



The Canadian Journal of Critical Care Nursing

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2016



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The Canadian Journal of Critical Care Nursing

Volume 27, Number 3, Fall 2016

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CANADIAN
ASSOCIATION OF
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Canadian Association of Critical Care Nurses

Vision statement

All critical care nurses provide the highest standard of patient and family centred care through an engaging, vibrant, educated and research driven specialized community.

Mission statement

We engage and inform Canadian Critical Care nurses through education and networking and provide a strong unified national identity.

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 Reflections

It is a warm August evening, as I sit quietly to reflect on the day, life and critical care nursing. There is so much going on around us, captivating our attention and our emotion in the media. Our thoughts are with those in Fort McMurray who are challenged once again with nature's beasts from the devastating fire in May to the recent floods.

Christine Halfkenny-Zellas, Chief Operating Officer, and I attended the 2016 AACN/NTI conference in May to further our relationship with the American Association of Critical-Care Nurses. We met many Canadian nurses at our exhibit booth and shared information regarding the benefit of joining their professional nursing association. We also shared information with exhibitors who are interested in attending Dynamics of Critical Care. Many of the American critical care nurses we met were embarrassed by the political campaign being waged for the presidency. Following these discussions, I have been following the political scene in the United States over the past several months and had the opportunity to hear several of the speakers at the U.S. Republican and Democratic conventions. One person who really impressed me was Michelle Obama. What a woman. What a leader. She is articulate, intelligent, level-headed, even tempered and fun (if you caught her with James Corden in his infamous Carpool Karaoke). So, as one political leader sends messages of a very different shift proposed for America, Michelle Obama shared her family creed, "When they go low, we go high" – when one talks of building a high wall, the other speaks of holding one's head high and building resilience.

Recently, my best friend, a nurse manager, was told to "F-off" by one of her employees. I never would have the nerve to speak to anyone that way, let alone my manager. Having a policy on respectful behaviour towards anyone, a colleague, a patient, a family member, is as disappointing (but organizationally necessary) as when a physician writes an order for mouth care. Yeah I know, mouth care is a part of total care for the patient, but some people don't grasp the full care picture.

What I am getting at is when the going gets tough, don't get tough. I like the saying "soft front, tough back." Be respectful and approachable, but stand to your convictions. Our theme is *Be the Difference*. When you are so frustrated with electronic documentation, don't throw the computer at the wall. We are all challenged by today's health care issues of workload, acuity, staffing, EMR, funding or lack thereof, support for education, compassion fatigue, stress and lack of support and resources. After more than 30 years, we are still writing articles on "Why do we eat our young?" What keeps you going? What keeps you passionate about critical care? For me, I would get all fired up at the annual CACCN Dynamics of Critical Care Conference.

Dynamics is a great way to network and connect with others facing similar issues in their intensive care units and hospitals. As our hospital has adopted the continuous performance improvement methodology, we strive to learn, grow and do better. We work together to uncover the best known way to do something. I was pleased to hear a nurse share at last year's conference that she likes to attend to get ideas to bring back to her unit to help improve patient care. Come and recharge your batteries, learn and connect.

This year's conference offers new and exciting changes to the program. The conference committee has introduced electronic posters and mastery sessions offering interactive learning, as well as a wonderful panel discussion on secondary trauma. Join us on Sunday for the Annual General Meeting during the luncheon period, then plan to attend the Gala Reception with support from the Canadian Intensive Care Foundation, where we will showcase the wonderful poster presentations and introduce you to our Dynamics exhibitors. It won't be all work though... as Spacelabs Healthcare has once again planned a fun "Sunday Social" that you will not want to miss. Monday brings about the Annual Dinner ... casual wear is in order—flip flops, sun hats and sand.

On behalf of the CACCN Board of Directors, I am sending a big thank you to the planning committee for Dynamics 2016. I look forward to seeing you in Charlottetown, Prince Edward Island, September 25–27.

May you continue to *Be the Difference* to your patients, families and colleagues. 

Sincerely,

Renée Chauvin
President, CACCN



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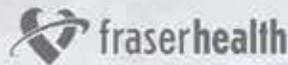
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BC Children's Hospital (BCCH) is a world-renowned facility providing care for the province's most acutely ill or injured children. The Emergency & Trauma Services department at BCCH treats more than 43,000 children each year across the province. The new Teck Acute Care Centre opening in the fall 2017 will be the heart of the BCCH and the flagship for the transformation of child health in BC.

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Canadian Association of Critical Care Nurses (CACCN) Conference

SEPTEMBER 25 – 27, 2016

CHARLOTTETOWN, PEI

BOD Nominations 2017–2019

A Call for Nominations for National Board of Director positions in Eastern and Western region commenced in April 2016. The closing date for nominations was July 5, 2016. The following members have been nominated for election to the National Board of Directors for a two-year term from April 1, 2017 to March 31, 2019:

Eastern: No nominees

Western: Sarah Crowe
Sandra Goldsworthy

PROFILING

CACCN Board of Director Nominees—Western Region

Sarah Crowe, MN, RN, CNCC (C) Fraser Health, Langley, BC

Nominated by Caroline Penner



My name is Sarah Crowe. I have been an RN since 2001. I graduated with my BSN from the University of Victoria in 2001, and began my nursing career as an ER nurse at Surrey Memorial Hospital.

In 2004, I realized that my passion lie with critical care patients, and transitioned to the ICU after completing a critical care specialty certificate. During my time in the ICU, I worked alongside a dedicated team of nurses as a bedside nurse and as a patient care coordinator. During this time, I completed my Master's of Nursing from Athabasca University in 2010, and my CNA certification for critical care in 2013. I am currently working as the Critical Care Clinical Nurse Specialist for Fraser Health.

I have been involved with the BC Chapter of CACCN. I have also had the opportunity to present at previous Dynamics Conferences. I am currently a member of the CACCN Professional Development Committee and am looking forward to working with this committee to inspire and support critical care nurses.

I am passionate about critical care and the complexities of the patients we serve. I hope to serve on the CACCN Board of Directors in order to support our critical care patients/families, and nurses nationwide. I am motivated and hard-working, and want to bring my passion and enthusiasm for innovation, change and evidence-based practice to the national level.

Thank you for the opportunity to be considered for the CACCN National Board of Directors—Western Region.

Sandra Goldsworthy, PhD, RN, CNCC(C), CMSN(C) University of Calgary, Calgary, AB

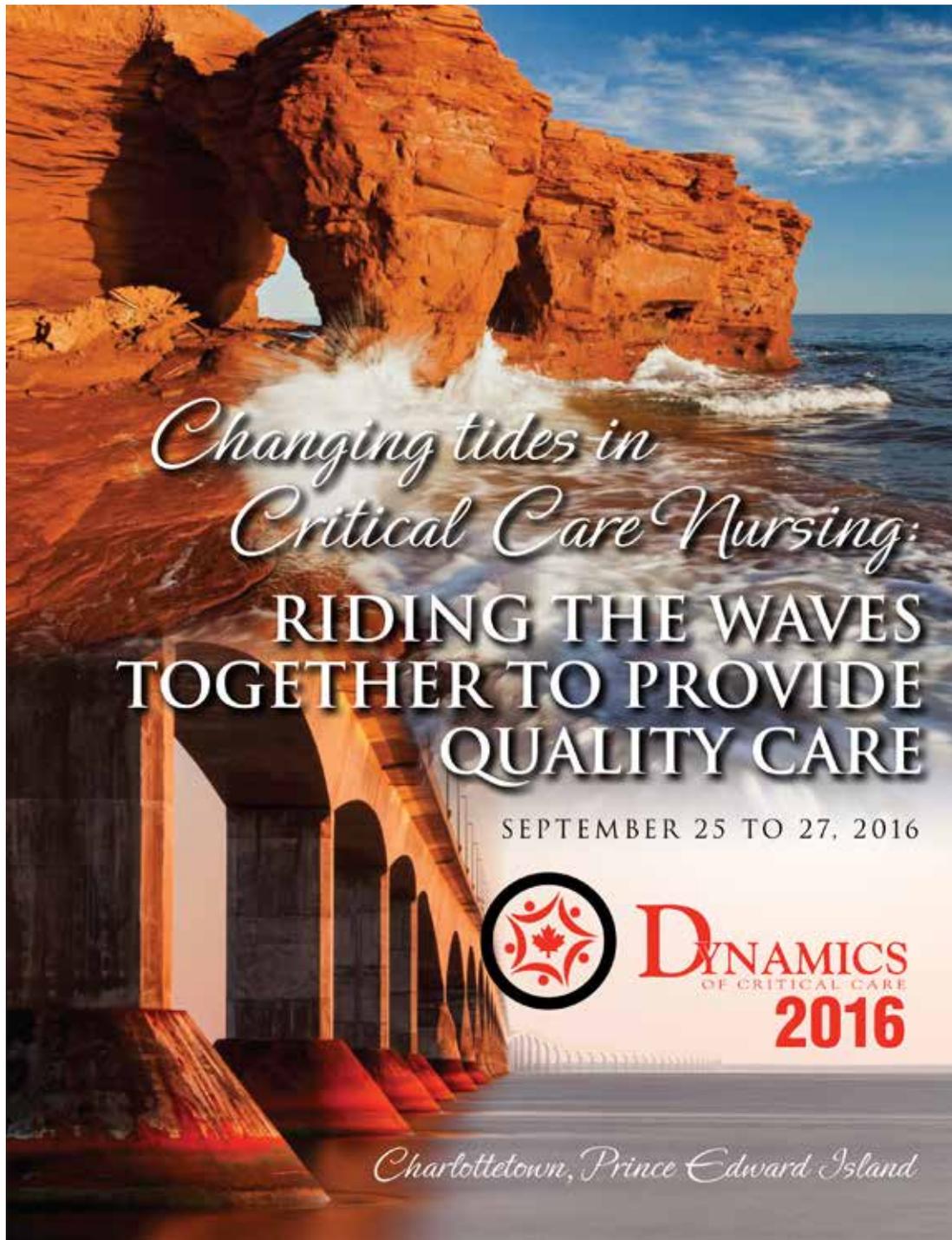
Nominated by Sarah Giesbrecht



My name is Sandra Goldsworthy and I have been a proud Canadian critical care nurse for almost 30 years. I am currently an Associate Professor at the University of Calgary. My nursing background and experience in critical care includes: practice, teaching, research and leadership. I have been a long-term member of

CACCN and have served on CACCN local executives, the editorial board and conference planning committees. I have also participated on the Standards Committee and the Professional Development Committee. I have established international critical care nursing collaborations and have been a strong voice for Canada at international tables. I am currently a board member of the World Federation of Critical Care Nurses.

I have a proven track record of leadership and service in critical care nursing and would like to contribute to the CACCN by working with the board to increase the profile of Canadian critical care nurses nationally and internationally. Specific areas of interest that I can contribute to most are related to healthy work environment strategies, national and international collaborations, professional development opportunities and retention strategies for critical care nurses. I also believe that, as Canadian critical care nurses, we have an opportunity to be recognized as a unique voice that will impact policy decisions and stay on the leading edge of critical care nursing practice. At the same time, advocating to improve working conditions, decrease moral distress and burnout rates, and rally for increased investment in professional development opportunities for Canadian critical care nurses. I am committed to making a difference in critical care and would welcome the opportunity to represent you on the CACCN board. 



The Dynamics of Critical Care™ 2016 Planning Committee and the CACCN Board of Directors look forward to welcoming all conference delegates, sponsors and exhibitors to Charlottetown, PEI, for Dynamics of Critical Care™ 2016 being held from September 25–27, 2016. View the conference brochure at www.caccn.ca. Final day for conference registration is September 5, 2016.

IMPORTANT NEWS—CHANGE TO THE CACCN ELECTION PROCESS!

CACCN is introducing **online voting** for the CACCN National Board of Director elections through **Simply Voting**. Simply Voting offers a secure, reliable, easy-to-use system for election voting. All members will receive an email with voting instructions and a link to the election along with login information. Member responses are encrypted and anonymous allowing for one vote per member. The election will be managed by Simply Voting with CACCN receiving the election results only.

How to vote by paper ballot: Those who wish to vote by paper ballot and those members without an email address on file, please contact CACCN National Office at caccn@caccn.ca to have a ballot emailed or mailed for return.

Please note – affiliates do not hold voting rights and will not be included in the election process.



CACCN Annual General Meeting

The National Board of Directors of the Canadian Association of Critical Care Nurses extends an invitation to the membership to attend the 32nd Annual General Meeting. The Annual General Meeting of the CACCN will be held Sunday, September 25, 2016, at the Delta Prince Edward Convention Centre, Charlottetown, PEI, in conjunction with Dynamics of Critical Care™ 2016.

World Sepsis Day

The Global Sepsis Alliance, in its continuing efforts to battle sepsis globally, has convened the 1st World Sepsis Congress (WSC). The WSA invites you, your colleagues, friends, and family to participate in the first WSC. The congress will take place completely online on September 8–9, 2016, as a prelude and introduction to the 5th World Sepsis Day on September 13, 2016. Participation is free of charge and requires only the completion of a short registration form, which can be found at: <http://global-sepsis-alliance.org/>

Revision to Abstract

In the *Canadian Journal of Critical Care Nursing*, Volume 27, Number 2, Summer 2016, three authors on the following abstract were unfortunately not included at the time of printing.

Page 17: “*Navigating the Transition of Critical Care to End-of-life Care Using a Strengths-Based Nursing Approach*”. The abstract authors are: Annie Chevrier, MSc(A), RN, CMSN(C), Elaine Doucette, MScN, RN, Sophie Bastarache, BSc(N) student, Valerie Duff-Murdoch, BSc(N) student, Julie Marceau, BN (I) student, Cecilia Marti, BN (I) student, Sarah Twardy, RN, BNI U2, Emily Yang, BScN, U2, and Judy Yang, BScN, U2, McGill University Health Centre, Montréal, Québec.

Certification update

Specialty Nursing Examination—Critical Care Nursing

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Dynamics of Critical Care Conference: Future Sites

Dynamics 2016: September 25–27, 2016, Charlottetown, PEI

Dynamics 2017: September 2017, Toronto, ON

Dynamics 2018: September 2018, Calgary, AB



CANADIAN
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Annual General Meeting Proxy Vote Form 2016

I, _____, a **voting member** in good standing of the Canadian Association of Critical Care Nurses (CACCN), hereby give my proxy to:

1. Renée Chauvin, President, Board of Directors, failing her, to
2. Lara Parker, Director, Chair—Member Relations Committee, Board of Directors.

OR (complete only if you wish to name someone other than the above, who will be in attendance at the AGM)

_____ as my proxy to attend, act, and vote on my behalf at the Annual General Meeting of members to be held Sunday, September 25, 2016, at the Dynamics of Critical Care™ Conference 2016, in Charlottetown, PEI (including adjournments thereof).

(please print)

Name: _____ Date: _____

Signature: _____

It is the responsibility of the member to determine whether the person to whom they assign the proxy is an active member who will be in attendance at the AGM and is able and agrees to act in the manner described.

Please ensure delivery of the completed proxy to CACCN by no later than 2359 ET on September 5, 2016:

by e-mail: caccn@caccn.ca

by fax: (519) 649-1458

by mail: Canadian Association of Critical Care Nurses

P. O. Box #25322

London, ON N6C 6B1

Critical care nursing north of the 60th Parallel: A qualitative pilot study

BY BRANDI VANDERSPANK-WRIGHT, PHD, RN, AND KIMBERLY McMILLAN, BScN, PHD(CANDIDATE), RN

Abstract

Background: There is growing knowledge specific to remote, rural and northern nursing practice in Canada's north. However, there is limited research that specifically addresses the experiences of critical care nurses working in Canada's northern communities.

