CANADIAN JOURNAL of EMERGENCY NURSING

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IN THIS ISSUE:

NENA

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Guidelines for submission

Editorial Policy

1. **Canadian Journal of Emergency Nursing** welcomes the submission of clinical and research articles, case studies, and book reviews relating to the field of emergency nursing.

2. Statements or opinions expressed in the articles and communications are those of the authors and not necessarily those of the editor, publisher or NENA. The foregoing disclaim any responsibility or liability for such material and do not guarantee, warrant or endorse a product or service advertised in this publication, neither do they guarantee any claim made by the manufacturer of such product or service.

3. Authors are encouraged to have their articles read by others for style and content before submission.

Preparation of manuscripts

1. The original copy of manuscripts and supporting material should be submitted to the **Canadian Journal of Emergency Nursing** editor. The author should retain one complete copy.

2. Manuscripts must be typed, double-spaced (including references), layout on 8½″ × 11″ paper with standard margins. Manuscripts must be submitted in Word or Word Perfect and sent electronically to the communications officer at **communicationofficer@nena.ca**.

3. Author's name(s) and province of origin, a high-resolution photo and a brief biographical sketch must be included.

4. Clinical articles should be limited to six pages unless prior arrangements have been made.

5. Direct quotations, tables and illustrations that have appeared in copyrighted material must be accompanied by written permission for their use from the copyright owner, and original author and complete source information cited. Plagiarized material will be rejected without explanation.

6. Photographs of identifiable persons, whether patients or staff, must be accompanied by signed releases, such as the following: "I hereby give (author's name) authorization to use the photograph of (subject's name) in the **Canadian Journal of Emergency Nursing.**"

Please submit articles to:
communicationofficer@nena.ca

Please include a brief biography and recent photo of the author.

Deadline dates:
January 31 and September 8

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President's Report

Greetings, NENA Members,

As always, thank you for your continued membership in and support of NENA. I sit here, writing what will be my last CJEN president's message, knowing it has been an honour to serve. I have been fortunate to work with a most professional and dedicated group of emergency nurses and I will miss every minute of it.

That being said, I am looking forward to whatever comes next for me on this journey of life. I am currently in California with my husband, where, for the next four weeks, we get to babysit our almost two-year-old grandbaby, while Dad works and Mom continues her nursing education – yay! A nurse to take my place. She has not decided her area of interest yet, but I am regularly guiding her towards emergency nursing.

NENA is a great organization, but can be even greater. More than 20,000 nurses in Canada list their area of specialty as emergency—why are we not 20,000 strong! Can you imagine the influence we could have at both provincial and federal levels? We have gone through significant change these past two years complying with the Canada Corporations Not for Profit Act. I am pleased to tell you that the Board of Directors has finalized a governance structure, representative of every region in Canada. A call for nominations has gone out and the new structure will be announced at the Charlottetown Annual General Meeting.

I offer you a challenge—in 2017, each member of NENA shall commit to bringing a friend or colleague into our organization and doubling our number. I will commit to taking this forward to the Board of Directors and working with our webmaster to see if we can track this activity.

Earlier, I mentioned I am in California—this morning, sitting outside reading the Sunday paper, I learned of a couple who have written a book reflecting people and their accomplishments today and asking a question – "What advice would you give to your 21-year-old self?" It made me think—what, if anything, would I do differently? What would you do?

In closing, as you finish reading this, please do this—either by yourself or with those around you. Stand up and clap—years ago, at a conference I was attending, a keynote speaker began the presentation with this same request. She then explained that everyone, at least once in their life, deserved a standing ovation.

Thank you. Take care of yourselves, your family and friends and, of course, the patients who need us. I look forward to seeing you in Charlottetown. Do not miss this—it is going to be great.

Sherry Uribe

Director of Education Report

NCAC, CTAS National Working Group, and EPICC (Emergency Practice Intervention and Care—Canada) working team are all invested in bringing educational opportunities for emergency nurses in Canada. CTAS revisions are expected in 2017. EPICC-Foundations course is now offered in five provinces and expanding to more each month. EPICC – Trauma is now in production with the first courses expected to be offered in Spring, 2017. Thank you to all Canadian emergency nurses who have participated in assisting with revisions to CTAS and the development of EPICC in the past several months.

Emergency nursing certification news

The application dates for initial certification and renewal are now available for 2017.

NENA will award up to five annual bursaries for $100 each for emergency nurses writing the exam for the first time. Go to the NENA website and click on the "Documents" tab. Applications for NENA bursaries are located under "Bursaries". New study materials are available online and are free to NENA members. Instructions for the study modules are located under "Courses" on the website. Click on the "Canadian Emergency Nursing exam" tab.

Initial applications

	Application window	Exam window	Results
Spr.	Jan. 3 – March 1	May 1 – 15	June
Fall	June 1 – Sept. 1	Nov. 1 – 15	Dec.

Renewal by continuous learning (CL)

	Application window
Renewal by CL	Jan. 3 – Nov. 30

NENA Emergency Nursing Certification Committee

NENA is developing learning and study programs for exam preparation and those ED nurses re-certifying. A call for interested certified emergency nurses will be coming via email soon.

Canadian Concussion Collaborative

If you are interested in resources for concussion care, go to **http://casem-acmse.org/education/ccc/**. Updated guidelines are expected in 2017.

Emergency Nurses Pediatric Course – 5th Edition update

Revision work is underway that includes revising the ENPC manual and course. The team will be working through the program development in 2017.

Canadian Course Directors—TNCC/ENPC

NENA policies require payment of course fees within 30 days of the course completion. Payments can be made through e-transfer. Contact **financeadmin@nena.ca** if you require an extension or have queries/questions regarding your invoices.

Margaret Dymond, RN, BSN, ENC(C)

Editor's Report

Hello to all of my fellow NENA members! Spring is a time for change and new beginnings. I'm excited to be taking over the editing duties of CJEN. A big shout out and thanks to previous CJEN leadership for their excellent work to promote emergency nursing across Canada and internationally! Stephanie Carlson has been doing a wonderful job working diligently to pull together this journal and I want to thank her personally for all of the assistance she's given me while I have struggled to understand the overwhelming process that is involved to bring CJEN to you, our readers. I look forward to continuing to uphold the excellent standards that CJEN has set.

I would like to use this space to reach out to our readers, the NENA members. I want each and every one of you reading this to know that you have something to contribute to this profession and to our NENA group. Each of us has a story to tell or a lesson to contribute. Never underestimate yourself. If you have an area of interest, seek out more information, do some research, make some connections. When you do, we want to hear about it! Consider submitting an article for publication. CJEN publishes clinical or research articles, case studies, and book reviews related to the field of emergency nursing. You can also consider becoming more involved in NENA at a national or provincial level. However you choose to be involved in NENA, as a contributor, leader, or a reader—we value your attention. Our strength, our members.

Ashleigh Malarczuk, RN, MN, ENC(C)

NCAC Report

I am excited to introduce you to our NCAC members: Dawn Paterson joins us from Alberta and will be representing the Western Provinces; Sharon Ramagnano hails from Toronto and will be representing our central provinces; Denis Bouchard returns to us from Montreal and is the voice for our French-speaking Canadian nurses; Maureen Doody comes from Newfoundland ("the Rock") and represents the Eastern provinces and Val Lamb joins us from northern BC (Ft. St. John) and will be the EPICC representative on the committee. I am Monique McLaughlin and I live in Vancouver, BC, and I am thrilled to be the Chair of this exciting committee. Our committee members have had varied careers in emergency nursing and our real jobs run the gamut of frontline emergency/ICU nurses, emergency educators, trauma coordinators, and emergency nurse practitioners. I am proud that we represent all aspects of emergency nursing.

Many of you have met the above individuals, either by being fortunate enough to work or teach with them, but also through our Facebook page. I would encourage you to join our **private closed** group TNCC ENPC EPICC (NCAC) where each of our committee members has given you a far more in-depth introduction of themselves and where each month each of the committee members will be posting interesting articles, links to podcasts, etc. It is also an opportunity for all TNCC ENPC EPICC instructors from across the country to share insights and to connect with one another. We have heard from course directors across the country about the issues with the TNCC textbooks and our Director of Education, Margaret Dymond, is working with ENA to resolve this issue. Some of you may be asking about how we are going to connect with those of you who are not on Facebook. I will immediately apologize, but it is my goal within the month to have an e-mail group for those of you who are not on Facebook to receive some of the important information. Understand though, that the richness of the comments, photos, etc., will not be captured in that e-mail group. For instructors who are NOT on Facebook or who would rather not be on the Facebook page—please e-mail me through **courses@nena.ca** – Attention Monique, and let me know the e-mail address you would like me to use.

