IN THIS ISSUE:

20  Research Review

21  Nurses’ experiences of providing care to bereaved families who experience unexpected death in intensive care units: A narrative overview

30  End-of-life care in the ICU: Supporting nurses to provide high-quality care

34  Implementation of a unique RRT model in a tertiary care centre in Western Canada
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Vision statement
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
1. Leadership:
   • Lead collaborative teams in critical care interprofessional initiatives
   • Develop, revise and evaluate CACCN Standards of Care and Position Statements
   • Develop a political advocacy plan

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

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

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

5. Membership:
   • Strive for a steady and continued increase in CACCN membership
Critical Reflections

Having just finished chipping the ice off my driveway after a hard day of work, I am thankful that Wiarton Willie (Ontario) and Shubenacadie Sam (Nova Scotia) have predicted an early spring. With Central and Eastern Canada reporting, I am wondering why we haven’t heard news of any Marmota Manox (aka woodchuck) activity out west? Perhaps he is still digging himself out.

Have you visited the CACCN website lately? Much like most of Canada this winter, we have been digging ourselves out of the volumes of information and links on the website (www.caccn.ca). Members indicated on the CACCN survey the difficulty in locating information quickly on the site. Christine Halfkenny-Zellas, our Chief Operating Officer, and Marie Josée Champagne, a CACCN member from Montréal, collaborated to refresh and reduce the information on the website for ease of use and to better reflect our strategic plan.

The strategic plan has had a slight refresh, as well. At the Annual General Meeting of the members in September 2016, we shared the work being completed by the Board of Directors, our National Committees and our local CACCN Chapters. After careful review and consideration, we have reduced our National committees to four committees rather than six. I think the diagram below depicts our current structure beautifully. The four committees of Member Relations, Professional Development, National Conference and Partner Relations all support the mission and vision for the CACCN.

Thank you to the committee members who have been working diligently on growing our membership, providing educational opportunities through webinars, planning a robust national conference structure to meet the needs of our members and through growing our partner relations to keep us united and vibrantly engaged as a critical care association.

At this time, I would like to recognize, Lara Parker, Director, Western Region (British Columbia) and Carla MacDonald, Director, Eastern Region (Nova Scotia) for their National Board participation. Lara and Carla were elected to the Board of Directors in April 2015. As Member Relation Committee Chair, Lara has led the team with creativity, positivity and innovation. Carla, with her facilitation skills, has led the team with humour and passion in her role as Conference Advisory Committee Chair. Lara and Carla complete their two-year term on the national board as of March 31, 2017. Thank you both for all your hard work and wonderful contribution to the CACCN.

At present, there is a lot of great work going on around Choosing Wisely Canada (CWC), Critical Care Certification competency review and the upcoming revision of the Canadian Nurses Association (CNA) certification exam for adult critical care. On behalf of the Board of Directors, thank you to everyone who shares their time and energy in the great work of our critical care association.

In the fall of 2016, the CACCN embarked on a collaborative with the Canadian Nurses Association (CNA) to assist nurses in Dubai with preparing for the Canadian Certification Exams in critical care. The Dubai Health Authorities (DHA) have created a strategic plan for their nurses to write one of 10 certification specialty exams. Emergency nursing was the first certification to be written in 2015. Critical care and nephrology were added in 2016 and perinatal and perioperative will be added for 2017. The structure outlined by the DHA is for two educators to provide certification review sessions for a total of three separate exam sessions over one year. This is providing a great opportunity for the CACCN to develop much sought-after Canadian preparation materials for certification and to grow our partner relations.

There are so many opportunities to be involved in your specialty association. Right now, we are in need of some keen individuals to get involved at a chapter level in Ottawa. Being a part of the CACCN can be challenging, yes, but very rewarding. We try to recognize the volunteer work that you do by supporting your participation at our national Dynamics conference and continue to strive to ensure the energy you put into the CACCN is meaningful and valued. If you are interested in getting more involved, please contact the CACCN National office.

We all share one thing in common. We are all critical care nurses who are trying to make a difference. James Oppenheim once said, “The foolish man seeks happiness in the distance, the wise man grows it under his feet.” You don’t have to go far to Be the Difference.

Stay well! Stay positive! Thank you for the opportunity to continue to serve as your association president. Sincerely,

Renée Chauvin
President, CACCN
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MEET WITH HEALTH MATCH BC

healthmatchbc.org
Canadian Nurses Association joins Choosing Wisely Canada to help nurses and patients engage in conversations about unnecessary care

Ottawa, January 9, 2017 — In a first for Canada, the Canadian Nurses Association (CNA) has partnered with Choosing Wisely Canada (CWC) to release a list of nine recommendations to minimize unnecessary care. The list identifies tests, treatments and procedures commonly used in nursing that are unsupported by evidence and could expose patients to harm. The aim is to encourage dialogue between patients and their health-care providers to help make smart and effective choices for high-quality care. In releasing the list, CNA joins over 50 national medical professional societies who have already published (or plan to) a CWC list of recommendations. CNA is the first non-physician national group in Canada to do so.

To develop the list CNA established a nursing working group that represented Canada’s geographic diversity and the diversity of practice across nursing specialties. The group reviewed almost 200 items with corresponding evidence to generate its recommendations. The final list, which covers a wide range of care settings and patient populations, then underwent consultation with CNA members and other stakeholders before receiving approval from CNA’s board of directors.

The value of the nine-item list is easily seen through an example, such as recommendation five, which discourages the routine use of incontinence containment products for older adult and low-mobility patients. While this is an all-too-common practice, the evidence shows adverse outcomes including diminished self-esteem and perceived quality of life and a higher rate of skin problems and bladder infections. The recommendation also proposes adopting a care plan with shared decision-making that includes the wishes of the clients, caregivers and the wider health-care team.

“Choosing Wisely Canada is focused on changing health-care’s ‘more is better’ culture when it comes to medical tests, treatments and procedures,” said Dr. Wendy Levinson, CWC chair and co-founder and University of Toronto professor of medicine. “The goal of the campaign is to help health-care providers and patients decide together about the right tests and treatments at the right time while avoiding those that are unnecessary.”

“The Choosing Wisely Canada nursing list is a great way to engage patients and nurses in conversations about care. These conversations are opportunities to provide evidence-based information to empower patients and offer better patient care and reduced adverse outcomes,” said CNA president Barb Shellian.

See CNA’s Nine Things Nurses and Patients Should Question [page 10].

The Canadian Nurses Association is the national professional voice representing over 139,000 registered nurses and nurse practitioners in Canada. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada’s publicly funded, not-for-profit health system.

Choosing Wisely Canada is a national health care campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and make smart and effective choices to ensure high-quality care.

For more information, please contact:

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Reprinted with permission from the Canadian Nurses Association (CNA)
CNA leads development of first nursing list for Choosing Wisely Canada

By Karey Shuhendler, RN, CCHN(C), MN


Reprinted from the Canadian Nurse online edition (January/February 2017) with permission from the Canadian Nurses Association

CNA is about to release Nine Things Nurses and Patients Should Question for the Choosing Wisely Canada campaign. This list of evidence-informed statements aims to reduce overuse of interventions that either have no clear benefit or could cause harm.

Choosing Wisely Canada was launched in 2014 to help clinicians and patients more easily discuss whether certain tests, treatments and procedures are necessary. To date, more than 50 national medical professional societies have engaged in the campaign, and 30 have already released more than 180 evidence-informed recommendations in total.

Highlighting nursing expertise, the CNA document will be the first non-medical list released as part of the campaign. “We are delighted to have nursing join the campaign, since tackling the problem of overuse needs the full health-care team in order to be effective,” says Dr. Wendy Levinson, chair and co-founder of Choosing Wisely Canada. “Nursing leadership is critical to many of these common overuse problems, and CNA is providing that leadership.”

Last April, CNA created a Choosing Wisely Canada nursing working group (NWG), made up of 12 CNA members from across Canada and across various specialties. NWG members were chosen from nominations submitted by selected groups of the Canadian Network of Nursing Specialties and by CNA’s jurisdictions. “The process enabled nurses across the country to have a voice to collectively advise about major care choices that have an impact on all Canadians, no matter where they live,” notes NWG member Marcia Carr from British Columbia. She is a clinical nurse specialist in medicine, geriatric medicine and geriatric psychiatry and a nurse continence advisor.

NWG members demonstrated a strong commitment, underscored by their belief that CNA should contribute its nursing voice and expertise to this project. “As a registered nurse, I expect our national professional association to provide up-to-date and relevant information that will influence my practice and the safety of my patients,” says Kathy Bouwmeester, a critical care nurse from Alberta and an NWG member.

CNA developed the list using a comprehensive validation method. First, the NWG reviewed existing recommendations, including items from Choosing Wisely Canada’s medical professional societies and the American Academy of Nursing’s Choosing Wisely list, which had already undergone rigorous evidence reviews. In addition, NWG members brought forward recommendations on new evidence-based items. They appraised 195 items for relevance to nursing, using a structured process developed for this work. The items went through several rounds of review before the group reached consensus on the final list of nine. A literature review was conducted to confirm the evidence for these items; supporting nursing research was added where appropriate. The list subsequently underwent extensive consultation with input from nursing experts in patient safety and various members of the Canadian Network of Nursing Specialties, as well as patient advocates, CNA’s jurisdictional members, CNA nursing staff and Choosing Wisely Canada’s internal clinician reviewers.

Deborah Viel, a supervisor of community public health nursing in Nunavut at the time she was an NWG member, says, “This group’s focus was to have a Choosing Wisely Canada list that represents a wide range of practice settings and a broad scope of nursing practice. That means there is still work to be done to develop lists that address overuse of interventions in specialty areas of practice.”

CNA is embarking on the next phase of this work, partnering with members of the Canadian Network of Nursing Specialties to develop two specialty lists later this year.

Kathy Bouwmeester, CACCN Vice-President and Chair Partner Relations Committee participated on the Choosing Wisely Canada Nursing Working Group.
Nine Things Nurses and Patients Should Question

1. Don’t insert an indwelling urinary catheter or leave it in place without daily assessment.
   The use of indwelling urinary catheters among hospital patients is common. Yet it can also lead to preventable harms such as urinary tract infection, sepsis and delirium. Guidelines support routine assessment of appropriate urinary catheter indications—including acute urinary obstruction, critical illness and end-of-life care—and minimizing their duration of use. Strategies consistent with CAUTI (catheter-associated urinary tract infection) guidelines regarding inappropriate urinary catheter use have been shown to reduce health care-associated infections.

2. Don’t advise routine self-monitoring of blood glucose between appointments for clients with diabetes who do not require insulin.
   Certain groups recommend self-monitoring of blood glucose (SMBG) to help clients with diabetes monitor glycemic control. Yet many studies show that, over time, routine SMBG does little to control blood sugar for most non-insulin-using adults with type 2 diabetes. It should be noted that SMBG would be indicated during illness or medication change, and this should be part of client assessment and education.

3. Don’t add extra layers of bedding (sheets, pads) beneath patients on therapeutic surfaces.
   Additional layers of bedding can limit the pressure-dispersing capacities of therapeutic surfaces (such as therapeutic mattresses or cushions). As a result, extra sheets and pads can contribute to skin breakdown and impede the healing of existing pressure wounds.

4. Don’t use oxygen therapy to treat non-hypoxic dyspnea.
   Oxygen is frequently used to relieve shortness of breath. However, supplemental oxygen does not benefit patients who are short of breath but not hypoxic. Supplemental flow of air is as effective as oxygen for non-hypoxic dyspnea.

5. Don’t routinely use incontinence containment products (including briefs or pads) for older adults.
   Adult incontinence containment products are frequently used for continent patients (especially women) with low mobility. Yet the literature associates their use with multiple adverse outcomes including diminished self-esteem and perceived quality of life, and higher incidence rates of dermatitis, pressure wounds and urinary tract infections. Among older adults, nurses should conduct a thorough assessment to determine the risk of such outcomes before initiating or continuing the use of incontinence containment products. The development of a continence care plan should be a shared decision-making process that includes the known wishes of clients regarding care needs and the perspectives of carers and the health care team.

6. Don’t recommend tube feeding for clients with advanced dementia without ensuring a shared decision-making process that includes the known wishes of clients regarding future care needs and the perspectives of carers and the health care team.
   Tube feeding for older adults with advanced dementia offers no benefit over careful feeding assistance related to the outcomes of aspiration pneumonia and the extension of life. While food is the preferred form of obtaining nutrition, oral supplements may be beneficial if this intervention meets the person’s known goals of care. Tube feeding may contribute to client discomfort and result in agitation, the use of physical and/or chemical restraint and worsening pressure wounds.

