Opinion

In 2011, I attended the National Teaching Institute (NTI), the national conference of the American Association of Critical-Care Nurses (AACN) for the first time. There I had the opportunity to attend a talk by Dr. Elizabeth Bridges entitled, "Critical Care Studies You Should Know About". Dr. Bridges provided an overview of numerous research studies pertinent to critical care, such as those on surviving sepsis, preventing central line infection and ventilator-associated pneumonia. She summarized the results, the context and, importantly, whether this evidence was enough to support a practice change in our critical care units. This lecture had a huge impact on me. It highlighted my need for resources, language and knowledge translation tools to help me have conversations, lead quality improvement projects, advocate during team meetings and provide support and education to patients, substitute decision makers and families—ultimately enabling me to effect change at the frontlines of critical care nursing practice.

Scenario 1: The patient you are providing care for is anuric and has been on continuous renal replacement therapy for 24 hours. You remove their Foley catheter and are doing intermittent bladder scans. The family worries the patient will be incontinent and want to know why you took it out.

Scenario 2: You have joined the hospital's acute resuscitation team and now run to every code blue in your facility. The resuscitation carts have an intraosseous (IO) access kit, but they are not routinely used even though you notice the team often struggles with gaining vascular access.

Scenario 3: You recently completed a chart review, as part of an incident debrief, and noticed your team avoided central line catheter insertions when medications could be managed through peripheral venous access. However, once the central line catheter was placed, no one wanted to remove it even when it was no longer needed. The original peripheral also remained in situ.

These three scenarios represent common situations that I have encountered in my critical care nursing practice. Each of the scenarios represents an outdated practice that requires effective change. To effect change, resources like current literature reviews and evidence, change agent(s) and new policies and/or procedures are required.

Effecting change…

In 2017, The Canadian Association of Critical Care Nurses (CACCN) and Canadian Nurses Association (CNA) partnered with Choosing Wisely Canada. Choosing Wisely Canada is an organization that leads a national campaign to reduce unnecessary tests and treatments in healthcare that do not provide benefit or may cause harm to patients. Eleven members of CACCN with representation for all regions of the country reviewed more than 300 practices and looked at all aspects of nursing in critical care to identify current evidence-informed recommendations and associated rationales. Using a rigorous approach, we developed a list of five recommendations of interventions or treatments that are commonly practiced in the intensive care unit (ICU) and are within the scope or influence of nursing. Each recommendation positively impacts the outdated practices highlighted in the previous three scenarios.

The Choosing Wisely – Critical Care Nursing collaboration has provided critical care nurses with evidence to have both a national voice and to communicate with patients, family members and the interdisciplinary team each day on rounds. Evidence-informed recommendations enable critical care nurses to advocate for patients, facilitate stewardship of their units and participate in rigorous processes that influence programs and look to improve outcomes. Critical care nurses are always striving to improve the safety and quality of care for patients in the ICU and this list echoes the scholarship presented by Dr. Bridges in 2011 and supports us in doing less, to do more.

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