Manitoba Chapter

CACCN Manitoba Chapter Newsletter

Spring 2012

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Greetings from the Manitoba Chapter CACCN Executive

Hello everyone and welcome to all new and returning members. It's hard to believe that Spring is just around the corner. The Manitoba Chapter Executive has had a busy and productive year.

In June 2011, the Executive met to formulate a plan for the upcoming year. We developed a list of goals and objectives focusing on the continued retention and recruitment of the Chapter as well as providing the critical care nursing profession with support for further knowledge acquisition and advancement of the science of critical care nursing. We look forward to hearing from membership about education needs and what the chapter can do to meet your expectations.

Education events continue to be offered. Watch for education sessions to come in the Spring and Fall of this year.

The annual Manitoba Chapter, CACCN Critical Care Conference, "Edge of Excellence 2012" was held on February 27, 2012 at the Norwood Hotel. Attendees had opportunity to mingle with fellow critical care nurses while enjoying a variety of topics and tasty food.

The day began with our AGM where we heard from our current executive followed by the election of the 2011-2012 Chapter Executive.

The AGM also included the presentation of the "Critical Care Nurse of the Year" award.

Do you need continuing competency credits? Watch for upcoming education sessions, featuring a variety of topics and speakers.

We will continue to use the website as a means to communicate as we work towards being "green".

CACCN Executive 2011/2012:

Tannis Sidloski (President)
Camille Meub (Vice-President)
Rhonda Dube (Secretary)
Rhonda Kaluzny (Treasurer)
Marjorie Chody (Co-Programs)
Ashleigh Shearer (Co-Programs)
James Danell (Membership)
Sara Unrau (Publicity/Newsletter)
Joy Mintenko (Member at Large)

Update on Education Sessions

An Update in Right Ventricular Failure: Implications for the ICU was held on December 7, 2011 at St. Boniface Hospital, Asper Clinical Research Institute – 5th Floor. A delicious pasta dinner was served. This session featured Dr. Eric Jacobsohn, Department Head and Medical Director of Anesthesia for University of Manitoba and WRHA. The session was well received with participants from various professional areas.

If you have any ideas or suggestions for upcoming seminars/educational sessions, please forward them to Tannis Sidloski at tsidloski@sbgh.mb.ca. We would love to hear from you!

Upcoming Education Sessions

Watch for upcoming education sessions in the Spring and Fall of 2012.

Updates on Events

Membership Challenge

Recruit your colleagues to win free coffee!

Is your unit up for the
Manitoba Chapter CACCN Membership Challenge?
From March 1 – May 1 2012,
the Intensive Care Unit with the greatest increase in percentage of CACCN members will win a Tim Horton's gift card for each CACCN member in that unit

Benefits of Membership

- A subscription to the peer-reviewed journal of CACCN
- A copy of the CACCN Standards for Critical Care Nursing Practice
- Publications such as CACCN's Annual Report and positions statements
- Awards and educational funds
- Reduced conference fees at Chapter and National Conferences
- Various opportunities to accumulate continuing education hours
- Access to the Member's Only Area of the website

To join, http://www.caccn.ca

Membership Recognition

Do you want to have your tuition for the next conference paid for?

If you have been a CACCN member
for **2 years or less**
and are interested in attending
Edge of Excellence 2013,
please submit your name
to sunrau@sbgh.mb.ca or tsidloski@sbgh.mb.ca
to be drawn for free tuition.

If you have been a CACCN member
for **greater than 2 years**
and are interested in attending
Dynamics of Critical Care 2012 in Vancouver, BC,
please submit your name
to sunrau@sbgh.mb.ca or tsidloski@sbgh.mb.ca
to be drawn for free tuition.

CACCN Website
Your Online Resource
http://www.caccn.ca

The CACCN Website offers many resources:

- CACCN Events
- CACCN Chapters
- Membership application National Chat Forum coming soon
- President's Blog
- Critical Care Publications
- Education and Resources
- Job Links
- Awards and Recognition
- Surveys
- Links to Canadian and International Critical Care Sites

Remember to visit the Members Only
section of the website
to let your voice be heard on political issues.

