VOLUME 24, NUMBER 4, WINTER 2013

DYNAMICS

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Journal of the Canadian Association of Critical Care Nurses

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DYNAMICS

Journal of the Canadian Association of Critical Care Nurses

Volume 24, Number 4, Winter 2013

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Author enquiries: Send manuscript enquiries or submissions to Paula Price, ACCN Program, Faculty of Health and Community Studies, Mount Royal University, 4825 Mount Royal Gate S.W., Calgary, Alberta T3E 6K6, email: pprice@mtroyal.ca

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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.

Pathways to success: Five pillars

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

CRITICAL THINKING

Having returned from attending another successful Dynamics in Halifax, I find my passion for critical care nursing rejuvenated. I was fortunate to speak and network with many of you at the conference. Some may recall I spoke of the benefits of belonging to a professional organization. I believe that belonging and contributing to a community of practice with other nurses is one of those benefits. I have been frequently asked how I have continued my practice in critical care for so many years and how I have managed not to burn out. I have noted that with every national conference or chapter workshop I have attended, my excitement and enthusiasm for our work has grown. They have fuelled my passion and allowed me to stay in critical care for my entire career as a nurse. I still find it exciting to work in critical care and truly can say that I love being a critical care nurse. By attending CACCN events I am able to network with a community of critical care nurses who are passionate about our specialty and the patients under our care.

The vision of CACCN is to be the Voice for excellence in critical care nursing. As leaders we wanted to ensure the organization's goals contributed to our vision. One way of ensuring that our path aligns with our vision and mission is choosing a president's theme. My president's theme "Speak with Conviction" has built on Past President Kate Mahon's theme of "Find Your Voice". Speaking with conviction could be as simple as advocating for family presence at rounds or the development of new position statements for CACCN. The national board of CACCN has worked diligently over the past two years to raise the profile of CACCN to meet our mission of being the "Voice for excellence in critical care nursing". We have worked to position ourselves as the organization that would be approached by others looking for input and direction on issues impacting critical care for Canadians. Our results have been tremendous.

"Speaking with Conviction" and "Finding Your Voice" came to life during Past President Kate Mahon's term, as CACCN sought and achieved intervenor status before the Supreme Court of Canada in the case of Mr. Hassan Rasouli v. Sunnybrook Health Sciences Centre, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld. This case illustrates the difficult nature of decision-making at the end of life and the need for direction in those instances where the health care providers and the family or substitute decision maker disagree. Arguably, critical care nurses are health care providers who are closest to patients and their families in terms of hour-to-hour contact, carrying out plans of care at end of life. We are positioned to support patients and families throughout their hospital stay, including at end of life, and to support other members of the health care team. As such, we were pleased that the Supreme Court of Canada recognized the need to understand these complex issues from the unique perspective of critical care nurses. As an intervenor before the Court, CACCN was represented on a pro bono basis by the legal team of Rahool Agarwal, Nahla Khouri and Nicholas Saint-Martin of Norton Rose Fulbright Canada LLP. Alongside these legal experts, we worked to represent the unique perspective of critical care nurses on this challenge to the health care consent legislation.

The Court held that the Ontario Health Care Consent Act applies in end-of-life contexts and, as such, physicians are obligated to seek consent to the withdrawal of life-sustaining therapies.

We appreciate the thoughtful review of this issue by the Justices of the Supreme Court of Canada.

As an organization that represents critical care nurses across the country, the CACCN Board of Directors is committed to the continued support of patients, their families and each other, our physicians and allied colleagues in this important aspect of our work. For more on this ruling please refer to the summary of the Supreme Court's decision by Marie Edwards, CACCN Director, Publications, on page 14.

During my own term, we began to see further results of Speaking with Conviction. We have been sought out by influential researchers seeking CACCN's support for research activities. Some of these relationships have resulted in opportunities for our organization to input into practice tools, educational priorities and work place improvements. For example, the PEPup study resulted in a new nutrition protocol. As well, we are working with researchers on a program called aC3Ktion Net, which is designed to improve the implementation access to evidence for best practices in critical care.

Further to these initiatives, CACCN has contributed to committees looking at the Canadian guidelines for the care of critically ill patients and addressing the Allocation of Blood in the event of a critical shortage, and is participating on the Canadian Deceased Donation Advisory Panel. Most recently we have been contacted by the Canadian Critical Care Society to participate in the development of Canadian guidelines on the process of withdrawal of life-sustaining therapy. CACCN has continued to develop key relationships with our colleagues in respiratory care and within medicine to look for opportunities to collaborate and promote critical care in Canada.

One opportunity led by CACCN was the rejuvenation of Canadian Intensive Care Week. Canadian Intensive Care Week was once again celebrated this year from October 27 to November 2. To promote Canadian ICU Week, the CACCN Canadian Intensive Care Spotlight Challenge was introduced to provide funds to a group hosting an event that will raise the profile of critical care to the public and to other health care professionals. The recipient of this year's award is Francis Cacao from the Toronto General Hospital MSICU. The Toronto General Hospital (TGH) plans included a full-day interprofessional exhibit displaying current critical care projects, services, research and best practice initiatives from all the Toronto General Hospital ICUs and a staff recognition breakfast. In addition to the exhibit and breakfast, the TGH was planning an "Honouring of the Hands" ceremony led by their spiritual care service to recognize the work of the ICU staff in the hospital. If your hospital held Canadian Intensive Care Week events, please remember to send your event information to CACCN, so we can spotlight your activities on our website.

Prior to Canadian Intensive Care Week, CACCN also collaborated with our Intensivist colleagues for World Sepsis Day, which was held on September 13, 2013. The message for World Sepsis Day is very simple: sepsis must receive the utmost priority, as a medical emergency, so that all patients can expect

to receive basic interventions, including antibiotics and intravenous fluids within the first hours if we hope to decrease the mortality associated with this condition. Sepsis claims 9,320 lives each year in Canada representing 11% of all deaths in Canadian hospitals.

The World Sepsis Day 2013 goal was to increase the number of hospitals signed up to support World Sepsis Day to a minimum of 2,500 hospitals. This goal was met and exceeded with the number of hospitals supporting World Sepsis Day increasing from 1,237 in 2012 to 2,600 in 2013. Non-profit organization support increased from 143 in 2012 to 200 in 2013, and health care workers embraced World Sepsis Day increasing their registrations from 1,075 in 2012 to 1,478 in 2013.

Although this year's program was successful, there is still room for Canada to improve, so we will continue to work with the World Sepsis Alliance to look at promoting additional events in support of World Sepsis Day—September 13, 2014.

Recently in partnership with the Canadian Critical Care Society, Canadian Critical Care Forum and the Canadian Trials Group, CACCN participated and supported a bid to host the World Congress on Intensive and Critical Care Medicine in Vancouver, B.C., in 2019. Unfortunately, the bid to host was not successful. We will be working with our colleagues towards placing a bid for the 2021 World Congress.

In addition to the above, the CACCN Board of Directors will continue to search for opportunities for CACCN to "Speak with Conviction".

CACCN National Board of Directors Nominees 2014–2016

The Board of Directors of the Canadian Association of Critical Care Nurses congratulates the following members who were acclaimed at the Annual General Meeting on September 22, 2013, to the 2014–2016 Board of Directors:

Director, Eastern Region

Barb Fagan
BScN, RN, CNCC(C)
Middle Sackville, NS

Director, Eastern Region

Kirk Dawe
MN, NP, RN
St. John's, NL

Director, Western Region

Rob Mazur
BN, RN
Winnipeg, MB

We wish to thank the nominees who put their names forward for election. We would also like to thank the CACCN members who participated at the Annual General Meeting held in Halifax, NS, in conjunction with Dynamics 2013. Your Voice Matters!

Sincerely,
Teddie Tanguay
President

Karen Dryden-Palmer
Vice-President

Your National Executive has been very active during the summer months preparing for some necessary transition and upcoming adaptations our organization will make. Specifically, I would like to acknowledge and thank Kirk Dawe, CACCN Director, and Christine Halfkenny-Zellas, Chief Operating Officer, for taking the lead on behalf of the CACCN in regards to the new Canada Not-for-Profit Corporations Act (CNCA).

The CNCA establishes the rules for all federal not-for-profit corporations. This new legislation replaces the century-old Part II of the Canada Corporations Act (the "CCA"). As a result of this change in law, the CACCN, as a federally incorporated not-for-profit corporation, sought and received the support of the membership at the Annual General Meeting for the new General Operating Bylaw No. 1 and also for the Board of Directors to apply for Continuance as a Non-Profit Corporation under the new CNCA. The filing of the continuance also allowed CACCN to register our association name in both official languages—Canadian Association of Critical Care Nurses and Association Canadienne des Infirmières et des Infirmiers en Soins Intensifs. I am delighted to advise that Corporations Canada granted approval and issued notice of our Continuance as a non-for-profit organization on October 22, 2013. For additional information, please visit page 16.

As well, Dynamics is an opportunity for the CACCN Board of Directors to meet face to face with our chapter leaders on Chapters Connections Day. It is exciting to see the sharing of ideas on how to run a successful chapter of CACCN. As a board, we were happy to see these leaders outline their chapter's goals for the coming year, goals that included an exchange of ideas on how to provide education to members across the country.

Chapter Connections Day provided an opportunity to officially welcome the executive of our newest chapter, the Vancouver Island Chapter, as well as the new executive of the New Brunswick Chapter. The New Brunswick Chapter has been in transition over the past couple of years and we welcome the unique partnership in New Brunswick between critical care flight nurses and hospital-based practitioners.

This year at Chapter Connections Day, we also worked with the chapter leaders to begin to develop CACCN's strategic plan. The themes that we developed for CACCN to focus on, as we move forward with strategic planning, are: education, membership, succession planning, and resource management. The board will continue to work with chapter leaders to finalize CACCN's strategic plan for the coming years and looks forward to sharing with you when it is complete.

In closing, I hope members in an area with a local CACCN Chapter will become active members by attending the wonderful activities that they plan. If you are looking for the events being offered, please visit the chapter webpages at **www.caccn.ca** (**www.caccn.ca/en/chapters/index.html**).

Take care and speak with conviction.

Teddie Tanguay, MN, NP, RN, CNCC(C)
President

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DYNAMICS 2013: *Shattering the Silence: Voices of Advocacy in Critical Care Nursing*

The silence was definitely shattered when almost 400 critical care nurses from across Canada, the United States and from as far away as Saudi Arabia gathered in Halifax, Nova Scotia, on September 22–24, 2013, for Dynamics of Critical Care, the national conference of the Canadian Association of Critical Care Nurses. This year marks the 30th anniversary for CACCN, so this made Dynamics extra special, as we took the time to celebrate the journey of our national association over the past three decades.

The opening ceremonies provided a lively start to the conference with a blend of Celtic and Scottish culture with fiddlers, a guitar player, and Irish and Scottish dancers. A very special welcome was provided in song by a native Mi'kmaq leader who honoured the work critical care nurses do through her soaring voice.

The conference opened on Sunday with keynote speaker and noted author and journalist, Suzanne Gordon, reminding delegates that the voices of nurses must be heard on issues of local, national and international importance. She encouraged us to continue to break through any remaining barriers to find our voice and "speak with conviction" on issues where the unique perspective of critical care nurses needs to be broadly shared. Suzanne spoke about the significance of effective teamwork in keeping patients safe and improving outcomes through her presentation on "Team Intelligence in Action."

W5 award winning journalist, Linden MacIntyre, opened the day on Monday by telling us that nurses are already very credible professionals in the eyes of the public. He indicated that we need to spend less time trying to get people to appreciate what we do and more time ensuring that we effectively articulate the message we want to be heard... as the "Message Matters". He provided valuable and sometimes humorous insight into how to partner effectively with the media. He encouraged nurses, as the largest group of health care providers, to speak from their experience.

Luncheon plenary presentations were all well received over the three days with an opportunity for many nurses to showcase their expertise and knowledge. This was very evident in the presentation done by the five members of the Nova Scotia Emergency Health Services Life Flight air medical transport team who had the audience spellbound, as they presented case studies of "Critical Care in the Air". These case studies demonstrated their superb critical thinking skills, extensive knowledge, competencies and advanced skills in caring for critically ill and injured patients in a flight environment.

Simulation sessions for both pediatric and adult populations enabled the audience to become active participants in the scenarios, which emphasized the importance of good communication and solid teamwork in managing resuscitations.

Melissa Fitzpatrick, Vice President and Chief Clinical Officer at Hill-Rom, spoke about patient care quality and safety and how to use people, process and technology to enhance care for patients and their caregivers. Thank you to Hill-Rom Canada for sponsoring Melissa's presentation.

Dr. Gail Tomblin Murphy, a past president of CACCN and an internationally recognized researcher from Halifax, spoke on utilizing evidence to empower change, with critical care nurses recognized as system change advocates.

A session with two Nova Scotia Health Authority CEOs, both nurses themselves, provided an opportunity for the audience to dialogue with powerful health system leaders. They spoke frankly about the accountability we all have to lead from where we stand and to speak proactively when a perspective is needed on issues within your organization.

Interprofessional learning was provided by respiratory therapists Kathy Johnston and Noel Pendergast, who presented an advanced ventilation session sharing the latest on innovations in mechanical ventilation for both children and adults.

The past, present and future presidents of CACCN engaged in an open forum with delegates sharing their insights with CACCN members on "Developing a National Presence-Speaking from Experience on Issues in Critical Care."

Francis Loos, a long-time member of CACCN, previous editor of *Dynamics: Journal of the CACCN* and the 2010 recipient of the Brenda Morgan Leadership Excellence Award, was the invited 30th anniversary speaker. Francis used his lengthy critical care career to take the delegates back in time, as he related the changes that have occurred in critical care over the past 30 years, highlighting the growth in CACCN in the same timeframe.

A highlight of the conference, and very moving plenary session on the final day, was delivered by the five-member panel speaking on patient and family-centred care (PFCC) in the ICU. The panel provided multiple perspectives on family presence in the ICU, from the viewpoint of a family member, patient advocate, critical care nurse, patient and PFCC expert. This session resulted in a line-up of delegates at the microphones to ask questions of the panel.

Poster presentations provided an opportunity for all to read and see the innovative projects and research nurses are engaged in across Canada to improve practice in critical care.

Closing speaker, Mark Black, a double lung and heart transplant recipient and a four-time marathon runner, captivated the audience with the story of his life and his choice to "live life with passion and purpose". His inspiring and motivational talk ended the conference on a "high" note with many delegates coming away with a renewed commitment to their own success.

The "flash mob" of the Xara Chorale Theatre Ensemble singers, a group of young women aged 18–24 years from Dalhousie University who deliver messages in song, provided a surprise

ending for delegates. The singers were interspersed secretly in the crowd prior to the closing ceremonies and "interrupted" the closing speeches. One-by-one they stood from their seats in the audience, each adding her voice to the singing, as they made their way to centre stage and entranced the crowd with their soaring and moving song, "One Voice," providing a perfect ending to our conference and its theme.

The delegates had plenty of time to enjoy the hospitality of Halifax with the conference's downtown location. The 200 people who attended the annual dinner, dressed in "Denim, Diamonds and Pearls", not only enjoyed a wonderful meal shared with new and old friends, but also had their dancing shoes on in force, as they danced the night away to the sounds of local band "Big Fish", who seemed to have as much fun as the delegates. At the annual dinner, CACCN acknowledged the generous educational support and commitment of GE Healthcare to the Dynamics Conference.

There are many people to thank, but it goes without saying that members of the planning committee of each year's conference are the ones who put this together on a volunteer basis, supported by Christine Halfkenny-Zellas, Chief Operating Officer of CACCN, who coordinates many of the details annually with each chair. I would like to, therefore, acknowledge the many months of work carried out by my hard-working and keen planning committee: Sandra Matheson, Valerie Banfield, Erin Sarrazin and Laurel MacIsaac (who had to leave the committee due to work commitments prior to the conference) from Halifax; from Newfoundland/Labrador: Joanne Baird and Patricia Rodgers. "What else can I do?" seemed to be the mantra of this committee, as they cheerfully took on any task needed and did it with a smile. As chair, it was my honour to serve CACCN in this capacity and, once again, it was not a role I ever saw myself doing, but I grew into it and it taught me so many new skills. I can honestly say that I thoroughly enjoyed the journey!

I would also like to thank our sponsors, supporters and exhibitors for their ongoing support of the Dynamics of Critical Care Conference. Without their financial support, donation of equipment for the simulation sessions and donation of door prizes, Dynamics would not be viable. (see page 13 for exhibitors).

Dynamics is the national conference of the CACCN. Due to the commitment, support and guidance of the Board of Directors and the direct input of Karen Dryden-Palmer, the Board of Director Dynamics Liaison, the conference remains the premier critical care nursing conference in Canada each year. The BOD provides "seed" money each year to book venues and hotel room blocks, as well as providing a generous donation to cover the costs of the poster board reception on the first evening of the conference.

I look forward to Dynamics 2014: "Speaking from Experience: Integrating Excellence as a Culture" when we gather once again with CACCN colleagues in Quebec City on September 21–23, skillfully chaired by Renée Chauvin. To you, I throw the torch, Renée!

As always... take care of yourself and each other.

Respectfully submitted,
Kate Mahon
Chair, Dynamics 2013

Dynamics Pre-conference Day—September 21, 2013

On Saturday, September 21, the CACCN Board of Directors was pleased to offer a series of three pre-conference education workshops leading into Dynamics 2013. These day-long workshops were created to meet the needs of members who are interested in accessing in-depth, focused learning opportunities not traditionally available in conference-style sessions. The topics offered in this pilot program included: a Pediatric Certification Review workshop facilitated by Karen Dryden-Palmer and Ruth Trinier, an Adult Certification—Neurological Review workshop facilitated by Brenda L. Morgan, and an Advanced Respiratory Techniques workshop—Bringing the Science to the Bedside facilitated by Kathy Johnston and Noel Pendergast.

