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Vision statement
The voice for excellence in Canadian Critical Care Nursing

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

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

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

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

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

Values and beliefs statement
Our core values and beliefs are:
• Excellence and Leadership
  ■ Collaboration and partnership
  ■ Pursuing excellence in education, research, and practice
• Dignity and Humanity
  ■ Respectful, healing and humane critical care environments
  ■ Combining compassion and technology to advocate and promote excellence
• Integrity and Honesty
  ■ Accountability and the courage to speak for our beliefs
  ■ Promoting open and honest relationships

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

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

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

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

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

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

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

5. Membership:
   • Strive for a steady and continued increase in CACCN membership
CACCN is busy preparing for Dynamics of Critical Care 2012 in Vancouver, B.C. This year’s conference theme, “Voices of Conviction from Sea to Sky: Speak Up, Speak Out, Be Heard” is extended from our national theme, “Speak with Conviction”. The robust academic program offered at Dynamics 2012 is full of exceptional projects and activities where critical care nurses are speaking with conviction about the provision of evidence-based patient focused care.

With Dynamics 2012, we have continued to minimize the effect on the environment. We have opted for a small informational conference flyer to accompany, for the first time, an electronic Dynamics program brochure. I urge you to visit our website at www.caccn.ca to view the Dynamics 2012 program, and register for this excellent educational opportunity. We look forward to you joining us in beautiful Vancouver.

**End-of-life in critical care**

For those who have been following the CACCN President’s Blog, you are aware that the CACCN National Board of Directors have been very active representing critical care nurses in recent end-of-life forums in Ontario. CACCN has been Speaking with Conviction on your behalf.

End-of-life (EOL) care continues to be a challenging and controversial issue in many parts of Canada, with variation in practice and legislation across the country. This diversity in practice impacts the process and priorities in decision-making and the relationships that are developed between the health care team and the patient and their family. Regrettably, there have been too many cases where disagreements between the health care team and the patient or substitute decision maker (SDM)/family have resulted in interpersonal conflict. This tension, unfortunately, occurs at a time when all individuals need to work in partnership towards best resolution for the patient. Occasionally, a few of these situations reach the public eye via the court system or the media. As health care professionals, we have an intimate perspective on the incredible time and energy necessary to deal with the conflict, and how conflict detracts from the focus of determining the best plan of care for the patient. In addition to the distractions to care, these situations may cause moral distress that can be severe enough to be career limiting or ending for health care providers. There are not many of us who have been untouched by such experiences in our careers, and who cannot recall the extreme toll it has taken on us or a colleague dealing with such cases.

The current case in Ontario of Mr. Hassan Rasouli v. Sunnybrook Health Sciences Centre, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, illustrates the difficult nature of decision-making between the health care providers and the SDM/family when disagreement arises around withdrawal of treatment and the resulting conflict. After a lower court ruling and an appeal, this case is now going to be heard at the Supreme Court of Canada on December 10, 2012.

CACCN became involved in this case after being approached in February 2012 by legal counsel for the critical care physicians. CACCN was asked to consider applying for intervenor status to the Supreme Court of Canada to provide input and a national view of critical care nurses’ perspectives and experiences in the provision of end-of-life care to critically ill patients and their families.

The National Board of Directors worked with a legal team from the law firm of Norton Rose Canada LLP in Toronto to prepare materials for the CACCN’s motion for leave to intervene at the Supreme Court of Canada. The affidavit submitted in March 2012 in support of the motion was grounded in CACCN’s Mission and Philosophy Statements, our Values and Beliefs, and our position statement “Providing End of Life Care in the Intensive Care Unit”, as well as the Canadian Nurses Association’s Code of Ethics.

On June 12, 2012, the CACCN Board of Directors was pleased to announce to our members and our critical care colleagues in Canada that CACCN has been granted intervener status before the Supreme Court of Canada, thus ensuring that the perspective of critical care nurses in Canada regarding end-of-life care will be heard at the highest court in the country.

The essential and unique points from the affidavit in support of our application for leave to intervene were summarized as:

- If granted leave to intervene, the CACCN will make the following submissions:
  - applicable legislation and common law should be interpreted in a manner that provides certainty for patients, families and medical professionals. Certainty is of tremendous value in the context of end-of-life decisions—it can significantly reduce conflict between health care providers and patients’ families and loved ones;
  - the legal analysis ought to be conducted with a view to establishing legal rules that apply uniformly in all Canadian common law jurisdictions; and
  - a third party decision-making process (such as Ontario’s Consent and Capacity Board) presents a reasonable balance between reliance on the expert medical opinions of physicians and the SDM’s knowledge of the patient’s best interests.

CACCN advocates that organizational processes and legal statutes provide clarity to what is now ambiguous, including the issue of consent, up to and including, when consent for treatment is needed (or not) from patients/families and specifically as it relates to the withdrawal of life-sustaining treatment. Further, that there be an appeal process such as a review board that is timely and is available to both patients/families and the health care team when there are disagreements about the plan of care. CACCN believes that the Supreme Court can provide needed clarity on these issues that can have national application.

The CACCN Board of Directors has continued to work with legal counsel to further refine and clarify our position. The mission statement of CACCN has a goal “to identify professional and political issues and provide a strong unified national voice.” When the board chose Speak with Conviction, I thought of how nicely the theme aligned with the CACCN Mission Statement, Values and Philosophy Statement. As the voice for excellence in critical care nursing, it is important for CACCN to speak out and be heard on issues of importance that impact critical care nursing in Canada.

The National Board of Directors feels strongly that critical care nurses, as the most constant care providers to patients and
families, are uniquely positioned to provide a key perspective on end of life care in the ICU. As nurses, we are obligated to advocate for our patients and their families in the health care system; and to effectively advocate we need to have the courage to speak with conviction on this issue that impacts the care they receive at the end of life. It was this strong belief that the unique perspective of critical care nurses needed to be heard on this issue before the Supreme Court that moved us forward. The Board of Directors looks forward to keeping you updated as this evolves and welcomes any comments or thoughts you may have on this important issue before the Supreme Court of Canada.

**CACCN partnerships**

**American Association of Critical-Care Nurses (AACN):** Over the past year, CACCN has continued the partnership with our American colleagues at AACN. While attending the AACN National Teaching Institute in May 2012, members of the Board of Directors met with the AACN executive and the co-editors/publisher of the AJCCN (American Journal of Critical Care Nursing) to discuss how our two organizations are able to continue to partner to improve critical care nursing in North America. The Board of Directors also accepted the offer of an association booth at the conference, providing delegates with membership, conference and award information. We also used the opportunity to make contact with exhibitors who do not currently attend Dynamics and have seen positive results from this endeavour.

On behalf of the CACCN Board of Directors, I wish to extend congratulations to the following CACCN members for their excellent presentations at NTI: Kara Livy, Edmonton, AB, Kate Mahon, White’s Lake, NS, and Eugene Mondor, Edmonton, AB. We would also like to congratulate the Foothills Medical Centre in Calgary, AB, on receiving the AACN ICU Design Award and the Carlo & Angela Baldassara & Family Cardiovascular ICU, Toronto, ON, for receiving the Beacon Award for Excellence in sustained performance and patient outcomes.

**The DAISY Foundation:** Through our partnership with AACN, we have been introduced to the founders of The DAISY Foundation, Bonnie and Mark Barnes. Following the passing of their son Patrick in 1999 from idiopathic thrombocytopenic purpura, Bonnie and Mark developed an award program that recognizes the meaningful contributions of nurses to patients and their families. CACCN is partnering with the DAISY Foundation in the coming months with the intent to expand this wonderful recognition program for critical care nurses in Canada (see page 11). I encourage you to visit our website at www.caccn.ca to discover more about this wonderful program and find out how your hospital can become involved.

**Canadian Nurses Association (CNA):** In June 2012, I also attended the Canadian Nurses’ Association biennial national conference as a member of the Canadian Network of Nursing Specialties. Attending the biennial was a great opportunity for CACCN to network with our colleagues from other specialties. When speaking to our colleagues at CNA and the executives of other specialties, it became apparent that it is not only the public that is not aware of end-of-life issues. Our nursing community is not fully informed either. Tricia Bray, CACCN Director, and I took the opportunity at the biennial to inform and educate some of our nursing colleagues around end-of-life care in critical care.

The CNA has indicated during our discussions that they had not heard from members that end-of-life care and withdrawal of care is a concern for them and, for that reason, it is not a matter of priority. CACCN is hoping to change that view over the coming year by working more closely with CNA to identify issues that are occurring in critical care across the country. The CACCN Board of Directors and I are asking our members to take the opportunity to speak to your colleagues, provincial associations and the CNA to highlight issues in your practice.

**Canadian Intensive Care Week**

In 2002, the Canadian Intensive Care Foundation (CICF) was instrumental in having Canadian Intensive Care Week proclaimed by Anne McLellan, the Minister of Health. The intent of Canadian Intensive Care Week was to celebrate and highlight intensive care to the public and to assist in increased funding for critical care research. Canadian Intensive Care Week was celebrated for a few years and then, unfortunately, fell by the wayside. In April 2012, the CACCN Board of Directors approached our critical care partners from medicine and respiratory therapy with a view to reviving Canadian Intensive Care Week. Be sure to stay tuned to our website, as more information on Canadian Intensive Week will be forthcoming. This is an exciting opportunity for CACCN to collaborate with our partners in care in the ICU:

- Critical Care Canada Forum
- Canadian Critical Care Society
- Canadian Critical Care Trials Group
- Canadian Intensive Care Foundation
- Canadian Society of Respiratory Therapists.

