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The Canadian Journal *of* Critical Care Nursing

Volume 37, Special Standards Issue, 2026

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Canadian Association of Critical Care Nurses

CACCN National Office
Chief Operating Officer:
Christine R. Halfkenny-Zellas, P.Mgr., CIM
P.O. Box 25322, London, Ontario N6C 6B1
caccn.ca
email: caccn@caccn.ca
phone: 519-207-7007
toll-free: 1-866-477-9077

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Author Enquiries: All manuscript submissions are to be sent to Chief Editor, Canadian Journal of Critical Care Nursing (CJCCN): cjccneditor@caccn.ca and CACCN National Office: caccn@caccn.ca. For Author Guidelines, refer to the Canadian Journal of Critical Care Nursing (CJCCN) website: https://cjccn.ca/

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CANADIAN
ASSOCIATION OF
CRITICAL
CARE
NURSES

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 scholarship, education, and networking providing a strong unified national identity.

Values and beliefs statement

Our core values and beliefs:

- 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 up for our beliefs
  - Promoting open and honest relationships

Pathways to success

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 and 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

Standards Review and Revision

Why Are Standards Needed?

The Canadian Critical Care Nursing Standards provide the legal and professional framework that defines safe, appropriate, and evidence-informed patient care.

They:

- Establish the legal and professional expectations for critical care nursing practice.
- Serve as a resource to guide Critical Care Nurses (CCNs) in applying best practices across Canadian critical care settings.
- Provide broad, overarching guidance that can be adapted at the local unit level to meet the needs of individual organizations while ensuring consistent, high-quality care for all critically ill patients and their families throughout Canada.

Historical Overview

Since its establishment in 1983, the Canadian Association of Critical Care Nurses (CACCN) has been committed to developing, maintaining, and promoting standards that define the scope and quality of critical care nursing practice in Canada.

CACCN has played a leadership role in advancing standards of practice for Canadian Critical Care Nurses. The Canadian Critical Care Nursing Standards have evolved over time through the following editions:

- 1992 – First Edition
- 1997 – Second Edition
- 2004 – Third Edition
- 2009 – Fourth Edition
- 2017 – Fifth Edition
- 2024 – Sixth Edition

Framework: Methodology and Methods

Previous revisions of the Standards used a variety of approaches. For the 6th Edition, a standardized revision methodology was developed to support consistency, transparency, and reproducibility for future updates.

The revision process included:

- Establishing a predefined framework and methodology.
- Conducting a comprehensive scoping review of the literature.
- Completing a modified Delphi study with an expert panel to achieve consensus on the revised standards.

Acknowledgements

The Canadian Association of Critical Care Nurses (CACCN) gratefully acknowledges the leadership and expertise of:

- *Dr. Brandi Vanderspank-Wright, PhD, RN, CNCC(C) – Immediate Past President, CACCN*
- *Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C) – Past President, CACCN*
- *Amanda Ross-White, MLIS, AHIP – Health Sciences Librarian, Bracken Health Sciences Library, Queen's University*

Their leadership and guidance were instrumental throughout the revision process.

CACCN also extends its sincere appreciation to the expert panel of CACCN members whose knowledge, experience, and dedication contributed to the development of the CACCN Standards for Critical Care Nursing Practice, 6th Edition.

Revising the Canadian Association of Critical Care Nurses Standards for Critical Care Nursing Practice: A Modified Delphi Protocol

Brandi Vanderspank-Wright, PhD, RN, CNCC(C), Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), for The Canadian Association of Critical Care Nurses, National Board of Directors

Abstract

Background: *Since 1992, the Canadian Association of Critical Care Nurses (CACCN) has set the Standards of Practice for Canadian critical care nurses. The current Standards were revised in 2017, after undergoing the fifth review since inception. The Association's practice has been to review the Standards approximately every five years.*

Aim: *The aim of this protocol is to provide a transparent and replicable process for Standards revision.*

Methods: *A two-phased design that includes a systematic review modelled on Joanna Briggs Institute (JBI) Scoping Review methodology and second, a Modified-Delphi consensus process. The reporting of this protocol is guided by PRISMA-P reporting guidelines.*

Outcomes: *All items included in the final consensus will be utilized to create the revised sixth edition of the CACCN Standards for Critical Care Nursing Practice. The standards will be published in the Canadian Journal of Critical Care Nursing, posted on the CACCN website (www.caccn.ca), and shared among the CACCN network to help inform Critical Care Nursing practice in Canada.*

Keywords: practice standards, systematic review, modified-Delphi, critical care nursing, protocol

Vanderspank-Wright, B., & Crowe, S. (2026). Revising the Canadian Association of Critical Care Nurses Standards for Critical Care Nursing Practice: A Modified Delphi Protocol. *The Canadian Journal of Critical Care Nursing, 37*(Special Issue), 6–9. (Reprinted from "Revising the Canadian Association of Critical Care Nurses Standards for Critical Care Nursing Practice: A Modified Delphi Protocol," (2023), *The Canadian Journal of Critical Care Nursing, 34*(3), 18–21. DOI: 10.5737/23688653-34318)

The Canadian Association of Critical Care Nurses (CACCN) is the national association representing critical care nurses (CCN) in Canada. Since 1992, the CACCN has set the standards of practice for Canadian CCNs. Standards of care provide legal guidance for what constitutes "safe and appropriate patient care" (Shapiro, 2019, p.102); nurses "are obligated to provide knowledgeable, competent, and safe care and act in the best interests of their patients" (Shapiro, 2019, p.101). Standards of practice also "delineate the scope, function, and role of the nurse in practice" (Shapiro, 2019, p.102). The Standards for Critical Care Nursing Practice (CACCN, 2017) are used to guide and to provide a resource for CCNs to ensure that best practices are utilized in Canadian critical care units. The Standards provide broad, overarching guidance that is then individualized at the unit level to ensure high quality care is provided to all patients and families accessing critical care in Canada.

The current Canadian Standards were revised in 2017, after undergoing the fifth review since inception. The Standards were initially developed utilizing literature reviews and expert nurse input in the past (Kidd et al., 1987). Although every attempt to complete a robust review has been made in the past, with the exception of the first published standards, there has not been a defined, standardized methodological process applied to the development or the review. Therefore, the aim of this protocol is to provide a transparent and replicable process for Standards revision. The reporting of this protocol is guided by PRISMA-P reporting guidelines.

Methods

Design: A two-phased design that includes a systematic review modelled on Joanna Briggs Institute (JBI) Scoping Review methodology and second, a Modified-Delphi consensus process.

Phase I: Identifying critical care nursing standards

In consultation with a medical information specialist, we will develop a rigorous search strategy to identify existing critical care nursing standards. The search will be two-fold.

First, we will conduct a systematic search of peer-reviewed publications specific to critical care nursing standards of practice. Dates for the search will be limited to 2017 to present, with the rationale that the current CACCN Standards were published in 2017. Language limits will be set to English and French given that these are the two official languages used in Canada. The following databases will be searched: Medline-OVID, CINAHL, Nursing & Allied Health. The search strategy will be developed in Medline and peer-reviewed. It will then be translated and executed into the remaining databases.

Second, we will conduct a robust grey literature search. Given the Canadian healthcare structure, which is under the auspices of individual provinces and territories, we will carefully collect all existing critical care nursing standards in Canada. Further, we will ensure that our grey literature search explores all major critical care nursing associations/federations. The latter will include a thorough review of websites and contact with each association via email if necessary. As a preliminary attempt to create a list of critical care nursing associations, we have drawn

on the membership of the World Federation of Critical Care Nurses (WFCCN) membership.

Citations retrieved from the first systematic search will then be uploaded into Covidence for screening. All duplicates will be removed. We will then use a two-step screening process completed by two reviewers who will act as independent reviewers. First, the title and abstract will be screened followed by full-text screening. In instances where consensus is needed, the two principal investigators (BVW or SC) will discuss and attempt to reach consensus. If consensus cannot be reached, a third expert will be consulted. A review of reference lists of included articles will also be done to satisfy hand-searching. A PRISMA flow diagram will be used to illustrate the screening process. Inclusion and exclusion criteria have been determined a priori and are articulated in Table 1.

For grey literature, we will search and include all documents that clearly indicate they are critical care nursing practice standards and collaborate with our medical information specialist for strategies to ensure we have adequately identified this literature.

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion	Rationale
Practice Standards	All other literature	We are specifically looking for practice standards.
Nursing	All other disciplines	We are specifically looking for practice standards that guide nursing practice.
Critical Care Defined as: Intensive Care Level 2 or 3 Neonatal, Pediatric, Adult	All other practice settings	Level 2 and 3 Critical Care Units are categories used within the Canadian context. This may include High Acuity Units and/or Progressive Care Units.

Quality appraisal

For peer-reviewed publications retrieved in the systematic search, we will use JBI quality appraisal tools. We will not exclude based on quality.

Data extraction

We will approach data extraction in two ways. First, from the peer-reviewed literature, we will extract the following data using the extraction tables.

Data Synthesis

Following extraction of the data from both the systematic search and grey literature retrieved we will then synthesize the extracted standards. We will engage in a process of mapping the standards against one another. Critical care nursing standards are generally written in the following way: an overarching standard statement and then more granular/itemized elements that reflect how the standard is actualized in clinical practice. As a result, we will group all high-level statements together and include all itemized elements with their respective statements.

The identified and mapped standards will be used to begin the Modified Delphi process. The findings from Phase 1 will constitute the literature review for this Modified Delphi.

Phase 2 – Modified Delphi

Design

A Modified Delphi modelled on Keeney et al. (2011).

Sample – Expert Panel Composition

We will establish an expert panel to participate in the consensus building process. We will aim to have maximum variation in our expert panel. We will recruit critical care nurses in a variety of roles (see Table 2), provinces and territories, as well as representation from rural, remote, community and academic centres and adult, pediatric, and neonatal clinical contexts. We will also ensure CACCN National Board of Directors Member representation in addition to the project leads (BVW, SC). All participants who express interest will be invited to participate. All participants must be members of the CACCN; have a minimum of 5 years of experience in critical care; and be actively practicing in critical care in Canada.

Extraction Table 1.0

Study ID#	Author and Title	Publication, Year	Country of Origin	Methodology Used to Establish Standards	Practice Setting Description	Sample Size	Data Collection	Data Analysis

Extraction Table 2.0

Setting Characteristics

Study ID#	Author and Title	Population: Neonatal, Pediatric, Adult	Unit Classification	Hospital Setting (Academic, Rural, Community) if described

Extraction Table 3.0

Reported Standards

Study ID#	Author and Title	Reported Standards	Supporting Evidence +/- GRADE[2] if reported

Table 2

Nursing Roles

Nursing Role
Clinical Nurses
Advanced Practice Nurses
Nurse Educators
Nurse Managers (Assistant)

Recruiting Expert Panel Members

The CACCN head office will send an email communication to the membership advertising the recruitment. Interested participants will be asked to provide relevant demographic information through a link to an online survey using the University of Ottawa's secure Survey Monkey to ensure that we satisfy the representation needed for the expert panel. Interested participants will be asked to provide their email address for future communication about the study including the Delphi rounds. Only the two project leads (BVW and SC) and the research assistant(s) will have access to the master list of participants' demographics and emails.

Data Collection – Delphi Rounds

All rounds of this Modified Delphi will be completed as follows: Using the online survey platform, Survey Monkey (license held by the University of Ottawa), we will seek consensus on revisions to the Standards. The first round will focus on the overarching standards statements/themes while the second, third (and fourth if necessary) rounds will focus on the itemized elements within each overarching standard statement. Each round will consist of six weeks, using Dillman's (1978) Total Design for Survey Research for survey distribution and reminders. An email with the electronic survey link to participate in the round will be sent with two reminders sent at weeks two and four.

All standards statements/itemized elements will be assigned a 5-Likert scale defined as follows: **1 – Not Applicable**, **2 – Not at All Important**, **3 – Somewhat Important**, **4 – Important** and **5 – Essential**. Consensus for rounds 1-3 will be established a priori as 75% based on recommendations from Foth et al. (2016).

In **Round 1**, overarching statements that are ranked at 4 and 5 with a minimum of 75% consensus (Important and Essential) will move forward to Round 2. Participants will be given the opportunity to identify missing elements that should be included through an open-ended question.

In **Round 2**, all itemized elements associated with the overarching statements will be included as well as missing elements identified from the open-ended question. Each element will require a rating. In this round, any element with a ranking of 4–5 with a 75% consensus will move forward to Round 3.

In **Round 3**, only elements ranked at 4 and 5 with a 75% consensus will move forward and constitute final consensus on the included Standards. If a fourth round is necessary because consensus was not reached during Round 3, we will require a 75% consensus on items ranked at Essential only.

In order for a participant to partake in a round they must have completed the previous round (if applicable; e.g., this would apply to all but Round One). We will track participation based on the 4-digit code created by participants. For Rounds 2–4, invitations to participate will only be sent for subsequent rounds based on confirmation of participation in the previous.

Data analysis

Analysis of data collected in each Delphi round will be analyzed primarily through descriptive statistics (N, %). Open ended Responses from Round 1 will be summarized, organized thematically and transformed into a standard statement.

Ethical considerations

Ethics consultation occurred and this project was deemed quality improvement by the University of Ottawa Research Ethics Board. We will seek implied consent from all participants at the beginning of each Delphi Round as part of the electronic survey. As indicated, participants will create a 4-digit identifier that will be used as their unique participant code to track participation across the Delphi rounds. A master list of participants and codes will be kept separately from the data and will be housed on the uOttawa secure SharePoint server. Only the principal investigators (BVW and SC) will have access to the master list. All collected data will be stored on uOttawa Survey Monkey account or in a separate, secure uOttawa SharePoint file. All files, folders, and platform access will be password protected. All uOttawa software/platforms/servers require a two-factor authentication.

