

Critical Comment

New Zealand College of Critical Care Nurses



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Message from the Chair

Welcome to the first edition of the year. Happy new Year to you all. The good weather seems to have arrived and hopefully you have had (or are looking forward to) some holidays and relaxing with friends and family.

We are very much in the lead up to this year's ANZICS conference in Napier. It is a little earlier than previous years at the beginning of March so keep an eye out for the notices from the organising committee and Works4U the conference organisers. Now is the time to get your registration in. Check out the adverts in this newsletter for more details. I am looking forward to catching up with as many of you as possible there.

Our thoughts are with the staff in Whakatane hospital, the trauma of White Island is something that is very hard to comprehend and appreciate. To be the first receiving hospital must have been a huge amount of work and a phenomenal amount of organising for the transfers on to other hospitals. I appreciate that everyone's unit has been very busy and we are all feeling a little exhausted after this event and the ongoing care of the victims.

You should have by now received the draft of the updated definition of the critical care nurse and given me your feedback on this so that we can work towards an agreed definition.

We have been able to support two members to attend the world congress that was held in Melbourne in October and they have written great articles so that we can all benefit from their experiences there.

Behind the scenes the committee has been working on the annual strategic plan and annual budget for the College. As always, our yearly General Meeting will be at the ANZICS conference in March. Notices for nominations, remits and any items for the agenda came out in December. I would encourage you all to be active in this. With your support, drive, advice and feedback we will be in a stronger position to deliver what you need. To reiterate, we want to be a more member driven college and would also encourage you all to become involved in this Newsletter with information and articles of interest. We want our email account to be used more and to that end have made it major focus to be more responsive to all emails and enquiries. With that in mind I look forward to hearing from you all.

Steve Kirby
Chairperson NZCCCN

Letter from the Editor

Welcome to the first 2020 edition of Critical Comment Newsletter. New year, new aspirations. I hope everyone has had a nice break and brilliant start to the new year. Before we spring ahead to the “what’s happening” in the critical care world, let us reflect on what has happened last year. The NZCCCN sponsored members and a colleague attended the world congress conference in Melbourne 2019. They have provided us with insightful and interesting articles for this newsletter.

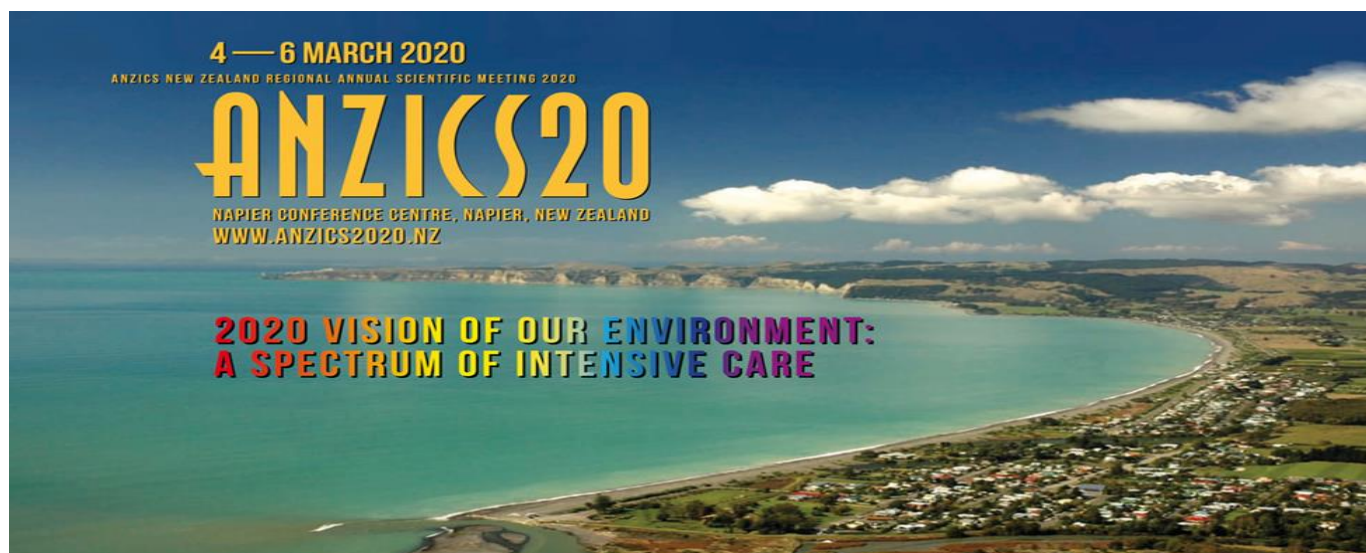
It was also a time where new graduates around the different ICUs were finishing their NeTP programmes. They have shared their experiences, challenges, and perspectives on being an ICU nurse in their respective places. Their experiences and challenges reminds us of where we started many moons ago and shape the ICU nurses we are now and the future nurses we want to be. I can relate to their experiences, challenges and perspective as recently I have started in paediatrics nursing. The care we deliver might be the same but it comes with different challenges altogether nursing the paediatrics population in intensive care.

