

VOLUME 23, NUMBER 4, WINTER 2012

DYNAMICS

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Journal of the Canadian Association of Critical Care Nurses



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DYNAMICS

Journal of the Canadian Association of Critical Care Nurses

Volume 23, Number 4, Winter 2012

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CANADIAN
ASSOCIATION OF
CRITICAL
CARE
NURSES



Canadian Association of Critical Care Nurses

Vision statement

The voice for excellence in Canadian Critical Care Nursing

Mission statement

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

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

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

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

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

Values and beliefs statement

Our core values and beliefs are:

- Excellence and Leadership
 - Collaboration and partnership
 - Pursuing excellence in education, research, and practice
- Dignity and Humanity
 - Respectful, healing and humane critical care environments
 - Combining compassion and technology to advocate and promote excellence
- Integrity and Honesty
 - Accountability and the courage to speak for our beliefs
 - Promoting open and honest relationships

Philosophy statement

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

The critical care nurse works collaboratively within the inter-professional team, and is responsible for coordinating patient care using each member's unique talents and scope of practice to meet patient and family needs. Each patient has the right to receive care based on his/her personal preferences. The critically ill patient must be cared for with an appreciation of his or her wholeness, integrity, and relation to family

and environment. Critical care nurses plan, coordinate and implement care with the health care team to meet the physical, psychosocial, cultural and spiritual needs of the patient and family. The critical care nurse must balance the need for the highly technological environment with the need for safety, privacy, dignity and comfort.

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



Pathways to success: Five pillars

1. Leadership:

- Lead collaborative teams in critical care interprofessional initiatives
- Develop, revise and evaluate CACCN Standards of Care and Position Statements
- Develop a political advocacy plan

2. Education:

- Provision of excellence in education
- Advocate for critical care certification

3. Communication & Partnership:

- Networking with our critical care colleagues
- Enhancement and expansion of communication with our members

4. Research:

- Encouraging, supporting, facilitating to advance the field of critical care

5. Membership:

- Strive for a steady and continued increase in CACCN membership

CRITICAL THINKING

Dynamics of Critical Care 2012 in Vancouver welcomed 454 critical care nurses from September 23 to 25, 2012. As a result of the conference, I am happy on behalf of CACCN to welcome approximately 200 new members to our Association. For those who attended Dynamics 2012, you may remember from my opening address that I acknowledged how present and previous National Board of Directors and Chapter President involvement in CACCN has made it the strong organization that it is today. However, it is not just executive members who strengthen our association, but you, the individual members as well. Without your involvement and passion, CACCN would not be able to fulfill our mission to be the *Voice for Excellence in Canadian Critical Care Nursing*.

At Dynamics 2012, I encouraged all the new members to take a moment to speak with longstanding members to gain insight on the rewards of being a member of CACCN, your professional association. I was fortunate to speak to some of you during the conference and I encourage all of you to be active in CACCN either by commenting on the President's blog, responding to a question in the members-only forum or attending events hosted by your chapter. We all share the same passion to promote excellence in critical care nursing.

Our theme *Speak with Conviction* was chosen because it is a bold statement intended to encourage critical care nurses to become informed and to speak confidently when stating their position on issues where they have the expertise and experience to make a difference and indeed influence practice or system design. Whether that is at the bedside where you advocate for your patients and their families or when you advocate for excellence in care, it is important to be informed and to have the facts to present to hospital administrators, and government officials to ensure that the appropriate decisions are made as it relates to the kind of resources and models of care we need to provide excellent care. We must be able to clearly articulate our position in a logical and factual manner to obtain not only the resources we need to do our jobs well but also to put the latest evidence into practice. That is what knowledge translation is all about.

I personally know, and am proud to recall, many examples of frontline nurses speaking with conviction. I would like share a few stories of nurses who are speaking with conviction and demonstrating passion for excellent patient care.

While at Dynamics 2012, I attended many excellent presentations that either increased my knowledge base or provided affirmation that my critical care unit was providing evidence-based care. I congratulate all the presenters at Dynamics for speaking up, speaking out and sharing their expertise with all of us. This is one example of speaking with conviction.

When critical care nurses in Newfoundland identified a significant issue with a new province-wide monitoring system that impacted patient safety, they went forward to hospital

administrators and government officials voicing their concerns. Through CACCN, these nurses were put in contact with nurse experts across the country to formulate their position in a convincing manner that caught the attention of decision makers. They have developed and written a position statement using the latest evidence to support their concerns for patient safety. Due to their diligence and persistence, a formal review process to evaluate the concerns they have raised is being implemented. These nurses continue to have the courage to speak with conviction on this issue and the results will be of benefit to their patients.

Indeed the voice of one nurse can become a chorus of voices and it is in the collective voice of all of us... and our wisdom that we have the power to advocate for excellence and safety in patient care and for ourselves for things like healthy work environments so we can sustain the work we do. **THAT** is what speaking with conviction is all about!

The recipients of this year's Spacelabs Innovative Project Award are another example of nurses speaking with conviction. As you all know, implementing change in practice is never easy. The early mobility protocol developed and implemented by nurses at the Royal Alexandra Hospital in Edmonton, AB, was based on the best evidence in critical care. Even with this evidence the adoption of this new practice was not automatic. It took the passion and boldness of nurse champions to speak with conviction to change the culture of this unit to one that promotes early mobility for their patients.

These are but a few examples of nurses being engaged and speaking out. I know that there are many more every minute of every day in intensive care units across this country. Take a moment to share your examples with all of us through the CACCN President's blog.

CACCN continues to build our partnership with the American Association of Critical-Care Nurses (AACN). This year at the National Teaching Institute conference, President Kathryn Roberts unveiled her theme, which was DARE TO. I think the themes that Kathryn and I have chosen complement each other nicely. In saying this I would like to now DARE YOU to **SPEAK WITH CONVICTION** in your everyday practice. It can be as simple as being a member of CACCN and having the courage to post your thoughts and share your experiences in the clinical forum on the CACCN website with your colleagues across the country. It could be encouraging another critical care nurse you work with to become a member of CACCN. Perhaps you choose to become involved with your local chapter or think about putting your name forth to the National Board of Directors to work on a committee or for a Chapter executive position. Or perhaps it is all of the above. I encourage you to contact members of the Board of Directors and your chapter executive to tell us what you think is important in Canadian critical care nursing. We want to hear from you! We are stronger together and it is our collective voice that will allow us to **"Speak up, Speak Out and Be Heard"**! When we do this, we will truly **SPEAK WITH CONVICTION**. 



Teddie Tanguay
CACCN President

RESEARCH REVIEW

Gutierrez, K.M. (2012). Advance directives in an intensive care unit: Experiences and recommendations of critical care nurses and physicians. *Critical Care Nurse Quarterly*, 35, 396-409.

Research objectives

To understand the benefits and limitations of advance directives to direct decisions about the care of critically ill patients in the Intensive Care Unit (ICU).

Design

Qualitative ethnographic study describing the perspectives of a purposive sample of critical care nurses and physicians.

Setting

Twenty-two bed open medical-surgical ICU in a large community hospital in the Midwestern United States where staff care for patients at high risk of death (defined as diagnosis of sepsis, late stages of cancer, persistent vegetative state, organ failure in two or more systems and with a mortality rate 50% or more).

Participants

Purposive sample of registered nurses (n=14), attending physicians (n=7) and fellow physicians (n=3) with advanced training in critical care medicine, consenting to provide information about the use of advance directives in the care of their patients at high risk for death in this ICU.

Data collection/method

Informal interviews while registered nurse (n=14) and physician (n=10) participants were working in ICU. Data were recorded in the researcher's journal using verbatim quotes. A formal semi-structured follow-up interview was conducted at a location away from the hospital with a purposive sample of registered nurses (n=5) and attending physicians (n=7) who had participated in an earlier informal interview. Formal interviews were audio-recorded, transcribed verbatim and analyzed into themes describing content with regard to the participants' clinical experiences with use of advanced directives in ICU and recommendations for improving advanced care planning for ICU patients.

Findings

From the perspective of all of the participants, advance directives had an extremely limited ability to direct decisions about the care of critically ill patients in ICU. Participants felt that the negative aspects of such directives included 1) difficulty communicating their contents across settings and providers therefore could not prevent unwanted life support, 2) lacking the specificity required to address clinical situations faced by patients in real life, 3) employing vague and confusing terminology, which could not be interpreted for decision-making, 4) physicians had to identify a terminal prognosis for the directive to be valid, which was present for exceedingly few patients during the study period, 5) impressions that litigious, difficult

families overturned such patient instructions, 6) patients/surrogate decision makers did not choose to share directives in some cases, and 7) patients and families who did not want to discuss death and dying would not elect to complete directives. Although participants felt that advance directives were a flawed approach to communicating patient wishes, they agreed that these previous discussions between patients and their families had several benefits, which included prompting discussions about end of life care or quality of life as well as providing participants with the opportunity to use the advance directive to decrease moral burden by shifting responsibility for choosing end-of-life options away from family members.

Conclusion

The author reports that while participants have identified many known issues with advance directives, one new finding was that a patient hesitated to share her advance directive for fear of physicians prematurely stopping life support. The author suggested that advance directives may help settle disagreements about the appropriate use of life support treatments before legal solutions are sought, although restricted the benefit of such clarity to a small proportion of patients who have either persistent vegetative state or diagnosed terminal illness. Participants in the study suggested that preparation of advance directives could either benefit or hinder family discussions. They offered examples of families who had beneficial family discussions in the process of writing advance directives but also offered examples of cases where advance directives were written in order to avoid such conversations. Advance directives were used by participants to reframe the decision to stop using life support (which would result in death) as respecting the patient's expressed wishes and thereby alleviate the (perceived) moral burden of grieving families. Finally, the author recognized that characteristics of the sample might limit the transferability of findings: a relatively homogeneous sample of white nurses and physicians, a community ICU with mostly medical patients, and attending physicians with pulmonary medicine certification.

Commentary

This manuscript is one of four recently published reports of an ethnographic study undertaken during Dr. Gutierrez's doctoral dissertation in order to examine how prognostic information was communicated to inform end-of-life decisions in ICU (Gutierrez, 2010). The research expands on her previous research examining moral distress among critical care nurses. As a critical care nurse herself, Gutierrez was both an "insider" to the ICU culture as well as an "outsider" to the ICU where the study was conducted. She used both informal and formal interviewing to accomplish data collection, which allowed her to benefit from expertise of professionals during their clinical practice and yet permitted more considered reflection on their practice during the later formal interview.

In this study, as in many others that investigate communication around end-of-life decision-making, the focus on decision-making may be a misnomer. One must have alternative options to be truly faced with a decision, therefore what is generally referred to as the "end-of-life decision" is actually a discrete choice within a larger decision problem about whether to use

life support to delay death, or to provide uniquely comfort care to manage the dying patient. Both the researcher's analysis and the participant quotes reflect a more focused aim: to communicate sufficiently well to gain (patient and) family support for a particular course of action (comfort care leading to end of life) that is also already preferred by the healthcare team. Indeed, when physicians refrain from communicating uncertain prognostic information, families are not invited to consider the larger decision problem. There are several themes that support the observation that participants in Gutierrez's study may have been seeking family agreement with comfort care through the advance directives. First, advanced directives were not celebrated by participants for their ability to secure aggressive life support treatment for patients who wanted to live despite their critical illness, but were criticized for their inability to "prevent unwanted aggressive treatments that prolong dying". Next, family members were observed to struggle with "letting go," which led to demands to continue life support treatment and threats of litigation; such desperate measures might not be employed by families if there was truly a choice with multiple viable options being presented. Participants had already made a choice (to focus on comfort at end of life) and were critical of families' inability to come to the same conclusion despite not being introduced to the decision problem earlier. Therefore, in the research under review, failure to consider the end-of-life decision more broadly may have in turn influenced attention to the data collected, the analysis, and the outcomes of the study.

The research clearly supports the impression that physicians hold the power when it comes to end-of-life decision-making. It would be interesting to investigate further whether there was justified concern that advanced directives might be used to frame choice when the physician was ready to "throw in the towel too early". In a related study, Schenker and colleagues (2012) reported that the strength of the physician's belief that life support should be withdrawn or withheld was the single significant predictor of offering comfort care as an option, where the latter option was offered to less than half of families despite a mortality rate in their study of 72%. Therefore, at least half of the families in that study were not invited to consider alternate options to life support for the patient. Such omissions do not seem to meet current professional and legal standards for informed consent. Schenker and colleagues go on to argue that a failure to discuss available treatment options is problematic because families cannot then prepare emotionally for

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potential withholding or withdrawal of the treatment later, and may experience death as a sudden event, which potentially contributes to complicated grief among family members. Future investigations could investigate how power could be equalized among healthcare teams and families to promote improved communication and decision-making.

Advance directives may be a helpful adjunct to advance care planning as a process of deliberation between patients and families in advance of critical illness. The concept "advance directive" is advanced here as a relatively problematic vehicle for "end-of-life decision-making". Unfortunately, this is not a new perspective. Halpern (2012) also advances some convincing critique of the structure of advance directives, but suggests in detail how they can be engineered in both content and delivery to overcome well-described cognitive biases, which impede decision-making at the end of life. More work is needed to understand how members of the healthcare team in ICU should integrate the patient's message from an advance directive in ongoing dialogue about whether the use of life support technologies are wanted in care at the end of life. The current challenge seems to be in identifying how physicians, nurses, families and patients in critical care settings are best supported to engage in explicit compassionate deliberation for this high stakes decision in the context of uncertain outcomes and complex health challenges. ❁

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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. 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 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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Chapter Connections Day—Dynamics 2012

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

After getting to know everyone with an ice breaker, President Teddie Tanguay and all of the Board of Directors reported on some of the board's initiatives over the past year and plans for the future. Teddie's theme of her presidency is Speak with Conviction. In keeping with this theme, Teddie and members of the board have been increasing our collaboration with partners nationally and internationally. Teddie attended the CNA biannual meeting and through the Canadian network of specialty groups she is working to increase awareness of what critical care nurses do. CACCN also received complimentary tuition and complimentary exhibit space at the 2012 AACN NTI Conference in Orlando. The board members who attended met with the AACN executive to continue to identify and discuss ways to promote our respective organizations. Teddie continues to write her President's blog and CACCN is on Facebook and Twitter. There were 454 registrants at Dynamics with only seven who were non-members of CACCN. The board is now looking at a national strategy for recruitment and retention of members.

CACCN submitted an affidavit to apply for Intervener Status at the Supreme Court. The application was granted and CACCN's lawyer will be speaking for us at the Supreme Court in December. CACCN is advocating for shared decision-making on end-of-life care and withdrawal of care. If that does not occur, then we are requesting third party arbitration. Further information can be found on the CACCN website in the members only forum under end of life in critical care.

The federal *Not for Profit Act* CACCN operates within was developed in 1918. It is now being revised and CACCN must reapply before October 2014. As a not-for-profit association, we will need to redo our constitution and bylaws. This will be done this coming year so that the members at Dynamics 2013 can vote on them.

The World Federation of Critical Care Nurses (WFCCN) contacted CACCN to join and provide a donation. We were not informed about what the plans are for the donation. CACCN is seeking further clarity about the WFCCN's strategic plans and the budgets for the last three years to assist in making a decision regarding membership. We did become a member of the World Federation of Pediatric Critical Care Nurses. There was no fee to join at this time.

The Canadian Intensive Care Week was originally proclaimed in 2002. This week was celebrated for a couple of years by the Canadian Intensive Care Foundation and then it disappeared. Canadian Intensive Care Week was celebrated again this year October 29–November 4, 2012.

CACCN purchased a new website database. This was a necessary expense in order to generate reports. We are looking

at automatic membership renewal in the future. The board is always looking for feedback about the website. There is still more implementation to be done.

The research committee is becoming more active. The committee is conducting a study about critical care nurses' attitudes toward research. The survey link has been emailed to all members—please take a moment to complete the survey.

As of September 1, 2012, CACCN had 1,136 members. That is an increase of 38 from last year.

CACCN has some promotional items available should chapters be interested in collaborating on a bulk purchase. There are minimum quantities required and CACCN will not order items without a firm commitment from the chapter(s) involved. Chapters are responsible for payment of the items.

A new mentorship initiative is beginning soon. This is for CACCN members wanting to advance their practice and scholarship. It will be facilitated through the online forum on the website. Mentees will identify themselves with their needs and goals. The online "room" will be facilitated by a mentor who is a volunteer with specific expertise. There will be two pilot rooms: writing for publication and preparing to present. This initiative will likely be launched during Intensive Care Week.

There was time for small group discussions with chapter presidents and their board liaison.

As of January 31, 2013, the membership charge will be \$75.00 + applicable taxes.

The afternoon consisted of presentations from some of the chapters. The topics were setting up online registration and payment (Toronto Chapter), writing successful newsletters (Manitoba Chapter), and Living our Vision and Mission (London Chapter). 

Respectfully submitted,
Paula Price, PhD, RN
Editor, Dynamics

Membership Fees/Tuition Taxation Change, Effective January 31, 2013

At the 2012 Annual General Meeting on September 23, 2012, the CACCN Board of Directors advised that CACCN Members will note a difference in how tuition and membership fees are charged in this fiscal year. In response to varying taxation rates across Canada, CACCN will be standardizing our budgeting process. In an effort to be fair and transparent to the membership, the Board of Directors has determined that all CACCN fees will be charged at a base rate subject to applicable taxes commencing January 31, 2013.

SPEAK with **CONVICTION!**

CACCN National Board of Directors Nominees 2013–2015

The Board of Directors of the Canadian Association of Critical Care Nurses congratulates the following members acclaimed at the Annual General Meeting on September 23, 2012, to the 2013–2015 Board of Directors:

Director, Central Region



Ruth Trinier
BScN, RN,
CNCCP(C)
Toronto, ON

Director, Western Region



Marie Edwards
PhD, RN
Winnipeg, MB

Director at Large



Renée Chauvin
MEd, BA, BScN,
RN, CNCC(C)
Ottawa, ON

We wish to thank the nominees who put their names forward for election. We would also like to thank the CACCN members who participated at the Annual General Meeting held in Vancouver, BC, in conjunction with Dynamics 2012. *Your Voice Matters!*

Sincerely,

Teddie Tanguay
President

Karen Dryden-Palmer
Vice-President

Dynamics 2014 Conference Planning Committee — Call for participation

Dynamics 2014 will be held September 21–23, 2014, at the Société du Centre des Congrès de Québec/Quebec City Congress Centre in Quebec City, QC. Planning committee selection will take place in March 2013. Please note, consideration will be given to those who are Montreal Chapter or Central Region members.