Bienvenue to all of our French members. Je m'excuse mon français ce n'est pas bon. Mais je suis très heureuse d'avoir tous les instructeurs canadiens français rejoignant la page Facebook. Certains d'entre vous ne souhaitent pas être sur Facebook. Veuillez m'envoyer un message à **courses@nena.ca**, attention à Monique, afin que je puisse ajouter notre e-mail à un e-mail de groupe.

We are also planning to resurrect our Twitter Account **@NCAC3**. This will likely happen after the NENA conference meeting.

Though we have had a Skype meeting together, while at the NENA Conference in beautiful Charlottetown, PEI, we will be having our first "official" face-to-face meeting. Some of you may be wondering about the role of NCAC—while we do have an official list of duties, which includes promoting educational courses, providing support to provincial issues, and quality assurance processes, NCAC has some larger goals for the next three years:

1. To connect TNCC/ENPC/EPICC instructors nationally and have all voices being heard (Connecter les instructeurs TNCC/ENPC/EPICC à l'échelle nationale et faire entendre toutes les voix)
2. To support education to ALL parts of Canada in both official languages (Appuyer l'éducation dans toutes les régions du Canada dans les deux langues officielles)
   - We want to be able to determine not only how many courses we are able to teach, but also how accessible education is for ALL nurses (particularly our nurses in remote sites). This will include supporting, promoting and developing a process for the NENA course, EPICC Foundations and in the future EPICC Trauma. To encourage succession planning in all of our provinces and territories (Appuyer la formation de nouveaux instructeurs, directeurs de cours et formateurs d'instructeurs partout au Canada)
   - How do we support and encourage new instructors, Course directors, instructor trainers? Succession planning is not only about finding our replacements, it is also about proactively developing others.

We really do want to hear from all of you—if you have issues about finding courses, becoming instructors, or concerns about the material you are teaching, please let us know. We are your voice and we cannot articulate your concerns if we don't know what they are. Our first accountability is to you. Si vous avez des questions concernant l'éducation et les cours que nous devons entendre de vous. Nous sommes votre voix et nous sommes responsables envers vous.

Monique McLaughlin

Certification in Emergency Nursing

By Yvonne Bauer, RN, Ontario ENAO/NENA member

Certification in Emergency Nursing (Canada) requires a professional obligation to complete 100 continuing education hours every five years to maintain credentialing through the Canadian Nursing Association. Through annual policy and procedure reviews at my employment, lunch and learn seminars, conferences and courses, I uphold the national requirement and participate in continued education initiatives, which support my renewal in emergency certification. Although there is a professional drive to enhance my learning, there additionally is a personal desire to seek the opportunity to improve.

When one engages in self-reflection you can analyze individual competence through reviewing strengths, weakness, and opportunity for growth. Strengths and weaknesses help identify what is lacking or limited in knowledge, which, in turn, may affect practice; opportunities to seek out aspects or areas where improvement is needed can lead to better practice stability and professional growth.

Many colleagues do not seize the opportunity to participate in continuing education and I have always wondered why. Are they afraid or intimidated by knowledge? Is there an element of embarrassment or stagnancy towards learning something new? How do they view themselves currently in their role; is it a profession or is it a job?

Learning is continuous and a process of change. Continued education should not be seen as a burden placed on the nurse in her chosen profession of nursing, but rather the process of ongoing learning. Today, globally, the world has become fast paced and the advancements made in research through innovative technology push forward at increasing speeds. New guidelines, best practice guidelines, and fluid algorithms have emerged in every science discipline.

Practice today is heavily weighed and guided by the aforementioned means and the nurses of today must actively ensure their practice is evidence-based and research driven. As a young nurse 30 years ago, the only algorithm I can recall was advanced cardiac life support; we had a large poster taped to the wall at the head of the bed in our resuscitation room. The ACLS poster guided the physician and nurse in rhythm analysis, defibrillation and cardiac drugs. We looked to this poster with pride, that we, as a team, were following the recommendations and accepting assistance when challenges to the event at hand were not responding to treatment. The mere movement towards an ACLS algorithm encouraged the promotion of dialogue between medicine and nursing and, in my opinion, became the key finding to support our past has developed our future; the collaborative advancements in health among the disciplines have led to new innovations.

The discipline of nursing over the years has changed; from a doctor dictated (nurse maiden) to a more collaborative engagement; changing the atmosphere of nursing. Nurses and physicians have always shared a common goal—a positive patient outcome. However, in order to achieve this goal, mutual respect for knowledge must exist. As an example, knowing the current recommendations set forth from the Cardiovascular Society or the Pediatric Society of Canada when treating atrial fibrillation or croup provides awareness to practitioners and supports a positive patient outcome. Development of awareness is key to understanding treatment in either of the above conditions. Working as a team to ensure proper management of conditions, the nurse not only utilizes the nursing process but, in addition, understands the best treatment option for the patient in collaboration with the team, thus promoting a positive patient outcome.

Continued education is paramount in nursing. Guidelines, standards and initiatives continually provide the nurse with the opportunity to grow professionally and personally. Expanding on knowledge provides the gateway to promoting patient health and well-being. Unknowingly, when you acquire new knowledge through active participation in continuing education you further endorse yourself as a nurse. You stand committed in your responsibility to maintain professional competence and use your knowledge with patients, the team you work with and your employer. The satisfaction of continued learning and acquired knowledge promotes your own personal and professional well-being, and will be evident in the way you work among your colleagues and with your patients.

Gordon (2006) has stated that in order to gain and maintain the respect of the public and other healthcare professionals, nurses must emphasize and communicate the knowledge and skills required for professional nursing. Once upon a time, the public agreed with the status quo (if you will) and the treatment plan as laid out by their practitioner. However, today there exists mundane influences on the public and for these reasons the nurse must be prudent in her delivery of information. Because the internet and television engross the public, often patients will offer their own treatment plan for their condition ("I researched it on the internet"). While their active participation in healthcare is paramount, the nurse must provide evidence that supports care options and treatment plans suitable for the needs of the patient, in their best interest, and for optimal outcomes.

Although this comes with its own set of challenges and, at times, frustration, the public has seized the opportunity to advance its knowledge (although misleading at times) and obtain a sense of empowerment in their healthcare choices. If this is evident with the public, why are nurses not doing the same in their professional roles?

Today, the big picture, as relating to patient care, focuses on evidence-based practice, standards and guidelines and algorithms. Nurses of today and yesterday need to update their knowledge and skills through continued learning, as it is integral to their role in meeting the best possible patient outcomes. Learning is lifelong—we learn every day from our families and friends in our personal lives. Is it any wonder that we should continue to learn in our professional lives? As a team, nurses share their insight and knowledge towards patient care and for this reason alone must

continue to learn and expand their knowledge. Nurses are seen as experts in their specialty and are required to keep abreast of new guidelines and standards, review the literature for practice that is evidence-based and utilize the many algorithms associated with treatment options.

Continuing education is challenging to the mind, body and soul. It is refreshing and rewarding to see the difference you make when acquired learning and knowledge is used in practice and directly impacts a positive patient outcome. Nursing is about making a difference. Nursing can transform. Nursing is professional and accountable to many investors. Nursing is enhanced through continued education and acquired knowledge. Competence in nursing through continued learning ensures the public is protected; the public deserves nursing that is current, research- and evidence-based. I promote and participate in continued education, support emergency nursing as a specialty, and try to make a difference every day. Nursing is my profession; it's who I am and what I do. Who are you?

Previously published in the Journal of the Emergency Nurses Association of Ontario (JENAO)

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Provincial reports

Alberta

NENA-Alberta's 366 members are well served by the nine regional representatives. These regional representatives report that education continues to be a priority for the nurses in both rural and urban sites. The rural emergency nurses in both northern and southern Alberta have been participating in the RN Supraglottic Airway Project and are excited about the number of nurses who are now educated.