Purpose: The purpose of this pilot study was to begin to explore and better understand the experiences of Canadian nurses providing critical care to patients and families in intensive care units north of the 60th parallel.

Study design: An interpretive phenomenological analysis was used.

Method: Telephone interviews were conducted with three registered nurses currently employed in the designated intensive care unit on a full-time, part-time or casual basis. Interviews were

thematically coded and analyzed. Member checks were used to ensure thick description for this pilot study was obtained.

Findings: The following themes evolved through the interpretive phenomenological analysis process, *Going North*, *The Role of the Northern ICU Nurse*, *Challenges*, *Support*, *Positive Aspects of the Experience*, and *The Northern Experience*.

Conclusions: Threaded throughout the main themes, participants made reference to "making it work". Making it work was reflected in how the participants described managing limited resources (particularly human resources), working within an expanded scope and managing the expectation that "the ICU nurse can do it."

Key words: critical care nursing, northern nursing, rural and remote nursing, qualitative research

Vanderspank-Wright, B. & McMillan, K. (2016). Critical care nursing north of the 60th Parallel: A qualitative pilot study. *Canadian Journal of Critical Care Nursing*, 27(3), 12-17.

Researchers have described the experiences of critical care nurses providing care to patients and families in various contexts. While there exists a growing body of knowledge specific to remote, rural and northern nursing practice (Andrews, Morgan, & Stewart, 2010; Kulig, Kilpatrick, Moffitt, & Zimmer, 2013; Pitblado, 2005), there is limited research that has specifically addressed the experiences of critical care nurses working in Canada's northern communities. For the purpose of this study, "northern" has been defined according to the Canadian Institute of Health Research (2010) as "north of the 60th parallel".

Background

Research to date has identified that often "[n]orthern nursing is commonly associated with expanded 'generalist' practice roles and functions" (Andrews et al., 2010, p. 57). Yet, facilities north of the 60th parallel with purposefully made intensive care units (ICUs) employ nurses requiring additional knowledge and skills beyond generalists to work in a recognized area of specialty nursing practice. In addition, Krieg, Martz, and McCallum (2007) have suggested that "the role of the northern [registered nurse (RN)] was found to entail more expanded-practice skills (e.g., the ability to perform minor surgical procedures" (p. 59) and that previous experience in acute care was essential.

Professional isolation is a prominent theme relating to rural and northern nursing contexts (Andrews et al., 2010; Martin-Misener et al., 2008). Professional isolation impacts continuing education opportunities, as well as the opportunity to collaborate with other health care providers. Limitations related to the

availability of resources (including human resources) have been identified as challenges related to northern nursing practice (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004a; MacLeod, Kulig, Stewart & Pitblado, 2004b). However, while "[n]ursing practice roles in the north were seen as unstructured in that nurses need to be available to attend to a variety of issues" (Andrews et al., 2010, p. 68) nurses working in this context of care also valued the autonomy afforded by the role. There is a dearth of literature exploring how such themes of generalized and expanded practice skills and professional isolation impact critical care nurses working north of the 60th parallel in sites that have purposefully made ICUs. Existing literature specific to critical care has highlighted many rewarding and challenging experiences of nurses providing care to patients and families. However, after conducting a literature review using both Medline (EBSCO) and CINAHL, little is known about the aspects of critical care nursing in a northern context where other challenges (including availability of resources and geographical isolation) are also cited. Further study is merited in order to begin to broaden our understanding of critical care nursing experiences in Canada's north.

Purpose

The aim of this pilot study was to begin to explore and better understand the experiences of Canadian nurses providing critical care to patients and families in ICUs north of the 60th parallel. This pilot study was guided by the following research question: What are the lived experiences of critical care nurses who provide care to patients and families in ICUs in Canada's north? The study objectives were to:

1. Describe and understand the experiences of intensive care nurses who provide care to critically ill patients and their families in Canada's north.
2. To identify similarities and differences of patient and family care experiences described by critical care nurses in this context of care as compared to what is currently described in the critical care nursing literature.
3. To identify rewards and challenges specific to the provision of care to critically ill patients and families within a northern context in Canada.

Design

Methods

The study was designed using interpretive phenomenological analysis (IPA) (Smith & Osborn, 2003). With underpinnings of a hermeneutic approach, the use of IPA facilitated a greater understanding of "meanings embedded in common life practices" (Lopez & Willis, 2009, p. 728). Phenomenological research explores the lived experiences of individuals and seeks a deeper understanding and meaning of their everyday experiences (van Manen, 1997).

Sample

While sampling size in phenomenological studies vary between five and 25 participants (Morse & Field, 1995), this sample is limited by the number of nurses employed in the ICU, which is less than 20. The sample for this pilot was three RNs, all of whom met the following inclusion criteria: must be an employee of the hospital, must be currently employed in the designated ICU full-time, part-time or on a casual basis, and must be English or French speaking.

Ethical considerations, recruitment and analysis

Ethics approval from both the Hospital Research Ethics Committee and University of Ottawa Research Ethics Board were received. Informed consent was obtained from study participants prior to participation in the study. Recruitment strategies included the posting of flyers in the designated ICU and the Clinical Nurse Educator informing the ICU nurses of the study. Potential participants were invited to contact the researcher for more information.

Telephone interviews were conducted with the participants. Verbal consent was obtained prior to the commencement of the interviews. All interviews were audio-recorded using a digital, password-protected device. Demographic data were collected at the commencement of participant interviews. All interviews were assigned a number whereby all identifiers were removed to ensure participant anonymity. The interviews lasted 60–90 minutes and were conducted using a semi-structured interview guide. Variability in the length of interviews was anticipated and was dependent on the participant's ability and willingness to articulate the phenomenon of interest. The sample of interviews revealed commonalities within the data provided. Member checks were used to ensure thick description for this pilot study was obtained (Denzin, 1989; Lincoln & Guba, 1985). All audio-recordings were transcribed verbatim and the transcription was verified against the audio for accuracy. Data analysis was completed using methods outlined by Smith and Osborn (2003).

Findings

The findings of this study have been organized into five themes including *Going North*, *The Role of the Northern ICU Nurse*, *Challenges*, *Support*, *Positive Aspects of the Experience*, and *The Northern Experience*. Each theme will be described and supporting evidence in the form of quotations provided. A limited description of the study site (clinical context) has been provided for the purpose of maintaining anonymity of the participants and to limit identifiers specific to the site.

Clinical context

This study was conducted in a purposefully built ICU north of the 60th parallel. This unit provides 24-hour care to critically ill patients experiencing both medical and surgical issues. The unit sees a primarily adult population. However, pediatric cases can be admitted. There is no neonatal unit. The ICU has the capacity to care for mechanically ventilated patients. It is also the referral centre for neighbouring communities and more outlying hospitals. However, it also relies on other hospitals when patients requiring care beyond the resources available within that ICU need to be transferred out. The unit is staffed primarily by RNs, the majority of whom have been employed with, at minimum, some critical care experience. Agency nurses with critical care experience are also part of the RN make-up for this ICU. Physicians include hospitalists and family medicine physicians who may or may not have additional training in anesthesiology. There is a physician in the hospital 24 hours per day, but on nights, is designated to the emergency department. There are no in-house respiratory therapists (RT).

Going north

Out of Canada's approximate 268,512 RNs, only 1,466 (less than 1%) are employed in the Northwest Territories, Nunavut and Yukon combined (Canadian Nurses Association, 2012). As such, one of the first questions asked of the participants was their motivation for "Going north." Both adventure and previous experiences in the north were common threads across the interviews. Participant two recalled: "*To be honest, I had a dream about the northern lights and I thought, 'I gotta go... this is my chance...I'm just going to go for it and not knowing a soul out here...I packed up my car and drove across the country.'*" Participant three added: "*It was for the adventure of...exploring the north*" rather than moving north for a nursing employment opportunity. However, participant one stated, "*I left...to go to nursing school, I knew I'd come back.*" The participant added: "*The winters are so cold and dark, you've got to get out every winter. And I wasn't making enough money in my previous position...to do that. So, I thought if I want to stay...which I did, I've got to find a job that affords me the lifestyle to live in the [location omitted] properly...i.e., leave.*"

The role of the northern ICU nurse

This theme highlights aspects of the role of the ICU nurse that appear to be more specific to a northern context with respect to an expanded scope of practice. Additionally, it suggests that the ICU nurses' role extends from simply being in the unit to other areas of the hospital, as well. Due to the complexity of their expanded role, the nurses in this study also described having to manage the expectation that "*the ICU nurse can do it*".

Due to the structure of the interprofessional team and limits of interprofessional staff, such as the availability of RTs, nurses in this study explained that their scope of practice also included taking on aspects of what might typically be part of the RT role in larger centres. Participant two stated: *“So we kind of play the role of a respiratory therapist at times... we draw ABGs on the ward... and we’re often consulted if they end up deteriorating on the ward.”* Participant two reflected: *“There’s also a requirement of our position to help out in Emerg if needed... So there’s times where I’m down there helping out, as well, whether it’s in a code or they need assistance with intubating or setting up. It’s required of us to set up the... ventilator. It’s required of us to... maintain and clean and put together the ventilator.”*

Participants in this study described being in the unit, but also the expectation of being available and present outside of the unit, as well. In addition to the direct care provided within the ICU, the nurses are also accountable for monitoring telemetry across the organization, as well as being a resource to nurses and physicians elsewhere in the hospital. Participant two elaborated, *“There’s also times where I’ve been asked to go to the recovery room itself down by the OR and recover patients down there and I’ve never been trained.”*

A general consensus across the interviews was reflected in statements like *“The ICU nurse can do it”* and that *“ICU can handle it”*, which in this clinical context/hospital environment extended to added roles and responsibilities, as a result of limited resources as part of the northern context, but also with a perception from those outside of ICU that the unit had a greater availability of resources than other areas in the hospital.

Challenges

Some of the challenges of northern nursing included unit staffing (such as nurse-patient ratios, coverage for holidays and sick calls), the role of the nurse, the role of agency nurses, building a skill set and maintaining competency, and caring for patients and families in difficult and complex situations.

The RN staffing complement for this particular unit is less than 20. As such, coverage for both holidays and sick calls can quickly have an impact on the unit. In order to manage RN staffing, the organization also relies on agency nurses to cover staffing needs in the ICU. While agency nurses come prepared with up-to-date knowledge in critical care, the agency nurses called in to the ICU are given priority in providing coverage for the unit, which can, on occasion, result in a regular ICU staff nurse being relocated to work on the medical ward.

It is important to add that critical care nurses in this organization have a dual role as both critical care and medical nurses. ICU nurses are also expected to work on, and staff the medical ward. Participant three explained: *“So one of the challenges with working in our ICU is that... you’re hired as an ICU/medical ward nurse, so... you rotate through... that was a real challenge for me when I came here. I was used to taking care of one to two ICU patients, but because you’re working out on medical, suddenly I’ve become a medical ward nurse, taking care of... up to 20 patients on a night shift. That was a huge challenge for me because I was not a medical ward nurse, I was an ICU nurse.”*

As previously explained, RNs within this clinical context have the added responsibility of ventilator care and management. As such, the participants also described this aspect of their role as challenging because caring for mechanically ventilated patients was not a regular, day-to-day occurrence in the ICU. Limited human resources, as the participants explained, directly impacted the length of time that it was feasible to keep ventilated patients prior to transferring them “south.” Participant three explained: *“One of the challenges in keeping up our skills on ventilated patients is that we may only keep patients here for two days because we’ve actually run out of nurses to continue caring for that patient 24 hours a day... then it’s hard to ...maintain that skill.”* Similarly, nurses genuinely feared the possibility of having to care for pediatric patients (which can occur in the study ICU). Participant two added: *“When we have a critically ill peds patient, usually there’s fear and terror that spreads through the ICU and I’m one of them. Because I’m not, I don’t even know what to do with a healthy child... so then we have to scramble and hopefully there’s someone on who does both critical care and peds, but if not, we have to just do the best we can.”*

The participants also described challenges related to caring for patients experiencing acute alcohol withdrawal. Patients experiencing acute and severe alcohol withdrawal were described as being physiologically unstable, and physical and emotional aggression was experienced by the nurses. Some of the participants interviewed reflected that limited human resources, nurse-patient ratios of greater than 1:1 and 1:2 augmented the challenges associated with caring for this patient population. Participant one reflected:

“Your five-point restraint person who’s ticking along too quickly and has just pulled out his central line and then your third person, whoever, and then your bank of... telemetry... and it’s the alcohol withdrawal person who’s going to get all the attention because he’s slinging his poo around because he’s totally hallucinating and he’s pulled out his central line and the minute you walk in there he calls you a [expletive removed], you know... it’s so unpleasant, it’s horrible and then Mr. Chest pain is not treated and who knows what the third patient’s doing, probably on the floor... that’s not an exaggeration.”

Support

Although several challenges were identified in relation to both the clinical context and role of the northern ICU nurse, there were important and unique ways that the participants identified as providing support. One mechanism for support is provided through a comprehensive referral system whereby staff from “down south” act as resources to help with the management of patient care, as well as facilitate the process of transferring patients out of the ICU. Participant one stated: *“We give them all of our stuff we can’t handle.”* Participant two explained, *“We’re generally pretty good at sending people south if they’re too sick for our capabilities.”* Participants one and three noted that when transferring patients “south,” the process can have its challenges such as bed availability and weather, but that, overall, it occurs quite easily.

While some challenges were identified by the participants with respect to interprofessional communication, in the majority of instances where communication was described from an interprofessional perspective, collegiality and respect for one another was emphasized. The participants reflected on working together, as a nursing team, but also working well with the physician group at the hospital. The latter provided an avenue where support for one another was a central theme and where communicating and working together was essential for and contributed to good patient care. Participant one reflected, “For the most part... I think it’s [a] really, really, positive relationship.”

Supporting one another, as nurses, was also identified as an important aspect of the support theme. The participants identified that their registered nurse colleagues, as well as ICU nursing leadership such as their nurse educator and nurse manager, were important sources of support. Participant two stated, “We have a massive collaboration of working together and helping each other out.” Participant one elaborated on the role of the educator, “We have a very supportive educator... she’s been wonderful... when things become acute she’s certainly there as a resource and she’s just really supportive.” Participant two recalled a personal experience whereby she felt the nurse manager went above and beyond and stated, “Having a manager who I can go to about anything is a definite perk.”

Additionally, the participants described the educational resources, such as online/web resources, made available to them and also reflected on a newly formed journal club. The purpose of the journal club was described as two-fold, first as a mechanism to remain up to date with current trends in critical care, such as treatment modalities, and second, it provides the ICU nurses an opportunity to socialize outside of the unit and to provide informal support to one another. One participant described the journal club as follows:

“It’s called... the ICU Journal Club. And every couple of months, we’ve only had it twice now, but with the help of our educator, [we] find an article, distribute it and then we get together. The ICU nurses get together at someone’s house, we make it kind of fun and social, have wine and [snacks] and talk about the article... [the hope is that it is] going to act as a means for supporting each other.”

