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DYNAMICS

The Official Journal of the Canadian Association of Critical Care Nurses

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DYNAMICS
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DYNAMICS

The Official Journal of the Canadian Association of Critical Care Nurses

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Canadian Association of Critical Care Nurses

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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 & Humanity
  - Respectful, healing and humane critical care environments
  - Combining compassion and technology to advocate and promote excellence
- Integrity & Honesty
  - Accountability and the courage to speak for our beliefs
  - Promoting open and honest relationships

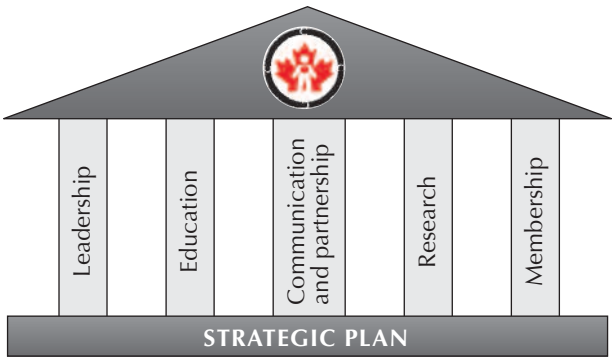
Philosophy statement

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

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

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

Strategic plan: Five pillars



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

Critical Thinking

Find your voice!

Edmonton was alive with the voices of critical care nurses in September at Dynamics 2010. Four hundred and forty critical care nurses to be exact… and what a noise we made together, as we shared our knowledge, told our stories, played, laughed and enjoyed each other's company for three days. I sat in the audience listening to many presentations and was in awe (but not surprised) of the expertise nurses had to share and had taken the time to speak on a subject or a story that needed to be told. I sat there with pride recognizing that I was a member of a very crucial group of nurses in Canada who have a lot to say when given the opportunity. But why do we wait sometimes to be "given" the opportunity to speak? We definitely have a lot to say when we are asked, and when we speak with conviction, when we speak from experience, when we speak from the position of trust the public has in us, people listen. You don't survive in critical care by being a wallflower. You are a critical care nurse and every day you speak, often on behalf of your patients and families who need you to be their voice.

So the national board of directors (BOD) has adopted the theme "Find Your Voice!" for the next couple of years, and you will see us using this theme to encourage all of our members to speak up and be heard. It can be easy. When the BOD was meeting in Edmonton, one phone call to the Edmonton Journal to let them know there were more than 400 critical care nurses in town resulted in a media interview the next day. It gave me a chance to speak about the role that critical care nurses play in the lives of our patients and families and the position of trust that comes with that privileged position we hold. The Edmonton Journal article was picked up by the wire service and made it to the *Vancouver Sun, The Province* (BC), *Montreal Gazette* and *The Ottawa Citizen*. One phone call and what we had to say was read by thousands of readers across Canada. Like the Staples ad proclaims: "That was easy!"

In November I spoke again at the Canadian Critical Care Forum national conference, where the majority of attendees were intensivists, on effective communication between critical care nurses and physicians. How did I get to do that you ask? Well, when they reached out to CACCN to partner more with us, I said that we could do so on one condition… that I would have an opportunity as president of CACCN to speak directly to the intensive care physicians registered for the conference on the topic of effective communication. They agreed. I found my voice and said what I needed to say. "That was easy!"

The vision of CACCN is "The voice for excellence in Canadian critical care nursing." The vision is one for which each of us can take personal responsibility. It starts in small, simple ways: in the units where you work and in the communities where you live. When I was a novice critical care nurse in 1982, I really looked up to those more senior, experienced nurses and I wondered how they came to be so confident and competent. How they were able to contribute to the advancement of practice in such meaningful ways in the unit where I worked and in the professional groups to which they belonged. I was still trying to master the skills of the PICU environment and acquire all the new knowledge I had to learn. I never thought I would ever be as good as they were, but they were my mentors. They taught me to speak and pretty soon I had something to say in my unit about the need for new nurses' notes and I quickly found myself offering to revise our documentation record. From that experience I learned that there was power in what I had to say and what I could change when I spoke about it. Small things we do when we speak up can create great changes. And on my "little" five-person team of nurses, we began to talk about what we wanted to do to stimulate our own professional growth and to contribute to the care we delivered in our unit. We started to form and get involved in various committees within our unit. We began to network with other critical care nurses in Halifax, where we worked, and soon a small group of us came together locally to form the Nova Scotia Chapter of CACCN in 1986. "That was easy!"

In 1990, I attended my first Dynamics conference held in Edmonton and I remember looking at the president and national board and thinking "What amazing people!" I

NEVER saw myself ever being on the national board, let alone one day the president of the association. At Chapter Connections Day this year in Edmonton, the chapter representatives and BOD had a thoughtful and reflective discussion on how to answer the question we often get asked when we approach people to encourage them to join CACCN. The most frequent question that gets posed is "So what do I get for joining?" The answer is NOT a great Canadian critical care journal, access to a website with a huge amount of resources for members only, or a copy of the Standards for Critical Care Nursing Practice, or access to a variety of awards or reduced rates to attend Dynamics, although all this is true. Rather, our discussion turned to a different answer and those of us present began to nod our heads in agreement as we realized what we "got" from joining CACCN. It is not so much the tangible "things", instead it is about what it means to become a member and instantly gain colleagues across the country who become your friends and who respond when you have a practice question. It is someone who is safe to share your story with, who knows and appreciates what you are saying and who cares about what you are saying. These are sustained and lifelong colleagues and friends in critical care that many of us have gained. It is about taking on a role at the chapter level that pushes you to learn new skills you never thought you had and, by gaining those skills, new doors open professionally and personally and new opportunities are presented. All of us agreed that these things had happened to us and changed us along the way and only now looking back do we realize how valuable that has been to each of us. We learned to find our voice and speak from the roles we played within CACCN. When we compared our stories and histories of how we came to be in the room together for Chapter Connections Day, we realized the journey we described was very similar and we acknowledged how our involvement with CACCN at the local and national levels had shaped who we had become as critical care nursing leaders in Canada. "That was easy!"

In my closing remarks at Dynamics, I encouraged and challenged each CACCN member in the room to go out and get one colleague to join. I got one person to join while I was at Dynamics and that was just by taking the time to stop and speak to him, and I think he may recruit others when he returns to his unit. My daughter, Sinead, is a second-year student nurse at St. Francis Xavier University in Nova Scotia and a birthday gift to her this November was a student membership with CACCN. Do you know a student? Perhaps it is a student who did a clinical placement in your ICU and did a great job… what a wonderful welcome to our profession if instead of the farewell cake and cookies, the unit presented the student with a $50.00 membership to CACCN, as a way of saying "we hope you return to us." If we all commit to do this, then next year at Dynamics we will be reporting that we have 2,200 members. Lofty goal? You bet! Can we do it? Find your voice and we can. I want to report next year at Dynamics, "That was easy!"

Take care of yourself and each other,
Kate Mahon, RN, BN, MHS
President

DYNAMICS 2011 - CALL FOR ABSTRACTS

Abstracts are currently being accepted for Oral, Oral Poster and Poster Presentations for **Dynamics 2011,** the annual national conference of the Canadian Association of Critical Care Nurses, to be held October 16 to 18, 2011, at the London Convention Centre in London, Ontario. Submissions must be evidence-based and, ideally, address the theme: ***"Critical Care Nursing: Our Kaleidoscope".***

Abstract Submission Guidelines

- Submissions **will only** be accepted through our Online Abstract Submission process at **www.caccn.ca.** Submissions will be reviewed under a blinded review process
- The Abstract Submission Process will be available until 2359 hours EST on January 31, 2011
- All requested information must be included at the time of abstract submission for your abstract presentation to be registered

Abstract Requirements

- Abstract to include a maximum of 400 words
- Include the abstract title, preferred format for presentation (oral or poster) and references with abstract (title, format and references not included in word count)
- Ensure there is no identifying information in the body of the abstract (i.e., author names, hospital names, city, province, acronyms, etc.)

Presenter Information

- Include the following contact information: 1) name, credentials, mailing address, telephone numbers and email for the first author, and 2) a list of the names and credentials for co-authors
- Enter presenter information into the online registration program as instructed

Important Notes

- Only completed submissions received by **January 31, 2011,** will be considered
- Notification regarding selection decisions will be provided by **April 1, 2011**
- All correspondence will be with first author **only**
- One presenter for each accepted abstract will be entitled to discounted tuition at Dynamics 2011; All other expenses are the responsibility of the presenter(s)
- Abstracts accepted for presentation at Dynamics 2011 must not be presented at a national or provincial level for a period of 12 months prior to and/or six months after Dynamics 2011.
- Abstracts are the property of CACCN during this period of time, and may be published in Dynamics, the Official Journal of the Canadian Association of Critical Care Nurses

Questions?

Please contact CACCN National Office, P. O. Box 25322, London, ON, N6C 6B1; www.caccn.ca; e-mail: caccn@caccn.ca; Toll free: 1-866-477-9077; Telephone: (519) 649-5284; Facsimile: (519) 649-1458

From the clinical editor

The administration of sedation and analgesia to critically ill children is complex and requires a multidisciplinary collaborative approach. Thomas and colleagues at the Children's Hospital of Eastern Ontario (CHEO) in Ottawa developed and tested a sedation and analgesia management (SAM) guideline for critically ill, intubated and ventilated infants and children. In this issue, the authors describe their experience in the development, dissemination and implementation of an interprofessional guideline. Their experiences may have implications for other settings looking to develop practice guidelines, not only with a pediatric population, but also in other settings.

The second original article in this issue is by Thompson and colleagues, who report on the research they conducted when they explored the experiences of novice critical care nurses with their first death in the ICU. Their findings have implications for clinical practice and academic settings and for further research in this relatively unexplored area of nursing.

At the Dynamics 2010 conference held in the fall in Edmonton, Alberta, the panel discussion on end-of-life issues in critical care sparked great interest and discussion. We want to build on this discussion and hope to have an issue of **Dynamics** dedicated to this theme (See the call for manuscripts). On Kate Mahon's challenge to "Find Your Voice", consider writing an article on this, or any other topic you are interested in related to critical care nursing. If you need help, please contact me or any member of the Editorial Review Board. If you know of someone who has completed a project, encourage him or her to submit an article.

P. Price, RN, PhD
Clinical Editor

CACCN Constitution and Bylaws

At the annual general meeting in September 2010, the membership voted to accept and approve the following revisions to the CACCN Constitution and Bylaws:

Article # VII, Officers, Section 9, Dynamics:

9.1 The chair for Dynamics will be a member of the board of directors at the time of appointment.
9.2 The Dynamics Conference for which the director is responsible will be completed within one year of the end of the director's term.
9.3 There shall be a board of directors' member on the Dynamics planning committee, as an ad hoc member.

To view the approved Constitution and Bylaws (September 2010), please visit the CACCN website at **www.caccn.ca** or request a copy via National Office at **caccn@caccn.ca**.

CACCN calendar of events

DATES TO REMEMBER!

November 26, 2010: CNA Renewal Certification Application deadline

January 1, 2011–April 30, 2011: "Twin and Win" Membership Program

January 31, 2011: Dynamics 2011 Call for Abstracts deadline

January 31, 2011: Smiths Medical Canada Ltd. Educational Award deadline

February 15, 2011: CACCN Research Grant deadline

March 1, 2011: Dynamics 2012 Planning Committee Application deadline

March 1, 2011: Spacelabs Innovative Project Award deadline

June 1, 2011: BBraun Sharing Expertise Award deadline

June 1, 2011: The Guardian Scholarship – The Baxter Corporation Award for Excellence in Patient Safety

June 1, 2011: The Brenda Morgan Leadership Excellence Award

June 1, 2011: Cardinal Health Chasing Excellence Award

Awards presented at Dynamics 2010 Edmonton, Alberta

Brenda Morgan Leadership Excellence Award

Francis Loos, Regina, SK

Nominated by: Brenda Morgan, Sandra Matheson and Gwynne MacDonald

Francis Loos and Brenda Morgan.

Sorin Group Chapter of the Year Award

London Regional Chapter

CACCN Lifetime Membership Awards

Bernice Budz, Vancouver, BC, and Brenda Morgan, London, ON

Kate Mahon, President, CACCN National Board of Directors, Bernice Budz and Brenda Morgan.

Edwards LifeSciences Editorial Award

Eileen Shackell and Mary Gillespie, Vancouver, BC

"The Oxygen Supply and Demand Framework: A tool to support integrative learning"

Winter 2009, Volume 20, Number 4, Pages 15–19, Dynamics: The Official Journal of the Canadian Association of Critical Care Nurses

Will Assad of Edwards Lifesciences, Eileen Shackell and Mary Gillespie.

CACCN Editorial Award

Elizabeth Gordon, Toronto, ON

"Innovations in technology—Novalung iLA: Challenges for the field of critical care nursing"

Fall 2009, Volume 20, Number 3, Pages 14–17, Dynamics: The Official Journal of the Canadian Association of Critical Care Nurses

Will Assad of Edwards Lifesciences, presenting the CACCN Editorial Award to Elizabeth Gordon.

Baxter Guardian Scholarship for Excellence in Patient Safety

Tracie Northway, Langley, BC, Kim Streitenberger, Toronto, ON, and Janelle Plouffe, Winnipeg, MB

"A Collaborative Approach to Improving Nursing Shift to Shift Handover in Pediatric Critical Care"

Anne-Marie Carli of Baxter Medical Canada, Janelle Plouffe, Kim Streitenberger, Tracie Northway and John Soliven-Llaguno of Baxter Medical Canada.

BBraun Sharing Expertise Award

Arkadi Shuman, Calgary, AB
Nominated by: Lois Crossman

Bob Comer of BBraun Medical and Kimberly Tateson, accepting the award for Arkadi Shuman.

Cardinal Health Chasing Excellence Award

Debra Bosley, Calgary, AB
Nominated by: Kathy Bouwmeester

Rhona Charron of Cardinal Health Canada and Debra Bosley.

Spacelabs Innovative Project Award

Valerie Banfield, Barbara Fagan and Carla Janes, Halifax, NS

"Creating Life-Long Critical Care Thinkers"

Peter Robertson, Spacelabs Medical, Valerie Banfield and Barbara Fagan.

Smiths Medical Education Awards

Fall 2009: Katherine Poser, Fredericton, NB
Winter 2010: Julie Weir, Riverview, NB

Anna Rae of Smiths Medical Canada and Julie Weir, Winter 2010 Recipient.

2010 CNCC(C) and CNCCP(C) Draw Prize Recipients *($250.00 each)*

Adult Initial Certification

- Jennifer Cullimore, Calgary, AB
- Monica Klein, Richmond Hill, ON
- Clarice Watt, Timmins, ON

Adult Re-certification

- Dawna Van Boxmeer, Ilderton, ON
- Marina Bitton, Thornhill, ON

Pediatric Initial Certification

- Charlotte Ryan, St. John's, NL
- Laurel Kathlow, Coquitlam, BC

Pediatric Re-certification

- Paula Mahon, Vancouver, BC

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

Dynamics 2010 report

The Canadian Association of Critical Care Nurses, Dynamics of Critical Care 2010 conference was held in Edmonton, Alberta, from September 19–21, 2010. The theme for Dynamics 2010 was ***"Changing Lives, Pushing Boundaries, Striving for Excellence: The Power of Critical Care"***. This year's conference provided 440 colleagues from across Canada with the opportunity to gain the knowledge and passion that will allow us to change lives, push boundaries and strive for excellence.

Cassie Campbell, former captain of Team Canada and a two-time Olympic medallist, spoke of consistent leadership leading to strong cohesive teams. These strong teams translate into success, whether that is a gold medal or excellent patient care. CACCN National Board President Kate Mahon, in her opening ceremony president's address, reminded us that finding our voice in critical care nursing generates power in critical care that makes a difference in patient's lives. Kate invited all of us to become a part of the voice of excellence in critical care nursing by becoming a member of CACCN. Charlotte Pooler and Brenda Morgan, both strong national clinical leaders in critical care, provided us with the newest evidence to help us push boundaries and strive for excellence while delivering care to our patients. Our final keynote speaker, Dr. Brian Goldman of CBC's *White Coat, Black Art,* emphasized the importance of sharing mistakes so we can improve safety while delivering care to our patients.

