December 2020 | criticalcarenurses@gmail.com

Critical Comment

New Zealand College of Critical Care Nurses

Contents

Message from the Chair

Welcome to the spring/summer edition of Critical Comment.

These are definitely extremely unsettling and worrying times at the moment. COVID-19 and surge capacity training has become a focus for both the Ministry of Health and Nursing as a whole. Thankfully at this time the numbers of infective cases seem to be fairly stable with most coming from the managed care facilities. Numbers of staff going across to work in these facilities seem to be steadily rising and this is having a staffing impact across the country. We have managed to update a couple of our standards but have, after some feedback, decided to do a major overhaul of the staffing standards. There have been some key changes related to managing pandemics highlighted and a big workforce shift has meant that a lot of units predominately have junior staff. This has changed the needs of these units and therefore our staffing standards need to reflect these changes, keeping units and staff safe, promoting excellence of care, and planning for the future development of our speciality and our nurses.

We must still check in and support each other and make this our normal practice. It is clear now that the past year has changed the way we practice and also live, it is not likely to change any time soon. We need to adapt but it is hard and will remain an on-going stress for us all. We are all going to need support.

In this edition of Critical Comment, we have some interesting articles for you to read and promotion of our up and coming AGM in March, this will be via Zoom and we are going to include some education sessions so that it will be beneficial to all.

This is a lot of hard work ahead but also some very exciting opportunities to develop and promote our profession and our speciality. We all need to grasp every one of these and run with it. I urge you all to keep your ear to the ground and keep your networks as wide and active as possible.

Have a wonderful holiday period and try to get good amounts of rest and family time. Please be kind to each other.

Be safe,

Steve Kirby Chairperson NZCCCN

Letter from the Editor

What a year! This year has felt like a rollercoaster, where the ups and downs have been extreme. We have done extremely well by supporting each other via teamwork, comradery in the workplace and self-care during these uncertain times and will need to continue to do so moving forward. We have included resources from the previous newsletter to remind ourselves of the importance of self-care in order to provide the best care towards our patients.

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-resources-health-professionals/covid-19-advice-all-health-professionals

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-health-advice-general-public/covid-19-mental-health-and-wellbeing-resources

https://www.mentalhealth.org.nz/get-help/getting-through-together/

https://www.justathought.co.nz/covid19

Although intensive paediatric nurses have not faced the same extent of COVID-19 as nurses working with adults and older people, there are lessons to be learned that can strengthen the quality of paediatric work environments and can be applied post COVID-19 era. Teamwork is dreamwork where highly effective teams are critical in the intensive care. These include transparent communication, decentralised and non-hierarchical decision-making authority, trust and a common purpose to care for the paediatric population. A colleague has written about the importance of teamwork highlighted in an article which is included in this newsletter.

I had the opportunity to attend virtually the Asia Pacific Intensive Care Symposium 2020 organised by the Singapore Society of Intensive Care Medicine in October 2020. The symposium aim was to focus on current evidence in ICU care to explore the potential range of preventive and therapeutic approaches toward the critically ill especially in the COVID-19 pandemic. The pandemic has put a huge strain on critical care resources worldwide where systems have struggled to provide high-quality care for a surge of the critical ill patients. The focus was mainly on adult critical care and had a small focus on the paediatric population. Therefore, included in this newsletter is a perspective of critical care and research that is happening for the paediatric population.

In the midst of the COVID-19 pandemic planned education workshops organised by NZCCCN are currently on hold temporarily until further notice. Look out for future education workshops and conferences adverts in the near future. Please save the date for 30th March 2021 for our AGM and virtual presentation; an email was sent out to all members promoting the agenda.

I hope you have enjoyed our NZCCCN newsletters thus far as this is my last issue as editor. Thank you for the opportunity and I hope we are able to provide you with a lot more interesting happenings around NZ critical care units.

Thank you to all the contributors towards this edition. Kia Kaha everyone and be kind.

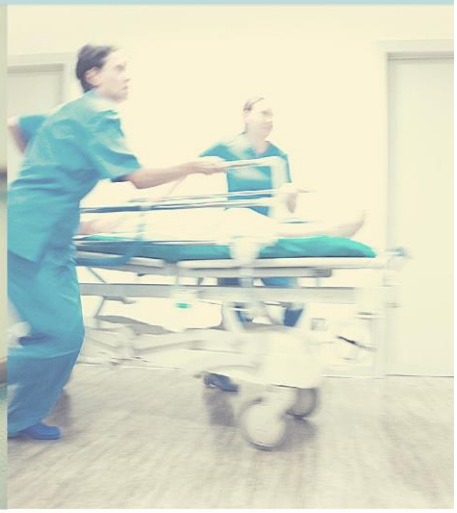
Critical Comment Editor NZCCCN

Rachel Yong

There is no I in team but there is a heirachy

Does our how we work as a team echo the advancements we see in modern medicine, or do we need to improve how we play the game?