Positive Aspects of the Experience

Analysis of the interview data revealed an overarching theme of nurses doing their best to “make it work”. Despite the identified challenges and unique aspects of the context of the northern ICU context, participant three stated: “We really do support each other in our work... we give really good patient care with the limited resources that we have.” Participants clearly emphasized the positive aspects associated with their role of being northern ICU nurses. Participant two recalled: “There are skills that I have learned here that I definitely wouldn’t have learned in a bigger centre... I guess because it’s a small hospital... I know pretty much everybody that works there, including the housekeeping and I say hi to them by name and I really like that aspect. It’s a small community feeling.” In reflecting on the smallness of the unit and the staff, participant one added: “I guess the biggest joy is because of its small staff and a small unit, it’s very easy to... follow-up on the

patients... so seeing people go from critically ill to sitting up in the chair... because of our size we can get some real joy. It’s from the follow ups and follow through. I’d say that’s one of my biggest joy stories.” The “smallness” also positively impacts the possibility for change. Participant three explained: “It’s the smallness... it’s the teamwork... if we have a concern here, it’s quite easy to talk to who you need to talk to, to make some changes... the ladder is smaller here... you have a manager... you have a director, you can even call up the minister of health if you want to or to talk to them... while standing in line at the grocery store.”

The Northern Experience

Participants in this study reflected on their individual reasons for choosing a career in critical care nursing within a northern context. However, the participants also reflected on their experiences north of 60. Participant one stated, “The people who live in the [north] are special. I think they’re special. We choose to live here, not for the career... they live here because of the lifestyle... there’s some similarities... and some really genuine people.” The participant added that inherent in the northern experience is, “I’d say similar values that are... connected to the land somehow. That people who live here are more connected to the environment and their surrounds than other places I’ve lived... people live a bit more deeply and think a bit more deeply here.” In reflecting on some of the challenges associated with the role, participant one added, “So even though eight to eight some days might feel like it’s tearing me apart, it’s for the most part or maybe even always worth it if I can live here.” Participant three reminisced, “I can remember when I first came here... I just thought ‘Oh my god, I cannot do this, this is not what I signed up for.’ And then I thought ‘well we can make this to a year, ok... but after a year I’m out of here’ and then some of the challenges... I just started to really enjoy the challenges... so here we are twenty five years later, we’re still here...”

Summary of findings—making it work. Threaded throughout the main themes identified in this pilot research, participants in this study made reference to “making it work”. Making it work was reflected in how the participants described managing limited resources (particularly human resources), working within an expanded scope and managing the expectation that “ICU can do it.” Making it work was also reflected in the collegiality expressed both intra- and interprofessionally. Importantly, making it work also reflected how participants worked through the challenges in order to continue to have their “northern experience.”

Discussion

The themes presented in this pilot, *Going North, The Role of the Northern ICU Nurse, Challenges, Support, Positive Aspects of the Experience, The Northern Experience*, are interwoven into an overarching theme of “making it work”. Nurses in this pilot study made more challenging and often resource-depleted environments work—because the tradeoffs were worth it—nurses felt they had increased autonomy in their workplace and increased engagement within the northern community. ICU nurses’ multifaceted roles in the north, combined with the smaller size of their work environment, provided more autonomy to address workplace challenges.

Nurses felt able to foster timely changes to address workplace challenges, more so than their counterparts working in more hierarchical, larger urban centres (Beardwood, Walters, Eyles, & French, 1999).

Northern nurses in the Martin-Misener and colleagues 2008 study cautioned new nurses contemplating working in the north to “consider whether your personal qualities are suited for northern practice” (p. 57). Perhaps it is a certain kind of personality that draws nurses to the north—the people, the lifestyle, the heightened connection to the community, but we suggest it may also be the work environment—the expanded roles/scope of practice and the autonomy it allows nurses. Expanding roles and increases in autonomy are areas of nursing practice that remain common in the north (Andrews et al., 2005; Kulig et al., 2008; Stewart et al., 2005; Zibrik et al., 2010). However, findings from the literature have suggested that large urban institutions often do not fully support nurse autonomy or the utilization of their full scope of practice (Fyke, 2001; Meyer Bratt, Baernholdt, & Pruszyński, 2014). A shrinking scope of practice and less autonomy over nursing work contributes to increasing rates of dissatisfaction among nurses (Finn, 2001).

Ongoing support and education

The nurses in this pilot study described ongoing support and education from colleagues and nursing leadership—which could mediate some of the negative experiences described by northern nurses in other Canadian studies that linked lower job satisfaction in the north with lower levels of support and education (Andrews et al., 2005; Martin-Misener et al., 2008; Stewart et al., 2011). For example, the nurses in this study demonstrated creativity by initiating a journal club, exemplifying the recommendations offered by northern nurse participants in the MacLeod and colleagues 2008 Canadian study, which emphasized the importance of creative, dynamic and accessible education delivery modalities “that matched the needs and realities of rural and remote practice” (p. 45). The initiation of a journal club also reflects the suggestion made by northern nurses in the Martin-Misener et al. (2008) study, who asked that nurses be provided with “opportunities for accessible, flexible, relevant continuing education” (p. 59).

Collaboration and community

Nurses in this pilot also described their ability to participate in institutional decision-making, reflecting suggestions from northern nurses found in the MacLeod and colleagues 2008 study where “rural and remote RNs emphasized the need for consultation, advising administrators to modify and adapt programs and policies to fit available resources, or what might be made available, in particular communities” (p. 47). Nurses in this study also felt their work environment was small enough to consistently foster strong, supportive working relationships with colleagues—which contributed to nurses’ positive aspects of their northern experiences. Smaller, community-like working environments that foster strong collegial relationships have been associated with higher levels of nurse job satisfaction and retention (Meyer Bratt et al., 2014)—Zibrik and colleagues (2010) call this phenomenon in Canada’s north “rural professionalism”. “Understanding professionalism in a rural context

has significant implications in terms of affirming and identifying sources of job satisfaction among rural nurses” (Zibrik et al., 2010, p. 21). In addition to strong working relationships, northern nurses described rural professionalism as including strong relationships to their northern communities—where work and life in the north are intrinsically woven together (Zibrik et al., 2010). The interweaving of nurses’ work lives and their lives within the northern community is a characteristic of the northern experience that nurses in this pilot study enjoyed, also reflected in Zibrik and colleagues (2010) findings, “There is an apparent degree of permeability between the rural workplace and the community setting, and this seems to enhance the lives and professional practice experiences of rural nurses.” (p. 24).

Future directions

It is imperative to continue to recognize and explore the challenges northern ICU nurses experience and work with northern nurses to formulate ways to alleviate their workplace challenges—as it appears the mentality “*the ICU nurse can do it*” may create unique challenges for northern ICU nurses. This could be an instrumental way of increasing retention and the longevity of [ICU] nurses’ time spent north of 60 (Andrews et al., 2005; MacLeod et al., 2004b)—a timely concern noted by Stewart et al. (2011) who found nearly one in five remote and rural nurses in Canada planned to leave their position in the next 12 months—for reasons that included “lower community satisfaction, greater dissatisfaction with job scheduling and lower satisfaction with their autonomy in the workplace” (p. 103). We believe that these contributing factors to northern nurse job dissatisfaction, particular to ICU nurses, may be alleviated by increased support and education, as well as a thorough understanding of the experiences of these critical care nurses. Continued efforts to address shortages of resources and the allocation of resources are required to enhance the work lives of ICU nurses working north of 60.

Limitations

Limitations include both the sample size and the pilot nature of this study. While qualitative studies do not necessarily include large sample sizes, this study was limited by the size of the unit nursing census itself. Further, due to the nature of the pilot design, this study is limited by the fact that it has only begun to explore the experiences of critical care nurses north of the 60th parallel. Further research is merited. Additionally, due to contextual factors and an effort to maintain participant confidentiality and to anonymize the study site, as best as possible, there are limited descriptions of the sample and descriptors related to the unit have been kept broad intentionally.

Conclusion

In conclusion, this qualitative, phenomenological pilot study has provided valuable insight and a starting point to understand the experiences of critical care nurses who work north of the 60th parallel. This study has contributed to existing nursing knowledge and has also shed light on the unique aspect of this critical care nursing context. 

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Changing laws on medical assistance in dying: Implications for critical care nurses

BY MARIE EDWARDS, PHD, RN

Abstract

In February 2015, the Supreme Court of Canada released its decision in the *Carter v. Canada (Attorney General)* case, declaring section 241(b) and section 14 of the Criminal Code invalid, and granting a one-year suspension on that declaration to enable the Parliament of Canada to respond. In June 2016, Bill C-14: An Act to Amend the Criminal Code and Make Related Amendments to Other Acts (Medical Assistance in Dying) was passed after much debate in the House of Commons and Senate of Canada. Brief

summaries of the *Carter v. Canada* case and the new federal law are provided and questions regarding medical assistance in dying are explored. The implications of the case and the new law for critical care nurses are also examined, including the need for nurses to attend to legislative changes, the need for education about the roles of nurses in medical assistance in dying, particularly what can be learned from other jurisdictions, and the importance of understanding the concept of conscientious objection.

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On February 6, 2015, the Supreme Court of Canada released its decision on the case of *Carter v. Canada (Attorney General)*. The Court issued the following declaration as part of its judgment:

Section 241(b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition (Carter v. Canada (Attorney General), 2015, s[147], p. 396).

The declaration was suspended for a period of one year, allowing time for the Parliament of Canada “to craft an appropriate remedy” (*Carter v. Canada (Attorney General)*, 2015, s[125], p. 389).

After a few months of apparent inactivity following the decision, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (2015) was appointed to identify options for a legislative response, with 11 provinces and territories participating, and the federal minister of justice appointed a three-member External Panel on Options for a Legislative Response to *Carter v. Canada* (2015). National and provincial professional and regulatory bodies also sought input from their members and the public to identify issues and inform statements or policies on assisted dying.

On January 15, 2016, based on the request of Canada’s attorney general, the Supreme Court of Canada granted an extension to the suspension of the “declaration of invalidity” of the two sections of the *Criminal Code* to June 6, 2016, and outlined a mechanism for individual exemptions to the suspension (*Carter v. Canada (Attorney General)*, 2016, s[2], p. 2). A Special Joint Committee on Physician-Assisted Dying, composed of members of the Senate of Canada and the House of Commons, was established to consult with stakeholders and provide recommendations to the federal minister of justice on a federal legislative framework for physician-assisted death. In

April 2016, Bill C-14: An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying) was introduced and, after considerable debate, was passed and received royal assent on June 17, 2016. So, what will all of this mean for critical care nurses in Canada?

In this article, brief overviews of the Supreme Court of Canada’s judgment in the *Carter v. Canada* case and the Parliament of Canada’s legislative response to it are outlined. Questions raised by health care providers in response to the judgment and new federal law are considered. In addition, Québec’s legislation related to medical aid in dying is briefly described. The article concludes with an exploration of the possible implications of the evolving legislative landscape for critical care nurses.

The *Carter v. Canada* Case

In June of 2012, the British Columbia Supreme Court released its judgment in the case of *Carter v. Canada (Attorney General)*. The case was launched by Gloria Taylor, Lee Carter and Hollis Johnson, Dr. William Shoichet, and the British Columbia Civil Liberties Association. The two people at the centre of the case were Gloria Taylor and Lee Carter’s mother, Kathleen. Both of these women had a serious, debilitating, chronic illness. Gloria Taylor was diagnosed with amyotrophic lateral sclerosis (ALS) in 2009. She expressed her concerns regarding her death in an affidavit read by the court:

There will come a point when I will know that enough is enough. I cannot say precisely when that time will be. It is not a question of “when I can’t walk” or “when I can’t talk”. There is no pre-set trigger moment. I just know that, globally, there will be some point in time when I will be able to say—“this is it, this is the point where life is just not worthwhile”. When that time comes, I want to be able to call my family together, tell them of my decision, say a dignified good-bye and obtain final closure—for me and for them. My present quality of life is impaired by the fact that I am unable to say for certain that I will have the right to ask for physician-assisted dying when that “enough-is-enough” moment arrives. I live in apprehension that my death will be

slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by (Carter v. Canada (Attorney General), 2012, s[54], p. 21).

Kathleen Carter was diagnosed with spinal stenosis in 2008 and experienced rapid deterioration over a period of months. She lived with chronic pain, required a wheelchair to mobilize, and could not carry out activities of daily living without assistance. In July of 2009, as her condition continued to deteriorate, Kathleen Carter told her adult children that she wished to die through physician-assisted suicide. In January of 2010, at the age of 89 years, she travelled with family members to the Dignitas Clinic in Switzerland, where she drank a prepared solution containing sodium pentobarbital and died (*Carter v. Canada (Attorney General)*, 2012; Todd, 2015).

Together, Gloria Taylor, Kathleen Carter's daughter, Lee Carter, and son-in-law, Hollis Johnson, and the other plaintiffs challenged the constitutionality of sections of the Canadian *Criminal Code*, including sections 14 and 241(b). These sections of the *Criminal Code* (1985) read as follows:

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given. (p. 38)

241. Every one who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years. (p. 283)

Justice Lynn Smith of the Supreme Court of British Columbia, using sections 15 (i.e., equality rights) and 7 (i.e., rights to life, liberty, and security of the person) of the *Canadian Charter of Rights and Freedoms*, ruled that provisions in the *Criminal Code* "unjustifiably infringe on the equality rights of Gloria Taylor and the rights to life, liberty and security of the person of Gloria Taylor, Lee Carter and Hollis Johnson" (*Carter v. Canada (Attorney General)*, 2012, s[1], p. 8). Justice Smith wrote:

...persons who are physically disabled such that they cannot commit suicide without help are denied that option, because s. 241(b) prohibits assisted suicide. The provisions regarding assisted suicide have a more burdensome effect on persons with physical disabilities than on able-bodied persons and, thereby, create, in effect, a distinction based on physical disability. The impact of the distinction is felt particularly acutely by persons such as Ms. Taylor, who are grievously and irremediably ill, physically disabled or soon to become so, mentally competent, and who wish to have some control over their circumstances at the end of their lives. The distinction is discriminatory, under the test explained by the Supreme Court of Canada in *Withler*, because it perpetuates disadvantage (*Carter v. Canada (Attorney General)*, 2012, s[15], pp. 10–11).

The challenged sections of the *Criminal Code* were declared invalid, but the declaration was suspended for a period of one year to enable the Parliament of Canada to consider a legislative response.

The case was appealed to the Court of Appeal for British Columbia, and heard in 2013 and then, ultimately, to the Supreme Court of Canada, which held hearings in October of 2014. By that time, Gloria Taylor had died at the age of 64 years from complications of a perforated colon (Stueck & Mickleburgh, 2012). Key aspects of the Supreme Court of Canada's judgment (*Carter v. Canada (Attorney General)*, 2015) on the appeal include:

a) a declaration that s. 241(b) and s. 14 of the *Criminal Code* are invalid, as they infringe on s. 7 of the *Canadian Charter of Rights and Freedoms*, with a 12-month suspension of the declaration;

b) recognition that "nothing in the declaration of invalidity ... would compel physicians to provide assistance in dying" (s[132], p. 391);

c) an acknowledgment that "the Charter rights of patients and physicians will need to be reconciled" (s[132], p. 391).

The Supreme Court of Canada's comments regarding physician-assisted dying deal specifically with "a competent adult person" who:

(1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition (*Carter v. Canada (Attorney General)*, 2015, s[127], p. 390).