Dynamics was not just about gaining knowledge. There was ample opportunity to network and join in fun activities with our colleagues from across the country. The Baxter reception was once again a great part of Dynamics. Delegates had a fun-filled evening talking and dancing into the night. The CACCN annual dinner was a fun-filled evening with a wonderful buffet dinner, casino games and a disc jockey. Delegates gambled without losing their shirts and danced into the wee hours.

I would like to thank the members of the Dynamics 2010 conference planning committee: Linda Slater-Maclean, Gwynne MacDonald, Eugene Mondor, Sara Pretzlaff, and Gwen Thompson. Without their dedication and commitment to critical care, Dynamics 2010 would not have been a success.

Teddie Tanguay
Chairperson
Dynamics 2010 Planning Committee

Call for Members—CACCN Position Statements

The CACCN Board of Directors will be reviewing, updating and developing the following Position Statements:

- Use of Non-Regulated Health Personnel (1997)
- Licensed Practical Nurse in Critical Care
- Guidelines for Nurse: Patient Ratios in Critical Care
- Patient and Family-Centred Care
- Family Presence during Resuscitation (2005)—seeking adult criticial care members

Copies of the current statements can be found at **www.caccn.ca.**

If you are interested in assisting with the revision of current statements or creation of new statements, please contact CACCN National Office at **caccn@caccn.ca** or via facsimile to 519-649-1458, with the following information:

- Statements that interest you
- Your name
- Contact information, including email address
- Brief resume indicating your area of practice, employer, etc.

Call for manuscripts

We are planning a special issue of Dynamics with the theme of "End-of-Life and Critical Care Nursing."

Please submit manuscript to Paula Price by May 1, 2011.

For inquiries, please contact Paula Price at **pprice@mtroyal.ca**

Call for Dynamics 2012 conference planning committee members

Dynamics 2012 will be held September 23–25, 2012 at the Westin Bayshore in Vancouver, British Columbia, and will be chaired by Tricia Bray. CACCN members interested in working on the conference planning committee should submit a resume/CV and summary of conference planning experience to the CACCN National Office by March 1, 2011. Planning Committee selection will take place in March 2011. For further information on this exciting opportunity, please contact the CACCN National Office, PO Box 25322, London, ON N6C 6B1; **www.caccn.ca;** e-mail: **caccn@caccn.ca;** phone: (519) 649-5284; fax: (519) 649-1458. *(Planning experience is appreciated, but not a requirement for submission.)*

Critical care nursing research

Are you interested in critical care nursing research?

CACCN is building a national network of critical care nurses with an interest in research. Our long-term goal is to conduct a national nursing study.

Please submit your name and contact information to CACCN National Office at **caccn@caccn.ca**

For inquiries please contact Tricia Bray, Director, Publications and Research at **publications@caccn.ca**

Report from Chapter Connections Day

I had the good fortune of attending Chapter Connections Day prior to the official start of the Dynamics 2010 conference. This is a day designated for all of the chapter presidents and the board of directors to meet and share information about what has happened over the last year, the issues chapters face, and plans for the future.

Kate Mahon gave her president's address with the theme of "Looking Back with Pride and Moving Forward with Vision". There have been many successful initiatives that were accomplished in the past year. Our national administrator's position was renamed given the responsibilities Christine Halfkenny-Zellas has. Her new title is Chief Operating Officer. CACCN has "stayed the course" despite challenges in the past. The national association is all about the chapters and the chapters are accomplishing amazing things. Last year, the vision, mission and values were revised, the standards were revised, and the website reconstruction was completed. Future initiatives will include increasing our visibility both in the public and with critical care nurses. We need to increase our membership; we currently represent only 1% of Canadian critical care nurses. Kate's vision is to see a stronger liaison with AACN and increased interaction with the members of CACCN. She wants critical care nurses to tell their stories. During the conference, Kate planned to meet with the news media to talk about critical care nursing and the role of critical care nurses in our health care system. Future initiatives also will include developing a new database and looking at succession planning for sustainability. Political activism is a direction the board of directors is pursuing.

Board of directors' highlights

Website: The Members-only website is live and password protected. Members can now go in and change their password. The Workopolis career advertising section on the website has not really taken off yet. The board of directors explored the possibility of having the website translated into French, but the cost to maintain the upgrades almost daily proved to be too costly. For Dynamics 2010, all abstract submissions were completed online.

Membership: Our current membership is 1,182. This tends to stay quite constant. The two-month grace period for renewing membership has been removed. This means that the CACCN membership will expire on the actual expiry date.

Standards: The critical care standards were approved last fall. They have now been translated into French and have been printed and distributed. They are also on the website.

World Federation of Critical Care Nurses: CACCN is a member of the WFCCN. Last year, the WFCCN was seeking financial support from CACCN to hold a joint conference in 2012 when Dynamics is hosted in Vancouver. This initiative is not being pursued. The board and members need more information and time to discuss this. The board will continue to seek information and continue to negotiate with the WFCCN and then will consult with the members.

Dynamics (the journal): An initiative being pursued by the board of directors and the editorial review board is a "renewal" of the journal. Aspects being discussed are the cover and design, format changes, paper, and theme issues. Discussions about increasing manuscript submissions also occurred.

Finances: The association is financially sound despite the economic downturn this past year.

Some of the current position statements will be updated and there will be some new position statements developed. Some of the new position statements will be on diversity in ICU, organ donation, structure of ICU, family-centred care, health work environments, and long-term ventilation.

There were four breakout sessions where participants spent one half-hour at two of the sessions and discussed a particular topic. The topics included enhancing chapter communication with members, the care and running of the operations of a chapter, developing/maintaining the chapter websites within the CACCN web page, and constitution/bylaw development and maintenance.

Chapter reports

Each chapter president was given the opportunity to share the challenges, accomplishments, innovative ideas and goals experienced this past year. The themes that emerged were the small number of people doing the work of each chapter, retention and recruitment issues, geographical issues and difficulties with recruiting executive members. Some of the goals expressed included providing relevant education sessions, exploring the use of webinars, paying attention to all generations in the workforce, needing to establish goals, succession planning, tapping into local talent, developing good handovers, use of Facebook, and chapter website development.

Discussions

Brenda Morgan presented London Chapter's experience with webinars. They used Go to Webinar, which has a free one-month trial. She discussed the process and concepts of webinars, the advantages, and learning curve.

Pam Cybulski facilitated a discussion of strategies for planning education days. Topics discussed included polling members for topics, seeking speakers, sponsorship, door prizes and pricing/registration incentives.

Tricia Bray facilitated a discussion about succession planning and team building. This was related, in particular, to recruiting new members to the chapter executives. Many of the suggestions related to seeking out potential members, role modelling and mentoring others. What then followed was a rich discussion of the meaningfulness of being a member of CACCN and taking leadership roles on either the local or national executives. The rewards include developing new competencies, meeting new people, learning new skills, personal growth and fulfillment, educational opportunities, and a sense of pride and accomplishment that you are contributing to a professional organization.

Respectfully submitted,
Paula Price
Clinical Editor

Canadian Association of Critical Care Nurses National Board of Directors

The national board of directors of the Canadian Association of Critical Care Nurses congratulates the following members elected at the annual general meeting on September 19, 2010, to the 2011–2013 National Board of Directors:

Director, Central Region
Karen Dryden Palmer
RN, BSN, MN(C), CNS
Barrie, ON

Director at Large, any Region
Céline Pelletier
RN, BScN, CNCC(C), MN-ACNP, NP
Yellowknife, NT

We wish to thank all 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 Edmonton, Alberta, in conjunction with Dynamics 2010. ***Your Voice Matters!***

Sincerely,

Kate Mahon
President

Teddie Tanguay
Vice-President

WHAT'S HAPPENING at www.caccn.ca?

Visit us today at www.caccn.ca

Members-only area

The Members-only area contains a wealth of information such as electronic copies of previous Dynamics journals, opportunities to earn Continuing Education Credits, and the members' discussion forum. Whether you are a seasoned discussion board veteran or new to the process, stop by … look around … post an introduction … answer a question …

Members are now able to change their passwords for easy access to the members-only site!

Not a CACCN Member?

What are you waiting for? Join the Association and take advantage of the Members-only benefits.

Dynamics 2011 Online Abstract Submission Process

The Dynamics 2011 Online Abstract Submission Process is now available. Only abstracts submitted through the online system will be accepted for submission. Deadline for submission is January 31, 2011 at 2359 EST.

DYNAMIC CAREER CONNECTIONS on www.caccn.ca

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

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

Employers: CACCN knows how important it is for you to find new ways to directly reach Critical Care Nurses. CACCN Dynamic Career Connections provides you with the opportunity to extend your reach to a targeted candidate pool, and post your jobs confidentially. Use the advanced pre-screening tools to automatically filter applicants for easy resume management. *Register to post your jobs!*

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

JOB LINKS on www.caccn.ca

JOB LINKS is a simplified web link page on the CACCN website designed to provide immediate links to critical care nursing career opportunities in Canada and around the world. If your facility is interested in taking advantage of this service, please visit **www.caccn.ca**, click on **JOB LINKS,** and view the PDF contract for more information.

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Seasonal flu shot

Seasonal flu vaccines protect against the three influenza viruses that research indicates will be the most common each year. This year's flu vaccine (2010–2011) will protect against:

- 2009 H1N1;
- H3N2 virus (Fujian flu);
- Influenza B virus.

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 age six months to get a flu shot. It is especially important for health professionals to be immunized to protect themselves, their families and their patients.

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

Make the right choice for all three!

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Research Review

Jukkala, A.M., & Henly, S.J. (2009). Provider readiness for neonatal resuscitation in rural hospitals. *Journal of Obstetrics, Gynecology Neonatal Nursing, 38*, 443–452.

Introduction

Although most critical care health care providers undergo periodic training for emergency response (ACLS, PALS, NRP), questions remain regarding the retention of this knowledge. This is particularly true when emergency skills and knowledge are used infrequently.

Research objective

To measure nurses' and physicians' knowledge, skills and comfort in neonatal resuscitation in rural hospitals.

To compare nurses' and physicians' levels of knowledge, skills and comfort in neonatal resuscitation in rural hospitals.

To examine correlations between the above factors and current Neonatal Resuscitation Program providership.

Design

Descriptive, correlational study.

Setting

Twenty-six rural hospitals in the U.S. midwest.

Participants

One hundred and sixty-five nurses and 59 physicians.

Data collection

Data were collected as part of a larger study examining the success of neonatal resuscitation. Two instruments, the Neonatal Resuscitation Index (Jukkala & Henly, 2007) and the Neonatal Resuscitation Experience Index (Jukkala & Henly, 2007) were administered to study participants.

Findings

The average score on the knowledge tests was 69%. Subjects reported that they had not performed many of the skills used in newborn resuscitation over the previous year. The items identified as most problematic included when to use epinephrine and how to confirm the placement of an endotracheal tube. A decreased comfort level with these skills was reported by nurses in the study ($p<.01$). Nurses reported a stronger relationship between comfort and frequency of skill performance than physicians did ($r=0.50$ versus 0.34). Nurses who were Neonatal Resuscitation Program (NRP) providers scored significantly higher in the areas of knowledge and comfort than non-NRP providers. Physician scores were not correlated with NRP provider status.

Conclusions

The authors of this study acknowledge that maintaining knowledge and comfort levels in newborn resuscitation is a challenge in settings where these skills are performed infrequently. They conclude that neonatal resuscitation education is valuable and that nurses and physicians should make special efforts to obtain continuing NRP education.

Commentary

A number of studies have found that even well trained nurses have deficits in CPR and resuscitation skills (Abella et al., 2005a; Abella et al., 2005b; Devlin, 1999; Kuhnigk, Sefrin, & Paulus, 1994). Other studies have shown that resuscitation skills deteriorate over time (Madden 2006; Moser & Coleman, 1992). This study identifies similar issues with resuscitation knowledge in both nurses and physicians, and highlights the challenges of skill and knowledge retention in the absence of opportunities for practice. It also validates the benefit of current certification in a relevant resuscitation program. One of the limitations of this study was that the assessment of both knowledge and comfort levels were measured via a questionnaire. A follow-up study using high-fidelity simulation would be beneficial in further evaluating the skills and knowledge of neonatal health care providers and in examining the issue of skill retention over time.

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Dynamics 2015: TBD, *Winnipeg, MB*

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

By Margot Thomas, RN, MScN, CNCCP(C), Sonny Dhanani, MD, Danica Irwin, BPharm, Hilary Writer, MD, and Dermot Doherty, MD

Abstract

Sedation and analgesia are administered to critically ill children to provide comfort and pain relief, decrease anxiety and to promote patient safety in relation to life-saving treatments. A comprehensive practice guideline focused on ways to implement evidence-based sedation and analgesia practices was developed, disseminated and implemented by an interprofessional team in the pediatric intensive care unit (PICU) at the Children's Hospital of Eastern Ontario (CHEO) in Ottawa, Canada. The goals of this quality of care initiative were to (1) reduce inconsistent practices, (2) improve patient outcomes related to comfort, and (3) enhance collaboration among health care team members caring for critically ill children. An evidence-based sedation and analgesia management (SAM) guideline for critically ill, intubated and ventilated infants and children was developed over a six-month period by a team composed of PICU physicians, pharmacists and nurses. The quality of patient care initiative focused on consistent use of (a) validated sedation and analgesia assessment tools, (b) a goal-directed approach by identifying daily therapeutic target scores and titrating interventions accordingly, and (c) non-pharmacologic, pharmacologic and adjunctive measures. The authors describe their experience in the development, dissemination and implementation of an interprofessional guideline directed at improving sedation and analgesia and patient safety in the PICU. Tools developed to support the practice change, challenges and lessons learned are shared.

Key words: collaborative practice, quality improvement, knowledge translation

Background

Sedation and analgesia management

The management of sedation and analgesia in critically ill children is complex and mandates a collaborative team approach to promote the use of evidence-based practices. Research in managing sedation and analgesia with adult critical care patients has been translated into "best practice" guidelines improving patient care (Chanques et al., 2006; Jacobi et al., 2002; Mehta et al., 2006). Applicability of this research in adults to the pediatric population is not straightforward, as certain pharmacotherapies such as propofol infusions are not approved for prolonged continuous sedation in children. The pharmacokinetics and pharmacodynamics of analgesics for children and adults are not the same (Berde & Sethna, 2002). In addition, strategies included in adult guidelines such as "sedation vacations" have not been widely adopted due to concerns of self-extubation. Findings from the adult literature as to the use of algorithms and goal-directed therapy are applicable to the pediatric population, as proposed by Playfor et al. (2006).

Knowledge translation

Translating research evidence into clinical practice is a current imperative in all sectors of health care and success requires interprofessional collaboration and creativity. Institutional customs and individual preferences continue to guide many clinicians' practices, although many clinicians strive to minimize what Graham et al. (2006) have called the Knowledge-to-Action (KTA) gap. Researchers suggest that the KTA process is a complex, poorly-understood and disorganized phenomenon and that single and passive dissemination of education materials is not effective in changing clinicians' practices. Current clinical practices often reflect poor translation of best clinical evidence and practice recommendations mainly due to a lack of resources and motivation (Bair, Bobek, Hoffman-Hogg, Slomka, & Arroliga, 2000; Turk, 2001).