In closing, I am very excited and proud of the program in place for the Dynamics of Critical Care Conference from September 23–25, 2012. Please take a moment to review the excellent educational and social opportunities via the conference brochure on our website at www.caccn.ca. While attending the conference, plan to participate at the Annual General Meeting of the CACCN. This is YOUR opportunity to Speak Up, Speak Out, Be Heard on the business of the association. If you are unable to attend the Annual General Meeting, please take a moment to complete the Proxy Vote Form (see page 14) and return to the CACCN National Office.

On behalf of the CACCN Board of Directors and the Dynamics 2012 Conference Planning Committee, I look forward to meeting many of you in Vancouver.

**Take care and Speak with Conviction**

Teddie Tanguay
President, CACCN

**Future sites of Dynamics conferences**

<table>
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<tr>
<th>Conference</th>
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<td>Dynamics 2013</td>
<td>September 22–24, Halifax, NS</td>
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<td>Dynamics 2014</td>
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<td>Dynamics 2015</td>
<td>October 4–6, Winnipeg, MB</td>
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<td>Dynamics 2016</td>
<td>September 25–27, Charlottetown, PEI</td>
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In the critical and noncritical pediatric and adult patients, does family presence on rounds compared with noninclusion of family members lead to positive outcomes and increased satisfaction?

**Data sources**

Studies were identified by searching Medline, CINAHL, OVID, Psychinfo, and Cochrane electronic databases and Central Register (1988 to 2010).

**Study selection**

Experimental (randomized or quasi-randomized controlled trials) and non-experimental designs, including qualitative, quality improvement (QI) reports, and systematic reviews reported in English were selected if they reported on family presence on rounds—defined as multidisciplinary rounds that occurred at the bedside in the presence of patients and family members and integrated patient and/or family perspectives and preferences into clinical decision-making—in pediatric and adult critical and noncritical care units. Standard rounds, the comparative intervention, was defined as noninclusive of family members; that is, clinical decision-making and discussions were conducted out of earshot of patients and families. Studies were excluded if they only concerned family presence during end-of-life meetings and/or conferences in palliative care.

**Data extraction**

Data were extracted on study methods, inclusion criteria, setting, participants, and outcome measures. Outcomes of interest were the findings reported as impact of family presence on rounds from the perception of patients, parents, families, and health care professionals.

**Main results**

Seventeen research studies, two QI reports and four anecdotal notes were identified, which represented 10% of the total articles reviewed.

Two studies with a level 1 grade of evidence (i.e., RCTs) and most of the 15 level 2 (i.e., quasi-experimental, observational) and level 3 grade of evidence (i.e., qualitative descriptive, mixed method) studies found that inclusion of families on rounds was seen as positive by families, with increased understanding of the patient's plan of care and condition, improved ability to communicate and be part of the team's discussion and decision-making, increased feelings of inclusion and respect and an improved attitude toward physicians. Feelings of violation of privacy were generally not perceived as a concern. Several studies identified that some family members expressed concern about the potential for increased confusion and anxiety and a feeling of being rushed to make a decision.

Nurses reported increased communication with family members, increased family member education and resultant facilitation of relations with the families.

Physicians perceived that inclusion of family on rounds increased communication opportunities for students, decreased need for plan clarification, facilitated the gathering of pertinent information for care planning, improved their relationships with family and improved family and health care professional satisfaction overall. Most studies reported that physicians perceived that family presence did not interfere with the education process, although one observational study concluded that residents were less enthusiastic about didactic teaching methods during rounds, as they were reluctant to make medical errors in front of family. Although residents recognized the value of patient care and family satisfaction, some doubted their own training. However, one observational study found that the most important factor associated with resident satisfaction with teaching on rounds was the attending physician.

**Conclusions**

From 1988 to 2010, only two RCTs and one quasi-experimental study were conducted on family presence and rounds. Only one study was conducted in an adult ICU and of the 15 studies conducted in the pediatric population, only nine were conducted in critical care units. Only five of the 17 studies addressed nurses' perceptions of the importance of family presence on medical rounds. Compared with noninclusion of family members, family presence on rounds may lead to positive outcomes and increased satisfaction among patients, family members, and healthcare professionals. Most study results were positive, although some research
findings were negative. Although the Society of Critical Care Medicine emphasizes the importance of patient-centred care that includes family-centred care, family presence on medical rounds remains the least-studied area in family-centred care. Further research is warranted to strengthen the level of evidence on this subject.

Commentary
There has been a steady and significant growing body of evidence that has demonstrated family member participation is important to the well-being of the patients and families. For example, pediatric and maternal-child units, among the first to embrace family-centred care nearly 50 years ago, have demonstrated through research that the presence of family members improves the child’s cooperation with procedures, improves activity levels, and reduces length of stay (Cushing, 2005). Researchers have demonstrated that families serve as valuable resources for patient care (Medina, 2005), retain a significant role in supporting patients’ well-being (Hupcey & Zimmerman, 2000) and are crucial to patient satisfaction (Krapohl, 1995) and positive patient outcomes (Medina, 2005). At the same time, researchers have reported that family members experience feelings of helplessness, which have, in turn, been associated with suppression of the family member’s immune system (Stewart, 1993), feelings of intense emotional distress (Hilbert, 1996) and a diagnosis of post-traumatic stress disorder post their relative’s hospitalization (Azoulay et al., 2005). Given that researchers have also found that the basic needs of family members in ICUs are information, reassurance, support and the ability to be near the patients (Miles & Carter, 1983, 1985; Damboise, 2003), family presence on rounds, if desired by family members, seems to be one primary way in which to reduce the impact of the negative sequelae of their critical care experience. Yet, as seen by this review, data are limited by lack of research studies conducted in this area, particularly in adult ICUs, and most published studies are descriptive in nature. However, the paucity of RCTs and quasi-experimental studies is perhaps not as problematic as one would first conclude, as it has already been determined—by such organizations as the Society of Critical Care Medicine (Davidson et al., 2007) and Institute for Family-Centered Care (http://www.familycenteredcare.org)—that family presence on rounds is needed and valued. Studies using naturalistic inquiry, such as grounded theory, ethnography and phenomenology, are now needed to explore in depth the nature and process of clinical rounds from family members’ and staff’s perspectives. The findings from these studies can then help us design interventional studies that examine how to build health care professionals’ comfort and confidence with family member presence on rounds and how to facilitate family member engagement in discussion and decision-making within this venue.

Judy Rashotte, PhD, RN, Director, Nursing Research & Knowledge Transfer Consultant, Children’s Hospital of Eastern Ontario, Ottawa, Ontario

REFERENCES


Notice of Annual General Meeting

The National Board of Directors of the Canadian Association of Critical Care Nurses extends an invitation to the membership to attend the 28th Annual General Meeting. The meeting will be held:

**Sunday, September 23, 2012, at 1645 hrs, Westin Bayshore Vancouver, Vancouver, B.C., in conjunction with Dynamics 2012.**

All CACCN Members and interested parties are invited to attend. Please note: Associate and Student Members do not hold voting rights and are ineligible to vote. If you are unable to attend the meeting, you may participate by completing the CACCN Proxy form on page 14.
Come for the job. Stay for the team.

Vancouver Coastal Health is world renowned for innovation and a focus on quality care and outcomes. The remarkable range of specialties places VCH at the forefront of career destinations. Launch an exciting career with us where you can apply your skills and develop new ones alongside some of Canada’s finest practitioners.

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

Positions available at:

• Richmond Hospital
• Vancouver General Hospital
• Lions Gate Hospital, North Vancouver
• Powell River General Hospital

To find out more and to apply, visit: jobs.vch.ca
I have worked at the Hospital for Sick Children in Toronto since 1984, originally as a clerk in the emergency department. It was my exposure there to nursing that inspired my return to school. While continuing my work at SickKids, I have continued to refine my knowledge in nursing through pursuit of a diploma, followed by a Bachelor of Science and, currently, through the pursuit of a Master’s in Nursing.

For the past 13 years I have had the privilege of caring for the children and families who have been admitted to the Pediatric Intensive Care Unit as a direct care provider. I can say with all honesty that I love my work. It is here that every day, I witness the impact of the care that a nurse can provide. In addition to patient care, I have had the advantage of being exposed to numerous opportunities for growth in the profession, including conference planning, education, preceptorships, research and more.

It has been my pleasure to serve on the National Board of Directors of CACCN, as one of the directors from the central region. For two years, I was privileged to act as the director responsible for Awards and Corporate Sponsorship. This position provided me with the opportunity to witness and recognize some of the truly amazing work that our members provide on a daily basis.

In March 2012, my term was originally extended by one year, as I have accepted responsibility for the role of treasurer with the BOD. Although new to the role, I have worked diligently to maintain accurate records and participate in discussion and decisions to maintain the fiscal responsibility of the organization. I look forward to the opportunity to continue to serve in this role with such a dynamic, energetic organization whose passion for critical care parallels my own.
CACCN is a proud supportive association of The DAISY Foundation!

DAISY is an acronym for Diseases Attacking the Immune System. The DAISY Foundation was formed in November 1999 by the family of J. Patrick Barnes who died at age 33 of complications of Idiopathic Thrombocytopenic Purpura (ITP). During his hospitalization, Pat’s family was truly touched by his nurses’ care—not only the impressive clinical skill, but especially the compassion and kindness they showed Pat and his family. So when he died, his family felt compelled to express their profound gratitude to nurses for the work they do for patients and their families every day. Today, The DAISY Award honours extraordinary nursing care in nearly 1,300 health care facilities in seven countries, including Canada. More than 40,000 nurses have been honoured to date, and more than 140,000 nurses nominated for The DAISY Award.

