

Prior to her involvement at the national level, Gwynne held a number of positions with the London chapter of CACCN, as president, president-elect and chairperson of the education committee.

Gwynne has worked as staff nurse, educator and clinical nurse specialist in critical care. She is currently coordinator, intensive care, at the University Campus of the London Health Sciences Centre, London, Ontario. Her research interests have included primary nursing, case management, therapeutic touch, and evidence-based protocols and guidelines for DVT prophylaxis, weaning and non-invasive monitoring.

Gwynne received her Bachelor of Science in Nursing from the University of Windsor, and Master of Nursing from the University of Alberta. She became a certified nurse in critical care, CNCC(C), in 1995.
Valerie Banfield, RN, BScN, MN, CNCC(C)  
**Eastern Region, Secretary**  
Valerie Banfield graduated with a BScN from Saint Xavier University, Antigonish NS, in 1979 and began working in critical care 17 years ago. She has held various positions since that time: staff nurse, instructor (diploma program and post-graduate program in critical care nursing), and project nurse. In 1992, she received a Master in Nursing from Dalhousie University. Her thesis was entitled “Informational needs of families of patients who are critically ill”.  
Presently, Valerie is a nurse educator in the perioperative area (post-anesthesia care unit) and the distance critical care program at the Queen Elizabeth II Health Sciences Centre, Halifax, NS. She has been an active member of CACCN and has held the research position on the executive at the provincial level. Valerie received her certification in critical care in 1995 and twice participated in certification exam development.  
Valerie is beginning her second year in the role of CACCN secretary, with the primary responsibility of preparing and coordinating national correspondence.

Cindy MacVicar, RN  
**Western Region, Treasurer**  
The board of directors welcomes Cindy to the board. Cindy has been a nurse for over 20 years. Her background has been extensive and varied, including general surgery, plastics, EENT, neurosurgery, small neuro intensive care, burn unit, and for the past 14 years adult intensive and coronary care.  
Cindy’s interest in CACCN is multifaceted... CACCN is a group that focuses on critical care in all its aspects, from practice and standards to a legislation aspect. The CACCN promotes continued education for critical care nurses, advocating us toward growth both personally and professionally. It also provides a network and forum for sharing concerns and bouquets for critical care nurses.  
Cindy has been president-elect and president of the Greater Edmonton Chapter during an extremely busy and active period.  
In addition to serving CACCN as national treasurer, Cindy looks forward to using her enthusiasm and energies to ensure the continued success of the association. Cindy wants to bring a western region point of view to the board, and a national perspective back to the western region.

Heather Camrass, RN, BScN, CNCC(C)  
**Central Region, Director**  
Heather Camrass is in the second year of her two-year term on the board of directors, and continues to be responsible for the corporate sponsorship and awards portfolio. During her last year, Heather was a planning committee member of the successful Dynamics of Critical Care ’99.  
Heather has worked in critical care nursing for 11 years in the cardiovascular ICU at the Heart Institute in Ottawa, Ontario. She has also worked as a clinical specialist for vascular surgery and taught clinical for Algonquin College at the basic level.  
After becoming a member of CACCN seven years ago, Heather joined the local Ottawa chapter executive as the chapter secretary, and four years ago became chapter president. Nationally, Heather has presented two oral presentations at Dynamics - Phrenic Nerve Frostbite and Minimally Invasive Direct Coronary Artery Bypass.  
As Heather continues to serve on the board of directors, she strives to bring nursing into the forefront by expanding the voice that critical care nursing has across this country.

Pam Hughes, RN, CNCC(C)  
**Eastern Region, Director**  
Pam was born and raised in rural Nova Scotia and settled in Halifax, Nova Scotia when nursing became a career choice. Prior to nursing, Pam completed a diploma in biology laboratory technology in agriculture. As do many other colleagues, Pam juggles working full-time, an understanding husband, and two great kids ages nine and six.  
Pam has been working in medical surgical ICU over the past 13 years and most recently added the third dimension of neuro critical care. She has been actively involved in CACCN at the chapter level since 1987, and successfully completed her certification in critical care in 1997. She is also a member of the CACCN’s working group finishing a position statement on end of life issues.  
Critical care nurses are a very dynamic, well-educated body of professionals that many of the other health team members look to for input, support and opinion in delivering compassionate, highly skilled care on a daily basis. Pam is proud to include herself in this group and encourages others to get involved in issues facing critical care nurses. Pam hopes to bring a new awareness of CACCN to the bedside - showing CACCN’s support of members and the educational opportunities available.
Brenda Morgan, RN, BScN, CNCC(C)
Central Region, Director

Brenda Morgan, who resides in London, Ontario, began her second term on the board on April 1, 2000. Brenda is the board liaison to the Canadian Nurses Association for certification and will be the chairperson for the development of a position statement on advanced practice nursing in critical care and a discussion paper on the recruitment and retention of critical care nurses in Canada.

Brenda graduated from the Centennial College diploma nursing program in 1975, and from the University of Western Ontario, BScN program in April 1998. She is currently in the MScN program at McMaster University. Brenda has worked in critical care at the London Health Sciences Centre for over 20 years in a variety of roles: staff nurse, charge nurse and educator.

This is Brenda’s second period of time on the board of directors. Her past activities include: London chapter president (1986-88), national president of CACCN (1992-94), Dynamics chairperson (1991, 1994 and 1999) and critical care representative on the Canadian Nurses Association’s advisory committee. Brenda is currently a member of the critical care certification committee and is the editor of the first and second editions of the Study Guide for the Critical Care Nursing Certification Examination, published by CACCN.

CACCN calendar of events

DATES TO REMEMBER!

May 31, 2000 Deadline for nominations for CACCN’s national board of directors - contact national office for a nominations package
June 24 - 29, 2000 Third World Congress on Paediatric Intensive Care, Montreal, QC
July 1, 2000 Deadline for Johnson & Johnson Innovative Project submissions
July 31, 2000 Deadline for CACCN Chapter of the Year submissions
September 1, 2000 Deadline for SIMS Educational Award submissions
September 7 - 8, 2000 CACCN board of directors’ face-to-face meeting, Halifax, NS
September 9, 2000 Chapter Connections Day 2000, Halifax, NS
September 10-12, 2000 Dynamics of Critical Care 2000 Conference, Halifax, NS, Westin Nova Scotian Hotel

NOTICE OF ANNUAL GENERAL MEETING

The national board of directors of the Canadian Association of Critical Care Nurses (CACCN) would like to extend an invitation to the membership to attend the 2000 annual general meeting of the CACCN. The CACCN annual general meeting will be held on Sunday, September 10, 2000 at 1615 hrs at the Westin Nova Scotian Hotel, Halifax, Nova Scotia in conjunction with Dynamics 2000. Members unable to attend the annual general meeting are reminded that their proxy votes must be received in CACCN national office by 2400 hrs, September 1, 2000. The proxy vote form is printed below, and can also be obtained from your chapter president or the CACCN national office.

Proposed constitution and bylaw change:

ARTICLE 7, SECTION 2:

There shall be elected six (6) seven (7) Directors of the Association with the Immediate Past President sitting as a seventh an eighth member of the Board.

Annual General Meeting Proxy Vote 2000

Every active member may, by means of proxy, appoint a person (not necessarily a member of the association), as his/her nominee to attend and act at the annual general meeting in the manner and to the extent and with the power conferred by the proxy. The proxy shall be in writing under the hand of the member or his/her attorney, authorized in writing, and shall cease to be valid after the expiration of one (1) year from the date thereof.

Proxy votes must be received in the national office no later than midnight, Friday, September 1, 2000.

Proxy votes may be mailed/faxed to: Canadian Association of Critical Care Nurses, P.O. Box 25322, London, Ontario N6C 6B1 (Fax) 519-652-5545

The following shall be a sufficient form of proxy:

I, _____________________, of _____________________,
an active member of the Canadian Association of Critical Care Nurses hereby appoint _____________________ of _____________________,

or failing her/him, _____________________ of _____________________.

as my proxy to vote for me and on my behalf at the meeting of members of the association to be held on the 10th day of September 2000, and at any adjournment thereof.

Dated at _____________________, this _____ day of _____________________, 2000.

Signature of Member: _____________________

CACCN Membership Number: _____________________
CACCN’s communications board – Have you seen one? Have you heard about it?

At Dynamics of Critical Care ‘99, CACCN unveiled its new CACCN communications board. The CACCN communications board is a large, wall-mounted display unit that provides a consistent location to display CACCN activities, position statements, membership applications, Dynamics of Critical Care information, CACCN annual reports, website information and much, much more. The primary goal for these boards is to provide timely materials of relevance and interest to Canadian critical care nurses!

Following a letter of invitation to almost 250 critical care units across Canada, 57 of these communications boards were issued in November 1999. The board of directors would like to acknowledge the following critical care nurses for endeavouring to maintain these communication boards and providing a valuable on-site resource person for CACCN.

**British Columbia**
- Children’s and Women’s Health Centre of British Columbia, Tracie Northway
- Peace Arch Hospital, Betty-Anne Leugner
- Penticton Regional Hospital, Dawn Pethybridge
- St. Joseph’s General Hospital, Rhonda Snook
- Surrey Memorial Hospital, Pam Dawson
- Vancouver Hospital and Health Sciences Centre, Michelle House-Kokan

**Alberta**
- Grey Nuns Community Hospital and Health Centre, Teddie Tanguay
- Rockyview General Hospital, Pat Jensen-Jeffery
- Royal Alexandra Hospital, Lori Wade

**Saskatchewan**
- Pasqua Hospital, Sheila Rotske
- Regina General Hospital, Marian Hutchinson
- Regina General Hospital, Diane Tyrer
- Royal University Hospital, JoJo Prokopetz
- St. Paul’s Hospital of Saskatoon, Susan Yuzik
- Victoria Hospital, Carol Churchill

**Manitoba**
- Concordia Hospital, Fran Chester
- Health Sciences Centre, Sandra Christie
- Salvation Army Grace General Hospital, Joyce Macsymetz
- Seven Oaks General Hospital, Sue Ihme
- St. Boniface General Hospital, Helga Borchert
- St. Boniface General Hospital, Irene Strembicki
- Victoria General Hospital, Cynthia Moorby

**Ontario**
- Brantford General Hospital, Kathy Herzig
- Cornwall General Hospital, Charlene Mainville
- Grand River Hospital Corp., Jan MacDowell/Joanne Costello
- Greater Niagara General Hospital, Liz Mackay
- Hotel Dieu Hospital (Cornwall), Shelley Snider
- Hotel Dieu Hospital (St. Catharines), Cindy Crosby/Jan Maquire
- Hotel-Dieu Grace Hospital - Hotel Dieu Site, May Mercer
- Kingston General Hospital, Brenda Luffman
- London Health Sciences Centre, Brenda Morgan
- London Health Sciences Centre, Cheryle Anne MacBelford
- Mount Sinai Hospital, Connie Supnet
- North York Hospital - Branson Site, Kathy Williams
- North Bay General Hospital - Scollard Site, Jody Hatton
- Orillia Soldiers’ Memorial Hospital, Cathy Petrie
- Ottawa Hospital - Ottawa Site, Sue Malone Tucker
- Ottawa Hospital - Civic Site, Joelyn Mugford
- Sarnia General Hospital, Tina Hurlock-Chorostek
- Sault Area Hospitals, Betsy Oben
- St. Joseph’s Health Centre, Yolanda De Vries
- St. Mary’s General Hospital, Lynne Voelzing
- Sudbury Regional Hospital, Vanda Cooper
- Sunnybrook Health Science Centre, Janice Beitel
- Welland County General Hospital, Eileen Rowe/Bonnie Morrison
- Windsor Regional Hospital - Metropolitan Campus, Rose Scoby
- Women’s College Hospital, Doreen Saint
- Woodstock General Hospital, Randy Hicks

**Quebec**
- Montreal General Hospital, Marie France Juneau
- New Brunswick
- Moncton Hospital, Pauline Black
- Nova Scotia
- Aberdeen Hospital, Marlene Elliot
- Queen Elizabeth II Health Sciences Centre, Sandra Matheson
- Yarmouth Regional Hospital, Danielle Bryne-Surette/Kathy Chetwind

**Newfoundland**
- Dr. Charles S. Curtis Memorial Hospital, Beverly Pittman

**Northwest Territories**
- Stanton Regional Hospital, Celine Pelletier

**Yukon Territory**
- Yukon Hospital Corporation - Whitehorse General Hospital, Kelly White

In addition to these boards, 11 CACCN chapters will be issued specially-adapted table-top communications boards for use at local chapter events.