Researchers of KTA identify that the uptake and use of practice guidelines are variable and influenced by many factors. Organizational context (e.g., culture, leadership and evaluation) has been consistently identified as influential in the use of research by nurses in their clinical practice (Gifford, Davies, Edwards, & Graham, 2006; Melnyk, Rycroft-Malone, & Bucknall, 2004; Pepler et al., 2005). The availability of user-friendly and accessible resources, teamwork and collaboration, and unit champions are factors that promote KTA at the unit level (Ploeg, Davies, Edwards, Gifford, & Elliott-Miller, 2007; Rashotte, Thomas, Gregoire, & Ledoux, 2008; Titler & Everett, 2001; Vazirani, Hays, Shapiro, & Cowan, 2005). Rashotte et al. (2008) suggest that a bundle of strategies including (a) an educational intervention, (b) KTA strategies such as unit-based champion activities and context-specific tools, and (c) resources (e.g., bedside reminders, unit educational sessions) combined to have had a synergistic effect on nurses' use of best practice guidelines for prevention of pressure ulcers in the PICU. Alternatively, it has been noted that nurses and physicians may choose not to implement practice guidelines for reasons such as unit norms, colleague expectations, clinical

expertise and experience in similar situations (Greenwood, Sullivan, Spence, & McDonald, 2000; Grimshaw, Eccles, & Tetroe, 2004). Arabi et al. (2007) suggest that the implementation of a multifaceted and multidisciplinary approach including point-of-use reminders, directed educational efforts, and opinion leaders is essential for the success of an ICU sedation protocol. In a one-year observational study of 131 children less than three years of age in a PICU in the Netherlands, Ista (2008) reports that three factors: (a) continuous involvement of a unit champion (research nurse), (b) a patient data management system that cued nurses to implement sedation assessment, and (c) the commitment of at least one physician in the PICU to develop and supervise the use of the protocol were influential in changing nurses' use of sedation assessment tools and a sedation medication protocol. Grol and Grimshaw (2003) propose obstacles to change in practice can arise at different stages in the health care system at the level of (1) the patient, (2) the individual professional, (3) the health care team, (4) the health care organization, or (5) the wider environment. They emphasize the importance of developing a good understanding of such obstacles to develop an effective intervention. In addition, strategies directed toward personal, unit and organizational change activities using a multiple intervention model have been proposed to enhance the uptake of evidence-based practices (Stevens, Lee, Law, Yamada, & Canadian Neonatal Network EPIC Study Group, 2007).

Context

During a unit strategic planning exercise, the PICU pharmacy, nursing and medical staff identified the implementation of strategies to address inconsistencies in sedation and analgesia practices as a unit quality improvement initiative in 2006. Nursing staff verbalized that treatment plans in relation to pain and sedation were based on practitioner preference and experience and that there was significant variability in the medical management of comfort. For example, adjunctive medications and a bowel protocol were not ordered by all physicians routinely for intubated and ventilated children in our unit. It was determined that a collaborative and creative approach was essential to develop, disseminate and implement practice changes. The PICU at CHEO is a 10-bed unit in which children aged newborn to 18 years receive tertiary level intensive care. More than 700 patients admitted yearly require specialty level of care for a variety of conditions including medical, cardiovascular surgery, neurosurgery, trauma management and extracorporeal life support. The health care team is composed of dedicated pediatric critical care physicians, nurses, pharmacists, respiratory therapists, physiotherapists, social workers and pastoral care support. Resources to support nursing clinical practice include a full-time advanced practice nurse/clinical nurse specialist, a half-time nurse educator and three nurse clinical leaders.

The project

In 2007, an interprofessional team composed of three critical care physicians, an advanced practice nurse (APN) and a unit-based clinical pharmacist focused on ways to enhance the use of research evidence related to sedation and analgesia in critically ill children to (a) reduce inconsistent practices, (b) improve patient outcomes related to comfort, and (c) enhance collaboration among health care team members caring for critically ill children. Goal-directed sedation therapy is the recommended standard in adult critical care practice to (a) avoid over-sedation, (b) promote earlier extubation, (c) reduce length of ICU stay, and (d) prevent potential consequences of prolonged intubation and ventilation such as ventilator-associated pneumonia (Chanques et al., 2006; Jacobi et al., 2002). Without agreed-upon target levels of sedation, different members of the health care team may have disparate treatment goals, which could negatively impact patient outcomes (Slomka et al., 2000). Using best practice evidence, the team collaborated on the following initiatives: (a) development of a sedation analgesia management (SAM) practice guideline, (b) revision of the standards of nursing care for pain management, and (c) dissemination of these practice changes to all interdisciplinary health care team members using a KTA framework that incorporated reflective practice activities, point-of-care reminders, chart audits and knowledge and attitude surveys. This quality care initiative focused on consistent use of (a) validated sedation and analgesia assessment tools, (b) goal-directed approach by the identification of daily therapeutic target scores and titration of interventions accordingly, and (c) non-pharmacologic, pharmacologic and adjunctive measures.

The Process

A. Development of the SAM practice guideline

Best practice evidence recommends the assessment of sedation and analgesia levels using validated tools and the titration of pharmacologic interventions to achieve targeted sedation goals using protocols, guidelines or algorithms (Playfor et al., 2006). Consequently, over a period of six months, the interprofessional team identified the available pediatric evidence to support the development of a guideline to direct our practices in providing analgesia and sedation to critically ill ventilated children in our unit.

Assessment tools. The goal of using validated sedation and analgesia assessment tools to reduce subjective impressions was identified as a priority by the interprofessional team. The sedation and analgesia literature (Acello, 2000; Bear & Ward-Smith, 2006; Brinker, 2004; Carnevale & Razack, 2002; Curley, Harris, Fraser, Johnson, & Arnold, 2006; Grap, Pickler, & Munro, 2006; Long, Horn, & Keogh, 2005; Razmus & Wilson, 2006; Van Dijk et al., 2000) was reviewed by the APN in conjunction with the unit Pain Resource Nurses (PRN). Assessment tools that were user-friendly, validated in similar populations and showed promise in helping the teamwork towards a goal-directed approach to therapy were identified. The team chose to adopt the use of two scales—(a) the State Behavioural Scale (SBS) (Curley et al., 2006) in relation to ease of use, and (b) the Modified Comfort Scale (MCS) (Carnevale & Razack, 2002), as no single tool to adequately address analgesia and sedation management in the ventilated children has been identified. The nursing review group felt it important to use the MCS based on our familiarity and past experiences in using the COMFORT scale (Van Dijk et al., 2000) in conjunction with the SBS, which, at the time of this project, had not been widely adopted in Canadian pediatric intensive care units.

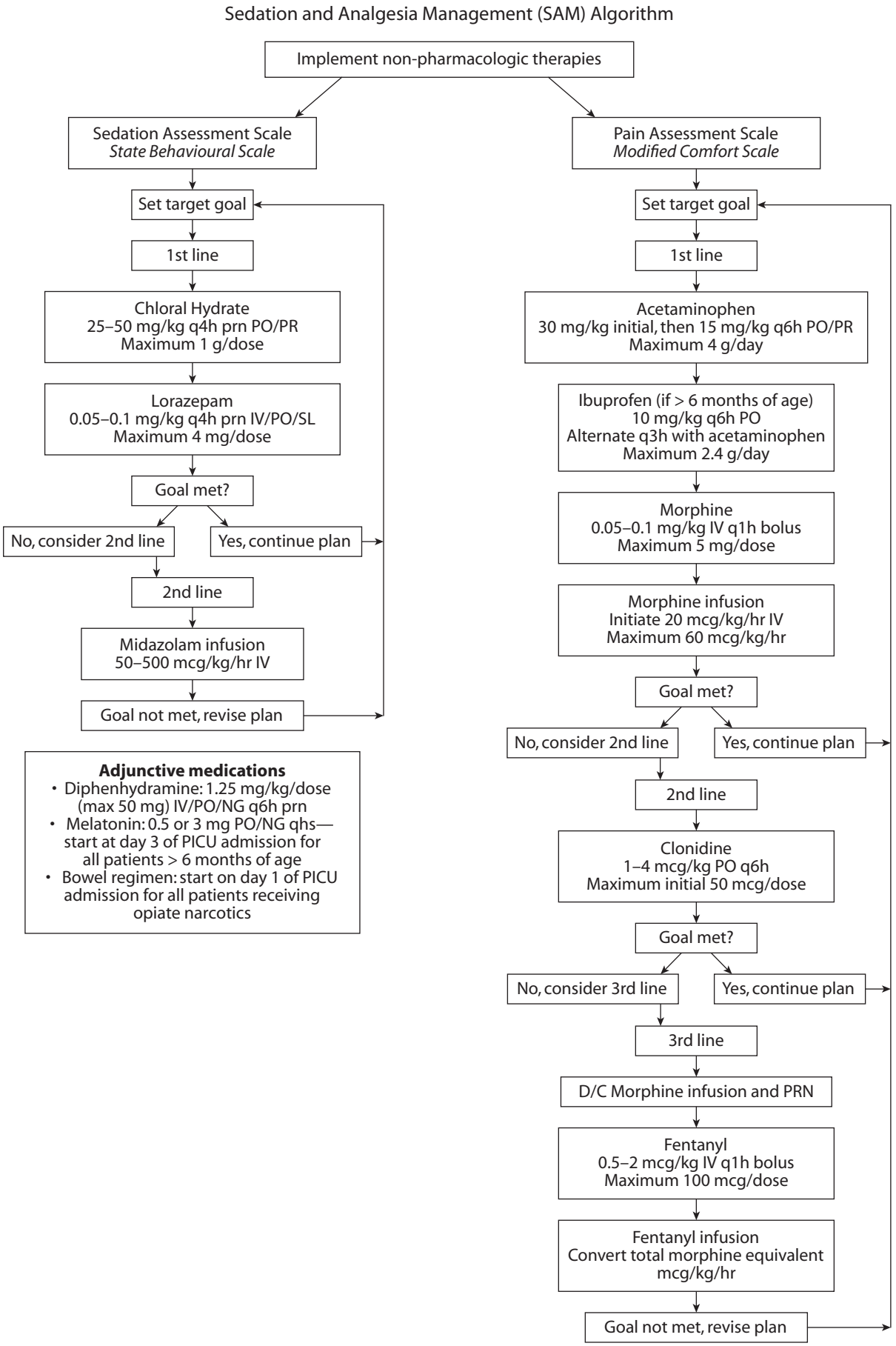

Figure 1. Algorithm

Pharmacologic measures. The pharmacist and critical care physicians reviewed current literature from a MEDLINE search related to the management of pain and sedation in critically ill adults and children (American Academy of Pediatrics, 2000; Aranda et al., 2005; Baker et al., 1999; Berde & Sethna, 2002; Boswinkel & Litman 2005; DeJonghe et al., 2005; Kemp, Biswas, Neumann, & Coughlan, 2004; Mehta et al., 2006; Plaisance & Ellis, 2002; Rainbow Babies and Children's Hospital, 2006; Richman, Baram, Varela, & Glass, 2006; Samarkandi et al., 2005; Schechter, Berde, & Yaster, 2003; Smits, Nagtegaal, van der Heijden, Coenen, & Kerkhof, 2001; Smits et al., 2003: Tobias, 2000, 2005). The evidence was reviewed and discussed in an open forum at five group meetings. The group decided on a stepped treatment guide (Berde & Sethna, 2002) commencing with the least invasive pain management strategies including (a) non-pharmacological measures, and (b) enteral administration of non-steroidal anti-inflammatory drugs. The practice of alternating administration of acetaminophen and ibuprofen was identified to reduce the total dose of either of these medications. The second step called for the addition of parenteral opiates and benzodiazepines. Morphine is the initial opiate administered, followed by fentanyl, as necessary, to achieve the targeted pain goal. Benzodiazepine administration begins with lorazepam intermittently and moves to midazolam per continuous infusion, as necessary, based on achievement of targeted sedation goals (Richman et al., 2006). Consensus was used to develop an algorithm (Figure 1) as part of the care guideline using the evidence reviewed to support the use of (a) target goals for sedation and analgesia, (b) adjunctive medications, (c) a bowel protocol, and (d) dosing and sequencing of the opiate and benzodiazepine medications. In addition, other Canadian pediatric intensive care practitioners were surveyed regarding their current sedation and analgesia management practices and guidelines. Our team agreed to develop and implement an approach specific to our unit due to contextual differences (number of beds, types of patients and background of team members) between our unit and those surveyed and the lack of a current "gold standard" for pediatric sedation based on randomized clinical controlled trials.

The SAM guideline was developed to promote goal-directed, evidence-based care for intubated ventilated children in the PICU. It was important to keep in mind that each patient and disease process is different and that no one approach can ensure optimal outcomes for all children. The guideline was developed to be intended for the majority of mechanically ventilated children aged newborn to 18 years. The use of this algorithm assumed a patient-centred flexible approach.

Non-pharmacologic measures. The APN had identified that nurses did not consistently maximize non-pharmacologic measures to promote comfort in our patient population. Following a review of the literature (Byers & Thorney, 2004; Ellis, Sharp, Newhook, & Cohen, 2004) and discussion with the interprofessional team, specific non-pharmacological aspects of nursing care including (a) modification of environmental stimuli (light and noise), (b) positioning, (c) therapeutic touch, (d) application of heat, (e) use of oral pacifiers, (f) administration of sucrose 24% for infants less than six months of age, and (g) distraction were embedded into the revised PICU standards of nursing care for pain management (CHEO, 2007). The implementation of non-pharmacologic measures was identified as the first step for all patients prior to consideration of any pharmacologic agent, as they are readily modifiable and within the scope of practice of nurses as supported by Playfor (2008).

B: Dissemination of the SAM practice guideline

The development of practice guidelines alone is not enough to improve patient care, and education alone does not change practice (Berry & Dahl, 2000). A multifaceted strategy (Table 1) that included education and practice supports for physicians and nurses was developed by the PICU APN and nurse educator to meet the following objectives:

- To verbalize understanding of the purpose and evidence supporting the implementation of the SAM program in the PICU.
- To demonstrate competency in the use of assessment tools in caring for mechanically ventilated children.
- To verbalize increased awareness of the underlying rationale and effectiveness of the use of non-pharmacological measures to promote comfort.
- To demonstrate increased accountability for patient comfort.

During guideline development, the team presented updates on our progress at unit staff and partnership council meetings. Unit staff was aware that there was an ongoing interprofessional initiative in the unit to improve comfort practices for the population of intubated/ventilated children. Research articles that supported the use of guidelines as a means of improving consistency in practice were posted weekly in advance of implementation of the guidelines. In addition, the evidence used to support the components of the guidelines (non-pharmacologic and pharmacologic strategies) was posted within the unit, as the article of the week. In-service sessions for nurses and physicians were provided by members of the interprofessional team. The pharmacist worked closely with nursing staff to understand and incorporate a change in the administration of opioid and sedative infusions using a standardized drug concentration approach based on the evidence from a research study completed at CHEO (Irwin et al., 2008). Prior to the launch of the guideline, posters outlining the assessment tools were affixed to the walls in the patient care rooms. The algorithm, adjunctive medications, opioid equivalency charts and assessment tools were printed and placed within the bedside binders to serve as an immediate resource for clinical staff. In addition, shortcuts to the assessment tools were placed on the desktop of the WOWS (workstations on wheels), which are used by the health care team during patient bedside rounds.

The use of teaching rounds led by a clinical nurse specialist has been suggested as a method of improving pain management skills in clinical nurses (Twycross, 2002). Therefore, a flip chart poster was created by the APN to highlight the upcoming introduction of the SAM guideline. The flip chart was used by the APN during bedside teaching rounds over a period of four weeks with nurses to introduce the concept and components of the SAM guideline.

