VOLUME 22, NUMBER 4, WINTER 2011

DYNAMICS

IN THIS ISSUE:

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Journal of the Canadian Association of Critical Care Nurses

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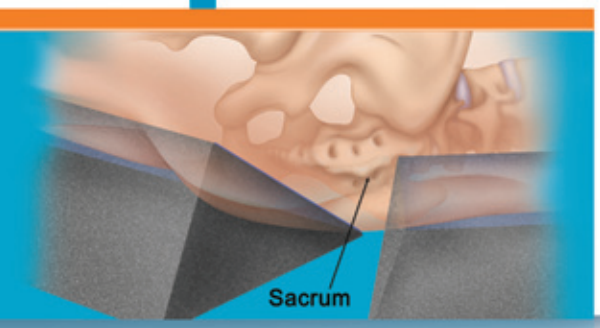

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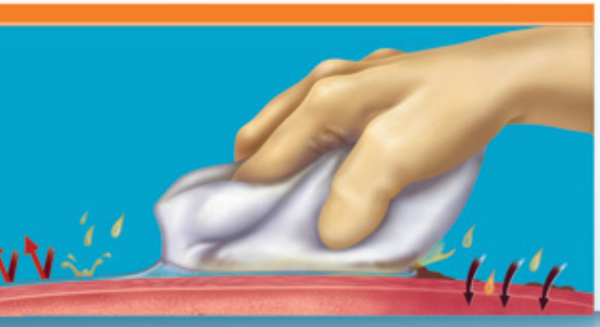

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DYNAMICS

Journal of the Canadian Association of Critical Care Nurses

Volume 22, Number 4, Winter 2011

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Canadian Association of Critical Care Nurses

Canadian Association of Critical Care Nurses

Vision statement

The voice for excellence in Canadian Critical Care Nursing

Mission statement

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

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

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

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

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

Values and beliefs statement

Our core values and beliefs are:

- Excellence and Leadership
  - Collaboration and partnership
  - Pursuing excellence in education, research, and practice
- Dignity and Humanity
  - Respectful, healing and humane critical care environments
  - Combining compassion and technology to advocate and promote excellence
- Integrity and Honesty
  - Accountability and the courage to speak for our beliefs
  - Promoting open and honest relationships

Philosophy statement

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

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

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

Strategic plan: Five pillars

1. **Leadership:**
   - Lead collaborative teams in critical care interprofessional initiatives
   - Develop, revise and evaluate CACCN Standards of Care and Position Statements
   - Develop a political advocacy plan
2. **Education:**
   - Provision of excellence in education
   - Advocate for critical care certification
3. **Communication & Partnership:**
   - Networking with our critical care colleagues
   - Enhancement and expansion of communication with our members
4. **Research:**
   - Encouraging, supporting, facilitating to advance the field of critical care
5. **Membership:**
   - Strive for a steady and continued increase in CACCN membership

In praise of servant leadership—Horizontal service to others

There was a story in the paper recently about the famous quote of President John F. Kennedy in his inaugural address on January 20, 1961, when he said: "Ask not what your country can do for you—ask what you can do for your country". The story was that the line he used was one that he had heard many times as a young man, from a professor at the college he attended, who encouraged his students to give back to the university, to have pride in their school and to be there for each other. So whether President Kennedy's line was original or not, it has made a lasting impression on many generations of people because it creates a paradigm shift in thinking—rather than expecting something to be given to you, you will offer something to others—freely.

At Dynamics in London this October, there were 460 people from across the country in attendance and I am happy to say that there were approximately 175 people who decided they had something to give back to others by sharing their information and knowledge through the oral and poster board presentations they created. They did not ask, "What will CACCN do for me?" Rather, they decided to have the courage to find their voice, speak up and give freely to others and, by doing so, they became part of "Our Kaleidoscope" sharing how the work that critical care nurses do threads through the lives of critically ill children and adults. So, to all the presenters, the National Board of Directors would like to thank you and congratulate you on giving back something meaningful to all of us who attended. We have all grown because of it. Likewise in each *Dynamics* journal, the original articles produced by authors, sharing their expertise, are another example of critical care nurses giving back to each other. Like Kennedy's statement, they said, "What can I do for CACCN?"

In my career, I have been a firm believer in a concept called "Servant Leadership", a term coined by Robert K. Greenleaf more than 40 years ago describing a number of leadership principles manifested as personality traits in a leader that are a way of managing people with respect, honesty, love and spirituality in a manner that encourages, empowers and inspires others to be the best they can be. (Greenleaf Centre for Servant Leadership is an excellent website on the topic, available at **http://www.greenleaf.org**). Simply put, a servant leader's purpose is to be in service to the people they lead, rather than one who expects to be served. It is not about a leader's positional power and authority within the organization to manage the workforce. It is about a humanistic way of believing in the best in others and doing everything you can to help them reach their full potential. It is about encouraging the hearts of those they lead, revelling in their success, supporting risk-taking to generate new ideas, and being there to guide staff in their personal challenges. I have been so very fortunate that throughout my nursing career of 31 years I have had the good fortune to have been nurtured by great servant leaders who helped me to grow, as a person and as a leader. They inspired me by their faith in me and what I could achieve. When someone else believes in you it is one of the most powerful gifts to receive and inspires you to push the limits to achieve greater things. Because of this early nurturing in my career, I learned to believe in myself and I took risks knowing that I would have the support of my leader in success or failure. I have experienced great job satisfaction as a result and felt positive about what I did. The result of this type of servant leadership is a workforce that rises together to meet challenges and where creativity flourishes through risk-taking that is promoted and supported by the leader. High morale and strong collegial relationships exist. Sadly though, I have to admit that I have also experienced the opposite (although thankfully not often and not in the early development years of my leadership career)—leaders who use their power and authority to control, rather than to nurture and develop those they lead. This leads to a work environment with little risk-taking evident and where blame is a predominant way of dealing with people, ultimately suppressing creativity and effectively paralyzing the workforce to take any initiative for fear of repercussions. The leader, like the fable of the *Emperor's New Clothes*, believes that others see them differently and they are being cheered on in a parade they lead. So, while they demand service to meet their goals, they, at best, get compliance, but seldom get collaboration. In due course, they destroy the spirit of the workplace.

But before you think I am just talking about servant leadership being only about those in formal leadership or management roles, I want to extend the concept to how you work with your co-workers in your unit. Servant leadership is also about being in service to each other horizontally, the colleagues you work with every day to help them to become the best they can be. It is about developing others, supporting them for success by offering yourself freely as a resource and committed to being there for them when they need you. So what does that look like? It starts with a question as straightforward as, "What do you need from me?" "What can I do for you?" and then confirmed with, "I am here for you" and finally, "I believe in you." What a potent affirming investment in another person! When we create that kind of environment in the units where we work, then we choose to create a place where morale is high and the outcomes for patients are excellent. However, if we continue to think that everyone else is responsible for our morale and

how we feel about coming to work, then we give away too much power to others and we become victims of the whims of others.

To instil a spirit of servant leadership where you work is not hard, but first it starts with a decision that you make yourself "be" and "act" differently. There is amazing power in that one decision. If we choose to be in service to one another so that success is not measured by how well you are doing, but rather how well the other person is doing who is working with you on this shift, then you begin to support others in a very different manner and you become connected in a meaningful way with your colleagues. We need this in critical care. We need to feel a spiritual connection working together. We give so much of ourselves to the patients and families we serve and it is this same concept that we need to give to one another. When we do this, we create a much deeper meaning, make significant connections, form strong collegial relationships and generate a positive spirit at work. The outcome for us is good morale and an "esprit de corps" that bonds us together. So how does one get from here to there?

James Autry (2001) describes five ways of "being" that will move you towards creating a culture in your unit of being in service to one another. They are:

1. **Be authentic:** Just be who you are and be the same person in every circumstance. It is about consistency in your behaviour that is based on the same values and it does not matter what role you are in, as others will know they can depend on you to act in a principle-centred manner. Know yourself and be yourself. Be trustworthy. Speak well of others who are not present and those who are present will trust you more.
2. **Be vulnerable:** Be honest when you don't know something or when you have doubts, fears or concerns. Admit to your own mistakes and apologize when you need to sincerely, humbly and without any qualification or excuse. It takes a great deal of courage to be vulnerable at such times, as you have to relinquish the notion that power comes from maintaining control. In fact, more power (and synergy) comes from depending on others and to freely admit when you were wrong. It can be as simple as saying, "That did not go well. I would do it differently if I could do it over," or, "That was a mistake (or "It was wrong of me") and I apologize for the impact it has had on you." Errors of judgment will be forgiven. Errors of the heart will be remembered.
3. **Be accepting:** Appreciate that disagreement, different opinions, opposing views and ideas are what lead to open discussion and growth. When we are open to contrary views, it is about finding a third alternative that neither of you have thought about. Conflict is a natural outcome of the highly charged environments we work in and not to be taken as a sign of a dysfunctional team, but rather a team who feels "safe" to disagree and safe to bring up the tough "stuff" in a respectful manner. As a servant leader, you accept that any ideas are valid and worth further discussion as a means to encourage dialogue on issues, not shut it down. It does not mean you have to agree with it. You start the conversation by saying "Good! You see it differently! Let's talk." It is not about a win-lose mentality, as authentic people never feel themselves to be losers, thus they never are losers. Changing your mind because you are open to others views is how you grow and by doing so others will trust that it is safe to discuss their views with you.
4. **Be present:** Think about how little children live in the moment. They are focused on what they are doing, concentrating on what they are playing with at a moment in time. To be present you need to be available first to yourself, then to others around you, as you respond to the challenges of the workplace. By drawing on all your past experience in the moments of chaos that are inevitable in a critical care environment, you can remain "centred" and calm and bring order and control to yourself and to those you work with at times of crisis. When others see you responding this way it brings confidence and a "can do" attitude to get through whatever you face. Teamwork can strengthen at these times of crisis and, over time, the memories of "the shift from hell" have a shared meaning, as people recall the events in a positive way as they worked together. How often have you sat and said, "Remember the shift when." Those are the times when you were probably the most present for yourself and others.
5. **Be useful:** A servant leader sees his or her role being a resource to others as his or her primary duty. This could manifest itself on a shift as being sure that everyone is doing all right with their assignment and offering assistance frequently. This means when you are caught up with your work you go proactively to a co-worker who is still busy and say, "I am caught up with my patient; tell me what I can do for you now." Simple acts of kindness and support like this lead to great feelings of camaraderie. You will be useful to others when you choose to act this way. You will also be present for them.

In closing, I share the concept of servant leadership with you as a means for you to personally reflect on how you view yourself in service to those you work with everyday. So often we hear about the issues of "horizontal violence" in the workplace with nurses being described as among the worst offenders in any workplace. Is that the image we wish for others to hold of us, as professional nurses? The time has come to stop focusing on the problem (as we know it exists) and start to focus on the solutions. Servant leadership is one solution and costs little to implement although it is elegant in its simplicity. I believe we can change from a culture of violence by choosing to create a culture of "horizontal service" to those we work with every day. That is how I want our profession to be described. The power lies within each of us to choose this solution. How will you choose to act when you go into work on your next shift?

As always… take care of yourself and each other,

Kate Mahon, BN, MHS, RN
President

Reference

Autry, J.A. (2001). *The servant leader.* New York: Three Rivers Press.

GUEST EDITORIAL

A critical care nurse's role in the provision of end-of-life care

The obituary read: "… passed away with dignity … and sincerest thanks to the doctors and nurses in the intensive care unit." I was so taken by the praise that the family had given to the members of the critical care team that I cut the small segment out of the newspaper to mentor me in writing this commentary. For me, it represented a value statement of what was most important in the provision of end-of-life care. The obituary also heightened my belief that, as a critical care nurse, helping patients die in comfort with dignity and peace is one of the greatest and final gifts of life that we can facilitate. Although I have enjoyed the dynamics of critical care for more than 30 years, the provision of end-of-life care and being present in the most intimate moments of a patient's and family's life have been extremely rewarding.

As a member of the Board of Directors of CACCN, I had the opportunity to coordinate the CACCN "Providing End-of-Life Care in the Intensive Care Unit" position statement in 2010. I would like thank CACCN members Dr. Marie Edwards, Sonia Hill and ethicist Bob Parkes, for their thoughtful insight and hard work in order to bring this statement to fruition. It is amazing the amount of literature review that goes into such a concise document that is no longer than two pages. However, that literature review provided our working group with tremendous insight into the multidimensional aspects in the provision of quality end-of-life care in addition to the roles and responsibilities of the critical care team.

Provision of quality end-of-life care is becoming a subspecialty of critical care and it's not surprising when you look at the statistics associated with death in the intensive care unit (ICU). A cross-sectional study of the Canadian death record showed that approximately 27% of deaths occurred in an ICU and that 42% of patients who die in hospital spend the last three days of their lives in a specialty unit (Bach, Ploeg, & Black, 2009). There is a strong movement towards integrating the principles of palliative care into critical care because of the frequency of death encountered.

Why has the navigation of the journey towards death become so convoluted? Is it because there have been amazing advances in critical care that can delay death indefinitely? Has the language associated with death and dying become so complicated that you need an interpreter and crib notes to understand the real picture? Is it related to living in a diverse, multicultural society in which we can no longer advocate to do for others as you would want done for yourself? When does withdrawal of care border on euthanasia? These are just a few of potential questions that the critical care community must continue to study and address.

In my opinion, quality end-of-life care begins with communication with the patient as soon as he/she is diagnosed with a terminal disease. It is about discussing the options with patients and families before a critical event arises so that the patient has the opportunity to decide for him/herself. Many of our patients with chronic lung, renal or heart disease live with their diagnosis for years, yet they never discuss with their families their wishes for end-of-life care. Then their disease trajectory takes a sudden and rapid decline and they end up in ICU unable to advocate for themselves, and their families must decide what they would have wanted. In oncology patients, the possibility of death is often downplayed in hopes that optimism and maintaining hope will increase their chances of survival. Then when the patient arrives in ICU and he or she is informed by the intensivist that chances of survival are slim, a sense of distrust develops. So there is a gap in the health care system in terms of providing patients and families with information about their prognosis so they can have realistic expectations and make informed choices about the types and extent of treatment they are willing to accept.

The term "Do Not Resuscitate" or "DNR" would be one of the first phrases that I would discard from the end-of-life glossary of terms. This term causes so much confusion for families when they are under great stress and may lack the capacity to make decisions of such magnitude. One of my colleagues in palliative care prefers to use the term "to allow a natural death to occur" instead of DNR. Families need to know that care will be provided to ensure that their family member is comfortable and will not suffer. The 24/7 role of the nurse as an interpreter and patient advocate in family conferences is critical in assisting the health care team to move towards consensus for the most appropriate therapy. End-of-life care is an evolving process in which differences in opinions between the health care team and families can arise. Communication strategies, end-of-life checklists and ensuring that moral and ethical obligations are addressed in a timely manner can help prevent conflict and facilitate mutual decision-making.

Dealing with end-of-life issues can have a tremendous negative impact on staff. I have seen how stressful it is on my colleagues when the family is unable to let go of their loved one and demands aggressive therapy that may result in pain and

suffering for the patient. I can remember a patient for whom I cared more than 25 years ago who I called the "Raging Bull". He was in his late seventies and had a long and complicated course with cancer of the pancreas. He was grossly jaundiced and so edematous that his facial features were barely recognizable, yet every time I suctioned or turned him I swear that I could see the raging of anger in his eyes despite being on maximum sedation. I moved to coronary care shortly after because I found it too difficult to prolong suffering when there was little chance of cure. I did eventually return to ICU, but still ask the questions that were once silent: "Are we acting in the best interest of this patient?" and "Is this what he/she would want?"

In many situations due to lack of palliative care beds or inability to take the patient off the ventilator, patients must die in the sterile, technological environment of ICU. Critical care nurses can make the difference in creating an environment that unites the patient and family for those final intimate moments in which suffering is eliminated and a dignified and peaceful death is supported. I hope that the principles outlined in the "Providing End-of-Life Care in the Intensive Care Unit" position statement and this special edition of *Dynamics* will support you to make the completion of the life cycle as compassionate as possible.

Pamela Cybulski, BA(Health Studies), RN, CNCC(C)
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Reference

Bach. V., Ploeg, J., & Black, M. (2009). Nursing role in the end-of-life decision-making in critical care settings. *Western Journal of Nursing Research, 31*, 496–512.

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PrPrecedex™ (dexmedetomidine hydrochloride for injection) is indicated for sedation of: initially intubated and mechanically ventilated postsurgical patients during treatment in an intensive care setting by continuous intravenous infusion. The Precedex™ infusion must not exceed 24 hours.

Precedex™ has been continuously infused in mechanically ventilated patients prior to extubation, during extubation, and post-extubation. It is not necessary to discontinue Precedex™ prior to extubation. After extubation, the dose of Precedex™ should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.

Non-intubated patients prior to and/or during surgical and other procedures by continuous intravenous infusion for the following procedures:

- Monitored Anesthesia Care (MAC) with an adequate nerve block and/or local infiltration and
- Awake Fiberoptic Intubation (AFI) with adequate topical preparation of the upper airway with local lidocaine formulations.

Due to insufficient safety and efficacy data, Precedex™ is not recommended for use in procedures other than the two listed above.

Precedex™ should be administered only by persons skilled in the management of patients in the intensive care or operating room setting. Due to the known pharmacological effects of Precedex™, patients should be continuously monitored while receiving Precedex™.

Caution should be exercised when administering Precedex™ to patients with advanced heart block and/or severe ventricular dysfunction. Because Precedex™ decreases sympathetic nervous system activity, hypotension and/or bradycardia may be expected to be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension and in elderly patients.

Transient hypertension has been observed primarily during the loading dose in association with the initial peripheral vasoconstrictive effects of Precedex™. Treatment of the transient hypertension has generally not been necessary, although reduction of the loading dose infusion rate may be desirable.

Clinically significant episodes of bradycardia and sinus arrest have been reported with Precedex™ administration in young, healthy volunteers with high vagal tone or with different routes of administration including rapid intravenous or bolus administration.

Reports of hypotension and bradycardia have been associated with Precedex™ infusion. In clinical trials, glycopyrrolate or atropine were effective in the treatment of most episodes of Precedex™-induced bradycardia. However, in some patients with significant cardiovascular dysfunction, more advanced resuscitative measures were required.

Pr Precedex™
(Dexmedetomidine Hydrochloride for Injection)

See prescribing summary on page 47

Precedex™
(Dexmedetomidine Hydrochloride for Injection)

Geriatrics (> 65 years of age): Dosage adjustment in this population is recommended.

Pediatrics: There have been no clinical studies to establish the safety and efficacy of Precedex™ in pediatric patients younger than 18 years of age. Therefore, Precedex™ should not be used in this population.

Precedex™ is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container.

In situations where other vasodilators or negative chronotropic agents are administered, coadministration of Precedex™ could have an additive pharmacodynamic effect and should be administered with caution.

The most frequently reported adverse events (AEs) during clinical trials of Precedex™ in short-term Intensive Care Unit sedation were hypotension 28%, hypertension 16%, nausea 11%, and bradycardia 7%; the most frequently reported AEs during conscious sedation trials were hypotension 54%, bradycardia 14%, and dry mouth 3%.

Please consult the Product Monograph for complete warnings, precautions, adverse events and patient selection criteria.

Hospira

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www.hospira.ca
For more information, please call
Hospira Clinical Support at 1-866-488-6088, Option 4

PAAB

CACCN calendar of events

DATES TO REMEMBER!