**If you would like to have more information about CACCN’s communications board, or if your unit would like to receive a board immediately, please contact CACCN’s national office. There are approximately 30 boards available for complimentary distribution in the year 2000! Requests are filled on a first-come, first-served basis!**

As CACCN strives to meet critical care nurses in their workplace, we hope these CACCN communications boards will become a valuable resource. If you have ideas about materials of specific interest to you and your colleagues, please let us know - we’d be most happy to hear from you!

Lori Garchinski, Vice-President Recruitment and Retention
Last fall we printed an issue of the journal that included all of the abstracts for Dynamics '99. That issue was very well received, however, CACCN members commented that it would be preferable to have it printed earlier so people could have a chance to read the abstracts and think about what sessions they would attend at the annual Dynamics conference. This year we are again printing an abstracts issue, but this time in the Summer issue. We hope you enjoy reading the many excellent topics that will be presented by poster or orally at Dynamics 2000. What an exciting conference Dynamics 2000 will be.

In addition to the abstracts, I have printed a copy of my presentation given at Dynamics '99 on publishing. I hope I have been able to provide a practical guide for those of you considering writing for publication. As always, we need manuscripts for the journal. If you have questions or an idea you wish to discuss, please do not hesitate to contact me or any member of the editorial review board. We are here not just to review manuscripts, but to offer advice and assistance through the publication process.

Paula Price RN, MN
Clinical Editor

Congratulations

The CACCN board of directors is honoured to recognize Bernice Budz and Jenny Poon as long-time service members (10 or more years of continuous membership). Their names did not appear in the list presented in the Winter 1999 journal.

CACCN publications and more!

Two key critical care nursing publications are available from CACCN’s national office.

**Study Guide for Critical Care Nursing Certification Examination in Canada** (2nd edition)
Cost: CACCN members $42.45 (includes GST and S&H)
non-CACCN members $63.85 (includes GST and S&H)

**Standards for Critical Care Nursing Practice** (2nd edition)
Cost: CACCN members - complimentary
non-CACCN members $18.55 (includes GST and S&H)
institution order $18.55 (includes GST and S&H)

CACCN logo pins are always available from our national office for $4.00 each. Share one with your colleagues!
by Paula M. Price, RN, MN,
Clinical Editor, Dynamics: The Official Journal
of the Canadian Association of Critical Care Nurses
Instructor, Advanced Studies in Critical Care Nursing
Program, Mount Royal College, Calgary, Alberta

This article is based on the presentation given at Dynamics ’99
in Ottawa, Ontario.

Abstract
“I couldn’t possibly write an article.”
“I don’t have anything worthwhile to write about.”
“I am not qualified to write for publication.”

Do any of these statements sound familiar? This article is intended to dispel these beliefs. You can write an article. You care for the most complex patients in the health care system so you do have something worthwhile to write about. Beside correct spelling and grammar there are no special skills, certificates or diplomas required for publishing. You are qualified to write for publication.

The purpose of this article is to take the mystique out of the publication process. Each step of publishing an article will be explained, from idea formation to framing your first article. Practical examples and recommendations will be presented. The essential components of the APA format necessary for Dynamics: The Official Journal of the Canadian Association of Critical Care Nurses will be outlined and resources to assist you will be provided.

In a recent survey conducted by the Canadian Association of Critical Care Nurses (CACCN), one of the most frequent comments regarding the journal was to increase its length. It is very difficult, however, to publish more articles when we receive so few. I hear from nurses that one of the reasons for the paucity of manuscripts submitted for publication is that they do not know where to start and how to proceed with writing an article.

The purpose of this article is to take the mystique out of the publication process. I would like to discuss the process by breaking it down into manageable pieces and I would like to share some of my experiences and views about each stage of the publication process. I have personally published articles and I have been associated with Dynamics for almost nine years, first as an editorial review board member, then as clinical editor, so I believe I can speak from both sides of the fence. In this article I will address some of the reasons for publishing, getting started, developing an idea, developing the topic, and gathering information. Then I will outline the parts of a manuscript, editing, submitting the manuscript to a journal, the review process, and the final publishing process.

Advantages of publishing
First, why publish anyway? Critical care nurses care for the most severely injured and ill patients in the health care system. We are on the front line of some of the most challenging health care issues and advances. New research, interesting clinical case examples, innovative management techniques, pharmacological interventions, educational techniques, and administrative practices are changing and advancing. Critical care nurses have something to say about our profession and everyone is capable of publishing their ideas. We need to learn from each other and share our knowledge, research findings, and program successes. Publishing in Dynamics and other peer-reviewed publications is an important way of disseminating information to other critical care nurses. In nursing, this exchange of ideas contributes to the improvement of the quality of patient care and enhances the image of nursing (Lawrence & Folcik, 1996).

Publishing is also a professional opportunity for nurses. It provides great personal satisfaction and in some cases may be rewarded in the workplace. Publishing may also lead to professional recognition and open doors to career opportunities (Halm, 1997).

But how does one get an article published? The process may seem daunting and intimidating. In actual fact it is neither. Let’s examine the process of getting started.

Getting started
Before even beginning to write anything, determine who will be involved. Do you want to write an article by yourself? Would you rather collaborate with one other person, two others? How many would be involved? From my own experience, working with others can be great. You can bounce ideas off each other and can even break the article down into sections so one person does not have all the work to do. I have also found working with others frustrating, especially if others do not pull their weight or get behind in the timeline and hold everyone back.

If you do decide to work with one or more colleagues, the next big hurdle that should be settled at the beginning is the authorship (Malone, 1998). Usually, the person providing the most leadership, “work”, ideas, writing, or coordination of the project is the first author (Wachs, 1996). The other authors take the second, third, fourth, etc. positions. It is important that this ordering is decided in the beginning and only those people
Developing an idea
Where do authors get their ideas for articles? Often it is just a matter of looking around you when you are in the clinical area. Is there a patient in the unit with a new or interesting illness or injury? Has a new therapy been initiated in your unit? Have you just completed a study and want to share the results with your colleagues? Is there new information about an old topic and are there implications for critical care nurses? What interests you?

Developing an idea takes some time and thought. Take the time to glance through the existing literature to see what others have written on the topic and look for ways to provide your own slant to the article. A well-written article is focused. That is, the article has a primary message.

Developing the topic and gathering information
The first thing I did when I agreed to present this information was develop an outline of the topics I wanted to address, the order I wanted to address them in, and reviewed the current literature. I never used to do an outline, but now I find it extremely helpful. It keeps me focused. I do not forget an area or topic I wanted to address them in, and reviewed the current literature. I never used to do an outline, but now I find it extremely helpful. It keeps me focused. I do not forget an area and I revise the outline as new information comes to light.

Some types of manuscripts have very straightforward outlines. For example, when publishing a research report you typically see the following sections:
- Background to the study
- Literature review
- Purpose
- Methodology
- Results
- Discussion
- Limitations
- Conclusion

In a clinical article you typically see the following sections:
- Overview of a clinical case
- Pathophysiology
- Assessment
- Interventions
- Results

I would highly recommend you develop an outline of what you want to include in your manuscript. Once the outline is complete, it is often a simple matter of just filling in the blanks, especially if your outline is quite detailed.

Researching the current literature on the topic is an extremely important step in developing the topic and generating an outline. Compiling the most recent and the most important writings on the topic has become quite easy with the computerized indexes available in the libraries such as MEDLINE and the Cumulative Index of Nursing and Allied Health Literature (CINAHL). Librarians are very helpful in this phase of the process by not only finding significant articles, but also securing them from other sources outside the library. Once the articles are obtained, keeping excellent notes is essential. Be meticulous about accuracy (Sullivan, 1999). Ensure citations are complete. Ensure your work, as well as that of others, is reported correctly. The accurate reference citation will be needed in the reference list.

Reviewers of a manuscript are very interested in the references used to develop the article. In particular, reviewers check to see that the references are current (within the last five years) and that there has been sufficient preparatory work done. For example, an article on the latest treatments of sepsis would be returned for further work if there were only five references cited. So I would suggest that you do a thorough literature review. And be prepared; the larger the topic, the more literature you will need to review.

In terms of currency of information, my general view is that journals tend to contain the most current information on specific topics. Textbooks tend to be adequate for general reviews of pathophysiology or clinical concepts. With the time it takes to get a textbook published, however, do not rely on them for the latest information.

Once you have decided on the topic, the areas to be addressed, the authorship and division of labour issues, and gathered all of the current literature, you are ready to begin writing.

Parts of a manuscript
Many people say the hardest part is getting started (Wachs, 1996). Perhaps that is because the hardest sentence is often the first one. Many writers overcome this hurdle by writing the first sentence last and going ahead with the body of the article. If, after avoiding the first sentence, words still do not come, authors can try other techniques to get the words flowing. Some writers plan to write at a certain time of the day or at a certain place, for example the library. Composing at the computer saves time and can be quite easy, but it does take practice. One person I heard from says that she does not try to have the perfect sentence or paragraph the first time, but rather just gets down the major ideas or even leaves a blank space if the right words do not come, and then goes back to connect ideas together and complete the work. Sometimes you need to leave the writing for a day or two and mull the ideas over in your mind and come back to it with a clear head. Some people write the introduction and conclusion at the beginning and some leave them until the end. In short, there is no right way or magic formula for writing. You choose what works best for you.

Title. Choosing the title can fill many people with grief and take hours to days to write, or it can be the most simple task. A title should summarize the main idea of the paper (American Psychological Association, 1994). It should sound interesting to hook the readers and make them want to read the article. The title should not be so long that it goes on for many lines and yet should give the readers a good idea about what the article is about. A title should be fully explanatory when standing alone. Avoid words that serve no useful purpose and
avoid using abbreviations. The recommended length for a title is 10 to 12 words (American Psychological Association, 1994).

**Title Page.** The title page of the manuscript should contain the title; all of the contributing authors’ names with their credentials, positions, and affiliations (institutions); and the name of the author where all correspondence should be sent and the address. This is usually the first author, but may not necessarily be so. The preferred form of an author’s name is first name, middle initial, and last name because this reduces the likelihood of mistaken identity with others (American Psychological Association, 1994). The title page is usually page one and the page number is placed in the upper right hand corner. For **Dynamics** it is not necessary to include a running head as outlined in the American Psychological Association (APA) manual. Other journals, however, may require it. See Figure One for an example of a title page.

