Hello everyone,

Thank you for your participation in "**Reflections: Stories from Canadian Critical Care Nurses**" on **January 18th, 2022**. This was our third "Reflections" where we invited CACCN members from across Canada to share our stories and reflect on our experiences as critical care nurses through this pandemic.

Thirteen of the twenty CACCN members who registered, attended this event. They represented critical care nurses from Nova Scotia, Newfoundland and Labrador, New Brunswick, Quebec, Ontario, Alberta, and British Columbia. Most worked in adult critical care settings, but a few attendees also cared for pediatrics populations. We also had a mix of direct care nurses, nurse leaders and nurse educators, from urban, academic, and rural settings, (including one retired nurse). Although fewer people attended this event than previous "Reflections", this did not diminish from the richness of the conversation as everyone was able to contribute their thoughts and ideas more fully.

Of the people who attended a previous "Reflections," they shared that while both events were similar in structure, no two conversations were the same. The summer 2021 event focused on the often-harrowing stories of adapting to rapid change, and providing care with insufficient resources, support, and/or training. In our Fall Event, the discussion shifted to focus on, how continued inadequate staffing negatively affected the quality of care we could deliver, patient outcomes, and our teams. We touched on the intersectionality of race, religion, and gender impacted our experiences of this pandemic differently, and we needed more time to reflect on these realities. We worried that if these issues were not adequately addressed, this would lead to a degraded healthcare system. We outlined calls to action to more concretely define the standards for health work environments in critical care, which include recommendations for safe patient ratios, adequate training to enter critical care, and embedding robust and tailored mental health supports to all critical care staff, at the frontline.

When we planned this "Reflections" event, many of us hoped the last of the COVID surges would be behind us, and we could begin talking about how we rebuild critical care services, however, we now find ourselves, again in the thick of surging volumes of critically ill patients, unsustainable workloads, and an exhausted team.

While this was not the conversation we hoped to be having now, it was no less important. This is a summary of that discussion.

Our healthcare system is facing the current surge of critically ill patients, with worse staffing resources than ever before.

While many people stepped up, leaned in and deferred retirement to stay longer in the first waves of this pandemic, after two years they are exhausted, injured (physically, emotionally, spiritually or some combination of), and they are leaving. Our ability to cover vacancies is harder now as we face this current surge because: experienced, knowledgeable people have left, those who stay are (rightly) choosing to advocate for their well-being and refraining from picking up extra shifts.

Upon reflecting on how we adapted our ICU to care for dramatic increases in patient volumes, at times ICUs swelling to over 250% their normal capacity, we never actually made more ICU beds, we took

them from other programs and services. This came at a cost, delivery of other health services was compromised, and other teams experienced the same strain critical care did. This workforce gap created by this pandemic is not limited to critical care. Rather, it is pervasive across the healthcare system, so even our ability to recruit, or even temporarily redeploy from other units is significantly impaired now. For a multitude of reasons, across Canada, our critical care services do not have the capacity they did even 1 year ago when COVID-19 was a well-established pathogen and vaccines first arrived.

In this reality, any action to preserve critical care services or to create efficiency has a meaningful impact, thus are worth investing in. Pulling from history, creating segregated units, or even hospitals (i.e., TB hospitals or Polio units) was one strategy to protect other health services from being overwhelmed by surges of patients with highly infectious pathogens.

A more recent idea to create efficiency was expressed in an article by Dr. Melinda Ashton entitled "Getting Rid of Stupid Stuff" focused on asking frontline staff to highlight perceived "waste of time" charting tasks to their "The Stupid Stuff" program so those issues could be corrected. The "Releasing Time to Care" follows the same principle of engaging with frontline staff to highlight inefficiencies (beyond charting tasks) to problem-solve how to fix them so more nursing time can be dedicated to patient care. Investment into these initiatives likely have a greater imperative now. Pre-pandemic, these strategies improved care and saved money; post-pandemic they could help to preserve and/or restore our abilities to deliver quality care.

New critical care nurses entering the field are facing significant challenges throughout their training and transition period.

Through the last two years, we have had several cohorts of nursing students, and critical care nursing students enter clinical practice and the challenges they have faced cannot be understated. These students have had to navigate unparalleled disruptions to their education, in addition to the stresses of living through a pandemic. Normal in-person classes flipped to virtual learning platforms. Nursing students likely have missed some of the socialization to the nursing profession that students historically benefited from.