Data will be kept for the maximum conservation period and at minimum until the next CACCN Standards revision. Following publication of the 7th edition of the Standards, the data will then be safely destroyed.

Outcomes and Prioritization

Upon completion of the final round of the Delphi, the elements ranked at 4 and 5 with a 75% consensus will move forward and constitute final consensus. All items included in the final consensus will be utilized to create the revised sixth edition of the CACCN CCN Standards. The standards will be published in the Canadian Journal of Critical Care Nursing, posted on the CACCN website (www.caccn.ca), and shared among the CACCN network to help inform CCN practice in Canada.

Author Notes

Brandi Vanderspank-Wright, PhD, RN, CNCC(C), Canadian Association of Critical Care Nurses, National Board of Directors; School of Nursing, University of Ottawa, Ottawa, Ontario.

Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), Canadian Association of Critical Care Nurses, National Board of Directors; Fraser Health Authority, British Columbia.

Corresponding author: *Brandi Vanderspank-Wright, Associate Professor, School of Nursing, University of Ottawa, Ottawa, ON. Email: bvanders@uottawa.ca*

Funding and Conflict of Interest Statement: *Dr. Brandi Vanderspank-Wright and Sarah Crowe are on the National Board of Directors for the Canadian Association of Critical Care Nurses. While the authors on behalf of the CACCN have consulted with the Board specific to project design, revision and drafting of this manuscript, the substantive work is being done within the boundaries of Dr. Vanderspank-Wright and Sarah Crowe's program of research. Aside from librarian expenses, no funds have been received by the co-author from the Canadian Association of Critical Care Nurses.*

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Keeney, S., Hasson, F., & McKenna, H. (2011). *The Delphi Technique in Nursing and Health Research*. Wiley.

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Canadian Critical Care Nursing Standards Revision Part 1: A Scoping Review

Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), Brandi Vanderspank-Wright, PhD, RN CNCC(C) and Amanda Ross-White, MLIS, AHIP for the Canadian Association of Critical Care Nurses – National

Abstract

Background & Purpose: *Critical care nursing demands high professional standards to safeguard patient outcomes. The Canadian Association of Critical Care Nurses (CACCN) publishes national standards to define and guide the practice of Canadian critical care nurses (CCNs). To ensure credibility, transparency, and methodological rigor in revising these standards, this scoping review was conducted as the first phase of a standardized protocol to inform the sixth edition of CACCN's Standards for Critical Care Nursing Practice.*

Methods & Procedures: *Guided by the JBI methodology for scoping reviews, the research protocol was developed a priori and executed across Medline, CINAHL, and Nursing & Allied Health databases. Peer-reviewed articles and grey literature from 2017–2022 were screened using Covidence software in a two-stage process by independent reviewers. Grey literature was sourced through targeted searches of critical care associations globally. Inclusion criteria required documents to contain published or public-facing standards related to critical care nursing practice.*

Results: *The review included 15 sources: 5 peer-reviewed studies and 10 grey literature documents. Standards were identified from 12 countries and federations. Key topics varied widely, encompassing educational requirements, ethical practice, clinical competencies, advocacy, leadership, communication, staffing, and safety. Most sources described the frameworks used to develop their standards.*

Discussion*: Results revealed variation across regions, highlighting the lack of a universal framework. This variation underscores the need for standardized methodologies to ensure consistency in CCN practice.*

Conclusion*: This review lays the foundation for evidence-based revision of CACCN's standards and supports the development of a structured approach to future updates.*

Keywords: critical care nursing, practice standards, scoping review, evidence-based practice

Crowe, S., Vanderspank-Wright, B., & Ross-White, A. (2026). Canadian Critical Care Nursing Standards Revision Part 1: A Scoping Review. *The Canadian Journal of Critical Care Nursing, 37*(Special Isssue), 10–17. https://doi.org/10.5737/23688653-37sp10

Implications for Nurses

- **Standardization Promotes Consistency**: The absence of a unified approach to developing critical care nursing standards globally underscores the need for standardized, evidence-based methodological frameworks for standards development. Implementing such approaches, such as scoping reviews to identify existing standards followed by a consensus-building methods like the modified-Delphi, ensures transparency, replicability, and consistency in how standards are created and revised.
- **Informed Practice Through Rigorous Review**: Conducting a structured scoping review allows nurses to base their practice on current, peer-reviewed, and grey literature. This promotes informed clinical decision-making that reflects evolving healthcare trends and best practices.

Critical care nursing is a disciplinary specialization that requires the highest standard of practice to ensure the safety and well-being of critically ill patients (AACN, 2019; ACCN, 2015; CACCN, 2017). The Canadian Association of Critical Care Nurses (CACCN), the national professional body representing critical care nurses (CCNs), has been committed to setting, maintaining, and promoting practice standards that define the roles, responsibilities, and quality of critical care nursing practice (CACCN, n.d.) since 1992. The CACCN (2017) has actively promoted the Standards of Critical Care Nursing Practice as one of its foremost mandates as an Association, ensuring that Canadian CCNs deliver high-quality, patient- and family-centred care in critical care units, where patients are often gravely ill, vulnerable, and where clinical decisions often carry significant consequences. Standards of care serve as a legal and professional framework, that outlines what constitutes "safe and appropriate patient care" (Shapiro, 2019, p.102). These standards compel nurses to deliver care that is knowledgeable, competent, and safe, always prioritizing their patients' best interests of (Shapiro, 2019). Beyond legal implications, standards of practice delineate the roles, responsibilities, and scope of CCNs, thereby ensuring clarity and consistency in nursing roles and promoting a unified approach to care delivery (Shapiro, 2019).

The *Standards for Critical Care Nursing Practice* published by CACCN (2017) serve as an essential resource for Canadian CCNs. They provide broad, high-level direction that can be tailored to meet the specific needs of individual units and critically ill patient populations. These standards not only establish a benchmark for best practice in critical care nursing but also promote a culture of continuous improvement and professional accountability within critical care settings. By adapting the standards at the unit level, CCNs can ensure that

the care delivered is both evidence-informed and responsive to the unique needs of patients and families accessing critical care services across Canada. The *Canadian Standards for Critical Care Nursing Practice* have undergone periodic revisions to stay current with evolving knowledge, technology, and patient care practices. The most recent revision, completed in 2017, marked the fifth revision of these standards since their inception. Historically, the development and revisions to these standards have involved robust literature reviews and expert input from experienced Canadian CCNs (Kidd et al., 1987). However, despite these efforts to incorporate rigorous review processes, a clearly defined and standardized methodological approach has not been consistently applied across all revisions. The absence of a structured process poses challenges to ensuring the transparency, reproducibility, and comprehensiveness of the standards.

To address this gap, there was an identified need to implement a standardized methodological framework for the development and revision of CACCN's standards. Having a standardized process serves to not only enhance the quality and credibility of the standards but also facilitate a more transparent and replicable review process for future revisions. Utilizing a structured protocol ensures that the resulting standards are evidence-based, systematically developed, providing alignment with the best available evidence as well as national CCN expert consensus. The protocol for the standards revisions was published in advance, ensuring transparency and adherence to a pre-established methodological framework (Vanderspank-Wright & Crowe, 2023). This manuscript reports on part one of the process which was a scoping review that was conducted a priori to the modified Delphi (Vanderspank-Wright & Crowe, 2023). Modelled on the JBI methodology for scoping reviews (Aromataris et al., 2024), this review reports on the methods used to search for and subsequently identify key literature that was used to inform the modified Delphi and subsequently inform the development of the sixth edition of the CACCN's Standards for Critical Care Nursing Practice.

Methods

Protocol

The research protocol for the Standards revision was developed a priori (Vanderspank-Wright & Crowe, 2023) and modelled on the JBI methodology for scoping reviews (Aromataris et al., 2024). Although the protocol was not formally registered, the JBI methodology was determined to be well-suited for this review purpose offering a structured approach to identifying, analyzing, and synthesizing evidence, thereby supporting the development of comprehensive, high-quality standards.

Eligibility

To be eligible for inclusion in this review, manuscripts and grey literature needed to include published or public-facing standards for critical care nursing practice. Table 1 further outlines inclusion and exclusion criteria along with an associated rationale.

In consultation with a medical information specialist, we developed a rigorous and replicable search strategy to identify existing critical care nursing standards literature. The search strategy was developed in Medline and peer reviewed (See Figure 1 for Medline Search Strategy). The search strategy was then translated and executed into the remaining databases. The following databases were searched: Medline (OVID), CINAHL (EbscoHost), Nursing & Allied Health (ProQuest).

The search was completed in two steps. First, we conducted a structured search of peerreviewed literature on critical care nursing standards of practice. We limited the search to 2017–June 7, 2022, to align with the publication of the 5th edition of the CACCN Standards (2017) and the initiation of revisions in June 2022. Language limits were set to English and French, Canada's official languages. Citations were retrieved and uploaded into Covidence systematic review software for screening. All duplicates were removed. We used a two-step screening process completed by two independent reviewers (Initials Blind for Review). First, the titles and abstracts were

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion	Rationale
Practice Standards	All other literature	We were purposefully seeking practice standards.
Nursing	All other disciplines	We were purposefully seeking practice standards that guide nursing practice.
Critical Care, Defined as: Intensive Care, Level 2 or 3, Neonatal, Pediatric, Adult	All other practice settings	Level 2 and 3 Critical Care Units are categories used within the Canadian context. This was inclusive of High Acuity Units and/or Progressive Care Units

Figure 1

Medline Search Strategy

Database: Ovid MEDLINE(R) ALL <1946 to June 07, 2022>

Search Strategy:

----

1 Critical Care Nursing/ (2568)
2 "critical care nurs*".mp. (5937)
3 exp Critical Care/nu [Nursing] (410)
4 exp Critical Care/ (64324)
5 exp Intensive Care Units/ (100097)
6 nurs*.mp. (784782)
7 (4 or 5) and 6 (28262)
8 1 or 2 or 3 or 7 (30520)
9 (practice adj2 standard*).mp. (12362)
10 exp clinical pathway/ (7513)
11 exp clinical protocol/ (184952)
12 clinical protocols/ (29693)
13 exp consensus/ (18602)
14 exp consensus development conference/ (12614)
15 exp consensus development conferences as topic/ (2996)
16 critical pathways/ (7513)
17 exp guideline/ (37083)
18 guidelines as topic/ (42007)
19 exp practice guideline/ (29876)
20 practice guidelines as topic/ (127343)
21 health planning guidelines/ (4164)
22 Clinical Decision Rules/ (869)
23 (guideline or practice guideline or consensus development conference or consensus development conference, NIH).pt. (46938)
24 (position statement* or policy statement* or practice parameter* or best practice*).ti,ab,kf. (41708)
25 (standards or guideline or guidelines).ti,kf. (127044)
26 ((practice or treatment* or clinical) adj guideline*).ab. (48362)
27 (CPG or CPGs).ti. (6221)
28 consensus*.ti,kf. (31765)
29 consensus*.ab. /freq=2 (30949)
30 ((critical or clinical or practice) adj2 (path or paths or pathway or pathways or protocol*)).ti,ab,kf. (24396)
31 recommendat*.ti,kf. or guideline recommendation*.ab. (53755)
32 (care adj2 (standard or path or paths or pathway or pathways or map or maps or plan or plans)).ti,ab,kf. (74841)
33 (algorithm* adj2 (screening or examination or test or tested or testing or assessment* or diagnosis or diagnoses or diagnosed or diagnosing)).ti,ab,kf. (9257)
34 (algorithm* adj2 (pharmacotherap* or chemotherap* or chemotreatment* or therap* or treatment* or intervention*)).ti,ab,kf. (11832)
35 (guideline* or standards or consensus* or recommendat*).au. (555)
36 (guideline* or standards or consensus* or recommendat*).ca. (1217)
37 or/9-36 (717590)
38 8 and 37 (3535)
39 limit 38 to yr="2017 -Current" (943)
40 limit 39 to (english or french) (931)

screened followed by full-text screening. In instances where consensus was needed, the two principal investigators (Initials Blind for Review) discussed and reached consensus. A review of reference lists of included articles was also done to satisfy hand-searching.

Our second step was to conduct a robust pre-established, grey literature search. Given the Canadian healthcare structure, which is under the auspices of individual provinces and territories, we collected all existing critical care nursing standards in Canada. In addition, we searched major critical care nursing associations and federations, including the Canadian Association of Critical Care Nurses (CACCN), the American Association of Critical Care Nurses (AACN), the Australian College of Critical Care Nurses (ACCCN), the European Federation of Critical Care Nursing Associations (EfCCNa), and other national bodies identified through the World Federation of Critical Care Nurses (WFCCN) membership list. This process involved systematic review of association websites and direct contact with organizations when necessary to ensure comprehensiveness. To maximize inclusivity, we included all available standards in English or French and used the most recent versions available, regardless of their publication date.