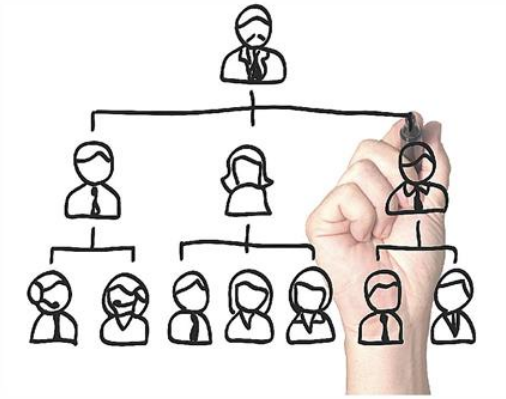




In the world of healthcare, working as a team is pivotal to optimising patient care. We even call ourselves the Multi-Disciplinary Team, like a dull version of the Avengers. However, no matter how many times we call ourselves a team, we cannot escape the natural hierarchy which falls amongst us, a non-spoken agreement formed from decades of hospital culture. But just as medicine has changed with time, with increasingly complex surgical interventions and weird and wonderful machines to sustain life, we need to assess how we interact as a team and question whether it has kept up with this modern world.

Every shift, every day, we are reminded of our role and our place in the hierarchy. These reminders come in the shape of the blue scrubs of the Registrars vs the business attire of the Consultants, the number 1,2 3 or 4 we write next to the title of Registered Nurse, and even the uniforms which have 'senior nurse' and 'nurse' lovingly stitched on the shoulder. We are bound by our roles, and in turn, when it comes to working as a team it is so easy to slot into the place in the hierarchy we feel we should sit. However there is another area of life where people are bound by uniforms, different roles and limitations of positions. They also call themselves a team. But here the hierarchy is flattened to an even playing field, literally.

Forget the role, understand the position



When comparing a medical team to a sports team there are many similarities. Everyone is working together to achieve the same goal, each individual brings different skills which support the team, and they are bound by the position, nay the role, they play. Growing up I was an avid netballer, a game where your position dictates where you can or cannot move on the court. The Center position can basically go everywhere, and they aid the ball through the court, whereas the Goal Shoot is only allowed as far as the edge of their third, but get to score the goals. These are two positions with vastly different skill sets and boundaries on the court, but are equally as valuable.

Both versions of a team have their advantages and disadvantages. On the one hand, it is beneficial to have someone with responsibility and knowledge to make important decisions and answer your questions. But then there are times, particularly within the nursing team, where the façade of being above or below one other in the pecking order influences effective team work and communication. When we view our team as mechanistic in structure people are viewed, and then in turn view themselves, as above or below each other. In my own practice, this view has created a barrier to speaking up in the past, especially if those who need to listen are perceived as more senior. We should instead strive to create an environment where everyone has value and their voice has equal worth. Some roles have more responsibility and require more knowledge or skill. However, we all depend on each other to keep the ball moving through the court and down to the goal. In this team, every role, every person, has equal value and equal worth.

As medical professionals, we need to remember we all have different skills and knowledge unique to our practice. We have all heard, and maybe even said, "I am JUST the nurse". But being a nurse is a valued role. Doctors and surgeons would not be able to do their job without the care nurses give or the information they provide, and nurses would not be able to do their job without the guidance of doctors. Unfortunately, hierarchical views of roles is especially rife within nursing. Lets start thinking of ourselves as equal to, rather than less than.

As I become more proficient in my nursing practice I experience first hand how self-perception develops, as well as how other perceive you. You have more knowledge, more responsibility and more complex patients. However, it is important to acknowledge you have not moved up the hierarchy, you have just changed roles, you have changed positions on the court.

Don't stop the game to criticise a player, learn to play more cohesively.