Thank you to all the contributors towards this edition.

Full steam ahead for the ANZICS conference happening in March at Napier. I hope everyone had an opportunity to register and update your calendars to attend the conference. NZ Resus conference is also fast approaching with early bird registration closing on the 14th February 2020. This gives us the opportunity to plan ahead, save the date for the NZ Resus conference. Details are within this newsletter. Look out for future education workshops adverts coming soon for this year organised by NZCCCN. We look forward to seeing some or all of you there.

Rachel Yong

Critical Comment Editor NZCCCN





Reports from the World Congress of Intensive Care 2019 (Melbourne, Australia)

Jessica Sanford RN

I recently had the very great pleasure of attending the World Congress of Intensive Care in Melbourne, Australia. I was the fortunate recipient of a scholarship gifted by the NZCCCN, and I want to extend an enthusiastic thank you to the college for supporting me. I work in the ICU at Christchurch Hospital. I am also grateful to my charge nurse manager, Nikki Ford, for supporting this professional development experience.

The World Congress of Intensive Care consisted of over 2,000 delegates and presenters, representing over 84 countries. Numerous sessions spanning complex and diverse topics were navigated throughout the week. I will present only a few topics of interest in this article, but should anyone like to hear more about my experience at the World Congress, I'd be happy to share.

World Federation of Critical Care Nursing – council meeting

Prior to the commencement of the conference, I was invited to attend the World Federation of Critical Care Nursing (WFCCN) council meeting as an observer. This was an excellent opportunity to witness an international group of nursing leaders coming together to reflect on the activities of the WFCCN, and plan for the future. There were several aspects of the meeting I found particularly interesting and potentially relevant to my critical care nursing colleagues here in New Zealand. The WFCCN offers individual membership, which among other benefits, gains the member free access to their journal 'Connect-The World of Critical Care Nursing.' A critical care nursing e-book is available to download *free* to anyone via the WFCCN website.

Opening Plenary, Welcome to the World Congress

Speeches celebrating culture, history, and critical care, and local musicians, welcomed us to Melbourne. As a group of delegates and presenters, we were challenged to learn and to share our knowledge with each other, our colleagues, and our patients.

Attending the first release of the ICU-ROX trial was amazing. Dr. Paul Young (Director of ICU, Wellington) introduced his session by reminding us that we evolved (life evolved on Earth!) over millions of years with an FiO_2 of 0.21, further stating that anything above this level is "inherently a physiologic stress." Dr. Young spoke eloquently about the research and the primary outcome, and emphasised the dedication and strong work ethic of his collaborators, and acknowledged the patients who participated in the trial.

In one of the opening presentations, Dr. Ian Roberts (Director of Clinical Trials Unit, London) shared his research, and enthusiastically expressed his feelings about randomised controlled trials, "I marvel at it [randomisation]; it moves me," it [randomisation] is "a gift of knowledge; a gift from the patients." His passion was clear, and I think we were all captivated by the thrill of research!

A Global Tour of Intensive Care

I attended several sessions as part of a Global Tour of ICU. Dr. Kapil Zirpe (Head of Neuro Trauma Unit, India) discussed their national society of critical care medicine as well as challenges facing intensive care across India. Eighty percent of the population does not have any significant health insurance, intensive care is not available to all. The society is also working on developing position statements on end of life care, as this aspect of patient care is at odds with Indian law, and thus there is great difficulty in caring for intensive care patients when active treatment is considered futile. Assem Abdel Razek from the department of critical care in Egypt shared stories of a relatively young development of critical care medicine as a specialty. A significant challenge for clinicians in Egypt is the great diversity in care provision across ICUs, and the nonexistence of intermediate/step down care. Representing Nigeria, Obashina Ogunbiyi (president of critical care society), spoke of the great

need for education and training in critical care. Medical staff are trained for critical care for 3 months in their junior residency, and 3 months in their senior residency. Finally, Dr. Arzu Topeli from Turkey described a heavily burdened system, with one ICU physician covering 40 patients, and ICU nurses on average caring for 3 ventilated patients.

