

THE ADVOCATE!

*"Keeping you in touch with our
collective critical care team"*

Nurse for a Day: 5 Things I Learned (or Confirmed)



As soon as I walked on to the 3rd floor of the VG, I knew which patient I had. There is a particular odor that lactulose administration causes. And as I was walking into the VG ICU, I had a sense who that patient was, and that I would be their nurse.

Although the clean-up challenged me (full mask, gown, and gloves), we got through it. Any misgivings I had really were unfounded, and I enjoyed myself. Likely more than Caitlin, who actually asked me to leave when (before?) my time was done: "I have to get my charting done!"

Confirmed: Nursing is a lot of work. Especially the way I did it. Although our patient was busy, and we had little down time, my shift flew by. Surprisingly, the only time we left the bedside was for break ("First break"!).

Learned: Charting is very challenging. Again, especially the way I did it. I have a new appreciation on the charting that is currently required by our bedside nurses. In a busy patient like ours, it was very difficult to keep up. In fact, we would have to fill things out several hours later. I can't even imagine being doubled and having to do this level of charting on 2 patients. Or, having a learner (like me) slow you down. Our charting should be re-evaluated.

Confirmed and learned: What a team! As physicians, we know we have a great team, but we likely don't appreciate how well we do actually work together. Everybody was more than willing to help, to check in, and to be flexible with what they were doing. Not just our nurses, but ward clerks, ward aids, physiotherapy, respiratory therapy, residents, medical students, pharmacists and consultants. It was impressive, and heartening to see.

Confirmed and learned: Nurses see a very unique perspective. Not only the minute to minute patients care stuff, but how families are doing, and how our trainees are performing. There is so much nurses are part of that allow simple observations which place them as a very unique and powerful source of information. I kind of knew this, but didn't fully appreciate it. I am going to figure out a way to tap into this more and more.

Confirmed and learned: Everyone is up for a good cause. I'm not sure what raised more funds: seeing me be a bedside nurse or the worthwhile 3 wishes program. It really doesn't matter, as everyone really had fun with it, and it was a really success. We saw similar enthusiasm with our mobility program, and will see it again with the next good initiative.

Overall, I certainly learned a lot and had a great time. I am not sure how to take being asked to leave early though. I now expect some seniority within the union. And, in a pinch, I may be available for overtime!

Rob



The Nurse for a Day
fundraiser raised an
exceptional

\$1797.00



The Canadian Association of Critical Care Nurses (CACCN) is a volunteer organization whose goal is to promote quality patient- and family-centered care for Canadian's experiencing life threatening illness and injury. Each year, the CACCN hosts a national conference, offering attendees an opportunity to share, learn and network. This year, we, Karen Webb-Anderson and Autumn Embree, attended the conference in Calgary, Alberta. We would like to take this opportunity to share a few of the many highlights.

End of Life Care in ICU



Quality end of life care is becoming an increasingly common topic at Dynamics. Nurses are sharing the challenges of providing this care in the traditionally medicalized ICU environment. Topics included communication about death, symptom management, bereavement care and creating meaning in death. There was great interest in our Three Wishes Project, and many people mentioned they hoped our team would present next year in Halifax!



Autumn's observations: *I think we do a good job at transitioning to comfort care and we try our best to look after the things we can do for the patient and family to ensure they are comfortable. I do think sometimes we could approach the EOL conversations sooner in certain situations to ensure the family is aware how sick the patient really is.*

Bedside Shift Report: Involving the Family in RN Report

This presentation provided an interesting perspective on the practice of involving the family in nurse-to-nurse shift report. In the literature, families ask for two things: i) presence, and ii) information. This approach addresses both of these.