DAISY partners with health care facilities to enable nurses to be nominated by their patients, families, and colleagues. DAISY Awards are presented throughout the year to provide ongoing recognition and exposure to DAISY’s message throughout the hospital. Each facility establishes its own specific criteria, addressing compassionate care, to ensure that the program fits its culture, vision, and values. Within each facility, a committee of nurses is appointed to administer the program and choose the honourees from among the many nominees. DAISY helps guide the process and provides all the tools needed to run the program and make it truly meaningful recognition, not only for the honouree, but for all the nurses present.

The DAISY Award presentation to each honouree takes place in the unit, generally as a surprise for the recipient. Each of the DAISY nominations written by patients, families, and colleagues expresses the impact a nurse has had on a patient—an impact that made a tremendous difference to a patient or family member. Most often, the impact is not the result of a clinical intervention. Rather, the things patients and families talk about are nurses’ acts of compassion and care that no one asks of them. Nurses just do them. And the most frequent response to a nurse’s DAISY recognition by her/his peers with The DAISY Award is, “But I didn’t do anything special. I was just doing my job.” The DAISY Foundation reaches out to all nurses to remind them never to take their work for granted. They do something special with every patient or family interaction!

The DAISY Foundation is especially proud to partner with CACCN. A great number of DAISY honourees are critical care nurses, and the Foundation is eager to expand the number of health care organizations in Canada who honour their nurses with The DAISY Award. As The DAISY Foundation expands its international reach, CACCN is the first international organization to join the list of nursing organizations that support The DAISY Foundation’s work.

For more information about The DAISY Award for Extraordinary Nurses and the Foundation’s other programs that serve the nursing profession, visit DAISYFoundation.org.

Original release: June 6, 2012

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Dynamics 2014 Conference Planning Committee Call for Participation

Dynamics 2014 will be held September 21–23, 2014, at the Centre des Congrès de Québec in Quebec City, QC. CACCN members interested in working on the conference planning committee should submit a resume/CV and summary of conference planning experience (planning experience is appreciated but not a requirement for submission) to CACCN National Office by March 1, 2013. Consideration will be given to planning committee applicants who are local to the conference venue and/or are from chapters/provinces adjacent to the conference venue. For further information on this exciting opportunity, please contact the CACCN National Office, P.O. Box 25322, London, Ontario N6C 6B1, www.caccn.ca, e-mail: caccn@caccn.ca, phone: (519) 649-5284, fax: (519) 649-1458. For frequently asked questions regarding Dynamics conference planning, please visit www.caccn.ca.

CACCN Merit Award Call for Committee Members

CACCN is creating a CACCN Merit Award for Intensive Care Units in Canada.

Over the past couple of months, the Board of Directors has been working on a framework for the proposed award with the intent of striking a committee to take the framework and create the criteria for the award. The committee will utilize the CACCN Members-Only Discussion Forum, teleconference and/or Skype for communication.

The CACCN Board of Directors is inviting you to consider participating on the CACCN Merit Award Committee.

If you are interested, please submit your name and CV/resume to CACCN National Office no later than October 15, 2012. Submissions may be sent by email to caccn@caccn.ca or facsimile to 519-649-1458.

The board is very excited about the proposed CACCN Merit Award and looks forward to your participation.
It’s NOT a “Small Adult”:
The Experiences of Nurses Admitting and Caring for a Child in a Small Community Adult ICU
Celine Pelletier, MN-ACNP, NP, RN, CNCC(C), Yellowknife, NT

In order to provide competent care to adults admitted to the intensive care unit of a small tertiary care hospital in Canada’s North, nurses undergo adult critical care training. Imagine their reaction when they were told they would be admitting a seven-year-old child with recurrent pneumonia who had recently been discharged home from a pediatric critical care unit in a major tertiary centre. They did not feel prepared to “anticipate, prevent, prepare for, recognize, and intervene” in a very possible life-threatening event, let alone promote an optimal physiological balance.

This presentation in the form of a case study will tell the story of the ICU nurses’ daylong journey with this child. The presenter will speak about the “on-the-spot learning” nurses had to experience in relation to the child’s admission diagnosis and other co-morbidities that complicated patient care. The presentation will include the plan of action taken by the Clinical Coordinator of the ICU and the Critical Care Committee to address the issue of providing appropriate care to the appropriate population given the lack of pediatric critical care specialty in our hospital and the resulting policies and safeguards put in place should the situation ever be repeated.

References

A Blonde, a Brunette, and a Whole Lotta Chest Pain: Speak Up! Speak Out!
Interpret those 12 Lead ECGs!
Eugene Mondor, MN, RN, and Cory Komant, BScN, RN, Edmonton, AB

Rapid and accurate assessment of a 12 lead electrocardiogram (ECG) for an adult critical care patient experiencing chest pain can be daunting to many staff nurses. Yet, the necessity of correctly identifying significant and potentially life-threatening changes in the 12 lead ECG is essential for safe patient care. This presentation will take a simplified and lighthearted approach to the analysis of chest pain and the 12 lead ECG. A review of some of the common causes of chest pain encountered in the adult ICU will be reviewed. The essential components of a normal 12 lead ECG, including an examination of the various “groups” of leads and their relationship to cardiac structure and function, will be identified. Moreover, abnormalities in 12 lead ECG recordings, including assessment for morphologic changes indicating ischemia, injury, and/or infarction, will be highlighted. Most importantly, a “step-by-step” approach to systematically analyzing the 12 lead ECG will be emphasized during this lecture. Audience members will participate in assisting with analysis and interpretation of selected ECGs to help reinforce key principles of 12 lead ECG assessment presented during this session.

References

Speak with Conviction!
Orla Smith, Craig Dale and Louise Rose, three members of CACCN’s Research Committee, are studying nurse attitudes to critical care research and are keen to hear from you. This is your opportunity to Speak with Conviction. Watch your inbox this fall for the CACCN Critical Connections E-News Bulletin that contains the link to the study survey. The link will be available for six weeks. CACCN is pleased to support critical care nursing through research activities of its members.
CONTAIN INFECTION.

To find out how: Visit us at Dynamics 2012
Vernacare Booth 402, September 23rd to the 25th, Vancouver, BC
Annual General Meeting
Proxy Vote 2012

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 in 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 by CACCN National Office before Friday, September 14, 2012, at 2359 EST.

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 _____________________,

Name of Proxy (please print)  City, Province

or failing her/him,

____________________  of _____________________,

Name of Proxy (please print)  City, Province

as my proxy to vote for me and on my behalf at the meeting of members of the association to be held on the 23rd day of September, 2012, and at any adjournment thereof.

Dated at _____________________, this _____ day

of _____________________, 2012.

Signature of Member*: _____________________

CACCN Membership Number: ________________

Chapter: _________________________________

*Electronic signatures accepted. Must be a replica of the actual signature. Typed names cannot be accepted.

Return completed proxy forms to:
Canadian Association of Critical Care Nurses
P.O. Box 25322, London, ON N6C 6B1
Fax: 519-649-1458
Scanned/ emailed to: caccn@caccn.ca

CACCN calendar of events

DATES TO REMEMBER!

September 1: Smiths Medical Canada Ltd. Educational Award deadline
September 7: Dynamics 2012 Conference Registration final deadline
September 20–21: BOD F2F Meeting, Vancouver, BC
September 22: Chapter Connections Day, Vancouver, BC
September 23–25: Dynamics 2012 Conference, Vancouver, BC
September 30: Chapter Quarterly Reports (July–Oct 2012) deadline
November 14: CNA Certification Initial Application deadline
December 3: CNA Certification Renewal Application deadline
December 31: Chapter Quarterly Reports (Oct–Dec 2012) deadline
January 31: Smiths Medical Canada Ltd. Educational Award
January 31: Call for Abstracts, Dynamics 2013 deadline
February 15: CACCN Research Grant deadline
March 1: Dynamics 2014 Planning Committee Application deadline
March 20–22: BOD F2F meeting, Toronto, ON
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Survey of Canadian critical care nurses’ experiences of conflict in intensive care units

By Marie Edwards, PhD, RN, Karen Throndson, MN, RN, and Julie Girardin, BN, RN

Abstract

The purpose of this study was to enhance our understanding of Canadian critical care nurses’ experiences of and responses to situations of conflict in the ICU. Through a 35-item web-based survey, members of the Canadian Association of Critical Care Nurses were asked questions regarding the types, causes and frequency of conflict experienced, the nursing interventions found most helpful in situations of conflict, and the resources found most helpful in responding to situations of conflict. A total of 241 nurses responded to the survey. The mean age of the nurses was 43 years, and the majority were female (89.2%), direct care providers (66.4%), with greater than 11 years of experience in critical care (58.3%), and working in medical/surgical ICUs (66.4%) in tertiary care hospitals (67.2%). Approximately 51% of the nurses reported being involved in at least one situation of conflict related to the management of a patient in the last week worked. The most common types of conflict encountered were disagreements between the team and family (46.5%) or within the team (35.3%). The nurses acknowledged the importance of clear, consistent and honest communication with patients and families when conflict arises and rank-ordered the resources found most helpful to patients, families, and nurses in conflict situations. Implications for practice and education are discussed and recommendations for future research are outlined.