The full-day sessions included instructional information, as well as hands-on and interactive components:

- Neurological workshop: attendees were able to view and work with a Teaching Skull, EVD Drain System and the Codman Express, thanks to the generous support of Codman Neuro for the educational day. Codman Neuro also provided an onsite representative to respond to any questions attendees may have had.
- Respiratory workshop: attendees were able to rotate through four case scenarios including ARDS, Hypercapnic Failure, Difficult to Wean and Inhalation Injury. The hands-on scenarios were thanks to the generous support of Draeger Medical Canada who provided four ventilators and staff representatives.
- The Pediatric Certification Review provided an opportunity for participating nurses to refresh and consolidate their pediatric critical care knowledge either in preparation for the national certification exam, or as a review of concepts specific to caring for the critically ill child and family. The small, discussion-based format supported learning across multiple domains of care for critical childhood illness and injury.

This pre-conference day format allowed for further exploration and knowledge building in areas relevant to everyday critical care nursing practice. CACCN is pleased to announce that based on the success and feedback from this pilot, we will offer pre-conference sessions again in 2014. Look for a later announcement for next year's exciting topics.

The CACCN would like to thank Karen Dryden-Palmer, Ruth Trinier, Brenda L. Morgan, Kathy Johnston and Noel Pendergast for sharing their expertise. The CACCN also thanks Codman Neuro and Draeger Medical Canada for their support of the CACCN Pre-conference Educational Day.

Sincerely,
Christine R. Halfkenny-Zellas
Chief Operating Officer

Awards presented at Dynamics 2013—Halifax, NS

Draeger Medical Canada Chapter of the Year 2012–2013

Manitoba Chapter

Eric Pothion, Draeger Representative, Tannis Sidloski, Manitoba Chapter President and Teddie Tanguay, CACCN President

Spacelabs Innovative Project Award

First Place

Anita Au, Barb Duncan, Melissa Adamson, Dr. Andre Carlos Amaral, Dara Guarau, Maria Barnes, Michelle Arcons and Nicky Holmes, Toronto, ON

"Errors are part of being human, but should we accept the cost of medication errors to patients/families?"

Bob Brooks, Spacelabs Healthcare, Barb Duncan, Anita Au, and Teddie Tanguay, CACCN President

Second Place

Allana LeBlanc, Vini Bains, Simmie Kalan and Christina Chong, Vancouver, BC

"Knowledge to action: Improving ICU delirium management at the point of care"

Bob Brooks, Spacelabs Healthcare, Vena Camenzuli, President, BC Chapter accepting on behalf of Allana LeBlanc, Vini Bains, Simmie Kalan and Christine Chong, and Teddie Tanguay, CACCN President

Third Place

Lisa Pell and Sherry Hergott, Kitchener, ON

"Family presence during resuscitation (FPDR)"

CACCN Editorial Awards, First Place

Franco Carnevale and Josée Gaudreault, Montreal, QC

"The experience of critically ill children: A phenomenological study of discomfort and comfort" (Dynamics, Spring 2013)

Mandy Ford, Edwards Lifesciences, Christine Echegaray-Benites and Mélanie Gauthier, Co-Presidents, Montreal Chapter accepting on behalf of Franco Carnevale and Josée Gaudreault and Teddie Tanguay, CACCN President

Second Place

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

"The building bridges project: Learning with, from and about to create an interprofessional end-of-life program" (Dynamics, Winter 2012)

Teddie Tanguay, CACCN President and Ingrid Daley, President, Toronto Chapter, accepting on behalf of Elizabeth Gordon, Brenda Ridley, Janine Boston and Eileen Dahl

Smiths Medical Canada Educational Award

Fall 2012: Linda Long, Brampton, ON

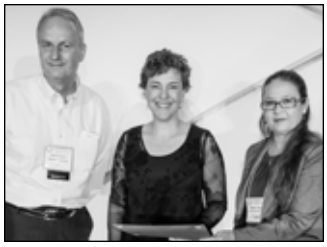
Master of Science in Nursing
Athabasca University

Winter 2013: Chad Johnson, Thunder Bay, ON

Master of Nursing
University of Indiana

Teddie Tanguay, CACCN President, Ingrid Daley, President, Toronto Chapter, accepting on behalf of Linda Long and Renée Chauvin, CACCN Secretary, Ottawa Chapter BOD Liaison, accepting on behalf of Chad Johnson

BBraun Sharing Expertise Award



Tricia Bray, Calgary, AB

Nominated by: Paula Price, Heather McLellan and Joy Teppler

Bob Comer, BBraun Canada, Tricia Bray and Teddie Tanguay, CACCN President

CACCN Research Grant

Louise Rose, Sangeeta Mehta, Lisa Burry and Elena Luk, Toronto, ON
"Predictors of restraint use in a multicentre randomized trial comparing protocolized sedation with daily sedation interruption versus protocolized sedation alone"

Marie Edwards, CACCN Director, Publications and Research, Teddie Tanguay, CACCN President, and Ingrid Daley, President, Toronto Chapter, accepting on behalf of Louise Rose, Sangeeta Mehta, Lisa Burry and Elena Luk

Cardinal Health Chasing Excellence Award

Nancy Breen, Toronto, ON
Nominated by Cecilia St. George-Hyslop, Natalie Lundy and Trisha Sutton

Joel Brown, Cardinal Health Canada, Ruth Trinier, CACCN Director, accepting on behalf of Nancy Breen and Teddie Tanguay, CACCN President

CACCN Canadian Intensive Care Week Spotlight Challenge Award

Francis Cacao, MSICU
Toronto General Hospital
Toronto, ON

CACCN CNCC(C) and CNCCP(C) Draw Prize Recipients

Adult Initial Certification
Meighan McColl, Edmonton, AB
Candace Pointer, Edmonton, AB
Jenny West-Thompson, Riverview, NB

Adult Certification Renewal
Laura Weir, Navan, ON
Kathryn Holodinski, Calgary, AB

Pediatric Initial Certification
Starlene Lundrigan, Conception Bay, NL
Sara-Claude Gilbert, Montreal, QC

Pediatric Certification Renewal
Denise MacIntyre, Dartmouth, NS

Dynamics 2013 Poster Awards

Delegates Choice Award (tie)

Michael Metzger, Red Deer, AB
"Hearing from the silent: patients' experiences of family presence during resuscitation"

Shirley Lee, Lisa Stamnes, Sherly Mathew and Catherine Rodriguez, Vancouver, BC
"Importance of nursing advocacy when implementing technology in critical care: Our experience with Novalung® iLA device"

Catherine Rodriguez, Shirley Lee, Sherly Mathew, Teddie Tanguay, CACCN President, Anita Au, Jaymie Anne Lim and Karen Smith

First Place Poster Awards (tie)

Jaymie Anne Lim, Katelynn Maniatis, Anita Au, Karen Smith, Melissa Adamson, Judy Knighton, Kim Furtado and Beth Linesman
"Nurses of many talents: Post-pyloric feeding tube (PPfT) insertion by nurses in a regional adult burn centre"

Kathleen Przybyl
"Use of a silicone border foam dressing to prevent sacral pressure ulcers in the ICU"

Ingrid Daley, Adrienne Nelson, Sarah Haimes, Linda McCaughey, Kwai Lau, Voula Grigoridis, Christine Minerva, Sharran Wong, Pam Rowan, Theresa Zamora, Morrisa McCreavy, Sandra Thant, Elizabeth Gordon, Nancy Parslow, Denise Morris and Hanora O'Connell
"Under pressure—Wound care for the high-risk ICU patient"

Adrienne Nelson, Sharran Wong, Ingrid Daley and Teddie Tanguay, CACCN President

Congratulations to all award recipients!
Thank you for the continued support of our sponsors and supporters, BBraun Medical Canada, Cardinal Health Canada, Draeger Medical Canada, Edwards Lifesciences and Spacelabs Healthcare!

CACCN Annual General Meeting 2013

As advised in May 2013, the CACCN Board of Directors was proposing revisions to the CACCN constitution and bylaws, as well as acceptance of continuation under the new Canada Not-For-Profit Act.

At the CACCN Annual General Meeting on September 22, 2013, in Halifax, NS, the members of the CACCN voted to accept the following as submitted to the membership:
1. CACCN financial audit 2012–2013
2. CACCN annual report 2012–2013
3. Changes to the CACCN constitution and bylaws
4. Articles of Continuance, Special Resolution and Bylaw No. 1

CACCN has submitted the required documentation and has received the Certificate of Continuance from Industry Canada under the new Canada Not-For-Profit Corporations Act. General Operating Bylaw No. 1 will be in effect on April 1, 2014.

The Board of Directors would like to thank all members who attended the meeting to Speak with Conviction on matters relating to your professional specialty association.

Thank You!

Background

(originally printed in Dynamics, Volume 24, No 2, Summer 2013)

Dear CACCN Members:

On behalf of the National Board of Directors of the Canadian Association of Critical Care Nurses, this letter provides notice to all members of the **proposed revision** to the association's current **constitution and bylaws** and the changes under the new Canada Not-For-Profit Act. These proposals will be brought forward at the 2013 Annual General Meeting (AGM) to be held on September 22, 2013, World Trade and Convention Centre, Halifax, Nova Scotia, as part of the annual Dynamics conference.

Existing constitution and bylaws

Our existing constitution and bylaws were originally approved by the membership in 1984 with the last revision approved September 2010. The current constitution and bylaws are available for review on our website at **http://www.caccn.ca/en/about/constitution_bylaws.html**

Federal Not-For-Profit legislation

With the implementation of the federal government's new Canada Not-For-Profit Corporations Act, CACCN must file articles of continuance and revised constitution and bylaws by no later than October 2014. Failure to meet the deadline set by the Federal Government will result in the association's Not-For-Profit status being revoked and such require closure of the association until the new documentation is in place. In an effort to ensure the ongoing operation of the association, the Articles of Continuance and the new constitution and bylaws are being presented to members for review and approval at the Annual General Meeting in September 2013.

Required changes to the current constitution and bylaws to proceed with continuance

To proceed with the new constitution and bylaws and continuance under the legislation, we must make changes to the current constitution and bylaws at the September Annual General Meeting that clearly define the criteria for "members" of the association.

Under the new constitution and bylaws only those holding voting rights will be classified as members of the association.

As a result, the proposed revision to the constitution and bylaws will remove student, associate, honourary and life "members". This change has been proposed based on legal counsel concerning effects of the new legislation and ongoing operations of the association. The new constitution and bylaws will carry one class of members only.

Although we are recommending removal of these member classes from the constitution and bylaws, CACCN will continue to offer fellowship to students and associates and will continue to bestow honourary and life recognition. However, these classes will not be recognized in the constitution and bylaws as "members", but will be recognized in a formal CACCN policy document as "affiliates" of the association.

Affiliates of the association will retain the same benefits as offered previously through their membership class.

Life Affiliates who meet the current member criteria will retain their voting rights until such time as they no longer meet the criteria for "member" status.

The National Board of Directors is seeking your comments and approval of the proposed changes, articles of continuance and new constitution and bylaws at the 2013 Annual General Meeting.

Current constitution and bylaw revisions under the current legislation:
- **Proposed Constitution and Bylaw Changes**
- **CACCN Affiliates Policy**
- **CACCN Chapter Policy**

Canada Not-For-Profit Corporations Act (new legislation):
- **Draft Articles of Continuance**
- **Draft Bylaw No. 1**

Should you be unable to attend the AGM, you may vote by **proxy**. Proxy votes must be received by CACCN National Office by no later than **2359 EST on September 6, 2013**.

Should you have any questions, please do not hesitate to contact National Office at 1-866-477-9077 or caccn@caccn.ca or the undersigned at president@caccn.ca.

Sincerely,

Teddie Tanguay, President
CACCN National Board of Directors

Thank you to our sponsors and exhibitors

Thank you to the Dynamics 2013 sponsors and exhibitors. The CACCN Board of Directors and the Dynamics 2013 Planning Committee wish to sincerely thank the following for their contributions to Dynamics 2013. The ability to provide quality programming during the Dynamics of Critical Care Conference depends upon the support of our sponsoring and exhibiting companies:

Contributors

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Supreme Court ruling

On October 18, 2013, the Supreme Court of Canada released its judgment on the appeal brought forward by two Ontario physicians in a case involving Mr. Hassan Rasouli. In October 2010, Mr. Rasouli had surgery in an Ontario hospital for the removal of a benign brain tumour, following which he developed bacterial meningitis, ultimately leading to placement on a ventilator (Rasouli v. Sunnybrook Health Sciences Centre, 2011). The physicians believed that Mr. Rasouli:

> *was in a persistent vegetative state, that all appropriate treatments for his condition had been exhausted, and that there was no realistic hope for his medical recovery. In their opinion, continuing life support would not provide any medical benefit to R[asouli] and may cause harm. They sought to remove his life support and to provide palliative care until his expected death (Cuthbertson v. Rasouli, 2013, p. 3).*

Mr. Rasouli's wife did not agree with this plan of care and applied for an order from the Ontario Superior Court of Justice to prevent the physicians from proceeding without her consent. The order was granted in March 2011, and upheld by the Court of Appeal for Ontario in June 2011. The physicians then appealed to the Supreme Court of Canada and arguments were heard in early December 2012. The appeal was dismissed in a five-to-two decision.

The arguments raised by the physicians in this case relate specifically to Ontario's *Health Care Consent Act* (1996) and revolve around the definition of "treatment" in the Act, and whether or not withdrawal of treatment constitutes "treatment", as defined in the Act. Chief Justice McLachlin, writing for the majority, identified that in Ontario's *Health Care Consent Act*, treatment is "broadly defined as 'anything that is done' for one of the enumerated purposes (therapeutic, preventative, palliative, diagnostic and cosmetic) or 'other health-related purpose'" (Cuthbertson v. Rasouli, 2013, p. 5). Life support "arguably falls within 'therapeutic' and 'preventative' purposes listed in the definition" (pp. 5–6). Chief Justice McLachlin concluded that life support meets the definition of a treatment under the Act, as does the withdrawal of life support. Consent, therefore, is required to withdraw life support.

Made clear in the judgment is the recourse physicians have if they believe that continuing life support is not in the best interests of the patient: application to the Ontario Consent and Capacity Board to determine if the substitute decision-maker's refusal of consent meets the principles outlined in section 21 of the Act (i.e., acting in the patient's best interests). The Act provides for substitution of the Consent and Capacity Board's opinion of best interests for that of the substitute decision-maker in certain circumstances (Section 37(1)). It is important to acknowledge that this judgment focuses on Ontario's *Health Care Consent Act* and its application to the case. No remedy is provided for jurisdictions that lack similar legislation or access to a decision-making body like the Ontario Consent and Capacity Board.

This is a case about patient rights, the duties owed to patients by physicians and substitute decision-makers, and disagreements over a plan of care. Ethical and legal concepts of autonomy, consent, and patient best interests are explored in both the reasons for the judgment and the dissenting arguments put forward by the justices of the Supreme Court of Canada. All critical care nurses are encouraged to read the judgment to better understand the issues debated in this case.

Marie Edwards, PhD, RN
CACCN Director, Publications

For Immediate Release
October 18, 2013

The ***Canadian Association of Critical Care Nurses*** (CACCN) welcomes the decision the Supreme Court of Canada released today in the case of *Mr. Hassan Rasouli v. Sunnybrook Health Sciences Centre, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld.*

The Court held that the consent regime imposed by the Ontario *Health Care Consent Act* applies and requires physicians to seek consent to the withdrawal of life support treatment. The decision recognizes the complexity that this issue poses for health care providers, critically ill patients and their loved ones.

"We appreciate the thoughtful review of this issue by the Justices of the Supreme Court of Canada and are very pleased that the perspective of critical care nurses was considered in the process," said CACCN President Teddie Tanguay. "It is our desire that today's ruling will provide clarity and consistency in Ontario in providing best end-of-life care for patients, families and their health care providers," added Ms. Tanguay.

As an organization that represents critical care nurses across the country, the CACCN will continue to support patients, their families and physicians in this challenging and important aspect of their shared work in a manner consistent with the Supreme Court of Canada's decision.

As an intervenor before the Court, CACCN was represented on a pro bono basis by the legal team of Rahool Agarwal, Nahla Khouri and Nicholas Saint-Martin of Norton Rose Fulbright Canada LLP.

Ms. Tanguay, Karen Dryden-Palmer, Vice President, and Kate Mahon, Past President of CACCN, will be available for interviews and comments. Legal questions regarding CACCN's oral and written submissions should be directed to Rahool Agarwal.

Background (December 2012)
The ***Canadian Association of Critical Care Nurses*** (CACCN) has been granted intervenor status before the Supreme Court of Canada in the case of *Mr. Hassan Rasouli v. Sunnybrook Health Sciences Centre, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld*. CACCN's participation in this proceeding will ensure that the perspective of Canadian critical care nurses regarding end-of-life decision making will be heard at the highest court in the country.

This case illustrates the difficult nature of decision making at the end of life and the need for direction in those instances where the health care providers and the family or substitute decision maker disagree on what is in the best interests of the patient. Critical Care nurses are healthcare providers who are closely engaged with families, patients and the healthcare team throughout their hospital stay including the end of life. As such, we are pleased that the Supreme Court of Canada has recognized the need to understand these complex issues from the unique perspective of critical care nurses.

Contact Information:

Teddie Tanguay
President, CACCN
Phone: 1-866-477-9077
Email: president@caccn.ca

Karen Dryden-Palmer
Vice President, CACCN
Phone: 1-866-477-9077
Email: vicepresident@caccn.ca

Rahool Agarwal
Norton Rose Fulbright Canada LLP
Phone: 1-416-216-3943
Email: Rahool.Agarwal@nortonrosefulbright.com

Kate Mahon
Past President, CACCN
Phone: 1-866-477-9077
Email: k.mahon@hotmail.com

CACCN toll free: 866-477-9077; Email: caccn@caccn.ca

REFERENCES

Cuthbertson v. Rasouli, 2013 SCC 53. Retrieved from http://scc.lexum.org/decisia-scc-csc/scc-csc/scc-csc/en/item/13290/index.do

Ontario Health Care Consent Act, 1996. Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_96h02_e.htm

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CACCN calendar of events

DATES TO REMEMBER!