Released January 9, 2017; Last updated January 9, 2017
Don’t recommend antipsychotic medicines as the first choice to treat symptoms of dementia.

People with dementia frequently exhibit responsive behaviors, which are often misinterpreted as aggression, resistance to care and challenging or disruptive behaviours. In such instances antipsychotic medicines are regularly prescribed. The benefit of these drugs is limited, however, and they can also cause serious harm including premature death. Their use should be limited to cases where non-pharmacologic measures have failed and where patients pose an imminent threat to themselves or others. Identifying and addressing the causes of behaviour change can render drug treatment unnecessary. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescriber.

Don’t recommend antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.

Signs and symptoms suggestive of urinary tract infection (UTI) are increased frequency, urgency, pain or burning on urination, supra-pubic pain, flank pain and fever. Dark, cloudy and/or foul-smelling urine may not be suggestive of UTI but rather of inadequate fluid intake. Cohort studies have found no adverse outcomes associated with asymptomatic bacteriuria for older adults. Not only does antimicrobial treatment for such bacteriuria in older adults show no benefits, it increases adverse antimicrobial effects. Consensus criteria have been developed for the specific clinical symptoms that (when associated with bacteriuria) define UTI. Exceptions to these criteria include recommended screening for and treatment of asymptomatic bacteriuria before urologic procedures where mucosal bleeding is anticipated. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescribers.

Don’t routinely recommend antidepressants as a first-line treatment for mild depressive symptoms in adults.

Antidepressant response rates are higher for moderate or severe adult depression. For mild depressive symptoms a complete assessment, ongoing support and monitoring, psychosocial interventions and lifestyle modifications should be the first lines of treatment. This approach can avoid the side-effects of medication and establish etiological factors important to future assessment and management. Antidepressants are appropriate in cases of persistent mild depression where a past history of more severe depression exists or where other interventions have failed. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescriber.

How the list was created

The Canadian Nurses Association (CNA) established its Choosing Wisely Canada nursing list by convening a 12-member nursing working group (NWG) of diverse nurse experts from across Canada representing a broad range of geographical regions, practice settings and experience. The NWG began considering its potential list by reviewing existing recommendations, including items from Choosing Wisely Canada’s specialty societies and the American Academy of Nursing (AAN) Choosing Wisely® list, which had already undergone rigorous evidence reviews. In addition, members brought forward recommendations on new evidence-based items. The NWG appraised 195 items for relevance to nursing using a structured process developed for this work. Each of these (171 Choosing Wisely Canada physician-related items, 15 AAN Choosing Wisely items and nine independently submitted items) was appraised by two independent reviewers. Using a modified Delphi process for the next two rounds of revision, the group then refined and adapted 36 items until reaching consensus on a final nine-item list. A literature review was conducted to confirm the evidence for these items, and supporting nursing research was added where appropriate. Subsequently, the final list underwent extensive consultation, in which further input was obtained from nursing experts in patient safety, various members of the Canadian Network of Nursing Specialties, CNA, its jurisdictional members and patient advocates. In November 2016, the Choosing Wisely Canada nursing list was presented to CNA’s board of directors, who gave it their full endorsement and support.
References


About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and help physicians and patients make smart and effective choices to ensure high-quality care.

For more information on Choosing Wisely Canada or to see other lists of Things Clinicians and Patients Should Question, visit www.choosingwiselycanada.org. Join the conversation on Twitter @ChooseWiselyCA.

About The Canadian Nurses Association

The Canadian Nurses Association (CNA) is a proud partner of the Choosing Wisely Canada campaign. CNA is a powerful, unified voice for Canada’s registered nurses. It represents registered nurses from 11 provincial and territorial nursing associations and colleges, independent registered nurses, and retired registered nurses across the country. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada’s publicly funded, not-for-profit health system.

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CACCN Committees

Revised February 9, 2017

At our board meeting in September 2016, the Board of Directors realigned the National Committees in an effort to evenly distribute the workload, as two committees are very work intensive. As a result of the discussions, the National Board dissolved the Finance and Communications Committee. The work of the Finance Committee will rest with the Board Executive Committee: president, vice-president, treasurer and chief operating officer. The work of the Communications Committee will rest with the Chief Financial Officer.

Under the realignment, the current national committees are as follows:

Conference Committee: Chair: Carla MacDonald  
*Incoming Co-Chairs: Shirley Marr and Angela Foote

Member Relations: Chair: Lara Parker  
*Incoming Chair: Rob Mazur

Partner Relations: Chair: Kathy Bouwmeester

Professional Development: Chair: Mélanie Gauthier  
*Incoming Co-Chair: Sarah Crowe

The committees have been actively working on projects that will benefit our membership. The following are brief updates of the committee work to date:

Conference Committee:
The Call for Abstracts for the Dynamics of Critical Care™ Conference 2017 in Toronto, ON, was prepared and released in the Winter 2016 Canadian Journal of Critical Care Nursing. The information was also provided directly to hospitals and the CACCN Communication Boards across the country. The committee is currently working on speaker selections prior to commencing the review of the abstracts received. The deadline for submission of an abstract for Dynamics 2017 is February 22, 2017, at 2359 PST.

Member Relations:
The member relations committee continues to work on recruitment and retention for the Association. As part of our attraction plan, the committee has been contacting critical care nursing programs around the country to introduce CACCN and to make arrangements for our chapter leadership to visit the graduating classes to share information about CACCN and how the association could be beneficial to their nursing careers. At the recommendation of the Member Relations Committee, CACCN will once again advertise a new member promotion in the Canadian Nurse magazine from March to June 30, 2017.

Partner Relations:
The partner relations committee has been busy with invitations from our critical care colleagues to participate on national committees. CACCN has participated on the following committees over the past year:

1. Canadian Nurses Association, Certification Program Advisory Committee. CACCN Committee Representative: Kimberly Pennell (AB).

2. Canadian Nurses Association, Certification Review Committee. CACCN has a number of members who participated in the Certification Examination Competency Development Session in December 2016: Vininder Kour Bains (BC), Tricia Bray (AB), Barbara Fagan (NS), Christine Filippek (AB), Mélanie Gauthier (QC), Trudy Nernberg (MB) and Betty Skarpinsky (SK).

3. Canadian Nurses Association, Network Grant Committee. Christine R. Halfkenny-Zellas, CACCN Chief Operating Officer is the CACCN representative.

4. Choosing Wisely Critical Care Working Group with our physician partners. CACCN Committee Representative: Brenda L. Morgan (ON).

5. Choosing Wisely National Nursing Working Group through the Canadian Nurses Association. CACCN Committee Representative: Kathy Bouwmeester, Vice President, Chair, Partners Committee (AB). The results from the working group were released in January 2017. See information on this page.

6. Ontario Ministry of Advanced Education and Skills Development (MAESD), Registered Nurse – Critical Care Nursing Program Standard Consultation, Review and Development. CACCN Committee Representatives: Patricia Connick (ON), Craig Dale (ON) and Sonia Hill (ON).


8. Accreditation Canada, Q-mentum Critical Care Standards. CACCN Committee Representatives: Karen Dryden-Palmer (ON) and Myriam Breau (NB).

9. Patient and Family Centred Care Project with our physician partners. CACCN Committee Representatives: Karen Dryden-Palmer (ON), Marie Edwards (MB), Michael Metzger (AB), Lara Parker (BC), and Sonia Hill (ON). Results from this project will be released by the researchers in the near future.

Professional Development Committee
The professional development committee has been actively reviewing and revising the CACCN Standards for Critical Care Nursing Practice (4th ed.) and the CACCN Certification—CNCC(C)—Study Tool. These items will be finalized in the coming months. As well, the professional development committee has been actively working with our partners to identify potential webinar topics for 2017. A pre-recorded webinar on CACCN Certification Study Tips will be available shortly to assist members to successfully write the certification examinations.

We thank our committee members for their participation! If you are interested in participating on a committee, please contact CACCN National Office at caccn@caccn.ca.
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September 25–27, 2017

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The Dynamics of Critical Care™ 2017 Conference Flyer/Brochure: The Summer Abstract Edition (May 2017) of the Canadian Journal of Critical Care Nursing™ will include a colour flyer providing information on the Dynamics 2017 conference, accommodation and travel. The full colour electronic brochure and online registration will be available on the CACCN website at www.caccn.ca in early June 2017.
“Having the official CNA certification credential after your name indicates to patients, employers, the public and professional-licensing bodies that you are qualified, competent and current in a nursing specialty/area of nursing practice. It distinguishes you as a registered nurse who Cares to Be the Best!” (http://nurse-one.ca/en/certification)

In April 2015, Tanya Spence and Kyla Murray, Alberta Children’s Hospital (Calgary, AB) and Ruth Trinier, Hospital for Sick Children (Toronto, ON) met in Ottawa with Assessment Strategies Inc., on behalf of the Canadian Nurses Association Certification Program to assist with question development for the Critical Care Pediatric practice examination. During the meeting, discussions were held regarding the value of specialty certification and the small numbers of pediatric nurses in Canada who hold the designation.

With a goal to improve the quality of care provided to all critically ill children in Canada, all pediatric intensive care units across the country were invited to participate in a CNCCP(C) (Certified Nurse in Critical Care Pediatrics) certification challenge issued jointly from the pediatric intensive care units at The Hospital for Sick Children and Alberta Children’s Hospital.

The criteria for the challenge was:
1. The unit in Canada with the highest percentage of CNCCP(C) nurses as of May 2016.
2. The unit in Canada with the greatest increase in percentage of CNCCP(C) nurses before and after the March 2016 exam.

The majority of the units providing critical care to children in Canada agreed to enter the challenge.

With CNA’s development of the online certification examination process, the examinations originally planned for May 2016 were delayed until the fall of 2016. With this change, the original challenge criteria were updated:
1. The unit in Canada with the highest percentage of CNCCP(C) nurses following the 2016 exam.
2. The unit in Canada with the greatest increase in percentage of CNCCP(C) nurses before and after the 2016 exam.

To assist nurses in their preparation for certification, CACCN offered a complimentary four-part webinar series during July and August 2016, reviewing competencies covered on the exam. These webinars were facilitated by Ruth Trinier and Karen Dryden-Palmer at the Hospital for Sick Children. Each webinar was recorded and archived on the CACCN Members Only website for those seeking certification in the future.

As a result of the challenge, Tanya and Ruth were pleased to note following the 2016 certification examination that the number of nurses certified in Critical Care Pediatrics had risen from 130 nurses to 156 nurses. This represents an increase of twenty percent (20%) over previous years.

CACCN Board of Directors is pleased to offer congratulations to the following units:

Highest percentage of CNCCP(C) nurses following the 2016 exam
Janeway Children’s Health and Rehabilitation Centre, St. John’s NL
50% of nursing staff CNCCP(C) certified

Greatest increase in percentage of CNCCP(C) nurses before and after the 2016 exam
Alberta Children’s Hospital, Calgary, AB
11% increase in CNCCP(C) certified nursing staff

The Board also congratulates the following units for taking part in the challenge:
- Alberta Children’s Hospital, Calgary, AB
- British Columbia Children’s Hospital, Vancouver, BC
- Children’s Hospital, London Health Sciences Centre, London, ON
- Hospital for Sick Children CCCU, Toronto, ON
- Hospital for Sick Children PICU, Toronto, ON
- Health Sciences Centre Children’s Hospital, Winnipeg, MB
- IWK Health Centre, Halifax, NS
- Janeway Children’s Health and Rehabilitation Centre, St. John’s, NL

Thank you to the unit leaders who embraced the challenge, and to Tanya and Ruth who designed and spearheaded the project. We would particularly like to thank the pediatric critical care nurses for your participation, dedication and commitment to your patients and families through critical care certification!

Congratulations!
Join the growing network of more than 18,000 CNA-certified RNs at the leading edge of health care. Being CNA certified shows that you’re committed to an advanced standard of professional competence and have a comprehensive understanding of your nursing specialty. Become CNA certified! Show that you Care to Be the Best.

Certified Nurses Day—March 19, 2017

Certified Nurses Day recognizes the contributions of certified RNs to advancing the profession and supporting continuing competence. Created by the American Nurses Credentialing Center and the American Nurses Association in 2008, it’s now celebrated around the world. In Canada, 18,039 RNs are CNA certified in one of 20 specialties/areas of nursing practice. Congratulations to all CACCN Members who are certified in our specialty—Canadian Critical Care Nurses Certification—Adult and Paediatric!