Pressure Injuries in ICU

Professor Fiona Coyer (RN, PhD; Australia) gave an excellent presentation on pressure injuries related to devices (DRPI = device related pressure injury). Professor Coyer highlighted the contributing factors to DRPI as tight securement, constant rubbing on skin, lack of repositioning, heat and humidity, and securement materials. The risks are many; the device doesn't conform to body contours, irregular or sharp surfaces, rigid/stiff materials, minimal instructions on proper use of device, inappropriate or ill-fitting size, inappropriate securement, and lack of awareness of PI prevention measures.

Professor Coyer emphasised that the devices we use today are often the same as they have always been (nasogastric tubes), so preventing DRPI comes from how devices are fit, secured and monitored. She stated that writing in the notes "PAC given" is just not enough!



Preventing Burnout in Critical Care

Associate Professor Sandra Goldsworthy (RN, PhD; Canada) asked the audience, "Do you ever have days where you feel like this?" The lion photograph above is not the exact lion shown on the day, but the image is essentially the same. Professor Goldsworthy grabbed our attention and as I looked around the room, most of the audience were laughing and nodding their heads in agreement. She explained that research has shown that ICUs have the highest turnover of any nursing specialty, and often when nurses leave critical care, they leave nursing altogether. Nurses make the decision to leave 6-12 months before actually leaving, and the majority leave because of their work environment.

A positive work environment can be protective, and can encourage nurses to stay in ICU. Professor Goldsworthy discussed how strong leadership, autonomy, professional development opportunities, manageable workloads, praise and recognition help to sustain nurses. Particularly, investing in professional development improves nurses' intent to stay in critical care.

There were several presentations on advanced practice nursing roles in ICU. Many of these looked at the various roles nurse practitioners have in ICU such as outreach, liaison nurse, and primary clinician participating in MDT and clinical assessment. As part of the 'free papers' presentations, nurses were able to present their current research. Susan Whittam looked at the experience of senior ICU nurses working with new graduates. One of her overall conclusions was that those nurses that support new grads, also need significant support in place to mediate the challenging effects of this responsibility.

Associate Professor Stuart Lane (MD; Australia) gave an enthusiastic presentation on making the workplace happy. He remarked "we should be happy and safe and be able to grow." One of his more poignant remarks was in reminding us as critical care clinicians, that what we do every day is remarkable.

"Sometimes we forget what we do in ICU; to that family, that patient, this is the most critical part of their lives." (Stuart Lane).

Family Centred Care

I attended several sessions on family centred care, with presenters from Denmark, Australia, and USA. Professor Ruth Kleinpell (RN, PhD; USA) explained how patient and family engagement involves collaboration, respect and dignity, decision making, information sharing, activation and participation. Professor Kleinpell's part in this research was part of several groups worldwide, and looked at concepts like open visitation, family conferences, families in 'rounds', family presence during resuscitation, etc. The results represented 40 countries, and the results of ICUs adopting these practices varied significantly. Some barriers identified to patient/family engagement in ICU were shortage of manpower and staff resistance, unit culture, time and lack of appropriate space, a perceived workflow interruption, lack of skill among nurses and lack of recognition among physicians about the importance of family inclusion.

Other presentations looked at the needs of families of trauma ICU patients, and the needs of patients and families after a necrotising skin infection like necrotising fasciitis.



End of Life Care in ICU

(NB. Image illustrates Neil Orford (speaking); Chairs: Stewart Moodie & Marion Mitchell; Seated: Thomas Buckley & Ranjana Srivastava)

Perhaps one of the more moving and impactful sessions came on the final day of conference. Dr. Ranjana Srivastava (Australia) is an oncologist and author. She gave examples of caring situations where the oncology patient required intensive care treatment, and how that came to pass, who were the decision makers, what were the conversations. Dr. Srivastava suggested that with so much treatment available now, end of life conversations have been pushed to the back. She talked about “living in a society that resists mortality,” and that cancer is “full of battle metaphors,” but wonders what battles we fight amongst ourselves as the treating clinicians.

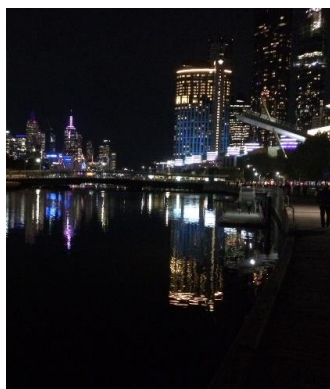
Associate Professor Thomas Buckley (RN, PhD;

Australia) was presenting his research on why narrative matters to staff and families. He summarised how the majority of [Australian] public prefer to die at home. Eighty percent of people actually die in institutions, with 51% of those in hospital, and 15% in ICU (Australia). Some of the complexities of palliative care in ICU include a significant group of those patients dying while on a ventilator, a proportion dying in pain, expectations and constraints on staff making it difficult to manage deaths while in ICU. For the survivors, Professor Buckley highlighted a great struggle, with significant groups of family experiencing depression, post-traumatic stress and anxiety.