December 2: Certification renewal application deadline

December 31: Chapter Q3 Reports deadline

January 31: Dynamics 2014 Call for Abstracts deadline

January 31: Smiths Medical Canada Ltd. Educational Award deadline

February 15: CACCN Research Award application deadline

March 1: Dynamics 2015 Planning Committee application deadline

March 2014: BOD F2F Meeting, Toronto, ON

April 5: CNA Certification Examination

June 1: BBraun Sharing Expertise Award deadline

June 1: Cardinal Health Chasing Excellence Award deadline

June 1: Spacelabs Innovative Project Award deadline

June 1: The Brenda Morgan Leadership Excellence Award deadline

July 5: CACCN Board of Directors Nomination deadline

Awards available to CACCN members

Criteria for awards available to members of the Canadian Association of Critical Care Nurses are published on pages 44–50 of this issue of Dynamics.

Industry Canada Industrie Canada

Certificate of Continuance

Canada Not-for-profit Corporations Act

Certificat de prorogation

Loi canadienne sur les organisations à but non lucratif

CANADIAN ASSOCIATION OF CRITICAL CARE NURSES
ASSOCIATION CANADIENNE DES INFIRMIÈRES ET DES INFIRMIERS EN SOINS INTENSIFS

Corporate name / Dénomination de l'organisation

145079-4

Corporation number / Numéro de l'organisation

I HEREBY CERTIFY that the above-named corporation, the articles of continuance of which are attached, is continued under section 211 of the *Canada Not-for-profit Corporations Act.*

JE CERTIFIE que l'organisation susmentionnée, dont les statuts de prorogation sont joints, a été prorogée en vertu de l'article 211 de la *Loi canadienne sur les organisations à but non lucratif.*

Marcie Girouard

Director / Directeur

2013-10-16

Date of Continuance (YYYY-MM-DD)
Date de prorogation (AAAA-MM-JJ)

Canada

CANADIAN ASSOCIATION OF CRITICAL CARE NURSES
ASSOCIATION CANADIENNE DES INFIRMIÈRES ET DES INFIRMERS EN SOINS INTENSIFS
GENERAL OPERATING BYLAW NO. 1

A Bylaw relating generally to the conduct of the affairs of

CANADIAN ASSOCIATION OF CRITICAL CARE NURSES
ASSOCIATION CANADIENNE DES INFIRMIÈRES ET DES INFIRMIERS EN SOINS INTENSIFS
(the "Association")

INDEX

GENERAL OPERATING BYLAW NO. 1
A Bylaw relating generally to the conduct of the affairs of

CANADIAN ASSOCIATION OF CRITICAL CARE NURSES ASSOCIATION CANADIENNE DES INFIRMIÈRES ET DES INFIRMIERS EN SOINS INTENSIFS
(the "Association")

WHEREAS the Association was granted Letters Patent by the federal Government of Canada under the *Canada Corporations Act* on the 16th day of February, 1983;

AND WHEREAS the Association has applied for a Certificate of Continuance to be continued under the *Canada Not-for-Profit Corporations Act S.C. 2009, c.23,* to be effective on April 1, 2014;

NOW THEREFORE BE IT ENACTED as a General Operating Bylaw of the Association to take effect in accordance with section 11.01 as follows:

SECTION 1
INTERPRETATION
1.01 Definitions
In all Bylaws and resolutions of the Association, unless the context otherwise requires:
(a) "Act" means the *Canada Not-for-Profit Corporations Act*, S.C. 2009, c. 23, including any Regulations made pursuant to the Act and any statute or Regulations that may be substituted, as amended from time to time.
(b) "Articles" means the original or restated articles of incorporation or articles of amendment, amalgamation, continuance, reorganization, arrangement or revival of the Association.
(c) "Board" means the board of directors of the Association.
(d) "Bylaws" means this bylaw and all other bylaws of the Association as amended and which are, from time to time, in force and effect.
(e) "Director" means a member of the Board.
(f) "Member" means a member of the Association and "Members" or "Membership" means the collective membership of the Association.
(g) "Officer" means an officer of the Association.
(h) "Operating Policies" means the operating policies approved by the Board in accordance with section 2.06 of this bylaw.
(i) "Ordinary Resolution" means a resolution passed by a majority of the votes cast on that resolution.
(j) "Proposal" means a proposal submitted by a Member of the Association that meets the requirements of section 163 of the Act.
(k) "Regulations" means the regulations made under the Act, as amended, restated or in effect from time to time.
(l) "Special Resolution" means a resolution passed by a majority of not less than two thirds (2/3) of the votes cast on that resolution.

1.02 Interpretation
In the interpretation of this Bylaw, unless the context otherwise requires, the following rules shall apply:
(a) except where specifically defined herein, all terms contained herein and which are defined in the Act shall have the meanings given to such terms in the Act;
(b) words importing the singular number only will include the plural and *vice versa*;
(c) the word "person" will include an individual, sole proprietorship, partnership, unincorporated association, body corporate, and a natural person; and
(d) if any of the provisions contained in the Bylaws are inconsistent with those contained in the Articles or the Act, the provisions contained in the Articles or the Act, as the case may be, shall prevail.

SECTION II
Financial and other Matters
2.01 Financial Year
Unless otherwise changed by resolution of the Board, the financial year end of the Association shall be the 31st day of March in each year.

2.02 Banking Arrangements
The banking business of the Association shall be transacted at such bank, trust company or other firm or corporation carrying on a banking business in Canada or elsewhere as the Board may designate, appoint or authorize from time to time. The banking business or any part of it shall be transacted by any Officer or Officers of the Association and/or other persons as the Board may by resolution from time to time designate, direct or authorize.

2.03 Execution of Documents
Deeds, transfers, assignments, contracts, obligations and other instruments in writing requiring execution by the Association may be signed by any two (2) of its Officers or Directors. In addition, the Board may from time to time direct the manner in which and the person or persons by whom a particular document or type of document shall be executed. Any person authorized to sign any document may affix the corporate seal (if any) to the document. Any Director or Officer may certify a copy of any instrument, resolution, Bylaw or other document of the Association to be a true copy thereof.

2.04 Public Accountant and Level of Financial Review
The Association shall be subject to the requirements relating to the appointment of a public accountant and level of financial review required by the Act.

2.05 Annual Financial Statements
The Association shall send copies of the annual financial statements and any other documents required by the Act to the Members between 21 to 60 days before the day on which an annual meeting of Members is held or before the day on which a written resolution in lieu of an annual meeting is signed, unless a Member declines to receive them. Alternatively, the Association may give notice to the Members stating that such documents are available at the registered office of the Association and any Member may request a copy free of charge at the registered office or by prepaid mail.

2.06 Operating Policies
The Board may adopt, amend, or repeal by resolution such Operating Policies that are not inconsistent with the Bylaws of the Association relating to such matters as terms of reference of committees, duties of Officers, Board code of conduct and conflict of interest as well as procedural and other requirements relating to the Bylaws as the Board may deem appropriate from time to time. Any Operating Policy adopted by the Board will continue to have force and effect until amended, repealed, or replaced by a subsequent resolution of the Board.

SECTION III

MEMBERS

3.01 Classes and Conditions of Membership

There shall be one (1) class of Members in the Association. Membership in the Association shall be available to any registered nurse with an interest in critical care, who possesses a current and valid licence or certificate in the province, territory or country in which the registered nurse practices. Membership may be further divided into categories of membership as described in the Association's Operating Policies. Each category shall have the privileges and pay the membership fee set out in the Operating Policies. Each Member shall have one (1) vote at meetings of the Members of the Association.

The Association may approve categories of Affiliates as further described in the Association's Operating Policies. Affiliates shall not be Members of the Association and shall have no voting privileges in the Association. Upon payment of the appropriate fee, Affiliates shall have the privileges set out in the Operating Policies.

3.02 Rights of Members

A Member of the Association shall have the right to receive notice of, attend, speak and participate at all meetings of Members and the right to one (1) vote at all meetings of Members.

3.03 Termination of Membership

Membership in the Association is terminated when:
(a) the Member dies;
(b) the Member ceases to maintain the qualifications for membership set out in section 3.01;
(c) the Member resigns by delivering a written resignation to the President in which case such resignation shall be effective on the date specified in the resignation;
(d) the Member is removed as a Member of the Association in accordance with section 3.05;
(e) the Member's term of membership expires, if any; or
(f) the Association is liquidated or dissolved under the Act.

Subject to the Articles, upon any termination of membership, the rights of the Member automatically cease to exist.

3.04 Membership Dues

The Directors may determine the amount and the manner in which membership dues are to be paid. Members shall be notified in writing of the dues payable at any time by them and, if any are not paid within one (1) calendar month of the membership renewal date, the Members in default shall thereupon cease to be Members of the Association.

3.05 Discipline of Members

The Board may suspend or remove any Member from the Association for any one or more of the following grounds:
(a) violating any provision of the Articles, Bylaws, or Operating Policies of the Association;
(b) carrying out any conduct which may be detrimental to the Association as determined by the Board in its sole discretion; and/or
(c) for any other reason that the Board in its sole and absolute discretion considers to be reasonable, having regard to the purposes of the Association.

In the event that the Board proposes that a Member should be expelled or suspended from membership in the Association, the President shall provide twenty (20) days notice of suspension or removal to the Member and shall provide reasons for the proposed suspension or removal. The Member may make written submissions to the President in response to the notice received within such twenty (20) day period. In the event that no written submissions are received by the President, he/she may proceed to notify the Member that the Member is suspended or removed from membership in the Association. Where written submissions are received in accordance with this section, the Board will consider such submissions in arriving at a final decision and shall notify the Member concerning such final decision within a further twenty (20) days from the date of receipt of the submissions.

SECTION IV

MEETINGS OF MEMBERS

4.01 Annual Meetings

An annual meeting of Members shall be held at such time in each year, as the Board may from time to time determine, provided that the annual meeting must be held not later than fifteen (15) months after holding the preceding annual meeting and no later than six (6) months after the end of the Association's preceding fiscal year. The annual meeting shall be held for the purpose of considering the financial statements and reports of the Association required by the Act to be presented at the meeting, electing Directors, appointing the public accountant and transacting such other business as may properly be brought before the meeting or is required under the Act.

4.02 Special Meetings

The Board may at any time call a special meeting of Members for the transaction of any business which may properly be brought before the Members. On written requisition by Members carrying not less than five percent (5%) of the votes that may be cast at a meeting of Members sought to be held, the Board shall call a special meeting of Members, unless the exceptions in the Act are met. If the Directors do not call a meeting within twenty-one (21) days of receiving the requisition, any Member who signed the requisition may call the meeting.

4.03 Place of Meetings

Meetings of Members may be held at any place within Canada as the Board may determine or outside Canada if all of the Members entitled to vote at such meeting so agree.

4.04 Special Business

All business transacted at a special meeting of Members and all business transacted at an annual meeting of Members, except consideration of the financial statements, public accountant's report, election of Directors and re-appointment of the incumbent public accountant, is special business.

4.05 Notice of Meetings

In accordance with and subject to the Act, notice of the time and place of a meeting of Members shall be given to each Member entitled to vote at the meeting by the following means:
(a) by mail, courier or personal delivery to each Member entitled to vote at the meeting, during a period of 21 to 60 days before the day on which the meeting is to be held; or

(b) by telephonic, electronic or other communication facility to each Member entitled to vote at the meeting, during a period of 21 to 35 days before the day on which the meeting is to be held.

Where the Association provides notice electronically, as referred to in section 4.05(b), and if a Member requests that notice be given by non-electronic means, the Association shall give notice of the meeting to the Member so requesting in the manner set out in section 4.05(a).

Notice of a meeting of Members shall also be given to each Director and to the public accountant of the Association during a period of 21 to 60 days before the day on which the meeting is to be held. Notice of any meeting of Members at which special business is to be transacted shall state the nature of that business in sufficient detail to permit the Member to form a reasoned judgment on the business and provide the text of any Special Resolution or Bylaw to be submitted to the meeting. The Directors may fix a record date for determination of Members entitled to receive notice of any meeting of Members in accordance with the requirements of section 161 of the Act. Subject to the Act, a notice of meeting of Members provided by the Association shall include any Proposal submitted to the Association under section 4.13.

4.06 Waiving Notice
A Member and any other person entitled to attend a meeting of Members may in any manner and at any time waive notice of a meeting of Members, and attendance of any such person at a meeting of Members is a waiver of notice of the meeting, except where such person attends a meeting for the express purpose of objecting to the transaction of any business on the grounds that the meeting is not lawfully called.

4.07 Persons Entitled to be Present
The only persons entitled to be present at a meeting of Members shall be those entitled to vote at the meeting, the Directors, the Officers and the public accountant of the Association and such other persons who are entitled or required under any provision of the Act, Articles or Bylaws of the Association to be present at the meeting. Any other person may be admitted only on the invitation of the chair of the meeting or by Ordinary Resolution of the Members.

4.08 Chair of the Meeting
The chair of Members' meetings shall be the President or the Vice-President if the President is absent or unable to act. In the event that the President and the Vice-President are absent, the Members who are present and entitled to vote at the meeting shall choose a Member to chair the meeting.

4.09 Quorum
Subject to the Act, a quorum at any meeting of the Members shall be two and a half percent (2.5%) of the Members. If a quorum is present at the opening of a meeting of Members, the Members present may proceed with the business of the meeting even if a quorum is not present throughout the meeting. For the purpose of determining quorum, a Member may be present in person, or by telephonic and/or by other electronic means.

4.10 Meetings Held by Electronic Means
A Members meeting may be held by telephonic or electronic means in accordance with the Act as follows:

(a) Any person entitled to attend a meeting of Members may participate in the meeting by means of such telephonic, electronic or other communication facility that permits all participants to communicate adequately with each other during the meeting, if the Association makes available such a communication facility and the meeting complies with the requirements in the Act and the Regulations. A person participating in a meeting by such means is deemed to be present at the meeting.
(b) Notwithstanding clause (a), if the Directors or Members of the Association call a meeting of Members, those Directors or Members, as the case may be, may determine that the meeting be held, in accordance with the Act and the Regulations, entirely by means of a telephonic, electronic or other communication facility that permits all participants to communicate adequately with each other during the meeting.
(c) Any person participating in a meeting of Members by means of a telephonic, electronic or other communication facility and entitled to vote at such meeting, may vote using the communication facility that the Association has made available for that purpose. When a vote is to be taken at a meeting of Members, the voting may be carried out by means of a telephonic, electronic or other communication facility only if that facility enables the votes to be gathered in a manner that permits their subsequent verification; and permits the tallied votes to be presented to the Association without it being possible for the Association to identify how each Member voted.

4.11 Absentee Voting by Proxy
Every Member entitled to vote at a meeting of Members may appoint a proxyholder, or one or more alternate proxyholders, who need not be Members, to attend and act at the meeting in the manner and to the extent authorized by the proxy and with the authority conferred by it subject to the following:
(a) a proxy is valid only at the meeting in respect of which it is given or at a continuation of the meeting after an adjournment;
(b) a Member may revoke a proxy by depositing an instrument in writing executed by the Member in accordance with the Regulations;
(c) a proxyholder or an alternate proxyholder has the same rights as the Member by whom they were appointed, including the right to speak at a meeting of Members in respect of any matter, to vote by way of ballot at the meeting, to demand a ballot at the meeting and, except where a proxyholder or alternate proxyholder has conflicting instructions from more than one Member, to vote at the meeting by way of a show of hands;
(d) a proxy shall be in writing, executed by the Member or such Member's attorney and shall conform with the requirements of the Regulations; and
(e) votes by proxy shall be collected, counted and reported in such manner as the chair of the meeting directs.

4.12 Votes to Govern
At any meetings of the Members, every question shall, unless otherwise provided by the Articles or Bylaws or by the Act, be determined by Ordinary Resolution. In case of an equality of votes, the chair of the meeting shall both on a show of hands and at a poll have a second or casting vote in addition to the vote to which the chair may otherwise be entitled.

4.13 Proposals at Annual Meetings
Subject to compliance with section 163 of the Act, a Member entitled to vote at an annual meeting may submit to the Association notice of any matter that the Member proposes to raise at the annual meeting (a "Proposal"). Any such Proposal may include nominations for the election of Directors if the Proposal is signed by not less than five per cent (5%) of the Members entitled to vote at the meeting. Subject to the Act, the Association shall include the Proposal in the notice of meeting and if so requested by the Member, shall also include a statement by the Member in support of the Proposal and the name and address of the Member. The Member who submitted the Proposal shall pay the cost of including the Proposal and any statement in the notice of meeting at which the Proposal is to be presented unless otherwise provided by Ordinary Resolution of the Members present at the meeting.

4.14 Resolution in Lieu of Meeting
A resolution in writing and signed by all the Members entitled to vote on that resolution at a meeting of Members is as valid as if it had been passed at a meeting of the Members, unless a written statement is submitted to the Association by a Director or by the public accountant in relation to their resignation, removal or replacement. A copy of every resolution of the Members shall be kept with the minutes of meetings of Members.

SECTION V
DIRECTORS
5.01 Powers
Subject to the Act and the Articles, the Board shall manage or supervise the management of the activities and affairs of the Association.

5.02 Number of Directors
The Board shall consist of a number of Directors between the minimum and maximum number of Directors specified in the Articles. The precise number of Directors on the Board shall be determined from time to time by the Members by Ordinary Resolution, or, if the Ordinary Resolution empowers the Directors to determine the number of Directors, by resolution of the Board. At least two of the Directors shall not be Officers or employees of the Association or its affiliates.

5.03 Qualifications
Each Director shall be an individual who is not less than eighteen (18) years of age. Each Director shall be a Member of the Association and currently working in or affiliated with a critical care specialty at the time of election. No person who has been found by a court in Canada or elsewhere to be mentally incompetent or who has the status of a bankrupt, shall be a Director.