CACCN members interested in working on the conference planning committee should submit a resume/CV and summary of conference planning experience (*planning experience is appreciated but not a requirement for submission*) to the CACCN National Office by **March 1, 2013**.

For further information on this exciting opportunity, please contact the CACCN National Office, P.O. Box 25322, London, Ontario N6C 6B1, www.caccn.ca, e-mail: caccn@caccn.ca, phone: (519) 649-5284, fax: (519) 649-1458. For frequently asked questions regarding Dynamics conference planning, please visit www.caccn.ca.

CACCN calendar of events

DATES TO REMEMBER!

December 3: CNA Certification Renewal Application deadline

December 31: Chapter Quarterly Reports (Oct–Dec 2012) deadline

January 31: Smiths Medical Canada Ltd. Educational Award

January 31: Call for Abstracts, Dynamics 2013 deadline

February 15: CACCN Research Grant deadline

March 1: Dynamics 2014 Planning Committee Application deadline

March 20–22: BOD F2F meeting, Toronto, ON

April 20: CNA Certification Examination

May 31: Draeger Chapter of the Year Award

June 1: BBraun Sharing Expertise Award

June 1: Cardinal Health Chasing Excellence Award

June 1: Spacelabs Innovative Project Award

June 1: The Brenda Morgan Leadership Excellence Award

Awards available to CACCN members

Criteria for awards available to members of the Canadian Association of Critical Care Nurses are published on pages 42–47 of this issue of Dynamics.

Membership Recruitment Program

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



Criteria:

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

www.caccn.ca

What's new at www.caccn.ca?

President's Blog

Check out the President's blog at www.caccn.ca.

CACCN Members Only!

- Start or join a discussion! The CACCN Members Only Discussion Forum is available to share information and meet nurses from coast to coast.

CACCN Facebook Page



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Future sites of Dynamics conferences

Dynamics 2013:
September 22–24,
Halifax, NS

Dynamics 2014:
September 21–23,
Quebec City, QC

Dynamics 2015:
October 4–6,
Winnipeg, MB

Dynamics 2016:
September 25–27,
Charlottetown, PEI

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

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DYNAMICS 2012

OF CRITICAL CARE

VOICES OF CONVICTION FROM SEA TO SKY

Speak Up Speak Out
BE HEARD

Dynamics of Critical Care welcomed 454 nurses to Vancouver, British Columbia, from September 23–25. The scenery at the hotel showcased the beauty of Canada's west coast with the sea wall just outside the door and Stanley Park a short walk away. Even the weather cooperated and the umbrellas provided to each delegate by Phillips Healthcare were not necessary. With the west coast scenery as a setting, inside the convention centre critical care nurses from across the country demonstrated their leadership by **Speaking with Conviction**, as delegates and presenters.

Opening keynote speaker Lesra Martin's presentation, "Voices of Hope, Heart and Human Spirit", reminded us that leadership begins from within by putting ourselves in the picture and that belief in ourselves and our abilities is essential. Monday's keynote Barb Langlois continued to build on the conference theme by giving us "3Cs to a Powerful You", as well as useful tips to silence our inner critic. Kate Mahon and Mary Stahl shared their leadership perspectives as past presidents of CACCN and AACN respectively, and demonstrated to delegates how the leadership skills they have developed at the bedside translate to Speaking with Conviction in other situations. Delegates heard from national nursing leaders from a variety of settings in Tuesday morning's panel discussion about the possibilities for the future of critical care. Concurrent sessions covered a wide variety of topics that offered learning opportunities for every nurse in every critical care setting and knowledge level.

As always, the social events at Dynamics were just as important as the learning. Nursing colleagues from across the country renewed friendships and laughed together. The "**Currents in Critical Care**" poster reception sponsored by the Canadian Intensive Care Foundation and the CACCN Board of Directors highlighted the hard work of the poster presenters and provided the opportunity to come together in a social setting to learn and network. Monday evening found nurses at the CACCN annual dinner dancing the night away to the sounds of The Young Executives. Chants of "one more song" closed out the evening, a sure sign of a good band and a good party.

I would like to share my closing remarks from the conference: *"No event of this size takes place without the work of many people. I have a number of people to thank:*

My colleagues on the board of directors who have been a tremendous support over the past two years.

Planning committees from previous years' Dynamics who provided models to follow and big shoes to fill.

The absolutely phenomenal staff at the Westin Bayshore. They were essential to the smooth planning and running of this conference. Every member of the hotel staff was supportive, attentive and friendly. In particular Richard and Brad and their teams from banquet services, Natasha, our executive meeting specialist, Daryl and Irene from PSAV, hotel manager Emma Fyfe and lastly Annabel Aspler, our completely amazing convention services manager. Annabel has been a pleasure to work with and we could not have done it without her.

I had the pleasure to work with a great group of people to plan this conference. They did not quite know what they had signed up for, but they stepped up and did a great job: Cecilia Baylon, Judy Fraser, Michelle House-Kokan, Dale Kastanis, Laurel Kathlow, Karen Lecomte, Christine Halfkenny-Zellas.

This conference is the result of wonderful teamwork and collaboration and my sincere thanks to all of you.

Most of all, I want to thank you, the delegates and speakers. Your enthusiasm and passion for critical care nursing brought an energy to the conference that could not be planned."

I hope your travel home was safe and I hope you carry that energy back to your home units. I look forward to seeing you in Halifax next fall. 

Tricia Bray
Dynamics 2012 Planning Chair

Awards Presented at Dynamics 2012 Vancouver, BC

Spacelabs Innovative Project Award

Royal Alexandra Hospital ICU Early Mobility Team,
Edmonton, AB

“Early mobilization in the intensive care unit”



Holly Tkachuk, Peter Robertson, Spacelabs Representative,
Liane Manz and Teddie Tanguay, CACCN President

Edwards LifeSciences Editorial Award

Brandi Vanderspank-Wright, Frances Fothergill Bourbonnais,
Susan Braitman and Pierre Gagnon, Ottawa, ON

*“Caring for patients and families at end of life: The experiences
of nurses during withdrawal of life-sustaining treatment”*
(Dynamics, Winter 2011)



Karen Steiner, Edwards Representative, Frances Fothergill-
Bourbonnais and Teddie Tanguay, CACCN President

CACCN Editorial Award

Isabelle Bilodeau, Jacinthe Pepin and Lyne St-Louis,
Montreal, QC

*“Journal club in a critical care unit: An innovative design
triggering learning through reading and dialogue”*
(Dynamics, Spring 2012)



Tricia Bray, CACCN Director/Publications Chair, Isabelle
Bilodeau and Teddie Tanguay, CACCN President

Smiths Medical Education Awards



Colleen Breen, London, ON
Master of Science in Nursing,
York University

Colleen Breen and Teddie
Tanguay, CACCN President



Kristyn Berube, Ottawa, ON
Master of Science in Nursing,
University of Ottawa

Frances Fothergill Bourbonnais,
accepting for Kristyn Berube,
and Teddie Tanguay, CACCN
President

BBraun Sharing Expertise Award

Orla Smith, Toronto, ON

Nominated by: Cecilia Santiago, Karen Wannamaker and Joyce Fenuta

“Orla’s leadership skills include her ongoing ability to encourage others to grow. She expects the best and is able to bring out the best in others. She is never too busy to give sound advice. Her readiness to share ideas shows her generosity. Her accomplishments underscore her commitment and pride as a nurse. I am proud that she is a nurse.”



Cecilia Santiago, accepting for Orla Smith, and Teddie Tanguay, CACCN President

CACCN Research Grant

Eileen Shackell and Mary Gillespie, Vancouver, BC

“The oxygen supply and demand framework: A tool to support integrative learning”



Tricia Bray, CACCN Director/Publications Chair, Eileen Shackell, Mary Gillespie and Teddie Tanguay, CACCN President

Cardinal Health

“Chasing Excellence Award”

Brenda Drouillard, Toronto, ON

Nominated by: Cecilia St. George-Hyslop, Lori Liske and Trisha Sutton

“For about 20 years, Brenda has been endlessly sewing beautifully designed bereavement gowns and blankets for infants and children who are dying. Her beautiful needlework supports the idea of dying with dignity and in their final moments infants and children may be dressed in these delicately handmade bereavement wear.”



Rhona Charron, Cardinal Health Representative, Karen Dryden-Palmer, accepting for Brenda Drouillard, and Teddie Tanguay, CACCN President

Draeger Chapter of the Year Award

Greater Edmonton Chapter

Chapter highlights 2011–2012

- 117 members March 31, 2012
- 43 new members
- 74 renewed members
- 34 total education hours presented
- Eight member presentations at Dynamics 2011
- Six member presentations at Chapter Educational Days



Eric Pothion, Draeger Representative, Liane Manz, Greater Edmonton Chapter President, Kirk Dawe, CACCN Board Member, and Teddie Tanguay, CACCN President

Brenda Morgan Leadership Excellence Award

Linda Nusdorfer, Mississauga, ON

Nominated by: Roberto Fuerte, Shahnaaz Dhalla and Angie Jeffs

"She has been an advocate in promoting the voice of critical care nurses and encouraging nurses to become involved grow both personally and professionally. She sees the CACCN as a vehicle for nurses to make a difference."



Brenda Morgan, Linda Nusdorfer and Teddie Tanguay, CACCN President

2012 CNCC(C) and CNCCP(C) Draw Prize Recipients (\$250 each)

Adult Initial Certification

Jenny Kent, St. Albert, AB
Paisley Marshall, Whitby, ON
Renee Regimbal, Yorkton, SK

Adult Re-certification

Richard Sutherland, Thunder Bay, ON
Julie Weir, Riverview, NB

Pediatric Initial Certification

Patricia Santos, Brampton, ON
Karen Sokalski, West Vancouver, BC

Dynamics 2012 poster awards

First place

Mary Mustard, Ellen Lewis,
Richard Bowry and Janice Glen

"A checklist for dynamic, real-time change management"

Second Place

Mai Nguyen, Julie Kinnon, Martin Darbouze,
Josie Delcampo and Winsome Wright

"Stop the noise...A quiet environment promotes healing"



Rob Morrow, CICF Secretary, Mai Nguyen, Julie Kinnon, Bea Kristine Canapi and Teddie Tanguay, CACCN President

Second Place

Jean Morrow and Eleanor Marris-Rogers

"Implementing routine delirium screening (ICDSC) and initial management in a critical care setting"



Eleanor Marris-Rogers, Teddie Tanguay, CACCN President and Jean Morrow

Second place

Stephen Manning, Walter Cariazo and Fergus Cabbage

"Reducing blood culture contamination rates in medical surgical intensive care unit (MSICU) with the introduction of a blood culture bundle"

Delegates' choice

Elaine Doucette, Sarina Fazio, Stephanie Gourdeau,
Brooke Latulippe, Vanessa Lauzon, Kayla Sliskovic,
Vanessa Lavergne and Maggie Wong

"Providing family-centred care in the PICU and NICU: Where does a student's voice fit in?"



Sarina Fazio, Elaine Doucette, Brooke Latulippe, Stephanie Gourdeau, Vanessa Lauzon, Vanessa Lavergne, Teddie Tanguay, CACCN President, Maggie Wong and Kayla Sliskovic

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

Thank you to the Dynamics 2012 Sponsors and Exhibitors

The CACCN Board of Directors and the Dynamics 2012 Planning Committee wish to sincerely thank the following sponsors and exhibitors. The ability to provide quality programming during the Dynamics of Critical Care Conference depends upon the support of our sponsoring and exhibiting companies:

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- Vancouver Coastal Health
- Vernacare

CNA Certification 2012

CACCN would like to congratulate the following members on successfully attaining / renewing their Certified Nurse in Critical Care—Canada (CNCC(C)) and Certified Nurse in Critical Care—Pediatrics Canada (CNCCP(C)) Designation in April 2012:

CNCC(C) Initial Certification

Name	City, Province
Jalil Jack Bahlis	Toronto, ON
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Susan Cameron	Ile-Perrot, QC
Karen Champagne	Cambridge, ON
Matthew Douma	Edmonton, AB
Adam Gagnon	Bathurst, NB
Sheena Gagnon	Yellowknife, NT
Serge Ganzburg	North York, ON
Meaghan Goff	Halifax, NS
Arlenne Gonzalvo-Atienza	Stouffville, ON
Ronnie Halabi	Edmonton, AB
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Jenny Kent	St. Albert, AB
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Carey Kinjerski	Gibbons, AB
Meghan Klatchuk	Edmonton, AB
Kendrah Krousoks	London, ON
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Dianne Walkom	Stratford, ON
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Jennifer Wright	Brampton, ON

CNCCP(C) Initial Certification

Sophie Joseph	Mississauga, ON
Patricia Santos	Brampton, ON
Karen Sokalski	West Vancouver, BC



Shattering the Silence: Voices of Advocacy in Critical Care Nursing

September 22–24, 2013, Halifax, Nova Scotia

As critical care nurses, we must unite our voices to speak with conviction to shatter the persistent silence surrounding the pivotal role we play in the care of critically ill patients and their families. The critical care nurse is the key coordinator of the complex minute-by-minute care each patient and family needs in the intensive care unit (ICU). ICU nurses draw on a vast scope of knowledge and scientific evidence, combining it with superb technical skills and organizational ability to ensure each patient is provided with an accurate diagnosis and a plan of action. As the most consistent bedside care providers, nurses ensure that ethical, culturally competent, compassionate, evidence-based health service is coordinated within the vastly complex systems of health care organizations and individualized to meet the unique strengths and needs of each patient and family.

We must break through and shatter any barriers that silence our voices while we embrace partnerships with the media and the public to assist us in getting our messages out, as we speak to issues where our knowledge, experience, expertise and unique perspective need to be shared and our voices heard. No longer will the crucial role of critical care nurses be kept a well-guarded secret. Dynamics 2013 in Halifax, Nova Scotia, will be a showcase of what we know and what we do to advocate for patients, families, colleagues and ourselves. Join your voice with colleagues nationally and internationally to tell your story of advocacy and to... shatter the silence!

CACCN/Dynamics 2013 invites submissions for oral and poster presentations in the general topic areas of clinical practice, education, research and leadership.

Dynamics 2013 Call for Abstracts

Abstracts for Dynamics 2013 are currently being accepted for

- Oral Presentations (*approx. 35-minute presentation, 10 minutes questions*)
- Poster Presentations

Submissions must be evidence-based and ideally address the conference theme. The abstract selection process is a blind peer-reviewed process. Abstracts may be submitted for pediatric and adult presentations. The abstracts submitted will be used to assist the planning committee in selecting those papers of the most value, and relevance to our membership, nursing specialty and to assist conference delegates in choosing the sessions they would like to attend. Presenters may select their preferred format of presentation (oral or poster), however the planning committee will make the final determination on presentation type.

Abstract submission guidelines

- The abstract submission process will be available from **November 1, 2012**, to **January 31, 2013**, at 2359 EST
- Abstracts must be submitted via the CACCN website at www.caccn.ca
- All requested information must be included at the time of the abstract submission, including references

Important points

- Potential presenters who do not meet the deadline and the submission guidelines will not be considered
- Abstracts received via email, fax or regular mail will not be considered
- Upon successful submission, presenters will receive a confirmation email with an abstract number (please retain this information)
- Notification regarding abstract selection will be provided by no later than March 15, 2013, via email
- All correspondence will be with first author only. It is the responsibility of the first author to communicate relevant information to any additional authors
- Abstracts may be published in Dynamics: Journal of the Canadian Association of Critical Care Nurses and on the CACCN website at www.caccn.ca

Abstract requirements

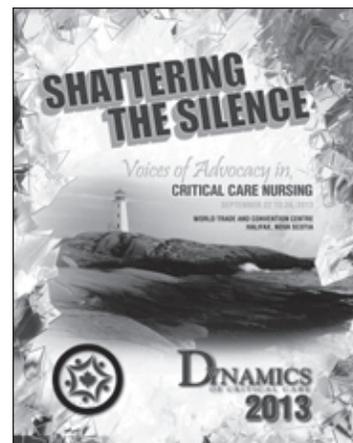
- Abstract submission (maximum of 2,000 characters including spaces)
- Abstract title (maximum of 130 characters including spaces)
- Preferred format for presentation (oral or poster)
- References:
 - submit five key references only, in APA format
 - references must be uploaded at the time of submission (word or PDF)
 - abstracts submitted without references will not be considered
 - references submitted in a format other than APA will be returned for revision if the abstract is selected for presentation
- Identifying Information:
 - the submission cannot contain any identifying information in the title, description, body or reference document (i.e. author/hospital names, city, province, acronyms, etc.)
 - abstracts submitted with identifying information will not be considered

Please read the full instructions on the CACCN website prior to proceeding with your submission

Ethics and disclosure

- Submission of an abstract constitutes a commitment by the author to present on **one** of the conference days (September 22, 23, or 24, 2013), if accepted
- The presenting author is required to disclose any real or perceived conflict of interest on behalf of all authors, in relation to the topic or material to be presented

Questions may be directed to: Dynamics 2013 Abstracts, Email: caccn@caccn.ca; Toll Free: 1-866-477-9077; Telephone: (519) 649-5284; Facsimile: (519) 649-1458. 



A survey of nurses' perceptions of the intensive care delirium screening checklist

BY TYLER J. LAW, MD, NICOLE A. LEISTIKOW, MPhil, LAURA HOOFRING, MSN, ARNP, PMH, SHARON K. KRUMM, PhD, RN, KARIN J. NEUFELD, MD, MPH, AND DALE M. NEEDHAM, PhD, MD

Abstract

Objectives: Delirium in critically ill patients is common and is associated with increased morbidity and mortality. Routine delirium screening is recommended by the Society of Critical Care Medicine. The Intensive Care Delirium Screening Checklist (ICDSC) is one validated and commonly-used tool, but little is known about nurses' perceptions of using the ICDSC, and of barriers to delirium assessment and treatment.