What this process looks like: Verbal agreement family wants to participate → Introductions → Nursing handover → 2 RN safety checks → Check in with family → Ask/answer any questions

When families opted to participate in report, the benefits included helping them to cope with critical illness, verifying the patient story with the family, and demonstrating the role the nurse plays in care. Some of the challenges included ensuring quiet confidential discussions during report, potential disruption of report with family questions, a fear of scrutiny or being judged by the family (i.e., we didn't get a dressing change done on our shift), and a loss of comradery with colleagues (it may feel as though you can't say "omg it was a horrible day" or vent/decompress).

Lessons learned from patients and their families:



- Patients' families are astounded by the knowledge of the RNs;
- There is a marked easing of the trauma experienced by families;
- This method provides the family with information in a systematic way, helping them make sense of all aspects;
- It greatly supports transparency in care;
- The families were not concerned about privacy and confidentiality.

Clinical Skills and Knowledge

As ICU Nurses, we love to expand our clinical skill-set! The conference offered lots of opportunities to augment skills; topics of interest included:

- Complications of massive transfusion – this included using a posted checklist during massive transfusions. We've brought a copy of this home and hoping our team can explore if this could be helpful for us;
- IV administration facts and myths / Managing multiple infusions;
- Low citrate concentration for CRRT;
- An approach to mobility that included cognitive exercises;
- Airway management – outlined how an 'Airway Management Pause' can improve team function, supporting all members to be empowered to speak up and contribute to the intubation plan

A New Concept to Us: Post-Traumatic Growth

Post-Traumatic Growth (PTG) is the positive change or benefit resulting from the struggle with a major life crisis or traumatic event. It does not mean the 'suffering ends' necessarily, merely that there is a benefit or 'a gain' from it. Interestingly, there is a link between PTG and happiness.

PTG is a phenomenon most often studied in relation to military experiences and burn patients. The presenter described the differences between acute stress disorder (normal coping in response to extraordinary life event – often what we see in our patients and families); PTSD; and, PTG. The presentation also focused on what we can do in ICU to support the potential for future development of PTG. The presenter described clinician's ability to provide 'expert companionship'. This highlights the value of being with people, listening to their experiences, encouraging them to express their feelings, and recognizing the role of the 'life narrative', each person's story.

Dr. Jack Rasmussen tells us this is becoming increasingly recognized in burn care. In the Burn Unit in Sunnybrook, both the burn physiatrist and social worker talk to patients about this. As well, it is a concept discussed at Burn Survivor meetings.

If interested in learning more, Jack refers to a literature review published in 2017, Burns 43 (459-470), by Martin et al.

Sharing by our QEII Critical Care Quality Team

Our group submitted one oral and two poster presentations. They were all well received, stimulating some great discussion. In the near future, we will be posting smaller versions of the posters in the units.

- Oral presentation: Supporting Critical Care Best Practice with an Integrated Approach to Quality Improvement
- Poster presentation: ICU Delirium: A Multifaceted and Multidisciplinary Approach to Prevention and Treatment
- Poster presentation: ICU Pressure Injury Prevention: When 'Under Pressure', Use Evidence to Inform Action!

Dynamics 2019

In September 2019, Dynamics will be held in Halifax! We encourage everyone, nurses and inter-professional team members, to consider participating.

The conference is now open to accept submissions for presentations – both oral and posters. The deadline is January 5, 2019. Here's the link: <https://www.caccn.ca/events/dynamics-2019/abstract-submission-2019.html>

If anyone is thinking of submitting an abstract and wants help, please let us know; there are people around to help brainstorm ideas and help develop the submission.

CACCN-Nova Scotia

Autumn Embree is the Liaison Contact for CACCN-NS for 3A ICU. They are looking for a Liaison Contact for 5.2; contact Autumn if interested.

The provincial group is planning an education day on May 9th – mark your calendars! Also, check out the CACCN Nova Scotia Chapter Facebook Group to keep abreast of provincial activities.

