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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://groups.yahoo.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.

Page Layout by Marisa Picciano

Editorial

Caring for a Critically Ill World: September 11th and the distress of children

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Editor

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There has been a new sentiment in North America following the events of September 11th, 2001. Much like the way a child's sense of security and optimism toward the world is broken when faced with the premature death of a parent or a dear friend, we in North America have suddenly learned about the fragility of peace and security in our everyday lives.

As the attacks took place, I was struck by how my parents (both in their seventies) were deeply overcome by their painful war memories (flashbacks) from their adolescence. They lived in Italy during World War II. Their 'ruler' had decided to align Italy with the Nazi Regime. Consequently, they faced extraordinary bombardment. My father saw his brother's leg get destroyed by a bomb. Horrendous memories that they carry with them to this day. War and violence profoundly ruptures our understanding of the world order.

As the events of 2001 continue to unfold around the world, we are surrounded by all sorts of analyses and commentaries in the media. Yet as a pediatric nurse, I am particularly concerned about how all of this affects the children of the world. In one part of the world, several thousand children immediately lost a parent, in another part of the world, children are living the daily terror of fleeing from bombs that drop from the sky, while in other regions, children are surrounded by adults that are fearfully guarding against threats of anthrax and other terrorist strikes. All of this is added to the already existing childhood suffering around the world due to war, poverty, HIV, and various forms of exploitation. A large proportion of the children of the world face daily hardship and a bleak future. **These** will be the adults of tomorrow.

It seems to me crucially important that we do what we can to help comfort and heal this profound suffering. **What can we do?**

As nurses, we hold a vitally important place in the life of humanity. We are present all over the world: in peace and in war, in wealth and in poverty, in sickness and in health, at the beginning of life and at the end of life, in the daytime and in the night-time - **we are there** - and we are globally recognized as voices for caring. We have a deep understanding of human suffering and distress - and a remarkable skill in comforting others under extreme circumstances.

I would like to call upon our global nursing community to act as advocates for children: as *nurses* in our workplace, as *citizens* in our nations, and as '*agents of care*' in our various national and international activities. Let us consistently strive to ensure that the voices of children are continuously heard and attended to.

As well, let us reach out to each other as fellow nurses and care for ourselves so that we can have the strength to continue our precious work: *caring for a critically ill world*.

September 11th, 2001 - A view from a New York City PICU

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September 11, 2001 began like any other day in the Pediatric ICU at New York Presbyterian - Weill Cornell Medical Center, beginning the day's routine, planning for admissions and starting patient rounds. Shortly before 9:00 am the television news reported a fire at the World Trade Center and there were vague reports that Tower 1 may have been hit by a plane, but this was unconfirmed. Immediately we began deciding which patients were stable enough to leave the ICU, how many beds we could make available, and how many staff were needed.

The Disaster Plan had been activated throughout the hospital and the PICU triage nurse was in the Pediatric ER waiting for patients to arrive. Telephone calls attempting to contact the staff were made, a difficult and frustrating task because phone service was sporadic at best. We transferred our stable patients to surrounding hospitals with secretaries, social workers, and hospital volunteers acting as messengers, running to the hospitals in question and relaying the necessary information to allow us to facilitate the transfers.

For the first time in New York City's history access in and out of the city was shut down. By 9:20 am the bridges and tunnels were closed and the subways were not running. Many patients were discharged to make room for the injured there was no place for those who lived in outer boroughs to go. The children's playroom on the General Pediatric floor and an area in the cafeteria were set up as areas for patients

who had been discharged. The Child Life staff was kept busy keeping the children engaged with projects that would help pass the time and keep their minds off what was happening downtown.

Within a few hours we had made available 11 PICU beds with the possibility of doubling up the rooms if needed. We were prepared to take any age patient, child or adult. People were being evacuated from "ground zero" and we anticipated getting admissions at any time. In the Emergency Room adult patients were beginning to arrive, with injuries that included lacerations, eye injuries, inhalation injuries, broken bones, and burns. Eventually it was announced that the downtown site was closed to rescue efforts because there were so many unstable buildings and they could not guarantee the safety of the rescue workers. This would happen several times throughout the day.

At this point a long wait began. Our ER would eventually see approximately 150 patients over the course of the day, most of whom were treated and discharged. The Burn Unit admitted 25 patients, many with what experienced burn nurses described as "the worst burns they had ever seen". But most of us just waited and watched the events of the day unfold on the many TV screens throughout the unit. For many of us, having to focus on work was the only way we were able to get through the day. There was shock and anger, a sense of wanting to stay strong for each other, and unbelievable teamwork.

There was a surreal quality to the images that we saw that day. This was our town and our people and we watched the buildings fall knowing that people we knew were in them. Our hospital lost two EMT's who had responded to the call for help and were killed when the buildings collapsed. One of our nurses got a call from her brother-in-law who was in Tower 2 when the second plane hit. He hadn't been able to get through to her sister and so he called her. It was the last time anyone spoke to him. Many of our staff are married to firemen and police officers and there was immediate concern for their safety. There were numerous stories of near misses and devastating losses.

As nurses we are trained to respond to any situation and the nurses of our PICU, our department, and the entire hospital responded magnificently to the tragedy of September 11th. People came to work as soon as they saw what was happening on television. Despite daunting security and transportation nightmares many of our staff made it to work that night and the next day. The physicians, respiratory therapists, social workers, child life staff, ancillary staff and others gave their best that day. The most frustrating and demoralizing result of the day was that there were so few injured to treat. The most vivid memories I have of September 11, 2001 will always be the amazing response of my colleagues to a scenario we could never have imagined, and the empty beds that remained in our unit at the end of the day.

Come & Join PICU-Nurse-International

An Internet discussion group of the
International Pediatric Intensive Care
Nursing Network.

For more information, visit our website:
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International](http://groups.yahoo.com/group/PICU-Nurse-International)
or contact Franco Carnevale (moderator) at
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INNOVATION IN NURSING PRACTICE: A Singapore Perspective

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Improving quality and performance has become the commitment for health care organization in Singapore. Nurses are not spared the need to participate in performing care processes with minimum effort, rework or waste. An increased health care cost is a contributing factor towards the need for deploying more cost-effective methods in the daily delivery of patient care. Service-driven frameworks that are increasingly responsive to customer demands and quality are also driving nurses to take a critical look at restructuring their nursing practices to adapt to change quickly and effectively. Hence, many traditional unproductive work systems and processes are reviewed and constructed from the perspective of a new paradigm. In responding to the change in work redesign for cost effectiveness and service responsiveness, nurses have to ensure that quality of care is not compromised.

In the area of innovative nursing practices, nursing leaders have a crucial role to play in assisting the nurses to find meaning in work and to go beyond mere tasks and functions. It is necessary to instil the value of ownership for nursing practices and ownership is fundamental to accountability and achievement of outcomes. The commitment of a nurse leader to personal, long-term involvement of being a facilitator, coordinator and integrator of processes is very crucial. Supports and encouragement are often needed to influence the nurses to perform successfully and it helps to boost up the confidence of nurses. The practice of empowering nurses must also be viewed as a principal component of effective management. The process entails providing nurses with skills and empowerment to make decisions especially those affecting them directly.