One final aspect of teamwork we can learn from sport is our reactions to deficits in knowledge and errors. We are all humans, and humans are not perfect. But instead of criticising nursing skills, knowledge or communication, we should aim to provide the skills and knowledge required to improve their practice and reduce the risk of repeat mistakes. No team would stop the game to criticise a player because they dropped the ball or misjudged a pass. The team uses this shortfall in play to inspire improved cohesiveness on the court and support to that player. When you watch athletes, you can see how communication and coordination increase when there is a error in play. We should strive to emulate this within our own team. Again, we are humans, and we all have deficits in one area or another. But we should not put people down for these, we should work together to provide an environment where everyone can learn and thrive.

We may not have yet optimised how we function as a team. Unfortunately, we may get it perfect. However, we can always be better and we should always strive to improve. There is no I in team, but the hierarchy in which it sits in no better. Lets take down the hierarchy and chuck the players on the court. Our roles are our positions, so lets create a team culture where we can play to the best of our abilities. For the safety and health of our patients and ourselves.

PICU Research @ Starship Child Health

The research team in PICU have had a few challenges this year with the knock-on effects that COVID-19 has had! Studies that we would normally recruit well for over the winter months have had virtually no enrolments as cases of bronchiolitis/pneumonia/influenza have all but disappeared. In general, the numbers of children admitted to PICU are slightly down from last year.

One study that has kept us ticking over is a collaboration between Australia and NZ PICU's called the Nitric on Bypass Study. This study is looking at whether adding Nitric Oxide to the bypass machine during surgery for congenital heart disease (CHD) results in improved post op morbidity. 1/100 children are born with CHD and about half of them will need corrective heart surgery. Bypass is used in about 80% of these surgeries and can have some major post op effects. The study aims to recruit 1320 children <2 years old who are randomised to either standard care or the intervention of Nitric Oxide. The study is blinded, only the perfusion team know which arm the children are in. Neuro-developmental follow up takes place at a year post surgery where parents complete a number of questionnaires to assess their child's development. So far Starship PICU is the 2nd highest recruiting site having enrolled 244 children to date. The study will achieve the recruitment target by the end of the year and analysis can begin in 2021. Once results are finalised parents will be informed which arm their child was in.

Other collaborative studies currently running in PICU are a sepsis pilot study called RESPOND – children <16years old with septic shock and an inotrope requirement are randomised to receive Vitamin C, Hydrocortisone and Thiamine or standard care, to see if this intervention leads to a more rapid resolution of shock. PROSPECT is an international multi-site study recruiting children with acute respiratory distress syndrome to compare the effects of prone positioning/supine positioning and high frequency oscillation ventilation/conventional ventilation on ventilator free days. Children <16 years are randomised to one of 4 groups using these therapies. The study has just started here in NZ but we are yet to enroll a patient as there have been minimal patients admitted with severe respiratory problems this year.

Patient recruitment generates income to pay salaries and with the current change in PICU patient demographics the coming months may require inventive ways to keep a productive research programme running!

Claire Sherring
Research Co-ordinator
PICU, Starship Child Health

COVID-19 and Children - Are they benign as we thought?

I had the opportunity to attend virtually the Asia Pacific Intensive Care Symposium 2020 organised by the Singapore Society of Intensive Care Medicine in October 2020. The symposium aimed to focus on current evidence in ICU care to explore the potential range of preventive and therapeutic approaches toward the critically ill patients including children especially during the pandemic. Are children really benign in this pandemic? Or so we thought.

Data presented was from the UK, India and Singapore. The epidemiology of COVID-19 in children data was taken from Wuhan, China. Research showed that of the 2143 children with laboratory confirmed SARS-CoV antigen, only 5.6% were hospitalized with severe respiratory symptoms and only 2% required PICU admission. Data showed globally from America, Europe and UK there was significantly low hospitalisation rates and mortality was also very low for those who were admitted to PICU. COVID-19 was considered an adult disease. In the early pandemic data, the symptoms presented in children were mild or they were asymptomatic. The report presented by Dr. Jayashree from the Centre for Diseases and Prevention of March to July 2020 showed that children less than 2 years old were in the higher risk group for hospitalisation globally; the younger the child the higher the risk of the disease being more complicated. The disease was seen predominantly in infants and children from reported data. The children hospitalised had pneumonia and MIS-C, some were managed on the wards with High Flow or BiPAP for their respiratory disease.