November 30:	Renewal CNA Certification application deadline
December 31:	Chapter Quarterly Reports (Oct.–Dec. 2011) due in National Office
January 31:	Smiths Medical Canada Ltd. Education Award
January 31:	Call for abstracts, Dynamics 2012 deadline
February 15:	CACCN Research Grant deadline
March 1:	Dynamics 2013 Planning Committee Application deadline
March 27, 28, 29:	BOD F2F Meeting, London, ON
April 12:	CNA Certification Examination
June 1:	Spacelabs Innovative Project Award
June 1:	BBraun Sharing Expertise Award
June 1:	The Guardian Scholarship—Baxter Corporation Award for Excellence in Patient Safety
June 1:	The Brenda Morgan Leadership Excellence Award
June 1:	Cardinal Health Chasing Excellence Award

Awards available to CACCN members

Criteria for awards available to members of the Canadian Association of Critical Care Nurses are published on pages 41–46 of this issue of Dynamics.

Future sites of Dynamics conferences

Dynamics 2012
September 23–25, Vancouver, BC

Dynamics 2013
September 22–24, Halifax, NS

Dynamics 2014
September 20–23, Quebec City, QC

Dynamics 2015
October 4–6, Winnipeg, MB

CACCN National Board of Directors

Directors 2012–2014

The National Board of Directors of the Canadian Association of Critical Care Nurses congratulates Lissa Currie (Western Region), Kirk Dawe (Eastern Region) and Barbara Fagan (Eastern Region) on their acclamation to the Board of Directors 2012–2014 at the Annual General Meeting on October 16, 2011, at the London Convention Centre, in conjunction with Dynamics 2011.

We would like to thank the CACCN members who participated at the Annual General Meeting held in London, ON, in conjunction with Dynamics 2011. ***Your Voice Matters!***

Sincerely,

Kate Mahon
President

Teddie Tanguay
Vice-President

Director, Western Region
Lissa Currie

BN, RN, CNCC(C)
Île des Chenes, MB
Coordinator, Critical Care Education
Winnipeg Regional Health Authority

I began my career in critical care in 1990 after completing the collaborative Adult Intensive Care Nursing Program at St. Boniface Hospital (SBH). My expertise and passion for critical care flourished over the following 11 years while working in the surgical intensive care unit at SBH. I then had the opportunity to combine my critical care expertise with my passion for teaching, as I took on an educator role for ICU and post-anesthesia care unit and then became an educator for the adult intensive care nursing program. I feel very blessed in my nursing career and recently have taken on a new challenge in the role of Coordinator, Critical Care Education with the Winnipeg Regional Health Authority. I obtained my certification in critical care and I am currently pursuing my master's.

I have been involved with the CACCN Manitoba Chapter at the local level since 1996, as a conference planning committee member, previous conference planning chair for our local conference and recently served as president for three years. I have frequently attended Dynamics and Chapter Connections over the years.

I have a strong belief in forming a strong unified voice for critical care nursing, patients and their families. I feel very passionate about critical care nursing and have worked hard at increasing our visibility, promoting CACCN membership and advocating on behalf of patients and families.

I would find it a privilege to work with such a dedicated group of individuals on the National Board.

Director, Eastern Region
Kirk Dawe

MN, NP, RN
Fortune, NL
Nurse Practitioner
Eastern Health

I graduated from Memorial University of Newfoundland with a bachelor of nursing degree in 2005. After graduation, I spent the following year working in adult rehabilitation and continuing care before moving into critical care. I took a position as a float nurse within the cardiac/critical care program at the Health Sciences Centre in St. John's. I subsequently left Newfoundland for the Northwest Territories where I worked in a mixed intensive care unit and also the emergency department at Stanton Territorial Hospital. I also spent some time working as a community/public health nurse in smaller settlements throughout the Northwest Territories.

In 2009, I returned to Newfoundland to pursue nurse practitioner education and a master's of nursing degree at the University of Toronto—which I completed in 2011. I am currently employed as a nurse practitioner in the same cardiovascular and medical/surgical intensive care units where I started my critical care career several years before.

I first joined the CACCN in 2006—looking to become part of an organization that would afford me the opportunity to network with peers who share the same passion for critical care nursing that I do. I had no idea then what an important role the association would play in my subsequent career development. From coast to coast, the CACCN provides critical care nurses with a collective voice, as we strive for excellence in nursing care. I hope that you, my fellow members, find my acclamation to the national board of directors amenable to your expectations and look forward to working with you dutifully, as we engage in supporting and furthering our profession.

Director, Eastern Region
Barbara Fagan

BScN, RN, CNCC(C)
Middle Sackville, NS
Registered Nurses' Professional Development Centre
Capital Health

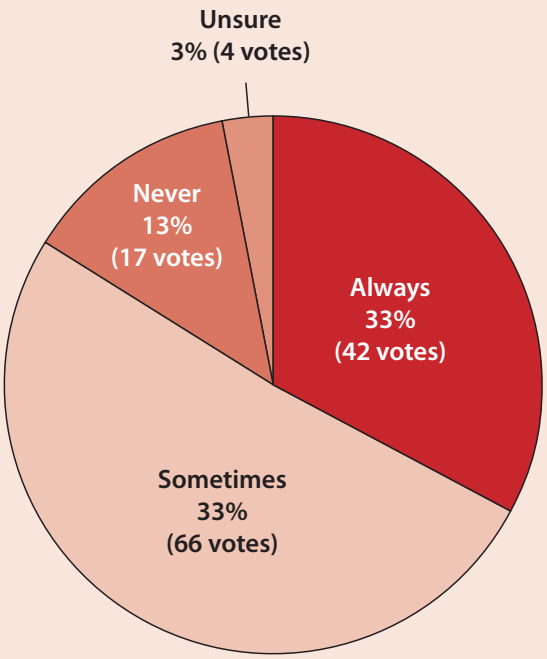
I graduated from Dalhousie University with my Baccalaureate in Nursing in 1991. After two years of great medical surgical experience, my thirst for knowledge called me to enrol in the Critical Care Nursing Program at the Post RN programs in Nova Scotia. Critical care nursing has become my passion ever since and I have not looked back. I was blessed with 15 years of amazing intensive care experience—as a staff member, preceptor and charge nurse. Twenty years later, with a wonderful husband and three fabulous children, I am even more called to our profession. For the past three years, I have had the privilege of being an instructor for the Critical Care Nursing Program with the RN-PDC (Registered Nurses Professional Development Centre) that was formerly part of the Post RN Program in Nova Scotia. It is funny how things come full circle in life.

I am currently enrolled in the Master's of nursing program at Athabasca University. I have been an active CACCN member and have had the privilege to present at the 2009 and 2010 Dynamics conferences. My colleagues and I were the fortunate recipients of the 2009 Spacelabs Innovation Award for our work on Creating Life-Long Critical Care Thinkers. We presented our findings of implementing a progressive teaching methodology called Team–Based Learning in our programming. In 2010, we presented our innovative interprofessional simulation lab team training. Working together with all members of the health care team to our full scopes of practice is another passion of mine. I am a member of our local Nova Scotia Chapter and have participated in local meetings and education sessions. I am looking forward to our province hosting Dynamics in 2013.

I would be honoured to represent the voice of critical care nursing in the Eastern Region and privileged to work with National Board of Directors at CACCN.

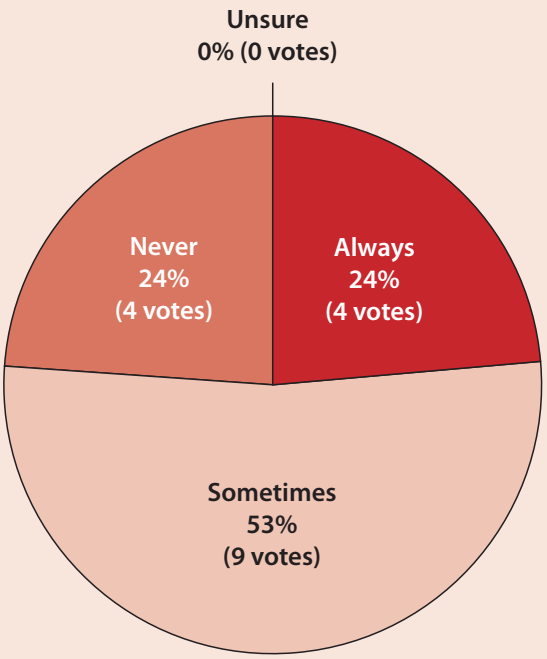
CACCN web poll results

Is it accepted practice to have family or individuals with personal relationships to the patient present for resuscitations and/or critical clinical events?



Total: 129 votes

I am satisfied with how critical care nurses contribute to the resolution of ethical dilemmas in my care environment.



Total: 17 votes

Dynamics of Critical Care 2011

London, Ontario, October 16–18, 2011

Critical Care Nursing: Our Kaleidoscope

Thank you to those of you who were able to attend Dynamics of Critical Care 2011 in London, Ontario. As a planning committee, our major objective was to ensure a quality conference that reflected the many dimensions of critical care and that was interactive. Each member of a planning committee brings his/her own unique perspective of ways in which to make the event a success. I believe that I was truly blessed to have such a committed group of individuals with whom to work. I would like to extend my thanks to Colleen Collier Breen (London, ON), Tanya Del Bianco (Comox, BC), Julia Jarecsni (Merlin, ON), Eleanor Marris Rogers (London, ON), Brenda Morgan (London, ON), Cecilia St. George-Hyslop (Newcastle, ON), Marie-Christine Walker (London, ON) and Christine Halfkenny-Zellas, COO, CACCN, and the CACCN London Regional Chapter.

This year "Critical Care Nursing: Our Kaleidoscope" was attended by 465 delegates from the provinces and territories of Canada, Australia and the United Kingdom. The opening procession began with a Royal Canadian Mounted Police flag bearer carrying the Canadian flag, followed by a piper, nurse representatives from the Canadian Armed Services, the CACCN Board of Directors and Chapter Presidents, our Journal Editor and the Dynamics 2011 Planning Committee. It is always with such a sense of pride that critical care nurses stand shoulder to shoulder, proud to be Canadian. The Teen Challenge Choir provided us with enthusiastic and joyful singing. This choir represents a group of individuals who have overcome drug and alcohol addiction. We felt that their presence might strengthen our belief that there is hope and potential for all individuals who cross our paths, as patients in critical care. Individuals such as Michael Beaubien, A.J. Fordham and his mother, Andrea, as well as the family of an H1N1 survivor shared their perspectives of what it is like to be recipient of critical care nursing and how the care that we provide makes such a difference in the lives of our patients and families.

Kate Mahon, CACCN President, was our keynote opening speaker. Kate, through her unique way of story telling, encouraged nurses to "Find Your Voice". Critical care nurses have always advocated for their patients and families at the bedside. However, when critical care nurses join their voices together nationally it can have tremendous impact on the way in which critical care is delivered and perceived by the public. Kate also advocated that in order to be effective change agents, we need to create a healthy work environment, which means taking care of ourselves and each other. Kathleen Bartholomew built on this concept by healing nurse-to-nurse hostility. Kathleen shared the stories of nurses who had experienced nurse hostility and how it had impacted their ability to deliver quality care.

There were also several presentations throughout the conference on how preceptoring new nurses is essential to ensure that critical care nurses will be prepared to face the ongoing challenges of their work. Kate Mahon was later joined by Dr. Rob Fowler and Michelle Stephens to share their strategies on effective interdisciplinary team communications by reviewing some entertaining, but realistic videos.

"**Click Here**" kicked off the first day of the conference. Delegates were able to participate in several presentations such as ACLS 2010 Guidelines, hemodynamics, blood transfusion, delirium, the top 10 list of critical care practices and acute renal failure using an audience response system. Throughout the conference, I received extremely positive comments from the delegates about the quality and variety of the presentations that were provided by this year's presenters. Thank you to Gambro and Hospira for supporting these interactive sessions.

The Computer Café was sponsored by NurseOne and the Canadian Nurses Association. These classes provided a "hands-on approach" for nurses to access educational resources through the NurseOne portal, explore ways in which to network using social media or improve their computer skills using Word or PowerPoint 2010.

The simulation lab was a new initiative for Dynamics this year. Participants had the opportunity to challenge their critical thinking skills in order to work through realistic scenarios using high fidelity mannequins provided by Laerdal Canada. Our simulation team worked diligently to ensure a fun and safe learning environment for our participants. I would like to extend my thanks to Cecilia St. George-Hyslop, Michelle Clelland, Doug Jowlett, Karen Laidlaw, Jackie Walker and Dawna VanBoxmeer who spent many hours to achieve such a state-of-the-art learning environment.

I would also like to extend my thanks to Laerdal Canada, Draeger Medical, Baxter Corporation, Hill-Rom and Philips Healthcare for their support of the simulation lab. Also many thanks to Philips Healthcare for the sponsorship of the delegate bags, 3M Canada for the lanyards, Hospira, Gambro, Octapharma, ONIg, ICU Medical Inc and Covidien for sponsoring dynamic speakers.

Dynamics is not only a conference, it is a product exhibition, which gives nurses opportunities to learn more about the types of products that we use to deliver the best possible care. The funding that we receive from our exhibitors helps ensure that we can provide such a grand scale educational event and I would like to thank our exhibitors for choosing CACCN Dynamics for their venue. This year, the "main stage" in the exhibit hall gave participants a chance to sit and eat their lunch while finding out more about new innovative products. I would also like to convey my gratitude on behalf of the delegates and exhibitors to the London Convention Centre who could not do enough to ensure that we had a great environment for our conference.

As with any Dynamics, there was time for fun and social networking. "Talk of the Town" was a sophisticated fun evening of networking with our colleagues from across the country and an opportunity to meet and get to know the CACCN Board of Directors. Delegates were able to review many of the excellent posters and discuss them with the authors. The ambience of this evening was also accentuated by great appetizers compliments of the board of directors, a live jazz band and perhaps a glass of wine. On Monday, we hosted our annual CACCN dinner where we also recognized the educational sponsorship support of GE Healthcare. As veteran rocker Prince would say, we "partied like it was 1999," but with a definite 1980s theme. I think it can be said that critical care nurses know how to make an evening fun and, if it wasn't the Boy George, Madonna or a Cindy Lauper costume that made you laugh, then it had to the karaoke version of your favourite 1980s tune.

So, after three days of learning, interacting, connecting and socializing, it was time to send our tired delegates home. What better way to go than with a brain illuminated with knowledge, new ideas and a smile on your face. Kate Davis, our closing keynote comedian speaker, known as the "Funny Mommy," delighted the audience on how to use humour with one another and make the workplace a "relatively" fun place.

To those of you who attended Dynamics "Critical Care Nursing: Our Kaleidoscope", we hope that you took back the clinical gems of knowledge that you gained from the conference and share them with your colleagues in your pursuit of clinical excellence. Wishing you well until next we meet at Dynamics 2012 in Vancouver, and remember:

"Creativity is a lot like looking at the world through a kaleidoscope,
You look at a set of elements,
The same ones everyone else sees,
But then reassemble those floating bits and pieces
Into an enticing new possibility.
Effective leaders are able to shake up their thinking
As though their brains are kaleidoscopes,
Permitting an array of different patterns
Out of the same bits of reality"

—Rosabeth Moss Krammer

Sincerely
Pamela Cybulski, BA (Health Studies), RN, CNCC(C)
Dynamics 2011 Planning Committee Chair

Awards Presented at Dynamics 2011, London, Ontario

Congratulations to all award and draw recipients! Thank you to our sponsors for your continued support of CACCN!

CACCN Chapter of the Year Award

Toronto Chapter

Ingrid Daley, President, Toronto Chapter and Tricia Bray, CACCN Director

Spacelabs Innovative Project Award—First Place

Elizabeth Gordon, Brenda Ridley, Janine Boston and Eileen Dahl, Toronto, ON

"The building bridges initiative"

Elizabeth Gordon, Brenda Ridley, Janine Boston and Peter Robertson, Account Manager, Spacelabs Medical

Spacelabs Innovative Project Award—Runner Up

The Critical Care Clinical Network Education Team: Eugene Mondor, Kari Taylor, Janice Phillips, Pam Hruska, Jennifer Courtney, Heather Brown, Kathy Sassa, Patty Wickson, Monique Fernquist, Ellen Reil, Cindy O'Flagherty, Jo Taylor and Dallus Khur, Edmonton, AB

"Specialty orientation program"

Eugene Mondor and Peter Robertson, Account Manager, Spacelabs Medical

Edwards LifeSciences Editorial Award

Margo Thomas, Sonny Dhanani, Danica Irwin, Hilary Writer and Dermot Doherty, Ottawa, ON

"Development, dissemination and implementation of a sedation and analgesic guideline in a pediatric intensive care unit... It takes creativity and collaboration".

Winter 2010, Volume 21, Number 4, Dynamics: Journal of the CACCN

Kristyn Berube, President, CACCN Ottawa Regional Chapter, accepting on behalf of M. Thomas, et al. and Tricia Bray, CACCN Director

CACCN Editorial Award—Runner Up

Gwen Thompson, Wendy Austin and Joanne Profetto-McGrath, Edmonton, AB

"Novice nurses' first death in critical care".

Winter 2010, Volume 21, Number 4, Dynamics: Journal of the CACCN

Gwen Thompson and Tricia Bray, CACCN Director

Smiths Medical Educational Award Fall 2010

Marie Aue, Markham, ON

Central Michigan University Master of Arts in Education program

Marie Aue and Tricia Bray, CACCN Director

Smiths Medical Educational Award Winter 2011

Ingrid Daley, Mississauga, ON

Master of Nursing Program, York University

Ingrid Daley and Tricia Bray, CACCN Director

The Guardian Scholarship The Baxter Corporation Award for Excellence in Patient Care

Orla Smith, Cecilia Santiago, Maria Teresa Diston and Karen Wannamaker, Toronto, ON

"Enhancing delirium awareness and recognition in the MSICU: An evidence-based patient safety and quality improvement initiative"

Cecilia Santiago, Orla Smith, Maria Teresa Diston and Marija Manojlovic, Marketing Manager, Infusion Devices and Data Management, Baxter Corporation

The Guardian Scholarship The Baxter Corporation Award for Excellence in Patient Care

Elena Luk, Louise Rose, Lisa Burry, Marc M Perreault, David Williamson and Barbara Sneyers, Toronto, ON

"Physical restraint use in Canadian ICUs"

Ingrid Daley, President, Toronto Chapter accepting on behalf of Elena Luk, et al. and Marija Manojlovic, Marketing Manager, Infusion Devices & Data Management, Baxter Corporation

BBraun "Sharing Expertise" Award

Cecilia St. George-Hyslop, Newcastle, ON
Nominated by: Lori Liske

Cecilia St. George-Hyslop and Bill McQuarrie, Senior Fusion System Specialist, BBraun Medical

Cardinal Health "Chasing Excellence" Award

Mai Nguyen, Montreal, QC
Nominated by: Julie Kinnon

Mai Nguyen and Alyssa Hrycyshyn, Sr. Market Manager, Medication Delivery & Supply Automation Cardinal Health Canada

CACCN Research Grant

Paula Mahon, Vancouver, BC
"From the inside out: A critical ethnographic view of PICU nurses"

Shawn Mason, President, British Columbia Chapter accepting on behalf of Paula Mahon and Ruth Trinier, CACCN Director

Brenda Morgan Leadership Excellence Award

Rosella Jefferson, Vancouver, BC
Nominated by: Lisa Krueckl and Karen LeComte

Rosella Jefferson and Kate Mahon, President, CACCN

2011 CNCC(C) and CNCCP(C) Draw Prize Recipients ($250 each)

Adult and Pediatric Initial Certification
Andrea Sunderman, Calgary, AB
Linda Massé, La Prairie, QC
Gaganpreet Suri, Brampton, ON
Kathryn Brunkard, Drayton,ON

Adult and Pediatric Re-certification
Kathleen Herzig, Ayr, ON
Karen Lecomte, Vancouver, BC
Patricia Connick, Bracebridge, ON

"Talk of the Town" Poster Awards

People's Choice Award

Stephanie Gillis, Cindy Cashman and Theresa Hagerman, Ottawa, ON

Cindy Cashman, Stephanie Gillis and Kate Mahon, President, CACCN

First Place

Joanna Bailey, Milla Kerusenko, Che Pang and Margaret Purden, Dorval, QC

Joanna Bailey and Kate Mahon, President, CACCN

Runner Up

Linda Nusdorfer and Art J. Lopez, Toronto, ON

Linda Nusdorfer, Art J. Lopez and Kate Mahon, President, CACCN

VOICES OF CONVICTION FROM SEA TO SKY

Speak Up Speak Out BE HEARD

Leadership is part of everyday critical care nursing practice. Leadership is required to provide excellent care for patients and families, to support healthy workplaces and healthy nurses. Using our voices to promote excellence in critical care is leadership in action. Dynamics 2012 is the place for you to give voice to your convictions. Lead from where you stand.