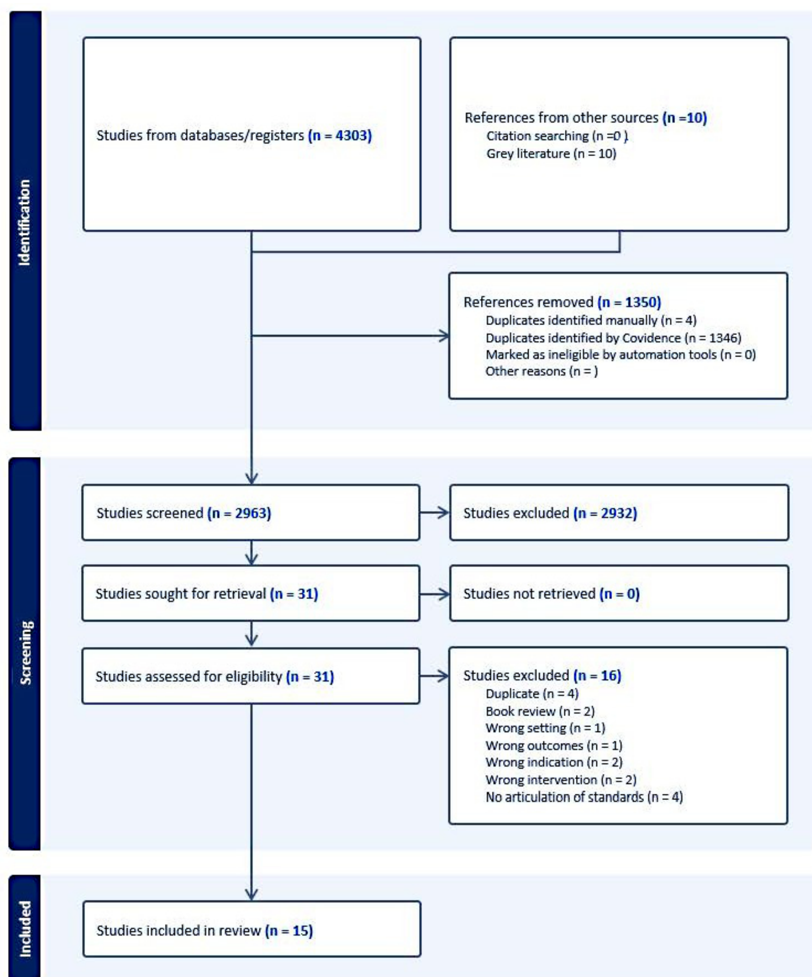
Results

The initial search of electronic databases yielded 4,303 citations. After removing duplicates, 2,953 unique titles and abstracts were screened (Figure 2). A total of 2,932 citations were excluded based on relevance, leaving 21 articles for full-text review. Sixteen additional articles were excluded at full-text screening for the following reasons: *n* = 4 were duplicates, *n* = 4 did not include extractable standards, *n* = 2 were book reviews, *n* = 2 addressed the wrong indication, *n* = 2 involved the wrong interventions, *n* = 1 was set in the wrong context, and *n* = 1 focused on the wrong outcome. This resulted in *n* = 5 studies being included. A hand search of grey literature was expanded to include all available critical care association standards where *n* = 10 additional relevant articles were identified. In total, 15 articles were included in the final review (Table 2). Further, it should be clarified that we included the existing CACCN 5th edition standards – these are not captured in the search, nor in the PRISMA. Consistent with scoping review methodology, we did not evaluate included articles for methodological quality (Peters et al., 2022).

Of the 15 articles included in the review, standards were identified from the following countries and federations: Canada

Figure 2

PRISMA Flow Diagram



(*n* = 1), the United States (*n* = 1), New Zealand (*n* = 1), Australia (*n* = 4), Great Britain (*n* = 1), Ireland (*n* =), Jordan (*n* = 1), Norway (*n* = 1), the Philippines (*n* = 1), China (*n* = 1), Europe (*n* = 1), and an international consortium (*n* = 1).

The majority of articles (*n* = 10) described the frameworks or processes used to develop their standards. These approaches included consensusbuilding methods such as Delphi studies (e.g., Gill et al., 2017; Zhang et al., 2019); systematic literature reviews combined with expert panel input (e.g., Chamberlain et al., 2018); position statements and competency frameworks developed through professional association consultation (e.g., AACN, 2019; EfCCNa, 2013); and national policydriven processes (e.g., Critical Care Services Ontario, 2018; Jordanian Nursing Council, 2017). These frameworks varied in rigor and transparency, with some offering detailed methodological accounts (Delphi, systematic reviews) and others relying on expert consensus without clear documentation. This variation highlights the lack of a universally applied methodology for standards development.

The included sources addressed a wide range of topics, including baseline education and competencies, ethical practice expectations, leadership and advocacy, staffing and safe practice environments (see Table 3). While most sources emphasized baseline education and ethical practice, fewer addressed leadership, advocacy, or evidence generation. This imbalance suggests that some aspects of critical care nursing practice remain underrepresented in global standards. Notably, frameworks that employed structured consensus methods (e.g., Delphi) tended to produce more comprehensive standards spanning multiple domains.

Table 2

Summary of Included Studies and Grey Literature

Author /Organization	Year Published	Country	Reported Standards	Supporting Evidence/ Process
Critical Care Services Ontario	2018	Canada	Standards and competency statements	Not included
New Zealand College of Critical Care Nurses	2019	New Zealand	Standards and sub-standard statements	Not included
American Association of Critical Care Nurses	2019	United States	Standards and competency statements	Framework and overview of process provided.
Australian College of Critical Care Nurses	2015	Australia	Standards, with elements and performance indicators	Framework and overview of process provided.
British Intensive Care Society	2013	Great Britain	Standards with rationale statement	Not included
European Federation for Critical Care Nursing Associations	2013	Europe	Standards with rationale statement	Framework and overview of process provided.
Intensive Care Society of Ireland	2019	Ireland	Standards with description	Not included
Jordanian Nursing Council	2017	Jordan	Standards, with core competency and measurement criteria	Framework and overview of process provided.
Norwegian Association of Critical Care Nurses	2017	Norway	Standards with sub-standard statement	Not included
Critical Care Association of the Philippines	2014	Philippines	Standard statements, with process, criteria, and outcome statements	Framework and overview of process provided.
Zhang et al.	2019	China	Principle Domains	Delphi study with documented process
Gill et al.	2017	Australia	Domains with standard statements	Mixed-method study with Delphi process
Chamberlain et al.	2018	Australia	Standards with substandard statements	Published research process
World Federation of Critical Care Nurses	2020	International	Position statements with central principles	Described process.
Bloomer et al.	2022	Australia	Standards with substandard statements	Framework and overview of process provided.

Table 3

Key Topics Addressed in Standards

Author/ Organization	Key Concepts Included								
	Education	Ethical Expectations	Patient Care	Advocacy	Leadership	Evidence	Communication	Staffing	Practice Environments
Critical Care Services Ontario	X	X	X						X
New Zealand College of Critical Care Nurses	X								
American Association of Critical Care Nurses	X	X	X	X	X	X	X		
Australian College of Critical Care Nurses		X	X		X				
British Intensive Care Society								X	
European Federation for Critical Care Nursing Associations	X	X	X		X	X	X		X
Intensive Care Society of Ireland			X		X			X	X
Jordanian Nursing Council	X	X	X	X	X	X	X		
Norwegian Association of Critical Care Nurses	X	X			X	X			
Critical Care Association of the Philippines	X	X	X	X	X	X	X	X	
Zhang et al.	X	X	X	X	X		X		
Gill et al.		X	X	X	X				
Chamberlain et al.	X		X					X	X
World Federation of Critical Care Nurses	X								
Bloomer et al.			X		X				

(X = Topic covered in document)

The findings from this scoping review provide the evidence base for the modified Delphi process guiding the sixth edition of CACCN's Standards. The variation in frameworks across the literature underscores the importance of adopting a transparent and replicable methodology—combining the scoping review with the Delphi approach—to ensure credibility in the Canadian revision process. At the same time, the breadth of domains identified internationally supports the development of comprehensive standards that extend beyond clinical competencies to encompass leadership, advocacy, and ethical practice. Notably, gaps observed in existing standards, such as limited attention to evidence generation and communication, highlight opportunities for Canadian standards to lead by example. By synthesizing these diverse approaches, this review ensures that the CACCN revision process is firmly grounded in international evidence while remaining responsive to the Canadian context.

Discussion

The scoping review highlights the considerable variation in both the frameworks used to develop critical care nursing standards and the domains prioritized across international sources, as seen by Table 3. While some standards were developed through structured methodologies such as modified Delphi studies or systematic literature reviews, others relied primarily on expert consensus or position statements with limited methodological transparency. This inconsistency underscores the absence of a universally applied framework for standards development and reinforces the importance of adopting a transparent, replicable process for the Canadian context. By combining a systematic scoping review with a modified Delphi, the CACCN revision process directly addresses this gap, ensuring that the sixth edition of the Standards is both evidence-informed and methodologically rigorous.

Comparisons across the 15 sources revealed that education, ethical expectations, and patient care were consistently emphasized, whereas domains such as leadership, advocacy, evidence generation, and communication were less frequently represented. This imbalance suggests that while foundational competencies are widely recognized, broader aspects of professional practice remain underdeveloped in many jurisdictions. For Canada, this presents an opportunity to lead by example: integrating underrepresented domains into the revised Standards will not only strengthen the comprehensiveness of the framework but also align with the evolving role of critical care nurses as leaders, advocates, and contributors to evidence-based practice.

The international variation in domains and development processes have direct implications for the Canadian revision. These findings confirm the need for a comprehensive framework that integrates both foundational competencies and underrepresented areas such as evidence generation, communication, and interprofessional collaboration. Incorporating these domains into the CACCN Standards strengthens their relevance within Canada while contributing to broader international efforts toward greater alignment in critical care nursing practice.

Looking forward, the integration of diverse frameworks and domains into the modified Delphi process will ensure that the revised Standards are responsive to both Canadian healthcare needs and global trends. Future work should continue to evaluate the implementation and impact of these Standards, exploring how they influence patient outcomes, nurse retention, and professional development. By embedding methodological transparency and inclusivity into the revision process, Canada can establish a replicable model for standards development that promotes consistency, credibility, and high-quality care across critical care settings.

While this review highlights the lack of consistency across international standards, the question of whether a universal approach is required remains complex. A single global framework may not be feasible given the diversity of healthcare systems, regulatory environments, and cultural contexts. Instead, what is needed is a standardized methodological process for developing standards, such as the combination of scoping review and modified Delphi, paired with flexibility in content to reflect local practice environments. This balance ensures credibility and transparency while allowing adaptation to unique patient populations and system structures. For Canada, the scoping review provides the evidence base that will directly inform the modified Delphi process, ensuring that the sixth edition of CACCN's Standards is comprehensive and methodologically rigorous. By grounding the revision in international evidence while tailoring domains to Canadian priorities, this process strengthens national practice while contributing to broader conversations about harmonization. In this way, the scoping review not only supports the CACCN revision but also offers a replicable model for other jurisdictions seeking to balance standardization with contextual flexibility.

Limitations

This scoping review has several limitations that should be acknowledged. First, while the research protocol was developed a priori and modelled on JBI methodology, it was not formally registered in a public repository, which may limit external verification of the process. Second, the search strategy was restricted to English and French language sources, potentially excluding relevant standards published in other languages. Third, although grey literature was systematically sought through targeted searches of critical care associations, unpublished or inaccessible standards may not have been captured. Fourth, consistent with scoping review methodology, included sources were not appraised for methodological quality, which may affect the strength of the evidence underpinning some standards. Finally, the review was limited to literature published between 2017 and 2022 to align with the timeline of the CACCN's fifth edition standards; while this ensured relevance to the current revision process, it may have excluded earlier standards that remain influential in some contexts.

Conclusion

The findings from this scoping review provide an overview of existing published peer-reviewed literature as all as public-facing grey literature that specifically outlines standards for critical care nursing practice globally. This literature highlights the current landscape of critical care nursing standards, potentially identifying areas that require attention in Standards development for CCNs, such as baseline education, ethical practices, patient care, and leadership. By synthesizing this diverse range of topics that are addressed in Standards globally, the scoping review offers valuable insights into the priorities and expectations that shape critical care nursing practice. Furthermore, the review emphasizes the importance of developing a standardized methodological framework for revising standards, ensuring they are evidence-based and aligned with the best available research and expert consensus. Such a framework will enhance the quality and credibility of critical care nursing standards, promoting consistency and clarity in nursing roles and responsibilities.

In conclusion, this scoping review identified all published standards relevant to critical care nursing, thereby establishing the evidence base for the modified Delphi process that will guide the revision of the CACCN's Standards for Critical Care Nursing Practice. By documenting a transparent search strategy and inclusion criteria, this review ensures that the standards development process is both replicable and grounded in the full scope of literature available. This methodological foundation supports the goal of ensuring that critical care nursing practice in Canada remains responsive to the evolving needs of patients, healthcare professionals, and the broader healthcare environment. Through continuous evaluation and improvement, these Standards will contribute to high-quality, patient-centered care and better outcomes for critically ill patients and their families in Canada.