5.04 Composition of Board
The Board shall be composed as much as possible of the following Directors:
(a) Two (2) Directors who shall be elected from the Western Region (Manitoba, Saskatchewan, Alberta, British Columbia, Yukon and Northwest Territories);
(b) Two (2) Directors who shall be elected from the Central Region (Ontario and Québec);
(c) Two (2) Directors who shall be elected from the Eastern Region (New Brunswick, Prince Edward Island, Nova Scotia and Newfoundland); and
(d) One (1) Director-at-Large.

5.05 Election of Directors and Term
(a) Subject to the Articles, Directors shall be elected by the Members by Ordinary Resolution at an annual meeting of Members at which an election of Directors is required.
(b) The terms of office of Directors shall be two (2) years or as determined by Ordinary Resolution of the Members.
(c) If Directors are not elected at a meeting of Members, the incumbent Directors shall continue in office until their successors are elected.
(d) Directors shall be eligible for re-election for one (1) additional consecutive term, not including a term as President or Vice-President. Directors may re-apply for nomination to the Board after a one (1) year leave of absence from the Board.
(e) The Board may establish a nominating committee, the details of which shall be set forth in the Operating Policies. In that event, the nominating committee will present a report to the Members for the election of Directors and such report will be prepared in accordance with the requirements of this Bylaw and the Operating Policies.

5.06 Appointment of Directors
Pursuant to the Articles, following the conclusion of the annual general meeting of Members each year, the Board may appoint Directors (the "appointed Directors") to hold office for a term expiring not later than the close of the next annual meeting of Members. The number of appointed Directors shall not exceed one-third (1/3) of the number of Directors elected by the Members at the previous annual meeting of Members.

5.07 Ceasing to Hold Office
A Director ceases to hold office when the Director dies, resigns, is removed from office by the Members in accordance with section 5.09, or no longer fulfils all of the qualifications to be a Director set out in section 5.03, as determined in the sole discretion of the Board.

5.08 Resignation
A resignation of a Director becomes effective at the time a written resignation is sent to the Association or at the time specified in the resignation, whichever is later.

5.09 Removal
The Members may, by Ordinary Resolution, passed at a meeting of Members, remove any Director from office before the expiration of the Director's term and may elect a qualified individual to fill the resulting vacancy for the remainder of the term of the Director so removed, failing which such vacancy may be filled by the Board.

5.10 Filling Vacancies
In accordance with and subject to the Act and the Articles, a quorum of the Board may fill a vacancy in the Board, except a vacancy resulting from an increase in the number or the minimum or maximum number of Directors, or from a failure of the Members to elect the number of Directors required to be elected at any meeting of Members. If there is not a quorum of the Board, or if the vacancy has arisen from a failure of the Members to elect the number of Directors required to be elected at any meeting of Members, the Board shall forthwith call a special meeting of Members to fill the vacancy. If the Board fails to call such meeting or if there are no Directors then in office, any Member may call the meeting. A Director appointed or elected to fill a vacancy holds office for the unexpired term of their predecessor.

5.11 Delegation
Subject to the Act, the Board may appoint from their number a managing director or a committee of Directors (which may be referred to as an executive committee) and delegate to the managing director or committee any of the powers of the Board, except those which may not be delegated by the Board pursuant to subsection 138(2) of the Act. Unless otherwise determined by the Board, such a committee shall have the power to fix its quorum at not less than a majority of its Members, to elect its chair and to otherwise regulate its procedure.

5.12 Committees
The Board may from time to time appoint any committee or other advisory body, as it deems necessary or appropriate for such purposes and, subject to the Act, with such powers as the Board shall see fit. Any committee member may be removed by the Board. Unless otherwise determined by the Board, a committee shall have the power to fix its quorum at not less than a majority of its Members, to elect its chair and to otherwise regulate its procedure.

5.13 Conflict of Interest
Every Director and Officer shall disclose to the Association the nature and extent of any interest that the Director or Officer has in a material contract or material transaction, whether made or proposed, with the Association, in accordance with the manner and timing provided in section 141 of the Act.

5.14 Confidentiality
Every Director, Officer, committee member, employee and volunteer, shall respect the confidentiality of matters brought before the Board or before any committee of the Board. Employees and volunteers shall also keep confidential matters that come to their attention as part of their employment or volunteer activities.

5.15 Indemnification
The Association shall provide present or former Directors or Officers with the indemnification described in section 151 of the Act.

SECTION VI
MEETINGS OF DIRECTORS
6.01 Calling of Meetings
Meetings of the Board may be called by the President, the Vice-President or any two (2) Directors at any time.

6.02 Place of Meetings
Meetings of the Board may be held at the registered office of the Association or at any other place within or outside of Canada, as the Board may determine.

6.03 Notice of Meeting
Notice of the time and place for the holding of a meeting of the Board shall be given in the manner provided in section 9.01 of this Bylaw to every Director of the Association not less than 48 hours before the time when the meeting is to be held. Notice of a meeting shall not be necessary if all of the Directors are present, and none objects to the holding of the meeting, or if those absent have waived notice of or have otherwise signified their consent to the holding of such meeting. Notice of an adjourned meeting is not required if the time and place of the adjourned meeting is announced at the original meeting. Unless the Bylaw otherwise provides, no notice of meeting need specify the purpose or the business to be transacted at the meeting except that a notice of meeting of Directors shall specify any matter referred to in subsection 138(2) of the Act that is to be dealt with at the meeting.

6.04 Regular Meetings
The Board may appoint a day or days in any month or months for regular meetings of the Board at a place and hour to be named. A copy of any resolution of the Board fixing the place and time of such regular meetings of the Board shall be sent to each Director forthwith after being passed, but no other notice shall be required for any such regular meeting except if notice is required to be given because a matter referred to in subsection 138(2) of the Act, is to be dealt with at the meetings.

6.05 Participation at Meeting by Telephone or Electronic Means
If all of the Directors consent, a Director may, in accordance with the Regulations, participate in a Board meeting, by means of a telephonic, electronic or other communications facility that permits all participants to communicate adequately with each other during the meeting. A Director participating in the meeting by such means shall be deemed for the purposes of the Act to have been present at that meeting. A consent pursuant to this section may be given before or after the meeting to which it relates and may be given with respect to all meetings of the Board and committees of the Board.

6.06 Quorum
A majority of the number of Directors specified in the Articles constitutes a quorum at any meeting of the Board, provided that where there is a minimum and maximum number of Directors specified in the Articles, a quorum shall be a majority of the number of Directors determined in accordance with section 5.02. For the purpose of determining quorum, a Director may be present in person, or, if authorized under this Bylaw, by teleconference and/or by other electronic means.

6.07 Votes to Govern
Each Director may exercise one (1) vote. At all meetings of the Board, every question shall be decided by a majority of the votes cast on the question. In case of an equality of votes, the chair of the meeting in addition to an original vote shall have a second or casting vote.

6.08 Resolutions in Writing
A resolution in writing, signed by all the Directors entitled to vote on that resolution at a Board meeting, shall be as valid as if it had been passed at a Board meeting. A copy of every such resolution in writing shall be kept with the minutes of the proceedings of the Board or committee of Directors.

SECTION VII
OFFICERS
7.01 Appointment
The Board may designate the offices of the Association, appoint Officers, specify their duties and, subject to the Act, delegate to such Officers the power to manage the affairs of the Association. A Director may be appointed to any office of the Association. An Officer may, but need not be, a Director unless this Bylaw otherwise provides. Two or more offices may be held by the same person.

7.02 Description of Offices
Unless otherwise specified by the Board (which may, subject to the Act, modify, restrict or supplement such duties and powers), the offices of the Association, if designated and if Officers are appointed thereto, shall have the following duties and powers associated therewith, as well as such other duties and powers as the Board may specify from time to time:
(a) President—The President shall be a Director. The President shall, when present, preside at all meetings of the Board and of the Members.
(b) Vice-President—The Vice-President shall be a Director. If the President is absent or is unable or refuses to act, the Vice-President if any, shall, when present, preside at all meetings of the Board and of the Members.
(c) Secretary—The Secretary shall be a Director. The Secretary shall attend and be the Secretary of all meetings of the Board, Members and committees of the Board. The Secretary shall enter or cause to be entered in the Association's minute book, minutes of all proceedings at such meetings; the Secretary shall give, or cause to be given, as and when instructed, notices to Members, Directors, the public accountant and members of committees; the Secretary shall be the custodian of all books, papers, records, documents and other instruments belonging to the Association.
(d) Treasurer—The Treasurer shall be a Director. The Treasurer shall be responsible for the maintenance of proper accounting records in compliance with the Act, as well as the deposit of money, the safekeeping of securities and the disbursement of funds of the Association; whenever required, the Treasurer shall render to the Board an account of all such person's transactions as Treasurer and of the financial position of the Association.
(e) Chief Operating Officer—The Chief Operating Officer, if one is appointed, shall supervise the day to day operations and administration of the Association. The Board may delegate to the Chief Operating Officer the power to manage and direct the business and affairs of the Association and to employ and discharge agents and employees of the Association. The Chief Operating Officer shall conform to all lawful orders given by the Board of Directors of the Association and shall at all reasonable times give to the Board all information it may require regarding the affairs of the Association.

The duties of all other Officers of the Association shall be such as the terms of their engagement call for or the Board or the President requires of them. The Board may from time to time and subject to the Act, vary, add to or limit the powers and duties of any Officer.

7.03 Term of Office
Officers, except the President, Vice-President, and Chief Operating Officer, shall hold their position for a period of one (1) year, or, in those cases where an Officer is appointed by the Board to fill a vacancy during the year, until the first meeting of the Board immediately following the annual general meeting. The President and Vice-President shall hold their position for a period of two (2) years.

7.04 Vacancy in Office
In the absence of a written agreement to the contrary, the Board may remove, whether for cause or without cause, any Officer of the Association. Unless so removed, an Officer shall hold office until the earlier of:
(a) the Officer's successor being appointed;
(b) the Officer's resignation;
(c) such Officer ceasing to be a Director (if a necessary qualification of this appointment); or
(d) such Officer's death.

If the office of any Officer of the Association shall be or become vacant, the Board may appoint a person to fill such vacancy.

SECTION VIII
CHAPTERS
8.01 Number and Organization
The Association shall have such number of Chapters as determined by the Board from time to time. Such Chapters may be organized in accordance with this Bylaw by any individuals, groups, area or Province in Canada with the consent of the Board.

Chapters shall consist of at least ten (10) Members of the Association in good standing as defined in section 3.01. When any group, area, or Province is recognized as being organized as a Chapter, all Members of the Association in the group, area, or Province, shall immediately become recognized members of the Chapter.

8.02 Application and Recognition
Any individuals, groups, area or Province in Canada wishing to apply for recognition by the Association as a Chapter shall make written application therefore to the Board of the Association in accordance with the process and requirements established by Operating Policy.

Once the Board has determined whether any individuals, groups, area or Province in Canada meet the requirements set forth in Operating Policy, the Members shall approve recognition of the Chapter by a Special Resolution. Thereafter, the operation of the Chapter may be examined by the Board before official recognition is extended to the Chapter.

8.03 Rights and Responsibilities
Each Chapter will comply with the Articles and Bylaws of the Association, and to operate in conformity with the purposes and objectives of the Association.

Each Chapter shall operate on a basis covering the groups, areas, or Provinces assigned by the Board of the Association to the Chapter concerned, and to attempt to procure membership in the Association from every person eligible within the territory of the Chapter.

8.04 Chapter Administration
Each Chapter may be administered by an executive committee, consisting of a president, vice-president and other members of the Chapter, in which case it is provided that:
Financial statements of the Chapter shall be forwarded to the Treasurer of the Association, not less than thirty (30) days after the end of the fiscal year; and

Each Chapter may operate under any suitable name of the area, but it is provided that they must indicate on their letterhead, on all stationary, promotional material and advertising, that they operate as "Blank" Chapter of the Association.

8.05 Termination
(a) Failure to comply with any of the filing requirements or other prescribed obligations shall constitute grounds for requiring a Chapter to show cause to the Board why it should not be terminated as a Chapter.

(b) Prior to terminating a Chapter, the Board shall provide thirty (30) days' notice of termination to the Chapter and shall provide reasons for the proposed termination. The Chapter may make written submissions to the President in response to the notice received within such thirty (30) day period. The Board will notify the Chapter concerning its final decision within a further fourteen (14) days from the date of the decision.

SECTION IX
NOTICES
9.01 Method of Giving Notices
Subject to sections 4.05 and 6.03, any notice to be given (which term includes sent, delivered or served) pursuant to the Act, the Articles, the Bylaws or otherwise to a Member, Director, Officer, member of a committee of the Board, or the public accountant shall be sufficiently given:
(a) if delivered personally to the person to whom it is to be given or if delivered to such person's address as shown in the records of the Association or in the case of notice to a Director to the latest address as shown in the last notice that was filed by the Association in accordance with the Act and received by Corporations Canada; or
(b) if mailed to such person at such person's recorded address by prepaid ordinary or air mail; or
(c) if sent to such person by telephonic, electronic or other communication facility at such person's recorded address for that purpose; or
(d) if provided in the form of an electronic document in accordance with the Act.

A notice so delivered shall be deemed to have been given when it is delivered personally or to the recorded address as aforesaid; a notice so mailed shall be deemed to have been given when deposited in a post office or public letter box; and a notice so sent by any means of transmitted or recorded communication shall be deemed to have been given when dispatched or delivered to the appropriate communication company or agency or its representative for dispatch. The Secretary may change or cause to be changed the recorded address of any Member, Director, Officer, public accountant, or member of a committee of the Board in accordance with any information believed by the Secretary to be reliable. The declaration by the Secretary that notice has been given pursuant to this Bylaw shall be sufficient and conclusive evidence of the giving of such notice. The signature of any Director or Officer of the Association to any notice or other document to be given by the Association may be written, stamped, type-written or printed or partly written, stamped, type-written or printed.

9.02 Computation of Time
Where a given number of days' notice or notice extending over a period is required to be given under the Bylaws, the day of service, posting or other delivery of the notice shall not, unless it is otherwise provided, be counted in such number of days or other period.

9.03 Undelivered Notices
If any notice given to a Member is returned on two consecutive occasions because such Member cannot be found, the Association shall not be required to give any further notices to such Member until such Member informs the Association in writing of his or her new address.

9.04 Omissions and Errors
The accidental omission to give any notice to any Member, Director, Officer, member of a committee of the Board or public accountant, or the non-receipt of any notice by any such person where the Association has provided notice in accordance with the Bylaw or any error in any notice not affecting its substance shall not invalidate any action taken at any meeting to which the notice pertained or otherwise founded on such notice.

9.05 Waiver of Notice
Any Member, proxyholder, Director, Officer, member of a committee of the Board or public accountant may waive or abridge the time for any notice required to be given to such person, and such waiver or abridgement, whether given before or after the meeting or other event of which notice is required to be given shall cure any default in the giving or in the time of such notice, as the case may be. Any such waiver or abridgement shall be in writing except a waiver of notice of a meeting of Members or of the Board or of a committee of the Board, which may be given in any manner.

SECTION X
ARTICLES AND BYLAWS
10.01 Amendment of Articles
The Articles of the Association may only be amended if the amendment is sanctioned by a Special Resolution of the Members. Any amendment to the Articles is effective on the date shown in the certificate of amendment.

10.02 Bylaw Confirmation
In accordance with the Articles and subject to the Act, any Bylaw, amendment or repeal of a Bylaw shall require confirmation by Special Resolution of the Members.

10.03 Effective Date of Board Initiated Bylaw, Amendment or Repeal
Subject to the Act, the Board may by resolution, make, amend or repeal any Bylaws that regulate the activities or affairs of the Association. Any such Bylaw, amendment or repeal shall be effective from the date of the Special Resolution of the Members approving such Bylaw, amendment or repeal. A Board resolution is not required to make, amend or repeal any Bylaw which is made pursuant to subsection 197 (1) of the Act.

SECTION XI
EFFECTIVE DATE
11.01 Effective Date
This Bylaw is effective upon the issuance of a Certificate of Continuance of the Association by the federal Government under the *Canada Not-for-Profit Corporations Act* and approval of the Bylaw by Special Resolution of the Members.

ENACTED by the Directors of the Association this 22 day of September, 2013.

Teddie Tanguay, President
Renée Chauvin, Secretary

APPROVED by the Members of the Association this 22 day of September, 2013.

Renée Chauvin, Secretary

Speak with Conviction and refer a colleague

Current CACCN members are eligible to receive a $10 coupon toward your next CACCN renewal, for each new member you refer to CACCN. By working together, we are building a stronger association!

CANADIAN ASSOCIATION OF CRITICAL CARE NURSES

Criteria:

1. Current / Active CACCN Members may participate.
2. Applicable on **NEW** member applications only. A new member is one who has not been a CACCN member previously, or has not been a CACCN member for a minimum of 12 months.
3. To qualify, **your name must be included** on the new member's application form or included in the online application submission, as the "sponsor" or "person who recommended joining CACCN". Coupons cannot be awarded if the sponsor/recommending information is not included when the member application is processed.
4. Members may receive a maximum of seven (7) coupons towards their next renewal.
5. Coupons expire on the member's renewal date.

www.caccn.ca

What's new at www.caccn.ca?

President's Blog

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 Facebook Page

Find us on Facebook!

Visit us on Facebook for updated information!

Follow us on Twitter: @CACCN1

twitter

Visit us today at www.caccn.ca!

Advertising opportunities

CACCN Dynamic Career Connections

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

JobLINKS on www.caccn.ca

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

Reach your audience directly on our website

MULTIVIEW

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

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

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

As always, we appreciate your support.

Thank you,
Christine Halfkenny-Zellas, CIM
Chief Operating Officer

CNA Certification 2013

CACCN would like to congratulate the following members on successfully attaining / renewing their Certified Nurse in Critical Care—Canada (CNCC(C)) and Certified Nurse in Critical Care—Pediatrics Canada (CNCCP(C)) Designation in April 2013.