We invite submissions for oral and poster presentations in the general topic areas of clinical practice, education, research and leadership.

Dynamics 2012 Call for Abstracts

Abstracts for Dynamics 2012 are currently being accepted for

- Oral Presentations (approx. 35-minute presentation, 10 minutes questions)
- Poster Presentations

Submissions must be evidence-based and ideally address the conference theme.

Presenters may select their preferred format of presentation; however, the committee will make the final determination on presentation. Please note the abstracts submitted will be used to assist the planning committee in selecting those papers of the most value and relevance to our membership, nursing specialty and to assist conference delegates in choosing the sessions they would like to attend. The abstract selection process is a blind peer-reviewed process. Abstracts may be submitted for pediatric and adult presentations.

Abstract requirements

Abstract submission of a maximum of 2,000 characters. Include:

- The abstract title (maximum of 130 characters)
- Preferred format for presentation (oral or poster)
- References must be uploaded to the system via a word or PDF document in APA format only
- The title, format and references are not included in character count
- The abstract submission cannot contain any identifying information (e.g. author names, hospital names, city, province, acronyms, etc.).
- Please read the full instructions on the CACCN website prior to proceeding with your submission (printing a copy of the instructions will be beneficial).

Ethics and disclosure

- Submission of an abstract constitutes a commitment by the author to present on one of the conference days, if accepted
- The presenting author is required to disclose any real or perceived conflict of interest on behalf of all authors, in relation to the topic or material to be presented.

Abstract submission guidelines

Program planning for the conference begins approximately 12 months prior to the actual event. Based on the planning timeframe, potential presenters are required to submit their abstracts by the deadline noted below:

- The abstract submission process will be available from **November 1, 2011 to January 31, 2012 at 2359 EST**
- Abstracts must be submitted via the CACCN website at **www.caccn.ca**
- Abstracts submitted other than via the CACCN website will not be considered
- All requested information must be included at the time of the abstract submission
- Upon successful submission, presenters will receive a confirmation email with an abstract number
- Potential presenters who do not meet the deadline and the submission guidelines will not be considered.

Important points

- Abstracts received after the deadline or via email, fax or regular mail will not be considered
- Notification regarding abstract selection will be provided by no later than April 1, 2012
- All correspondence will be with first author only. It is the responsibility of the first author to communicate relevant information to any additional authors
- Abstracts may be published in *Dynamics, the Journal of the Canadian Association of Critical Care Nurses* and on the CACCN website at **caccn@caccn.ca**.

Questions may be directed to

Dynamics 2012 Abstracts
Email: **caccn@caccn.ca**; Toll Free: 1-866-477-9077; Telephone: (519) 649-5284; Facsimile: (519) 649-1458

WHAT'S NEW at www.caccn.ca?

President's Blog

Written by a Critical Care Nurse for Critical Care Nurses! Check out the President's blog at www.caccn.ca.

CACCN Members Only!

- Start or join a discussion! The CACCN Members Only Discussion Forum is available to share information and meet nurses from coast to coast.

CACCN is on Facebook and Twitter!

Find us on Facebook!

Visit us on Facebook for updated information!

twitter

Follow us on Twitter: @CACCN1

Visit us today at www.caccn.ca!

DYNAMIC CAREER CONNECTIONS on www.caccn.ca

CACCN Dynamic Career Connections is the official job site for the Canadian Association of Critical Care Nurses. Our mission is to connect employers with hard-to-fill positions with the brightest, most qualified Critical Care Nurses in Canada.

Job Seekers: This job site provides you with the opportunity to post your resume confidentially, view and apply for positions from some of the best employers in Canada, set up job alerts to search and notify you when a job matches your criteria and, best of all, registration for job seekers is always FREE. *You do not need to be a member of CACCN to register with Dynamic Career Connections. Register your resume today!*

Employers: CACCN knows how important it is for you to find new ways to directly reach Critical Care Nurses. CACCN Dynamic Career Connections provides you with the opportunity to extend your reach to a targeted candidate pool, and post your jobs confidentially. *Register to post your jobs!*

If you are interested in taking advantage of this new service, please visit www.caccn.ca, click on **CACCN Dynamic Career Connections,** and register to start searching for your new career or team member.

JOB LINKS on www.caccn.ca

JOB LINKS 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, click on **JOB LINKS,** and view the PDF contract for more information.

Website banner advertising

CACCN is offering the opportunity to have your logo and website link accessible to our members and the general public 24 hours a day, seven days a week. Why not consider a banner advertisement on the homepage of the CACCN website at www.caccn.ca? If you are interested in taking advantage of this new service, please email CACCN National Office at caccn@caccn.ca for more information.

Chapter Connections Report 2011

On the Saturday prior to Dynamics, the CACCN Board of Directors sets aside the day to hold a special meeting with the entire CACCN chapter presidents. I was delighted to attend and bring you this summary of the day.

President Kate Mahon began the day with her welcoming comments. This was followed by introductions and an icebreaker exercise facilitated by Karen Dryden-Palmer.

K. Mahon gave her president's address. She spoke of where CACCN is in growth and development. The association has gone through some pains, but has remained strong because of the commitment of CACCN members. CACCN is the voice of only a small percent of the potential Canadian critical care nurses. Our goal is always to increase membership. The association is seeing the two-year membership initiative starting to pay off. We are also ***Finding Our Voice.*** For example, K. Mahon's letter to the editor in the *Globe & Mail* was recently published and CACCN was in the news last year speaking on obesity and the critically ill patient.

To be the voice of critical care nursing nationally does come with a financial cost. For example, we have translated documents that are unlikely to change in the near future into French, CACCN is now on Facebook, and have implemented the President's blog. We are trying to make the website more interactive. The next initiative for the association will be the database upgrade to make it more useful for our needs.

CACCN, over the past year, has reached out internationally to the American Association of Critical-Care Nurses (AACN). K. Mahon and T. Tanguay attended NTI this year and met with the AACN president and executive. The association is looking at joint initiatives with AACN such as position statements. R. Trinier met with the British Association of Critical Care Nurses (BACCN) this summer and they are interested in liaising with us. We will be seeking collaboration with the Australian Critical Care Nurses Association. The Irish Critical Care Nurses Association approached us to use our standards. We continue to liaise with the World Federation of Critical Care Nurses (WFCCN). The board sought these partnerships to increase the profile of the organization nationally and internationally.

Over the past year, the board of directors has begun to take a stand on issues relevant to critical care nursing. We have begun to poll the membership using the website. There has also been some interaction with the Critical Care Forum (critical care physicians) with the president and president-elect being invited to speak. Many partnerships are being forged at the national level. But it is also important to forge partnerships at the local level, so the board of directors is going to seek out help from local chapters.

The board of Directors each submitted a brief report from their portfolio:

Website: The online abstract submission is again in place for the 2012 abstracts. Facebook and the President's blog have been added. The discussion forum has begun to be used. It is like a community of practice online. We are looking for new pictures for the website. A new forum for chapter executive members will soon be implemented.

Publications/Research: T. Bray asked about suggested topics for future special issues of the journal.

Dynamics Conference: This is a new portfolio led by K. Dryden-Palmer and continues to evolve. The intent of this position is to act as a liaison with the board of directors and Dynamics planning committee.

Membership: Membership has remained fairly static but, as of August 2011, we are down compared to one year ago. Discussion occurred about getting new members, but the bigger struggle is retention.

Award/Sponsorship: Applications for awards are low, but when submitted the quality is high. There have been some slight wording changes to some of the awards. Sorin Medical is no longer sponsoring the Chapter of the Year award. We are grateful for the support from Sorin Medical for the award over the past 10 years.

Treasurer's report: J. Baird presented the annual report to the chapter presidents. The report will be posted on the members' only site on the website.

A highlight of Chapter Connections Day is the roundtable for chapter information sharing. Three questions were posed to the chapter presidents:

1. **What is the one thing you want to discuss and leave with the CCD that will assist you?**

There was much discussion about the struggle to retain CACCN members. Hypotheses were posed as to why nurses do not renew their membership. Is it because they do not see the value of joining a professional association? Are nurses not in critical care for a career, but just for a short time? What are the benefits of joining? Many suggestions were discussed about recruitment strategies.

2. **What is the one thing you are most concerned about in leading your chapter?**

There were several concerns expressed. Many chapter presidents are struggling to get members engaged in the local chapter, even suggesting what educational topics they would be interested in. There are difficulties getting people together to attend educational sessions. Strategies were discussed, such as using Skype. There is also the struggle of the large geographical areas and engaging those across the chapter region. Succession planning is also an issue.

3. **What is the one thing you wish somebody had told you?**

There were four themes that arose: time management and how long it takes to plan and implement events, the support that is available from national office, connecting with the past-president, and knowing the expectation and responsibilities.

In the afternoon, K. Dryden-Palmer facilitated a discussion of developing a Mentorship Program within CACCN. This initiative came from a discussion at Dynamics 2010. She presented a framework, some of the guidelines that would need to be developed, and the advantages. Watch for more news to come about this initiative.

The AACN has a "Beacon Award" that is a recognition award for critical care units based on established criteria. There was a general expression of interest to have a similar award offered by CACCN. It would be a recognition program that your unit has reached a level of excellence. This would be an award where units would apply for recognition. The award would be based on our five pillars and standards. It must be achievable in any size of ICU. A committee will be formed to develop this award to put a proposal forward. The name of the award is to be determined.

In the open forum time there was discussion about the Healthcare Accord and the needs to still speak to critical care. There was also discussion about ethical issues and the use of scarce resources in critical care. Staff mix in ICU is also becoming an issue in some units.

Congratulations are extended to the Toronto Chapter as Chapter of the Year.

Respectfully submitted,
Paula Price, PhD, RN
Editor, Dynamics

Finding Our Voice internationally

Colette Laws-Chapman, Director, BACCN, Ruth Trinier, Director, CACCN and David Waters, Director, BACCN, in front of the Florence Nightingale monument at St. Thomas' Hospital, London, England, July 29, 2011.

The British Association of Critical Care Nurses (BACCN) was established in 1985 and has grown and developed through the hard work and dedication of its members, regional committees and the national board. The 14 BACCN regions span Great Britain and Northern Ireland providing one of the largest and most influential professional organizations within critical care. The BACCN mission and philosophy statements mirror those of the Canadian Association of Critical Care Nurses (CACCN).

In July 2011, Ruth Trinier, Director, CACCN National Board, took time from her personal travel itinerary to meet with David Waters and Colette Laws-Chapman, Directors of the National Board for the British Association of Critical Care Nurses in London, England. David and Colette were delighted with the contact with a similar association and graciously provided Ruth with a tour of St. Thomas' Hospital, the setting for Florence Nightingale's original nursing school and also her museum. Unfortunately, Ruth was unable to tour the critical care unit, as it was closed to visitors due to a C. difficile outbreak.

David is the Industrial Liaison/European Federation of Critical Nursing Associations (EfCCNa), with responsibility for awards and sponsorship for the BACCN annual conference. David is also a Senior Lecturer in Critical Care at Buckinghamshire New University, Uxbridge, Middlesex, and maintains a clinical position in an adult intensive care unit in Oxford. Colette Laws-Chapman is the BACCN Conference Director with responsibility for their annual conference. Colette is the Associate Chief Nurse for Education at St. Thomas' Hospital.

BACCN has a membership of approximately 2,000 critical care nurses. The association operates similarly to CACCN with revenue gained through membership fees and involvement through BACCN chapters across the country and Northern Ireland, including a military chapter. Much like CACCN, the BACCN chapters provide educational days, liaisons for information boards, contests and more. The BACCN annual conference was in Brighton, England, from September 12–13, 2011.

The BACCN is looking forward to establishing links with CACCN in the near future and we encourage all critical care nurses in Canada and abroad to visit the BACCN website and their Facebook page.

BACCN
British Association of Critical Care Nurses

BACCN Contact Information:
Website: **http://www.baccn.org.uk/**
Conference: **http://www.baccnconference.org.uk/**
Facebook: **http://www.facebook.com/BACCN**
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Learning end-of-life care in ICU: Strategies for nurses new to ICU

By Brandi Vanderspank-Wright, MScN, RN, CNCC(C), Frances Fothergill-Bourbonnais, PhD, RN, Sue Malone-Tucker, BScN, RN, CNCC(C), and Sharon Slivar, MEd, RN

Abstract

The experience of critical care nurses caring for patients and families during the withdrawal of life support has recently been explored (Vanderspank-Wright, Fothergill Bourbonnais, Brajtman, & Gagnon, 2011). In that study, the nurses were able to find, using their developing knowledge and experience, their own way, over time, through the process of withdrawing life support. Challenges in caring for patients and families were described by the participants in themes such as "the runaway train of technology," which explored nurses' experience of caring in a technologically complex environment. In this current article, the authors will explore the importance of providing "good care" in relation to withdrawal of life-sustaining treatment. The principles of providing "good care" such as patient comfort, open and frequent communication with families, support by fellow co-workers and time to reflect on the care given are fundamental to the overall experience of providing quality end-of-life care in the critical care environment. Practical solutions will be offered to help both new graduates and nurses who are new to ICU, find their way to care for patients and families within this context.

Vanderspank-Wright, B., Fothergill-Bourbonnais, F., Malone-Tucker, S., & Slivar, S. (2011). Learning end-of-life care in ICU: Strategies for nurses new to ICU. *Dynamics, 22*(4), 22–25.

Nurses have been caring for dying patients and their families in ICU for decades. Caring for dying patients is an important and frequent reality of this environment. But, where patients in the past died, for example, from traumatic injuries or complications from surgery, increasingly there are patients in ICUs with oncological conditions, and an elderly patient population with multiple co-morbidities. Advances in medical technology and life-support modalities have provided the capacity to prolong life even when a viable outcome for the patient is not possible. Death, as a result of withdrawal of life support is common (Kjerulf, Regehr, Popova, & Baker, 2005; Van Rooyen, Elfick, & Strumpher, 2005). There is a change in goal from curative to comfort measures, and this situation can be stressful for nurses, as well as other members of the interprofessional team, and for the families There may be scenarios in which families want life-support measures continued even though the ICU team may not view this as a measure that will improve the patient's quality of life. There are also situations where the inverse exists; families may want to discontinue life supporting measures when the ICU team may deem it as inappropriate. In this article, the authors explore the importance of providing "good care" in relation to withdrawal of life-sustaining treatment. Strategies will be offered to help both new graduates and nurses who are new to ICU find their way to care for patients and families within this context.

Critical care nurses provide a continual presence at the bedside for patients and their families. They deliver highly sophisticated technological interventions, as well as provide measures to promote patient and family comfort and well-being. Critical care nurses are directly involved in withdrawal of life support and are providers of end-of-life care in this environment (Badger, 2005).

Vanderspank (2009) and Vanderspank-Wright, Fothergill-Bourbonnais, Brajtman and Gagnon (in press) explored critical care nurses' experiences of caring for patients and families throughout the process of withdrawing life support using a phenomenological approach. The nurses interviewed ranged in experience from six months to more than 25 years in critical care. The nurses viewed the patient's comfort as paramount to the experience while simultaneously providing care and direction to the family. For example, they helped the families to understand the complexity of critical illness and to help move the family to a place where they were more accepting and comfortable with the decision to withdraw treatment when curative measures were no longer helpful. This process of supporting the family through this experience usually took place over several days and involved frequent contact of the family with nursing staff, as well as family meetings with the interprofessional team. The importance of consistent messages to the family by all concerned was emphasized. The nurses noted that both their knowledge and level of comfort in providing care in this context to the patient and family developed over time and with experience.

Acknowledging that dying in ICU is different

What makes death in ICU different? Yang and McIlfatrick (2001), in a phenomenological study of intensive care nurses caring for dying patients, found that nurses with less than two years of ICU experience often felt fear and guilt after the death of a patient. This finding was also found earlier in the work of Rashotte, Fothergill-Bourbonnais and Chamberlain (1997). Rashotte et al. (1997) also found that novice practitioners, due to a lack of knowledge and experience, could perceive that they had somehow contributed to a child's death.

Vanderspank (2009) found that nurses spoke frequently of the "fine line" that stems from the use of sedation and analgesia during withdrawal of life support and how, over time and with experience, critical care nurses become comfortable with the sometimes higher rates of medication used during withdrawal of life support. Patient comfort comprises both pharmacological (sedation and analgesia) and non-pharmacological interventions (turning, repositioning and providing psychosocial support). When providing care during the withdrawal of treatment, the principles of providing comfort measures to patients remain, but the main difference, with particular reference to sedation and analgesia, is that the rate of infusion may increase. The following statements from participants contrast the relative inexperience of a new to ICU nurse and a critical care nurse with many years of experience. One nurse stated: "*It's stressful for me considering I don't feel like I have enough experience to really say, ok, they need more sedation to keep them comfortable or they need more narcotics. I'm always scared at the point where I'm scared to give them too much and then at the last minute...well, now they're in respiratory distress...*" (Vanderspank, 2009, p. 58). However, the nurse with many years of experience reflected: "*You could see the patient was working at breathing, was on the ventilator...I went over and I would explain* [to the family]*...you see what he's doing...and they would agree...he wasn't breathing like that awhile ago...well, that's him working at breathing...and we don't want him to be working at breathing like that, so I'm going to give him a little bolus through the intravenous for pain and for* [dis]*comfort*" (Vanderspank, 2009, p. 58).

The other confounding factor is the timeline in which the patient may die once the process of withdrawal of life support begins. Often death occurs within four hours, leaving a short timeframe for the nurses to prepare the family as to the actual procedure and what to expect, as well as care for the patient (Wunsch, Harrison, Harvey, & Rowan, 2005). It is, therefore, essential that good communication with the family about the process of withdrawing life support occur, as this shortened timeframe can impact the nurse's ability to help the family through the dying experience.

Avoiding the dichotomization of "good care" and "end-of-life care"

Critical care nurses (particularly those new to the critical care practice setting) may not feel prepared to provide care to terminally ill patients in the ICU due to limited education on end-of-life care in general, limited experience with dying patients and, in the case of the new to ICU nurse, lack of experience and exposure to patients dying as a result of withdrawing life-supporting treatment (Brus, 2010; Espinosa, Young, Symes, Haile, & Walsh, 2010; Vanderspank, 2009). However, when reflecting on the care provided during the process of withdrawing life-supporting treatments in comparison to the care provided on a daily basis, we cannot discredit what it means to provide "good care". Care at end of life in ICU focuses on patient comfort and open and frequent communication with patients (when possible) and families. Clarke et al. (2003) identified quality indicators for provision of end-of-life care in critical care: 1) communication, 2) patient- and family-centred decision-making, 3) continuity of care, 4) emotional and practical support, 5) symptom management and comfort care, 6) spiritual support, and 7) emotional and organizational support for critical care clinicians.