Registration and exam information

- January 3–March 1: CNA Certification Applications open
- May 1–15: CNA Certification Examination Dates
- June 1–September 1: CNA Certification Applications open
- November 1–15: CNA Certification Examination Dates
- Register Online ~ visit Get Certified at: www.nurse-one.ca/en/certification

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CACCN online

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Dynamics of Critical Care Conference: Future Sites

Dynamics 2017: September 25–27, 2017, Toronto, ON

Dynamics 2018: September 2018, Calgary, AB
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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.

By working together, we are building a stronger Association!

CACCN Award Ceremony 2016
Sage Poster Bursary Recipients

CACCN calendar of events

DATES TO REMEMBER!

Jan. 3–March 1: CNA Certification Applications open
March 11–12: BOD F2F Meeting
March 31: Dynamics 2018 Call for Planning Committee Members deadline
May 1–15: CNA Certification Examination Dates
May 31: Chapter of the Year Award Application deadline
June 1: Brenda Morgan Leadership Excellence Award deadline
June 1: Spacelabs Healthcare Innovative Project Award deadline
June 1: CACCN “Chasing Excellence” Award deadline
June 1: BBraun “Sharing Expertise” Award deadline
June 1–Sept. 1: CNA Certification Applications open
July 5: Board of Directors Nominations deadline
August 15: CACCN Canadian ICU Week Spotlight Challenge Award
August (tbd): Dynamics 2017 Early Bird Registration Deadline
September (tbd): Dynamics 2017 Final Registration Deadline
Sept. 22–23: BOD F2F Meeting
September 24: Chapter Connections Day
Sept. 25–27: Dynamics of Critical Care Conference
November 1–15: CNA Certification Examination Dates

Criteria:
1. Current / Active CACCN Memberships 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 received per quarter.

www.caccn.ca

CACCN Membership Recruitment Referral Draw Recipients

Congratulations to the following CACCN members who received a complimentary one-year membership ($75 value) for their member referral:

Q3 – October 1 to December 31, 2016
Peter Anderst, Edmonton, AB
Guylaine Gotchia, Regina, SK

National Nursing Week

National Nursing Week, May 9–16, 2017, includes International Nurses Day and Florence Nightingale’s birthday on May 12.

With more than 408,000 regulated nurses in Canada, the largest of any health provider group, nurses are the backbone of our health system. National Nursing Week recognizes the nursing profession for its dedication and commitment to making Canada a healthier nation.
Research Review

Citation

Background
Delirium is a common occurrence for patients in the ICU and can have a profound and lasting impact on them. There have been relatively few studies that describe the perceptions of critically ill patients who have experienced delirium.

Purpose of the study
To describe intensive care patients’ perceptions of delirium.

Research approach and methods
A hermeneutic qualitative study was designed using semi-structured interviews. The design was based on Crist and Tanner’s (2003) interpretative hermeneutic framework.

Setting and sample
The study was conducted in ICUs of a general public hospital in Antwerp, Belgium. Purposive sampling was used to select participants. Every patient who scored positive for delirium at least once during the ICU stay was eligible for inclusion. Screening for delirium was done by nurses using the Neelon and Champagne Confusion Scale (van Rompaey et al., 2008). The participants were English- or Dutch-speaking adults, with a minimum Glasgow Coma Scale of 13 at the time of the interview, and a stay of at least 24 hours in the ICU. The participants were interviewed at least 48 hours after the last positive score for delirium.

Findings
Data saturation was achieved after interviewing 30 patients. Most of the participants remembered being delirious, and they were able to vividly describe perceptions and feelings. Some patients recalled the period as “bizarre”, and they were not able to describe exactly what happened. Few patients indicated they had no recollection, but one patient denied he was ever confused or delirious.

Perceptions were categorized in four themes: contact and communication, feelings, sleep and time, and implication of the delirious period. Contact and communication were disrupted due to a deficit in self-expression. Both oral and written communication were limited. The communication with nurses, however, was considered normal and nonthreatening. Moreover, when the staff approached the patient calmly, the patients were reassured. The perception of time was disturbed heavily, resulting in an abnormal sleep pattern. The prominent feeling was fear, although the origin of fear was seldom defined. Frustration, anger, guilt and shame were also expressed. Patients felt embarrassed when they became abusive towards nursing staff or visitors. Loneliness, restlessness, incomprehension and tiredness were also reported. A striking feeling was the joy at the end of the delirious period. The start of the period was less remembered, and the recovery was gradual. Participants reported relief when the delirium had ended.

Commentary
Using the hermeneutic study design, the researchers’ prior knowledge and experience are important to the interpretation of the findings. Since the researchers of this study had prior knowledge of delirium, it was an appropriate method to use. During the process, the prior knowledge is subject to changes leading to a deeper understanding of the studied phenomenon. Moreover, hermeneutic approaches are suitable to clarify incomplete, confusing or conflicting data, thus again being an appropriate approach in delirium research.

As with most studies, there are strengths and weaknesses associated with this one. Generalizability and credibility are biased inherent to the study design. In a similar recent study Whitehorne, Gaudine, Meadus, and Solberg (2015) studied the lived experience of critically ill patients who experienced delirium and found only one similar theme: “Fear and safety concerns”. The other themes they found contrary to this study were “I can’t remember”, “Wanting to make a connection”, and “Trying to get it straight”.

Since all interviews were performed by one interviewer and there was no observation or intervention from a third person, this provides a strength to the study. Another strength was the open-minded interview with a large number of patients, thus minimizing the risk of bias of results caused by socially desirable answers. In addition, interviewing the patients shortly after the delirium enabled a fresh recall of the perceptions.

The results of this study have given us an additional understanding of patients’ perceptions during delirium in the ICU. To further explore patients’ perceptions, the derived themes can be further explored through nursing research.

Paula Price, PhD, RN
Editor CJCCN
Acting Director, School of Nursing and Midwifery
Mount Royal University

REFERENCES
Nurses’ experiences of providing care to bereaved families who experience unexpected death in intensive care units: A narrative overview

By Aalia Shariff, MN, RN, Joanne Olson, PhD, RN, FAAN, Anna Santos Salas, PhD, RN, Lisa Cranley, PhD, RN

Abstract

Background: Death is a common occurrence in intensive care units (ICUs) and the complexity of care makes it difficult for nurses to find a balance between the patient’s physical needs and the family’s emotional needs, especially in circumstances of unexpected death. Cumulative or unresolved grief for families can have lasting negative repercussions. Nurses, therefore, need access to bereavement education in order to provide optimal bereavement support.

Purpose: The purpose of this review is to identify challenges and facilitators that nurses experience in delivering bereavement support during and after sudden or unexpected death in ICUs.

Methods: A narrative overview was conducted based on a literature search using CINAHL, Medline, PsyInfo, Scopus, and Proquest databases, as well as grey literature, revealing 241 articles, 15 of which met inclusion criteria.

Findings: Four themes surrounding bereavement support in the ICUs emerged: influence of hospital policies and organizational constraints; significance of time and trust; level of knowledge and support of staff; and nurses’ inner conflict, moral distress, and personal ways of coping.

Conclusion: The availability of up-to-date literature in this area is limited. Further research could inform organizational policies, nursing education, and nursing staff development to address existing barriers. With adequate resources, practical strategies could be implemented to provide bereavement support that ensures optimal bereavement outcomes for families experiencing sudden or unexpected death in ICUs.

Key words: Sudden death, unexpected death, bereavement support, grief support, intensive care, end of life, death and dying, nurses’ experience, family support

The experience of death and dying has changed significantly throughout history. Advances in science and technology have increased treatment options in modern medicine, making patient survival a priority. Death, once viewed as a normal process, is now seen as an encroachment on life and increasingly difficult to accept. Indeed, intensive care units (ICUs) were designed to prevent death, not to support the dying (Liaschenko, O’Conner-Von, & Peden-McAlpine, 2009).

The loss of a loved one is among the most distressing emotional experiences people face (Kurian et al., 2014). When a death occurs suddenly, caregivers have little time to anticipate the experience and those bereaved have had little or no emotional preparation for facing the loss of someone they love (Eastham, 1990; Kobler, 2014). Sudden death, according to Brysiewicz (2008), is “a natural or unnatural death which is unexpected; occurs without warning, and in some cases, could have been prevented” (p. 224). The occurrence of unexpected events and the complexity and intensity of the environment make the experience of losing a loved one in the ICU significantly different from other hospital settings (Van der Klink et al., 2010).

The sequence of events preceding the death of a loved one and the care of the family during this time is crucial in the bereavement process (LeBroc et al., 2003; Van der Klink et al., 2010). Bereavement is defined by Onstott (1998) as “the state of having experienced the loss of someone close through death” (p. 830) and bereavement support in the hospital is “remaining with the family, as they absorb the information that their loved one has passed, answering any questions they may pose, listening to them express their feelings, providing emotional support, and remaining with them as they view the deceased” (Kurian et al., 2014, p. 31). Insufficient support or inadequately addressing emotions around grief can result in complicated or unresolved grief with long-term repercussions (Brysiewicz, 2008; Kurian et al., 2014). Grief is a process in reaction to the loss of a loved person or thing (Eastham, 1990), and an unanticipated death can exaggerate this process for the bereaved (Brysiewicz, 2008).

In the ICU, nurses spend more time with patients and their families than any other health professional does, and are in a unique position to facilitate the exchange of information among all persons involved in patient care (Hamric & Blackhall, 2007). Arbour and Weigand (2014) found that ICU nurses are aware of their roles and responsibilities with end-of-life care, but consider themselves underprepared and unable to carry them out. The struggle to find a balance between addressing the physical and emotional needs of the patient and family makes satisfactory end-of-life care in critical care settings difficult to achieve, leaving nurses dissatisfied and frustrated (Van der Klink et al., 2010).

Frequent exposure to death and dying, along with the complex emotions involved, makes nurses vulnerable to emotional, physical, and psychological ramifications (Stayt, 2010). Stayt (2010) suggests that awareness of the factors that affect nurses’ response to patient death are necessary to direct educational programs, organizational policies and accommodate the provision of adequate resources in order for nurses to develop effective coping strategies when caring for families who experience the unexpected death of a loved one.
**Purpose**
The purpose of this literature review was to explore the literature related to experiences of registered nurses delivering end-of-life care and bereavement support to families of patients who die suddenly or unexpectedly in the ICU. We sought to investigate published accounts of the challenges nurses face in delivering satisfactory bereavement support and facilitators of this process.

**Methods**
A narrative overview was adopted as the framework for this review. This is one of three types of narrative literature reviews described by Green, Johnson, and Adams (2006) as useful for synthesizing published information into a single source, thus bringing practitioners up to date. A search of bereavement literature was conducted using key and synonymous terms for “sudden/unexpected death”, “intensive/critical care”, and “grief/bereavement support”. Additionally, articles from grey literature, including those obtained during preliminary research and through manual reference list checks were considered. Articles were included if they discussed sudden/unexpected death or rapid deterioration of a patient leading to death, and met the following criteria: discussed (a) nurses’ experiences with supporting families while caring for the dying patient; (b) death that took place in a critical care or ICU setting (due to the limited information found specific to ICU, the search was later expanded to include sudden deaths in emergency rooms [ERs] and operating rooms [ORs] as death in both of these settings can be very similar to ICUs); and (c) deaths of adult patients; or (d) strategies for nurses to deal with sudden death or bereavement programs applicable to adult ICUs; or (e) an exploration of families’ lived experience with sudden or unexpected death providing insight into useful behaviours of healthcare providers.

**Findings and discussion**
As shown in Figure 1, a total of 241 records were retrieved: 176 from CINAHL/Medline for 1975 to September 2015; 16 from PsycInfo for 2000 to September 2015, 33 from Scopus for 2000 to September 2015, five from Proquest for 2000 to 2012 and 11 articles constituting grey literature. Removal of duplicates reduced this number to 107 and screening titles and abstracts for relevance left 28. These remaining articles were subject to a full-text assessment of which 15 articles were included in the narrative overview. Table 1 presents a brief summary of these articles, in alphabetical order.

The articles that informed the study were published between 1989 and 2015 and included a combination of quantitative studies (n=3), qualitative studies (n=7), a case study (n=1), an administrative review (n=1) and discussion pieces (n=3). An inductive approach identified four themes that captured nurses’ perceptions around bereavement support in the ICU: influence of hospital policies organizational constraints; significance of time and trust; level of knowledge and available support staff; and inner conflict, moral distress, and personal ways of coping.