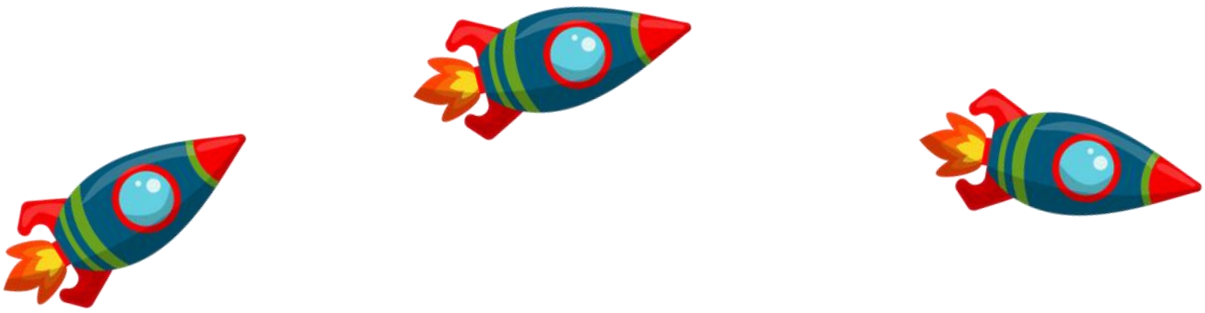
During the early pandemic the number of cases were higher in Asia compare to America, Africa and Europe. India contributed a third of new cases with 100 case incidence per million of the population a week as reported by the World Health Organisation. Currently, the number of cases are decreasing in the South East Asian Region (SEAR) compared to Europe which is experiencing their 2nd wave which contributed to their increase in death rate. Although India has peaked to 91% cases per week due to the lack of testing resources, only 3.6% comprise of children of the total cases. This mirrors what was seen in China and US. It was reported that in India the children hospitalised were hypoxic or asymptomatic with mild manifestations of the disease compare to adults. Those that require ICU intervention were due to multisystem inflammatory syndrome (63%) and out of this 63% only 9% had COVID-19 with 1 child passing away. This shows low mortality rate in PICU admission for pediatrics admitted with COVID-19.

"We were relaxed in the pediatric world" a UK intensivist stated, as children were not clogging up the ICU as echoed with India and Singapore. They were managed in the ward instead of ICU as some children had very mild symptoms or presented asymptomatic to hospital. However, the presentation of COVID-19 like diseases in children are different as observed by UK in April 2020 during their lockdown. The children presented to hospital with abdominal pain, vomiting and diarrhea, warm shock syndrome typical of respiratory symptoms. Case definitions from the Royal School of Medicine and World Health Organisation (WHO) were created quickly in light of the increase in ICUs seeing the same manifestations in children. UK PICUs found that those children admitted were due to multisystem inflammatory syndrome which had similar manifestations to Kawasaki Disease, Kawasaki Shock Syndrome, Toxic Shock Syndrome, MAS/HLH and sepsis. However, MIS-C appears to be a distinct disorder with intense inflammation in older age group of children. There were high rates of patient admission to PICU requiring warm shock management for heart failure and mechanical ventilation. The treatment included IVIG, IV steroids, and biologics historically for inflammatory diseases from other countries but the guidelines are quickly evolving to adapt to the situation as reported by the UK intensivist.

In Singapore, the admission for influenza and RSV showed a marked drop to PICU admission. This was a worldwide phenomenon where it echoed through Australia, New Zealand with reduced RSV/Influenza admission. This may have been due to the fear of presenting to hospital and as a result patients were sicker during these later presentations to hospital. If the trend continues this will have implications for PICU research worldwide, recruiting patients and clinical training for doctors and nurses. As we know children are under-represented in large clinical trials. The PICU guideline for COVID-19 is evolving to support managing pediatric COVID-19 patients in Singapore as it was initially considered a mild disease for the pediatric population. Early discussions included management of respiratory conditions like the use of HFlow vs NIV/ Intubation. There was no discussion about MIS-C as very little research was known about COVID-19 in pediatrics. Do we adapt adult trials towards the pediatric population with a "living" guideline for COVID-19 when it is not one size fits all? It was seen in Singapore that COVID-19 had more impact on the child with other comorbidities like heart failure and diabetes. Resurgence of old preventable diseases could be on the rise as the lack of access for vaccination due to COVID-19 restrictions in Singapore. Naturally with the added stress of lock down, school being closed, and financial/economical stresses can impact on the child and their family in their mental health. The added stress can result in an increase in self harm, suicide and Non-Accidental Injury (NAI), requiring PICU admission. It was reported in the US, that poisoning in people less than 5 years old increased markedly in hospital admission rates. There is a need for greater support for health care workers working in these situations as observed by the Singapore intensivist who presented this segment.