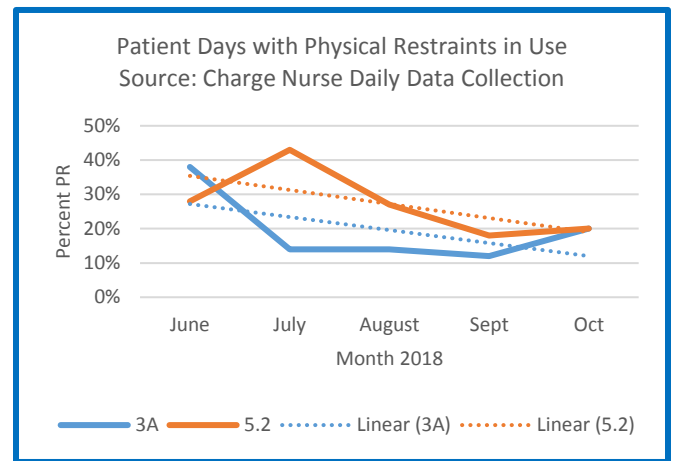


Changing How We Think About Restraints

In Critical Care, we all know our approach to care is evolving – gone are the days of a unit of quiet sedated patients! We are constantly learning about the impact of treatments such as sedatives and bedrest, and we now work to minimize sedation, and get patients moving.

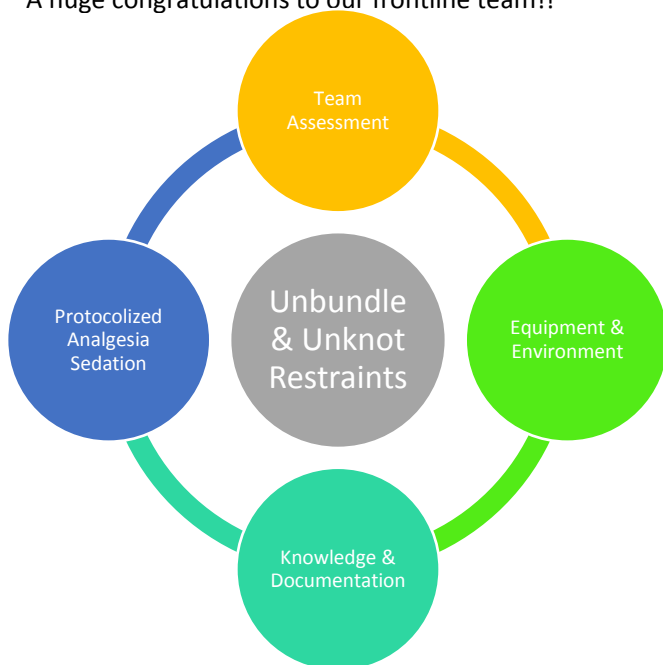
As part of this, we are learning more and more about the impact of physical restraints. We apply physical restraints, most often, with the intent of preventing self-harm. But despite our intentions, numerous repeated studies show, paradoxically, restraints increase all the ill-effects we are trying to prevent, including:

- MORE unplanned extubations (local data collected on 5.2 supports this, with 81% of the patients that self-extubate having bilateral wrist restraints in place)
- MORE line removals
- INCREASED agitation
- HIGHER benzodiazepine, opioid and antipsychotic use
- GREATER risk for delirium



As part of our ICUs' focus on delirium, just as we championed early mobility, we have moved to reducing our restraint use. So far, over the past few months, our chief strategy has simply been to TALK ABOUT RESTRAINTS. Historically, those wrist restraints were just part of the "wallpaper" in the ICU – we were so used to them, we didn't notice them. Now, by talking about them in relation to each patient, we are seeing an astounding reduction! Each morning, Charge Nurses collect some basic information about each patient. In June, we added a question related to restraints: "Number of patients with physical restraints in use". Between the two ICUs, from June to October, this data has been collected on a total of 148 days, and 2065 patient days. (Note: October 1st the question changed slightly to include restraint use in the past 24 hours; we anticipated a small rise given the wording change)

A huge congratulations to our frontline team!!



Next Steps...