Author notes

Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), Fraser Health Authority, Langley, British Columbia

Brandi Vanderspank-Wright, PhD, RN CNCC(C), Faculty of Health Sciences, University of Ottawa, Ottawa, Ontario

Amanda Ross-White, MLIS, AHIP, Bracken Health Sciences Library, Queen's University, Kingston, ON and JBI Queen's Collaboration for Health Care Quality, University of Adelaide, Australia

Corresponding author:** Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), Fraser Health Authority, Langley, British Columbia Email: **sarah.crowe@fraserhealth.ca

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Revising the Canadian Standards of Critical Care Nursing Practice 6th Edition: Part 2 – A Modified Delphi Process

Brandi Vanderspank-Wright, PhD, RN, CCNC(C,) and Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), for the Canadian Association of Critical Care Nurses – National

Abstract

Background: *The Canadian Association of Critical Care Nurses (CACCN) establishes the national standards of practice, to guide safe, competent, and evidence-informed critical care nursing practice, which are reviewed regularly to ensure they remain current and responsive to emerging evidence. Previous revisions lacked a standardized methodology, prompting this study to employ a Modified Delphi process to revise the Standards for Critical Care Nursing Practice (6th edition).*

Methods: *An expert panel of Canadian critical care nurses (≥5 years' experience) was recruited to ensure representation across provinces, care settings, and patient populations. Three Delphi rounds, with a fourth for peer review, were conducted using secure online surveys. The overarching standard of practice statements along with sub-standard statements included were generated from a previously conducted scoping review. Standards and sub-statements were rated on a 5-point Likert scale, with consensus defined a priori as ≥75%.*

Results: *Attrition occurred across rounds, but consensus was achieved on eight overarching standards and 42 sub-statements, emphasizing accountability, evidence-informed practice, ethical care, leadership, collaboration, specialized education, and high-quality care across the illness trajectory. Protocol deviations, including stricter inclusion criteria for later rounds, were implemented to maintain rigour.*

Conclusion: *This structured, reproducible approach strengthens the validity of the revised standards and provides a framework for future updates. The findings underscore the importance of systematic, collaborative processes in defining national practice standards for critical care nursing in Canada.*

Vanderspank-Wright, B., & Crowe, S. (2026). Revising the Canadian Standards of Critical Care Nursing Practice 6th Edition: Part 2 – A Modified Delphi Process. *The Canadian Journal of Critical Care Nursing, 37*(Special Issue), 18–40. DOI: 10.5737/23688653-37sp18

Background

The Canadian Association of Critical Care Nurses (CACCN) is the national association representing critical care nurses (CCN) in Canada. Since 1992, the CACCN has set the standards of practice for Canadian CCNs. Standards of care provide legal guidance for what constitutes "safe and appropriate patient care" (Shapiro, 2019, p.102); nurses "are obligated to provide knowledgeable, competent, and safe care and act in the best interests of their patients" (Shapiro, 2019, p.101). Standards of practice also "delineate the scope, function, and role of the nurse in practice" (Shapiro, 2019, p.102). The Standards for Critical Care Nursing Practice (CACCN, 2017) are used to guide and to provide a resource for CCNs to ensure the best practices are utilized in critical care units. The Standards provide broad, overarching guidance that is then individualized at the unit level to ensure high quality care is provided to all patients, families and substitute decision makers accessing critical care in Canada.

The most recent Standards were revised in 2017, after undergoing the fifth review since inception. Historically, the Standards were developed utilizing literature reviews and expert nurse input in the past (Kidd et al., 1987). Although previous revisions constituted a robust review of literature and contemporary practice, with the exception of the first published standards, there has not been a defined, standardized methodological process applied to their development, review or revision. Therefore, the aim of this 6th revision of the Standards, was to use a Modified Delphi process to provide a structured, anonymous collaboration among expert Canadian CCNs. Given the volunteer nature of the Association whereby there is turnover of the National Board and committees, this approach was devised to provide CACCN National a process to move forward and modify as necessary overtime. The associated protocol was published in the Canadian Journal of Critical Care Nurses (Vanderspank-Wright et al., 2023). The following describes the Modified Delphi process and outcomes in detail. Where appropriate, protocol deviations are identified, described and an associated rationale provided.

Design and Methods

Design

A Modified Delphi (Keeney et al., 2011) study was conducted and guided by the study protocol (Vanderspank-Wright et al., 2023).

Sample – Expert Panel Composition

To ensure adequate representation of critical care nursing practice experience and expertise, we anticipated the recruitment of an expert panel of approximately 107 participants. Our original sample size estimation included an effort to ensure maximum variation (e.g., nursing roles); provincial and territorial representation; representation from rural, remote, community and academic centres; as well as adult, pediatric, and neonatal clinical contexts. We also anticipated attrition during each

round. Further, we aimed to ensure CACCN National Board of Directors members representation in the Delphi sample but excluded the primary authors. All participants who expressed interest were invited to participate.

Recruiting Expert Panel Members

To recruit expert panel members, CACCN National Office sent an email to current CACCN members (as of November 2022) with a link to express an interest in participating. The link corresponded to a secure Survey Monkey platform where the following information was requested: 1) confirmation of CACCN membership; 2) confirmation of a minimum of 5 years of critical care experience; 3) an expression (yes/no) of interest in participating in the revision of the Standards; 4) an email address for contact; 5) creation of a four-digit code that would be used for future survey participation; along with pertinent demographic information (province or territory of current practice; description of hospital setting; patient population; role in critical care; range of years of experience).

For a participant to continue to partake in subsequent rounds they had to have completed the previous round (this would apply to all but Round 1). We tracked participation based on the four-digit code created by participants. This resulted in the following process: expressions of interest were received; from the expressions – an invitation to participate in Round 1 was sent. Those who participated in Round 1 were invited to Round 2. This same process continued, albeit with attrition, through to Round 4.

Data Collection – Delphi Rounds

Using the online survey platform, Survey Monkey (secured and licensed by the University of Ottawa), we aimed to complete three rounds of consultations with participants, with a fourth round being conducted only if necessary. Each round was 6 weeks in duration and followed Dillman's Total Design for Survey Research (1978) for survey distribution and reminders. An email with the electronic survey link was sent to all participants who had completed a round, and reminders were sent in weeks 2 and 4. Other than the original email sent by CACCN for expressions of interest, all further email communications were sent by the study leads (BVW, SC). Attrition was captured for each round.

All standards of practice statements were rated for the purpose of achieving consensus, using a 5-point Likert scale defined as follows: ***1 – Not Applicable, 2 – Not At All Important, 3 – Somewhat Important***, ***4 – Important***, and ***5 – Essential***. Consensus was established a priori as 75% based on recommendations from Foth et al. (2016).

In **Round 1**, we focused on the overarching standards statements and themes that were retrieved from the scoping review of literature conducted (Crowe et al., 2026). In this process, all overarching statements were extracted from the included manuscripts/standards documents and using a process of aggregation, like statements were combined into a theme (See Figure 1). In Round 1, overarching statements that were ranked at 4 and 5 with a minimum of 75% consensus (Important and Essential) were moved forward to Round 2. Participants were also given the opportunity to identify missing elements that should be included/considered for inclusion in the revised Standards through an open-ended question format.

In **Round 2**, all sub-standards associated with the overarching statements were included from those categories that were rated 4–5 with a 75% consensus in Round 1. Each sub-standard was rated. In this round, any substandard with a rate of 5 and a corresponding 75% consensus was moved forward to Round 3. This represented a protocol deviation and is explained in the corresponding section of this manuscript.

In **Round 3**, only sub-standards rated at 5 with a 75% consensus from the previous round were included. For this round only sub-standards rated at 5 with a consensus of 75% were included in the final list of sub-standards that would constitute the draft Standards.

Ultimately, we completed a fourth round of consultation with expert panel participants. While this was a protocol deviation, this was done to ensure that the draft of the standards received an element of peer-review. For this final round we prepared, via Survey Monkey, a final questionnaire including the eight standards and their sub-standards. The expert panel was asked to determine whether or not the proposed sub-standards were appropriate, inappropriate, or not needed for the overarching statement. The intent of this questioning was not to determine whether the sub-standard would or would not be included, because this was determined through the consensus process. Rather, we wanted to ensure a best-fit of the sub-standard statement to the overarching standard statement it was listed under. If deemed inappropriate or not needed, a corresponding text-box was included where participants were asked to provide an associated rationale for their recommendation. To manage the

Figure 1

Processes Related to Overarching Standard Statements & Sub-Standard Statements

feedback and maintain a consensus orientated process, only instances where >75% of expert panel members identified a concern with the same statement were addressed. While the authors have reported this section under methods, it yielded no change and the eight overarching statements and accompanying sub-standard statements were accepted.

Data Analysis

Data collected in each Delphi round were analyzed using descriptive statistical methods (N, %). Open ended Reponses from Round 1 were carefully reviewed and cross-referenced with standard and sub-standard statements to ensure they were reflected in the final Delphi round.

Ethical Considerations

Implied consent was obtained from all participants at the beginning of each Delphi Round as part of the electronic survey. A copy of the implied consent text is available on request to the authors or to CACCN National. Participants created a 4-digit identifier that was used as their unique participant code to track participation across the Delphi rounds. A master list of participants and codes has been kept separately from the data and is housed on the uOttawa secure SharePoint server. Only the principal investigators (BVW and SC) will retain access to the master list.

Data will be kept until the next CACCN Standards revision. Following publication of the 7th edition of the Standards, the data will be safely destroyed.

Results

Expert Panel Composition

From the initial expressions of interest in participating, a total of 76 participants accessed the corresponding link and ultimately n = 72 individuals met the inclusion criteria required of the expert panel and n = 69 provided complete demographic information. Figure 2 represents the outcomes of the expressions of interest and Table 1 represents the initial demographics of the sample.

Results from Round 1

An invitation to participate was sent to all those who expressed an interest in participating in the modified Delphi study. Of the 72 emails received, a total of 69 individuals consented to participate in Round 1; however, of the 69 who consented, only 42 provided ratings on the overarching standard statements. Table 2 represents the findings from Round 1. As evidenced from the data provided, all overarching statements moved forward to Round 2 given ratings of "Very Important" or "Essential" at greater than 75%. No statement was identified as Not Applicable by participants. Data from the open-ended response in Round 1 were incorporated into the final peer-reviewed round and are discussed therein.

Figure 2

Expression of Interest

Table 1

Initial Demographics Expert Panel Expressions of Interest

Variable	*n* (%) (N=69)
Province of Territory of Practice	
British Columbia	8 (11.59)
Alberta	9 (13.04)
Saskatchewan	2 (2.90)
Manitoba	2 (2.90)
Ontario	28 (40.58)
Quebec	8 (11.59)
New Brunswick	3 (4.35)
Nova Scotia	7 (10.14)
Prince Edward Island	0 (0)
Newfoundland & Labrador	0 (0)
Yukon	0 (0)
Northwest Territories	1 (1.45)
Nunavut	1 (1.45)
Hospital Descriptor	
Rural	6 (8.70)
Community	23 (33.33)
Remote/Northern Community	2 (2.90)
Health Centre	38 (55.07)
Academic Centre/Teaching Hospital	
Patient Population	
Neonatal	0 (0)
Pediatric	3 (4.35)
Adult	59 (85.51)
Mixed Ages	7 (10.14)
Role in Critical Care	
Clinical Nurse/Staff Nurse	31 (44.93)
Clinical Nurse Educator	18 (26.09)
Clinical Nurse Specialist	4 (5.80)
Nurse Manager	3 (4.35)
Assistant Manager	2 (2.90)
Advanced Practice Nurse	3 (4.35)
Critical Care Nurse Practitioner	0 (0)
Professor/Faculty with Focus on Critical Care	8 (11.59)
Years in Critical Care	
5–9	15 (22.73)
10–14	22 (33.33)
15–19	8 (12.12)
20–24	13 (19.70)
>25	8 (12.12)

Table 2

Round 1: Overarching Statements

Statement	Not At All Important n (%)	Somewhat Important *n* (%)	Important *n* (%)	Essential *n* (%)	Total N
1. CCNs provide high-quality care across all transitions in the critical illness trajectory – admission through to survivorship or bereavemen	0 (0.00)	1 (2.38)	3 (7.14)	38 (90.48)	42
2. CCNs utilize evidence to inform their practice.	0 (0.00)	0 (0.00)	3 (7.14)	39 (92.86)	42
3. CCNs contribute to critical care nursing research & knowledge development.	0 (0.00)	4 (9.52)	21 (50.00)	17 (40.48)	42
4. CCNs demonstrate leadership qualities	0 (0.00)	2 (4.76)	21 (50.00)	19 (45.25)	42
5. CCNs recognize when organizational leadership practice does or does not align with critical care practice.	0 (0.00)	5 (11.90)	15 (35.71)	22 (52.38)	42
6. CCNs engage in ethical practice.	0 (0.00)	0 (0.00)	3 (7.14)	39 (92.86)	42
7. CCNs demonstrate accountability for their own professional practice.	0 (0.00)	0 (0.00)	3 (7.14)	39 (92.86)	42
8. CCNs utilize clear, effective communication in their practice.	0 (0.00)	0 (0.00)	9 (21.43)	33 (78.57)	42
9. CCNs engage in collaboration with all care providers involved in the care of critically ill patients.	0 (0.00)	0 (0.00)	4 (9.52)	38 (90.48)	42
10. CCNs advocate for a safe working environment.	0 (0.00)	0 (0.00)	9 (21.43)	33 (78.57)	42
11. CCNs advocate for responsible human resource utilization in critical care.	0 (0.00)	0 (0.00)	19 (45.24)	23 (54.76)	42
11. CCNs advocate for responsible critical care resource utilization including facilities, equipment, & technology.	0 (0.00)	3 (7.14)	19 (45.24)	20 (47.62)	42
12. CCNs advocate for strong leadership of critical care environments and teams.	0 (0.00)	1 (2.38)	13 (30.95)	28 (66.67)	42
13. CCNs advocate for safe, acuity-based staffing.	0 (0.00)	1 (2.38)	7 (16.67)	34 (80.95)	42
14. CCNs require specialized training provided by experts.	0 (0.00)	0 (0.00)	4 (9.52)	38 (90.48)	42
15. CCNs engage in ongoing education to maintain competence.	0(0.00)	0 (0.00)	8 (19.05)	34 (80.95)	42
16. CCNs demonstrate a commitment to life-long learning.	0 (0.00)	0 (0.00)	14 (33.33)	28 (66.67)	42
17. CCNs advocate for practice transition support at all levels of experience.	0 (0.00)	2 (4.67)	23 (54.76)	17 (40.48)	42
18. CCNs utilize the nursing process to deliver high-quality critical care.	0 (0.00)	0 (0.00)	16 (38.10)	26 (61.90)	42
19. CCNs advocate for patient- and family-centred care based on current recommendations.	0 (0.00)	0 (0.00)	16 (38.10)	26 (61.90)	42
20. CCNs demonstrate awareness of complication/ iatrogenic harm that may arise during or from critical illness.	0 (0.00)	1 (2.38)	7 (16.67)	34 (80.95)	42
21. CCNs provide high-quality care across all transitions in the critical illness trajectory – admission through to survivorship or bereavement.	0 (0.00)	0 (0.00)	7 (16.67)	35 (83.33)	42

*Highlighted columns reflect consensus of >75% at a ranking of 3 or 4 (Important or Essential)
**N/A = Not applicable

Results from Round 2

As indicated, all overarching statements included in Round 1 met criteria for Round 2 inclusion (≥75% consensus at a rating of 3 or 4). This resulted in all related sub-standards being incorporated into Round 2 of consensus. As a result, this round was much more involved for participants. At the outset, 21 overarching statements and a total of 270 sub-standards required a rating. It is presumed that due to the length of the survey, we saw participant attrition. Initially, there was an N = 32 who completed assessment of statement 1. At statement 2, there was attrition of five participants (N = 27), with a final N = 26 (attrition of 1 other participant) beginning at statement 3 and through all remaining statements in the survey. The results of Round 2 are available as a supplemental document on request to the authors or CACCN. At the conclusion of the Round, only 27 sub-statements did not meet the threshold of ≥75%. Given this finding, a protocol deviation was established for Round 3 (reported under Protocol Deviations).