Some of Professor Buckley’s work on bereavement, I felt, really could inform nurses’ practice while caring for patients and families in ICU. The death of a spouse hospitalised increases the survivor’s risk of enduring bereavement. This bereavement has the potential for many adverse physiologic changes (cardiovascular etc.). Research has found that how prepared people are for death is a strong predictor for prolonged grief – i.e. minimal preparation may result in prolonged grief. Denial and self-blame are also strong predictors. Therefore, Professor Buckley concluded that we as nurses could help patients and families understand what is expected or possible. There is often a mismatch between what families know/expect and what we as clinicians know/expect – working on marrying up the two perspectives could help people be better prepared and have a chance to do/say things in the anticipation of getting closure.

Finally, Dr. Neil Orford, Director of ICU in Geelong, Australia, shared personal stories in his talk ‘Back on deck tomorrow, strengthening ICU teams through improving end of life care.’ Three themes he identified while experiencing his own grief were *getting on with it, caring for each other, caring for ourselves*. The “narrative voice is important; people engage with it.” A doctor present at the final session made the comment that these sessions “nourish me as a clinician” (Andrew Davies). Fitting words, certainly attending the World Congress of Intensive Care has left me feeling very well nourished.

(An amusing observation: (!) my jacket was nearly an exact match to the wall colour of the Plenary venues in the Exhibition Centre; Melbourne at night)



Links that may be of interest:

www.wfccn.org
www.stopbombinghospitals.org
<https://www.humanizingicu.com/>
<https://www.icn.ch/what-we-do/campaigns/nursing-now>
https://www.who.int/hrh/news/2018/nursing_now_campaign/en/



Medical Assistance in Dying and Organ Donation

Kaylee Ye-eun Nam (ICU nurse in Department of Critical Care Medicine)

Between 14th and 18th of October 2019, I attended the World Congress of Intensive Care conference held in Melbourne. It is the largest biennial gathering of official critical care societies from over 84 countries including over 2000 delegates and speakers sharing their knowledge from a global perspective. As a delegate I had the opportunity to choose among various sessions to attend that interested me.

I work in an intensive care ward that facilitates organ donation. Initially I found the topic very difficult and uncomfortable to talk about, but I have developed an interest in it over the last few years; especially through listening to donor families stating it is the only blessing that could come out from the terrible and sad situation. A session from the conference that really caught my attention was the talk on organ donation after Medical Assistance in Dying (MAiD) – it felt like a raw topic to me as I had not known it existed and I wanted to share this with you in hope that it will be as informative to you as it was for me.

The first MAiD was in 2015 and initial reactions from the Canadian deceased donation organization were reluctant about coupling MAiD with organ donation. As you can imagine, it was culturally, ethically and morally a complicated issue from the deceased donation point of view. The organ donation team needed to have the conversation around potential and unforeseen issues in MAiD and organ donation.

Physicians, nurses and pharmacists in Canada can help provide MAiD without being charged under criminal law. They must follow set rules and policies in the criminal code within their provincial and territorial laws. There are strict criteria a person must meet to be eligible for MAiD. They must be eligible for health services funded by the federal government (visitors to Canada are not eligible); they must be at least 18 years old and mentally competent to make healthcare decisions for themselves; they must have a grievous and irremediable medical condition; they must make a voluntary request for MAiD that is not from outside pressure or influence and give informed consent to receive MAiD.

A grievous and irremediable medical condition means having a serious illness, disease or disability that cannot be reversed – these patients must experience unbearable physical or mental suffering and be at the point where natural death has become reasonably foreseeable.

Currently there have been 56 MAiD patients referred to the organ donation organization. Thirty of these patients were organ donors and there were 66 transplants. Twenty percent of the 56 MAiD patients had amyotrophic lateral sclerosis – a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, causing loss of muscle control. The exact pathophysiology is not clear and there is no cure for this fatal disease.

The biggest difference in organ donation after MAiD and donation after circulatory or brain death is that the patient is conscious and competent and can participate in their end-of-life and organ donation decisions. They also provide first person consent from a medical, legal and ethical perspective. Personal stories from patients explaining their decision of MAiD (for example Dr. Shelly Sarwal and her last project; <https://herlastproject.ca/2019/08/14/extraordinary-story/>) has been influential in helping healthcare professionals realize regardless of the providers ethical and/or moral belief system, MAiD is a fundamental issue of personal autonomy, self-determination in end-of-life. These patients have taken their decision for MAiD seriously and spent months planning. As healthcare professionals we are bound by our duty to care, placing our patient's wishes first. Regardless of the inevitable clashes of individual moral and ethical beliefs we must not let this interfere with our ability to provide honest and unbiased care and refer them to other services when available. MAiD is still a growing movement

and remains controversial and it does not sit easily with all healthcare professionals' beliefs and values; therefore federal legislation respects this and does not force any person to facilitate or assist with MAiD.