**Influence of hospital policies and organizational constraints**
According to Bloomer and O’Connor (2012), nurses are aware of the importance of allowing bereaved families time and privacy to grieve the loss of their loved one. Restrictions, such as inflexible visiting hours or restrictions on number of family members allowed in a patient’s room at one time, as well as the pressures placed on ICU staff to make beds available for admissions, are organizational constraints that hinder the provision of adequate time and emotional support (Bloomer & O’Connor, 2012; Iglesias, Pascual, & de Bengoa Vallejo, 2013). Further challenges include the pressure to attend to post-mortem care and rituals,
Table 1: Summary of articles included in narrative overview

<table>
<thead>
<tr>
<th>Author</th>
<th>Research design and/or Objectives</th>
<th>Sample characteristics</th>
<th>Results/findings/key themes</th>
<th>Strengths and limitations</th>
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| Bloomer, M., & O'Connor, M. (2012).         | Qualitative, explorative study using focus groups To examine how nurses support family members during and after death in the intensive care unit | Two focus groups of up to 6 nurses were undertaken at each ICU (no demographic data provided)                                                                                                                            | Participants expressed importance of spending time with family, maintaining open communication, preparing them for impending death and supporting them after death; however, organizational constraints and pressures often make this challenging. This includes pressure to take new admissions and lack of specialist support personnel, particularly outside of office hours | Limitations:  
- Limited geographic scope of study  
- Small sample size  
- No demographic data provided  
Strengths:  
- Interviews recorded for ease of transcription  
- Data independently analyzed by each investigator |
| Brysiewicz, P. (2008).                     | Qualitative, Hermeneutic phenomenology to describe the lived experiences of families in KwaZulu-Natal, South Africa who had lost a loved one to sudden death | Five bereaved family members who had lost a loved one to sudden death and who were members of a bereavement support group                                                                                               | Five themes were revealed:  
1) Cold reception of staff: nurses that were evasive in providing information and spent too much time on protocols  
2) Lack of closure: inadequate information provided  
3) Acknowledgement of loss through small gestures (snack or a drink) or offering help (calling other family); preparing the body for viewing demonstrating care; being present  
4) Loneliness of grief: knowing where to access support or counselling  
5) Helping others: families felt inspired to help others | Limitations:  
- Focus on family perceptions versus nurses’ experiences  
Strengths:  
- Findings inform nursing behaviours that were useful and those that were less helpful |
| Collins, S. (1989).                        | Discussion article that outlines a protocol for critical care nurses to deal with sudden death and assist patient relatives. | One case application included.                                                                                                                                                                                         | Aspects of a sudden death protocol are described as follows: Use of team approach, notification of survivors, meeting the survivors, providing emotional support, viewing the body, following the viewing, follow up support | Limitations:  
- No description on the process of developing the protocol or sources of evidence for the development of the protocol  
- Dated literature review (published in 1989)  
Strengths:  
- Practical strategies provided with case application  
- Protocol focuses on sudden death  
- Promotes interdisciplinary approach |
| Eastham, K. (1990) doi:10.1016/0266-612X(90)90020-8 | Discussion paper                                                                                                                               | N/A                                                                                                                                                                                                                      | Discussion of the psychological responses to dying and bereavement, stress of caring for bereaved families, and the provision of education, training, and support to staff | Limitations:  
- Lacks a systematic approach to analyze the literature  
- Article from 1990, so the discussion is based on dated literature review  
Strengths:  
- Specific to critical care (expected and unexpected death)  
- At the time of publication, this paper provided an informed discussion on the topic. |
| Hinderer, K.A. (2012)                      | Qualitative, phenomenological pilot study to explore the lived experience of the critical care nurse who encounters patients’ death                       | Six critical care nurses:  
- Mean age 41 years  
- Average years of experience in critical care 15.7 years  
- All female  | Four major themes were identified:  
1) Ability to cope with death associated with years of clinical experience and family's acceptance  
2) Personal distress as one of the worst responses to patient death.  
3) Emotional disconnection as a coping mechanism  
4) Attitude towards death  
Study findings suggest that critical care nurses would benefit from continuing education on healthy coping mechanisms | Limitations:  
- Homogenous sample, limiting generalizability  
- Small sample size  
- Researcher had relationship with participants  
- Demographics of participants was consistent with demographics of unit of recruitment  
Strengths:  
- Lacks a systematic approach to analyze the literature  
- Article from 1990, so the discussion is based on dated literature review  
Strengths:  
- Specific to critical care (expected and unexpected death)  
- At the time of publication, this paper provided an informed discussion on the topic. |
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<tr>
<th>Authors</th>
<th>Description</th>
<th>Sample</th>
<th>Findings</th>
<th>Limitations</th>
<th>Strengths</th>
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<tr>
<td>Iglesias, M.E.L., Pascual, C., &amp; de Bengoa Vallejo, R.B. (2013).</td>
<td>Quantitative study using questionnaires to identify aspects of care that health professionals consider to be either facilitators or barriers to providing good care to patients and their families in end of life situations.</td>
<td>227 critical care nurses: 190 females, 35 males, 194 adult, 33 pediatric. Range of experience in ICU 4–16 years. Age range 28–39 years. ICU in 2 highly complex hospitals.</td>
<td>Barriers: - When physicians are evasive and avoid the family - When terminally ill patients experience painful interventions - When the family is not accepting of a poor prognosis Facilitators: - When families experience a peaceful and dignified bedside scene when the patient dies with the privacy and time to grieve.</td>
<td>Limitations: - Homogenous sample size with volunteer participation affecting attitude of respondents versus non-respondents - Study limited to questions in the survey Strengths: - Large sample size - Clear methodology provided with description on questionnaire and measurement tools</td>
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<td>Kobler, K. (2014).</td>
<td>Case study of unit’s response to unexpected death, to identify strategies to best guide teams when death arrives without warning and provide ideas for co-creating rituals to honour relationship in the midst of tragedy.</td>
<td>Case study presents one unit’s response (interdisciplinary team) to a clinical scenario in a Level III NICU involving an unexpected death of a long term male patient.</td>
<td>The article provided valuable insight into: - Mobilizing team resources to cope with death - Effective communication after death - Administrative acknowledgement of caregiver grief - Team processing - Encouraging reflective practice and self-awareness - Use of rituals.</td>
<td>Limitations: - Strategies were developed to assist pediatric nurses respond to unexpected death - Findings are limited to the case study and a larger study would enhance transferability Strengths: - Multidisciplinary approach was used to develop coping strategies, based on real case</td>
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<td>Kurian, M.J., Daniel, S., James, A., James, C., Joseph, L., Malecha, A.T., ... Mick, J.M. (2014).</td>
<td>Quantitative, post-test only survey was used to ascertain ICU nurses' current practice and beliefs about bereavement care, their role in bereavement support and their interest and education related to bereavement, after receiving training through a bereavement program.</td>
<td>Sample of 130 RNs: - Age 56% 18–39 years, 44% 40–50 years - Years of experience: 65% 0–15 years, 35% 16–21 years - 4 adult ICUs at a trauma hospital</td>
<td>- 110 RNs completed the survey - Majority agreed it was their role to provide bereavement support to relatives - 46% indicated insufficient education and training with providing bereavement care - No significant association between age and or experience and bereavement support.</td>
<td>Limitations: - No baseline data - Family satisfaction was not evaluated - Data collected from one site - Target sample size not met Strengths: - Interdisciplinary team approach to survey implementation - Participants recruited from 4 sites</td>
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<td>Leash, R.M. (1996).</td>
<td>Guidelines developed as a result of an exploratory survey that sought to develop a protocol for notifying and supporting the bereaved.</td>
<td>Survey included 200 medical professionals, 100 university students in death and dying courses and 100 bereaved family members.</td>
<td>- The guidelines developed outlined the following areas: timing of contact, notification setting, selecting a notifier, facilitating the family arrival, telephone disclosure, building a context of loss, viewing the body.</td>
<td>Limitations: - Not specific to sudden death Strengths: - Practical strategies identified in collaboration with healthcare professionals, students, and families - Large sample size - Participants from multiple settings</td>
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<td>LeBrocq, P., Charles, A., Chan, T., &amp; Buchanan, M. (2003).</td>
<td>An administrative review to evaluate the effectiveness of an intervention originated in a qualitative clinical project. The goal of the intervention was to improve the care of all those involved with a death in the emergency department (ED).</td>
<td>No sample size or demographics available. Participants included staff and family members of patients who experienced death in the ED.</td>
<td>- The program was developed in response to a need expressed by staff with focus on improving care at two stages. 1) in the ED following the death of a critically ill patient, 2) routine follow up. This was achieved through increased awareness, education, collaboration and evaluation. The feedback received in the evaluation process contained positive comments in support of the program from both staff and families.</td>
<td>Limitations: - Poor response rate from both ED nurses (42%) and families (11%) Strengths: - Evaluation of program included staff and family members - Multidisciplinary involvement in developing the program</td>
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<tr>
<td>Study</td>
<td>Methodology</td>
<td>Participants</td>
<td>Themes/Findings</td>
<td>Limitations</td>
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<td>Liachenko, J., O’Connor-Von, S., &amp; Peden-McAlpine, C. (2009).</td>
<td>Qualitative study to investigate factors influencing critical care nurses’ inclusion of family in end of life care</td>
<td>27 critical care RNs: • Mean age 43 years • Mean years of critical care experience 15 years • Recruited from 2 western medical centres</td>
<td>Three key themes identified: 1) Supporting the family’s journey through the dying process by orchestrating, interpreting and acting on information for families; building trusting relationships with families; taking the unit culture and its influences into consideration 2) How space influence end of life care: advocating for privacy and space; manipulating the environment to accommodate needs of the family 3) The importance of narrative in providing end of life care in critical care: creating a culture of knowledge and encouraging participation</td>
<td>• Limited geographic scope of the study • Limited demographics provided</td>
<td>Strengths: • Interviews were audiotaped and transcribed verbatim for accuracy</td>
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<td>Onstott, A.T. (1998).</td>
<td>Qualitative study using focus groups and individual discussions on 4 areas dealing with unexpected death: 1) Occurrence, 2) Storytelling, 3) Grief process 4) Skill self-assessment</td>
<td>Perioperative nurses (no sample size or demographic data available)</td>
<td>The acronym “CARES” (Control, Anger, Review procedures, Expect time to heal, Scarcity of knowledge and time) synthesises how OR nurses experienced sudden death. “RELIEVE” was developed as an educational model to guide the management of sudden death. (Remain calm, Evaluate family’s anticipatory grief, Let family participate, Information giving, Elements of physical, emotional, and spiritual care, Validate family’s grief, Emotional experience- seek out support and self-care)</td>
<td>• No clear methodology provided • No demographic data</td>
<td>Strengths: • Expands on psychosocial nursing care</td>
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<td>Shorter, M., &amp; Stayt, L.C. (2010).</td>
<td>Qualitative study, Heideggerian phenomenological approach to explore critical care nurses’ experiences of grief and their coping mechanisms when a patient dies</td>
<td>Eight critical care RNs: • All female • Range of experience in ICU 8 mo–6 years • had not experienced death of a loved one within 6 months of the study</td>
<td>The death experience: • Good death perceived as being expected and controlled • Establishing a relationship with the family in order to provide good nursing care. Close relationships also made nurses’ response to grief more upsetting • Coping mechanisms: Formal (clinical supervision or debriefing) vs informal (peer support,) support, normalization of death and emotional dissociation</td>
<td>• Single clinical setting • Majority of nurses &lt;6 years of experience • All female participants</td>
<td>Strengths: • Incorporated variation of experience • Rigour was maintained in data collection through annotated versions of each interview</td>
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<td>Stayt, L. (2010).</td>
<td>Article originated from a qualitative study, to explore critical care nurses’ grief and their experiences of caring for dying patients</td>
<td>Eight critical care nurses (no demographic data available)</td>
<td>Factors that influence the grief experience: • Perspective on what constitutes a good death • Emotional disassociation as a coping strategy • Chatting with colleagues as a way of coping • Level of education and awareness</td>
<td>• No demographic data • No clear methodology provided</td>
<td>Strengths: • Thematic analysis generated themes of the study</td>
</tr>
<tr>
<td>Van der Klink, M.A., Heijboer, L., Hofhuis, J.G.M., Hovingh, A., Rommes, J.H., Westerman, M.J., &amp; Spronk, P.E. (2010).</td>
<td>Quantitative, exploratory cross-sectional study using structured telephone interviews to describe the characteristics of bereavement, to find out if there is a need for follow-up bereavement services and to determine if the information of care in the ICU is sufficient for relatives of deceased ICU patients</td>
<td>51 family members who met following criteria: • Their relative had died between June 2008 and June 2009 in the ICU • They were involved in loved ones’ ICU stay • Spoke Dutch</td>
<td>The most common bereavement characteristic was sleeping problems • Most of the respondents were satisfied with ICU care and understood the sequence of events that lead to the death • Those who were not satisfied complained about communication and lack of information • There is a need for a follow-up bereavement program</td>
<td>• Single clinical setting, limiting transferability • Recollection bias, as data was collected from family members 4–16 months after their loved one had died</td>
<td>Strengths: • 75% response rate • Questionnaires provided to participants before the telephone interview increased opportunity for reflection • In addition to multiple choice and yes/no responses, room was available for explanatory comments • ICU staff unaware that their care would be evaluated</td>
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paperwork, and ongoing support for those grieving while concur-ently preparing to receive the next critically ill patient (Bloomer & O’Connor, 2012; Onstott, 1998). Strategies described by nurses to overcome these barriers include taking their time to report a death, which allows them to attend to responsibilities associated with end-of-life care (Bloomer & O’Connor, 2012). Kobler (2014) suggests that charge nurses are in an ideal position to assume responsibility for workload rearrangements and should attempt to do so by shifting assignments, so individuals or team members working directly with the dying patient devote attention where it is needed. In addition, accommodations for uninterrupted time for documentation would ensure accurate and complete reporting of end-of-life and resuscitative interventions (Hill, 2012).