As the PICU standards of nursing care for pain management were revised to incorporate the components of the SAM guideline, staff was updated as to the rationale and evidence to support the changes to our expectations of nursing practice. Communication strategies during the one-month lead-up to the go live date included posters, messages at staff meetings and the APN newsletter. Trainee physicians received printed copies of the guideline and were coached by the PICU staff physicians to incorporate the algorithm into the medical plan of care during morning rounds. In addition, the unit orientation program was revised to include a didactic session with the APN focusing on the assessment of pain and the use of non-pharmacologic measures to improve patient comfort. A survey, based on the work of Manworren (2001), Horbury, Henderson and Bromley (2005) and Twycross (2002), to determine the practitioners' level of knowledge in relation to these care aspects and attitudes towards sedation and analgesia management was sent electronically to unit nursing staff two months prior to the implementation of the guideline in our unit. The results (return rate of 48%) analyzed by the APN suggested that, although nurses had theoretical knowledge related to pain assessment and management strategies in critically ill children, this knowledge was not consistently used in practice. Misconceptions that have been previously noted about pain in children (Mullen & Pate, 2006) were not evident in the nursing survey responses. The results indicated that all

Table 1. Education and Practice Supports

Strategy	Content	Timeline and continued activities	Responsibility
Article of the week	• Tobias (2005) Sedation and analgesia in the PICU. • Brinker (2004) Sedation and comfort issues in the ventilated infant and child. • Byers & Thorney (2004). Cueing into infant pain. • Curley et al. (2006). State Behavioral Scale: A sedation assessment instrument for infants and young children supported on mechanical ventilation	Weekly starting two months before target go live date	APN
Independent reflective activity	• Knowledge and attitude survey (Manworren, 2001) completed, discussed with a colleague • Learning plan developed	One month before go live date	APN
Bulletin board presentation	• Introduction of algorithm • Explanation of assessment tools (MCS, SBS)	Two months before go live date	NE
Enhancing access to assessment tools	• WOW icon in place • 4 Posters of SBS and MCS produced, laminated and placed in patient care areas	One month prior to go live Weekly reinforcement of use of assessment tools by APN on walkabout rounds with PICU nursing staff	NE and APN
Bedside nursing in-services	• Small group discussion to introduce evidence to support the assessment tools, SAM algorithm	Three times/week one month before go live date Presentation to all PICU RN staff on orientation continues	Pharmacist, APN and NE
Bedside teaching rounds with resident physicians and nurses	• Bedside coaching on use of assessment tools • Dialogue with health care team on issues of pain and sedation management on a case-by-case basis	Three times/week one month before go live date Fellows/residents receive teaching in relation to SAM during clinical rotation	Pharmacist, APN, NE, and MD champions
PICU daily goal sheet	• Modified to incorporate components of assessment tools and algorithm • Involved discussion with unit quality management team	Day of go live Daily goal sheet completed daily by members of the interprofessional teams continues to present Latest revision of goal sheet January 2010	APN and MD champions
SAM pins	• Visual reminder of SAM algorithm, and assessment tools	Go live date	PRN, APN and NE

APN: Advanced Practice Nurse, NE: Nurse Educator, PRN: Pain Resource Nurse

respondents believed that the management of analgesia and sedation was a priority for their nursing care and that they valued an interprofessional approach to this aspect of caring for critically ill children. The development of the content of educational sessions and practice supports was informed by the findings of the survey.

C: Implementation of the guideline

The interprofessional team identified a specific date when key team members would be within the unit for the launch of the guideline. The team gathered prior to rounds to verify that the physicians, nurses and pharmacist working that day were aware of the purpose and nature of the guideline and supportive of implementation of the practice changes. Crucial to the success of this initiative to change practices is the role of champions—members of the health care team who (a) are well versed in the practice change, (b) understand the rationale and evidence supporting that change, (c) are considered credible experts by the staff in the unit, and (d) are committed to making a practice change happen. The three physicians and APN involved in the development of the guideline and the unit pain resource nurses role modelled the practice change as unit champions. Similar to others (Arabi et al., 2007; Alexander et al., 2003; Rashotte et al., 2008) specific KTA activities were purposefully selected to enhance the uptake and sustainability of this practice change in the unit. The APN revised a point of care reminder (the daily goal sheet) to incorporate components of the SAM into the bedside dialogue on rounds.

Results

The goal of the project was to enhance the use of research evidence related to sedation and analgesia in critically ill children in order to:

- reduce inconsistent practices,
- improve patient outcomes related to comfort,
- enhance collaboration among health care team members caring for critically ill children.

To examine progress towards the goals of this quality improvement project, we used a survey, direct observation, and focused interviews to see and hear how staff used the guideline. In addition, we evaluated the multiple dissemination strategies used for this project.

Consistency in practice

To determine our progress towards reducing inconsistent pain management practices, use of the SAM guideline has been evaluated over time. Response rates for an online survey administered to staff three months after the implementation of the SAM guidelines were 33% for physicians, 100% for pharmacists, 29% for registered nurses, and 26% for respiratory therapists. 85% of RN respondents indicated that they had discussed the SAM guideline two to nine times in the previous two weeks; whereas physicians and pharmacists indicated that they had referenced the guideline more than 10 times in that same timeframe. There has been increased documentation and communication of sedation and analgesia goals and interventions by both nursing and physician staff. Prior to the implementation of the guideline, a review of nursing documentation identified that the assessment of pain and sedation in intubated and ventilated children was not documented. Findings from the online survey about the use of unit assessment tools (Table 2) identify that practitioners used a variety of tools and support the premise of ensuring that information can be accessed in a variety of modalities. The majority of respondents indicated that they used the bedside paper resources rather than the online (workstation on wheels) resources to support their discussions of sedation and analgesia management strategies.

One month following the launch of the SAM guideline, three PICU pain resource nurses completed chart audits of 10 patients for whom the SAM guideline was applicable to evaluate the use of the guide and the frequency of documentation of sedation and analgesia assessment scores.

Table 2. Use of tools by discipline

	Nurse (n=14)	Respiratory Therapist (n=6)	Physician (n=4)	Pharmacist (n=2)
Assessment tools on bedside computer	3 (21%)	0 (0 %)	2 (50%)	0 (0 %)
Assessment tools in bedside manuals	14 (100%)	2 (33%)	3 (75%)	0 (0 %)
SAM algorithm in bedside manuals	11 (79%)	2 (33%)	4 (100%)	2 (100%)
Posters of SBS and MCS assessment tools	12 (86%)	2 (33%)	4 (100%)	2 (100%)

Table 3. Confidence that guideline has improved patient care by discipline

	Nurse (n=14)	Respiratory Therapist (n=4)	Physician (n=4)	Pharmacist (n=2)
Not at all	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Somewhat	0 (0%)	1 (25%)	1 (25%)	0 (0%)
Moderately	8 (57.1%)	0 (0%)	2 (50%)	0 (0%)
Very	6 (42.9%)	2 (50%)	1 (25%)	2 (100%)
Did not answer	0 (0%)	1 (25%)	0 (0%)	0 (0%)

MCS and SBS scores were documented at least once per shift on all patients and the medical treatment plan reflected the SAM guidelines in six out of 10 patients. Not only did this give the team a sense of the degree of uptake of the practice change, but nursing staff verbalized that completing the audit directly enhanced their knowledge of the process and made a difference in how they cared for their patients following the audit completion, supporting the proposal that audit and feedback are effective strategies in changing clinical practice (Stevens et al., 2007).

An audit of the daily goals checklists two years after the implementation of the guidelines indicates that the SAM approach is discussed at rounds on more than 80% of patients who are intubated and ventilated. As well, in a recent audit completed by the APN, 15 of 20 medication profiles included the sedation and analgesia regimens of the SAM guideline.

Improvement in patient outcome

In the online survey three months after implementation of the SAM guideline, staff members were asked if they perceived that patient care had improved. Table 3 identifies responses by discipline. Eighty per cent of respondents felt moderately to very confident that the use of the SAM guideline promoted improved care in our unit. The APN conducted three focused interviews with the unit clinical leaders to evaluate patient outcomes of the guideline. The respondents shared that because nurses are able to anticipate the pharmacologic regimen in the guideline, medication infusions can be prepared prior to the admission of the patient, thereby increasing efficiency in the administration of comfort measures to this population. As well, this group has observed an improvement in relation to reducing constipation in this population. As prior to the implementation of the guideline we did not use validated measures of pain or sedation for intubated and ventilated children, we are unable to measure objective change in patient comfort over time.

Enhanced collaboration

During bedside rounds, the team identified that daily reminders of the SAM guideline would continue to enhance uptake. In response, components of the guideline were included in the PICU daily goals checklist to cue daily collaborative discussion of pain management strategies on interprofessional rounds. We continue to observe that unit clinical leaders are more consistent and confident in promoting the team discussion on rounds in relation to pain management in this population. Discussions on rounds reflect a more collaborative approach with nurses, pharmacists and physicians equally contributing to the plan of care through suggestions for target goals, titration of medications, and use of adjunctive medications.

Dissemination strategies

In disseminating this interprofessional practice change, we employed multiple independent and group activities. We sought feedback from all disciplines in relation to the use of the education and practice support strategies. Table 4 identifies strategies used by discipline. Nurse and physician respondents used a greater variety of sources of information about the guideline than did the pharmacist and respiratory therapist respondents. Nursing staff identified that the informal bedside information sessions, one-on-one bedside coaching, and attending a nursing in-service on the unit were more helpful than self-directed learning packages posted on the unit or distributed by the email systems to learn about the program. In the evaluation of the in-services offered, one nurse shared, "It was really important that nurses, physicians, and respiratory therapists all learned together". In contrast, the physician and pharmacist respondents indicated that they predominantly used self-directed learning activities such as reading the posted research and the SAM document.

Discussion

Throughout this quality initiative the team has learned some valuable lessons. First, it is not easy to sustain change in collaborative practices across a variety of health care team members. Prior to the implementation of the SAM guideline, nurses in the unit did not consistently use any validated sedation/pain tools to assess and communicate the comfort status of intubated/ventilated patients. Now we note that when unit nurses incorporate this information in the dialogue during rounds, the use of the pharmacologic algorithm by physicians is facilitated. Suggestions to improve the update of this practice improvement, as identified in the online survey from physicians included ensuring (a) that nurses present their

Table 4. Use of dissemination strategies by discipline

	Nurse (n=14)	Respiratory Therapist (n=4)	Physician (n=4)	Pharmacist (n=2)
Attended unit in-service presented by APN	8 (57%)		1 (25%)	
Attended meeting with colleagues	4 (29%)		2 (50%)	2 (100%)
Learned about SAM during report/rounds	5 (36%)	3 (75%)	1 (25%)	2 (100%)
Read articles posted in unit	5 (26%)		2 (50%)	2 (100%)
Completed self directed learning activity about beliefs/values	2 (14%)		1 (25%)	
Read the SAM document/guideline	10 (71%)		4 (100%)	2 100%)
Reviewed PowerPoint presentation prepared by APN	6 (43%)	1 (25%)	3 (75%)	

assessment using the MCS and SBS, and (b) the tools were very visible throughout the unit, consistent with the recommendations of Ploeg et al. (2007). This observation is similar to the findings of Ista, de Hoog, Tibboel, and van Dijk (2009) and of Stevens et al. (2007) regarding "the importance of a multidisciplinary approach (e.g., a representative from each major discipline in the unit) for integrating clinical changes in a hospital unit" (p. 292).

Another lesson learned is that when a practice change is not seen as having a significant and direct positive patient outcome, its uptake is not viewed as an imperative within unit practices. Although the management of pain and sedation of intubated and ventilated children remains a priority in our unit, the patient consequences of not incorporating the SAM guideline remain covert. It may well be that changes in clinical practice are only partly within each practitioner's control. The extent of the uptake and use of evidence-based practice changes is largely influenced by the individual, unit, organizational and professional culture towards quality. In this project, ongoing innovative strategies to continue to sustain the change in nurse and physician practices, behaviours and attitudes continue to be essential today. One year later, reinforcement of all components of the guidelines (use of assessment tools, daily sedation targets, and consistent use of pharmacologic and non-pharmacologic measures) by unit champions continue to be needed at least weekly within our unit although 75% of physicians and 100% of nurses who responded to the online survey indicated that they were moderately to very confident that the SAM guideline improves sedation and analgesia management in the PICU. Strategies including ongoing audits with feedback of results to staff in a timely manner, bedside coaching with practitioners, unit contests and gaming activities continue to be implemented monthly. These findings lend support to the findings of another KTA study completed in our unit (Rashotte et al., 2008) examining the impact of a two-part, unit-based, multiple intervention on the use by pediatric critical care nurses of best practice guidelines for pressure ulcer prevention.

It is important to acknowledge that practitioners may purposefully choose not to implement practice guidelines for reasons such as unit norms, colleague expectations, clinical expertise and experience in similar situations (Greenwood et al., 2000; Grimshaw et al., 2004). The APN has noted during rounds and bedside coaching sessions with staff that some nurses and physicians feel that the SAM guideline does not fit some patient populations and, consequently, they do not see the value in using a standardized and consistent approach. During the evaluation survey one nurse had suggested that the presence of the APN on rounds to clarify misconceptions was helpful in promoting the use of the guideline. When the current evidence is shared through discussion on rounds, participants indicate that although the guideline is a valuable improvement in our unit, the needs of each patient are unique and must be considered in developing a plan of care. Grol and Grinshaw (2003) propose that obstacles to change in practice can arise at different stages in the health care system: at the level of (a) the patient, (b) the individual professional, (c) the health care team, (d) the health care organization, or (e) the wider environment. Most theories on implementation of evidence in health care emphasize the importance of developing a good understanding of such obstacles to develop an effective intervention. To continue to support these practice changes in our unit, we have purposefully imbedded the pain and sedation assessment tools within our electronic documentation system that has been implemented this year. Another organizational support is the inclusion of the assessment tools used in the SAM guideline in the work of the procedural sedation team at CHEO.

We have learned throughout this project that monitoring success in achieving the goals of a quality improvement project can be as challenging as implementing the practice change itself. The response rate to the online survey sent to staff was small, thus making it difficult to generalize the findings to all unit staff. In our next quality improvement project focused on weaning of analgesia and sedation in critically ill children, we will ensure that surveys are offered both online and in hard copy to facilitate an increased response rate. We will schedule specific evaluation activities at three months, six months and at one year after implementation of this project to more fully explore the challenges of sustaining a practice change. As well, the APN will schedule specific focus group sessions with all staff at predetermined timeframes to collect feedback from unit staff. In addition, a focused observation tool will be developed to be used by the APN to gather data when attending interprofessional rounds.

We have learned that, indeed, Knowledge to Action is complex. We have shared our experience in the development, dissemination, and implementation of an interprofessional guideline in a Canadian PICU. Establishing interprofessional teams requires commitment and passion to sustain the efforts involved in sustaining practice changes in a clinical environment.

How do I apply this information to nursing practice?

In implementing evidence-based practice changes in complex clinical environments, nurses need to consider implementing the following strategies:

1. Interprofessional teams committed to working with nurses to develop and sustain the practice change.
2. Unit-based interprofessional champions who are committed to acting as role models for the practice change.
3. Educational programs that include weekly research postings, independent reflective learning activities, self-assessment surveys, bedside teaching rounds and group in-services directed at all members of the interprofessional team.
4. Practice support activities that include bedside coaching, role modelling and visual reminders (posters and checklists).

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Novice nurses' first death in critical care

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Abstract

Background: *The curative focus of critical care and the advanced technology may overshadow the fact that critically ill patients die. Research investigating critical care nurses' involvement with death has predominately focused on experienced nurses, but these findings may not be applicable to novice nurses. Increasingly, novice nurses are beginning their careers in critical care and there is minimal research describing their experiences with death.*

Purpose: *To explore the experiences of novice nurses with their first patient death in critical care.*

Method: *Approval was received by the University of Alberta Health Research Ethics Board and the health region's Nursing Division Administration to conduct a qualitative research study. Five nurses, employed in a medical-surgical intensive care unit, participated in the study. Data collection involved an unstructured interview with each participant.*

Findings: *Analysis of the data revealed five themes: anticipating death, transition from life to death, the moment of death, being with the family, and carrying on. These findings are discussed with implications for academic and clinical settings and suggestions for future nursing research.*

The curative focus of critical care, advanced technology and life support measures can overshadow the fact that critically ill patients often die. Critical care education emphasizes assessment skills, timely interventions, and resuscitation protocols, potentially leading nurses to view death as failure. Low patient:nurse ratio facilitates interaction with patients and their families and can lead to significant nurse involvement with dying patients. Although death and dying occurs regularly in critical care, it often receives little attention in academic or clinical settings (Delaney, 2003; Simpson, 1997).