Results from Round 3

In Round 3, a total of 21 overarching statements and an accompanying 243 sub-statements were rated by expert panel participants. Attrition during this round was as follows: N = 18 participants began the survey, N = 16 participants rated the overarching statements 1 and 2, N = 15 participants continued to rate the remaining statements.

From Round 3, all statements identified at "Essential" and over 75% consensus were moved forward into a final fourth round and peer-review component. In total, 8 overarching statements and corresponding sub-statements (N = 41) were assessed (See Table 3). Statements that moved forward are provided in Table 4. In this last consensus round, it is possible that deviations are noted from wording in Table 4 and from the final Standards document. This is possible for the following reasons: a verbatim statement reflected in a published document moved forward, or a substandard statement was moved to another standard that was more reflective of its meaning. In this next-to-final version, we also reflected on open-ended feedback received during the first round to assess whether the feedback was captured or could meaningfully be incorporated into a statement already in use. Examples included but are not limited to principles of patient autonomy, staff-wellbeing, equity, diversity and inclusion, and mentorship.

Protocol Deviations with Associated Rationales

In the recruitment phase of the Delphi, rather than make use of a generic email to receive expressions of interest, we proceeded to send an email via CACCN National with a link to an online questionnaire (Interest in Participate Questionnaire). All responses were kept confidential. Between Rounds 2 and 3, we made a decision to include only statements rated at 5 (Essential) with a >75% consensus to move forward into the final round of peer-review. This decision was made due to responses received in Round 2, whereby all statements received a rating of 4 (Very Important) or 5 (Essential) at a >75% consensus. We maintained this approach through the final peer-reviewed round. The final, Round 4, was, in itself, a protocol deviation. This was not conceived in the original protocol; however, it had utility. It provided a final consensus process and helped to ensure that the Standards were acceptable to the expert panel. These Standards were later presented to the membership of the CACCN at the 2024 Canadian Critical Care Nursing Conference.

Strengths and Limitations

The methods used to revision the CACCN Standards of Critical Care Nursing Practice have resulted in a reproducible approach for subsequent revision. Using a systematic approach for retrieving published, peer-reviewed international critical care nursing standards in addition to the grey literature included (see Crowe & Vanderspank-Wright for CACCN, Under Review), has facilitated both national and international perspectives specific to critical care nursing standards of practice offering a broad but also Canadian-centric lens. Limitations include attrition that is associated with the Delphi process. The latter may have resulted in lack of representation from provinces as well as the territories. Potential mitigation strategies might include consultation with the National Board of Directors and active chapters to provide suggestions on yielding a diverse and meaningful representation from all provinces and territories, including critical care nursing roles in their respective contexts. There was no neonatal representation in the expert panel group from the time of expressions of interest and a very limited number of pediatric representatives (N = 3 in the expressions of interest). Consultations with this subset of CACCN membership and, perhaps, their like Associations may be of benefit. Further, as Artificial Intelligence and technological advancement continues, these tools may be considered for utility in the standards revisions processes.

Conclusion

This manuscript presents the results of a modified Delphi process that was used to revise the CACCN Standards for Critical Care Nursing Practice. It provides a systematic and reproducible approach for subsequent standards revision for the CACCN.

Author notes

Brandi Vanderspank-Wright, PhD, RN, CNCC(C), Faculty of Health Sciences, University of Ottawa, Ottawa, Ontario

Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C), Fraser Health Authority, Langley, British Columbia

Corresponding author: *Brandi Vanderspank-Wright, PhD, RN, CNCC(C), Faculty of Health Sciences, University of Ottawa, Ottawa, Ontario*
Email: bvanders@uottawa.ca

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Table 3

Round 3 Results

Overarching Statement *Sub-standards**	Not At All Important *n* (%)	Somewhat Important	Important	Essential	Total N
1. CCNs demonstrate accountability for their own professional practice.					
1.1 The CCN clinical practice is focused on improving quality of care	0 (0.00)	2 (12.5)	6 (37.50)	8 (50.00)	16
1.2 The CCN describes clinical problems using evidence generated within a clinical setting, such as patient assessment data, outcomes management, and quality-improvement data.	1 (6.25)	0 (0.00)	2 (12.50)	13 (81.25)	16
1.3 The CCN evaluates practice and trends data.	0 (0.00)	1 (6.25)	7 (43.75)	8 (50.00)	16
1.4 The CCN evaluates and implements practice changes based on processes and patient outcomes.	0 (0.00)	0 (0.00)	6 (37.50)	10 (62.50)	16
1.5 The CCN participates in quality improvement activities.	0 (0.00)	1 (6.25)	11 (68.75)	4 (25.00)	16
1.6 The CCN obtains and maintains professional certification.	0 (0.00)	3 (18.75)	8 (50.00)	5 (31.25)	16
1.7 The CCN identifies and develops strategies to enhance quality care and promote healthy work environments.	0 (0.00)	2 (12.50)	9 (56.25)	5 (31.25)	16
1.8 The CCN fosters an interprofessional approach to integrating safety into practice.	0 (0.00)	1 (6.25)	6 (37.50)	9 (56.25)	16
1.9 The CCN uses systematic observation and assessment to identify an elevated risk or actual health decline at an early stage and implement measures to prevent further deterioration.	0 (0.00)	0 (0.00)	2 (12.50)	14 (87.50)	16
1.10 The CCN conducts a professional, complete systematic patient assessment.	0 (0.00)	0 (0.00)	1 (6.25)	15 (93.75)	16
1.11 The CCN promotes patient wellness through the use of appropriate technology.	0 (0.00)	0 (0.00)	8 (50.00)	8 (50.00)	16
1.12 The CCN implements medical treatment in collaboration with the patient's medical team, assuming joint responsibility for safe and appropriate treatment	.0 (0.00)	0 (0.00)	2 (12.50)	14 (87.50)	16
1.13 The CCN ensures patient safety through routine equipment and alarm checks/verification.	0 (0.00)	0 (0.00)	3 (18.75)	13 (81.25)	16
1.14 The CCN recognizes significant others of patients as a resource for the patient, providing information, guidance and support for them to facilitate participation in the care of the patient.	0 (0.00)	1 (6.25)	3 (18.75)	12 (75.00)	16

2. CCNs utilize evidence to inform their practice.					
2.1 The CCN consults with colleagues, subject matter experts, and identified stakeholders to initiate changes in nursing practice and the healthcare delivery system.	0 (0.00)	1 (6.25)	10 (62.50)	5 (31.25)	16
2.2 The CCN conducts and participates in quality improvement activities, taking into consideration patient and family beliefs, values, and preferences.	0 (0.00)	1 (6.25)	10 (62.50)	5 (31.25)	16
2.3 The CCN ensures patient confidentiality in reporting any quality data.	0 (0.00)	1 (6.25)	3 (18.75)	12 (75.00)	16
2.4 The CCN evaluates practice in an ongoing process, based on best evidence.	0 (0.00)	0 (0.00)	5 (31.25)	11 (68.75)	16
2.5 The CCN participates in the development, implementation, evaluation, and revision of policies, procedures, and/or guidelines to improve the quality and effectiveness of nursing practice.	0 (0.00)	2 (12.50)	8 (50.00)	6 (37.50)	16
2.6 The CCN uses creativity and innovation to enhance quality nursing care.	0 (0.00)	3 (18.75)	6 (37.50)	11 (43.75)	16
2.7 The CCN demonstrates quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner and in a clear and retrievable format.	0 (0.00)	0 (0.00)	6 (37.50)	10 (62.50)	16
2.8 The CCN participates in interprofessional quality-improvement committees which may focus on implementing practice changes or developing care process models, protocols, or order sets.	0 (0.00)	5 (31.25)	6 (37.50)	5 (31.25)	16
2.9 The CCN assists with quality-improvement audits which evaluate process measures proven to improve clinical outcomes.	0 (0.00)	3 (18.75)	7 (43.75)	6 (37.50)	16
2.10 The CCN maintains patient care standards to ensure that the same quality and level of care are provided across the continuum of care.	0 (0.00)	0 (0.00)	4 (25.00)	12 (75.00)	16
2.11 The CCN queries the interprofessional team to assess barriers to providing quality care.	0 (0.00)	0 (0.00)	6 (37.50)	10 (62.50)	16
2.12 The CCN consistently reports perceived barriers to the leadership team.	0 (0.00)	0 (0.00)	5 (31.25)	11 (68.75)	16
2.13 The CCN consults with peers and other hospital systems to determine if alternate innovative strategies could be applied to achieve quality outcomes.	1 (6.25)	3 (18.75)	7 (43.75)	5 (31.25)	16
3. CCNs contribute to critical care nursing research & knowledge development.					
3.1 The CCN questions current practices.	0 (0.00)	1 (6.67)	7 (46.67)	7 (46.67)	15
3.2 The CCN identifies opportunities to improve practice.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
3.3 The CCN considers current research and experts to help inform and develop practice policies.	0 (0.00)	2 (13.33)	7 (46.67)	6 (40.00)	15
3.4 The CCN maintains current knowledge and practice.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15

3.5 The CCN implements best practice standards to improve patient outcomes.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
3.6 The CCN involves additional experts as needed to support patient outcomes.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
3.7 The CCN utilizes appropriate technology to support patient outcomes.	0 (0.00)	1 (6.67)	7 (46.67)	7 (46.67)	15
3.8 The CCN collaborates with educational institutions to ensure optimal learning environments and mentorship.	0 (0.00)	4 (26.67)	4 (26.67)	7 (46.67)	15
3.9 The CCN engages with and supports a nurse researcher role within the organization to identify, promote and conduct research to improve patient care.	0 (0.00)	3 (20.00)	4 (26.67)	8 (53.33)	15
4. CCNs demonstrate leadership qualities.					
4.1 The CCN promotes and maintains a healthy work environment.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
4.2 The CCN provides leadership through mentorship and other professional development strategies.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
4.3 The CCN demonstrates flexibility and responsiveness to rapidly changing patient needs.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
4.4 The CCN participates on committees, councils, interprofessional teams, and participates in professional organizations.	0 (0.00)	3 (20.00)	6 (40.00)	6 (40.00)	15
4.5 The CCN develops a culture of safety for patients, families and the interprofessional team.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
4.6 The CCN promotes development and implementation of innovative solutions.	1 (6.67)	3 (20.00)	6 (40.00)	5 (33.33)	15
5. CCNs recognize when organizational leadership practice does or does not align with critical care practice.					
5.1 The CCN practices self-reflection and seeks feedback from others in the health care team to monitor own practice.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
5.2 The CCN constantly engages in learning to meet areas for improvement.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
5.3 The CCN provides constructive feedback to others either formally or informally.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
5.4 The CCN in consultation with relevant staff, addresses poor workplace behaviours that affect patient outcomes and team performance.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
5.5 The CCN provides formal and informal mentorship to student learners and other nurses	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
5.6 The CCN contributes to local training and education strategies.	1 (6.67)	0 (0.00)	6 (40.00)	8 (53.33)	15
5.7 The CCN participates in a professional organization that has direct benefit for critical care practice.	0 (0.00)	1 (6.67)	9 (60.00)	5 (33.33)	15

5.8 The CCN promotes critical care to novices and students of nursing.	1 (6.67)	0 (0.00)	6 (40.00)	8 (53.33)	15
5.9 The CCN acts as a leader and positive role model for peers and other members of the health care team.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
5.10 The CCN promotes a safe working environment.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
5.11 The CCN promotes system changes to encourage innovation and improved patient care.	0 (0.00)	3 (20.00)	7 (46.67)	5 (33.33)	15
6. CCNs engage in ethical practice.					
6.1 The CCN engages in self-evaluation and reflective practice on a regular basis, identifying areas of strength as well as areas where professional growth would be beneficial.	0 (0.00)	0 (0.00)	5 (33.33)	10 (67.67)	15
6.2 The CCN takes action to achieve goals identified in the evaluation process.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
6.3 The CCN obtains feedback regarding his/her own practice from patients, families, peers, and professional colleagues.	0 (0.00)	1 (6.67)	4 (26.67)	10 (67.67)	15
6.4 The CCN practice is guided by provincial and / or national code of ethics.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
6.5 The CCN promotes ethical accountability and integrity in relationships, organizational decisions, and stewardship of resources.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
6.6 The CCN protects patient confidentiality within legal and regulatory parameters.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
6.7 The CCN advocates for the concerns of patients, their families, and the community.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
6.8 The CCN delivers care in a nonjudgmental and nondiscriminatory manner that meets the diverse needs of the patient, family, and community.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
6.9 The CCN maintains patient autonomy, dignity, values, beliefs, and rights at all times.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
6.10 The CCN uses available resources in formulating ethical decisions.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
6.11 The CCN demonstrates a commitment to self-care and self-advocacy.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
6.12 The CCN reports unethical, illegal, incompetent, or impaired practices.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
6.13 The CCN assists patients and family in self-determination and informed decision-making.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
6.14 The CCN maintains a therapeutic and professional nurse/patient relationship within appropriate role boundaries.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
6.15 The CCN contributes to resolving ethical issues involving the patient, family, and interprofessional team.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15