Our next step in reducing restraint use and improving our compliance with the ABCDEF bundle will be improving our collective, consistent sedation practices. Key components include:

- Sedating to target. Every patient on any sedative needs a goal RASS. The expectation will be that this goal is documented in the orders each day on Rounds. Every hour, when the RN assesses RASS, sedation is assessed to reach the goal RASS.
- Deep sedation correlates with increased delirium rates, length of stay/ventilation and mortality. No sedation / minimizing sedation is our goal to do best for our patients.
- Analgesia-first. Pain is assessed in ICU patients at minimum, every hour. Target pain before sedating.
- Bolus sedation is better than a continuous infusion (results in lower total dose over 24h)

Message from Leadership: Dr. Tony O'Leary, Critical Care Department Head

Dear Colleagues,

I have been in my current post as the new Department Head for just over 6 months now. Firstly, I want to thank everybody for making me feel so welcome over that time, and for making the transition to Halifax so easy.

For those I haven't met yet, a bit of my background. I was born in London England, completed my BSc and MD in Scotland, and completed training in Anesthesia and Critical Care in Nottingham where I was Head of Critical Care. Additionally, I have worked in the UK private healthcare system as chair for the new Nottingham Spire Hospital and national advisor for Anesthesia, Resuscitation and Critical Care. During this time, I also completed my Masters in Healthcare Leadership.

I have spent much of my time since arriving here talking to, and learning from, many colleagues and stakeholders of critical care. We have many practices in common and share many common goals, number one of which is to provide high quality best practice care to our patients. I firmly believe that patients should be at the centre of everything we do and every decision we make. I have heard and sensed your frustrations when system barriers prevent you from performing at your best or prevent better ways of working.

I have witnessed fantastic examples of innovation, QI, professionalism and clinical expertise at work in your clinical units. However, there are still many areas where these examples of best care are not embedded as standard care. Many (too many) years ago I worked for a company whose tag-line was *"Quality comes as Standard."* At the risk of plagiarising their theme, I believe we should constantly strive to ensure our standard care is exemplary for everyone by everyone; this includes the care we give to each other as we support our colleagues in the workplace.

As professionals we should endeavour to continually improve ourselves and our practice. To embed best practice in all we do, will require changes. Many view any "change" with trepidation and as a threat to their long established practices. As adults in professional healthcare settings it is our duty to stay abreast of new changes and practices, and to adopt life-long learning into our everyday mantra. Change is not easy, and not always comfortable, however it is the opportunity we have to better ourselves and the care we provide to our patients and their families.

Thank you again for the warm welcome to Nova Scotia. I look forward to working with you all as we further develop our department in its trajectory toward being even more outstanding.



Dr. Jennifer Hancock and Dr. Marko Balan recently attended a ceremony at the Sacred Heart School, and accepted a donation of 75 handmade fleece blankets and 200 cards from students at Sacred Heart School on Monday. The donations are for the 3 Wishes Project. The blankets were made by students from Grade 6 to 12. Students in Primary to Grade 5 created cards with messages of support, peace and love.





Question to the NSHA Privacy Officer: The family of a patient asks to review part of the patient chart. *What is the process to accommodate this request? Do we need a special release or consent form signed?*

Answer:

- The physician can sit down and review the chart with the family. If the patient has capacity you must have approval from the patient for the review. Be sure to document in the chart that the patient agrees to the review and understands that their family will be reviewing their medical records, i.e. *"Patient's family wishes to review the chart with the physician, spoke to patient about letting their family review their medical record and patient agrees to the review"*
- If the patient lacks capacity, ensure our usual appropriate paperwork has been completed (*Declaration of Capacity to Consent* and *Declaration of Substitute Decision Maker*).
- If the family member is not the SDM, ensure the SDM is in agreement. Document in the chart this discussion (similar to the outlined above)
- Document the review with the Physician in the chart.
- If the request is thought to be in response to a particularly contentious situation or when releasing to a 3rd party, such as a lawyer, insurance company, community service agency, or law enforcement, a special consent form should be completed to formalize the release of information (CD0016MR). In this situation, contact the Privacy Office (privacy@nshealth.ca or 473-4866) or Access to Personal Health Information (APHI) for assistance (APHI@nshealth.ca or 473-5512) or NSHA Legal Services for assistance.