Are you looking for funding for education sessions?
Look no further . . .

Visit the CACCN website, Manitoba Chapter

for more information on

the Education Fund.

Edge of Excellence 2012
Winnipeg, Manitoba
Conference Report

Edge of Excellence 2012 was held on February 27, 2012 at the Norwood Hotel. The day was a success with many sponsors and attendees.

The day started with a presentation on ***A 'Shocking' Case Study: a Nursing and Patient Perspective*** by Rhonda Dube (nurse) and Marc Perreault (patient).

This was followed by ***Anticoagulation to Modulate Inflammation in Sepsis*** by Dr. Ryan Zarychanski. He discussed a new study to be started in several Winnipeg hospitals, investigating heparin and sepsis.

The poster presentations of "***Get up and Go"*** by James Danell and Amber Matwychuk***, "Demystifying VADs"*** by Nicolle Choquette, and ***"Phototherapy in the ICU"*** by Alanna Chau were a great addition with information on work being done by our fellow colleagues.

Helen Cooper and Alissa Peppin, shared a fascinating case study called ***"Hope, Faith & Science: a Pediatric Cold Water Submersion Story".***

Shana Chiborak kept the audience on the edge of their seats with ***CSI 2012***. All participants enjoyed speculating on diagnosis and management of the patient in this case study.

The Conference Planning Committee would like to extend a special thank you to all the speakers. A big thank you is extended to the Edge of Excellence 2012 Planning Committee for all their hard work and support to make this event happen.

Sara Unrau & Tannis Sidloski (Conference Chairs)

Critical Care Nurse of the Year Award 2012

Lissa began her nursing career in 1987 when she graduated from the St. Boniface General Hospital (SBGH) School of Nursing. She worked in Portage La Prairie, Manitoba before heading out west to work in the Creston Valley Hospital in British Columbia.

In 1988 Lissa returned to Winnipeg and worked in St. Boniface Hospital in the surgery program. Looking to challenge herself she entered into the Adult Intensive Care Nursing Program. In 1990 after graduation she worked in the surgical intensive care unit at SBGH until 2001 when she when to Concordia Hospital as the intensive care unit educator.

In 2006 Lissa completed her Bachelor if Nursing Degree and returned to St. Boniface Hospital to be a unit educator for the Surgery Program followed by the Cardiac Sciences Program.

In 2007 Lissa took a position as an educator for the Adult Intensive Care Nursing Program. She was part of the core team that re-developed curriculum and moved towards the amalgamation of a community and tertiary hospital critical care programs into one regional program which is our current Winnipeg Critical Care Nursing Education Program (WCCNEP).

Lissa is dedicated to CACCN. Lissa was the Manitoba Chapter President from 2007-2011. During her time as president, she worked hard to promote identified goals, resulting in the Manitoba Chapter winning the Chapter of the Year Award in 2009.

Lissa works hard to promote critical care nursing and CACCN. She was pivotal in establishing Manitoba Chapter CACCN Awards for students who clinically excel in the WCCNEP.

In 2011 Lissa became the first Coordinator of Critical Care Education for the Winnipeg Regional Health Authority. Lissa has been instrumental in making many positive changes in critical care education delivery. This has included inclusion of pediatric and neonatal intensive care education within the WCCNEP.

Manitoba Chapter CACCN Executive would like to congratulate

Lissa Currie

on receiving the
Critical Care Nurse of the Year Award!

Winnipeg Critical Care Nursing Education Program

Graduating Class of April 2011

The Winnipeg Critical Care Nursing Education Program (WCCNEP) is proud to celebrate the success of these deserving and hard working nurses.