The findings suggest nurses are able to accommodate families in situations under their control, but hospital policies and protocols need to be reassessed to ensure they support families experiencing crisis. Nurses can exercise some flexibility within their means, such as number of visitors in the patient’s room or visiting hours, but other pressures such as those stemming from administration policies can be overwhelming. Effective communication, compassion and collaboration between and among administration and front-line workers can further facilitate supportive care.

Significance of time and trust
For patients, families and members of the healthcare team, trust is crucial to the credibility of ICU nurses (Liiaischenko et al., 2009). Time constraints can, therefore, impose limits on developing trusting therapeutic relationships and meaningful engagement with families. Liiaischenko et al. (2009) revealed that one of the biggest challenges reported by nurses was caring for dying patients and their family members with whom they had no prior relationship. In the event the patient rapidly deteriorated or death was imminent, preparing families emotionally for the possibility of losing their loved one while concurrently focusing on providing physical care for the patient was challenging (Liiaischenko et al., 2009; Van der Klink et al., 2010). Brysiewicz (2008) validates that the need to deliver complex physiologic care in an ICU can lead nurses to view families as obstacles, and to exclude them from care and overlook their emotional needs.

In a study by Shorter and Stayt (2010), some nurses reported valuing the time to organize (and control) the physical environment (e.g., removing unnecessary equipment and monitors, stopping unnecessary drugs, ensuring paperwork is up-to-date) to prepare for a peaceful death. However, when a patient dies suddenly, nurses are stripped of time, preparedness, and their ability to remain in control, leaving them dissatisfied with their nursing care. In contrast, other nurses in the same study perceived the ICU as a setting in which they felt more prepared to expect and deal with death, than the non-ICU wards, making the experience more controlled, less traumatic, and less likely to cause negative feelings (Shorter & Stayt, 2010).

Perhaps the varying perceptions regarding death in the ICU can be attributed to different personality types, adaptability to stressful situations, and individual responses to and previous experiences with death. These findings indicate that nurses require time to establish interpersonal relationships with families to establish a rapport, but struggle to develop these relationships when so much time is taken by task-oriented activities.

Level of knowledge and availability of support staff
Eastham (1990) states that health professionals of that time received little or no preparation to respond to their own reactions to death or provide families with grief support. End-of-life care content in nursing education programs continues to be largely overlooked and nurses report limited knowledge related to religious and cultural considerations of the dying patient and post-mortem care (LeBrocq, Charles, Chan, & Buchanan, 2003). Not knowing what to do or say can be particularly uncomfortable for a nurse trying to provide compassionate support to the family of a deceased patient (LeBrocq et al., 2003). Increased attention has been given to integrating care of the dying patient and patient’s family into nursing curriculum, as seen in Matzo, Sherman, Penn, and Ferrrell (2003). Their article describes the End-of-Life Nursing Education Consortium (ELNEC) experience, which prepares educators to competently teach end-of-life content, as an integral part of nursing curriculum. Eastham (1990) and Onstott (1998) stress the importance of consulting with bereaved families to assess their specific cultural and religious needs and to understand, respect, and make provision for them. As this is not always possible, a foundation of knowledge, through educational programs or professional development, outlining common cultural and religious practices surrounding end-of-life care would be beneficial to nurses.

When death occurs outside of daytime hours, access to support personnel such as social workers, chaplains, or other religious community leaders is limited (Bloomer & O’Connor, 2012). Social workers or chaplains are an important resource for nurses and patients, as they act as an additional comforter and supporter and can assume responsibility for assessing the bereavement needs of family members, allowing nurses to focus on other aspects of care (Collins, 1989). In addition, they are often capable of providing support for a longer time, crisis intervention, follow-up, and referrals, and are in a better position to facilitate the exchange of information between care providers and family members (Leash, 1996). A participant in Bloomer and O’Connor’s (2012) study found that social workers “on call” did not always find it “necessary” to come into the hospital to attend to families’ bereavement needs, as this was not considered an emergency. This was because social workers, particularly those on call, did not always have an established rapport with family members in the ICU and felt like strangers compared to the bedside nurse; the role of “social worker”, therefore, may become the nurse’s responsibility (Bloomer & O’Connor, 2012). While nurses may be able to provide some emotional support, they report feeling ill-equipped to deal with many legal and social questions that social workers are trained to address (Bloomer & O’Connor, 2012).

A number of these studies imply that nurses lack the formal and informal education to provide bereavement support in unexpected circumstances. ICUs often have intensive orientation programs, featuring skill-based learning that involves
the management of complex procedures or mandatory recertification that focuses on hospital protocols. Surprisingly, management of death is largely overlooked. The studies also indicate that nurses’ desire to provide satisfactory bereavement support, when minimum support staff are available, often leads to stress and internal conflict for the nurses. Although social workers and chaplains might possess the skills and abilities to provide bereavement support to families, their relationship with the patient and/or family does not always put them in an ideal position to do so.

**Inner conflict, moral distress, and personal ways of coping**

ICUs are often perceived by patients, families and health professionals as places that “fix everything” (Liaschenko et al., 2009). Advances in technology and medicine lend themselves to such beliefs and, indeed, ICUs are deserving of the credit, as a large proportion of patients are successfully treated. Because of these perceptions, some health professionals perceive death as medical failure and feelings of frustration, anger, guilt, and powerlessness are often associated with the inability to save a patient's life, despite working hard and exhausting all resources (Hinderer, 2012; Onstott, 1998). In contrast, others report feeling distressed when life-prolonging decisions are made leading to perceptions of the patient suffering through futile care. This distress is particularly common when families struggle to accept the reality of a patient’s prognosis (Bloomer & O’Connor, 2012; Iglesias et al., 2013). According to Liaschenko et al. (2009), the nature of nurses’ work and their proximity to patients makes them aware of things that others are not, such as recognizing patient deterioration and, therefore, have a responsibility to advocate for patients and families to help foster an acceptable journey toward death. Nurses have little time to process their own experience of the loss, as their focus is on the immediate needs of the patient and family. Therefore, they end up coping or not coping with their own internal conflict and grief while caring for others (Collins, 1989; Kobler, 2014).

It is imperative for nurses to acknowledge their own responses to death and to develop coping strategies to support themselves and each other in order to prevent cumulative grief, the consequences of which include denial, preoccupation with death, and feelings of decreased professional competency (Marino, 1998). Cumulative or unresolved grief can be a limiting factor to nurses’ personal functioning, impacting their ability to deal with future deaths and the needs of grieving families (LeBrocq et al., 2003). Although emotional attachment to dying patients and their relatives is not uncommon (Shorter & Stayt, 2010) and meaningful engagement is essential in providing care for the dying, a close bond with a patient or their family has the potential to evoke emotions when the patient dies (Hinderer, 2012; Shorter & Stayt, 2010). Emotional disconnection is one strategy often used by nurses to cope with loss of a patient, and this involves engaging in physical aspects of care while emotionally or socially distancing oneself from the situation at hand. Exercising some control over their emotional involvement with patients, as a way of self-preservation, enables nurses to continue to practise. However, nurses must be careful that this emotional barrier does not also result in ignoring the bereavement needs of families (Shorter & Stayt, 2010).

Formal and informal support for nurses are additional approaches used to cope with death. Formal support, such as organized debriefings, provides a safe place with uninterrupted time for all participants to be heard. Debriefing usually includes all team members involved in a case, a trained leader responsible for facilitating the process, and enough time to reflect on the incident (Kobler, 2014). While some nurses find debriefing useful for reflective practice, others find it difficult to express themselves in this formal setting (Shorter & Stayt, 2010). In addition, conflicting schedules and shift work often make it difficult for all those involved to attend debriefing if it does not occur immediately after a critical incident (Bloomer & O’Connor, 2012). Shorter and Stayt (2010) state that while the principle of formal support is a good idea, it is less practical in reality. Informal support appears to be a useful approach for nurses who turn to their peers to manage their grief and seek comfort in informal conversations with colleagues. According to Onstott (1998), peer support is a central form of maintaining nurses’ well-being. Shorter and Stayt validate that nurses value support from their peers and place great emphasis on these relationships, as their colleagues are often present during an incident or able to relate to the situational context. Lastly, some nurses prefer neither formal nor informal support. Instead, they defer their own emotional responses to private moments where they are able to express emotion away from the bereaved family (Bloomer & O’Connor, 2012; Hinderer, 2012).

**Recommendations for nursing practice**

The paucity of information and resources for nurses to provide bereavement support in ICUs or other critical care settings, particularly in circumstances of sudden or unexpected death, limits the provision of adequate end-of-life nursing care (Kurian et al., 2014). Eastham (1990) suggests that an emphasis in nursing education on the psychological aspects of dying and bereavement, as well as an overview in techniques of counselling would assist nurses to fulfill their role in bereavement support. Bloomer and O’Connor (2012) and Hinderer (2012) reiterate the dire need for structured staff training and adequate support systems for nurses to combat the detrimental emotional, physical, and psychological effects of grief. Examples of support systems found in the literature that have been beneficial for nurses include bereavement packages, bereavement follow-up services, structured staff education, and the use of a sudden death counselling protocol. Although these support services do not provide direct solutions to some of the challenges nurses face, having them available alleviates some of the pressures nurses face in being solely responsible for providing bereavement support. For example, Wright (1996) suggests packages or booklets with information on death registration, death certificates, the bereavement process, and support group contacts would be extremely beneficial for nurses, as a resource to provide to families. Bereavement follow-up services give care providers an opportunity to express concerns and offer their condolences, which may have been unintentionally neglected while delivering complex physiological care to the patient (Van der Klink et al., 2010).

Staff education, focusing on content such as tasks of grieving, the grieving process, caring for families, and caring for staff,
as illustrated in LeBrocq et al. (2003), would equip nurses with foundational knowledge on grief and bereavement. Integration of a sudden death protocol would serve as a practical resource for nurses to guide clinical practice for optimum bereavement support. Highlights of a sudden death counselling protocol, as illustrated in Collins (1989), include meeting the survivors, using death notification strategies, providing emotional support, allowing family to view the body, and providing follow-up support. In addition, Roe (2012) suggests a death counselling protocol that includes relatives during cardiopulmonary resuscitation, if appropriate. While these guidelines might seem self-explanatory to some care providers, they are a great resource for care providers who are inexperienced or unfamiliar with end-of-life and bereavement care.

Finally, it is imperative for nurses to acknowledge their own perceptions of death and dying. Doing so will enable nurses to establish personal coping strategies to facilitate their own grief processes. Administrative leaders such as unit managers or charge nurses should make every effort to ensure that their staff feel supported and individual responses to death are honoured. This can be achieved by providing opportunities for formal debriefings after critical incidents, as well as respecting informal individual self-care activities (e.g., reflective journaling, talking to peers and meditation). Creating a unit culture supportive of its staff enables nurses to continue to practise competently, as valued members of the healthcare team.