In Singapore, the Quality Circle movement has spurred up the health care setting to form Quality Circle (QC) teams. Many nurses are equipped with the knowledge of using Quality Improvement Tools to refine their work processes by adopting the **Plan Do Check Action** (PDCA) framework. PDCA cycle provides a step-by-step guide to effectively identify and analyze problems, and also implement solutions that are achievable. Quality Circle movement is very much a team effort approach to improving work processes and managing resources in a cost-effective manner. The engagement of people who are directly involved creates an advantage to improving the system and work processes as these people know best about how to improve and tackle problems collectively and make recommendations.

The scope of Quality Circle in the current setting is mainly directed at improving the work environment, clinical quality management of patient care, work methods and reducing wastage of resources. Often in a work environment, there may be areas where the system or the work processes are tedious and may hinder nurses from performing their responsibilities efficiently. The significant role of the QC teams is to analyze the work processes and eliminate unnecessary steps, allowing work to be carried out in a more effective and meaningful way.

Besides reviewing processes, the introduction of innovative ideas to work practices is also an integral part of the task contributed towards quality improvement process by the QC team in the unit. For example, the use of a water mattress placed underneath the trunk of a haemodynamically unstable child is a method

adopted by the Children's ICU (CICU) for fever control. Through initial observation, this method proved to be more effective than wet sponging and antipyretics in reducing temperature. This innovative idea is advantageous to a group of patients where antipyretics are contraindicated and fever control is predominantly a problem. Initial assessment seems to be more useful but the evidence of effectiveness still requires further studies. A positive observation that we have noted, nurses are more convinced to conduct studies to prove the effectiveness of water mattresses in reducing temperature. Along with the innovative ideas, there will be many challenges and opportunities ahead for nurses to excel in the field of research. Therefore, a study is currently conducted by a group of nurses in CICU comparing the effectiveness of fever control between the use of water mattresses versus antipyretics in critically ill children.

The Quality Circle movement has indeed set the nurses thinking, and they are able to visualize problems in a wider perspective. Nurses have gained good knowledge not only in problem-solving skills but have also acquired an increased awareness of cost impact on our health care funding. Nurses should be empowered with decision-making, and encouraged to set vision toward their work, extending their work into new areas of activity, while maintaining operational effectiveness and improving both the standards and processes. The change in work redesign that brings about improvement in the quality of care service responsiveness, an improved cost and work environment can be achieved with the recognition that nurses have the ownership of their work. The responsibility of nursing leaders in the area of work redesign is to trust, empower and support our nurses throughout the journey in the process of implementing innovative nursing practices.

Searching for a Logo: Calling for Imaginative Ideas

The International Editorial Advisory Board is searching for a Logo for this publication. We are now 2 years old and have established an identity of our own. We would like to complete this by creating our own distinctive logo.

We therefore call on all our readers, and friends of our readers, to submit any original designs that you wish to propose - set your imaginations free!

The Board will select one such logo among the proposals that we receive. Please send your proposal to the Editor (Franco Carnevale): frank.carnevale@muhc.mcgill.ca

Initiation of a Pediatric Nurse Practitioner program at St. Louis Children's Hospital in St. Louis Missouri

*Nancy Rollins Gantz, PhD, RN, MBA, CNA
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Participants:

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Carol Massmann, RN, MSN, CPNP, PICU Nurse Practitioner

Lara Smith, RN, MSN, CPNP, PICU Nurse Practitioner

Introduction

St. Louis Children's Hospital, a level-one trauma hospital, comprises two hundred and fifty-two beds and is one of 12 hospitals in the Barnes-Jewish Health System. It is the number one transplant center in the world for Neonates and Pediatrics in lung transplantation, as well as offering top-line heart, liver and kidney transplantation. There has been strong support during the past ten years for the Nurse Practitioner role for both in-patient care and outpatient services, and most especially in the Neonatal ICU unit where approximately 14 neonatal nurse practitioners (NNP's) practice.

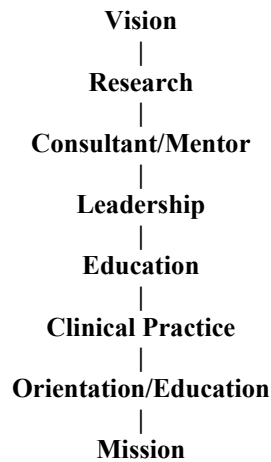
In February of 2001, a program was initiated in the 26-bed PICU unit, 53% of the patient population being Cardiovascular surgery. This program began with three Nurse Practitioners, all of whom had worked as staff nurses in the unit, and two of them recently obtaining their Pediatric Nurse Practitioner certification. The other Practitioner had been functioning in the role of the Clinical Nurse Specialist (CNS) for the PICU unit during the previous two years.

The Mission of this program was to develop and implement a Pediatric Nurse Practitioner (PNP) Program for the twenty-six bed PICU that would provide training and education not only for St. Louis Children's Hospital but, in the future, a training facility for other hospitals and PNP programs across the country. The literature strongly supports that with the use of Nurse Practitioners health promotion, preventative health care with proven cost-effectiveness, positive patient outcomes and efficient utilization of resources will occur.

Goals of the Program:

- 1) To empower and maintain the epitome of quality patient care.
- 2) To empower and maintain consistency of patient care.
- 3) To enhance patient/parent satisfaction through improved - teaching, interaction and care related activities; psycho-social support; and coordination of care.
- 4) To provide consultation to nursing staff and other healthcare team members.
- 5) To provide ongoing education of nursing staff.
- 6) To consistently mentor nursing staff and provide a professional role-model.
- 7) To significantly contribute to the Pediatric Critical Care knowledge base through research, publication and Conference presentation.
- 8) To provide significant impact on timely, safe, cost-effective patient care services in the PICU through the efficient use of resources, decreasing length of stay and insuring optimal outcome.

PICU/PNP Model for Success
Facing the Challenge: Constructing the Future



Our vision for this program was to create a professional nursing environment throughout the Pediatric Intensive Care Services areas, where the role of the Advanced Practice Nurse is viewed as the core value for clinical practice, education and collaboration among services.

Competency statements were developed for the Pediatric Critical Care Nurse Practitioner, and they addressed both the role of the Pediatric Critical Care Nurse Practitioner at St. Louis Children's Hospital and the practice for the Nurse Practitioner. Many of the program guidelines were adapted from the Neonatal Nurse Practitioner educational preparation that was prepared in 1995 by the National Association of Neonatal Nurses.