It is important to note that the words terminal or terminal illness are not included in these criteria.

The Parliament of Canada's response

On April 14, 2016, *Bill C-14: An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*, was introduced in the House of Commons. After considerable debate it was passed on May 31, 2016, and sent to the Senate. The Senate proposed some amendments (SenCA Plus+, 2016), the most controversial of which involved the removal of the criterion for medical assistance in dying that "natural death has become reasonably foreseeable" (*Bill C-14*, 2016, s[241.2(2)d, p. 6]. This proposed change to the bill was rejected by the House of Commons. The bill was passed and received royal assent on June 17, 2016.

Questions raised by the Supreme Court's decision and the new legislation

Throughout this process, from the release of the Supreme Court's *Carter v. Canada* decision to the debate over *Bill C-14*, a number of questions have been raised. Four of these questions will be considered here.

1. What do the Supreme Court of Canada's decision and the new Act to Amend the Criminal Code tell us about how assisted death will be carried out?

In the Supreme Court of Canada's decision, the definition of physician-assisted dying used by the appellants in the *Carter v. Canada* case was presented: "For the purposes of their claim, the appellants use 'physician-assisted death' and 'physician-assisted

dying' to describe the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient" (*Carter v. Canada (Attorney General)*, 2015, s[40], p. 360). Note the words "provides or administers medication." Canadian legal scholar Jocelyn Downie (2015) argued that, based on the terminology used in the decision and the two *Criminal Code* provisions deemed invalid by the Court, it can be concluded that both providing a lethal prescription for the patient to take on his or her own (i.e., physician-assisted suicide) and the direct administration of a lethal dose of drugs by the physician (i.e., euthanasia) could be permitted.

In the *Act to Amend the Criminal Code and to Make Related Amendments to Other Acts* (2016), the language has changed from physician-assisted dying or death to medical assistance in dying, with the means by which it may be carried out included in the term's definition:

241.1 (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

(b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (p. 5)

2. Who is able to request access to medical assistance in dying? The criteria for eligibility for medical assistance in dying are outlined in the new act.

According to section 242.2(1), the person must be eligible for government-funded health services in Canada, be at least 18 years of age, be capable of making his/her own health care decisions, have a "grievous and irremediable medical condition" (*An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts*, 2016, p. 5), make a voluntary request for this intervention, and provide informed consent "after having been informed of the means that are available to relieve their suffering, including palliative care" (p. 6). A grievous and irremediable medical condition is further defined in section 241.2(2). The person must have a "serious and incurable illness, disease or disability", be in an "advanced state of irreversible decline in capability", be experiencing "enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable", with "natural death ... reasonably foreseeable" (p. 6).

3. Who will be involved in medical assistance in dying?

Only physicians were discussed in the Supreme Court of Canada's decision. In fact, a word search revealed that the words nurse and pharmacist are not found in the judgment. The Provincial-Territorial Expert Advisory Group (2015) recommended that the *Criminal Code* be amended to allow for the provision of physician-assisted death by physicians, nurse practitioners, or a "regulated health professional" (p. 24), including registered nurses acting under the direction of a physician. The amendments to the *Criminal Code* passed in June 2016 allow for medical practitioners (i.e., those entitled to practise medicine according to provincial laws) and nurse practitioners (i.e., registered nurses entitled to practise as a nurse practitioner according

to provincial laws) to administer or prescribe the medications for medical assistance in dying. The Canadian Nurses Protective Society (2016) advised that, prior to participating in medical assistance in dying, nurse practitioners will need to: review legislation, documents provided by their nursing regulatory body, and policies within their health care organization; and ensure they have the "necessary scope of practice" and "knowledge, skills, and judgment to fulfill their responsibilities" (para. 2).

The broader question is what do we know about the willingness of physicians and nurse practitioners to be involved in medical assistance in dying? The Canadian Medical Association (2015) surveyed 5,000 of their members in 2014 and found that "45% of respondents favoured legalizing physician-assisted death, while 27% said they would probably participate if the act is legalized" (p. 5). In its annual report for 2014, the Canadian Nurses Association (2015) reported that "nearly 60% (of more than 700 RNs) said they were in favour of legislation allowing medically assisted dying and would agree to work alongside physicians involved in assisted death" (p. 21). No data specific to nurse practitioners were found. Further research is needed to understand the perspectives of physicians, nurse practitioners, and nurses in Canada in relation to medical assistance in dying.

Literature from the Netherlands and Belgium, where euthanasia is legal, proves helpful in anticipating possible roles nurses may play in medical assistance in dying. Both qualitative and quantitative studies from these countries provide evidence of the following roles assumed by nurses: receiving the request from a patient for information about the option of physician-assisted dying; receiving the request from a patient for assistance in dying; participating as a member of the health care team in the decision-making process related to the request for assistance in dying; care of the patient if the request is denied; care of the patient if the request is agreed to, including presence or assistance during the administration of the drugs; aftercare of the patient; aftercare of the family; and debriefing of the team (De Bal, Dierckx de Casterle, De Beer, & Gastmans, 2006; De Bal, Gastmans, & Dierckx de Casterle, 2008; De Beer, Gastmans, & Dierckx de Casterle, 2004; Denier, Dierckx de Casterle, De Bal, & Gastmans, 2009; Denier, Dierckx de Casterle, De Bal, & Gastmans, 2010; Dierckx de Casterle, Denier, De Bal, & Gastmans, 2010; Dierckx de Casterle, Verpoort, De Bal, & Gastmans, 2006; Haverkate & van der Wal, 1998; Inghelbrecht, Bilsen, Mortier, & Deliëns, 2009; Inghelbrecht, Bilsen, Mortier, & Deliëns, 2010; Muller, Pijnenborg, Onwuteaka-Philipsen, van der Wal, & van Eijk, 1997; van Bruchem-van de Scheur et al., 2008; van de Scheur & van der Arend, 1998). There is some evidence from both Belgium and the Netherlands that small numbers of nurses have been involved in administering the medication used in euthanasia, even though it is illegal for them to do so in both jurisdictions (Bilsen, Robijn, Chambaere, Cohen, & Deliëns, 2014; Inghelbrecht, Bilsen, Mortier, & Deliëns, 2008; Muller et al., 1997).

4. Will conscientious objection be permitted?

The Supreme Court of Canada was clear that physicians would not be compelled to provide patients with assistance in dying. The Special Joint Committee on Physician-Assisted Dying

(2016) recommended that processes be established that respect “a health care practitioner’s freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying” (p. 26). In Belgium, where euthanasia is permitted by law, and Oregon, where physician-assisted suicide is permitted by law, provisions for conscientious objection are included in the legislation for both physicians and other health care providers (Lewis & Black, 2012). Harter (2015) defines conscientious objection as “opposition and refusal by a health care professional to provide certain treatment because the individual believes that helping to provide those treatments would violate personal core ethical tenets in a way that compromises his or her integrity” (p. 224). At the Canadian Medical Association annual meeting in August 2015, delegates approved a resolution to “support the right of all physicians, within the bounds of existing legislation, to follow their conscience when deciding whether to provide medical aid in dying” (Anonymous, 2015, p. 978). Ninety-one percent of delegates voted in favour of this resolution (Eggertson, 2015).

The Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses*, under Value G: Being Accountable, includes the following statement:

If nursing care is requested that is in conflict with the nurse’s moral beliefs and values, but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person’s needs or desires. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care in advance so that alternative arrangements can be made (p. 19).

Steps for declaring a conflict with conscience are outlined in Appendix D of the code of ethics.

Conscientious objection was a topic that received considerable attention in the debates related to *Bill C-14* in the House of Commons and Senate. In the preamble to the *Act to Amend the Criminal Code and to Make Related Amendments to Other Acts* (2016), the following whereas statements are found:

Whereas everyone has freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms*;

Whereas nothing in this Act affects the guarantee of freedom of conscience and religion; ... And whereas the Government of Canada has committed to develop non-legislative measures that ... respect the personal convictions of health care providers (p. 2).

It is not clear what these “non-legislative measures” will be. It is anticipated that further guidance related to conscientious objection may come from provincial laws or regulations and provincial regulatory bodies.

The law in Québec

While the *Carter v. Canada* case was working its way through the courts, Québec was engaged in its own public discussion and consultation on assisted dying. A bill was introduced into

the National Assembly of Québec in 2013 and *An Act Respecting End-of-Life Care* came into force in late 2015. Included in this legislation are provisions for medical aid in dying, defined in the act as “care consisting in the administration by a physician of medications or substances to an end-of-life patient, at the patient’s request, in order to relieve their suffering by hastening death” (*An Act Respecting End-of-Life Care*, 2014, s. 3(6)). Medical aid in dying is permitted in Québec when the patient meets certain criteria, including being of “full age” and capable of consenting to the care requested, being at the end of life, and suffering from a “serious and incurable illness” and experiencing “constant and unbearable physical or psychological suffering” such that it cannot be relieved in ways the patient deems “tolerable” (*An Act Respecting End-of-Life Care*, 2014, s. 26). Québec’s act has a conscientious objection provision (i.e., section 50) that includes physicians and other health professionals, with the proviso that the health professionals involved must ensure the patient is provided with continuity of care. No specific roles for nurses in relation to the procedures in medical aid in dying are outlined in this legislation.

Implications for critical care nurses

What will the legislative changes in Québec and Canada mean for critical care nurses? Based on literature from Belgium and the Netherlands, requests for euthanasia from patients in intensive care units (ICUs) are rare (van der Hoven, de Groot, Thijssen, & Kompanje, 2010; Vincent et al., 2014). One of the major reasons this is the case relates to the decision-making capacity of critically ill patients. In a study involving 37 European ICUs in 17 countries, Cohen et al. (2005) found that 95% of patients lacked decision-making capacity when end-of-life decisions were being made. Similar statistics have been cited for North America (Truog et al., 2008). In both the Québec and federal legislation, the person requesting assistance to die must be a competent adult. As in other jurisdictions, this will likely limit the occurrence of physician-assisted dying in ICUs. Even acknowledging this reality, the changes to Canadian and Québec law still warrant the attention of critical care nurses.

The Canadian Nurses Protective Society (2015) encourages nurses to stay informed of the changing legal landscape. In a survey carried out in Belgium approximately five years after assisted-dying legislation was introduced, nurses (n = 3,321) were asked to agree or disagree with the following statement: “Most nurses are acquainted with which actions they are allowed to perform in case of euthanasia” (Inghelbrecht et al., 2009, p. 1213). The responses were revealing: 35.9% of nurses disagreed with the statement; 30.3% were neutral; and 33.8% agreed. Like all other nurses in Canada, critical care nurses will require education regarding the changing laws, particularly in relation to the roles of nurses in medical assistance in dying. Critical care nurses must understand the distinctions between withholding and withdrawing life-sustaining treatments at the request of a competent and informed adult or legal substitute decision-maker, a practice that is currently legal in Canada, and medical assistance in dying. Nurses must also understand the legal and regulatory limits of their roles in medical assistance in dying.

Finally, critical care nurses need to understand conscientious objection and how that might play out in critical care settings in Canada. In a literature review of studies on nurses' attitudes, Evans (2015) found support ranging from 23% for assisted suicide in Japan and 23% for euthanasia in Finland, in studies published in 2001 and 2002, to 92% for euthanasia in Belgium in a study carried out five years after euthanasia became legal in Belgium. In some surveys, nurses' support for physician-assisted dying is high, but much smaller percentages of nurses indicate they would participate in the process (DeKeyser Ganz & Musgrave, 2006; Tepehan, Ozkara, & Yavuz, 2009). The Oregon Nurses Association (1997) has clear guidelines regarding involvement of nurses in physician-assisted suicide, making clear that involvement is a choice. Nurses cannot abandon patients, and may withdraw "only when assured that alternative sources of care are available to the patient" (Oregon Nurses Association, 1997, p. 1). The guidelines also address nurses' duties to confidentiality and avoiding subjecting others to "unwarranted, judgmental comments or actions" (Oregon Nurses Association, 1997, p.1). The Canadian Association of Critical Care Nurses' (2011) position statement titled *Providing End of Life Care in the Intensive Care Unit* identifies a role for nurses in policy development related to care at end of life. It is anticipated that nurses will be involved in the development of institutional policies related to medical assistance in dying, and, flowing from legislation and statements from nursing regulatory bodies, conscientious objection is one area that will need to be addressed.

Conclusion

The Supreme Court of Canada's decision in the *Carter v. Canada (Attorney General)* case set in motion legislative changes that will influence practice across health care settings in this country, including ICUs. Both Québec and Canada have implemented legislative changes to permit medical aid or medical assistance in dying. In the months ahead, critical care nurses are encouraged to pay attention to the response from provincial governments, nursing regulatory colleges or associations, and the health care institutions within which they work. Familiarity with legislation, relevant codes of ethics, practice statements or directives from regulatory colleges, and hospital policies will be essential, as we navigate these changes.

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Intensive care nurses' assessment of pain in patients who are mechanically ventilated: How a pilot study helped to influence practice

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Abstract

Background. Pain is a common experience among patients in intensive care units (ICUs). Many patients in ICUs have difficulty communicating their pain because of mechanical ventilation, and issues can arise when the nurse attempts to interpret the severity of pain and work towards effective pain management.

Purpose. The aim of this study was to determine the suitability of the Critical-Care Pain Observation Tool (CPOT) as an assessment tool to be used by ICU nursing staff to assess pain in adult patients who are mechanically ventilated.

Methods. This pilot study was descriptive in design and employed both quantitative and qualitative methods. Quantitative data resulted from the CPOT scores obtained. In addition, a data collection sheet, developed by the authors, recorded sedation and

analgesia used and interventions provided. This separate sheet was completed each time the CPOT was used. Nurses were asked to evaluate the CPOT using a Likert scale. Qualitative data were collected through open-ended questions related to using the CPOT.

Results. Twenty-three participants each assessed pain five times in a total of 23 patients using the CPOT over a 12-hour shift. Nurses stated the tool was easy to use and that it would be helpful to them.

Conclusion. The results of this pilot study contributed to the decision to implement the CPOT at the study ICUs. The systematic use of a tool may promote more goal-directed management of pain.

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Background

Pain is a common experience among patients in intensive care units (ICUs) (Campbell & Happ, 2010; Puntillo, Smith, Arai, & Stotts, 2008). It is caused by underlying pathology, surgical and medical procedures and also by nursing interventions such as repositioning and suctioning (Vazquez et al., 2011). Assessment is an essential first step in managing pain. Because of the subjective nature of pain, self-report is the gold standard for assessment (Registered Nurses Association of Ontario, 2013), but self-report cannot always be obtained. Many patients in ICUs have difficulty communicating their pain because of mechanical ventilation or changes in level of consciousness (Stites, 2013). Inadequately managed pain can contribute to adverse physiological and psychological outcomes for patients such as unstable hemodynamic status and delirium (Haymore & Patel, 2016; Wells, Pasero & McCaffery, 2008).

Behavioural assessment tools can help to identify the presence of pain and to evaluate treatment (Herr et al., 2006; Pasero & McCaffery, 2011). The use of a behavioural measure for pain is required for non-communicative critically ill patients (Gelinias & Johnston, 2007). Implementing behavioural pain scales such as the Critical Care Pain Observation Tool (CPOT) (Gelinias, Fillion, Puntillo, Viens, & Fortier, 2006) can support nurses in documentation of pain assessment. For example, Arbour, Gelinias and Michaud (2011) found in a review of 30 medical files (15 pre and 15 post CPOT implementation) that pain assessments and identification of pain episodes occurred more frequently after the CPOT was implemented and fewer patient complications were charted.

