CACCN Manitoba Chapter Newsletter

Spring 2010

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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 another busy and productive year.

Back in June 2009, the Executive met to formulate a plan for the upcoming year. We developed a list of goals and objectives focusing on the continued growth 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.

A number of education events were offered including an evening of simulated mock code blues held at the "high tech" SIM Lab and Interpretation of Lab Values, everything you wanted to know and more. Both sessions were well attended with glowing reports. Watch for our upcoming session on heart sounds planned for late Spring.

In addition to planning educational opportunities, the committee has been busy revising the constitution & bylaws, and continued to further develop the web site to become greener. We have also had the opportunity to work with Joy Mintenko in the role of "member at large" which has proved to be a valuable addition to the Executive.

Mark your calendars for our annual Manitoba Chapter CACCN Critical Care Conference, "Edge of Excellence 2010" to be held on May 10th at the Norwood Hotel. Come and mingle with your fellow critical care nurses while enjoying a variety of topics and tasty food.

The day will begin with our AGM where we will be hearing from our current executive followed by the election of the 2010-2011 Chapter Executive. Positions up for election include:

- Program Chairperson
- Membership Chairperson

Please see website for position descriptions and nomination forms. We will then be voting on the proposed changes to the Constitution and Bylaws followed by the presentation of the "Critical Care Nurse of the Year" award.

CACCN Executive:

Lissa Currie (President)
Tannis Sidloski (Vice-President)
Rhonda Matheson (Secretary)
Andre Dube (Treasurer)
Chris Kuttnig (Programs)
Anna Martin (Membership)
Sara Unrau (Publicity/Newsletter)

Proposed Constitution and Bylaw changes will be emailed to members and posted on the website.

NOTICE OF MEETING AND CALL FOR NOMINATIONS

Notice is hereby given by the Manitoba Chapter President of CACCN to all members that the Annual General Meeting of the Chapter will be held on Monday, ***May 10, 2010*** from **0730 – 0830, at the Norwood Hotel*,*** 112 Marion St., Winnipeg, Manitoba. This will be a general Chapter meeting where all members are welcome to attend. The purpose of this meeting is to review annual activities of the Chapter, accept committee reports, discuss Chapter business, vote on the proposed Constitution and Bylaws changes, elect Executive Officers for 2010/11, and present the Manitoba Chapter Critical Care Nurse of the Year Award(s).

Elections for Program Chairperson and Membership Chairperson will occur at this meeting. Duties for 2010/11 Executive will begin in June for a term as outlined in the Constitution and Bylaws. Please refer to the website for job descriptions www.caccn.ca.

NOMINATION PROCEDURE

Members are invited to submit nominations of members to serve in these positions. This invitation will include the time and date for receipt of nominations, approximately one month prior to the date of the AGM.

Nominations will also be accepted from the floor at the AGM. Once there has been a reasonable opportunity to nominate, it will be announced that nominations are closed. Voting may be performed by secret ballot or by a show of hands. The chief scrutineer presents the results to the president, who will in turn announce the results to the general membership.

MANITOBA CHAPTER - CANADIAN ASSOCIATION OF CRITICAL CARE NURSES
ELECTION OF ASSOCIATION EXECUTIVE OFFICERS
NOMINATION FORM

I, ____________________________________ A MEMBER IN GOOD STANDING WITH THE

C.A.C.C.N., DO HEREBY NOMINATE ____________________________________.

FOR THE POSITION OF ____________________________________.

______________________________. ______________________________.

Signature of nominator *Signature of nominee*

______________________________. ______________________________.

Membership number Membership number

VOTING

If members are unable to attend the annual general meeting but wish to have a vote cast, a proxy form may be completed and given to a member who will be in attendance at the meeting.

Each member present (or represented by proxy) shall be entitled to one vote on each matter of business brought before the general membership. Proxy votes must be registered with the secretary of the Manitoba Chapter prior to commencement of the meeting. All members shall be entitled to vote and must present their membership card upon request, as proof of active membership.

