April 2021 | criticalcarenurses@gmail.com

Critical Comment

New Zealand College of Critical Care Nurses

NZCCCN
New Zealand College of Critical Care Nurses
NZNO

Contents

Message from the Chair

Welcome to autumn edition of the Critical Comment. I hope you are able to have some time away from work to enjoy this lovely autumn weather we have been having.

Looking back, this time last year we were in lockdown, getting used to a new way of life at home and in the community, whilst professionally, watching with anticipation and a level of fear, watching what was happening overseas and hoping our isolated spot at the bottom of the world would offer us some protection. Professionally, we all have had an important role to play, from quickly preparing our environments and our nursing model of care to be able to cope with the unknown, to learning to don and doff with a whole new level of importance. Throughout the country we have had different experiences of how COVID-19 has affected us from a personal and professional point of view, but we can be proud of our response as a country as well as a critical care workforce. Twelve-months on, and we are queueing for our COVID-19 vaccinations. So much has changed in the last 12-months, and I am sure we have much more change and uncertainty facing us for the next year ahead.

At the end of March we held our online education session. We were fortunate to have Megan Stowers present on the challenges faced meeting the cultural needs of patients in ICU with COVID-19. Megan is a RN in Waikato ICU, and she described the impact hearing and speaking te reo had on her patient and his whānau while he was critically ill. This was an amazing comfort to him and his whanau to have her caring for him and advocating for his cultural needs. From this, a

Māori Support Nurse role has been set up and Megan describes the impact it has had not only on her patient and their whānau, but her colleagues while she coaches them through the provision of culturally safe care for Māori.

Leona Dann who is a specialist in patient safety for Health Quality & Safety Commission discussed resilient systems in healthcare. This covered how our systems need to be set up to manage the unexpected, and how we can learn from all events to look at what goes right and why this goes right most of the time – making our usual success easier. There are always complexities with what we do as there are people involved so it is important to build systems to manage this.

Both these presentations are now available on the NZCCCN webpage of the NZNO website. I urge you to watch these videos. Thanks to Megan and Leona for your time and commitment to providing this for us.

In our general meeting we welcomed two new members to our committee. Rachel Atkin is a nurse educator in Tauranga ICU, and David Aveyard is an Associate Charge nurse Manager. Welcome to the committee and thank you for volunteering for this role. With welcomes also come goodbyes. Erin Williams and Sarah Rogers have finished their service on the committee. Both these women have held key roles with over the years and been pivotal to our success. I thank you both for your time, enthusiasm and commitment to our work. Steve Kirby has also stepped down from chairperson and I have now taken over this role. Thanks to Steve for your leadership over the last three years, and I am appreciative of your ongoing support and mentorship from the vice chairperson role.

Noho ora mai
Tania Mitchell
Chairperson NZCCCN

Letter from the Editor

There are some lovely opportunities in this edition to become involved internationally without leaving the country. Check out the offers from WFCCN and BACCN in this edition. We also have an article from the staff at PICU. This looks very worthwhile as a read and I would encourage you to take the time to read it.

Does this inspire you to put pen to paper, or fingers to keyboard, more accurately? It does not have to be a long article and can just be an opinion piece or information. If you want to get some information out to the wider critical care community, why don't you write something for the newsletter and we will put it in for you.

New research is coming in May, read about it and see if you want to be involved, it is tackling the hard topics of bullying, harassment, and discrimination. Perhaps you have been a target or witnessed behaviour that is not acceptable. This may be the confidential anonymised route you have been looking for to get your experience out there.

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

I look forward to, and welcome, feedback and articles for the newsletter.

Be safe,

Steve Kirby

Editor NZCCCN

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

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INVITATION TO PARTICIPATE

Bullying, discrimination and sexual harassment amongst Intensive Care Unit nurses in Australia and New Zealand

We would like to invite you to participate in a survey to determine the extent and impact of bullying, discrimination and sexual harassment experienced and witnessed by ICU nurses in Australia and New Zealand. As a participant in this research, you will contribute vital data to help us better understand this issue. Your answers will help us to develop policies and guidelines to support ICU nurses.