Limitations
This review of bereavement literature revealed readily available information related to palliative and end-of-life care. However, very few studies examined nurses’ experiences in circumstances of sudden or unexpected death in the ICU. The literature search was, therefore, expanded to include sudden death in the OR and ER. A second limitation was inclusion of articles published more than 15 years ago. Despite this, the authors believe the review provides valuable information applicable to contemporary nursing. Lastly, narrative overviews are considered a better method of reviewing studies for peer-reviewed journals: Secrets of the trade. Intensive and Critical Care Nursing, 6, 185–191. http://dx.doi.org/10.1016/j.iccn.2013.12.002


Conclusions
The lack of current research studies specific to nurses’ experience of unexpected death in ICUs suggests more research is required in this area. The literature exploring nurses’ experiences in delivering bereavement support to families who experience unexpected death of a loved one in the ICU revealed four themes: influence of hospital policies and organizational constraints; significance of time and trust; level of knowledge and available support staff; and inner conflict, moral distress, and personal ways of coping. Challenges and facilitators were explored in each of these domains. Changes in hospital policies, optimizing staff training, creating a unit culture supportive of death and dying, and improving nursing education on this topic could address the current challenges to providing satisfactory bereavement support in circumstances of unexpected death. Further recommendations to ensure healthy grieving include the use of bereavement information packages, bereavement follow-up services, a sudden death counselling protocol and collaboration with support staff when possible.

A potential question for future research would be whether nursing staff in ICUs that follow specific sudden death protocols report increased satisfaction in providing bereavement support. Furthermore, an inquiry into whether Canadian educational institutions are incorporating more end-of-life care content into their curriculums would be beneficial. Finally, identifying an end-of-life care framework applicable to sudden or unexpected death, similar to the palliative care paradigm, might minimize ethical quandaries that arise in ICUs and other critical care settings.

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End-of-life care in the ICU: Supporting nurses to provide high-quality care

By Sarah Crowe, MN, RN, CNCC(C)

Abstract
ICU care has traditionally focused on curative treatment, but there is an increasing awareness of the key role palliative and comfort care play. Through a review of recent literature on end-of-life care and withdrawal of life-sustaining therapies in the intensive care unit, four themes have emerged: the challenges of making the decision to withdraw life-sustaining therapies, the barriers to providing good end-of-life care, factors that support good end-of-life care, and specific guidelines for the withdrawal of life-sustaining therapies. Using this information, a checklist to support end-of-life care by critical care nurses was created.


Traditional goals of intensive care unit (ICU) care centre on curative interventions for patients with life-threatening illnesses. Although some patients will fully recover, many will not. Many conditions are not curable; some patients will have chronic care needs and some will die. As a general estimate, approximately 20% of hospital deaths occur in ICU (Grant et al., 2013; Mirel & Hartjes, 2013). Critical care is, therefore, an environment that supports care and cares for the dying. In its most narrow interpretation, palliative care is seen as the practice of preventing/relieving pain and suffering for those at end-of-life (Attia et al., 2012). Although this is a central focus, the practice of palliative care includes approaches that address the quality of life for those facing life-threatening and life-limiting illnesses. Palliative care emphasizes the prevention and control of pain and other symptoms, while attending to the patient and family's psychological, social, and spiritual needs (Attia et al., 2012). As such, palliative care is increasingly accepted as an integral component of comprehensive ICU care for all critically ill patients, including those pursuing cure or every reasonable treatment to prolong life (Adolph et al., 2011; Canadian Association of Critical Care Nurses, 2011; Stawicki et al., 2011; Truog et al., 2008). The goals of palliative and critical care are in accordance and, thus, complementary of each other. The purpose of this paper is to examine recent relevant literature for the purpose of developing and creating support for ICU nursing practice for the withdrawal of life-sustaining therapies and end-of-life care.

Method
A literature search was conducted using the key words: withdrawal of life support, terminal weaning from mechanical ventilation, end of life, and palliative care. The search was originally limited to the past three years, but was later expanded to include several articles within the last 10 years. Articles were limited to those written in English. The databases CINAHL, Medline, OVID, and Biomedical Reference Collection were used for these searches. One hundred and nineteen articles were found to have met the above criteria, and were reviewed; of these articles, 21 provided in-depth information on the actual hands-on process of withdrawal of life-sustaining therapies. The articles were examined for major themes, current recommendations, current practices, and nursing recommendations.
of ethical implications, and the involvement of families and available to help guide practitioners in making the decision to withdraw of life-sustaining therapies. The literature overall was lacking in research that provided specific steps and interventions for this purpose. There is an abundance of literature available to help guide practitioners in making the decision to withdraw life-sustaining therapies, including considerations of ethical implications, and the involvement of families and substitute decision makers. There were also a number of recommendations for what constituted good end-of-life care and what were perceived as barriers.

With this in mind, the following are recommendations for the support of nursing practice in the critical care environment to assist bedside nurses in the withdrawal of life-sustaining therapies in ICU. To begin, considerations should be given to the facility’s palliative care program’s philosophy to ensure the ICU’s end-of-life care policy is aligned with it (Mirel & Hartjes, 2013). Next, guidelines or a framework under which the multidisciplinary team will conduct family/patient meetings should be determined in order to facilitate effective communication and shared decision-making (Truog et al., 2008). Using a framework ensures patient and family involvement in decision-making, including providing an opportunity for questions and time for reflection (Velarde-Garcia et al., 2016). On determination and consensus of the choice to change the goal of care from curative to comfort, a checklist to guide the bedside nurse through the withdrawal of life-sustaining therapies should be implemented (see Table 1).

The checklist provides a framework for the bedside ICU nurse to ensure proper process, and consistent care is provided to all patients and families at end of life. The guideline is broken down into sections, and while these sections may have already been completed by the team, serve as an important reminder to ensure a thorough procedure and attention to detail to ensure a smooth transition from curative to comfort care. The first section, labelled decision-making, is made up of questions that reflect the process of making the decision to withdraw life-sustaining therapies and move to comfort care. The questions serve as cues to ensure all relevant information is considered when planning the goals of care (Wiegand et al., 2013). Relevant information includes being aware of patient and family directives, ensuring all necessary family members are present and part of the decision-making process, family are provided adequate time for questions and reflection, as needed, and ensuring the multidisciplinary team is aware of the intended plan as well (Attia et al., 2012; Coombs et al., 2012; Jensen et al., 2013; Truog et al., 2008).

The second section of the checklist involves the preparation for the withdrawal of life-sustaining therapies. This section involves ensuring the patient and family are aware of the plan and how it will likely be implemented, and ensuring all necessary orders and documentation are completed (e.g., resuscitation orders changed, end-of-life orders written). Communication is vital, and is recognized as a fundamental aspect of providing good end-of-life care (Wiegand et al., 2013). It is important to note that once the plan has been developed it is up to the team, in collaboration with the patient and family, to determine how and when the process takes place, and to make adjustments or changes, as required (Attia et al., 2012; Coombs et al., 2012; Jensen et al., 2013; Truog et al., 2008). In addition to the medical plan and documentation, ensuring end-of-life choices, such as religious or spiritual support/services, family presence or support requirements, and the option for organ donation after death are important options to offer the patient and family (Accreditation Canada, 2015; Penrod et al., 2012; Rocker & Dunbar, 2000; Truog et al., 2008).
Table 1: ICU Withdrawal of Life-Sustaining Therapies Bedside Nursing Checklist

<table>
<thead>
<tr>
<th>ICU Withdrawal of Life-Sustaining Therapies Checklist</th>
<th>Yes/No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Decision Making</td>
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<tr>
<td>1. Does the patient have a living will, an advance directive, enduring Power of Attorney for health issues? If YES, is the proposed decision to withdraw or withhold life-sustaining therapies in accordance with the available information?</td>
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<td>2. Has a multidisciplinary team meeting occurred to discuss the plan for withdrawal of life-sustaining therapies? If YES, ensure meeting information is documented in the patient’s chart.</td>
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<td>3. If the patient is able, has he/she been involved in the decision-making process?</td>
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<td>4. If the patient is not capable, or is unconscious, has the next of kin/substitute decision-maker been involved in the decision-making process?</td>
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<tr>
<td>5. Has a family meeting occurred? The family should be involved with the initial and ongoing decision-making. Have follow-up meetings occurred with the family? All meetings are documented in the health record by all professionals involved (e.g., physicians, nurse, and social worker).</td>
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<tr>
<td>Preparation</td>
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<tr>
<td>6. Has the option of organ and/or tissue donation been offered to the family (including eye bank referrals)?</td>
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<td>7. Has the physician communicated the plan of care to the family? Orders are written, or a signed copy of the ICU Withdrawal of Life-Sustaining Therapies pre-printed orders is on the patient’s chart. Updated code status documentation is on the patient’s chart. All members of the health care team involved in the patient’s care are aware of the change of care focus.</td>
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<td>8. Has the family been offered spiritual or religious support? And, if yes, have the appropriate people been notified?</td>
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<td>9. Have family preferences with regard to presence during the withdrawal of life-sustaining therapies been identified, documented, and planned for?</td>
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<tr>
<td>10. Have family requests for interdisciplinary supports (e.g., social worker) during the withdrawal of life-sustaining therapies been identified, documented, and arranged?</td>
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<td>11. Have the patient and/or family had the opportunity to speak with a spiritual resource person if requested? Are there any specific religious/cultural practices or other special requests to be followed prior to, during, or at the time of death?</td>
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<td>Implementation</td>
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<tr>
<td>12. In preparation for the withdrawal of life-sustaining therapies please ensure: 1) If able, move the patient to a private room. 2) Ensure patient is clean and comfortable (allow family to participate in final care if desired) 3) Prepare the room. (Remove as much technology / equipment from the room as possible; ensure adequate chairs for family members; ensure tissues available to family; dim lights) 4) Turn off bedside cardiac and ventilator monitor alarms (either remove entirely or change to central monitoring only) 5) Allow for special requests (e.g., favourite blanket to be placed on patient, music, etc…)</td>
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<tr>
<td>13. Have all comfort measures been implemented? Have all other non-comfort treatments been discontinued?</td>
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<tr>
<td>14. During the withdrawal of life-sustaining therapies, the nurse will frequently monitor the patient for signs and symptoms of distress (pain, anxiety, or other), and adjust medications accordingly. Document in the nurses’ notes. During the withdrawal of life-sustaining therapies the nurse will communicate frequently with family members present to ensure their comfort, and their perceived comfort of the patient, and respond accordingly.</td>
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The final section of the checklist provides direction for the actual implementation of the withdrawal of life-sustaining therapies. These questions were designed to guide nurses to implement comfort measures in preparation for death, including preparing the physical environment, discontinuing any/all interventions that do not provide comfort, and preparing any additional comfort-related interventions (e.g., additional analgesia or sedatives) that are not already implemented (Iglesias et al., 2013; Stacy, 2012; Truog et al., 2008). The final question provides a reminder for nurses to frequently monitor and treat the patient for any signs of discomfort to prevent pain or anxiety from escalating.

Overall, this checklist serves as a guide to promote best practice and includes recommendations from the available literature to help guide the bedside nurse through preparation of the patient and family, preparation of the environment, and the physical withdrawal of life-sustaining therapies and implementation of comfort measures.

Nurses should also be educated and provided training on the importance of comfort and end-of-life care. This training should include how the administration of analgesics and sedatives relates to this, and also provide clear understanding of the ethics behind providing care and comfort versus euthanasia (Velarde-Garcia et al., 2016).

Although the gaps present in the literature make it challenging to develop guidelines, the gaps also serve as a potential for further research. Recognition of the importance of palliative care in the ICU is increasing, and with it the need for further nursing research in order to maintain the best possible evidence-based practice for our patients and their families during end-of-life care.

Although ICU care traditionally focuses on curative treatment, there is an increasing awareness of the key role palliative and comfort care play. Through this review and identifications of themes, recommendations for the support of bedside nurses were made and a potential checklist to support the end-of-life practice in critical care was created.

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Implementation of a unique RRT model in a tertiary care centre in Western Canada

By Teddie Tanguay, MN, NP, RN, CNCC(C), and Reagan Bartel, BScN, RN, CNCC(C)

Abstract
In early 2010, the Royal Alexandra Hospital (RAH) was the only tertiary hospital in Edmonton, Alberta, without a rapid response team (RRT). Once funding was obtained, the RAH RRT was developed with the mission of “Helping you make it happen” with the underlying philosophy that any call is a good call and the team is there to support care on the wards. The RAH RRT is unique, as it uses a registered nurse/respiratory therapist model rather than the physician model used by most tertiary centres.

The RAH RRT provides consistent and efficient response to deteriorating patients and visitors to the hospital. The RRT does not replace the attending team, rather the team supports them to provide improved patient care and to escalate care if required. Other major centres in Alberta have heard about the success of the RAH model and are moving toward a similar model.