**Abstract.** The next page is the abstract. The abstract is a brief summary of what is included in the manuscript. Readers often decide on the basis of the abstract whether to read the entire article. So, the abstract needs to be brief with information but also readable, well organized, brief, and self-contained (American Psychological Association, 1994). Often it resembles the introductory paragraph, but should not be identical. It should contain more information than just the introduction. In a research report, it actually contains some of the results and implications. The abstract should not exceed 960 characters and spaces, which is about 120 words (American Psychological Association, 1994). Make each sentence important, especially the first sentence.

An abstract of a report of a study should contain the problem, the subjects, the experimental method used including data-gathering methods and tools used, the findings, and the conclusions and implications.

An abstract for a clinical or theoretical article should contain the topic in one sentence, the purpose and scope of the article, the sources used (e.g. literature review and case study) and the conclusions.

**Introduction.** The introduction section of the manuscript is a very important part of the article. It should tell the readers what topics are included in the article. Because the introduction is clearly identified by its position in the article, it is not labeled with a heading (American Psychological Association, 1994).

**Body.** The body of the manuscript is where all of your work and your ideas are contained. The body should be organized in such a way that ideas flow from one to the other and there is a logical sequence. The writing must be clear and succinct. There should be transition sentences from one section to the next. Vary sentence length and structure (Sullivan, 1999).

Plagiarism is “the theft of intellectual property either in written or oral form (King, McGuire, Longman, & Carroll-Johnson, 1997). When using someone else’s ideas, that person must be given credit. There are two ways you can do this. One way is to directly take the words of the person in full and directly quote them. To do this you copy their words exactly, put quotation marks on either end of them, and then explain where this is written by documenting the author(s), date, and page number. The entire reference then goes in your reference list. I would highly recommend you limit the number of direct quotations in your manuscript to only a few and they should be really good. It is actually more difficult to read an article with a lot of quotations.

When using a short quotation there are the two possible ways to do it, as printed below. The complete reference is then added to your reference list.

“It is a professional accomplishment to have a manuscript accepted for publication and an event that should be celebrated” (Wachs, 1996, p. 276).

or

Wachs (1996) states that it “is a professional accomplishment to have a manuscript accepted for publication and an event that should be celebrated” (p. 276).

The other way to give someone credit is to paraphrase his or her words and then document the author(s) and the date. The complete reference is then added to your reference list.

Pulse oximetry has been reported to be accurate within 5% +/- 2% of the measurements obtained by blood gas analysis (Ahrens, 1993; Kissinger, Hamilton, & Rozycki, 1991).

If there are one or two authors, their names are always cited followed by the date. If there are greater than two but less than six authors, all names are listed with the first citation and then they are cited as first author followed by “et al.” and the date as in the following example.

So, in the presence of high levels of MetHb, SpO2 is erroneously low when SaO2 is above 85% and erroneously high when SpO2 is below 85% (Mardirossian & Schneider, 1992; Wahr et al., 1995).

If there are more than six authors then all citations, including the first one, are by first author followed by “et al.” and the date.
References are important to support statements, indicate sources of information, or guide the reader to pertinent literature (Brooks-Brunn, 1998). Finding the appropriate balance in referencing a manuscript is often a difficult task. When should a statement, thought or idea be referenced? In general, if information is common knowledge or known to the average reader, then a reference is not necessary, such as, the heart has a left and right ventricle. However, statements that cite another’s work, thoughts, or provide documentation must always be referenced (Brooks-Brunn, 1998).

Try to keep your writing in the active voice (e.g. norepinephrine causes vasoconstriction vs. vasoconstriction is caused by the effects of norepinephrine). Avoid wordiness and unnecessarily long words. My particular pet peeve is the word “utilize”. Short words and short sentences are easier to understand than long ones. Some examples of wordiness are:

- based on the fact that
- at the present time
- utilize
- for the purpose of

Avoid redundancy. In the following examples, the bolded words are redundant and should be avoided:

A total of 68 participants
Observations, which were exactly the same as before
Absolutely essential
Summarize briefly
The reason is because

Period of time

Subheadings are very useful in the body of the manuscript. They help break up the text both visually and provide clearer transitions for the reader.

In terms of the types of headings to use in your article, I often see the use of either two or three levels of headings. For two levels of headings, you would use:

Title

Section 1
Paragraph starts here and continue until you reach the next section.

Section 2
And so on.

If you have another level of subheading underneath the above sections then you would use:

Title

Section 1
Subheading under each section. Then continue on with the text here.

Next subheading would be here. Continue on with this subsection.

Section 2
Subheadings again would appear.

Paragraph length must also be watched. Single-sentence paragraphs are abrupt and paragraphs that are too long are likely to lose the reader’s attention (American Psychological Association, 1994). New paragraphs provide a pause for the reader. If a paragraph runs longer than one manuscript page, look for a logical place to break it or reorganize the material.

Ensure that you are using the correct word for what you mean. The biggest source of error I find is people tend to write sentences such as “Nurses feel there is no room for more equipment at the bedside.” The word “feel” is actually an emotion. The correct word is “believe” or “think”. “Nurses believe there is no room for more equipment at the bedside.”

The use of pronouns can easily confuse readers. The pronouns this, that, these, and those can be the most troublesome. To avoid confusion, try writing, for example, this test, that case, these participants, etc.

Another common problem in writing is called “anthropomorphism” – meaning ascribing human characteristics to nonhuman sources. The most common anthropomorphism I see is “This article will describe …” (an article cannot describe anything - a person can describe something) or “This study will measure ….” This error can be corrected by changing these examples to “This article will include …” or “The authors will measure …”

The use of abbreviations often eases reading. If you are going to abbreviate a word or series of words, the first time you abbreviate it must be spelled out in full and from then on you may use just the abbreviation. For example:

The American Psychological Association (APA) recommends avoiding excessive use of abbreviations. The APA also permits the use of widely accepted abbreviations now used as words, such as AIDS, and HIV.

Incorrect grammar and careless construction of sentences distract the reader and impair communication of ideas (American Psychological Association, 1994). I do not want to make this article into a grammar textbook, so I will leave it by saying: read your manuscript over carefully and correct grammatical errors, or have someone else do it for you.

Conclusion/summary/implications. At the end of the body of the manuscript it is very important to leave with a big bang. It is like the “so what” of this topic. A summary simply summarizes all of the main points but does not add anything new. A conclusion is more of a synthesis and final statement of what this all means. Finally, an implication to nursing is important because it gives the reader direction (e.g. what can I do with this information – use it in my clinical practice, do further study?)

If you are reporting on a study you have completed, the discussion section is used to evaluate and interpret the implications of your results. You are free to examine, interpret, and qualify the results, as well as to draw inferences from them. Similarities and differences between your results and the work of others should clarify and confirm your conclusions (American Psychological Association, 1994).

References. The reference list begins on a new page of the manuscript. All citations in the manuscript must appear in the reference list, and all references must be cited in the text. The
reference list is always in alphabetical order. The first line of each reference is indented five spaces.

The APA style for listing references is very specific. Considering that I see mainly journal articles and books used, I will give some examples for how to reference these items and also include an example of referencing an online source. I refer you to the fourth edition of the APA manual for further examples.

Referencing a journal article:


Notice the order of the reference. First the last names then initials, followed by the date in brackets, the title of the article, the journal and volume number underlined, and the page numbers. Notice how the first example has the issue of the journal in brackets following the volume. The reason for that is because each issue begins with page one whereas in some journals page one only appears in the first issue of the year then all following issues just continue with the page numbers.

Referencing a book:


Referencing a chapter in an edited book:


Referencing an online source:

Author’s Surname, Initials. (year, month day of publication on the internet). Document Title [WWW document]. URL place here

Tables and figures. Tables and figures can also be included in an article and come after the references each on a separate sheet of paper. Tables and figures should be used to clarify main points, but should not be a repetition of the text (Wachs, 1996).

Tables are efficient because you can present a large amount of information in a small amount of space. Tables are often used for displaying numerical values and the data are arranged in an orderly fashion. A table can also be used to present information in the form of words. All tables are numbered and titled.

A figure may be a chart, graph, photograph, drawing, or other illustration. Figures are especially useful in describing an interaction. All figures are numbered and titled.

Tables and figures must be printed on separate sheets of paper from the text and just a note in the text is included as to where the table or figure should be placed. When you use tables and figures, be certain to mention all of them in the text. Refer to all tables as tables and all graphs, pictures, or drawings as figures. Tables and figures supplement the text; they cannot do the entire job of communication. Always tell the reader what to look for in tables and figures (American Psychological Association, 1994).

Editing

After finishing the first draft of the manuscript, someone needs to read through the entire paper and edit it. Read it to see if the manuscript flows well and is logical. Is the primary message clear? Is the manuscript interesting and easy to read? Is there wordiness or redundancy in the manuscript? One technique Wachs (1996) recommends to evaluate the readability of a manuscript is to read it aloud. Wrong words and clumsy sentences come clear when heard. Typographical errors and grammar problems must be corrected.

After the self-editing phase is completed, it is often very advantageous, especially for new authors, to send the manuscript out for peer editing. This does not mean that you send your manuscript to your best friend to edit, but rather select someone with writing ability and content expertise who will give you honest and thoughtful feedback.

Submitting the manuscript

After you are happy with the manuscript and you can do no more, it is time to submit the manuscript to the journal of your choice. Ethically, the manuscript can be under review by only one journal at a time so do not send it out to several journals hoping one will accept it (King, McGuire, Longman, & Carroll-Johnson, 1997). Duplicate publication can be considered as self-plagiarism (Malone, 1998). If the manuscript is rejected, then it is acceptable to submit it to another.

To prepare the manuscript for submission check the author guidelines for that journal. For example, for Dynamics the article must be maximum 15 pages including tables, figures, and references. It must be double spaced with 1 1/2 inch margins on all sides. Pages are numbered sequentially. References are documented according to the fourth edition of the APA manual.

The accuracy of the references is also the author’s responsibility. Checking the reference list can be a tedious, time-consuming job, but references are very important to readers and a source of endless frustration when they are inaccurate or absent (Wachs, 1996). Studies of citations demonstrate an error rate ranging from 31% to 56% (Foreman & Kirchhoff, 1987; King, McGuire, Longman, & Carroll-Johnson, 1997; Taylor, 1998). Inaccurate citations give the impression of sloppy scholarship and hinder the retrieval of materials. They also cause the authors not to receive due credit and may impact delays and costs for verifying and retrieving materials (Taylor, 1998).

Ensure that each reference citation in the body of the work appears in the reference list at the end. Be sure all references in the reference list are cited in the article. If using any copyrighted material, a letter from the original publisher giving permission must accompany the manuscript.

When submitting a manuscript, a cover letter to the editor is
The review process

Once I receive a manuscript for consideration for publication I do three things. First I send a receipt letter to the contact person stating that I received the manuscript. Then I set the manuscript into the review process. I send a copy with no identifying information to two or three review board members. The review process is double blinded, meaning you will never know who reviewed your manuscript and the review board does not know who wrote the manuscript. I then review the work myself. Each reviewer comments on the appropriateness of the article to the journal, its accuracy or research rigor, and its reader appeal. Organization, clarity, and grammar are also addressed. Peer review ensures a minimum level of quality of manuscripts. Because it leads to revisions and improvement of manuscripts, peer review enhances acceptance by professional peers and maintains literature at the highest level (Bauer, 1998).