Jan Kenneth Borce
Lauren Douglas
Kelly Hallock
Young Hee Lee
Aileen Paraguas
Kendall Eden Sorrell
Nichole Tao
Danielle Fiola
Michelle Hodnett
Lindsay Maxwell
Robyn Vinck
Amber Cook
Robin Friesen
Angela Hearn
Laura Moniz
Ashley Pylypowich
Alana Spindler
Brigitte Chappellaz
Ashley Hardy
Bonnie Kibalski
Geraldine Peratero
Mailia Cruz
Crystal Gurney
Jon Jackson
Mayumi Nagaoka
Katrina Quinjano
Janelle Talbot
Theresa Ewere
Elaine Hassan
Corinne Lamotte
Jodi Thiessen

Graduating Class of September 2011

Jacqueline Henry
Darryl Jamero
Cherylann Koop
Kerri Wien
Khristine Joy Florendo
Francis Jarme
Pamela Castillo
Jency Joseph
Rebecca Albrecht
Gurmeet Gujral
Marijebi Zamora
Leslie Zachanowich
Kimberley-Ann Regnier
Sonja Enns
Erin Hamm
Manjit Gill
Rebecca Sereda
Kitty Kam
Adrian Eisma
Karen Blundell
Al Reggie Novecio
Leonarc Fontanilla
Nicole Young
Manuel Mendoza
Lianne Lemoine
Jolene Unrau
Rebecca Thiessen
Tracy Nordal
Albert Alcala
Katie Reid
Cameron Driedger
Danielle Gauthier
Deanne Wiebe
Darcy McBurney
Ashley Klassen
Kathryn Pietryk
Erin Evecsyn
Tammy Fleming

These nurses completed the 14 weeks of Theory and Clinical, and went on to complete the Specialized Orientation portion of the program at the units and sites where they have taken positions, hroughout the Winnipeg region in a variety of hospitals.

The rewards and benefits of the WCCNEP are many. The advanced knowledge will help these nurses care for the critically ill patient. We wish them success in their critical care nursing careers.

Information about the WCCNEP can be found on the WRHA website at: www.wrha.mb.ca/prog/criticalcare

CACCN Manitoba Chapter
would like to recognize

Ashley Hardy, Theresa Ewere and Kelly Hallock

Katie Reid and Darryl Jamero

on the receipt of the
Manitoba Chapter Recognition Award for Clinical Excellence!

Spotlight on . . .

We have done a feature on Brandon ICU, Victoria ICU and Seven Oaks ICU, Concordia ICU, and Boundary Trails Health Centre ICU and we would like to hear continue to hear from and about your ICUs and your experiences.

Send your story to sunrau@sbgh.mb.ca for the next newsletter!

Located in St. James-Assiniboia, the ***Grace Hospital ICU*** is an eight bed unit that provides critical care services primarily to the West sector of Winnipeg. The unit also receives critically ill patients from many rural areas of Manitoba, and has even had patients from as far away as Nunavut.

With a baseline staffing of 5 nurses per shift, and 24-hour HMO coverage, the unit is equipped to provide multi-organ support including invasive and non-invasive ventilation and advanced cardiac monitoring.

The Grace ICU is supported by a multi-disciplinary team of health care professionals delivering some of the most complex medical interventions to assist patients to a speedy recovery. Typically, the ICU can accommodate 5 ventilated and 3 non-ventilated patients while also providing telemetry and Code Blue response services for the facility.

In 2011 there were 251 admissions, and 2,290 hours of ventilator time. Positive changes being implemented include the CAM-ICU assessment and Early Mobilization. A new Program Director joined us in 2011. We are currently evaluating rotations to best suit the staff.

The Grace ICU is committed to foster the provision of the highest quality of care to patients, the promotion of patient safety, education and research, and professional development. Constantly recruiting and teaching new staff members, we welcome new WCCNEP graduates as they make the transition into critical care and join our health care team.

Ryan Hayward RN
Grace ICU

Ask The Expert

If you have a question, chances are half your colleagues will have the same question!

Send us your questions and we will find the expert to answer.
Send any questions to sunrau@sbgh.mb.ca.

If you have an article, case study, or other information to share with the critical care community we would love to hear from you. Please send them to sunrau@sbgh.mb.ca

CACCN Manitoba Chapter Education Fund Submissions

"...Not Another Skin Tear!!"