Your answers are anonymous and will not personally identify you. We expect that this survey will take up to 20 minutes to complete.

Who is conducting this research?

This study is being led by Associate Professor Rachael Parke, Cardiothoracic and Vascular ICU, Auckland City Hospital; Kat Mason, University of Auckland; Sam Bates, Western Health; Melissa Carey, University of Auckland; Adele Ferguson, Whakatane Hospital; Naomi Hammond, The George Institute; Fiona Joyce, CVICU, Auckland City Hospital; Steve Kirby, Middlemore Hospital; Tess Moeke-Maxwell, University of Auckland and Francis Nona, University of Queensland.

This group represents ICU nurses and researchers who are experienced in quantitative and qualitative research methodologies. The group also includes Māori and indigenous Australian researchers who bring a unique skill set and are instrumental in the data analysis from a cultural perspective.

The research has been supported with a grant from the University of Auckland, Auckland New Zealand.

The research has been supported by the New Zealand College of Critical Care Nurses, the Australian College of Critical Care Nurses and the Intensive Care Research Coordinator Interest Group.

The research study is looking to recruit participants who are registered nurses working in an ICU in Australia or New Zealand.

Participation in this study is voluntary. If you do not want to take part, you do not have to.

The findings of the research will be published and presented at national/international meetings of ICU nurses; in peer-reviewed journals; by providing the study findings to all ICUs in Australia and New Zealand and through social media such as Facebook and Twitter.

If you decide you want to take part in the research study, please follow the link below to read the full participant information sheet and complete the questionnaire.

Link to questionnaire: https://auckland.au1.qualtrics.com/jfe/form/SV_0ifFmVXnrT4Kmiy

Contact details for Māori cultural support or to lodge a complaint: If you require Māori cultural support, talk to your whānau in the first instance. Alternatively, you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.

If you have any questions or complaints about the study, you may contact the Auckland and Waitematā District Health Boards Māori Research Committee or Māori Research Advisor by phoning 09 4868920 ext 3204.

AHREC Chair contact details: For concerns of an ethical nature, you can contact the Chair of the Auckland Health Research Ethics Committee at ahrec@auckland.ac.nz or at 373 7599 ext83711, or at Auckland Health Research Ethics Committee, The University of Auckland, Private Bag 92019, Auckland 1142

Approved by the Auckland Health Research Ethics Committee on 16th March 2021 for three years. Reference number AH22006.

Approved by the University of Southern Queensland Health Research Ethics Committee on 24th March 2021 until 16th March 2024. Reference number H21REA061.

We thank you for your time and for considering whether you would like to participate.

Ngā mihi,

Associate Professor Rachael Parke, Principal Investigator, School of Nursing, University of Auckland; Cardiothoracic and Vascular Intensive Care Unit, Auckland City Hospital, Auckland, New Zealand

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Critical Reflection

Angela Gerrand

This critical reflection is using Gibbs' (1998) reflective cycle cited in (Wilding, 2008) and (Paterson & Chapman, 2013) to evaluate feelings of moral distress caused by perceived medical futility faced by myself whilst working in PICU.

What happened?

Eric (pseudonym) was an 8-year-old boy with cancer admitted with a toxoplasmosis infection in the brain, severe mucositis, severe graft versus host disease and subsequently developed respiratory distress, full torso subcutaneous emphysema, and multi-organ failure. He had been off all sedation for around six weeks, and he only responded to painful stimuli and remained fully ventilated. Initially he was orally intubated but this was changed to nasal due to his mucositis. His mother Sarah (pseudonym) was the person at his side the most often, with his father coming in in the evenings and his siblings very occasionally.

What was I thinking and feeling?