Education :

A curriculum was developed for the three selected Nurse Practitioners and originally had been developed as a twelve-week orientation period. Each week consisted of both didactic and clinical experience in the PICU through a variety of ways. As we worked through each week we learned something new and we would alter the program as we saw fit. There were many changes to the program and challenges! The first thing we realized is there somehow had to be more of a balance to the clinical component and that the didactic component had to be more in-depth, as this was the main area the three PNP's felt that they were most deficient. Throughout the program, that has remained so and we have tried various ways to increase their education and 'sense of competence' so they feel that they have the tools needed to function as a PNP in the critical care area. It became obvious in starting a program such as this that there is a big difference between the education of a Fellow/Resident and the Nurse Practitioner. The Fellow and Resident has a very in-depth pathophysiology, physiology/anatomy and disease specific education in their medical training. However, we knew that the PNP education lacked that component, and that a 'sense of competence' would evolve over a period of time working in the PICU environment. As the program proceeded we continued to work with the physicians and staff collaboratively. The biggest challenge with the program has been bringing it to a point where the Physicians and staff feel that the PNP role is indispensable and that their function in the PICU is one of critical need. Also we came to realize that one of the best resources for the Nurse Practitioners were the Fellows, especially as they were willing to teach and work closely with them.

In Closing

By no means is the program developed to where the Practitioners feel like they have a defined and concrete role in this twenty-six bed PICU unit even though we are ten months out since the program's inception. For any unit I believe it is a challenge to implement a program such as this and it takes a strong commitment, not only from the medical staff and the nursing staff, but Administration and the Hospital as well. We are very fortunate in that Administration and the Vice-President of Family & Child Services, Velinda Block, RN, MSN, are very strong supporters of the Nurse Practitioner role in that we have over sixty nurse practitioners throughout the hospital setting, functioning in a variety of environments. We are continually fine-tuning the program and the job description for the Nurse Practitioner and I believe that one of the things that will make a difference and move the program forward will be the addition of two more Nurse Practitioners (2 full time equivalents) thus leveling out responsibilities and enabling one Nurse Practitioner to be off service at all times. This will eliminate the frustration the Practitioners feel about not having as much time for other duties (i.e., research, education for the nursing staff and their own growth, and committee involvements) that contribute to and promote their role and function.

I am confident that we will demonstrate the value and positive outcomes of this program. It has been filled with challenges and opportunities from the beginning. But then, growth and change bring opportunity and challenge in abundance. We would be happy to share our experience thus far with other hospitals. In parting, I am reminded of the saying that there are no short cuts or easy ways to any place that is worth going.

* * *

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Pediatric Intensive Care Links

Come visit many interesting website links to various international nursing societies as well other important resources:

Go to our website: <http://groups.yahoo.com/group/PICU-Nurse-International>
and click on 'Bookmarks'

Nursing Involvement in Clinical Decisions: A perspective from Wuerzburg, Germany

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University Children's Hospital

Wuerzburg, Germany

Within the last few years it has been realized how important it is to have a good collaboration between nurses and physicians especially in Intensive Care Units. This not only improves patient outcome but also job satisfaction. There are many areas where nurses should be involved much more: involvement in ethical issues as well as clinical decisions.

Historically, the physician has been identified as the key decision-maker, but with changes in nursing education and the development of technology, nurses are taking on more complex roles. These require the skills and knowledge to assume leadership in the decision-making process.

Nursing has moved from being a novice to expert professional. Clinical decision-making is an essential and integral aspect of clinical practice. However, the process is poorly understood and the involvement of nursing is fairly new. Currently, the vast majority of literature on clinical decision-making emanates from the experiences of nurses in North America.

In this paper I would like to share with you my experience and insight into nurses' involvement with clinical decision-making. This will be based on my experience as a nurse working in a 18-bed Neonatal and Pediatric Intensive Care Unit in Germany.

Two important questions should be noted from the start:

Why do we need to be involved in clinical decision-making and who benefits?

Should we be discussing the nature and skills required to be good clinical decision makers ?

To understand this complex issue, it is first necessary to set the context of the educational system in Germany. Unlike physicians, nursing education is based on a 'training' rather than university level education. Nurses enter training at 17-18 years of age after completing their basic education. Sometimes there is a requirement for nurses to have experienced some kind of social service (e.g. nursery) before commencing their nursing training.

Training is three years in length and nurses have to decide from the outset whether to undertake children or adult nursing training. Education is provided through theoretical teaching and practical skills are gained within the clinical setting. Nurses are assessed through written, oral and practical examinations. A post registration intensive care course is available, which is two years in duration. The entry requirements are two years experience as a qualified nurse, with at least 6-month of this in a PICU or NICU setting. However, the qualification is not essential for working in PICU or NICU. Only recently have nurses been able to study management and care, although the career structure for nurses is still unclear.

Sadly, all these qualifications are only recognised in a few European countries. To work in other countries German nurses have to undertake further examinations.

Despite our education, there is conflict and no clear agreement within the multidisciplinary team regarding individual responsibilities in clinical decision-making. In the end, the physician has overall responsibility for clinical decision-making. Until the medical profession acknowledges

the nurses' role in clinical decision-making, and policies allow us to take on a more independent role, this position will not change.

There has been some realisation in the last few years, of the importance of nursing input. However, in my experience, a great deal of energy is required to effect change.

Within the PICU (and NICU), patient care is multidisciplinary due to the large number of groups involved. It is only through this multidisciplinary approach that the child's needs can be truly met.

In which clinical decisions should the nurse be involved? The nature of the work involves a variety of complex interventions:

- Pain and sedation
- Weaning of ventilation
- Nutrition
- Physiotherapy and positioning
- Discharge planning
- Ordering of procedures and investigations

I will now discuss the factors that influence nurses' involvement in clinical decision-making.

1. Educational System

As previously alluded, the education plays an important role in developing nurses that have the knowledge and authority to be actively involved in autonomous clinical decision-making. However the "power" of the physician is the most important factor.

It seems to me that if nurses are going to have more input in clinical decision-making, the relationship between physicians and nurses has to improve. This is supported by Prescott, Dennis, and Jacox (1987) who found that "Improved doctor/nurse relationships in specialist and critical care areas meant, that nurses felt they had more freedom to make decisions and thus derived more satisfaction from those decisions."

2. Education and Experience of the Nurse

Clinical decision-making takes place within the context of a philosophy of care. In my experience I have observed that

physicians and nurses have different philosophies of care. This is perhaps inevitable because of our different education and perceived professional roles. However, it is important that both professions understand and respect each other's philosophies in order to insure cohesive clinical decision-making.

Until recently, most nurses have based clinical decision-making on practices that have been around for many years. The mentality of "this is how we have always done it" has prevailed. With the emergence of evidence-based nursing, this method of decision-making is changing.

Many experienced pediatric intensive care nurses use their intuitive skills to assess their clients and make clinical decisions (which might be highly acceptable). But as Young (1987) found, nurses may experience difficulty in finding adequate language to describe their intuitive experiences while on the other hand, they should. In order to make rational decisions, nurses need to be able to make their knowledge and judgement explicit. Unfortunately, medical staff do not always recognize this knowledge as scientific. Consequently, nurses' contribution to the clinical decision-making process may therefore be dismissed.