The position statement on providing end-of-life care in the ICU developed by the Canadian Association of Critical Care Nurses (CACCN) (2011) reaffirms the quality indicators identified by Clarke et al. (2003). These elements should be part of "good care" in all settings. By advocating for their patients and focusing on their needs, critical care nurses are in tune with the patients' experience. Nurses' explanations, reassurance and vigilance help patients and family deal with uncertainty and declining health. Nurses new to ICU, as they are learning to competently give patient care and manage the myriad of technology and invasive treatments, can also focus on providing good care. Providing "good care" is inclusive of patient comfort, open and frequent communication with families, support by fellow co-workers and providing time to reflect on the care provided at end of life. In focusing on "good care" we can avoid dichotomizing the care provided at end of life in ICU with the care provided on a daily basis. We can begin to explore how to better educate and support both seasoned nurses and novice nurses in providing end-of-life care in critical care environments. Just as the withdrawal of life-support is a process, so, too, is educating, supporting and transitioning new-to-ICU nurses in caring for patients and families at end of life. They can then participate in end-of-life care even though they are not familiar or comfortable with the more advanced skills such as sedation and analgesia titration, which will be acquired with time and experience.

Orientating nurses to ICU—Realities and challenges

The Ottawa Hospital, for example, hires both experienced and new graduate nurses in the ICU. Critical care education emphasizes extensive assessment skills and the ability to intervene promptly in crisis situations. Nursing orientation to the ICU includes an intense focus on critical care skill acquisition, such as cardiac monitoring of patients, and introduction to various procedures and equipment, such as understanding mechanical ventilation and modes of ventilation. While meeting both the needs of patients and families remains paramount, clinical competencies and pragmatic issues related to patient care and patient safety are essential. The ability to safely care for patients is critical in becoming comfortable at the bedside with patients and their families. Through theory and clinical practice, nurses also are exposed to a myriad of drug protocols not only for maintaining hemodynamic stability, but also related to sedation and analgesia.

Role modelling experience in end-of-life care

Nurses who have experience on medical or surgical units may have had more exposure to patients dying than a recently graduated nurse. However, neither has been exposed to patients dying in the ICU environment. Working with a more experi-

enced nurse helps the novice nurse to care for the family and the patient and, as well, witness coping strategies used by the more experienced nurses in working in these end-of-life situations. Rashotte et al. (1997) also suggested that the novice nurses receive positive reinforcement through this mentoring experience. This facilitates self-reflection and provides an environment that supports the new nurse and acknowledges death as a difficult event and that discussion around it is part of everyday practice in this environment.

Thompson, Austin and Profetto-McGrath (2010) in their study of five novice nurses in ICU, found that novice nurses, when confronted with their first death experience in ICU, did not know what to do given the complexities of the situations. However, these researchers also pointed out that the nurses responded with compassionate nursing care. The knowledge and skills associated with providing comfort measures at end of life should be part of all nursing curricula. If the new nurse can focus on these measures then she or he is contributing to the patient's care even though she/he may not be able to converse with the family, for example, with details of symptom management interventions when withdrawing life support. Over time, new nurses mentored by an experienced nurse gradually learn these protocols and other aspects of end-of-life care, such as what equipment stays connected, how the withdrawal process will proceed, what the patient will look like as death nears, as well as the messages to give to families and the timing of them. The CACCN supports the need to provide nurses employed in critical care the opportunity to mentor novice nurses in order to develop their competencies in providing end-of-life care (CACCN, 2011).

Time for reflection

Critical care educators at the Ottawa Hospital have noted that one key aspect of helping novice critical care nurses understand and begin to feel comfortable with the process of withdrawing life support is offering time to reflect on the experience. Conversations regarding withdrawal of life support often occur nearer to the end of the nurses' orientation process. For example, debriefing in post-clinical sessions is a frequent occurrence. Meltzer and Huckabay (2004) recognized that caring for patients who may not recover is often linked with moral distress and emotional exhaustion and Truog et al. (2008) recognized that care providers have bereavement needs. Vanderspank (2009) found that nurses often used the time following the patient's death and after the family had left to reflect on the care that was given. Since the time from initially withdrawing life support to time of death is usually very short, but can be variable, nurses can move through this experience very quickly or over a longer period of time. Critical care educators at the Ottawa Hospital have found that nurse orientees will use the post-clinical conferences to discuss their experiences with their peers (who are often experiencing similar situations) and that this may be an essential part of the process of learning to care for dying patients and their families in ICU.

Informal and formal support

While caring for patients and families is central to the role of the critical care nurse, caring for and supporting peers is another. Critical care nurses suggest that peer support is crucial (Rashotte et al., 1997). One nurse likened the experience of caring for patients during withdrawal of life support to packaging experiences in shoe boxes and that while shoe boxes can be stacked on shelves, it is only a matter of time until the shelf is full and the experiences need to be brought to light (Vanderspank, 2009). Peer support can be as simple as acknowledging the difficulty a fellow nurse is having that particular day and giving him/her a few minutes to step away from the bedside and have a coffee. Inherent in the post-clinical conference experience of the orientees is the beginning of an informal support system that can be nurtured over time. There is an experiential learning process involved in coping with multiple accumulated patient deaths (Rashotte et al., 1997). In cases where novice and experienced staff have had particularly distressing experiences, shifts off are offered to staff.

Nursing rounds have also been instituted whereby staff have had the opportunity to speak about issues contributing to moral distress. A supportive environment, where there are open lines of communication, where there is respect for all team members and recognition of the contributions of the interprofessional team in difficult patient and family situations, is key to helping experienced and novice critical care nurses provide care to patients in areas where there are high death rates.

Within the critical care program at the Ottawa Hospital, more formalized support mechanisms are also in place. Programs such as the Employee Assistance Program are accessible to all staff. Spiritual care staff and the clinical ethicist are also readily available to staff who need more formal discussion and debriefing of their clinical experiences.

At the end of day

At the end of the day we see that despite the fact that ICU has been identified as a clinical area where uncertainty and heightened emotional experiences are an everyday reality, nurses often remain in critical care for a very long time (Race & Skees, 2010). Despite working in a context that sees death as a daily experience, nurses take pride in the care they provide at end of life and view it as a privilege (Calvin, Kite-Powell, & Hickey, 2007). End-of-life care can be rewarding when all is done to ensure a comfortable, pain-free, dignified death. Ensuring good care throughout the patient's stay facilitates this goal.

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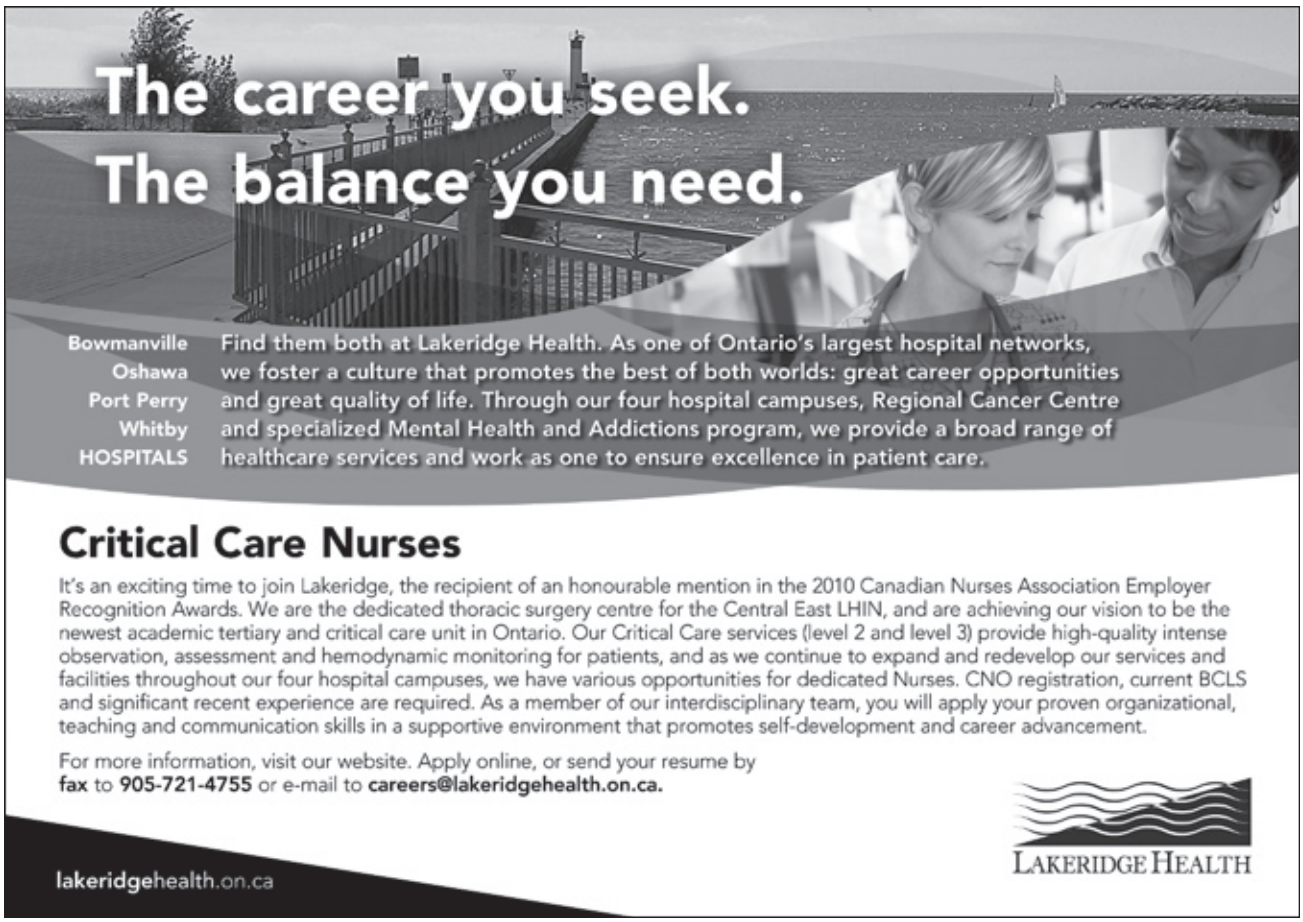

Conversations about challenging end-of-life cases: Ethics debriefing in the medical surgical intensive care unit

By Cecilia Santiago, MN, RN, CNCC(C), and Steve Abdool, PhD, MA, BA, RN

Abstract

Clinicians frequently encounter and grapple with complex ethical issues and perplexing moral dilemmas in critical care settings. Intensive care unit (ICU) clinicians often experience moral distress in situations in which the ethically right course of action is intuitively known, but cannot be acted on. Most challenging cases pertain to end-of-life issues. Researchers have shown that moral distress and moral residue are common among critical care nurses. It is, therefore, essential that all ICU clinicians (and nurses, in particular) have an ongoing opportunity to work safely through these ethical dilemmas and conflicts. In this article, we describe the medical surgical intensive care unit (MSICU) experience with its monthly ethics initiative and explore the next steps to enhance its use through maximizing attendance and value to MSICU clinicians. To optimize attendance of staff, a small group discussion among critical care clinicians (n = 8) was conducted asking about their perceptions of the debriefing sessions and their suggestions on how to promote their use. Process changes were implemented based on the group's suggestions. The process changes resulted in increased awareness of the benefits, increased frequency of sessions and demonstrated utility. Lessons learned from the MSICU experience will inform the development of education curricula to help critical care nurses with challenging end-of-life situations.

Santiago, C. & Abdool, S. (2011). Conversations about challenging end-of-life cases: Ethics debriefing in the medical surgical intensive care unit. *Dynamics, 22*(4), 26–30.

In the intensive care unit (ICU), severe illness is always accompanied by vulnerability where clinicians, particularly nurses, see patients and family members endure critical illness, fear, and tragic loss. The majority of the cases that are considered challenging by ICU clinicians pertain to complex end-of-life issues and dilemmas. The experience of caring for severely ill patients often provides a highly stressful and anxiety-provoking situation for which many nurses are ill equipped to effectively cope. Ethics debriefing provides an opportunity for ICU clinicians, especially nurses, to decompress and process their feelings toward ethical dilemmas and conflicts. In this article, the authors describe the MSICU experience with a monthly ethics initiative and explore the next steps to enhance its use through maximizing attendance and value to MSICU clinicians. The following vignette is an account nurses may have encountered in ICU.

Mrs. B., an 80-year-old woman, was in the ICU for a year. She was dependent on mechanical ventilation and intermittent hemodialysis. Mrs. B. became unable to make treatment decisions. Her advance care directive stated she did not wish to be kept on life support for a prolonged period in the event that her medical condition became irreversible. The ICU team met with Mrs. B.'s family on multiple occasions to review the patient's expressed wishes, current medical condition, and likely outcome, including death. Her family decided to keep her on life support. Eventually, Mrs. B. suffered two cardiac arrests and died during the second one. As one of the nurses who tried to resuscitate her, Mina helped disconnect the various tubes and lines, and provided post-mortem care. The process was very technical. Most post-mortem scenarios in the ICU are similar to this. Because of the fast pace of the event, little time was left for contemplation. At the end of the day, Mina reflected on this, and other similar situations with which she had been involved. She lamented, "There are not a lot of good deaths in the ICU." With regard to Mrs. B.'s death, Mina noticed that some of her colleagues expressed a feeling of relief while others simply shrugged their shoulders.

Boyle and Carter (1998) suggest that high levels of death anxiety among those working in health care may negatively influence their attitudes and behaviours toward the dying patient and her/his family, thus creating obstacles in striving to provide quality care for those living in the face of death. Many nurses in the ICU feel abandoned in the experience of looking after the dying and deceased (Solomon et al., 1993). In a study comparing nurses with physicians, the former experienced more moral distress, perceived their ethical environment as more negative, and were less satisfied with the quality of care provided on their units than the latter (Hamric & Blackhall, 2007). All too often, nurses express how ill equipped they feel in their role as comforter, supporter and bearer of bad news to the patient's family (Costello, 1995). Relating to the vignette, we can change the culture in critical care settings so that the provision of palliative or supportive care is integrated into existing ICU practice. One way of attaining this is through ethics debriefing sessions where ICU clinicians have an opportunity to critically work through pressing ethical concerns or dilemmas, explore perceptions and process their feelings. As such, ethics debriefing sessions offer an opportunity for interprofessional collaboration to cope with moral distress and compassion fatigue. Hamric and Blackhall (2007) propose that improving the ethical climate in ICUs

through explicit discussions of moral distress, recognition of differences in nurse/physician values, and improving collaboration may mitigate frustration and anxiety. Debriefings, in general, have the potential to enhance communication between health professionals, educate about the process of withdrawing or withholding treatment, and improve patient care and reduce burden on nurses (Halcomba, Dalyb, Jackson, & Davidson, 2004).

Moral distress is experienced in situations in which the ethically right course of action is intuitively known by health care professionals, but cannot be acted on for a variety of reasons (Canadian Nurses Association, 2003). Researchers show that moral distress is predominant among critical care nurses (Elpern, Covert, & Kleinpell, 2005). On the other hand, compassion fatigue is commonly associated with the emotional or psychological cost of caring for others who are clearly suffering (Figley, 1995). It has been described as secondary traumatic stress (Stamm, 1995; 1997), or vicarious trauma (McCann & Pearlman, 1990). It is naturally related to the term "compassion," which is defined as a "feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Webster, 1989, p. 229).

End-of-life discussions, moral distress and compassion fatigue

Clinicians frequently encounter and grapple with complex ethical issues and perplexing moral dilemmas in critical care settings. A common disconcerting issue occurs when ICU clinicians and substitute decision-makers disagree over the benefit and value of the continuation of "aggressive" medical interventions. Feeling that they are incapable of advocating for their most vulnerable patients, clinicians may experience tremendous anguish and torment, which can lead to compassion fatigue and moral distress.

The effect of nurses' attitudes and behaviours on both their personal and professional lives, caused by their empathetic engagement with their patients' experiences, lead to moral distress (Corley, 2002) and compassion fatigue (Clark & Gioro 1998). Known causes of moral distress include the failure to respect a patient's known prior expressed capable wishes, failure to protect patients from harms, the treatment of patients as objects, and the prolongation of the dying process (Badger & O'Connor, 2006; Corley, 2002).

Researchers associate moral distress in critical care nursing with challenging end-of-life issues. In a study of surgical intensive care unit nurses (n = 12), Gutierrez (2005) reported 11 out of 12 participants described "overly aggressive treatments" (p. 232). Elpern et al. (2005) reported that medical surgical intensive care nurses (MSICU) (n = 28) rated highest levels of moral distress in situations when aggressive care is provided to patients not expected to benefit from that care. McClendon and Buckner (2007) found that the two highest-ranked situations of moral distress for intensive and coronary care units (n = 9) were following the family's wishes to continue aggressive life-sustaining support even though it was not in the best interests of the patient, and initiating extensive life-saving actions only to prolong death. These findings are consistent with the experiences of nurses involved in the above scenario, as many of the attending physicians were very hesitant to challenge the substitute decision-maker's refusal to honour the patient's prior expressed wishes (as required by legislation) through appropriate legal mechanisms, such as the Consent and Capacity Board of Ontario.

McGibbon, Peter and Gallop (2010) posit that there are three conceptualizations of nurses' stress: occupational distress, moral distress, and vicarious traumatization. Vicarious traumatization or compassion fatigue is the cumulative transformative effect on the helper of working with survivors of traumatic life events (Bloom, 2003). In an attempt to ameliorate the feelings of anxiety, nurses may employ negative or unhealthy coping strategies such as avoidance and evasive treatment of dying patients (Clark & Gioro, 1998). This can be an obstacle in the provision of quality care for dying patients and in the support provided to grieving families. In the case of Mrs. B., the nurses went about the process of post-mortem care like automatons—it is simply part of the job! Nurses may express mixed emotions towards a patient's death, for example, with Mrs. B. some felt relieved, some did not care, and others felt that the whole situation just reinforced dissatisfaction with end-of-life care.

Benefits of ethics debriefing

Ethics debriefing sessions provide a safe and respectful forum where ICU team members are able to share varying perspectives and feelings around issues and dilemmas they may be grappling with (irrespective of the source), validate and support one another, and provide a sense of solidarity and interconnectedness. These sessions also help caregivers to navigate through complex moral, professional and legal issues, clarify complex concepts and issues and develop a strategy to address these concerns in a timely manner. When ethical dilemmas occur, the American College of Critical Care Medicine Task Force recommends that the interprofessional team be kept fully informed of treatment goals and care plans so that the messages conveyed to the substitute decision-maker/family are clear, coherent and consistent, thereby reducing any tension or friction among team members and between the care team and substitute decision-maker/family (Davidson et al., 2007). In addition, the task force recommends that a mechanism is created whereby all staff members may request a debriefing to voice concerns with the treatment plan, decompress, vent feelings, or grieve (Davidson et al., 2007).

The MSICU experience

Similar to others' efforts in implementing evidence-based practice, we encountered challenges in implementing ethics debriefing sessions in the MSICU. Rycroft-Malone (2004) proposed that successful implementation of evidence-based practice is dependent on the nature of research evidence being used, the quality of context, and the type of facilitation to enable the change process. As reflected in the nature of evidence presented by the American College of Critical Care

Medicine Task Force, there are few studies that support the reception of ethics debriefing sessions in critical care settings. Despite this, our MSICU has a strong unit-based organizational support, and interprofessional collaboration to facilitate ethics debriefing sessions.