Burnout Study

submitted by Dr. Jenn Hancock

Many of you will have listened to and read myriad news stories talking about **BURNOUT**. Burnout has become a significant problem for healthcare providers across all disciplines, and has several potentially deleterious consequences for individuals, their patients and the healthcare organization as a whole. Critical Care is not immune, and globally, Burnout rates for Critical Care practitioners are among the highest. Photo media accompanying news stories often portray someone looking stressed out and at the end of their rope. While this certainly may be the end result, there are many ways that features of Burnout may present: **Emotional exhaustion** is the most recognizable – the sense of overwhelming fatigue or having nothing left to give at the end of a shift; **Depersonalization** is manifest by cynicism, detachment and loss of empathy for your patients; and finally, **Low Sense of Personal Accomplishment** – the feelings that you are no longer making an impact at your work or of "why bother...nothing is going to change".

In January 2018, the physicians, nurses and respiratory therapists working in the Department of Critical Care participated in an online survey evaluating Burnout and Moral Distress among our team members. Results from this survey demonstrate that both Burnout and Moral Distress are significant problems for all members of the healthcare team. **High** and **moderate** levels of **emotional exhaustion** are present in 27.3% and 39.4% of the sample, respectively. **Depersonalization** was rated at a **high** level in almost 14% of those surveyed and a **moderate** level in 33.3%. **Feelings of low personal accomplishment** were experienced by 27.9%. Perhaps most concerning, 55.2% of participants reported feeling **moral distress at least a few times a month**, and almost 30% reported feeling moral distress *at least once a week*.

As a team, we have an obligation to take this seriously and work to improve the overall wellbeing of our colleagues. This fall a multi-disciplinary working group was formed to help better understand the issues specific to our units, and to determine selective interventions that will help mitigate burnout and build resiliency. **To do this we need you!** In the coming months we will be asking for your thoughts and opinions. We hope you will join us to help build a better, more positive work environment!



Free Resource Open to Everyone:

Navigating Medical Emergencies – An Interactive Guide to Patient Management

The Royal College of Physicians and Surgeons of Canada is very pleased to announce this eBook is now complete, and openly available.

A key strength of the e-book has been the support and contributions of Canadian healthcare professionals, including a number for our team. This has resulted in an excellent teaching and clinical resource relevant to healthcare professionals caring for patients during a medical emergency.

To date, the eBook has accumulated over 7500 unique users from over 90 countries around the world. View the finalized [NavME eBook](#).

Upcoming Events

Date:	Topic:
Monday, Dec. 3 0800-0900	Cardiology Grand Rounds, RBT: What is the benefit of an early invasive strategy in low risk ACS? A critical review of old evidence. It is OK (not) to conservatively manage low risk ACS
Tuesday, Dec. 4 1200-1300	Critical Care Journal Club, by Dr.'s Rasmussen & Clayden, Rm 378 Bethune
Monday, Dec. 10 0800-0900	Cardiology Grand Rounds, RBT: PVC's: What to do with more than (insert a percentage here) PVC's and a reduced EF? Do PVC's cause or worsen a dilated cardiomyopathy?
Tuesday, Dec. 11 1200-1300	Critical Care M & M Rounds, Rm 378 Bethune
Tuesday, Dec. 18 1200-1300	Critical Care Grand Rounds, by Dr Al Khalaf, Rm 378 Bethune
Monday, Jan. 14 0800-0900	Cardiology Grand Rounds, RBT: What is an MI? Do the new ESC definitions simplify or complicate clinical decision making?
January 20 - 24	Canadian Critical Care Trials Group Winter Meetings, Lake Louise, AB

Fall 2018 - Comings and Goings

Welcome to Avril Jean-Jacques (Administrative Assistant) and Leigh Purcell (Program Administrator) to the Critical Care office. Kristen Griffiths returned from education leave early to start her new role as Interim Manager on Oct 30th.