Key words: RRT, rapid response teams

Rapid response teams (RRT), also known as medical emergency teams (MET), began in the early 1990s and assisted with managing developing emergencies in a hospital setting, but outside of critical care. The primary goal of these teams was to intervene early in order to prevent further deterioration of patients with eventual admission to the intensive care unit (ICU) or a code blue leading to death.

Use of these teams became prominent in the United States (U.S.) in 2004 when the Institute for Healthcare Improvement included activation of an RRT as one of the six quality improvement measures in the Save 100,000 Lives Campaign. In Canada, “Safer Healthcare Now” and the Canadian ICU Collaborative advocated for the implementation of RRTs as an intervention aimed at reducing adverse events experienced in the hospital setting (Safer Health Care Now, Oct., 2008).

Hospitals that initiated RRT teams expected to see the following benefits in their institutions:
- Provision of optimal care to at-risk patients on a hospital wide basis (Safer Health Care Now, 2008).
- Reduced time between acute deterioration and initiation of treatment (Franklin & Matthew, 1994).
- Decreased cardiac arrests and Code Blues outside of the critical care units (Dacey et al., 2007; King, Horvath, & Shulkin, 2006).
- Facilitation of timely ICU admission, while reducing overall ICU admissions and length of stay (Dacey et al., 2007).
- Sharing of critical care skills and expertise through educational partnership (Cziraki, Lucas, Rogers, Page, Zimmerman, Hauer, ... Gregoroff, 2008; Murray & Kleinpell, 2006).
- A thorough audit of acutely deteriorating patients in the hospital (Higgins, Maries-illott, Quinton, & Richmond, 2008; Peberdy et al., 2007).
- Proactive strategy to improve nurse assessment and intervention skills for new graduates and internationally trained nurses (Murray & Kleinpell, 2006; Rankin, 2006).
- Enhanced end-of-life care for patients and their families by de-emphasizing resuscitation efforts and allowing time to deliver active and holistic care of the dying (Dacey et al., 2007; Lawler, 1999).

The RRT is a team of clinicians who bring critical care expertise to acutely deteriorating patients outside of the ICU. Although abnormal vital signs or symptoms of deterioration may be recognized by care teams, there is often a “failure to rescue” or to escalate care to a higher level, as the patient deteriorates (Cretikos & Hillman, 2003).

Researchers suggest that four systemic issues contribute to failure to rescue:

1. Failure in planning (including assessments, treatments and goals),
2. Failure to recognize a deterioration in patient condition,
3. Failure to react to the deteriorating patient condition and communicate (staff to staff, staff to physician, etc.), and
4. Failure to escalate communication when needed (RN directly to attending physician, junior resident to attending physician, etc.) (Cretikos & Hillman, 2003; Franklin & Matthew, 1994; Offner, Heit, & Roberts, 2007).

On a 24-hour basis, an RRT provides confidence to physicians, nurses, patients and families simply through knowing that an immediate response for escalation in care or general help is available. Actively working to combat failure to rescue is another primary goal of an RRT.

In Canada, there were 56 registered RRT teams working under different team models. Some models were led by an experienced ICU nurse, nurse practitioner or respiratory therapist (RT) while others were led by physicians.

In 2010, the Royal Alexandra Hospital (RAH) was the only tertiary hospital in Edmonton, Alberta, without an RRT or MET. While experiencing significant expansion including the opening of two new wings that increased the geographic

dispersion of the hospital and the overall patient population, it was thought by senior executive that a well-trained team should be made available to assist in the delivery of coordinated and effective care. A committee was formed early in 2010 to develop a funding proposal and plans for the implementation of an RRT at the RAH. After a thorough review of the literature and the opportunity to speak with other RRTs in hospitals similar to the RAH, it was decided to implement a registered nurse (RN)/respiratory therapist (RT) model. This model is unique, as other tertiary centres have chosen to have a physician-led model rather than the RN/RT. The RAH model requires that the RN/RT are the first responders and they work directly with the attending medical services and nursing service to address patient care needs rather than having an outside team arrive to take over care of the patient. Calls are triaged using established algorithms. However, the RN/RT team has immediate access to an intensivist for any unstable rapidly deteriorating patients.

Development

Once funding had been obtained, the RRT committee began developing a framework for the function of the team. Activation triggers, management protocols/algorithms, and standardized education/training programs for the RRT team members were all developed specifically with the needs of RAH site in mind. It was decided that the patient’s own attending service, or most responsible healthcare provider must be consulted ideally before the RRT, but certainly at the same time so that they would be able to assist in early resuscitation and facilitate the goals of therapy while meeting patient needs. In the event that the attending service or the RRT thought the patient required escalation of care, the ICU physician would be contacted for consultation to provide advice on plan of care and/or to consider admission to the ICU.

It was decided that the RRT would remain to help the attending team even if they did not require ICU care. Therefore, the RRT development committee determined that using RNs/RTs with patient assignments would not be acceptable, as it would directly impact the quality of care delivered to the ICU patients. So, the RN/RT team assigned to the RRT would need to be supernumerary beyond the ICU staff counts.

Education

The RRT required specialized emergency response training that focused on SHARED (Simulation, History, Assessment, Recommendations, Evaluation and Documentation) to guide the care of the patient. The team also required communication skill training to ensure they could work effectively with all members of the healthcare team to achieve the best outcome for the patient. Prior to the launch of the RRT, education was provided to all hospital staff on the RRT activation criteria and how to activate the team. The members of the RRT spearheaded this education by visiting each unit in the hospital and providing education on who the team was and what the attending service (nursing and medicine) could expect from the RRT once activated. Education also included expectations for the unit nursing staff activating the RRT. The expectation that the unit nurses would remain involved in the care of the patient while the RRT would assist and provide guidance was a prominent part of the rollout.

Special education was provided to the hospital physicians and medical residents, as our model for RRT was different from most models and differed from the other tertiary sites within our own city. This was important, as they needed to fully understand their role within the team in order to make the team effective. Prior to the launch of the RAH RRT, the team was marketed widely as a resource whose mission was “Helping YOU make it happen.” The vision was that the RRT would empower patient care teams, assisting with patient safety through early rescue, thereby enhancing the quality of care provided through education and real-time feedback.

Implementation and evaluation

On September 17, 2012, the RAH launched its dedicated RRT to facilitate prompt assessment and targeted intervention for acutely deteriorating patients across the hospital. Since the launch, the RRT has built a strong collegial network of support from all departments and programs across the site. RRT has achieved success because it is not perceived as “taking over care” when it is called to assist with a patient. It is seen rather, as assisting patient care teams in providing excellence in patient care.

The RRT is in a unique position to assist and support new and ongoing RAH quality initiatives around the site. It provides the hospital with an extra resource for education. The RRT has helped to roll out safe practice and quality improvement initiatives such as Goal of Care Designation, “No Excuse” Clean Your Hands Campaign, and the initiation of a Comfort Care bed protocol. Informally, the RRT educates staff on the inpatient units, diagnostic imaging, all outpatient clinics and services such as physiotherapy, occupational therapy and even classes of nursing students who are rotating through the RAH site. The RRT facilitates hospital-wide simulation scenarios, as well as part of ongoing training for all staff to improve patient safety and skills. The RRT works to build solid relationships, as educators, and is quite happy to provide one-on-one education for physicians, clinical associates and nurse practitioners so that they have a more in-depth understanding of the RRT protocols, which allows them to then use the RRT to its fullest potential.

Focusing on seven objectives to provide the right care by the right provider at the right time for the right reason was the goal of the RAH RRT. The following objectives were determined:

1. Prevent failure to rescue
2. Provide timely intervention and reduce duration of patient suffering/deterioration
3. Decrease the number of Code Blue calls
4. Prevent unnecessary ICU admissions and readmissions
5. Timely inpatient stroke response
6. Response to non-patients who required care
7. Improve morale, staff empowerment and create supportive partnerships.
Failure to rescue is defined as an inadequate or delayed response to clinical deterioration in hospitalized patients (Subbe & Welch, 2013). At the RAH, the average time interval from trigger identification to the arrival of the RRT is 20 minutes. Call volume has been consistent since the launch of the RRT, averaging 100 calls per month, which demonstrates the continuing value of the team to clinical practice. An RRT utilization rate per 1,000 admissions is a measure of crisis detection. The overall RAH RRT utilization rate in 2013 was 29 calls per 1,000 patient admissions, which is associated with improved patient outcomes (Jones, Bellomo, & DeVita, 2009).

Prior to the implementation of the RRT, when a patient condition was in decline, staff had two options: going through the cumbersome system of trying to contact a resident or physician who was often unavailable, or to call a Code Blue. RRT provided the staff with a proactive immediate option for when a patient first starts exhibiting signs of distress or deterioration, which, ultimately, leads to improved patient outcomes, improved patient and staff satisfaction and family satisfaction. This system does not replace the resident or physicians; it allows them extra time to arrive at the situation, as they are still contacted. The reality of a hospital environment, and certainly the RAH, is that the site is quite large, the emergency, medicine and surgery departments are quite busy and the acuity of patients is increasing. The RRT supports the patient until the attending care team can arrive and stays to help them provide care.

The RRT supports safe transition to the ward from the ICU by following up on each patient within 24 hours of transfer. The RRT follows up within eight hours of transfer if the patient has left the ICU after 5 p.m. It supports the patient during the transition and works with unit staff to assess the physical condition and to clarify any questions related to the plan of care or transfer orders. Prior to the implementation of the RRT, the RAH ICU had an readmission rate of approximately 3.97%. In 2013, 17% of RRT calls were for patients who had previously been admitted to the ICU, with 20% of those patients requiring readmission, a readmission rate of 2.63%.

Providing extra, dedicated staff to help safely monitor, transfer and potentially resuscitate a patient and help prevent adverse events are large roles of the RRT. If, after assessment, a patient does not require admission to the ICU, the RRT can facilitate transfer of the patient to an appropriate observation bed and then continues to follow the patient to ensure his/her clinical condition does not deteriorate further.

The significant impact of the RRT can also be seen through its response to inpatient strokes. Prior to the RRT, patients were at risk of missing the “window of opportunity” to receive anticoagulation protocols due to system issues and the lack of a dedicated stroke team. The RRT now takes the lead in managing stroke calls by facilitating a stroke algorithm, involving key players (stroke physician), ensuring patients are treated promptly and receive faster access to stroke expertise through telehealth technology. The RRT accompanies all suspected stroke patients to CT imaging and then, based on radiology discussion with a senior medicine physician, facilitates transfer to the emergency department for telehealth consultation, which ensures safety and quality of patient care while in transition.

The RRT provides the RAH with a consistent and efficient response to non-patient medical emergencies. Prior to the implementation when there were emergencies in the RAH public areas, such as a visitor falling down stairs or having a syncopal episode, 9-1-1 was called. Now the RRT is able to respond, eliminating the need to enlist emergency medical services and providing safe transfer for the non-patient to the emergency department. Since implementation, the RRT has assisted more than 25 visitors at the RAH with no calls to 9-1-1.

After the launch of the RRT, monthly meetings and data collection continued to ensure that the team was meeting the seven objectives and to ensure accountability of the team for quality care. The RN and RT RRT members attend these meetings at which all calls are reviewed and the team offers its input and receives feedback in order to evaluate the team and its effectiveness. Data are reviewed to identify trends and to recognize barriers that may prevent the RRT from functioning optimally.

Systemic issues requiring further action are identified and solutions are engaged. Dealing with system and clinical issues with high priority allows the team to improve at a very fast pace.

Positive feedback regarding the RRT from across the RAH has been overwhelming. A survey of 20 patient care units highlighted the positive perception of the RRT. The majority of respondents report their interactions with the RRT to be positive and helpful. They believe the RRT prevents a minor problem from becoming a major problem. Moment-in-time teaching by the RRT is reported to help staff become better prepared when managing acutely deteriorating patients. The RRT is seen to be readily available and responsive when needed. The majority of RRT members surveyed (95%) enjoy being part of the team and believe they are making a difference and improving the quality of patient care at this site (86%) by ensuring actively deteriorating patients receive timely, efficient, and competent care. Overall improvement in RRT members’ leadership and clinical skills has enhanced their competence as highly skilled RNs and RTs who play a vital role at this site.

Staff feedback indicates that the RAH RRT embodies all seven of Alberta Health Services’ values of respect, accountability, transparency, engagement, safety, learning and performance.

The RAH RRT’s motto is “any call is a good call,” which helps to create a respectful working environment. The team has created a supportive structure where no staff member, resident, or physician feels stranded, and all have the opportunity to receive help for their patient in a non-confrontational, and non-threatening atmosphere. RRT members have been given training in providing feedback and performing situational debriefing so they can provide constructive, positive, in-the-moment feedback to unit staff during or after a call. This approach has provided continuous reinforcement, transparency and education of best clinical practice, which has enhanced overall patient safety at the RAH.