In his landmark book about decision-making in health care, Katz (1984) identified that health is “an ambiguous state” about which people and their health care providers may have “conflicting expectations” (p. 98). Given the nature of patients’ illnesses and the decisions required in an intensive care unit (ICU), it is not surprising that it is a place where disagreements about the plan of care can arise. Despite the fact that critical care nurses are an integral part of the team providing care to patients and families, relatively little is known about their experiences with conflict situations. Increasing our knowledge in this area will assist us to better understand conflict in the ICU and to identify strategies for preventing and/or dealing with it.

Background to the problem

To date, studies on conflict in ICUs, defined by researchers as disagreements over patient care, have focused on the rates, causes and types of conflict experienced. Reported rates of conflict have varied between 32% and 78% of patient situations in the presence of a prolonged length of stay in ICU (Studdert, Burns, et al., 2003; Studdert, Mello, et al., 2003) or discussions regarding withholding or withdrawing treatment (Abbott, Sago, Breen, Abernethy, & Tulsky, 2001; Breen, Abernethy, Abbott, & Tulsky, 2001). In a large multi-national survey (Azoulay et al., 2009), 72% of health care providers (n=7,358 in 24 countries) reported at least one perceived conflict in their last week of work in ICU. In that survey, Azoulay et al. (2009) defined conflict more broadly than other researchers, including interpersonal conflict in the definition, even if unrelated to patient care.

From these studies and research on both end-of-life care and families’ experiences in ICU, it is known that conflict can arise for a number of reasons, including unclear, insufficient, or inconsistent communication, perceived inappropriate behaviours, unrealistic family expectations, inattention to patient wishes, differing perspectives regarding patient prognosis or goals of care, and/or family stress (Abbott et al., 2001; Azoulay et al., 2009; Breen et al., 2001; Danjoux Meth, Lawless, & Hawryluck, 2009; Kirchhoff et al., 2002; Nelson et al., 2006; Norton, Tilden, Tolle, Nelson, & Eggman, 2003; Studdert, Burns et al., 2003; Studdert, Mello et al., 2003). Conflict can lead to anxiety and distress for family members (Abbott et al., 2001; Kirchhoff et al., 2002), strained relations between family members and health care providers (Abbott et al., 2001; Breslin, MacRae, Bell, Singer, & the University of Toronto Joint Centre for Bioethics Clinical Ethics Group, 2005; Robichaux & Clark, 2006), strained team relations (Melia, 2001), and distress or burnout for health care providers (Danjoux Meth et al., 2009; Heland, 2006; Poncet et al., 2007; Workman, McKeever, Harvey, & Singer, 2003). Clearly, situations of conflict can create emotional burden for patients, families, and caregivers.

Study purpose and objectives

Given the rates of conflict reported in previous studies and the potential impact on all involved, and given nurses’ proximity to patients (Malone, 2003), it would be useful to gain an understanding of the current situation for registered nurses working in ICUs in Canada. The purpose of this study was to enhance our understanding of Canadian critical care nurses’ experiences of and responses to situations of conflict in the ICU. The research objectives were to: 1) identify the types, causes, and frequency of conflict experienced by critical care nurses in ICU settings; 2) identify the nursing interventions critical care nurses find most helpful in situations of conflict; 3) describe the knowledge and skills required by critical care nurses when working in situations of conflict; and 4) identify the resources critical care nurses find helpful in responding to situations of conflict. Objectives 1, 2, and 4 will be examined in this article.
Methods

Based on an extensive review of the literature, a questionnaire was developed for this descriptive study. The questionnaire was reviewed by a sample (N=11) of critical care nurses, advanced practice nurses, educators, and researchers with expertise in survey design to assess readability, relevance, and appropriateness of the questions, and then revised based on their feedback.

After obtaining research ethics board approval, the 35-item questionnaire was loaded on SurveyMonkey©, an online platform. The Canadian Association of Critical Care Nurses (CACCN) agreed to send out an email message on our behalf to members with an email contact address, inviting them to complete the questionnaire. Three additional reminder messages were sent out at one week intervals during the month of April 2010. Data were entered in the Statistical Package for the Social Science (SPSS 18) program and means, percentages, and scores were calculated as appropriate. Qualitative responses were analyzed using content analysis (Weber, 1990); categories were identified and responses were sorted into appropriate categories.

Results

At the time the survey was carried out, CACCN informed us that they had approximately 1,100 members, with email addresses for 990 people. A total of 325 nurses responded to at least a part of the survey, with 241 nurses completing the survey. Demographic data for these nurses can be found in Tables 1 and 2.

Approximately 51% (122) of the nurses reported being involved in at least one situation of conflict, defined as a disagreement or dispute related to the management of a patient (Studdert, Mello, et al., 2003), in the last week worked; 26.1% (63) reported being involved in more than one conflict situation.

Table 1: Demographics (n=241 nurses)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (mean 43 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–29 years</td>
<td>22</td>
<td>9.1</td>
</tr>
<tr>
<td>30–39 years</td>
<td>52</td>
<td>21.6</td>
</tr>
<tr>
<td>40–49 years</td>
<td>86</td>
<td>35.7</td>
</tr>
<tr>
<td>50+ years</td>
<td>56</td>
<td>23.2</td>
</tr>
<tr>
<td>Missing</td>
<td>25</td>
<td>10.4</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>215</td>
<td>89.2</td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>5.4</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td>5.4</td>
</tr>
<tr>
<td>Province/Territory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quebec and Ontario</td>
<td>129</td>
<td>53.5</td>
</tr>
<tr>
<td>Western provinces (MB, SK, AB, BC)</td>
<td>86</td>
<td>35.7</td>
</tr>
<tr>
<td>Maritimes &amp; Newfoundland/Labrador</td>
<td>15</td>
<td>6.2</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>4.6</td>
</tr>
<tr>
<td>Current position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct care provider</td>
<td>160</td>
<td>66.4</td>
</tr>
<tr>
<td>Manager/administrative role</td>
<td>22</td>
<td>9.1</td>
</tr>
<tr>
<td>Educator</td>
<td>21</td>
<td>8.7</td>
</tr>
<tr>
<td>Clinical resource nurse or charge nurse</td>
<td>16</td>
<td>6.6</td>
</tr>
<tr>
<td>Clinical nurse specialist or nurse practitioner</td>
<td>11</td>
<td>4.6</td>
</tr>
<tr>
<td>Multiple Roles and Other</td>
<td>11</td>
<td>4.6</td>
</tr>
<tr>
<td>Total years of nursing experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>2</td>
<td>0.83</td>
</tr>
<tr>
<td>1–5 years</td>
<td>27</td>
<td>11.2</td>
</tr>
<tr>
<td>6–10 years</td>
<td>36</td>
<td>15.0</td>
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<tr>
<td>11–15 years</td>
<td>29</td>
<td>12.0</td>
</tr>
<tr>
<td>16–20 years</td>
<td>27</td>
<td>11.2</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>118</td>
<td>49.0</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>0.83</td>
</tr>
<tr>
<td>Total years of critical care experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>2</td>
<td>0.83</td>
</tr>
<tr>
<td>1–5 years</td>
<td>53</td>
<td>22.0</td>
</tr>
<tr>
<td>6–10 years</td>
<td>45</td>
<td>18.7</td>
</tr>
<tr>
<td>11–15 years</td>
<td>32</td>
<td>13.3</td>
</tr>
<tr>
<td>16–20 years</td>
<td>35</td>
<td>14.5</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>73</td>
<td>30.3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>72</td>
<td>29.9</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>121</td>
<td>50.2</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>34</td>
<td>14.1</td>
</tr>
<tr>
<td>Missing</td>
<td>14</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Table 2: Work settings of nurses (n=241)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary care hospital (university affiliated)</td>
<td>123</td>
<td>51.0</td>
</tr>
<tr>
<td>Tertiary care hospital (non-university affiliated)</td>
<td>39</td>
<td>16.2</td>
</tr>
<tr>
<td>Community hospital</td>
<td>63</td>
<td>26.1</td>
</tr>
<tr>
<td>Rural hospital</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Multiple facilities</td>
<td>8</td>
<td>3.3</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Type of ICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/surgical ICU</td>
<td>160</td>
<td>66.4</td>
</tr>
<tr>
<td>Pediatric or neonatal</td>
<td>27</td>
<td>11.2</td>
</tr>
<tr>
<td>Medical ICU</td>
<td>14</td>
<td>5.8</td>
</tr>
<tr>
<td>Surgical ICU</td>
<td>11</td>
<td>4.6</td>
</tr>
<tr>
<td>Cardiac ICU</td>
<td>10</td>
<td>4.1</td>
</tr>
<tr>
<td>Other Mixed ICU</td>
<td>10</td>
<td>4.1</td>
</tr>
<tr>
<td>No specific unit (work in critical care float pool)</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Multiple units</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Usual shift duration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 hours</td>
<td>44</td>
<td>18.3</td>
</tr>
<tr>
<td>10 hours</td>
<td>7</td>
<td>2.9</td>
</tr>
<tr>
<td>12 hours</td>
<td>171</td>
<td>71.0</td>
</tr>
<tr>
<td>Mix of 8 and 12 hours</td>
<td>16</td>
<td>6.6</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Daily rounds in unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>218</td>
<td>90.5</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>7.5</td>
</tr>
<tr>
<td>Missing</td>
<td>5</td>
<td>2.0</td>
</tr>
</tbody>
</table>
The nurses identified factors associated with conflict through an optional open-ended question; 162 responses were provided. Conflict was reported to be associated with patients' wishes (n=8), language barriers (n=6), and estranged family members (n=6). The most frequently reported team factors were the involvement of multiple physicians in a patient's care (n=13) or poor team-family communication (n=8).