Welcome to Hillary Ferguson – Data Management Clerk (helping with the CC Database); Rita Snow, RN to 5.2 RN from CCU; Allie Bennett, RN to 5.2; Ute Soucy, CTA to 5.2 from the Rehab.

Welcome to Catherine Bennett, RN to 3A; Lisa Forrestall, CTA to 3A.

Congratulations and farewell to Dr. William Gallacher and to Diane King, RN on their retirements.

Congratulations to the following people on MLOA: Katie Gordon (daughter); Stephanie Proffitt (son); Ellen & Steve Walsh (daughter), Karolyn Holland (son), Sarah Kennedy (son), Alyssa Ouellett (son) & Cheryl Barrie (son).

Congratulations to our new Clinical Leaders, Lesley Bishop, RN for 3A and Elinor Kelly, RN for 5.2.

Farewell to 3A's Caitlin Bearnes, Emma Etienne & Daniel Sheppard, who have all moved on to different positions within NSHA.





A Multicenter Observational Study of Family Participation in ICU Rounds

Au et al., Crit Care Med (May 7, 2018)

The integration of patients and families is a foundational component of quality healthcare. The 2017, the *Society for Critical Care Medicine Guidelines* identified family participation in ICU rounds as a strategy to improve satisfaction with communication and to increase family engagement.

This Canadian observational study described family participation in ICU rounds, assessing if attendance was associated with changes in rounding processes including duration, nature of communication, trainee teaching and quality. It included 33 intensivists, from seven hospitals. Quantitative and qualitative data were collected using standardized observational tools. The authors concluded that family attendance in ICU rounds is associated with modestly longer duration of rounds, but did not negatively impact the frequency of trainee teaching, discussions of prognosis, or quality of rounds.

How are we doing with family participation in bedside rounds?

Examining the Daily Rounds Toll data (Apr 1 – Jun 30), on 667 bedside rounds (3A +5.2), families participated in bedside rounds 25% of the time. The data indicates that 62% of the time, family was not present at the hospital to participate, suggesting an opportunity for improvement!



Balanced Crystalloids versus Saline in Critically Ill Adults

Semler et al., The New England Journal of Medicine (March 2018)

In September 2018, Dr Shannon Murphy presented this publication at Critical Care Journal Club.

This study was a pragmatic, cluster-randomized, multiple-crossover trial conducted in five ICUs at an academic center. It involved 15,802 patients and compared outcomes after receiving 0.9% sodium chloride vs. a balanced crystalloid (lactated Ringer's solution or Plasma-Lyte A). The primary outcome evaluated was major adverse kidney event within 30 days (death from any cause, new renal replacement therapy or persistent renal dysfunction).

The study found that the use of balanced crystalloid solutions resulted in a lower rate of major adverse kidney event (14.3%) compared to saline (15.4%) at 30 days. The researchers extrapolated that the use of balanced crystalloids rather than saline could prevent 1 ICU patient in 94 from either new RRT, persistent renal dysfunction, or from death.

This study reinforces the findings of previous studies, demonstrating the negative impact of saline. Perhaps even more concerning in this recent study was the low volume (~ 1000 mLs) of saline needed to demonstrate a negative impact.

The Journal Club group had a good discussion about the evolution of our practice to limit the use of saline, and how to improve further. From this discussion, in support of efforts to limit saline:

- 1000 mL bags of saline will be removed from stock in our ICUs.
- Adopt an approach of only using saline when we can't give medications in another base solution. Do not use saline for fluid replacement / resuscitation unless a specific clinical indication (i.e., TBI). This message is being re-enforced in the fall Nursing Education Days.
- Base solution will be a consideration in the provincial Critical Care IV Pump Library build and the provincial Critical Care Standardized Order Set project.