Our first EPICC course ran in November. It was well attended and we were able to train new instructors. Lethbridge, in southern Alberta, just ran an EPICC course at the end of February and Edmonton has one planned for June. It is exciting to see the emergency nurses across Alberta embracing our Canadian-based emergency course.

We are in the process of planning our annual AGM/conference for October. The theme this year is "Jack of All Trades, Master of Many" allowing us to pursue an eclectic collection of topics.

I am looking forward to joining many of you in Charlottetown in June to "Find the Edge"!

Jean Harsch
NENA-AB President

Manitoba

The anticipation of spring is always exciting, as the snow melts across the prairies, the days become longer, and new life emerges from underneath the winter blanket of snow. Emergency nurses continue their dedicated work across the province, caring for all Manitobans.

Budgetary constraints have become a reality across the province since the new PC provincial government was elected in April of 2016. Our new Premier, Brian Pallister, made it clear after the election last spring that the Regional Health Authorities (RHAs) will need to tackle their deficit now and going forward. Our new Board of Directors for the Winnipeg Regional Health Authority also received a mandate letter from the province compelling it to not accept a budget that is not balanced.

The WRHA is facing a significant budget deficit. Therefore, a number of initiatives are aimed at controlling costs between now and the end of the fiscal year. They include: a 0.5% expenditure reduction for all sites, programs and departments; a hiring freeze on all non-union position vacancies; non-clinical overtime is frozen and clinical overtime is to be limited where possible; Constant Care requests are also to be limited and service volumes cannot be exceeded without prior approval. With implementation of all of these measures, we must maintain a focus on patient safety, quality and improvement.

On a more exciting note, planning for NENA conference 2018 in Winnipeg has begun. Venues and dates are being explored at the moment. We are looking for enthusiastic emergency nurses from across the province who would like to help Conference 2018 be an amazing one. If you are interested in being part of the conference planning team, please contact **mbdirector@nena.ca**

TNCC, ENPC and CTAS courses continue to be offered in all areas of the province, including many northern communities such as Thompson, The Pas, and Gillam. TNCC is currently being planned for Churchill for May 2017. TNCC will now be offered six times per year, as part of the WRHA Emergency Orientation for nurses new to emergency practice. ENPC will be offered twice per year within the WRHA. TNCC courses continue to be offered frequently in many of the RHAs throughout the province thanks to the dedicated course directors and instructors in all areas of Manitoba. A TNCC Instructor Course was recently held in Winnipeg with eight new instructor candidates. Well done, everyone!

For those of you who are not aware, I have been appointed into one of the new Director-at-Large positions on the NENA Board, therefore allowing me to have voting capacity. The Provincial Directors' voting abilities changed with the new Not-for-Profit Canada Corporations Act in the fall of 2016. I took part in NENA Board meetings held in Edmonton in November 2016.

If you are interested in joining us on the NENA Board, please see the call for nominations that was sent to all NENA members this past week. It is a wonderful opportunity to join a dynamic group of emergency nurses from across the country.

Take a breath of fresh air Manitoba emergency nurses! Spring is here ☺

Respectfully submitted,
Marie Grandmont, RN, BN, ENC(C)
Director, Emergency Department Nurses Association of Manitoba

New Brunswick

February is here... A winter ice storm passed through New Brunswick last week leaving thousands of homes without electricity for more than a week. There were several incidents of carbon monoxide poisoning with

two confirmed deaths. More education is needed surrounding the use of generators, propane camp stoves and propane barbecues in the home or an enclosed space to prevent these unfortunate incidents.

Education
TNCC is offered throughout the province on an ongoing basis. Trauma New Brunswick with Horizon Health Network and Vitalite' support this initiative.

ENPC is offered two to three times per year in Saint John and Moncton.

CTAS is offered around the province in French and English, as needed, as well as CTAS instructor courses, as needed.

NENA NB continues to promote emergency nursing as a speciality, challenging and encouraging ER nurses to write their certification exams. CNA has made access easier with the online application process and two offerings per year, providing more opportunity for nurses to complete their certification.

Education through simulation continues in southern NB! We continue to provide education to RNs, LPNs, RTs and MDs in our rural hospitals through case-based simulation. It is great to see positive outcomes from the collaboration between MDs, RTs and nursing! Bi-weekly in-situ simulation at the Saint John Regional Hospital, the level-one trauma centre in New Brunswick continues followed by structured debriefing. Education through simulation improves skills, communication, and processes.

New Brunswick Health Authorities, Horizon Health Network and Vitalite' with the Department of Health in collaboration with University of New Brunswick and Universite' de Moncton support a provincial Critical Care Nursing Program that offers two streams—emergency care and critical care. The program is three months in length and is offered four times per year. It provides opportunity for continued professional development to nurses across the province in both French and English. This program is opened to the novice nurse who wants to work in the emergency or critical care area. Applications are received through UNBCEL and Université de Moncton. This initiative has been in place since 2002 and is an excellent example of collaboration.

Work environment
Emergency nurses continue to struggle with overcrowding in the emergency departments around the province. Acutely ill patients are waiting in the ED for placement within the hospital. Inpatient beds filled with alternate level of care patients waiting for placement in care facilities... the problem continues.

As seasoned emergency nurses, we cope with the challenges. It is very difficult to train our novice nurses to work in this environment. Providing quality care for these acute admissions, as well as the patients presenting to our emergency departments is very challenging and stressful.

Senior administration of the health authorities continues to work to improve the situation.

Currently, the ED at Saint John Regional Hospital has a working group that is trying to improve the flow through the department to decrease our wait time for the assessment of CTAS 3 patients. Utilizing space for the sick patients and optimizing flow by keeping the patients who are not acutely ill upright. As well, we're educating the public on who should be coming to an emergency department and who can go to an urgent care centre. This is a work in progress.

Flu season is here! Nurses who are not immunized must wear a mask when caring for patients.

NENA NB has 61 members!
We continue to promote membership at all educational courses! NENA NB is sponsoring three ER nurses to attend the 2017 NENA conference in Charlottetown, Prince Edward Island. You have to be a NENA member to be eligible. We hope to see a large number of NB nurses attend!

As NENA's voice grows, hopefully we can increase awareness of the problems faced by ER nurses. These issues impact patient care! These issues impact nurses! Emergency nurses make a difference!

Looking forward to the 2017 NENA conference in Charlottetown, PEI!

Respectfully submitted
Debra Pitts, RN,BN, ENC(C)
NENA-NB Director / NENA Director at Large

Nova Scotia

Greetings to everyone from Nova Scotia. We are excited for the NENA conference to be coming to the Maritimes. I had the privilege of attending the QEII Emergency Nurses Education Day in October 2016 where we drew for a lucky NSENA member to attend the NENA conference with their registration cost covered by NSENA. We are also planning to provide some funding for five NSENA members to attend the NENA conference.

Mandatory courses are still ongoing with our emergency nurses of TNCC, ENPC, ACLS, PALS and CTAS. We are looking forward to an exciting spring and summer in the emergency nursing world.

Hope to see everyone in PEI.

Respectfully submitted,
Mary Spinney, BScN, RN, ENC(C)
Director NSENA

Ontario

Happy New Year 2017 to all of our emergency nursing colleagues across Canada from the Emergency Nurses Association of Ontario (ENAO)!

This past September, ENAO held our biennial 2016 provincial conference in Belleville, Ontario. Emergency nurses from throughout Ontario joined together to enjoy many awesome speakers, presenting on a diverse assortment of pertinent and timely topics. ENAO proudly donated two ENAO / NENA one-year memberships as conference prizes. Our many corporate sponsors were most generous, both through their financial support, conference donations, and the provision of information packages about new products, innovative equipment, improved processes, latest best practices and current research. Many emergency nurses took advantage of this excellent educational opportunity, networking with old and new friends, while earning valuable CECH hours.

ENAO was honoured to welcome the NENA President Sherry Uribe who joined us for our entire conference, our 2016 AGM, our social event and addressed the attendees during the opening ceremonies. The nurses took full advantage of the opportunity to personally meet Sherry, and to discuss the current challenges in their

professional lives with her. ENAO recognizes the significant travel time and challenges between Sechelt, BC, and Belleville, Ontario, for the NENA President. Thank you for your support of this educational event, Sherry and NENA.