Design: A survey was administered to 189 critical care-trained nurses working on four oncology inpatient units, where the ICDSC has been used for greater than five years.

Results: Eighty-four nurses (44%) responded to the survey. Respondents indicated that they had knowledge of delirium, confidence in the ICDSC, and that the ICDSC was useful.

Respondents perceived that physicians did not value the ICDSC results. Similar to prior nurse surveys for other delirium screening tools, physicians were the most frequently identified barrier to both delirium assessment and treatment, with other frequent barriers being lack of time, feedback on performance, and knowledge of delirium.

Conclusions: The ICDSC is viewed favourably by nurses with experience using the tool. Future delirium screening programs should encourage physician engagement early in the planning process to help address perceived barriers to delirium assessment and treatment.

Key words: delirium, intensive care units, nursing staff, nursing diagnosis, psychiatric status rating scales

Law, T.J., Leistikow, N.A., Hoofring, L., Krumm, S.K., Neufeld, K.J., Needham, D.M. (2012). A survey of nurses' perceptions of the intensive care delirium screening checklist. *Dynamics*, 23(4), 18–24.

Delirium occurs in up to 80% of critically ill patients and is associated with both short- and long-term morbidity and mortality (Ely, Inouye et al., 2001; Ely, Margolin et al., 2001; Ely et al., 2004; Girard et al., 2010; Pisani et al., 2009; Salluh et al., 2010). Hallmarks of delirium include inattention and an acute and fluctuating change in mental status (American Psychiatric Association, 1994) with delirium being considered a marker of brain dysfunction (Ely, Siegel, & Inouye, 2001; Granberg, Engberg, & Lundberg, 1996; McNicoll et al., 2003; Webb, Carlton, & Geehan, 2000). Knowledge is rapidly expanding regarding modifiable risk factors and interventions for the prevention and treatment of delirium (Pandharipande et al., 2006; Pandharipande et al., 2007; Pun & Ely, 2007; Riker & Fraser, 2009). For these reasons, regular assessment for delirium using a validated screening tool is recommended by the Society of Critical Care Medicine, as part of its clinical practice guidelines for sedation and analgesia in the intensive care unit (ICU) (Jacobi et al., 2002).

The Intensive Care Delirium Screening Checklist (ICDSC) is a validated, reliable and sensitive delirium screening tool that improves nurses' evaluation of delirium (Table 1) (Bergeron, Dubois, Dumont, Dial, & Skrobik, 2001; Gesin et al., 2012; Ouimet et al., 2007; Skrobik et al., 2010). Prior studies have evaluated health care professionals' general perceptions of delirium screening and perceptions of specific delirium screening tools (Devlin et al., 2008; Patel et al., 2009; Pun et al., 2005; Soja et al., 2008). A previous study showed that nurses report the ICDSC makes delirium easier to identify, but barriers to delirium screening remain a challenge (Gesinde et al., 2012).

Purpose

As part of a quality improvement initiative focused on routine delirium screening, the purpose of this survey was to evaluate nurses' perceptions regarding use of the ICDSC and barriers to delirium assessment and treatment. A survey of perceptions can help identify areas of potential change to improve quality of care.

Table 1: The Intensive Care Delirium Screening Checklist (Bergeron et al., 2001)

Assign one point for items 1–8 if the item is present. A score of >4 has a 99% sensitivity to detect delirium.

1. Altered level of consciousness (A–E)
If A or B, do not complete patient evaluation for the period
A: No response, score: None
B: Response to intense and repeated stimulation (loud voice and pain), score: None
C: Response to mild or moderate stimulation, score: 1
D: Normal wakefulness, score: 0
E: Exaggerated response to normal stimulation, score: 1
2. Inattention
3. Disorientation
4. Hallucination—Delusion—Psychosis
5. Psychomotor agitation or retardation
6. Inappropriate speech or mood
7. Sleep/wake cycle disturbance
8. Symptom fluctuation

Methods

Survey population. The survey was conducted in four oncology inpatient medical units at a National Cancer Institute-designated comprehensive cancer centre in Baltimore, MD, where the ICDSC has been used for more than five years. In these units, nurses provide critical care (including mechanical ventilation), intermediate and general acute medical care, as required. The nurse-to-patient ratio changes to one to one when mechanical ventilation is necessary. All 189 full-time staff nurses in the four units are trained in critical care and were eligible for the survey. The unit policy is for the ICDSC to be performed twice daily (once per shift).

A description of the proposed project was reviewed by the Institutional Review Board (IRB) chair, who determined it to be a quality improvement initiative within the context of ongoing quality improvement efforts undertaken in this setting, and therefore, not requiring IRB review or consent. Participation in the survey was voluntary and anonymous.

Instruments. We used a web-based survey to collect demographic information regarding nurses' experience with the ICDSC. The survey had two major sections: (1) nurse perceptions of key aspects of delirium screening using the ICDSC (14 questions), and (2) nurse perceptions of potential barriers to the assessment and treatment of delirium (seven questions each). Nurses received up to two weekly email reminders and one verbal reminder during a staff meeting to complete the survey, with responses permitted for approximately three weeks after the initial survey request.

In the first section of the survey, 12 of the 14 questions were based on two prior ICU nursing surveys, which collected feedback after implementation of another ICU delirium screening tool, the Confusion Assessment Method for the ICU (CAM-ICU) (Pun et al., 2005; Soja et al., 2008). This replication of questions was done to enable direct comparisons of nurse perceptions of delirium screening with prior studies in order to understand if there were common barriers generalizable beyond individual hospital sites (not intending to directly compare nurse perceptions of the ICDSC to the CAM-ICU). These questions evaluated four domains: (1) knowledge of delirium and the ICDSC tool (four questions), (2) confidence in performing the ICDSC (three questions), (3) utility of the ICDSC (four questions), and (4) physicians' value of the ICDSC (one question). Two new questions were added and were reviewed for clarity and face validity by two members of nursing leadership on the participating units to further evaluate the following issues: (1) the perceived accuracy of delirium screening assessments ("My colleagues' delirium assessments are accurate" added to the domain evaluating confidence), and (2) whether the ICDSC was administered at least once per shift, as per recommended nursing practice for these specific hospital units ("The ICDSC is being completed twice a day for the time the patient is in the oncology unit" added to the domain evaluating utility).

In the second section of the survey, all seven barrier questions were drawn from the two prior ICU nursing surveys of the CAM-ICU (Pun et al., 2005; Soja et al., 2008). These questions addressed the following potential barriers to each of delirium

assessment and treatment: time, physicians, lack of feedback on performance, lack of support by leadership staff, lack of confidence in performing the ICDSC, lack of resources to answer questions, and lack of knowledge about delirium.

Scoring the survey. The 14 perception questions in the first section were scored on a five-point Likert scale, where 1 = "Strongly disagree", 3 = "Neither agree nor disagree" and 5 = "Strongly agree".

The seven barrier questions in the second section were evaluated using binary "Yes/No" responses for each of delirium assessment and treatment, separately, for a total of 14 barrier questions per nurse respondent. The survey separately asked about physician barriers according to level of training (i.e., separate questions for resident, fellow and attending physicians), which were scored by group and in aggregate, as a single physician group. Given the similarity in responses across the physician categories, only the aggregate physician group has been presented in this paper.

Statistical analysis. In the first section, the mean and standard deviation Likert scale score was calculated for each question and in aggregate for each of the four domains. To evaluate any effect of duration of use of the ICDSC on nurse responses, respondents were arranged, on an a priori basis, into three groups (<2 years, 2–4 years, and >4 years experience with the ICDSC) and mean scores for individual questions and the four domains were compared among these three nursing groups using Students' t-tests. To enable comparison with the two prior surveys (Pun et al., 2005; Soja et al., 2008), the proportion of responses scoring four or five ("Agree" or "Strongly agree") was calculated for each question and proportions were compared using Chi-square.

In the second section, Chi-square tests were used to compare frequencies of the binary responses regarding potential barriers to assessment and treatment of delirium. Respondents were again grouped into the same three groups as above. Chi-square tests were used to compare the frequency with which each barrier was identified as an assessment versus as a treatment barrier. Missing responses were reported in the results and excluded from the calculation of means and proportions. A p-value ≤ 0.05 was considered statistically significant. SPSS software (version 15) was used for statistical analyses (SPSS Inc., Chicago, Illinois).

Results

Of the 189 eligible nurses, 84 (44%) responded to the survey. More than 80% of the respondents had been practising for greater than two years and using the ICDSC for greater than two years.

In the first section, 13 of 14 individual questions and three of four domains had a mean score >3, indicating that, on average, nurses tended to "agree" that they had knowledge of delirium, confidence in the ICDSC and found the ICDSC to be useful. The one question domain relating to the value that physicians place on the tool had a mean score of 2.9, indicating that nurses, on average, perceived that physicians did not value the ICDSC data. The overall mean score for this domain was significantly lower than each of the three other domains (Table 2).

When comparing mean survey scores by respondents' length of ICDSC use, 13 of 14 individual questions and three of four domains showed a similar pattern across the three groups (Tables 2 and 3). Specifically, the nursing group with less than two years of use had the highest mean score, the two-to-four-

year group had the lowest, and the greater-than-four-year group's mean score was between the scores of the other two groups. Scores for the group of respondents with less than two years' use were significantly higher than the group with two to four years of use. However, the differences in mean scores

Table 2: Nurses' perceptions of the ICDSC by years of ICDSC use

Domain	Survey question	Overall mean N = 84	Mean (SD) values ^a			p-value compared with 2–4 years ^b	
			< 2 yrs N = 17	2–4 yrs N = 32	> 4 yrs N = 35	< 2 yrs	> 4 yrs
Knowledge	I understand what delirium is and the types of delirium	3.7 (0.9)	4.0 (0.5)	3.5 (1.1)	3.8 (0.9)	0.05	0.35
	If asked on the spot, I can give a definition for delirium	3.5 (0.9)	3.5 (0.8)	3.4 (1.0)	3.6 (0.9)	0.59	0.35
	My knowledge about delirium has increased since using the ICDSC	3.8 (1.1)	4.2 (0.7)	3.5 (1.4)	4.0 (0.9) ^d	0.01	0.10
	I received adequate education on the ICDSC and delirium assessments	3.7 (1.1)	4.0 (0.6)	3.4 (1.2)	3.9 (1.1)	0.03	0.11
Confidence	I feel confident in completing the ICDSC	4.0 (1.0)	4.3 (0.6)	3.8 (1.4)	4.1 (0.8)	0.06	0.28
	My delirium assessments are accurate	3.7 (0.9)	3.9 (0.7)	3.6 (1.1) ^c	3.8 (0.8)	0.24	0.29
	My colleagues' delirium assessments are accurate	3.6 (0.9)	3.8 (0.5)	3.5 (1.1) ^c	3.7 (0.9) ^c	0.15	0.44
	The ICDSC is easy to complete	4.1 (1.1)	4.6 (0.5)	3.9 (1.4)	4.1 (0.9)	0.02	0.42
Utility	The ICDSC is a useful tool	3.9 (1.0)	4.1 (0.7)	3.6 (1.2)	4.0 (0.9)	0.05	0.11
	Patient care is enhanced by the ICDSC	3.7 (1.0)	3.8 (0.7)	3.4 (1.1)	3.8 (1.0) ^c	0.16	0.21
	The ICDSC has improved the organization of my neuro assessment	3.4 (1.1)	3.5 (0.9)	3.1 (1.1)	3.7 (1.0)	0.28	0.03
	Monitoring for delirium has helped me perform a more comprehensive patient assessment	3.8 (1.0)	3.9 (0.7)	3.5 (1.2)	4.1 (0.9)	0.11	0.03
	The ICDSC is being completed twice a day for the time the patient is in the oncology unit	4.2 (1.1)	4.7 (0.5)	4.0 (1.4)	4.1 (1.0) ^c	0.02	0.70
Physician value	The physicians value the ICDSC assessment data	2.9 (1.0)	2.8 (1.0)	2.8 (0.9) ^c	3.0 (1.1)	0.95	0.38

Intensive Care Delirium Screening Checklist (ICDSC)
^aResponses scored on a 5 point Likert scale where 1 = strongly disagree, 3 = neither agree nor disagree, and 5 = strongly agree;
^bp-value for Students' t-test; ^cOne missing response

Table 3: Nurses' perceptions of the ICDSC grouped according to domains, by years of ICDSC use

Domain	Mean (SD) Values ^a				p-value compared with 2–4 years ^b	
	Overall N = 84	< 2 yrs N = 17	2–4 yrs N = 32	> 4 yrs N = 35	< 2 yrs	> 4 yrs
Knowledge	3.7 (0.9) ^c	3.9 (0.5)	3.4 (1.1)	3.8 (0.8)	0.03	0.14
Confidence	3.9 (0.9) ^c	4.1 (0.5)	3.7 (1.1)	3.9 (0.8)	0.05	0.32
Utility	3.8 (0.9) ^c	4.0 (0.6)	3.5 (1.1)	3.9 (0.8)	0.05	0.09
Physician value	2.9 (1.0)	2.8 (1.0)	2.8 (0.9)	3.0 (1.1)	0.95	0.38

Intensive Care Delirium Screening Checklist (ICDSC)
^aMean values of survey questions grouped according to domain as outlined in Table 1. Responses scored on a 5 point Likert scale where 1 = strongly disagree, 3 = neither agree nor disagree, and 5 = strongly agree;
^bp-value for Students' t-tests; ^cp ≤ 0.05 when compared to "Belief about physician value"

between the two-to-four-year and greater-than-four-year group did not reach statistical significance (Table 3). In the domain related to physicians valuing the ICDSC, all three groups had a mean score <3, indicating that all groups perceived that physicians did not value the ICDSC data. There were no significant differences in mean score between groups in this domain.

In the second section of the survey, the barriers identified most frequently were the three physician groups (residents, fellows and attending physicians). When aggregated into a single group, physicians still represented the most frequent barrier, being identified by 42% of nurses (Table 4). Physicians

were considered a significantly greater barrier to treatment of delirium versus assessment of delirium. There were no differences in nursing perception of barriers by physician training level (i.e., resident, fellow, or attending physician), and no factor was identified more frequently, as a barrier to assessment versus treatment of delirium (Table 4). Other frequently perceived barriers were: lack of time (27%), lack of feedback on performance (27%), and lack of knowledge about delirium (24%). There were no differences in the frequency that a barrier was identified by amount of nursing experience with ICDSC (Table 5).

Table 4: Proportion of nurses identifying a factor as a barrier to assessment and to treatment of delirium

Factor	Number of respondents identifying a factor as a barrier (%) ^{ab}			p-value (assessment vs treatment) ^c
	Assessment or treatment N = 168	Assessment N = 84	Treatment N = 84	
Physicians	70 (42)	20 (24)	50 (60)	0.001
Lack of feedback on performance	46 (27)	23 (27)	23 (27)	1.00
Time	45 (27)	22 (26)	23 (27)	0.86
Lack of knowledge of delirium	40 (24)	16 (19)	24 (29)	0.15
Lack of resources to answer questions	33 (20)	14 (17)	19 (23)	0.33
Lack of confidence in performing the ICDSC	18 (11)	11 (13)	7 (8)	0.32
Lack of support by leadership staff	13 (8)	5 (6)	8 (10)	0.39

Intensive Care Delirium Screening Checklist (ICDSC)
^aProportions are the number of nurses identifying a factor as a barrier to assessment or treatment divided by the total number of nurse respondents
^bProportions do not add to 100%, as nurses could select more than one response
^cp-values for Chi-square

Table 5: Factors identified as barriers to assessment and treatment of delirium by years of ICDSC use

Factor	Assessment ^a				p-value comparing 2-4 years ^b		Treatment ^a				p-value comparing 2-4 years ^b	
	<2 yrs N=17	2-4 yrs N=32	>4 yrs N=35	% overall N=84	<2 yrs	>4 yrs	<2 yrs N=17	2-4 yrs N=32	>4 yrs N=35	% overall N=84	<2 yrs	>4 yrs
	Physicians	20%	35%	45%	24%	1.00	0.71	18%	40%	42%	60%	0.52
Lack of feedback on performance	12%	31%	31%	27%	0.17	0.99	24%	22%	34%	27%	1.00	0.26
Time	12%	22%	37%	26%	0.47	0.17	35%	19%	31%	27%	0.30	0.23
Lack of knowledge of delirium	18%	16%	23%	19%	1.00	0.45	18%	38%	26%	29%	0.15	0.30
Lack of resources to answer questions	12%	9%	26%	17%	1.00	0.08	24%	16%	29%	23%	0.70	0.20
Lack of confidence in performing the ICDSC	18%	6%	17%	13%	0.33	0.26	0%	6%	14%	8%	0.54	0.43
Lack of support by leadership staff	6%	3%	9%	6%	1.00	0.61	6%	3%	17%	10%	1.00	0.11

^aResponses scored either "yes" or "no"; proportions are number of nurses answering "yes" divided by all respondents in each category
^bp-values for Chi-square and Fisher Exact test as appropriate

Discussion

Our survey demonstrates that nurses perceive delirium screening using the ICDSC to be useful and have knowledge and confidence in using it. This perception tended to be strongest among nurses with the least (<2 years) and greatest (>4 years) experience in using the ICDSC compared to nurses with intermediate experience (two to four years). Strikingly, nurses perceived that physicians did not value delirium screening, and reported that physicians were the greatest barrier to the assessment and the treatment of delirium. This information is particularly useful for ICUs to consider when seeking to implement or improve nurse-based delirium screening, as part of routine care.