Once the reviewers finish their review, they return the manuscript to me with all of their comments and their recommendation. I then compile all of the comments on a clean copy of the manuscript and return it to the author(s) with our decision regarding publishing. This entire process takes about eight weeks, sometimes longer if the reviewers are quite busy with their own work.

I do not recall ever seeing a manuscript accepted with no changes. Some accomplished authors may have very few changes, but for the most part I see a fair bit of revision required to make the manuscript more complete and easier to read. Never, ever take the feedback personally. And never, ever give up. I have been crushed and “not very happy” with some of the comments I have received on the reviews of some of my work. If you see the words: “Congratulations your manuscript has been accepted for publication but with ….” - do not dwell on the extent of revisions requested. Many authors become very discouraged, hurt and angry to receive comments and corrections to work they have spent so long on (Thomas, 1998). Concentrate on the word “congratulations”. I try to give the most explicit feedback possible so the revisions can be done with relative ease.

Sometimes, an article is not accepted for publication. There are many reasons for this including: the idea may have been overworked, the topic is not relevant to the journal readership, a similar article has already been accepted for publication, or the article is not of a quality acceptable to the journal. Perseverance and a quality manuscript are both needed to publish an article.

The final publishing process

When the revisions are made, resubmit the article in a timely manner with a new cover letter thanking the journal reviewers for their assistance and offering to revise it again as needed.

Once a manuscript has been accepted for publication in a journal such as Dynamics the journal then holds the copyright. This means that even if you want to use a table or figure from the published article, you must write to CACCN to get permission. Also, once articles are accepted many authors want to know when they will appear in print. Some journals have a manuscript backlog of years, while others will publish the article in less than six months.

When the article is published, the first author is sent several complimentary copies of the journal from the publisher. Authors are not permitted to copy the article and distribute because the authors no longer hold the copyright to the article. If copies are required, authors can request reprints from CACCN.

Summary

So where do you begin? Start with an idea, give it an innovative slant, complete the library research, and write the body of the article. Include an interesting introduction, informative tables and figures, an accurate reference list, and concluding summary of the article’s main points. There are no secrets to publishing an article, rather there is a process, methodical and orderly, that moves us from idea to publication (Wachs, 1996).

References


Critical Care Nursing Abstracts

Four of the strategic goals of CACCN are: 1) to provide educational opportunities for critical care nurses; 2) to optimize the quality of critical care nursing practice; 3) to provide varied opportunities to profile critical care nursing research; and 4) to provide opportunities for nursing colleagues to network.

CACCN’s national conference, Dynamics of Critical Care, provides an excellent venue for accomplishing all of these goals, however, only a portion of CACCN members are able to attend a Dynamics conference annually. Cognizant of this, CACCN is pleased to be printing its second annual “Special Dynamics Issue” which includes a selection of the abstracts from Dynamics 2000.

The following abstracts represent a selection of the concurrent session and poster abstracts being presented during Dynamics of Critical Care 2000 being held in Halifax, Nova Scotia, September 10-12, 2000. To assist the reader, the abstracts have been divided into three sections: clinical, research and professional development/leadership.

It is our hope that CACCN members interested in pursuing a profiled topic will contact our national office at (519) 652-1989 or caccn@caccn.ca to receive information regarding how to contact the author about the work.

We hope you will carefully consider the critical care nursing topics currently being investigated and discussed in various centres across Canada!

DYNAMICS 2000

CLINICAL ABSTRACTS

Cardiac arrhythmias and treatment modalities in critical care
E. Doucette and G. Kelsall, Montreal, Quebec

Since the advent of coronary care units in the late 1960s and early 1970s, health care professionals have been involved in a continuous educational process in arrhythmia recognition. The advances in diagnosis and therapy continue to give great impetus to this study.

As well in the last decade, we have seen the development of pharmacologic agents that are effective in salvaging myocardium as a result of cardiac arrest, acute myocardial infarction, acute coronary syndrome, and stroke. These agents are limited in that they must be administered within a set window of time from onset of symptoms, a window of opportunity to improve outcome of devastating events. The modern era of reperfusion therapy, risk stratification, and significant pharmacologic therapy has made a significant difference in the lives of patients and families who are affected.

It is vital for critical care nurses caring for patients with abnormal heart rhythms to be able to recognize and treat common arrhythmias.

Managing systemic lupus erythematosus in the intensive care unit
J. Glowa and J. Van Eck, Calgary, Alberta

Systemic lupus erythematosus (SLE) is a chronic disease characterized by an abnormal increase of systemic inflammatory response in multiple organs and a decrease of protective immunity of the host. Affecting women more than men, SLE occurs when the body produces antibodies against its own cells and the resulting antigen/antibody complexes damage connective tissues. A disease of exacerbations and remissions, SLE may be triggered by genetic, hormonal, and environmental factors. Untreated, it can be fatal.

Although SLE in most cases can be medically managed, an acute flare-up may require admission to an intensive care unit (ICU) due to manifestations such as uncontrolled hypertension, seizures, and kidney failure.

This interactive workshop will cover:
I. Arrhythmia detection and recognition;
II. Review of cardiovascular medications that treat arrhythmias;
III. Obtaining and interpreting a 12-lead ECG;
IV. Treating arrhythmias with pacemakers.
This presentation will discuss the clinical signs, diagnosis, treatment, and nursing care of a patient with SLE. A case study of a young woman with multiple ICU admissions for complications of SLE will be presented.

**New modes of mechanical ventilation in pediatric respiratory failure: A case presentation**

*J. Rashotte and M. Thomas, Ottawa, Ontario*

Severe respiratory failure in newborn and pediatric patients is associated with significant morbidity and mortality. Numerous research studies have led to advances in our understanding of ventilator-induced lung injury and in optimizing the supportive use of conventional strategies. In addition, over the past few years, progress has been made in alternative therapies for ventilating children with severe respiratory failure.

The purpose of this presentation is to focus on the current trends in ventilation and supportive adjuncts for the pediatric patient in severe respiratory failure. Through the use of a real case study, the techniques of permissive hypercapnia, inhaled nitric oxide, surfactant, intratracheal pulmonary ventilation, and extracorporeal life support will be reviewed. Ventilatory management of this pediatric patient will include a discussion of such ventilatory modes as high frequency oscillatory ventilation, pressure control-inverse ratio, pressure-regulated volume control, and volume support. The patient’s pulmonary parameters, including measures of oxygen uptake, will be integrated into the discussion to better understand the rationale for utilization of this full armamentarium of respiratory management strategies throughout the course of this child’s stay in the pediatric intensive care unit.

**Multi-visceral transplantation: A nursing perspective**

*A. Harwood, T. Robitaille and K. Pettapiece, Toronto, Ontario*

The University Health Network (UHN) has developed one of the most successful transplant programs in Canada. The multi-organ transplant program performs annually 20 heart transplants, 25 lung transplants, 80 liver transplants, 100 kidney transplants and 15 kidney/pancreas transplants. Recently the UHN performed its first multi-visceral transplant (fifth in Canada), involving the liver, stomach, pancreas and small bowel. When the ICU staff learned that they were to receive this patient, intrigue, fascination and trepidation immediately set in for the primary caregivers - the nurses.

The lack of knowledge and information surrounding this procedure prompted a group of nurses in the unit to research this case to provide updated information to their peers. Subsequently, a decision to present this patient as a case study was made. The experience that was gained during this time was important and we as nurses want to share this with our colleagues outside of the University Health Network.

The case study will be presented through an oral presentation that will look at many issues surrounding this complex case. The goal of the presentation is to provide knowledge to our peers so that exemplary patient care can be provided.

The case study will focus primarily on the patient during the critical care period. A brief overview of the patient’s previous medical history will be presented along with details of the work-up for a multi-visceral transplant and the 15-hour surgical procedure. This will be followed by an indepth look at the post-operative course in the intensive care unit. Issues that surround the care of the patient will be addressed - infection/rejection, immunosuppression, psychological issues and nursing care in a critical care environment.

To conclude the case presentation, the authors will focus on future developments in the critical care practice of providing care for multi-visceral transplant patients. A look at what the future may hold for patients requiring this type of surgical intervention based on current and possible future research will also be addressed.

**The development of an insulin sliding scale in the cardiovascular intensive care unit**

*H. Camrass, J. Leblanc and A. Jackson, Ottawa, Ontario*

The incidence of diabetes for patients undergoing cardiac surgery is 24.6% in our cardiovascular intensive care unit. Previous practice has been to treat elevated blood glucose
levels with an intravenous infusion of Humulin R titrated by a sliding scale. There was no formal protocol and the sliding scales were variable among the ordering physicians. The need for a standardized sliding scale was identified. The collaborative team of nursing, pharmacy, and medicine developed an evidence-based protocol using the Portland Protocol (Furnary, 1999) sliding scale model. This pilot study was used with patients with type II diabetes who had undergone cardiac surgery. A prospective analysis was done with 40 patients requiring insulin therapy to test the effectiveness of the insulin protocol and to measure the primary outcomes of blood glucose control, wound infections and length of stay. As well, a retrospective analysis was done on 40 patients to examine the same outcomes.

This presentation will identify the significant issues surrounding the care of patients with diabetes undergoing cardiac surgery, the development and implementation of the protocol, the results of the data collected, and the nursing implications.

Acute respiratory distress syndrome and high frequency oscillation

A. Jeffs and P. Hynes-Gay, Toronto, Ontario

Nursing care of the patient with acute respiratory distress syndrome (ARDS) has become increasingly complex in light of various etiologies and treatment modalities. Treatment regimes have been traditionally supportive in nature including use of mechanical ventilation, fluid management and pharmacological support. The introduction of high frequency ventilation as a strategy in maximizing oxygenation, with the hope of preventing any further lung injury, has become a principle objective in the delivery of care. High frequency oscillation as a form of high frequency ventilation has been commonly used among the pediatric critical care population. Although still investigational, it is being trialed more and more as an alternative ventilatory strategy on adult patients in our intensive care unit who are difficult to ventilate. This has resulted in the establishment of nursing guidelines in caring for these types of patients, particularly around respiratory assessment, ventilatory management, hemodynamic monitoring and use of neuromuscular blocking agents. This oral presentation will focus on a brief review of the pathophysiology of acute respiratory distress syndrome, the principles and indications for high frequency oscillation in relation to the ARDS patient, as well as nursing management of patients receiving high frequency oscillation as an alternative mode of ventilation.

Fever in ICU: To treat or not to treat

V. Toor and S. Yard, Vancouver, British Columbia

Fever is not synonymous with infection. The literature states that as few as 50% of all fever found in the ICU is caused by sepsis. Yet we often overlook the many other causes of fever such as atelectasis, trauma and drug fever (eg., colace). To help us determine the cause of fever, we need to review how we assess fever. The literature suggests that we look at a fever curve rather than an individual temperature value, as well as examine onset, patient history and concurrent symptoms.