Ethics debriefing was first introduced in our MSICU in 2008. The initial debriefing sessions were not consistently well attended, not held on a regular basis and, consequently, were not readily integrated and sustained in the MSICU. Our bioethicist leading the sessions revisited the need to revitalize ethics debriefing sessions with the clinical leader manager (CLM) in 2009. In turn, the CLM approached the clinical nurse specialist (CNS) to assist with organizing the sessions each month.

With interprofessional collaboration among the nurse leaders and the bioethicist, a more organized and systematic approach to ethics debriefing was initiated in MSICU in February 2009. The MSICU provides debriefing sessions every second Tuesday of the month. Debriefing sessions are coordinated by the CNS. Trained personnel, including the bioethicist, social workers, and chaplain co-facilitate the sessions. Occasionally, the MSICU medical director joins the round table discussion. While interprofessional ethics debriefing sessions are scheduled regularly and considered beneficial by ICU clinicians, particularly nurses, attendance at these opportunities to decompress and process emotions was not optimal.

Despite the changes to formalize the process, the 2009 MSICU debriefs after critical incidents were well attended, but attendance at regular monthly sessions was low. In order to optimize attendance of staff, particularly the nurses, the facilitators and CNS conducted a small group discussion (that is, a quasi-focus group) among interprofessional team members (n = 8), of which five participants were nurses, in order to solicit feedback and input in December 2009. Participants in the group were asked about their perceptions and experiences of the sessions. They were also asked about their suggestions on how to promote greater attendance.

The following changes were implemented in 2010 as a result of the discussion:

1. **Meeting location and proximity to ICU.** Ethics debriefing sessions had been held in one of the conference rooms outside of the MSICU. The nurses in the small group discussion suggested that some nurses felt quite anxious leaving their patients in the middle of their shift, particularly when the unit was busy and patient assignment coverage may become an issue. The nurses recommended that the sessions be relocated to the nurses' lounge on the unit to make it easier for nurses and other care professionals to come in and out of the session more readily when their assigned patient's status changed, and could be called back to the bedside.
2. **Advertisement of sessions.** Sessions are advertised well in advance using multimodal methods. The ethics debriefing session is included in the monthly unit calendar emailed to MSICU staff at the beginning of each month, as well as posted in the bathrooms. Posters are placed in common areas such as the easel (located at the nursing station), washrooms, and the nurses' lounge. The design of reminder posters is changed every month to capture the care team's attention. Email reminders are circulated two days before the sessions, and this is followed by verbal reminders early in the morning on the day of ethics debriefing sessions. One of the facilitators also circulates around the unit to remind and encourage team members to attend the session just before its commencement.
3. **Incentives to attend.** Snacks are provided to promote staff attendance. This also serves to convey the message that the staff members are appreciated, and that the sessions are a valued resource. Sessions are held at flexible times to also include night staff.
4. **Topics and themes.** Team members are provided with opportunities to share a challenging topic/theme/case for discussion, in addition to processing the emotional component of their experiences. The sessions have an open agenda, and the entire ethics debriefing session is devoted exclusively to what participants feel pressing, relevant or emotionally challenging.

Results

As part of the changes made in organizing ethics debriefing sessions, the CNS also started tracking attendance and participation at these sessions. Comparing the number of team members attending the sessions in 2009 with 2010 (Figure 1), out of which ≥ 25% are nurses, and from anecdotal accounts from team members, the following positive results were noted:

Increased awareness. Anecdotally, the MSICU team members have expressed their increased awareness of the value and benefits of ethics debriefing. The improved awareness allows more proactive, collective and consistent planning, preparation and implementation of optimal holistic care of family and support for families. It also promotes staff's well-being and welfare, and fosters a safer, healthier and enhanced ethical culture.

Increased frequency of sessions. The 2010 MSICU debriefing sessions graph (Figure 1) shows the attendance at the regular monthly debriefing sessions. Team members have also been asking for sessions when they identify a need to debrief, rather than wait until a major critical incident occurs. Hence, frequency of debriefing sessions has increased (nine sessions in seven months in 2010 versus seven sessions in seven months in 2009). We also observed a slight increase in the number of attendees in the debriefing sessions, from six to 17 attendees in 2009 to eight to 21 attendees in 2010.

Demonstrated utility. Ethics debriefing sessions have been effective in collectively exploring alternatives and strategies to address concerns prior to family meetings and to try to reach a team consensus on care plans for patients and families with complex needs. It, therefore, respectfully draws from the expertise and competencies of interprofessional team members. The sessions facilitated the team to arrive at consistent messages to patients and families. This is augmented by the incorporation of the strategies and approaches in the patients' care plans. The care plan documentations are displayed prominently in the chart for team members' reference. This is particularly important for providing consistent messages and care deliv-

ery processes in a unit with approximately 200 staff. Azoulay and colleagues (2009) described that the absence of decision-making processes associated with end-of-life care was independently associated with conflicts among team members, and suggested that communication around end-of-life care is a target for improvement. We posit that ethics debriefing is a valuable strategy to meet this need.

Alignment with corporate initiatives. In 2009, our institution launched its three-year Best Practice Spotlight Organization (BPSO) candidacy journey. BPSO is a designation awarded by the Registered Nurses' Association of Ontario (RNAO) on successful implementation, evaluation and knowledge translation of established nursing best practice guidelines (BPG). MSICU decided to implement, evaluate and sustain two BPGs: establishing therapeutic relationships and professionalism in nursing.

We found that ethics debriefing sessions provide opportunities to embed concepts about cross-disciplinary ideas of professionalism and establishing therapeutic relationships by injecting BPG concepts relevant to topics discussed.

Alignment with accreditation standards. Meaningful and consistent family-centred, patient-focused care through an interprofessional delivery process is supported by ethics debriefing sessions. The health and well-being of caregivers is enhanced and issues relating to moral distress and compassion fatigue are mitigated through effective and timely ethics debriefing sessions as reported anecdotally by the majority of participants.

Provide educational opportunities. On team members' requests, lunch-and-learn sessions are held to provide feedback about discussions on challenging cases. Following ethics debriefing sessions after critical incidents, the CNS organized lunch-and-learn sessions facilitated by our bioethicist and medical director. These sessions allow team members to ask more questions pertaining to practice issues related to the critical incidents. It is important to note that the most frequent issues discussed at all sessions invariably pertain to end-of-life situations and the multiple complex ethical dimensions, including their lasting impact on staff.

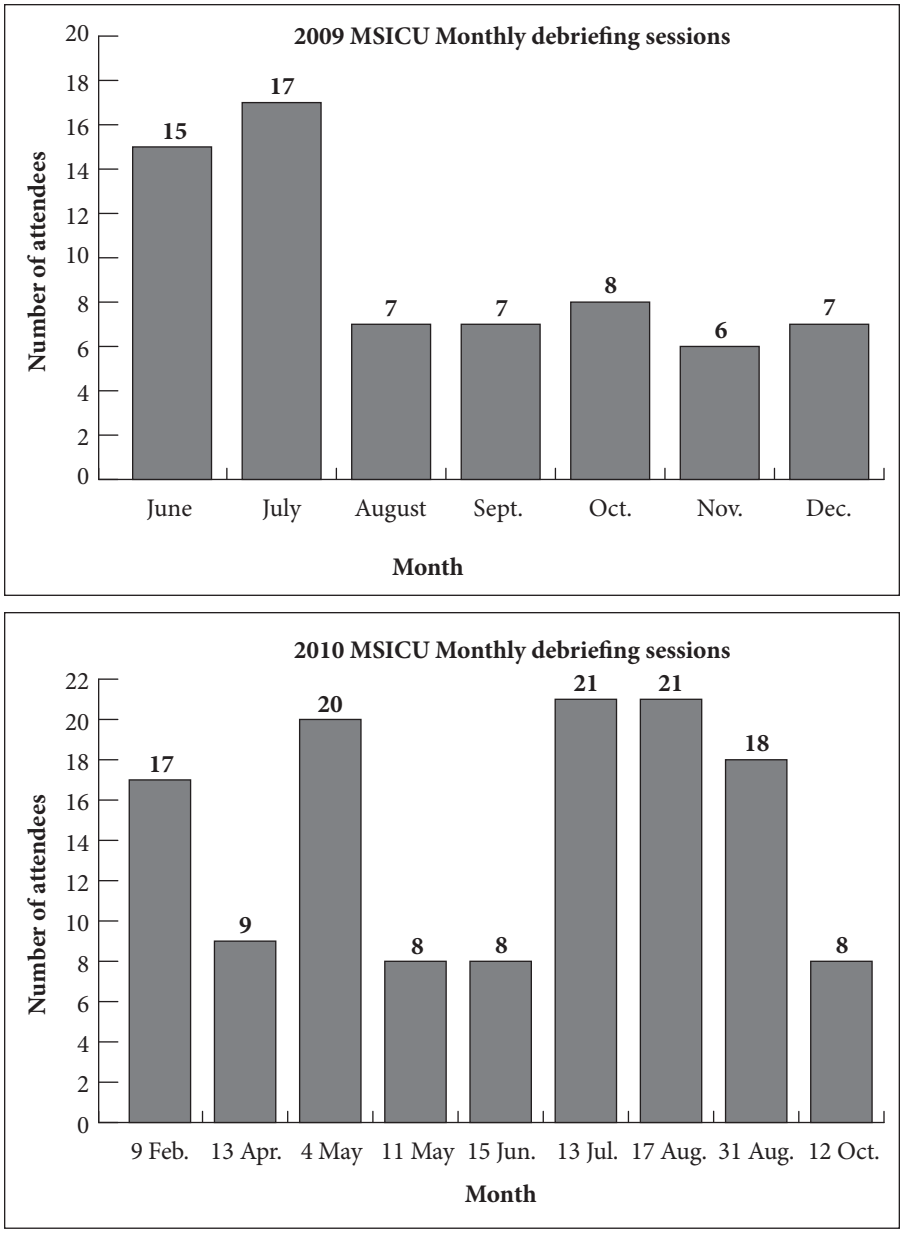

Figure 1: Top: Number of attendees—2009 MSICU monthly debriefing sessions. Bottom: Feb.–Oct. 2010: Nine debriefing sessions held in seven months, number of attendees per session

Next steps

We are enthused by the positive results from the changes made to the process of providing regular ethics debriefing sessions in the MSICU. However, since our experience is mostly anecdotal, we plan to implement an outcome measure or tool to systematically evaluate team members' attitudes and perceptions of ethics debrief sessions. Since the MSICU team also expressed the need for a follow-up on technical (rather than the emotional) issues raised in ethics debriefing discussions, we also plan to assess the feasibility of a systematic mechanism to inform the team about the outcomes of ethics debriefing sessions. Technical care planning details, the result of (ideally) consensus decision-making, are different and are naturally shared with other care team members. It is important to note that perceptions and emotions shared at all ethics debriefing sessions are kept confidential and/or are anonymized unless there is collective agreement to share these outside the group.

The lessons learned from our experience of establishing scheduled ethics round table discussions will also help inform the development of education curricula for MSICU nurses. Although efforts are being made to improve education, critical care nurses still lack knowledge about providing end-of-life care and have variable opportunities for continuing education to improve end-of-life care (Hansen, Goodell, DeHaven, & Smith, 2009). Critical care nurses also have a great deal to learn about dealing and coping with complex end-of-life situations to prevent moral distress and compassion fatigue. Given that some nurses expressed a common coping strategy, "not thinking about" the challenges they faced during end-of-life care and how they perceive such avoidance as "normal behaviour" so that they can "move on to look after their next patient," it simply reinforces the need for more ongoing education and support. Arguably, it is conceivable that many critical care nurses not only lack knowledge about palliative care in general, but also lack knowledge about the process of effectively caring for themselves. Frequent education sessions on end-of-life care, death and dying, and the importance of reflective practice and feedback should be provided to decrease the caregivers' feelings of isolation, moral angst, and despondence, and increase his/her knowledge base and personal and professional fulfillment and satisfaction. This could only serve to enhance holistic patient care and support to the worried family. Open discussion about end of life during ethics debriefing session would inevitably lead to consistent ethical practice and a safer, healthier, more respectful and therapeutic work environment.

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Caring for patients and families at end of life: The experiences of nurses during withdrawal of life-sustaining treatment

By Brandi Vanderspank-Wright, MScN, RN, CNCC(C), Frances Fothergill-Bourbonnais, PhD, RN, Susan Brajtman, PhD, RN, and Pierre Gagnon, MD, FRCPC

Abstract

Background: *Withdrawal of life-sustaining treatment is a process in which active treatment and the accompanying technology are removed, ending in the death of the patient.*

Purpose: *To understand the lived experience of critical care nurses who care for patients during the process of withdrawal of life-sustaining treatment.*

Methods: *A phenomenological study was undertaken and interviews were conducted with six critical care nurses.*

Results: *The essence of this experience was described by these nurses as "trying to do the right thing". Three major themes emerged: A journey—creating comfort along the way, working in professional angst, and providing memories.*

Vanderspank-Wright, B., Fothergill-Bourbonnais, F., Brajtman, S., & Gagnon, P. (2011). Caring for patients and families at end of life: The experiences of nurses during withdrawal of life-sustaining treatment. *Dynamics, 22*(4), 31–35.

Background

As in other areas of health care, death and dying have been a reality of intensive care units (ICU). Historically, patients have died in critical care units as a result of their injuries or failure of the body systems to respond to treatment. Despite the advances that have been made in critical care medicine, there continues to be a high number of deaths occurring in critical care units. In Canadian teaching hospitals, approximately 27% of all deaths occur in special care units such as the ICU (Heyland, Lavery, Tranmer, & Taylor, 2000). In the United States, approximately 20% of all deaths occur in the ICU (Curtis, 2005). However, it is important to note that dying in a critical care unit is often associated with a decision to discontinue the use of life-sustaining technology (Keenan, Mawdsley, Plotkin, Webster, & Priestap, 2000; Kjeruf, Regehr, Popova, & Baker, 2005; van Rooyen, Elfick, & Strumpher, 2005).

The critical care environment is often described as fast paced, technologically complex and fraught with uncertainty. Patients are admitted with acute, life-threatening and complex health problems, such as pulmonary and cardiovascular disease, sepsis, trauma, and cardiac arrest, as well as gastrointestinal and central nervous system disease/conditions (Cook et al., 2003). Often patients have multiple organ dysfunction/failure and, subsequently, require mechanical ventilation, hemodynamic support, or both (Cook et al., 2003).

Advances in medical technology have made it increasingly possible to sustain critically ill patients for prolonged periods of time (Jones & FitzGerald, 1998; Stroud, 2002). However, often on exhaustion of technological interventions, redirection of care from curative to palliative measures is instituted (Miller, Forbes, & Boyle, 2001). As such, deaths occurring in ICUs may follow a conscious decision made by the health care team and the family of the patient to discontinue the use of life-sustaining technology (Keenan et al., 2000; Kjerulf et al., 2005; van Rooyen et al., 2005).

Nurse-patient ratios in the majority of Canadian ICUs is kept as close as possible to one-to-one due to the need for continuous monitoring and the ever-present possibility that rapid nursing/medical intervention will be required. Researchers have identified that nurses are usually the primary caregivers of patients who are terminally ill and dying (Bradley et al., 2001; Dawe, Verhoef, & Page, 2002) and that within the critical care environment, it is the nurse who is directly involved in end-of-life care, including withdrawal of life-sustaining treatment (Badger, 2005; Ingham, 2001; Nelson & Danis, 2001). Critical care nurses provide a continuous presence at the bedside for patients and their families. Nurses in these environments deliver highly sophisticated and technological interventions and provide measures to promote patient and family comfort and well-being. However, prior to the 1990s, there was limited published literature that focused specifically on describing the role that critical care nurses play with regard to the care of patients dying in ICUs.

Withdrawal of life-sustaining treatment—How does it come about?

After the decision to admit a patient to the ICU, life-sustaining interventions are begun. For example, if a patient is

experiencing severe respiratory distress, interventions could possibly include the use of high amounts of inspired oxygen or a need to intubate the patient in order to either prevent or treat respiratory failure. The consequences of implementing life-sustaining treatment in order to stabilize and treat a patient can be continued dependence on technology such as mechanical ventilation for prolonged periods and perhaps continued deterioration of the patient's condition. Death may then come as a result of a conscious decision by the health care team, along with the family, to withdraw the life-sustaining interventions and to provide comfort and support in the dying process.

In a retrospective study conducted by Rocker et al. (2005), variability in the time from discontinuing life support until death was examined. Ninety-eight patient records revealed a mean time of death of 1.5 hours (range 0.5 to 5.3 hours) following the withdrawal of treatment. The results of this study demonstrated that a narrow timeframe existed from the actual decision to withdraw treatment until death occurred. Indeed, patients may die within minutes of the nurse commencing withdrawal of treatment, leaving the nurse to care for an emotionally distraught and shocked family.

Despite the fact that death in the ICU is predictable and common subsequent to withdrawal of life-sustaining treatment, inconsistent approaches to treatment and lack of continuity of care can prevail. Bowman (2000) identified that ICUs typically have large interprofessional health care teams composed of members from different backgrounds, educational and philosophical perspectives, which may influence the approach to treatments provision. Hylton Rushton, Williams and Hartman Sabatier (2002) indicated that urgent timeframes for decision-making in the ICU and conflicting values among team members can also contribute to inconsistency and lack of continuity of care.

In summary, most often death in critical care follows a decision to withdraw life support when active treatment has not benefitted the patient. Nurses are the primary caregivers to patients and families during this process. A review of the literature found few studies that explored the nursing experience of caring for patients and families during withdrawal of life-sustaining treatment. Therefore further exploration was of merit.

Purpose and objectives

The purpose of this study was to explore the experience of critical care nurses who care for patients during the process of withdrawal of life-sustaining treatment. The specific research objectives were to explore the nurses' experience and to identify factors that nurses perceived to facilitate them or hinder them in caring for these patients.

Methods

Design. Interpretive phenomenology was used to better understand the experiences of critical care nurses caring for patients for whom life-sustaining treatment was being withdrawn. Van Manen (1990) described phenomenological research as exploring the lived experience: the deeper understanding and meaning of everyday experience. The experience of each individual is dependent on the context of his/her own life. Thus, the goal of a hermeneutic (interpretive) inquiry is to seek to understand, at a greater depth, the everyday skills, practices and experience of people (Leonard, 1994).

This phenomenological study took the experience of the ICU nurses caring for patients during withdrawal of treatment and made their experience known. It is also imperative to highlight that in phenomenological inquiry, individuals' understanding (or interpretation) of their experience is shaped by both the context in which that experience develops, and by time.

Ethics. Ethics approval was received from the institution's research ethics board prior to the commencement of the study. Participants provided written informed consent prior to the interviews, which were audio-taped. To ensure participant anonymity and confidentiality, pseudonyms were assigned to each participant.

Sample & setting. A purposive sample of six critical care nurses was used for this study. Sample size was continually re-evaluated until commonalities within the data were revealed through thick, rich descriptions with numerous comments and examples (Munhall, 1994). Participants in this study were recruited from an ICU at one of three sites of a 944-bed academic health sciences centre in Ontario. The ICU was a combined medical/surgical unit with a total of 24 beds. The types of patients admitted included trauma, vascular and other surgical, and those with life-threatening medical conditions, such as septic shock.