As a nurse I strive to provide the best care for my patients, using best practice and not causing pain by my actions and interventions. I like to think that I do no harm with my actions and interventions, however, whilst caring for Eric I often felt that I caused him more pain than comfort. In the course of a twelve-hour shift I had to turn him, perform mouth cares every four hours, do a full wash and sheet change, as well as change his nappy as he had profuse diarrhoea due to his graft versus host disease and skin breakdown around his perianal region.

In assessing Eric's GCS, his motor score was a 4-5 as when pressing on his collar bone he would move his arms either away from his body or slightly up towards the source of the pain, so this is how I knew he could feel even though he showed no purposeful movement or opened his eyes. I noted the same movements with my routine cares, but most especially with mouth cares, changing his nappies, and with suctioning of the endotracheal tube. In addition to showing pain movements Eric would clamp his mouth closed when trying to perform mouth cares.

I felt very conflicted when performing my cares as I understand the importance of them in an immunocompromised patient, but I really didn't want to cause him any more pain. I felt this went against everything I want to be as a nurse. Eric wasn't on any sedation as the medical team was wanting to see if there was any change to his current baseline of non-responsiveness after the commencement of treatment for toxoplasmosis. It was reported to the PICU team by the infectious disease team that Eric required at least six weeks of treatment to see if there would be any improvement in cognitive functioning. I felt as though, while we were wanting to assess function, we were continuing to cause him pain with our basic interventions. Eric had multi-organ failure and his liver was particularly affected so the use of paracetamol was contraindicated, so the pain relief we were using was xylocaine viscous gel applied in the mouth prior to doing his mouth cares. When turning Eric or changing his nappy I had help from either his mother or another nurse to reduce the amount of discomfort Eric would feel. This situation had me thinking about Eric's quality of life, was prolonging it by keeping him intubated in Eric's best interests. The futility of the situation, I felt, made it distressing for me as I didn't like the thought or feeling that I was causing Eric more pain. I was also conflicted as I felt it wasn't my place to be thinking that we shouldn't be doing this to Eric, but instead felt that I should be doing my best to minimise distress to Eric and his family.

What were the thoughts and feelings of others involved and how do I know?

Sarah would be at Eric's bedside during the day and would take frequent breaks outside of the room. I found Sarah to be very quiet and keeping to herself but I would always make the effort to talk to her and allow opportunities for questions and voicing of concerns. I would explain the reasons for our interventions and she remained very proactive with

participating in cares such as the nappy changes. Nurses performed the mouth cares as Sarah was unable to due to the oral tube, but Sarah was able to guide how she'd like them done, such as only using a sponge swab instead of a toothbrush as his mucositis was so bad that the slightest knock to his oral mucosa would make his mouth bleed and the condition had necessitated the removal of some teeth in the past week, the sites of which were slow in healing. Prior to performing mouth cares, I had made sure that I had applied the xylocaine gel 10 minutes beforehand, and after my second shift with Eric, Sarah verbalised to me that this was the first time she hadn't seen Eric accept the cares without clamping his mouth shut.

The moral distress at the perceived futility of Eric's situation was noted by other staff; nurses appeared reluctant to nurse him on a frequent basis, meaning Eric and his family quite often had different nurses. Sarah would often ask that nurse if they would be back nursing them the next day, as it was nicer to have familiar nurses.

Medical staff also expressed their feelings of futility to me with varying concerns and goals of care between teams, likely associated with the multi-factorial, multi-system issues faced by Eric.

Analysis: Making sense of the situation

When exploring moral distress, it is first helpful to distinguish it from a moral or ethical dilemma. Initially the concept of moral distress was developed to differentiate it from a moral dilemma. A moral dilemma is where someone has to make a choice where that choice may conflict with their personal beliefs, such as doing no harm; or their past experiences where situations were handled differently (McLeod, 2014). Moral distress appears to happen when the person feels they know the right action to take, but their moral values are inhibited by the realities of the work environment and feel that it is jeopardising their integrity (Austin, Kelecevic, Goble, & Mekechuck, 2009). It can also be further defined as a state of psychological imbalance or painful feelings of knowing the ethical action to take but not being able to carry it through (Mobley, Rady, Verheijde, Patel, & Larson, 2007).