Fever has been recognized as a protective response. It is part of the general immune response that research has shown to have many beneficial effects such as enhanced immunity. It also increases metabolic demands resulting in an increased cardiopulmonary workload (ie., tachycardia and tachypnea). Relatively healthy patients can cope with this increased workload, however critically ill patients are often greatly compromised. Critical care professionals often err on the side of caution, choosing to forego the benefits of fever and instead decrease oxygen demand by reducing core body temperatures via antipyretics or active cooling strategies. Recent studies in the literature are suggesting that there may be deleterious effects not previously recognized related to cooling patients, such as aceteminophen-related hypotension. In light of this new research, we should be re-examining our present practice of aggressively treating fever in critically ill patients. The complexity of our critically ill patients negates the possibility of developing hard rules on fever treatment, nevertheless, we can improve our understanding of the role of fever in the critically ill, and hopefully make more patient centered decisions of when and how to treat fever.

Stroke treatment with intravenous tissue plasminogen activator (IV TPA) in Halifax

J. Jarret, S. Phillips and G. Gubitz, Halifax, Nova Scotia

Introduction: In February 1999, tissue plasminogen activator (TPA) was approved for use in acute ischemic stroke in Canada. In our hospital, we have used open-label TPA for acute stroke since June 1996, following the positive results of the National Institute of Neurological Disorders and Stroke (NINDS) trial. We present our cumulative experience with stroke patients treated with TPA over a four-year period.

Methods: Our multidisciplinary stroke team maintains a database of admitted patients, including information about stroke type (using the Oxfordshire Community Stroke Project [OCSP] classification), adverse events, length of stay and discharge disposition. Clinical outcome is measured using the Barthel Index. Data are currently available for 50/57 TPA-treated patients. Using the OCSP classification, 29 (58%) of these patients had total anterior circulation strokes (TACS). From the database, we compared the outcomes of TPA-treated (n=29) and non TPA-treated (n=201) TACS patients.

Results: Fatal intracranial hemorrhage occurred in 6% of the TPA-treated patients. The median length of stay was shorter for TPA-treated patients (12 days versus 28 days). The mean Barthel Index score at the time of discharge was higher for TPA-treated patients (46 versus 29 points). More TACS patients treated with TPA went home (21% versus 15%) and fewer went to a nursing home (26% versus 34%).
Conclusions: The fatal intracranial hemorrhage rate is similar to that reported in the NINDS trial. Examination of early clinical outcomes of severe stroke patients at our institution demonstrates safe and effective care in our routine clinical practice.

Creating a clinical pathway to optimize outcomes for children and families following cardiac surgery
L. Edmond and C. Maser, Toronto, Ontario

Aim: To raise participants’ awareness and knowledge of the pediatric utilization protocol for the atrial septal defect (ASD) repair.

Outcome:
1. To gain an historical understanding of the care of children undergoing atrial septal defect repair.
2. To understand the process of creating a 72-hour discharge plan for the ASD repair population.
3. To effect thoughtful practices in the care of pediatric patients post ASD repair.

Atrial septal defects account for approximately 10% of all congenital heart defects (Hazinski, 1988). At the Hospital for Sick Children, Toronto, the average length of stay for these patients was approximately seven days, with three of them being spent in the critical care unit. In an effort to improve patient outcomes and decrease length of hospital stay, a 72-hour discharge plan was designed and implemented.

This oral presentation will outline the planning and implementation of the protocol and address an outcome evaluation of the ASD: Pediatric Utilization Protocol.

The second part of the presentation will outline the necessary partnership with the family and patient to optimize patient outcome following open heart surgery.

Finally, the collaborative efforts of the critical care and cardiac units, which proved to be invaluable, will be described. Ideally, extubation of the patient happens within two hours of the child’s arrival in the critical care unit, and transfer to the floor occurs four to six hours after extubation. “It is apparent from the literature that the use of critical paths or similar documents can influence clinical outcomes for patients and financial outcomes for hospitals.” (Griffith, D., Hampton, D., Switzer, M., and Daniels, J. (1996). Facilitating the recovery of open heart surgery patients through quality improvement efforts and CareMAP implementation. American Journal of Critical Care: 5, 346-352; Hazinski, M., (1988). Nursing Care of the Critically Ill Child. St. Louis: Mosby).
Adult respiratory distress syndrome in the trauma patient: A case study
D. Patterson, Montreal, Quebec

Adult respiratory distress syndrome (ARDS), first identified among critically wounded soldiers during World War II, is a serious and often fatal syndrome that presents itself in a variety of patient populations. Trauma patients often obtain injuries that precipitate pulmonary problems requiring long-term ventilation and immobilization, and therefore are at higher risk for developing this syndrome.

ARDS continues to be associated with high mortality rates despite numerous advances in critical care. These patients require nursing care on all levels: basic care such as turning and positioning, as well as nursing care necessitated by mechanical ventilation and hemodynamic monitoring.

This presentation will cover:
I. A brief history and definition of ARDS
II. Course, characterizations and complications of this syndrome
III. Current treatment and management, as well as prevention and prediction methods for the patients at risk, such as the trauma population
IV. Implications for critical care nursing.

A case study will be presented to illustrate the practical application of this information, and to outline some interventions in nursing care for a trauma patient with ARDS. The importance of nursing knowledge as well as appropriate and supportive care for both the patient and their family will be discussed.

Immunocompromised patients in the intensive care unit... what every ICU nurse should know
K. Schnell, Winnipeg, Manitoba and C. Schwindt, Halifax, Nova Scotia

Critical care nursing has evolved, as nurses reflect on their history and embrace changes that technological advances have brought forth. In the past, immunocompromised patients suffering from cancer, autoimmune disorders or HIV were not considered to be suitable candidates for intensive care units, as these diseases were associated with imminent death. However, as medical technology and treatment of malignancies has advanced, the prognosis and treatment options have dramatically improved. These immunocompromised patients are now being seen with increasing frequency in critical care areas across the country. As critical care nurses envision their future, they must embrace this trend towards caring for immunocompromised patients and become knowledgeable about the issues that these patients face.

A clinical review of immunocompromised patients will be analyzed to give a foundation to this topic, along with the diseases and therapies that can cause a patient to be in this altered state. The presentation will focus on the most important issues of the immunocompromised patient that require critical care intervention: anemia, bleeding and infection. The treatment and therapies utilized to care for an immunocompromised patient will be discussed, with an emphasis on the nursing interventions. In order to illustrate the clinical picture seen in the intensive care unit, one will review a case presentation and corresponding nursing care plan.

The asplenic patient and overwhelming sepsis: Is your patient at risk?
S. Martin and B. Luffman, Kingston, Ontario

The spleen “the organ of mystery” has the function to cleanse, filter and opsonize the blood. It is vital to our defense system. However, even with this critical role in disease prevention, splenectomies frequently occur, whether related to trauma, preventative medicine or incidental during surgery.

The risk for post-splenectomy infection is highest in the first two years, but will remain a life-long threat. In fact, serious infections in asplenic patients remain equal to the general population but the incidence of sepsis is 58 times more fatal (Lynch, 1996). Despite advancement in medical technology and therapeutics, mortality and morbidity remain high. In addition, the lack of health care provider knowledge, patient education and patient compliance further increases mortality. An infected asplenic patient only has 24 to 36 hours to seek medical attention and receive antibiotic therapy. Without it, there is a 50 to 75% chance death will occur within 24 to 48 hours. (Steffen, 1999)

This presentation will review the indications for splenectomy, with a focus on the early detection and assessment of infection, and the nursing management of the asplenic patient with an infection and/or overwhelming sepsis. It will also include a discussion of the organisms that generally infect these high-risk patients, current treatment practices for the patient in septic shock, and recommendations for drug therapy.

To demonstrate the urgency of overwhelming sepsis in the asplenic patient, this presentation will be summarized with two case studies that presented to our intensive care unit. An asplenic patient could present to any critical care unit. The information in this presentation will be useful to all critical care nurses.

Continuous renal replacement therapy (CRRT) in critically ill children: Understanding the dynamics
C. St. George-Hyslop, Toronto, Ontario

Continuous veno-venous renal replacement therapy (CRRT) is a common treatment modality used in the management of fluid and electrolyte disorders in critically ill children. It offers the advantage, over other renal replacement therapies, of continuous gentle fluid removal while maintaining in comparison, a relative hemodynamic stability. The health care
team must have a clear understanding of the principles behind renal therapies and the complexities involved in managing and monitoring pediatric patients on CRRT. Consideration of the intricacies of therapy and the potential for complications is fundamental. These may involve hemodynamic instability, bleeding, fluid and electrolyte changes, anaphylactic reactions, thermoregulation and sepsis.

The scope of this presentation will encompass a review of the indications, modes of therapy, mechanism of clearance, sieving coefficients, access & catheter issues, selection of solutions, machines (Prisma & BSM), order sets, documentation, & complications. Modes of therapy described are ultrafiltration (SCUF), continuous veno-venous hemofiltration (CVVH), continuous veno-venous hemodialysis (CVVHD), and continuous veno-venous hemodiafiltration (CVVHDF). The presenter will discuss the challenges of caring for children on CRRT, from meeting psychosocial needs of the child and family to educating staff and maintaining user competency.

Current research in CRRT will be examined, including its queried role in cytokine removal in septic patients. The clinical experience with patients on CRRT in the critical care unit at the Hospital for Sick Children in Toronto will be used to highlight key points. Case studies will help illustrate current guidelines on management and monitoring of critically ill pediatric patients receiving continuous renal replacement therapy.

Continuous EEG monitoring in the comatose critically ill patient
A. Burling, London, Ontario

Standard electroencephalography (EEG) records a brief sample of the patient’s cortical activity. Many neurology patients are at risk of developing seizures or other life-threatening conditions such as status epilepticus or stroke. Continually monitoring the EEG (CEEG) of high-risk patients in the critical care setting alerts the nurse and physician to potential deterioration in level of consciousness and is the best method for detecting seizure activity or therapeutic response at a reversible stage.

Previously, monitoring of these patients has been limited to clinical observation and intermittent EEGs. Occasionally, as with barbiturate coma, continuous EEG monitoring has been employed, but the sheer bulk of the equipment and the reams of paper generated data made this monitoring technique at best, difficult. With the technological advances in computers and software in the 1990s, continuous computerized EEG monitoring has proven effective in diagnosing disorders, monitoring both the course of disease and the effectiveness of treatment, and in predicting prognosis. It has been especially beneficial in the diagnosis and treatment of non-convulsive seizures.
Post-transplant non-Hodgkin’s lymphoma (NHL) has been identified as a major complication of immunosuppressant therapy. Patients who require intensive immunosuppressant therapy during the early post-transplant period, as in heart, lung or liver transplantation, are at a significantly higher risk than kidney recipients of developing a lymphoma. There is also evidence in the literature that heart recipients require higher immunosuppressive maintenance doses than kidney recipients, and that the incidence of lymphomas has increased since the introduction of cyclosporine in the mid-1980s. The majority of post-transplant lymphomas are of B-cell origin, and are associated with the Epstein-Barr virus (EBV) infection. This presentation will discuss the risk of developing neoplasm, the pathogenesis, clinical manifestations, incidence, prevention, treatment and prognosis of post-transplant lymphomas, commonly referred to as post-transplant lymphoproliferative disorders (PTLD).

Cardiac surgical repairs in infants
J. Guimond and K. Johnston, Toronto, Ontario

Historically, infants requiring cardiac surgery were primarily managed medically, with corrective surgical options only being considered once a baby had gained weight. Current research now indicates that early surgical intervention offers improved outcome for infants with congenital cardiac defects.