Joy Mintenko, RN
CACCN Manitoba Chapter Education Fund Recipient

In October, I had the privilege of going to Dynamics 2011 in London, Ontario. Among the many interesting concurrent sessions that I attended, I was especially impressed by the presentation given by Nancy Giles-McIntosh. This charge nurse from the London Health Sciences Critical Care Trauma Center presented a topic on "Wound Care....What to do with what you see" which is very pertinent to the bedside nurse. Many times I have been stymied by numerous weeping puncture sites, skin tears and pressure areas on my patient. A consult to the Wound and Skin Team has been submitted but in the meantime, what product should I use?

Nancy briefly described the four phases of wound healing: 1) Hemostasis: The immediate response to an injury where there is coagulation of blood from damaged, inflamed or dilated vessels. Platelets escape from injured vessels and release vasoconstrictive elements to slow blood loss. Cytokines are generated to interact with the platelets to form thrombin which converts to fibrinogen to plug the injured vessel.

2) Inflammatory Phase:(0 -4 days) Injured area becomes red and swollen due to vascular dilation. If this does not resolve in 48 – 72 hours, look for signs of new tissue damage or infection.

3) Proliferation Phase: (4 – 21 days) Granulation tissue formation and contraction need to occur before epidermal cells can migrate across the wound to close it. Collagen formation occurs so new blood vessels can be developed to assist in providing the wound with necessary oxygen and nutrients vital for wound repair.

4) Maturation Phase: (up to 2 years) Superficial wounds heal by generating new epidermis. Deep wounds achieve only about 80 % of their original strength.

Nancy then discussed exactly what causes skin to breakdown. Systemic factors include: age, body build, stress, nutrition, medication, tissue oxygenation and concurrent disease conditions. Local factors like perfusion, edema, wound temperature, cytotoxic agents, necrotic tissue, bacterial burden and an excess of exudate all contribute. Other local factors that are very common in the ICU are pressure, friction, shearing and moisture.

Nancy stresses that Moist Wound Healing is the best practice method. Gone are the days of leaving the wound exposed to "scab over". Epithelial cells require moisture to migrate from the wound edge in order to close a wound. If a wound is dry, epithelial cells have to burrow beneath the wound bed to find moisture and so healing is delayed. Most "Advanced Wound Care Dressings" now maintain moist wound conditions. They promote autolytic debridement. When used appropriately, these dressings can be changed less frequently so are cost effective and less painful for the patient.

Things to remember when changing the dressing include: measure the wound, use warmed sterile saline or water, protect periwound area, document findings, reassess wound (dressing requirements will likely change during healing process) and date the dressing.

Nancy gave a brief overview of the types and uses of Wound Care Products that are available today.

SKIN PROTECTANT: used to protect vulnerable skin against chemical contamination, reduce friction and shear, remember to use for single patient only (infection control).

TRANSPARENT DRESSING: has no absorptive properties, protect against outside contaminants, aids in autolytic debridement, aids in pain control as there is decreased need for dressing changes, can be a secondary dressing. Possible uses include: stage one pressure ulcers, superficial wounds with scant drainage, minor burns, and lacerations.

HYDROCOLLOID DRESSING: hydrophilic particles in the dressing react with wound exudates to form a soft gel over the wound which promotes autolytic debridement, not recommended for wounds with undermining, tunnels or sinus tracts. Change dressing every 3 to 7 days. Possible uses include: minimal to moderate exudating wounds, stage 2 pressure ulcer, road rash, smaller venous wound, skin tears without too much drainage, and lacerations.

ACRYLIC DRESSING: With this dressing wound exudates move through perforations in the bottom layer of transparent film and absorb into the clear acrylic polymer pad, moisture vapour is released through top, Change dressing every 21 days. Possible uses include:

small to moderate draining skin tears, pressure ulcers, and abrasions.

HYDROGELS: this dressing will hydrate dry wounds, assist to soften and loosen slough and necrotic debris. Too much moisture in a wound can cause maceration. Change dressing daily to up to every 7 days depending on amount of exudate. Possible uses include: wound with dried eschar or slough and dry wound that needs moisture to help with autolytic debridement.