Currently, the time from assessing to approval of MAiD takes 16 days. The time from MAiD request to organ donation consent takes 25 days. Patients undergoing organ donation after MAiD need an evaluation of organ function and acceptance through a number of blood and imaging tests. Many of these patients have debilitating neuromuscular weakness, therefore accessibility to hospital is paramount. Some patients refuse imaging tests potentially influencing their eligibility for donation. After MAiD, a "dead-donor" rule must always be respected so no attempt for organ retrieval may be made before the patient is declared dead. This involves a 5-minute "no touch" period of continuous observation – this also means retrieving organs cannot in any

way contribute to, or be, the cause of the patient's death.

Challenges arise when patients want to choose their organ recipients and when they wish to die at home and get transported into the hospital. Another issue is donor coordinators who are traditionally working with families of comatose patients, who now have to take the journey with a patient who is anticipating death. Donor coordinators report these situations as being particularly difficult to manage.

I certainly found this conference talk very interesting and I wanted to share this with you to let you know this is happening in other countries such as Canada and the Netherlands. It may be a possibility that more countries will engage in MAiD with organ donation in the future and just maybe New Zealand could be one them.

I hope you found this to be a thought-provoking read. I certainly found MAiD confronting, especially with euthanasia being debated in Parliament at the moment. As I mentioned at the start – organ donation and the processes involved can be a controversial

topic. Even after working with multiple patients and families in the organ donation process and also waking up a transplant recipient after surgery, I know talking openly about what I know will always be a challenge and never be easy. I am aware some may still see it as a taboo topic, however I wanted this to be a reminder and a learning opportunity from our international counterparts regarding processes such as MAiD, so we can continue to discuss our medical care in a way that encompasses a holistic approach in New Zealand.

I would also like to thank NZCCCN for sponsoring me to participate in the World Congress. I certainly enjoyed my time at this conference, and it was a pleasure to learn from others regarding their work.





The Symphony of Intensive Care: A junior nurse's perspective of the 2019 World Congress of Intensive Care

Charlotte Jackson

I am a junior nurse, a second violin, one nurse among many in an orchestra which plays the symphony of intensive care medicine. Flying over to Melbourne for the World Congress of Intensive Care (WCIC) I felt like a high school musician about to play with the London Symphony Orchestra. Excited to learn, but very out of my depth and unsure of how I could provide any further value. However, after a week of listening to amazing doctors, nurses and researchers, I have found that this second violin has discovered how to not just improve my own playing ability but also how to understand the orchestra and really listen to the music.

Preparation and expectations

If you are another junior nurse reading this and you want to know 'how do I know if I am ready to go to the next WCIC?' then this is my perspective.

It is important to be prepared. It helps to have learnt the instrument and be able to read the notes. You need an established critical thinking, an in-depth understanding of medications, pathophysiology, and anatomy. You also need a good understanding of research values and be able to interpret these values quickly. Otherwise, you will become rather lost while listening to speakers trying to fit in months or years of research into a 20-30 minute talk. However, most importantly you need a developing curiosity and the enthusiasm for the 'why'.

The WCIC, although a trip overseas is a professional event. It is important to be prepared to communicate and behave in a professional way for a week. This means interacting with doctors, and senior nurses in a more casual, but still professional, manner.

What I have learnt

The WCIC has left my brain very tired and overwhelmed with how much I have learnt. As much as I would like to replay the whole overture, here are some of my favourite melodies of the week.

Nurses of every level play an important role in research – *it's hard to create a melody without any notes.*

One thing that many speakers had in common was acknowledging and thanking the nurses. Nurses were responsible for a vast amount of data creation, either to be used retrospectively or in real-time. Having data to collect is vital in helping ensure the development and growth of ICU medicine. Without a large amount of accurate data, it is difficult to create quality research studies. In practice documenting that one piece of data on one single day for one single patient can feel insignificant. But don't forget you cannot create a melody and then a symphony, without any notes.

Don't forget the child in the bed – *We play the music not for ourselves, but for the patients who are listening*

In the world of ICU, where patients are hidden beneath the wires and tubes, it can be easy to remember patients for their disease, not their names. One huge lesson I learnt at the WCIC is to remember that although nursing is my career, we are ultimately nurses for our patients. Although it can be very easy to focus on our own progression, on being a second violin when we want to be a first, our patients are the reason we create the music. These children and families are not just the illness in the bed, but are multidimensional people who have their own specific health culture, health history and spirituality. We can provide better care if we listen to and work to understand our families as the people they are. We would not invite our patients to hear us play just to make them wear earmuffs. So, let's take them off and remember this symphony is for our patients.