At The Hospital for Sick Children in Toronto we have been increasing the number of surgical repairs performed on infants. Early surgical correction is now recommended if a baby is symptomatic, regardless of weight or age.

This presentation will explore developments that have arisen to enable us to provide complete surgical repair in infants with congenital heart defects. These developments include, but are not limited to:

1. Prenatal diagnosis of cardiac defects.
2. Improved understanding of the physiology of neonates with congenital heart disease.
3. Advances in the use of technology such as colour doppler, placement of PD catheters and ECMO.
4. Improved pre-op and post-operative medical and nursing management in the critical care unit.

Current research on the topic will be incorporated throughout the presentation. Future directions in the nursing care of this high-risk patient population will be highlighted.

Lymphoma post transplant: A unique case study
V. C. Cronin, Ottawa, Ontario (poster)

A case study of a 58-year-old male patient who underwent a cardiac transplantation in June 1999 for cardiomyopathy of unknown origin will be reviewed to illustrate this. Four months post heart transplant, Mr. X was readmitted to hospital with fever, chills, night sweats, progressive weight loss, lethargy and shortness of breath. He rapidly deteriorated, experiencing multi-system organ failure, requiring endotracheal intubation and mechanical ventilation. He was later diagnosed with a high grade B-cell lymphoma. Mr. X died November 10, 1999.

The patient’s wife works full-time as an operating room nurse. Mrs. X spent several hours every day at the hospital, playing a significant role in her husband’s care. When therapy was withdrawn and discontinued, Mrs. X assisted with removal of invasive lines and tubes, and later with preparation of the body. The role that Mrs. X played in the cardiac ICU will be discussed, and her perspective presented to illustrate the emotional and family aspects of this unique scenario.

The administration of neuromuscular blocking agents in the ICU
N. Holmes and P. Hynes-Gay, Toronto, Ontario (poster)

Pharmacologic neuromuscular blockade is an important aspect of the management of intensive care patients with respiratory failure. However, recent evidence suggests that prolonged administration of non-depolarizing neuromuscular blocking agents can have adverse effects such as persistent paralysis, muscle weakness and, subsequently, an inability to wean (Murray, 1997). It is believed that metabolites of these drugs retain blocking capabilities that accumulate during long-term use. Correct dosing is, therefore, essential in ensuring that only the amount of the drug necessary to achieve 75-90% neuromuscular blockade is administered.

The recommended standard of care for paralyzed patients involves the use of peripheral nerve stimulation and train-of-four monitoring to guide the depth of paralysis. When used routinely, peripheral nerve stimulation can assist in optimizing this therapy as it allows a more precise titration of neuromuscular blocking agents than clinical evaluation alone. Furthermore, it is not confounded by factors such as sedatives/narcotics that often affect our ability to assess clinical parameters.

This presentation will discuss the indications for the use of neuromuscular blocking agents in critically ill patients, and two aspects of the care of the paralyzed patient that have been detailed in the literature: over-paralyzation and the need for sedation and analgesia. Guidelines for monitoring the paralyzed patient will be highlighted.
Now appearing in ICU: POEMS Syndrome
R. McCready, London, Ontario (poster)

POEMS syndrome is a rare, multisystemic syndrome characterized by the association of polyneuropathy, organomegaly, endocrinopathy, M protein, and skin changes. The manifestations of the disorder are secondary to a plasma cell dyscrasia and are not limited only to the five in the acronym; patients can also present with renal failure, finger clubbing, pleural effusions, pulmonary hypertension, thrombocytosis and acute arterial obliteraton.

Due to its rarity, critical care nurses will not likely care for many patients with this syndrome. However, care of these patients is very challenging due to the many systems involved; thus, a thorough knowledge of all aspects of this devastating disorder will assist the nurse in providing care to the patient.

A review of the literature has revealed that POEMS is a chronic, difficult to diagnose condition which has an obscure pathogenesis. It is also referred to as Crow-Fukase syndrome and was first described in 1956. Most authors agree that at least three of the five features that the acronym stands for must be present for a diagnosis to be made. The majority of patients will have a peripheral polyneuropathy. Radiotherapy, chemotherapy, corticosteroids, plasmapheresis and interferon can be used as treatments. There is little data about prognosis in the literature.

This poster presentation will discuss the pathogenesis, diagnosis, symptoms, treatments and nursing considerations for this disorder through the presentation of a case study.

Right heart thrombus: A success story
J. Baird, C. Dalton, and S. Feener,
Grand Falls-Windsor, Newfoundland (poster)

Mr. X., a 57-year-old man, was transferred emergently to the intensive care unit (ICU) 28 hours after admission to the medical floor. He was grey, short of breath, hypotensive, agitated, confused and his SpO2 was 80% on 10 litres non-rebreather O2 mask. A transthoracic echocardiogram taken on arrival in ICU showed a floating thrombus extending from the inferior vena cava through the right atrium extending into the right ventricle.

The Central Newfoundland Regional Health Centre is a regional centre with 139 beds. It is located four to five hours by road from the closest tertiary health care facility. In the experience of the medical and nursing staff, this was the first time such a diagnosis had been reached in this institution. A computer search of current nursing literature was undertaken. No previous reports of this condition in mainstream nursing journals were found. A search of broader health/medical literature suggested that floating right heart thrombus was a rare phenomenon and that treatment was controversial.

Therapeutic options included: surgical embolectomy during cardiopulmonary bypass, thrombolitics, heparin or interventional percutaneous techniques including basket retrieval of thrombus. According to a communication from the licensee of “Activase”, its use in treatment of right heart thrombus must be considered investigational.

In our institution, the treatment options available were intravenous thrombolytic therapy or heparin therapy. “Activase”, tissue plasminogen activator, was administered according to the current thrombolytic therapy protocol. A repeat echocardiogram, taken 90 minutes later, showed that the thrombus had disappeared.

This poster will describe right heart thrombus; intervention options, treatment and outcome in the context of Mr. X., and current medical literature. In addition, the role of the critical care nurse with the biopsychosocial educative demands for this specific case will be outlined.

Extubation outcomes following an RN/RT driven spontaneous breathing trial
P. Hynes-Gay, J. Fulton, A. Brindley, T. McRae and W. Chu, Toronto, Ontario (poster)

Background: Widespread acceptance of the importance of discontinuing ventilator support at the earliest possible opportunity has resulted in a number of efforts to develop a standardized approach to the timing of extubation.

Purpose: To determine the percentage of patients who will pass an RN/RT driven spontaneous breathing trial (SBT) and progress to extubation. To determine the rate of reintubation within 48 hours among those patients who were extubated following their first SBT. Of those patients who did not pass their first SBT, to determine the reasons for failure.

Method: A prospective pilot study conducted in the medical/surgical intensive care unit of a university-affiliated hospital enrolled the first 47 consecutive patients who were identified by the multidisciplinary team as ready to undergo a one-hour SBT of pressure support ventilation 6 cm H2O, 0 cm positive end-expiratory pressure (PEEP), in preparation for extubation. Patients were screened to confirm their readiness to proceed to the SBT. Patients with a tracheostomy were excluded. Extubation outcomes were formulated in terms of the percentage of patients who required reintubation within 48 hours of being extubated. Results: 39 (83%) of patients were extubated after a single successful one-hour trial of spontaneous breathing. Five of these patients (12.8%) required reintubation within 48 hours. Among the 17% (eight patients) who could not be extubated following their first SBT, the most frequent cause was anxiety (four patients).

Conclusions: A systematic approach to extubation using a one-hour SBT appears to be an effective means of disconnecting ventilator support in medical/surgical intensive care patients. The impact of such a trial on patient morbidity and mortality remains to be evaluated.
Heart health and gender
P. Hynes-Gay, Toronto, Ontario (poster)

Rationale: Although mortality from cardiovascular diseases is at least as high among women as among men, the notion that such illnesses are gender-specific, afflicting mainly males, continues to influence our present-day understanding of heart disease.

Objectives: To compare the average length of stay in CCU for males and females; To compare the rate of cardiac catheterization in males and females admitted to the CCU.

Methods: All patients admitted to the CCU of a university-affiliated hospital over a 14-month period were included in the study (n=167); T-test and chi-square were used to analyze means and percentages, respectively.

Results: Significantly more males than females gained admittance to the CCU during the timeframe of this study (p < .001); Differences in average length of stay for males and females were noted, but were not statistically significant; Similar numbers of males and females underwent cardiac catheterization.

Conclusions: Gender considerations have emerged as a major issue in the diagnosis and treatment of heart disease in women; Although fewer females than males were admitted to the CCU during the study period, similar percentages had invasive interventions performed.

Trauma RN on-call: Building new partnerships
J. Kojlak, P. Weaver, T. Charyk Stewart, B. Clarke, S. Mason and K. Reiger, London, Ontario (poster)

London Health Sciences Centre, Victoria Campus, is a designated lead trauma hospital in Ontario, with 45,000 visits per year to the adult emergency/trauma program. The traditional fixed staffing model was being challenged by heavy census (volume and acuity), prolonged stays in the emergency department (ED) of patients waiting for an inpatient bed, and increasing occurrences of multiple critically ill patients, including trauma cases.

A physician trauma team leader (TTL) on-call system was already in place for trauma patients presenting in the ED with an injury severity score (ISS) >12. The TTL worked in collaboration with the ED physician, respiratory and nursing staff currently on duty to manage and care for the trauma patient throughout their emergency stay until the time of disposition. To maintain optimal continuity of patient care and ensure adequate nursing hours appropriate for patient volume and acuity, an enhanced staffing model that included a dedicated trauma RN on-call program was introduced.

An interdisciplinary team from the adult emergency program and trauma services met to plan and implement the trauma RN on-call program. A review of the current staffing model and associated RN FTEs indicated a shortfall in providing 24-hour coverage of trauma RNs on-call. This presented the opportunity to partner with skilled RN staff of the critical care trauma centre (CCTC) to cover the on-call period through a voluntary sign-up roster.

A pilot was conducted from July 1999 to January 2000. The expected outcomes of the program include: i) improved continuity of care; ii) improved communication and support for the family; iii) promotion of continuous learning; iv) enhanced partnerships between emergency care/trauma team and CCTC; and v) improved quality of worklife.

The poster presentation will outline the process for initiating this program, and will highlight the outcome measures of the trauma RN on-call program.

Quality of life for persons with spinal cord injury
J. Beitel, Toronto, Ontario

In North America, 32-35 people per million population suffer a permanent traumatic spinal cord injury (SCI) and survive every year (Canadian Paraplegic Association, 1993; National Spinal Cord Injury Statistical Centre, 1994). As a result of their SCI and other injuries, patients may spend days to months in the ICU setting.

In practice, quality of life is of increased importance as it is recognized that health, quality of life and professional care are interrelated (Calman, 1984; Ferrans, 1990; Gill & Feinstein, 1994; Holmes, 1989; Parse, 1994). Indeed, as an evaluation of outcome, quality of life is used to assess the value of treatment, intervention and rehabilitation in health care (Brown et al., 1996). Research on quality of life and life satisfaction with persons living with quadriplegia/paraplegia is limited. Previously, no studies focused on what life was like for...
persons with SCI in the ICU or acute care setting. Consequently, nurses have no available information on how the quality of life for persons with SCI can be enhanced in the ICU setting.