We compared our results to similar nursing surveys of the CAM-ICU delirium screening tool conducted in other centres in order to compare similarities and differences in nursing perceptions of delirium screening. This comparison was not intended to identify nurse preferences between different delirium screening tools since each nursing group was exposed to only one screening tool. A smaller proportion of respondents in our survey felt that they understood delirium (Table 6) (Pun et al., 2005). However, the proportion in our survey was similar to the proportion observed in a prior study evaluating the CAM-ICU in a trauma ICU (Soja et al., 2008). In addition, a greater proportion of nurses in our survey reported that patient care was enhanced by delirium screening, and that they have

Table 6: Nurses' perceptions of the ICDSC, compared to previous nursing surveys evaluating the CAM-ICU

Domain	Survey question	% of nurses who "Agree" or "Strongly agree" ^a		
		ICDSC	CAM-ICU	
		Present survey N=84	Trauma ICU N=42	Medical ICU N=55
Knowledge	I understand what delirium is and the types of delirium	76	67	95
	If asked on the spot, I can give a definition for delirium	54	NA	48 ^c
	My knowledge about delirium has increased since using the ICDSC/CAM-ICU	72 ^c	NA	80
	I received adequate education on the ICDSC/CAM-ICU and delirium assessments	69	62	NA
Confidence	I feel confident in completing the ICDSC/CAM-ICU	83	60	71
	My delirium assessments are accurate	71 ^c	64	NA
	My colleagues' delirium assessments are accurate	65 ^d	NA	NA
	The ICDSC/CAM-ICU is easy to complete	88	43	67
Utility	The ICDSC/CAM-ICU is a useful tool	76	NA	71
	Patient care is enhanced by the ICDSC/CAM-ICU	65 ^c	17	NA
	The ICDSC/CAM-ICU has improved the organization of my neuro assessment	49	NA	60
	Monitoring for delirium has helped me perform a more comprehensive patient assessment	75	NA	65
	The ICDSC is being completed twice a day for the time the patient is in the oncology unit	86 ^c	NA	NA
Physician value	The physicians value the ICDSC/CAM-ICU assessment data	24 ^c	17	32 ^d

Intensive Care Delirium Screening Checklist (ICDSC); Confusion Assessment Method for the ICU (CAM-ICU); not applicable (NA).
^aQuestions marked "NA" were not asked in the survey; ^bp-values for Chi-square; ^cOne missing response; ^dTwo missing responses

confidence in completing screening (Pun et al., 2005; Soja et al., 2008). These differences may be because 80% of nurses in this evaluation had been using the ICDSC for greater than two years, while in the two prior studies, the survey was administered during early implementation of the CAM-ICU delirium screening tool.

In our survey, 88% of respondents reported that the ICDSC was easy to complete. This contrasts with prior studies reporting that 33% to 57% of nurses found that the complexity of screening instruments was the top barrier to delirium assessment or that screening was not easy to complete (Devlin et al., 2008; Pun et al., 2005; Soja et al., 2008). However, without a direct comparison, we cannot conclude that the ICDSC is easier to use than other delirium screening tools, especially given the greater than five-year duration of institutional experience and training in the use of the ICDSC in our setting. One prior study reported that 37% of nurse respondents had never received any training in delirium assessment (Devlin et al., 2008), versus all nurse respondents having received training in our setting. Even the least-experienced nurses felt confident in performing the delirium screen in the current survey, perhaps because their training was more recent than the other respondents. However, in both prior CAM-ICU surveys where nurses had recently received training in delirium screening, respondents reported feeling less confident than nurses in this survey (Table 6) (Pun et al., 2005; Soja et al., 2008). These differences in perception of delirium screening may be used to help identify areas where further quality improvement efforts may be targeted, such as additional or periodic education on delirium and screening tools.

The belief that physicians were the greatest barrier to delirium assessment and treatment is likely related to nurses' perceptions that physicians did not value the ICDSC. Unlike responses to other survey questions, this perception did not vary among nurses with different levels of ICDSC experience, demonstrating consensus. This finding is consistent with the two prior studies of the CAM-ICU, where only 17% and 32% of nurses felt physicians valued the delirium screening data, and another study where 27% of nurses perceived that physicians not using delirium assessments was one of the top three barriers to delirium evaluation (Table 5) (Pun et al., 2005; Soja et al., 2008). These findings regarding perceived barriers underscore the importance of ensuring physician "buy-in" throughout planning and implementing of delirium screening, to ensure they understand and support it. In our experience with recently implementing delirium screening in the medical ICU setting (after administering this survey), using a structured quality improvement model (Pronovost, Berenholtz, & Needham, 2008) with emphasis on "engaging" and "educating" all clinicians (including physicians) about the importance of delirium screening is vital prior to implementation. ICUs with existing delirium screening programs may find that renewed interdisciplinary engagement with physicians may improve the utility of delirium screening. Leadership from all disciplines, including physicians, is needed to ensure the success of delirium screening programs.

There are limitations to this survey. First, it is a single-site evaluation with a relatively small sample size ($n = 84$ respondents) and a low response rate. However, the sample size and response rate are comparable to the existing published literature of other single-site nursing surveys of delirium screening tools (Devlin et al., 2008; Pun et al., 2005; Soja et al., 2008). Second, since this is a survey of nurses' perceptions, it may not reflect the actual practice of delirium screening. Additionally, because of structure of the unit, some of these perceptions may be based on assessments performed on patients receiving acute care, not critical care. However, nursing perceptions help identify gaps in implementation and areas of miscommunication surrounding the ICDSC. Moreover, this survey builds on the foundation of the prior published studies. We focused on nursing perceptions of the ICDSC, whereas prior studies have either examined delirium screening in general, or the CAM-ICU tool specifically (Devlin et al., 2008; Pun et al., 2005; Soja et al., 2008). We have also specifically separated identified barriers to assessment and to treatment of delirium, as barriers to one may not be barriers to the other.

Conclusion

The ICDSC delirium screening tool is viewed favourably by nurses. However, nurses perceive that physicians do not value the ICDSC results. Physicians are the most frequently perceived barrier to both delirium assessment and treatment. Future quality improvement projects for delirium screening should specifically target physicians, especially early on in the process of engaging and educating clinicians about delirium. 

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Burnout in critical care nurses: A literature review

BY KIRSTIN EPP, BScN, GN

Abstract

Burnout and its development in critical care nurses is a concept that has received extensive study, yet remains a problem in Canada and around the world. Critical care nurses are particularly vulnerable to developing burnout due to the chronic occupational stressors they are exposed to, including high patient acuity, high levels of responsibility, working with advanced technology, caring for families in crisis, and involved in morally distressing situations, particularly prolonging life unnecessarily. The purpose of this article is to explore how the chronic stressors that critical care nurses are exposed to contribute to the development of burnout, and strategies for burnout prevention. A review of the literature between the years 2007 and 2012 was conducted and included the search terms burnout, moral distress, compassion fatigue, intensive care, critical

care, and nursing. The search was limited to the adult population, English language, and Western cultures. The results revealed that nurse managers play a crucial role in preventing burnout by creating a supportive work environment for critical care nurses. Strategies for nurse managers to accomplish this include being accessible to critical care nurses, fostering collegial relationships among the different disciplines, and making a counsellor or grief team available to facilitate debriefing after stressful situations, such as a death. In addition, critical care nurses can help prevent burnout by being a support system for each other and implementing self-care strategies.

Key words: burnout, critical care nurses, moral distress, compassion fatigue

Epp, K. (2012). Burnout in critical care nurses: A literature review. *Dynamics*, 23(4), 25–31.

Burnout is a topic that has received considerable attention in the last few decades, particularly in relation to critical care nurses. The hallmarks of burnout include emotional exhaustion, depersonalization, cynicism, or detachment, and feeling ineffective at work (Bakker, Le Blanc, & Schaufeli, 2005; Bühler & Land, 2003; Lederer, Kinzl, Traweger, Dosch, & Sumann, 2008; Leiter & Maslach, 2009; Leiter & Spence Laschinger, 2006; McFeely, 2007; Peterson et al., 2008; Schaufeli & Greenglass, 2001). Despite extensive research on the topic, burnout continues to be a problem in critical care nurses around the globe and in Canada (McFeely, 2007; O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010). According to Storlie (1979), “burnout is a process so insidious that an exact etiology is difficult to trace” (p. 2108). In an effort to understand how burnout develops in critical care nurses and how it can be prevented, a review of the literature from 2007–2012 using the terms burnout, moral distress, compassion fatigue, intensive care, critical care, and nursing was conducted. Databases included: CINAHL Plus with Full Text, MEDLINE, PsycARTICLES, PsycINFO, Nursing Reference Center, Health Policy Reference Center, Health Source—Consumer Edition, E-journals, ERIC, SocINDEX with Full Text, and Humanities International Complete. Findings revealed that nurse managers, colleagues, and critical care nurses themselves are jointly responsible for implementing strategies to prevent burnout in critical care nurses. Some of those strategies will be explored in this article, as well as how the environment and nature of critical care nursing places critical care nurses at risk of burnout.

Burnout is a debilitating condition that can develop in anyone, regardless of their occupation (Schaufeli & Greenglass, 2001). Individuals who work in human services, especially nurses and those who work in the intensive care unit (ICU), are at a particularly high risk of developing burnout because of the chronic stress they experience (Bakker et al., 2005; Bühler & Land, 2003; Daines, 2000; Lederer et al., 2008; Leiter & Spence Laschinger, 2006; McFeely, 2007; Sawatzky, 1996). In reviewing the literature, there appears to be no precise definition of burnout, although there are many descriptions. Leiter and Maslach (2009) and Leiter and Spence Laschinger (2006) refer to burnout as an occupation-induced psychological syndrome that is the extreme opposite of engagement, while Storlie (1979) views burnout as more of a spiritual phenomenon in which a person experiences disillusionment deep within the very essence of who they are, or, in other words, a “collapse of the human spirit” (p. 1208).

While there seems to be no standard definition of burnout, it is described commonly throughout the literature as having three key elements: 1) high emotional exhaustion; 2) high depersonalization, cynicism, or detachment; and 3) low levels of personal effectiveness or accomplishment (Bakker et al., 2005; Bühler & Land, 2003; Lederer et al., 2008; Leiter & Maslach, 2009; Leiter & Spence Laschinger, 2006; McFeely, 2007; Peterson et al., 2008; Schaufeli & Greenglass, 2001). Leiter, and Spence Laschinger (2006) and Schaufeli and Greenglass (2001) define emotional exhaustion as feeling

emotionally drained and lacking the emotional energy necessary to provide the services required. It is understood to be the core symptom of burnout, and is influenced by an individual's work environment (Bakker et al., 2005; Leiter & Spence Laschinger, 2006). While emotional fatigue is identified as a key element of burnout, physical and mental fatigue may also be experienced (Lederer et al., 2008; Schaufeli & Greenglass, 2001). Depersonalization is a state in which individuals have mentally distanced themselves from their work, including the people they interact with, and is influenced by the extent to which emotional exhaustion is present (Leiter & Spence Laschinger, 2006; Schaufeli & Greenglass, 2001). This element of burnout is characterized in a person through detached, callous, unfeeling, and even dehumanizing interactions with people at work, and a negative, bitter attitude (Bakker et al., 2005; Bühler & Land, 2003; McFeely, 2007; Schaufeli & Greenglass, 2001; Storlie, 1979). Feeling ineffective or lacking in accomplishment is a subjective evaluation made by an individual and is influenced by depersonalization (Leiter & Spence Laschinger, 2006; Schaufeli & Greenglass, 2001). Storlie (1979) describes this element of burnout as "the perception that no matter what you do or how hard you try, you cannot make a difference" (p. 2109).

Critical care nurse burnout

Even though the concept of burnout in critical care nurses is not a new topic, burnout continues to be a problem (Bakker et al., 2005). McFeely (2007) states that burnout "is so pervasive in the ICU that it almost has become a part of the background noise" (p. 37). In a study by Poncet et al. (2007), 2,392 nursing staff (including 1,937 [81%] nurses, 359 [15%] nursing assistants, and 96 [4%] head nurses) from 165 ICUs in France anonymously completed the Maslach Burnout Inventory questionnaire. The findings revealed that 798 (32.8%) respondents were severely burned out, and that 60% of those with severe burnout were contemplating leaving the nursing profession. While there are no specific statistics on burnout in Canadian critical care nurses, a pan-Canadian study of nurse turnover rates identified ICUs as having the second highest turnover rate, second to psychiatric units and significantly higher than medicine and surgical units combined (O'Brien-Pallas et al., 2010). Since burnout is reported to be a contributing factor to a nurse's decision to leave his or her unit or even the profession of nursing altogether, the results from the O'Brien-Pallas et al. (2010) study can be interpreted as an indication that burnout is a problem in Canadian critical care nurses.

The development of burnout in critical care nurses

Emotional exhaustion. A large contributor to the development of emotional exhaustion and, ultimately, burnout in critical care nurses is stress (Bakker et al., 2005; Lederer et al., 2008; McFeely, 2007; Sawatzky, 1996; Storlie, 1979). Many factors influence the stress level in ICUs, with one of the most obvious being the high acuity of patients (Bakker et al., 2005; Lederer et al., 2008; Sawatzky, 1996). Critically ill

patients have great demands for complex care, which results in a heavy workload for critical care nurses (Bakker et al., 2005; Lederer et al., 2008). Since ICU patients are in critical condition and critical care nurses have the closest contact with them, performance expectations of critical care nurses are high (Bakker et al., 2005; Lederer et al., 2008; Sawatzky, 1996). The critical care nurse is expected to assess, monitor and manage his or her patients continuously; coordinate, implement, evaluate and revise plans of care as needed; manage multiple therapies at once; anticipate, prevent and recognize situations that will negatively affect the health of their patients; and prioritize care (Canadian Association of Critical Care Nurses [CACCN], 2009). In addition, critical care nurses are expected to respond quickly to patient crises and make sound clinical judgments in reaction (CACCN, 2009; Sawatzky, 1996). The stress of having so much responsibility and taking care of patients who are extremely ill can lead to emotional exhaustion, which is a key element of burnout (Bakker et al., 2005; Lederer et al., 2008).

Another stressful aspect for critical care nurses that can lead to burnout is the many morally distressing situations they are regularly faced with due to the critical and complex condition of their patients (Gutierrez, 2005; McClendon & Buckner, 2007; Sundin-Huard & Fahy, 1999). Moral distress is experienced when people are unable to act in accordance with what they believe to be ethical, or when they act in a way that is contrary to their personal or professional values (Gutierrez, 2005; McClendon & Buckner, 2007). What makes these situations so distressing to people is that their authenticity and integrity are undermined (McClendon & Buckner, 2007). Critical care nurses are particularly vulnerable to being in morally distressing situations because their ability to make decisions regarding patient care is limited (Bakker et al., 2005; Hamric & Blackhall, 2007; Lederer et al., 2008; McClendon & Buckner, 2007). Critical care nurses have been found to be more susceptible to burnout than physicians, and it is thought that the key to this difference is that physicians are able to make final decisions whereas nurses must accept and execute them, within reason (Canadian Nurses Association [CNA], 2008; Lederer et al., 2008). Although the nursing perspective is claimed in the literature to be vital in planning patient care, in practice, critical care nurses often implement plans of care that they have had little input in formulating, which can place them in situations of moral distress (Bakker et al., 2005; Hamric & Blackhall, 2007; Lederer et al., 2008).

The most frequently occurring morally distressing situation for critical care nurses is that in which the patient's family wants to continue aggressive medical treatment when the nurse does not think it will be of benefit to the patient (Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007; Sawatzky, 1996). Furthermore, unnecessary prolongation of life has been reported as one of the most intensely stressful situations for critical care nurses (Hamric & Blackhall, 2007; Sawatzky, 1996). The ability to prolong life has increased greatly over the years with ever-developing life-sustaining technology

(Gutierrez, 2005; McClendon & Buckner, 2007). While the life-sustaining technology in the ICU is often viewed as positive, it can lead to ethical dilemmas regarding prolonging life (McClendon & Buckner, 2007; McGrath, 2008). In general, the nurses in McGrath's (2008) study viewed technology in the ICU in a positive light, but believed that it had also "surpassed human wisdom, as they were left to implement heroic caring for dying patients, while decisions failed to be made on what technology realistically had to offer" (pp. 1101–1102).

The advanced technology in the ICU can also be a stressor contributing to burnout in other ways (Bakker et al., 2005; Lederer et al., 2008; McGrath, 2008; Sawatzky, 1996). When technology malfunctions or is insufficient to meet the patient's needs, critical care nurses find the situation to be intensely stressful and threatening (Sawatzky, 1996). Since ICU nurses must possess advanced knowledge and skills to work with the sophisticated technology, novice nurses often feel overwhelmed and stressed when they first start working in the ICU (McGrath, 2008). It takes time for them to feel confident and competent, and they often rely on the expertise of experienced nurses (McGrath, 2008). This becomes an issue when adequate novice-to-experienced-nurse ratios are not in place, as is often the case due to the nursing shortage, because the experienced nurse can feel stressed from being overextended (McGrath, 2008). Noise from the various technologies in the ICU can also be stressful (Lederer et al., 2008; Ryherd, Persson Waye, & Ljungkvist, 2008). While more research is needed to explore the physiological effects of noise on critical care nurses, Ryherd et al. (2008) report that critical care nurses perceive that the noise contributes to them feeling irritated and fatigued, which can contribute to burnout.

Another major stressor for critical care nurses that can result in emotional exhaustion and, ultimately, burnout is caring for the patient's family (Stayt, 2007). In the past, critical care nurses were expected to care for just the patient (Stayt, 2007). While care of the patient remains the priority for the critical care nurse, critical care nursing has evolved to include the patient's family as an extension of the patient that also needs care, because the family often makes decisions on behalf of and acts as an important emotional support for the patient (Stayt, 2007). Caring for both the family and the patient is at the centre of Canadian critical care nursing philosophy, and creates the foundation for a family-centred model of care on which the practice standards for Canadian critical care nurses are based (CACCN, 2009). While it is very clear that critical care nurses must care for both the family and patient, there are emotional costs to the nurse associated with that care (Lederer et al., 2008; McFeely, 2007; McHolm, 2006; Stayt, 2007).