For the purpose and objectives of this research study, the participants (registered nurses) met the following inclusion criteria: currently employed in the designated ICU full-time or part-time, had cared for a patient for whom life-sustaining treatment had been withdrawn within six months prior to the initiation of the study, had been employed in the designated ICU for six months prior to consenting to participate, and were English speaking.

Data collection. Individual in-depth interviews were conducted. The guiding questions of the interview were open-ended, which allowed the interaction between the researcher and participant to be conversational in nature (Polit & Beck, 2004). The interview began with a broad question related to the aim of the study: *"Can you tell me what it is like to care for patients during withdrawal of life-sustaining treatment."* Prompting questions facilitated meeting the objectives of the study. These prompts included: *"What makes the process harder or easier for you, as the nurse?" "Is there a specific situation that you can recall that would help to describe what makes it harder or easier?"*

Interviews with participants each lasted approximately one hour. Throughout the study the researcher kept field notes and a reflective journal to record her personal thoughts and

reflections. The reflective journal was also used to record all methodological decisions made with regard to the study so as to provide an audit trail. As part of the study design, participants consented to a second audio-taped interview of approximately one-half hour. The purpose of the second interview was to verify whether the researcher's interpretation of the data reflected their interview.

Data analysis. Data analysis was based on the methods outlined by Colaizzi (1978), namely: reading all the participants' descriptions, identifying key words and phrases, highlighting and coding key words and phrases, and placing the codes into broad categories as patterns were identified. Themes were then developed from the broad categories. Subsequently, the researcher returned to the participants with a summary of findings. Rigour was established through credibility (returning to participants for clarification of results), dependability (audit trail), confirmability (reflective journaling) and transferability (context described so that others can determine applicability to their own setting).

Results

The essence of this experience was: "trying to do the right thing". One participant shared, *"You're always trying to do the right thing, the right thing by the patient, the right thing by the family and the right thing by even the nurses, even by the staff."*

Nurses' ways of trying to do the right thing were captured in three major themes: ***a journey: creating comfort along the way***, ***working in professional angst,*** and ***providing memories***. These themes were further divided into categories.

A journey: Creating comfort along the way was a major theme that was divided into three categories: *1) stepping in, 2) in the middle of it—withdrawing life-sustaining treatment,* and 3) *at the end of the journey*. *Stepping in* described how nurses established rapport with families, how nurses worked to get families to a place where they could accept the death of the patient and how the nurses themselves strived to gain comfort in their own role during the process of withdrawing life-sustaining treatment. *In the middle of it—withdrawing life-sustaining treatment*, described the various aspects of patient comfort, comfort for the families, and the nurses' thought processes related to the use of sedation and analgesia. *At the end of the journey* elaborated on the work that was entailed in caring for patients and families during the process of withdrawal of life-sustaining treatment and, also, how nurses required both support and recognition in their role. The theme *at the end of the journey* also included how nurses reflected on their experiences and their role.

Working in professional angst comprised two categories: *not being on the same page* and the *runaway train of technology*. *Not being on the same page* described in detail the experience of critical care nurses, as they tried to navigate the conflict that stemmed from lack of clear and consistent communication with the health care team regarding treatment and goals of care that were either unclear or constantly changing. The nurses became the *"middle man"* dealing with the health care team, as well as patients and their families. *The runaway train of technology* explored the appropriateness or inappropriateness of technology and the multitude of treatment options that are often discussed or offered to critically ill patients.

Lastly, ***providing memories*** was a theme that described the lengths that critical care nurses would go to ensure that, despite the unfortunate circumstances related to critical illness, patients especially, and their families, had the most positive experience possible.

Of the theme ***a journey—creating comfort along the way*** and the three categories identified, one category, *stepping in* merits further discussion. *Stepping in* literally depicted the nurse stepping in to care for a patient and family. It involved "*building on relationships*", "*getting the family there*" and "*achieving a comfortable place for the nurse*". This process, although at first only a physical action, actually encompassed a multitude of complex and context-specific scenarios. For example, the nurse might or might not have known the patient or the family. Knowing or not knowing the family added to the complexity of withdrawing life-sustaining treatment. If the nurse knew the patient and family, there was a sense of familiarity, the nurse could enter the situation with *"ease"*. One participant reflected *"I think if you have a good… rapport with the families… I always feel a lot more at ease, if you've developed some sort of relationship with them… you've developed a good bond with the family."* Conversely, not knowing the family and not having previously established a rapport or level of trust created a situation that was much more challenging *"[it] can be a little more challenging emotionally and if you… step in on a situation where you're withdrawing care and you're just stepping into it, and you don't know the patient, it's always a little more awkward… you don't want to be coming in as the death nurse"*. In the latter scenario, nurses described having to quickly establish rapport with the family and described how they would do this. *"I try to read the cues, mostly the non-verbal cues from the family… I'm close without being intrusive… I try to focus on the patient… I'll ask them if there's something I can do for them… I'll close the curtains so they have some privacy."*

From the theme ***working in professional angst***, *not being on the same page* was a category identified by all of the participants. This category reflected the experience of the various players: nurses, physicians and family members, not being in agreement with regard to patient care. Conflict that arose related to patient care stemmed most often from two key sources: the physicians wanting to continue or discontinue life-sustaining treatment, and the family wanting the converse. The critical care nurse became the mediator between the two opposing sources of conflict. One participant reflected: *"We do need to work as a team… there's nothing worse than walking into a family conference when you think you're going in there for one thing and the doc starts talking and he's going in a completely different direction… we need to be all on the same page at the same time… it's number one."* Conflict also stemmed from

the weekly changing of the "team" and constant fluctuation of different physicians in and out of the ICU. Sometimes initial decisions regarding the plan of care were altered and aggressive treatments continued. A participant referred to this as "*back pedaling*": *"It makes the nursing staff or myself, it makes me angry that we put all this work into the patient, into the family and this was or where we were going and now this has been halted… so now you've got to back pedal because this person will have spoken to the family perhaps, and I say perhaps because maybe they haven't and now we're trying to explain to the family what we're doing… it's just an emotional yoyo for them and so for us, if we are all not on the same page, end-of-life issues are just not going to be dealt with."*

From the theme ***providing memories***, the participants spoke of their privileged position in being able to provide care for these patients and their families. They spoke of "the little things" being what they felt family members would remember most—not the advanced monitoring and technological sophistication of critical care nursing and medicine. One participant described taking a patient outside to feel the sunshine for the last time. Another spoke of washing and tying back a young women's hair for her family to see her one last time. A participant reflected, *"I still say it's a privilege… to be with them, this is something that family members will remember all of their lives when the family member died and so if you can make that experience as positive as you possibly can, it's not going to be a good experience, it can be a positive one without actually being good."* Another participant said, *"I do believe that you can make it a pleasant experience."*

Participants' reflections on the research findings. When the researcher returned to the participants for the second interview (satisfying the credibility criteria for rigour), participants read and reflected on the research summary that was provided to them. They acknowledged that the findings reflected their experiences: "*With each part of it, I can basically see … it's the essence of who we are.*"

Discussion

Families are central to the experience of caring for patients in the ICU environment. Provonost, Rodriguez-Pas and Mohammad (2007) suggested the following be incorporated into philosophy of care of ICUs: include families in rounds, extend visiting hours, provide the information they need to navigate the ICU environment, have weekly conferences with families so they are up to date with the plan of care and, finally, get feedback regarding their experience. The findings of this current study reveal that working with families is central to the participants' care in the process of withdrawing life-sustaining treatment. The participants also suggest that consistent approaches are important in working with families and the importance of the nurse having a previous relationship with the family. Building rapport and trust is important for comfort for both the nurse and the family. Therefore, strategies need to be explored to facilitate the assignment of nurses to patients and families with whom they have established a relationship.

For the participants in this current research, conflict resulted with members of the team "not being on the same page" with regard to goals of care. Critical care environments have been focused on saving lives and restoring health (Hylton Rushton et al., 2002) and although deaths in this environment historically have occurred, some intensivists still may view death of patients as medical failure (Cicarrello, 2003).

Information relayed in conversations regarding critical illness can be complex, confusing and quite overwhelming for families (Curtis, 2004). Curtis (2004) has identified that in order to provide high-quality care to critical care patients and their families, highly effective communication skills are essential between all parties involved—among the health care team and between the health care team and families. As such, open and honest communication can help to keep everyone on "the same page", to clearly discuss, identify and clarify (if necessary) the goals of care.

The rotation of intensivists on a weekly basis also had a major impact on the experience of critical care nurses and communication processes, as it resulted in inconsistency in decision-making and treatment plans. The ultimate effect was loss of a trusting relationship with the family, who then questioned the intentions of the previous physician and health care team. Effective and frequent communication is essential in all aspects of care, but particularly as it relates to end-of-life care (Curtis, 2004; Dracup & Bryan-Brown, 2005). Consistent policies and procedures openly discussed among team members would facilitate team members being on the "same page" as to goals of care.

This research illustrated how nurses in critical care created memories for families, as they cared for the patient and family at end of life. More research is needed on the importance of memory-making, as nurses travel with families in this journey.

Conclusion

This study's unique contribution is the description of the process of nurses caring for patients and families within the context of withdrawal of life-sustaining treatment. The participants in this study described the challenges in providing a supportive experience for families. They also described the satisfaction they received from caring for these patients and their families, which came from being present with the family and walking with them through this journey. More research is required on how critical care nurses contribute to the end-of-life experience for patients and families.

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COMMENTARY

Last rights: Guidelines for religious accommodation at end of life

By Klara Siber, MDiv, MHSc(Bioethics)

Siber, K. (2011). Commentary: Last rights: Guidelines for religious accommodation at the end of life. *Dynamics, 22*(4), 36–37.

Over the past century, Toronto's multicultural immigration has significantly changed the city's ethnic composition, making Toronto one of the most religiously diverse cities in the world (Kopun & Keung, 2007). As the city's population diversifies and ages, standards for reasonable accommodation of health care for religious groups have become increasingly important for patients and health care professionals. Religious beliefs play a key role in how decisions are made at end of life (EOL), and religious accommodation is a significant component of palliative care. A study examining the impact of religious coping on health care preferences of patients with advanced cancer demonstrated that patients' use of religion as a means of coping with EOL was associated with receipt of more intensive life-prolonging medical care at EOL (Phelps et al., 2009). Another study of patients who had terminal cancer showed that belief in divine intervention, turning to a higher power for strength, support and guidance, and using spirituality to cope with cancer were associated with preference for cardiopulmonary resuscitation, mechanical ventilation, and hospitalization at EOL (True et al., 2005).

Knowing these particular preferences, are health care providers obliged to offer medical treatment based on religious values, even when the treatment is deemed no longer medically indicated? There is no simple answer and most hospitals have no explicit guidelines. As an interfaith spiritual care provider in a large teaching hospital in Toronto, I value the role of spirituality and religion. I encourage patients and families to use their spiritual resources and respect diverse beliefs that inform EOL decision-making. Nevertheless, with the ongoing challenge to meet exceeding demands and optimize limited health care resources, I believe organizations need to develop institutional guidelines for fair and inclusive religious care accommodation.

Advances in medical technology and practice have created situations where religion and medicine come into conflict. Medical decisions are based on values that do not necessarily represent the religious values and beliefs of patients. Currently, EOL care, from the medical perspective, focuses on providing a comfortable, and pain-free death. It does not address religious and spiritual needs for the journey into afterlife. What is perceived as a good death from the medical perspective does not always agree with religious beliefs. Religious teachings of many traditions hold that after death the physical body ceases to exist, but the individual personality persists beyond death in a recognizable form, as an entity variously named the "essence", "soul", "spirit", or "self". While the goal of palliative care is to ensure comfort through pain management, at the core of religious beliefs are provisions for life beyond the material existence of the person. For example, in Buddhist traditions monks may advise to keep the dying individual non-medicated so they maintain awareness of the transition from the physical life to the non-physical life (death). They may request chanting for hours before and after death. For Buddhists, the last thoughts in this life heavily influence the nature of both the after-death experience and the state of one's next human incarnation. When the goal of palliative care is to relieve pain, this request creates practical and ethical challenges.

Monotheistic religious traditions maintain that God is the giver and sustainer of life. Therefore, it is commonly believed that God should be the only one who can "take" a human life. The belief in the sanctity of life along with the Biblical commandment, "Thou shall not kill", may be interpreted as prohibitive of discontinuing life-sustaining therapies. Religious beliefs also foster a hope that a miracle may occur. In a survey of 1,006 members of the general public in the United-States, 57% believed that God could heal a patient even if physicians had pronounced further medical efforts to be futile (Jacobs, Burns, & Bennett Jacobs, 2008).

Religious communities differ in their understandings of when death occurs and how death should be defined. The difference between medical and religious beliefs is most evident with regard to brain death. Since the development of the Harvard Brain Death Criteria in 1968, the concept of "neurological death" commonly called "brain death" has gained acceptance within the medical profession and among legislatures and courts in Canada. However, this view of death does not agree

with the traditional understanding of death in Orthodox Judaism, for example. Throughout Jewish scriptures, breathing is discussed as the determinant of the transition from life to death: "And God breathed into his nostrils the breath of life" (Genesis 2:7). Likewise, the words *neshimah* (breathing) and *neshamah* (soul or life) share a common root (Steinberg, 1990). Some rabbinic authorities recognize the medical criteria for brain death. However, families who reject brain death on religious grounds have been known to request artificial respiration until cardiac arrest (Inwald, Jakobovits, & Petros, 2000). For the health care team, providing intensive care considered futile to a brain-dead person is a great source of moral distress.

In practice, to resolve these differences, families and health care professionals frequently engage in stressful discussions that may result in negotiations involving administrators, clergy, ethicists and lawyers. Decision-making is put on hold while patient care is kept at a status quo. Some patients and families have the resources to dispute the decisions made by the health care team and their requests are granted, while other families are not able and must abide by the decisions made by the health care team.

The recent Winnipeg case of the 84-year-old Mr. Samuel Golubchuk publicly exposed the challenges faced by medical professionals with regard to religious accommodation at EOL. In accordance with their religious values, the family of Mr. Golubchuk believed that ICU technology should keep Mr. Golubchuk alive. When the medical team decided to withdraw life-sustaining therapies, his family obtained a court order to keep Mr. Golubchuk on life support. These physicians described keeping Mr. Golubchuk on life support akin to torture and felt that modern medicine was interfering with Mr. Golubchuk's natural dying process. Eleven months later, Mr. Golubchuk died in hospital. Since the case of Mr. Golubchuk was not resolved in court, we are left with no legal precedent. Hence, the important question—who has the ultimate right to decide when life support should be withheld or withdrawn?—remains unanswered in the court of law. In our hospitals, health care professionals are making considerable efforts to meet the religious needs of patients. However, without an appropriate framework that respects the diverse religious and spiritual beliefs and practice at EOL and also upholds the professional expertise of physicians, cases like Mr. Golubchuk continue to burden and remain a source of moral distress for health care professionals.

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Seasonal flu shot

Seasonal flu vaccines protect against the three influenza viruses that research indicates will be the most common each year. Each year, the viruses in the vaccine change based on international surveillance and scientists' estimations about which types and strains of viruses will circulate in a given year. The flu shot offers the best protection against these viruses, when combined with regular hand washing. Canada's National Advisory Committee on Immunization (NACI) encourages all Canadians over the age of six months to get a flu shot. It is especially important for health professionals to be immunized to protect themselves, their families and their patients.

The Canadian Association of Critical Care Nurses (CACCN) encourages its members and all health care workers to become informed about the benefits to **you, your family** and **your patients** when you get vaccinated.

Make the right choice for all three!

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COMMENTARY

Practical steps for discontinuation of life-sustaining treatment

By Lara Parker, MSN, RN

Abstract

Discontinuing life-sustaining interventions requires an artful skill perhaps even more challenging than providing life-sustaining treatments. Critical care nurses require advanced skills to provide comfort care and, ultimately, a "good death" that encompasses the family and patient. Educational focus has been placed on maintaining the living, but with increasing palliation in critical care, education must include comfort care. This article focuses on the art of discontinuing life-sustaining treatment and providing a seamless, comfortable transition for patient and family. Included in it are seven steps, derived from my own experiences, that are meant to assist new practitioners in their beginning journeys of providing a "good death". The seven steps are interconnected and, depending on the context, will flow back and forth, as needed. The seven steps are: talk with the family, ensure orders are written, prepare drugs, to extubate or not, what about the monitor, ensure readiness, and proceed.

Parker, L. (2011). Commentary: Practical steps for discontinuation of life-sustaining treatment. *Dynamics, 22*(4), 38–40.

Transition of care: Our privilege

Practising as a critical care nurse in a fast-paced, machinery-driven environment encompasses many facets including exceptional assessment skills and managing advanced technologies. This is all done to provide life-sustaining interventions for patients. But, unfortunately, in critical care, death occurs alongside life. Maintaining life and providing a good death each require individualized advanced nursing skills. It could be said that transitioning care to comfort, to provide a good death, perhaps even requires nursing skills beyond that of life-sustaining, as it requires a comfort with dying. Described within this article are seven steps that have been informed by my experience in practice that are meant to assist new practitioners when the direction of care has shifted to comfort. I have come to realize that providing a seamless, comfortable death is a nursing privilege requiring a skilful art. In my experience, education in this skilful art is secondary to life-sustaining measures, so I hope this article will assist others and be their guide as they develop their own comfort with this art.

The decision has been made within the interdisciplinary team that it is time to shift the focus of your patient's care from life-sustaining to comfort. Instantly, as the nurse, you need to change your focus of care, as the patient is not going to survive despite best interventions. As a nurse, a mental and physical transition must occur. In your mind, these words resonate: "Stop treatment; focus on comfort for both family and patient; let the dying transition be seamless, comfortable, and calm". Physically, perhaps you have just spent the last four hours running to save a life. Now that same effort must be expended in making the patient's final transition the best you can. Now it is our honour and privilege to be present for this family and patient during this transition.

This can be a challenging transition for a nurse, but imagine what impact this has on the family. These families are in the midst of crisis experiencing fear, anxiety, and depression (Davidson, 2009), and may believe that critical care will save their loved one. The family, even more than before, becomes a significant component of your care, ending with the family as the focus after the patient has passed away; hence, family-centred care in its full vision.

So, what do you do? How do you prepare the family and patient for this journey? If you have never discontinued life-sustaining treatment before, this can be a daunting experience. Just as there is an expert method for initiating life-saving treatments, there is an expert method for discontinuing them. Kirchhoff and Kowalkowski (2010) have concluded that critical care nurses need to be formally trained in the withdrawal of life-sustaining treatments. Keeping that in mind, let's see if I can share some pearls that include seven interconnected steps I have used within in my practice during discontinuation of life-saving care.

Seven interconnected steps

Within these steps is one overarching principle, family-centred care, that the family comes first and is engaged in the process (if they choose to be). These steps might occur

linearly, but they are interconnected and, therefore, can shift backward and forward as needed dependent on each scenario and context. These steps are to be initiated after the family conference where together the decision has been made to discontinue life-sustaining treatment. The seven steps are: talk with the family, ensure orders are written, prepare drugs, extubate or not, what about the monitor, ensure readiness, and proceed.

***Step 1*—Talk with the family**... my motto is **"THE FAMILY WILL TEACH ME**". It stands true in every facet of my interactions with families, which is why questioning, listening, and presence are important skills. The most important aspect here is that families do not understand, or shouldn't be expected to understand, what the process is going to be other than the fact that their loved one is going to die. You need to be their guide.