What the other countries are going through in the pediatric world is definitely reflected in New Zealand PICU. We had very little respiratory viral illness pediatric admission into PICU during this winter compare to previous winter. NAI and planned surgery admissions were unchanged in our unit. This has impacted on research done in PICU, Starship hospital for the pediatric population. It also highlights the need for more teamwork, collaboration and research for the pediatric population in this evolving COVID-19 disease. So, are children more benign with COVID-19? Or this is not really seen with the lack of research.

Rachel Yong,
PICU RN, Starship Hospital.



CORONAVIRUS COVID-19

Looking after yourself

SOME PRACTICAL TIPS AND WHERE TO GO FOR MORE SUPPORT

Your wellbeing is important and there are simple things you can do to help manage uncertainty and fear. Research tells us looking after ourselves and each other is the best place to start.

FIND THE RIGHT PEOPLE TO TALK TO

Share your thoughts and feelings with someone you trust, share facts.

'How is this conversation helping me to feel good and function as best as I can right now?'

WATCH YOUR MEDIA DIET

Take a break from following the news and social media.

'Look at your media intake over 24hrs and ask yourself is this helping or harming the way I feel?

FOCUS ON RELATIONSHIPS

Connecting with others who make you feel safe, loved and connected is one of the most important things you can do.

GET THE FACTS

Seek information on COVID-19 only once or twice a day. The constant stream can cause anyone to feel worried.

Get the facts from reliable sources www.covid19.govt.nz

DO WHAT MAKES YOU FEEL GOOD

Care for your mind, body, soul and family nurture all aspects of your wha.

Te whare tapa wha and five ways to wellbeing: www.mentalhealth.org.nz/get-help/covid-19/top-tips-to-get-through/

STICK TO ROUTINES

Keep supportive daily routines.

It tells our brains it's safe to dial the stress response back down and prevent us from being more anxious.

TAKE CARE OF BASIC NEEDS

Rest and time out help, at work and away from work.

Keep well through appropriate rest, eating and actions to boost your immune system. Use wellbeing strategies that work for you or create new ones.

PACE YOURSELF

This is likely to be a marathon. Be aware of bandwidth, it may take longer to think things through and make sense of things and that's okay.

FOCUS ON WHAT MATTERS

Focusing your resources on what you can control and what matters.

Worrying about things you can't change can be upsetting and frustrating.

NEED MORE SUPPORT?

If over days and weeks your distress or stress symptoms are escalating, or you feel you are not coping, help and professional support is available.

You can talk to your manager, director, professional lead, professional supervisor, team leader, or HR lead.

For health advice call Healthline **0800 611 116**

Need to Talk?

1737 National Telephone Counselling Service. Available 24/7 text or call

Employee Assistant Programme (EAP) support for you or your team **0800 735 343**

Adapted from: Nelson Marlborough Health New Zealand Institute of wellbeing and resilience, real – time strategies for coping with Coronavirus www.nziwr.co.nz Intensive Care Society UK. Author: Dr Julie Highfield, Consultant Clinical Psychologist, Cardiff Critical Care, 2020https://www.ics.ac.uk/ICS/Education/Wellbeing/ICS/Wellbeing.aspx Mental Health Foundation, Top tips to get through Corona Virus and Advice for sustaining staff wellbeing in Critical Care during and beyond COVID-19 www.mentalhealth.org.nz/get-help/covid-19

Some ways to Take Care of Yourself

Self- care is essential but in a stressful time it can be a challenge to put this into action. Having a list of possibilities can help.