Nurses were asked to describe the feelings they experienced when involved in a situation of conflict related to the management of a patient. The most common feeling described was frustration (n=108/209 responses), manifested across various scenarios and arising from the situation or the actions of the team, physician, or family, as illustrated in the examples below.

- *I feel frustrated because arguments between team members sometimes extend over many hours or days and detract from the team's ability to make decisions about patient care in a timely manner. Arguments between team members detract from keeping the patient/family as the focus of care, and can hinder the patient's clinical progress.*
- *Frustrating when dealing with poor decision-making on the part of the lead physician and, at times, morally distressing to witness the patient and family suffering when faced with an inevitable poor outcome while we sustain life and watch the patient deteriorate and decline.*
- *Frustration that feelings of the family of guilt or inability to adjust to the reality of what is happening skew their objectivity in decision-making leading to the patient not being the focus of the issues.*

Other feelings reported included sadness (n=9), anger (n=8), or helplessness (n=6), while some nurses felt isolated or dismissed in the situation (n=6). Eleven nurses described feeling “caught in the middle” or “torn” between the patient and family, the family and the team, or between various members of the health care team.

The nurses were asked to identify the most helpful nursing interventions (exclusive of providing quality care to the patient) in situations of conflict involving the patient and/or family (Table 4) and the most helpful resources (exclusive of the bedside nurse) for patients and families when conflict arises (Table 5). Clear, consistent, and honest communication was ranked as the most important nursing intervention, followed by arranging for informal or formal family meetings with physicians in attendance. The top three ranked resources for patients and families in conflict situations were attending physicians, social workers, and charge nurses.

Questions were also asked regarding supports for the nurse in situations of conflict (Table 5) and access to and use of resources to assist with addressing conflict. The top three ranked sources of support for nurses were other general duty nurses, attending physicians, and charge nurses. The majority of nurses (80.9%) identified that they had access to an ethics committee, 64.3% had access to an ethics consultant or ethicist, and 22.4% had access to a mediator or mediation services. Approximately half of the respondents who had used each of these services expressed satisfaction with the consult/service; dissatisfaction was associated with, for example, time delays or the lack of clear guidance from the people involved.

### Table 3: Nurses' perceptions of most common types of conflict (n=241)

<table>
<thead>
<tr>
<th>Type of conflict</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispute or disagreement between the team and family</td>
<td>112</td>
<td>46.5</td>
</tr>
<tr>
<td>Dispute or disagreement within the team</td>
<td>85</td>
<td>35.3</td>
</tr>
<tr>
<td>Dispute or disagreement between family members</td>
<td>30</td>
<td>12.4</td>
</tr>
<tr>
<td>I have no experience with conflict</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Dispute or disagreement between the team and patient</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Dispute or disagreement between the patient and family</td>
<td>3</td>
<td>1.2</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>1.7</td>
</tr>
</tbody>
</table>

*Participants were instructed to select the most helpful, second most helpful and third most helpful nursing interventions (exclusive of providing quality care to the patient). Interventions selected as most helpful, second most helpful, and third most helpful were assigned 3 points, 2 points, and 1 point respectively. Interventions not selected by respondents were given no points. All points were summed to determine the total score for each nursing intervention. Interventions in Table 4 appear ranked from highest to lowest scored.*

### Table 4: Most helpful nursing interventions in situations of conflict

<table>
<thead>
<tr>
<th>Nursing intervention (n=228)</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing clear, consistent, and honest information to patient/family</td>
<td>538</td>
</tr>
<tr>
<td>Arranging for the physician to meet with the patient/family at the bedside to answer questions</td>
<td>294</td>
</tr>
<tr>
<td>Ensuring that other health care team members receive information about the patient's or family's wishes or concerns when known</td>
<td>220</td>
</tr>
<tr>
<td>Referring patient/family to other resources (e.g., patient advocate, social work, pastoral care)</td>
<td>143</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

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Discussion

The results of this study provide a snapshot of the frequency with which a sample of critical care nurses from across Canada encountered conflict in their practice, the types of conflict encountered, factors perceived to be associated with conflict, and the resources used to support families and/or health care providers in situations of conflict. The relatively low response rate (24%) and the limitations of web-based surveys, particularly of an open survey and a non-random sample, need to be acknowledged (Couper, 2000). The mean age of respondents was similar to the national average for critical care nurses: 43 years in our sample and 41.7 years (N=19,096) nationally (Canadian Nurses Association [CNA], 2011). Our sample differed in terms of education, with 50.2% of our sample baccalaureate prepared and 14.1% having completed a graduate program, compared to 37.5% of critical care nurses in Canada reporting degree preparation and 1.7% reporting master's preparation (CNA, 2011).

Just over half of the nurses in this study (50.6%) reported experiencing at least one situation of conflict in their last week of work prior to completing the questionnaire. This is in keeping with previously reported rates of between 32% and 78% of patient situations (Abbott et al., 2001; Breen et al., 2001; Studdert, Burns et al., 2003; Studdert, Mello et al., 2003), but less than the rate of 72% reported in response to the same question in the Azoulay et al. (2009) study. It is important to note that Azoulay and colleagues used a broader conflict definition, included other health care providers (from 24 countries) in their sample, and did not provide the rate for Canadian respondents alone (Azoulay et al., 2009). As with previous studies (Abbott et al., 2001; Breen et al., 2001; Studdert, Burns et al., 2003; Studdert, Mello et al., 2003), the two most common types of conflict were team-family and within team disagreements.

The frustration expressed by the nurses related to conflict situations highlight the importance of nurse-family communication. Other researchers have identified that good communication is key in preventing and resolving conflict in ICU (Azoulay et al., 2009; Fassier & Azoulay, 2010; Hartwick & Jones, 2010). There are clear implications for education from these findings in terms of the inclusion of content related to effective communication in both undergraduate programs and courses designed for critical care nurses.

The frustration expressed by the nurses related to conflict situations is worrying. Robichaux and Clark (2006) identified that nurses (N=21) experienced “resignation and frustration” when faced with situations where they believed “continued aggressive medical interventions were not warranted” (p. 480). In our study, there were many sources of nurses’ frustration (e.g., communication, decision-making processes, the perceived suffering of patients, families’ plight, nurses’ treatment as team members). Given the consequences of these feelings, more study is needed to enhance our understanding of nurses’ frustration in the face of conflict.

Others have written about the in-between position of nurses and the “perils” of nurses’ proximity to patients and families (Heland, 2006; Peter & Liaschenko, 2004; Varcoe et al., 2004). For many reasons, not least of which is the potential for conflict situations to become emotionally charged (Breslin et al., 2005), access to resources is essential for families, nurses, and the team. Previous studies have reported that conflict is a trigger for ethics consultations (Aleksandrova, 2008; DuVal, Sartorius, Clarridge, Gensler, & Danis, 2001). More work is needed to understand how resources like ethics committees, ethicists, and mediators are used by nurses and the results of such consultations. The support of nursing colleagues and physicians emerged as important to the nurses in this study. This was also true in our previous work (Edwards, Thronson, & Dyck, 2009) and highlights the value of working together as a team.

In conclusion, conflict is a known concern in ICUs. The results of this study add to our understanding of Canadian critical care

Table 5: Nurses’ perceptions regarding most helpful resources in conflict situations

<table>
<thead>
<tr>
<th>Resource (excluding staff nurse)</th>
<th>For patients/families (n=226)</th>
<th>Score</th>
<th>Resource</th>
<th>For nurses (n=220)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physicians</td>
<td>379</td>
<td>Other staff nurses</td>
<td>253</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers</td>
<td>373</td>
<td>Attending physicians</td>
<td>246</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charge nurses</td>
<td>158</td>
<td>Charge nurses</td>
<td>246</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pastoral/spiritual care providers</td>
<td>115</td>
<td>Social workers</td>
<td>177</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manager of the ICU</td>
<td>110</td>
<td>Manager of the ICU</td>
<td>147</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical resource nurses</td>
<td>55</td>
<td>Clinical resource nurses</td>
<td>89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>50</td>
<td>Advanced practice nurses</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced practice nurses</td>
<td>45</td>
<td>Pastoral/spiritual care providers</td>
<td>37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient advocates</td>
<td>39</td>
<td>Educators</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents</td>
<td>23</td>
<td>Residents</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry/liaison nurses</td>
<td>21</td>
<td>Other</td>
<td>26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Participants were instructed to select the most helpful, second most helpful and third most helpful resources. Resources selected as most helpful, second most helpful, and third most helpful were assigned 3 points, 2 points, and 1 point respectively. Resources not selected by respondents were given no points. All points were summed to determine the total score for each resource. Resources in Table 5 appear ranked from highest to lowest scored.*
nurses’ conflict experiences and illustrate the frequency with which conflict arises in practice. More research is needed in this area in order to assist nurses and other health care providers to prevent conflict or address it when it does arise.