HYDROFIBRE: the hydrofibre in this type of dressing interacts with wound fluid to form a gel, made of sodium carboxymethycellulose. Do not use this dressing on dry wounds. Change the dressing daily to up to every 7days depending on amount of exudate. Possible uses include: surgical wound with open skin that drains, draining stage 2 or 3 pressure ulcer, and tracheal erosion.

ALGINATE DRESSING: is derived from brown seaweed, it is non-adherent, easily rinsed with normal saline, and highly adsorptive(it can hold up to 20 times its' weight). Change dressing every 1 to 7 days, dependant on type of use. Possible uses include: draining wound cavities, pressure ulcers, vascular wounds, surgical incisions, wound dehiscense, tunnels, sinus tracts, skin graft donor sites, exposed tendons, infected wounds, and tracheal erosion with moderate drainage.

FOAM DRESSING: is highly adsorptive, comfortable and conformable to an area of patient's body. It is not to be promoted as padding for bony prominence. Change dressing every 7 days(depending on type of foam). Possible uses include: moderately draining skin tear, draining abrasion, draining coccyx wound, and draining venous wound.

CONTACT LAYER DRESSING: put the dressing next to the wound base to prevent dressing from sticking. This allows exudates to pass through to secondary dressing while allowing wound to granulate. A secondary dressing is required. Change this type of dressing every 7days. Possible uses include: draining skin tears and heavily draining venous wounds.

SILVER DRESSING: can inhibit growth of pathogens, can be immediate or sustained release. It comes in many forms: contact layer, impregnated dressing, foam, and packing strip. It is appropriate for infected or highly colonized wounds. Possible uses are dependent on mode of delivery.

HONEY: has been used in Egyptian times for infected wounds. The hydrogen peroxide that is found in honey has excellent antibacterial effects, may reduce odour, swelling and scarring , and may prevent dressing from sticking to the wound. Possible uses include: venous wounds and other chronic wounds where healing has stalled.

Nancy suggests some helpful Websites:

Canadian Association of Wound Care
www.cawc.net

RNAO Best Practice Guidelines
www.mao.org

Ostomy Wound Management www.o-wm.com

Canadian Association of Enterostomal Nurses
www.caet.ca

References:
Wound Care Canada Best Practice Recommendations-Reprint Edition Vol. 4, No. 1, 2006
Wound Care Canada-Special Issue- Key Information from the Third Congress of the World Union of Wound Healing Societies. Vol. 6, No. 2, 2008

QT Interval: "To measure or Not to Measure" That is the Question

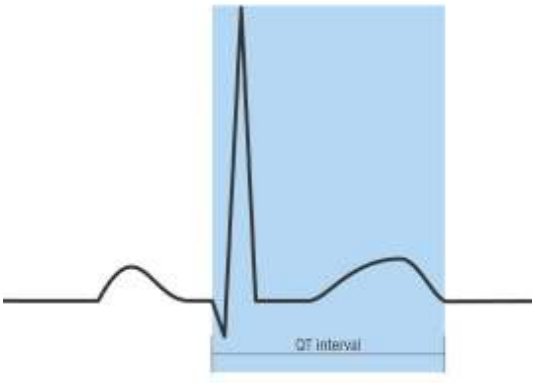
Submitted by Lissa Currie RN BN CNCC(C)
CACCN Manitoba Chapter Education Fund Recipient

That is a question! I, like many critical care nurses, wondered what the standard of practice should be, which is why I decided to attend the session by Darlene Hutton at Dynamics 2011 in London, ON. I have struggled with the fact we measure many other intervals which have less of an impact on patient mortality but often neglect QT interval. QTs offer critical care nurses a biomarker for ventricular tachycardias such as Torsades de Pointe and risk for sudden cardiac death. Darlene decided to collect data to see if nurses were measuring QT and if not

why. She surveyed 5 urban and 7 community/rural hospitals and discovered less than 30% in urban centers and less than 23% in community centers even looked at QTs. Upon further analysis the main reported reasons given for not routinely measuring QT intervals were they did not know how to accurately measure or the important of the measurement.
She implemented a 15 minute educational session to address the how and why of QT measurements. Darlene then conducted a post implementation survey to see the impact the training had. She was pleased to find 100% of the respondents reported that they would measure QTs "all of the time" as a result of the information that they had learned. Respondents also reported they were surprised at how easy it was to measure and the significance of why we should.