But the most important factor in developing clinical decision-making is a supportive multidisciplinary team where permission is given to take risks (without harming the patient of course).

3. Leadership and Environment

One of the key attributes of a leader is the ability to support and develop autonomy in his/her staff. This can take place through encouraging nurses to be involved in providing information about their patients to the physicians during ward rounds and becoming active members of the decision-making team.

Why is it so important to be involved in clinical decisions?

Nurses are in a key position when being involved in clinical decisions because they have 24-hour contact with the patient,

which gives them a much better view of the patient and his/her needs. The nurse is also the constant link between the child and parents, in assessing their need for psychological and practical support.

Patient outcome correlates closely with the degree of co-operation between the nurse and physician. It is only through working as a well functioning and communicative team that mistakes can be minimised through early identification of problems. Good co-ordination not only reduces costs by avoiding unnecessary procedures but also promotes job satisfaction for nurses. It is only through valuing the contribution of nurses that a sense of empowerment will be created and the quality of work life will improve.

So how can we improve this?

1. Teaching, training and education

Only recently we implemented rounds only with nurses. We look at one special patient more closely. First, problems in care can be discussed, and second the nurse learns to speak in front of others and learns to express herself better.

2. Attending physicians' ward rounds

These take place every morning and the nurse responsible for the patient as well as the head nurse attend. These rounds provide the opportunity to discuss nursing issues and changes to medical and pharmacological treatment. It also provides a chance to ask questions and to plan for procedures and investigations as required.

3. Being present when doctors talk to patients and parents

This allows the nurse to listen to what is said to parents and where required to "translate" or repeat for them later. It also ensures that parents do not receive conflicting information.

4. Special meetings within the team

We have a weekly meeting which should not take longer than 30 – 45 minutes. Every 4 to 6 weeks we have a big staff meeting where physicians and other members from the multidisciplinary team also attend.

In concluding, pediatric and neonatal critical care nurses certainly face many decision-making challenges in their role. These are linked to developments in pediatric practice and their professional status within medicine.

Looking back more than 15 years when I entered pediatric critical care nursing, I must say that we have already changed many things - things that we honestly thought to be in the best interest of our patients and families.

These changes include (a) no more "visiting hours," (b) including parents in the care of their child, (c) improved pain management in neonatal and pediatric patients, among many others.

I am confident that with the particular experience and power of nursing, we will get the acceptance and recognition necessary to be involved more and more in clinical decisions.

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Questions & Answers from PICU-Nurse-International

This column features particular dialogues that unfolded on the PICU-Nurse-International egroup that were particularly pertinent, stimulating, generated significant interest, and provided particularly informative replies.

In-Line Suctioning

Question

I have a technical question. We have a 6-month-old with pneumonia on an oscillator and 20 PPM nitric oxide, and he has a tracheostomy (he is a preemie with BPD to boot). He decompensates severely - bradycardia and desaturation - each time we suction yet he needs frequent suctioning due to the volume of secretions. He also takes an hour or more to 'regroup' after suctioning. He sounds like the perfect candidate for in-line suctioning except that the in-line suction catheter would be Y'd in with the oscillator (that's how the adaptor is built) and our Attending physician feels that we couldn't effectively oscillate through the slight bend in the adaptor (she wants it to be a straight path from the oscillator to the patient) except that a straight path is not possible due to the tracheostomy. Any thoughts???

Michigan, United States

Answers

1) I never hear anymore of a crew ventilating with HFOV and using open suctioning technique today. It is the first price to pay in HFOV that 'if' (for one reason or another) you wish to use the open technique, you de-recruit instantaneously and that you may deal with a lot of problems to recruit the lungs again. If 'your' settings are at the limits of non-obiterated venous return, post-(open)suctioning recruitment or getting 1 or a few hPa too high in CAP can result in decreased VR and oxygenation drop (which is what you are telling us?).

HFOV is the ultimate way to ventilate according to the principles of open lung concept, and in this concept there is no place for open suctioning technique - that is if you want to work 'state of the art'. It's a pity I only have it on VHS, but I videotaped an experiment we did on 'real' pig lungs, just to show nurses the effects of open vs. closed technique and what effort has to be done to recruit the lungs when open is used. This experiment is not a 'wild fantasy'. It is done by the company and people who advocate HFOV-use, just to show how nice or unpleasant things can be.

By the way, we use Ballard in-line suctioning on both HFOV (sensormedics), HFPPV (servolator VDR) and SV300 and SV'i'.

Brussels, Belgium

2) We do not experience any difficulties by using the in-line suctioning catheter. We use only the Ypass of the Trach-Care in-line suctioning. Especially with NO it is safer and not a problem to oscillate with the TrachCare.

Amsterdam, The Netherlands

3) We use inline suction on our hifi patients. It does not drastically affect our outcomes, although I suspect the MD is right about changing the frequency of the oscillations, but it has not been clinically significant since you change the settings according to blood gases and oxygenation (titrating to effect, so to speak.)

Florida, United States

E.T. Tube Clamping

Question

In our hospital, there are several adult ICU's that clamp ET tubes when peep is >8 cm H₂O when they must disconnect the patient for changing respirator hoses. The duration of this clamping is a few moments. The reason is that PEEP remains while disconnecting the patient from the respirator, and the alveoli will not collapse. My questions are: Who has ever heard about this practice? Who has heard or even done this with ventilated **children**?

Aachen, Germany

Answers

1) We are currently studying this practice in our PICU. We do it on specific patients...such as ones that are prone to collapse, ones with ARDS and such.

Edmonton, Canada

2) Assumed that a ventilated child's gases are humidified actively over a heated wire system, the Dutch 'WIP' suggests a circuit change every week. They use the word 'suggest' themselves, because they state that a circuit in fact does not need to be changed 'until visible contamination occurs'. Therefore (but this is a personal opinion) I'd rather try to use the circuit for a longer time until the child gets better and PEEP is turned down. More, a child ventilated with high PEEP is likely to be ventilated with high PiP and sharp I:E settings. The price to pay is a decreased venous return and decreased cardiac output: in other words 'oxygenation' are the pesetas you turn in. If your patient needs a PEEP of > 8 hPa, I am not very fond of the idea to put a clamp on the tube and to obstruct the venous return even more. But again, this is very personal - and probably 'retarded' point of view of someone who never heard of this practice.

Brussels, Belgium

3) I spoke with our research expert in respiratory therapy, and he said that he didn't know of this practice being used anywhere in pediatrics (clamping the ET tube to retain PEEP during tubing changes.) When we have to take a child off of high PEEP for any reason, we use an anesthesia bag with a PEEP valve and a manometer, and it seems to me that this would be a safer way of retaining recruitment.

Minnesota, United States

4) We have been known to clamp the ET tube following re-recruitment with the bagging circuit prior to reconnecting to the ventilator and only for a few seconds. However this is a doctor-led procedure and is not carried out by nurses unsupervised.

