Hello everyone,

Thank you for your participation in "**Reflections: Stories from Canadian Critical Care Nurses**" on **September 29th, 2021**. This was our second "Reflections" event where we invited CACCN members from across Canada to share our stories and reflect on our experiences as critical care nurses through this pandemic.

Fourteen of the 25 CACCN members who registered, attended this event. They represented critical care nurses from Nova Scotia, Quebec, Ontario, Alberta, and British Columbia. Most worked in adult critical care settings but a few attendees also cared for mixed adult and pediatrics, or exclusively pediatric populations. We also had a mix of direct care nurses, nurse leaders and nurse educators from both urban and rural critical care settings. While this was the first "Reflections" event for most of the attendees, a few participants had also attended our July 29th "Reflections" event.

Of the few who attended both events, they shared that while both events were similar in structure, the conversation was noticeably different. In the summer event, participants shared their clinical context and stories, focusing more on unpacking the experiences of this pandemic. They disclosed the harrowing and all too common stories of providing care with insufficient resources, team nursing, and adapting to rapidly changing evidence.

At our September event, the discussion shifted to our state of being in the fourth wave. It was not about the rapid changes we all navigated in previous waves as COVID-19 had become a familiar adversary. This conversation focused on our current state, what we worried about today, or hoped to see in our future.

This is a summary of that engaging conversation.

Moderate and high vaccination rates helped, but the 4th wave was inescapable.

Some communities were successful in mitigating the fourth wave, while other jurisdictions are seeing the largest surges in cases yet. Communities that experienced early outbreaks, especially small communities where everyone knew someone affected by COVID-19, also benefited from successful vaccination campaigns, which resulted in greater success in preserving critical care capacities (and our workforce) in the fourth wave. That relief was short-lived because any preserved capacity was soon filled by overflowing patients from neighbouring jurisdictions that continued to struggle severely in the fourth wave.

Our workforce has not recovered from the 3rd wave, & we face the 4th wave with worse staffing levels.

Most (if not all) of our critical care communities have been traumatized to some degree by the experiences we endured, and have not had adequate time or space to reflect on, and process those

experiences. Unlike early in this pandemic, staff are limiting picking up extra shifts. Additionally, many staff have left positions, been hurt physically and mentally, retired, or returning staff have refused to come back to clinical practice in our critical care units. Even agency nurses, which many jurisdictions used in the third wave, now refuse to return to the hardest hit areas citing poor working conditions and too heavy workloads. Those nurses who choose to stay, and are still standing have done so by tightly banding together and supporting each other, each and every day.

There is a greater reluctance to participate in and/or trigger redeployment to critical care.

We have not been able to rely on redeployment strategies in the fourth wave as we had in previous surges. In the third wave when many nurses were redeployed to critical care, there was a nervous but in some ways excited energy to pitch in and help in the ICU. Redeployment and team nursing was a novelty. That novelty has worn off, the willingness and energy is gone. Critical care can be a scary place for a new fully trained nurse because there is so much to know, patients are so vulnerable, and mistakes are costly. This stress is amplified when that nurse received an inadequate fraction of the training, orientation, and mentorship needed to transition to critical care. Many who came to help were traumatized by that experience.

Secondly governments and health leaders are more hesitant trigger surgical and program slow-downs to enable redeployment again. After our first experience with redeployment, the human and system costs to patients in delayed care, missed screening, and worsening surgical backlogs were measured, made tangible and shown to have a significant negative impact on patient outcomes.

Despite herculean efforts, increasing workloads are having a visible negative impact on patient outcomes.

The critical care teams that remain are banding together and resorting to extraordinary measures to try to maintain the standards of care. Unfortunately, the reality is, despite this effort, normal care standards (i.e., dressing changes, mouth care, turning, early mobilization, etc.) cannot be consistently met under these conditions. Not only have we been put in positions where normal care standards are unachievable, but we are also the eye-witnesses to the impact of this decline - patients are experiences more complications, longer lengths of stay, and worse outcomes than we could have achieved with appropriate human resources. This is contributing to moral injury amongst nurses and nurse leaders.