Some big changes on the ENAO Board of Directors took place at the 2016 AGM. The membership unanimously voted to approve a motion presented by the BOD to combine the two executive roles of Secretary and Membership Secretary into one position. Angela Arnold has graciously agreed to continue serving in this expanded role. Thank you, Angie.

Longtime ENAO Webmaster Motsi Valentine personally created the ENAO website (**www.enao.me**), consistently maintained it, diligently upgraded it and developed it over many years into the very professional electronic face of ENAO. Motsi has now moved on to a new chapter in his professional life, as well as exciting changes in his personal life, as a first-time dad. ENAO is truly grateful to Motsi for his dedication, commitment and expertise.

At the recent ENAO AGM, Sarah Gaudet was acclaimed to the position of Webmaster. ENAO is grateful that she has committed to sharing her unique talents, as she plans to expand the social media opportunities within ENAO.

Several years ago, ENAO created a new executive position of Education Coordinator, to hopefully facilitate us better meeting the educational component of our Mission. ENAO is happy to announce the acclamation of Deb Mitchell to this new opportunity.

ENAO is pleased to welcome Sharon Ramagnano to her new position as the Ontario representative on NENA's National Course Administration Committee (NCAC). Thank you, Sharon, for stepping up to this important role of facilitating the availability of valuable ENAO/NENA endorsed courses across our province.

ENAO is excitedly anticipating the initial phase of the rollout for the eCTAS electronic program in February 2017 in select Ontario emergency departments. We have been honoured to participate on the steering committee for this great project throughout its development, and look forward to a successful implementation across our entire province.

In support of the ongoing education for Canada's emergency nurses, NENA nationally, and the Prince Edward Island Emergency Nurses Association (PEIENA), ENAO will be awarding some Ontario members with the financial reimbursement of their early-bird member NENA 2017 conference registration fees, following the conference (final reimbursement number TBD at the spring 2017 ENAO BOD meeting). Hoping to see many "old – longtime" friends and meet many "new" friends at the upcoming NENA 2017 conference in Charlottetown.

Yours in Emergency Nursing,
Janice L. Spivey, RN, ENC(C), CEN
ENAO President

Director of Membership and Promotion report

Membership in NENA, as of today, is 1,168. This number is down from 1,197 in mid-December. This, I believe, is the "normal" fluctuation of the numbers that comes with the year-round membership. WE all need to do our 'jobs' promoting NENA within our provinces! Talk it up, there are still many emergency nurses who have no IDEA what NENA is, or what the benefits of membership are!

A membership survey was sent out to all NENA members in the past few weeks, as well as a survey to all of the Board of Directors (including all the provincial directors) with a link to a survey for each to forward to as many emergency nurses as possible who are NOT yet NENA members. There are 30K nurses who identify themselves as emergency nurses with the CNA, so we are missing out on a great number of potential members. I will have a report of the results/answers for the Annual General Meeting in Charlottetown at NENA 2017.

We are now out of stock of NENA promotional merchandise—pens, pins, name badge pulls, brochures and business cards. The remaining stock of Go Mugs were sent to PEI, Quebec and NWT for promotion of NENA in those areas. New merchandise for promotion of NENA will be redesigned to use the "new" bilingual logo, and will be inclusive of our mission statement and tagline on printed material. Ideas and suggestions for more ways to promote NENA are appreciated and welcomed. Please feel free to email me your ideas!

I am actively working on the establishment of a NENA-North and hope to assist in the establishment of NENA-QC, these two endeavours will make NENA truly a national organization!

The NENA Bursaries application and information are now on **nena.ca** and I would encourage any NENA members with the listed criteria to apply for these. They are monetary incentives that NENA has available to you, a member, that can help you with educational endeavors having to do with emergency nursing, albeit a course, conference or the ENC(C) exam/recertification.

I hope to meet you or rekindle friendships at the **NENA 2017 Conference, Find the Edge: Prospects for Emergency Nursing, in Charlottetown on June 2–4, 2017.** What a great way to celebrate Canada's 150 Birthday!

Our Strength: Our Members
Notre Force: Nos Membres

Respectfully submitted,
Pat Mercer-Deadman, RN, ENC(C)
NENA Director of Membership and Promotion

The NENA Bursary

NENA recognizes the need to promote excellence in Emergency Nursing care and to this end, to provide financial assistance to its members. NENA will set aside a predetermined amount of monies annually with the mandate of providing a high standard of Emergency care throughout Canada. All sections of the Emergency Nursing team are eligible for consideration including staff nurses, managers, researchers and educators.

Applications must be submitted prior to the spring Board of Directors meeting of NENA for review by the standing committee for Bursary disbursements.

On April 1 of each year, the number of bursaries awarded will be determined by the number of current registered members per province [for that NENA fiscal year]:

1–99 members:	1 bursary
100–199 members:	2 bursaries
200–299 members:	3 bursaries
300–399 members:	4 bursaries
400–499 members:	5 bursaries
500–599 members:	6 bursaries
600+members:	7 bursaries

One Bursary will be available to NENA Board of Directors members and one Bursary per year will be available to an independent NENA member.

Successful candidates may receive a Bursary once every three years.

Application process:
Each candidate will be reviewed on an individual basis and awarded a number of points as set out below:

1. Number of years as a NENA member in good standing

2 years	1 Point
3–5 years	2 Points
6–9 years	3 Points
10 + years	5 Points

2. Involvement in Emergency Nursing: (associations/groups/committees)

Provincial member	1 point
Provincial chairperson	2 points
Special projects/committee/ provincial executive	3 points
National executive/NENA chairperson	5 points

3. Candidates with certification in Emergency Nursing and/or involved in Emergency Nursing research will receive an additional 5 points.

If two candidates receive an equal number of points, the committee will choose the successful candidate.

All decisions of the NENA Bursary Committee are final.

Each application will be reviewed once at the spring board meeting.

Preference will be given to actively-involved NENA members and those actively pursuing a career in Emergency Nursing. Those members requesting assistance for Emergency Nursing certification, TNCC, ENPC, CTAS, as well as undergraduate or post-graduate studies that would enhance Emergency Nursing care will also receive preference.

Candidates must have completed Forms A, B and C (available on the NENA website: **www.nena.ca**). The provincial director may forward applications at the spring board meetings following electronic notification to committee.

Any incomplete forms will be returned to the provincial director for correction if possible.

Eligibility:
- Current RN status in respective province, territory or country.
- Proof of registration required.
- Active member in NENA for at least two consecutive years.
- Proof of membership required.
- Working at present in an emergency setting which may include:
  - Emergency department
  - Nursing station
  - Pre-hospital
  - Outpost nursing
  - Flight nursing

Application process:

Candidates must complete and submit the following:
a. NENA Bursary application form "A".
b. Bursary reference form "B"
c. 200-word essay
d. Photocopy of provincial RN status.

Provincial Director responsibilities:
a. Completes bursary candidates' recommendation form "C"
b. Ensures application forms are complete *before submission* to Bursary chair.
c. Brings to Board of Directors meeting all appropriately completed applications.

Selection process:
The standing committee for NENA bursaries will:
1. Review all applications submitted by provincial directors and make recommendations to award bursaries based on the NENA selection criteria.
2. Forward names of approved candidates to the NENA Board of Directors for presentation by the President.

National Emergency Nurses Association Annual Conference • June 2–4, 2017

Rodd Charlottetown, 75 Kent Street, Charlottetown, Prince Edward Island

DAY ONE – JUNE 2

07:00-08:00 Continental Breakfast/Registration

07:50-08:15 **OPENING CEREMONIES & WELCOME** - April Mills and Sherry Uribe

08:15-09:00 **Everything I Learned About Leadership, I Learned from Being an ER Nurse**
Dr. Kimberly Critchley, PhD, Bsc, RRT, Deputy Minister of Health PEI

Dr. Critchley is the Deputy Minister of Health for Prince Edward Island. An 'old emergency nurse', Dr. Critchley has an uplifting message for us about our work, our importance and value in Canada's Health Care System.