Purpose

The aim of this pilot study was to determine the feasibility and clinical utility of the CPOT (Gelinias et al., 2006) as an assessment tool to be used by nursing staff to assess pain in mechanically ventilated patients in an adult intensive care unit.

Methods

Design

This pilot study was descriptive in design and employed both quantitative and qualitative methods. Quantitative data resulted from the scores obtained through use of the CPOT tool (see Table 1) by ICU nurses assessing pain in patients who were mechanically ventilated. In addition, there was a data collection sheet (see Table 2) developed by the authors to record any sedation and analgesia infusions, whether the medication was titrated up or down and any bolus medications given with the assessment for pain. Interventions associated with assessment such as repositioning were noted. This separate sheet was completed each time the CPOT was used. Nurses also were asked to evaluate the CPOT using a Likert scale (see Table 3). This scale had items such as 'ease of use' and 'clarity of instructions' to examine feasibility as well as items such as 'usefulness in assessing pain' to examine clinical utility (Gelinias, 2010). There were also demographic data questions related to participants' full or part-time status, years of experience in ICU nursing and in study units, and attendance at an in-service on CPOT. Qualitative data were obtained through open-ended questions regarding use of CPOT.

Table 1 Description of the Critical-Care Pain Observation Tool			
Indicator	Description	Score	
Facial expression	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening, and levator contraction	Tense	1
	All of the above facial movements plus eyelid tightly closed	Grimacing	2
Body movements	Does not move at all (does not necessarily mean absence of pain)	Absence of movements	0
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	Restlessness	2
Muscle tension Evaluation by passive flexion and extension of upper extremities	No resistance to passive movements	Relaxed	0
	Resistance to passive movements	Tense, rigid	1
	Strong resistance to passive movements, inability to complete them	Very tense or rigid	2
Compliance with the ventilator (intubated patients)	Alarms not activated, easy ventilation	Tolerating ventilator or movement	0
	Alarms stop spontaneously	Coughing but tolerating	1
	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator	2
OR Vocalization (extubated patients)	Talking in normal tone or no sound	Talking in normal tone or no sound	0
	Sighing, moaning	Sighing, moaning	1
	Crying out, sobbing	Crying out, sobbing	2
Total, range			0-8

Table 1: Description of CPOT. Used with permission of *American Journal of Critical Care* (Gelinas et al., 2006, 15(4), p. 421).

The CPOT (see Table 1)

At the time of this pilot study (2012), the ICUs at the selected institution did not have a tool for assessing pain in mechanically ventilated patients. The CPOT was selected by the researchers because it has established interrater reliability and content validity, it is a bilingual tool, and it is intended for use with ventilated and non-ventilated patients. Permission to use the tool was obtained from Dr. Gelinas. Interrater reliability of the CPOT (French version) has demonstrated k coefficients ranging from 0.52–0.88 (Gelinas et al., 2006; Gelinas & Johnston, 2007). Discriminant validity and criterion validity were present (Gelinas, Harel, Fillion, Puntillo, & Johnston, 2009; Gelinas & Johnston, 2007). Gelinas et al. (2009) evaluated the sensitivity and specificity of the CPOT and found it to be 86% and 78% respectively during painful procedures.

The tool was originally developed in French (Gelinas, Viens, Fortier, & Fillion, 2005) and then translated into English. The tool includes four behavioural categories: 1) facial expression, 2) body movements, 3) muscle tension, 4) compliance with ventilator for ventilated patients (Gelinas & Johnston, 2007). Items in each category are scored from 0–2 with a possible total score ranging from 0–8. Descriptions are given for the expected expression of each behaviour from 0–2 to enable consistent scoring. Higher scores reflect higher pain levels.

Setting and sample

The setting was a tertiary care academic centre in Eastern Canada with three sites, two of which had an ICU. Site one

had 28 beds for patients with neurosurgery, trauma, vascular, and general medical-surgical conditions. Site two had 27 beds primarily for patients with oncology, pulmonary and medical-surgical conditions. A convenience sample of 23 nurses used the tool to assess 23 patients.

Inclusion criteria for staff nurses. Full- or part-time staff nurses who had been employed in either of the two units for at least six months.

Inclusion and exclusion criteria for tool to be used on patients. The nurse could use the CPOT if the patient was 18 years of age or older, intubated and unable to speak. Exclusion criteria for assessing a patient were if the patients were receiving neuro-muscular blockade with agents such as rocuronium or cisatracurium, had a high spinal cord injury or a traumatic brain injury. These recommendations were based on Herr, Coyne, McCaffery, Manworren, & Merkel (2011) so that when the tool was used, the patient could respond in all categories of behaviour comprising the CPOT. The assessment of pain in patients incapable of spontaneous neuromuscular movement remains a challenge (Stites, 2013).

Data collection

A flyer explaining the study was posted in each of the units. In-service sessions were done by the co-investigators, and included an explanation of the study, the description of the CPOT indicators and the scoring process, and what was required of nurses who chose to participate. Copies of the tool

Table 2: Questionnaire Accompanying Pain Assessment Tool				
<ul style="list-style-type: none"> • The CPOT is not to be used on patients receiving paralytic agents such as rocuronium, cisatracurium • Patients must be 18 years of age or older • <i>The patient must not be ventilator dependent such as a patient with a high cervical spine injury.</i> 				
Prescribed medications				
<i>Prescribed medication for analgesia and/or sedation. Identify any medications given with assessment:</i> <input type="checkbox"/> Propofol <input type="checkbox"/> Midazolam <input type="checkbox"/> Dilaudid <input type="checkbox"/> Fentanyl <input type="checkbox"/> Ketamine <input type="checkbox"/> Other: _____	Bolus	Dose titrated up	Dose titrated down	No change
<i>Medication route:</i> <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Epidural <input type="checkbox"/> Central line (including dialysis catheter) <input type="checkbox"/> Peripheral line <input type="checkbox"/> PCA				
<i>Nursing Assessments</i> <input type="checkbox"/> Routine assessment <input type="checkbox"/> Assessment pre-intervention / procedure <input type="checkbox"/> Assessment post-intervention <input type="checkbox"/> Other Comment: _____				
<i>Nursing Interventions</i> <input type="checkbox"/> Repositioning <input type="checkbox"/> Warm blanket <input type="checkbox"/> Other (e.g., suctioning) _____				

with instructions were left in envelopes on the units. Each envelope had five copies of the tool (labelled A–E) so that the nurse could independently assess the patient up to five times over the 12-hour shift.

The data collection sheet (see Table 2) was completed each time the CPOT was used. The nurse assessed if pain was present using the tool and then intervened and managed the patient's pain. If the nurse assessed the patient's pain later in the shift, then another copy of the data collection sheet was used. The evaluation of the CPOT (see Table 3) was completed only once by the nurse at the end of the 12-hour shift. The nurses also completed a demographic data questionnaire. The completed forms were left in a designated box in each of the two ICUs.

Ethics

Ethics approval was obtained from the Research Ethics Board of the selected institution. Confidentiality was maintained by using code numbers.

Data analysis

The responses to the open-ended questions were analyzed to obtain feedback on the tool, barriers to its use, and recommendations for its use. For the quantitative data, total CPOT scores were recorded for each assessment and CPOT mean scores were calculated. Mean scores were calculated for each of the

nurse's responses on the Likert scale items in Table 3. Although Likert scales are considered to be ordinal in nature, they have frequently been treated as interval data (Burns & Grove, 2001). Demographic data of the nurses and data related to sedation and analgesia were calculated as percentages.

Results

Demographics. Although 25 nurses participated in the study, the final sample included 23 participants (one subject's data were excluded because the patient was not ventilated and one nurse did not provide data related to using the tool). Eleven nurses were from site one and 12 were from site two. Of these 23, 15 provided demographic data: 13/15 (87%) were full-time and 2/15 (13%) were part-time. Experience in the specific units ranged from six months to 31 years.

CPOT scores. Each patient was assessed five times. Therefore, there was a total of 115 nurse-patient interactions (23 x 5 CPOT sheets). Of these 115, 98 scores were completed in total, and of these, 75 were a positive score on the CPOT indicating pain (range 1–8). The mean pain score was 3.03 and median was 3.0 (SD was 1.65). Table 4 provides the frequency of indicators recorded on the CPOT. The most frequent indicators were muscle tension-tense/rigid (39), facial-tense (37), and compliance with ventilator-coughing, but tolerating (37).

Table 3: Evaluation of the Critical Care Pain Observation Tool (CPOT)				
A. Please rate the tool on the following items:				
Ease of use:				
1	2	3	4	5
Very easy			extremely difficult to follow	
Time to administer:				
1	2	3	4	5
Very easy			extremely difficult to follow	
Clarity of instructions:				
1	2	3	4	5
Very easy			extremely difficult to follow	
Clarity of scoring:				
1	2	3	4	5
Very easy			extremely difficult to follow	
Usefulness in assessing pain:				
1	2	3	4	5
Very easy			extremely difficult to follow	
B. Please reply to the following questions—space is provided for comments.				
1. What does the CPOT offer you in assessing patients who are mechanically ventilated?				
2. Would you like to use this tool on a regular basis to assess patients who are mechanically ventilated?				
3. Do you see any barriers to using this tool on a regular basis in the unit?				
4. What would need to happen in the unit for you to use this tool on a regular basis with patients who are mechanically ventilated?				
5. Any other comments.				

Medications administered. Eighty-three percent of the patients were on a continuous infusion with the majority receiving Propofol (Diprivan) and Hydromorphone (Dilaudid), or Midazolam (Versed) and Dilaudid. Boluses, rather than titration of infusions, mainly were used to respond to pain. Table 5 provides the frequency of bolus medications given by the nurses in responding to a positive CPOT score. It was noted that for 20/75 (27%) of the interventions, the patients received Propofol (used for sedation) for pain while 16/75 (21%) received Propofol and Dilaudid, 5/75 (7%) received Midazolam and Dilaudid, and 4/75 (5%) received Dilaudid alone. There were no additional medications (analgesia/sedation) given for 22/75 (29%) of positive scores.

Nursing interventions. Nurses were asked to indicate what interventions were provided with positive pain scores. Thirty-two of the 75 (43%) possible responses were associated with repositioning the patient, 11/75 (15%) were related to repositioning along with other measures such as suctioning or having an X-ray. Other interventions 5/75 (7%) were related to physiotherapy, dressing change or extubation. For 27 (36%) of the data collection sheets, no comment was provided. The nurses gave the medication either in response to a positive score after,

Table 4: Frequency of Indicators on CPOT	
BEHAVIOUR OBSERVED	FREQUENCY
Facial – Tense	37
Facial – Grimacing	20
Body movements – Protection	20
Body movements – Restlessness/agitation	9
Compliance with ventilator – Coughing but tolerating	37
Compliance with ventilator – Fighting ventilator	14
Muscle tension – Tense/rigid	39
Muscle tension – Very tense/rigid	2

Table 5: Frequency of Drugs Administered in Response to Positive Pain Score: N=75		
DRUG ADMINISTERED	FREQUENCY	PERCENTAGE
Propofol	20	27%
Midazolam	1	1.3%
Dilaudid	4	5%
Fentanyl (Sublimaze)	2	3%
Ketamine, Propofol and Dilaudid	1	1.3%
Propofol and Dilaudid	16	21%
Midazolam and Dilaudid	5	7%
Midazolam, Propofol and Dilaudid	2	3%
Propofol and Haldol (Haloperidol)	2	3%

for example, repositioning or gave the medication due to a positive score before repositioning. For example, one patient had an infusion running of Propofol and Dilaudid. A bolus of Propofol was given post repositioning for a pain score of three. On the next assessment (nurse recorded specific times with each assessment), the pain score was four and another bolus of Propofol was given. However, since times were not routinely recorded it was not always possible to ascertain if the intervention was in response to the score or if the intervention resulted in the score.

Nurses' evaluation of the CPOT. Nurses were asked to evaluate their use of the CPOT using a Likert scale with one meaning very easy to a score of five indicating very difficult. The means are presented in Table 6 and reflect that the tool was useful to assess pain and that directions were clear, it was easy to use, and quick to administer.

Ease of use	1.5
Time to administer	1.5
Clarity of instructions	1.6
Clarity of scoring	1.4
Usefulness in assessing pain	1.8
Key: 1=very easy and 5=very difficult	

The comments by nurses on the open-ended questions were collated and reflected that the CPOT was easy to use, allowed communication about pain with ventilated patients, provided a way to determine effectiveness of interventions, provided a method to document pain and justified analgesic use. The participants also stated that it should be part of the ICU flow sheet.

Comments supporting the tool:

- It offers a pain scale for patients who cannot communicate their own discomfort. It provides a measure to determine the effectiveness of the interventions used to reduce pain (subjects 8, 10, 11, 13, 18, 23)
- Put it in the flow sheet (subjects 4, 7, 8, 10, 16, 18, 19)
- Easy to use (subjects 7, 10, 14, 16, 18, 23); provides method to communicate and document and justifies boluses (subjects 7, 14)

Comments related to scoring:

- Is this tool actually measuring pain or can it be measuring things like anxiety? (subjects 5 and 6).
- More clarification on meaning of scores (subjects 14, 16).

Discussion and implications

Having nurses in this study document medications given with a positive pain score provided a beginning understanding of their medication practices with sedation and analgesia. The results of this pilot study revealed that nurses, at times, used sedation boluses without analgesia for positive pain scores, with 27% using Propofol, 3% using Propofol and Haldol (Haloperidol) or Midazolam (1.3%). As well, no additional sedation or analgesia was given for 29% of positive scores. Appropriate analgesia and minimal sedation is preferred over deep sedation to decrease ventilator days, improve mobility, decrease incidence of delirium and decrease ICU length of stay (Reade & Finfer, 2014; Strom, Martinussen, & Toft, 2010; Treggiari et al., 2009). The systematic use of tools, such as for pain and agitation, which could be used with ventilated patients, might contribute to more accurate communication among care providers and promote more effective management including patient-focused care and use of medications such as analgesics to meet specific goals (Sessler, Grap, & Ramsay, 2008). Further research is needed to examine the use of analgesia/sedation by nurses in ICU patients and the impact.

Two nurses questioned whether the CPOT was assessing pain or other symptoms such as anxiety. Tate, Devito Dabbs,

Hoffman, Milbrandt, and Happ (2012) cited that anxiety and agitation are challenging, as their behavioural manifestations are similar to pain and delirium. In addition, Stites (2013) stated that the presence of delirium or agitation makes ascertaining pain difficult. Clinicians need education and support to distinguish pain versus agitation and determine when to use analgesia versus sedation.

Rose et al. (2012) conducted a survey of 802 Canadian critical care nurses to determine their knowledge and perceptions of pain assessment and management practices. Nurses considered preemptive analgesia important for repositioning and wound care, but less so for endotracheal suctioning. In the current study, many interventions involved repositioning. Both repositioning and tracheal suctioning are common procedures in ICU that can precipitate acute pain (Cade, 2008).