6.16 The CCN questions healthcare practice when necessary for safety and quality improvement.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
6.17 The CCN collaborates with the interprofessional team to promote palliative care or end-of-life discussions, decisions, and care.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
6.18 The CCN promotes understanding of care plans, goals of care, advance directives with peers, patients, patient families, and community.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
6.19 The CCN adopts occupational health and safety standards relevant to critical care practice.	0 (0.00)	0 (0.00)	8 (53.33)	7 (46.67)	15
6.20 The CCN ensures that colleagues are aware of their responsibilities and accountability in relation to the legal implications for nursing practice in common critical care situations.	0 (0.00)	1 (6.67)	7 (46.67)	7 (46.67)	15
6.21 The CCN acts as a role model within the health care team.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
6.22 The CCN promotes the adoption of standards for critical care nurse practice i.e. workforce, education.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
6.23 The CCN recognizes the need for and adopts strategies to facilitate critical care communication by utilizing a structured approach to documenting and communicating in the critical care setting.	0 (0.00)	2 (13.33)	5 (33.33)	8 (53.33)	15
6.24 The CCN understands the requirement to maintain 'open disclosure' and 'freedom of information' while proactively working to protect the patient and family from harm.	0 (0.00)	3 (20.00)	4 (26.67)	8 (53.33)	15
6.25 The CCN utilizes and accesses different sources of evidence when making complex decisions: considers the patient or family's preference towards their treatment and interventions; understands the research process, the importance of evidence-based practice & can demonstrate critical appraisal of literature.	0 (0.00)	4 (26.67)	4 (26.67)	7 (46.67)	15
6.26 The CCN effectively communicates, guides and supports patients, families or significant others during their critical illness; can break bad news in a sensitive & compassionate manner; can communicate effectively in complicated situations, i.e. dealing with conflict, resolving aggression.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
6.27 The CCN recognizes the need and is able to participate in peer support and debrief colleagues.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
6.28 The CCN effectively maintains patient records or documentation in a systematic and chronological manner, in accordance with best practice and associated legislation.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15

7. CCNs demonstrate accountability for their own professional practice.					
7.1 The CCN actively seeks feedback on practice from others in the health care team, and from patients and their families.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
7.2 The CCN uses reflection to assess and identify areas for improvement in own practice.	0 (0.00)	1 (6.67)	2 (20.00)	11 (73.33)	15
7.3 The CCN takes actions to improve and enhance own practice to maintain a consistent high standard.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
7.4 The CCN seeks clarification on unclear instructions and questions interventions to ensure safe outcomes.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
7.5 The CCN engages in self-reflection, performance appraisal, and peer review to ensure competent professional practice.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
7.6 The CCN complies with the credentialing and privileging process within the organization or system.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
7.7 The CCN evaluates role performance according to professional practice standards, institutional guidelines, and relevant statutes and regulations.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
7.8 The CCN reflects on self and staff competence and keeps her/him and staff up to date with current health issues and health care trends in the dynamic environment like critical care nursing.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
8. CCNs utilize clear, effective communication in their practice.					
8.1 The CCN assesses communication format preferences of critically ill patients, families, and the interprofessional team.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
8.2 The CCN practices interprofessional communication skills and reflects upon personal communication style including the need for interpreters.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
8.3 The CCN solicits feedback to improve own communication and conflict-resolution skills.	0 (0.00)	1 (6.67)	7 (46.67)	7 (46.67)	15
8.4 The CCN conveys accurate information to critically ill patients, families, and the interprofessional team.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
8.5 The CCN questions the rationale supporting care processes and decisions with all members of the inter-professional team.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
8.6 The CCN discloses observations or concerns related to safety, hazards, and errors in care or the practice environment as appropriate.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
8.7 The CCN maintains open communication with other providers to minimize risks associated with patient handoffs, transfers, and transitions in care; including mentoring others and providing feedback.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15

8.8 The CCN exhibits respect for others' perspectives in discussions with patients, family, and the interprofessional team.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
8.9 The CCN advocates for escalation of care delivery when the needs of the patient are not met adequately.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
9. CCNs engage in collaboration with all care providers involved in the care of critically ill patients.					
9.1 The CCN partners with others to effect change and produce positive outcomes through knowledge-sharing.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
9.2 The CCN maintains appropriate professional behaviour to promote a healthy team.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
9.3 The CCN collaborates with patients and interprofessional team to promote safe patient transitions.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
9.4 The CCN engages in communication, teamwork and conflict resolution.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
9.5 The CCN updates patients and interprofessional team of current care plan and any changes.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
9.6 The CCN gains personal knowledge of interprofessional team, and organizational / community supports that are available for families.	0 (0.00)	2 (13.33)	5 (33.33)	8 (53.33)	15
9.7 The CCN promotes wellbeing and mentorship of new staff including nurses and non-nurse team members.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
9.8 The CCN respects expertise and experiences of all interprofessional team members.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
9.9 The CCN facilitates provision of clinically competent care through education, role modeling, team building, and quality monitoring.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
9.10 The CCN fosters an interprofessional approach to safety, quality improvement, evidence-based practice, research, and translation of research into practice.	0 (0.00) 2	(13.33)	4 (26.67)	9 (60.00)	15
9.11 The CCN establishes collaborative relationships within and across disciplines that promote patient safety, culturally competent care, and clinical excellence.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
9.12 The CCN leads and participates in activities such as interprofessional rounds and community health-related activities.	0 (0.00)	5 (33.33)	3 (20.00)	7 (46.67)	15
10. CCNs advocate for a safe working environment.					
10.1 The CCN assesses the individual patient needs and available resources to achieve desired outcomes.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
10.2 The CCN works collaboratively with the interdisciplinary team, delegating elements of care as appropriate.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
10.3 The CCN works collaboratively with the interdisciplinary team and patient to determine their care needs and create the plan of care.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15

Item					
10.4 The CCN ensures patient, and family are aware of care options available and appropriate information to make an informed decision.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
10.5 The CCN advocates for additional resources that enhance nursing practice and quality of care.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
10.6 The CCN minimizes environmental risk factors that may cause physical harm or injury to patients, families, and the interprofessional team.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
10.7 The CCN implements strategies to reduce the impact of environmental factors that jeopardize health, such as sound, odor, noise, and light.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
10.8 The CCN instigates appropriate debriefing after critical incidents.	0 (0.00)	2 (13.33)	4 (26.67)	9 (60.00)	15
10.9 The CCN implements strategies for overcoming conflict among members of the health care team.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
10.10 The CCN provides support for colleagues facing challenging or difficult patient care situations.	0 (0.00)	0 (0.00)	5 (33.33)	10 (67.67)	15
10.11 The CCN promotes career development and role development of nurses.	0 (0.00)	0 (0.00)	8 (53.33)	7 (46.67)	15
10.12 The CCN facilitates development of clinical judgment in healthcare team members through role modeling, teaching, coaching, and/or mentoring.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
10.13 The CCN uses defined processes for communicating errors, near misses, or patient safety concerns.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
11. CCNs advocate for responsible critical care resource utilization including facilities, equipment, & technology.					
11.1 The CCN incorporates patient care assignments on the identified patient characteristics and matches them with the clinical competency characteristics of nurses.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
11.2 The CCN uses tools and systems to determine the number and mix of staff needed at a specific time. Such systems should reflect the dynamic nature of patients in the acute and critical care setting.	1 (6.67)	1 (6.67)	6 (40.00)	7 (46.67)	15
11.3 The CCN ensures colleagues with the appropriate expertise are present to assist with care decisions, expert consultations, or care-delivery needs. Delegates aspects of care as needed to improve patient outcomes.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
11.4 The CCN collaborates with case managers and care coordinators to communicate patient/family needs and resource availability to ensure that appropriate resources are provided to the patient and family.	0 (0.00)	2 (13.33)	4 (26.67)	9 (60.00)	15
11.5 The CCN educates the patient and family on the importance of nursing interventions and discloses risks and benefits when performing bedside education.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15

12. CCNs advocate for strong leadership of critical care environments and teams.					
12.1 The CCN develops a process to delegate care activities based on the assessment of potential harm to an individual patient, complexity of task, amount of problem solving and innovation required, unpredictability of outcome, and level of patient and family participation.	1 (6.67)	4 (26.67)	3 (20.00)	7 (46.67)	15
12.2 The CCN ensures interprofessional team members are heard when voicing safety concerns.	0 (0.00)	0 (0.00)	8 (53.33)	7 (46.67)	15
12.3 The CCN promptly recognizes early warning signs and advises senior colleagues or other members of the clinical team and others as required.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
12.4 The CCN provides continuous monitoring, care and intervention for critically ill patients.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
12.5 The CCN plans and prioritizes patient care appropriately.	0 (0.00)	1 (6.67)	2 (13.33)	12 (80.00)	15
12.6 The CCN fosters open communication and collaboration.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
12.7 The CCN recognizes, reports, and acts on adverse incidents appropriately.	0 (0.00)	1 (6.67)	2 (13.33)	12 (80.00)	15
12.8 The CCN implements evidence-based guidelines and recommendations.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
12.9 The CCN maintains work-life balance and promotes mental wellbeing.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
12.10 The CCN maintains a safe working environment (including handling of physical equipment, space, and dangerous substances.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
12.11 The CCN monitors and addresses workplace wellbeing including alarm fatigue and environmental stressors.	1 (6.67)	1 (6.67)	5 (33.33)	8 (53.33)	15
12.12 The CCN ensures medication safety and appropriate delivery.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
12.13 The CCN understands and participates in patient data collection and auditing to improve outcomes.	1 (6.67)	1 (6.67)	8 (53.33)	5 (33.33)	15
13. CCNs advocate for safe, acuity-based staffing.					
13.1 The CCN advocates for safe patient ratios.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
13.2 The CCN has advanced specialized training.	0 (0.00)	1 (6.67)	2 (13.33)	12 (80.00)	15
13.3 The CCN is provided with appropriate orientation and mentorship.	0 (0.00)	0 (0.00)	4 (2.6.67)	11 (73.33)	15
14. CCNs require specialized training provided by experts.					
14.1 The CCN requires advanced specialized education and training to work in critical care areas.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
14.2 The CCN who is experienced provides new staff with supportive mentorship and preceptorship after they have completed their basic training.	0 (0.00)	0 (0.00)	3 (26.67)	11 (73.33)	15
14.3 The CCN is provided an orientation program prior to working independently in a new unit.	0 (0.00)	0 (0.00)	2 (20.00)	12 (80.00)	15

15. CCNs engage in ongoing education to maintain competence.					
15.1 The CCN participates in ongoing learning experiences and activities to develop and maintain clinical and professional skills and knowledge.	0 (0.00)	1 (6.67)	3 (30.00)	11 (73.33)	15
15.2 The CCN seeks learning opportunities that reflect current and evidence-based practice.	0 (0.00)	1 (6.67)	2 (13.33)	12 (80.00)	15
15.3 The CCN shares educational findings, experiences, and ideas with peers.	0 (0.00)	3 (20.00)	2 (13.33)	10 (66.67)	15
15.4 The CCN contributes to a work environment conducive to the education of healthcare professionals.	0 (0.00)	2 (13.33)	4 (26.67)	9 (60.00)	15
15.5 The CCN maintains professional records or a portfolio that provides evidence of competence and lifelong learning.	0 (0.00)	2 (13.33)	6 (40.00)	7 (46.67)	15
15.6 The CCN reviews own learning needs and sets realistic measurable goals to achieve these needs yearly.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
15.7 The CCN seeks out mentors where appropriate to encourage personal and professional growth.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
15.8 The CCN attends in-services and learning opportunities to ensure competence with new equipment, processes or best practice initiatives.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
15.9 The CCN identifies unit learning needs and brings this information forward to educators / management.	0 (0.00)	2 (13.33)	6 (40.00)	7 (46.67)	15
15.10 The CCN maintains competence in information and patient care technologies appropriate to role and patient population.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
15.11 The CCN is aware of how to access learning and educational opportunities/resources, which would support continuing professional development.	1 (6.67)	1 (6.67)	4 (26.67)	10 (66.67)	15
15.12 The CCN obtains and maintains specialty certification.	0 (0.00)	3 (20.00)	7 (46.67)	5 (33.33)	15
16. CCNs demonstrate a commitment to life-long learning.					
16.1 The CCN ensures all employees receive an orientation to the assigned clinical area which reflects facility-wide requirements as well as unit specific needs.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
16.2 The CCN with advanced preparation, education or experience in critical care nursing is responsible for direct patient and family-centred care.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
16.3 The CCN ensures that patient assignments are based on skills, knowledge, and ability of the critical care nurse and the patient's needs and acuity.	0 (0.00)	4 (26.67)	4 (26.67)	7 (46.67)	15