According to Dr. C. Pooler, who provides critical care education in the region, increasing numbers of novice nurses are beginning their careers in critical care in the health care region where the data for the study was collected (personal communication, October 1, 2010).

A novice nurse is a registered nurse (RN) who graduated from an accredited and/or approved nursing program, successfully passed the Canadian Nurses Registration Examination and is employed in critical care within 12 months of graduation. Previously, RNs hired to critical care had approximately two years of acute care experience. However, recently managers have employed novice nurses to maintain staffing levels and fill vacancies. Novice nurses with limited practice experience and without exposure to death and dying during their nursing education may find themselves unprepared to deal with this aspect of critical care nursing.

Transition from nursing student to graduate nurse is stressful (Boychuk Duchscher, 2009; Ross & Clifford, 2002) and novice nurses may experience reality shock when they realize their nursing education program may not have adequately prepared them for clinical practice (Kramer, 1974). Although novice nurses increasingly work in critical care, research describing their experiences with patients' death is limited. The first death experienced by novice nurses may potentially affect their future view of death and their response to dying patients.

Literature review

A comprehensive literature review was completed using CINAHL, HealthSTAR/OVID, PsychINFO, MEDLINE, and ERIC databases based on key words *death and dying, nurses, novice* or *graduate nurses, nursing students, critical care* or *intensive care, terminal care* or *terminally ill patient, patient death,* and *attitude to death*. The review focused exclusively on nurses' experiences with deaths of adults. Research studies were reviewed for appropriateness based on the title and abstract. Published studies' reference lists were also examined for authors not captured in the initial search.

In *Awareness of Dying,* physicians and nurses who frequently encountered death and dying tended to avoid dying patients (Glaser & Strauss, 1965) leading them to feel ineffective and uncomfortable in caring for dying patients. Nurses' involvement with dying patients was a source of emotional distress. Quint (1967) investigated how nursing programs prepared student nurses for their involvement with death and dying and revealed that their first encounters could influence their future responses.

Several authors have identified the importance of preparing student nurses to deal with death and dying through death-related discussions and work with dying patients in clinical settings (Hurtig & Stewin, 1990; Mallory, 2003; Quint, 1967). According to Goodwin (2005), death education was part of curricula in most Canadian baccalaureate programs (82.9%). One-third of respondents expected their students to care for a dying patient during their program while only 25% believed their students felt prepared to care for a dying patient when they graduated (Goodwin, 2005).

Research studies examining nurses' experiences with death and dying in critical care settings primarily involved experienced nurses (Badger, 2005; Isaak & Paterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; McClement & Degner, 1995; Simpson, 1997; Yang & Mcilfatrick, 2001). Badger identified participants with one month of critical care experience, but did not report findings specific to novice critical care nurses. Nurses with less than two years of practice experience commonly reported fear and guilt after the death of a patient (Yang & Mcilfatrick, 2001). According to Simpson (1997), inexperienced nurses had more difficulty understanding decisions to continue or withdraw treatment than their experienced colleagues.

Experienced critical care nurses identified the importance of ensuring a good death for dying patients and their families (Halcomb, Daly, Jackson, & Davidson, 2004; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; McClement & Degner, 1995; Simpson, 1997). However, for them the most distressing aspects of end of life were exclusion from discussions to withdraw treatment, dissension among family members, providing futile care and perceptions of torturing patients (Badger, 2005; Halcomb et al., 2004; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; Simpson, 1997). Experienced nurses coped with patients' deaths by focusing on patients and their families' needs, and talking about their experiences with colleagues.

Two phenomenological studies specifically addressed the experiences of novice nurses with death and dying in acute medical settings (Hopkinson, 2001; Hopkinson, Hallet, & Luker, 2003). Participants were employed as RNs for two to 36 months with an average of 12 months. Hopkinson reported that novice nurses felt unprepared to interact with dying patients and their families and had difficulty knowing what to say or do, especially when they didn't know them. Hopkinson et al. (2003) explored qualified staff nurses' perspectives of caring for dying people in U.K. hospitals' medical wards. Nurse participants believed dying patients should receive a certain type of care and had specific views of an ideal death that evolved with time and experience. Caring for dying patients exposed nurses to situations that differed from their personal ideal and they experienced tension if their ideal was not realized during patients' deaths, resulting in feelings of helplessness, guilt, uncertainty, frustration and anger. The RNs were not able to answer questions posed by patients and/or family members because they lacked the knowledge or experience with death and dying. They also described feelings of being alone resulting from death-related events or lack of understanding from others. They used several strategies to avoid tension and promote personal comfort and a sense of acceptance and satisfaction.

Literature about student nurses' experiences provides their perspective with their first death and may be applicable to novice nurses. Student nurses who cared for dying patients reported feeling fear, sadness, frustration, anxiety, uselessness and guilt (Beck, 1997; Cooper & Barnett, 2005; Kelly, 1999; Wong & Lee, 2000). They felt anxious when they didn't know what to say or do (Beck, 1997; Cooper & Barnett, 2005; Kelly, 1999). Entry-level students viewed death as a negative aspect of nursing but recognized the rewarding features of caring for dying patients (Kiger, 1994). Novice and student nurses felt unprepared to deal with dying patients and their families and as a result felt inadequate. Novice nurses learned to care for dying patients through experience and by observing their colleagues in similar situations.

Experienced, novice, and student nurses identify a desire to ensure a good death for dying patients. While students and novice nurses often need to reconcile their image of such a death to what they encounter in the clinical setting, experienced critical care nurses struggle with futile or prolonged care, family dissension, and lack of involvement in the decision-making process to withdraw or withhold treatment. Relationships with patients and families (or the lack of it) influence nurses' responses to patients' deaths. The literature reveals a gap in our understanding of novice nurses' experiences with death and dying, as it is primarily focused on student and experienced nurses. Thus, the purpose of this study was to explore the experiences of novice nurses with their first patient death in critical care.

Method

This study used interpretive description, a non-categorical qualitative method for developing nursing knowledge (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Interpretive description is generated through questioning, using reflective techniques, and critical examination. The goal of interpretive description "is a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon being studied and also accounts for the inevitable individual variations within them" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p. 7).

Five participants (whose pseudonyms became Lynn, Billie, Striker, Leslie, and Gail) employed full-time in a Canadian tertiary care hospital were recruited. The research was approved by the University of Alberta Health Research Ethics Board and the health region's Nursing Division Administration. Inclusion criteria were employment in critical care within 12 months of graduation and experience with the death of an assigned patient. The type of death, whether sudden or expected, and the quality of the death, either good or bad, was not the focus of this project. Unstructured interviews were used to obtain descriptions of novice nurses' experiences with their first patient death. Participants were asked to "*Tell me what happened when your patient died*." The overall research question was "*What did you experience when your first patient died?"*

The analytic framework of interpretive description encourages questions such as "what is happening here?" and "what am I learning about this?" (Thorne et al., 1997, p. 174) to explore novice nurses' experiences with the death of their first patients in critical care. Data analysis begins with data collection, as each interview is compared to the previous ones to determine similarities and differences while being attentive to unique individual aspects. A summary of each participant's experience was created and titled with a phrase using their own words that captured its essence. Their words appear in italics.

Findings

Analysis of the novice nurses' experiences with their first death in critical care revealed five themes: anticipating death, transition from life to death, the moment of death, being with the family, and carrying on. **Anticipating death** was the first theme that emerged as nurses realized during report that their assignment involved a dying patient. Lynn, Leslie and Gail described being told that their patients were expected to die during the next 12 hours. Leslie started by saying: *I got my report from the nurse and we knew it was compassionate care at that point*. Gail's patient assignment posed another challenge: *I came on shift and realized I was doubled… but when I approached the two bedsides, one was withdrawal of treatment*. Anticipating death includes an element of the unknown. Although some of the nurses expected their patients to die, they did not know when this would occur. Striker's patient was receiving active treatment and the unknown hinged on whether the patient would respond to a transvenous pacemaker (TVP). Her ICU experience played a role in anticipating death, as she assessed and monitored her patient.

That's why I was looking at the monitor. Because I thought, "He's really sick, I wouldn't be surprised if I turned him and didn't see anything." I thought that in my head. That's why I was watching the screen.

In Billie's situation, anticipating death evolved as the futility of continuing treatment became apparent and treatment was withdrawn.

Nurses who work in ICU expect to encounter death and dying. The participants had worked in ICU for approximately six months when they experienced their first death. It is likely they had observed or assisted their colleagues caring for dying or deceased patients. Gail acknowledged: *Every day that you go in there [ICU] you're hoping that your patient is not withdrawal of treatment and then, finally, one day you are withdrawing treatment*. Billie noted: *I knew that is the place I would go and probably see the most death*. Leslie described the timing of her first patient death: *About five to six months after I started working there. It wasn't soon, I don't think, but it was soon enough*.

Despite these expectations of encountering death, novice nurses can feel unprepared. Participants expressed feelings of nervousness, avoidance, distress, and surprise. Lynn reported feeling nervous because it was her first death. Leslie's response to her assignment was: *Can I go home? I just wanted to go home*. Gail stated: *It was quite an overwhelming experience knowing not only [that you] you doubled, but one of your patients is withdrawal of treatment*. Striker indicated: *… it will be two years and I've never had my own patient die. So it was different*. Although Billie expected to encounter death in ICU, she responded, *I hadn't really thought about it in the context of "I'm starting work and this is going to happen."* The emphasis in critical care on life-sustaining technology may have seemed incongruent with caring for dying patients. Striker, who had worked in ICU the longest, described her first death as *different*. This was the first time death had terminated her care for a patient. Transferring patients to another unit is quite different than sending them to the morgue. Knowing patients die in ICU is one thing; being responsible for a dying patient and their family members is another; it is a significant event.

The second theme, **transition from life to death** encompasses their experiences of presiding over their first death and observing their patients' passage from life to death. Transition suggests a change or movement towards something different or new. The nurses described what they saw, heard and felt as their patients died. Leslie described the changes she observed: *When I first came on she didn't look well, pale, sleeping and… not responding. But throughout the night… the mottling in the hands, the feet, and the back; very cool to touch. The skin temperature was cold, cold, cold*.

Gail found the sound of her dying patient disturbing:
… the sounds of someone being withdrawn from [treatment]… he was basically drowning on his own [secretions]… it was scary for me, but I can't imagine what the family felt when they heard this.

These first experiences of caring for dying patients may have exposed the nurses to aspects of death and dying they had not considered. Responsibility for dying patients and family at the bedside was daunting, as the nurses watched and waited as their patients' lives gradually ebbed away.

Time was an element. Lynn waited several hours before her patient was withdrawn from life support. Leslie also spent most of her 12-hour shift watching her patient's vital signs slowly drop. She recalls: *It was a long night… in a way I wish, just to make it easier on the family, make it easier on everyone… including the patient, just to let go*. In contrast, Billie's patient died soon after she initiated compassionate care and Gail's patient died at the beginning of her shift. Striker's patient died when the TVP failed to capture.

The nurses described their feelings, as their patients moved closer to death. Billie was surprised by how quickly her patient died even though she knew he could not survive the continuous blood loss. Leslie recalled how difficult it was to witness the gradual deterioration of her patient throughout the night:
It's hard to watch… You basically see it happen right before you. …I remember her daughter saying, "How long does this take? Sometimes I think this waiting is more hurtful than it just happening. Just happen, let me deal with it."

Leslie monitored both her dying patient and the daughter at the bedside. Despite her own discomfort with her patient's slow decline, she was acutely aware of the effect on the daughter.

Knowing how to treat their dying patients and interacting with family members was challenging. This was a new experience, one without procedures or protocols for guidance. The nurses identified colleagues as valuable resources of support and advice. According to Lynn:
I had help from more experienced nurses… they were really great with helping me through it… what I needed to tell [the family] and once we withdrew do I keep the monitor on… things like that that I didn't really know.

Leslie perceived experienced colleagues were less affected because of their previous exposure to patients' deaths.

We [watched the cardiac monitor] at the station, I just found it hard to watch… everyone else just glances at it … I guess they've seen it more than me.

Providing comfort measures was the focus of nursing care during the transition from life to death. The nurses also described being attentive to the appearance of their patients, as family members were often present. Billie explained priority of care when treatment was withdrawn:
Mouth care and trying to keep her clean and the linen not showing a lot of the blood. We put tape over the endotracheal tube tapes because they'd been totally covered in blood…

One of Gail's first actions was to suction her dying patient; she found the "death rattle" very upsetting, especially with his family in the room. Billie and Gail described disturbing aspects of dying and tried to minimize the effect on the family. Leslie involved her patient's daughter in the nursing care to lessen the long vigil:
I gave her a nice bath and the daughter wanted to stay… It was important that I turned her… and the daughter wanted to be in there, she wanted to help. And we put cream on her feet together and rubbed her back...

The nurses emphasized comfort measures such as eye, mouth, and skin care. Although this is standard nursing practice for patients in ICU, these familiar activities may have provided much-needed structure and may have provided a sense of accomplishment in a difficult situation.

As their patients' transitioned from life to death, the novice nurses were also transitioning. Their patients' deaths were a career "first".

Transition from life to death concluded at **the moment of death.** Striker defined the moment of death by the sudden change in her patient's electrocardiogram (ECG) tracing and the colour of his face. Lynn observed the following when treatment was withdrawn from her patient:
Basically nothing happened, his chest just stopped rising and falling and that was it. After he passed away, his face was blanched and he became cold quite quickly.

Gail recalls: *So I heard, I kind of glanced out at the monitor and I saw that he had gone asystole. Right away he was cold to touch and he was already getting stiff.*

Leslie summoned her patient's daughter when death appeared imminent:
I just had a feeling, I have to go get her daughter because it's starting to trend down, slower, slower, even though she was up and down all night. So, as we were walking back to the room things starting bonging off and I just peeked at the monitor and she was going. As soon as we walked in, the patient was taking her last.

Some of the visual and auditory signs of death were specific to ICU: pacing spikes without capture, asystole on the monitor and alarms ringing, while others were more common indicators of death: lack of respiratory movement, pallor, coldness and stiffness. The moment of death presented with a sense of abruptness, a sudden and irreversible transformation of being.

The emotional responses generated by their first death varied among the novice nurses. Although Striker knew her patient was critically ill and suspected he may not tolerate being turned, there was disbelief when he died.
I can't believe my patient actually just died. I didn't think, "Is there anything else we can do?" It was more like, "Whoa, this really happened to me. This patient actually died!"

Billie expressed these feelings while driving home:
And then, on the way home, I guess when you're driving is the first time that I sat back and went, "Okay, all of that happened, and whoa, oh my!" … Going home and going to bed was probably the worst.

This passage suggests a surreal quality to Billie's first day in ICU. The activity of the morning and the equally busy afternoon prevented Billie and her preceptor from discussing their patient's death. After work she acknowledged the personal impact of witnessing the death of a stranger:
It was almost like for some reason you feel like you have to grieve for these people even though it's kind of weird because you're only with them for… eight hours.

Leslie described her thoughts leaving work after her patient died:
I was like, okay, I go home now. It was just weird how… okay, my patient just passed on me and now I'm going home to bed, it was just such a weird… But I was sad… I wasn't angry, I was just sad. I just felt for the daughter and what she was thinking at that point and just how sad it really is.

Leslie was able to identify with the daughter's loss. This very significant event is finalized by the patient being sent to the morgue, the patient's daughter leaving the hospital, and Leslie going home. Lynn said of her reaction to her patient's death: *It's just weird. I felt with my first death I thought it was… there was just no connection there at all.* Assuming care for a patient who was brain-dead did not allow Lynn to know him, as a person, and left her feeling emotionally distant when he died. Gail described her feelings towards her patient's death:
…one of the moments where it hit me that he really was dead was when we were putting him in the body bag for security to take him to the morgue, just turning him and knowing how stiff he was and the discolouration and it just… hits you that this gentleman has passed away and you wish you would have had more training on how to deal with it.