In this study, muscle tension-tense/rigid had the highest frequency as an indicator of pain, followed by tense facial expression along with ventilator compliance-coughing, but tolerating. However, in Rose et al.'s (2012) study, nurses were given a list of behaviours suggestive of pain and thought that grimacing was the most important indicator. More research into nurses' assessment of pain in patients unable to communicate is warranted.

Enhancing practice. Through presentation of the results to medical and nursing staff, the use of sedation in ICU patients with positive pain scores was revealed. Since nurses in the pilot study liked the tool, found it easy to use, and thought that it provided a way to facilitate communication, the CPOT was implemented in the study ICUs. It became one of the elements in the mobility bundle that was introduced later and included pain, sedation, delirium and sleep. The CPOT has been recommended for clinical use by the American College of Critical Care Medicine/Society for Critical Care Medicine (ACCM/SCCM) clinical practice guidelines for the management of pain, agitation and delirium (Barr et al., 2013).

Limitations

This pilot study has several limitations. There was a small sample size and the data reflected only one 12-hour shift. Some of the nurses who used the tool did not receive the training in advance and, so, interpreted the CPOT behaviours with only the help of the instructions given by the authors. Confusion assessment method (CAM) scores were not recorded at the same time as the CPOT, so the authors were not aware if the patient had agitation and/or pain. Although the score sheets were labelled for the nurses to use in sequence, there was no place to record the time of assessment and interventions. Given that times were not recorded, it was not always possible to ascertain if the interventions were in response to the score or if the intervention influenced the score. In addition, there were no paired observations to determine interrater reliability.

Conclusions

The researchers have determined the suitability of the CPOT as the pain assessment tool to be used by nursing staff with mechanically ventilated patients in an adult ICU. The

researchers also provided an exploration of ICU nurses' medication practices while assessing and managing pain. Following this research, the CPOT was instituted in the study ICUs and continues to be used to assess pain among patients who are mechanically ventilated. ❁

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Research Review

Citation

Messer, P., Comer, L., & Forst, S. (2015). Implementation of a progressive mobilization program in a medical-surgical intensive care unit. *Critical Care Nurse*, 35(5), 28–41. doi:http://dx.doi.org/10.4037/ccn2015469

Background

In recent years there has been a move toward early and progressive mobilization of critically ill patients in the intensive care unit (ICU) because of the long-term disabilities that occur with patients experiencing prolonged bedrest, such as functional and cognitive impairment, and impaired quality of life. Research on early mobilization of critically ill patients has indicated positive effects on mortality, hospital and ICU length of stay, duration of mechanical ventilation, functional status, delirium, prevalence of pressure ulcers, and adverse effects. Current researchers recommend implementation of progressive mobility protocols in ICUs, but there are many barriers to mobility including clinicians' fear and lack of knowledge, competing priorities, current cultures of mobility, limited view of how much mobility a critically ill patient is capable of, sedation and delirium, lack of staff and equipment, and risk of self-injury of patients (Atkins & Kautz, 2014; Backer & Norrenberg, 2014; Jolley, Regan-Baggs, Dickson, & Hough, 2014; Morris, 2007; Vollman & Bassett, 2014). The specific aim of this project was to increase mobilization of critically ill patients and to determine whether an educational program for nurses affected their knowledge and mobilization practices.

Purpose of the study

To evaluate the effect of education about a mobilization program for critical care nurses on knowledge and performance.

Research approach and methods

A pretest-posttest evaluation was conducted and a chart review was performed before and after implementation of an education intervention to evaluate changes in knowledge and practice.

The educational session consisted of a didactic classroom presentation with a focus on evidence-based benefits of and barriers to mobility and adverse effects of immobility in critically ill patients. Also, a physical therapist presented simulations of range-of-motion exercises, dangling, transferring to a chair, and use of assistive devices.

Setting and sample

The study took place in a 14-bed medical-surgical ICU in North Carolina. The staff in this ICU care for adult critically ill patients who are socioeconomically and racially

diverse, and have a wide range of acute illnesses, including pneumonia, renal failure, sepsis, cardiac and respiratory arrest, and maternal critical illness.

Findings

The sample consisted of 41 nurses who all participated in the education session. Scores after the educational intervention were significantly higher than scores before the intervention ($t=2.02$; $P<.001$). Overall, mobilization ($P=.04$) and dangling ($P=.01$) increased significantly after the education also, but there were no significant increases in ambulating or getting patients up to a chair.

Commentary

While the findings show an increase in nurses' knowledge about the dangers of immobility and the importance and advantages of mobility among critically ill patients, these results should not come as a surprise. The posttest was delivered immediately after the educational intervention. The authors confess that the test consisted solely of items at the low recognition-recall cognitive level rather than synthesis or application, and the tool was not tested for reliability or validity. Also, the test consisted of a small number of test items and they were not well developed or significantly reliable. Furthermore, the authors acknowledge the increase in the posttest scores might have been related to the phenomenon of testing (effects of taking a pretest on the performance on a posttest). While it is not surprising that knowledge increased at the posttest, it is surprising that the increase in knowledge did not translate into a change in practice in terms of ambulating patients and getting them up into a chair. The authors hypothesize several reasons for this. One being that during the education session, the nurses never practised mobilizing patients and only watched the simulations by a physical therapist. Another reason attributed was the lack of time during a nurse's shift.

What I found quite interesting to read toward the end of this report was "one year after the mobility protocol had been implemented in this facility, two full-time employee positions were created to improve mobility of patients on the unit. Certified nursing assistants were hired to fill the roles of **mobility technicians**; the mobility technicians cover two medical-surgical ICUs and follow patients to step-down units to extend mobility beyond the ICUs" (p. 39). Mobility should be a nursing priority of care for critically ill patients. It appears from this study that while education increases knowledge, it is not sufficient to change practice. The authors suggest leadership and coaching are necessary to ensure the successful implementation of a mobility program. Perhaps other teaching strategies could have been implemented during the education component, such as

actually ambulating a patient with the help of a physical therapist or getting a patient up into a chair, so that the nurses had a guided experience.

I leave you with asking yourself—How does your unit implement early mobilization and is it a priority? 

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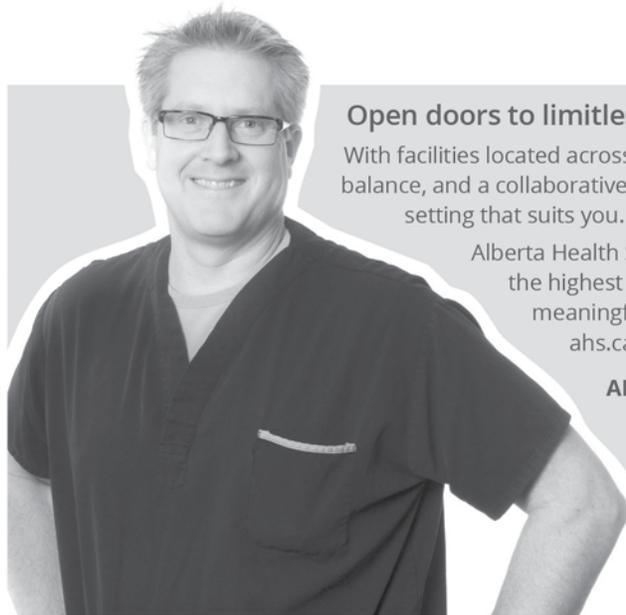
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CAREER OPPORTUNITIES

Pediatric and Adult Critical Care Nurses



Open doors to limitless possibilities.

With facilities located across the province, a strong commitment to work/life balance, and a collaborative work environment, you can build your career in a setting that suits you.

Alberta Health Services puts patients and their families first to provide the highest quality of care. Working here allows you to make a meaningful difference in the lives of Albertans. Find your fit at ahs.ca/careers.

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Flexible hours; dynamic teams; urban and rural opportunities

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Membership Recruitment

Are you a critical care nurse or interested in critical care nursing?
Join your National Association!
Visit www.caccn.ca and join today!



CACCN Membership Recruitment Referral Draw Recipients

The following members are the recipients of a one-year complimentary membership for membership referrals received from April 1 to June 30:

1. Shelley Groves-Johnston, Spruce Grove, AB
2. Alicia Larkey, Victoria, BC

The recruitment referral draw is a blind draw once per quarter. Members who are indicated as referring a new member are

entered into the draw for each new member referred. Please review Membership Recruitment for more information.

Current CACCN members are eligible to be entered into a quarterly draw to receive a complimentary one year CACCN membership (value \$75) for new members referred to CACCN.

Criteria:

- Current / Active CACCN Members may participate.
- Applicable on NEW member applications only. 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.
- 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".
- Names cannot be entered into the draw if the sponsor / recommending information is not included when the member application is processed.
- Members may be entered to win a complimentary membership for each referral once per quarter.

ADVERTISING OPPORTUNITIES

CACCN Dynamic Career Connections

CACCN is offering the opportunity to post individual employment opportunities on the CACCN website. If you are interested in taking advantage of this advertising opportunity, please visit CACCN Advertising Opportunities on the CACCN website at www.caccn.ca for rates and information.

JobLINKS on www.caccn.ca

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.

Reach your audience directly on our website

Together with our publishing partner, MultiView, we are bringing you closer to your audience and connecting your business with the buyers you need.

If you have any questions or are interested in learning more about how to feature your company on the CACCN website, please call Jon Smith, Display Advertising Manager, at 972-402-7023. For more information about this opportunity, please request a media kit via jsmith@multiview.com.

CACCN calendar of events DATES TO REMEMBER!

- August 15:** Canadian ICU Week Spotlight Challenge Award deadline
- August 22:** Dynamics 2016 Early Bird Registration deadline
- Sept.–Oct.:** CNA Certification Examinations
- September 1:** CACCN Educational Award deadline
- September 5:** Dynamics 2016 Final Registration deadline
- September 5:** Proxy Vote Form deadline
- Sept. 19–Oct 7.:** CNA CNCC(C) and CNCCP(C) Certification Examinations
- September 22–23:** Board of Directors Meeting, Charlottetown, PE
- September 24:** Chapter Connections Day, Charlottetown, PE
- September 25–27:** Dynamics 2016 Conference, Charlottetown, PE
- September 25:** CACCN Annual General Meeting, Charlottetown, PE
- Oct. 30–Nov. 5:** Canadian Intensive Care Week
- November 15:** Call for Abstracts 2017 online submission available

Awards available to CACCN members

Criteria for awards are published on pages 33–43 of this issue of Canadian Journal of Critical Care Nursing.

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 activities of the Chapter with specific emphasis on service to members and promotion of the specialty of Critical Care Nursing including, but not limited to publications, presentations, and certification activities.

Note: this award application process is complementary to the Annual Chapter Report. We recommend completion of the Annual Chapter Report prior to proceeding with calculating the Chapter of the Year score.

Award funds available: \$500.00
Recognition plaque

Submission deadline: May 31 annually

Application process: Mandatory submission for all Chapters

Criteria for the award program

- Eligible chapter activities for the period of April 1 to March 31 each year
- The chapter awarded the most points will be the successful recipient of the Chapter of the Year Award
- In the case of a tie, CACCN BOD will determine the final recipient of the award
- The successful chapter will be announced at Chapter Connections Day
- Plaque and cheque will be presented at the annual awards ceremony at Dynamics by the Chapter of the Year recipients for the previous year.

Conditions for the award program

- All chapters of CACCN are eligible for Chapter of the Year Award
- Chapters that have not submitted their annual report and quarterly financials by the required deadline quarterly/annually to National Office will not be eligible for the award
- Chapters will be responsible for ensuring that National Office receives all required documentation to be considered for the award
- Points will be awarded for only chapter activities that have been validated with supporting documentation
- The successful Chapter will be announced at the annual CACCN Awards Ceremony and in CACCN publications
- *All Chapter reports/and individual chapter scores will be available for review at Chapter Connections Day/Dynamics.*

Points system

Points are accumulated in each of six activity categories:

Section	Category
1	Member education
2	Promotion of critical care specialty
3	New member recruitment
4	Sustained membership
5	Academic activity
6	Certification activity

Instructions:

1. Complete the Chapter Annual Report
2. Gather validation documents for each of the categories of activities in the past year
3. Calculate scores for sections 1 thru 6
4. Add section scores for total Chapter of the Year score
5. Submit the application with documentation to CACCN National Office by May 31 annually.

Section instructions

Section 1: Member education

- Any educational event coordinated and hosted by the local chapter is eligible
- The total number of hours for an educational session are considered (excluding meal breaks and social events)
- Concurrent sessions are not cumulatively totalled. It is presumed that the session participants would be split between the concurrent session, therefore, hours of education for participant is not altered
 - For example: an eight-hour educational day that includes six concurrent sessions would be counted as eight hours for a total of six CL hours
- Please contact CACCN head office if your delivery model is different than reflected in this section
- **Suggested validation documents:**
 - Brochure, advertising or pamphlet
 - Copy of agenda (including hours of education)
 - Attendee numbers
 - Evaluation forms or report from each event.

Formula:

- *To create the member education score, the total number of hours of education provided in the year is divided by the total number of Chapter members, this number is then multiplied by 1,000 in order to establish a score that is not dependent on the size of the individual chapter.*

Total hours of education offered in the year

Total number of Chapter members x 1,000 = member education

Example:

Chapter A

- Donation after Cardiac Death educational meeting – 3 hours
- Total Chapter Membership number 26
- 3 hours divided by 26 members = 0.115 multiplied by 1,000 = 115
- therefore the membership education innovation score is 115

Chapter B

- Neuro education and bioethics education session offered
- Total education hours – 28 hours
- Membership number 310
- Formula: 28 hours divided by 310 members = 0.090 multiplied by 1,000 = 90
- Therefore, the member membership education score is 90

Section 2: Promotion of critical care specialty

Total hours of any public or community service event coordinated and hosted by the local chapter are eligible.

- Concurrent sessions are calculated as per member education hours. For example: an eight-hour event that includes six concurrent sessions would be counted as eight hours
- Eligible event must be clearly indicated as sponsored/hosted by CACCN. Event examples: participating in blood pressure clinics, teaching CPR to the public, participation in health fairs.

Validation documents:

- Documents to identify event as CACCN sponsored
 - For example, submitting a letter from the receiving group or a picture of the event, etc.

Formula:

To create the Promotion of Critical Care Specialty score, the total number of promotional event hours provided in the year is divided by the total number of Chapter members. This number is then multiplied by 1,000 in order to establish a score that is not dependent on the size of the individual chapter.

Total hours of events offered

Total number of chapter members x 1,000 = Promotion of Critical Care Specialty

Chapter A

- Total specialty promotion hours – 4 hours
- Membership number 38
- Formula: 4 hours divided by 38 members = 0.105 multiplied by 1,000 = 105
- Therefore the **Promotion of Critical Care Specialty** score is 105

Chapter B

- Total specialty promotion hours – 2 hours
- Membership number 110
- Formula: 2 hours divided by 110 members = 0.018 multiplied by 1,000 = 18
- Therefore the **Promotion of Critical Care Specialty** score is 18

Section 3: New Member Recruitment

- Calculated based on the percentage of new members recruited up to March 31 of the award 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, as 10 months have passed since the membership expired

- i.e., a membership expires April 2011 and is renewed June 2012. This member would be considered a new member due to the lapse in membership of 14 months
- Use the Membership Recruitment/Retention spreadsheet from the CACCN National Office to obtain the number of new members.

Formula:

To create the recruitment score, the total number of recruited members is divided by the total number of chapter members as of March 31 of the award year. This number is then multiplied by 100 to give you the percentage of new members. The points awarded are noted on the chart based on the percentage of new members.