CNCC(C) Initial Certification

Tara L. Allred	Calgary, AB
Leanne Gosse	Calgary, AB
Ashley S. Hacquoil	Calgary, AB
Lidel Rivera	Calgary, AB
Lindsey M.R. Wright	Calgary, AB
Castro D. Arias	Edmonton, AB
Jeanne M. Hetu	Edmonton, AB
Meighan N. McColl	Edmonton, AB
Candace Pointer	Edmonton, AB
Sarah M. Stauffer	Edmonton, AB
Gillian Brown	Red Deer, AB
Anita A. Joa	Red Deer, AB
Lyndsay S. Clarke	Red Deer County, AB
Holly M. Tkachuk	Spruce Grove, AB
Caroline A. Penner	Langley, BC
Sarah J. Crowe	Surrey, BC
Sarah Gilchrist	Winnipeg, MB
Kimberley L. Krahn	Winnipeg, MB
Shirley Roy	Petit-Rocher-Sud, NB
Jenny L. West-Thompson	Riverview, NB
Natalie A. Brown	Robertville, NB
Treena L. Campbell	Bedford, NS
Bonnie L. Chiasson	Truro Heights, NS
Sabrina Drepaul Jeethan	Brampton, ON
Shabana Lalji	East York, ON
Vera L. Heldmann	Kitchener, ON
Elizabeth Stire	Oshawa, ON
Cecilia Ho	Ottawa, ON
Courtney McMullen	Peterborough, ON
Lynn Chartrand	Sudbury, ON
Wendell C. Greenidge	Toronto, ON
Samantha L. Kim	Toronto, ON
Daniela M. Toman	Toronto, ON
Bruno Hogue	Magog, QC
Sandra Cook	Montreal, QC
Amanda Di Florio	Montreal, QC

CNCC(C) Recertification

Lois J. Crossman	Calgary, AB
Shauna Greenough	Calgary, AB
Kathryn M. Holodinsky	Calgary, AB
Margaret A. McCoy	Calgary, AB
Laura Jacqueline Robinson	Calgary, AB
Liane Manz	Edmonton, AB
Lindsay D.M. Stadnick	Edmonton, AB
Kathleen E. Alary	Surrey, BC
Maureen E. Doran	Winnipeg, MB
Rhonda J. Thorkelsson	Winnipeg, MB
Catherine A. Murphy	Rothesay, NB
Mary E. Mustard	Etobicoke, ON
Kathryn A. Van Rhijn	Guelph, ON
Renée J. Chauvin	Kemptville, ON
Cheryl A. Burt-Di Nino	London, ON
Nancy J. Cronin	London, ON
Linda Nusdorfer	Mississauga, ON
Deborah A. Sewell	Mississauga, ON
M. Laura Weir	Navan, ON
Jennifer Smith	Pickering, ON
Maryann Magnotta	St Catharines, ON
Carolynn Roche	Terra Cotta, ON
Fiona A. Harrington	Toronto, ON
Anisa Khan	Toronto, ON
Marinka Kocjan	Toronto, ON
Cecilia C. Santiago	Toronto, ON
Orla M. Smith	Toronto, ON
Colleen Palmer-Melville	Toronto, ON
Linda Grosz	Waterloo, ON
Catherine E. McKeown	Lasalle, QC
Maria S. Prattico	Montreal, QC
Sharon L. Smith	Montreal-Ouest, QC
François N. Laramée	Quebec, QC
Lucie Bissonnette	Saint-Lambert, QC
Connie J. Mischuk	Prince Albert, SK

CNCCP(C) Initial Certification

Vena M. Camenzuli	Vancouver, BC
Starlene M. Lundrigan	CBS, NL
Jessica A. MacLellan	Timberlea, NS
Sara-Claude Gilbert	Montreal, QC

CNCCP(C) Recertification

Rosella V. McCarthy	Vancouver, BC
Denise Marie MacIntyre	Dartmouth, NS
Ruth M. Trinier	Toronto, ON

Those who were active members of the CACCN as of September 1, 2013, and have provided permission to CNA to release their information to CACCN are included on this listing. If you have certified and you are not noted on the list, please contact CACCN National Office at ***caccn@caccn.ca*** *so we may update our records.*

PHYSIO CONTROL

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Chapter Connections Day—September 21, 2013

Every year at Dynamics, the CACCN Board of Directors meets with all of the CACCN chapter presidents. This is a brief report of some of the discussions from this year's Chapter Connections Day.

After getting to know everyone with a fun ice-breaker, President Teddie Tanguay and members of the Board of Directors reported on some of the board's initiatives over the past year and plans for the future. A brief synopsis of the initiatives discussed is provided below:

- In keeping with the president's theme of *Speak with Conviction*, Teddie and members of the board continue the work started in 2012 of increasing our collaboration with national and international partners. CACCN once again received complimentary tuition and exhibit space at the 2013 American Association of Critical-care Nurses (AACN) National Teaching Institute (NTI) in Boston, MA. The attending board members met with the AACN executive to continue identifying and discussing ways to promote our respective organizations. Attendance at AACN NTI has resulted in an increase in membership, exhibitors and delegates for our Dynamics conference. Kathryn Roberts, the AACN Immediate Past President, and Ramón Lavendero, AACN Senior Director for Strategic Alliances, Communications, Marketing, Publishing and Member Recognition, attended Dynamics 2013 providing additional collaboration for the Board of Directors, as well as two inspiring and informative concurrent presentations for our members.
- The federal government has revised the legislation governing not-for-profit corporations in Canada. To meet the requirements of the new Canada Not-for-Profit Corporations Act, which CACCN operates within, significant changes, were required before October 2014. As a not-for-profit association, we are required to prepare new constitution and bylaw documentation, as well as a request for continuance to be filed with the government to allow us to continue to operate. The board has worked with our legal counsel to prepare the Continuance, the Special Resolution of the Members and Bylaw No. 1, which was presented to the membership at the CACCN Annual General Meeting held at Dynamics 2013 (see page 17). Chapters have been removed from the General Operating Bylaw and are now covered under a CACCN Operational Policy. Chapters are no longer required to prepare a constitution and bylaws, however, should create an operational chapter policy from their current documents to use as a guiding principle for organizational process.
- Also, it was recognized there is a struggle for members to send in proxy forms by the deadline for the Annual General Meeting. Often members are unsure who should be granted their proxy. In future, proxy forms will be sent electronically to all members. Members may assign their proxy vote to someone of their choice or they may assign their proxy to the CACCN board secretary and/or CACCN president.
- CACCN submitted an affidavit to apply for Intervenor Status at the Supreme Court, which was granted. CACCN's lawyer spoke on our behalf at the Supreme Court in December 2012. CACCN advocated for shared decision-making on end-of-life care and withdrawal of care. If disagreement arises, the option of a third-party decision-making body should be available to resolve the conflict. Further information can be found on the CACCN website in the member's only forum under end of life in critical care. The decision from the Supreme Court was released on October 18, 2013 (see page 14).
- The World Federation of Critical Care Nurses (WFCCN) contacted CACCN to provide a donation to assist with its international work. After reviewing the WFCCN's strategic plans and budgets for the past three years, the board agreed to grant a donation of $1,000. Additional donations to WFCCN will be considered on a case-by-case basis.
- CACCN was also contacted by our critical care partners to provide support to host the 2019 World Congress on Intensive and Critical Care Medicine in Vancouver, B.C. Unfortunately, the bid committee was not successful. The committee has indicated it is their intent to submit a bid for the 2021 World Congress and will be looking for partner support at that time.
- CACCN participated, along with the Global Sepsis Alliance (GSA) and our Canadian critical care partners, in planning for World Sepsis Day held on September 13, 2013. The purpose of World Sepsis Day is to draw attention to the impact of sepsis: we lose approximately 9,300 Canadians annually to sepsis. It is our hope to continue to work with the GSA over the coming year in raising awareness of the implications of sepsis in Canada. Information about World Sepsis Day is located on the CACCN website.
- The Canadian Intensive Care Week was originally proclaimed in 2002. This week was celebrated for a couple of years by the Canadian Intensive Care Foundation and then it disappeared. Canadian Intensive Care Week was celebrated again from October 29–November 4, 2012. Our CACCN chapters embraced Canadian Intensive Care Week and held many events to raise awareness of the work of the various team members in ICUs. Canadian Intensive Care Week will be held from October 27 to November 2, 2013, with many chapters planning events in their area. This year also marked the inaugural year for the CACCN Canadian Intensive Care Week Spotlight Challenge Award, valued at $450.
- The new CACCN database has been implemented along with automatic renewal for all members paying by credit card. The board is always looking for suggestions/feedback about the website. CACCN will also be undertaking a refresh of the website to give a more modern look and feel over the coming months. A leader board will be added to the website for advertisements as an additional source of non-dues revenue for the association.
- Teddie, with the assistance of guest bloggers from the Board of Directors, continues to write the President's blog. CACCN also continues to be active on Facebook and Twitter, and is pleased that several chapters have started their own Facebook pages.
- CACCN invited members to participate in a study about critical care nurses' attitudes toward research last September. The

results of that survey have not yet been released. CACCN has actively participated on a number of committees and provided our support for the following projects: PepUp Protocol, aC³KTion Net (a Canadian Critical Care Knowledge Translation Network). CACCN continues to respond to requests for support of research grant applications.

- The Editorial Review Board for *Dynamics: Journal of the Canadian Association of Critical Care Nurses* will be looking at highlighting/featuring nurses in the journal over the coming months.
- As of September 1, 2013, CACCN had 1,171 members. That is an increase of 58 from last year.
- The CACCN Mentorship pilot initiative has been successful in terms of implementation. CACCN opened two 'rooms' in the forum: "Writing for Publication" (Paula Price, mentor) and "Professional Presentation Skills" (Eugene Mondor, mentor). The mentorship program is currently under review.
- The Board of Directors reported on the strategic planning exercise undertaken at the board meeting prior to Dynamics. Using the SWOT approach (Success, Weaknesses, Opportunities, Threats) and responses from the chapters and board members, the board commenced strategic planning discussions. Information from the strategic planning day was presented to the chapter representatives to ensure the board was on the correct path.

The afternoon consisted of World Café presentations from chapters and the board of directors:

1. Melanie Gauthier and Christine Echegaray-Benites, Montreal Chapter Co-Presidents, presented on the successful implementation/transition of forming a new executive for their chapter and the challenges faced.
2. Nicki Johal, Southern Alberta Chapter President, presented on the success of the Alberta TeleHealth Certification Examination Preparation Course. This preparation course involves members from the Southern Alberta and the Greater Edmonton Chapters.
3. Teddie Tanguay, President, presented tips on how to run a successful chapter. This presentation outlined the roles and responsibilities of the chapter executive, how to recruit and manage volunteers, keys to success, marketing the chapter and the importance of being up to date on national initiatives, policies and procedures.
4. Ruth Trinier, CACCN National Treasurer, presented information on the financial responsibilities of the chapter. This presentation highlighted the importance of maintaining accurate records, including expense reports/receipts, and reporting financial information to national office and chapter members.

The Draeger Chapter of the Year 2012–2013 was announced and the recipient was the **Manitoba Chapter**! Members of the Manitoba Chapter, like all of our chapters, work hard to provide quality educational events. Congratulations to the Manitoba Chapter!

Pam Cybulski, past-board member and chair, Dynamics 2011, had provided CACCN with a donation of $500 to be used at the board's discretion. The board of directors determined a draw would be held at Chapter Connections Day for $250/each. Recipients of the draw were Nicki Johal (Southern Alberta Chapter) and Laurel Kathlow (British Columbia Chapter). Congratulations! Thank you to Pam Cybulski for her generous donation.

Teddie spoke of the importance of the 12 CACCN chapters to our membership and extended a warm welcome to the executive members of our newest chapter, Vancouver Island Chapter, and to the new executive of the revitalized New Brunswick Chapter. Teddie expressed the board's gratitude for the level of commitment and volunteerism of our chapter executive members.

Sincerely
Christine R Halfkenny-Zellas
Chief Operating Officer

Influenza notice

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!**

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.

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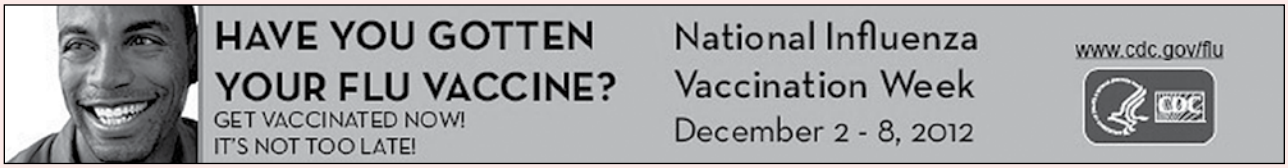

Napping during breaks on night shift: Critical care nurse managers' perceptions

By Marie P. Edwards, PhD, RN, Diana E. McMillan, PhD, RN and Wendy M. Fallis, PhD

Abstract

Background: *Fatigue associated with shiftwork can threaten the safety and health of nurses and the patients in their care. Napping during night shift breaks has been shown to be an effective strategy to decrease fatigue and enhance performance in a variety of work environments, but appears to have mixed support within health care.*

Purpose: *The purpose of this study was to explore critical care unit managers' perceptions of and experiences with their nursing staff's napping practices on night shift, including their perceptions of the benefits and barriers to napping/not napping in terms of patient safety and nurses' personal health and safety.*

Methods: *A survey design was used. Forty-seven Canadian critical care unit managers who were members of the Canadian Association of Critical Care Nurses responded to the web-based survey. Data analysis involved calculation of frequencies and percentages for demographic data, use of the Friedman rank test for comparison of managers' perceptions, and content analysis for responses to open-ended questions.*

Results*: The findings of this study offer valuable insights into the complexities and conflicts perceived by managers with respect to napping on night shift breaks by nursing staff. Staff and patient health and safety issues, work and break expectations and experiences, and strengths and deficits related to organizational napping resources and policy are considerations that will be instrumental in the development of effective napping strategies and guidelines.*

Key words: nurse managers, napping, nurses, night shift, patient safety, shift work, critical care

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In 2010, the Canadian Nurses Association (CNA) and the Registered Nurses Association of Ontario (RNAO) issued a report titled *Nurse Fatigue and Patient Safety*, suggesting their findings represented "a clarion call … about the rising levels of nurse fatigue" (p. 1). Evidence has shown that shiftwork, particularly the combination of day and night shifts, contributes to nurses' fatigue (Admi, Tzischinsky, Epstein, Herer, & Lavie, 2008; Akerstedt & Wright, 2009; Berger & Hobbs, 2006; Hartenbaum, Van Cauter, & Zee, 2011; Kilpatrick & Lavoie-Tremblay, 2006; Muecke, 2005). Napping on night shift is a strategy used in environments outside of health care to assist workers to cope with shiftwork and improve work performance (Purnell, Feyer, & Herbison, 2002; Signal, Gander, Anderson, & Brash, 2009; Takeyama, Kubo, & Itani, 2005). This practice, however, remains controversial in nursing (Alspach, 2008; Humm, 2008).

Managers are recognized as pivotal change agents within the health care system and are in a strategic position to influence work environments through policy development and system innovations to decrease nurses' fatigue and promote a culture of safety (Caruso & Hitchcock, 2010). At present, we have limited knowledge of nurse managers' perspectives on napping during breaks on night shifts. The purpose of this study was to explore critical care unit managers' perceptions of and experiences with nursing staff's napping practices on night shift.

Napping on night shift breaks

A review of published literature from the past 20 years was carried out using PubMed and CINAHL. Evidence is available to support the use of brief naps on night shifts to improve alertness and performance on the job and enhance safety of different types of workers (Asaoka, Fukuda, Murphy, Abe, & Inoue, 2012; Bonnefond et al., 2001; Purnell et al., 2002; Ruggiero & Redeker, 2013; Signal et al., 2009; Takeyama et al., 2005). Significant variability was found across reports in terms of the duration and timing of naps during the night shift, with most naps lasting between 20 and 120 minutes and falling somewhere between midnight and four a.m. Sleep inertia, defined as "the state of impaired cognition, grogginess, and disorientation commonly experienced on awakening from sleep" (Wertz, Ronda, Czeisler, & Wright, 2006, p. 163), is identified as a safety concern in some napping studies (Kubo et al., 2010; Takahashi, Arito, & Fukuda, 1999; Takeyama et al., 2004).

Two small studies have examined nurses' napping behaviours on night shifts. A group of eight intensive care unit (ICU) nurses in France kept a sleep diary for one month (Daurat & Foret, 2004). Four of the nurses napped at work, recording naps on 75% of their night shifts, with an average nap length of 150 minutes. The researchers concluded that whether or not the nurses napped on night shift appeared to be determined by circadian influences. In a study exploring emergency department (n = 9) and intensive care (n = 4) nurses' experiences with napping during breaks on night shift (Fallis, McMillan, & Edwards, 2011), 10 of 13 nurses reported regularly napping on breaks. Although performance or practice outcomes were not measured, nurses identified benefits of feeling energized or refreshed after a brief nap.

Takahashi et al. (1999) examined the effects of timing and length of nurses' naps on 16-hour night shifts on subjective symptoms. Nineteen of 20 nurses in the study napped on their night shifts, with a mean nap length of 1.5 hours. Compared to pre-nap levels, sleepiness, fatigue, and dullness increased directly after the nap, with post-nap fatigue lasting longer, as the length of the nap increased, especially beyond 1.5 hours. Smith-Coggins et

al. (2006) carried out a randomized control trial with emergency department physicians (n = 25) and nurses (n = 24) to assess the impact of a 40-minute night shift nap at 3:00 a.m. on cognitive and motor performance and on a simulated drive home after working 12 hours. The 26 participants in the nap group had fewer performance lapses, reported less fatigue and sleepiness, reported more vigor and exhibited less signs of sleepiness during a driving simulation than the non-nap group.

Night-shift naps have also been examined in the context of a broader program to address nurses' fatigue. Scott, Hofmeister, Rogness, and Rogers (2010a) evaluated the feasibility of implementing a fatigue countermeasures program, including the use of strategic napping during breaks, for medical-surgical nurses in three hospitals. None of the nurses (n = 47) reported using naps at work in the pre-intervention period; 57 naps at work were reported at four weeks and 13 naps at 12 weeks. Nurses who napped reported that they felt guilty when doing so. In focus groups held with the nurses (n = 46) and their managers (n = 8) to assess the program, managers expressed concerns regarding a lack of organizational support and the inability to locate physical space for napping (Scott, Hofmeister, Rogness, & Rogers, 2010b).

