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

Mission statement
We engage and inform Canadian Critical Care nurses through education and networking and provide a strong unified national identity.

Values and beliefs statement
Our core values and beliefs are:

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

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

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

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

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

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

Pathways to success: Five pillars

1. **Leadership:**
   - Lead collaborative teams in critical care interprofessional initiatives
   - Develop, revise and evaluate CACCN Standards of Care and Position Statements

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

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

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

5. **Membership:**
   - Strive for a steady and continued increase in CACCN membership

Canadian Association of Critical Care Nurses
Critical thinking

Nursing has always been esteemed by the public as a trusted and valued profession. How often have we each heard someone say: “I couldn’t do what you do” or “your work must be so difficult”. Many of us will smile, and acknowledge that it is hard work yet very rewarding. Rewarding as it may be, the unique challenges within critical care nursing require a persistent professional who is committed to achieving excellence in their practice. Critical care nurses choose to place themselves in a unique environment of practice. We care for the most vulnerable of patients, we make choices in unpredictable circumstances and we understand that our actions can have a profound impact on people’s lives and well-being. We intentionally seek out the gaps of critical illness care and create the many vital bridges that link environments, diverse perspectives and the complex relationships that are embedded in the domain of critical care. Critical care nurses focus on solving dilemmas and endeavour to make sense of the senseless even when the task is daunting. Critical care nurses are solution and strength oriented in an illness and problem focused setting.

The Canadian Association of Critical Care Nurses has a sustained history of shining the spotlight on critical care nursing; speaking with conviction and stepping up together to ensure that the important contributions of our nursing specialty are recognized. CACCN pledges to support and advance the practice of critical care nursing in Canada. Our vast network of volunteers, partners, members, regional leaders and associates demand and deserve an association which is responsive to the changing context of critical care, the evolving expectations for critical care nursing practice and is poised to lead in the generation of best evidence and innovation for our patients and families.

In partnership with Erin Roberts of Zzeem, the CACCN Board of Directors have spent the past eight months actively reflecting, evaluating listening and reviewing the fit of CACCN’s mission, goals and strategic plan for members, partners and the Canadian health care community. On behalf of the National Board of Directors, our Chief Operating Officer, Christine Halfkenny-Zellas and our Chapter Leadership team, I would like to share our progress to date.

In response to our member’s and regional leader’s feedback, we have refreshed our mission statement and refined our vision for the future of Canadian Association of Critical Care Nurses. We have reviewed our strategic objectives, our deliverables, accountabilities and resource needs to inform and support our continued success in the future. In addition, the Board has completed a redesign of National Board processes and Director portfolios to align our day-to-day activity closely with our fresh mission and goals.

CACCN Mission

We engage and inform Canadian Critical Care nurses through education and networking and provide a strong unified national identity.

CACCN Vision

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

We are very excited for this new direction and the opportunities it will shape for us.

I wish to extend my sincere thanks to all the members who participated in the survey, interview and focus groups. Your presence and wisdom have been invaluable. My appreciation is also extended to Erin and her team at Zzeem and to Christine Halfkenny-Zellas for leading the way and ensuring a robust process was designed in order to achieve our organization’s full potential.

Please join us at the 2015 Dynamics conference and Annual General Meeting in Winnipeg where we will share in detail our strategic planning report along with all the amazing developments we can look forward to in the future. If you would like to get more involved or have something to share, please write to me at president@caccn.ca or through National Office at caccn@caccn.ca.

Together We Can achieve our vision.

Sincerely,

Karen Dryden-Palmer, MN, RN
President, CACCN
World Sepsis Day
September 13, 2015

The Canadian Association of Critical Care Nurses (CACCN) is asking for the support of your hospital/organization for the World Sepsis Declaration for World Sepsis Day.

World Sepsis Day is an initiative from the Global Sepsis Alliance and its founding members, the World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM), the World Federation of Intensive and Critical Care Societies (WFICCS), the World Federation of Critical Care Nurses (WFCCN), the International Sepsis Forum (ISF) and the Sepsis Alliance (SA).

As you know, sepsis is a leading killer of Canadians, responsible for more than 30,000 hospitalizations in 2008–2009, and for the deaths of 20,000 or more of our fellow citizens. It is a leading cause of preventable morbidity in the contemporary health care system. Worldwide, sepsis is the final common pathway to death for four of the ten most common deaths. Mortality has declined from 50% at the turn of the 21st century to 25 to 30% today, and efforts to raise public and professional awareness of the problem have played an important role in this victory. But there is still much that needs to be done to raise awareness, and to move sepsis into the category of public health triumphs.

The Global Sepsis Alliance (GSA, www.globalsepsisalliance.com) was formed to promote professional and public awareness about sepsis. In 2012, the GSA held the first World Sepsis Day, with the support of a thousand hospitals and health care institutions around the world. Last year the list of supporters increased to more than 2,200.

The Canadian Association of Critical Care Nurses supports World Sepsis Day and we invite you to add your name to the list.

Please register and encourage your hospital/organization to raise the profile of sepsis with the World Health Organization! Registration is available online at: www.world-sepsis-day.org/register or contact the World Sepsis Day Head Office, email: office@world-sepsis-day.org.

We urge you to join the global movement dedicated to reducing the health, economic and human burden of sepsis by committing to the World Sepsis Declaration.

Global Sepsis Alliance for the World Sepsis Day
Center for Sepsis Control and Care
Email: office@world-sepsis-day.org
#WSD14

Dynamics of Critical Care 2015

The Dynamics 2015 Planning Committee and the CACCN Board of Directors look forward to welcoming the conference delegates, sponsors and exhibitors to Winnipeg, MB, for Dynamics of Critical Care 2015 being held September 27–29, 2015.

View the conference brochure at www.caccn.ca. Final day for conference registration/payment is September 5, 2015.

Dan Harper / Tourism Winnipeg
Annual General Meeting Proxy Vote Form 2015

I, ___________________________, a voting member in good standing of the Canadian Association of Critical Care Nurses (CACCN), hereby give my proxy to Karen Dryden-Palmer, President of the Board of Directors, failing her, to Renée Chauvin, Vice-President of the Board of Directors.

OR (complete only if you wish to name someone other than the above as your proxy)

________________________________________________________________________

as my proxy to attend, act, and vote on my behalf at the Annual General Meeting of members to be held Sunday, September 27, 2015, at the Dynamics of Critical Care Conference 2015, in Winnipeg, MB (including adjournments thereof).

Name: _________________________  Date:_________

Signature:_____________________________________

It is the responsibility of the member to determine whether the person to whom they assign the proxy is able and agrees to act in the manner described.

Please ensure delivery of the completed proxy to CACCN by no later than Friday, September 5, 2015, at 2359 ET:

by email: caccn@caccn.ca

by fax: (519) 649-1458

by mail: Canadian Association of Critical Care Nurses

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Membership Recruitment Draw Recipients

Two complimentary memberships are drawn each quarter for a one-year membership from the eligible CACCN members who have referred members to the association.

Congratulations to the following members who received a complimentary one-year membership under the CACCN Membership Recruitment program.

- Third Quarter—October 1 to December 31, fiscal 2014–2015:
  Maria Lourdes Aspa, Montréal, QC
  Christine Filipek, Calgary, AB
- Fourth Quarter—January 1 to March 31, fiscal 2014–2015:
  Nina Beslic, Toronto, ON
  Mélanie Gauthier, Montréal, QC
- First Quarter—April 1 to June 30, fiscal 2015–2016:
  Natalie Tolfo, Victoria, BC
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_The Canadian Journal of Critical Care Nursing_ is published four times annually (Spring, Summer, Fall and Winter) and is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, the International Nursing Index, MEDLINE and RNdex Top 100. This means that many nurses nationally and internationally will have access to your article.

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

Manuscripts should be submitted via email to Paula Price, Editor, _pprice@mtroyal.ca_, with a copy to CACCN National Office at _caccn@caccn.ca_.

For more information regarding _The Canadian Journal of Critical Care Nursing_, please visit “Publications” on the CACCN website at _www.caccn.ca_.

See page 46 for information for authors.

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Dynamics 2016 Call for Abstracts

The Dynamics 2016 Call for Abstracts will be released with the Canadian Journal of Critical Care Nursing, Volume 26, Number 4, Winter 2015. The online submission process will be available as of November 15, 2015. Deadline for abstract submissions will be January 31, 2016.

Submitting a poster abstract? You may be eligible to qualify for the Sage Poster Bursary, page 43.

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Future sites of Dynamics conferences

- **Dynamics 2016**: September 25–27, 2016, Charlottetown, PE
- **Dynamics 2017**: September 24–26, 2017, Toronto, ON
- **Dynamics 2018**: September 23–25, 2018, Saskatoon, SK

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An educational approach for “non-compliant” patients

BY GERALDINE S. WHITTAKER, BScN, MHS, RN

Abstract

Patients frequently are readmitted to the intensive care unit (ICU) because they did not make lifestyle changes (Clark & Moss, 2011) that put them at risk for cardiac issues. Nurses view this lack of change as “non-compliance”. According to Alikari and Zyga (2014), compliance implies “an unintentional act of subjection to authority” (p. 184). The author of this article will identify some contributing factors affecting the ability of cardiac patients with coronary heart disease (CHD) who are often challenged by behaviour changes required to improve their health. Also included in this article will be an educational approach and recommended strategies to address patient factors leading to non-compliance that ICU nurses can use when engaging with their patients to address lifestyle behaviours, such as increasing exercise, smoking cessation, and healthy eating.

Factors contributing to non-compliance

Cardiac patients with CHD are often challenged by the behaviour changes they need to make to improve their health. These issues contribute to non-compliance. For example, a patient may not take antihypertensive medications because of their side effects. However, the use of the term “non-compliance” has negative connotations. To the author, the term non-compliance assumes being bad, rebellious, and uncar ing. The author also believes that competent patients have the right to choose not to change their behaviour, even if this may endanger their lives. However, their decision to do so must be informed following an open and honest discussion of personal factors related to these lifestyle behaviours. Instead, nurses should look at what is contributing to this lack of change; these include both nursing and patient factors.

A nursing factor contributing to non-compliance

Several nursing factors exist that contribute to non-compliance. Nursing’s view on non-compliance will only be discussed in this paper.

As nurses, we have a duty to provide care that aims to improve patients’ health. However, non-adherence is a significant challenging obstacle in delivering this nursing care (Miloh & Annunziato, 2010). Nurse authors view compliance from evaluative, rationalization, and acceptance perspectives (Murphy & Canales, 2001). Whittaker’s (2011) critical discourse analysis of non-compliance in a 14-bed unit located in a small Canadian city argued how the practical discourse on non-compliance, as viewed through the empirical paradigm, (re)produces dominance by maintaining the status quo, limiting power, marginalizing, and providing culturally insensitive care. From an epistemological viewpoint, the empirical paradigm allocates an ethnocentric assumption. Empirical researchers “adhere to subject-object dualism in that they stand apart from …[individuals]… and treat them as having an independent existence” (Kim, 2003, p. 11). The empirical paradigm also “excludes individual meaning” (Gephart, 1999, p. 1). The empirical paradigm is based on a cause-and-effect perspective; the medical model of treatment is guided by this paradigm (Kim, 2003). As a result, the cardiac patient may be challenged to make the necessary changes in order to improve his/her health due to not being actively involved in the health care experience. The patient then continues with his/her current lifestyle and is labelled non-compliant by the nurse.

Patient factors contributing to non-compliance

While nursing’s view of non-compliance can lead to lack of behavioural changes, two patient factors can also contribute to the lack of behavioural changes. These include patients’ perceptions of their health risk and decreased motivation.