Total new members

Total number of chapter members x 100 = percentage of new members

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

Chapter A

- Total number of new members 23
- Total number of chapter members 110
- Formula: 23 new members divided by 110 members = 0.209 multiplied by 100 = 20.9 % - rounded up to 21%
- 21% corresponds with the 21-30% level on the chart. Therefore 30 points will be awarded.

Chapter B

- Total number of new members – 12
- Total number of chapter members – 38
- Formula: 12 new members divided by 38 members = 0.315 multiplied by 100 = 31.5 % - rounded up to 32%
- 32% corresponds with the 31-40% level. Therefore 40 points will be awarded.

Section 4: Sustained members

- Calculated based on the percentage of renewing members up to March 31 of the award year
- Any member with a membership lapse of less than 12 months will be considered a renewed member
 - i.e., a membership expired April 2013 and is renewed February 2014. This member would be considered a **renewing** member as the renewal is within less than 12 months of the expiry
 - i.e., a membership expires April 2013 and is renewed June 2014. This member would be considered a new member as the “renewal” is more than 12 months of the expiry
- Use the Membership Recruitment/Retention spreadsheet from the CACCN national office to obtain the number of new members

Formula:

To create the sustained members score, the total number of renewed members is divided by the total number of chapter members as of March 31 of the award year. This number is then multiplied by 100 to give you the percentage of sustained members. The points awarded are noted on the chart based on the percentage of new members.

Total new members

Total number of chapter members x 100 = percentage of new members

Percentage	Points	Percentage	Points
01–10%	5	51–60%	30
11–20%	10	61–70%	35
21–30%	15	71–80%	40
31–40%	20	81–90%	45
41–50%	25	91–100%	50

Example:*Chapter A*

- Chapter A renewed 70 members this past year
- They have 250 total chapter members
- 70 divided by 250 = 0.28 multiplied by 100 = 28%
- 28% corresponds with the 21–30% category; therefore 15 points are awarded.

Section 5: Academic activity

- This section accounts for the activity of each chapter related to contribution to the science and specialty of critical care nursing. This can include publications and presentations in local, national and international journals, and presentation delivered by chapter members
- Participation in national position statements, standards work and other committees is also scored.

Formula:**Publications**

- Points will be calculated for chapter members who have contributed articles to:
 - The chapter newsletter
 - Canadian Journal of Critical Care Nursing (excluding the Summer Abstract Journal)
 - Any other peer reviewed journal where the author is affiliated with CACCN
- Chapters are responsible for providing:
 - list of member contributions, together with a copy of the chapter newsletter
 - list of member contributions to the journal or publication (full reference).

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 be awarded only once for the 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 listing the chapter member as a presenter.

Each Presentation = 25 points

Committee work

- Points will be calculated for chapter members who have contributed to committee work on behalf of CACCN at the local, provincial and national CACCN activities levels
- Points will be awarded only once for each member on each committee, regardless of the number of meetings or level of participation of the member
- Chapters are responsible for providing: list of member contributions.

Total points from all three areas:**Example***Chapter A*

- An article was published by a member in the chapter's newsletter = 25 points
- One article from a chapter member was published in Canadian Journal of Critical Care Nursing = 25 points
- One chapter member presented at the local education day = 25 points
- Three members presented separate presentations at a Dynamics conference = 75 points

Total points = 150

Section 6: Critical care certification—CNCC(C) and CNCC(P)

- Points will be calculated for chapter members who have successfully completed and/or renewed the CNA Certification Examination in the award year
- Validation of certification status of submitted members will be obtained via the Canadian Nurses Association.

Formula initial certification

To create the certification score, the total number of certified members of the chapter in the award year is divided by the total number of chapter members. This number is then multiplied by 100 to give you the percentage of certified members. Multiply this number by 10 to give you the number of points awarded.

Number of members certified/renewed

Total number of chapter members x 100 = Percentage

10 points for each percentage of the total number of chapter members who are new certifications in the award year.

Percentage x 10 = certification points

Example*Chapter A*

- Initial certification = 3 members
- 250 chapter members
- 3 divided by 250 = 0.012 multiplied by 100 = 1.2%
- multiplied by 10 = 12 points

Formula renewal certification

To create the renewal certification score, the total number of renewed certifications of the chapter in the award year is divided by the total number of chapter members. This number is then multiplied by 100 to give you the percentage of certified members. Multiply this number by 5 to give you the number of points awarded.

Number of members renewed

Total number of chapter members x 100 = Percentage

5 points for each percentage of the total number of chapter members who are new certifications in the award year.

Percentage x 5 = certification points

Example

Chapter A

- Renewed certification = 11 members
- 250 chapter members
- 11 divided by 250 = 0.044 multiplied by 100 = 4.4%
- multiplied by 5 = 22 points
- Add initial certification total with renewal total for points awarded in certification category
- Initial certification points + renewal certification points = total certification score for chapter
- Example Chapter A: 12 + 22 = 34 certification points

Submission: Tally the points from all categories on the calculation form, complete the application form and forward all to National Office with supporting documentation.

Draeger Medical Canada and the CACCN Board of Directors look forward to receiving your application. Good luck in your endeavours!

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

Criteria Revisions: October 2014

CACCN Document: Award Criteria Revised March 2011

Form Design Revision Date: January 2011

The Draeger Medical Canada Inc. Chapter of the Year Award

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 post-marked 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 *Canadian Journal of Critical Care Nursing*
- 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 *Canadian Journal of Critical Care Nursing* 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.

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 the *Canadian Journal of Critical Care Nursing*.

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

CACCN Educational Awards

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, masters and doctorate levels.



Award funds available: Two awards - \$1,000.00

Deadline for submission: January 31 and September 1

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

Mail to: CACCN, P.O. Box 25322, London, ON N6C 6B1

Mailed applications must be postmarked on or before January 31 or September 1

Eligibility criteria

The applicant must:

- be an active member of the Canadian Association of Critical Care Nurses for a minimum of one (1) year
- be accepted to an accredited continuing education program relevant to the practice, administration, teaching and research of critical care nursing
- not have been the recipient of this award in the past two years.

Application process

- submit a completed CACCN Educational Award application including all required documentation. Submit a letter of reference from his/her current employer
- incomplete applications will not be considered
- presentations considered for merit points are those that are **not** prepared as part of your regular employment role/responsibilities — oral and poster presentations will be considered.

Selection process

- CACCN reserves the right to withhold the award if no candidate meets the criteria
- The successful candidate will be notified via email and regular mail
- The successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September)
- The successful candidate's name/photograph will be published in *The Canadian Journal of Critical Care Nursing* (Winter edition)
- Current members of the National Board of Directors are not eligible.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

CACCN Recruitment and Retention Awards



The Canadian Association of Critical Care Nurses Recruitment and Retention Awards were established to recognize chapters for their outstanding achievements with respect to recruiting and retaining membership.

Award funds available:

Full Dynamics Conference Tuition Coupons

Partial Dynamics Conference Tuition Coupons

Deadline: Fiscal year end – March 31

The CACCN Office will track chapter recruitment and retention for the fiscal year.

Chapters will receive a copy of the Recruitment and Retention Report annually in April with coupon allotment noted.

Coupons will be issued electronically to all chapters.

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) – Dynamics of Critical Care Conference three-day early bird** tuition coupon
- **Minimum of 33%** of membership is “**NEW**” between April 1 to March 31, the chapter will receive **one (1) – Dynamics of Critical Care Conference three-day early bird** tuition coupon and **one (1) – Dynamics of Critical Care Conference partial** tuition coupon.

Partial coupons are equal to one-day early bird members tuition.

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 **one (1)—Dynamics**

of Critical Care Conference three-day early bird tuition coupon and two (2)—Dynamics of Critical Care Conference partial tuition coupons

- If the chapter has **greater than 70% renewal** of its previous year's members, the chapter will receive **two (2)—Dynamics of Critical Care Conference partial** tuition coupons
- If the chapter has **greater than 60% renewal** of its previous year's members, the chapter will receive **one (1)—Dynamics of Critical Care Conference partial** tuition coupon.

Partial coupons are equal to one-day early bird members tuition

Tuition coupon policy

- Tuition coupons are for full or partial tuition
- Tuition coupons may only be used by active members of the Canadian Association of Critical Care Nurses
- Coupons are issued to chapters annually in May
- Coupons are valid on early bird tuition only
- Coupons must be redeemed by the early bird tuition deadline
- Coupon codes may be used only once
- Tuition coupon values are determined annually by the CACCN National Board of Directors
- Coupons may not be used for dinner, tour, hotel or other conference activities
- Coupons are not redeemable for cash
- Tuition coupons cannot be carried over to the next fiscal year
- Tuition coupons are non-transferable
- Exceptions to this policy must be approved by the CACCN National Board of Directors.

For additional information, please refer to the Canadian Association of Critical Care Nurses Tuition Coupon Policy.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

CACCN Document: Award Criteria

Content Revision Date: March 2014

Form Design Revision Date: January 2011

Content Revision Date: April 2008

Chapter Recruitment and Retention Awards

BBraun Sharing Expertise Award

The BBraun Sharing Expertise Award is a peer-nominated award and will be presented to an individual who exhibits stellar leadership and mentoring abilities in critical care.

The nominee for this award is an individual who supports, encourages, and teaches colleagues. The nominee 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. It is not necessary for the candidate to be in a formal leadership or education role to qualify for this award.

The award funds may be used to attend educational programs or conferences related to critical care.

Award funds available: \$1,000.00

Deadline for submission: June 1

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

- The nominee must be an active CACCN member for a minimum of one (1) year
- The nominee must have a minimum of three (3) years of critical care nursing experience
- Preference is given to a nominee who has CNA Certification [CNCC(C) or CNCCP(C)]
- The nominee practises to the CACCN Standards of Critical Care Nursing Practice (4th ed., 2009)
- Each nomination must have the support of a critical care nursing colleague and the nominee's manager
- Members of the CACCN Board of Directors are not eligible for consideration of the BBraun Sharing Expertise Award.

Nomination process

- Three letters in support of the nominee are required and must be sent to the CACCN
- The nomination letter must provide information outlining the qualities of the nominee and the reasons the nominee should be selected for the award
- One letter of support must be written by a CACCN member
- The other two letters must include one written by the nominee's manager—must testify to the eligibility
- Incomplete nomination packages will not be considered.

Selection process

- Each nomination will be reviewed by the CACCN Award Review Committee
- The awards committee reserves the right to withhold the award if no candidate meets the criteria
- The successful candidate will be notified by the CACCN Director of Awards and Corporate Sponsorship via email and regular mail
- The successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September)
- The successful candidate's name/photograph will be published in *Canadian Journal of Critical Care Nursing* (Winter edition).

The Board of Directors of the Canadian Association of Critical Care Nurses and BBraun Medical retain the right to amend the award criteria.

CACCN Document: Award Criteria

Content Revision Date: March 2014

Form Revision Date: April 2012

Form Design Revision Date: January 2011

Content Revision Date: January 2010

BBraun Sharing Expertise Award



The Brenda Morgan Leadership Excellence Award



The Brenda Morgan Leadership Excellence Award is a peer-nominated award. The award was established to recognize Brenda Morgan's contribution and leadership to CACCN.

The Brenda Morgan Leadership Excellence Award 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 the nominee'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 the Canadian Association of Critical Care Nurses to recognize and honour a nurse who exemplifies excellence in leadership, in the specialty of Critical Care.

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

Deadline for submission: June 1

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

Critical care nurses who are nominated for this award will have consistently demonstrated qualities of leadership and are considered a visionary and an innovator in order to advance the goals of critical care nursing.

The nominee must:

- be an active 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
- hold a valid adult or pediatric specialty in critical care certification from CNA (preferred)
- demonstrate leadership in the specialty of critical care
- engage others in the specialty of critical care nursing
- role model and facilitate professional self-development and lifelong learning
- exemplify the following qualities and values:
 - Innovation
 - Accountability
 - Visionary
 - Teamwork and Collaboration
 - Respect/Integrity
- contributes or has contributed to the Canadian Association of Critical Care Nurses at the regional and/or national levels.

Application process

- the application involves a nomination process
- submit two (2) letters describing how the nominee has met the requirements under the Eligibility Criteria:

- Use as many examples as possible to highlight why the nominee should be considered for the award and what this nominee does that makes her/him outstanding
- The nomination letters should be as detailed as possible, as the CACCN Award Committee depends on this information to select the award recipient from amongst many deserving candidates.

Selection process

- each nomination will be reviewed by the CACCN Director of Awards and Corporate Sponsorship and the CACCN Award Review Committee
- The Brenda Morgan Leadership Award Review Committee will consist of:
 - Two members of the Board of Directors
 - Brenda Morgan (when possible)
- the Awards Review Committee reserves the right to withhold the award if no candidate meets the eligibility criteria
- the successful candidate will be notified by the CACCN Director of Awards and Corporate Sponsorship via email and regular mail
- the successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September) conference
- the successful candidate's name/photograph will be published in *Canadian Journal of Critical Care Nursing* (Winter edition).

Terms and conditions of the Award:

- the award recipient will be encouraged to write a reflective article for *Canadian Journal of Critical Care Nursing* sharing their accomplishments and describing their leadership experience
- the article should reflect on their passion for critical care nursing, their leadership qualities and how they used these effectively to achieve their outcome.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

CACCN Document: Award Criteria

Content Revision: March 2014

Form Design Revision Date: January 2011

Content Revision Date: January 2010

The Brenda Morgan Leadership Excellence Award

The CACCN "Chasing Excellence" Award



The CACCN "Chasing Excellence" Award is presented annually to a member of the Canadian Association of Critical Care Nurses who consistently demonstrates excellence in critical care nursing practice.

The CACCN Chasing Excellence Award is to be used by the recipient for continued professional or leadership development in critical care nursing.

Award Funds Available: \$ 1,000.00

Deadline for Submission: June 1

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

Mail to: CACCN, P. O. Box # 25322, London, ON, N6C 6B1

Mailed applications must be postmarked on or before June 1.

The CACCN Chasing Excellence Award is a peer nominated award. The CACCN Chasing Excellence Award is awarded to a critical care nurse who:

- is an active member of the Canadian Association of Critical Care Nurses for a minimum of one (1) years
- has a primary role in direct patient care in critical care
- holds Canadian Nurses Association certification in critical care [CNCC(C) or CNCCP (C)] (*preferred*)
- 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 and 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

Nomination Process:

- **Three** letters in support of the nominee must be sent to CACCN by the deadline
- One letter of support must be written by a CACCN member. A supporting letter from a **supervisor** such as a unit manager or team leader is also required.
 - The nomination letters must describe three clinical examples outlining the nominee's clinical excellence and expertise
- Incomplete nomination packages will not be considered.

Selection Process

- each nomination will be reviewed by the Canadian Association of Critical Care Nurses Awards Review Committee
- The awards committee reserves the right to withhold the award if no candidate meets the criteria
- The successful candidate will be notified by the CACCN Director of Awards and Corporate Sponsorship via email and regular mail
- The successful candidate will be recognized at the Awards Ceremony at the Dynamics of Critical Care Conference (annually in September)
- The successful candidate's name/photograph will be published in *Canadian Journal of Critical Care Nursing* (Winter edition)
- Current members of the National Board of Directors are not eligible.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

Reference

Benner, P. (1984). *From novice to expert, excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley Publishing Company.