Their learning has been greatly impacted by the shortage of clinical instructors. Clinical instructors have been tasked to deliver education to more students, or programs have changed from clinical instructor-led instruction to preceptor-led instruction. The preceptors who have been asked to take on more students have also been heavily burdened with the increasing workload due to pandemic surges. With fewer clinical instructors, preceptors, and mentors, these students have had less one-on-one support during a time when they likely needed it far more than before.

The practicum opportunities, and the clinical staff who support students are also different than before. With the massive influx of COVID-19 patients, the clinical experiences nursing and ICU students are less diverse: they are not getting the exposure to the variety of patient populations they normally would have, and thus have gaps in the non-COVID related knowledge. The clinical staff who support students, and act as role models are over-burdened, and traumatized. Students are routinely witnessing unsafe nurse-patient ratios, unhealthy work environments, inadequate coping skills, and altered care, potentially leading them to think this is the norm.

This pandemic has caused us to compromise on the principles of providing care that is patient and family centred care.

With the visitor restrictions and pandemic strains, our practice for patient and family centred care has been the most compromised. Student and new nurses have far less exposure to witness (and be coached by) experienced nurses and healthcare teams to do such things as: communicate difficult information to families; invite patients and families to participate in care and decision making; and spend precious time to develop therapeutic relationships between nurses, patients and their family.

The effects of this pandemic on new nurses entering nursing, and eventually entering critical care will be felt for years to come. Returning our healthcare system to a place of resiliency will require us to both

appreciate the disruptions to nursing education, as well as to actively mitigate those gaps that have developed. We will need to augment resources to support new staff transition to practice, especially in non-COVID related patient populations, patient and family centred care, and healthy work environments.

Patients and family members of COVID-19 deniers are exposing our workforce to a new and harmful form of emotional abuse.

Providing care for the occasional patient and family that have become distrustful of their healthcare team is not a new phenomenon, however, what we are seeing today is different. First, we have to recognize that in addition to the strain of nursing through a pandemic, across this country, healthcare workers have faced aggressive abuse from a small group of Canadians who promote pandemic disinformation, and conspiracy theories. Healthcare workers have been physically assaulted, verbally abused, and called liars for sharing information about COVID-19, public health measures, our healthcare system, and the suffering we witnessed. This is something none of us have seen before, and to a certain degree, we all carry the effects of this trauma. Secondly, the COVID-19 patients who require ICU today, are largely the unvaccinated, many of whom remained unvaccinated because they deeply held beliefs in pandemic conspiracy theories. Some may have even participated in protests against public health measures. Direct care nurses are being put in the position of attempting to provide quality care, to a patient and family members who are incredibly distrustful, steeped in disinformation, and sometimes outright abusive to staff. Nurses recognize the importance of having family during a critical illness, and how stress can sometime manifest in anger. We have worked with traumatized and distrustful families before, but this is very different. Some of this behaviour is abusive, and it is hitting our own trauma as healthcare workers during this pandemic.

When we do not protect our staff, ask them to accommodate bad behavior, we lose nurses, in one way or another.

Unfortunately, because this is a new phenomenon, too often direct care nurses are being asked to accommodate bad and abusive behaviour, rather than establishing safe boundaries and having leadership support do this. We have to recognize that when we ask direct care nurses to endure this, we are silencing them and “silence is the cornerstone of abuse.” We have to recognize the seriousness of this issue. The cost not recognizing and responding to this will be losing nurses. They will either leave the profession by choice or leave because of the mental injury they have suffered. It is paramount that leadership act to protect direct care staff, establish clear and enforced boundaries for a health work environment, and offer tailored mental health support to aid in recovery.

Calls to Actions

Attendees recommended that as a nursing community, these are the priorities attendees identified to re-establish and enhance resiliency in critical care:

- more concrete recommendations of safe staffing levels.
- statements on including psychological support resources, and psychological safety in the workplace.
- leadership support to establish safe boundaries in the context of this pandemic.
- greater attention to education and mentorship especially for new nurses entering the field.
- re-establishing the principles of patient and family centred care.

Resources

- Ashton M. (2018). Getting rid of stupid stuff. *The New England Journal of Medicine*, *379*(19), 1789–1791. https://doi.org/10.1056/NEJMp1809698
- BCPSQC (2021). Resources for Releasing Time to Care. downloaded on January 20, 2021, from: https://bcpsqc.ca/resources/releasing-time-to-care/
- Wright, S., & McSherry, W. (2013). A systematic literature review of Releasing Time to Care: The Productive Ward. *Journal of Clinical Nursing*, *22*(9-10), 1361–1371. https://doi.org/10.1111/jocn.12074
- 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
- Stats Canada (2021) Mental health among healthcare workers in Canada during the COVID-19 pandemic. The Daily.
- 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/