Confusion, miscommunication, and misunderstanding can occur for families when their loved one is going to die, which is why open, honest communication and family education about the discontinuation of life-saving process is so vital. I have seen some families run to the bedside after the family conference thinking that we were turning off support while they were in the family meeting. I have had other families believe the moment we turn the machines off their loved one will die. Some family members want to be there and others don't. I have had some families want to wait for the long-lost brother to arrive, or wait for a special time, moment, etc. Each situation has to be handled individually, but with the intent of **"not prolonging the suffering of the patient in the bed".**

So, how do we be the families' guide?

A) Begin with talking with the family and gather their understanding of the process. This is done with great care, compassion, and timed appropriately.
   - Can you tell me in your own words what we are doing for your loved one?
   - Has your loved one ever talked about what they would like during this time (e.g., music, special blanket, token)?
   - As a family, who do you want to be present?
   - Do you have questions?

B) Then, in simple terms, starting with the basics, explain the process and reassure them.
   - Inform them the machines supporting their loved one will not be turned off until the family is ready (within reason, negotiate with the family) because these machines are keeping them alive and when we turn them off is when the dying process will begin.
   - Inform them to gather and connect with family members who want to be present.
   - Inform them the priority is comfort.
   - Inform them about removal of equipment, if there is to be any, and provide them the choice of remaining present or stepping out of the room briefly.

Families might have many questions, but I find there are two very common ones: prediction of the moment of death, and how long the process will take. This is where your critical thinking, communication skills, knowledge of the patient, and experience becomes indispensable. Two possible answers are:

"I am unsure how long ___ will stay with us, but he/she was on a great deal of life-support, therefore…"

"I am unsure how long ___ will stay with us, but considering the injuries and he/she is a young individual with a strong heart, then..."

To answer this important question, one needs to consider many factors, such as length of time in the unit, age, number of organs involved in illness, what level of inotropic and ventilator support they are receiving, and will they have the drive to breathe. For example:

Mr. Young is an 80-year-old man with sepsis and ARDS, on PCV of 22, riding the ventilator, sedated on morphine 5 mg/hr and midazolam 2 mg/hr. On levophed 40mcg/min and amiodarone 30mg/hr with feeds occurring.

In this example, with the patient's age and high level of ventilator and inotropic support my clinical decision would be to ensure the family is close when the levophed is turned off and he is extubated, because his passage might be within minutes. But, no matter what scenario exists for each patient, answer the prediction of death question cautiously, as sometimes predictions can be wrong and you want to prevent unnecessary confusion for the family.

So, what can you do for the family? As a nurse, you can be present for them, assess their social support, and ensure their comfort. Remember my previous motto, "They will teach you", so make sure you ask them questions. For example, do they want you in the room or not. If they choose the latter, let them know you are close and available. If they ask you stay, consider this a moment to share this family's transition. The first time a family asked me to stay was a life-changing moment and the beginning of my refocusing that we are privileged to have this role... and to make the transition from life to death as seamless as can be... for the patient and his/her family, truly an art.

> *I was caring for a young man who was switched to comfort care and was dying before his parents, with no other individuals present. When I asked if they would like me to remain in the room, they asked me to stay. I let my charge nurse know where I was and I sat with them… all three of us, together with their son… It began with light conversation… can I get them anything, can I answer any other question. Please let me know, if you believe he is in pain or discomfort of any kind, as you know your son better than I… and then we sat, and sat, allowing silence to be part of this transition. Then, it began… they started to tell me stories of their son from birth to present, laughing, and sharing with me. I had the privilege of being… present… an honour to me to be with them during their grief…*

***Step 2*—Ensure the orders are written.** This is an important step because full care is given to the patient until these orders are present. This prevents any discrepancy or confusion in direction of care for the nurse and the family, for example,

withholding a medication simply because we are planning on discontinuing care in two hours. Until those orders are written we are providing full care. In many units there are pre-printed comfort care orders to assist in this process. These orders cover components to be considered such as pain control, feeding, removal or not of ET tube, stopping support medications, preparing family, and others.

***Step 3*—Prepare drugs**. When you start comfort care orders, you might or might not need to sedate or provide further analgesics for your patient. What you want to prevent is running out of pain medications or sedatives when you need them the most. For example, your patient is audibly moaning and the family is in distress and you have run out of morphine. On our unit we have both infusions and syringes for boluses ready.

***Step 4*—To extubate or not?** The decision to change to comfort care has been an interdisciplinary one and the decision to extubate or place on t-piece also becomes a team decision and is based on the patient's condition and diagnosis. Some factors to be considered are comfort, drive to breathe, and airway protection. A large component of this decision is visual comfort for the family so that they can remember their loved one, at their last moments, without a large tube down the mouth.

***Step 5*—What to do about the monitor?** There is often a debate whether you leave the bedside monitor on or off. Who do I ask? The family? Some families choose to have the monitor on so they are fully aware of the moment of death, they watch for the flat line. Unfortunately, be aware that families who make this choice can become distracted and end up focusing only on the monitor, instead of their loved one. When a family wants the monitor on, I observe them. If they spend their time focusing on it only, I reassure them that I can turn it off and tell them the moment of passage, so they can focus on their loved one. Again, remember the family probably has not walked this path before and has no understanding of what they want, they are in crisis, therefore decisions are difficult to make, the world is a loss to them, and our job is to help guide them as best as we can, as much as we can.

> *I worked with a family who wanted the monitor on, so they could know the exact moment of passing, but as I watched them, they spent the whole time staring at the monitor, not saying goodbye, not holding their loved one's hand… I realized the moment of death had become their overwhelming centre of focus due to its importance… I offered to do that role for them, so they could focus on their loved one. The relief was audible… I turned off the monitor and they talked to their loved one.*

***Step 6*—Ensure everyone is ready.** This does mean everyone, from family having all loved ones present or having said goodbye, to the multidisciplinary team ready to perform their skills.

***Step 7*—Proceed. Breathe.** Be present. Keep the patient and family comfortable. Each discontinuation of life-sustaining treatment will present a little differently, but they all include removal of ET tube, stopping IV inotrope support, and providing analgesia and sedation, as needed. Try to give the family privacy, draw the curtains, give them chairs, perhaps even water to drink…

Discontinuing life-sustaining treatment is a skill and an art. As a new practitioner to critical care it can be a daunting journey. I hope these seven steps will assist others to be prepared for the process, understand the importance of family, and provide all critical care nurses steps to reflect on in their own practice.

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Dynamics 2013 conference planning committee Call for participation

Dynamics 2013 will be held September 22–24, 2013, at the World Trade and Convention Centre in Halifax, Nova Scotia. Dynamics 2013 will be chaired by Kate Mahon. CACCN members interested in working on the conference planning committee should submit a resume/CV and summary of conference planning experience *(planning experience is appreciated, but not a requirement for submission)* to the CACCN National Office by March 1, 2012. Planning Committee selection will take place in March 2012. *Consideration will be given to planning committee applicants who are local to the conference venue or are from chapters/provinces/adjacent to the conference venue.* For further information on this exciting opportunity, please contact the CACCN National Office, P.O. Box 25322, London, ON N6C 6B1, **www.caccn.ca**, email: **caccn@caccn.ca**, phone: (519) 649-5284, fax: (519) 649-1458. *For frequently-asked questions regarding Dynamics conference planning, please visit **www.caccn.ca**.*

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The Dräger 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.

Award funds available: $500.00 plus a plaque

Deadline for consideration: End of current fiscal year (March 31)

Application process: Eligible chapters are automatically included

Criteria for the award program

- All chapters of CACCN are eligible for consideration of the Chapter of the Year Award provided all quarterly and annual financial/activity reports are on file with CACCN National Office for the qualifying period. If the above conditions are not met, the Chapter will not be eligible for consideration
- The award program will be for the period of April 1 to March 31 of each year
- Chapters may win the award for one year followed by a two-year lapse before winning again.

Conditions for the award program

- A point system has been developed to evaluate chapter activities during the year
- **Chapters will be responsible for ensuring National Office receives all required documentation to validate accumulated points**
- The chapter with the most points will be the successful recipient of the Chapter of the Year Award
- CACCN reserves the right to adjust points depending upon supporting materials submitted
- In the case of a tie, CACCN reserves the right to determine the recipient of the award
- The award winner will be announced at Chapter Connections Day and at the annual awards ceremony at Dynamics
- Announcement of the successful Chapter will be published in CACCN publications
- The successful chapter will be profiled at Chapter Connections Day and Dynamics.

Categories and their corresponding points

- Educational programming—please provide an accompanying brochure/advertisement of events that occurred in the award year:
  Programs between:
  1–3 hours: 25 points each
  3–8 hours: 50 points each
  > 8 hours: 100 points each

- Recruitment: Points are calculated based on the percentage of new members recruited, as compared to the total membership of the previous year:

  01–10%: 10 points
  11–20%: 20 points
  21–30%: 30 points
  31–40%: 40 points
  41–50%: 50 points
  51–60%: 60 points
  61–70%: 70 points
  71–80%: 80 points
  81–90%: 90 points
  91–100%: 100 points

Points will be calculated for chapter members who have contributed presentations at local, provincial and national CACCN activities. Points will only be awarded once for a presentation, regardless of the number of times or venues at which it is presented.
Each presentation: 25 points

Points will be calculated for chapter members who have contributed articles to the chapter newsletter, or who have had a paper published in *Dynamics, the Journal of the Canadian Association of Critical Care Nurses*. Please provide a copy of the associated chapter newsletter.
Each article or paper: 25 points

Projects that provide public education, community service and/or promote the image of critical care nursing or CACCN. These projects must be presented under the auspices of the CACCN chapter (i.e., participating in blood pressure clinics, teaching CPR to the public, participating in health fairs, recruitment booths, etc.).
Each project: 50 points

Good luck in your endeavours!

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

CACCN Research Grant

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

Award funds available: $2,500.00

Deadline for submission: February 15

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

Eligibility:
The principal investigator must:

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

- Publish an article related to the research study in *Dynamics, the Journal of the Canadian Association of Critical Care Nurses*
- 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 the receipt of the grant
- Any changes to the study timelines require notification in writing to the board of directors of CACCN
- All publications and presentations arising from the research study must acknowledge CACCN
- A final report is to be submitted to the board of directors of CACCN within three months of the termination date of the grant
- The research study is to be submitted to the *Dynamics, Journal of the Canadian Association of Critical Care Nurses* 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

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

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

Editorial Awards

Edwards

1st place award value: $750.00 Edwards

Runner-up award value: $500.00 CACCN

Deadline: None. Awards committee selection process.

The Editorial Awards will be presented to the authors of two written papers in *Dynamics,* which demonstrate the achievement of excellence in the area of critical care nursing. An award, provided by Edwards Lifesciences, will be given to the author(s) of the best article, and another award is given to the author(s) of the runner-up article. It is expected that the money will be used for professional development. More specifically, the recipient must use the funds:

1. Within 12 months following the announcement of the winners, or within a reasonable time
2. To cover and/or allay costs incurred while attending critical care nursing-related educational courses, seminars, workshops, conferences or special programs or projects approved by the CACCN, and
3. To further one's career development in the area of critical care nursing.

Eligibility:

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

Criteria for evaluation:

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

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

Selection:

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

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

The Spacelabs Innovative Project Award

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

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

Deadline for submission: June 1 each year

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

Mailed applications must be postmarked on or before June 1

Do you have a unique idea?

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

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

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

Smiths Medical Canada Ltd. Educational Award

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

Deadlines: January 31 and September 1 of each year

The CACCN Educational Awards have been established to provide funds ($1000.00 each) to assist critical care nurses to attend continuing education programs at the baccalaureate, master's and doctorate of nursing levels. All critical care nurses in Canada are eligible to apply, except members of the CACCN board of directors.

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

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

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

CACCN Chapter Recruitment and Retention Awards

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

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

Retention Initiative:
This initiative will benefit the chapter if the following requirements are met:
- If the chapter has greater than 80% renewal of its previous year's members, the chapter will receive three $100.00 coupons to Dynamics of that year

- If the chapter has greater than 70% renewal of its previous year's members, the chapter will receive two $100.00 coupons to Dynamics of that year
- If the chapter has greater than 60% renewal of its previous year's members, the chapter will receive one $100.00 coupon to Dynamics of that year.

BBraun Sharing Expertise Award

Award funds available: $ 1,000.00

Deadline for submission: June 1 each year

The BBraun Sharing Expertise Award will be presented to an individual who exhibits stellar leadership and mentoring abilities in critical care.

The candidate is an individual who supports, encourages, and teaches colleagues. The candidate 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.

Each nomination must have the support of another colleague and the individual's manager. It is not necessary for the candidate to be in a formal leadership or education role to qualify for this award.

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:
- Nominee must be a CACCN member for a minimum of one (1) year
- The nominee must have at least three (3) years of critical care nursing experience
- At least one nomination letter must be written by a CACCN member
- Preference is given to a mentor who has CNA Certification
- The nominee must demonstrate an awareness of, and adherence to, the standards of nursing practice as determined by the provincial nursing body, and the Standards of Critical Care Nursing (2009)
- CACCN board of directors are not eligible to apply for the award.

Three (3) letters of support are required:
- The nominator must outline the qualities of the candidate, and reasons the candidate should be chosen to receive the award
- Two additional letters must testify to the eligibility of the candidate, as well as outline his/her attributes (one must be written by the nominee's manager)
- All three letters must be sent by electronic mail by each person on the same day with the subject matter: "BBraun Sharing Expertise Award—Candidate's Name" to the Director responsible for awards at National Office (caccn@caccn.ca).

Selection process:
- Each nomination will be reviewed by the Awards Committee in conjunction with the CACCN Director of Awards & Sponsors
- The successful candidate will be notified by email and regular mail
- The successful candidate will be recognized at the annual Awards Ceremony at the Dynamics conference and her/his name will be published in *Dynamics, Journal of the CACCN*
- The awards committee reserves the right to withhold the award if no candidate meets the criteria
- The funds may be used to attend educational programs or conferences related to critical care
- The Awards Committee reserves the right to withhold the award if no candidate meets the criteria outlined.

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

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

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

Deadline: June 1 of each year.

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

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

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

A complete application form that includes:
- A proposal of a project, or a description of a completed project, which makes a significant contribution toward patient and caregiver safety in critical care
- The proposal will include the background perspective, statement of the problem, and intended means to change practice. The proposal should include a timeline by which the project will occur

- Brief curriculum vitae for the principal applicant and team members describing educational and critical care nursing background and CACCN participation
- Proof of active CACCN membership
- If this project requires ethics approval, please submit evidence of approval with your application.

Review process:
- Each proposal will be reviewed by the awards review committee and a representative of the Baxter Corporation
- Proposals are reviewed for their contribution to patient safety, evidence of transferability of the project, innovation, sustainability, and leadership within critical care practice areas
- Deadline for receipt of applications is **June 1** of each year
- The successful candidate will be chosen and notified in writing by **July 1.**

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

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

The total funds available are $5,000.00.

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

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

The Brenda Morgan Leadership Excellence Award

Award funds available: $1,000.00 plus award trophy

Deadline for submission: June 1

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

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

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

Send applications to CACCN National Office at
caccn@caccn.ca or fax to 519-649-1458 or
Mail to: CACCN, PO Box 25322, London, ON N6C 6B1
Mailed applications must be postmarked on or before June 1

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

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

Application process:

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

Selection process:

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

Terms and conditions of the award:

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

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

Cardinal Health Chasing Excellence Award

Award value: $1,000.00

Deadline: June 1 annually

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

The *Cardinal Health Chasing Excellence Award* is given to a critical care nurse who:

- In critical care, has a primary role in direct patient care
- Has been a CACCN member in good standing for three or more years
- Holds a certificate from CNA in critical care CNCC(C) or CNCCP(C) (preferred)
- Note: Current members of the national board of directors are not eligible.

The *Cardinal Health Chasing Excellence Award* recipient consistently practises at an expert level as described by Benner (1984). Expert practice is exemplified by most or all of the following criteria:

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

Nominations:

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

Selection:

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

References:

Benner, P. (1984). *From novice to expert. Excellence and power in clinical nursing practice.* Menlo Park: Addison-Wesley.

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical Wisdom and Interventions in Critical Care: A Thinking-in-action Approach.* Philadelphia: Saunders.

Precedex™
(Dexmedetomidine Hydrochloride for Injection)

Prescribing Summary

Patient Selection Criteria

THERAPEUTIC CLASSIFICATION: Alpha$_2$-adrenergic agonist

INDICATIONS AND CLINICAL USE:

Intensive Care Unit Sedation

Precedex™ is indicated for sedation of initially intubated and mechanically ventilated postsurgical patients during treatment in an intensive care setting by continuous intravenous infusion. The Precedex™ infusion must not exceed 24 hours.

Precedex™ has been continuously infused in mechanically ventilated patients prior to extubation, during extubation, and post-extubation. It is not necessary to discontinue Precedex™ prior to extubation. After extubation, the dose of Precedex™ should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.

Conscious Sedation

Precedex™ is indicated for sedation of non-intubated patients prior to and/or during surgical and other procedures by continuous intravenous infusion for the following procedures:

- Monitored Anesthesia Care (MAC) with an adequate nerve block and/or local infiltration; and
- Awake Fiberoptic Intubation (AFI) with adequate topical preparation of the upper airway with local lidocaine formulations.

Due to insufficient safety and efficacy data, Precedex™ is not recommended for use in procedures other than the two listed above.

CONTRAINDICATIONS

Patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see the Dosage Forms, Composition and Packaging section of the product monograph.

SPECIAL POPULATIONS

Pregnant Women: There are no adequate and well-controlled studies in pregnant women. Precedex™ should be used during pregnancy only if the potential benefits justify the potential risk to the fetus.

Labor and Delivery: The safety of Precedex™ during labor and delivery has not been studied. Therefore, Precedex™ is not recommended during labor and delivery including cesarean section deliveries.

Nursing Women: It is not known whether Precedex™ is excreted in human milk. Radio-labeled Precedex™ administered subcutaneously to lactating female rats was excreted in milk. Because many drugs are excreted in human milk, caution should be exercised when Precedex™ is administered to a nursing woman.

Pediatrics: There have been no clinical studies to establish the safety and efficacy of Precedex™ in pediatric patients below 18 years of age. Therefore, Precedex™ should not be used in this population.

Geriatrics: Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection in elderly patients, and it may be useful to monitor renal function **(see Dosage and Administration).**

Safety Information

WARNINGS AND PRECAUTIONS

General

Precedex™ should be administered only by persons skilled in the management of patients in the intensive care or operating room setting. Due to the known pharmacological effects of Precedex™, patients should be continuously monitored while receiving Precedex™.

Cardiovascular

Hypotension, Bradycardia and Sinus arrest: Clinically significant episodes of bradycardia and sinus arrest have been reported with Precedex™ administration in young, healthy volunteers with high vagal tone or with different routes of administration including rapid intravenous or bolus administration.

Reports of hypotension and bradycardia have been associated with Precedex™ infusion. If medical intervention is required, treatment may include decreasing or stopping the infusion of Precedex™, increasing the rate of intravenous fluid administration, elevation of the lower extremities, and use of pressor agents. Because Precedex™ has the potential to augment bradycardia induced by vagal stimuli; clinicians should be prepared to intervene. The intravenous administration of anticholinergic agents (e.g., glycopyrrolate, atropine) should be considered to modify vagal tone. In clinical trials, glycopyrrolate or atropine were effective in the treatment of most episodes of Precedex™-induced bradycardia. However, in some patients with significant cardiovascular dysfunction, more advanced resuscitative measures were required.