Overall, the studies on health care providers reported here involved small samples and varying approaches to napping and the assessment of its benefits (e.g., length and timing of nap, self-reported benefits of napping versus measurement of performance). No study has identified the optimal nap time in critical care settings and more studies are needed to assess the impact of napping on performance in these settings.

Methods

A web-based survey of critical care nurse manager members of the Canadian Association of Critical Care Nurses (CACCN) was undertaken in 2009. Following research ethics board approval, permission was obtained from CACCN's board of directors to recruit critical care managers through invitations sent on our behalf by CACCN to all members with an active email account. A link to the survey was embedded in the email message. Individuals who self-identified as a critical care manager were invited to follow the link to SurveyMonkey© and to complete the survey. At the time of the survey, CACCN had email addresses for approximately 1,030 members and estimated that six to eight per cent of members were in administrative positions.

The web-based survey was developed by the research team founded on a review of the literature, the results of a qualitative study on napping/non-napping experiences of critical care nurses (Fallis et al., 2011), and the clinical experience of the research team. To assess content validity, three individuals with management experience piloted the survey and provided feedback regarding clarity and completeness. In addition, three experts in survey development reviewed the questions and made suggestions for revisions. The final survey consisted of 28 questions. Twelve questions elicited information to describe the sample. The remainder of the survey was divided into three sections: night shift routines (seven questions), perceptions of napping on night shift (five questions), and knowledge of incidents related to fatigue (three questions). The section on night shift routines included five yes/no questions on the presence of a napping policy, availability of a nap room, and the practice of napping in the manager's unit, and two Likert-scale questions on frequency of getting or combining breaks on night shift. The next section included three Likert-scale questions on perceptions of napping and two yes/no questions on whether or not there were benefits or drawbacks to napping on breaks, with an option to list perceived benefits or drawbacks. The questions on fatigue-related patient safety issues, nurse injury, and accidents on the drive home from work were yes/no in nature, with space provided to describe any incidents. The final question provided an opportunity for additional comment.

Data analysis

Data were identified by code only and downloaded from SurveyMonkey© and entered into a Microsoft Excel spreadsheet and SPSS software for analysis. Quantitative data analysis involved descriptive and inferential analysis of closed-item responses using SPSS version 18. Descriptive statistics were used to report numerical data relating to the managers' age and nurses' break duration. Relative frequencies expressed as percentages were employed to describe data such as gender, years of experience in a critical care setting and as a manager, and type of facility. The Friedman rank test was used to examine differences in the managers' own perceptions of napping and their perceptions of colleagues' and administrators' views of napping. Open-ended responses were downloaded into a Word document and entered into Ethnograph 6.0, a software program for data management, then analyzed using content analysis (Weber, 1990). Two team members independently reviewed the responses on a question-by-question basis and grouped the responses into broad categories and then met to agree on and collapse the categories to organize data.

Results

Forty-seven managers, representing nine provinces, responded to the survey (Table 1). The mean age of the managers was 49.5 $\pm$ 7.2 years, with 45% (21) identifying a baccalaureate degree and 28% (13) a graduate degree as their highest level of education. Most (77%) had more than 20 years of experience as a registered nurse, 60% (28) had worked in critical care for more than 20 years and the majority (58%) had at least six years of experience as a manager. Almost all (92%) had worked night shifts as a critical care nurse during their career. The managers were drawn nearly evenly from tertiary (55%) and community hospital settings (45%), with the majority managing a mixed ICU (72%) in which nurses worked 12-hour shifts (85%).

Patient and nurse safety

Fatigue was identified by the managers as a threat to patient and nurse safety. Nineteen managers (40%) reported being aware of situations where nurse tiredness on night shift had led to incidents or errors affecting patient care. Examples provided of threats to patient safety included medication errors, mislabelled blood samples, calculation errors and missed orders. Fatigue was also reported as a factor in known work-related injuries and near injuries (19%) for nurses, for example, needlestick injuries and not taking the usual precautions when lifting

Table 1: Demographic characteristics of nurse manager participants (N = 47)		
Variables	n	%
Highest level of education		
Diploma	11	23.4
Baccalaureate	21	44.7
Graduate (master's or doctorate)	13	27.7
Missing	2	4.3
Total years experience as a registered nurse		
6–10 years	2	4.3
11–15 years	2	4.3
16–20 years	4	8.5
>20 years	37	78.7
Missing	2	4.3
Total years experience in critical care setting		
≤ 1 year	1	2.1
2–5 years	0	0
6–10 years	3	6.4
11–15 years	8	17.0
16–20 years	7	14.9
> 20 years	28	59.6
Total years experience as a manager		
≤ 1 year	7	14.9
2–5 years	13	27.7
6–10 years	14	29.8
11–15 years	10	21.3
16–20 years	0	0
> 20 years	3	6.4
Type of facility		
Community hospital	21	44.7
Tertiary hospital (university affiliated)	26	55.3
Primary area of responsibility		
Mixed ICU	36	76.6
Medical ICU	3	6.4
Pediatric ICU	4	8.5
Surgical ICU	1	2.1
Other	3	6.4
Usual shift duration for nurses in unit		
12 hours	40	85.1
Mix of 8 and 12 hours	7	14.9
Province or territory		
Quebec and Ontario	20	42.6
Western Provinces (MB, SK, AB, BC)*	18	38.3
Maritimes & Newfoundland/Labrador	6	12.8
Missing	3	6.4
*MB = Manitoba, SK = Saskatchewan, AB = Alberta, BC = British Columbia		

patients. Almost half (47%) of managers knew of staff injuries or near injuries that had occurred on the drive home following night shift. Examples included falling asleep at or driving through red lights, driving off the road and collisions or near collisions with pedestrians or other vehicles.

Breaks and napping behaviour

The managers' perceptions of the ability of staff to get a break varied from sometimes (9%), frequently (68%), to always (21%). Thirty managers (64%) reported that staff members frequently or always combined their breaks on night shifts, with a mean duration of combined breaks of 84.5 minutes (range 60 to 120 minutes). Most managers (98%) reported that at least some nurses from their unit napped during night break. In the majority of cases, managers reported either that their hospital had no written napping policy (77%), or that they were unaware of a napping policy (13%). While 49% (23) and 28% (13) of managers felt there should be or maybe should be a nap room for nurses respectively, only 11% (5) reported that they had a room in or near their unit specifically designated for napping and available for nurses.

Managers varied in terms of their approval of nurses napping during breaks on night shifts and their perceptions of napping approval by colleagues and administration. While 55% (26) of managers either somewhat or strongly approved of napping, fewer (28%) perceived that their manager colleagues somewhat or strongly approved of napping, and only 4% (2) perceived senior administration as somewhat or strongly supportive of napping during night shift break (Table 2). A related-samples Friedman's two-way analysis of variance by ranks, two-sided test was conducted to evaluate differences in medians (Md) among these perceptions for managers' own perceptions (Md = 2.0), their perceptions of their manager colleagues' views (Md = 4.0), and their perceptions of the views of senior administration (Md = 5.0). The Friedman's test was significant $\chi 2$ (2, N = 45) = 60.45, $p < .0001$. Response categories of "missing" and "don't know" were excluded from the analysis.

Naps were viewed to have both positive and negative consequences on night shift, with 70% (33) of the managers indicating on a yes/no question there were benefits to napping and 70% (33) indicating that there were drawbacks. The managers' perceptions of the benefits and drawbacks of napping, as outlined in open-ended comments, are provided in Table 3. Eighteen managers (38%) indicated that a nap could enhance the nurses' alertness post nap, while 23 (49%) expressed concerns regarding the practice of combining breaks to permit an extended nap. In addition to the drawbacks noted in Table 3, five managers (11%) expressed concerns related to nurses not coming to work rested and relying on getting a nap on break and six (13%) identified issues with the use of hospital resources for napping (e.g., empty patient beds or stretchers, hospital linens).

Discussion

In the past few years, three reports have recommended that organizations create fatigue management plans and programs for staff (CNA & RNAO, 2010; Joint Commission, 2011; Quality Worklife Quality Healthcare Collaborative, 2007). The CNA and RNAO (2010) have also recommended that organizations

Table 2: Managers' perceptions of approval or disapproval of napping during breaks on night shift by self, colleagues, and senior administration

	Managers' perceptions					
	Own views		Perception of manager colleagues' view		Perception of senior administrators' view	
Response categories	Freq	%	Freq	%	Freq	%
Strongly approve	13	27.7	0	0	0	0
Somewhat approve	13	27.7	13	27.7	2	4.3
Neither approve nor disapprove	11	23.4	6	12.8	7	14.9
Somewhat disapprove	6	12.8	14	29.8	10	21.3
Strongly disapprove	2	4.3	8	17.0	15	31.9
I don't know	0	0	4	8.5	11	23.4
Missing	2	4.3	2	4.3	2	4.3

Note: Related-samples Friedman's two-way analysis of variance by ranks, two-sided test, χ^2 (2, N = 45) = 60.45, p < .0001

Table 3: Managers' comments regarding benefits and drawbacks of napping on breaks

Perceived benefits of napping on breaks	Perceived drawbacks to napping on breaks
Refreshes, recharges, increases alertness for safer care (n = 18) • *It allows the nurse time to refresh and they are sharper mentally after a nap* • *Refreshes, makes mental faculties more acute to allow for better reaction time and decision making* • *It helps to recharge, keeps your mind sharper* Physiological benefits (n = 8) • *Avoid that sick feeling between 3-5 a.m. Help the body adjust to the day/night cycle* • *Provides the body rest* • *Some are physically ill without a rest* Safer drive home after night shift (n = 2) • *Safety driving home after shift*	Practice of combining breaks to nap (n = 23) • *Extended breaks did not provide adequate staffing coverage to match the patient acuity* • *Family concerns/complaints regarding length of break and the fact that nurses nap on their break* • *Covering staff may not be as proactive with patient care when not their assigned patient* Difficulty waking up or functioning post-nap (n = 26) • *Nurses that are part of a code team often cannot function properly when awakened to attend a code* • *Some people don't wake up on their own and staff [members] have to leave the unit to get them* Issues with shared use of napping area (n = 8) • *With only one lounge, those who stay up are often outnumbered by those who sleep, and are forced out of the lounge* • *Non-sleepers are asked to be quiet or unable to enjoy their break*

Note: Numbers do not total 47 as some managers provided no comments, while others identified more than one benefit or drawback

provide sleep facilities for nurses for use during breaks on evening and night shifts. The support of managers and administrators is essential for these recommendations to proceed and the results of this survey highlight a tension for nurse managers. While 70% of managers felt there were benefits for nurses associated with napping during breaks on night shift, 70% acknowledged there were drawbacks. Our results suggest a need for education of and support for managers regarding fatigue and fatigue management, clear guidelines for napping on breaks on night shift, and the creation of napping space.

The majority of managers in our study perceived that their colleagues (72%) and senior leadership (96%) were either neutral towards or disapproving of napping during breaks on night shift. These perceptions, if correct, illustrate a potential challenge for the development of evidence-based policy and infrastructure for restorative napping practices in work settings (Baxter & Kroll-Smith, 2005). Research is needed to examine levels of support for restorative napping on breaks on night shift among hospital administrators and managers throughout the hospital. The RNAO (2011) best practice guidelines for preventing and mitigating nurse fatigue include recommendations for government funding to support mandatory education for managers, possibly through occupational health and safety programs, and for organizations to educate leadership on fatigue recognition and prevention. Gander et al. (2011) identified that a neglected aspect of such programs is evaluation of the effectiveness of the education, so it is important to incorporate an evaluative component into these programs.

In their examination of factors affecting the feasibility and sustainability of a fatigue management program for nurses, Scott et al. (2010b) identified that a barrier to such programs was the "organizational culture related to staff sleeping during work hours" (p. 238), including outdated human resource policies. A total of 90% of the managers in our study reported either that their hospital had no written napping policy or that they were unaware of a napping policy. As recommended by the RNAO (2011), policy is needed in this area. In addition to policy, guidelines for napping, including the appropriate nap length and allowance of time for a recovery period before returning to work are needed (Kilpatrick & Lavoie-Tremblay, 2006). Naps as short as 20 minutes on a night shift have been shown to improve speed of response on a vigilance test (Purnell et al., 2002). Smith-Coggins et al. (2006) found clear benefits in terms of fatigue, performance and vigour with a 40-minute nap in an

emergency department setting. Involvement of managers in the development of napping guidelines that are evidence-based would ensure maximal benefit for nurses and patients and could address a number of the managers' concerns.

The issues related to sleep inertia identified by the managers are a concern, particularly in dynamic and rapid-paced clinical environments. While it is acknowledged that recovery time from a nap may not always be possible (e.g., in emergency situations), guidelines ought to incorporate recovery time whenever possible. Signal, van den Berg, Mulrine, and Gander (2012) recommend that "particular care should be taken if work has to resume within 15 minutes after nap opportunities of up to 60 minutes, in order for sleep inertia effects to dissipate" (p. 778). Studies involving napping and nurses in hospital settings are needed to extend our understanding of sleep inertia post nap.

As with the Scott et al. (2010b) study, environmental factors were identified in our survey as barriers to staff achieving a nap. Few managers (11%) reported that nurses had access to a nap room in their facilities. The RNAO (2011) recommended that organizations "create a safe, secure area where nurses can have uninterrupted (excluding emergencies) rest and sleep periods" (p.9). Managers can play a role in advocating for or creating such space on or near their units.

There are strengths and limitations to this study. While managers and survey experts reviewed and provided feedback on the content of the survey questions providing preliminary support for the face and content validity of the tool, future work could be conducted to assess, confirm and/or enhance these and other psychometric properties. Additionally, the use of a web-based survey ensured the feasibility of this study, but this approach has drawbacks, including the possibility of technical challenges (Ahern, 2005). Although our sample was drawn from a broad geographic pool, the 47 managers who participated may not reflect the views of all managers in more than 400 intensive care units in Canada (Canadian Intensive Care Foundation, 2010). It is also possible that the views of managers who are members of CACCN may differ in some way from critical care managers who are not members of the organization.

Conclusion

The critical care nurse managers participating in this survey identified health, safety and patient care issues that support the need for a restorative nap during breaks on night shift, but also identified issues with napping as it is currently practised in their units. In addition, it was evident that barriers currently exist both within organizations and proximal work environments for achieving naps. Managers are in a unique position to provide leadership to promote patient and nurse safety in their units and organizations. To provide this leadership in relation to fatigue prevention and management, nurse managers require education and organizational support. This will assist them to contribute to the development of sound napping policies and guidelines and to work toward the creation of appropriate space for nurses to nap while on breaks.

About the authors

Marie P. Edwards, PhD, RN, Associate Professor, Faculty of Nursing, University of Manitoba

Diana E. McMillan, PhD, RN, Associate Professor, Faculty of Nursing, University of Manitoba

Wendy M. Fallis, PhD, Adjunct Professor, Faculty of Nursing, University of Manitoba

Address for correspondance: *Marie Edwards, 381 Helen Glass Centre, Faculty of Nursing, University of Manitoba, Winnipeg, MB R3T 2N2. Phone: 204-474-8218;* ***Marie.Edwards@ad.umanitoba.ca***

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Reflective debriefing to promote novice nurses' clinical judgment after high-fidelity clinical simulation: A pilot test

By Patrick Lavoie, MSN, RN, Jacinthe Pepin, PhD, RN and Louise Boyer, PhD, RN

Abstract

Background: *Novice nurses are increasingly beginning their career paths in critical care areas, where they are expected to care for patients whose lives are potentially threatened. They are unable to benefit from years of experience to facilitate their clinical decisions. Reflection after simulation could possibly improve nurses' clinical judgment in complex situations.*

Design: *An educational project was conducted to pilot-test a teaching intervention, which combined reflective debriefing with a simulated critical care experience.*

Method: *Five nurses beginning in an intensive care unit participated in the pilot test. Their perception of their learning and satisfaction with the reflective debriefing and the simulation were collected using open-ended questionnaires. A clinical nurse educator, a faculty member and the first author participated in a group discussion to review the time plan and the affective components of the teaching intervention.*

Results: *Participants reported that the reflective debriefing helped them understand their cognitive processes during the simulation and contributed to clinical judgment development and to their care prioritization and assessment capacities. Observers reported the time plan was adequate and that attention to participants' negative feelings was necessary.*

Conclusion: *The results of this pilot test provide preliminary information that reflective debriefing may be a safe and potentially effective way for novice critical care nurses to learn from a clinical experience and enhance clinical judgment.*

Key words: clinical judgment, clinical reasoning, reflection, debriefing, high-fidelity clinical simulation, critical care

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Background

As a result of the nursing shortage in Quebec, hiring criteria based on work experience are less stringent in the critical care units (St-Pierre, Alderson, & St-Jean, 2010) and this is where an increasing number of newly graduated nurses are beginning their careers (Marleau, 2012). This translates into less nursing expertise at the bedside caring for patients with life-threatening conditions (Hardin & Kaplow, 2005). These novice nurses might sometimes unintentionally miss significant changes in a patient's condition (Levett-Jones et al., 2010; O'Neill, Dluhy, & Chin, 2005; Simmons, 2010). Failure to recognize a deteriorating patient may delay communication with appropriate health professionals and response to a critical health condition (Beaumont, Luettel, & Thomson, 2008; Clarke & Aiken, 2003). Furthermore, death from complications in the hospital setting within 30 days of admission, labelled "failure to rescue" (Clarke & Aiken, 2003), has been linked to nursing staff characteristics, such as education level and experience (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2001).

The capacity to recognize early signs of deterioration in a patient's condition would be one feature of safe clinical judgment (Hardin & Kaplow, 2005). Expert nurses, through years of clinical practice, develop a sense of what is most salient in a patient situation, which allows an intuitive response (Benner, 1984; Benner, Sutphen, Leonard, & Day, 2010; Rew, 2000; Tanner, 2006). However, a serious question regarding patient safety is raised if inexperienced nurses, who are prone to miss significant signs of deterioration, manage their care.