Benner, P., Hooper-Kyriakidis, P. & Stannard, D. (1999). *Clinical Wisdom and Interventions in Critical Care A Thinking-in-action Approach*. Philadelphia: Saunders.

The CACCN "Chasing Excellence" Award

Revision: January 2015

Content Revision: March 2014

Logo Revision: 2012

Form Design Revision Date: January 2011

Canadian Intensive Care Week "Spotlight" Challenge



The Canadian Association of Critical Care Nurses Canadian Intensive Care Week "Spotlight" Challenge will be presented to a group of critical care nurses who develop an activity and/or event that will profile their local Critical Care Team during Canadian Intensive Care Week (annually in October/November).

Award funds available: \$500.00 total

Deadline for submission: August 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 June 1.

Award criteria

- the primary contact person must be an active member of the Canadian Association of Critical Care Nurses for a minimum of one (1) year
- a completed Canadian Association of Critical Care Nurses application form must be submitted.

Award requirements

- the event/activity must be held during Canadian Intensive Care Week

- following the event/activity, a report must be submitted for publication, with photographs*, for publication on the Canadian Association of Critical Care Nurses website and/or in *Canadian Journal of Critical Care Nursing*
- Canadian Association of Critical Care Nurses photographic consent forms must accompany all submitted photographs
- all submissions become the property of the Canadian Association of Critical Care Nurses and may be used in current/future publications (print and electronic).

Award review

- applications will be judged by blind review
- applications will be considered based on the following criteria:
 - increase the visibility of critical care services in your local community
 - uniqueness/creativity of the activity/event
 - relevance to the objectives of Canadian Intensive Care Week
 - feasibility of activity/event.

The Board of Directors of the Canadian Association of Critical Care Nurses retains the right to amend the award criteria.

Canadian Intensive Care Week “Spotlight” Challenge

Criteria Revision: March 2014

Criteria Revision: December 2013

Approved: March 2013

CACCN Life Member Award

CACCN Life Member status is awarded to individuals who have demonstrated sustained support and exceptional contributions to the Canadian Association of Critical Care Nurses and its Mission and Vision. Life members have contributed to the advancement of the art and science of critical care nursing through practice, education, research leadership and advocacy for the specialty.



This award is conferred by the Canadian Association of Critical Care Nurses.

As a Life Member, the recipient will be provided a complimentary annual CACCN membership. The recipient will retain CACCN voting privileges until such time as they actively retire from registered nursing and/or cease to hold an active practising nursing licence, at which time the complimentary membership will revert to an affiliate membership.

Awards available

- Award of choice
- Funding for travel, tuition and hotel accommodation to Dynamics to accept the award

Deadline for submission: June 1 annually

Send nominations to

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

Mail to: CACCN, P. O. Box # 25322, London, ON, N6C 6B1

Eligibility criteria

- The candidate must be a CACCN member in good standing for a minimum of 10 years (with no lapse of membership)

- The candidate has contributed to the Mission and Vision of CACCN in two or more of the following ways:
 - Providing leadership in direct patient care practice, education, research and advocacy with a focus on critical care
 - Assuming CACCN leadership roles within the organization through national or chapter executive/project work or contributions to the *Canadian Journal of Critical Care Nursing* (editorial board, columnist)
 - Contributing to the advancement of the science of critical care nursing via evidence generation, education or quality assurance activities on behalf of the CACCN at local, regional and national levels
 - Demonstrating the values of CACCN in their practice
 - Acting as a resource/expert in a domain of critical care nursing (practice, education, research and leadership)
 - Advocating for the practice of critical care nursing at the regional, provincial or national level.

Exclusion criteria

- The candidate is not a member of CACCN
- The candidate does not hold a registered nursing licence
- Self-nominations will not be accepted
- Nominations of elected officers at the national or chapter level of the CACCN will not be accepted during an active term of office.

Nomination procedure

The primary nominator is required to provide the following for consideration:

- Candidate Personal Information:
 - Curriculum Vitae; **or**
 - Resume, **or**
 - Name
 - Address
 - Educational history
 - Employment history including number of years of practice
- Candidate's CACCN activities including:
 - Positions and terms of office with the CACCN (local and/or national)
 - Relevant contributions, for example, committee work (local and/or national), guideline development, educational contributions certification exam support.

Nominators (two CACCN members) must each provide a written statement about the candidate's eligibility for a lifetime member award:

- Candidate statements cannot exceed one page
- The statement should highlight the impact the candidate has had on the growth of the association and the achievement of the association's mission
- The statement should also provide examples of outstanding contributions to CACCN and/or critical care nursing practice.

Consideration/selection

- Candidates must be nominated by a current CACCN Member
- Only candidates meeting the award criteria will be considered
- Selection shall be made by candidate review and Lifetime membership will be awarded by the National Board of Directors of the Canadian Association of Critical Care Nurses

- Successful recipients will be notified of their selection via email and regular mail
- Successful recipients will be:
 - announced at the Annual General Meeting (AGM)
 - acknowledged at the CACCN Awards ceremony at Dynamics of Critical Care
 - in the *Canadian Journal of Critical Care Nursing* (Winter); and
 - posting on the CACCN website.
- The award will be presented in person wherever possible
 - If the recipient is not in attendance at Dynamics, a National Board of Director or Chapter President will present the award in person
 - In circumstances where a personal presentation is not possible, the Chief Operating Officer shall mail the award to the recipient in a timely manner following the announcement
- The CACCN Board of Directors is not eligible to submit nominations
- The CACCN Board of Directors has the right to forego a designation in a given year
- The CACCN Board of Directors has the right to alter the award criteria as required.

Terms of Reference

- At the time of the award, CACCN shall provide recipients with the following:
 - Complimentary CACCN Membership for life
 - A commemorative certificate
 - A commemorative gift (recipient's choice)
 - Dynamics Conference tuition for the day of the Awards ceremony
 - Travel expenses of up to \$500 to be used to attend the Awards Ceremony at the Dynamics of Critical Care Conference; Travel expenses must be used in the year the award is presented
 - Hotel accommodation for two nights at the conference host hotel.

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

CACCN/Sage Products Poster Bursary



The CACCN/Sage Products Poster Bursary provides a \$500 award to eligible applicants to attend the Dynamics of Critical Care Conference to present a poster with a focus on the prevention of complications or deleterious impacts of critical illness hospitalization. Maximum of ten (10) recipients may be selected annually.

Award funds available: \$500/each

Ten (10) bursaries available (annually)

Application year: Dynamics of Critical Care Conference Call for Abstracts (annually)

Deadline for submission: January 31 (annually)

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

Eligibility

- First/presenting poster author is an active CACCN member
- **First-time** poster submission to CACCN Dynamics conference
- Focus of the poster is on the prevention of complications or deleterious impacts of critical illness hospitalization for example (but not limited to): prevention of hospital acquired infection, including; pressure injury reduction; and early mobility)
- Completed **CACCN/Sage Products Poster Bursary** application
- Poster is reviewed through the abstract submission system and is accepted for presentation at CACCN's Dynamics of Critical Care conference.

Note:

- No branding of the poster for Sage Products is required
- The poster does not need to address prevention using products provided by Sage Products.

Application process

- Applicants must submit a poster abstract online at www.caccn.ca as per the CACCN Dynamics abstract submission process by no later than 2359 ET – January 31 annually
- Applicants complete and submit the **CACCN/Sage Products Poster Bursary** application to CACCN National Office (caccn@caccn.ca) at the time of abstract submission or by no later than 2359 ET – January 31 annually
- The poster abstract will be blind reviewed according to CACCN's abstract review policies
- Following review, eligible abstracts will be listed based on review scores
- The first ten (10) eligible abstracts with the highest review scores will receive a bursary of \$500/each;
- Successful poster presenters will be notified via email and regular mail
- Acceptance of the Sage Products – CACCN Bursary indicates a commitment by the presenter to attend the Dynamics conference to present the poster
- A letter of acceptance must be signed by the recipient prior to the distribution of the funds
- **CACCN/Sage Products Poster Bursary** may only be used to offset conference expenses: registration, travel, accommodation, meals, poster preparation/printing, etc.
- **CACCN/Sage Products Poster Bursary** recipients will be acknowledged by CACCN and Sage Representatives at the CACCN Awards Ceremony
- Recipients are required to attend the CACCN awards ceremony and the Sage Products Exhibit Booth at the conference for photographs
- The successful applicant will forfeit the bursary if they fail to attend the Dynamics of Critical Care Conference, the CACCN Awards Ceremony and the Sage Products Booth.

69,000

needlestick injuries per year

COSTS FROM

\$45M to \$73M¹



AND

76%

of sharps injuries occur between use and disposal¹



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THE CANADIAN JOURNAL OF CRITICAL CARE NURSING

Information for Authors

The Canadian Journal of Critical Care Nursing (CJCCN) 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 *The Canadian Journal of Critical Care Nursing* 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

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.

Vision Statement

All critical care nurses provide the highest standard of patient- and family-centred care through an engaging, vibrant, educated and research driven specialized community.

Mission Statement

We engage and inform Canadian Critical Care nurses through education and networking and provide a strong unified national identity.

Benefits of Membership

- A strong, unified voice for critical care nursing in Canada
- A subscription to the Canadian Journal of Critical Care Nursing
- CACCN Standards for Critical Care Nursing Practice (4th Ed.)
- Annual Report
- Position Statements
- Awards, Grants and Bursaries
- CNCC(C) Certification Study Guide
- Opportunities for nurses to present at local and national levels
- Educational opportunities to accumulate continuing learning hours
- Opportunities to network with peers
- Reduced tuition fees

Become a member of your professional association today!

Revised April 2016

Application for membership

Name: _____

Address: _____
(Street)

(City) (Province) (Postal code)

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

Email: _____

Employer: _____

Position: _____

Area of Employment: _____

Nursing Registration No.: _____ Province: _____

Chapter Affiliation (if known): _____

Sponsor's Name: _____
(If applicable)

Type of membership:

- New Member—one year \$75.00 + taxes New Member—two years \$140.00 + taxes
 Renewal—one year \$75.00 + taxes Renewal—two years \$140.00 + taxes
CACCN # _____
 Student Member—one year \$50.00 + taxes

Membership fees: add GST/HST based on province of residence

Are you a CNA/RNAO member? Yes No

Signature: _____

Date: _____

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

email: caccn@caccn.ca; website: www.caccn.ca

Visa/Mastercard: _____ Exp.: ____/____ CVV (back of card): _____

Continuous renewal

Continuous renewal: We have made it easier to maintain your membership. By providing a credit card number, your membership will automatically renew on the next membership expiry date, so you will no longer have to worry about remembering to renew! Depending on the month and type of membership selected (one or two years), one or two years later, CACCN will charge your credit card for membership dues based on your membership at the time of renewal. Following automatic renewal, CACCN will mail your membership card/receipt. For FAQs on automatic renewal, visit www.caccn.ca/JOINUS

How to complete your Membership Application / Renewal with CACCN

- **New Members:** Online at www.caccn.ca – select **JoinUs**
- **Renewals:** select **JoinUS/Renewals** – Sign in with your User Name and Password; Forget your user name and password? Select **Forgot Password** under the sign in boxes.
- **Fax** the membership form with credit card information (Visa/MasterCard) to 519-649-1458
- **Mail** membership form with a cheque, money order or credit card information to CACCN National Office

CACCN Membership Information:

- **Active member:** Any registered nurse, with an interest in critical care, who possesses a current and valid licence or certificate in the province, territory or country in which the registered nurse practises.
- **Affiliates:**
 - **Student:** Any student nurse in an accredited professional nursing program, who is **currently NOT licensed** as a registered nurse or graduate nurse. *If you hold a registered nursing license, affiliate-student application does not apply.*
 - **Associate:** Any person with an interest in critical care, who does not meet the requirements for an Active Member.

Active / Affiliate Province of Residence	Taxation Rate	Base Member Fee	Tax Rate	Total Incl. Taxes
Alberta, British Columbia, Manitoba, Northwest Territories, Nunavut, Quebec, Saskatchewan, Yukon	5% GST	\$ 75.00	\$ 3.75	\$ 78.75
		\$ 140.00	\$ 7.00	\$ 147.00
New Brunswick, Newfoundland/Labrador, Ontario	13% HST	\$ 75.00	\$ 9.75	\$ 84.75
		\$ 140.00	\$ 18.20	\$ 158.20
Nova Scotia	15% HST	\$ 75.00	\$ 11.25	\$ 86.25
		\$ 140.00	\$ 21.00	\$ 161.00
Prince Edward Island	14% HST	\$ 75.00	\$ 10.50	\$ 85.50
		\$ 140.00	\$ 19.60	\$ 159.60
International (outside of Canada)	N/A	\$ 75.00	\$ 0.00	\$ 75.00
		\$ 140.00	\$ 0.00	\$ 140.00
Student Affiliate	5% GST	\$ 50.00	\$ 2.50	\$ 52.50
	13% HST	\$ 50.00	\$ 6.50	\$ 56.50
	14% HST	\$ 50.00	\$ 7.00	\$ 57.00
	15% HST	\$ 50.00	\$ 7.50	\$ 57.50

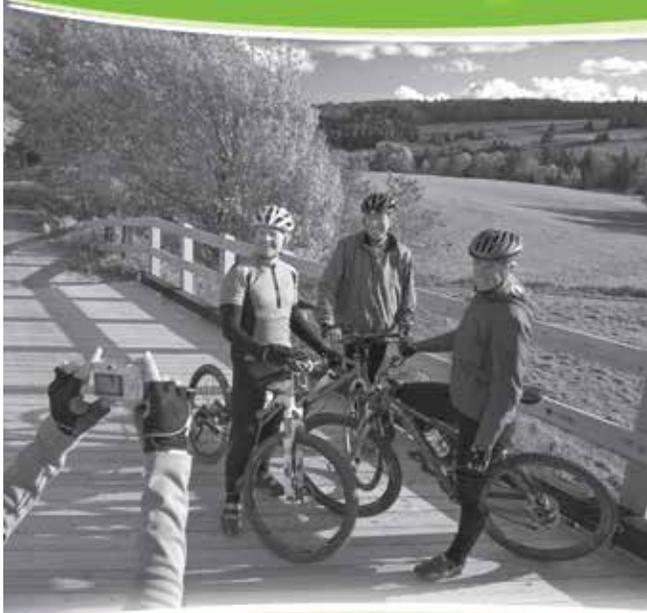
Canadian Association of Critical Care Nurses

P. O. Box # 25322, London, ON, N6C 6B1

Toll Free: 1-866-477-9077 • Telephone: 519-649-5284 • Facsimile: 519-649-1458

Email: caccn@caccn.ca Website: www.caccn.ca

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Basins may contain pathogens associated with hospital-acquired infections (HAIs).^{1,2} Need more proof? We'll sample your basins for FREE!

Replace your basins now. Our comprehensive, rinse-free patient cleansing products can help standardize patient care and may address a risk factor for CAUTI through eliminating the basin.³



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or call 800.323.2220

REFERENCES: 1. Marchaim D, et al. Hospital bath basins are frequently contaminated with multi-drug resistant human pathogens. Poster presented at SREA 21st Annual Scientific Meeting, April 2011. 2. Johnson D, Linoway, Mazon L. Patients' bath basins as potential sources of infection: a multi-center sampling study. AJCC, Vol 18, No 1, Jan 2009. 3. 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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