Gail had observed asystole on the cardiac monitor; she heard the physician's pronouncement of death, but it was the act of placing his body in the shroud that made it real for her.

Post-mortem care was a significant aspect of these first death experiences. Striker finished her patient's bath and worried about transferring him onto the morgue stretcher and *made sure… not to let his head [drop].* Lynn described preparing her patient for the morgue:
You always hear how they lose their bowels and… that's exactly what happened. We turned him and cleaned him …making sure you got him cleaned up [with] dignity…

Gail recalled preparing her patient for the morgue after his family left:

I remember cleaning him up… he had the traditional marking that his family had put on him. I remember thinking to myself, "Should I wipe it off?" … You don't want to do something… that might insult the family. So of course I didn't wipe it off…

These passages recounting post-mortem care revealed the dignity and respect by the novice nurses. They elaborated on their feelings of being with a deceased patient. Although Billie did not prepare her patient for the morgue, she discussed being in the room with a dead patient.
I was kind of dreading… Okay, we'll have to go in… and clean up the body and the body bag and…for some reason it's just… a weird feeling… it's a person, but it's not. And it's that weird feeling of "Oh, my goodness"… they've just died and I'm going to be there standing by myself... it gives that frantic kind of "Huhhhh, oh no!"

Leslie talked about being with her deceased patient:
It doesn't bother me that they've passed, but it's just a different feeling. You're waiting for them to take the breath, you're waiting, you're looking at the monitor, where's their heart rate? Where's their blood pressure? But I always find it a little, I don't want to say weird, a little eerie, it's just a strange different feeling. It just feels different, like the expectations you have… I'm not used to being around a dead person, basically. You expect them to be breathing; you expect… they're going to open their eyes…

Striker discussed being in her patient's room after he died:
I wasn't by myself once in the room. The nursing attendant stayed in there with me the whole time. It was nice, it was peaceful. [Being alone in the room] would have been a little more peaceful because it would have been quieter. But I think that would have made me a little more upset because I think that I would have been thinking more about it.

Lynn compared her patient to other patients she helped prepare for the morgue:
There have been instances where I've helped get other patients ready for the morgue and it kind of creeped me out a little bit… I think it creeped me out because [while they were still alive] I've seen them open their eyes and try and communicate, but my patient wasn't responding right from the beginning, so there was really no change for me [after he died].

Gail discussed her time alone with her deceased patient:
I remember for quite some time I was in there by myself and I kind of chose to be there by myself because it was a learning experience for me too. And just as I was doing up his lines and clamping his catheter and stuff, all I could think about was I'm still telling him what I'm doing. Everything I did I would say "Okay, I'm just going to clamp this off" or "I'm going to wash your face now." It made me feel a little better, but then a couple of minutes into it I'm like, "What am I doing? This gentleman passes away and I'm still talking to him like he's alive."

The nurses described needing time to process and accept that death has occurred. Placing their patients in the shroud post-mortem was difficult, as it finalized the death of their patients. Striker stated: *I didn't like putting him in a body bag. I didn't like zipping that up*. Gail reflected: *I zipped up the body bag and it was weird… it was just that you knew this was the end for this life…*

Lynn described:
It gives you kind of a strange feeling… when you put somebody in a bag. Because you think "Oh, they can't breathe in there!" But they're not breathing anyways. And how claustrophobic and I'm claustrophobic myself, so I can imagine …

Understandably, positioning the body in a shroud and zipping it up is a disturbing process. Securing the zipper usually begins at the patient's feet and as the zipper closes, the last visible feature is the face. In the time it takes to zip up the shroud, the patient disappears leaving a plastic bag with a body outline. Reconciling this sight with the person who was in the bed earlier is a significant moment. Transferring the shroud-encased patient onto the morgue stretcher represents the nurses' final physical contact with their patients.

The nurses reflected on the quality of their patients' deaths. Billie recalled: *All I could think about was how it was such a horrible way to die and it was just sad*. Leslie stated: *But a good death, I think I did okay for the first one in ICU and it was good… I felt happy with how I approached the situation and handled it*. For Striker: *It was nice because it felt like he died with some dignity*. Classifying death as good acknowledges the circumstances surrounding the event rather than the actual cessation of life. For Leslie, being able to provide the type of care she felt was appropriate was important to how she viewed the death. Leslie viewed her first death positively, as did Striker, who identified the death as peaceful and dignified. A sense of awe and aura of mystery surrounding death emerged as the nurses discussed their thoughts and feelings.

Being with the family was the fourth theme. Nurses' availability and their ability to translate the unfamiliar ICU environment foster a connection with patients and their families, especially with extended ICU stays. Often, it is the family who speaks on behalf of the critically ill patient. Families faced with uncertain outcomes for their loved ones confide their hopes and fears to the nurses who are receptive and available to listen. These interactions influence the relationships nurses establish with families. With regards to her relationship with her patient's family, Billie stated:
I think attachment; even in a sense of I was with my preceptor for seven hours or eight, so I had no previous history. Even though it's not like you're having huge conversations with these people, but you see them come in and they even ask little things. You have more of a relationship with the family, even though it's only an eight hour relationship, which kind of seems like a short time but at the same time, it's not …

As Billie and her preceptor cared for their critically ill patient, they also supported the family who was progressing from life-saving measures to compassionate care and ultimately death. Gail reported the difficulty coming on shift and being with the family of a dying patient:
I was pretty much a stranger coming in to share the last moments of this patient's life with him …and trying to be there for the family when I didn't have rapport with them. I gained more rapport with them than I thought was possible.

As Striker's patient became more unstable she experienced a different family situation:

When we made the phone call to the family at about 10:30, they still made the decision not to come in, so maybe they did understand how sick he was and just didn't want to deal with it there. Maybe they just wanted to say their goodbyes [when they left at shift change], maybe they did say their goodbyes then. I was shocked the family didn't come in. It almost felt like something was missing with them not being there.

It was difficult for Striker to accept that the family chose to stay home after being told of the patient's deteriorating condition. Although she rationalized why they stayed away, Striker still struggled with their decision, thinking how she would have responded if this was her family:
I'm very close with my family. Even if they were expecting him to die, I think that I would still be there … I wouldn't have left. And if I got that phone call I'd be right back there.

It's not uncommon for nurses to have deep-seated beliefs towards families' behaviour during end-of-life situations. Strong views on what is acceptable can make it difficult for nurses to understand families' decisions. Yet, supporting family members as they processed the loss of their loved one was important to the nurses. Each situation was unique and revealed the complexities of interacting with families facing the death of a loved one. The novice nurses who established bonds with their patients' families did so by being physically and emotionally available to them. Leslie's experience with her patient's daughter clearly demonstrated this. The nurse's availability was only one component; the family had to be receptive to the nurse. Lynn described the family dynamics she encountered:
I got the sense of an emotional detachment from him. I didn't get the sense that there was closeness within the family at all. … It wasn't that hard to interact with them … but it was just very professional … no sense of personal closeness to them at all.

Not all families are receptive to outward emotional support which highlights the importance of distinguishing what is appropriate for a family and responding accordingly. In these emotionally charged situations, the novice nurses needed to pay attention to the nuances of family dynamics, as well as being attentive to their needs.

Time was a factor in being with the family. Leslie was able to sit and talk with her patient's daughter who was otherwise alone with her dying mother. Billie and her preceptor were a vital presence for a family dealing with a rapid transition from active treatment to compassionate care and death. Gail struggled with time restrictions as she assumed care for a patient at the brink of death, while being responsible for another patient.

The novice nurse participants had not previously cared for the patients or met their family members before being involved with their deaths. Some of the deaths recounted involved patients who died soon after their admission to ICU. Caring for a dying patient and their family when they have an established relationship may be a very different experience. Lynn described:
But a patient I had last week … had a really wonderful, very sweet caring family and he was almost palliative and they withdrew on him yesterday and then I became very teary and emotional. I just went to see them … to see how they were doing and I didn't realize that they were going to withdraw and the whole family was there … The wife … was so thankful and told us how wonderful we were and how she appreciated all the care …

With her first patient's death, Lynn felt disconnected from the patient and his family, and this situation revealed very different feelings. Gail also described a similar experience:
The patient in the next pod passed away and it was quite a shock because I had cared for the lady… I felt like I could connect with the family more. There was a rapport there from weeks ago, so when I walked in the room I almost felt like they had a sigh of relief that it was me who was coming in the room and it felt good under the circumstances. But it was still difficult… I was in shock because it was [her] that had passed away.

Gail was confident she could comfort the family of a patient who died because of their previous relationship. However, knowing the patient and family proves to be a double-edged sword, as Gail coped with her feelings towards the patient's death.

As the novice nurses discussed being with the family, the emotional impact of dealing with death and dying in a critical care setting became evident as they imagined their own family members dying in similar circumstances. Billie revealed the following:
I couldn't imagine watching one of my loved ones in that bed. And I always think, especially in the ICU… if that was my family member in the bed how would I be dealing with it, or just the looks of the patient, everything, and I found that watching the blood come out of her mouth was very hard and I think it was just hard because I thought "Oh my goodness, if that was one of my family members… that would be absolutely horrible to watch." I couldn't imagine my mother dying like that, with that much blood coming out…

The death of Gail's patient was especially relevant to her personal life because he was her age.
… I always think [this could have been my husband]. When I have patients who are around my age it could very well be anyone of us…

Consoling the family of this patient, especially the wife, may have been poignant for Gail.

Novice nurses identified positive aspects of their first death experiences. Leslie stated: *That's how I would want to be treated, that's how I would want [my mother] to be treated.* Leslie considered her first experience with death a good death and one she would want for her mother. Striker also viewed her patient's death as a desirable way for a family member to die: *Yes, yes, I would love my family member being washed and with a couple people in there with him and just to go peacefully.* Being present with an elderly patient who died a peaceful and dignified death was important for Striker, especially in the absence of his family.

These first experiences with death reveal the complexities of family dynamics and the relationships nurses develop with families. Forming significant connections with family members and providing comfort and support contributed to the

positive experiences. These initial experiences with death caused some of the novice nurses to contemplate their family members in similar circumstances and what they perceived to be a good or disturbing death.

Carrying on described the novice nurses coping with their first death. These first experiences were significant events, but in the context of a 12-hour shift they constituted only part of the shift. An element of "life goes on" emerged, as the novice nurses discussed what they did after their patients died. Carrying on constitutes practical and emotional components. Practical aspects involved preparing the deceased patient for the morgue, cleaning and restocking the room, taking another patient assignment, or being available to help in the unit. This suggests the functioning of the unit and patient care took precedence over the fact that these nurses had just experienced their first death.

The emotional component was more complex. The novice nurses had to deal with their emotions and support the grieving family while ensuring the tasks associated with a patient's death were completed. They may not have welcomed any special attention and sought to deal with their emotions alone. Carrying on until the end of the shift involved a reluctance to display emotions at work and the challenges of having another patient assignment. As Gail described:
Maybe it's the nursing mentality, but it's kind of like you just have to separate your emotion and get back to your work. And deal with whatever you're feeling when your shift is over. ... I quickly pulled it together and I just went on with my night. … I've had my first withdrawal of treatment and I honestly thought that it couldn't have been more overwhelming just because of the whole doubling thing…

Gail exemplified carrying on; doing what was needed for the deceased patient, preparing the room for cleaning, and caring for her other patient. Billie also experienced a similar situation when she and her preceptor admitted another patient soon after their first patient died:
All of a sudden we had to admit, so we sort of just jumped on to the next person. We had the next patient come and she had to be intubated and everything [proceeded] quickly. She was quite sick and it was one of those things where in 45 minutes she was intubated and all this sort of stuff and it was just like "Oh my, here we go again!"… We just flipped to another person and it was like a whole new beginning… a brand new family…

Even though Billie and her preceptor spent a busy morning with a patient who died, they were required to admit another critically ill patient, even before their first patient went to the morgue. There was no time for Billie and her preceptor to debrief before they were assigned a second patient. It was only after Billie arrived home that she acknowledged the emotional impact of her first day in ICU: *Just sort of one of those things where you're like, "Oh, I just have to let it out and then I'll feel a little bit better."* Billie identified crying as a way of dealing with her emotions and was able to do so in the privacy of her bedroom. Even though Billie was able to express her emotions, she imposed limits; *Just a little bit of a cry and then I'll just move on and keep going*. In spite of Billie's horrific first shift in ICU, she carried on by returning to work: *The next day was fine… It didn't really bother me going to work…*

After Lynn's patient died:
They kept saying "When are you going to be done? We need you to take over for this double such and such." So I said okay, and it was just so rushed. I had no time to think…

As soon as Lynn sent her dead patient to the morgue, she assumed care of another patient. The quick turnover did not provide an opportunity for Lynn to reflect on her first death. Although Leslie accepted her patient's death and viewed her first death as a positive experience, the emotional impact lingered. Leslie described dealing with her patient's death:
I was okay the next day. I talked with [a] close friend… And you sort of get… not used to it, but I was okay with it. But… the daughter, I think about it once in a while when I pass the room. I know I was in there… was thinking that her mother [died] in that room.

Striker described her response to her patient's death:
I phoned [my husband] and said "Hon, can you come get me?" … we went and had tea [during my break]. That was nice… we just talked about other things. [For the rest of my shift] I was extra, helping out. That gave me the opportunity to talk to everyone about it… [I went home to bed] and then I woke up and I never really thought about it again.

Striker coped with the death by reaching out to her husband and colleagues. Spending her break with her husband allowed Striker time to refocus before returning to work. Discussing her first death with peers soon after it occurred provided Striker with support and reassurance.

These first experiences with death were viewed as learning opportunities by the novice nurses. Their exposure to death provided them with specific knowledge they would need again. Most of the knowledge gained was practical, such as how to monitor a dying patient or prepare the body for the morgue. Consoling and supporting the family of a dying patient was another first. Gail felt more confident interacting with the family when she encountered her second death.

After the novice nurses' first patient death they had to complete the paper work or "death bundle" required after a patient dies, yet another challenge for them. Gail described her reaction:
I got all the paperwork out that I was supposed to do and I asked for help from my pod mate… because I'd never seen it before in my life…

Leslie also discussed the death bundle:
But we have the package to fill out after, so I've never done that and then the charge nurse came. "I'll sit down with you and we'll go through this." I don't remember what exactly was on it, stickers and okay this goes where and the doctor has to sign... If I had to do it again I'd have to ask someone, I honestly would.

Striker described her response after her patient died:
Afterwards I had no idea what to do. So I just got somebody to help me find the bag, find the package for the doctor to fill out, how [to] pronounce them… where their belongings go and that sort of thing. So, just kind of figuring that stuff out and just asking questions.

Lynn also identified the procedures after a death:
I knew I needed to get the cadaver bag and then just in terms of all the paper work and stuff I needed to fill out I wasn't really sure what my role was, I knew the doctor had to do something, so of course I got the physician to come in and pronounce him. All the little, I guess legalities and logistical things that I needed to do, that I wasn't too clear on that needed to be done. And really it's quite simple now that I know how to do it.

It is only after the death of a patient that a nurse is exposed to the death bundle, an imposing stack of papers. Completing paperwork may seem minor, but it was another new and unfamiliar task to master. As well, this formality associated with death reinforced the fact they had experienced their first death. They were responsible for ensuring the paper work specific to nursing was correctly completed; documentation that would forever link them with this death.

Although novice nurses found aspects of their first death difficult, they also viewed it as a milestone in their nursing career. Despite the circumstances of Gail's first death, she was relieved to have experienced her first death. Striker described similar feelings: *Emotionally, yes, it was kind of nice to get that under my belt and deal with the emotional part of it.*

Lynn discussed the practical aspects of her first death:
I could focus more on what I needed to do and not worry so much about what I was feeling. So then, come the time when a different situation comes up and it's a little more emotional, I at least know that other aspect of it…

Billie regarded her first experience with death as a benchmark for future deaths:
I think it will also be interesting to see if, that was my first death and what it's like in a year from now, when you have a patient that dies. Because I wonder if you still react to it the same way, in the sense of driving home and just being… "Oh my!"