Voting shall be by a show of hands unless otherwise directed by the residing officer. The residing officer of the meeting shall appoint two or more members of the general membership to act as scrutineers. The scrutineers shall arrange for the holding of any vote, shall distribute, collect and count ballots if used, and shall report the results. Any decision made, as a result of a vote at a meeting shall take effect at the conclusion of the meeting if it is consistent with the National Association's bylaw.

Please refer to the website www.caccn.ca for the PROXY FORM.

Call for Nominations

Manitoba Chapter
Critical Care Nurse of the Year Award

Background:

Since 1990, the Manitoba Chapter CACCN has presented the Critical Care Nurse of the Year Award to a local Chapter member who consistently exemplifies critical care nursing excellence. This award recognizes chapter member(s) who promote critical care nursing, exhibit professionalism, and demonstrate proficiency in critical care. Extra-ordinary nurses and their accomplishments should not be taken for granted! The selection will be made by the Manitoba Chapter Executive, Awards Sub-Committee. The award consists of a commemorative plaque and honorarium presented at the Annual General Meeting on May 10, 2010. The nomination deadline is **April 10, 2010**.

Eligibility:

1. Must be a member in good standing of the Manitoba Chapter CACCN.
2. A Critical Care Nurse working in Pediatric, Neonatal or Adult Critical Care.
3. A Critical Care Nurse working at the bedside or in management, research, administration or education.

Ineligibility:

1. A member of the Executive of the Manitoba Chapter - CACCN.
2. A past recipient of less than 3 years.

Information Required for Nomination:

1. A completed nominee form found below.
2. A write up (minimum: 250 words) describing why the nominee should receive the award. This should include a specific example in at least one of the following areas:
   - . Promotion of critical care nursing in Manitoba
   - Exhibits a high degree of professionalism
   - Demonstration of proficiency in critical care

Submission Deadline – April 10, 2010

Nominee Information:
Name:________________________________
Address: ______________________________ Postal Code____________________
Telephone (Home)________________________ (Work) _______________________
Employer ______________________________
Nominated by: (print name/signature)
1.____
2.____
Certification by Nominee:
I, ___________________________ have read the information contained herein and certify it to be accurate.
I hereby allow my name to stand for nomination of the Manitoba Chapter Critical Care Nurse of the Year Award.

Mail to: Awards Committee
Manitoba Chapter CACCN
Box 2236
Winnipeg, Manitoba R3C 3R5

Winnipeg Critical Care Nursing Education Program
Graduating Class of September 2009

Congratulations to the WCCNEP Graduating Class of September 2009

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

These nurses completed the 14 weeks of Theory, and Clinical, and went on to complete the Specialized portion of the program at the units and sites where they have taken positions. The rewards and benefits of the WCCNEP are many. The advanced knowledge will help these nurses care for the critically ill patient. They have taken positions throughout the Winnipeg region in a variety of hospitals. We wish them success in their critical care nursing careers.

Remember – **YOU** are our best ambassadors to recruit, so please encourage nurses to take the program and become critical care nurses.

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 Anna Gauvin and Danielle Yaffe on the receipt of the CACCN Manitoba Chapter Recognition Award!

Spotlight on . . .

We have done a feature on Brandon ICU, Victoria ICU and Seven Oaks 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!

"What's a Few Seeds among friends"

By André Dubé, RN
Recipient of Education Funding CACCN Manitoba Chapter

"What's a Few Seeds among friends" is a presentation from Dynamics 2009 in Fredericton that interested me because of its uniqueness and that it provided knowledge and intervention in this type of intoxication. Jimson Weed (also known as Locoweed, Angel's Trumpet, Mad Apple, Stink Weed, Mad Hatter) has seen a rise in use in adolescents in United States and in Canada over the last few years. It grows as a wild plant in Southern Canada, maturing in late fall.

All parts of the plant are poisonous. The seeds and leaves can be smoked, but seeds can be chewed and swallowed in a tea form which leads to hallucinogenic effects that can last 24 to 36 hours. Clinical presentation can occur as soon as 1 to 4 hours after ingestion and faster if smoked or consumed as a tea. The initial symptoms are as follows; dry mucus membranes, flushed dry skin, dysphagia and dysarthia, photophobia, blurred vision, tachycardia and urinary retention. After the initial symptoms, patients will progress to hypothermia, confusion, agitation, combativeness and seizures, coma and then death.