We thrive when we communicate and work as a team – *The music is better when we play the symphony as an orchestra instead of individual players.*

When we work collaboratively and encourage participation it motivates us to flourish in our practice. A good orchestra becomes a great one when all sections play cohesively together. Great communication is not only vital across professions, but also amongst the nursing team. Effective communication and teamwork contribute to workplace flourishing, and this flourishing, in turn, leads to a happier team with more personal and professional growth. And all of this leads to better patient outcomes. However, just as we don't expect a single violin to play over the horns, communication becomes obsolete if we cannot provide the space where people can speak up.



My own message to fellow junior nurses based on the lessons I have learnt is, although we don't have the melodies of the first violins, we can still be heard, and our part is important. Without the harmonies and rhythmic support of the second violins no symphony would be complete. It is important to take pride in being a junior nurse. We may not be the conductor or the concertmaster, but we are a valuable part of this medical orchestra. Our value lies in the work we do every day, creating the data to be used in life-changing research, caring for our patients and advocating for them as people, and being a cohesive member of the team.

My NeTP year in Whangarei ICU

Kathy Lorenz

I had never been in an intensive care unit until my final practicum of my nursing degree, subsequently I did not know what to expect when I was offered to spend my transition placement in the Whangarei ICU. The first day began with a handover that left me wondering if I had learnt anything in the past two and a half years of studying as most of the words sounded foreign to me. My preceptor and I were allocated a young woman who was suffering from Guillain-Barré syndrome. She required mechanical ventilation via a tracheostomy, and total assisted cares as she was hardly able to move her limbs or head. It was astonishing to me that we had to plan our day nearly to the minute although we were looking after one patient only. Within the ten weeks I got to spend in the ICU I found myself beyond impressed by the innumerable skills the nurses exhibited and by the collaborative work of the multidisciplinary team. At the end of my placement I left the unit inspired and with the aspiration to continue my learning in the critical care environment, although knowing that it would be a major challenge. I felt very lucky when I ascertained that my application for a job in the Whangarei intensive care unit was successful and I would be spending my new graduate year learning from- and working among the team there.

Indeed, being a new graduate nurse in the ICU has come with its challenges. One of the major obstacles I have encountered is a lack of confidence due to very limited practical experience, as well as having unrealistic expectations on myself and my progress. Consequently, I started to put too much pressure on myself initially, a pattern I know only too well that frequently hinders my learning. Moreover, despite looking after only one patient at a time, time management has proved to be a considerable difficulty. Whether due to various medications to be given, observations, cares or other critical interventions to be rendered, I often struggle to complete tasks on time. All of these challenges have been accompanied by feelings such as distress, self-doubt and insecurity, which can be tough to deal with at times. However, working within a supportive team environment has alleviated most of these struggles. For the first few months as a new graduate nurse in the Whangarei ICU I have been rostered with a clinical coach who supports me and the development of my (critical care) nursing skills. As in Whangarei hospital high dependency- and intensive care are combined in one unit, I have started out with looking after relatively stable high dependency patients, before moving on to the more complex cases later on. As I develop further skills, become increasingly competent and require less support, I begin to work more independently, until my clinical coaches will finally step back completely. The coaches have been incredibly supportive and reassuring, which has helped me greatly to become more comfortable and confident in my new role, as well as to relieve me from the pressure that I have been putting on myself. What is more, every three weeks a meeting with the nurse educator of the unit is scheduled, where I get time to debrief, reflect on- and evaluate my progress and receive feedback. These meetings have been markedly helpful to discuss areas where more comprehensive learning may be necessary and to set achievable goals accordingly.

Fortunately, I did not start my position in the ICU alone, but alongside another novice nurse. Sharing my journey with a fellow new graduate has proved to be more than valuable for the reason that we get to exchange our experiences, to debrief and discuss our struggles, as well as to motivate and reassure one another. It makes a notable difference to talk with someone who is living through the same- or at least very similar situations. We are usually working on opposite shifts, however every now and then we are rostered on a 'skills day' together. These days have been planned by the nurse educator to discuss and practice skills that are specific to the ICU environment, as well to review more in-depth knowledge of the body systems in

order to promote further critical thinking and understanding. Both of us genuinely enjoy these days as they are not only greatly informative but also a lot of fun.