Continuously working to foster effective working relationships and engaging all staff and physicians at a local level is a mandate of the RRT. The team has evolved to not only respond to deteriorating patients, but to take an active role in the ongoing education of frontline staff at the RAH. Call volume is high...
when compared to other similar teams, demonstrating that the RRT has built effective working relationships across the site and is seen as a valuable service.

Summary
In summary, the RAH RRT is a 24/7 service with dedicated staff and is supported and highly valued by attending physicians, ICU intensivists, nurse practitioners, nurses and all clinical programs and staff across the RAH site. Feedback continues to illustrate that the RRT is an essential service at the RAH and is important for the provision of high-quality care and patient safety. The RRT improves the overall patient and family experience.

Striving for excellence through continuous improvement is an RAH RRT core value. Continually improving the service the RRT provides to the RAH site remains a high priority. By providing advanced education and simulation training, the team is challenged to think differently and learn. Partnerships with clinical programs at the RAH and supporting educational needs and new initiatives ensures the RRT will remain visible and connected.

The RAH RN/RT model is highly valued by all members of the health care team and has become an integral part of patient care at the RAH. Each year, the RRT enhances its positive reputation by continuing to build an internal network of support. This collaborative network of colleagues from all areas of expertise works together towards a common goal of decreasing patient suffering and improving quality of care.

Other major centres in Alberta have heard about the success of the RAH RN/RT model for RRT and are in the process of moving toward implementation of a similar model at their site. The RAH RRT has provided essential tools, educational materials, coaching and mentoring on our model to the project manager from those hospitals to help with implementation of their teams. Seeing the spread of our RRT model across other zones in Alberta is a true marker of its success.

About the authors
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REFERENCES
The Draeger Medical Canada Inc. “Chapter of the Year” Award

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

The Chapter of the Year criteria are founded on the CACCN Mission Statement and recognize the 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>
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<tr>
<td>1</td>
<td>Member education</td>
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<td>2</td>
<td>Promotion of critical care specialty</td>
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<tr>
<td>3</td>
<td>New member recruitment</td>
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<td>4</td>
<td>Sustained membership</td>
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<td>5</td>
<td>Academic activity</td>
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<td>6</td>
<td>Certification activity</td>
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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 are 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 1,000 = 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 1,000 = 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 1,000 = 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 are 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 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 1,000 = 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 1,000 = 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 1,000 = 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 renewing member, as 10 months have passed since the membership expired
- i.e., a membership expires April 2012. This member would be considered a new member due to the lapse in membership of 14 months
- 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

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<thead>
<tr>
<th>Percentage</th>
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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 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 less than 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 more than 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 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

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<tr>
<td>41–50%</td>
<td>25</td>
<td>91–100%</td>
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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 levels
- 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.

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.

Number of members renewed
Total number of chapter members x 100 = Percentage
5 points for each percentage of the total number of chapter members who are new certifications in the award year.
Percentage x 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 post-marked on or before February 15.

Eligibility:
The principal investigator must:
- Be a member of CACCN in good standing for a minimum of one year
- Be licensed to practise nursing in Canada
- Conduct the research in Canada
- Publish an article related to the research study in Canadian Journal of Critical Care Nursing
- CACCN members enrolled in a graduate nursing program may also apply
- Members of the CACCN board of directors and the awards committee are not eligible.

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

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

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

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

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

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.

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
The applicant must:
• 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, 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

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 successful candidate's name/photograph will be published in Canadian Journal of Critical Care Nursing (Winter edition).

The Board of Directors of the Canadian Association of Critical Care Nurses and BBraun Medical retain the right to amend the award criteria.

CACCN Document: Award Criteria
Content Revision Date: March 2014
Form Revision Date: April 2012
Form Design Revision Date: January 2011

BBraun Sharing Expertise Award
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
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@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 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) year
- 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 Canadian 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
The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

Canadian Intensive Care Week “Spotlight” Challenge
Criteria Revision: March 2014
Approved: March 2013

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 practising 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 and research 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.

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 about 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 Lifetime 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 is 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.

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.
THE CANADIAN JOURNAL
OF CRITICAL CARE NURSING

Guidelines for Authors

The Canadian Journal of Critical Care Nursing™ (CJCCN), formerly known as Dynamics: The Journal of the Canadian Association of Critical Care Nurses, is distributed to members of the CACCN, to individuals, and to institutions interested in critical care nursing. The journal is published four times annually.

The editorial board invites submissions on any of the following: clinical, education, management, research and professional issues in critical care nursing. Original articles on any aspect of critical care nursing are welcome. The journal is listed in CINAHL and Medline.

The journal provides a forum for:
- New clinical practices
- Clinical case studies
- Research papers
- Short reports
- Reviews
- Arts-informed scholarship
- Letters to the Editor

Manuscripts submitted to the CJCCN must include the following:
- A covering letter stating the work has not been published and is not under consideration for publication elsewhere.
- Permission from the copyright holder for any previously published material that appears in the manuscript.
- If the report is similar to another study previously published, or is part of multiple studies on the same topic, include a brief explanation of how the manuscript differs from other published work, or work submitted for publication.

Manuscripts submitted for publication must follow the following format:

1. Title page with the following information:
   - Author(s) name, and credentials, title/position
   - Place of employment/affiliation
   - If there is more than one author, co-authors' names, credentials, titles/positions should be listed in the order that they should appear in the published article
   - Indicate the primary person to contact and address for correspondence
   - Provide five key words for indexing

2. A brief abstract of the article on a separate page of 150–250 words.

3. Acknowledgements
   - Other contributing individuals and sources of research funding should appear in an acknowledgement section.

4. Body of manuscript:
   - Length: a maximum of 23 pages including tables, figures, and references
   - Format: double spaced, 2.5 cm margins on all sides. Pages should be numbered sequentially including tables, and figures.
   - Prepare the manuscript in the style as outlined in the American Psychological Association’s (APA) Publication Manual 6th Edition. An exception from APA is the spelling where applicable.
   - Use only generic names for products, devices and drugs.
   - Suggested format for research papers is background, methods, findings/results, discussion.
   - The CJCCN supports the SAGER guidelines and encourages authors to report data systematically by sex or gender when feasible.
   - Tables, figures, illustrations and photographs must be submitted each on a separate page after the references. Illustrations should be computer-generated or professionally drawn. Images should be in electronic form and high resolution. The CJCCN is only printed in black and white copy. If you want to publish a photograph of people, you must include a consent from them.
   - If you want to publish a case study, if the patient/family can possibly be identified by anyone (e.g., even your own staff), please include a consent.
   - 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.

5. Implications for Nurses
   - Provide a separate page with three to five important points or clinical/research implications relevant to the paper. These will be published with the paper and possibly in CACCN social media (e.g., CACCN eNewsletter, Facebook, Twitter).

6. Copyright:
   - Manuscripts submitted and published in the CJCCN become the property of CACCN.

7. Submission:
   - Submit manuscripts electronically as a Word document to the editorial office and CACCN national office (caccn@caccn.ca).
   - Submit a signed Author Declaration. 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.

8. Review process and timelines
   - All manuscripts are reviewed through a blinded, peer review process.
   - Accepted manuscripts are subject to copyediting.
   - Expected timeline from submission to response is approximately eight weeks.
   - Papers can be accepted as is, accepted with minor revisions, sent back for revisions and a request to resubmit, or rejected.
   - If a paper is rejected, that decision is final.
   - Once a manuscript is accepted, time to publication is approximately three to six months.

REFERENCES


Revised January 2017
The CACCN is a non-profit, specialty organization dedicated to maintaining and enhancing the quality of patient and family centred care by meeting educational needs of critical care nurses.

**Mission Statement**
We engage and inform Canadian critical care nurses through education and networking and provide a strong unified national identity.

**Benefits of Membership**
- A strong, unified voice for critical care nursing in Canada
- A subscription to the Canadian Journal of Critical Care Nursing
- CACCN Standards for Critical Care Nursing Practice (4th Ed.)
- Annual Report
- Position Statements
- Awards, Grants and Bursaries
- CNCC(C) Certification Study Guide
- Opportunities for nurses to present at local and national levels
- Educational opportunities to accumulate continuing learning hours
- Opportunities to network with peers
- Reduced tuition fees

*Become a member of your professional association today!*  

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**Application for membership**

Name: _____________________________________________________________

Address:  ___________________________________________________________

____________________________________  _____________   _____________

W (____) ____ - ________  H (____) ____ - ________  F (____) ____ - ________

Email:  _____________________________________________________________

Employer:  ___________________________________________________________

Position:  ___________________________________________________________

Area of Employment:  _________________________________________________

Nursing Registration No.: _______________________ Province:  _____________

Certified?  ☐ Yes ☐ No  CNCC(C)_______  CNCCP(C)______  Year_______

Chapter Affiliation (if known):  __________________________________________

CACCN Referral Name:  _______________________________________________

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*Please note, this application is for both National and Chapter membership*

**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
- ☐ CACCN #
- ☐ Student Member—one year $50.00 + taxes
- ☐ Affiliates—one year $75 + taxes

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

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

**Signature:**  __________________________________________________________

**Date:**  ______________________________________________________________

Visa/Mastercard: ______________________  Exp.: ____/____  CVV (back of card):_____  

**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

**Continuous renewal**

Continuous renewal: We have made it easier to maintain your membership. By providing a credit card number, your membership will automatically renew on the 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), 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. For FAQs on automatic renewal, visit www.caccn.ca/JOINUS, or see page 50.

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email: caccn@caccn.ca; website: www.caccn.ca
Continuous renewal FAQs

What is Continuous renewal?
The CACCN “Continuous renewal” feature allows for continuous renewal of your membership on its expiry date if you pay via credit card. **You will no longer have to worry about remembering to renew!** Following the completion of your membership application, CACCN will charge membership dues to your credit card. Following this, CACCN will automatically charge your credit card at the selected membership interval (i.e. every one or two years). After each renewal CACCN will send your membership card and receipt via mail. With this worry-free feature, your membership benefits will continue without interruption!

How am I included? **Signing up for continuous renewal is very easy!**
Members who complete their membership online are **automatically included** in the Continuous renewal Program.

If sending your membership using the printed membership / renewal form and a CREDIT CARD, the membership will be processed via the online system and “continuous renewal” will be implemented.

On your next renewal date depending on the membership term selected (one or two years); CACCN will renew your membership using the credit card information provided.

If your credit card information or expiry date changes, be sure to let CACCN know by emailing caccn@caccn.ca or calling 1-866-477-9077 / 519-649-5284.

Refund of payment cannot be issued for continuous renewal of membership fees if the member has not contacted CACCN National in writing a minimum of 15 days prior to the membership expiry date to cancel continuous renewal.

How does it all work?
Provided you continue to meet membership criteria (active or associate), your continuous renewal participation will continue until you choose to opt out of the program or you cancel your membership. If there is a change in CACCN membership dues prior to continuous renewal, the newly determined fees will be applied. Any change in membership dues will be communicated well in advance of implementation.

Does CACCN store my credit card information?
CACCN **does not** store your credit card information in our database nor in any record held at National Office. All credit card information is explicitly stored with the credit card processing company Eigen Developments. Eigen Developments meets and exceeds all industry standards in ensuring the financial safety of our members. CACCN will maintain a record of those participating in the program via membership number and contact information.

Can continuous renewal be cancelled?
CACCN provides notification to members of the impending auto renewal of membership approximately forty-five (45) days prior to the renewal date via Canada Post and also provides notification via email when possible.

Cancellation of continuous renewal may be completed by submitting a written request to CACCN National Office **a minimum of fifteen (15) days** prior to your membership expiry date: CACCN, P. O. Box # 25322, London, ON, N6C 6B1; via email to caccn@caccn.ca; or via fax to 519-649-1458.

ADVERTISING OPPORTUNITIES

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
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.
When Safety Matters Most
Introcan Safety® 3 Catheter and Space Infusion Systems

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When “good enough” just isn’t enough for the ones you love.

Others claim it, but we can prove it.

3M has over 70 pieces of clinical evidence supporting 3M™ Cavilon™ No Sting Barrier Film use in a wide variety of clinical applications: prevention of incontinence-associated dermatitis; medical adhesive related skin injuries; protection of skin around wounds; ostomies and devices; and protection of skin during radiation therapy.

To learn more, contact our 3M Critical & Chronic Care Solutions Sales Representative, call 1-800-563-2921 or visit www.3M.ca/skinwound.

References: