
Pediatric Intensive Care Nursing

Newsletter of the International Pediatric Intensive Care Nursing Network

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This newsletter is produced as a publication of the International Pediatric Intensive Care Nursing Network (for more information, visit our website and join our egroup: <http://www.egroups.com/group/PICU-Nurse-International>). Readers are encouraged to use any part of this Newsletter for nursing newsletters in their own regions, as long as this publication, as well as the article's author, is recognized as the original source.

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Editorial Welcome

Welcome to the Second Issue of **Pediatric Intensive Care Nursing** : *The Newsletter of the International Pediatric Intensive Care Nursing Network*. This Newsletter aims to: (a) promote international communication among nurses interested in the care of critically ill children; and (b) foster the ongoing development of the International Pediatric Intensive Care Nursing Network (a semi-formal network of national and regional pediatric intensive care nursing associations, as well as interested individual nursing members).

We encourage you as readers to post copies of the Newsletter in your departments. As well, we encourage you to publish articles from this publication in your own national or regional nursing newsletters but we request that you indicate the original author, as well as the name and date of this Newsletter for any material you choose to use.

At present, the editorial process for the preparation of this Newsletter is still semi-formal. That is, preparation is largely coordinated by Franco Carnevale (Canada), in consultation with Wil de Groot-Bolluijt (The Netherlands) and Patricia Moloney-Harmon (United States) – the 3 nursing members of the World Federation of Pediatric Intensive and Critical Care Societies. In the near future, this will be formalized through the creation of an International Editorial Board that will ensure a more systematic representation of international issues.

We hope you enjoy OUR Newsletter!

Franco Carnevale, R.N., Ph.D., Montreal, Quebec, Canada

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Innovations & Controversies

The Swan Ganz Catheter – A Critical Review

Dirk Danschutter, Brussels, Belgium

Introduction:

The pulmonary artery catheter (PAC) was introduced in 1970. During the eighties and the nineties while assuming it improved outcome in the severely ill patient, use of the PAC underwent an exponential growth.

Historical Background:

Lewis Dexter introduced the first PAC in 1945 to diagnose congenital malformations of the heart (ASD, VSD, TOF,...). From 1950 to 1970 the PAC was mainly used by cardiologists in the cardiac catheterization lab. Manipulation remained laborious and fluoroscopy was indicated to maneuver the PAC into the correct site. Since the PAC was not yet provided with a balloon, wedging of a distal branch of the pulmonary artery occurred by pushing up the tip of the PAC itself (1). Bradley introduced cardiac output measurement by means of thermodilution in 1968 but Swan and Ganz launched the PAC career in 1970 by introducing it as a ‘flow-directed balloon-tipped catheter’ (2). The big innovation was the presence of a small, inflatable balloon at the tip of the catheter, which caused the PAC to get caught (‘to sail’) by the drag of the right heart-stream (3). Fluoroscopy was not mandatory anymore, while the procedure of occluding a distal artery became less iatrogenic. The principle of cardiac output measurement by thermodilution was added to the ‘balloon-tipped’ PAC in 1972: the ‘Swan Ganz’ catheter (SGC) raised like a phoenix beyond the cardiac catheterization lab walls to the intensive care units worldwide.

Critique:

In 1987, Gore et al. conducted a retrospective observational study that identified a higher mortality in a group of acute myocardial infarction patients where PAC had been placed (4). An accompanying editorial raised the issue of the need for a randomized clinical trial of PAC use. A bold statement like E. Robin’s *‘the mass use of the PAC was a form of iatro-epidemic, systemic error introduced into medicine which causes harm or death to masses of patients’* (5,6) however did not stop the PAC march and new ‘seducing’ concepts were presented (pacing port, continuous SVO₂ or - cardiac output measurement,...). Even in pediatrics, several attempts to promote the merits of the SGC were made (7).

About a decade later - in 1996 - Connors et al. compared mortality among different United States teaching hospitals in a so-called prospective observational cohort study. Data used was collected for another purpose as part of the Study to Understand Prognoses and Preferences for Outcomes

and Risks of Treatments ('SUPPORT'). Detailed information was collected on 9105 patients who had a 50% risk of 6-month mortality. Data from a subgroup of 5735 ICU patients was analyzed, but relied greatly on the use of a 'propensity score' (a logistic regression of several variables to predict the likelihood of PAC insertion). So, about 5000 patients with an equal severity of illness (all etiologies) were divided in a SGC and a non-SGC group. 2016 patients were matched and analysed. Results were not in favor of the PAC: mortality was lower in the non SGC-group (8). In the accompanying editorial Dalen and Bone wondered 'if it was time to pull the PAC?'(9). 'Randomized controlled and multicentre studies is urgently indicated' it sounded (10,11).

Survival interval	nSGC: survival, (%)	SGC: survival, (%)
30 d	677 (67,2)	630 (62,5)
60 d	604 (59,9)	550 (54,6)
180 d	522 (51,2)	464 (46,0)

In 1998, Jean Louis Vincent et al. stepped on many toes by stating: '... if mortality is increased, a possible explanation is related to the fact that patients lay in open ICU's. Therefore, PAC's are not necessarily placed by trained ICU physicians...', hence criticizing Connors' study. The march and overuse of the SGC in the US hospitals was to blame: 38% of ICU admitted patients got a SGC, a percentage that was never encountered in European ICU. Poor selection criteria led to over consumption with morbidity and mortality as the price to pay (12). Vincent also quoted an equal minded: '... Only the bad workman blames his tools...' (13). Even though this PAC overview was classified as provocative and opinion-based opponents agreed that technology introduced on the rationale of physiologic measurement without hard data about potential benefits, costs and harms had to be subjected to evaluation (11)

Rational use:

The SGC is not a medication: it will not cure a patient. It is a diagnostic item and therefore implies a price to pay. Damage caused by the SGC, how small ever, can only be justified when valuable clinical information is the end result.

Diagnostic procedures however have to be of simple and non-iatrogenic concept. Though the list of complications due to SGC-use can be very loaded: pneumothorax, hemorrhage, pericardial tamponade, arrhythmia's, endocardial lesions, rupture of the PA, lung infarction, infection, septicemia, thrombosis, etc... There has been estimated that SGC use leads to all kind of complications in 5 to 10%., 1% are life-threatening (1).

How much are the obtained data reproducible or accurate, when the difference between volume overload or hypovolemia depends on the height of a transducer? Pressures are translated to volumes while volume itself is not measured. I.e. PWCP is taught to be a measure for the LVEDV, but what about the compliance of the left ventricle? As one study concluded: 'PCWP is nothing but a poor surrogate for cardiac filling'.

Not all available data are always used during SGC placement: CO is not always measured - even

not connected (known as the 'red cap' syndrome (12), while not everybody is equal familiar with SVO₂ readings, although it's the most sensitive parameter displaying the balance (or imbalance) between VO₂ and DO₂.

Not in favor of the SGC either is that data can be obtained by newer and less- or non-invasive techniques. Transesophageal echography (TEE) and pulse contour continuous (cardiac) output (PiCCO) are 2 examples. Another technique (in pediatrics) combining Fick's law and Wesseling's algorithm is based on indocyanine green (ICG) injections with transdermal CO measurement. Restoring parts of these and older techniques (like measuring impedances) has now been tuned up again in concepts based on bio-impedance (14).

An examination (multiple choice questions) designed by 16 intensivists from 13 different centers out of the US and Canada led to the amazing result that only 53% of the examined (n=496) could interpret a PWCP. '*Treatment based on coin toss is probably as good as treatment based on PWCP*' it sounded (15). A European study revealed analogue results (16).

In most cases the SGC 'reveals' what the clinician already knew, though it is believed by many that such invasive technique should not be used for confirmation, but rather for steering or changing of installed therapy. This steering should lead to outcome improvement, which till today is not in favor for the SGC. Selection criteria are probably the most important parameters. Very ill patients with end-stage heart disease, gut ischemia or MOSF will not cure because of a PAC. There is also no need to put a SGC in the (formerly) healthy multiple trauma patient. Is it necessary to elaborate ever increasing cardiac output in the septic patient, and if so, does this improve outcome? Not everyone is ready yet to accept a downgraded use of alpha- and- beta-mimetics or lower (but acceptable!) blood pressures. Is this lower cardiac output embargo and massive attack with inotropes not the same as 'beating a sick horse to run ever faster'? Does the clinician become more aggressive or invasive with a SGC at his side? Like the vascular surgeon who performed 70 abdominal aneurysm operations in 2 different hospitals A and B. At A, 20% got a SGC, while in B 95%. 9% did not survive at A's, while the patients at B's got 4 liters more. 28% died... (1)

Conclusion:

In the realm of SGC, several attempts to promote its use in pediatrics have been made. These efforts were successful. Yet the SGC sometimes failed. This author too has witnessed in children a few of SGC 's major complications, including quadriceps necrosis. Even death has been the price to pay for diagnostics... It's for 10 years now the SGC is therefore and locally 'replaced' by the other techniques. They do fine. So what 's the need to bring back old harms and fears in pediatrics?

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Suctioning children: Rethinking old rituals

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From the recent discussion on the PICU-Nurse-International discussion group we were interested to note the differences in suctioning practices. Once again it has highlighted the controversy of suctioning being considered a clean versus sterile technique. The discussion was prompted by an inquiry about changing practice from passing a new suction catheter each occasion the ETT was entered, to the practice of reusing the same catheter for each suctioning episode (e.g. 2-3 times). The table below summarises our 'all-inclusive' responses and diverse practices. One begins to wonder if it is possible to create any other ways!

In the endeavour to have a consistent approach to nursing care, it would be useful to resource the available evidence to inform our nursing practice. But, as we all know this evidence does not always exist. Therefore, the next best approach might be to use logic to inform practice. Performing endotracheal suctioning is a "bread and butter" procedure for paediatric intensive care nurses, yet our practice does not seem to be based on logic or evidence.

Let's look at the 'clean' versus 'sterile' issue. Sterile procedures are conducted to prevent 'contamination'. So, presumably it is contamination of the airway and lungs that we are endeavouring to avoid. The airway of an intubated patient is already open to the surrounding environment via the patient's nose and the mouth. Indeed, it is not a sterile field at all, but instead a 'clean' area. Of course we want to keep it clean and prevent any further contamination and in particular, prevent any cross contamination. Therefore, it is logical to use 'clean' gloves

and a ‘clean’ catheter. The use of sterile gloves and catheters is not logical when performing suctioning on the intubated patient. It is interesting that the Centers for Disease Control and Prevention (CDC) do recognise that there is not adequate evidence to recommend the use of sterile gloves in preference to unsterile gloves. Yet, in contrast, they do recommend the use of a sterile single-use catheter for suctioning when an open-suction system is employed.

Now, let us examine the issue of single-use versus reuse of catheters. If you accept the argument of a ‘clean’ airway it therefore follows that it is not necessary to have a new sterile catheter for every ‘pass’ into the ETT, or indeed for each suctioning episode. This then raises the question of what period of time can the same catheter be safely reused? Reusing suction catheters has not been routine in the current ‘disposable’ era. However, more recently it has been established that the practice of reusing disposable suction catheters within a closed -circuit is safe, although this has not been established when reusing a disposable catheter with an open-suction system.

We have attempted to resolve this issue and have completed a randomised controlled trial in a tertiary paediatric intensive care centre and have demonstrated that it is safe to reuse a disposable suction catheter on the same patient for up to 24 hours. We studied 486 patients and found there was no significant difference in the development of nosocomial pneumonia. Therefore, we challenge the ritual of suctioning being performed as a sterile procedure (further details can be found in the conference proceedings from the 3rd World Congress in Pediatric Intensive Care, Montreal, 2000). As a group of dedicated paediatric intensive care nurses it would be good to sort out this aspect (and many others) of our suctioning policy. We welcome further contribution so that we might reach some consensus.

Table 1 Summary of suctioning practices identified from responses to the discussion group.

<i>CLOSED –SYSTEM</i>	<i>OPEN –SYSTEM</i>
◆ For patients on oscillator	◆ New catheter each time ETT entered
◆ For patients ventilated > 48 hours	◆ New catheter each suction episode
◆ Change weekly	◆ Clean glove as have sterile sleeve on catheter
◆ Change if stained or weekly	◆ Sterile glove
◆ Advantage: cost effective, no loss of PEEP, do by self, cleaner as closed	◆ Sterile kit with gloves, catheter
	◆ Re-use catheter 24 hour, clean glove

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International News

International Paediatric Nursing Research Network (IPNRN)

Submitted by Bev Copnell, Melbourne, Australia

In March this year, a group of paediatric nurses met together to discuss the possibility of forming an international network for researchers in the field of paediatric and child health nursing. The proposal received overwhelming support, and 22 of those people present volunteered to form a planning committee to develop the network.

The broad aims of the IPNRN will be to:

1. Enhance the care of children and their families through use of research findings.
2. Raise the profile of research in child health and paediatric nursing.
3. Enhance the conduct of nursing research concerning the health of infants, children and adolescents and their families.
4. Provide a focal point for the sharing of research evidence, experience and expertise for nurses wishing to conduct research concerning the health of children and their families.
5. Facilitate communication between researchers in the field of child health care.
6. Identify areas where research is needed, preventing unnecessary duplication.
7. Foster international research collaboration for research studies concerning child health care.

The work of the planning committee to date has involved informing paediatric nurses of our intention to establish this network. To that end, a document has been circulated to all relevant journals and newsletters, and should be published over the next few months. This document can also be found on the PICU-Nurse-International website. We plan to formally launch the network at the International Paediatric Nursing Conference in Beijing next year. Currently we are investigating possibilities of obtaining funding for the activities of the network.

While the IPNRN will not be specific to critical care, I believe it will provide an exciting opportunity for PICU nurses who are interested in conducting or using research to network with each other and with the wider community of paediatric nurses; it will also be an extremely valuable resource. If anyone is interested in joining the planning committee, please contact Sarah Neill, the IPNRN Planning Group Co-ordinator, by e-mail: sarah.neill@talk21.com or sarah.neill@northampton.ac.uk

Note: For further information and background on this Network visit the PICU-Nurse-International egroup website (www.egroups.com/group/PICU-Nurse-International) and click on 'Files.'

**Reflections On The Art And Science of Paediatric Intensive Care Nursing
7th Symposium ESPNIC Nursing 2000**

Colin Way, London, England, UK

European Society of Pediatric and Neonatal Intensive Care (Nursing)

September 2000 was an eventful month in my diary. Firstly the UK petrol shortages were in full swing, the 7th Annual ESPNIC Nursing Symposium was scheduled for 22-23 September and I had just completed my full time MSc in clinical nursing. My first concerns were that because of petrol shortages I would not be able to make it to the symposium, but thankfully British Airways didn't let me down and I arrived in Innsbruck on the 21st

I have been privileged to be involved with these biyearly events for the last four years and it never fails to amaze me how much hard work goes on behind the scenes. Organisation of this conference started two years ago with members of the Innsbruck organising committee and the scientific and executive committees of ESPNIC Nursing. The standard and quality of these symposia continues to improve and this year was a truly spectacular event with a variety of good quality scientific papers. This year was a significant event in ESPNIC's history because we established our first one-day nursing postgraduate course, which extended the symposium to three days. Two courses were on offer, "The Ventilated Child" (in English) and "Controversies in withdrawal of treatment" (in German). There was a truly international flavour to the postgraduate course with speakers from Amsterdam, Germany and Austria and a representative from Sensormedics. The programme was evaluated well and the standard of presentations high. Because of ESPNIC's commitment to developing practice we intend to hold these post graduate courses on a regular basis.

The symposium was held at the faculty of social science at the University of Innsbruck. The venue was large and impressive with excellent information technology facilities including simultaneous transmission on the Internet and provided the ideal venue for the symposium. As always there were a large number of delegates from all over Europe and it was great to see both old and new colleagues and have the opportunity to socialise and debate important PICU issues. The programme was varied and provided topics of interest to both PICU and NICU nurses. Andrew Darbyshire (ANP UK), Huder Huijer Abu-Saad (Meistricht) and Denizman Selliman (Turkey) were our distinguished invited speakers and provided the delegates with a wealth of information and the opportunity to discuss important nursing issues. It was great to see the programme reflecting the title of the symposium "art or science" and identifying how our speciality is a complex balance between the art and science of our profession. This can be illustrated by the variety of papers presented, ranging from aspects of transitional care, developments in cardiac practice and research in nursing practice.

This symposium was especially memorable to me due to the fact that some of my friends and colleagues officially stood down from positions within ESPNIC Nursing and others joined us. It is now a very exciting time for the scientific and executive committees with new challenges and horizons. We are all now focused on organising our next symposium which will take place in Gothenburg 13-14 September 2002 and we hope to see many of you there.

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Other Recent Events

Romania: Romanian pediatric nursing leader Irina Iusan helped orchestrate a congress of the Asociatia Asistentilor de Therapie Intensiva Pediatrica - The Association of Paediatric Intensive Care Nurses, on May 4-5, 2000 in Brasov, Romania. This successful congress brought together pediatric intensive care nurses and physicians from throughout Romania.

7th Annual Japanese Workshop on Pediatric Intensive Care: This Workshop was held in conjunction with the 3rd World Congress on Pediatric Intensive Care held in Montreal June 25-29 2000. Also entitled The Post World Congress Japanese Workshop, this event was held in Toronto on June 30, 2000. This brought together 100 delegates from Japan (approximately 40 nurses, 40 physicians, and 20 other participants from varied health care disciplines, students, and the private sector). The workshop consisted of a variety of teaching sessions, hands-on clinical sessions, and hospital tours.

Submitted by Maria Laslop, Clinical Nurse Specialist, Pediatric Critical Care Unit, Hospital for Sick Children, Toronto, Canada.

ESPNIC (Nursing): The European Society of Pediatric and Neonatal Intensive Care (ESPNIC) has recently launched their website at: www.espnic.org

This very informative site was developed largely through the efforts of fellow PICU nursing colleague Hans Schulte from The Netherlands.

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International Pediatric Intensive Care Nursing Network

This Network is a semi-formal affiliation of national and regional pediatric intensive care nursing associations, as well as interested individual nursing members. This was founded on June 26, 1996, in Rotterdam, The Netherlands, at the 2nd World Congress on Pediatric Intensive Care. The next meeting was held on June 30, 1997, in Ottawa, Canada (in conjunction with the World Congress on Intensive & Critical Care Medicine).

The following are the Minutes from the most recent meeting of the International Pediatric Intensive Care Nursing Network held on June 26, 2000 in Montreal, Quebec, Canada (in conjunction with the 3rd World Congress on Pediatric Intensive Care).

This meeting was attended by over 30 nurses from at least 9 countries (including Australia, Canada, Germany, Lebanon, The Netherlands, New Zealand, Norway, United Kingdom, United States).

**International Pediatric Intensive Care Nursing Network
Minutes from the General Meeting
Montreal, Quebec, Canada, June 26, 2000
Prepared by Pat Moloney-Harmon, United States**

1. **Introduction:** Wil deGroot introduced the 3 nursing facilitators:
Franco Carnevale, Montreal, Quebec, Canada
Wil deGroot-Bolliujt, Rotterdam, The Netherlands
Pat Moloney-Harmon, Baltimore, Maryland, USA

2. **Developing a PICU Network**

This idea has been germinating for awhile. There are benefits to a semi-formal network which include establishing links, and avoiding the need for formal rules and regulations.

Everyone was asked to leave a point of contact – information sheets were passed out to all delegates. Delegates were asked to list their societies or themselves as contacts. Most delegates have access to the Internet.

3. **World Federation of Pediatric Intensive and Critical Care Societies**

What is the role of nursing in WFPICCS?
What is the role of nursing societies in WFPICCS?
What ideas are there for the future of WFPICCS?

One suggestion was to use WFPICCS to promote charitable endeavors. NACHRI (National Association of Children's Hospitals and Related Institutions) was suggested as a model for this kind of work.

All delegates are interested in having both the network and WFPICCS.

Franco described that many nurses cannot move around the world. Can we create alternative ways to communicate such as a website?

There is difficulty in finding out what is going on in other countries. What other ways

can information be obtained?

Bev Copnell informed the group of an International Pediatric Nursing Research Network. It is in the planning stage with a new website. An announcement will go in the journals this year. The goal is to share research and resources. Bev asked that if anyone was willing to put the announcement in their journal for no charge to contact her.

Several delegates expressed concern that WFPICCS was seen more as focusing on the “medical” specialty. Also, delegates asked about more nursing representation in the opening ceremonies.

The PICU Global Nursing Network can be used to promote nursing in WFPICCS.

Suggestions for projects/activities:
Support the 2003 Congress in Buenos Aires.
Develop webpage/newsletter.
Exchange program

Develop educational standards worldwide as a basis for practice.

Examine recruitment and retention of nurses into pediatric critical care. For example, NACHRI completed a survey of 7- PICUs in hospitals in the US. The data will be available soon. Could this be done worldwide to examine recruitment, retention, stress, mandatory overtime.

How can projects be funded?

Attach to existing venues such as a university webpage.
WFPICCS
Attach to societies that have a Webpage.
Establish links.

4. Outcomes of this meeting

List of nursing societies and representatives.
Can nursing meet on an annual basis? Maybe small groups can work together on projects.

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Call for Pediatric Intensive Care Nursing Societies & Associations

We need information about the Nursing Societies or Associations that pediatric intensive care nurses participate in, within your country. This will help us continue to develop our International Pediatric Intensive Care Nursing Network as well as the nursing membership of the World Federation of Pediatric Intensive and Critical Care Societies.

Listed below is a list of groups that we presently have information about. If the national Nursing Society or Association that is most pertinent for pediatric intensive care nurses in your country is not listed below, please send us information about it by email to frank.carnevale@muhc.mcgill.ca

Australia

Paediatric Intensive Care Special Interest Group - Confederation of Australian Critical Care Nurses

Canada

Canadian Association of Critical Care Nurses

Europe

European Society of Pediatric and Neonatal Intensive Care - Nursing

France

Société française des infirmières en soins intensifs (SFISI)

Romania

A.A.T.I.P./ A.P.I.C.N - The Association of Paediatric Intensive Care Nurses

Turkey

The Critical Care Nurses Society

United Kingdom

Royal College of Nursing - Paediatric Intensive Care Forum

United States

American Association of Critical-Care Nurses

Society of Pediatric Nurses

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Announcements

The 2nd International Congress on Pediatric Nursing & 23rd International Congress of Pediatrics

September 9-14, 2001, Beijing, China, www.chinamed.com.cn/pediatrics

8th Nursing Symposium of the European Society of Pediatric and Neonatal Intensive Care

September 13-14, 2002, Gothenburg, Sweden, www.espnic.org

4th World Congress on Pediatric Intensive Care

Buenos Aires, Argentina, 2003, Email: info@eventsintl.com

News From PICU-Nurse-International@egroups.com

This Internet discussion egroup was founded on July 4, 2000, following the Montreal World Congress, to help foster ongoing international dialogue among pediatric intensive care nurses and serve as a principal forum for promoting the activities of the International Pediatric Intensive Care Nursing Network. If you are interested in further information visit our website at www.egroups.com/group/PICU-Nurse-Internation, or contact the moderator by email at frank.carnevale@muhc.mcgill.ca

Membership:

The egroup's membership has grown remarkably within a very short period of time. Currently, this includes 238 members from 22 countries. A more detailed profile of the egroup's membership is outlined below:

Egroup Membership

Number after each country indicates the number of members from that country.

Argentina	1
Australia	31
Austria	1
Belgium	1
Brazil	2
Canada	59
Czech Republic	1
Denmark	2
Finland	2
France	1
Germany	4
Hong Kong/China	2
Iceland	2
Indonesia	1
Japan	1
Netherlands	11
New Zealand	1
Norway	4
Singapore	1
Spain	2
United Kingdom	26
United States	82

Total Members: 238 from 22 Countries

Messages Posted on PICU-Nurse-International Egroup

Members of the group have discussed a large number of highly varied and interesting topics (members of the egroup can review all past messages from the website, after ‘Signing In’ and then clicking on ‘Messages’). These are outlined below in terms of (a) number of messages posted by month, and (b) number of messages posted for each topic:

Total Messages Between July 4-November 30, 2000: 589

Breakdown of Messages by Month:

July 130
August 56
September 136
October 153
November 114

Breakdown of Messages by Topic:

Numbers after each topic indicate the number of messages posted on that topic. Numbers in parentheses indicate the number of total messages posted within that category.

Egroup Technical Matters (40)

Extra-corporeal Circuits (42)

ECMO 7
CVVH 32
Bleeding/VAD 3

Cardiac Pacing (17)

Respiratory (78)

Endo-tracheal tube suctioning 28
Ventilation 8
Ventilation weaning 11
tcpO₂ 4
BPD 3
Tracheostomy tubes 7
ETT tape/Hy-Tape 10
Pleural-peritoneal shunts 1
Prone positioning 6

Professional Networking (61)

European Society of Pediatric and Neonatal Intensive Care - Nursing (ESPNIC) 8
International Congress on Pediatric Nursing, Beijing, China 3
3rd World Congress, Montreal, Canada 17
4th World Congress, Buenos Aires, Argentina 2
Looking for contacts 7
Newsletter 4
Jobs in Canada 2
Website links 12
International Pediatric Nursing Research Network 1
Nurse practitioner programs 5

Psychosocial (75)

- Noise 13
- Sensory imbalance 4
- 'Visiting' policy 35
- Pet therapy 10
- Patient transfer 6
- Child-friendly ER 6
- Follow-up clinic 1

Sedation/Analgesia (35)

- Withdrawal reactions 2
- Sedation/pain scoring 21
- Propofol 10
- Morphine monitoring 2

Intravascular lines/Medications (103)

- Pressure monitoring 7
- Swan Ganz catheter 13
- UA lines 2
- Drips 14
- Inotrope survey 10
- Blood gases sampling 10
- IV infiltrations 2
- Heparin/saline irrigation 12
- FFP 7
- KCl 3
- Lipid infusions 2
- Medication errors 10
- Oral medications 6
- Medication records 5

Miscellaneous (138)

- Skin care 19
- Chest dressing changes 8
- Enteral feedings 11
- Transport 2
- Urinary catheter care 6
- Temperature taking 10
- Historical development of pediatric intensive care 4
- Charting 5
- Guidelines/policies/procedures 2
- Synergy model/clinical ladders 3
- Training needs analysis 4
- Head injury 2
- Cervical/spinal guidelines 4
- Cooling 10
- Dialysate 14
- Jehovah's Witnesses 5
- Nurse/patient ratios 8
- Various 21

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