What I appreciate most about working in the ICU is the fact that nurses are given the opportunity to look after a person in a holistic manner that goes beyond merely their



physical health. Due to the critical condition patients in the intensive care unit may find themselves in, looking after their mental health, their emotional- as well as their whanau health is just as important. Moreover, as the ICU environment is based on a multidisciplinary team approach, it is exciting to collaborate and work closely together with health professionals of different backgrounds to achieve best

health outcomes for clients and their families. Furthermore, instead of working in areas that are specific to certain conditions, critical care nursing offers a wide variety of skills that can be acquired and fostered including medical, surgical, orthopaedic, paediatric, as well as palliative care nursing skills. Additionally, critical care nursing provides the opportunity to develop sound critical thinking and to apply and expand knowledge of the human body and pathophysiology on a daily basis. Every day is different in the ICU. I find it intriguing to walk through the doors at the beginning of a shift not knowing what to expect. Some days the unit is nearly full, some days there are no patients at all. Some days start off with many and end up with hardly any patients, and on some days the shift begins in a nearly empty unit, but the beds fill up within hours.

Overall, being a new graduate in the ICU may be associated with challenges, however as evident in literature, most new graduate nurses will encounter obstacles at some stage in their first year. Nonetheless, being able to contribute to someone's recovery from critical illness, or to provide comfort cares and meaningful time with loved ones for those in their final days of life, outweigh the obstacles as it is greatly rewarding. From my personal experience I know that the ICU environment may seem intimidating at times, particularly when lacking experience. However, I believe with the appropriate support it is an incredible opportunity to learn, acquire and foster skills that are relevant to various areas of nursing practice. This journey does not solely entail the development of nursing skills, but also considerable personal growth. To say it with the famous words of Barney Stinson (although in a slightly different context): Challenge accepted!

NETP in a secondary ICU/CCU

Yvette Llagas (RN – ICU/CCU; Rotorua Hospital)

When I received notification I was accepted in ICU/CCU for NETP, I was ecstatic. During my transition placement there as a nursing student, I knew this was where I would like to practice. I must admit that I felt anxious due to the complexity of nursing care and extensive knowledge required. As a new nurse graduate, I knew I had a lot to learn but also knew from my transition placement how supportive the Rotorua Hospital ICU/CCU staff and management were. I was excited to accept the job. I was thrilled because even though the programme was only for a year, I knew that I would come out with knowledge and skills that I could use for the rest of my career.

From the day I started, no day has been the same and this is exactly what I enjoy about ICU/CCU nursing. Everyday I learn new things and skills such as nursing infants with bronchiolitis and their families along with how to manage bubble CPAP. I find

providing support and education to parents very fulfilling as well. In CCU I found learning about and identifying the many heart rhythms very challenging and know this is an ongoing process. What I found most challenging at first was talking with the doctors. Initially it was very scary, and I would ask myself “what do I know and can I give recommendations around patient care?” I can say that I am now more confident to speak up for patient safety and provide input to aid the speedy recovery of my patients.

As all critical care nurses know the learning never stops. I am now beginning to learn about ventilation. I am excited about this as I find respiratory management very interesting.

NETP is now coming to an end and I am grateful that I have been offered a further year contract to continue my career in ICU/CCU. I am looking forward to learning more, however, I expect that the challenges will be greater as the expectation becomes higher. But you know what, I am ready for that. 😊

New Graduates belong in the Intensive Care Unit

Amelia Spring

I remember exactly where I was when I read the email from my Charge Nurse Manager offering me my dream job. The stress of nursing school was finally over, and I had sat states the previous day, and I had all my hopes pinned on one email to be the cherry on top. Then I had it, a New Graduate position in Wellington Regional Hospital’s Intensive Care Unit, something I had wanted since I had stepped foot in the ICU three years ago as a naive first-year nursing student.

Now, I am writing this article as I congratulate a friend on gaining an ICU NeTP position for 2020, 10 months on from when I first started as an ICU nurse. Reflecting on the year, it has been both hard and enjoyable. The physical, mental and emotional challenge of a new graduate year is something that nursing school does not quite prepare you for, however, I don’t think I could have been more supported to make this transition into ICU. I’ve heard the phrase “new graduates don’t belong in the ICU.” Thankfully not from any of my colleagues.

I was fortunate enough to work in the ICU part-time as a health care assistant in my last year of nursing school, as well as do my 9-week transition placement there. Both of these opportunities set me up well by the time I began my NeTP year. I was working with people I had known for the last year, in an environment I knew. This meant I had fewer things to worry about when starting which is nice when beginning something that is making you incredibly nervous. I was also fortunate enough to be one NeTP out of four of us who gained ICU positions, which meant I instantly had a support group of colleagues who are navigating a similar experience to my own at the same time. This meant we supported each other through similar experiences. Completing this year without fellow ICU new graduate nurses would have made this challenge more isolating, and I would have had fewer opportunities to reflect on my experiences.