The novice nurses experiencing their first death revealed varied responses to the dying process and the actual death. Although aspects of their first death were difficult, they were able to accept them and move on. They recognized that dealing with death and dying was part of their role as critical care nurses and acknowledged relief they had experienced their first death.

Although the novice nurses received advice and support from their colleagues to deal with the practical aspects of a patient's death, it appeared they were left on their own to sort out their emotions towards their first death. Striker was the only nurse who described talking to colleagues at work about her first death. This may reflect the amount of time she had worked in the unit and the fact she was an extra nurse for the remainder of the shift. Some of the nurses seemed to prefer being on their own. Gail described how she regrouped:
After the body had gone down to the morgue I just went to the washroom and I just kind of you know, "Sigh," just let it go in a sense that I wasn't crying, but I just felt like I should be and I felt that I knew I could, but that it wasn't the right place or the right time…

Leslie spoke of needing some solitude at the end of her shift:
But I didn't want to talk to anybody, not that I, because I'm a talker, I like talking about things… Although Gail and Leslie spent some time reflecting on their feelings about their first death, they also described sharing their experience with others. Gail described driving home with her husband after her shift:
My husband came to pick me up, so it was kind of like a vent session on the way home… He just listened and I think in that circumstance that's all I needed… someone to listen.

Leslie spoke to a close friend:
… She likes the nursing field and she always respects what we do and she was talking about it with me and just listening, so that was nice.

The novice nurses used various strategies to cope with the emotions generated by their first death. For some, "carrying on" occurred immediately after their patients went to the morgue, but others described needing time alone to reflect and process the experience. Their ability to share the experience with someone who was willing to listen was important for them to carry on.

Discussion

The experiences of novice nurses with their first death in critical care were studied by exploring five nurses' experiences of their initiation to the death of a patient. Two related studies of novice nurses' experiences with patients' deaths were situated in the acute care setting (Hopkinson, 2001; Hopkinson et al., 2003) while other studies were focused on experienced nurses (Isaak & Paterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; McClement & Degner, 1995; Simpson, 1997; Yang & Mcilfatrick, 2001). This research study presents the challenges novice nurses face with death and dying in critical care. The novice nurses in this study felt unprepared to care for their dying patients. This could be due to limited classroom instruction and discussion and/or the lack of direct involvement in caring for dying patients during their program. It is also possible that their death-related experiences as students were not transferable to critical care. Recounting their first experiences with patients' death and dying in ICU, the novice nurses did not mention situations that had occurred during their student years. Although the novice nurses stated that they expected to encounter death and dying in critical care, their initial response to an assignment with a dying patient suggested otherwise. Feeling unprepared or not knowing what to do when confronted with a dying patient is supported by research that investigated the experiences of student nurses (Cooper & Barnett, 2005; Kelly, 1999, Kiger, 1994) and novice nurses (Hopkinson, 2001; Hopkinson et al., 2003). However, this study also demonstrated that in spite of their first reactions, the novice nurses responded to their dying patients with compassionate nursing care. The emphasis on providing comfort measures to their dying patients is supported in the research with student nurses (Beck, 1997; Cooper & Barnett, 2005) and experienced nurses (Halcomb et al., 2004; Kirchhoff et al., 2000; McClement & Degner, 1995; Rittman, Paige, Rivera, Sutphin, & Godown, 1997; Simpson, 1997; Yang & Mcilfatick, 2001).

Caring for a dying patient exposed the novice nurses to aspects of death they had not previously considered or experienced. Researchers have reported that student nurses (Kelly, 1999; Kiger, 1994) and novice nurses (Hopkinson et al., 2003) revise their image of death after their first encounter with a dying patient. The novice nurses also spoke of responding to disturbing sights and sounds in an attempt to make the situation easier for the family. Students and experienced nurses have identified their efforts in maintaining a normal environment when a patient is dying (Cooper & Barnett, 2005; Simpson, 1997).

The significance of the relationship nurses developed with their patients' families was highlighted in this study. Although some of the novice nurses did not have an opportunity to interact with the family, those who did described the emotional impact of their involvement. Research has shown that student, novice and experienced nurses were more affected by patients' death when there was an existing relationship with them or their family (Cooper & Barnett, 2005; Halcomb et al., 2004; Isaac & Patterson, 1996; Simpson, 1997). Some participants acknowledged difficulty caring for dying patients and their families when the nurse did not know them, an aspect documented in previous research involving novice and experienced nurses (Hopkinson, 2001; Isaak & Patterson, 1996). The novice nurses met the families' needs by spending unlimited time with the patients, including them in the patients' care, and offering emotional support. These actions are consistent with research studies describing student, novice and experienced nurses' involvement with families of dying patients (Beck, 1997; Halcomb et al., 2004; Kirchhoff et al., 2000; McClement & Degner, 1995; Rittman et al., 1997; Simpson, 1997; Yang & Mcilfatick, 2001).

When discussing their patients' deaths, the novice nurses recalled feelings of awe, surprise and disbelief, as they witnessed their patients die. The very fact of being with a dead body was discomforting because it was a new and unfamiliar experience. This reaction is not unusual. Similar responses have been described by student and novice nurses in previous studies (Beck, 1997; Cooper & Barnett, 2005; Hopkinson et al., 2001; Kelly, 1999; Yang & Mcilfatick, 2001). Most of the novice nurses experienced sadness when their patients died, which is a common response noted by other researchers (Beck, 1997; Cooper & Barnett, 2005; Isaak & Paterson, 1996; Kelly, 1999; Loftus, 1998; Simpson, 1997; Yang & Mcilfatrick, 2001). The novice nurses found aspects of post-mortem care difficult, which is congruent with researchers' reports of student nurses' struggles with post-mortem care (Cooper & Barnett, 2005). As the novice nurses prepared their patients, they used that time to reflect on the deaths, an aspect reported in the research focused on experienced nurses (Isaak & Paterson, 1996; Maeve, 1998). Treating their deceased patients with respect during post-mortem care was also discussed by the novice nurses and corresponds to the practices of experienced nurses (Isaak & Paterson, 1996; McClement & Degner, 1995).

In response to the deaths of their patients, the novice nurses spoke of controlling their emotions and focusing on what needed to be done. These coping strategies are documented in other research involving student, novice and experienced nurses (Badger, 2005; Cooper & Barnett, 2005; Halcomb et al., 2004; Hopkinson et al., 2003; Isaak & Paterson, 1996). Similar to experienced nurses, the novice nurses also reported needing to keep their emotions under control because they had other work-related responsibilities (Isaak & Paterson, 1996; Kirchhoff et al., 2000). Although the novice nurses were able to control their emotions when their patients died, some described needing to release their emotions when they were alone or had left work. Similar findings have been reported in research with student, novice and experienced nurses (Cooper & Barnett, 2005; Hopkinson et al., 2003; Isaak & Paterson, 1996; Kiger, 1994, Loftus, 1998; Maeve, 1998).

Most participants in this study talked to someone outside of work about their first experience with death. Some of the novice nurses chose not to discuss their experiences with family members because they felt it was too upsetting or believed they would not understand. This reluctance to discuss their patients' death at home has also been reported by experienced nurses (Badger, 2005; Kirchhoff et al., 2000). Researchers have identified that student nurses find talking to other students, friends, or nursing staff beneficial (Cooper & Barnett, 2005; Kiger, 1994; Loftus, 1998), whereas experienced nurses cite the importance of talking with colleagues (Badger, 2005; Jones & FitzGerald, 1998; Kirchhoff et al., 2000).

Participants did not acknowledge receiving emotional support after the death of their patients and this is congruent with findings of researchers who have investigated student, novice and experienced nurses (Halcomb et al., 2004; Hopkinson et al., 2003; Kiger, 1994; Loftus, 1998; McClement & Degner, 1995). These researchers also identified that students and nurses felt they were left to cope on their own after the death of a patient in the clinical setting.

The novice nurses discussed positive aspects of their first experience with death; feeling satisfied with the care they provided and expressions of appreciation by the patients' families. These findings are similar to research involving novice and experienced nurses (Hopkinson et al., 2003; Kirchhoff et al., 2000). The novice nurses also acknowledged learning from these first experiences with death: gaining practical knowledge about caring for a dying patient, preparing a body for the morgue, and completing the paper work. As well, they gained experience with emotional aspects of supporting a grieving family, seeing a patient die, and coping with their own feelings as these events transpired. This finding is supported by researchers who found that student, novice and experienced nurses learn from death-related experiences (Badger, 2005; Beck, 1997; Hopkinson, 2001; Hopkinson et al., 2003; Kiger, 1994; McClement & Degner, 1995).

These first experiences with death in critical care did not expose the novice nurses to any of the issues at the end of life that experienced critical care nurses find distressing (Badger, 2005; Halcomb et al., 2004; Isaak & Paterson, 1996; Jones & FitzGerald, 1998; Kirchhoff et al., 2000; Simpson, 1997; Yang & Mcilfatrick, 2001). The novice nurses in this study

experienced their first death caring for patients who were compassionate care or had a "do not resuscitate" status. These nurses knew their patients had a poor or nonexistent chance for a meaningful recovery and agreed with the decision to withdraw or withhold treatment. Other research described student nurses' and inexperienced nurses' difficulty with withdrawal of treatment or DNR (Cooper & Barnett, 2005; Simpson, 1997). This was not shown in this study.

A revelation in this study was the novice nurses' acknowledgement of the relief that accompanied their experience of their first death. In spite of the challenges they faced and the emotional impact of their patients' first death, the participants were relieved to have this experience behind them. It is a landmark that nurses know will be reached at some time in their career. For these novice nurses, the expectation of encountering death and dying in critical care was high, as was exposure to colleagues caring for dying patients. Considering the potential scenarios for a death in critical care, the relief of these novice nurses may be related to the fact they encountered deaths that were expected and peaceful, although one was visually disturbing.

Implications and suggestions for nursing education and nursing practice

Although one may assume that nurses acquire experiences with death and dying during their nursing program, there is a distinct possibility that they do not. Novice nurses can begin their nursing careers without encountering death and dying. An examination of death education in Canadian nursing degree programs revealed that instruction on death and dying is integrated in the curriculum of most nursing education programs, but many students never care for dying patients (Goodwin, 2005). Nurse educators working with students in the clinical setting need to acknowledge the importance of providing students with death-related experiences while also assuming responsibility for providing emotional support. They face challenges in doing so, however, given the shortage of suitable clinical placements for students (Goodwin, 2005).

Clinical managers and nurse educators are also challenged to provide orientation to the critical care unit that includes instruction about caring for the dying patient and its inherent challenges. Predicting when a novice nurse will encounter death in the clinical setting is difficult, which impacts clinical managers' and nurse educators' abilities to prepare and support nurses. In addition, rotating schedules make it difficult for the clinical managers and nurse educators to follow the novice nurses. Assignments in critical care often reflect the acuity of the patients, and clinical managers or charge nurses may not have a choice when novice nurses are assigned dying patients. Ideally, they should be able to rely on their colleagues, but this can be challenging on a busy unit. Staffing shortages could result in a novice nurse being assigned a dying patient and another patient.

Employee assistance programs (EAP) and debriefing sessions are available for nurses in this particular institution. The novice nurses who participated in this research study were aware of EAP. Debriefing sessions are organized by the clinical managers in response to a traumatic event, but there can be delays due to scheduling. Chaplains are available, but the nurses need to contact them unless the unit's Chaplain was aware of the impending death. Social workers are available during week days and meet with patients, families and nurses, as needed. Although assistance is available to nursing staff struggling with a difficult situation, often the onus is on the individual to initiate contact. Researchers have identified reluctance to participate in debriefing sessions (Jones & FitzGerald, 1998) and fear of being ridiculed by colleagues (Halcomb et al., 2004) as obstacles for nurses seeking help. However, it is also the responsibility of clinical managers and nursing educators to ensure nurses know these services are available, organize debriefing sessions after traumatic situations, and provide support and advice as needed.

Limitations of the study

A limitation is that all the participants worked in the same clinical area and were female. Another limitation is that participants experienced the death of a patient after treatment was withdrawn or withheld; no participant experienced an unexpected or sudden death. It is possible that the novice nurses who experienced unexpected deaths viewed the event negatively and were unwilling to discuss the death of their patient with the researcher.

Recommendations for future research

This study was conducted in one medical-surgical intensive care unit. Conducting this study in other speciality areas within critical care and acute care may provide different perspectives. Conducting similar research in pediatric and/or neonatal critical care would add another dimension to what is known about novice nurses' experiences with death and dying. Additional research focusing on the overall experiences of novice nurses in critical care would provide useful information that could be considered for recruitment and retention purposes.

Identifying novice nurses' challenges when they begin their careers in critical care could be used to ensure they receive the preparation and support required to retain them in the speciality area. In addition, findings from research investigating why novice nurses leave critical care could provide specific information that could be applied to orientation programs and preceptorship of new hires to retain staff. Although this research study focused on novice nurses in critical care, findings from this study revealed that novice nurses felt unprepared to interact with dying patients. Therefore, it may be helpful to explore what types of experiences student nurses have with death and dying and when this occurs in their program.

Conclusion

This study revealed that the novice nurse shared many similarities with students and experienced nurses in relationship to their involvement with death and dying. This is not surprising considering the novice nurse's role represents the transition from student to registered nurse and

their nursing experience and knowledge are reflections of their exposure to the clinical setting. This research also acknowledges that novice nurses need to experience the death of a patient before they can incorporate death and dying into their nursing practice. As novice nurses recounted their first experience with death in critical care, they provided poignant images that revealed not only the challenges critical care nurses face while caring for dying patients and their families, but also the rewarding aspects. In spite of their limited experience with death, the novice nurses focused their attention on comfort measures for their dying patients and support for their family members. Satisfaction with the care they provided and feeling that they had met the families' needs were significant and positive factors in the novice nurses' views of their first death. These first experiences with death illustrate the novice nurses' progression from anticipating death to carrying on.

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Award information

CACCN Chapter of the Year Award Program

Award value: $500.00 plus a plaque.

Deadline: There is no application process, rather the award program will be for the period of April 1–March 31 each year.

Purpose: The Chapter of the Year Award is to recognize the effort, contributions and dedication of a chapter of CACCN in carrying out the purposes and goals of the association.

Criteria for the award program:

1. Chapters may win the award for one year followed by a two-year lapse before entering again.
2. A point system has been developed to evaluate chapter activities during the year. The chapter with the most points will be the winner of the Chapter of the Year Award. CACCN reserves the right to adjust points depending upon supporting materials submitted.
3. The award winner 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 to participate provided they have on file at national office all of their financial (quarterly) and activity (annual) reports required for the qualifying period. Chapter website must be current.

If the above conditions are not met, the entry will be disqualified.

Announcement of the winner will be published in CACCN publications.

Categories and their corresponding points that will be used to determine the winning chapter are as follows:

1. Any educational programs that occurred during the fiscal year.
   Programs between:
   1–3 hours .....25 points each
   3–8 hours .....50 points each
   > 8 hours .....100 points each
2. A list of new members recruited during the fiscal year, including national CACCN membership numbers. Calculate your points based on the percentage of new members recruited as compared to the total membership of the previous fiscal year (prior to the qualifying period).
   1–10% .....10 points
   11–20% .....20 points
   21–30% .....30 points
   31–40% .....40 points
   41–50% .....50 points
   51–60% .....60 points
   61–70% .....70 points
   71–80% .....80 points
   81–90% .....90 points
   91–100% .....100 points
3. Evidence of chapter members who have contributed articles to either the chapter newsletter, or had a paper published in **Dynamics, the Official Journal of the Canadian Association of Critical Care Nurses.**
   25 points for each article/paper
4. Projects that provide public education, community service and/or promote the image of critical care nursing. 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). Validation must be provided that the event was a CACCN-sponsored project by, for example, submitting a letter from the receiving group or a picture of the event, etc.
   50 points for each project

In the case of a tie, CACCN reserves the right to determine the winner. Good luck in your endeavours!