Caring for the patient and family requires a great deal of compassion, and can emotionally exhaust critical care nurses (Stayt, 2007). Compassion fatigue is a state of emotional exhaustion that occurs in nurses when they identify on a personal level with their patients and the families to the extent

that they absorb the suffering and pain of the patients and families (McHolm, 2006). "Giving high levels of energy and compassion over a prolonged period to those who are suffering, often without experiencing the positive outcomes of seeing patients get better" leads to compassion fatigue (McHolm, 2006, p. 14). Since critical care nurses care for patients and families in crisis and do not always see their patients improve, they are at an increased risk for burnout due to emotional exhaustion (Bakker et al., 2005; Lederer et al., 2008; McHolm, 2006).

Stayt (2007) explored critical care nurses' experiences of caring for the families of patients, and findings revealed that nurses have low confidence in managing the emotional needs of families. Critical care nurses often worry that they will not be able to provide sufficient answers to families' questions, or that they will say the wrong thing and negatively affect families' ability to cope (Stayt, 2007). In addition, there is often incongruence between critical care nurses' expectations regarding their supporting role to the family, and what they are realistically able to accomplish (Stayt, 2007). Critical care nurses often want to "make things right" or "take the pain and the worry away," and feel guilt and self-disapproval when they can't (Stayt, 2007, p. 626). Interestingly, critical care nurses' expectations of care for families in the study stemmed from their own perceptions and self-imposed standards rather than institutional guidelines, ethical mandates, or standards of practice (Stayt, 2007). Regardless of where the role strain or conflict originates from, it is believed to be a contributing factor to burnout when experienced over an extended period of time (Stayt, 2007).

One contributing factor to role conflict in critical care nurses is balancing care of the family with care of the patient (Stayt, 2007). This can be difficult because the patient is often unable to voice his or her needs and demands while the family can, which can make the nurse feel that he or she must attend to the family first (Stayt, 2007). Consequently, the critical care nurse can feel that the family is an obstacle to the patient's care (Stayt, 2007). In Stayt's (2007) study, one nurse in this situation stated that the family was "really worried and needed support, but the patient's wellbeing has to come first and that is final... I had to be very firm with the family as I felt... they were preventing me from doing my job" (p. 627).

Another contributing factor to role stress in critical care nurses is conflict between their professional role and personal self (Stayt, 2007). The code of ethics for registered nurses (CNA, 2008) mandates that nurses build trusting relationships with the patient and family, as a way to understand their needs and provide safe, compassionate, competent and ethical care. Building trust between the nurse and family is identified by the CACCN (2009) as an important aspect of partnership in family-centred care. Critical care nurses in Stayt's (2007) study acknowledged the importance of this relationship, but maintained that it requires personal investment. The difficulty for critical care nurses is in determining

where the boundary lies between being professional and becoming too personally involved (Stayt, 2007). Becoming too personally involved in a relationship with the family can be detrimental, as the nurses' clinical judgment can become clouded and they can experience emotional pain, suffering, and stress (Stayt, 2007).

Depersonalization. The next step in beginning to comprehend the development of burnout in critical care nurses is to understand how depersonalization, cynicism and detachment, the second key element of burnout, are developed (Bakker et al., 2005; Bühler & Land, 2003; Lederer et al., 2008; Leiter & Maslach, 2009; Leiter & Spence Laschinger, 2006; McFeely, 2007; Peterson et al., 2008; Schaufeli & Greenglass, 2001). Research conducted by Leiter and Spence Laschinger (2006) on a nursing worklife model of burnout identified emotional exhaustion as a contributing factor to depersonalization, which is understood to be a coping, self-preserving technique in response to emotional overload (Bühler & Land, 2003; Sawatzky, 1996).

One of the aspects of critical care nursing that has the potential to emotionally overload the nurse is caring for the patient's family (Stayt, 2007). Families who have a loved one being cared for in the ICU are in crisis (Stayt, 2007). Families are often emotionally distressed, anxious, in shock, and have difficulty processing what is happening. Sometimes, critical care nurses find the family's distress too overwhelming and seek to put distance between themselves and the family, as a self-preservation technique (Stayt, 2007). This can be accomplished by creating space, whether it is physical space, psychological space by focusing on tasks and equipment, or emotional space by "brushing over the personal stuff" (Stayt, 2007, p. 628).

Detachment can also occur in critical care nurses in response to morally distressing situations (Gutierrez, 2005; McClendon & Buckner, 2007). When critical care nurses are unable to resolve a moral conflict, such as in the instance of prolonging life unnecessarily, a common response is to put distance between themselves and the situation (Gutierrez, 2005; McClendon & Buckner, 2007). Gutierrez (2005) likens this tendency to the basic "flight or fight" response to a threat. Detachment can take the form of requesting to be assigned to another patient, or intentionally avoiding the family (Gutierrez, 2005). In addition, when a morally distressing situation is not resolved to the nurse's satisfaction, a cynical attitude can develop in response to feeling powerless and constrain the nurse from attempting to enact moral judgment and action in future situations (Gutierrez, 2005).

Ineffectiveness and lack of personal accomplishment. The third and final key element of burnout is when an individual feels that he or she is ineffective and/or lacking in personal accomplishment. In helping families deal with the critical illness of a loved one, Stayt (2007) reports that critical care nurses often undervalue the emotional support they give, and feel that they do not make enough of a difference. Many critical care nurses have such high standards of care and expectations of themselves

that they are not able to meet them and, consequently, are at risk of feeling a lack of personal accomplishment (Stayt, 2007). The nurse can also feel a lack of accomplishment and ineffectiveness in morally distressing situations that they are unable to resolve (Gutierrez, 2005). When physicians do not value the nurse's viewpoint and expertise and exclude them from making decisions regarding patient care, critical care nurses can feel a lack of personal accomplishment and find themselves in morally distressing situations that can lead to burnout (Gutierrez, 2005; Hamric & Blackhall, 2007; Papanthanasoglou et al., 2012; Sundin-Huard & Fahy, 1999). Feelings of ineffectiveness are further compounded when the critical care nurse does not feel supported by his or her nurse manager. Disturbingly, none of the critical care nurses in Gutierrez's (2005) study thought that management was a source of support in morally distressing situations. Rather, as one critical care nurse put it, "[nurses] are a liability to be paid out" (Gutierrez, 2005, p. 237). Such feelings of ineffectiveness and lack of personal accomplishment contribute to the development of burnout in critical care nurses (Gutierrez, 2005).

Preventing burnout in critical care nurses: Nursing implications

Only some of the contributing factors to the development of burnout in critical care nurses have been explored, but one thing is clear: burnout in critical care nurses continues to be a problem and needs to be addressed. The chronic stress that critical care nurses experience at work is a major contributor to burnout, as it wears the critical care nurse down emotionally (Bakker et al., 2005; Lederer et al., 2008; McFeely, 2007; Sawatzky, 1996; Storlie, 1979). McFeely (2007) asserts that:

The first step in attempting to control work stress is for an organization to understand that work stress is an organization-level problem, not an individual employee's problem, and that prevention and treatment of burnout requires an integrated response from the institution, as well as the individuals working in the ICU (p. 38).

The nurse manager of an ICU plays an important role in preventing burnout in the unit's critical care nurses (Leiter & Maslach, 2009; Leiter & Spence Laschinger, 2006; Manojlovich & Laschinger, 2008; McFeely, 2007; O'Brien-Pallas et al., 2010; Peterson et al., 2008; Sawatzky, 1996; Schaufeli & Greenglass, 2001; Stayt, 2007). Using the Nursing Work Index survey and a Maslach Burnout Inventory assessment, Leiter and Spence Laschinger (2006) tested the relationships between the variables in the nursing work life model with 8,597 nurses who were employed in various acute care hospitals in Canada. Findings confirmed that nursing leadership (i.e., nursing management) determines the extent of nurse-physician collaboration, how policy is implemented and developed, if a nursing model of care is used, and if staffing on the unit is adequate. By influencing these factors, nursing management can also influence the levels of emotional exhaustion, depersonalization, and feelings of personal accomplishment that employee's experience, which contribute to burnout (Leiter

& Spence Laschinger, 2006). Since leadership, according to this model, has an extensive effect on the development of burnout, and occupational stress is the leading cause of burnout in critical care nurses, strategies to prevent burnout must be put into action by nursing managers (Leiter & Spence Laschinger, 2006; Manojlovich & Laschinger, 2008; McFeely, 2007).

Throughout the literature, critical care nurses reiterate the need for a supportive environment (Bakker et al., 2005; Daines, 2000; Gutierrez, 2005; Lederer et al., 2008; Leiter & Spence Laschinger, 2006; McFeely, 2007; O'Brien-Pallas et al., 2010; Peterson et al., 2008; Sawatzky, 1996; Schaufeli & Greenglass, 2001; Stayt, 2007). Nurse managers can create a supportive environment by improving communication with critical care nurses at the bedside to ensure that nurses know they are supported by the unit's management and problems within the unit can be addressed and resolved (Gutierrez, 2005; Sawatzky, 1996; Schaufeli & Greenglass, 2001). Coles (2010), suggests that one way nurse managers can do this is by staying out of their office, as much as possible, and participating in a daily walking report with the charge nurse.

Nurse managers can also work to prevent burnout by working to decrease the amount of moral distress critical care nurses experience (Coles, 2010; Gutierrez, 2005; McClendon & Buckner, 2007). Although the literature regarding moral distress in critical care nurses is abundant, tested interventions that nurse managers can put into practice to help prevent moral distress in critical care nurses are sparse (Coles, 2010). Coles (2010), an ICU manager herself, suggests that ICU managers can help prevent moral distress in their units' nurses by being visible and assisting in planning patient care. In doing so, critical care nurses will feel supported and their managers will have a greater understanding of what is happening on the unit (Coles, 2010). This will also help the nurse manager get to know the nursing staff so that he or she can recognize signs and symptoms of moral distress in nurses early, so that action can be taken before the nurse becomes burned out (Coles, 2010). Not only should nurse managers be educated about moral distress, but critical care nurses, as well (Coles, 2010). This can be accomplished through educational sessions that enable critical care nurses to recognize moral distress in themselves and their colleagues, and give them the tools and strategies to rise above it (Beumer, 2008; Coles, 2010).

A moral distress workshop for critical care nurses was designed and tested by Beumer (2008) and included the American Association of Critical Care Nurses' 4As model to cope with moral distress. When the pre-workshop questionnaire of the 21 nurses who participated in the workshop was compared to the identical post-workshop questionnaire administered seven to 10 weeks afterwards, the results showed a decrease in the nurses' experiences of moral distress, which was lower than that of the control group (Beumer, 2008). Although the study was small and the reliability and validity of the questionnaire needs to be evaluated, the results suggest that moral distress workshops may decrease critical care nurses' experiences of moral distress and, consequently, prevent burnout (Beumer, 2008).

Another way nurse managers can prevent burnout is by increasing interdisciplinary collaboration through fostering collegial relationships between critical care nurses and other health care professionals, especially physicians (Gutierrez, 2005; Leiter & Spence Laschinger, 2006; Leiter & Maslach, 2009; McFeely, 2007; Sawatzky, 1996). In a pilot study conducted by Hamric and Blackhall (2007), survey questionnaires were administered to 29 physicians and 196 critical care nurses to explore their experiences of caring for dying patients in the ICU. Particular attention was paid to the relationships between moral distress, ethical climate, nurse-physician collaboration, and satisfaction with care, which are all factors that contribute to burnout (Gutierrez, 2005; Hamric & Blackhall, 2007; McClendon & Buckner, 2007). Findings revealed that the critical care nurses experienced moral distress more frequently than the physicians, although the nurses and physicians largely agreed on which situations were morally distressing and felt equally distressed by them (Hamric & Blackhall, 2007). Furthermore, the critical care nurses rated their ethical environment and level of collaboration with physicians lower than the physicians' ratings (Hamric & Blackhall, 2007).

According to Hamric and Blackhall (2007), specific interventions are needed to improve nurse-physician communication and collaboration, as "general exhortations to 'collaborate' will not improve the interactions" (p. 427). Although there is lack of tested interventions, many suggestions have been made, including communication seminars to foster teamwork, a forum for all the different disciplines that provides a safe and respectful place to discuss issues and provide constructive feedback, and work socials (Gutierrez, 2005; Lederer et al., 2008; McClendon & Buckner, 2007; McFeely, 2007). In addition, nurse managers can help foster collegial nurse-physician relationships by providing a nursing perspective in their discussions with physicians, so that nursing issues and perspectives are acknowledged and attended to (Manojlovich & Laschinger, 2008).

Another way that nurse managers can foster a supportive environment is by having a counsellor or psychologist available for critical care nurses to debrief with after a difficult situation, such as a death, as unresolved grief can lead to burnout (Brosche, 2003; Brosche, 2007; Gutierrez, 2005; Lederer et al., 2008; McClendon & Buckner, 2007; McFeely, 2007).

Mourning over the death of a patient is not part of the culture of the ICU and is somewhat taboo. Nurses, therefore, seldom talk about their grief and often do not feel they have a socially recognized right, role, or the capacity to grieve over their patients (Brosche, 2007, p. 21).

Brosche (2007) asserts that a grief team, composed of chaplains, nurses with special training, and support staff is a cost-effective way to help nurses feel supported, cared for, and process their grief in a healthy way that prevents burnout (Brosche, 2007). A well-designed grief team includes clearly delineated purpose, mission and goal statements, a framework to guide actions, such as Watson's Theory of Human Caring, and staff who are available around the clock to assist nurses after a death

(Brosche, 2007). In addition, Brosche (2007) recommends that a grief team working in the ICU be notified of every death so they can follow-up with the nurse who cared for that patient if that nurse thinks it would be beneficial. It is important to note that before enacting any burnout prevention strategies for critical care nurses, the nurse manager must determine what the stressors are in the unit by speaking with the bedside nurses, and select appropriate interventions to mitigate those stressors with input from the bedside nurses (Brosche, 2007; Sawatzky, 1996).

In a study by Bakker et al. (2005), burnout was shown to be contagious among nurses working in ICUs. "Nurses who reported the highest prevalence of burnout among their colleagues were most likely to experience high levels of burnout themselves" (Bakker et al., 2005, p. 284). This study highlights the potential that critical care nurses have to either build each other up or tear each other down, and that critical care nurses are responsible for each other.

Burnout can be prevented in critical care nurses when they act as support systems for each other (Bakker et al., 2005; McClendon & Buckner, 2007). McClendon and Buckner (2007) stress that "we [nurses] must support one another and let each other know that we can make it through tough situations" (p. 205). They suggest that an internal support system could be built through an after-shift social where critical care nurses can debrief with one another, or a buddy system whereby a critical care nurse is paired with one or two other critical care nurses and they call each other regularly to provide encouragement and support. To foster supportive relationships among the nursing staff, one neonatal intensive care unit gave awards to nurses who were nominated by their colleagues for giving superb care (Ewing & Carter, 2004). In addition, regular work socials were planned by the nursing staff, and staff members' birthdays and anniversaries were celebrated each month with food and decorations that were provided by the nursing manager (Ewing & Carter, 2004).

Finally, critical care nurses also have a personal responsibility to prevent burnout in themselves (McFeely, 2007). A literature review conducted by Fearon (2011) regarding personal burnout prevention strategies revealed that using both positive emotion-focused and problem-focused strategies can help prevent burnout. Making healthy lifestyle choices, such as taking vacations, eating a balanced diet, limiting alcohol, caffeine and nicotine intake, and getting enough rest can also help reduce stress and prevent burnout (Royal College of Nurses [RCN], 2005). It is also important for nurses to manage their personal work environment by taking breaks, delegating tasks when appropriate, saying "no", as necessary, and not working overtime when they cannot or do not want to (RCN, 2005). Practising self-reflection and releasing emotions by talking to others or journaling can help nurses prevent stressors from compounding and affecting them negatively (RCN, 2005). In addition, taking courses in communication and stress management can be helpful (RCN, 2005). If a nurse is no longer able to cope with stress, he or she should consider seeing a personal counsellor and/or

family physician, or talk to a career counsellor (RCN, 2005). While implementing self-care strategies to prevent burnout can be difficult, it is essential. As Hernandez (2009), a registered nurse, comments, "Before we can care for others, we must first care for ourselves" (p. 130).

Conclusion

Burnout is a complex phenomenon that includes three key elements: 1) emotional exhaustion, 2) depersonalization/cynicism/detachment, and 3) feelings that one is ineffective or lacking in personal accomplishment (Bakker et al., 2005; Bühler & Land, 2003; Lederer et al., 2008; Leiter & Maslach, 2009; Leiter & Spence Laschinger, 2006; McFeely, 2007; Peterson et al., 2008; Schaufeli & Greenglass, 2001). Critical care nurses are particularly vulnerable to developing burnout due to the chronic occupational stressors to which they are exposed (Bakker et al., 2005; Lederer et al., 2008; McFeely, 2007; Sawatzky, 1996; Storlie, 1979). Stressors that critical care nurses are exposed to and that were explored include high acuity of patients, high levels of responsibility, working with advanced technology, caring for patient and families in crisis, and exposure to morally distressing situations, particularly that of prolonging a patient's life unnecessarily. Nurse managers play a crucial role in preventing burnout in critical care nurses by creating supportive work environments (Leiter & Maslach, 2009; Leiter & Spence Laschinger, 2006; McFeely, 2007; O'Brien-Pallas et al., 2010; Peterson et al., 2008; Sawatzky, 1996; Schaufeli & Greenglass, 2001; Stayt, 2007). Strategies for nurse managers to accomplish this include being accessible to critical care nurses at the bedside, fostering collegial relationships among the different disciplines and making a counsellor or grief team available to critical care nurses to deal with stress and process grief. In addition, critical care nurses can help prevent burnout by being supportive of one another and implementing self-care strategies.

While there is extensive research regarding the various elements of critical care nursing and the ICU that contribute to burnout in critical care nurses, studies testing specific interventions to prevent burnout at the organizational level are severely lacking. "In 'caring for the carers', the challenge for health care organizations lies in developing respect and care for their employees in the same way they require their employees to care for patients" (Huggard, 2003). If burnout is to be effectively prevented in critical care nurses, research must be conducted into what organizational interventions are effective so that health care institutions can do their part in mitigating burnout. 