United Kingdom

5) I have never heard of this practice, was my answer some weeks ago. Now, on our PICU we have to care for a 15-year-old boy with severe ARDS after chemotherapy. He needs a PEEP of more or less 10. And in this context a colleague suggested to clamp the ET tube just for the second to change from the ventilator to the ventilation bag with PEEP ventilation (to maintain the PEEP). This is now usual practice in the adult ICU in patients who needs a high PEEP and the idea behind is to keep the alveoli open. Sure. On this unit they worked with an animal model, a pig lung, to demonstrate their colleagues how quickly the alveoli collapse. But to open the lung again it will take a lot of time and effort.

Mainz, Germany

6) We do use this practice in our PICU. The funny thing is, when I moved from the PICU in Utrecht to the PICU in Amsterdam I was surprised to learn this practice you describe. If our colleagues from Utrecht use this kind of practice these days, I don't know.

Amsterdam, The Netherlands

Children in Adult ICU

Question

I am seeking information about protocols, education programs etc. for adult Intensive care units that are combined pediatric/adult populations. I am also curious to know how staff in these units handle developmental and parenting issues as well as opinions about caring for children in this environment.

United States

Answers

1) I am a teacher Practitioner in paediatrics, currently we have a paediatric HDU (high dependency unit) and an adult ICU that takes children. It is my responsibility to organise education for predominantly adult-trained nurses in the ICU to care for children. I have been in this post for only 4 months so the program is in its infancy. Our protocols and standards are developed jointly between the paediatrics and critical care divisions.

United Kingdom

2) We admit both adults and children into our ICU and although it may not be the most perfect of situations we find that we do pretty well with our kids. Unfortunately we don't have a defined program for education although we have gotten access to the "paediatric transition program" written by staff from the Brisbane hospitals. This program guides nurses through the first year of practice in PICU nursing. Although we cannot get credit for this course, the information contained in it is very good. We are also in the process of updating our policies regarding care of infants and children within our unit. I would like to add that although I agree that, if practical, moving children to specialized hospitals and units is the "gold standard" you have to remember that we all don't live in countries which have their centers reasonably close together. To get our kids to specialized units involves at least a 3 hour flight or a 12 hour drive. We service an area where the thought of a child being taken to Brisbane involves considerable hardship for most of our families not to mention taking them away from valuable support systems. I would love to get some more information and help from any other hospital that would be willing to share their education materials.

Queensland, Australia

3) We are moving our children away from the adult setting. However in my opinion, if the numbers are small, the children's hospital should still be located near an adult general hospital so that we could tap on their facilities. Here in Singapore, we have a population of 4 million and do have private hospitals having children and adult mixed. It may not be ideal as Paediatrics is a very specialized area where they really need Paediatrics experts. One of our tertiary hospitals here has a small wing of Paediatrics specialty. Besides, we also have a 350 bed Children's Hospital with a 16 bed PICU and a 24 bed NICU. Our PICU is a multidisciplinary unit together with cardiac. We have a Paediatric Emergency Transport (PET) and a Code team in our unit. Our retrieval team is quite equipped with level III care equipment, our ambulance is specially designed to take critically ill children. Currently, we only do land transport but will be going to regional air retrieval soon. Cases referred to our PICU will be fetched by our PET however there may be some borderline cases where the referred hospital transports the case across, that is when they don't think they need the level of service.

Singapore

4) Yes with reference to 'Bridge to the future' it would be ideal to send all children to dedicated PICU's however this is not always the case. I work in Hull and our designated centre is Leeds. Having recently left the Leeds PICU I am aware of the fact this unit is extremely busy and at times unable to take referrals. Hull works closely with Leeds and acts as a sort of satellite unit taking on average 5 - 10 children a month. It would be impossible for Leeds to take all these children as

well as those it already takes. Given the fact that whilst working in Leeds PICU last winter when on several shifts the nearest PICU beds to us were in Guys or Edinburgh, it shows that there is still a necessity to nurse children in adult areas rather than nowhere! Thus the education of those working in such areas is still important until we have the adequate PICU beds nationally.

United Kingdom

5) Here in Victoria there is 1 dedicated PICU (approximately 16 beds) and 1 mixed adult and paediatric unit (I believe this unit has 3 dedicated paediatric beds). Both units are in metropolitan Melbourne. Children may be admitted to adult ICUs in the state but only on a temporary basis. All units follow the '24 hour rule' (i.e. if children need to be intubated for more than 24 hours they are transferred to a PICU). Previous state governments have offered to introduce legislation to make this compulsory, but Prof. Shann has always said there is no need while units comply voluntarily. We do have the advantage of being the smallest mainland state, so families have to travel much shorter distances to reach the city - Victoria is somewhat larger than the entire United Kingdom. Distances are relative! All Australian states seem to have different practices. I do find it a concern that in other states children are managed in adult units for prolonged periods - especially as there are no requirements for nurses caring for children to have paediatric qualifications (as there are in the UK for instance).

Melbourne, Australia

Hypertonic Broncho-Alveolar Lavage

Question

I would like to know if anyone could give me information about suction/rinsing with hypertonic saline? We had a premature baby recently with a chylothorax that had quite thickish secretions. A Pulmonologist of another hospital recommended hypertonic saline rinses with suctioning. I do not agree with it, as I think we disturb the surfactant film in the alveoli. This specific baby did develop severe atelectasis, and I wondered if the hypertonic saline contributed to the worsening of the condition?

Do any of you have references to articles on this?

South-Africa

Answer

One study that has some relevance is this one that demonstrated 1/4 Normal saline (0.225%) is the least disruptive to pulmonary function when compared with 0%, 0.45%, 0.9%, 2% and 3% saline solutions in simulated near-drowning of dogs.

Reference: Orłowski et al (1987) Effects of tonicities of saline solutions on pulmonary injury in drowning. Critical Care Medicine, 15 (2) 126 - 130.

Melbourne, Australia

Spinal Cord Lesion

Question

Who has experience with children with a high spinal cord lesion (cervical 2-3)? We are interested in all information about this disease. Our questions are: What is your experience with complete nursing care? What are the possibilities for communication? What do you think about quality of care and what can we do to make this better? Is there any experience in revalidation?

Rotterdam, The Netherlands

Answers

1) "What are the possibilities for communication?" My experience with pediatric cervical injuries is primarily in children 10-16 year-old. One of the most positive things I have seen in the placement

of fenestrated or "Communitrach" devices that allow the child to verbalize again. In the few I have seen this seems to give them back some sense of control and in many cases eases severe anxiety.

United States

2) We have had two very young children age 2 and 3 with high cord injury. Both received the IV steroid protocol for spinal injury Both were placed in 4 post jacket devices within a week. Mobilization from side to side with good pressure relief surface is essential but was not done until the child was placed in the fixation brace. Both were on long term ventilation. One of them is now able to be off the ventilator for 2-3 hours at a time, but did not regain extremity motor function. The other recovered full motor skill over 6 months.