We were given a mnemonic to remember the symptoms which make them easier to remember:

- "Red as a beet" - Flushing
- "Dry as a bone" - Dry skin and mucus membranes
- "Blind as a bat" - Mydriasis with loss of accommodation
- "Mad as a hatter" - Altered mental state
- "Hot as a hare" - Fever

The pathophysiology of the drug: Tropane alkaloids inhibit acetylcholine receptors to produce anticholinergic syndrome. Tropane delays gastric emptying and absorption. Scopolamine (antagonist) is a tropane alkaloid drug which acts at the peripheral and central muscarinic receptors. Jimson Weed seeds has the highest concentration of tropane alkaloids (0.1 mg atropine) per seed, lethal dose is 10 mg, which makes it very potent! The presentation was enhanced with a case study to help us identify what needed to be done.

First, a timely identification and confirmation through the Poison Control Center is key. Diagnosis may be based on history of exposure and physical examination. Typical features include dilated pupils, dry mouth, flushed skin, and tachycardia. Next, is a trial of Physostigmine (cholinergic acetylcholinesterase inhibitor) to reverse effects of neuromuscular blocking agents. This will confirm the toxicity.

Once Jimson Weed poisoning is confirmed, the next appropriate step is to support the patient. Supportive care included maintaining hydration and treating hyperthermia with external cooling, mechanical ventilation may be required to maintain good gas exchange and tissue oxygenation, fluid resuscitation, monitoring circulatory compromise and a foley catheter to monitor output. Drugs used to help this patient were inotropes, benzodiazepines to prevent seizures, electrolyte replacement and Physostigmine. Prevention of ICU complications are also key such as; VAP prevention, DVT prophylaxis, stress ulcer prophylaxis and glucose control.

Physostigmine is the drug of choice to help against anticholinergic toxicity from Jimson Weed as indicated in the literature. Adverse common side effects of Physostigmine are; vomiting, diaphoresis, diarrhea, abdominal cramping. There is a small percent of patients that may get bradyasystole.

What was stressed to me in this case study was promptly identifying this drug toxicity to properly manage the effects. This drug is quite dangerous since it is not illegal to use, yet quite deadly if used by people, especially by youth today is the key, but for those who slip through, we, as ICU nurses, should be prepared to identify and treat this uncommon and deadly drug.

References

Arnett, A. (1995). Jimson Weed Poisoning. *Clinical Toxicology Review, 18*(3).

CTV Toronto. (2007). *Three Niagara boys treated for Jimson seed poisoning*. CTV News Toronto. Retrieved from http://toronto.ctv.ca/servlet/an/local/CTVNews/20071009/jimson_weed_071009/20071009?hub=TorontoHome.

Kahn, R. (2008, September). The other weed. *The Boston Globe*. Retrieved from http://www.boston.com/news/local/massachusetts/articles/2008/09/21/the_other_weed/?page=2#.

The Introduction of an ICU Nurse Clinician: Successes, Challenges and Lessons Learned

by Rhonda Matheson, RN, MN
Recipient of Education Funding CACCN MB Chapter

There were so many fantastic topics at the 2009 Dynamics Conference in Fredericton, but I decided to review a presentation titled 'The Introduction of an ICU Nurse Clinician: Successes, Challenges and Lessons Learned'. I had never heard of a 'Nurse Clinician' role, so I was very curious about the topic. We have all probably heard of Clinical Nurse Specialists (CNS's) and Nurse Practitioners (NP's), both of which CACCN have written position statements on their importance, however a Nurse Clinician is different, which will be discussed in this review article.