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Delirium in the intensive care unit: Role of the critical care nurse in early detection and treatment

BY TERRA OLSON

Abstract

Critically ill patients are at increased risk of developing delirium, which has been considered one of the most common complications of intensive care unit (ICU) hospitalization. Despite the high occurrence of delirium in the ICU, researchers have shown it is consistently overlooked and often undiagnosed. An understanding of delirium and the three clinical subtypes of hyperactive, hypoactive and mixed-type delirium that exist are key to early detection and treatment. Critical care nurses are in the frontline position to detect and monitor for risk factors that contribute to the development of delirium in the ICU. Recognition of predisposing risk factors and the elimination of precipitating risk factors for delirium can prevent the devastating short-term and long-term consequences for the critically ill patient. The importance

of the use of validated assessment tools, such as the Confusion Assessment Method for the ICU (CAM-ICU) and the Intensive Care Delirium Screening Checklist (ICDSC) to detect key features of delirium development is emphasized. Recommendations to improve the practice of critical care nurses include continuing education regarding the causes, risk factors and treatments of delirium, and education sessions on the use of validated assessment tools. Early prevention strategies, such as modification of the ICU environment to promote normal sleep/wake cycles, including reduction of unit noise and nighttime interruptions, are examined as interventions to avoid the development of delirium.

Key words: delirium, intensive care unit, risk factors, nursing, critical care

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Intensive care units (ICUs) are known to be the treatment area reserved for patients who require state-of-the-art care by health care professionals to treat life-threatening illnesses and diseases. This vulnerable population is at high risk for developing delirium, which has been shown to be one of the most common complications of ICU hospitalization, affecting 20% to 80% of patients (Allen & Alexander, 2012; Pun & Ely, 2007; “When patients suddenly”, 2011). Despite the alarming prevalence of delirium in the ICU, researchers suggest there is a worrying trend of under-detection and diagnosis (Hamdan-Mansour, Farhan, Othman, & Yacoub, 2010).

Delirium is most often described as “an acute confusional state defined by fluctuating mental status, inattention, and either disorganized thinking or an altered level of consciousness” (Pun & Ely, 2007, p. 624). The presence of these manifestations combined with a diagnosis of delirium has implications for not only the critically ill patient, but also the family, critical care nurse, health care team, and the entire health care system. Critical care nurses have an important role to play in the prevention, detection, and early diagnosis of delirium in critically ill patients. The purpose of this paper is to analyze and explore the issue of delirium within the ICU with the aim of increasing awareness of this troubling issue. A discussion of the impact of delirium on the patient, family, critical care nurse, and the health care system illustrates the importance of thorough assessment and diagnosis. Recommendations for improving the practice of critical care nurses in the ICU are discussed with a focus on the important role of the critical care nurse in prevention, detection and treatment of ICU delirium.

Delirium in the intensive care unit

A comprehensive literature review was undertaken to identify the current knowledge regarding the presence of delirium in the ICU. The author used numerous online databases including CINAHL Plus with Full Text, MEDLINE, PsycINFO, E-Journals, and Academic Search Complete. A variety of key words were used in the literature search including delirium, intensive care unit, critical care, registered nurse and nursing, assessment, treatment, short-term and long-term outcomes, and family. Research studies and papers were reviewed for appropriateness based on the title and abstract. Published reference lists were also examined for authors and content that were not identified in the initial literature search.

Throughout the literature review process, various definitions of delirium were discovered. The description of delirium used most often is that from the American Psychiatric Association (APA) (1994) and remains unchanged in the most recent version, the *DSM-IV Text Revision (DSM-IV-TR)* produced in 2000 by the APA. “The essential feature of a delirium is a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a pre-existing or evolving dementia” (APA, 1994, p. 124). Further diagnostic criteria listed by the APA (1994) include (a) an impairment in ability to focus, sustain, or shift attention, (b) changes in cognition and/or development of perceptual disturbances, and (c) disturbance of consciousness that develops over a relatively short period of time, often within hours to days, and fluctuates throughout the course of a day. These criteria provide the hallmark signs for the development of delirium.

To further define the manifestation of delirium, one must differentiate between the three clinical subtypes that exist: hyperactive, hypoactive and mixed type (Allen & Alexander, 2012; Arend & Christensen, 2009). These subtypes are categorized depending on the patient's level of psychomotor activity and level of alertness (Arif & Grap, 2009).

Hyperactive delirium. In a study completed by Peterson et al. (2006) of more than 600 critically ill patients admitted consecutively to an ICU in Tennessee, it was found that purely hyperactive delirium was rarely (1.6% of all delirium episodes) observed in the ICU. Hyperactive delirium is characterized by agitation, restlessness, attempts to remove necessary medical equipment from the body and emotional lability (Allen & Alexander, 2012; Arif & Grap, 2009). In the past, hyperactive delirium in the ICU was labelled "ICU psychosis" due to the outwardly visible symptoms of restlessness and agitation (Pun & Ely, 2007). Agitation can also be accompanied by hallucinations, delusions, and paranoia, which can result in patients becoming combative and potentially harmful to themselves or those around them including staff and family (Arif & Grap, 2009). Due to its more outwardly visible manifestations, hyperactive delirium is more readily diagnosed and is associated with an overall better prognosis (Pun & Ely, 2007).

Hyperactive delirium can be devastating for the patient if life-saving equipment is removed in outbursts of agitation or if the patient becomes confused and resistant to care being provided. This state can also be devastating for family—to watch as their loved one often acts very differently than what is normal for him or her.

Hypoactive delirium. Hypoactive delirium is often characterized by "lethargy rather than agitation, withdrawal, flat affect, apathy and decreased responsiveness" (Hardin-Pierce, 2010, p. 596). Due to these somewhat vague signs and symptoms, patients with hypoactive delirium are often misdiagnosed with depression due to its similar manifestation and overlap of symptoms (APA, 1999; Marchington, Carrier, & Lawlor, 2012). As a result of the less disruptive nature of hypoactive delirium, this condition more commonly goes undiagnosed in as many as 66% to 84% of cases (Pun & Ely, 2007; "When patients suddenly", 2011). This high rate of missed diagnosis is one of the most concerning aspects of hypoactive delirium, since Peterson et al. (2006) found that hypoactive delirium was present in 43.5% of patients with delirium in their study. Despite its quiet appearance, hypoactive delirium is a serious complication for critically ill patients.

Mixed-type hyper/hypoactive delirium. A third type of delirium is that of mixed-type delirium. Truman and Ely (2003) define mixed-type delirium as the "concurrent or sequential appearance of some features of both hyperactive and hypoactive delirium" (pp. 26–27), which describes its fluctuating nature. Symptoms of one type of delirium may appear initially only to resolve and reveal symptoms of the opposite type. Mixed-type delirium accounted for 54.9% of all delirium episodes in the Peterson et al. (2006) study, making it the most commonly occurring subtype of delirium.

The impact of ICU delirium

Numerous short-term and long-term adverse consequences occur for patients who develop delirium in the ICU. In a study

by Ely et al. (2004) of 275 mechanically ventilated adult medical and coronary ICU patients, it was found that delirium was associated with a higher six-month mortality rate, an average increase in length of stay in the hospital of 10 days, a longer post-ICU stay, and a higher incidence of cognitive impairment at time of discharge. Girard et al. (2010) further confirmed that the presence of delirium was associated with long-term cognitive impairment showing that longer durations of delirium from one day of delirium to five days were associated with worse cognitive performance a full year after the critical illness. Consequences such as these are detrimental to the health and overall quality of life for patients who survive critical illness. The development of delirium in critically ill patients is not only detrimental to the health of the individual, it also has an impact on the patient's family, critical care nurses and other health care providers, and the health care system.

Impact on family. Researchers studying the lived experience of delirium have reported that families of patients who have experienced delirium also show signs of distress. In a study of 101 hospitalized patients who had complete resolution of their delirium episode, Brietbart, Gibson, and Tremblay (2002) report that "although 80% of patients experienced delirium as severely distressing, 76% of spouses/caregivers ... reported similar levels of distress" (p. 192). It can be a very stressful time for a family when a loved one is critically ill in an ICU. Witnessing a family member experiencing delirium symptoms, whether it be agitation and confusion in hyperactive delirium or lethargy and reduced responsiveness in hypoactive delirium, can add to an already stressful situation and be very concerning for the family.

Impact on nurses and the health care system. Critical care nurses are in direct contact with patients who are likely to develop delirium during some point of their critical illness. Lou and Dai (2002) acknowledge that caring for delirious patients can be difficult, stressful and, at times, even dangerous. Patients who are confused, lethargic, agitated, or restless require more hands-on constant care, increasing the workload of nurses. Lou and Dai (2002) emphasize the struggle that nurses experience between increased workload, trying to provide adequate care to delirious patients and maintaining their own and their patients' safety. This battle is one of concern for critical care nurses in the ICU environment where patient acuity and complexity are highest.

With outcomes such as increased morbidity and mortality due to ICU delirium, the associated health care costs are also certain to increase. In a study by Milbrandt et al. (2004) of the economic costs of delirium in 224 mechanically ventilated patients, it was shown that "delirious patients had significantly higher costs in most major subcategories of ICU cost, including bed expenses, pharmacy, and laboratory" (p. 956). Patients who developed delirium in ICU were shown to have a 39% increase in ICU cost, and a 31% increase in total hospital cost compared to non-delirious patients (Milbrandt et al., 2004). These numbers are staggering statistics showing the ultimate financial costs associated with delirium development in the ICU. This is further justification for the importance of early screening and assessment to detect symptoms of delirium and the removal of risk factors that accelerate its development.

Etiology and risk factors

Despite decades of research, the exact pathophysiological processes that contribute to the formation of delirium remain poorly understood (Ali et al., 2011; Girard, Pandharipande, & Ely, 2008). A number of causative theories are discussed in the literature including imbalances of neurotransmitters in the brain (e.g., acetylcholine, dopamine, serotonin and gamma-aminobutyric acid), sepsis and severe inflammatory processes causing disruption of the blood brain barrier, medications (e.g., sedatives and analgesics) and inadequate oxygen supply to the brain causing inadequate oxidative metabolism (Ali et al., 2011; Allen & Alexander, 2012; Gunther, Morandi, & Ely, 2008). These are the most commonly discussed causative factors in the development of delirium and are highly dependent on the patients and circumstances surrounding their illness.

There are numerous risk factors involved in the development of delirium. These risk factors are frequently divided into predisposing risk factors and precipitating risk factors (Allen & Alexander, 2012).

Predisposing risk factors. Risk factors that are present at the time of ICU admission are classified as predisposing risk factors for the development of delirium. Allen and Alexander (2012) describe predisposing risk factors as those that are less modifiable and are a result of a patient's overall health prior to ICU admission. Advanced age (65+ years), chronic illness such as hypertension, severity of presenting illness, tobacco and/or alcohol use, baseline cognitive impairment, and visual or hearing impairment have all been listed as predisposing risk factors for delirium in both medical and critically ill patients (Allen & Alexander, 2012; Dubois, Bergeron, Dumont, Dial, & Skrobik, 2001; Girard et al., 2008).

Precipitating risk factors. Allen and Alexander (2012) state "precipitating risk factors are those risk factors that are not present at ICU admission and may be most modifiable" (p. 6). These are risk factors that occur after a patient has been admitted to ICU and may also be called "iatrogenic risk factors" (Vasilevskis et al., 2010, p. 1225). The most commonly listed modifiable risk factor for delirium is the use of medications, especially benzodiazepines and opioids, which are commonly used in the ICU environment (Allen & Alexander, 2012). Other precipitating risk factors include metabolic disturbances and alterations in sodium, calcium and blood urea nitrogen levels, acute infections, dehydration, sleep deprivation, and immobilization (Allen & Alexander, 2012; Dubois et al., 2001; Girard et al., 2008). Due to the multiple contributing risk factors and the numerous theories regarding the etiology of delirium in the ICU environment, it is clear that early detection through thorough assessment is key to the treatment and perhaps prevention of this devastating condition.

Delirium assessment

Critical care nurses who provide care 24 hours a day in the ICU are in the best position to carry out thorough assessments using established assessment tools. "ICU nurses are on the front line for detecting and monitoring delirium. Accurate identification and prompt modification of the risk factors ... may prevent many

adverse outcomes associated with this phenomenon" (Truman & Ely, 2003, p. 34). Multiple assessment tools have been created for the detection of delirium within the hospital setting including the Delirium Detection Score, the Neelon and Champagne (NEECHAM) Confusion Scale, and the Cognitive Test for Delirium (CTD) (Bruno & Warren, 2010). The two most commonly used screening tools in the research of delirium within the ICU are the Confusion Assessment Method for the ICU (CAM-ICU) and the Intensive Care Delirium Screening Checklist (ICDSC) (Bruno & Warren, 2010).

Confusion assessment method for the ICU (CAM-ICU). The Society of Critical Care Medicine (SCCM) has outlined clinical practice guidelines for the assessment of delirium in the ICU stating "routine assessment for the presence of delirium is recommended" (Jacobi et al., 2002, p. 134). The SCCM recommends the use of the CAM-ICU as a "promising tool for the assessment of delirium in ICU patients" (Jacobi et al., 2002, p. 134). The CAM-ICU is a modified version of the original confusion assessment model, and has been developed for use in the ICU setting with nonverbal intubated and ventilated critically ill patients (Bruno & Warren, 2010). This tool is a valid and reliable tool for bedside clinicians, such as critical care nurses, to perform a quick and thorough assessment of the patient based on the *DSM-IV* definition and criteria for delirium (Guenther et al., 2010; Pun et al., 2005). Four key features of delirium are assessed including fluctuating change in mental status, inattention, disorganized thinking and the presence of an altered level of consciousness. A positive delirium diagnosis results when three out of four features exist (Truman & Ely, 2003). Using the CAM-ICU, critical care nurses can quickly and accurately assess and detect the presence of delirium. Prompt assessment of delirium with a reduction in risk factors can prevent adverse short-term and long-term complications that occur as a result of delirium.

Intensive care delirium screening checklist (ICDSC). The ICDSC is an eight-point questionnaire that uses the *DSM-IV* criteria for delirium combined with key features of delirium to detect its presence (Allen & Alexander, 2012, p. 8). The checklist assesses for altered level of consciousness, inattentiveness, disorientation, psychomotor agitation or retardation, inappropriate speech or mood, sleep/wake disturbance, symptom fluctuation, and hallucinations/delusions (Girard et al., 2008). Each symptom present receives a score of 1 for a total score out of 8, and a score ≥ 4 suggests a diagnosis of delirium (Pun & Ely, 2007).

These assessment tools are validated and reliable assessments that can be used by critical care nurses. They provide quick assessments that will alert the critical care nurse to the development of delirium symptoms and allow for diagnosis and interventions to be implemented.

Resources for the assessment and treatment of ICU delirium are available for physicians, nurses and other health care professionals online from the Vanderbilt University Medical Center (2011). Resources include a complete training manual for the use of the CAM-ICU, a CAM-ICU algorithm flow sheet that can be used during bedside assessment by critical care nurses, and the ICDSC.

Strategies to improve detection of delirium in the ICU

Various barriers have been acknowledged in the implementation of assessment tools in the ICU environment. Devlin et al. (2008) reported difficulties assessing intubated/sedated patients, the complexity of assessment tools, and lack of confidence in using assessment tools as barriers to the evaluation of delirium in ICU. Strategies to overcome these obstacles include ongoing education sessions for critical care nurses constructed from evidence-based practice regarding the etiology, risk factors, and interventions recommended for delirium in the ICU. Devlin et al. (2008) recommend education sessions that emphasize the “rationale for delirium assessment, the fluctuating and transient nature of delirium, the effect that screening for delirium may have on improving patients’ outcomes, and the importance of using a validated tool for screening” (p. 563). Further education will improve the competence of critical care nurses in the detection of delirium, especially the subdued symptoms of hypoactive delirium. In-services and training on the use of assessment tools are important to ensure adequate, thorough assessment and detection of risk factors are incorporated into the daily assessment by critical care nurses and the health care team.

Prevention and management of delirium in ICU

The primary focus of delirium management must be a focus on prevention and early detection within the ICU environment. “Both prevention and treatment should focus on minimizing and/or eliminating predisposing and precipitating risk factors” (Truman & Ely, 2003, p. 34). Throughout the literature, interventions to prevent or treat delirium are divided into two categories of non-pharmacological and pharmacological interventions.

Critical care nurses can play an important role in the implementation of non-pharmacological interventions for the prevention and management of ICU delirium. Despite the prevalence of delirium in the ICU, very few research trials have been completed specifically to evaluate the use of non-pharmacological interventions in such environments (Bruno & Warren, 2010; Girard et al., 2008; Truman & Ely, 2003). A study by Inouye et al. (1999) of 852 elderly general medicine (non-ICU) patients revealed numerous non-pharmacological interventions that were found to decrease the development of delirium and these interventions are often cited in the literature on delirium in the ICU (Allen & Alexander, 2012; Girard et al., 2008; Pun & Ely, 2007). Inouye et al. (1999) found that by incorporating cognitively stimulating activities throughout the day, continuously reorienting patients, providing a non-pharmacologic sleep protocol of relaxing music, noise reduction, and adjustment of medication times to avoid interrupting sleep, the rates of delirium in medical patients were reduced. Further interventions that contributed to a substantial reduction in the development of delirium included range-of-motion exercises and early mobilization, removal of catheters and other immobilizing devices as soon as able, providing visual and hearing aids, as required, correcting dehydration and ensuring timely pain management. Although these interventions are based on elderly medical patients, critical care nurses can incorporate these strategies into their daily care of critically ill patients, as their illnesses

permit. These are simple strategies that can facilitate the reduction of risk factors that contribute to the development of delirium.

Early prevention strategies should also incorporate alterations to the ICU environment that will promote normal sleep/wake cycles and levels of activity during the day. Suggestions include ICU environments that allow daylight into patient rooms, the use of lights to mimic daytime and nighttime if daylight is not an option, ensuring unit noise is kept to a minimum, and timing patient care procedures to promote uninterrupted sleep. During the day, patients should be encouraged to remain awake and participate, as able, in activities of daily living. Critical care nurses can facilitate this participation by assisting patients to perform basic grooming and hygiene practices such as using a warm damp facecloth to wipe the face and hands.