New Hampshire, United States

3) Kids always continue to amaze me with their resilience and adaptation. I have had experience in two different hospitals with high-level spinal cord injuries. One child approximately 3 or 4 years old was ventilator dependent, but eventually had a mechanism placed to stimulate his diaphragm to aid in the respiratory process. This allowed him to be off the ventilator for periods of time. We also have used a Passy Muir valve on our trached kids that allowed them to communicate with the one-way valve. It is a long haul for these kids and they usually go through all the stages of grieving. It can also be emotional for the staff, especially at the outset. We also used adaptation for call lights, pressure pads that can be used by the cheek or a straw device that they can blow into. They are also provided with headsets so they have some independence talking on the phone.

One of the best settings I have ever been in for these kids is where I work currently at Shriners Hospital for Children in Northern California. They specialize in spinal chord injury rehabilitation for non-ventilator dependent injuries. Once these kids get through their spinal shock they are moved from the ICU to the floor where their rehabilitation training starts immediately. Most importantly bladder and bowel training, a major obstacle to overcome for greater independence and a healthier lifestyle when you consider the dysreflexia side of the equation. Physio and occupational therapy is extremely important and can never start too soon. We start upon admission. These kids are surrounded by peers with similar injuries and are usually assigned a mentor of some sort. They also meet with support groups, and if school age, are soon started on a modified school program again. Child Life Therapists also play a very important role in their hospital stay. These patients are at a very high risk for bedsores so are monitored closely. Airbeds and air mattresses are sometimes used, good turning protocols, chest physiotherapy, multipodus boots to protect the heels, etc. Interaction with a psychiatrist also starts soon after admission mostly for the patient, but does include the caregivers to a point. This doesn't necessarily mean that these kids are placed on medication immediately. In fact a majority of them don't require it, but if there is a need, we do not hesitate to use antidepressants.

Northern California, United States

4) 'Our' ORL-specialists are not in favour of fenestrated tracheal tubes since they would increase granuloma growth (evidence?). Plus, small fenestrated tubes are not commercially available so the openings are 'custom-made' at the patient's site. This causes polymer wall destruction and leaching of plasticizer (mostly DEHP) which certainly causes granuloma- and giga-cell growth (quite some literature on that).

Instead we use a smaller tube then indicated for the age size - in combination with so-called speaking-valves (which you probably well know) available in different configurations. We mostly use the PMV 005 (Passy-Muir) for non-ventilated and the PMV 007 for ventilated children. The smallest children we start the use of these valves are approximately 1 year old. I have to admit this is a 'gut-feeling-based' estimation: we never looked it up in literature. But it works well, the kids are sent home with it - both ventilated and non-ventilated (so both Ondine's, high C-lesions and tumours, others,...)

Brussels, Belgium

5) The one case I have seen was a six-year-old. We didn't expect him to live, but he did. After initial stabilization, he was placed in a halo brace, which was continued for six months. Ventilatory support was gradually weaned as tolerated. A gastrostomy tube was placed. Meticulous turning and hygiene care was necessary, as well as pneumatic compression hose, Jobst stockings and splints for his hands and feet. I feel that we, in the PICU, didn't do as much as we could with psychosocial rehabilitation. There was a language barrier involved. Once off the ventilator for sprints, the patient had a Passey-Muir speaking valve. During his prolonged hospitalization, he learned to speak English. He is now able to breathe on his own, eat by mouth and speak. He has a specially designed wheelchair. He is cared for at home by his mother and a team of home care nurses.

California, United States

Contents of Previous Issue

Pediatric Intensive Care Nursing Newsletter of the International Pediatric Intensive Care Nursing Network Volume 2, Number 1, June 2001

If you have missed this past issue, as well as any other issue, you can access them at our website: <http://groups.yahoo.com/group/PICU-Nurse-International> (just click on 'Files')

Medical Earthquake Relief Mission to Gujarat, India

Changing syringes containing inotropic medications: A review of two methods

PICU Nurse-Patient Ratios: In search of the 'right' numbers

Congress Report

*Jared Jeffrey PCCRN
Women's and Children's Hospital
Adelaide, South Australia*

The Paediatric Intensive Care Nursing Seminar, Sydney Australia, 28th Oct 2001.

The venue of Sydney in spring for a conference almost makes you want to skip the sessions and enjoy the beautiful sunshine and deep blue sea of the harbour. The shops the food the sun, meeting old friends, oops this is about the conference!!

Recent world events altered somewhat the feel and the attendance at this conference, some people did not attend, speakers, companies and audience alike. Those who did attend enjoyed a great conference in a beautiful setting.

The paediatric seminar was organised in a short time by two Australian nurses, Tina Kendrick and Bev Copnell from the Australian College of Critical Care Nurses (ACCCN) Paediatric group, to answer a strong request from nurses like myself for some paediatric only issues. We were rewarded with a strong programme covering important issues to PICU's around the globe, Trauma and Resuscitation, Staffing issues in PICU & Issues in Paediatric Ventilation; we were also rewarded with some excellent speakers.

Trauma and Resuscitation

Pat Moloney-Harmon (USA) spoke of the current controversies related to head injuries in the US, especially looking at changes in bedside management and nursing care and considerations in looking after these challenging patients. Fenella Gill (Australia) explored the broader issues of trauma with its impact upon the families while in PICU and impact severe trauma has upon the nursing staff caring for the family and the child. Sharon Kinney (Australia) looked at the recent changes in paediatric resuscitation guidelines in Australia and general changes around the world, and explored what we might expect in the future.

Staffing Issues in PICU

Lydia Dennett (Australia) gave an Australian perspective to the issue of finding, educating and retaining staff in the Australian nursing environment.

Herlina Pakpahan (Indonesia) gave an Indonesian perspective of the issues where nursing is an evolving profession that still has many unqualified staff. Herlina developed an innovative way forward for her staff so that they may work towards a degree and beyond.

Pat Moloney-Harmon (USA) looked at the tough times that are ahead in the US and the impact that this is having with in the units and also on the global perspective as non US nurses move into the US for the money.

Overall this session showed that nursing is beginning to face a critical time of nurse shortages. With less nurses entering training programmes worldwide this problem is set to intensify, giving us many challenges ahead.

Issues in Paediatric Ventilation

Mary Lou Morritt (Australia) gave an excellent presentation on the Sydney Children's Hospitals experience of using the Sensormedics 3100, a high frequency oscillator (HFO). Mary explored the unique challenges and knowledge needed by the nurse at the bedside when caring for the child on HFO.

Jane Darlington (Australia) told us about the Melbourne Royal Children's Hospital use of Non Invasive ventilation for a wide variety of client groups. Moving its use outside of the PICU into the ward areas and into the home environment with ongoing support.

Anne-Sylvie Ramelet (Australia via Switzerland) is studying for her doctorate while working in PICU at the Princess Margaret Hospital in Western Australia. She presented some of her initial findings in her research on pain assessment in critically ill infants. She raises some important points and I hope she will publish it once she has finished. It is an important study and needs more space than I have.