09:05-09:45 **Disease on the Lookout - Message from the Chief Public Health Officer**
Dr. Heather Morrison, MD, PhD, Bsc, RRT, Dphil,
Chief Public Health Officer, PEI

Dr. Morrison chairs the Canadian Council of Chief Medical Officers of Health, is PEI's Chief Medical Officer and is an emergency physician. She is delighted to present to the NENA delegates messages, from the Public Health Agency of Canada.

09:50-10:30 CONCURRENT SESSIONS

Smoking, Heavy Breathing and Drama - Sounds Like Ventilation in the ED to Me!
Choice 1A: Wade Norquay, Bsc, RRT,
Clinical Leader Respiratory Therapy, Queen Elizabeth Hospital

Got a grasp on the principles of ventilation? This presentation should help familiarize the audience with the basics of ventilator care and give practical tips on monitoring and treating these patients.

Poisons That Can Kill
Choice 1B: Laurie Mosher, Bsc (Hed), BScN, RN, CSPI,
Clinical Leader, IWK Poison Centre

Why do some people die from overdose or poisoning and what is the role antidotes have in the reduction of mortality.

One Big Happy Family: Integrating Rural and Urban EDs in a Regional Health Authority
Choice 1C: Julie Bartlett, BN, RN, ENC© and Sandra Gear, MN, RN

12 EDs? In one unified program? Come learn about how one system met the challenge of creating an inclusive orientation and continuing education program, challenging the obstacles of geography and budgetary constraints.

10:30-11:00 Nutrition Break

11:00-12:30 **Annual General Meeting - NENA**

12:30-13:15 Lunch and Trade Show

13:15-14:00 CONCURRENT SESSIONS

Non-Fatal Strangulation - At the Edge of Death
Choice 2A: Stephanie Carlson, RN, SANE-A, CFN

Strangulation occurs in a significant percentage of sexual assaults. Strangulation is a demonstration of power over someone's life for the assailant; it is an act of unspeakable horror for the victim; it is an underappreciated threat for the police; it is a challenge for the emergency department. Stephanie will review risks, recommended nursing actions and discharge teaching for patients.

To Do or Not to Do....
Choice 2B: Dawn Peta, BN, RN, and Thora Skeldon, BSN, RN

Dawn and Thora will present case scenarios that demonstrate pitfalls in Emergency Nursing practice....learning from stories will highlight how nursing can find their voice and advocate for patient needs and avoid critical errors and events.

A Rural Emergency Department Success Story
Choice 2C: Dr. Christopher Patey, BSc, MD, CFPC, FCFP
and Paul Norman, BN, RN

How do rural emergencies find resources to create efficient process, flow and happy customers? Mr. Norman and Dr. Patey have done it! Come steal some ideas!

14:05-14:45 CONCURRENT SESSIONS

Battle of the Sexes
Choice 3A: Monique McLaughlin, NP(F), MN, and
Landon James, BScN, MA, CEN, PCP

The popular duo of Landon and Monique present the mystery of why males and females present, respond and react differently in a variety of case presentations.

Primary Care in the Rural ER - Right Place?
Choice 3B: Paul Norman, BN, RN

"The outpatient department and primary care clinics are now closed, the emergency room will remain open" - good or bad announcement to the emergency department waiting room. Hmm. What does Paul say?

Interesting Rural Newfoundland Emergency Cases
Choice 3C: Dr. Christopher Patey, BSc, MD, CFPC, FCFP

Comically delivered, learn this interesting view on unique Newfoundland emergency cases.

14:45-15:10 Nutrition Break

15:10-15:50 CONCURRENT SESSIONS

The Street Drug Scene
Choice 4A: Corporal Andy Cook

A member of the Royal Canadian Mounted Police, Andy will provide an overview of current trends and drugs of concern from across the country, with a presentaton up to date on June 2, 2017!

Through the Looking Glass: An Experience From the Other Side
Choice 4B: Rosemary Schmidt, RN, BScN, MN, ENC©

As we strive to provide excellent care to patients, what is the patient's perception of their experience? Come hear a story told from the patient's perspective.

Understanding the Experience of Miscarriage in the ER
Choice 4C: Kate MacWilliams, RN, MN

NENA 2017 is privileged to have Kate enlighten us about the perceptions of this patient population, giving valuable insight on the nursing role in patient satisfaction.

15:55-16:40 **Do I need legal advice? CNPS Services: Who We Are and How We Can Help You.**
Alanna Lawson, LLB, LLL, Canadian Nurses Protective Society

Most nurses in Canada are eligible for CNPS Services, yet many are not aware of the scope of services available from the CNPS. Join Alanna and learn about the legal services available from CNPS for nurses who work as employees and nurses who work in independent practice.

16:40-16:45 **CLOSING DAY ONE** - April Mills and Sherry Uribe

17:30-18:30 **Historic Walk of Charlottetown - Confederation Players**
Meet in lobby at 17:20.

Join the Confederation Players for an informative - and maybe spooky - walk and guided tour through historic Charlottetown $10/per person, meet and pay in the Rodd lobby at 17:20.

EVENING EVENT **East Coast Kitchen Party: Gahan Brewery**
Don't forget to register for an Islander Kitchen Party!
$100.00 per person - includes Island specialty food items and authentic Island Entertainment. Transportation is provided for return to the Rodd Charlottetown. For more details see the conference guide at NENA.ca.

DAY TWO – JUNE 3

07:00-08:00 Continental Breakfast

07:00-14:00 Registration Open

08:00-08:10 **HOUSEKEEPING ITEMS** - April Mills

08:10-09:10 **Not Criminally Responsible**
Patsy MacLean, Q.C.

Patsy MacLean is a nurse-lawyer and the Chairperson of the PEI Review Board. Ms. MacLean is pleased to present an overview of the PEI Review Board. What does "not criminally responsible" and "unfit to stand trial" really mean? What are the implications of community living for patients and their treatment team? How do emergency nurses adapt to these patients when they are sick?

09:15-10:15 **A Funny Thing Happened on the Way Through the Jungle**
Jeff Solheim, MSN, RN, CEN, TCRN, CFRN, FAEN

Jeff Solheim is the Executive Director of a not-for-profit medical organization, allowing him to travel with medical teams to some of the most desolate areas of the world. In this very visual and emotional presentation, Jeff takes participants on a trip around the world, sharing life-lessons learned from nearly every corner of the earth.

10:15-10:45 Nutrition Break

10:30-15:00 **Simulation Stream:** Group A/B: Megan, Group C: April, Group D: Dan

10:45-11:15 **Use of the Emergency Department Within 30 days of Discharge**
Choice 5A: Dr. Marilyn Hodgkins, RN, PhD, Associate Professor, Faculty of Nursing, UNB

CONCURRENT SESSIONS

In an attempt to slow the revolving door, Marilyn and her research team examined the characteristics of patients who presented to the ED within 30-days of a hospital discharge. Hear what they discovered.

CSI in the Emergency Department
Choice 5B: Jan Calnan, RN, BScN, FNE

It is a busy Friday night, and a patient arrives who was found down with multiple abrasions and a "wound" in his chest. So what is considered forensic like samples that may be collected from patients who present to your ED? Learn the basics in forensic evidence collection from a forensic nursing expert.

Tightening the Safety Net: Risk Screening for the Older Adult
Choice 5C: Mary Ostrowski, RN, MSN GNC©, and Tara Snyder, RN, BScN

Emergency departments care for a variety of ages, with geriatrics being one of the most complex and vulnerable. Learn from Mary and Tara how to 'tighten the safety net' for this special population.

11:20-12:00 **The Opioid Crisis and Widespread Narcan Use**
Choice 6A: Landon James, RN, BScN, MA, CEN, PCP and Monique McLaughlin, NP(F), MN

CONCURRENT SESSIONS

At epidemic proportions, Canada is fighting the crisis in opiod overdose. Landon and Monique walk delegates through the use of Narcan, the benefits and potential pitfalls of current strategies.

You Put Who, Where? A Triage Audit Tool
Choice 6B: Richard Drew, RN and Wendy Gillespie, NP, MN

Are you a Triage Nurse, Educator, or Manager? Have you ever wondered how the triage and triage reassessment processes are working? Join Richard and Wendy in a discussion of a CTAS audit tool they have developed that provides individual and departmental feedback about the triage and triage reassessment process.