About the authors

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REFERENCES


BiVADs: A bridge to the future for patients and their families: The art and science of nursing combined in the face of technology

BY ELAINE DOUCETTE, MScN, RN, JESSICA CYR, BScN, RN, ROBYN GRAHAM, BScN, RN, TIEGHAN KILLACKEY, BScN, RN, LAURA LEBLANC, BScN, RN, KYLA MARTINSON, BScN, RN, AND JEANNETTE VERLEUN, BScN, RN

Abstract

Approximately 500,000 Canadians live with heart failure (Ross et al., 2006). These numbers continue to rise due to advancing technology and successes in treating cardiac conditions and potentially fatal events such as myocardial infarctions. According to Carrier (2005), individuals with damaged hearts are living longer, and lives are being successfully saved with the surge of cardiovascular assist devices developed in recent years, which are increasingly used as a bridge to transplant. Despite the lifesaving capabilities of ventricular-assist devices, these innovations pose risks and complications that can be debilitating for patients and their families (Carrier, 2005). As this complex trajectory is navigated, nurses provide care and support to the patient and family while playing a unique role in the assessment and monitoring of these devices.

A family-centred nursing model provides a framework for practice when nursing patients and families are in crisis. The foundations of the McGill Model of Nursing are focused on a strengths-based approach, revolving around collaboration between patients, family resources, and tailored interventions (Gottlieb & Feeley, 2005). As students placed in a critical care setting, we began to realize the complexity of care required to nurse these patients and their families. In this paper, a case study is used to describe and share our learning experiences of caring for a patient with a biventricular assist device, as well as the principles that guided our interventions.

Recent Canadian statistics reveal that more than 500,000 Canadians live with heart failure (Ross et al., 2006). The prevalence of this chronic illness continues to be on the rise due to ever-increasing technology and successes in treating cardiac disease. As people with damaged hearts continue to live longer, they become more at risk for developing heart failure (Ross et al., 2006). Heart failure patients have a poor prognosis, with an average one-year mortality rate of 25% to 40% (Love & Sawatzky, 2007). Over the past two decades, lives that would have been lost were successfullySaved with different types of mechanical circulatory support devices and even heart transplantation, which has developed into a widely accepted treatment option for end-stage heart disease.

Ventricular assist devices (VADs) play an increasingly important role in the care of cardiovascular patients. Developed initially for support of cardiothoracic surgery patients experiencing difficulty in weaning from the cardiopulmonary bypass pump, these devices have been used extensively as a bridge to cardiac transplantation for patients who are failing on medical management, resulting in an increase in the number of patients surviving to transplant (Richards & Stahl, 2007). In this acute care setting, the VAD not only stabilizes the patient’s clinical condition but, by providing optimal perfusion, allows for the improvement of the patient’s cardiac output. This leads to improved end organ function and restored activity tolerance, resulting in improved patient outcomes when cardiac transplantation does occur (Richards & Stahl, 2007).

Despite the lifesaving capabilities of VADs, these recent innovations pose risks and complications that can be debilitating for patients and their families. As a group of students placed in an intensive care unit for our first acute clinical rotation, we were overwhelmed not only by the complexity of illnesses and treatment plans presented to us, but by the amount of new technology we were introduced to within the first few hours.

One of the cases that best illustrates the challenges we encountered on both a technological and interpersonal level throughout our time in the intensive care unit (ICU) was Patient X. Over the course of several weeks, many discussions were held in post-clinical conferences where we had the opportunity to share our individual experiences while caring for Patient X at different stages of the illness. This case study and our corresponding student reflections serve to illustrate the array of challenges we encountered, as students who did not have years of clinical intuition and experience to draw on as we worked to support families through the stress of an acute illness and, in this case, end-of-life care within a high-technology environment.

Case study

Patient X presented to the emergency room with symptoms of an upper respiratory tract infection. Subsequent testing revealed elevated troponin levels and deteriorating left ventricular function. Patient X was diagnosed with congestive heart failure with evidence of evolving ischemic heart disease. Patient X was transferred for an emergency coronary angiogram, which was followed by urgent
As students in the ICU, we participated in the care of Patient X and the family following surgery to insert a biventricular assist device. Continuous monitoring and care were provided to maintain hemodynamic stability. Throughout this time, the goal of the ICU team was to prepare for eventual cardiac transplantation, while preventing all potential complications, such as hemorrhage, cardiac tamponade, thromboembolism, infection, dysrhythmias, and technical VAD malfunction (Buda & Kendall, 2001).

In the short term, the biventricular assist device was functioning well and Patient X remained stable. However, after three weeks of hospitalization, Patient X became unresponsive with significant deterioration of neurological vital signs. A CT scan revealed a massive cerebral infarction, one of the many serious complications that can arise from the use of mechanical devices due to increased risk of thrombosis. After several more days of monitoring, no improvement in neurological status was noted and irreversible brain damage was confirmed. During this time, many family meetings were held with the interdisciplinary team to provide support and to answer the myriad of questions and concerns the family had. As a result of this severe complication, the hopes and prayers of the family now turned to despair, as they faced the almost inevitable death of their loved one. In the final days of the hospitalization, the ICU team took a more palliative approach to caring for Patient X despite the BiVAD remaining functional. After a few more days, the family decided to remove mechanical life support and Patient X passed away.

Crossing the boundaries from critical care to end-of-life care

Palliative care provides a holistic framework that focuses on quality of life and promoting dignity while decreasing emotional and physical suffering (Freysteinson, 2010). The goals of palliative care are meant to support the multidimensional needs of patients and family members before, during, and after death (Casarett, 2008). In an ICU setting, there may be the perception that little can be done for patients receiving palliative care. However, according to Morrison, Dietrick, and Meier (2008), palliative patients often have complex medical needs, as they are typically suffering from multiple disease processes, and knowledge and consideration of the body, as a whole unit, are required. Critical care nurses are providing end-of-life care more often than ever before, contrary to the original purpose of the ICU: to promote recovery and healing (Ferrell & Coyle, 2006). As one student expressed:

Death is scary, and nurses do not escape its emotionally powerful grip. As my first experience with death, I questioned how I could provide true support for others, as I struggled to cope myself. I quickly realized there is no “one way fits all” prototype for how to care for a family during crisis. To know when to allow space, and when simply a hand on a shoulder and an ear to listen will be the most meaningful care you can offer is a difficult concept to truly grasp in the classroom.

This demonstrates that it was not only the physical care of Patient X that was complex, but also the communication with and support of the entire family that was crucial throughout the illness experience. During end-of-life care, nurses often perform various complex medical and nursing interventions, while simultaneously providing information and support for loved ones in crises (Espinosa, Young, Symes, Haile, & Walsh, 2010).

The art and science of nursing

As students in our first medical-surgical rotation, we were captivated by the technology surrounding us, yet very intimidated by the prospect of working with patients and families under extremely stressful conditions. Therefore, in order to not lose sight of the art of nursing practice, despite the science-based setting, we drew on the theory and concepts of the McGill Model of Nursing. This model defines the entire family unit as the patient, and guided us to create collaborative partnerships and to use a strengths-based approach to health promotion (Feeley & Gottlieb, 2000). These concepts provided us with a framework of care for Patient X and the family throughout a constantly shifting illness trajectory.

The art of nursing is concerned with caring for the family unit over time; this includes everyday health practices, as well as illness crises (Gottlieb & Rowat, 1987). Families are deeply affected by their loved ones’ illnesses, and we cannot underestimate the impact that these events will have on the functioning dynamics of the family. Nurses play a pivotal role in helping families navigate through uncertain events, and a family may grow or deteriorate in response to these events (Doucette et al., 2010). In the case of Patient X, we observed how nursing care can affect family and patient outcomes in this setting. One student commented:

As a student, I was afraid that my inexperience with complex patient and family situations could be a barrier for interactions. In fact, this was not so much a barrier, but a viewpoint that allowed me to stay open-minded and be attentive to patient and family needs.

The McGill Model defines the relationship between nurses and families as a collaborative partnership (Gottlieb & Feeley, 2005). At a time when patients are not able to make their opinions known, such as the case with Patient X, the family’s knowledge about the patient is essential for developing goals that are valued by the health care team, as well as the patient and their family. By recognizing the family’s knowledge and insight, a collaborative relationship is possible wherein the contributions of both partners are valued and tapped (Gottlieb & Feeley, 2005). As another student expressed:

We want to empathize with our patients. We expect to get feedback to tailor our care to the individual and make it more human. I now appreciate the luxury of being able to put stories to the faces we see. For me, it was essential to learn about the person I was caring for, and the family gave me a glimpse into the life and experiences that have made the person who they are today, and about the life that the person wanted and planned for in the future. This insight into their hopes and dreams renewed my motivation and commitment to work towards the goals for transplant, recovery or, ultimately, comfort and dignity in death.
The process of dying with dignity is described as being “free from avoidable distress and suffering for patient, family and caregivers, in general accord with patients’ and families’ wishes, and reasonably consistent with clinical, cultural, and ethical standards” (Chochinov, 2006, p. 85). We witnessed the anxiety and grief that families must sometimes go through and felt powerless, as we came to the realization that even the best medical interventions cannot always save a person’s life. As health care professionals, we are taught to prolong and preserve life, and when the prognosis is grim, it can be difficult to shift from a curative to a palliative care focus and allow death to result.

When dying with dignity is achieved, the hope that families had held on to throughout the hospital stay can be renewed, and they can be comforted with the idea that their loved one passed away in an environment of love and respect. Hope is essential to all life, and is especially important in the face of an illness experience. As students, identifying and cultivating hope despite an uncertain prognosis was a key aspect of the care that we were able to provide to Patient X and the family members. As one student stated: Working with critically ill patients was an emotionally challenging experience. It was our first time becoming involved in the lives of critically ill patients and their families, and in the case of Patient X, I found myself hoping for a transplant procedure and eventual recovery. It was definitely an invaluable lesson to learn that although recovery may not always be the end result for every patient, hope is not lost. The ability to hope for something other than a full recovery, although counterintuitive at first, seemed to allow death to become a more normalized experience and helped the family part with their loved one in peace.