An intensive care unit provides unique challenges on top of the situations faced by other nurses. It is a complex work environment which exposes the nurse to extra stresses, such as end-of-life discussions and decisions and the prolonging of life with ventilators and other artificial life support, increasing the potential for giving inappropriate care (Mealer & Moss, 2016). We also need to factor in the concept that advances in critical care of children have allowed us to prolong the life of children with life-threatening illnesses and have them survive conditions that were historically life-limiting or fatal (Denis-Laroque, Williams, St-Sauveur, Ruddy, & Rennick, 2017). I feel this sometimes leads to the feeling amongst nurses that we are doing interventions because we can, not considering whether we should, leading to feelings of moral distress as nurses may feel they have to follow a plan of action laid out by medical staff and family wishes and don't feel they have a voice. A study suggested "that nurses see themselves as simply following orders for decisions they do not necessarily support…" pg. 2025 (Laurent, Bonnet, Capellier, Aslanian, & Hebert, 2017).

Saving these children has also increased the number who go home with significant disabilities, and the number of dedicated families who care for them at home. This can cause nurses to maybe question if they are doing more harm than good; as well as facing the reality that many deaths in the PICU follow a decision to withdraw life-sustaining treatment (Garros, Austin, & Carnevale, 2015).

The result of this moral distress and the inability to cope with it can cause burnout. "Burnout has been described as an occupational hazard of the helping professions" pg. 204 (Meltzer & Huckabay, 2004). Burnout is associated with depersonalisation which can result in a cynical attitude towards the patients and families in their care; a negative view of their own nursing ability; and emotional exhaustion which is where the nurse has nothing left to give emotionally, resulting in indifference and lack of concern (Meltzer & Huckabay, 2004). Also, the ever-evolving technology of the health care sector and care-delivery increase the burnout risk in health care professionals, and these professionals may have less time to give the best care to their patients or may not recognise that they are taking unnecessary risks or the consequences of these risks or actions (Tawfick, et al., 2019). A way to cope is to avoid the issue altogether, but a risk with this is that the nurse can become withdrawn or disconnected and affect the care they provide (Forozeiya, Vanderspank-

Wright, Bourbonnis, Moreau, & Wright, 2019). As a defence mechanism, nurses can sometimes withdraw as an attempt to cope with the consequences of ethical conflicts witnessed at the bedside, this can be manifested by the nurse being unwilling to care for that patient as a primary nurse. Nurses may not see this as an issue with regards to affecting patient care, but it can raise problems with communication, fragmented care and reduction in advocacy for the family (Gutierrez, 2005). This was the exact issue that Sarah raised, she had voiced frustration with not having a consistent nursing team, she felt she was always having to explain Eric's cares and feeling like she was developing a new relationship every shift, and felt she didn't have a nursing team to advocate for her and Eric.

Some studies discovered that nurses feel that moral distress is present in their everyday practice not just distinct instances, and seeking support from colleagues can be a strategy to help cope, and developing skills to cope is important to avoid withdrawing and to continue to provide excellent quality care to their patients (Forozeiya, Vanderspank-Wright, Bourbonnis, Moreau, & Wright, 2019).

While the negative effects of moral distress are well documented, there isn't a wide range of documentation focussing on the positive outcomes from a morally distressing situation; moral resilience could be the way to highlight these outcomes (Young & Rushton, 2017). However if we can understand the association between burnout and resilience, it could be a way to improve patient outcomes and the health and well-being of the nurse as well (Guo, et al., 2018).