Dad, Can We Take a Break? A Case Study of a 12-Year-Old with Pediatric Stroke
Choice 6C: Traci Surette, RN, BN

Traci walks delegates through a case presentation of a pediatric stroke, in a tale of collaboration and difficult decision making.

12:00-12:45 Lunch, Exhibitor Display and Poster Presentations

12:45-13:30 **Front Line Perceptions on Alcohol Abuse: What Are They?**
Choice 7A: Cindy Schumlick, RN, BN, MN(cand)

CONCURRENT SESSIONS

Patients present to our emergency departments regularly and can be a source of frustration for emergency nurses. Are they getting optimal care?

Taking a Multipronged Approach to Rural Trauma: Combining Primary Prevention and Frontline Training
Choice 7B: Adrienne Seabrooke, RN, BScN, Med and Rachel Roy, MSc, BSc, BA

Rural Emergency departments are an important component of trauma systems. Andrienne and Rachel tell us about strategies to streamline the process to make the most efficient use of rural emergency departments.

CONCURRENT SESSIONS

Assessing ED Health Professionals' Perceptions of Family Witnessed Resuscitation: A French Canadian Study
Choice 7C: Steve Gagne, RN, BScN, MSN(cand), CNCC©

While validating tools translated to French, Steve investigates how nurses are doing with family witnessed resuscitation. How are you doing?

13:30-14:30 **Doctors Without Borders: Opportunities for Nursing**
Choice 8A: Doctors Without Borders: TBD

Got a travel itch? Want to engage in assisting in world crisis? What is it all about anyway?

It's All Shades of Grey to Me: X-Ray Interpretation for the Non-Radiologist
Choice 8B: Jeff Solheim, MSN, RN, CEN, TCRN, CFRN, FAEN

What are they looking at? Jeff will review components of Xray interpretation for ED nurses.

14:35-15:00 Nutrition Break and Exhibitor Display

CONCURRENT SESSIONS

15:00-15:40 **Improving Access in a Pediatric Emergency Department: A Fast-Track Approach for Children With Respiratory Problems.**
Choice 9A: Nathalie Cloutier, RN, MSc(cand), KL Then, and JA Rankin

Long wait times? Kids getting sicker in your emergency department waiting room? Nathalie will report to congress, the results of a fast-track area that uses nursing and respiratory therapy to accommodate a vulnerable population.

COPD and the Knowledge of the Triage Nurse
Choice 9B: Mary Harris, RN, BScN, MN(cand)

Do we know? Mary discusses the advantages of the triage nurses' knowledge of COPD and how it can be used to connect patients to primary care services.

Period of Purple Crying
Choice 9C: Sharron Lyons, RN

Parents struggle with infant crying, not understanding normal expectations. As parents present to the ED, Sharron explains the acronym 'PURPLE' and how to help parents easily understand normal infant behaviour.

15:40-16:40 **Developing a Culture of Citywide and Hospital Preparedness**
Meg Femino, HEM

It was not a matter of if, but when. Learn how Boston coordinated preparedness planning. A seasoned professional in Emergency Management, Meg will not disappoint.

16:40 **CLOSING DAY TWO** - Sherry Uribe

EVENING EVENT **Coach Bus Tours & Lobster Supper at New Glasgow Lobster Suppers!**
$120.00 per person. Enjoy Prince Edward Island scenery on a bus tour, then partake in an elegant lobster supper at one of PEI's most popular restaurants.

DAY THREE – JUNE 4

07:00-8:00 Continental Breakfast

08:10-09:30 **2013 Boston Marathon Bombings: Reflections, Challenges and Lessons Learned**
Meg Femino, HEM

On the third Monday in April 2013, the hearts and minds of not only Bostonians but also millions throughout the world were forever changed by the twin bombings that occurred at the finish line of the Boston Marathon. How did they prepare and accomplish the unbelievable - all that made it to the hospital survived? Meg, once again, helps us understand the importance of preparedness.

09:30-10:00 Nutrition Break

10:00-10:20 **TBA**

Where was nursing at the birth of the country? A humorous look at nursing at Confederation time

10:20-11:00 **Early Recognition and Sepsis; a Project Using qSOFA at Triage**
Mike MacDonald, RN, BN, ENC(c), and Dr. Gregory German, MD

Last year the sepsis guidelines changed-out with SIRS in with SOFA. In a Provincial Quality Team study, The Queen Elizabeth Hospital adapted qSOFA in EMS and triage assessments. Mike and Greg deliver a humorous view of the advantages of early recognition of septic patients in the ED, leaving you with a few questions as the two do not always agree!

11:00-12:00 **MCI Response. Is Your ER Ready? Your Hospital Won't Be.**
Dr. Trevor Jain, MSM, CD, MD, MSc

An expert in disaster and a member of the Canadian Military, Dr. Jain wants to deliver a message to emergency nurses.

12:00-12:10 **Next Year's Conference Announcement!**

12:10-12:30 **CONFERENCE CLOSING REMARKS** - April Mills, Sherry Uribe

PLEASE NOTE: SPEAKERS SUBJECT TO CHANGE. REFER TO ONLINE BROCHURE FOR MOST UP-TO-DATE SCHEDULE AT NENA.CA

Come Early and Stay Late!

meetingsandconventionspei.com/our-services/come-early-stay-late/

Thank you,

Meetings and Conventions PEI!

Meetings & Conventions Prince Edward Island

Impact of trauma and a shift in focus on healthcare

By Jamie Seto

Jamie is nearing completion of his Certificate in Forensic Health Sciences at British Columbia Institute of Technology (BCIT). He has experience in many areas of nursing and has been adding to his knowledge and skills by bringing principles of forensic nursing practice into his own practice. He spent a clinical practicum with Lori Baker, RN, CNCC(C), CCNC(C), Trauma Coordinator, Coastal Health, Lion's Gate Hospital, North Vancouver, BC.

His article reflects on the after effects of trauma caused by any number of reasons, as patients and families work to a new norm after a life-altering experience. Healthcare providers especially can be affected personally by the trauma of others, as well. Forensic nursing practice takes into account that it is not only the medical needs of a patient, but the inclusion of possible forensic needs, as well, that may assist patients and their families to better outcomes post trauma and violence.

– Introduction by Sheila Early

Trauma can be defined as: 1) an injury (as a wound) to living tissue caused by an extrinsic agent, or 2) a disordered psychological or behaviour state resulting from severe mental or emotional stress or physical injury (Merriam-Webster, 2016). It can also be further broadened when you take into account that trauma does not only affect the victim. The spectrum of trauma is spread across a multitude of characteristics and people involved. According to Courtois (1993), vicarious traumatization (VT) is a transformation in the self of a trauma worker (i.e., a nurse) or helper (family member) that results from empathic engagement with traumatized clients and their reports of traumatic experiences. It is a special counter transference stimulated by exposure to the client's traumatic material (Courtois, 1993). Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms can mimic those of post-traumatic stress disorder (PTSD).

Trauma and stress can be physical, emotional, financial, and/or psychological. It can be singular in its burden, or compound itself with any combination of the aforementioned, becoming ever more cyclical and insidious in its nature from the acute through to the chronic.

According to the World Health Organization (WHO), injury kills more people each year than HIV, TB, and malaria combined, and this occurs predominantly in low-middle-income countries (WHO, 2016). Timely emergency care saves lives: if fatality rates from severe injury were the same in low- and middle-income countries as in high-income countries, nearly 2 million lives could be saved every year (WHO, 2016). This has necessitated the creation of assessment tools to streamline essential emergent care, such as the WHO Trauma Care Checklist:

http://www.who.int/emergencycare/publications/trauma-care-checklist.pdf?ua=1

The WHO Trauma Care Checklist was launched on August 18, 2016, at the World Trauma Congress in New Delhi, India, in collaboration with the Government of India and the WHO Global Alliance for Care of the Injured.

This is congruent with the emergent care assessment of trauma victims by trained personnel. The Trauma Nursing Core Course teaches that the first few minutes of trauma care are critical to achieve better patient outcomes. The A–I mnemonic and the Trauma Nursing Assessment will assist nurses in providing appropriate and early intervention:
A – airway with simultaneous c-spine stabilization
B – breathing
C – circulation
D – disability (neurological status)
E – expose patient/environmental control
F – full set VS/five interventions/facilitate family
G – give comfort
H – history/head-to-toe assessment
I – inspect posterior surfaces" (TNCC, 2016).