Sorin Group sponsors this award

CACCN Research Grant

Award value: $2,500.00

Deadline for submission: February 15 of each year.

Grant available: A 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.

Eligibility: The principal investigator 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 findings in **Dynamics, the Official Journal of the Canadian Association of Critical Care Nurses.**

CACCN members enrolled in graduate nursing programs may also apply. Members of the CACCN board of directors and the awards committee are not eligible.

Application requirements:

- A completed application form.
- A grant proposal not in excess of five pages exclusive of appendices. Appendices should be limited to essential information, e.g., consent form, instruments and budget.
- A letter of support from the sponsoring agency (hospital, clinical program) or thesis chairperson/adviser (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 the CNA publication **Ethical Guidelines for Nursing Research Involving Human Subjects**.
- 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 is to be included.
- Proof of CACCN active membership.

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:

- A research review committee will review each proposal. 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.
- Deadline for receipt of application in CACCN national office is February 15. The recipient of the research grant will be notified by mail.

Terms and conditions of the award:

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

Editorial Awards

Edwards

1st place award value: $750.00 Edwards

Runner-up award value: $500.00 CACCN

Deadline: None. Awards committee selection process.

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

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

Eligibility:

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

Criteria for evaluation:

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

Style:

The paper is written according to the established guidelines for writing a manuscript for **Dynamics, the Official Journal of the Canadian Association of Critical Care Nurses**.

Selection:

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

Presentation:

Representatives of the sponsoring company or companies will present the awards at the annual awards ceremony during the Dynamics conference. Their names will be published in **Dynamics, the Official Journal of the CACCN**.

The Spacelabs Innovative Project Award

SPACELABS Healthcare

Award Value: $ 1,500.00 (Total)
Deadline: March 1.

The award funds of $1,500.00 will be granted annually:

- $1,000.00 will be granted to the Award winner and $500.00 for the runner up.

Do you have a unique idea?

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.

The primary contact person for the project must be an active member of CACCN (for at least one year).

If the applicant(s) are previous winners of this award, there must be a one-year lapse before submitting again.

Applications will be judged according to the following criteria:
1. the number of nurses who will benefit from the project
2. the uniqueness of the project
3. the relevance to critical care nursing
4. consistency with current research/evidence
5. ethics
6. feasibility
7. timeliness
8. impact on quality improvement.

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

Smiths Medical Canada Ltd. Educational Award

smiths medical
bringing technology to life

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

Deadlines: January 1 and September 1.

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 responsibilities.
6. Oral and poster presentations will be considered.

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

Chapter Recruitment and Retention Award

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

B|BRAUN

Award value: $1,000.00

Deadline for nominations: 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.

Criteria:

- Nominee must be a CACCN member.
- 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).
- Members of the CACCN board of directors are not eligible.

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 and 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 Official Journal of the CACCN**;
- The awards committee reserves the right to withhold the award if no candidate meets the criteria;
- The funds may be used to attend educational programs or conferences related to critical care.

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

Baxter

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

Deadline: June 1 of each year.

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

Eligibility

The applicant must:

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

Application Requirements

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

A complete application form that includes:

- A proposal of a project, or a description of a completed project, which makes a significant contribution toward patient and caregiver safety in critical care.
- The proposal will include the background perspective, statement of the problem, and intended means to change practice. The proposal should include a timeline by which the project will occur.
- Brief curriculum vitae for the principal applicant and team members describing educational and critical care nursing background and CACCN participation.
- Proof of active CACCN membership
- If this project requires ethics approval, please submit evidence of approval with your application.

Review Process

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

Terms and Conditions of the Award

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

Budget and Financial Administration

- One half of the awarded funds will be available to support the project expenses immediately.
- The remaining funds will be awarded upon the publication of an article describing the project in **Dynamics, the Official Journal of CACCN.**

The total funds available are $5,000.00.

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

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

Revised March 24, 2010
Board of Directors

The Brenda Morgan Leadership Excellence Award

Award value: $1,000.00

Deadline: June 1 of each year.

The Brenda Morgan Excellence 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 is the first recipient. 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.

This 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.

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:

a) Have demonstrated a leadership role or have held a key leadership position in an organization related to the specialty of critical care.
b) Demonstrated volunteerism and significant commitment to CACCN, i.e., have participated in CACCN activities at local or national levels (been a member of provincial executive or national board of directors, 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.
c) Have been a member of CACCN for a minimum of five years.
d) Have a minimum of five years of critical care nursing experience.
e) Be registered to practise nursing in Canada.
f) Hold a valid adult or paediatric specialty in critical care certification—Certified Nurse in Critical Care, CNCC(C) or CNCCP(C) from the CNA (preferred).
g) Consistently conducts themselves in a leadership manner.
h) Have effectively engaged others in the specialty of critical care nursing.
i) Have role-modelled commitment to professional self-development and lifelong learning.
j) Have inspired and mentored others to contribute to critical care nursing.
k) 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
   - committed/passionate/dedicated/motivator
   - advocates for patients and families.

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.

The winner will be awarded The Brenda Morgan Leadership Excellence Award and honoured during the awards ceremony at the annual Dynamics Conference. The winner's name will be published in **Dynamics, the Official Journal of the CACCN.**

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

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 Excellence 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.

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 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 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 Official Journal of the CACCN**. 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.

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Cathy, RN, Oakville

We have exciting full-time and part-time opportunities within our **Emergency** and **ICU** departments for **Critical Care Nurses** who are registered with the College of Nurses of Ontario, and have related experience. With over 53,000 visits annually, Oakville Hospital ER includes a 23-stretcher capacity in the main area, a Fast Track Area and a 4-bed Rapid Assessment Zone, where our health team provides treatment to adult and paediatric patients. Oakville Hospital ICU is a 12-bed unit where our experienced Critical Care nurses provide care to a diverse adult population of critically ill medical, surgical and cardiac patients. Come and contribute your knowledge, skills and insights towards the ongoing advancement of care delivery at Halton Healthcare. For further information, and to apply, please visit our website.

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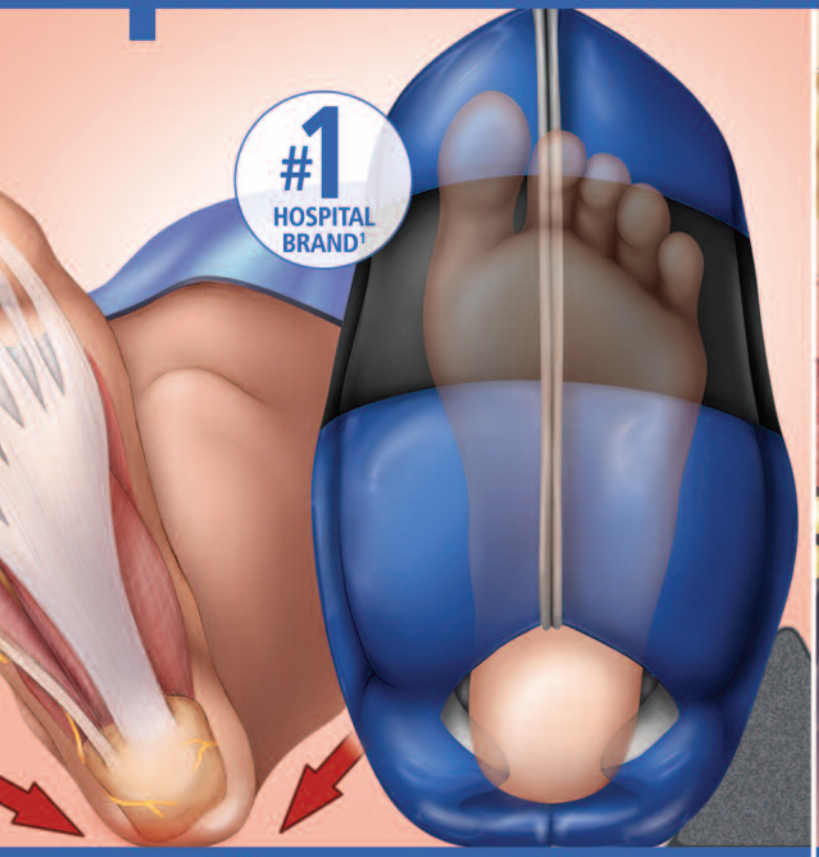

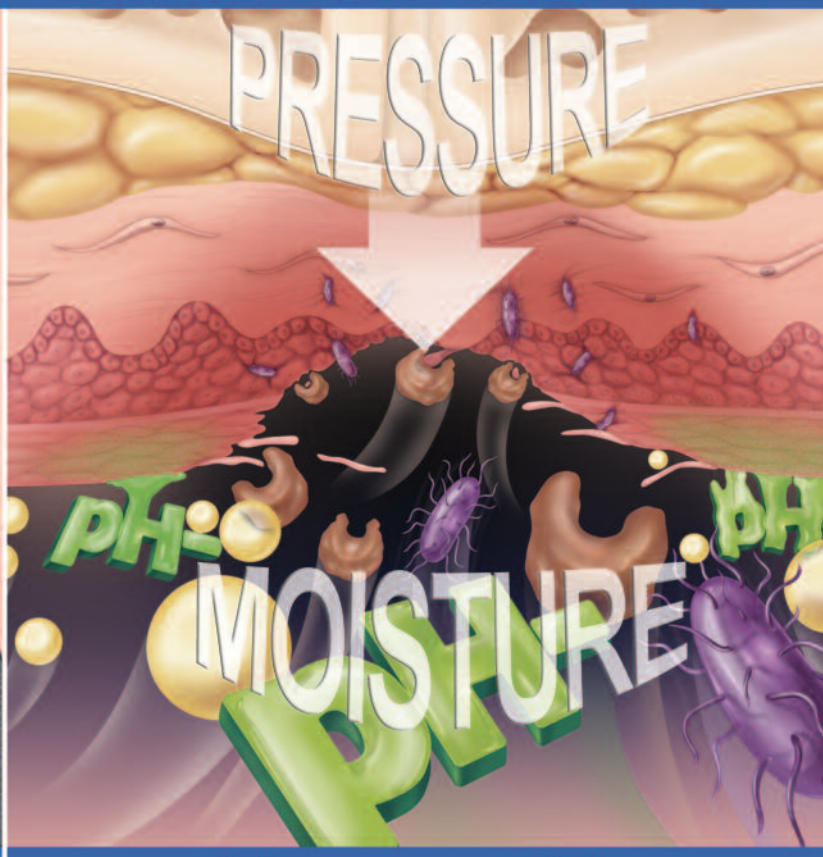

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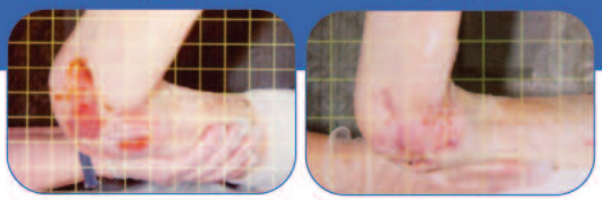

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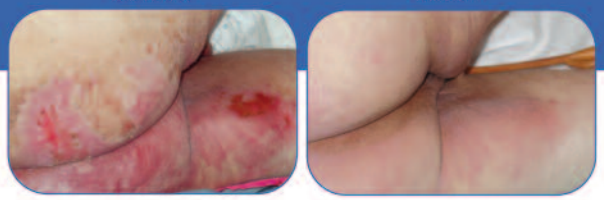

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1. GHX Trend Report (Dollars), 4th Quarter, 2009 Hospital. **2.** Garrett D, Intervention with a new heel protection device and silver alginate dressing to prevent amputation of lower leg due to stage IV ulcer of the heel and malleolus, Salem Village Nursing and Rehabilitation Center, 2006. **3.** Meyers T, et al., Successful prevention of heel pressure ulcers and foot drop in the high risk ventilation patient population. Poster presented at 3rd Congress of the World Union of Wound Healing Societies, Toronto, Canada, June 2008. **4.** Sluser S, Consistency the key for treating severe perineal dermatitis due to incontinence, ASWC, 2005. **5.** Wolfmann, A. It's easy: preventing incontinence-associated dermatitis and early stage pressure injury, 3rd Congress of the World Union of Wound Healing Societies, 2008.

W H Y C A C C N ?

Vision: ***The voice for excellence in Canadian Critical Care Nursing***

CACCN Mission Statement

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

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

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

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

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

CACCN Values Statement

Our core values are:

Excellence and Leadership
- Collaboration and Partnership
- Pursuing excellence in education, research, and practice

Dignity & Humanity
- Respectful, healing and humane critical care environments
- Combining of compassion and technology to advocate and promote excellence

Integrity & Honesty
- Accountability and the courage to speak for our beliefs
- Promoting open and honest relationships

Revised November 2010

Application for membership

Name: _____

Address: _____
(Street)

_____
(City) (Province) (Postal Code)

W (____) ____ - _____ H (____) ____ - _____ F (____) ____ - _____

E-mail: _____

Employer/School: _____

Position: _____

Area of Employment: _____

Nursing Registration No.: _____ Province: _____

Chapter Affiliation (if known): _____

Sponsor's Name: _____
(If applicable)

Type of membership:
Please review types of membership noted below and check one (all include applicable GST/HST):

❑ New Member—one year $75.00 ❑ New Member—two years $140.00
❑ Renewal—one year $75.00 ❑ Renewal—two years $140.00
CACCN Number _____
❑ Student Member—one year $50.00

Are you a CNA member? ❑ Yes ❑ No

Signature: _____

Date: _____

Please Note: This application is for both national and chapter membership.

Make cheque or money order payable to:
Canadian Association of Critical Care Nurses (CACCN)
Mail to: CACCN, P.O. Box 25322, London, ON N6C 6B1
Or fax with Visa/MasterCard number, expiry date to: 519-649-1458
Telephone: 519-649-5284; Fax: 519-649-1458; Toll-free: 1-866-477-9077
e-mail: **caccn@caccn.ca**; website: **www.caccn.ca**

Types of Membership

Active Member: Any registered nurse who possesses a current and valid licence or certificate in the province, territory or country in which the registered nurse practises.

Student Member: Any student in an accredited professional nursing program, who is currently not licensed as a registered/graduate nurse.

Associate Member: Any person with an interest in critical care, but who does not meet the requirements for an Active Member.

DYNAMICS
The Official Journal of the Canadian Association of Critical Care Nurses

Information for Authors

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

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

Manuscripts submitted for publication must follow the following format:

1. Title page with the following information:

- Author(s) name and credentials, position
- Place of employment
- If there is more than one author, the names should be listed in the order that they should appear in the published article
- Indicate the primary person to contact and address for correspondence

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

3. Body of manuscript:

- Length: a maximum of 15 pages including tables, figures, and references
- Format: double spaced, one-inch margins on all sides. Pages should be numbered sequentially including tables, and figures. Prepare the manuscript in the style as outlined in the American Psychological Association's (APA) Publication Manual 6th Edition.
- Tables, figures, illustrations and photographs must be submitted each on a separate page after the references.
- References: the author is responsible for ensuring that the work of other individuals is acknowledged accordingly. Direct or indirect quotes must be acknowledged according to APA guidelines
- Permission to use copyrighted material must be obtained by the author and included as a letter from the original publisher when used in the manuscript

4. Copyright:

- Manuscripts submitted and published in Dynamics become the property of CACCN. Authors submitting to Dynamics are asked to enclose a letter stating that the article has not been previously published and is not under consideration by another journal.

5. Submission:

- Please submit the manuscript electronically as a Word attachment to the editorial office as printed in the journal. Hard copy manuscripts may also be submitted through the national office. Accepted manuscripts are subject to copy editing.

October 2009