Wellington ICU orientation period was great, eight weeks of precepting, with a checklist to ensure you have cared for certain patient types and completed specific tasks. You’re orientated by an experienced group of nurses, which includes a NeTP graduate from the previous year, and your main contact for the year is an educator. This educator also works a shift with you each roster throughout the year and is there for all your questions. Working with an educator, and having a NeTP as a preceptor are two of the best parts of the orientation package. Working with an educator allowed me to extend my ability safely, and benefit from eight hours of bedside teaching every 6 weeks. Then working with a NeTP graduate from last year allowed me to see how far I could progress in a year, and having a preceptor who had just been in my shoes helped calmed my nerves just a tad.

Nerves can signal challenges and stressful situations, but one of my challenges this year was a mental one. I realised about 6 months into the year, in the height of winter that I wasn’t looking forward to coming to work. I asked myself why? Was it just because of the winter pressure? After talking it over with an experienced colleague, I realised it was because I wasn’t being challenged enough with my patient allocation. The patients I was caring for required more emotional nursing and physical activity rather than a mental challenge. I enjoyed caring for these long-term patients in amongst caring for patients in acute states of illness or injury, but caring for these patients back to back was leading towards reduced enjoyment at work and physical and emotional burnout. I talked to one of the experienced nurses at work, and we walked around the unit that afternoon and found an appropriate patient for my allocation the next day. This nurse listening and helping me identify why I felt this way ensured I didn’t burn out or stay in my slump. She also pointed out that I don’t have to feel guilty for wanting a challenge at work, or for asking for a change.

I also remember tearing up during handover going into my third night less than 6 months in, because I had been allocated two patients instead of the usual one. Doubling is part and parcel of caring for HDU patients and short staffing in ICU. I had experienced a tough shift my first night and had cared for my first double on my second night, which was tricky and I had left late. One experienced nurse also pointed out that my first double was an easy double, which left me feeling a bit worse for wear after I'd found it hard. Coming back and seeing my name was down for another double, stressed me out to no end. What I should have done was talk to the charge nurse there and then, before they started handover to see if I could swap. Instead, I got upset during handover. Not ideal! But the charge nurse swapped my allocation and reassured me that that was okay. She also checked on me during the shift and was understanding about what had occurred.

I remember caring for a person following cardiac surgery who was bleeding significantly from his chest drains. I was completing a buddy shift with my nurse educator. It was my first time taking a post-operative cardiac since orientating and I would have been about 4 months in, and I felt incredibly out of my depth. Both my educator and I were worried, and we had notified both the intensivist and the cardiac surgeon. My educator still needed a lunch break so the ACNM of the day supported me through that half-hour with this sick patient. Standing at the end of the bed I rattled off to my ACNM all the things I was thinking of or had done to manage this patient, and she said I can't think of anything you've missed. That's when I realised that I could handle this, at least for some time. I knew what I needed to do somewhere in my head. That same ACNM later reflected with me about how impressed she was with how I handled that patient, and this feedback instilled a little bit more confidence than I had before. This was the same shift I also realised that looking up and seeing all 6 cardiothoracic registrars plus the surgeon at the end of the bed, mean your worry is very justified!

Challenges are not always patient emergencies. It's mostly navigating the first year of nursing; you will have many different types of challenges, mostly unexpected! You need to become familiar with recognising your limits and when you're showing signs of burnout or dissatisfaction in your job. To be able to have people to talk to and have these people listen and help you through your troubles. Having a work/life balance, and practicing self-care strategies that work. The first year of nursing is tough, let alone in ICU, but it's also so great.

Some of the ways my ICU has supported me in my new graduate year includes study days, placing me next to or allocating me challenging patients, positive and constructive feedback, and encouraging learning. Role modelling and teamwork here is exemplary, and no one will tell you a question is silly, they are encouraged. You're not expected to have all the answers and not ask any questions, I've heard our senior nurses say some version of "I don't know but I'll/we'll found out" more than a few times. These are the same nurses that come up to you at the end of a busy shift with a tough patient and congratulate you on a job well done.

ICU is exactly where I want to be for the next few years of my career. I have the opportunity to care for multiple patient types and learn to manage numerous pieces of equipment. I have the privilege of caring for people and their families on some of their toughest days and at the end of their days. I have the opportunity to attend a variety of study days and also look ahead to a career path of flight nursing or the patient at risk service. I was a fresh slate for all these experienced nurses, as well as our MDT, to place a wealth of knowledge onto which I utilised readily. All this because someone decided that new graduates will do just fine in the ICU, with the right bundle of support.

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