16.4 The CCN ensures that all critical care nursing personnel receive a performance appraisal, in accordance with the hospital's policies, which is based on the written job description, discussed with the staff members involved, and includes a process for the development of mutually agreed upon goals and objectives.	0 (0.00)	3 (20.00)	6 (40.00)	6 (40.00)	15
16.5 The CCN stays current with evidence informed practice changes on the unit and identifies and reports to supervisor if further skill development required.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
16.6 The CCN attends in-services and/or education to maintain clinical competency.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
16.7 The CCN promotes research, evidence-informed practice, and dissemination of best practice.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
16.8 The CCN provides leadership to other members of the critical care team by acting as a resource person & mentor.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
17. CCNs advocate for practice transition support at all levels of experience.					
17.1 The CCN actively advocates on behalf of patients and their families to ensure best practice in care is provided.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
17.2 The CCN informs and creates opportunities for input by patients and their families on critical care decisions and planning pathways.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
17.3 The CCN promotes family-centred approaches to care, including open visiting where possible and respecting cultural variations in family expectations.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
17.4 The CCN informs patients and families of their rights and responsibilities as consumers of health care services.	1 (6.67)	1 (6.67)	6 (40.00)	7 (46.67)	15
17.5 The CCN ensures informed consent is obtained for critical care procedures and advocates effectively for vulnerable patients.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
17.6 The CCN seeks to ascertain the patient's (or parent/guardian's) wishes in relation to his or her care and treatment, including extent of family involvement.	0 (0.00)	0 (0.00)	7 (46.67)	8 (53.33)	15
17.7 The CCN monitors the effectiveness of family involvement in care, including the patient's preferences and opportunities that arise for family participation.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
17.8 The CCN assesses the patient's social situation by sensitively interviewing the patient and family.	0 (0.00)	2 (13.33)	7 (46.67)	6 (40.00)	15
17.9 The CCN explores the patient's 'likes and dislikes', such as his or her preferred name, and documents and communicates these to the health care team.	0 (0.00)	2 (13.33)	6 (40.00)	7 (46.67)	15

17.10 The CCN ensures any existing sensory needs are recorded and aids are used when appropriate, such as glasses and hearing devices.	0 (0.00)	2 (13.33)	9 (60.00)	6 (40.00)	15
17.11 The CCN establishes day and night routines to optimize weaning from critical care therapies and to enhance wellbeing.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
17.12 The CCN assesses and plans care to address pain, agitation, and delirium; uses pharmacological and non-pharmacological therapies.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
17.13 The CCN orientates the patient and family to the unfamiliar critical care environment in a welcoming and supportive manner.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
17.14 The CCN recognizes the boundaries of a therapeutic professional relationship.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
18. CCNs utilize the nursing process to deliver high-quality critical care.					
18.1 The CCN collects data from the patient, family, other healthcare providers, and the community, as appropriate, to develop a holistic picture of patient needs.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
18.2 The CCN prioritizes data collection based on patient characteristics related to the immediate condition and anticipated needs.	0 (0.00)	1 (6.67)	3 (20.00)	11 (73.33)	15
18.3 The CCN uses valid evidence-based assessment techniques, instruments, and tools.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
18.4 The CCN documents relevant data in a clear and retrievable format.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
18.5 The CCN validates diagnoses with the patient, family, and other healthcare providers.	1 (6.67)	0 (0.00)	5 (33.33)	9 (60.00)	15
18.6 The CCN respects patient and family perspectives and values in formulating culturally appropriate outcomes in collaboration with the patient and family, and with the interprofessional team.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
18.7 The CCN employs critical thinking and judgment in developing an individualized plan using best evidence.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
18.8 The CCN collaborates with the patient, family, and interprofessional team to develop the plan.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
18.9 The CCN establishes priorities and continuity of care within the plan.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
18.10 The CCN considers associated risks, benefits, current evidence, clinical expertise, resources, and cost when developing the plan.	0 (0.00)	3 (20.00)	5 (33.33)	7 (46.67)	15
18.11 The CCN employs strategies to promote and maintain safe environment.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
18.12 The CCN intervenes to prevent and minimize complications and alleviate suffering.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15

18.13 The CCN provides age- and developmentally appropriate care in a culturally and ethnically sensitive manner.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
18.14 The CCN revises the assessment, diagnoses, outcomes, and interventions based on the information gained during the evaluation process.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
18.15 The CCN prioritizes treatment and care according to the patient's needs and available resources.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
18.16 The CCN performs comprehensive or focused health assessments as necessary.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
18.17 The CCN recognizes the need for help, and appropriately delegates when unable to provide appropriate care due to workload or other factors.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
18.18 The CCN remains aware of patients and colleagues in adjoining bed spaces, assisting as required.	1 (6.67)	2 (13.33)	5 (33.33)	7 (46.67)	15
18.19 The CCN prioritizes the needs of patients and anticipates unplanned events.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
18.20 The CCN trouble shoots problems with equipment rapidly and effectively.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
18.21 The CCN incorporates information technology appropriately into critical care practice.	0 (0.00)	0 (0.00)	8 (53.33)	7 (46.67)	15
18.22 The CCN allocates resources as appropriate to the priorities of care and treatment for the entire patient group. Refers technology or practice issues that arise to the relevant senior staff.	0 (0.00)	3 (20.00)	5 (33.33)	7 (46.67)	15
18.23 The CCN uses a wide range of strategies to gather relevant patient assessment data from a range of sources, including physical assessment, patient and family interviews, data from diagnostic equipment, laboratory results and health records.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
18.24 The CCN includes long-term goals in planning; for example, incorporates early mobilization in care, or weaning from ventilation and inotropes.	0 (0.00)	2 (13.33)	4 (26.67)	9 (60.00)	15
18.25 The CCN uses structured clinical handover approach to ensure information and advice obtained from other health professionals, patients and family is communicated and documented.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
18.26 The CCN recognizes and addresses potential for untoward trends in patient data; for example, in ventilation parameters, changes in cardiac output and renal function.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
18.27 The CCN ensures all emergency equipment is regularly checked, available and in working order.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
18.28 The CCN uses a systematic, consistent approach to patient assessments.	0 (0.00)	1 (6.67)	2 (13.33)	12 (80.00)	15

18.28 The CCN can recognize, assess, stabilize and manage a critically ill patient who has acutely deteriorated or collapsed.	0 (0.00)	0 (0.00)	1 (6.67)	14 (93.33)	15
18.29 The CCN is able to prioritize patient care based on assessment findings.	0 (0.00)	0 (0.00)	1 (6.67)	14 (93.33)	15
18.30 The CCN adheres to facility standards for assessment and documentation frequency.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
18.31 The CCN is competent to implement ACLS guidelines and care as required.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
18.33 The CCN is able to develop a care plan in collaboration with the patient, family or significant others and healthcare professionals in a way that promotes each member's contribution toward achieving the desired outcomes.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
18.34 The CCN proactively performs primary and secondary surveys (where possible) prior to patient deterioration in order to prioritize care. Responds appropriately and manages emergencies in unfamiliar environments, such as cases of patient deterioration out of critical care, Medical Emergency Team calls and Code Blue situations.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
19. CCNs advocate for patient- and family-centred care based on current recommendations.					
19.1 The CCN actively advocates on behalf of patients and their families to ensure best practice in care is provided.	0 (0.00)	1 (6.67)	5 (33.33)	9 (60.00)	15
19.2 The CCN informs and creates opportunities for input by patients and their families on critical care decisions and planning pathways.	0 (0.00)	3 (20.00)	4 (26.67)	8 (53.33)	15
19.3 The CCN promotes family-centred approaches to care, including open visiting where possible and respecting cultural variations in family expectations.	0 (0.00)	2 (13.33)	5 (33.33)	8 (53.33)	15
19.4 The CCN informs patients and families of their rights and responsibilities as consumers of health care services.	0 (0.00)	3 (20.00)	6 (40.00)	6 (40.00)	15
19.5 The CCN ensures informed consent is obtained for critical care procedures and advocates effectively for vulnerable patients.	0 (0.00)	0 (0.00)	2 (13.33)	13 (86.67)	15
19.6 The CCN seeks to ascertain the patient's (or parent/guardian's) wishes in relation to his or her care and treatment, including extent of family involvement.	0 (0.00)	0 (0.00)	6 (40.00)	9 (60.00)	15
19.7 The CCN monitors the effectiveness of family involvement in care, including the patient's preferences and opportunities that arise for family participation.	0 (0.00)	1 (6.67)	6 (40.00)	8 (53.33)	15
19.8 The CCN assesses the patient's social situation by sensitively interviewing the patient and family.	0 (0.00)	3 (20.00)	5 (33.33)	7 (46.47)	15

19.9 The CCN explores the patient's 'likes and dislikes', such as his or her preferred name, and documents and communicates these to the health care team.	0 (0.00)	2 (13.33)	6 (40.00)	7 (46.47)	15
19.10 The CCN ensures any existing sensory needs are recorded and aids are used when appropriate, such as glasses and hearing devices.	0 (0.00)	1 (6.67)	8 (53.33)	6 (40.00)	15
19.11 The CCN establishes day and night routines to optimize weaning from critical care therapies and to enhance wellbeing.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
19.12 The CCN assesses and plans care to address pain, agitation, and delirium; uses pharmacological and non-pharmacological therapies.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
19.13 The CCN orientates the patient and family to the unfamiliar critical care environment in a welcoming and supportive manner.	0 (0.00)	1 (6.67)	4 (26.67)	10 (66.67)	15
19.14 The CCN recognizes the boundaries of a therapeutic professional relationship.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
20. CCNs demonstrate awareness of complication/iatrogenic harm that may arise during or from critical illness.					
20.1 The CCN completes appropriate environmental risk assessments and implements strategies to mitigate risk, e.g. fall risk assessment and implementation of fall prevention strategies.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
20.2 The CCN implements or promotes strategies to provide a patient-centred environment which improves rest, such as reducing ambient noise or following institutional policy to reduce alarm fatigue.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
20.3 The CCN completes environmental health risk assessment when conducting patient history review on admission.	0 (0.00)	2 (13.33)	7 (46.67)	6 (40.00)	15
20.4 The CCN collaborates with colleagues to educate patients and families about environmental health risks and how to reduce or mitigate risks.	0 (0.00)	3 (20.00)	6 (40.00)	6 (40.00)	15
21. CCNs provide high-quality care across all transitions in the critical illness trajectory – admission through to survivorship or bereavement.					
21.1 The CCN undertakes and documents an assessment of patient and/or family needs and preferences including: Ensuring key members of the patient's family, their relationship to the patient, and contact details are documented; Cultural preferences including cultural and religious beliefs and customs; The need for social work or other support services to address additional family needs including those that may extend beyond the critical care unit, for example, family accommodation; Location of death e.g. remain in unit, transfer to hospice, ward, home, or on country.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15

21.2 The CCN seeks family interest in, and permission to, involve religious /spiritual/cultural leaders for ongoing family support.	0 (0.00)	1 (6.67)	8 (53.33)	6 (40.00)	15
21.3 The CCN supports patient / family to facilitate visitation by identified family, friends, or others as identified.	0 (0.00)	2 (13.33)	6 (40.00)	7 (46.67)	15
21.4 The CCN facilitates privacy and space for the patient and/or family by offering to relocate the dying patient to a single room or larger bed space, where available.	0 (0.00)	0 (0.00)	8 (53.33)	7 (46.67)	15
21.5 The CCN participates and contributes to family meetings for their allocated patient to: Advocate for the needs of the dying patient and family; Support family member's contribution to decision-making in accordance with the patient's prior expressed goals of care and family preferences; Provide immediate support for family, during and after family meetings; comprehensively document family involvement, family perspectives, and key outcomes of the family meeting.	0 (0.00)	0 (0.00)	5 (33.33)	10 (66.67)	15
21.6 The CCN seeks clear instruction to guide the process for withdrawal and withholding of life-sustaining treatment including: Reducing and/or ceasing life-sustaining drugs and treatment modalities (e.g., continuous renal replacement therapy); Weaning ventilation, extubation, and oxygen therapy; Use of sedation, analgesics, anticonvulsant, and/or anti-muscarinic drugs.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
21.7 The CCN removes any unnecessary equipment and monitoring from the patient bedside, rationalizing lines and equipment attached to the patient.	0 (0.00)	0 (0.00)	4 (26.67)	11 (73.33)	15
21.8 The CCN determines whether family would like to be present for withdrawal of treatment and before and after death.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15
21.9 The CCN ensures comfort, including hygiene, pain and anxiety control, during the dying process.	0 (0.00)	0 (0.00)	1 (6.67)	14 (93.33)	15
21.10 The CCN alerts the team of the dying patient to ensure support of colleagues, staff, and ensure appropriate consideration of family.	0 (0.00)	0 (0.00)	3 (20.00)	12 (80.00)	15

*It is possible that sub-statements are written verbatim from a published international standard or from grey literature. All references are provided in Crowe et a., (Under Review) and back-mapping is available on request.