Resilience can be defined as an individuals' capacity to cope with stresses and difficulties without being damaged, and even to use them as an opportunity for personal growth (Babanataj, Mazdarani, Hesamzadeh, Gorji, & Cherati, 2019). Guo et al (2018) further define resilience as "the ability of individuals to bounce back or cope successfully despite adverse circumstances" pg. 446. Resilience is important in the health care setting as health care practitioners who are resilient will be familiar with their strengths and limitations at their moral core, they will be able to vocalise with clarity any threat to that moral core and be able to differentiate between their own suffering and that of their patients and families (Rushton, 2016). Young & Rushton (2017) further found that a lowering of moral distress can lead to resilience, at the same time as having resilience can lower the amount of moral distress.

To relate this back to my situation with Eric, I feel that I may have the start of resilience as whilst I felt distressed at the situation Eric, Sarah and the family were in, I still tried to relieve the stress on them by alleviating Eric's pain as much as I could with his cares, and the distress on Sarah by working in partnership with her to care for Eric and keep her informed of Eric's progress. I looked after Eric on multiple occasions, and whilst I found it challenged me and my beliefs, I didn't consider asking not to be assigned Eric in the future. I hope that more exposure to situations such as Eric's will only bolster my resilience.

Medical futility can be described as the feeling that there is the use of aggressive interventions in patients that are unlikely to survive the course of their illness, and the frequency of these perceived futile situations have increased due to the advances in medicine (Mobley, Rady, Verheijde, Patel, & Larson, 2007). Furthermore, care could be considered futile is the patient has a low chance of a meaningful recovery to a stage of independence and being able to interact with their environment (Chow, 2014), and nurses feel that providing care where the only aim is to prolong the patient's life is futile as well (Laurent, Bonnet, Capellier, Aslanian, & Hebert, 2017). In fact, a study conducted by questionnaire found that among the biggest issues faced by the nurses, two of them were: "using all available technical and/or human resources despite believing they will produce no significant improvements in the clinical status of patients in intensive care" and "performing treatments or applying procedures that are too aggressive given the status of the patient, and in so causing the patient additional suffering" pg. 2229 (Pishgooie, Barkhordari-Sharifabad, Atashzadeh-Shoorideh, & Falco-Pegueroles, 2019). Whilst caring for Eric I had heard nurses saying that they felt it was cruel to continue to treat Eric, and leaving him intubated was only causing him pain, and to an extent I felt the same way. This was because there had appeared to be no improvement in Eric's neurological status, in six weeks of being off sedation, and being on treatment for the toxoplasmosis, Eric still was not opening his eyes or making any purposeful movements.

The aim of a PICU is to try to cure diseases and save lives, but when the child no longer responds to treatment palliative care needs to be considered, and as nurses work the closest to the patient they often perceive the need for palliative care before physicians (Forsner & Mattsson, 2019). A PICU nurse will spend a twelve-hour shift at the patient's bedside and find

that providing treatment past the hope of survival to be torture (Austin, Kelecevic, Goble, & Mekechuck, 2009), and prolonging suffering can make a nurse feel like a torturer (Laurent, Bonnet, Capellier, Aslanian, & Hebert, 2017).

Oral mucositis is considered to be a frequent and severe complication of chemotherapy treatment and is a primary cause of pain (Allen, Logan, & Gue, 2010). Mucositis affects more than just a patients mouth as the mucosa runs the entire length of the gastro-intestinal tract, it's just that the oral mucosa is more readily visible (Eliers & Million, 2007). Having in place an effective pain relief regimen is important; non-steroidal anti-inflammatory drugs are contraindicated with chemotherapy, and paracetamol should be used with caution so that its anti-pyretic abilities doesn't mask a developing underlying infection. (Bennett, 2016). Eric was in severe liver failure so these simple analgesics were not prescribed for him. Opioid analgesia also has side effects such as nausea, vomiting and constipation as well as a tolerance build-up with higher continued doses; also there is a risk of opioid-induced increase in pain with higher doses (Bennett, 2016). Eric was not prescribed opioids and when I asked why I was told it was because we were keeping him off sedation to assess neurological function/recovery. Looking back, I do wish I had questioned this as maybe a dose of opioid analgesia before cares may have reduced the discomfort Eric felt. While Allen, Logan & Gue (2010) suggest that there isn't any evidence to support the use of viscous xylocaine rinses to the mouth, I found this to be an effective form of analgesia for Eric.