The two most often used medications to manage delirium once it has developed are haloperidol and atypical antipsychotics such as olanzapine, ziprasidone and quetiapine (Allen & Alexander, 2012). Researchers have shown that “benzodiazepines and narcotics that are often used in the ICU to treat ‘confusion’ (delirium) actually worsen cognition and exacerbate the problem” (Truman & Ely, 2003, p. 34). There is no easy answer for the management of delirium with medications. Further research is required into the potential harms and benefits of antipsychotic medications used in the treatment of delirium in critically ill patients, as well as other alternatives that may be available.

Critical care nurses who provide care 24 hours a day play a vital role in the prevention, early assessment and detection of delirium. Instituting routine monitoring and assessment for delirium through the use of validated assessment tools such as the CAM-ICU and ICDSC, critical care nurses can detect the early development of delirium. Early identification and removal of possible precipitating risk factors that can quickly lead to delirium may prevent its development and subsequent adverse outcomes. Interventions and treatments implemented by critical care nurses will impact the severity of delirium development and, ultimately, the short-term and long-term outcomes for critically ill patients and their families.

Conclusion

The development of delirium in the intensive care unit is a common complication for critically ill patients. Critical care nurses are key in the prevention, detection and early treatment of delirium with the goal of reducing risk factors and providing improved patient care. Delirium has been shown to have negative impacts on the health of the patient, the family, the care giving abilities of the critical care nurse, and the economy of the health care system. Through ongoing education regarding delirium, the use of validated assessment tools and the integration of early prevention strategies within the ICU environment, the incidence and devastating effects of delirium in the ICU can be diminished. 

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The Building Bridges Initiative: Learning *with, from* and *about* to create an interprofessional end-of-life program

BY ELIZABETH GORDON, BEd, BN, RN, BRENDA RIDLEY, MAEd, RN, CCN(C), JANINE BOSTON, BScN, RN, CCN(C),
AND EILEEN DAHL, BSc(HON), MDIV

Abstract

In this paper, the authors outline the rationale, planning, delivery, results, evaluation and knowledge transfer strategies employed in offering an eight-hour education day offered 12 times in 2010, to a total of 200 staff in three Toronto General Hospital (TGH) intensive care units (ICU) at the University Health Network (UHN). The integration of members from the point-of-care staff teams into the planning, development, presentation and attendance was a critical success factor for this initiative. Organizers and participants had the opportunity to build bridges with each other and across teams and programs by engaging in interprofessional learning, sharing narratives and consolidating increasing awareness of resources with facilitation from staff from nursing, medicine, palliative care, bioethics, social work, physiotherapy, respiratory therapy, wellness and spiritual care.

The format, which will be outlined with examples and stories of engagement, included an opportunity to explore common elements of ICU work including moral distress, demonstrated wellness and team communication strategies, as well as the introduction of an interprofessional patient/family meeting checklist reviewed and evaluated by participants. An assessment of quality of life in an ICU was explored using a panel, case study and discussion. The results of the evaluation, which included a qualitative reflection on collaborative themes, a program evaluation and an individual learning assessment, will be discussed, as well as sustainability and transferability possibilities specific to interprofessional programming and team development.

Gordon, E., Ridley, B., Boston, J. & Dahl, E. (2012). The Building Bridges Initiative: Learning *with, from* and *about* to create an interprofessional end-of-life program. *Dynamics*, 23(4), 37–41.

Rationale

Background

Toronto General Hospital is a quaternary care centre affiliated with the University of Toronto. It serves an adult population from the Greater Toronto Area and patients from elsewhere in Ontario and beyond. TGH has large transplant and cardiac programs, using the majority of beds in its three ICUs: the Coronary ICU (CICU), Cardiovascular ICU (CVICU), and Medical Surgical ICU (MSICU).

High patient acuity and mortality rates in ICUs create high-pressure situations and unique stressors for patients, family and staff. Research indicates that one in five Canadians will die in an ICU (Mularski & Osbourne, 2003). Seventy to 90 per cent of deaths occur after a decision to withdraw life support. Due to these factors, caring for dying patients and their families is integral to critical care nurses and the critical care team (Mularski & Osbourne, 2003).

Jameton (1984) defined moral distress as occurring “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 1). In fast-paced, high-acuity inpatient care settings like ICU, it is difficult to bring teams together and, therefore, such an opportunity must be carefully planned for interprofessional learning, program development and team transformation.

Why build bridges?

“Point-of-care providers often see patients take one step forward and two back” (Janine Boston, personal communication, May 2012). It can be difficult giving comfort to families who are waiting for something to happen—good or bad—to their loved one. “We all experience the same feelings, but from different perspectives. That is why we started the building bridges program, to break down barriers between professions and units—learning, healing and growing together” (UHN News-Nursing Week, May 2012).

Planning and delivery

End-of-life issues and staff wellness had been ongoing concerns and goals of the ICUs. Individual units had engaged in various initiatives and a TGH Quality of Life taskforce had been reviewing institutional end-of-life concerns. The managers of CICU and CVICU and the integrated spiritual care staff member met to explore opportunities to bring together the units and assist staff in these areas. MSICU was also invited to join the initiative.

Key collaborators and contributors were identified to be ICU clinical nurse educators, spiritual care, palliative care, bioethics, physicians, wellness and human resources. The framework for an eight-hour staff care/education day was developed with three main areas of focus: moral distress and staff wellness, communication, and quality end-of-life care. The spiritual care

professional in the CICU and CVICU was the project lead and the clinical educators from the ICUs were team leaders of the three main components. The planning committee consisted of the unit managers, project lead and three team leaders.

Interprofessional teams of ICU team members and TGH staff were recruited to further develop objectives and create a curriculum. More than 30 TGH professionals collaborated in the development of this program: five RNs and four RN clinical educators, four allied health, four bioethics, two wellness, three spiritual care and nine physicians. An additional 26 professionals acted as contributors, as moral distress panellists, wellness leaders or standardized patients. A standardized patient (SP) is a healthy person trained to portray the personal history, physical symptoms, emotional characteristics and everyday concerns of an actual patient.

There were six spring sessions called *Building Bridges—Building on Our Strengths*, and six fall sessions, sessions with a name change to *Quality End of Life—A Collaborative Journey*. The spring sessions took place on site in one of the ICUs, while the fall sessions were held in the medical education facilities, a space neutral to all units. The promotional materials and educational content were consistent throughout. Attendee recruitment varied by unit—including both voluntary and mandatory attendance. No external funding was provided. Funding for the development, supplies, staff attendance, standardized patients, wellness facilitators, refreshments and meals was provided by contributing units, departments or medical directors.

Goals of the program

1. Raise awareness of moral distress and end-of-life challenges while creating a safe environment for expression and exploration.
2. Create opportunities for interprofessional dialogue regarding moral distress and end of life to minimize feelings of isolation and increase understanding among professions within the ICU community.
3. Increase awareness of UHN resources for patients, families and staff about palliative care, bioethics, spiritual care, employee assistance program and wellness.
4. Build relationships and foster interprofessional learning between the ICUs and ICU teams.

Pedagogy

The delivery of the content varied throughout the day. Successful content delivery was attributed to the following components: varied teaching strategies and interprofessional teaching. This met a variety of learning needs and maintained participant and facilitator energy. Material was presented and discussed in panel format in small and large groups. Interprofessional teaching models promoted team and patient communication and patient-centred care.

Methodology

Moral distress. Moral distress definitions were used to start the morning session followed by a standardized patient role-play using the standardized patients from the University of Toronto. The scenario introduced two parallel themes of a staff RN coping with end-of-life issues and end-of-life decisions for a

cardiac patient. This was followed by a panel discussion with various health care professionals speaking of their experiences regarding moral distress.

Panel members were asked to share experiences within their profession as to “*What keeps you, as a health care professional, up at night?*” This panel discussion allowed for increased awareness of each other’s roles. There was opportunity for large group discussion and people felt comfortable sharing their stories.

Staff care and wellness. Hands-on activities included meditation/yoga, Acuball, relaxation and bedside stretches for staff. These activities could be done in a moment at the bedside, in the workplace using the wellness programs available to all UHN staff or incorporated into self-care activities. These activities were designed to support staff in the moment, as time away from a busy ICU setting is difficult. Often, end-of-life situations are followed up by a new, acutely ill admission or urgent transfer into the ICU. Staff often switches from end-of-life supporting care to acute resuscitation or managing critical illness.

In the spring sessions, participants completed a Myers Briggs Assessment to aid in understanding themselves and others. Participants were provided UHN resource sheets listing institutional resources available for staff and/or patients and families, with information such as when and how to refer to appropriate support, availability and contact information.

Participants were also given a “Plan to Thrive” worksheet to plan for ways to cope with distress and end-of-life issues in the ICU. Participants were invited to identify and list their personal survival strategies: people, places or activities that enable them to a) cope *during* a difficult shift, and b) recover and recharge *after* a challenging shift. Strategy sharing was encouraged. Participants were also encouraged to identify areas that would benefit from change in their personal practice, unit or institution.

Communication. Decision making, in crisis situations or at the end of life, is emotionally charged, frequently time sensitive and often requiring patients and families to comprehend new or complex medical information. Day-to-day communication and techniques for conflict management were explored, both within the team and with patient and family, using case studies and participant scenarios. Common reasons for conflict and de-escalation strategies were explored.

The medical director of cardiology presented his unique perspective regarding patient/family meetings and facilitated discussions advocating opportunities for expanded roles for nurses and allied health personnel, before, during and after meetings. Participants then explored this further, as they discussed and evaluated the *Draft Communication Checklist: Patient/Family Meetings* (see Table 1) in small groups, recording feedback and suggestions that were later incorporated into the checklist. Proposed pre-meeting opportunities included such tasks as scheduling and preparing the meeting place, assessing understanding, preparing the patient and family by describing what to expect, assisting them in clarifying questions, identifying the patient’s values, goals and wishes, answering questions, explaining medical terms that may arise, ensuring appropriate family members, support

continued on page 40...

Table 1.



Draft Communication Checklist: Patient/Family Meetings

Meeting Triggers:

- Acuity
- Change in Condition
- Initiated by Pt/Family
- LOS
- Code Status
- Initiated by Staff
- Other:

Before: Set Up

- Pt/family's understanding assessed "what is your understanding of..."
- Pt/family's questions and expectations identified and reviewed by RN
- Pt's wishes elicited. Advance Care Plan added to chart if applicable
- Discussion with pt/family regarding who pt is, their values, what is dear to them, hopes and fears, etc. has been completed (ex. Patient Values Statement)
- Orientation, education and agenda regarding meeting provided to pt/family
- Pt/family communication needs elicited
- Power of Attorney/Substitute Decision Maker identified, Name: _____
- Participants invited, as necessary:
 - Pt (if not, why?)
 - MD
 - Palliative Care
 - Family (list names)
 - PCC/IC
 - Social Work
 - POA/SDM
 - RT
 - Spiritual Care
 - UHN Interpreter
 - Pharmacy
 - Other:
 - Consult Services
 - PT/OT/SLP
 - Bedside RN
 - Bioethics
- UHN Interpretation Services booked or phone line utilized in emergencies
- Pre-family meeting scheduled for interprofessional team to determine plan and objectives for meeting
- Consider ratio of pt/family members to staff to not overwhelm
- Meeting facilitator identified: Name: _____
- Room booked and set up—chairs, tissue

During: Team Facilitation

- Introductions
- Pt/family's understanding assessed "what is your understanding of..."
- Pt/family questions elicited and addressed throughout
- Case reviewed: background, current status, prognosis
- Pt/family's expectations explored
- Team members checking for pt/family understanding throughout
- Next steps of care plan explored with pt/family: treatment options, trial of treatment, withdrawal of life support/comfort measures etc., next meeting if applicable, time frames
- Utilization of compassionate language, "We were hoping... but..."
- Reassurance of continued care if recommendation is comfort measures
- Acknowledgement of pt/family's emotional response
- Emotional and spiritual support identified and provided as necessary

After: Care and Planning

- Pt/family emotional support provided through dialogue and action
- Assistance offered to help pt/family contact additional supports if needed
- A team member debriefs meeting with pt/family
 - assesses pt/family understanding, expectations and care needs
 - communicates new information or areas requiring clarification to team
- Team debrief, as necessary
- Family Meeting Record completed by MD
- Chart notes completed
- Next meeting scheduled as necessary _____

Boston, J., Dahl, E., Fairley, G., Gordon, E., Kaufmann, H., Ridley, B., & Newton, G. (2011). *Communication Group-Building Bridges Project. Draft Communication Checklist: Patient/Family Meeting*. Toronto: ON: University Health Network.

individuals and health care professionals were present, as well as assessing team discord and scheduling a pre-meeting for the team, if needed. During and after meetings, the importance of nurses and allied health staff actively participating, as advocates for the patient and family, conducting ongoing assessment, clarification of patient and family goals, understanding expectations and support needs, participating in team debriefing, charting and scheduling further meetings, as necessary, were stressed.

Quality of life. Researchers at the University of Toronto's Quality of Life Research Unit define quality of life as, "The degree to which a person enjoys the important possibilities of his or her life" (Quality of Life Research Unit, 2010).

It is important to establish, as part of the care plan, the wishes of the patient. The Patient Values Statement (developed in the MSICU) is a tool that addresses patient wishes, as well as gives a personal picture of the patient. The patient value statement may be filled out by the patient and/or family and focuses on their life, career, family, hopes and goals.

Quality of life rounds are beneficial to the patient and staff to discuss the wishes and goals of the patient early in the ICU admission. This can assist in establishing goals in light of patient wishes and provide a platform for family discussion.

Panel discussions, case studies and assessment of quality of life in an ICU, particularly in end-of-life situations, were explored. Topics included maximizing quality of life when quantity may be limited, "what is euthanasia", pain and symptom management and patients who want to discontinue care while the family wants all the care we can provide to the end. The management of technology of care discussion was centred on:

- Have the advances in technology created a culture of care that is death denying and death defying?
- How do we measure success?
Death = bad, life = good
- Why does it become difficult for us to give up?

How do we de-medicalize the process of withdrawal of care? This was another topic that generated much discussion with many suggestions to assist the patient and family. Some discussion points included use of music, ritual (both religious and non-religious), symbols (e.g., a flower on patient's door to indicate end-of-life situation to care team), monitors, alarms and sounds that may be comforting or distressing, changing/bending the rules regarding visitation, pros and cons of extubation and comfort versus specific ventilator settings and options for sedation and pain medication.

Results and evaluation

The Building Bridges Education Day was delivered 12 times over six months to approximately 200 ICU staff. Attendees were predominantly critical care nurses, but included a mix of allied health, pharmacy, spiritual care, trainees, fellows, students and physicians. There was a high satisfaction rating. Ninety-two per cent of the attendees agreed or strongly agreed that the program increased their ability to discuss end-of-life issues in ICU settings and 96 per cent of participants felt they would use the techniques and strategies in their work places. (See Figure 1)

The aspects participants liked most about the day included:

- The chance to listen and learn from colleagues in other professions
- Recognizing signs of moral distress
- A better understanding of quality end of life from all disciplines
- All of the different interprofessional practices involved and testimonials
- Communicating each other's experiences in the ICU and how everyone dealt with stressful situations.

Challenges and lessons learned

What's in a name? The project of the title changed between the spring and fall sessions to better emphasize the goals of the program. It was not just Building Bridges, but creating Quality of Life through a Collaborative Journey.

Leadership support. A key to success of the Building Bridges program was leadership support. Despite fiscal constraints in our health care environment, funds were found to support wellness activities, educational materials, staff resources and the standardized patient actors from the University of Toronto standardized patient program. With this support, staff was

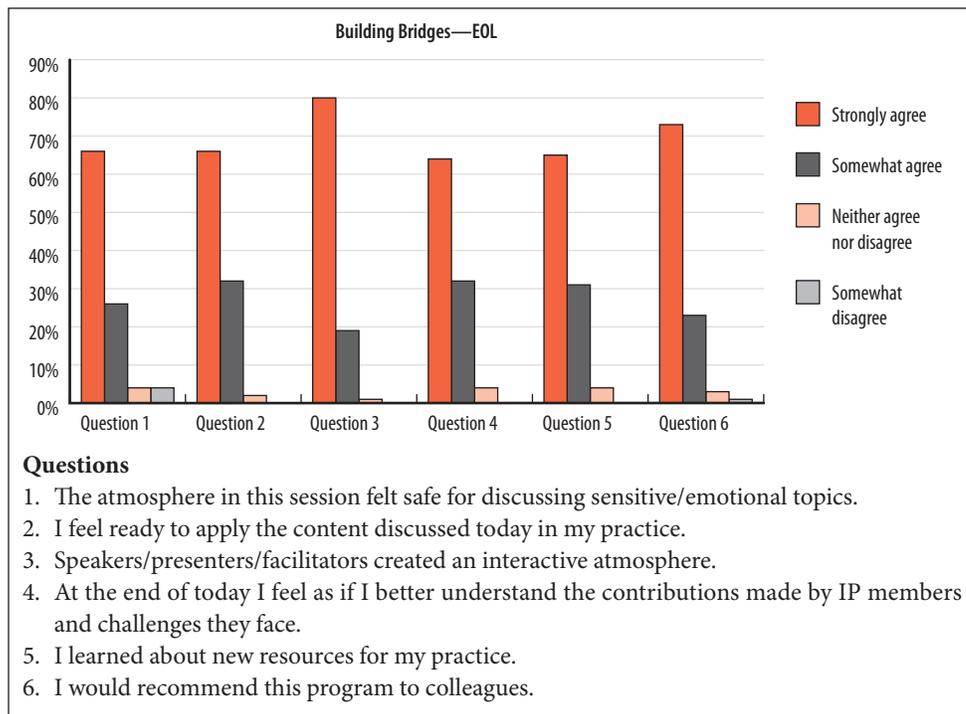


Figure 1: Evaluation results

released from clinical roles to participate in the eight-hour day. This was achieved by collaboration from management, clinical directors and the director of nursing.