Caution should be exercised when administering Precedex™ to patients with advanced heart block and/or severe ventricular dysfunction. Because Precedex™ decreases sympathetic nervous system activity, hypotension and/or bradycardia may be expected to be more pronounced in patients with hypovolemia, diabetes mellitus, or chronic hypertension and in elderly patients. In situations where other vasodilators or negative chronotropic agents are administered, coadministration of Precedex™ could have an additive pharmacodynamic effect and should be administered with caution.

Transient Hypertension: Transient hypertension has been observed primarily during the loading dose in association with the initial peripheral vasoconstrictive effects of Precedex™.

Treatment of the transient hypertension has generally not been necessary, although reduction of the loading dose infusion rate may be desirable.

Dependence/Tolerance

Precedex™ is not a controlled substance. The dependence potential of Precedex™ has not been studied in humans.

Endocrine and Metabolism

The available evidence is inadequate to confirm if dexmedetomidine is associated with significant adrenocortical suppression. The adequacy of the adrenocortical function should be individually assessed and managed.

Hepatic/Biliary/Pancreatic

Since Precedex™ clearance decreases with severity of hepatic impairment, dose reduction should be considered in patients with impaired hepatic function.

Renal

Precedex™ is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. **(see Dosage and Administration)**

Peri-Operative Considerations

Arousability: Some patients receiving Precedex™ have been observed to be arousable and alert when stimulated. This alone should not be considered as evidence of lack of efficacy in the absence of other clinical signs and symptoms.

Withdrawal

Intensive Care Unit

Precedex™ is indicated only for sedation of initially intubated and mechanically ventilated postoperative patients recovering in a post-operative care unit or an intensive care unit. During the use of Precedex™ in an intensive care setting, the patients must be monitored continuously, particularly for their cardiovascular safety indicators.

If Precedex™ were to be administered for more than 24 hours and stopped abruptly, withdrawal symptoms similar to those reported for other alpha-2-adrenergic agents may result. These symptoms include nervousness, agitation, and headaches, accompanied or followed by a rapid rise in blood pressure and elevated catecholamine concentrations in the plasma. Precedex™ infusion must not exceed 24 hours.

Conscious Sedation

Withdrawal symptoms were not seen after discontinuation of short term infusion of Precedex™.

Patient Counselling Information

Precedex™ is indicated for short-term intravenous sedation. Dosage must be individualized and titrated to the desired clinical effect. Blood pressure, heart rate and oxygen levels will be monitored both continuously during the infusion of Precedex™ and as clinically appropriate after discontinuation.

- When Precedex™ is infused for more than 6 hours, patients should be informed to report nervousness, agitation, and headaches that may occur for up to 48 hours.
- Additionally, patients should be informed to report symptoms that may occur within 48 hours after the administration of Precedex™ such as: weakness, confusion, excessive sweating, weight loss, abdominal pain, salt cravings, diarrhea, constipation, dizziness or lightheadedness.

Intensive Care Unit Sedation

A total of 849 patients in the clinical studies were 65 years of age and over. A total of 242 patients were 75 years of age and over. In patients greater than 65 years of age, a higher incidence of bradycardia and hypotension was observed following administration of Precedex™. Therefore a dose reduction should be considered in patients over 65 years of age **(see Dosage and Administration).**

Conscious Sedation

A total of 131 patients in the clinical studies were 65 years of age and over. A total of 47 patients were 75 years of age and over. Hypotension occurred in a higher incidence in Precedex™-treated patients 65 years or older (72%) and 75 years or older (74%) as compared to patients <65 years (47%). Pre-specified criteria for the vital signs to be reported as adverse reactions are footnoted below Table 2 **(see Adverse Reactions)**. A reduced loading dose of 0.5 mcg/kg given over 10 minutes is recommended and a reduction in the maintenance infusion should be considered for patients greater than 65 years of age **(see Dosage and Administration)**.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

Use of Precedex™ has been associated with the following serious adverse reactions:

- Hypotension, bradycardia and sinus arrest **(see Warnings and Precautions)**,
- Transient hypertension **(see Warnings and Precautions)**.

Most common treatment-emergent adverse reactions, occurring in greater than 2% of patients in both Intensive Care Unit and conscious sedation studies include hypotension, bradycardia and dry mouth.

Intensive Care Unit Sedation

Adverse event information derived from the placebo-controlled, continuous infusion trials of Precedex™ for sedation in the surgical intensive care unit setting in which 387 patients received Precedex™. Overall, the most frequently observed treatment-emergent adverse events included hypotension, hypertension, nausea, bradycardia, fever, vomiting, hypoxia, tachycardia and anemia **(see Table 1).**

Conscious Sedation

Adverse event information is derived from the two trials for conscious sedation in which 318 patients received Precedex™. Treatment-emergent adverse events occurring at an incidence of >2% are provided in **Table 2**. The most frequent adverse events were hypotension, bradycardia, and dry mouth.

Post-Market Adverse Drug Reactions

Hypotension and bradycardia were the most common adverse reactions associated with the use of Precedex™ during post approval use of the drug.

DRUG INTERACTIONS

Drug-Drug Interactions

Anesthetics, sedatives, hypnotics, opioids

Co-administration of Precedex™ with anesthetics, sedatives, hypnotics, and opioids is likely to lead to an enhancement of effects. Specific studies have confirmed these effects with sevoflurane, isoflurane, propofol, alfentanil, and midazolam. No pharmacokinetic interactions between Precedex™ and isoflurane, propofol, alfentanil and midazolam have been demonstrated. However, due to possible pharmacodynamic interactions, when co-administered with Precedex™, a reduction in dosage of Precedex™ or the concomitant anesthetic, sedative, hypnotic or opioid may be required.

Neuromuscular Blockers

In one study of 10 healthy volunteers, administration of Precedex™ for 45 minutes at a plasma concentration of 1 (one) ng/mL resulted in no clinically meaningful increases in the magnitude of neuromuscular blockade associated with rocuronium administration.

Cytochrome P450
In vitro studies in human liver microsomes demonstrated no evidence of cytochrome P450 mediated drug interactions that are likely to be of clinical relevance.

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Administration

Dosing Considerations
- Precedex™ should be used in only facilities adequately staffed and equipped for anesthesia, resuscitation, and cardiovascular monitoring.
- Precedex™ dosing should be individualized and titrated to the desired clinical response.
- Precedex™ is not indicated for infusions lasting longer than 24 hours.
- Precedex™ should be administered using a controlled infusion device with adequate precision.

Recommended Dose and Dosage Adjustment
Intensive Care Unit Sedation
- Precedex™ is indicated for post-surgical patients in an intensive care setting, e.g. in Post Anesthesia Care Unit or Intensive Care Unit.
- An assessment of the level of sedation and the need for Precedex™ should precede the initiation of Precedex™.
- Another intravenous sedative (e.g. midazolam or propofol) may be added if Precedex™ provides inadequate sedation at the highest recommended dose level.
- The need for Precedex™ continuous infusion post-extubation must be assessed individually.

If the continuous infusion is needed post-extubation, the infusion speed should be reduced by half. The mean time of continued infusion is approximately 6.6 hours.
- Precedex™ use should not exceed 24 hours in an ICU setting.

A dose reduction for both the loading and maintenance infusions should be considered in patients with impaired hepatic or renal function and in patients over 65 years of age.

Initiation: For adult patients, Precedex™ is generally initiated with a loading infusion of up to one mcg/kg over 10 to 20 minutes, if needed. For patients being converted from alternate sedative therapy a loading dose may not be required.

Maintenance: Adult patients will generally require a maintenance infusion of 0.2 to 0.7 mcg/kg/hr. The rate of the maintenance infusion should be adjusted to achieve the desired level of sedation.

Conscious Sedation
- Based on the Ramsay and Observer's Assessment of Alertness/Sedation Scales, the loading infusion provides clinically effective onset of sedation 10 to 15 minutes after start of infusion.
- For use in Monitored Anesthesia Care, an adequate nerve block and/or local infiltration should be used.
- For Awake Fiberoptic Intubation, the upper airway should be topicalized with proper lidocaine formulations.

Initiation: For adult patients, Precedex™ is generally initiated with a loading infusion of one mcg/kg over 10 minutes. For patients over 65 years of age or those undergoing less invasive procedures such as ophthalmic surgery, a loading infusion of 0.5 mcg/kg over 10 minutes may be suitable.

Maintenance: The maintenance infusion of Precedex™ is generally initiated at 0.6 mcg/kg/hr and titrated to achieve desired clinical effect with doses ranging from 0.2 to 1 mcg/kg/hr. The rate of the maintenance infusion should be adjusted to achieve the targeted level of sedation. Following the load in awake fiberoptic intubation, a fixed maintenance dose of 0.7 mcg/kg/hr is recommended until the endotracheal tube is secured.

Dosage Adjustment: Due to possible pharmacodynamic interactions, a reduction in dosage of Precedex™ or other concomitant anesthetics, sedatives, hypnotics or opioids may be required when coadministered. A dose reduction for both the loading and maintenance infusions should be considered in patients with impaired hepatic or renal function and in patients over 65 years of age.

Administration
Precedex™ must be diluted in 0.9% sodium chloride solution to achieve required concentration (4 mcg/mL) prior to administration. Preparation of solutions is the same, whether for the loading dose or maintenance infusion.
Strict aseptic technique must always be maintained during handling of Precedex™.
To prepare the infusion, withdraw 2 mL of Precedex™ and add to 48 mL of 0.9% sodium chloride injection to a total of 50 mL. Shake gently to mix well. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit.

Study References

1. PRECEDEX™ (Dexmedetomidine Hydrochloride for Injection) Product Monograph, December 8, 2009, Hospira Healthcare Corporation.

Supplemental Product Information

Clinical Trial Adverse Drug Reactions: *Because clinical trials are conducted under very specific conditions, the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.* **Intensive Care Unit Sedation** Adverse event information derived from the placebo-controlled, continuous infusion trials of Precedex™ for sedation in the surgical intensive care unit setting in which 387 patients received Precedex™. In these studies, the mean total dose was 7.06 mcg/kg (SD = 2.86), mean dose per hour was 0.51 mcg/kg/hr (SD = 0.39) and the mean duration of infusion of 15.6 hours (range: 0.17 to 29.08). Midazolam or propofol was used as the rescue medication for patients on Precedex™ or placebo. The population was between 19 to 83 years of age, 43% > 65 years of age, 73% male and 97% Caucasian. Treatment-emergent adverse events occurring at an incidence of >1% are provided in Table 1.

Table 1: Treatment-Emergent Adverse Events Occurring in >1% Of All Dexmedetomidine-Treated Patients in the Randomized Placebo-controlled Continuous Infusion Short-Term Intensive Care Unit Sedation Studies

Adverse Event	Randomized Dexmedetomidine*	Placebo with Midazolam Rescue	Placebo with Propofol Rescue
	(N=387)	(N=181)	(N=198)
Hypotension	28%	15%	10%
Hypertension	16%	13%	23%
Nausea	11%	9%	10%
Bradycardia	7%	3%	2%
Fever	5%	6%	4%
Vomiting	4%	6%	6%
Atrial Fibrillation	4%	4%	3%
Hypoxia	4%	5%	3%
Tachycardia	3%	7%	3%
Hemorrhage	3%	6%	4%
Anemia	3%	4%	1%
Dry Mouth	3%	2%	<1%
Rigors	2%	3%	4%
Agitation	2%	3%	3%
Hyperpyrexia	2%	3%	2%
Pain	2%	3%	1%
Hyperglycemia	2%	3%	1%
Acidosis	2%	<1%	3%
Pleural Effusion	2%	<1%	2%
Oliguria	2%	1%	<1%
Thirst	2%	<1%	<1%

*Data combined from studies conducted in post-surgical patients recovering in an ICU setting.

Conscious Sedation event information is derived from the two trials for conscious sedation in which 318 patients received Precedex™. Midazolam was used as the rescue medication for patients on Precedex™ or placebo. The mean total dose was 1.6 mcg/kg (range: 0.5 to 6.7), mean dose per hour was 1.3 mcg/kg/hr (range: 0.3 to 6.1) and the mean duration of infusion of 1.5 hours (range: 0.1 to 6.2). The population was between 18 to 93 years of age, 36% > 65 years of age, 52% male and 61% Caucasian. Treatment-emergent adverse events occurring at an incidence of >2% are provided in Table 2. Prespecified criteria for the vital signs to be reported as adverse reactions are footnoted below the table. The decrease in respiratory rate and hypoxia was similar between Precedex™ and comparator groups in both studies.

Table 2: Adverse Events with an Incidence >2% – Conscious Sedation Population

Body System/Adverse Event	Precedex™ N = 318 n (%)	Placebo N = 113 n (%)
Vascular disorders		
Hypotension[1]	173 (54%)	34 (30%)
Hypertension[2]	41 (13%)	27 (24%)
Respiratory, thoracic and mediastinal disorders		
Respiratory depression[5]	117 (37%)	36 (32%)
Hypoxia[6]	7 (2%)	3 (3%)
Bradypnea	5 (2%)	5 (4%)
Cardiac disorders		
Bradycardia[3]	45 (14%)	4 (4%)
Tachycardia[4]	17 (5%)	19 (17%)
Gastrointestinal disorders		
Nausea	10 (3%)	2 (2%)
Dry mouth	8 (3%)	1 (1%)

1 Hypotension was defined in absolute and relative terms as Systolic blood pressure of <80 mmHg or <30% lower than pre-study drug infusion value, or Diastolic blood pressure of <50 mmHg **2** Hypertension was defined in absolute and relative terms as Systolic blood pressure >180 mmHg or >30% higher than pre-study drug infusion value or Diastolic blood pressure of >100 mmHg. **3** Bradycardia was defined in absolute and relative terms as <40 bpm or <20% lower than pre-study drug infusion value. **4** Tachycardia was defined in absolute and relative terms as >120 bpm or >30% greater than pre-study drug infusion value. **5** Respiratory Depression was defined in absolute and relative terms as respiratory rate (RR) <8 bpm or >25% decrease from baseline **6** Hypoxia was defined in absolute and relative terms as SpO_2 < 90% or 10% decrease from baseline

Post-Market Adverse Drug Reactions *The following adverse reactions have been identified during post approval use of Precedex™. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.*

Table 3: Adverse Events Experienced During Post approval Use of Precedex™

Body System	Preferred Term
Body as a Whole	Fever, hyperpyrexia, hypovolemia, light anesthesia, pain, rigors
Cardiovascular Disorders, General	Blood pressure fluctuation, heart disorder, hypertension, hypotension, myocardial infarction
Central and Peripheral Nervous System Disorders	Dizziness, headache, neuralgia, neuritis, speech disorder, convulsion
Gastrointestinal System Disorders	Abdominal pain, diarrhea, vomiting, nausea
Heart Rate and Rhythm Disorders	Arrhythmia, ventricular arrhythmia, bradycardia, hypoxia, atrioventricular block, cardiac arrest, extrasystoles, atrial fibrillation, heart block, t wave inversion, tachycardia, supraventricular tachycardia, ventricular tachycardia
Metabolic and Nutritional Disorders	Acidosis, respiratory acidosis, hyperkalemia, increased alkaline phosphatase, thirst, hypoglycemia
Psychiatric Disorders	Agitation, confusion, delirium, hallucination, illusion
Red Blood Cell Disorders	Anemia
Renal disorders	Blood urea nitrogen increased, oliguria
Respiratory System Disorders	Apnea, bronchospasm, dyspnea, hypercapnia, hypoventilation, hypoxia, pulmonary congestion
Skin and Appendages Disorders	Increased sweating
Vascular disorders	Hemorrhage
Vision Disorders	Photopsia, abnormal vision

Compatibility with Other Fluids Precedex™ has been shown to be compatible when administered with the following intravenous fluids: Lactated Ringers, 5% Glucose in Water, 0.9% Sodium Chloride in Water, 20% Mannitol in Water. Dexmedetomidine has been found to be compatible with water solutions of the following drugs when administered via Y-site injections: thiopental sodium, vecuronium bromide, pancuronium bromide, glycopyrrolate bromide, phenylephrine hydrochloride. **Compatibility with Natural Rubber** Compatibility studies have demonstrated the potential for absorption of Precedex™ to some types of natural rubber. Although Precedex™ is dosed to effect, it is advisable to use administration components made with synthetic or coated natural rubber gaskets. **Incompatibilities** Precedex™ infusion should not be co-administered through the same IV catheter with blood, serum, or plasma because physical compatibility has not been established. Precedex™ has been shown to be incompatible when administered with the following drugs: amphotericin B, diazepam. **OVERDOSAGE** The tolerability of Precedex™ was studied in one study in which healthy subjects were administered doses at and above the recommended dose of 0.2 to 0.7 mcg/kg/hr. The maximum blood concentration achieved in this study was approximately 13 times the upper boundary of the therapeutic range. The most notable effects observed in two subjects who achieved the highest doses were first degree atrioventricular block and second degree heart block. No hemodynamic compromise was noted with the atrioventricular block and the heart block resolved spontaneously within one minute. Five patients received an overdose of Precedex™ in the intensive care unit sedation studies. Two of these patients had no symptoms reported; one patient received a 2 mcg/kg loading dose over 10 minutes (twice the recommended loading dose) and one patient received a maintenance infusion of 0.8 mcg/kg/hr. two other patients who received a 2 mcg/kg loading dose over 10 minutes, experienced bradycardia and/or hypotension. One patient who received a loading bolus dose of undiluted Precedex™ (19.4 mcg/kg), had cardiac arrest from which he was successfully resuscitated. **STORAGE AND STABILITY** Store at controlled room temperature, 25°C (77°F) with excursions allowed from 15 to 30°C (59 to 86°F). (See USP.) **DOSAGE FORMS, COMPOSITION AND PACKAGING** Precedex™ (dexmedetomidine hydrochloride for Injection) is a sterile, nonpyrogenic solution suitable for intravenous infusion following dilution. Each 1 mL of Precedex™ contains 118 mg of dexmedetomidine hydrochloride equivalent to 100 mg dexmedetomidine and 9 mg of sodium chloride in water. The solution is preservative-free and contains no additives or chemical stabilizers. Precedex™ (Dexmedetomidine Hydrochloride for Injection), 100 mcg/mL as the base is available in 2 mL clear glass vials (200 mcg/2 mL). Vials are intended for single use only.

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DYNAMICS

Information for Authors

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

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

Manuscripts submitted for publication must follow the following format:

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- Indicate the primary person to contact and address for correspondence

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

3. Body of manuscript:

- Length: a maximum of 15 pages including tables, figures, and references
- Format: double spaced, 1 inch margins on all sides. Pages should be numbered sequentially including tables, and figures. Prepare the manuscript in the style as outlined in the American Psychological Association's (APA) Publication Manual 6th Edition.
- Use only generic names for products and drugs.
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- All authors must declare any conflicts of interest and acknowledge that they have made substantial contributions to the work and/or contributed substantially to the manuscript at the time of acceptance.

Revised November 2011

WHY CACCN?

Vision: The voice for excellence in Canadian Critical Care Nursing

CACCN Mission Statement

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

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

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

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

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

CACCN Values Statement

Our core values are:

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

Dignity & Humanity
- Respectful, healing and humane critical care environments
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Revised November 2010

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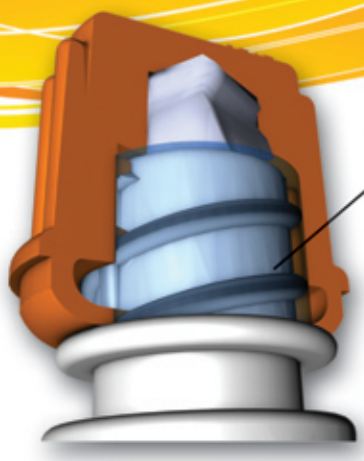

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