The first patient factor to be considered is patients’ perceptions of their health risk. Patients need to understand their health risk in order to make changes. Researchers have found that individuals lack knowledge and understanding of cardiovascular risk factors. In one study, participants thought that a cause of heart disease was older people thinking too much (Ton et al., 2011). Lefler (2009) found that perceptions of older, high-risk women toward their CHD risk were not accurate or realistic because they did not understand how CHD risk factors related to their personal risk for a myocardial infarction. Farrimond,

Key words: non-compliance, cardiac patient, empirical paradigm, perception of health risk, lack of motivation, interpretive paradigm, self-disclosure, patient-centred care, risk communication, motivational interviewing
Saukko, Qureshi, and Evans (2010) found that many participants were surprised to be considered at high risk of CHD and that ageing was a CHD risk factor for many participants.

In addition to the individual's lack of knowledge and understanding of cardiovascular risk factors, other factors affect patient's perception of health risk. The nature of cardiovascular disease outcomes affects risk perception (Kennedy, 2008). CHD was perceived as invisible, unknown, and new by Jordanian women and adult Jordanians with no family member with CHD (Ammouri, Neuberger, Mrayyan, & Hamaideh, 2009).

An individual's tolerance of risk is another factor that affects risk perception (Kennedy, 2008). Grable's and Rabbani's (2014) study of risk tolerance in males and females aged 45-53 years found that risk tolerance is most likely a generalized attitude that people held, rather than a domain-dependent attitude. That is, there was consistency in assessing their willingness to take risks across risk situations. Driving, financial, occupational, health, interpersonal, romantic, and life change risk tolerance were studied. For example, if a person is willing to take health and occupational risks, it may be a sign that this person may be also willing to engage in an extramarital behaviour. Patients must weigh the benefits for and risks against making a change. Macaden and Clarke (2006) explored how type 2 diabetes affected a person's ability to socialize. They found that either a person did not follow his/her diabetic dietary practices (i.e., not bringing a snack to someone's house), or he/she weighed the consequences of committing a social offence with following an imperfect diabetic diet and then making a compromise (i.e., bringing sweets versus fruit to someone's house).

A second patient factor contributing to reluctance to make behaviour changes is decreased motivation. In order to make changes, patients need to be intrinsically and extrinsically motivated. According to Cerasoli, Nicklin, and Ford (2014), extrinsically motivated behaviours "are governed by the prospect of instrumental gain and loss (i.e., incentives)" (p. 980), while intrinsically motivated behaviours "are engaged for their own sake (i.e., task enjoyment)" (p. 980). Intrinsic and extrinsic factors impact motivation. Rodriguez (2013) believed that diabetic patients' motivation to engage in necessary self-care behaviours may be impacted by factors intrinsic and extrinsic to these patients. Barriers intrinsic to these patients were attitudes and health beliefs, limited diabetes knowledge and technical skill, decreased functional health literacy, and inadequate self-efficacy to engage in positive behaviour changes; while barriers extrinsic to these patients were financial considerations, inadequate family and community support systems, ineffective clinical relationships, and limited access to effective diabetes healthcare delivery (Rodriguez, 2013).

Examples of decreased motivation to make behaviour changes have been reported in the literature. Jones, Jolly, Rafferty, Lip, and Greenfield (2007) found that a patient in the home cardiac rehabilitation (CR) program had extrinsic motivation knowing "it was to help me to get better [instrumental reason] and it was up to me to do these things" (p. 354). However, she could not complete the home CR program since she experienced boredom. An example of a decreased intrinsic motivator is anxiety about exercising with others in an unfamiliar setting (Oerkild et al., 2011). Others have found that patients' emphysema, arthritis, and back pain affected their ability to do an exercise program (Jones et al., 2007). Chronic illness and back or knee pain was an exercise barrier for adults with a high risk of type 2 diabetes (Korkiakangas et al., 2011). Muscle pain, which is a common side effect of statins (Luria & Zelicha, 2009), also caused patients to stop taking their statins (Garavalia, Garavalia, Spertus, & Decker, 2009).

**A different nursing approach to patient education**

To assist cardiac patients in changing their behaviours, nurses need to move from traditional approaches in patient education to one that strives to achieve a win-win situation for both the nurse and the patient. The author proposes an educational approach that mitigates nurse and patient factors leading to non-compliance, which ICU nurses can use when engaging their patients to address lifestyle behaviours, such as increasing exercise, smoking cessation, and healthy eating. This approach involves three processes: incorporating a worldview based on the interpretive paradigm, self-disclosure, and patient-centred care (PCC).

**Interpretive versus empirical paradigm**

Nurses need to embrace a worldview, based on the interpretive paradigm, and have compassion for non-compliant patients. An assumption of interpretivism is that reality is socially constructed in an intersubjective world (Gephart, 1999). Gephart (1999) explains intersubjectivity as the "process of knowing others' minds" (p. 5). Therefore, the focus of the interpretive paradigm is to seek understanding of the patient's definition of the situation and the interpretation or perspective given to each situation by the patient. This leads to a better understanding by the nurse of why the patient is not following the recommended regimen. The nurse is better able to realize that she/he has to give power back to her/his patient in order to have a win-win situation, and compromise with rather than simply instruct the patient. As a result, the nurse seeks to establish a therapeutic relationship with the patient in order to strive for intersubjectivity by assuming that the patient is an active participant in care rather than a passive recipient of care (Whittaker, 2011).

**Self-disclosure by nurses**

Arnold and Boggs (2011) define self-disclosure by the nurse as the "intentional revealing of personal experiences or feelings that are similar to, or different from those of the client" (p. 96). Kirk (2007) suggests that, if nurses do not self-disclose to some extent, then the reciprocity needed for intimate knowing that facilitates disclosure of significantly sensitive information is absent. Nurses can be major players in facilitating patient disclosure (Saiki & Lobo, 2011). A theme in Shattell, Starr, and Thomas' (2007) study of mental health service recipients' experience of the therapeutic relationship were using participants' own words: "relate to me" (p. 278). One way that participants in the study reported that health care professionals related to them was through self-disclosure.
The intensive care nurse telling her cardiac patient who has high triglyceride levels that she (the nurse) has only been successful in cutting down the number of times she (the nurse) treats herself to eggs and bacon for breakfast rather than stopping eating them altogether is an example of self-disclosure. According to Deering (2004) patients mirror transparency and will then relate to the nurse valuable information such as their challenges, needs, and life's realities when the nurse relates to her/his patient, as a real person rather than as an authority figure. By incorporating the patient's life experiences and acknowledging the importance of the patient's self-knowledge, the nurse shifts power and authority to the patient (Russell, Daly, Hughes, and op’t Hoog, 2003). This can lead to a win-win situation where the nurse has a better understanding of the patient’s “non-compliance”, and the patient is less challenged with following recommendations.

Patient-centred care
“The originators of client-centred and patient-centred health care were well aware of the moral implications of their work, which was based on deep respect for patients as unique living beings, and the obligation to care for them on their own terms” (Epstein & Street, 2011, p. 100). Patients will be less challenged to make changes required of them since their socio-cultural context and life circumstances, which determine the degree of prescribed health intervention adherence (Wilson & Neville, 2008), will be known, and if these moral implications are kept in mind by nurses. PCC involves nursing moving from “our way” to “their way” (Wilson & Neville, 2008, p. 173) and changes centuries of physician-dominated dialogues to conversations that engage patients (Epstein & Street, 2011). Applying PCC will support the worldview shift of viewing patient non-compliance from the empirical paradigm to the interpretive paradigm (Whittaker, 2011).

I have spent more than 20 years as a registered nurse and during this time I have been challenged by the cardiac patient who is, in turn, challenged in making a behaviour change despite having been provided with the information by me. I have recently become a novice instructor of nurses in undergraduate education. Being a novice instructor has changed my approach of how I engage the cardiac patient who is challenged to make a behaviour change. I now use the analogy of learner-centred teaching to patient education. As an instructor, I aim to make my teaching learner-centred. Weiner (2013) proposes five characteristics of teaching that make it learner-centred: (a) engage students in learning, (b) teach students how to learn, (c) encourage student reflection, (d) motivate students by sharing power, and (e) encourage collaboration.

The goal of transitional care is patients actively participating (Fleming, 2014). Possessing the knowledge of learner-centred teaching may facilitate transitional care and, thus, PCC. For example, Fleming (2014) suggests to (a) assess the patient's (the learner) readiness for learning, (b) have a conversation with the patient asking for him/her to become their own health advocate, and (c) support the patient's self-directed learning skills. Fleming (2014) suggests that health care professionals need adult educators to help them understand adult learning. As a registered nurse and instructor, I agree with this suggestion.

Strategies to addressing patient factors
When people perform an activity (quit smoking) by choice due to personal importance (recovering from a myocardial infarction) they are extrinsically motivated (Stephan, Boiche, & Le Scanff, 2010). Since patients admitted to ICU feel vulnerable and are often willing at that time to change behaviour (Clark & Moss, 2011), a stable cardiac patient represents a teaching opportunity for nurses because a patient is extrinsically motivated. The author also provides strategies to address patient factors leading to non-compliance that ICU nurses can use when engaging with their patients to address lifestyle behaviours, such as increasing exercise, smoking cessation, and healthy eating. The strategies to address patient factors regarding perception of health risk and decreased motivation are discussed below.

Helping patients to understand their cardiovascular risk
Risk communication, defined by Edwards, Elwyn, and Mulley (2002) as “the open two-way exchange of information and opinion about risk, leading to a better understanding and better decisions about clinical management” (p. 827), can be used by health care professionals to assist patients to understand their cardiovascular risk (Kennedy, 2008). This strategy has optimal results when the nurse is equipped with effective communication skills and an understanding of risk (Kennedy, 2008). Communicating risk involves (a) assisting the patient to identify factors affecting his/her probability of a risk, (b) exploring his/her understanding and knowledge of the risk, (c) assessing his/her risk perception, and (d) delivering the risk message (Kennedy, 2008). This can lead to acknowledgement by the patient that his/her health is at risk due to CHD and changing his/her behaviour.

Motivating patients to change their health behaviours
If a patient determines the solutions to health issues, a positive health behaviour change is more likely (Tierney, 2011). Motivational interviewing (MI) is a way of communicating and its goal is to draw out personal intrinsic motivation for change (Thompson et al., 2011). This is facilitated through collaboration, evocation, and autonomy (Thompson et al., 2011). For example, the intensive care nurse works with the cardiac patient to inspire solutions to the health concern in order for the patient to change his/her behaviours, rather than the intensive care nurse telling the cardiac patient how to change his/her health behaviours.

MI is an effective tool (Antiss, 2009) for nurses to motivate cardiac patients to change their behaviours (Tierney, 2011). In order to facilitate behaviour change, the nurse can use the following principles to guide MI: “express empathy … roll with resistance, and support self-efficacy” (Miller & Rollnick, 2002, p. 36). For example, the intensive care nurse may begin by acknowledging the challenges experienced by patients when they try to change their behaviours. The nurse allows for self-expression while deflecting resistance and continuing with education. Then, the nurse can facilitate a discussion around the behaviour change where the patient comes up with acceptable solutions to the issue that will work for him/her (Perry & Bennett, 2006). This can lead to patients being intrinsically motivated. As a result, patients are more likely to change their behaviour.
Conclusion
Intensive care nurses need to engage their cardiac patients by incorporating a worldview based on the interpretive paradigm, self-disclosure, and patient-centred care. As a result, patients may be more willing to make the changes required of them to improve their health, since they are involved in the solutions. Only then will the circumstances surrounding patients’ non-compliance be addressed and, consequently, both parties less challenged. Intensive care nurses need education in communication skills and MI. The author also recommends that research be conducted in the ICU to assess the need for adult educators to work along with registered nurses and cardiac patients. The results of this research project may lead to needed policy changes in interprofessional education.

About the author
Address for correspondence: Geraldine Whittaker
Email: Geraldine.Whittaker@albertahealthservices.ca

REFERENCES
Checklist to meet Ethical and Legal Obligations in the consent pathway for critically ill patients (ChELO): A quality improvement project and case studies

By Andrew B. Cooper, MD, MHSC, Paula Chidwick, PhD, Pamela Cybulski, BA, RN, CNCC(C), Robert Sibbald, MSc

Abstract
Ethical or legal errors related to the consent pathway for incapable patients are an everyday reality. Quality improvements in communication or palliative care have been attempted, but little attention has been given to meeting basic legal and ethical obligations. In this paper, the authors share lessons learned during two years of implementing the Checklist for meeting Ethical and Legal Obligations (ChELO) in the intensive care unit of a large community hospital in Ontario. We use a case-based approach to demonstrate the need for our intervention, our use of positive deviance in a change strategy, and the effectiveness of the checklist itself. Through stories, we show common ethical and legal errors related to the consent pathway and how we were able to resolve them with this innovative tool.

Key words: end of life, best interests, consent and capacity, substitute decision making, risk management, critical care

In this paper, we present the lessons we learned in a pilot implementation of the Checklist for meeting Ethical and Legal Obligations (ChELO) (Sibbald, Chidwick, Handleman, & Cooper, 2011) in a large intensive care unit (ICU) serving a culturally diverse community. ChELO guides the health care professional’s discussion with the family or substitute decision maker in a 15-minute meeting with explicit and limited goals. The checklist supports an interviewer with five evidence-based, scripted questions to elicit an incapable patient’s perspective on treatment, based on the wishes and values he or she expressed while capable. The goal is to prevent errors in the consent pathway by implementing a checklist to ensure that basic legal obligations are met for patients who no longer are able to advocate for themselves.

Our quality improvement project applies elements of a positive deviance-based change framework (Heath & Heath, 2010). We describe our experience and lessons learned in a case-based format. In the cases here we have fictionalized clinical details to protect the privacy of the clinicians, patients and families in our care while retaining the defining features of the challenges we encountered.

Background
Case 1: Ethical error—An example
Grandpa came to the emergency department with shortness of breath and a racing heart. After successful resuscitation, he made a full neurological recovery. After weeks of supportive treatment he could not be liberated from mechanical ventilation in the ICU, and the doctors tried to find medical, surgical or interventional cardiology options to improve his condition.

On his 47th day in the ICU, Grandpa’s preferences for treatment remained unknown. To explore what they might be, we administered the ChELO checklist in a meeting that lasted 15 minutes. We documented that, currently, he was incapable of making decisions for himself. His daughter was the legally correct substitute decision maker. We gave the information bundle (i.e., substitute decision-making guide, evidence-based family information leaflet and values exploration sheet) to her. She explained that her father had a will for personal belongings, but not for personal care. He had put nothing in writing to provide guidance for decision making. He had never really discussed how he would feel about being in this kind of predicament. During the conversation, one grandchild remembered that on the way to the hospital Grandpa did say that if he died on the way “that would be it.” We asked about his personal values and beliefs and explored what was most important to him. Grandpa was Catholic and went to church every week before becoming sick. Even in the ICU he would mouth the words of prayers with the grandchildren. We ended the meeting when the ChELO checklist was completed and thanked the family for helping us to understand him better. We dictated a note in the hospital electronic record to document our assessment and the components of the consent pathway that it established.

A few days later when Grandpa developed severe oxygenation failure due to cardiorenal syndrome, the family approached us with a request to provide comfort treatment only, rather than initiating renal replacement therapy.

Error, ethical and legal obligations for incapable patients
The Institute of Medicine’s (IOM) monograph “To err is human: Building a safer health system” (Kohn, Corrigan, & Donaldson, 2000) launched a new paradigm in the culture of patient safety. Our own paradigm shift is to move problems in the development of a plan of treatment for incapable patients into the culture of patient safety. In the IOM report, medical errors are defined as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (Kohn, Corrigan, & Donaldson, 2000, p. 28).
We are most familiar with error in the context of adverse events and it is well accepted that there are clear obligations to “do something” when there is an error (i.e., report, disclose and investigate the error) (The Canadian Medical Protective Association, 2008). In the clinical setting, medication or surgical errors are immediately addressed, remedied and reported. Applying the IOM classification system, failures to meet basic ethical and legal obligations are equivalent to treatment errors because (a) they occur in the performance of a procedure (creating the plan of treatment for an incapable patient), and (b) they occur during the administration of treatment. Our quality improvement strategy considers actions that prevent health care providers and institutions from meeting their autonomy and stewardship-based obligations as errors that should be remedied immediately and prevented from occurring again (Oliver, Chidwick, & Sibbald, 2014).

The role of the Health Care Consent Act of Ontario is to define the considerations required for treatment plans to protect a patient’s autonomy and to ensure appropriate medical therapy. In clinical practice, it is useful to apply these considerations in a stepwise process: the Consent Pathway (Figure 1). We are concerned with consent as a process with a series of legally defined steps. In Cuthbertson v. Rasouli, the Supreme Court of Canada re-affirmed the role of the Ontario Health Care Consent Act and the Consent and Capacity Board for resolving disagreements over all aspects of treatment for health-related purposes, including withdrawal of life support (Cuthbertson v. Rasouli, 2013).

“The doctor’s obligations should include, for example, providing notice and a thorough and accommodating process for determining the condition and best interests of the patient” (Cuthbertson v. Rasouli, 2013).

A process to improve the reliability and correctness of the process leading up to a treatment plan is recommended, and failing to follow a process can contribute to making an error in law.


**Figure 1: Consent Pathway**

**ChELO: An evidence-based checklist**

Our interest in problems of consent regarding a plan of treatment prompted us to conduct three empirical studies. In a purposive sample of 12 written decisions of the Ontario Consent and Capacity Board (CCB), hearings were held because of conflicts between physicians and substitute decision makers regarding the best interests of incapable patients in relation to the plan of treatment. Substitute decision makers (SDM) frequently appealed to the relevance of God or religion, and could emphasize their own values above those of the incapable patient. Physicians narrowly focused on clinical evidence and their predictions of whether the treatment plan was likely to benefit the patient or to cause harm. Decisions of the CCB consistently indicated that substitute decision makers and physicians ought to follow statutory obligations for the consent pathway (i.e., the patient’s best interests) when considering whether a treatment plan was correct or incorrect for an incapable, seriously ill patient (Sibbald & Chidwick, 2009). In an investigation of later CCB decisions, we found that some SDMs report that their loved one values suffering, that SDMs can have unrealistic hopes for recovery and may even believe they can communicate and receive guidance from an incapable patient. A need for education regarding the obligations of the SDM role and for time to provide consent was identified (Chidwick, Sibbald, & Hawryluck, 2013). In a purposive sample of 29 CCB decisions (2003–2012) regarding the use of life-sustaining treatments at the end of life, we showed the importance of correctly defining “best interest” during a CCB hearing. In some of these cases, where physicians incorrectly associated medical benefit with the patient’s best interest, the CCB ruled for continuation of life-sustaining treatment, even though the standard of care appropriate to the circumstances would have been to withdraw or withhold life support (Hawryluck, Sibbald, & Chidwick, 2013).

Until now many bioethicists, physicians and nurses have been preoccupied with trying to solve the problem of ‘inappropriate care’ at the end of life. Our research has identified a different, less recognized problem with ‘inappropriate consent’. Our quality improvement strategy has a different objective—reducing ethical and legal errors in the consent pathway. Accordingly, we decided to use different methods to achieve our goal. The success of the surgical safety checklist in reducing medical error (Haynes et al., 2009) and its relative simplicity led us to
consider a checklist for our own attempt to reduce consent related-errors and to ensure that ethical and legal obligations (Table 1) are met for seriously ill patients in our hospital. Based on our research and in consultation with a former chair of the CCB, we proposed a simple checklist to minimize common errors (Sibbald et al., 2011). Having decided on an intervention to apply, we sought a change strategy to implement the new approach within our clinical culture.

Case 2: Positive deviance in our ICU

A 63-year-old man walked into his workplace and suddenly collapsed, striking his head on a concrete floor as he fell. When the paramedics arrived he was pulseless, but he regained spontaneous circulation with resuscitation. On initial assessment in the ICU he manifested spinal shock and had no spontaneous breathing. MRI later showed a C1-2 level fracture dislocation with spinal cord compression. After the third day, with no pupillary light reflexes and evidence of global cerebral ischemia on the scan, our patient had diffuse severe anoxic brain injury. A neurologist predicted that he would not regain meaningful cognitive function. On day nine a second neurologist gave the same prognosis. On day 90, the intensive care physicians characterized his neurologic status as a persistent vegetative state. By the second month in ICU the patient could maintain spontaneous respiration for short periods of time and his airway had been secured with a tracheostomy. He had been treated for several ventilator-associated pneumonias, clostridium difficile infections and high-grade pressure sores at his sacrum and neck.

All attempts to establish a consistent treatment plan failed. With each new complication, his wife requested everything to be done. The critical care medicine team treated him with mechanical ventilation, sometimes after several ventilator-free days had passed.

On day 165, he was ventilator-free and a transfer to a non-ICU care area was considered. In preparation, a critical care physician outlined a palliative care treatment plan to the patient’s wife. In this plan he would not be readmitted to the ICU because mechanical ventilation was no longer consistent with the medical standard of care. She refused to consent to the proposed treatment plan. She was adamant that the patient himself would request mechanical ventilation, even in his irreversible state of disability. She also maintained that she believed in the miraculous power of God to heal and felt that his intermittent eye opening was an indication of ongoing improvement in his condition.

Under the terms of the Health Care Consent Act, the physician initiated an application for a hearing before the Consent and Capacity Board (CCB). On Day 189, the hearing took place (Consent and Capacity Board, Government of Ontario, 2011). When questioned, the patient’s son and wife were unable to identify a relevant previously expressed wish. The question of whether the patient’s wife was following his values and beliefs when requesting ongoing life support was of great importance. The hearing discovered that one of the many physicians involved in his care had conducted a values history, and had documented that, while he enjoyed sports and being close to his family, he did not willingly attend religious events. Although the patient’s wife said he identified himself as Hindu, and that he believed God would take him when he was ready, she did not have specific information about his values and beliefs. The patient’s wife believed in miracles, and she admitted that the patient himself did not share in these beliefs with her.

The CCB concluded that the patient had no applicable, prior wish. It also noted that there was no evidence of the patient’s own values and beliefs that could guide end-of-life decision making. The patient’s wife had not considered the likelihood of life support helping the patient’s condition to improve. Nothing in the evidence suggested that he would want to be subjected to unnecessary medical interventions. On day 196, the Board directed the patient’s wife to consent to the palliative care only treatment plan, including no mechanical ventilation. On day 204 he died naturally on a general medicine unit with his wife next to him.

In this case, during the first five months of care, many changes of attending physician occurred and many conversations with the patient’s wife were documented in the chart. However, 2. An application to the Consent and Capacity Board, asserting that a SDM failed the test of decision making in the patient’s best interest by refusing consent to the proposed treatment plan http://www.ccbboard.on.ca/scripts/english/publications/ccbtemplates.asp

<table>
<thead>
<tr>
<th>Table 1: Results</th>
<th>Baseline 01-Jun-11</th>
<th>Intervention 1 11-Jul-11</th>
<th>Intervention 2 12-Aug-11</th>
<th>Post Intervention 29-Aug-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>ChELO –U</td>
<td>47 (32-54)</td>
<td>74 (63-87)</td>
<td>60 (51-75)</td>
<td>60 (50-70)</td>
</tr>
<tr>
<td>ChELO –B</td>
<td>n/a</td>
<td>64 (45-83)</td>
<td>81 (59-100)</td>
<td>90 (78-100)</td>
</tr>
<tr>
<td>N patients &gt;72 h LOS</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td>17</td>
</tr>
</tbody>
</table>

For an individual patient, checklist completion status was calculated as a simple ratio ChELO –U = 100*SUM(completed checklist items 1-8)/8).

ChELO –U (representing ChELO checklist statuses in the entire intensive care unit) for all eligible patients on the measurement day is the median of the aggregated individual patient ChELO u scores.

ChELO –U 8 items (5 interview questions, 3 printed information bundle items delivered to family)
ChELO –B 3 items (information bundle items given to family)
LOS length of stay
no progress was made towards comprehensively defining the requirements for consent that would lead to a treatment plan, and the plan itself changed many times—at each crisis returning to full treatment, despite a team consensus that it was not right for care to be directed by the patient’s wife. The team’s concern was that she was not representing the patient’s best interests. By applying the legislative mechanism for ensuring that the principles of consent for treatment were followed and using resources that were readily available (e.g., existing clinical documentation, clinical ethicist, hospital legal counsel) one physician demonstrated the potential to avoid ethical and legal error, even in a busy community ICU.

Our second narrative serves as an example of the phenomenon of positive deviance. Positive deviance is defined as an approach to behavioural and social change based on the observation that in any community, there are people whose uncommon but successful behaviours enable them to find better solutions to a problem than their peers, despite facing similar challenges and having no extra resources or knowledge (Anonymous, n.d.). Change strategies that harness the power of positive deviance are grounded on agreed on problems and they harness behaviours that can be easily learned and adopted with a minimum of extra resources. Steps in our strategy to engage
our multidisciplinary team were suggested by the framework presented by Heath and Heath (2010), which arise from case studies of successes in a wide variety of change-resistant environments.

**Quality improvement project**

**Objectives**

Our goals were to ensure that ethical and legal obligations were met and to minimize common errors that may occur in the consent pathway for critically ill patients. A quality improvement pilot project called “Checklist for Meeting Ethical and Legal Obligations (ChELO)” was performed between June to August 2011 in the 24-bed level III ICU of William Osler Health System, serving a culturally diverse population of 819,000 within a locally integrated health network. In 2011–2012 William Osler Health System reported 50,404 in-patient admissions. Institutional research ethics board approval was not required for this pilot quality improvement project.

**Material**

Through a consensus process, four experts developed ChELO through a review of the Ontario Health Care Consent Act (HCCA) and two qualitative studies that examined published written decisions of the legislatively appointed Consent and Capacity Board (Sibbald et al., 2011). Our intervention consisted of the ChELO bundle (i.e., ChELO checklist – Figure 2, substitute decision-maker pamphlet, family information leaflet, and patient values information sheet) combined with a positive deviance-based change strategy. Physician-led meetings with SDMs were held in a quiet meeting room (Pochard et al., 2001) and began with an exploration of the family’s understanding of the illness (Azoulay et al., 2000; Lautrette, Ciroldi, Ksibi, & Azoulay, 2006) allowing them time to speak (Lautrette et al., 2007; McDonagh et al., 2004). Next, a physician or a nurse led a ChELO checklist meeting, limiting the meeting time to 10–15 minutes. Our goal was to encourage interdisciplinary teamwork in the completion of the checklist, acknowledging the shared moral responsibility of all members of the team (Ferrand et al., 2003) and harnessing the potential of nurses to increase uptake of the new practice in a community hospital setting (Black et al., 2013).

**Measurements**

Because our goal was to meet ethical and legal obligations, the performance metric for our quality improvement project calculated the median percentage of completed checklist items on a single day, per patient, over all patients in our 24-bed ICU. Two scores were calculated at measurement times. For an individual patient, checklist completion status was calculated as a simple ratio ChELO u =100* [(SUM(completed checklist items 1–8))/8]. ChELO –U yields a number that increases to 100 as more checklist items are completed, making it analogous to performance on a test score. ChELO –U (representing ChELO checklist status in the entire ICU) for all eligible patients on the measurement day is the median of the aggregated individual patient ChELO –U scores. We displayed this result on message boards in the ICU during the project for the interest of the multidisciplinary team. ChELO –B evaluated the distribution of the communication and information bundle items given to the family or SDM in the same way, but only for these three non-interview items in the ChELO checklist. To show how the results were distributed, we also calculated 95% confidence intervals.

**Figure 3: Results**

Box and whisker plots showing medians, upper and lower quartiles for our implementation measurement ChELO-U at the study time points.

Day 79 P= 0.04 vs. baseline.
Effectiveness of our change strategy was evaluated at four measurement times (a) during a pre-intervention period, before we held our small group training sessions, (b) at two points while we were actively promoting the checklist in the ICU culture, and (c) after we had stopped our interaction with the team for two weeks (see Figure 3).

Method
As the project began, to harness clinicians’ emotional connection to the proposed project we held 30-minute sessions for physicians and nurses in which we facilitated a narrative exploration to elicit their positive and negative experiences with the consent pathway. To provide a rationale for our initiative we presented the evidence base for our project and recounted our own positive experience in the second narrative. We explained how to deliver the ChELO bundle to the family and how to perform the consent checklist.

On weekdays, a research assistant screened all patients in the ICU to identify those who had been admitted for at least 72 hours. She gave the ChELO bundle to the patient’s bedside nurse and followed up with the team to assist them in completing the checklist, requesting training support from the investigators, as required. In this way, during the intervention we trained 87 nurses. Any team member who participated in checklist completion was given a badge with a picture of a cello (musical instrument) to identify them as a “ChELO champion”.

Results
In Figure 3, we present our ChELO –U results at the four measurement times as box and whisker plots showing the median, upper and lower quartiles of the data set at each time. At baseline (June 1, 2011), 15 ICU patients had a length of stay of at least 72 hours. ChELO –U was 47; 95% confidence interval for the metric was 32–54. ChELO –B was not calculated at this point because no routine practice for distribution of the bundle items existed before our project. On day 30 (July 11, 2011), there were 12 patients who had a length of stay of at least 72 hours. ChELO –U was 74; 95% confidence interval was 63–87. ChELO –B was 64; 95% confidence interval was 45–83. At the completion of active intervention on day 62 (August 12, 2011), there again were 12 patients who had a length of stay of at least 72 hours. ChELO –U was 60; 95% confidence interval of 51–75. ChELO –B was 81; 95% confidence interval of 59–100. With no ongoing interaction between the investigators and the multidisciplinary team in the ICU, on day 79 (August 29, 2011) there were 17 patients who had a length of stay of at least 72 hours. ChELO –U was 60; 95% confidence interval of 50–70. ChELO –B was 90; 95% confidence interval of 78–100 (See Table 1).

Choosing our baseline measurement and post-intervention measurements to show the impact of our change process, we performed an F test to confirm that these two data sets had equal variance. We then performed a two-tailed Student’s T test to determine if the means were significantly different. Our p result was 0.04, indicating that a statistically significant increase in mean ChELO –U scores was achieved. All calculations were performed in Microsoft Excel.

Discussion: Lessons learned
Case 3: Scripting the critical moves
Nurse S became an enthusiastic champion of the ChELO pilot project. She always completed her checklist and encouraged the other ICU nurses to join. When we looked at the checklists S completed, we did not see much narrative information, just check marks for the items completed. Although the checklist was completed, supporting observations of the incapable person’s wishes, beliefs or values were not there. We invited S to join us for a checklist meeting to see how she conducted the interview. To our surprise, when we reached the values question, we saw S sometimes had difficulty exploring past an initial yes/no answer.

This experience showed how our initial assumption—that the interdisciplinary team already had the needed communication skills for the checklist—was false. We needed to create a checklist that would allow exploration of the domains that could be done in a reliable manner by anyone, using just basic communication skills. This led us to script the exploratory questions for each item. To improve accessibility and share our exploratory questions with a larger community, we created a clinician resource of the checklist as a smartphone app.

Case 4: Shrinking the change
We held a ChELO checklist meeting that included a patient’s husband, our social worker, the patient’s nurse and a critical care resident. After exploring the husband’s understanding of the illness, we began the ChELO checklist questions. Immediately, he became suspicious and guarded. He was not expecting “another family meeting”. Before answering any of the questions he vehemently told us he would not agree to limitations of treatment for his wife. We explained that the family meeting was a routine in our unit and that we were not planning to discuss treatment; our goal was merely to establish the patient’s beliefs, values and wishes with more certainty. After this, he agreed to continue and gave frank answers.

The patient previously had surgery for a spinal stenosis and had undergone a long and complex multi-level spinal decompression. She stayed at home after the surgery for a period of about 10 months before being able to resume her usual activities and return to work. The husband characterized her attitude to illness as that of a “fighter”. She did have a religious faith. With regard to life and death, the husband answered that for his wife that meant “only God knows when it is our time”. He felt she would continue to request full treatment until able to walk out of the ICU under her own power. She seemed to be a determined, hard-working person who was very proud of bringing up her children.

We completed the checklist by explaining that she would be considered now to be incapable of making decisions for herself and that he, the patient’s husband, would be the legally correct SDM. We gave him the SDM pamphlet and Family Information Leaflet and explained that his role in making treatment decisions would be guided by what was in his wife’s best interest, as defined in the HCCA. We learned that she had started to work on a living will before the present illness began. However, he did not know of a previously expressed wish of relevance to the situation she was in now. Knowing the importance of faith for the patient and her husband, we followed up by increasing spiritual support for them.
At the time this meeting took place, our checklist included a survey of life-sustaining treatments proposed by the attending physicians and whether they had been accepted or refused by the patient’s decision makers. In this meeting we learned that discussing treatment as part of a checklist meeting could undermine our relationship with a SDM. In this instance, we were able to complete the exploration by reassuring the patient’s husband that we were not going to talk about treatment. From this meeting onward, we decided to journey on the consent pathway in stages, rather than trying to assess everything in a single meeting. We revised the checklist by excluding the review of life-sustaining treatments and printed a new batch of paper checklists for the team’s use.

This experience also taught us that it is important to normalize the activity of administering the checklist. A checklist meeting is simply a routine activity to avoid making ethical or legal errors. Excluding treatment from the checklist meeting preserves the team’s relationship with the SDM and supports an empathic connection. In this case, as in the following narrative, the previous wishes and beliefs questions demonstrate an empathic interest in the incapable person to the SDMs and can awaken their own empathic understanding of the person they are responsible for, as a decision maker.

Within a few days of the meeting, the husband’s approach to his wife’s predicament completely changed. He cried at the bedside and called his family members to see her with him. A few days later when she deteriorated with a hemorrhage he did not request “aggressive” treatment and accepted the physician’s recommendation to increase palliative care therapy.

Case 5 and 6: Cutting through perceived cultural barriers in the consent pathway

At an educational meeting of the Department of Critical Care Medicine, a representative of the provincial organ and tissue donation program spoke of her perplexity with a low rate of participation from eligible families in the ICU. She speculated that the lack of participation was due to a cultural or religious belief system, which she presumed was prevalent within the diverse community our hospital serves. There were murmurs of agreement. We suggested that the barrier might not exist as a result of culture, but rather from an inability to effectively address personal wishes, values and beliefs within the diverse cultural context. To show this we recalled the following two checklist meetings.

Case 5. An elderly woman who was a devout Muslim had severe prosthetic aortic valvular stenosis and suffered a cardiac arrest at home. Return of circulation was achieved after prolonged field and in-hospital resuscitation. On the second day, when the hypothermia protocol ended, her pupillary light reflexes were absent and she had no motor response to pain stimuli. We met with her family to perform the ChELO checklist. When we asked about her previously expressed wishes, we learned that she had spoken about critical illnesses before with the family. For her grandfather, who had suffered a stroke, she had reflected that care be continued to the end of life for religious reasons. Asking what she might have meant, the family said she felt there was potential for recovery in that situation. The other family member she spoke about was an uncle with a chronic medical illness who required intensive care when he went into shock. Here she said it would not be good to continue treatment for a long time because the overall situation and prospects for recovery were not as good. When exploring her values we learned that her family was the most important thing for her. We asked how she would view an outcome in which she could not interact with them, and the children told us she would probably not want to be kept alive. When we asked how she practised her religion, they told us that she was very faithful and prayed at the prescribed times, as well as observing all the other practices. When we asked about how her religion might influence her views about treatment, if she were unable to communicate or interact with them, they answered that they did not know.

Case 6. A middle-aged man described by his family as a devout Muslim presented to the hospital with congestive heart failure in association with severe ischemic cardiomyopathy. In the course of his treatment he developed pulmonary edema and renal failure and was transferred to the ICU for mechanical ventilation and dialysis. We performed a ChELO checklist on the third day in the ICU. When asking about his reaction to the time he had spent in the cardiac surgery ICU, the family told us that he did not like being there and he often felt isolated and lonely. When we explored his values and beliefs, they told us that he is almost too concerned with them and seemed to live just for them. With regard to how he would feel about not being able to interact with them, they told us that life would be terrible for him and not worth living. With regard to how religion might influence his preferences for treatment they told us he prayed five times a day. When we asked them whether his religious perspective would dictate what he would want in the event that he had a stroke they told us that there was nothing specific in that regard.

As these narratives demonstrate, the ChELO checklist can deconstruct a perceived barrier to end-of-life decision making. Rather than relying on assumptions of what religion or culture might bring to a dialogue about end-of-life care, we were able to go directly to what was important for the individuals for whom we were caring.

Conclusion

We conducted a pilot project to introduce the ChELO checklist into our ICU’s practice culture by applying a strategy that used positive deviance to effect the change. ChELO –U, the mean completion of the checklist items per patient as a measure, was low on baseline assessment and showed a statistically significant increase on day 79, two weeks after active change management was concluded. ChELO –B, the distribution of information bundles within the checklist also showed an increasing trend, which might have approached statistical significance, even after we had completed our change intervention. We increased the number of participating practitioners in our interdisciplinary critical care team during the intervention. We are confident these results indicate (a) that introducing the ChELO checklist is feasible, (b) that it can increase the number of fulfilled legal and ethical obligations, and (c) that interdisciplinary participation in preventing ethical and legal errors on the consent pathway can be
achieved. By excluding discussion of treatment from a scheduled ChELO checklist meeting, we found that its values-based questions demonstrate the team's interest in the incapable patient, as a person, and can strengthen the team's relationship with SDMs.

Although we achieved a statistically significant increase in checklist completion, measured by ChELO –U, we believe our results are not as good as they might have been. In this pilot implementation project we trained 87 ChELO champions during the intervention phase, but we may not have reached enough of the team to create enough positive deviance “zeitgeist” to inspire team members who had not yet adopted the checklist in their own clinical practices. We also discovered that we had underestimated the level of communication skill required to administer the checklist. Therefore, we redesigned a fully scripted checklist to increase the reliability and useful output of a ChELO checklist meeting. Our post-intervention walk-through of the quality improvement project also identified a barrier to participation of nurses in the checklist activity: lack of a documentation platform in the hospital electronic medical record. To address this we began a conversation with our information services with a goal of creating a common charting platform that can be populated and accessed by physicians and nurses throughout the hospital.

Our choice of metric was a process measure (ChELO score), rather than an outcome measure such as errors per patient day or length of stay. The nature of an interaction between the prevalence of ethical errors and access to critical care resources (e.g., through a hypothetical effect on length of stay) is a question of importance for the health care system to be assessed in future studies. However, while improved communication may reduce the prevalence of ethical error, it may not independently affect length of stay (Black et al., 2013). We hypothesize that the median prevalence of ethical and legal errors per patient bed day is greater than one. The effect of a 10–15 minute ChELO checklist meeting on the interdisciplinary team’s moral distress cannot be overstated. Our chosen metric could not convey this to the team, although the increase in fulfilled ethical and legal obligations we achieved almost certainly reduced errors. The consequences of such errors could be more effectively assessed by outcome measures such as burnout scores in caregivers, or symptoms of post-traumatic stress disorder in family members. Measuring and reporting such outcomes in future investigations might create conditions for increased adoption of the new behaviour.

Nursing implications
Implementing the ChELO checklist in our ICU had many positive implications for critical care nurses. This concrete action gave the nurses a way to fulfill their professional roles as patient advocates in end-of-life care, when many patients and families are at their most vulnerable. Nurses’ experience of the consent pathway before the project was that patients and families needed better support in the decision-making process that leads to a plan of treatment. Specific tools to explore and communicate an incapable patient’s previously expressed wishes, values and beliefs increased nurses’ capacity to meet this need. The ChELO checklist brings nurses into full participation in the consent pathway. In doing so, it strengthens nurses’ relationships with patients, families and intensive care physicians. Bringing nurses into the process initially met with some barriers. First the determination of incapacity, as a starting point for a nurse-led checklist interview, was a problem. The nurses overcame this by training the early adopters to ask for a physician’s assessment of incapacity before initiating a nurse-lead checklist interview. While literature shows that families may be more satisfied when interviews are held in a private meeting room (Heyland et al., 2002; Pochard et al., 2001), many nurses were uncomfortable leaving the patient to perform the checklist. Working closely with the nurses, we found that support from the core group of trainers alleviated the perception of having too many questions to ask and made them more comfortable to be away for a short time. We also restructured our daily work rounds “must ask” list to incorporate the values information bundle item, so that it could be completed independently and in advance of the ChELO checklist meeting. Training needs of nurses who wish to adopt the ChELO checklist can be met with a low-fidelity simulation activity. We developed two standardized patient interview scenarios to allow nurses to develop familiarity with asking the questions and to cope with anticipated challenges. Intensive care nurses at higher risk of burnout are those who are closest to patients and families in their day-to-day clinical activity (Poncet et al., 2007). Our future research will explore how the ChELO checklist may mitigate the risk of burnout in critical care nurses.

About the authors
Andrew B. Cooper, MD, MHSC, Attending Physician, Department of Critical Care Medicine, William Osler Health System, and University of Toronto, Faculty of Medicine, Department of Anesthesia

Paula Chidwick, PhD, Director, Clinical and Corporate Ethics, William Osler Health System

Pamela Cybulski, BA, RN, CNCC(C), Educator, Department of Nursing, William Osler Health System

Robert Sibbald, MSc, Clinical Ethicist, London Health Sciences Centre, London ON

Address for correspondence: Andrew B. Cooper, MD, William Osler Health System, Brampton Civic Hospital, Department of Anesthesia & Critical Care Medicine, S2-508, 2100 Bovaird Drive E, Brampton, ON L6R 3J7

Email: andrew.cooper@williamoslerhs.ca

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Approach to unplanned extubations in a pediatric intensive care unit

By Kusum Menon, MD, MSc, Belinda Dundon, EC, MN, RN, Betty-Lou Twolan, RRT, and Salman AlShammari, MD

Abstract
An unplanned extubation is defined as an extubation that occurs at a time other than that planned for the procedure. It may result in life-threatening complications such as laryngospasm, pulmonary or cardiac failure. Quality improvement initiatives have targeted an unplanned extubation rate of 0% in pediatric intensive care units.

Objective: To determine if a targeted approach specific to local practices and unit culture could decrease the incidence of and, ultimately, eliminate unplanned extubations in our tertiary care PICU.

Method: This study used a mixed methods design involving three phases. Phase 1 involved the retrospective collection of data on all unplanned extubations from September 2011 to August 2013. Phase 2 involved development of a quality improvement program and Phase 3 involved prospective collection of data on all unplanned extubations from January to August 2014.

Results: There were 12 unplanned extubations in Phase 1 resulting in a rate of 0.9 per 100 patient ventilator days. The majority of unplanned extubations occurred in children less than one year of age (66.6%, 8/12), and during the nightshift (91.7%). In addition, 25% of events occurred during chest radiographs. Forty-one per cent of patients who had an unplanned extubation required re-intubation and one of the seven children who remained extubated required non-invasive airway support. Staff concerns included inadequate sedation, loose endotracheal tubes and frequent manipulation of endotracheal tubes. Following Phase 2 and a more comprehensive tracking method, we recorded 10 unplanned extubations with a rate of 0.9 per 100 patient ventilator days, but there were no unplanned extubations in patients less than a month of age or during chest radiographs and only four unplanned extubations occurred during the nightshift (40%).

Conclusion: Our initiatives were successful in decreasing the unplanned extubations associated with certain high-risk factors in our unit, but not in decreasing our overall unplanned extubation rate. We have identified several issues to target for our next round of audit and feedback. While it is important to learn from studies that show a decrease in unplanned extubation rates, we think that it is equally important to understand why others do not achieve their desired goals, as these studies may provide support and ideas for other units struggling with the same issues.

Key words: unplanned extubation, quality assurance, pediatric critical care, pediatric intensive care


Background
An unplanned extubation may be defined as the displacement of an endotracheal tube that occurs at a time other than the time chosen for this procedure. Unplanned extubations are potentially life-threatening events and have been associated with laryngeal and tracheal injury or spasm, pulmonary or cardiac failure, increased length of mechanical ventilation and increased pediatric intensive care unit (PICU) length of stay (Klugman et al., 2013; Kurachek et al., 2003).

Therefore, understanding the factors that lead to unplanned extubations and implementing programs to decrease the frequency of these events are of utmost importance.

To date, there have only been a few studies that have specifically focused on unplanned extubations in the PICU environment. These studies have primarily assessed the incidence of unplanned extubations (Frank & Lewis, 1997; Orlowski, Ellis, Amin, & Crumrine, 1980; Rivera & Tibballs, 1992), the factors contributing to these unplanned events (Scott, Eigen, Moye, Georgitis, & Laughlin, 1985) or have focused on quality improvement initiatives related to one specific risk factor for unplanned extubations (Marcin et al., 2005; Rachman, Watson, Woods, & Mink, 2009; Ream et al., 2007). Only one study developed and assessed a comprehensive quality improvement program based on unit-specific risk factors (Sadowski et al., 2004) and showed a subsequent decrease in the rate of unplanned extubations. However, the applicability of their approach to other units is, as yet, unknown and unplanned extubations still remain a significant problem in PICUs (da Silva, Reis, Aguilar, & Fonseca, 2013; Klugman et al., 2013; Rachman & Mink, 2013).

Recent patient safety initiatives have targeted an unplanned extubation rate of 0% as the goal for intensive care units. Therefore we decided to convene a multidisciplinary team to determine whether or not we were meeting this goal and, if not, to try and determine the reasons why. The objective of this project was to determine if a targeted approach specific to local practices and unit culture could decrease the incidence of and, ultimately, eliminate unplanned extubations in our tertiary care PICU.

Methods
We conducted a retrospective chart review from September 2011 and August 2013, developed and implemented a targeted quality improvement program (QIP) from September to November 2014 and prospectively collected data on unplanned extubations from December 2013 to August 2014 to determine the effectiveness of our QIP. This study was conducted at the Children’s Hospital of Eastern Ontario (CHEO), which is an academic tertiary care PICU with ~600 medical and surgical admissions per year. The unit provides a 1:1 nurse to patient ratio for all intubated patients. 
Phase 1: Data collection
A multidisciplinary research team consisting of a PICU advanced practice nurse (APN), a registered respiratory therapy practice leader (RRT-PL), a staff intensivist and a pediatric intensive care fellow was set up to spearhead this project. Our team identified patients who had experienced an unplanned extubation from September 2011 to August 2013 using the hospital safety reporting system (SRS). A tracking tool was developed to allow comprehensive data collection, as the SRS was not thought to provide enough detail to fully understand the circumstances surrounding the unplanned extubations. Individual patient charts were obtained from medical records to collect the data needed.

Descriptive statistics were to be used to summarize the study sample. We examined the qualitative text inputted by staff to determine themes that emerged surrounding the unplanned extubations. We noticed that a significant number of variables were not available from our retrospective review and, therefore, revised the unplanned extubation tracking tool to include these fields for future events. The unplanned extubation rate was calculated as the number of unplanned extubations divided by the number of patient ventilator days in the same time period and reported as number of unplanned extubations per 100 patient ventilator days (Little, Koenig, & Newth, 1990). The univariate associations between the unplanned extubation rate and the number of admissions and number of patient ventilator days were tested using Pearson correlation tests.

Phase 2: Development and implementation of quality improvement program
Phase 2 involved four specific steps: (a) dissemination of the results of Phase 1 to staff, (b) consultation with staff, (c) development of the quality improvement program, and (d) implementation of the program.

We disseminated the information obtained from Phase 1 via three methods. An email was sent out to all critical care staff (RNs, RTs and intensivists) regarding the modifiable and non-modifiable risk factors observed in our PICU. Next we posted the results on information boards in the PICU. Third, we presented our data to the PICU Partnership Council, an inter-professional working group composed of RNs, RTs and physicians, which meets on a quarterly basis to address issues relevant to staff and patients in the PICU.

We also solicited input from the Partnership Council to determine additional themes and to determine best practices related to prevention of unplanned extubations. In addition, we discussed each unplanned extubation with at least one involved person to elicit insights and themes related to the event. Finally, we presented the results at the PICU Multi-disciplinary Research Rounds for further input.

Our QIP was developed as per the recommendations of da Silva and de Carvalho (2010) and included (a) establishment of a quality improvement team as detailed above, (b) development of appropriate data tracking tools, (c) staff education and training, (d) standardization of routines for monitoring endotracheal tubes, and (e) standardization of procedures such as tracheal tube fixation, tube suctioning and patient transport. Standardization of routines and procedures was achieved by using best practice guidelines in the literature and the consultation process described above.

To implement our QIP, we disseminated information about the program using the same methods as for the results of Phase 1. We also distributed the unplanned extubation tracking tool with an explanation of its use and the additional documentation required. Physicians, RNs and RTs were reminded of the requirement to enter all unplanned extubations into the SRS and the PICU APN and clinical nurse educator checked with staff daily to determine whether or not an unplanned extubation had occurred in the past 24 hours and to ensure that a SRS was completed.

Phase 3: Audit and feedback on quality improvement program
The final phase of our QIP was to collect data on all unplanned extubations following its implementation, to provide feedback directly to personnel involved and all PICU staff and to assess the effectiveness of our program after nine months.

Results
Phase 1
Patient demographics. There were a total of 1,142 admissions between September 2011 and August 2013 and 1,309 patient ventilator days. During this time 12 unplanned extubations were reported through the hospital safety reporting system (SRS) with a resulting unplanned extubation rate of 0.9 per 100 ventilator days.

Incidence of risk factors identified in the literature. The summary of the risk factors is shown in Table 1. There were four unplanned extubations in children less than one month (33.3%, 4/12) and in patients with oral endotracheal tubes (91.7%, 11/12). Staff was documented to be at the bedside in 50.0% of cases (6/12) and inadequate sedation was documented in one case. A significant majority of unplanned extubations occurred during the nighttime (91.7%) and a quarter of the extubations occurred during a chest radiograph (3/12). No comment could be made on the status of the endotracheal tubes tapes due to lack of documentation.

Patient outcomes. Forty-one percent of patients who had an unplanned extubation required re-intubation and one of seven children who remained extubated required non-invasive airway support. In 5/12 children (41.2%), discussions surrounding a planned extubation had occurred in the 24 hours prior to the event and all of these children remained extubated (100%). Of the remaining seven patients in whom an extubation was not already planned, five experienced an unplanned extubation during a bedside intervention and four patients required re-intubation (80.0%).

Staff’s written comments and concerns about unplanned extubations. Documentation was limited during this time period, but some nurses recorded concerns about loose endotracheal tube tapes, inadequately sedated patients and patients suddenly moving their heads. Nurses also frequently commented on frequent manipulations of endotracheal tubes.

Phase 2
Dissemination of results to staff. We shared the following information with staff: children under the age of one appeared to be at higher risk of unplanned extubations, these events seemed to be more prevalent at night, and patients for whom...
extubation was already planned seemed to be at greater risk of premature extubation. It was also communicated that though the majority of these patients did not require reintubation, the premature extubations were still associated with increased risk of harm to the patient.

**Staff consultation regarding unplanned extubations.** Staff reported concerns with endotracheal securement and sedation including, “tapes became loose with vomiting”, “tapes reinforced in the last 24 hours” and “patient suddenly awake”. Staff reported an increasing frequency of endotracheal tube manipulation (advancing 1 cm followed by pulling back 1 cm, etc.) after the morning x-ray. The overall themes that emerged from staff are summarized in Table 2.

**Quality improvement program.** Discussions began on standardizing the morning x-ray routine. Best practice guidelines were communicated to staff including using a two-person technique while lifting patients and having the RT verify endotracheal tube placement following the morning x-ray. In addition, a ‘High Alert’ sign was placed at the head of the bed of patients less than one year of age to remind staff of the increased risk of unplanned extubation in these patients.

**Phase 3**

**Patient demographics.** Following Phase 2, there were 10 unplanned extubations over 1,060 ventilator days leading to an overall rate of 0.9 unplanned extubations per 100 ventilator days over the nine month follow-up period (see Figure 1). Data on these unplanned extubations were collected using the refined tracking tool for all unplanned extubations.

**Incidence of risk factors identified in the literature.** A summary of findings is shown in Table 1. There were no unplanned extubations in patients less than a month of age. The nurse was at

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**Table 1: Data on unplanned extubations over the study period**

<table>
<thead>
<tr>
<th>Age: n (%)</th>
<th>Baseline data (N = 12)</th>
<th>After phase 2 (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 month</td>
<td>4 (33.3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>1 – 4 months</td>
<td>2 (16.7)</td>
<td>4 (40.0)</td>
</tr>
<tr>
<td>4.1 – 12 months</td>
<td>2 (16.7)</td>
<td>1 (10.0)</td>
</tr>
<tr>
<td>12.1 months – 3 years</td>
<td>2 (16.7)</td>
<td>2 (20.0)</td>
</tr>
<tr>
<td>&gt; 3 years</td>
<td>2 (16.7)</td>
<td>3 (30.0)</td>
</tr>
</tbody>
</table>

**Diagnostic category: n (%)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Baseline data (N = 12)</th>
<th>After phase 2 (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac surgery</td>
<td>3 (25.0)</td>
<td>4 (40.0)</td>
</tr>
<tr>
<td>Ear, nose and throat surgery</td>
<td>4 (33.3)</td>
<td>1 (10.0)</td>
</tr>
<tr>
<td>Other surgery</td>
<td>1 (8.3)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Medical</td>
<td>4 (33.3)</td>
<td>5 (50.0)</td>
</tr>
</tbody>
</table>

**Interventions: n (%)**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Baseline data (N = 12)</th>
<th>After phase 2 (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest radiograph</td>
<td>3 (25.0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Endotracheal tube manipulations</td>
<td>2 (16.7)</td>
<td>2 (20.0)</td>
</tr>
<tr>
<td>Patient care</td>
<td>2 (16.7)</td>
<td>4 (40.0)</td>
</tr>
<tr>
<td>Device removal</td>
<td>0 (0)</td>
<td>1 (10.0)</td>
</tr>
</tbody>
</table>

**Potential risk factors: n (%)**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Baseline data (N = 12)</th>
<th>After phase 2 (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral endotracheal tube</td>
<td>11 (91.7)</td>
<td>8 (80.0)</td>
</tr>
<tr>
<td>Night shift</td>
<td>11 (91.7)</td>
<td>4 (40.0)</td>
</tr>
<tr>
<td>Caregiver not in room</td>
<td>N/A*</td>
<td>3 (30.0)</td>
</tr>
<tr>
<td>Plan for extubation in next 12 hours</td>
<td>5 (41.2)</td>
<td>4 (40.0)</td>
</tr>
<tr>
<td>Received sedation in prior 2 hours</td>
<td>3 (25.0)</td>
<td>8 (80.0)</td>
</tr>
</tbody>
</table>

**Consequences of extubation: n (%)**

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Baseline data (N = 12)</th>
<th>After phase 2 (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-intubation</td>
<td>5 (41.2)</td>
<td>3 (30.0)</td>
</tr>
<tr>
<td>Non-invasive ventilation</td>
<td>1 (8.3)</td>
<td>5 (50.0)</td>
</tr>
</tbody>
</table>

*Information not documented in 6 patients

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**Table 2: Common themes from RN and RTs around unplanned extubation events (N=22)**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient vomited</td>
<td>2 (9.0)</td>
</tr>
<tr>
<td>Patient coughed/wretched</td>
<td>4 (18.2)</td>
</tr>
<tr>
<td>Patient suddenly awake</td>
<td>8 (36.3)</td>
</tr>
<tr>
<td>Patient inadequately sedated at baseline</td>
<td>1 (4.5)</td>
</tr>
</tbody>
</table>

*More than one theme may apply to some patients.

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**Figure 1: Unplanned extubation rate over time**

**Figure 2. Relationship between Unplanned Extubation Rate and Business of Unit**
the bedside for seven of the unplanned extubations and in four cases the patient was described as having woken up suddenly. Four unplanned extubations occurred during the nightshift (40%). There was no relationship between the unplanned extubation rate and number of admissions (Pearson's coefficient = -0.17, P = 0.78) or number of patient ventilator days (Pearson's coefficient = -0.11, P = 0.78) (see Figure 2).

**Patient outcomes.** Three children needed to be re-intubated and five of the remaining seven patients needed non-invasive airway support. Of the four children in whom discussions surrounding a planned extubation had occurred in the previous 24 hours, only one patient required re-intubation.

**Discussion**

The objectives of our project were to first determine the rate of unplanned extubations in our unit and to identify the risk factors that were relevant to our PICU. Once we had this baseline data, our next objective was to develop a targeted approach to decrease the frequency of these events and, ultimately, eliminate them.

There were several limitations to our initial method of data collection. The hospital SRS system depended on the health care team filling out a report following an unplanned extubation. The SRS was a voluntary new system and it is, therefore, highly likely that these events were under-reported and our true unplanned extubation rate was much higher. Following Phase 2, staff was asked to complete our tracking tool and file an incident report for all unplanned extubations. Staff compliance with these measures was verified by checking with the resident each morning and was found to be 100%. There was also an improvement in data collection accuracy, as well as an increase in staff commitment towards tracking unplanned extubations pre and post Phase 2.

Using the hospital SRS system, we found the rate of unplanned extubations from September 2011 to August 2013 to be 0.9 events per 100 patient ventilator days. Following Phase 1 and using our new comprehensive tracking tool, we found our rate also to be 0.9 events per 100 patient ventilator days. This rate falls well within the range reported in the literature of 0.2 to 1.2 (da Silva, de Aguia, Neto, & de Carvalho, 2008; Marcin et al., 2005; Popernack, Thomas, & Lucking, 2004; Ream et al., 2007; Sadowski et al., 2004). Given the limitations of the data collection in Phase 1 compared to the comprehensive data collection following Phase 2 it is impossible to draw conclusions regarding the actual trend in the rate of unplanned extubations pre and post Phase 2.

Many risk factors for unplanned extubations have been reported in the literature and include younger patient age (da Silva et al., 2008), inadequate sedation (Marcin et al., 2005), inadequate endotracheal tube fixation (Piva et al., 1995; Sadowski et al., 2004), and weaning from mechanical ventilation. In our PICU in Phase 1, we identified younger children, patient interventions, the night shift and patient weaning from mechanical ventilation as risk factors for unplanned extubations. Therefore in Phase 2 we focused on greater vigilance for endotracheal tube manipulations and chest radiographs and having someone at the bedside for patients being weaned for extubation. Following Phase 2, there were no unplanned extubations in patients less than one month of age or in patients having chest radiographs. However, there were still unplanned extubations in patients being weaned from mechanical ventilation and although all intubated patients had 1:1 nursing ratios, at least four events occurred while the nurse was outside of the room. These latter findings highlight the need to understand reasons why nurses may be pulled away from the bedside in order to address safety concerns around unplanned extubation.

Our overall re-intubation rate was 36.4%, which falls well within the range of 14% to 65% reported in the literature (da Silva et al., 2008). Children who were being actively weaned from mechanical ventilation at the time of the unplanned extubation were at higher risk of a premature extubation but experienced a lower re-intubation rate of 11.1% (1/9) suggesting that the majority of these patients might have been able to be extubated earlier. Interestingly, five out of these nine premature extubations occurred overnight or first thing in the morning before rounds. This raises the possibility of whether the team or the resident may have been waiting till rounds or till more people were available prior to extubation.

Individual strategies for preventing unplanned extubations in the literature have included use of restraints, methods of endotracheal tube fixation, and provision of adequate sedation. Our unit does not allow regular use of physical restraints, which is supported by Marcin et al. (2005) who found no association between unplanned extubations and use of physical restraints. It is too early to tell if our implementation of a formal approach to assessing and re-taping endotracheal tubes (da Silva et al., 2008; Frank & Lewis, 1997; Little et al., 1990; Ream et al., 2007) has resulted in a decrease in unplanned extubations from deficient endotracheal tubes, but there has been an anecdotal decrease in the number of nursing concerns raised regarding endotracheal tube fixation. Our unit has had a sedation algorithm in place for several years and had only one unplanned extubation documented as being related to inadequate sedation. We are not able to comment on actual level of sedation as measured by the Modified Comfort Score at the time of the unplanned extubation, as this was not recorded in most instances. Interestingly, in a third of unplanned extubations, the patient was felt to have been adequately sedated at baseline, but woke up suddenly. The approach to such patients going forward remains unclear, as it would not be appropriate to over-sedate them to prevent the possibility of them suddenly awakening.

Da Silva and de Carvalho (2010) developed recommendations based on the premise that a care bundle would result in a greater improvement in care than approaching each risk factor individually. Their recommendations included (a) nurse to patient ratio of 1:1, (b) a continuous quality improvement team, (c) development of appropriate data tracking tools and data collection, (d) staff education and training, (e) standardization of routines for monitoring endotracheal tubes and, (f) standardization of endotracheal tube related procedures. We essentially followed these recommendations as part of phase...
2, but have not, as yet, noticed an improvement in unplanned extubation rates over the nine-month period they have been in place, thus re-enforcing the challenges inherent in quality improvement programs.

Our study demonstrated an improvement in our ability to track unplanned extubations and an increase in staff awareness of this issue. We were also able to identify several potential risk factors for unplanned extubation that were specific to our PICU environment. We have been successful in decreasing the unplanned extubation rates in our younger patients (0% versus 33%, P = 0.044), as well as during the night shift (91.7% versus 40%, P = 0.009), but have not, as yet, been able to decrease our overall unplanned extubation rate. The next phase of our program is to launch a more intensive educational initiative, as well as to establish further requirements for assessing and monitoring of endotracheal tubes in our PICU. While it is important to learn from studies that show a decrease in unplanned extubation rates, we feel that it is equally important to understand why others do not achieve their desired goals, as these studies may provide support and ideas for other units struggling with the same issues.

REFERENCES


About the authors
Kusum Menon, MD, MSc, Pediatric Intensive Care Physician, Department Pediatrics, University of Ottawa, Children’s Hospital of Eastern Ontario Research Institute, Ottawa
Belinda Dundon, EC, MN, RN, PICU Nurse Educator, Children’s Hospital of Eastern Ontario, Ottawa
Betty-Lou Twolan, RRT, Respiratory Therapy Clinical Practice Leader, Children’s Hospital of Eastern Ontario, Ottawa
Salman AlShammari, MD, Pediatric Intensive Care Fellow. Department Pediatrics, University of Ottawa, Children’s Hospital of Eastern Ontario, Ottawa
This study was conducted at the Children’s Hospital of Eastern Ontario

Address for correspondence: Kusum Menon, MD, MSc, Children’s Hospital of Eastern Ontario, 401 Smyth Road, Ottawa, ON K1S 3H2
Tel: 613-737-7600 ext 2538
Email: menon@cheo.on.ca

About the authors
Kusum Menon, MD, MSc, Pediatric Intensive Care Physician, Department Pediatrics, University of Ottawa, Children’s Hospital of Eastern Ontario Research Institute, Ottawa
Belinda Dundon, EC, MN, RN, PICU Nurse Educator, Children’s Hospital of Eastern Ontario, Ottawa
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Address for correspondence: Kusum Menon, MD, MSc, Children’s Hospital of Eastern Ontario, 401 Smyth Road, Ottawa, ON K1S 3H2
Tel: 613-737-7600 ext 2538
Email: menon@cheo.on.ca
BOD Nominations 2016–2018

A Call for Nominations for National Board of Director positions commenced in February 2015. The deadline for nominations was July 5, 2015.

The following members have been nominated for election to the National Board of Directors for a two-year term from April 1, 2016, to March 31, 2018:

**Eastern**: Angela Foote, Mélanie Gauthier and Karen Webb-Anderson

**Central**: Shirley Marr and Rob Mazur

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**CACCN Board of Director Nominees—Central Region**

**Shirley Marr, MHScN, MEd, RN**

William Osler Health System
Mississauga, ON

Nominated by: Pamela Cybulski

I started work in ICU/CCU in 1991 at Wellesley Hospital in Toronto and, in 2003, moved into the educator role. I have worked at William Osler since 2011. I immigrated to Canada in 1989 with a diploma in nursing and have since gained a nursing degree and two masters—one in health education and one in health science in nursing. I have been CNCC certified for 15 years and have certificates in gerontology and critical care from Ryerson University. I attended my first Dynamics conference in 1992. This conference was an important milestone in my journey in critical care.

I want to join the board of Director of CACCN as I am passionate about excellence in critical care nursing, and CACCN is an important vehicle to achieving this goal. Some of the issues I believe we are starting to face in nursing are the aging population, doing more with less, and staff recruitment and retention. Working with CACCN I believe we must liaise with the different provincial and federal agencies to ensure that these issues are understood by all.

I have been fortunate in my nursing career to have worked with some excellent nurses who have mentored me. As an educator in critical care I hope I am able to provide the same support and mentorship to others. My nominator, Pam Cybulski, has been, over many years, one of these mentors and her journey with CACCN has inspired me to seek this role.

---

**Robert Mazur, BN, RN, CNCC(C)**

Winnipeg Regional Health Authority
Winnipeg, MB

Nominated by Paula Price

I am a registered nurse in Winnipeg, MB.

I graduated in 1999 with a BN from the University of Manitoba. Since 1999 I have worked in psychiatry and medicine in Northern MB nursing stations, Aeromedical Transport and, most recently, in ABI/stroke. I became a flight nurse with Keewatin Air/Nunavut Lifeline in 2004.

After five years of transporting Nunavut patients who, at times, were critically ill, I successfully completed the Winnipeg Critical Care Nurses Education Program (WCCNEP) in 2009. After completing the WCCNEP I worked in ICUs at HSC and the Victoria Hospital in Winnipeg.

With the completion of the WCCNEP and my Aeromedical experience I was offered the position of CRN/Nurse Manager at Keewatin Air. My position at Keewatin Air expanded my leadership skills, it involved logistical/medical on-call, educating flight nurses, and it has allowed me to move into a management position within the Winnipeg Regional Health Authority (WRHA).

I joined CACCN to help prepare me for the CNA CNCC(C) certification exam, which I successfully wrote in the spring of 2013. I feel my experience in caring for critical care patients in ICUs, nursing stations and in aircraft will benefit the CACCN because these environments require critical thinking, and an ability to think ‘outside the box’. These qualities, I feel, would greatly benefit in helping shape new approaches to the management of critically ill patients.

I was elected to the CACCN Board of Directors in 2014 for a two-year term. I am seeking re-election for the 2016–2018 term. It is my hope that my continued participation, as a member of the Board, will benefit critical care nurses and their patients across the country.

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**CACCN Board of Director Nominees—Eastern Region**

**Angela Foote, BSc, RN, CCNP(C)**

Pictou County Health Authority
New Glasgow, NS

Nominated by Kathy Ross

I am honoured to have been nominated for a seat on the Board of Directors for the Eastern Region.

I began my journey in critical care eight years ago. The complexity of patients who are critically ill and the critical thinking this entails both challenges and makes me excel in my practice.

My passion for education and always wanting to stay current with the best practices in critical care have led me to numerous education days, Dynamics conferences and teleconferences, always bringing this back to my peers.
After four years working in ICU, I was approached with an opportunity to advance in a clinical leadership education role. This led me to become the cardiac rehabilitation program coordinator. As an intensive care nurse, this position provided additional insight into the importance of primary prevention and facilitation of safe physical exercise programs for persons with MI, CABG, stroke and COPD. My experiences with this program have been invaluable.

Currently I have been working in the intensive care unit and I am also a sitting member of the Nova Scotia CACCN Chapter executive, holding the position of secretary. Should I be elected to the Board of Directors, being the young, passionate and energetic person I am, I would love to get more critical care nurses in rural areas affiliated with the support network CACCN offers.

I have learned the mission and vision of the CACCN and I am able to work collaboratively with other board and association members, both at our chapter and national levels. As critical care nurses, we are the true leaders in our field!

Mélanie Gauthier, M Int Care N, BScN, RN, CNCC(C)
McGill University Health Centre
Montréal, QC
Nominated by Karine Allard

My name is Mélanie Gauthier and I have been the president of the Montreal Chapter since April 2015. I was co-president from January 2013-March 2015. Since my involvement, the Montreal Chapter membership has grown from fewer than 100 members to more than 215 today.

I am currently a CNCC(C) Certified Nurse Clinician in a quaternary care ICU, where I have practised for more than six years. I hold a Bachelor of Science in Nursing from McGill University and a Master's in Intensive Care Nursing from the University of Sydney, Australia.

For the past two years I have been a clinical instructor and course coordinator/instructor for McGill University Bachelor of Nursing students. I am actively involved in several professional development initiatives at my workplace, such as co-chair of the orientation committee, active preceptor and mentor to new nurses, and member of the ICU skin care team.

As a younger nurse, I can provide a voice to the newest generation of nurses and help bridge the gap between care and compassion by empowering and inspiring them to take an active role in their own development and that of the nursing profession. Sustainability and executive recruitment have been long-standing challenges of the CACCN and I would love to take the opportunity to help the Eastern Region and all CACCN Chapters grow by advocating for their unique needs and foster a stronger link between the chapters and the CACCN National Office. I appreciate your consideration and look forward to the collaboration.

Karen Webb-Anderson, MN, RN, CCN(C)
Nova Scotia Health Authority
Beaver Bank, NS
Nominated by Pamela Hughes

Nursing has offered me a multitude of opportunities. Combining the experiences nursing has provided with my lifelong commitment to learning, I am committed to giving back to my profession.

As a bedside nurse, I have worked in critical care, cardiology and air medical transport. I have experience in clinical teaching and research, and in coordinating the Accreditation process for our healthcare district.

In 2014, I took on a new role as a Critical Care Quality Leader. My passion is to use my experience and education to support patient care by fostering a positive workplace, helping to build capacity by respecting the knowledge, abilities and intent of those delivering care.

I believe one of the keys to health care reform is to support care providers. I commit to demonstrating this respect for frontline care providers through my actions. I have demonstrated this belief in my academic work, exploring the experience of night shift fatigue and the use of workplace napping to mitigate the risk, and I currently co-lead an initiative to develop an organizational fatigue management strategy. I also strive to demonstrate this belief daily as a critical care nurse and quality leader. As a member of the CACCN Board of Directors, I will bring this deep respect and regard for frontline care to the role.
Membership Recruitment

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

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

www.caccn.ca

ADVERTISING OPPORTUNITIES

CACCN Dynamic Career Connections
CACCN is offering the opportunity to post individual employment opportunities on the CACCN website. If you are interested in taking advantage of this advertising opportunity, please visit CACCN Advertising Opportunities on the CACCN website at www.caccn.ca for rates and information.

JobLINKS on www.caccn.ca
JobLINKS is a simplified web link page on the CACCN website designed to provide immediate links to critical care nursing career opportunities in Canada and around the world. If your facility is interested in taking advantage of this service, please visit www.caccn.ca.

Reach your audience directly on our website
CACCN is pleased to announce a new opportunity for you—the chance to advertise your company’s products and services directly on the CACCN website.

Together with our publishing partner, MultiView, we are bringing you closer to your audience and connecting your business with the buyers you need.

If you have any questions or are interested in learning more about how to feature your company on the CACCN website, please call Jon Smith, Display Advertising Manager, at 972-402-7023. For more information about this opportunity, please request a media kit via jsmith@multiview.com.
The Draeger Medical Canada Inc. “Chapter of the Year” Award

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

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

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

Award funds available: $500.00
Recognition plaque
Submission deadline: May 31 annually
Application process: Mandatory submission for all Chapters

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

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

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Member education</td>
</tr>
<tr>
<td>2</td>
<td>Promotion of critical care specialty</td>
</tr>
<tr>
<td>3</td>
<td>New member recruitment</td>
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<tr>
<td>4</td>
<td>Sustained membership</td>
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<tr>
<td>5</td>
<td>Academic activity</td>
</tr>
<tr>
<td>6</td>
<td>Certification activity</td>
</tr>
</tbody>
</table>

Instructions:
1. Complete the Chapter Annual Report
2. Gather validation documents for each of the categories of activities in the past year
3. Calculate scores for sections 1 thru 6
4. Add section scores for total Chapter of the Year score
5. Submit the application with documentation to CACCN National Office by May 31 annually.

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

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

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

Example:
Chapter A
- Donation after Cardiac Death educational meeting – 3 hours
- Total Chapter Membership number 26
- 3 hours divided by 26 members = 0.115 multiplied by 1000 = 115
- therefore the membership education innovation score is 115
Chapter B

• Neuro education and bioethics education session offered
• Total education hours – 28 hours
• Membership number 310
• Formula: 28 hours divided by 310 members = 0.090 multiplied by 1000 = 90
• Therefore, the member membership education score is 90

Section 2: Promotion of critical care specialty

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

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

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

Total hours of events offered
Total number of chapter members x 1000 = Promotion of Critical Care Specialty

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

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

Section 3: New Member Recruitment

• Calculated based on the percentage of new members recruited up to March 31 of the award year
• Any member with a membership lapse of 12 months or more will be considered a new member
  • i.e., a membership expires April 2011 and is renewed February 2012. This member would be considered a renewal member as the renewal is within 12 months of the expiry
  • Use the Membership Recruitment/Retention spreadsheet from the CACCN national office to obtain the number of new members.

Formula:
To create the recruitment score, the total number of recruited members is divided by the total number of chapter members as of March 31 of the award year. This number is then multiplied by 100 to give you the percentage of new members. The points awarded are noted on the chart based on the percentage of new members.

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

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Points</th>
<th>Percentage</th>
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</tr>
</thead>
<tbody>
<tr>
<td>01–10%</td>
<td>10</td>
<td>51–60%</td>
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<td>11–20%</td>
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<td>31–40%</td>
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<td>81–90%</td>
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</tr>
<tr>
<td>41–50%</td>
<td>50</td>
<td>91–100%</td>
<td>100</td>
</tr>
</tbody>
</table>

Chapter A
• Total number of new members 23
• Total number of chapter members 110
• Formula: 23 new members divided by 110 members = 0.209 multiplied by 100 = 20.9 % - rounded up to 21%
• 21% corresponds with the 21-30% level on the chart. Therefore 30 points will be awarded.

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

Section 4: Sustained members

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

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

<table>
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<td>61–70%</td>
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<td>21–30%</td>
<td>15</td>
<td>71–80%</td>
<td>40</td>
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<tr>
<td>31–40%</td>
<td>20</td>
<td>81–90%</td>
<td>45</td>
</tr>
<tr>
<td>41–50%</td>
<td>25</td>
<td>91–100%</td>
<td>50</td>
</tr>
</tbody>
</table>

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

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

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

Each article = 25 points

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

Each Presentation = 25 points

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

Total points from all three areas:

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

Total points = 150

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

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

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

Percentage x 10 = certification points

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

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

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

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.

Number of members renewed
Total number of chapter members \( \times 100 = \) Percentage
5 points for each percentage of the total number of chapter members who are new certifications in the award year.

Percentage \( \times 5 = \) certification points

Example

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

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

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

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

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

The Draeger Medical Canada Inc. Chapter of the Year Award

CACCN Research Grant

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

Award funds available: $2,500.00

Deadline for submission: February 15

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

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

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

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.

The recipient of the research grant will be notified in writing.

Funds must be utilized within 12 months from the date of award notification.

Funds are to be issued to support research expenses.

The research study is to be submitted to the Canadian Journal of Critical Care Nursing for review and possible publication.

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**The Spacelabs Innovative Project Award**

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

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

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

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

Mailed applications must be postmarked on or before June 1.

**Do you have a unique idea?**

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

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

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

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**CACCN Educational Awards**

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

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

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

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

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

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

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

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

*The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.*
CACCN Recruitment and Retention Awards

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

Award funds available:
- Full Dynamics Conference Tuition Coupons
- Partial Dynamics Conference Tuition Coupons

Deadline: Fiscal year end – March 31

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

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

Coupons will be issued electronically to all chapters.

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

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

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

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

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

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

- If the chapter has **greater than 70% renewal** of its previous year’s members, the chapter will receive **two (2)** – Dynamics of Critical Care Conference partial tuition coupons

- If the chapter has **greater than 60% renewal** of its previous year’s members, the chapter will receive **one (1)** – Dynamics of Critical Care Conference partial tuition coupon.

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

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

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

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

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

BBraun Sharing Expertise Award

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

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

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

Award funds available: **$1,000.00**

Deadline for submission: **June 1**

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

Mailed applications must be postmarked on or before June 1.
Eligibility criteria

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

Nomination process

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

Selection process

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

The Brenda Morgan Leadership Excellence Award

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

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

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

Award funds available: $1,000.00 plus award trophy

Deadline for submission: June 1

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

Mailed applications must be postmarked on or before June 1.

Eligibility criteria

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

The nominee must:

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

contributes or has contributed to the Canadian Association of Critical Care Nurses at the regional and/or national levels.

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

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

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

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

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

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

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

Award Funds Available: $1,000.00  
Deadline for Submission: June 1

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

Mailed applications must be postmarked on or before June 1.

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

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

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

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

**Reference**

**The CACCN “Chasing Excellence” Award**
Revision: January 2015
Content Revision: March 2014
Logo Revision: 2012
Form Design Revision Date: January 2011
**Canadian Intensive Care Week “Spotlight” Challenge**

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

**Award funds available: $500.00 total**

**Deadline for submission: August 15**

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

Mailed applications must be postmarked on or before June 1.

**Award criteria**

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

**Award requirements**

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

**Award review**

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

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

**CACCN Life Member Award**

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

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

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

**Awards available**

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

**Deadline for submission: June 1 annually**

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

**Eligibility criteria**

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

**Exclusion criteria**

- The candidate is not a member of CACCN
- The candidate does not hold a registered nursing licence
- Self-nominations will not be accepted
- Nominations of elected officers at the national or chapter level of the CACCN will not be accepted during an active term of office.

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**Canadian Intensive Care Week “Spotlight” Challenge**

Criteria Revision: March 2014
Criteria Revision: December 2013
Approved: March 2013
Nomination procedure
The primary nominator is required to provide the following for consideration:

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

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

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

Consideration/selection

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

Terms of Reference

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

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

CACCN/Sage Products Poster Bursary

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

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

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

Deadline for submission: January 31 (annually)

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

Eligibility

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

Application process
• Applicants must submit a poster abstract online at www.caccn.ca as per the CACCN Dynamics abstract submission process by no later than 2359 ET – January 31 annually
• Applicants complete and submit the CACCN/Sage Products Poster Bursary application to CACCN National Office (caccn@caccn.ca) at the time of abstract submission or by no later than 2359 ET – January 31 annually
• The poster abstract will be blind reviewed according to CACCN’s abstract review policies
• Following review, eligible abstracts will be listed based on review scores
• The first ten (10) eligible abstracts with the highest review scores will receive a bursary of $500/each;
• Successful poster presenters will be notified via email and regular mail
• Acceptance of the Sage Products – CACCN Bursary indicates a commitment by the presenter to attend the Dynamics conference to present the poster
• A letter of acceptance must be signed by the recipient prior to the distribution of the funds
• CACCN/Sage Products Poster Bursary may only be used to offset conference expenses: registration, travel, accommodation, meals, poster preparation/printing, etc.
• CACCN/Sage Products Poster Bursary recipients will be acknowledged by CACCN and Sage Representatives at the CACCN Awards Ceremony
• Recipients are required to attend the CACCN awards ceremony and the Sage Products Exhibit Booth at the conference for photographs
• The successful applicant will forfeit the bursary if they fail to attend the Dynamics of Critical Care Conference, the CACCN Awards Ceremony and the Sage Products Booth.
Application for membership

Name: _____________________________________________________________
Address:  ___________________________________________________________
____________________________________  _____________   _____________
W (____) ____ - ________  H (____) ____ - ________  F (____) ____ - ________
Email:  _____________________________________________________________
Employer:  __________________________________________________________
Position:  ___________________________________________________________
Area of Employment:  _________________________________________________
Nursing Registration No.: _______________________ Province:  _____________
Chapter Affiliation (if known):  __________________________________________
Sponsor’s Name:  _____________________________________________________
Type of membership:
☐ New Member—one year $75.00 + taxes   ☐ New Member—two years $140.00 + taxes
☐ Renewal—one year $75.00 + taxes   ☐ Renewal—two years $140.00 + taxes
☐ Student Member—one year $50.00 + taxes

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

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

Signature: __________________________________________________________
Date:  ______________________________________________________________

This application is for both national and chapter membership.

Make cheque or money order payable to:
Canadian Association of Critical Care Nurses (CACCN)
Mail to: CACCN, P.O. Box 25322, London, ON N6C 6B1
Or fax with Visa/MasterCard number, expiry date to: 519-649-1458
Telephone: 519-649-5284; Fax: 519-649-1458; Toll-free: 1-866-477-9077
email: caccn@caccn.ca; website: www.caccn.ca
Visa/MasterCard: _________________________________ Expiry: _______________

Automatic renewal

CACCN has implemented an “Automatic Renewal” feature. Under the auto renewal, if
you provided a credit card number, your membership will automatically renew on your
next membership expiry date, so you will no longer have to worry about remembering to
renew! Depending on the month and type of membership selected (one or two years) when
your membership application is completed, one or two years later, CACCN will charge
your credit card for membership dues based on your membership at the time of renewal.
Following automatic renewal, CACCN will mail your membership card/receipt. You will
no longer have to worry about a thing, as your member benefits will continue without
interruption! For FAQs on Automatic Renewal, visit www.caccn.ca/JOINUS
Information for Authors

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

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

Manuscripts submitted for publication must follow the following format:

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

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

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

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

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

*Revised November 2011*
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BC's Top Employers 2015
61% of hospital-acquired pneumonia happens to non-ventilated patients.

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Continue your prevention success outside the ICU. Non-ventilator hospital-acquired pneumonia (NV-HAP) has the potential to affect more patients, be more costly, and be as lethal as ventilator-associated pneumonia (VAP).

For more information, or to schedule a FREE pneumonia prevention Lunch & Learn at your facility call 800.323.2220