Hope is fundamental not only to our ability to thrive, but to our ability to live and should not be abandoned in the face of death. By placing emphasis on simply “being” while also “doing” during end-of-life care, we can allow this hope of dignified death to become a reality for patients and staff.

Conclusion

Overall, working with a patient suffering from heart failure allowed us to experience highly acute medical interventions combined with intensive emotional support for a patient and family during periods of uncertainty. Our dependence on technology for the treatment of this life-threatening illness has raised not only our own expectations of biomedicine, but also the public’s expectations of us, as health care professionals. If we compare the complexity of treatments now to what was possible only decades earlier, the learning curve that nurses are confronted with is astounding. Our personal experiences can attest to the array of challenges encountered by critical care nurses working in high-acuity settings.

What we have explored in this paper are the skills we can rely on to avoid becoming overly captivated by exciting new equipment in the hope that we do not lose sight of the person at the receiving end. As our clinical trajectories have progressed and as we enter the nursing profession, these lessons have proven invaluable and consistently applicable to patients we have encountered in various settings. Although it will not always be easy, we hope to adapt to new technology by relying on the fundamentals we have studied. As our profession and clinical interventions continue to move forward, we are committed to carrying the art of nursing into the future for clients and families.

About the authors

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REFERENCES


FRASER HEALTH is proud to be named one of the Top 55 Best Employers in BC.

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(Standard message and data rates may apply)
The Draeger Medical Canada Inc. “Chapter of the Year” Award

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

The Chapter of the Year criteria are founded on the CACCN Mission Statement and recognize the Chapter activity in this regard with specific emphasis on Member Service, Innovation, Specialty Promotion and Fiscal/Membership Health.

**Award funds available:** $500.00 plus a plaque

**Deadline for submission:** May 31 annually

**Application process:** Chapters must apply for consideration

**Criteria for the award program**

- The award program will be for the period of April 1 to March 31 each year
- Chapters may receive the award for one year followed by a two-year lapse before receiving again
- A point system has been developed to fairly evaluate chapter accomplishments during the year
- The chapter that accumulates the most points will be the successful recipient of the Chapter of the Year Award
- CACCN reserves the right to adjust points depending upon supporting materials submitted
- In the case of a tie, CACCN reserves the right to determine the recipient of the award
- The award recipient will be announced at Chapter Connections Day and at the annual awards ceremony at Dynamics.

**Conditions for the award program**

- All chapters of CACCN are eligible for consideration of the Chapter of the Year Award provided all quarterly and annual financial/activity reports are on file with CACCN National Office for the qualifying period
- Chapters will be responsible for ensuring national office receives all required documentation to validate accumulated points
- If the above conditions are not met, the chapter will not be eligible for consideration
- Announcement of the successful chapter will be published in CACCN publications
- All chapter reports /scoring will be available for review at Chapter Connections Day/Dynamics.

**Points system**

**Innovation**

- Any educational event coordinated and hosted by the local chapter is eligible. Total hours of education offered in the award period will be total (concurrent sessions are accumulated) and divided by the membership number as a denominator. This will be converted to a rate/1000

- **Formula:** \( \frac{\text{Total hours of education offered}}{\text{total chapter members}} \times 1000 = \text{innovation score} \)

- Using this calculation, the final educational contribution hours will be adjusted for size of chapter and expressed in rates for direct comparison.

**Public education, community service: Promoting the image of critical care nursing**

- Any public or community service event coordinated and hosted by the local chapter is eligible. Total hours offered in the award period will be total (concurrent activities are accumulated) and divided by the membership number as a denominator. This will then be converted to a rate/1000

- These projects must be presented under the auspices of the CACCN chapter (i.e., participating in blood pressure clinics, teaching CPR to the public, participating in health fairs)

- **Formula:** \( \frac{\text{Total hours of events offered}}{\text{total chapter members}} \times 1000 = \text{innovation score} \)

**Communication—Fiscal health—Membership sustainability**

**Recruitment Points**

- Calculated based on the percentage of new members recruited, as compared to the total membership of the previous year:

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- **Formula:** \( \frac{\text{Total new members}}{\text{total chapter members}} \times 100 = \text{Recruitment points} \)

**Sustained membership points**

- Points are allotted for percentage of membership sustained over this past year

- Any member with a membership lapse of 12 months or more will be considered a new member

- i.e., a member expires April 2011 and renews their membership February 2012. This member would be considered a *renewing* member

- i.e., a member expires April 2011 and renews their membership June 2012. This member would be considered a new member due to the lapse in membership of more than 12 months.

- Sustained membership points are calculated based on the percentage of renewing members in the fiscal year.
**CACCN Research Grant**

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

**Award funds available:** $2,500.00

**Deadline for submission:** February 15

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

**Eligibility:**
The principal investigator must:
- Be a member of CACCN in good standing for a minimum of one year
- Note: where a student is submitting the research grant application and is ineligible to act as the principal investigator, the student must be a member of CACCN in good standing for a minimum of one year
- Be licensed to practise nursing in Canada
- Conduct the research in Canada
- Publish an article related to the research study in *Dynamics*
- CACCN members enrolled in a graduate nursing program may also apply
- Members of the CACCN board of directors and the awards committee are not eligible.

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

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

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

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**Percentage Points**

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- Formula: Total renewed members/total chapter members × 100 = Recruitment points

**Contribution to specialty knowledge—Publications and presentations**

**Publications**
- Points will be calculated for chapter members who have contributed articles to:
  - the chapter newsletter or *Dynamics*, Journal of the Canadian Association of Critical Care Nurses (Fall, Winter, Spring Journals for the fiscal year—the Summer Abstract Journal is not included)
- Chapters are responsible for providing:
  - list of member contributions, together with a copy of the chapter newsletter
  - list of member contributions to the journal, together with the journal issue/date.

  Each article = 25 points

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

  Each presentation = 25 points

**Critical care certification—CNCC(C) and CNCC(P)**
- Points will be calculated for chapter members who have successfully completed the CNA Certification Examination
- Points will be calculated for chapter members who have successfully renewed their CNA Certification
- Members’ names must appear on the certification list received directly from the CNA to qualify.

  Initial certification = 10 points per %
  Renewal certification = 5 points per %

Add together for total certification score
- Formula Initial Certification: Number of members certified / total chapter membership × 100 = Percentage
- Formula Certification Renewal: Number of members re-certified / total chapter membership × 100 = Percentage
- Add the two percentages together for certification score.

*Good luck in your endeavours!*

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

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

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

Editorial Awards

1st place award value: $750.00 Edwards

Runner-up award value: $500.00 CACCN

Deadline: None. Awards committee selection process.

The Editorial Awards will be presented to the authors of two written papers in Dynamics, which demonstrate the achievement of excellence in the area of critical care nursing. An award, provided by Edwards Lifesciences, will be given to the author(s) of the best article, and another award is given to the author(s) of the runner-up article. It is expected that the money will be used for professional development. More specifically, the recipient must use the funds:
1. Within 12 months following the announcement of the winners, or within a reasonable time
2. To cover and/or allay costs incurred while attending critical care nursing-related educational courses, seminars, workshops, conferences or special programs or projects approved by the CACCN, and
3. To further one’s career development in the area of critical care nursing.

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

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

Style:
The paper is written according to the established guidelines for writing a manuscript for Dynamics.

Selection:
1. The papers are selected by the awards committee in conjunction with the CACCN board of directors
2. The awards committee reserves the right to withhold the awards if no papers meet the criteria.

Presentation:
Representatives of the sponsoring company or companies will present the awards at the annual awards ceremony during the Dynamics conference. Their names will be published in Dynamics.

The Spacelabs Innovative Project Award

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

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

Deadline for submission: June 1 each year

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

Mailed applications must be postmarked on or before June 1

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

Award requirements:
- Within one year, the winning group of nurses is expected to publish a report that outlines their project in Dynamics.

Smiths Medical Canada Ltd.

**Educational Award**

**Award value:** $1,000.00 each (two awards)

**Deadlines:** January 31 and September 1 of each year

The CACCN Educational Awards have been established to provide funds ($1,000.00 each) to assist critical care nurses to attend continuing education programs at the baccalaureate, master's and doctorate of nursing levels. All critical care nurses in Canada are eligible to apply, except members of the CACCN board of directors.

**Criteria for application:**
1. Be an active member of CACCN in good standing for a minimum of one (1) year
2. Demonstrate the equivalent of one (1) full year of recent critical care nursing experience in the year of the application
3. Submit a letter of reference from his/her current employer
4. Be accepted to an accredited school of nursing or recognized critical care program of direct relevance to the practice, administration, teaching and research of critical care nursing
5. Has not been the recipient of this award in the past two years
6. Incomplete applications will not be considered; quality of application will be a factor in selecting recipient.

Application process:
1. Submit a completed CACCN educational award application package to National Office (forms package online at [www.caccn.ca](http://www.caccn.ca))
2. Preference will be given to applicants with the highest number of merit points
3. Keep a record of merit points, dating back three (3) years
4. Submit all required documentation outlined in criteria—candidate will be disqualified if documentation is not submitted with application
5. Presentations considered for merit points are those that are not prepared as part of your regular role and responsibilities
6. Oral and poster presentations will be considered.