Therefore, nursing education, at the entry-to-practice and continuing levels, is faced with the imperative to develop teaching strategies that promote the development of clinical judgment. In this paper, the authors report on an educational innovation with the goal to assist in the development of clinical judgment among novice nurses in a critical care setting. To achieve this, a teaching intervention combining high-fidelity simulation (HFS) and reflective debriefing was developed and pilot-tested.

Literature review

Clinical judgment

Simmons (2010) defined clinical reasoning as a "complex cognitive process that uses formal and informal thinking strategies to gather and analyse patient information, evaluate the significance of this information and weigh alternative actions" (p. 1155). Tanner (2006), in a model based on a substantial review of the literature, defined the result of this cognitive process, the clinical judgment, as "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response" (p. 204).

In the clinical judgment model (Tanner, 2006) nurses' knowledge and values have a major influence on their clinical decision-making. They notice changes worthy of attention in patients' conditions when they compare their perception of unique experiences with their expectations of similar situations drawn on experiential and formal knowledge. Then, they interpret and understand data collected through a variety of cognitive processes, from analytical to intuitive. This leads them to identify actions to be taken to respond appropriately, according to their value of what is "good" or desirable in the situation. Reflection is embedded in the whole process, as Tanner (2006) argues that reflection-in-action brings nurses to adapt their interventions to patients' responses and reflection-on-action "contributes to their ongoing clinical knowledge development and their capacity for clinical judgment in future situations" (Tanner, 2006, p. 209).

The concept of reflection can be traced to Dewey (1910). Dewey defined reflective thought as an "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tend" (Dewey, 1910, p. 6). Schön (1984) is mostly responsible for professionals' interest in reflection. In his seminal work, he stated that tacit knowledge embedded in practice could be elucidated through critical examination of knowledge and feelings. Therefore, as professional practitioners undergo this kind of cognitive exercise, their practice would improve. The process is based on changing individuals' habits of expectation to develop mindfulness and more accurate perceptions of situations (Mezirow, 1991).

In the educational context, reflection and reflective practice are used as learning tools. Ruth-Sadh (2004) identified several outcomes of reflection. According to studies that she analyzed, reflective educational strategies had a positive impact on self-esteem (Johns, 1995) and self-awareness (Bonde, 1998). Most importantly in our case, nurses and nursing students learned from experience (Atkins & Murphy, 1993), integrated theoretical concepts in their practice (Davies, 1995; Scanlan, Care, & Udod, 2002; Wong et al., 1997) and could enhance their critical thinking and judgment making (Brookfield, 2000; Coombs, 2001; Smith, 1998) along with their clinical knowledge (Glaze, 2001; Hyrkas, Tarkka, & Paunonen-Ilmonen, 2001; Paget, 2001).

In order to provide guidance on reflection for nursing students, Nielsen, Stragnell and Jester (2007) developed a "Guide for Reflection", which consists of a list of questions that address clinical experiences through Tanner's (2006) model. Although these questions focus on the process of clinical judgment, they also attend to emotions, as a fundamental aspect of reflection (Johns, 2010). Only one paper was found reporting the use of the Guide as a basis for journal writing on a clinical experience in an American university (Lasater & Nielsen, 2009). Students and faculty members who used the Guide described positive outcomes, such as learning from experience and developing confidence. Therefore, we believed it could be used as a reflective tool for debriefing after a simulated experience.

Debriefing

Few researchers have evaluated debriefing strategies after HFS, both from nursing (Neill & Wotton, 2011) and medical (Fanning & Gaba, 2007) disciplines. Although literature on this topic is scarce, some key points have emerged. First, experts agree that debriefing is the most important element of HFS (Issenberg, McGaphie, Petrusa, Lee Gordon, & Scalese, 2005). Shinnick, Woo, Horwich and Steadman (2011) reported that learners' (*N*=162) exposure to a simulated learning experience would only increase clinical knowledge when they were exposed to a guided reflective debriefing. Whereas Buckley and Gordon (2011) reported that participants (*N*=38) rated debriefing as the most useful aspect of simulation training to improve their ability to recognize an unstable patient and respond in a systematic way.

Second, there is interest in the literature on the necessity to structure debriefing sessions. Neill and Wotton (2011) found that, even in the absence of evidence, nurse researchers (Brackenberg, 2004; Decker, 2007; Dreifuerst, 2009, 2010; Kuiper, Heinrich, Matthias, Graham, & Bell-Kotwall, 2008) tend to promote structured debriefings, as they might be more effective for students' learning. Of these studies, Kuiper et al. (2008) proposed reflection based on a theory of clinical reasoning (Pesut & Herman, 1998), but they did not clearly report the effect reflection had on clinical reasoning. Dreifuerst (2010) reported a significant difference in the improvement on the Health Sciences Reasoning Test (HSRT), a clinical reasoning score, when comparing students who were exposed to a reflective debriefing based on learning theories and students who experienced traditional debriefing, which consists of questions addressing clinical knowledge (N=238 students).

Third, debriefing should last at least two to three times longer than the clinical scenario (Waxman, 2010). As discussed by Neill and Wotton (2011), shorter debriefing of 10 or 20 minutes has been found to be unsatisfactory for participants (Childs & Sepples, 2006; Wotton, Davis, Button, & Kelton, 2010). Wotton et al. (2010) and Cantrell (2008) found that learners usually prefer the debriefing to occur immediately after the scenario.

Fourth, the affective component of debriefing must not be overlooked. Establishing a climate of trust seems to be an essential role of the debriefing's facilitator (Fanning & Gaba, 2007; Neill & Wotton, 2011; Waxman, 2010; Wickers, 2010). Dreifuerst (2009) also noted the emotional response of participants as potentially influential on learning and suggested to allow some time to discuss their feelings as part of the debriefing.

These key points need to be considered with caution, since most studies did not isolate the debriefing from the simulation experience, which makes it difficult to conclude a direct relation between results and the debriefing process. Moreover, most researchers did not describe the methods used for their debriefing, nor were standardized methods used, which makes it difficult to compare results. More research focusing on debriefing methodology and outcomes is required.

Purpose

The purpose of this pilot was to test a teaching intervention combining HFS and reflective debriefing.

Method

This project focused on participants' and educators' perception of the teaching intervention. Immediately after the pilot test, participants completed an open-ended questionnaire, with items such as "What did you learn today?", "What did you like the most/least about the activity?" and "How did this activity contribute to the development of your clinical judgment?" Two observers were present during the pilot test: the clinical nurse educator on the targeted intensive care unit (ICU) and a faculty member. They were asked to evaluate the adequacy of the time plan and to pay attention to affective components of the activity. This was discussed and reviewed as a group after the participants left. The discussion was recorded for further analysis and the questionnaires were compiled and analyzed.

Sample

A convenience sample of five nurses who were about to finish their orientation program in an ICU in a francophone teaching hospital were recruited for this project. The orientation program consisted of 100 hours of traditional classes introducing essential notions of critical care nursing (e.g., hemodynamics, shock, common surgeries) and 60 hours of preceptorship in patient care. This unit was selected because the unit's nurse educator had shown interest in the project as an upgrade to the orientation program.

The authors approached each potential participant who was part of the orientation program to explain the project. All of them agreed to participate and gave consent for the use of their questionnaire answers to document their perception of the activity. They were told they had the right to withdraw at any time during the pilot test. Participants' data were kept confidential; the questionnaire was anonymous. Scientific approval was provided by a faculty committee and the project was presented to the institutional ethical review board of our university, which confirmed that it did not require ethics approval.

Procedure

The teaching intervention combining HFS of 45 minutes with a period of reflection (90 minutes) inspired by Nielsen, Stragnell and Jester's work (2007) was developed. Since this activity was to conclude the novice nurse's orientation program, it was conceived as an integrative exercise focusing on their learning needs.

Simulation. Neurosurgery and cardiac monitoring were identified as the main themes for the simulation, since nurse preceptors reported that they were the most problematic for trainees on the targeted unit. Consequently, using a high-fidelity patient simulator, a scenario was developed where a patient with a known neurological issue would undergo a cardiac complication. A patient chart was created and all necessary equipment was available so the simulation would reach an optimal level of realism.

During the HFS, participants had to manage care of a simulated patient who had just undergone surgical clipping of a cerebral aneurysm. As he was admitted to the ICU, participants had to conduct a nursing assessment and to manage cardiac monitoring and other devices. In the beginning of the scenario, the patient did not experience any particular complications. Next, the patient developed atrial fibrillation, which would lead to chest discomfort and a slight drop in blood pressure. Participants were expected to recognize, analyze and intervene with these changes. They were required to communicate with other health professionals to obtain assistance in preserving cerebral perfusion, with treatments such as antidysrhythmic medications and fluid administration. Eventually the heart rate would accelerate and cause a significant drop in arterial blood pressure and an altered level of consciousness. Following the physician's order, participants were required to convert the dysrhythmia to normal sinus rhythm using electrical cardioversion. The clinical simulation ended with the patient regaining consciousness after stabilization of his vital signs.

Debriefing. Since learning occurs when one compares his or her perceptions with those of his or her peers (Lasnier, 2000), the authors decided that debriefing would occur as a group with all participants (N=5). The Guide for Reflection (Nielsen et al., 2007), originally designed for an individual nursing experience, was adapted so it could be used in a group setting. Most questions were left as is, except those addressing previous experiences with the patient and family, which were not consistent with the scenario. The questionnaire was translated into French, respecting the vocabulary chosen by the original authors and then revised by two faculty members, to ensure the essence of the reflective process had been preserved. Subsequently, a diagram was created for this project representing the Guide (see Figure 1), so it could be distributed to participants in a more appealing visual format for future use in clinical practice. In this paper, the diagram is presented as an illustration of the reflective process used in the pilot test.

Pilot test. On the day of the pilot test, participants were welcomed, the schedule was explained and they were introduced to the high-fidelity patient simulator, since it was their first contact with such mannequins. The first author, being a faculty educator, acted as the facilitator during the teaching intervention and explained the objectives of the session, which were to gain insight into and to improve their nursing thinking process through a simulated clinical experience combined with reflective debriefing. Then, the HFS began, with the facilitator limiting his interaction in the participants' interventions to a succinct explanation on how to operate the defibrillator, as they showed poor understanding of the device even though it was explained during the orientation program. The HFS ended with the improvement of the patient's condition.

After a short break, the faculty educator facilitated debriefing with all participants. Through group discussion, participants assessed their clinical reasoning and clinical judgment process according to the adapted Guide for Reflection. The diagram representing the Guide was also used to help the participants analyze their own cognitive processes with respect to the main concepts of Tanner's (2006) model.

As depicted in the diagram, the reflection began with consideration of the context (the dashed line) and the influences of emotions, the nursing role, previous experiences and formal

knowledge. Attendance to these components was meant to show how participants' characteristics, as unique persons with different backgrounds and reactions to a situation, and the context of the simulated situation interacted to influence outcomes. Then, the nursing situation was described thoroughly and the participants were asked to reflect on what they noticed as important, how they interpreted it and to which conclusions it led them. Then, their group response and the way they adjusted to the reactions of the patient and colleagues were addressed (reflection-in-action). It is essential to note that questions and themes in the Guide were used as a flexible structure for the debriefing, and not asked systematically, as a formal questionnaire. Moreover, the educator's role was to guide the reflection with questions, and not to answer for the participants.

Results

Participants reported that reflection contributed to their care prioritization and organization, their nursing assessment capacities, and their global clinical judgment in the situation. They indicated that debriefing helped them understand how they reached a decision regarding the patient's situation. The debriefing was perceived to be a useful exercise to connect theory and practice. They also thought the reflective debriefing led them to evaluate their psychomotor and cognitive performances and to identify creative solutions to improve their skills, particularly communication.

Observers reported that the teaching intervention was an excellent integrative exercise for novice critical care nurses, as it demanded a great variety of skills and knowledge. The reflective debriefing was an opportunity for trainees to gain deeper insight and analyse their thinking process, as they were faced with a complex nursing situation.

Time allotted for all parts of the activity (45 minutes simulation and 90 minutes debriefing) was found to be sufficient. As for the debriefing, the authors believe that shortening the period of discussion would have resulted in a superficial consideration of experience, which would have been inadequate for the purposes of the activity. Furthermore, the timing of the debriefing, which was conducted immediately after the HFS, was considered ideal, both by participants and observers. The observers and the facilitator reviewed the affective component of the debriefing. They found an array of negative feelings experienced by participants, which will be further discussed in the next section.

Discussion

The activity combined a HFS with reflective debriefing focusing on clinical judgment. The goal of this activity was for participants to gain a reflective insight into their thinking process so it could be assessed and improved. Through a group analysis of their experience, they had to reflect on their thoughts and actions, according to a theoretical model of clinical judgment.

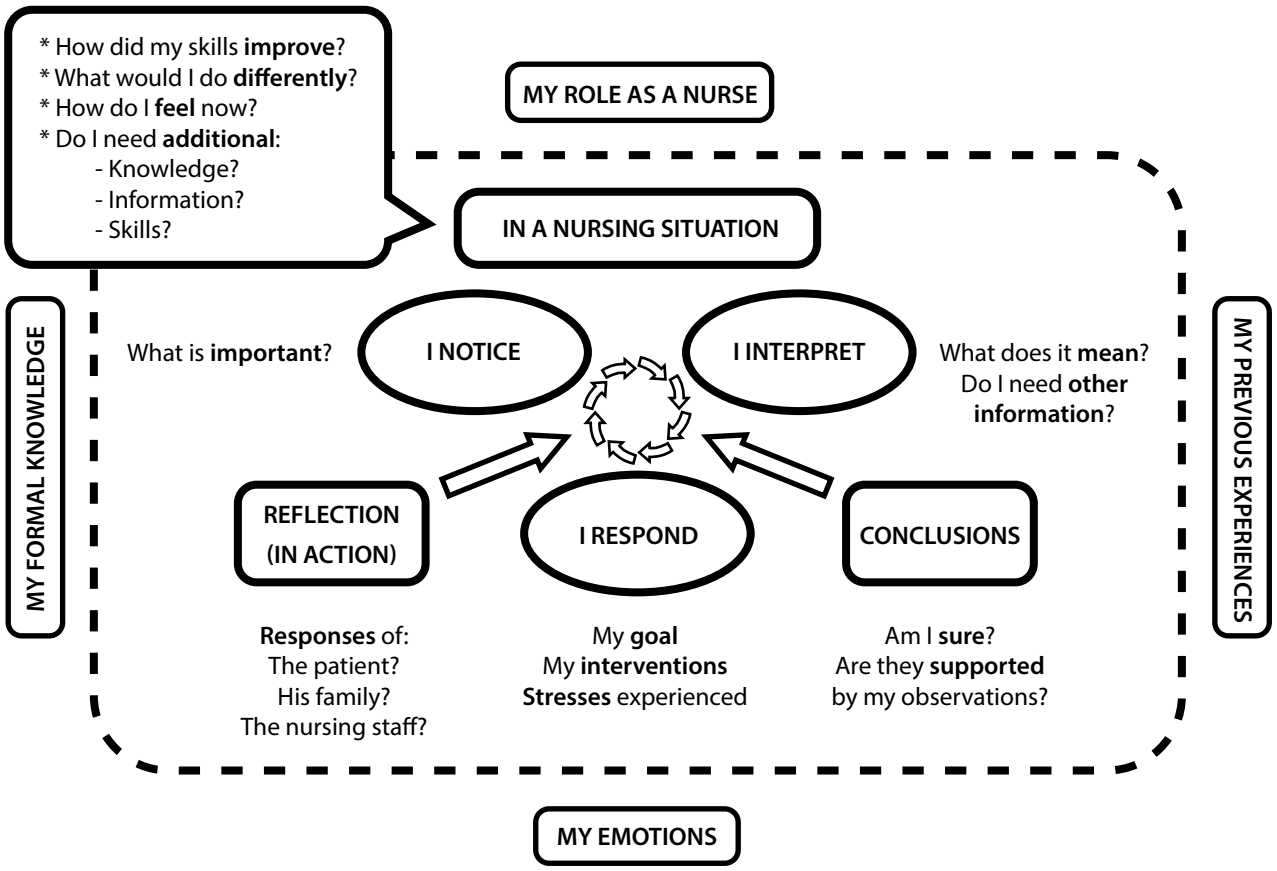

Figure 1: Diagram Representing the Adapted Reflective Debriefing (inspired by Nielsen et al., 2007)
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According to participants' and observers' perceptions, the goal of the combined teaching intervention was reached. Even though the sample was small and the tool used for evaluation was not validated, the authors found preliminary perceptions of participants to be sufficiently meaningful to believe that this type of reflection after HFS should be studied in future research.

As the reflective debriefing was structured along Tanner's (2006) model of clinical judgment, the emphasis was placed on the act of noticing, interpreting and responding in a simulated clinical situation. Throughout the discussion, significance of the concepts presented in the model emerged, and it was easier to link practice to theory. By comparing their thoughts, participants reached a point where concepts proposed by Tanner (2006) made sense and were linked to elements of the experience they just lived. Critical consideration of their thoughts in a group was a positive experience for most as it allowed new perspectives to emerge.

Immediately after the simulation, every learner, as the quality of his/her performance was not as high as he/she expected, expressed a sense of failure. The presence of those emotions created a difficult climate where learning could be impeded. Therefore, the facilitator decided to probe more deeply into what the participants felt for 15 minutes. This time has been found to be particularly helpful, as the participants' expression of negative feelings helped them deal with their subjective perception of their performance. This aside, they were more inclined to examine their cognitive process. The facilitator reported that he felt the affective debriefing had been an effective intervention to develop a trusting environment. The occurrence of this phenomenon brought the authors to believe that a consideration of the affective component of simulated experience should always be planned and conducted.