Samantha Keogh (Australia via UK) another doctoral candidate, while working at the Brisbane Royal Children's Hospital, gave us an insight into her work on weaning from ventilation, another work that is needed in the literature and something I hope she publishes allowing you all to see her findings.

As you can see it was a great half-day, with a strong world feel to it. The presenters all did an excellent job as did the session chairs (ensuring we were on time). Again thanks to Tina & Bev for putting it all together. For those of you who missed it, start planning for Argentina in 2003 for the Paediatric World Congress. www.PIC2003.com

8th World Congress on Intensive and Critical Care Medicine, Sydney Australia, 28th Oct-1st Nov 2001

What can I say such a feast of ideas from around the globe, with often eleven sessions running at the same time, it was hard to choose which to miss out on. A wonderful job by the organising committee especially to Melanie Prittard for the nursing content and Malcolm Fisher as the Congress President.

Last I heard 3,500 people attended this great conference in the wonderful warm spring of Sydney, and yes it was sunny every day. The congress started with a fanfare of fun at the opening ceremony, some great music from a variety of well known (to us Aussies) artists, some highly talented musical skills were exhibited by some well known medical staff from around the world, and some old patients of intensive care came back to say thanks and remind everyone of why we do what we do and the impact that it can have.

The session ran to themes covering a wide range: ARDS; Cardiovascular 1 & 2; Clinical Updates; Nursing; Nutrition; Pediatrics; Social Issues; Trauma; Free Papers 1 - 3; Speakers Corner. Over 110 to choose from in 4 days, add on the choice of 16 breakfast sessions and a strong plenary session each day and it was a busy time.

Highlights for me were:

The greater recognition by the medical staff of how large the impact is going to be if the nursing shortage is not resolved, this came from many medical staff in many sessions from around the world. The question still remains as to how we can intervene and get high school students interested in nursing as a career, and how we channel them into the intensive care environment and then retain them.

The pediatric session on Monday on congenital heart disease, G Nunn an Australian paediatric heart surgeon had filmed a range of repairs for complex congenital heart disease and showed and discussed the recent changes in repairs, excellent as it is probably the only time I will see clearly a repair of a beating and non-beating paediatric heart. In the same session G Barker (Canada) discussed the ethics of treating congenital heart disease in a resource-rich environment and M Klein (South Africa) discussed doing the same job in a resource poor environment, something that makes you appreciate what you have.

The question of skill mix and advanced practice roles were certainly hot topics as always. Several sessions across the meeting looked at this from a variety of angles, the great feeling still is that there is scope for greater practice roles and skills for advanced nurses (what ever the title). Our medical colleagues urge caution in this, as medicine is about to hit similar staffing issues to those faced by nursing. There is concern that replacing the junior doctor with an experienced nurse or giving more responsibility to the nurse and less to the doctor may not give the junior doctor the exposure needed to spark the interest in intensive care as a career. A time for nurses and doctors to consider what the best options are and to realise that what another country is doing may not work in your country.

The South African issue of HIV and AIDS was raised at several sessions by the speakers from South Africa, R Mathivha from Soweto, Johannesburg gave several particularly excellent talks regarding the epidemic and its impact upon treatment of both the paediatric and adult population. Patients are refused admission to PICU and ICU given the low resources they have and the high mortality and morbidity of this population. Her talk on trauma was particularly chilling as it works on an almost negative triage system; those with the most injuries are often left, so that treatment can be given to those most likely to survive. In an area with few if any ambulances and a time from incident to hospital of several hours they work with minimal equipment and resources, a credit to them all that they have survivors in what appears to be a very challenging environment.

There is much more to share from this conference but I fear if I go on I shall miss Franco's deadline for getting a report in. Overall an excellent conference with great speakers, a wonderful feel of collaboration and something that will be hard to beat in 4 years time.

Information For Authors

Pediatric Intensive Care Nursing welcomes paper submissions for upcoming issues of this publication. Papers may focus on any clinical or professional topic relevant to nursing the critically ill child and pertinent to an international nursing readership. Submissions should be 2-4 double-spaced pages in length.

Send your proposed papers directly to Franco Carnevale (Editor):
frank.carnevale@muhc.mcgill.ca

The World Federation of Critical Care Nurses Has Arrived

Williams, G., Rogado, I., Budz, B., Albarran, J., Speed, G., Kim, D., Baktoft, B., Wong, E.

It is our pleasure to announce to readers of *Pediatric Critical Care Nursing* that, the World Federation of Critical Care Nursing (WFCCN) was formally established and launched on 30 October 2001. This historically significant and professionally important achievement occurred as part of the proceedings of the 8th World Congress on Intensive Care in Sydney, Australia.

Critical Care emerged as a specialty of nursing in the late 1960's in many western countries and has expanded across all continents and most countries of the world. During the last 30 years or more critical care nurses have worked together, taught each other, established networks and formed organisations to support the growth and refinement of their clinical and professional expertise.

These networks and organisations of critical care nurses have evolved into strong and active professional associations, with a common goal of wanting to improve the quality and effectiveness of care and treatment afforded our most critically ill patients and their families. Constitutionally almost all such networks and associations have been confined in their purposes and activities to states and nations within limited jurisdictional borders.

In 1999 the European Federation of Critical Care Nursing Associations (EfCCNa) formed a formal coalition of Critical Care Nursing Associations who now number 20 member associations (1).

The establishment of WFCCN in 2001 expands on the work of EfCCNa and a world wide study of critical care nursing associations conducted in 1998-2000 (2). The WFCCN can now work with the many individual associations of critical care nursing of the World and provide a world-wide forum for the advancement of critical care nursing practice and fellowship.

The WFCCN has made the following statements in relation to their philosophy, purpose and objectives:

PHILOSOPHY

The philosophy of the WFCCN is to assist critical care nursing associations and nurses regardless of age, gender, nation, colour, religious beliefs or social background in the pursuit of the objectives of the WFCCN.

PURPOSE

The purpose of the WFCCN is to link critical care nursing associations and nurses throughout the world, to strengthen the influence and contribution of critical care nurses to health care globally and to be a collective voice and advocate for critical care nurses and patients at an International level.

OBJECTIVES

The objectives of the WFCCN are:

1. To represent critical care nurses and critical care nursing at an International level.
2. To improve the standard of care provided to critically ill patients and their families throughout the countries of the world.
3. To advance the art and science of critical care nursing in all countries throughout the world.
4. To promote co-operation, collaboration and support for critical care nursing organisations and individuals.
5. To improve the recognition given to critical care nursing throughout the world.
6. To maintain and improve effective co-operation between all health professionals, institutions, agencies and charities who have a professional interest in the care of critically ill patients.
7. To establish standards for education, practice and management of critical care nursing.
8. To foster and support research initiatives that advance critical care nursing and patient/family care.
9. To encourage and enhance education programs in critical care nursing throughout the world.
10. To provide conferences, written information and continuing education for critical care nurses.

The founding country associations for the first Council of Representatives meeting of the WFCCN included:

- Australia
- Canada
- Denmark
- England
- Hong Kong
- Korea
- New Zealand
- Philippines

The inaugural Core Administration to drive the establishment of WFCCN include:

- A/Prof Ged Williams (Australia) – Chair (ged.williams@nt.gov.au)
- Isabelita Rogado (Philippines) – Secretary (bellerogado@yahoo.com)
- Bernice Budz (Canada) – Treasurer (bbudz@u.washington.edu)
- John Albarran (UK) – Trade & Industry Sponsorship Coordinator (John.Albarran@uwe.ac.uk)

We anticipate a rapid increase in the number of member associations from many more countries and to work with critical care nurses in countries where such associations do not exist to help establish networks and associations in those countries.

Initial activities and pursuits agreed to at the first meeting of the Council of Representatives were:

- To promote the existence of the WFCCN to potential member associations and encourage application and membership
- The identification of an official journal of the WFCCN to be distributed to all member associations and their members
- Develop a website of relevant information that is easily accessible to critical care nurses the world over.
- To explore long term legal, financial and constitutional arrangements that will best serve the purposes and objectives of the WFCCN and its member associations.

Persons interested in knowing more about WFCCN and its members may contact the Core Administration as described above. The next meeting of the core administration and available council representatives will occur in Paris, France in association with the EfCCNa Critical Care Nursing Conference 26-27 May 2002.

A second report of the WFCCN and its activities will be provided to all member associations and relevant critical care journal editors following this meeting.

References

(1) www.efccna.org.

(2) Williams G, Chaboyer W, Thornsteindottir R, Fullbrook P, Shelton C, Chan D, Wojner A. 2001. World Wide Overview of Critical Care Nursing Organisations and their Activities. *International Nursing Review*. (Accepted for Dec. 2001)

4th World Congress on Pediatric Intensive Care

March 30 – April 3, 2003

Buenos Aires – ARGENTINA

www.pic2003.com

News From PICU-Nurse-International@yahoogroups.com

This Internet discussion egroup was founded on July 4, 2000, 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 <http://groups.yahoo.com/group/PICU-Nurse-International>, or contact the moderator (Franco Carnevale) by email at frank.carnevale@muhc.mcgill.ca

This egroup continues to consistently serve as a forum for the discussion of various clinical issues (number of posted messages are indicated below). However, September was a peculiar month - only 37 messages were posted. Immediately following the tragic September 11th events, there was a silence for a few days. Then a unique exchange emerged. Messages were posted to express concern and support for the victims of the attacks in particular, and for our American nursing colleagues in general. Messages were sent from Argentina, Australia, Belgium, Canada, The Netherlands, Singapore, Spain, and of course, the United States. This was followed by several expressions of gratitude by American members.

Indeed, in light of the difficult events that recently unfolded, the Editor (Franco Carnevale) temporarily postponed the production of this Newsletter edition. Uncertain about whether it was appropriate to resume 'normal' activities, Franco consulted with members of the International Editorial Advisory Board for their opinion. The Board responded immediately and unanimously by deciding that the terrorist events should not be allowed to inhibit our important activities. Work on the Newsletter was then resumed within a matter of days. In fact, the Board worked actively to discuss changes in the structure and content of the Newsletter.

Number of Messages Posted:

The following table outlines the number of messages posted since the last Newsletter

2001	June	66
	July	87
	August	79
	September	37
	October	114

PICU-Nurse-International Membership

This Internet egroup has continued to grow. Membership now spreads across 24 countries spanning every continent (except Antarctica).

Egroup Membership by Country

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

Argentina	1
Australia	45
Austria	1
Belgium	1
Brazil	2
Canada	77
Czech Republic	1
Denmark	2
Finland	2
France	1
Germany	4
Hong Kong/China	2
Iceland	2
Indonesia	1
Japan	1
Netherlands	9
New Zealand	1
Norway	4
Saudi Arabia	1
Singapore	1
South Africa	1
Spain	2
United Kingdom	31
United States	98

Total Members: 291 from 24 Countries

What are your comments?

The Editorial Board would appreciate your comments on this publication. This can include any thoughts that you have regarding the structure as well as the content of the Newsletter. We would particularly appreciate your suggestions on topics or issues that you would like to read about in future editions.

Forward your ideas to Franco Carnevale (Editor) :
frank.carnevale@muhc.mcgill.ca

Upcoming Conferences

Topics in Intensive Care

6 November 2001, Lunteren, Netherlands
A multi-disciplinary congress: Nursing,
Medical, Technicians, Pharmacology
Language: Dutch
Info: Mirjam Bams
email: mbams@hetnet.nl

XXI Congress of the Société Française des Infirmiers en Soins Intensifs

Adult and Pediatric Intensive Care
17-18 January, 2002, Paris, France
Language: French
Info: www.sfisi.asso.fr or info@sfisi.asso.fr

22nd International Symposium on Intensive Care and Emergency Medicine

19-22 March 2002, Brussels, Belgium
Language: English
Info: www.intensive.org

Trauma Care 2002

23-25 May 2002, Stavanger, Norway
Language: English
Info: www.traumacare2002.com

12th Congress Western Pacific Association of Critical Care Medicine

22-25 August 2002, Bali, Indonesia
Language: English
Info: www.WPACCM.com

Austrian International Congress 2002 Anaesthesia & Intensive Care:

Art or Science?

11-13 September 2002, Vienna, Austria
Info: www.oegari.at
Language: German & English

8th Symposium of The European Society of Paediatric and Neonatal Intensive Care (ESPNIC) Nursing

13-14 September, 2002, Göteborg, Sweden
Info: www.espnic.org

15th annual congress European Society of Intensive Care Medicine

29 September - 2 October 2002
Barcelona, Spain
Info: www.esicm.org
Language: English (and Spanish translation)

Australian and New Zealand Intensive Care Meeting

October 2002, Perth, West Australia
The one day paediatric and neonatal
conference will be run concurrently on
Friday 18th with the main (adult 3 day)
intensive care meeting and there will be
paediatric and neonatal sessions included
on the Saturday. The theme is cardiac.
Invited confirmed speakers are:
Dr Ian Adatia, Cardiologist, Critical Care
Unit, Hospital for Sick Children, Toronto
Dr Lisa Hornberger, Cardiologist (Fetal
echocardiography) Hospital for Sick
Children, Toronto.
Dr Jenny Sokol, Neonatal Intensive Care
Specialist, Princess Margaret & King
Edward Hospitals, West Australia.
Jos Latour, Nurse manager PICU and NICU,
Vu Hospital, Amsterdam.

10th European Burns Association Congress

10-13 September 2003, Bergen, Norway
info: eba2003@congreg.no
Website to be announced
Main topics:
Burns in developing countries
Reconstructive surgery
Quality of life
Burn related research