In addition to the A–I of trauma assessment, emergency departments utilize algorithms to further care of the victim. An example is Code 99 Trauma Activation. This applies to new patients **and** transfers. According to (Baker, 2014) activating Code 99 if the patient meets ANY of the following criteria (Table 1).

Care of the patient, whether it be a trauma in the emergency department, or a code blue on any unit, includes many members of the interdisciplinary team: physician(s), nurses, respiratory therapist(s), social worker, and pharmacist. In addition to the aforementioned roles, other personnel and services are essential in the care and management of the patient. This may, and likely includes unit clerk, laboratory technician, blood bank, ECG technician, x-ray technologist, and hospital security. Other hospital departments are often mobilized in preparation for potential use—CT scan and operating room.

The impact of trauma is multifactoral: physical, emotional, and financial, and likely compound one another, as it is seldom a single factor alone.

Violence, as it pertains to trauma, as defined by the WHO (2017) is "the intentional use of physical force or power, threatened or

Table 1.		
	Adult Criteria (16 Years of Age and Over)	**Pediatric Criteria (Less Than 16 Years of Age)**
Mechanism of Injury	Significant Mechanism of Injury Adult patient trauma activation is not based on mechanism alone. One of the criteria below must *also* be met.	MVC—patient thrown from vehicle - prolonged extrication of >20 minutes - other occupant killed/injured severely Pedestrian vs. Motor Vehicle—Thrown Bicycle vs. Motor Vehicle—Thrown Any fall from 3 times the child's height or more *Even if none of the below criteria are met, Code 99 should be activated in the pediatric patient based on mechanism alone.*
Physiologic	Respiratory rate <10 or >29/min Systolic blood pressure <90mmHg Glasgow Coma Scale ≤13 Any patient requiring ventilatory support (i.e. BVM, Intubated) Any patient requiring blood products to resuscitate in sending facility (Transfers only)	
Anatomic	Penetrating injury to the head, neck, chest, abdomen, groin, proximal extremities Flail chest Burns >20% TBSA Unstable pelvic fracture Amputation proximal to wrist and ankle Traumatic limb paralysis (spinal injury with deficits) ≥2 proximal long-bone fractures	
Other	If any of these are the only criteria met, activation is optional based on the EP/CRN decision: Pregnant patient with significant MOI Extremes of age Other significant comorbidities (Cardiac disease, respiratory disease) At the discretion of the EP, is considered high-risk for life or limb-threatening injury	

actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." Whether experienced firsthand or indirectly, violence affects the lives of millions, with long-lasting consequences. The WHO compiled data from 133 countries, covering 6.1 billion people and representing 88% of the world's population. Detailed in the *Global Status Report on Violence Prevention 2014*:

> *"There were an estimated 475,000 deaths in 2012 as a result of homicide. Sixty percent of these were males aged 15–44 years, making homicide the third leading cause of death for males in this age group. Within low- and middle-income countries, the highest estimated rates of homicide occur in the Region of the Americas, with 28.5 homicides per 100,000 population, followed by the African Region with a rate of 10.9 homicides per 100,000 population. The estimated rate of homicide is in the low- and middle-income countries of the Western Pacific Region, with 2.1 per 100,000 population. Over the period from 2000 to 2012, homicide rates are estimated to have declined by just over 16% globally (from 8.0 to 6.7 per 100,000 population), and, in high-income countries, by 39% (from 6.2 to 3.8 per 100,000 population). By contrast, homicide rates in low- and middle-income countries have shown less decline over the same period. For both upper and lower middle-income countries the decline was 13%, and for low-income countries it was 10%. Nevertheless, deaths are only a fraction of the health and social burden arising from violence."*

As recognized by WHO (2016), crisis events involving exposure to trauma and sudden loss occur in all communities of the world. Orientation in psychological first aid gives responders a framework and tools to better approach and respond to victims in a natural, supportive, and practical manner. They also acknowledge that a common mistake in current humanitarian responses in many countries is to only make psychological first aid available in the absence of other care (WHO, 2016). Psychological first aid is feasible and appropriate during crises and should be complemented with other essential mental health, physical, and psychosocial activities (WHO, 2016). In the long run, all communities need to have mental health, social and educational services that address the long-term increase in needs, alongside the acute response (WHO, 2016). This needs to be multisectorial!

This need for a multisector approach to healthcare has long been established but, unfortunately, is not widespread. In the 1990s Lynch and McCracken, both nurses (psychiatric and emergency respectively) with many years of experience and forensic expertise, recognized the necessity for a shift in paradigm. Lynch, in *Forensic Nursing* (2006), explains that clinical forensic practice derives from the broader field of forensic medicine and is defined as "the application of clinical and scientific knowledge to questions of the law and the civil or criminal investigation of survivors of traumatic injury and/or patient treatment involving court-related issues (p. 4)" Lynch adds that living forensic patients are the survivors of criminal or liability-related injuries that result in an investigation by a legal entity. Lynch further states that "no longer can healthcare providers work in isolation from the legal issues previous delegated to law enforcement." It is the responsibility of the healthcare professionals to maintain a high index of suspicion and to protect victims. As stated in *Forensic Nursing Science* (Duval & Lynch, 2010), "The application of forensic aspects of healthcare combined with the bio/psycho/social/spiritual education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of violence, criminal activity and traumatic accidents. It provides direct services to individual clients and consultation services to nursing, medical- and law-related agencies, and it provides expert court testimony in areas dealing with questioned death investigative processes, adequacy of services delivery and specialized diagnoses of specific conditions, as related to nursing." This is further corroborated in *Forensic Nursing* (2006), McCracken's mnemonic, the ABCs of clinical forensic nursing, to assist nurses with their medico-legal responsibilities:

"A: Assessment of the victim
B: Bridge the gap; liaison with outside agencies such as law enforcement and the medical examiner
C: Chain of custody; know the methods of evidence collection and establish continuity of evidence possession and disposition
D: Documentation of findings
E: Evidence
F: Families; keep them informed
G: Going to court; be prepared to provide written or oral testimony
H: Hospital policies; know where and how to access your institution's forensic protocols
I: Index of suspicion; be aware of signs of abuse and violence (p. 4)."

It has long been known that trauma care providers are very good at finding out what is injured. Emergency department nurses and trauma physicians excel in the "E" part of the mnemonic of trauma care. We "expose" the patient to see what is hurt. Unfortunately, we are also very skilled at throwing away the soiled clothing, washing the wounds, applying ointments, and making judgements when we are not expertly trained in that field. There were no guidelines and, at present, I would dare to say many emergency departments lack guidelines, nor is training provided regarding basic forensic evidence collection. This statement can be corroborated by my colleagues at the Royal Columbian, Surrey Memorial and Vancouver General Hospital emergency departments. I have been told by colleagues that the first thing on their mind when stabilizing a victim of a gunshot wound, is medical care, first and foremost. It is not the intended purpose to destroy evidence and unintentionally obstruct justice, but a result of not knowing any better because of a lack of training and education. The practice of evidence preservation is not engrained in them. So, what happens as a result? In many instances, they cut through the hole created by the projectile, destroying evidence. How many individuals know that powders, particulates, and residue are deposited on the clothing and can aid in the investigation in determining the distance from the muzzle of the firearm? The only ones with definitive training and knowledge pertaining to medical care in congruence with evidence preservation are the certified Sexual Assault Nurse Examiners, and they are few and far between!

Virginia Lynch discovered this incongruence in our medical-legal system in 1982 when she had an opportunity to visit a crime laboratory. During the visit, she realized that she and her colleagues had been inadvertently destroying important evidence when crime victims came into their emergency department and, as a result, created a new nursing specialty (Elsevier, 2014). This passion has drawn many others to the cause (Sheila Early, Aimee Falkenberg, Lori Baker—several of my own esteemed instructors whom I have had the privilege of knowing), to bring to light what many would consider a special calling. A shift in perspective to want to know, to educate others about what is not taught in nursing or medical schools—forensic medicine.

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Research to action: The Sea to Sky Sexual Health Survey

By Tamara Dudley

The essence of change begins with individuals and groups who will no longer tolerate the status quo.