**Post-application process:**
1. All applications will be acknowledged in writing from the awards committee
2. Unsuccessful applicants will be notified individually by the awards committee
3. Recipients will be acknowledged at the Dynamics of Critical Care Conference and be published in the journal.

**CACCN Chapter Recruitment and Retention Awards**

This CACCN initiative was established to recognize the chapters for their outstanding achievements with respect to recruitment and retention.

**Recruitment Initiative:**
This initiative will benefit the chapter if the following requirements are met:
- Minimum of 25% of membership is new between April 1 to March 31, the chapter will receive one (1) full Dynamics tuition
- Minimum of 33% of membership is new between April 1 to March 31, the chapter will receive one (1) full Dynamics tuition and one (1) $100.00 Dynamics tuition coupon.

**Retention Initiative:**
This initiative will benefit the chapter if the following requirements are met:
- If the chapter has greater than 80% renewal of its previous year’s members, the chapter will receive three $100.00 coupons to Dynamics of that year
- If the chapter has greater than 70% renewal of its previous year’s members, the chapter will receive two $100.00 coupons to Dynamics of that year
- If the chapter has greater than 60% renewal of its previous year’s members, the chapter will receive one $100.00 coupon to Dynamics of that year.
Selection process:
• Each nomination will be reviewed by the Awards Committee in conjunction with the CACCN Director of Awards & Sponsors
• The successful candidate will be notified by email and regular mail
• The successful candidate will be recognized at the annual Awards Ceremony at the Dynamics conference and her/his name will be published in Dynamics
• The funds may be used to attend educational programs or conferences related to critical care
• The Awards Committee reserves the right to withhold the award if no candidate meets the criteria outlined.

The CACCN Board of Directors & BBraun Medical retain the right to amend the award criteria.

The Guardian Scholarship – Baxter Corporation Award
for Excellence in Patient Safety

Award value: One award of $5,000.00 or two awards of $2,500.00 each

Deadline: June 1 of each year

The Baxter Corporation Guardian Scholarship will be presented to an individual, or an interdisciplinary team, who proposes to make, or who has made, significant contributions toward patient and/or caregiver safety in the critical care environment. Recipients of this award will identify ideas that encompass safety and improve the quality of care in their practice area.

Eligibility:
The applicant must:
• Be an active member of CACCN in good standing for a minimum of one (1) year
• Be licensed to practise nursing in Canada
• Members of the award review committee and/or the board of directors are not eligible.

Application requirements:
• The project will describe an innovative approach, to develop new or revised processes, to encompass patient safety and improve the quality of care at the unit, hospital or health care system level
• The project/proposal will show evidence of collaboration among team members.

A complete application form that includes:
• A proposal of a project, or a description of a completed project, which makes a significant contribution toward patient and caregiver safety in critical care
• The proposal will include the background perspective, statement of the problem, and intended means to change practice. The proposal should include a timeline by which the project will occur
• The project/proposal will show evidence of collaboration among team members.
• Brief curriculum vitae for the principal applicant and team members describing educational and critical care nursing background and CACCN participation
• Proof of active CACCN membership
• If this project requires ethics approval, please submit evidence of approval with your application.
Review process:
- Each proposal will be reviewed by the awards review committee and a representative of the Baxter Corporation
- Proposals are reviewed for their contribution to patient safety, evidence of transferability of the project, innovation, sustainability, and leadership within critical care practice areas
- Deadline for receipt of applications is June 1 of each year
- The successful candidate will be chosen and notified in writing by July 1.

Terms and conditions of the award:
- A proposed project must be initiated within three months of receipt of the scholarship
- Any changes to the timelines require written notification to the board of directors of CACCN
- All publications and presentations must recognize the Baxter Corporation and CACCN
- An article related to the project is to be submitted to Dynamics for publication.

Budget and financial administration
- One half of the awarded funds will be available to support the project expenses immediately
- The remaining funds will be awarded upon the publication of an article describing the project in Dynamics.

The total funds available are $5,000.00.

The award funds may be granted to a maximum of two applicants ($2,500.00 each).

NOTE: The CACCN Board of Directors & Baxter Corporation retain the right to amend the award criteria.

The Brenda Morgan Leadership Excellence Award
Award funds available: $1,000.00 plus award trophy

Deadline for submission: June 1

The Brenda Morgan Leadership Award was established in June 2007 by the CACCN Board of Directors to recognize and honour Brenda Morgan, who has made a significant contribution to CACCN and critical care nursing over many years. Brenda was the first recipient of the award. Brenda is highly respected for her efforts in developing, maintaining and sustaining CACCN in past years.

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

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

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

Eligibility criteria:
Persons who are nominated for this award will have consistently demonstrated qualities of leadership and are considered visionaries and innovators in order to advance the goals of critical care nursing.

The nominee must:
- Have been a member of CACCN for a minimum of five (5) years
- Have a minimum of five (5) years of critical care nursing experience
- Be registered to practise nursing in Canada
- Have demonstrated volunteerism and significant commitment to CACCN
- Have participated in CACCN activities at local or national levels
- Been a member of the CACCN chapter executive or national Board of Directors
- Have helped to plan a workshop or a conference or indirectly provided support of CACCN activities through management activities—supporting staff to participate in CACCN projects or attend conferences
- Hold a valid adult or pediatric specialty in critical care certification—Certified Nurse in Critical Care—CNCC(C) or CNCCP(C) from the CNA (preferred)
- Have demonstrated a leadership role or have held a key leadership position in an organization related to the specialty of critical care
- Consistently conducts themselves in a leadership manner
- Have effectively engaged others in the specialty of critical care nursing
- Have role modelled commitment to professional self development and lifelong learning
- On a consistent basis, exemplifies the following qualities/values:
  - pro-active / innovator / takes initiative
  - takes responsibility/accountability for actions
  - imagination/visionary
  - positive communication skills
  - interdependence
  - integrity
  - recognition of new opportunities
  - conflict resolution skills/problem solving skills.

Application process:
- The application involves a nomination process
- Please submit two letters describing how the nominee has demonstrated the items under the criteria section of this award
- Please use as many examples as possible to highlight what this candidate does that makes her/him outstanding
- The selection committee depends on the information provided in the nomination letters to select award winners from amongst many deserving candidates.
• Members of the CACCN board of directors and the awards committee are not eligible
• Award recipients will be notified in writing of their selection for the award
• Recipients will be honoured during the awards ceremony, at the annual Dynamics Conference
• Recipient names and possibly a photo will be published in Dynamics.

Selection process:
• Each nomination will be reviewed by the award committee in conjunction with the CACCN Director of Awards and Sponsorship
• The Brenda Morgan Leadership Awards committee will consist of:
  • Two members of the board of directors and Brenda Morgan (when possible)
• The awards committee reserves the right to withhold the award if no candidate meets the criteria outlined.

Terms and conditions of the award:
• The award recipient will be encouraged to write a reflective article for Dynamics, sharing their accomplishments and describing their leadership experience. The article should reflect on the recipient’s passion to move critical care nursing forward, their leadership qualities and how they used these effectively to achieve their outcome.

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

Cardinal Health Chasing Excellence Award

Award value: $1,000.00

Deadline: June 1 annually

This award is presented annually to a CACCN member who consistently demonstrates excellence in critical care nursing practice. The Cardinal Health Chasing Excellence Award is $1,000.00 to be used by the recipient for continued professional or leadership development in critical care nursing.

The Cardinal Health Chasing Excellence Award is given to a critical care nurse who:
• In critical care, has a primary role in direct patient care
• Has been a CACCN member in good standing for three or more years
• Holds a certificate from CNA in critical care CNCC(C) or CNCCP(C) (preferred)
• Note: Current members of the national board of directors are not eligible.

The Cardinal Health Chasing Excellence Award recipient consistently practises at an expert level as described by Benner (1984). Expert practice is exemplified by most or all of the following criteria:
• Participates in quality improvement and risk management to ensure a safe patient care environment
• Acts as a change agent to improve the quality of patient care when required
• Provides high-quality patient care based on experience and evidence
• Effective clinical decision-making supported by thorough assessments
• Has developed a clinical knowledge base and readily integrates change and new learning to practice
• Is able to anticipate risks and changes in patient condition and intervene in a timely manner
• Sequences and manages rapid multiple therapies in response to a crisis (Benner, Hooper-Kyriakidis & Stannard, 1999)
• Integrates and coordinates daily patient care with other team members
• Advocates and develops a plan of care that consistently considers the patient and family and ensures they receive the best care possible
• Provides education, support and comfort to patients and their families to help them cope with the trajectory of illness and injury, to recovery, palliation or death
• Role models collaborative team skills within the interprofessional health care team
• Assumes a leadership role as dictated by the dynamically changing needs of the unit
• Is a role model to new staff and students
• Shares clinical wisdom as a preceptor to new staff and students
• Regularly participates in continuing education and professional development.

Nominations:
Two letters describing the nominee's clinical excellence and expertise are required, one of which must be from a CACCN member. The nomination letters need to include three concrete clinical examples outlining how the nominee meets the above criteria and demonstrates clinical excellence in practice. In addition, a supporting letter from a supervisor, such as a unit manager or team leader, is required.

Selection:
Each nomination will be reviewed by the awards committee in conjunction with the CACCN director of awards and sponsors. The successful recipient will be notified by mail, recognized at the annual awards ceremony at the Dynamics conference and her/his name will be published in Dynamics. The awards committee reserves the right to withhold the award if no candidate meets the criteria.

References:
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