Table 4

Standards and Statements in Peer-Review Round

Standard 1	Critical care nurses are accountable for their own professional practice by:
1.1	Conducting a professional, complete and accurate systematic patient assessment
1.2	Using systematic assessments to identify patients at risk for or experiencing deterioration and implements measures to prevent further deterioration
1.3	Implementing the care plan and treatments in collaboration with the patient's medical team, assuming mutual responsibility for safe and appropriate care and treatment
1.4	Ensuring patient regular safety checks of equipment and alarms
1.5	Recognizing the importance of the patient's partner, family or friends as a resource to the patient, providing information, guidance and support
1.6	Advocating for patient and family-centred care based on current recommendations
Standard 2*	**Critical care nurses use evidence to inform their practice by:**
2.2	Implementing evidence-based guidelines and recommendations
2.3	Maintaining patient care standards to ensure high quality consistent care is provided across the continuum of care
2.4	Describing clinical issues using evidence collected from the clinical setting, such as patient assessment data, outcomes, and quality-improvement data
2.5	Seeking current learning opportunities for evidence-based practice
2.6	Contributing to critical care research and knowledge development
Standard 3	**Critical care nurses engage in ethical practice by:**
3.1	Practicing guided by their provincial and / or national code of ethics
3.2	Protecting patient confidentiality
3.3	Advocating for the concerns of patients and their support network
3.4	Delivering care in a nonjudgmental and non-discriminatory manner that meets the diverse needs of the patient, family, and community
3.5	Always maintaining patient autonomy, dignity, values, beliefs, and rights
3.6	Reporting unethical, illegal, incompetent, impaired or any other unprofessional practices
3.7	Ensuring informed consent is obtained for procedures and appropriately advocates for vulnerable patients
3.8	Practicing in a manner that actualizes concepts of equity, diversity, and inclusion
Standard 4	**Critical care nurses demonstrate accountability in their professional practice by:**
4.1	Seeking clarification on unclear instructions and questioning interventions to ensure safe outcomes
4.2	Engaging in self-reflection, performance evaluation, and peer review to ensure competent practice
4.3	Reflecting on their practice and maintaining awareness of their capacity to provide safe and competent nursing care

Standard 5	Critical care nurses both demonstrate and advocate for strong leadership in critical care by:
5.1	Engaging in collaboration with all care providers involved in the care of the patient
5.2	Maintaining professional behaviour to promote a healthy team and work environment
5.3	Recognizing early warning signs of unit and/or patient instability and advising senior colleagues or other members of the clinical team and others as needed
5.4	Advocating for appropriate, safe, acuity-based staffing
5.5	Providing formal and informal mentorship to learners, including nursing students and other nurses
5.6	Recognizing when organizational practice does or does not align with critical care practice and communicating members of the clinical team or critical care nursing leadership as needed
Standard 6	**Critical care nurses advocate for strong leadership of critical care environments and teams by:**
6.1	Engaging in collaboration with all care providers involved in the care of the patient
6.2	Maintaining professional behaviour to promote a healthy team and work environment
6.3	Quickly recognizing early warning signs and advises senior colleagues or other members of the clinical team and others as needed
6.4	Advocating for appropriate, safe, acuity-based staffing
Standard 7	**Critical care nurses are recognized as specialized in their practice by:**
7.1	Requiring specialized education and training (provided by experts) to work in critical care areas
7.2	Participating in an orientation program prior to working independently
7.3	Quickly recognizing early warning signs and advises senior colleagues or other members of the clinical team and others as needed
7.4	Engaging in ongoing education to maintain competence
Standard 8	**Critical care nurses provide high-quality care across all transitions in the critical illness trajectory – admission through to survivorship or bereavement by:**
8.1	Determining family preference to be present (or not) for withdrawal of treatment and before and after death
8.2	Ensuring comfort, including hygiene, pain and anxiety control, during the dying process
8.3	Proactively performing primary and secondary assessments to prioritize care in an attempt to prevent deteriorations
8.4	Informing the team of about a dying patient to ensure support of colleagues, staff, and ensure appropriate consideration of family
8.5	Supporting patients and their family through all trajectories of death and dying in critical care (e.g. donation)

* One sub-standard was removed due to lack of consensus on the final round.

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6TH EDITION

Standards for **Critical Care Nursing Practice**

Canadian Association of Critical Care Nurses (CACCN)

6TH EDITION

Edition 1 1991
Edition 2 1997
Edition 3 2004
Edition 4 2009
Edition 5 2017

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6TH EDITION

Standards for Critical Care Nursing Practice

Canadian Association of Critical Care Nurses

We gratefully acknowledge the dedication and contribution of our members who participated under the leadership and guidance of Dr. Brandi Vanderspank-Wright, PhD, RN, CNCC(C) and Sarah Crowe, MN, PMD-NP(F), NP, CNCC(C) in the modified Delphi process to produce the Standards for Critical Care Nursing Practice 6th Edition.

THE CANADIAN ASSOCIATION OF CRITICAL CARE NURSES

PO Box 25322, London, Ontario N6C 6B1

www.caccn.ca
email: caccn@caccn.ca

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Standards for Critical Care Nursing Practice

Critical care nursing is a specialty which cares for vulnerable patients experiencing, or at risk of, life-threatening health crises.

The purpose of the Canadian Standards for Critical Care Nursing Practice is to set expectations for critical care nurses nationally. The standards are achievable expectations regarding critical care nursing practice. While these standards include such expectations, registered nurses in Canada are accountable to their provincial regulatory body and respective scope of practice.

These standards are composed with the assumption that the minimum level of licensure required to practice in critical care is that of the registered nurse.

Standard 1

Critical Care Nurses are accountable for their own professional practice by:

1. Conducting a professional, complete, and accurate systematic patient assessment.
2. Using systematic assessments to identify patients at risk for or experiencing deterioration and implements measures to prevent further deterioration.
3. Providing continuous monitoring, care, and interventions.
4. Implementing the care plan and treatments in collaboration with the patient's medical team, assuming mutual responsibility for safe and appropriate care and treatment.
5. Ensuring patient safety through routine equipment and alarm checks.
6. Seeking clarification on unclear instructions and questioning interventions to ensure safe outcomes.
7. Reflecting on their practice and maintaining awareness of their capacity to provide safe, competent nursing care.

Standard 2

Critical Care Nurses use evidence to inform their practice by:

1. Implementing evidence-based guidelines and current practice recommendations.
2. Maintaining patient care standards to ensure high quality consistent care is provided across the continuum of care.
3. Describing clinical issues using evidence collected from the clinical setting, such as patient assessment data, outcomes, and quality-improvement data.
4. Seeking current learning opportunities for evidence-based practice.
5. Contributing to critical care research and knowledge development.

Standard 3

Critical Care Nurses engage in ethical practice by:

1. Practicing according to their provincial and / or national code of ethics.
2. Practicing in a manner that actualizes concepts of anti-racism, equity, diversity, and inclusion.
3. Delivering care in a nonjudgmental and non-discriminatory manner that promotes personhood and meets the diverse needs of the patient, family, and community.
4. Recognizing, reporting and acting on adverse events.
5. Advocating for the concerns of patients and their support network.
6. Maintaining patient autonomy, dignity, values, beliefs, and rights.
7. Reporting unethical, illegal, incompetent, impaired or any other unprofessional practices.
8. Ensuring informed consent is obtained for procedures and appropriately advocates for vulnerable patients.

Standard 4

Critical Care Nurses demonstrate and advocate for strong leadership of critical care environments and teams by:

1. Engaging in collaboration with all care providers involved in the care of the patient.
2. Maintaining professional behaviour to promote a healthy team and work environment.
3. Quickly recognizing early warning signs and advises the most responsible provider and other members of the clinical team as needed.
4. Advocating for appropriate, safe, acuity-based staffing.
5. Providing formal and informal mentorship to learners, including students and other nurses.
6. Recognizing when organizational practice does or does not align with critical care practice.

Standard 5

Critical Care Nurses are recognized as specialized in their practice by:

1. Acquiring specialized education and training to work in critical care areas.
2. Participating in an orientation program prior to working independently.
3. Engaging in ongoing education to maintain competence.
4. Obtaining a certificate or certification through post-graduate education and/or specialty exam(s).

Standard 6

Critical Care Nurses provide high-quality care across all transitions in the critical illness trajectory - admission through to survivorship or bereavement by:

1. Advocating for patient and family-centred care across the trajectory of care.
2. Recognizing the importance of the patient's partner, family, or friends as a resource to the patient, providing information, guidance, and support.
3. Providing care to support survivorship and reduce post-intensive care syndrome for patients and their family.
4. Determining family preference to be present (or not) for withdrawal of life-sustaining measures and before and after death.
5. Ensuring comfort, including hygiene, pain and anxiety control, during the dying process.
6. Informing the team about a dying patient to ensure support of colleagues, staff, and ensure appropriate consideration of family.
7. Supporting patients and their family through all trajectories of death and dying in critical care (e.g. donation).

6E ÉDITION

Normes de l’ACIISI pour la pratique infirmière en soins critiques

Association canadienne des infirmières et infirmiers en soins intensifs (ACIISI)

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Normes pour **la pratique infirmière en soins critiques**

Association canadienne des infirmières et infirmiers en soins intensifs

Nous soulignons le dévouement et la contribution de nos membres qui ont participé, sous la direction et les conseils du Dr Brandi, Vanderspank-Wright, PhD, inf. aut., CSI(C) et de Sarah Crowe, M. Sc. inf., PMD-NP(F), IP, CSI(C) au processus Delphi modifié pour élaborer les Normes pour la pratique infirmière en soins critiques, 6e édition.

ASSOCIATION CANADIENNE DES INFIRMIÈRES ET INFIRMIERS EN SOINS INTENSIFS

CP 25322, London, Ontario N6C 6B1

www.caccn.ca
Courriel : caccn@caccn.ca

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Normes de l'ACIISI pour la pratique infirmière en soins critiques

La spécialité des soins infirmiers intensifs s'intéresse aux patients vulnérables qui sont atteints d'une maladie ou qui risquent de subir un problème de santé pouvant mettre leur vie en danger.

Les Normes canadiennes pour la pratique infirmière en soins critiques visent à définir, à l'échelle nationale, des exigences par rapport à la pratique infirmière en soins critiques. Il s'agit d'attentes réalisables et bien que les normes soient reconnues nationalement, les infirmières et infirmiers autorisés au Canada sont réglementés, pour leur champ d'exercice, par l'organisme de réglementation de leur province.

Ces normes sont fondées sur le principe selon lequel le niveau minimal de certification requis pour exercer en soins critiques est celui de l'infirmière ou l'infirmier autorisé.

Norme 1

Les infirmières et infirmiers en soins critiques sont responsables de leur pratique professionnelle :

1. Faire une évaluation professionnelle, complète et précise des patients.
2. Effectuer des évaluations systématiques pour repérer les patients dont l'état se détériore ou est susceptible de se détériorer et mettre en œuvre des mesures pour prévenir son aggravation.
3. Assurer une surveillance, des soins et des interventions continus.
4. Mettre en œuvre le plan de soins et de traitements en collaboration avec l'équipe de soins des patients, en assumant une responsabilité partagée pour des soins et des traitements sûrs et appropriés.
5. Assurer la sécurité des patients par des contrôles réguliers des équipements et des alarmes.
6. Demander des éclaircissements lorsque les consignes sont peu claires et s'interroger sur les interventions pour garantir des résultats sûrs.
7. Réfléchir à sa pratique et rester consciente ou conscient de sa capacité à dispenser des soins infirmiers sûrs et compétents.

Norme 2

Les infirmières et infirmiers en soins critiques fondent leur pratique sur des données probantes :

1. Mettre en œuvre des lignes directrices fondées sur des données probantes et des recommandations pratiques actualisées.

2. Respecter des normes de soins aux patients garantissant la cohérence et la qualité des soins tout au long du continuum de soins.

3. Décrire les problèmes cliniques en utilisant les données recueillies dans le cadre clinique, comme les données de l'évaluation des patients, les résultats de santé et les données relatives à l'amélioration de la qualité.

4. Chercher des possibilités d'apprentissage actualisé pour une pratique fondée sur des données probantes.

5. Contribuer à la recherche et au développement des connaissances en matière de soins intensifs.

Norme 3

Les infirmières et infirmiers en soins critiques respectent l'éthique dans leur pratique :

1. Respecter le code de déontologie de leur province ou leur pays.
2. Pratiquer de manière à actualiser les concepts d'antiracisme, d'équité, de diversité et d'inclusion.
3. Dispenser des soins sans porter de jugement ni faire de discrimination, de manière à promouvoir la dignité humaine et à répondre aux divers besoins des patients, de leurs proches et des communautés.
4. En cas d'événements indésirables, les reconnaître, les signaler et agir.
5. Défendre les intérêts des patients et de leur réseau de soutien.
6. Maintenir l'autonomie, la dignité, les valeurs, les croyances et les droits des patients.
7. Signaler les comportements non éthiques, illégaux, incompétents, l'exercice sous l'influence de stupéfiants ou toute autre pratique non professionnelle.
8. Veiller à obtenir le consentement éclairé des patients pour les interventions et défendre de manière appropriée les patients vulnérables.

Norme 4

Les infirmières et infirmiers en soins critiques font preuve de leadership et le favorisent dans les équipes et dans le milieu des soins critiques :

1. Collaborer avec tous les prestataires de soins participant dans la prise en charge des patients.
2. Agir avec professionnalisme pour favoriser des équipes et un environnement de travail sains.
3. Reconnaître rapidement les premiers signaux d'alarme et en informer le prestataire responsable principal et les autres membres de l'équipe de soins si nécessaire.
4. Plaider en faveur d'une dotation en personnel adéquate, sûre et basée sur la gravité de l'état des patients.
5. Offrir un mentorat formel et informel aux personnes apprenantes, y compris aux étudiants et aux autres infirmières et infirmiers.
6. Savoir quand la pratique organisationnelle est en phase avec la pratique des soins intensifs et quand elle ne l'est pas.

Norme 5

Les infirmières et infirmiers en soins critiques font reconnaître leur spécialisation :

1. Obtenir une éducation et une formation spécialisées pour travailler en milieu de soins critiques.
2. Suivre un programme d'orientation avant de travailler de manière indépendante.
3. Maintenir ses compétences par la formation continue.
4. Obtenir un certificat ou un certificat post-diplôme dans un programme de deuxième cycle, ou encore en passant l'examen ou les examens de certification dans une spécialité.

Norme 6

Les infirmières et infirmiers en soins critiques prodiguent des soins de qualité à toutes les étapes de la trajectoire d'une maladie grave, de l'admission à la survie ou au deuil :

1. Plaider pour des soins centrés sur la personne malade et ses proches tout au long de la trajectoire de soins.
2. Reconnaître l'importance du conjoint, de la famille ou des amis de la personne malade en tant que source d'informations, de conseils et de soutien pour elle.
3. Fournir des soins pour favoriser la survie et pour réduire le syndrome post-soins intensifs pour les patients et leurs proches.
4. Déterminer si les proches souhaitent être présents lors du retrait des mesures de maintien en vie et avant et après le décès.
5. Assurer le confort, y compris l'hygiène, tout en soulageant la douleur et l'anxiété, pendant le processus de mort.
6. Informer l'équipe lorsqu'une personne est mourante pour s'assurer du soutien des collègues et du personnel et veiller à ce que les proches soient pris en considération de manière adéquate.
7. Soutenir les patients et leur famille tout au long de la trajectoire du décès et du processus de mort en soins intensifs (par exemple, le don).

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