Acknowledging the gap in research regarding quality of life for persons with SCI, a graduate research study was undertaken to ascertain the meaning of quality of life from the perspective of persons with SCI. The human becoming theory was the nursing perspective for this descriptive-exploratory study in which six individuals participated. Findings of the research included four themes related to the meaning of quality of life for the participants that centred around: 1) significance of relationships; 2) resolve; 3) uncertainty; and 4) seeing life differently after the injury.

This presentation will briefly review the research process involved in the study and share participant excerpts that contributed to the findings. Findings will be analyzed in context of previous research regarding quality of life for persons with SCI. Session participants will be invited to discuss the implications findings have for caring for persons with SCI in the critical care setting. Implications for further research will be identified.

Ethnocultural influences on pain expression
V. C. Cronin, Ottawa, Ontario

Pain is a complex subject and this complexity increases when cultural factors come into play. Culture is an important force affecting a person’s perception, expression, response and tolerance of pain. How pain is expressed, to what extent, and what pain signifies for the patient and the family will depend on the cultural background and belief system. The meaning of pain for the individual can have a significant impact on pain expression. Pain expression varies widely among different cultural groups, for example people of Greek and Italian ancestry tend to be more vocal and expressive of pain, while people of Chinese and Vietnamese ancestry have a tendency to be less vocal and expressive of pain. Knowledge, understanding and acceptance of how cultural traditions influence pain expression are important in providing adequate pain management during patient recovery. It is important to understand the cultural background of the patient and the meaning of the pain experience, so that appropriate cultural, physiological and psychological interventions can be identified and implemented. Cultural influences add to the complexities encountered by health care professionals when providing care to patients from different cultures. This presentation will explore ethnocultural influences on pain behaviour, responses to pain and expression of pain. Specific examples from different cultures will be examined. The results of a pilot study on ethnocultural expression of pain post cardiac surgery will be discussed.

Factors influencing critical care nurses’ participation level in continuous nursing education
R. Whelan, Halifax, Nova Scotia

Critical care nurses require a strong knowledge base, technological competence, and the ability to make sound clinical judgments if they are to practise competently in their rapidly-changing environment. Continuing nursing education is recognized and supported by nursing as one of the ways to achieve continuing competence. In this time of diminished resources, it is imperative that continuing nursing education programs be designed to enhance participation while supporting the registered nurse’s professional obligation to provide competent nursing care.

Several studies have demonstrated that participation in continuing nursing education is influenced by a number of factors. Understanding the factors influencing critical care nurses’ participation level in continuing nursing education would provide nurse educators and administrators with the basis to direct the limited resources towards designing and implementing educational activities which are appropriate for this unique group of nurses. In turn, these activities would support critical care nurses in the enhancement of their professional competencies while advancing nursing practice.

This presentation will describe a recent research study that examined the relationship among motivational orientations, demographic characteristics, and the level of participation by critical care nurses in continuing nursing education. The significant findings from the study will be discussed and recommendations for future research will be presented.

How did we do? Assessing family satisfaction with patient care in the intensive care unit

Many units ask the question “Could we do better?”. Whether it be after a family conference or an informal discussion, we wonder if we are meeting the needs of families.

Identifying the general needs of families with relatives in a critical care setting has been well presented in the literature, beginning with Molter’s Critical Care Family Needs Inventory (Molter, 1979). This area of research began the movement towards family centred care and more liberal visitation policies in most critical care units today. But, are we meeting the specific needs of families in our intensive care unit?

This is the question that led to the development of our family satisfaction survey. Satisfaction is the extent to which family expectations and needs are satisfied. While previous studies have shown that health care providers have less insight into patients’ and relatives’ satisfaction than anticipated (Guyatt,
Influence of age and gender on rapid recovery following coronary artery bypass graft surgery

J. Reimer-Kent, New Westminster, British Columbia

Ever since the late 1960s coronary artery bypass graft (CABG) surgery has been a mainstay in the management of coronary artery disease. CABG surgery has received more investigation than any other operation in the history of surgery. Yet, only recently have women and the elderly been included in these studies. Historically, women and the elderly have not been treated as aggressively for heart disease. Today, however, it is commonplace for cardiac surgery nurses to help both women and the elderly recover from this operation.

This changing patient profile comes at a time when health care is experiencing cutbacks, leading many cardiac surgery centres to look at innovative ways of reducing their costs while simultaneously maintaining standards of practice and clinical outcomes, and improving the quality of their service. One way to achieve this goal is through programs that support rapid recovery.

At one cardiac surgery centre, many of its rapid recovery program’s clinical and financial goals were attainable as a decrease in intubation time, length of stay, laboratory testing and costs was demonstrated. It was evident from this program evaluation that men and younger patients did not solely achieve the expected outcomes, but that women and the elderly were also able to rapidly recover from this surgery. But just what, if any, influence did age and gender have on rapid recovery?

To answer these questions, a secondary analysis was done on the original program evaluation data. Comparisons were made between 74 male and 18 female patients under the age of 70 years with 25 male and 18 female patients 70 years of age or older who had been admitted into this rapid recovery program following CABG surgery. This presentation will discuss the origins of this program, the results of this retrospective, descriptive study along with the implications for nursing practice and future research.

Critical care nurses’ attitudes and knowledge of organ donation

M. Kjerulf, Toronto, Ontario

The disparity between organs available for transplant and the number of recipients on transplant waiting lists continues to grow larger. Current research shows that barriers to organ donation can be overcome by the use of trained requestors to ask for consent for organ donation, early notification of a potential organ donor by health care professionals, education of health care professionals, and quality end-of-life care for the potential organ donor family.

This descriptive, explanatory study examined critical care nurses’ attitudes and knowledge of organ donation. Survey method was used to describe critical care nurses’ attitudes and knowledge of organ donation. The total size of this sample was 106 nurses. Fifty-eight surveys were returned (54.7%) from nurses employed in intensive care, the emergency department and the operating room in a tertiary trauma and neurosurgical referral centre. As a result of this study, the researcher gained a better understanding of the impact of care for organ donors and organ donor families upon the critical care nurse. Further, this study has allowed the researcher to identify gaps in knowledge and variations in attitudes toward organ donation.

Education programs were developed and delivered to critical care nurses in this centre. The researcher, along with the centre’s organ donation task force, also educated and implemented an organ donation support team composed of critical care nurses. The organ donation support team acts to facilitate the organ donation process, support and provide information to the potential organ donor family, and obtain consent for organ donation.

This centre feels that it is crucial that critical care nurses are a vital and integral part of the organ donation process. This centre has positively impacted the organ donation process by increasing awareness, and providing education and support to critical care nurses. As a result, the quality and the quantity of organ donation have improved at this centre.

Evaluation of acute bereavement interventions in a pediatric intensive care unit

T. Northway, D. Scott, K. Ryall, G. Straw and A. Macnab, Vancouver, British Columbia

A study of families who have had a child (newborn to adolescent) die in our pediatric intensive care unit was conducted to determine how the behaviours and actions of the
Relationship of structured transfer information on family member transfer anxiety

W. Rudnick, Winnipeg, Manitoba

This presentation will highlight the findings of a quasi-experimental research study involving the family members of patients transferred from a surgical intensive care unit (SICU) to an in-patient unit or ward. The study was conducted at a large tertiary hospital and is an extension of a research study completed by Leith (1998) that determined the majority of patients and family members experienced a moderate to severe form of transfer anxiety after transfer from a medical intensive care unit to a general medical ward.

Transfer anxiety is a phenomenon common to many practice settings and usually referred to as relocation stress syndrome (Harkulick and Brugler, 1991 cited in Barnhouse et al, 1992). The Model of Back Transport Experience developed by Kuhnly et al (1993) was selected to guide the research hypothesis that a nursing intervention in the form of a structured transfer information process for family members of patients transferred from SICU to an in-patient unit will reduce transfer anxiety in family members following patient transfer. Findings of this research study will contribute to the practice of critical care nursing by measuring the outcome of a critical care nursing intervention on family member transfer anxiety.
Resource nurses and clinical support nurses: Offering leadership and clinical excellence
N. Vandenbergh and E. Childs, Toronto, Ontario

The pediatric critical care unit (CCU) at the Hospital for Sick Children in Toronto is a 36-bed unit serving the needs of children with a multitude of medical and surgical concerns.

Nursing leaders in the CCU include the resource nurse and clinical support nurse. Together, they provide continual coordination and facilitation of the clinical and administrative activities of the critical care unit and ensure effective use of resources. The resource nurses are experienced critical care nurses who provide administrative support through organization of the shift-to-shift activities of the CCU. This role requires the resource nurse to function as a leader, role model and coach to assist staff with professional development and achievement of program and personal goals. Clinical support nurses function as a resource to ensure the delivery of quality care to all patients, families and health care team members. They are experts in the area of pediatric critical care and possess strong leadership abilities that help to facilitate the development of others.

The purpose of this presentation is to discuss how the collaborative work of these roles creates an environment which fosters clinical excellence and a supportive work environment for staff, patients and families. Discussion will include an overview of the resource nurse and clinical support nurse roles and how the collaboration of these positions with those of other health care team members creates a healing, caring, knowledge-based environment for patients and families. Current research findings will be incorporated throughout the presentation.

Stressors patients most commonly face in the coronary care unit
C. Czartorski and M. R. Sumitro, Ottawa, Ontario (poster)

Patients in coronary care units are exposed to a variety of stressors. These stressors, ranging from physiological, psychological, sociological and environmental factors, can affect the patients’ state of health and recovery. Stressors perceived as harmful or disturbing by patients can lead to a sympathetic response manifested by increased heart rate, blood pressure, myocardial oxygen consumption and cardiac workload.

The objective of this pilot study is to identify those stressors most likely to be experienced by the patient admitted to the coronary care unit. Identification of these common stressors will assist nurses in the implementation of appropriate interventions, thereby reducing recovery time and improving patient outcomes.

Certain stressors affecting patients admitted to the ICU environment have been well documented. A questionnaire listing these stressors will be presented to those CCU patients who are stable and “transferable”. These patients will be asked to check those stressors which they experienced while in the CCU. A descriptive analysis of findings will be reported. Conclusions and implications for nursing practice will be discussed.
Increasing our understanding of a patient’s perceptions of being cared for in a critical care area

D. Larson, New Westminster, British Columbia

In a time of complex technology and constant change, bedside nursing in a critical care unit can easily become task oriented. Novice critical care nurses can be overwhelmed by the amount of equipment they are expected to understand and operate, as well as the level of care that is necessary in such a setting. These nurses need reminding that their actions and words can have a profound effect on the person in the bed. Understanding what a critically ill patient might be experiencing, both physically and emotionally, is often hindered by their inability to communicate effectively when intubated or medicated.

To help the registered nurses enrolled in our specialty nursing programs understand, at least in part, how the noises and movements of staff around the bedside might be interpreted by patients, a “mock patient” scenario is included in their curriculum.

Told only that they would be pretending to be a patient in ICU, a volunteer is obtained from the student group. Measures taken to help this volunteer “feel the part” include limiting their vision, movement and speech. They are placed in a bed equipped to simulate a critical care setting. Auditory and physical stimuli of a non-invasive nature are provided.

The remaining class members act as observers. All participants answer a questionnaire immediately upon completion of the scenario and participate in a discussion of the various psychological aspects of being a critically ill patient.