What would you do if the situation arose again: Conclusion

This assignment has allowed me to see that the issues of moral distress and medical futility are not black and white nor easy to define, rather a complex inter-relationship between medical teams, family and myself. I think I will still find it difficult to nurse patients who I feel that we are causing more harm to with our interventions but hope that I will continue to remain professional and provide the utmost care to them. The concept of resilience is appealing as it states that something positive can come from a negative situation, and make the nurse stronger for future morally distressing situations. I hope that I will be able to be a comfort to the families especially if a palliative care route is being considered and not make it harder for them at the time.

Whilst I didn't consider it with Eric, there have been patients in the past that I have requested not to nurse again the next day due to the emotional exhaustion I felt. As a result of this I will now think about the reasons behind these feelings, and will also consider if this will have any implications for their care due to multiple nurses looking after them. As I've progressed with my PICU career, I have noticed that situations where I feel I can't look after someone have reduced.

I have learnt from nursing Eric that I can acknowledge my own distress but not allow it to interfere with the care I am providing. A perceived weakness I feel I can work on is to speak up with the medical teams, especially with regards to pain relief for interventions, to enable me to provide these cares comfortably for both the patient and their families. The comment that Sarah made to me that she had never seen Eric not clamp his mouth closed with the mouth cares has stuck with me as it was nice to know I could bring some comfort to Eric.

Eric's respiratory status continued to deteriorate and he later passed away in Sarah's arms.

References

Allen, G., Logan, R., & Gue, S. (2010). Oral Manifestations of Cancer Treatment in Children: A Review of the Literature. *Clinical Journal of Oncology Nursing, 14*(4), 481-490.

Austin, W., Kelecevic, J., Goble, E., & Mekechuck, J. (2009). An Overview of Moral Distress and the Paediatric Intensive Care Team. *Nursing Ethics, 16*(1), 57-68.

Babanataj, R., Mazdarani, S., Hesamzadeh, A., Gorji, M. H., & Cherati, J. Y. (2019). Resilience training: Effects on occupational stress and resilience of critical care nurses. *International Journal of Nursing Practice, 25*(e12697), 1-6.

Bennett, M. (2016). Pain management for chemotherapy-induced oral mucositis. *Nursing Children and Young People, 28*(10), 25-29.

Chow, K. (2014). Ethical Dilemmas in the Intensive Care Unit Treating Pain and Symptoms in Noncommunicative Patients at End of Life. *Journal of Hospice & Palliative Care Nursing, 16*(5), 256-260.

Denis-Laroque, G., Williams, K., St-Sauveur, I., Ruddy, M., & Rennick, J. (2017). Nurses' perceptions of caring for parents of children with chronic medical complexity in the pediatric intensive care unit. *Intensive and Critical Care Nursing*(43), 149-155.

Eliers, J., & Million, R. (2007). Prevention and Management of Oral Mucositis in Patients With Cancer. *Seminars in Oncology Nursing, 23*(3), 201-212.

Forozeiya, D., Vanderspank-Wright, B., Bourbonnis, F. F., Moreau, D., & Wright, D. K. (2019). Coping with moral distress-The experiences of intensive care nurses: An interpretive descriptive study. *Intensive & Critical Care Nursing*(53), 23-29.

Forsner, M., & Mattsson, J. (2019). Caring for Dying Children in the Pediatric Intensive Care Unit, Nurses and Parent's Perspective. *Online Journal of Complementary & Alternative Medicine, 1*(2), 1-7.

Garros, D., Austin, W., & Carnevale, F. A. (2015). Moral Distress in Pediatric Intensive Care. *JAMA Pediatrics, 169*(10), 885-886.