It was also important to ensure that the skills solicited by the clinical simulation were appropriate for the participants' level of knowledge and capacities. Hence, this enables nurses to evaluate the development of their knowledge and to identify a need for further work in some areas. This was found to be greatly useful, as trainees returned to their ICU and consciously took the appropriate measures to overcome their difficulties.

Future Considerations

The authors believe that this type of debriefing could potentially be integrated into other types of simulated clinical scenarios related to critical care or in other domains of nursing. As the nursing thinking process described by Tanner (2006) can apply to all nursing specializations, no particular adaptation is needed before the tool described in this article can be used in other settings. Other specializations could possibly see positive effects of structured reflective debriefing, as clinical judgment is not exclusive to critical care. Therefore, the reflective debriefing was integrated to various HFS in clinical courses (critical care, surgery and nursing assessment) of a nursing baccalaureate program. Further research is planned to explore how and why this debriefing works.

Nevertheless, clinical reasoning and clinical judgment are as hard to assess as they are to define. These results should be accepted with caution, as this was only a pilot and needs to be evaluated with a larger sample and with tools that have been validated. There is no evidence that this intervention allowed participants to transfer learning in the clinical setting or that it had positive effects on patient outcomes. Greater levels of evidence are needed to justify the development of such resource-consuming strategies using costly technologies and a great amount of time with small groups. Therefore, it is imperative that nursing education researchers concentrate their efforts to develop approaches to study and evaluate teaching interventions targeting clinical reasoning and clinical judgment.

About the authors

Patrick Lavoie, MSN, RN, Doctoral Student, Faculty of Nursing, l'Université de Montréal

Jacinthe Pepin, PhD, RN, Professor and Director of the Center for Innovation in Nursing Education (CIFI), Faculty of Nursing, l'Université de Montréal

Louise Boyer, PhD, RN, Assistant Professor and Researcher at CIFI, Faculty of Nursing, l'Université de Montréal

Address for correspondence: Patrick Lavoie, ***patrick.lavoie.1@umontreal.ca****, Faculty of Nursing, Pavillon Marguerite-d'Youville, C.P. 6128 succ. Centre-ville, Montreal, QC H3C 3J7. Telephone: 514-699-3072, fax: 514-253-4550*

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RESEARCH REVIEW

Monitor alarm fatigue

Cvach, M. (2012). Monitor alarm fatigue: An integrative review. *Biomedical Instrumentation & Technology, 46*, 268–277.

Question

Does the amount of noise (false or nuisance alarms) as context to signal (true alarms) interfere with the nurse's response to physiologic monitor alarms?

Data sources

Studies were identified by searching PubMed, Embase, and CINAHL (1/1/200 to 10/1/2011), hand searching and reviewing seminal articles.

Study selection

The search terms "clinical alarm OR equipment failure AND physiologic monitor OR cardiac monitor" were used for the selection process. All levels of evidence were selected and assessed using the scoring system found on the Johns Hopkins Nursing Evidence-Based Practice appraisal tool*:

- Level I [experimental—randomized controlled trials (RCTs) and systematic reviews of same, with or without meta-analysis],
- Level II [quasi-experimental and systematic reviews of same or combined with RCTs, with or without meta-analysis],
- Level III [non-experimental designs, systematic reviews of same or combined with RCTs and/or quasi-experimental studies with or without meta-analysis, qualitative studies with or without meta-synthesis],
- Level IV [opinion of respected authorities and/or reports of nationally recognized expert committees/consensus panels based on scientific evidence], and
- Level V [evidence obtained from literature reviews, quality improvement initiatives, program evaluations, financial analysis, case reports, opinion of nationally recognized expert(s) based on experiential evidence].

If information did not meet at least the Level V criteria (e.g., not an expert opinion or case study), such as those found in magazine articles written by journalists rather than an individual working within the healthcare system, the articles were excluded (M. Cvach, personal communication, September 13, 2013).

Main results

177 abstracts and 85 articles in their entirety were reviewed. Only 72 articles met the inclusion criteria for this integrative review synthesis. Five studies were a Level I grade of evidence, 13 Level II , 23 Level III, 5 Level IV, and 25 Level V. All 5 RCTs were related to alarm sounds and audibility, based on small sample sizes, and conducted in laboratories. Of the research articles reviewed, 28% involved staff, patients or monitor alarm data in critical care —PICU (3), NICU (2), adult ICU (15).

The research evidence was organized into five themes.

1. *Excessive alarms and effects on staff*: Excessive false alarms occur frequently and contribute to alarm desensitization, mistrust, lack of caregiver response, and disruption in patient care, often resulting in alarm disablement.
2. *Nurses' response to alarms*: Perceived alarm urgency contributes to the nurses' alarm response. Nurses' use of additional clinical information (e.g., patient acuity, alarm duration, and frequency of a specific patient's alarms combined with the probability that the alarm is true), workload conditions, and task complexity of other competing work priorities determines their responses to monitor alarms.
3. *Alarm sounds and audibility*: Melodic alarm sounds are difficult to identify and cannot be discriminated when there is task overlap. Distinguishing alarm sounds is a learned process. Conflicts exist between the recommendation for alarm levels to ensure audibility by healthcare providers and that of environmental noise levels during daytime and nighttime hours.
4. *Technology to reduce false alarms*: Technology based on physiological trends, signal filtering, algorithms, and artificial intelligence systems help to reduce the number of false alarms.
5. *Alarm notification systems*: Many institutions consider monitor watchers and central alarm management as advantageous to patient safety despite lack of research to support the benefit of human monitor surveillance.

The non-research evidence was organized into two themes, both of which are focused on mechanisms for reducing alarm desensitization:

1. *Strategies to reduce alarm desensitization*: Currently there are no standards for setting default alarm parameter thresholds or graduation of alarms related to degree of urgency. To reduce technical alarms, proper skin preparation and replacing ECG leads and electrodes routinely is recommended.
2. *Alarm priority and notification systems*: Audible alarms are delineated as high-priority (urgent situation that requires immediate attention), medium-priority (dangerous situation requiring a quick response), and low-priority (attention is needed) alarms. Basic alarm notification models are considered useful if they complement the monitoring equipment, staffing model, alarm response protocol, and unit architectural layout. Alarm enhancement technology provides additional means to deliver alarm signals from monitors to caregivers.

Conclusions

Evidence-based practice recommendations to decrease monitor alarm fatigue are provided that focus on the technology, the organization, and the caregiver. The four technology-related recommendations focus on the use of smart alarms, technology that incorporates short delays, standardization of alarm sounds, and use of animated steps on the monitoring equipment. The seven hospital-related recommendations focus on the engagement of interdisciplinary alarm management committees, development of alarm setting and response protocols, determination of actionable alarm limits and levels, assessment of staffing models, use of alarm technology enhancements, initial and ongoing alarm device training, and employment of noise reduction strategies. Four caregiver-related recommendations focus on alarm suspension, alarm adjustment, proper skin preparation and routine ECG lead and electrode replacement, and alarm parameter documentation.

Commentary

It is all too human for individuals to become sensory overloaded from environmental noise that is excessive in volume, pitch, and frequency. The average number of different alarms in an ICU has increased over the past 20 years from six to more than 40 per patient location (Borowski et al., 2011; Kerr & Hayes, 1983). Monitor alarms and health care provider responses to alarms have been studied by clinicians, managers, and engineers for 30 years. Similar to Cvach's integrative review, Edworthy's (2013) recently published narrative medical review of audible alarms shows that there has been a steady and significant growing body of evidence demonstrating that alarms activate too frequently, disrupt patient care, and reduce trust due to the excessive number of false positive alarms. These problems continue to exist despite the changes in alarm devices using the fields of statistics and artificial intelligence, as well as biomedical and human factors engineering (Ansermino et al., 2009; Imhoff & Kuhls, 2006; Siebig et al., 2010).

As this review demonstrates, there are alarmingly (please disregard the pun) few RCTs related to monitor alarm fatigue that take into consideration the various clinical practice contexts (e.g., neonatal, pediatric and adult age-groups; health care provider experiential expertise; and/or patient condition). Moreover, outcome research with a focus on patient outcomes is sadly lacking. Few studies have yet to show efficacy and effectiveness in reducing the rate of false alarms in clinical studies or to prove clinical relevancy (Görges, Markewitz, & Westenskow, 2009; Siebig et al., 2010). One recent prospective, observational clinical study conducted in a medical ICU in Tokyo, Japan, found that in 2,697 patient-monitored hours for 18 patients, only 6.4% of alarms were considered clinically relevant and that positive correlations were established between patient clinical severity and the proportion of relevant alarms (Inokuchi et al., 2013). Findings from this type of study demonstrate the need for more research that examines the practice of direct human surveillance (i.e., use of nurse monitored rooms or monitor technicians) with "at risk" patients compared with the use of alarm devices (i.e., central monitor surveillance, wireless technologies). We also need to clearly define the parameters of "false" alarms when engaging in clinical research because *technically* false alarms require different solutions than those caused by patient-mediated (e.g., crying, restlessness) or clinician-mediated (e.g., lead placement) issues. More research using data collection techniques such as digital tape recordings (Momtahan, Hétu, & Tansley, 1993) are also needed to counter the problems of intra- and inter-observer variability and the Hawthorne effect (Imhoff & Fried, 2009) that are inherent with observational studies. Meanwhile, the immediate need to provide safe patient care is enough justification for health care providers to respond to the level of evidence-based research that is currently available. Cvach's recommendations are congruent with the American Association of Critical-Care Nurses' (2013) Alarm Management initiative and the Joint Commission (2013) and serve nurses well in identifying their role to reduce patient harm related to alarm systems.

Judy Rashotte, PhD, RN
Director, Nursing Research & Knowledge Transfer Consultant
Children's Hospital of Eastern Ontario
Ottawa, Ontario

**Information about the Johns Hopkins Nursing Evidence-Based Practice appraisal tool as applied to this integrative review was found on the Individual Evidence Summary Table and Synthesis and Recommendations Tool, which was made available by the author at the email address provided in the article. Maria Cvach granted permission to cite information from these two pieces of information to supplement this article review (personal communication, September 13, 2013).*

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The Draeger Medical Canada Inc. "Chapter of the Year" Award

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

The Chapter of the Year criteria are founded on the CACCN Mission Statement and recognize the Chapter activity in this regard with specific emphasis on Member Service, Innovation, Specialty Promotion and Fiscal/Membership Health.

Award funds available: $500.00 plus a plaque

Deadline for submission: May 31 annually

Application process: Chapters must apply for consideration

Criteria for the award program

- The award program will be for the period of April 1 to March 31 each year
- Chapters may receive the award for one year followed by a two-year lapse before receiving again
- A point system has been developed to fairly evaluate chapter accomplishments during the year
- The chapter that accumulates 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 recipient will be announced at Chapter Connections Day and at the annual awards ceremony at Dynamics.

Conditions 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
- Chapters will be responsible for ensuring the national office receives all required documentation to validate accumulated points
- If the above conditions are not met, the chapter will not be eligible for consideration
- Announcement of the successful chapter will be published in CACCN publications
- All chapter reports /scoring will be available for review at Chapter Connections Day/Dynamics.

Points system

Innovation

Member Service

- Any educational event coordinated and hosted by the local chapter is eligible. Total hours of education offered in the award period will be total (concurrent sessions are accumulated) and divided by the membership number as a denominator. This will be converted to a rate/1000
- **Submission guidelines:**
  - Brochure, advertising or pamphlet and copy of agenda (including hours of education)
  - Attendee numbers
  - Evaluation of session
- **Formula: Total hours of education offered/total chapter members × 1000 = innovation score**
- Using this calculation, the final educational contribution hours will be adjusted for size of chapter and expressed in rates for direct comparison.

Public education, community service: Promoting the image of critical care nursing

- Any public or community service event coordinated and hosted by the local chapter is eligible. Total hours offered in the award period will be total (concurrent activities are accumulated) and divided by the membership number as a denominator. This will then be converted to a rate/1000
- 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)
- **Submission guidelines:**
  - Validation must be provided that the event was a CACCN-sponsored project
  - For example, submitting a letter from the receiving group or a picture of the event, etc.
- **Formula: Total hours of events offered/total chapter members × 1000 = innovation score.**

Communication—Fiscal health—Membership sustainability

Recruitment Points

- Calculated based on the percentage of new members recruited, as compared to the total membership of the previous year:

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

- **Formula: Total new members/total chapter members × 100 = Recruitment points**

Sustained membership points

- Points are allotted for percentage of membership sustained over this past year
- Any member with a membership lapse of 12 months or more will be considered a new member
  - i.e., a membership expires April 2011 and is renewed February 2012. This member would be considered a **renewing** member
  - i.e., a membership expires April 2011 and is renewed June 2012. This member would be considered a new member due to the lapse in membership of more than 12 months.
- Sustained membership points are calculated based on the percentage of renewing members in the fiscal year.

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

- **Formula: Total renewed members/total chapter members × 100 = Recruitment points.**

Contribution to specialty knowledge—Publications and presentations

Publications

- Points will be calculated for chapter members who have contributed articles to:
  - the chapter newsletter or Dynamics, Journal of the Canadian Association of Critical Care Nurses (Fall, Winter, Spring Journals for the fiscal year—the Summer Abstract Journal is not included)
- Chapters are responsible for providing:
  - list of member contributions, together with a copy of the chapter newsletter
  - list of member contributions to the journal, together with the journal issue/date.

Each article = 25 points

Presentations

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

Each presentation = 25 points

Critical care certification—CNCC(C) and CNCC(P)

- Points will be calculated for chapter members who have successfully completed the CNA Certification Examination
- Points will be calculated for chapter members who have successfully renewed their CNA Certification
- Members' names must appear on the certification list received directly from the CNA to qualify.

Initial certification = 10 points per %
Renewal certification = 5 points per %
Add together for total certification score

- Formula Initial Certification: Number of members certified / total chapter membership × 100 = Percentage
- Formula Certification Renewal: Number of members re-certified/total chapter membership × 100 = Percentage
- Add the two percentages together for certification score.

Good luck in your endeavours!

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

CACCN Research Grant

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

Award funds available: $2,500.00

Deadline for submission: February 15

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

Eligibility:

The principal investigator must:

- Be a member of CACCN in good standing for a minimum of one year
- Note: where a student is submitting the research grant application and is ineligible to act as the principal investigator, the student must be a member of CACCN in good standing for a minimum of one year
- Be licensed to practise nursing in Canada
- Conduct the research in Canada
- Publish an article related to the research study in *Dynamics*
- CACCN members enrolled in a graduate nursing program may also apply
- Members of the CACCN board of directors and the awards committee are not eligible.

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

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

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

The Editorial Awards

The Editorial Awards will be presented to the authors of two written papers in *Dynamics*, the Journal of the Canadian Association of Critical Care Nurses, which demonstrate the achievement of excellence in the area of critical care nursing.

Award funds available: $1,250.00 total
- $750.00 award will be given to the author(s) of the best article
- $500.00 award will be given to the author(s) of the runner-up article
- It is expected that the award funds will be used for professional development
- More specifically, the funds must be used by the recipient within 12 months following the announcement of the winners, or within a reasonable time, 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 to further one's career development in the area of critical care nursing.

Deadline for submission: Fall, Winter and Spring Journal manuscripts annually.

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

Eligibility
- 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)
- The author(s) is prepared to present the paper at Dynamics of Critical Care Conference (optional)
- The paper contains original work, not previously published by the author(s)
- Members of the CACCN board of directors, awards committee or editorial committee of *Dynamics*, the Journal of the Canadian Association of Critical Care Nurses, are excluded from participation in these awards.

Criteria for evaluation
- The topic is approached from a nursing perspective
- The paper demonstrates relevance to critical care nursing
- The content is readily applicable to critical care nursing
- The topic contains information or ideas that are current, innovative, unique and/or visionary
- 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*, the Journal of the Canadian Association of Critical Care Nurses
- For the *Dynamics* manuscript submission guidelines, please refer to the CACCN Information for Authors at **http://www.caccn.ca/en/publications/dynamics/authors.html**

Selection

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

Presentation

The awards are presented by representatives of the sponsoring company or companies at the Dynamics of Critical Care Conference.

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

The Spacelabs Innovative Project Award

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

Award funds available: $1,500.00 total

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

Deadline for submission: June 1 each year

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

Mailed applications must be postmarked on or before June 1

Do you have a unique idea?

Award criteria:

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

Award requirements:

- Within one year, the winning group of nurses is expected to publish a report that outlines their project in *Dynamics*.

The CACCN Board of Directors and Spacelabs Healthcare retain 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 ($1,000.00 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 their names will 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*
- 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 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.*

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,* 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 inter-professional health care team
- Assumes a leadership role as dictated by the dynamically changing needs of the unit
- Is a role model to new staff and students
- Shares clinical wisdom as a preceptor to new staff and students
- Regularly participates in continuing education and professional development.

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.

Canadian Intensive Care Week "Spotlight" Challenge

The CACCN Canadian Intensive Care Week "Spotlight" Challenge will be presented to a group of critical care nurses who develop an activity and/or event that will profile their local critical care team during Canadian Intensive Care Week.

Award funds available: $450.00 total

Deadline for submission: August 15

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

Mailed applications must be postmarked on or before August 15. *Share your Canadian Intensive Care Week activities!*

Award criteria

- The primary contact person for the project must be an active member of CACCN (for at least one year).
- Applications will be judged according to the following criteria:
  - increase the visibility of critical care services in your local community
  - uniqueness/creativity of the activity/event
  - relevance to objectives of Canadian Intensive Care Week
  - feasibility of activity/event

Award requirements

- Event/activity must be held during Canadian Intensive Care Week
- Following the event/activity, a report must be submitted with photographs*, if possible, for publication in the *Dynamics* Journal within 45 days of the event being held
- All submissions become the property of CACCN and may be used in current/future publications (print and electronic)

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

** CACCN Photographic Consent forms must accompany all photographs submitted*

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[1] The Joint Commission Sentinel Event Alert Issue 49, August 8, 2012.
[2] Taenzer AH et al. Anesthesiology. 2010;112(2):282-287.
[3] Taenzer AH et al. Anesthesia Patient Safety Foundation Newsletter Spring-Summer 2012.
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