Recent studies have shown that a significant number of patients recall with some clarity their time in the critical care unit. Our awareness and understanding of these issues can only improve our clinical practice.

Surviving amalgamation....or not

K. Connell, E. Blondahl, B. Weatherbie and P. Hughes, Halifax, Nova Scotia

In these times of economic restraint, it is theorized that the size of a healthcare organization can be directly related to its financial success. 1997 was a record year for merger and acquisition activity (Kamrad-Marrone, Stabile and Smeltzer, 1999). It has been said that the most difficult part of a merger is handling the intangible issues, that of people assets, culture and governance (Kamrad-Marrone, Stabile and Smeltzer, 1999). Amalgamation brings uncertainty into the lives of those it affects. This uncertainty impacts staff in their professional and personal lives (Geddes, Salyer and Mark, 1999). It was in February 1997 that our journey began when several health care facilities in a large urban city amalgamated. It is a journey of critical care nurses, coping with the challenge of change.

This presentation will focus on examining the roles; management, bargaining units, physicians and the distribution of patient services had on critical care nursing staff as three distinct critical care areas merged. Areas of concern for our critical care colleagues were not that different from those identified in other healthcare merger processes. These areas are: the dramatic loss of workplace identity, lack of control over practice, patients as players in the health care game, support systems that become non-support systems (Geddes, Salyer and Mark, 1999). With a humorous and sincere approach, we will discuss the rewards, challenges and outcomes that we faced and continue to face from this amalgamation process. As well, we will make personal recommendations for future consolidations. Video clips of critical care nurses sharing their thoughts and feelings about this process will support our dialogue.

Aboriginal cultural beliefs and organ donation

D. Tyer, Regina, Saskatchewan

The intensive care nurse is a critical link in the organ donation process. Recognizing potential donors, preparing and supporting families, maintaining the patient, and coordinating organ retrieval are roles of the critical care nurse. This can be a very rewarding experience. In 1999, we had two native organ donations. Prior to that, I had never seen a native organ donation. Why did these two families consent to organ donation when native people traditionally have refused? Is their culture changing, or are these isolated cases?

Through lecture, this presentation will describe the culture and beliefs that influence the native population regarding organ donation. I will present two case studies. These case studies will identify why these families agreed to organ donation and subsequent problems with the donation process. Both cases are very complex and unique. This presentation will highlight the role of the critical care nurse in organ donation.

The journey toward transformation and healing:
Triumph over the adversity of traumatic events

T. Bergal, Winnipeg, Manitoba

Intensive care unit (ICU) nurses are exposed to human tragedy of great immensity. In this past decade, literature has demonstrated the existence of critical incident stress in professional nursing. Yet, little is still known about the nature of the experience of critical incident stress within the professional and personal world of the nurse. The lived experience of ICU nurses who have encountered a critical incident was explored in an ethnographic study conducted in 1998. Key findings from this study, detailed in this presentation, have helped provide new understanding of the
struggle of ICU nurses as they triumph over the adversity of traumatic events.

Case studies of nine study participants serve to illustrate the antecedent, concomitant, and post-event factors present in an ICU nurse’s life, in relation to experiencing a critical incident. A multitude of variables related to the dimensions of person and environment shape the nurses’ subjective response to the traumatic event. Finding meaning in the events surrounding the incident had important healing power for the nurses. Participants who were able to cognitively restructure the event gained a new perspective of self and of their world. Though the nurses’ incidents were forever impregnated in their minds, they were able to look onward in their professional and personal lives.

Recommendations for creating a caring and supportive work environment for ICU nurses will be provided, based on the findings of the research study. The journey toward transformation and healing after exposure to a traumatic event can be an expedition of pain and anguish. As we journey into this new millennium we must devise strategies for ICU nurses to attain personal adaptation and renewal as a result of exposure to traumatic events. Healing must not come at the end of a long, tortuous pilgrimage but must be an active ingredient in caring, supportive work environments.

Using the intranet to support critical care nursing
P. Hynes-Gay, Toronto, Ontario (poster)

Purpose: Information technologies have become pervasive throughout society. As a group, nurses appear to be undereducated in this arena, and a lack of computer skills will impede the ability to meet future challenges in an increasingly technological health care environment. An intranet site was developed specifically for nurses in the medical-surgical ICU of a university affiliated hospital. The objective was to facilitate the integration of information technology into clinical practice and to encourage participation in further developing this tool.

Description: Critical care nursing://1999 incorporates the following:
1. Policies and procedures
2. Learning materials
3. Direct link to the hospital library where academic journals are available full-text on line.

Detailed instructions for how to access this intranet site were made available and assistance was offered on a regular basis.

Evaluation and outcomes: Nurses were asked to complete an online survey eliciting their evaluation of the website and feedback on how they would like to see it unfold in the critical care setting. While the percentage of nurses who completed the intranet survey was low (17%), we are now able to identify the nurses in the group who can act as resources for their peers.

Providing opportunities for nurses to develop computer skills is an essential component of professional development.

Fundraising? Fun raising!!
M. Hamilton and W. Bean, Halifax, Nova Scotia (poster)

As health care cutbacks continue, the financial support available in institutions for capital projects and for educational support are predicted to become more and more limited. Funding from non-traditional sources will need to be explored and utilized to provide these items.

This presentation will present the essential steps to successful fundraising. It will provide you with some ideas for fundraising for educational opportunities and will include our experience with a two million dollar campaign to build a 12-bed medical-surgical intensive care unit.

We will share with you some unique ideas that you can use for fundraising for your association, your educational fund, or for capital projects. We will also review some of the spin-offs of these events - the significant positive impact on staff morale in the ICU and the development of a team spirit with departments across the institution.

Pediatric organ donation - the team approach
L. MacCarthy, Toronto, Ontario (poster)

Based on an eight-year retrospective review in our critical care unit, we identified factors influencing organ donation consent and procurement rates in the pediatric population. We recognized the need for a team approach with focus on mandatory request, multicultural issues, “decoupling” and post consent management.

This multidisciplinary team is based in the critical care unit and includes dedicated physicians, an organ donor coordinator, organ donor support nurses, chaplaincy and social work. The team is assembled by the organ donor coordinator who organizes all aspects of the consent process and maintains 24-hour coverage of the program.

Although we are seeing fewer potential donors, our current data suggests that having a dedicated team of experts who are trained to approach families improves organ donor consent and procurement rates. With a team process in place, our actual donation rate has improved.
Response to crisis:
Recruitment, education and mentoring of staff RNs for CCU/MICU
N. French, F. Harrington, D. Layton, J. Fulton and F. Howarth, Toronto, Ontario (poster)

At the end of the twentieth century, health care systems around the world find themselves facing the cyclical problem of decreased availability of registered nurses. Several factors, including the aging of the baby boomers and declining enrollment in nursing programs, have caused the current shortage to have an increased impact especially on the pool of nurses with critical care education and experience.

Recruitment, retention and shortages of critical care nursing staff are recurrent themes in nursing history. However, globalization of economies and freer movement of health care professionals across international borders provide the opportunity of integrating nurses with diverse educational and life experiences into North American critical care areas. The patient care coordinators of the medical coronary care unit in an urban community hospital developed, delivered, and evaluated a unit based six-week orientation program. In this program, nurses with wide-ranging backgrounds were provided with the chance to expand their critical care knowledge and apply it in a clinical setting, while supervised by experienced staff (preceptors). The formal orientation was followed by independent practice, supported by a preceptor.

Evaluation indicated two major challenges:
1. part-time and flexible schedules meant new staff were not always aligned with the same preceptor, and
2. many of the preceptees were at a novice level of nursing practice.

This required creativity in developing a sustainable preceptor program. The preceptors held a workshop to share concerns and develop the preceptor role and communication strategies.

The authors will discuss how a creative program successfully integrated nurses with varied backgrounds into the critical care unit and positioned them to provide the leadership and expertise necessary to meet the needs of the future.

Improving end-of-life care in the ICU
M. Winstanley and D. Murray, Halifax, Nova Scotia (poster)

Caring for dying patients and their families is an important and difficult part of critical care nursing. The issue of withdrawal of care was brought to a head in Halifax in May of 1997 when an ICU physician was charged with murder in the care of a dying patient. As a result, we conducted an indepth review of our practice in Halifax to attempt to improve our end-of-life care.

This presentation will discuss the findings of the review of end-of-life care in Halifax that demonstrated a wide variation in the practices of individual nurses and physicians. The work of an end-of-life collaborative group, formed to improve the satisfaction of families surrounding end-of-life issues, will be discussed. This group identified families’ concerns about how we addressed issues of pain control, dyspnea, spiritual support, and bereavement support. All ICU nurses and physicians were given case scenario surveys to measure the range of medication use they felt was appropriate in end-of-life situations.

We will present the development and implementation of the documents we now use in our effort to standardize and improve end-of-life care. This includes level of care and withdrawal of care checklists used by physicians to clarify limits to interventions and standardize the process of withdrawal of active support. We will discuss the incorporation of pain, restlessness, sedation and dyspnea scores into our hourly charting. We will also present the other changes we have incorporated into our practice in response to the collaborative group’s recommendations as well as the results of a survey of the response of the nursing staff to these changes. A very traumatic event in our ICU has led to an objective review of how we care for patients, and real improvements in end-of-life care.

Celebrating great nursing work:
Envisioning a great work environment

The aims of this study and project were: 1. to assess work satisfaction and morale in PICU nurses; and 2. to implement a project to improve the work environment. Nursing staff in the PICU were participants in a National Association of Children’s Hospitals and Related Institutions (NACHRI) PICU Multisite Nursing Retention Study. These results were then used to plan and implement sessions aimed at improving factors identified that decrease job satisfaction for nurses. Participants in these sessions identified common values in order to celebrate what nurses do and then focused on energizing staff to identify problems and generate solutions. Staff are currently involved in improving the work environment using active and innovative strategies. The results from the research project stimulated several changes and, moreover, contributed significantly to our skills in moving beyond survey results to initiate new directions for research in altering the PICU work environment.
DYNAMICS

The Official Journal of the Canadian Association of Critical Care Nurses

Information for Authors

Dynamics, the Official Journal of the Canadian Association of Critical Care Nurses (CACCN) is circulated to members of the CACCN, and to individuals and institutions interested in critical care nursing. The journal 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 bio-physio-psychosocial 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
   - 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 not to exceed 100 words. To be abstracted by CINAHL.**

3. **Body of manuscript:**
   - Length: a maximum of 15 pages including tables, figures and illustrations, and references
   - Format: double spaced, 1 1/2 inch margins on all sides. Pages should be numbered sequentially including tables, figures and illustrations. Prepare the manuscript in the style as outlined in Chapter 3 of the American Psychological Association’s (APA) Publication Manual 4th Edition.
   - 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, the Official Journal of the Canadian Association of Critical Care Nurses become the property of the journal. Authors submitting to the journal are asked to enclose a letter stating that the article has not been previously published and not under consideration by another journal.

5. **Submission:**
   - The original and three copies should be forwarded to: CACCN National Office, P.O. Box 25322, London, Ontario, N6C 6B1 or to the editorial office as printed in the journal. Disks are not requested with the original submission. If the manuscript is accepted for publication the author(s) will be requested to submit the manuscript on disk. Accepted manuscripts are subject to copy editing.
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