Guo, Y.-F., Luo, Y.-H., Lam, L., Cross, W., Plummer, V., & Zhang, J.-P. (2018). Burnout and its association with resilience in nurses: A cross-sectional study. *Journal of Clinical Nursing, 27*, 441-449.

Gutierrez, K. M. (2005). Critical Care Nurses' Perceptions of and Responses to Moral Distress. *Dimensions of Critical Care Nursing, 24*(5), 229-241.

Laurent, A., Bonnet, M., Capellier, G., Aslanian, P., & Hebert, P. (2017). Emotional Impact of End-of-Life Decisions on Professional Relationships in the ICU: An Obstacle to Collegiality. *Critical Care Medicine, 45*(12), 2023-2030.

McLeod, A. (2014). Nurses' views of the causes of ethical dilemmas during treatment cessation in the ICU: a qualitative study. *British Journal of Neuroscience Nursing, 10*(3), 131-137.

Mealer, M., & Moss, M. (2016). Moral distress in ICU nurses. *Intensive Care Med, 42*, 1615-1617.

Meltzer, L. S., & Huckabay, L. H. (2004). Critical Care Nurses' Perceptions of Futile Care and Its Effect on Burnout. *American Journal of Critical Care, 13*(3), 202-208.

Mobley, M. J., Rady, M. Y., Verheijde, J. L., Patel, B., & Larson, J. S. (2007). The relationship between moral distress and the perception of futile care in the critical care unit. *Intensive and Critical Care Nursing, 23*, 256-263.

Paterson, C., & Chapman, J. (2013). Enhancing skills of critical reflection to evidence learning in professional practice. *Physical Therapy in Sport, 14*, 133-138.

Pishgooie, A.-H., Barkhordari-Sharifabad, M., Atashzadeh-Shoorideh, F., & Falco-Pegueroles, A. (2019). Ethical conflict among nurses working in the intensive care units. *Nursing Ethics, 26*(7-8), 2225-2238.

Rushton, C. H. (2016). Moral Resilience: A Capacity for Navigating Moral Distress in Critical Care. *Advanced Critical Care, 27*(1), 111-119.

Tawfick, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., . . . Ioannidis, J. P. (2019). Evidence Relating Health Care PRovidor Burnout and Quality of Care. *Annals of Internal Medicine, 171*(8), 555-568.

Wilding, P. M. (2008). Reflective practice: a learning tool for student nurses. *British Journal of Nursing, 17*(11), 720-724.

Young, P. D., & Rushton, C. H. (2017). A concept analysis of moral resilience. *Nursing Outlook, 65*, 579-587.

The BACCN 2021 Virtual Conference will take place on Monday 13th and Tuesday 14th September 2021 and can be accessed from anywhere in the world (where you can access the internet!). This year's conference theme "Critical Care Across the World: Breaking Down Barriers" as this exemplifies what Critical Care is as a speciality, but even more so, what Critical Care Nurses have done across the world over the last 12 months whilst being in the centre of this unprecedented global pandemic. The international focus on Critical Care services have significantly increased because of COVID-19. A significant proportion of patients diagnosed with COVID-19 required input and/or admission to Intensive Care which required an unprecedented action to increase capacity to cope with the influx of patients on top of an already busy system. Delivering sufficient critical care (throughout the whole patient and family journey) goes far beyond the physical infrastructure, such as beds and equipment – it first and foremost requires a highly trained, skilled and experienced multidisciplinary workforce to deliver the individualised care we all believe each patient deserves. At conference we will not just share our learning and experiences but celebrate our profession, for this year and years to come.