Basics for Measuring QTs:

1. Measure from the beginning of the QRS complex to the end of the T wave. (represents ventricular depolarization and repolarization)



2. Normal QT should be less than ½ the R to R interval

One of the reasons many critical care staff gave for not performing QT measurement was the accuracy of the measurement. We have all heard about the corrected QT (cQT) which is the QT interval corrected for heart rate. Unfortunately there are numerous formulas (21 in fact) out there on how to calculate a cQT and not even the experts can agree on which one is best to use. One that is frequently reported in the literature is the Bazett's Formula [QTc=QT÷√ (RR interval) however it was obtained from a small sample of 39 young men and is also not completely accurate. All 21 different formulas have their limitations and questions of accuracy assuming their formulas can be applied to diverse populations and individuals. Darlene's take home message was QTs should be measured due to the significance of prolongation and in the absence of a consensus on the best formula we should use the simplest method of ½ the RR interval. After all it is about obtaining a baseline in which we can use for comparison throughout the patient's ICU stay.
The identified limitations of this simplified approach to keep in mind are as follows:

- Atrial Fibrillation- recommendation is to average of 10 beats
- Wide QRS complexes- suggest QTc<500ms
- Significant Bradycardia- HR<45

Causes of Prolonged QT Intervals
There are many identified causes of prolonged QTs. The list is long with many of them being pharmacological in nature and prescribed for the majority of our patients. (amiodarone , procainamide, doperidone, ampicillin, ciprofloxacin, sulfa and ventolin to name a few). Generally one agent alone is not enough to induce prolonged QT however many of our patients are on a number of identified offending medications. Other known potential causes of prolongation include electrolyte imbalances, hypothermia, MI, severe bradycardia and congenital prolonged QT syndrome.

Darlene continued to collect surveys from February 2008 to June 2011, in a total of 63 hospitals and found the practice of routine measurement had not significantly increased. She found urban centers had better rates than community, critical care/coronary care units were more likely to routinely measure and emergency departments were more likely to measure with certain patient presentations.

The obstacles to getting the message across were identified as the lack of consensus on how to measure and hospital protocols for routine QT assessment. On March 31, 2010 Health Canada released its final revision to its "Guide for the Analysis and Review of QT/QTc Interval Data" which supports the practice of QT measurement. There are many facilities across Canada that have now built in QT interval measurement as standard of practice. It is recommended and taught in many of the critical care orientation/certificate programs including the Winnipeg Critical Care Nursing Education Program.

References:
"What Clinicians Should Know about the QT interval", JAMA, April 23, 2003.

Health Canada March 31, 2010 Guidance Document: Guide for the Analysis and Review of QT/QTc Interval Data

A survey of health care practitioners' knowledge of QT iinterval. 2005, Journal of General Internal Medicine, 20, 392-396.

Straus SM, Kors JA, De Bruin ML, et al. Prolonged QTc interval and risk of sudden cardiac death in a population of older adults. J Am Coll Cardiol. 2006;47:362-367.

Moss AJ. QTc prolongation and sudden cardiac death. The association is in the detail. J Am Coll Cardiol. 2006;47:368-369.

Manitoba Chapter Education Fund

The Manitoba Chapter of CACCN annually allocates funds to promote professional development and financially support members attending short-term critical care educational sessions.

At the discretion of the Education Fund Committee, funding will be awarded to those seeking critical care CNA certification, or those attending critical care workshops or conferences.

Funding covers costs such as tuition, registrations, flights and hotel accommodations.

For more information on the Education Fund please visit the CACCN website, Manitoba Chapter.

Manitoba Chapter

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