- Give yourself permission to sit and relax, especially when you're tired. Visualise a safe, relaxing scene and imagine stepping into it and soaking up the peace.
- Explore nature. Sit in the sun. Watch the sunset. Listen to the birds.
- Have a warm drink.
- Create quality time for you by taking the phone off the hook.
- Eat something nourishing. Cook something special. Buy yourself a treat.
- Notice your achievements and give yourself credit for them.
- Lie on the grass.
- Write in your journal. Write down everything you love about yourself. Write about your special accomplishments in your journal. Write about what you are feeling. Say soothing, loving things to yourself.
- Go for a walk. Go to the library. Go to the beach or bush
- Have breakfast in bed.
- Have a massage. Have a spa, swim or sauna.
- Play with an animal.
- Give yourself a hand or foot massage.
- Get some exercise. Do some yoga.
- Go to the movies or a show. Do something creative just for pleasure. Draw or paint a picture.
- Write some poetry. Play some calming music. Phone a friend. Write a letter to a friend.
- Go window shopping.
- Walk in the rain.
- Tune into yourself and find out what you're feeling and what you need. Ask someone for a hug. Ask for the help and support you need. Take mental health day off if you really need it.
- Plan something fun – an outing, treat, celebration or holiday. Plan a get together with friends.
- Dance. Play your favourite music.
- Stop and smell the flowers. Spend time in the garden. Buy yourself some flowers or a plant/plants.
- Meditate or pray.
- Watch a funny video.
- Relax with a good book.
- Make a list of things that make you happy.
- Go to a park and swing on the swings.
- Go to bed early. Wake up early and watch the sunrise.
- Make a special meal just for you.
- Give yourself a facial.
- Read an inspirational book.
- Take a warm scented bath. Have a foot bath. Burn some essential oil in the oil burner.

So What Do I Do?

2 minutes

- Breathe
- Stretch
- Daydream
- Take your stress temperature
- Laugh
- Doodle
- Acknowledge one of your accomplishments
- Say no to a new responsibility
- Compliment yourself
- Look out the window
- Spend time with your pet
- Share a favourite joke

5 minutes

- Listen to music
- Have a cleansing cry
- Chat with a co-worker
- Sing out loud
- Jot down dreams
- Step outside for fresh air
- Enjoy a snack or make a cup of coffee/tea

10 minutes

- Evaluate your day
- Write in a journal
- Call a friend
- Meditate
- Tidy your work area
- Assess your self-care
- Draw a picture
- Dance
- Listen to soothing sounds
- Surf the web
- Read a magazine

30 minutes

- Get a massage
- Exercise
- Eat lunch with a co-worker
- Take a bubble bath
- Read non-work related literature
- Spend time in nature
- Go shopping
- Practice yoga
- Watch your favorite television show

Soothing Senses

Taste:

- Green tea
- Chocolate
- Mango
- Gum
- Crunchy snack
- Vegetable soup
- Milk
- Oatmeal
- Celery
- Bananas
- Nuts and seeds
- Eggs

Smell:

- Lavender
- Eucalyptus
- Peppermint
- Green apple
- Coconut

Sounds:

- Leaves
- Water stream
- Seaside
- Water
- Fireplace
- Summer night
- Rain
- Thunderstorm
- Wind
- Forest
- Coffee shop
- Train
- Fan
- White noise

Touch:

- Playdough/Putty
- Soft objects
- Stress-relief magnets
- Stress balls
- Tactile beads
- Wood, metal, etc.
- Rubber bands
- Rubbing stones
- Beanbags
- Kneading eraser

Sight:

- Use your favorite color.
- Wallet-sized picture of someone or something you enjoy.
- Landscapes
- Baby animals
- Funny photos
- Pictures
- Blowing bubbles
- Positive affirmations

http://healthofmind.tumblr.com/post/22571448384/self-soothing-sensory-kit

NZ College of Critical Care Nurses [NZNO]
2020 national committee members

Position	Name	Term	Region
Chair	Steve Kirby	5th	Northern
Vice Chair	Tania Mitchell	3rd	Central
Secretary	Sarah Rogers	4th	Midlands
Treasurer	Erin Williams	4th	Midlands
Membership	Renee Holland	2nd	Southern
Website/Newsletter	Rachel Yong	3rd	Northern
Consultation Documents	Lara Millar	3rd	Central
Committee	Randy Gopalla	2nd	Mid- south
NZNO Liaison	Angela Clark	N/A	NZNO

Update your NZNO or NZCCCN Membership

If you move address, change your name, change your job/position, or no longer want to be a member section please update your details with NZNO. You can do this by emailing Sharyne Gordon: SharyneG@nzno.org.nz with your NZNO number and a simple request to alter your details or to remove you from the membership database of the college

NZCCCN

New Zealand College of Critical Care Nurses

Critical Care and Coronary Care Unit Nurses

Are you a member?

Membership is FREE

- Join a large community of likeminded nurses
- Scholarships available for courses and education
- Discounted registration to ANZICS conferences
- Critical Comment Newsletter
- Support education and safe staffing standards

For more information or to join, visit our website:
www.nzno.org.nz/groups/colleges_sections/colleges/new_zealand_college_of_critical_care_nurses

OR

New Zealand College of Critical Care Nurses