As part of our conference programme, we are exceptionally honoured and privileged to welcome two internationally renowned Critical Care Rehabilitation Practitioners as keynote speakers; Dr Dale Needham, Professor of Pulmonary and Critical Care Medicine, and of Physical Medicine and Rehabilitation at Johns Hopkins University in Baltimore and Peter Nydahl, Nursing Research and Department of Anaesthesiology and Intensive Care Medicine, University Hospital of Schleswig Holstein, Germany. Mr Nydahl & Dr Needham, alongside our very own Kate Tantam (the #rehablegend herself) will be facilitating our Humanising Critical Care conference stream across the 2 days. Kate and Peter have assembled a fantastic group of practitioners from across the spectrum of rehabilitation within Critical Care, discussing subjects that will include nurse led rehab, humanising critical care, the MDT approach and how to become a rehab legend in your own unit.

And this is just a small element of what's in store at this year's event! To find out more visit www.baccn.org/conference

15th World Congress of Intensive and Critical Care opts for virtual format

For several years, as we gradually ramped up our planning for the ***15th World Congress of Intensive and Critical Care***, we were most excited about welcoming our colleagues from around the globe to Vancouver, Canada. It is such an exciting, vibrant and beautiful location and would be the perfect backdrop to share knowledge about ***Caring Intensively***.

Now, just 8 months away, the ongoing global coronavirus crises and uncertainty related to vaccine distribution and travel has convinced us that a virtual congress is the only prudent way to proceed. We examined various scenarios and postponed the difficult decision as long as possible.

Our abstract submission portal opened late last year, and we encourage you to submit your work. Soon, we will update our preliminary program on the website. Despite the change in format, our themes will remain the same. The main program will occur as planned from **Sept 11 to 15**, as previously advertised through our "Save The Date" messages. What you can expect to change is that selected content will likely be available both before and after these dates.

Our planning and scientific committees remain committed and excited to deliver a superb program with innovative and engaging formats together with internationally acclaimed speakers. A core value of the program is that **every** session will demonstrate **Equity, Diversity and Inclusiveness**. Registration details and fees will be announced soon and will support participation by all disciplines and income levels.

Please sign up for our email list and bookmark the website. And we still hope to welcome you to Canada as a visitor in the future when travel becomes possible!

Claudio Martin, MSc MD FRCPC Chair, 15th World Congress of Intensive & Critical Care	Janice Zimmerman, MD, MCCM, MACP President, World Federation of Intensive and Critical Care

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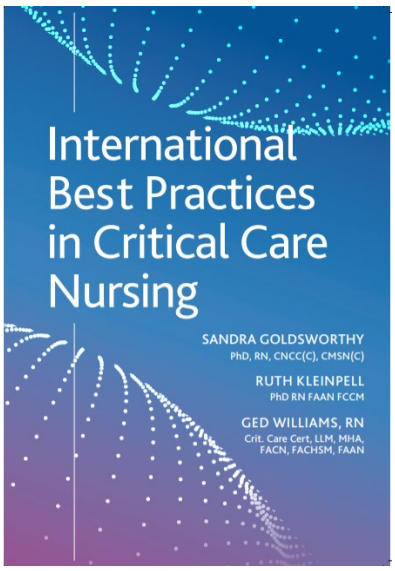
Message from the WFCCN for WFCCN Members,

We would like to offer all members an opportunity to place a link on their association website or Facebook page that provides their members direct access to the 2nd edition of the International Best Practice in Critical Care E book from the WFCCN.

Below is the cover of the E-Book, access the E-book here



We hope your members find this resource helpful in their care of critically ill patients.

Kind regards,

Violeta

Dr. Violeta Lopez, RN, MNA, MPET, PhD, FACN

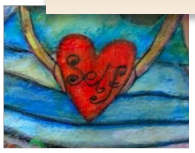
Board of Director (Secretary) and Ambassador, WFCCN

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

Position	Name	Year	Region
Chair	Tania Mitchell	4th	Central
Website/Newsletter	Steve Kirby	6th	Northern
Treasurer	Rachel Atkin	1st	Midlands
Membership	Renee Holland	3rd	Southern
Secretary	Rachel Yong	4th	Northern
Consultation Documents	Lara Millar	4th	Central
Committee	Randy Gopalla	3rd	Mid- south
Committee	David Aveyard	1st	Midlands
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

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