

GUEST EDITORIAL

Acute and Critical Care

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This issue of *CJNR* arises from a call for papers on research conducted in tertiary/high-acuity and critical care settings. Increasingly, we are recognizing that optimal management of the acutely and critically ill spans a continuum related to progression through physical locations within an acute-care institution. For example, interventions such as early goal-directed therapy for severe sepsis and septic shock emphasize the important role played by early recognition of critical illness in the emergency department (Rivers et al., 2001). Critical Care Outreach Teams (also known as Medical Emergency Teams or Rapid Response Teams) recognize the potential for critical illness to develop in any location within the hospital and the need for timely intervention.

However, critical illness also spans a continuum related to progression from the acute event to physical and neurocognitive rehabilitation, interventions to promote psychological well-being, and educational strategies for health promotion, as reported in the study by Fredericks and colleagues in this issue of *CJNR* on educational interventions for culturally diverse patients following cardiac surgery.

For non-survivors of critical illness, optimizing end-of-life care is an important consideration. The articles selected for this issue of the Journal reflect this continuum but offer greater insights into the events experienced at its end as opposed to at its beginning. Another important emphasis in the selected contributions is the role that nursing plays as one of the professions represented on the interprofessional team managing acute and critical illness. Lack of role integration and potential stressors associated with the functioning of the interprofessional team are noted.

Frank and colleagues describe a nurse-led quality-improvement intervention using a previously validated questionnaire (Canadian Health Care Evaluation Project, or CANHELP) to measure the quality of end-of-life care for patients at high risk of death admitted as acute medical inpatients. Health-care teams were informed of potential improvement opportunities identified by the questionnaire as well as patient symptom profiles using the Edmonton Symptom Assessment Scale. The study's results indicate small improvements in satisfaction with high-priority

aspects of end-of-life care. However, the authors note inconsistent adherence on the part of various medical teams to recommendations made by the study nurse. Better integration of the nursing role in improving end-of-life care as part of the medical team is recommended for future study.

Using a descriptive qualitative design, Gélinas and colleagues describe stressors experienced by nurses providing end-of-life care in the intensive care environment. Using the categories *organizational*, *professional*, and *emotional* identified by Fillion, Saint-Laurent, and Rousseau (2003), the authors identify difficulty with interprofessional collaboration as well as a lack of continuity and palliative approach to care as major stressors.

The role of nurses in situations of conflict between family members and health-care providers in the intensive care unit (ICU) is explored in the study reported by Edwards and colleagues. Interestingly, when encouraged to tell a story about their experience of conflict, 11 out of 12 nurses gave an example from end-of-life care. Participants described their role as providing a “bigger picture” of the patient to other members of the health-care team, building or repairing relationships and building trust, and providing support to each other in the context of a highly stressful environment.

It is interesting to note that these three articles addressing the important topic of end-of-life care all identify areas of concern regarding inter-professional team functioning and the potential for conflict. Over a decade ago, Baggs et al. (1999) reported that ICUs with high levels of nurse-doctor collaboration demonstrated improved mortality rates and reduced length of stay. Lack of collaboration and hierarchical team functioning is recognized as impacting negatively on patient safety (Reader, Flin, Mearns, & Cuthbertson, 2007). In a large, multicentre international survey (Azoulay et al., 2009), end-of-life care was reported as the main source of conflict in the ICU setting due to the absence of psychological support, suboptimal decision-making or symptom control, and disregard for family preferences; the second source of conflict was poor interpersonal or general behaviour. Furthermore, intra-team conflict between ICU physicians and nurses was identified by 33% of the 7,498 respondents from 323 ICUs in 24 countries. Obviously there is a need for knowledge development to focus on interventions designed to ameliorate conflict during end-of-life care in the ICU.

The Discourse contribution in this issue of the Journal concerns the potential impact of critical illness on psychological well-being. The lead author, Mona Ringdal, has a program of research focused on the impact of memory on psychological health-related quality of life for survivors of critical illness. Based on the work of Ringdal and that of other investigators, such as Christina Jones (Jones et al., 2007), factual memory and avoidance of delusional memories related to critical illness are now rec-

ognized as influential in psychological recovery. Interventions such as the nurse-written diaries and nurse-led ICU follow-up clinics discussed in the Discourse have been widely adopted in Scandinavian countries (Akerman, Granberg-Axéll, Ersson, Fridlund, & Bergbom, 2010) but have yet to receive much attention in Canada. The promising results of a recent randomized controlled trial examining the impact of diaries on psychological functioning (Jones et al., 2010) may serve to increase interest in this intervention in Canadian ICUs. Further opportunities for research on this intervention include exploration of such issues as the mechanism by which diaries influence psychological well-being and optimal timing of diary handover to the patient and family.

I believe that over the next decade we will continue to see growth in research exploring interventions designed to improve both psychological and physical health related to quality of life in survivors of critical illness. Alongside these investigations, we need to develop and validate tools for identifying those patients most in need of follow-up interventions as well as refine tools so that they will be able to accurately detect the effects of those interventions.

It has been my great pleasure to serve as guest editor for this issue of *CJNR* and I look forward to future developments in nursing research relevant to the topics raised in the articles you are about to read.

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