The limited number of RRTs in our system is the Achilles' heel of our critical care services.

Critical care service requires interdisciplinary team of health professionals who specialize in critical care. During this pandemic, while all professions (nurses, doctors, respiratory therapists, social workers, pharmacists, physiotherapists, etc.) have been stretched beyond their normal capacity, the one profession whose limitations were most felt has been registered respiratory therapists (RRT). In so many ways RRTs have been at the forefront of this pandemic playing a vital role. They are involved in every stage of COVID-19 care, from emergency rooms, wards, patient transports, and critical care areas. They have acted as the unofficial rapid response system monitoring for clinical deterioration in COVID-19 patients on inpatient wards, and triggering early intervention. They are also involved in the highest risk activities such as intubation and delivering advanced respiratory support.

Unlike critical care nurses or intensivists, there are not many options of where to pull human resources from to augment an RRT's role. Our early pandemic surge strategies did not account for the shortfall of RRTs we had, and the vital role they have played in this pandemic. Building back our critical care services to be more resilient in the future means we need to advocate for increasing our RRT workforce, and RRT training capacity.

Those in leadership roles also suffered "side-line guilt" from witnessing the strain of direct care staff, and feeling helpless to mitigate it.

Attendees who were in leadership roles had backgrounds as critical care clinicians. They shared that although we highly recognized the value of their leadership to advocate for direct care teams, and implement strategies to mitigate the strain, they also felt guilt for not going back to the bedside to help.

Our trauma has not been addressed, our pre-pandemic mental health resources are inadequate; what is needed are tailored, long-term resources if we hope to recover.

Most of us only started to unpack our experiences over this past summer, but now are back in the thick of this pandemic again. We are going through now familiar motions juggling too patients, missing breaks, leaving care incomplete, and witnessing families grieve over an IPad. In moments, the things we witness hit us harder than expected, and we realize there is still much left unprocessed.

We have not even scratched the surface of the intersectionality of our collective and diverse pandemic experiences: of how belonging to a female dominated profession impacts our experience or of what it means when we also are members of the BIPOC, LGBTQ2S+, indigenous, and/or other marginalized communities. We have not had a moment to contemplate how huge social awakenings of this pandemic such as concepts of systemic racism, antiracism, and decolonization need to be addressed in critical care. Or how we have not been experiencing one healthcare crisis, but two, yet the substance use/overdose crisis has been largely unspoken about.

Early and ongoing studies have unveiled the alarming severity and widespread prevalence of symptoms of post-traumatic stress disorder (PTSD) amongst critical care nurses. While most healthcare facilities had pre-existing employee and family assistance programs (EFAP) with mental health supports, they are largely not being utilized. It is suggested that pre-existing EFAP services are not accessible enough for an overworked team, and/or the generic services available do not meet the specific and complex needs of a critical care staff in the context of this pandemic.

What is needed are *tailored services, embedded in the frontline, delivered by practitioners who understand the clinical context of what we have been experiencing. These services need to be available for the long-term.*

There are good examples the type of mental health support that is needed. Two examples shared were the **Ottawa Paramedic Peer Support Unit** and the **Peer Quick Resource Support Team (PQRST)** from Queensway Carleton Hospital in Ottawa.

Prior to this pandemic, Ottawa Paramedics developed the Ottawa Paramedic Peer Support Unit in response to high rates of PTSD amongst their paramedics. This team is led by fellow paramedics with additional training in mental health support. They intend to provide, quick, in the moment assessment and support. When needed, they activate more specialized care for their fellow paramedics in acute distress.

Queensway Carleton Hospital recently adapted the Ottawa Paramedic model fit the context of critical care clinicians at the forefront of this pandemic and who are at high risk of suffering moral injury. The team consists of health professionals, spiritual care, social work health leaders with additional training in mental health support. Like the Ottawa Paramedics, they assess, support and if needed

connect clinicians to additional support if needed. The offer both one-on-one peer support or debriefing as a group and are available 24/7 (see Resources section for additional information).