Interprofessional team members. Staff, who were participants, panellists and facilitators were also permanent staff integrated into the ICUs and involved in end-of-life care. This grassroots approach to the program optimized trust and support. Staff brought a real awareness of unit-level issues regarding moral distress, communication and end-of-life care concerns. The workshop provided a forum to support staff and bring tangible tools and activities back to the units to support practice attendance.

Physical space. The shift to a neutral space rather than unit-based classrooms helped to facilitate engagement between the ICUs in discussions. The ICUs are physically separate and are specialty focus units.

Lunch and refreshments. Providing food was essential for modelling self-care, facilitating relationship building and expressing staff appreciation.

Serial workshops. As participants went back to their units and talked about the day, they created a ‘buzz’, thus optimizing enrolment.

Organization level impact

Staff shortages affected attendance (due to higher acuity, vacant positions). Education endeavours can drive change (e.g., looking at processes, policies, gaps in resources for patients and staff). This, in turn, leads to an improved practice environment and increased staff satisfaction.

Interprofessional and inter-unit education initiatives can drive innovation and opportunities. Inter-unit initiatives can build bridges within and throughout an organization.

Long-term successes

The success of the Building Bridges programs was recognized at many levels at UHN.

Organization-wide. The event became an initiative (e.g., members of the development team assisted allied health personnel to develop and deliver Building Bridges half-days on moral distress). Members of the Building Bridges development team were invited to present at the organization-wide change collaborative.

Across participating ICUs. Bridges built: Increased referrals to the palliative care team and bioethics, bioethics-unit update meetings, improved patient-family meetings and a patient-family meeting brochure were developed in coordination with patient education.

Unit-based. Interprofessional rounds have begun, palliative care resource binders were developed and an end-of-life toolkit was developed with books and ideas for working with children, hand-mould kit, multi-faith resources and various resources for staff.

The Building Bridges initiative began as a response to the unique stressors and needs of ICU teams, the desire to improve communication and minimize isolation through interprofessional dialogue and education. By focusing on the common challenges and experiences of moral distress and staff wellness, communication, family meetings and quality end-of-life care, participants were able to see their experiences as a part of the larger ICU community. In this way, participants recognized that the challenges faced by individuals who work in an ICU are more similar than different and were able to learn **with, from** and **about** each other toward the goal of improved end-of-life care for our patients, families and teams. 

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AWARD INFORMATION

The Draeger Medical Canada Inc. “Chapter of the Year” Award



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

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

Award funds available: \$500.00 plus a plaque

Deadline for submission: May 31 annually

Application process: Chapters must apply for consideration

Criteria for the award program

- The award program will be for the period of April 1 to March 31 each year
- Chapters may receive the award for one year followed by a two-year lapse before receiving again
- A point system has been developed to fairly evaluate chapter accomplishments during the year
- The chapter that accumulates the most points will be the successful recipient of the Chapter of the Year Award
- CACCN reserves the right to adjust points depending upon supporting materials submitted
- In the case of a tie, CACCN reserves the right to determine the recipient of the award
- The award recipient will be announced at Chapter Connections Day and at the annual awards ceremony at Dynamics.

Conditions for the award program

- All chapters of CACCN are eligible for consideration of the Chapter of the Year Award provided all quarterly and annual financial/activity reports are on file with CACCN National Office for the qualifying period
- Chapters will be responsible for ensuring national office receives all required documentation to validate accumulated points
- If the above conditions are not met, the chapter will not be eligible for consideration
- Announcement of the successful chapter will be published in CACCN publications
- All chapter reports /scoring will be available for review at Chapter Connections Day/Dynamics.

Points system

Innovation

Member Service

- Any educational event coordinated and hosted by the local chapter is eligible. Total hours of education offered in the award period will be total (concurrent sessions are accumulated) and divided by the membership number as a denominator. This will be converted to a rate/1000

Submission guidelines:

- Brochure, advertising or pamphlet and copy of agenda (including hours of education)
- Attendee numbers
- Evaluation of session

Formula: Total hours of education offered/total chapter members × 1000 = innovation score

- Using this calculation, the final educational contribution hours will be adjusted for size of chapter and expressed in rates for direct comparison.

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

- Any public or community service event coordinated and hosted by the local chapter is eligible. Total hours offered in the award period will be total (concurrent activities are accumulated) and divided by the membership number as a denominator. This will then be converted to a rate/1000
- These projects must be presented under the auspices of the CACCN chapter (i.e., participating in blood pressure clinics, teaching CPR to the public, participating in health fairs)

Submission guidelines:

- Validation must be provided that the event was a CACCN-sponsored project
- For example, submitting a letter from the receiving group or a picture of the event, etc.

Formula: Total hours of events offered/total chapter members × 1000 = innovation score.

Communication—Fiscal health—Membership sustainability Recruitment Points

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

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

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

Sustained membership points

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

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

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

Contribution to specialty knowledge—

Publications and presentations

Publications

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

Each article = 25 points

Presentations

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

Each presentation = 25 points

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

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

Initial certification = 10 points per %

Renewal certification = 5 points per %

Add together for total certification score

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

Good luck in your endeavours!

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

CACCN Research Grant

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

Award funds available: \$2,500.00

Deadline for submission: February 15

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

Eligibility:

The principal investigator must:

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

Budget and financial administration:

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

Review process:

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

Terms and conditions of the award:

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

Application requirements:

- A completed application form
- A grant proposal not in excess of five single-spaced pages exclusive of appendices and application form

- Appendices should be limited to essential information, e.g., consent form, instruments, budget
- A letter of support from the sponsoring agency (hospital, clinical program) or thesis chairperson/advisor (university faculty of nursing)
- Evidence of approval from an established institutional ethical review board for research involving human subjects and/or access to confidential records. Refer to CNA publication *Ethical Guidelines for Nursing Research Involving Human Subjects*
- A brief curriculum vitae for the principal investigator and co-investigator(s) describing educational and critical care nursing background, CACCN participation, and research experience. An outline of their specific research responsibilities
- Proof of CACCN active membership and Canadian citizenship
- Facility approval for commencement of study.

CACCN Research Grant Application located at <http://www.caccn.ca/en/awards/index.html> or via CACCN National Office at caccn@caccn.ca.

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

Editorial Awards

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*, 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* 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*.

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 Spacelabs Innovative Project Award



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

Award funds available: \$1,500.00 total

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

Deadline for submission: June 1 each year

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or

Mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1

Do you have a unique idea?

Award criteria:

- The primary contact person for the project must be a CACCN member in good standing for a minimum of one year
- Applications will be judged according to the following criteria:
 - the number of nurses who will benefit from the project
 - the uniqueness of the project
 - the relevance to critical care nursing
 - consistency with current research/evidence
 - ethics
 - feasibility
 - timeliness
 - impact on quality improvement.

- If the applicant(s) are previous recipients of this award, there must be a one-year lapse before submitting an application
- Members of the CACCN board of directors and the awards committee are not eligible.

Award requirements:

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

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

**Smiths Medical
Canada Ltd.**



Educational Award

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

Deadlines: January 31 and September 1 of each year

The CACCN Educational Awards have been established to provide funds (\$1,000.00 each) to assist critical care nurses to attend continuing education programs at the baccalaureate, master's and doctorate of nursing levels. All critical care nurses in Canada are eligible to apply, except members of the CACCN board of directors.

Criteria for application:

1. Be an active member of CACCN in good standing for a minimum of one (1) year
2. Demonstrate the equivalent of one (1) full year of recent critical care nursing experience in the year of the application
3. Submit a letter of reference from his/her current employer
4. Be accepted to an accredited school of nursing or recognized critical care program of direct relevance to the practice, administration, teaching and research of critical care nursing
5. Has not been the recipient of this award in the past two years
6. Incomplete applications will not be considered; quality of application will be a factor in selecting recipient.

Application process:

1. Submit a completed CACCN educational award application package to National Office (forms package online at www.caccn.ca)
2. Preference will be given to applicants with the highest number of merit points
3. Keep a record of merit points, dating back three (3) years
4. Submit all required documentation outlined in criteria—candidate will be disqualified if documentation is not submitted with application
5. Presentations considered for merit points are those that are not prepared as part of your regular role and responsibilities
6. Oral and poster presentations will be considered.

Post-application process:

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

CACCN Chapter Recruitment and Retention Awards

This CACCN initiative was established to recognize the chapters for their outstanding achievements with respect to recruitment and retention.

Recruitment Initiative:

This initiative will benefit the chapter if the following requirements are met:

- Minimum of 25% of membership is **new** between April 1 to March 31, the chapter will receive one (1) full Dynamics tuition
- Minimum of 33% of membership is **new** between April 1 to March 31, the chapter will receive one (1) full Dynamics tuition and one (1) \$100.00 Dynamics tuition coupon.

Retention Initiative:

This initiative will benefit the chapter if the following requirements are met:

- If the chapter has greater than 80% renewal of its previous year's members, the chapter will receive three \$100.00 coupons to Dynamics of that year
- If the chapter has greater than 70% renewal of its previous year's members, the chapter will receive two \$100.00 coupons to Dynamics of that year
- If the chapter has greater than 60% renewal of its previous year's members, the chapter will receive one \$100.00 coupon to Dynamics of that year.

BBraun Sharing Expertise Award



Award funds available: \$ 1,000.00

Deadline for submission: June 1 each year

The BBraun Sharing Expertise Award will be presented to an individual who exhibits stellar leadership and mentoring abilities in critical care.

The candidate is an individual who supports, encourages, and teaches colleagues. The candidate must demonstrate a strong commitment to the practice of critical care nursing and the nursing profession. These qualities may be demonstrated by continuous learning, professional involvement, and a commitment to guiding novice nurses in critical care.

Each nomination must have the support of another colleague and the individual's manager. It is not necessary for the candidate to be in a formal leadership or education role to qualify for this award.

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or

Mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1

Eligibility criteria:

- Nominee must be a CACCN member for a minimum of one (1) year
- The nominee must have at least three (3) years of critical care nursing experience

- At least one nomination letter must be written by a CACCN member
- Preference is given to a mentor who has CNA Certification
- The nominee must demonstrate an awareness of, and adherence to, the standards of nursing practice as determined by the provincial nursing body, and the Standards of Critical Care Nursing (2009)
- CACCN board of directors are not eligible to apply for the award.

Three (3) letters of support are required:

- The nominator must outline the qualities of the candidate, and reasons the candidate should be chosen to receive the award
- Two additional letters must testify to the eligibility of the candidate, as well as outline his/her attributes (one must be written by the nominee's manager)
- All three letters must be sent by electronic mail by each person on the same day with the subject matter: "BBraun Sharing Expertise Award—Candidate's Name" to the Director responsible for awards at National Office (caccn@caccn.ca).

Selection process:

- Each nomination will be reviewed by the Awards Committee in conjunction with the CACCN Director of Awards & Sponsors
- The successful candidate will be notified by email and regular mail
- The successful candidate will be recognized at the annual Awards Ceremony at the Dynamics conference and her/his name will be published in *Dynamics*
- The funds may be used to attend educational programs or conferences related to critical care
- The Awards Committee reserves the right to withhold the award if no candidate meets the criteria outlined.

The CACCN Board of Directors & BBraun Medical retain the right to amend the award criteria.

The Brenda Morgan Leadership Excellence Award

Award funds available: \$1,000.00 plus award trophy

Deadline for submission: June 1

The Brenda Morgan Leadership Award was established in June 2007 by the CACCN Board of Directors to recognize and honour Brenda Morgan, who has made a significant contribution to CACCN and critical care nursing over many years. Brenda was the first recipient of the award. Brenda is highly respected for her efforts in developing, maintaining and sustaining CACCN in past years.

This award for excellence in leadership will be presented to a nurse who, on a consistent basis, demonstrates outstanding performance in the area of leadership in critical care. This leadership may have been expressed as efforts toward clinical advances within an organization, or leadership in the profession of nursing in critical care. The results of this individual's leadership must have empowered people and/or organizations to significantly increase their performance capability in the field of critical care nursing.

The Brenda Morgan Leadership Excellence Award has been generously sponsored by CACCN in order to recognize and honour a nurse who exemplifies excellence in leadership, in the specialty of Critical Care.

Send applications to CACCN National Office at caccn@caccn.ca or fax to 519-649-1458 or

Mail to: CACCN, PO Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before June 1

Eligibility criteria:

Persons who are nominated for this award will have consistently demonstrated qualities of leadership and are considered visionaries and innovators in order to advance the goals of critical care nursing.

The nominee must:

- Have been a member of CACCN for a minimum of five (5) years
- Have a minimum of five (5) years of critical care nursing experience
- Be registered to practise nursing in Canada
- Have demonstrated volunteerism and significant commitment to CACCN
- Have participated in CACCN activities at local or national levels
- Been a member of the CACCN chapter executive or national Board of Directors
- Have helped to plan a workshop or a conference or indirectly provided support of CACCN activities through management activities—supporting staff to participate in CACCN projects or attend conferences
- Hold a valid adult or pediatric specialty in critical care certification—Certified Nurse in Critical Care—CNCC(C) or CNCCP(C) from the CNA (preferred)
- Have demonstrated a leadership role or have held a key leadership position in an organization related to the specialty of critical care
- Consistently conducts themselves in a leadership manner
- Have effectively engaged others in the specialty of critical care nursing
- Have role modelled commitment to professional self development and lifelong learning
- On a consistent basis, exemplifies the following qualities/values:
 - pro-active / innovator / takes initiative
 - takes responsibility/accountability for actions
 - imagination/visionary
 - positive communication skills
 - interdependence
 - integrity
 - recognition of new opportunities
 - conflict resolution skills/problem solving skills.

Application process:

- The application involves a nomination process
- Please submit two letters describing how the nominee has demonstrated the items under the criteria section of this award

- Please use as many examples as possible to highlight what this candidate does that makes her/him outstanding
- The selection committee depends on the information provided in the nomination letters to select award winners from amongst many deserving candidates
- Members of the CACCN board of directors and the awards committee are not eligible
- Award recipients will be notified in writing of their selection for the award
- Recipients will be honoured during the awards ceremony, at the annual Dynamics Conference
- Recipient names and possibly a photo will be published in *Dynamics*.

Selection process:

- Each nomination will be reviewed by the award committee in conjunction with the CACCN Director of Awards and Sponsorship
- The Brenda Morgan Leadership Awards committee will consist of:
 - Two members of the board of directors and Brenda Morgan (when possible)
- The awards committee reserves the right to withhold the award if no candidate meets the criteria outlined.

Terms and conditions of the award:

- The award recipient will be encouraged to write a reflective article for *Dynamics*, sharing their accomplishments and describing their leadership experience. The article should reflect on the recipient's passion to move critical care nursing forward, their leadership qualities and how they used these effectively to achieve their outcome.

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

Cardinal Health Chasing Excellence Award

Award value: \$1,000.00

Deadline: June 1 annually

This award is presented annually to a CACCN member who consistently demonstrates excellence in critical care nursing practice. The Cardinal Health Chasing Excellence Award is \$1,000.00 to be used by the recipient for continued professional or leadership development in critical care nursing.

The Cardinal Health Chasing Excellence Award is given to a critical care nurse who:

- In critical care, has a primary role in direct patient care
- Has been a CACCN member in good standing for three or more years
- Holds a certificate from CNA in critical care CNCC(C) or CNCCP(C) (preferred)
- Note: Current members of the national board of directors are not eligible.

The Cardinal Health Chasing Excellence Award recipient consistently practises at an expert level as described by Benner (1984). Expert practice is exemplified by most or all of the

following criteria:

- Participates in quality improvement and risk management to ensure a safe patient care environment
- Acts as a change agent to improve the quality of patient care when required
- Provides high-quality patient care based on experience and evidence
- Effective clinical decision-making supported by thorough assessments
- Has developed a clinical knowledge base and readily integrates change and new learning to practice
- Is able to anticipate risks and changes in patient condition and intervene in a timely manner
- Sequences and manages rapid multiple therapies in response to a crisis (Benner, Hooper-Kyriakidis & Stannard, 1999)
- Integrates and coordinates daily patient care with other team members
- Advocates and develops a plan of care that consistently considers the patient and family and ensures they receive the best care possible
- Provides education, support and comfort to patients and their families to help them cope with the trajectory of illness and injury, to recovery, palliation or death
- Role models collaborative team skills within the inter-professional health care team
- Assumes a leadership role as dictated by the dynamically changing needs of the unit
- Is a role model to new staff and students
- Shares clinical wisdom as a preceptor to new staff and students
- Regularly participates in continuing education and professional development.

Nominations:

Two letters describing the nominee's clinical excellence and expertise are required, one of which must be from a CACCN member. The nomination letters need to include three concrete clinical examples outlining how the nominee meets the above criteria and demonstrates clinical excellence in practice. In addition, a supporting letter from a supervisor, such as a unit manager or team leader, is required.

Selection:

Each nomination will be reviewed by the awards committee in conjunction with the CACCN director of awards and sponsors. The successful recipient will be notified by mail, recognized at the annual awards ceremony at the Dynamics conference and her/his name will be published in *Dynamics*. The awards committee reserves the right to withhold the award if no candidate meets the criteria. 

References:

- Benner, P. (1984). *From novice to expert. Excellence and power in clinical nursing practice*. Menlo Park: Addison-Wesley.
- Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical Wisdom and Interventions in Critical Care: A Thinking-in-action Approach*. Philadelphia: Saunders.



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REFERENCES: 1. Stone S, et al., Removal of bath basins to reduce catheter-associated urinary tract infections. Poster presented at APIC 2010, New Orleans, LA, July 2010.
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DYNAMICS

Information for Authors

Dynamics: The 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 physiologic 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, 1-inch margins on all sides. Pages should be numbered sequentially including tables, and figures. Prepare the manuscript in the style outlined in the American Psychological Association's (APA) Publication Manual 6th Edition
- Use only generic names for products and drugs
- 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. Accepted manuscripts are subject to copy editing.
- All authors must declare any conflicts of interest and acknowledge that they have made substantial contributions to the work and/or contributed substantially to the manuscript at the time of acceptance.

Revised November 2011



WHY CACCN?

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.