The presentation was put together by three nurses from Surrey, British Columbia. Surrey is approximately 40 km away from Vancouver and is the second largest hospital in BC. The ICU had 12 beds, which had recently expanded to 15 beds in 2008. It is a combined medical-surgical unit that has a typical nurse patient ratio of 1:1 or 1:2 if the patient is stable. With the increase in physical bed capacity this ICU had recruited 59 new staff to meet the growing unit. It was identified that a role needed to be established to mentor and support the new staff at the bedside and to support all staff in the developing advanced care practices (CRRT, PA catheters, PD, and PICC line management). The Nurse Clinician was also a support for the charge nurse to help with patient flow and clinical initiatives. In short, the ICU Nurse Clinician was seen as "The bridge that spans the theory-practice gap". Among their many roles, besides mentoring and providing clinical support, they planned and arranged 'buddy' shifts for the new employees based on their personality and learning needs, facilitated critical thinking development, completed 90 day performance appraisals and assisted in creating learning plans for those ICU nurses requiring competency development.

The Nurse Clinician was based in the unit and was able to accompany intra and inter hospital transfers for first time staff, relieve staff at the bedside to allow them to attend in-services and workshops, carry out campaigns, such as a "Back to Basics" campaign to remind staff of basic patient care needs, and provided support for the Code Team staff. There were many successes to the role as evidenced by positive testimonials from the staff, however there were also many challenges. Since this was a new role there was no definition of the role and some resistance to change within the health care team. The Clinician identified that it was a challenge to get to know all the staff and to identify their educational and support needs. The successes included that the Clinician was an invaluable resource at the bedside to all the staff and helped to reduce the anxieties of new staff. The Clinician promoted safety in the highly technical fast paced environment, as well as provided valuable communication between all the team members.

The presenters of this session had mentioned that there was no literature on the role of a Nurse Clinician and their only reference was Benners' (1984) from Novice to Expert model. When I searched CINAHL, I too could not find an article on Nurse Clinicians within critical care. There seemed to be a lot of role confusion with Nurse Practitioners, and there were articles on Nurse Clinicians within other areas, such as oncology, however not in the ICU. I did find other centers such as one in Ontario that described the role of the Nurse Clinician as used in Surrey. The other thing I found interesting about this role is that it did not take the place of the ICU Educator and the Clinician did not require any additional formal education. Nurse Practitioners and Clinical Nurse Specialists have a Masters in Nursing, however, the Nurse Clinician was experienced in Critical Care and possessed the appropriate skills to educate, support and mentor the nurses. I think one of the reasons I took an interest in this role is because I struggle in my own practice to find a balance between being an ICU Educator and being available as a clinical support to the staff. I think the ICU Nurse Clinician would be an asset to large ICU's that have a large number of new staff or a unit that is undergoing dramatic changes, such that Surrey, BC did.

References

Jones, J., Mayer, D. & McElheran, P. (2009). Presentation at Dynamics 2009. The Introduction of an ICU Nurse Clinician: Successes, Challenges and Lessons Learned.

Ask The Expert

Pediatric Code Blue Response

Submitted by Jannell A. Plouffe RNEP
Nurse Practitioner Pediatric Intensive Care Unit
Winnipeg Children's Hospital

Question:

I am a code response nurse in an adult-only teaching hospital. I am wondering what approach you would recommend when responding to a pediatric code in the cafeteria or on a visiting child?

Thanks for the opportunity to answer this excellent question.

Pediatric code events are reportedly infrequent occurrences and often one of the most feared situations within any health care institution. We all know infants and children are not just little adults; yet application of these differences in a resuscitation event is difficult. The likelihood and risk of error given the complexity of weight based dosing for medications and life sustaining equipment, adds to the complexity and stress of the resuscitation.

One essential component of the code response cart is a length based resuscitation tape to determine the infant or child's weight, taking the uncertainty out of the situation. This tape provides not only the weight but all the common resuscitation medication doses, as well the correct size equipment to be used. This makes it easy to do the right thing, improving your confidence and ability to act competently.

For success in pediatric resuscitations let's go 'back to the basics' for the provision of appropriate timely interventions. Before we begin; we need to acknowledge an important difference in pediatric cardio respiratory failure.

The main reason for which children experience cardio-respiratory failure is due to progressive respiratory illness, not a primary cardiac event [1, 2]. Many of the pediatric anatomic and physiologic differences contribute to development of rapid hypoxia and hypoxemia and resultant organ dysfunction. We will assume these infants and children are generally healthy. Thus the most likely respiratory causes for cardio-pulmonary compromise / arrest would be related to airway obstruction from foreign body aspiration, seizures or anaphylaxis. There is however, a large body of evidence supporting the early application of AEDs, as there is a surprising number of shock advised rhythms within this population[3]. The use of the biphasic AED with pediatric pads (less than 15 kg) is an important life saving intervention that should be considered in all pediatric arrest situations. Adult pads may be used, with anterior posterior placement in a smaller child with no reported harm due to the biphasic delivery energy. (not indicated less than 1 year of age[3])

The approach to resuscitation of an infant or child follows the principles of Pediatric Advanced Life Support[4] (2005).

General Assessment: Pediatric Assessment Triangle

This is a visual and auditory evaluation of the infant or child completed within a few seconds; examining general appearance, work of breathing and circulation. Based on the assessment, you may perform life-saving interventions (CPR) or position, apply oxygen and begin the next step in the assessment.

Primary Assessment

This entails a rapid, hands-on ABCDE evaluation of cardiopulmonary and neurologic functions, including vital signs and oxygen saturations. Assessment of ABCDE and categorization determines the necessary interventions. (Table 1.) Description of specific interventions are beyond the scope of this response.

Pediatric Code Blue Response (continued)

Primary Assessment	Element
Airway	Determine airway patency. Airway may be maintained by simple interventions: positioning, suctioning, foreign body removal oral or nasopharyngeal airway insertion. There may be a desire at this stage to intervene with an advanced airway maneuver such as intubation or cricothyroidotomy, but most often advanced interventions can be deferred and simple interventions used until the full assessment is completed.
Breathing	Evaluate respiratory rate, effort, airway and lung sounds, depth of inspiration, oxygen saturation. Application of oxygen alone or with assisted ventilation may be required.
Circulation	This includes assessment of cardiovascular (CV) and end organ functioning. CV function assessed by: skin color and temperature, heart rate and rhythm, pulses (central and peripheral), capillary refill time and blood pressure. End organ functioning is assessed by brain perfusion (mental status), skin and renal perfusion (urine output). Interventions range from compressions and cardiac medications to intravenous or IO insertion with fluid resuscitation.
Disability	Assess by establishing child's level of consciousness: GCS or AVPU (alert, verbal, response to pain, unresponsive)
Exposure	Remove clothing to examine for evidence or trauma, rashes. Measure core temperature and keep the child warm to prevent hypothermia.
Based on the above assessment, the child is illness categorized by type and severity: Respiratory (respiratory distress or failure) or circulatory (compensated or hypotensive shock). This categorization leads to the required interventions	

Utilizing the approach to assessment and evaluation decision making as outlined such as from AHA PALS[4], provides the algorithms to determine the interventions. Thank you again for this great question.
Jannell Plouffe

References

1. International Liaison Committee on Resuscitation. 2005 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations. *Circulation.* 2005; 112.
2. Zaritsky A, Morley P. 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Editorial: The evidence evaluation process for the 2005 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations. *Circulation.* 2005: 112.
3. Samson RA, Berg RA, Bingham R, et al. Use of automated external defibrillators for children: an update. An Advisory Statement from the Pediatric Advanced Life Support Task Force, International Liaison Committee on Resuscitation. Circulation. 2003;107:3250-3255.
4. Heart and Stroke Foundation of Canada & American Heart Association. (2006). Pediatric Advanced Life Support: PALS Course Guide.

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.

Dates to Remember

April 19, 2010	May 10, 2010
The Critical Eye . . . Focus On “Eating, Breathing, Sleeping Beyond the Basics” McPhillips Street Station 484 McPhillips Street Registration Deadline: April 9, 2010 Contact: Louise Lemoine (204) 787-3699	CACCN, Manitoba Chapter Edge of Excellence 2010 Norwood Hotel 112 Marion Ave Pamphlet and registration to follow Contact: Sara Unrau at sunrau@sbgh.mb.ca

For further information go to www.caccn.ca

Manitoba Chapter

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