Long-term, well-coordinated, investment and attention (not short-term fixes) is needed to address the critical care staffing shortages and build more resilient staffing strategies.

Greater advocacy is needed to ensure we return to safe nurse:patient ratios and healthy workplace environments in critical care as soon as possible. There is worry that after almost 2 years of facing a pandemic, and experiencing much higher volumes of patients than our health system was designed to accommodate, high nurse:patient ratios, unsafe working conditions, and compressed or inadequate critical care training will become the norm. Currently, we have nuanced tools to assess what adequate staffing ratios should be which factor in variables such as clinical environment, nursing skill, and patient characteristics (e.g., from CACCN and AACN). While these tools more accurately measure staffing requirements, they also place an undue burden on direct care nurses to apply complex formulas to justify safe nursing ratios, when in this pandemic, direct care nurses may be better served with less accurate, but more straight-forward staffing recommendations.

Whether this is true or not, there is a pervasive sense that no one in higher leadership, or government is advocating for immediate, mid, and long-term strategies to address the staffing crisis in health care but especially in critical care. Nursing and especially critical care nursing had a longstanding and predicted staffing shortage looming before this pandemic, which only has been exacerbated with COVID-19. The fear is this staffing crisis is not being addressed, or governments are only considering short term, inadequate Band-Aid solutions.

New nurses that have entered critical care during the crucible of a pandemic face bigger challenges as they transition into ICU than in the past. Today's new critical care nurses have developed specialized skills to deal with ARDS and COVID-19 illness, but that skillset may have come at the expense of the caring for the other diverse patient populations we normally see in critical care. New nurses also have not had the same support and mentorship as they transitioned into critical care before this pandemic, because more experienced nurses do not have the capacity to do so. Seasoned nurses are less available to: support them in their learning, to help navigate our ethically complex environment, to develop skills to managed the emotional work of critical care nursing, safeguard one's work/life balance and mental health, especially now, when demands are greater than ever. Leadership and nurse education teams need to take this into account, and address the learning, and mentorship gaps new nurses face with intentional, robust and long term solutions.

Calls to Action for the CACCN

Attendees recommended that the CACCN lead the work to update our position statement on healthy workplace environments and recommendations for safe staffing in critical care, incorporating the hard lessons learned in this pandemic. They called for including:

- more concrete recommendations of safe staffing levels
- statements on including psychological support resources, and psychological safety in the workplace,
- greater attention to education and mentorship especially for new nurses entering the field.

Resources

- Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD (2020) Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury. Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD, ISBN online: 978-0-646-82024-8
    - **Executive Summary**

MI-Guide-Executive-Summary.pdf

- Stats Canada (2021) Mental health among healthcare workers in Canada during the COVID-19 pandemic. The Daily.
- Queensway Carleton Hospital's Peer Quick Response Support Team Announcement

Peer Quick Response Support Team (PQRS

PQRST poster.pdf

- CACCN (2018) Position Statement on "Healthy Work Environments" https://caccn.ca/wp-content/uploads/2019/10/PS032018PSHWEnviron.pdf
- CACCN (2019) Position Statement on "Models of Nursing Care in the Critical Care Unit" https://caccn.ca/wp-content/uploads/2019/10/PS032018PSHWEnviron.pdf
- AACN (2021) website resources on "Health Work Environments" (including tools to assess workplaces) https://www.aacn.org/nursing-excellence/healthy-work-environments
- AACN (2021) website resources on "Staffing in Acute & Critical Care" (includes tools to assess staffing ratios, team nursing, and other pandemic staffing strategies) https://www.aacn.org/clinical-resources/staffing
- CACCN – "Call to Action" Advocacy Letter: https://caccn.ca/advocacy-letter/
- CACCN Resources Page: https://caccn.ca/education-certification-resources/