Tamara Dudley's article documents her research data on sexual violence along the Sea to Sky Highway, which extends from Vancouver, BC, to just north of Whistler, BC. The article demonstrates that access to timely care in regards to sexual violence is not equal in all parts of Canada. Urban centres are more likely able to provide the medical and/or forensic care depending on the patient's wishes than non-urban or rural communities. Tamara describes how one community (Squamish, BC) decided to gain access to the care needed by those who have been sexually assaulted in their community. It has taken many dedicated individuals and groups to accomplish a health-care response to sexual violence, so that care can be provided within the health framework of the community itself.

This process brings to mind Margaret Mead's quote: "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

—Introduction by Sheila Early

Introduction

Sexualized violence is a pressing concern to stakeholders and residents of the Sea to Sky Corridor, an area located on the West Coast of Canada. Between 2000 and 2009, the Sea to Sky Corridor had almost three times more sexual offences per capita (95.65 per 100,000 population), than urban centres such as Richmond or North Vancouver (34.56 and 37.81 sexual offences per 100,000 population, respectively) (Ministry of Public Safety and Solicitor General Police Services Division, 2011; British Columbia Statistics, n.d.). Furthermore, domestic violence spiked by 46% throughout the Sea to Sky Corridor in 2013, and jumped by 87% in the community of Squamish alone (Enders, 2014). As of Fall 2013, no forensic nursing services existed in the Sea to Sky Corridor; residents who experienced sexual assault had to travel to Vancouver, up to three hours away by car, in order to access forensic nurse examination (Cooley-Herdman, Sherkat, & Bulloch, 2012). Furthermore, no independent research had been conducted exploring rates of reported and unreported sexualized violence in the Sea to Sky Corridor. As a response to this lack of research, the Sea to Sky Sexual Health Survey was created to establish baseline data for better insights into the service and programming needs of the corridor with regards to sexual health and sexualized violence.

Methods

Using a cross-sectional survey design, this study had three areas of focus: sexual health, service use, and sexual assault. Participants were recruited by word of mouth, online distribution of the survey via social media and partner websites, and posters distributed throughout Squamish and Whistler. Participation was not randomized. All genders, sexes, and sexual orientations were invited to participate. In total, 251 individuals participated in the survey; 205 were eligible for inclusion. Data collection occurred over a period of three months, and were collected through an anonymous and confidential online survey. Participants were excluded from the analysis if under the age of 19, if they did not provide their informed consent, if they were not residents of the Sea to Sky Corridor, or if they did not answer key questions. Furthermore, due to a lack of participation from individuals who identify outside the gender binary (i.e., do not identify as a woman or as a man), this population was excluded from the analysis to avoid bias. The survey drew from the Canadian Criminal Code (Statistics Canada, 2008) and from the literature (McMahon, 2011; Coxell & King, 2010; Harrell et al., 2009; Rape, Abuse & Incest National Network, 2009; Busch-Armendariz, DiNitto, Bell, & Bohman, 2010) to define sexual assault as unwanted sexual contact, including, but not limited to unwanted touching, kissing, or penetration.

Univariate[1] analysis of counts and frequencies was conducted for demographic variables and variable experiences of sexual assault. Bivariate analysis was conducted analyzing the association between demographic characteristics and being a survivor of sexual assault. Unadjusted odds ratios and confidence intervals, and *p*-values are provided in Tables 1 and 2. Additional bivariate analysis was conducted exploring the association between demographic characteristics with experiencing multiple sexual assaults, in addition to the association between number of assaults experienced and reporting rates for forensic evidence collection and police involvement.

Results

Sample Characteristics

A total of 205 participants were included in the final analysis. Approximately three-quarters identified as women (73%), while 27% identified as men. The majority of participants were between ages of 19 and 25 (53%); 12% identified as being a visible minority. In the sample, 23% of participants identified as being survivors of sexual assault; of those participants, 52% had experienced multiple sexual assaults.

[1]Univariate: statistical analysis of one variable (e.g., calculating the percent of participants who identified as women).
[2]Bivariate: analysis of two variables—specifically the explanatory (e.g., age) and outcome (e.g., having experienced sexual assault) variables.

Bivariate Analysis

Table 1 describes the bivariate[2] relationships between the sample characteristics and having experienced sexual assault. Identifying as a woman was statistically significantly associated with having experienced a sexual assault [OR 3.18 (1.27, 7.97)]; no other demographic variables were significantly associated with experiencing a sexual assault.

Characteristics of Assault

Only 9% of assaults had occurred in the past 12 months for multiple assault survivors, while 23% of assaults for single assault survivors had occurred in the past 12 months (15% overall). The majority of both single and multiple assault survivors in the sample lived in Squamish (91%, 88%). Nine percent of assailants were unknown to single assault survivors, while 17% of assailants were unknown to multiple assault survivors (38% had experienced assaults with both known and unknown assailants).

There was no difference between single assault survivors and multiple assault survivors whether the only or most recent assault had occurred recently (within the past year) or more than one year ago [OR 0.31 (0.05, 1.79)]. Furthermore, there

Table 1: Bivariate Analysis – Experienced Sexual Assault

Sample characteristics	Overall % (n)	Experienced Sexual Assault		Bivariate crude odds ratios (95% Confidence Intervals)	p-value
		Yes % (n)	No % (n)		
Age					
≥26	47.3 (97)	9.3 (19)	38.0 (78)	0.66 (0.34, 1.28]	0.22
19–25	52.7 (108)	14.1 (29)	38.5 (79)		
Gender					
Women	73.2 (150)	20.5 (42)	52.7 (108)	3.18 (1.27, 7.97)	0.01
Men	26.8 (55)	2.9 (6)	23.9 (49)		
Ethnicity					
Visible Minority	11.7 (24)	3.4 (7)	8.3 (17)	1.41 (0.55, 3.62)	0.48
White	88.3 (181)	20.0 (41)	68.3 (140)		
Schooling					
Post-secondary or higher	90.7 (186)	21.5 (44)	69.3 (142)	1.16 (0.37, 3.68)	0.80
Up to high school	9.3 (19)	2.0 (4)	7.3 (15)		
Location of Residence					
Squamish	90.2 (185)	21.0 (43)	69.3 (142)	0.91 (0.31, 2.64)	0.86
Other	9.8 (20)	2.4 (5)	7.3 (15)		

Number of Assaults

Of the survivors, 52% had experienced multiple assaults. However, bivariate analysis showed that no demographic factors were associated with having experienced multiple assaults, although age approached significant [OR 3.07 (0.91, 10.37). p=0.07]. Table 2 describes the bivariate relationships between the assault characteristics and having experienced more than one sexual assault.

Table 2: Bivariate Analysis – Number of Sexual Assaults Experienced

Sample characteristics	Overall % (n)	Experienced Multiple Sexual Assaults		Bivariate crude odds ratios (95% Confidence Intervals)	p-value
		Yes % (n)	No % (n)		
Age					
≥26	60.4 (19)	27.1 (13)	12.5 (6)	3.07 (0.91, 10.37)	0.07
19–25	39.6 (29)	25.0 (12)	35.4 (17)		
Gender					
Women	88.0 (44)	45.8 (22)	41.7 (20)	1.10 (0.20, 6.09)	0.91
Men	12.0 (6)	6.3 (3)	6.3 (3)		
Ethnicity					
Visible Minority	14.6 (7)	6.3 (3)	8.3 (4)	0.65 (0.08, 4.41)	0.70
White	85.4 (41)	45.8 (22)	39.6 (19)		
Schooling					
Post-secondary or higher	91.7 (44)	50.0 (24)	41.7 (20)	3.51 (0.26, 196.5)	N/A
Up to high school	8.3 (4)	2.1 (1)	6.3 (3)		

was no association between whether the assault(s) occurred on a weekday or weekend [OR 1.71 (0.50, 5.92)] or whether the assault(s) occurred during the day or at night [OR 1.06 (0.20, 5.51)] and number of assaults experienced.

Reporting Assault

Only one out of 46 survivors in the sample had forensic evidence collected. Furthermore, only 9% of survivors reported their assault(s) to the police. The top reasons reported by survivors for not seeking forensic evidence collection were: "I didn't want to tell anyone," (19%), "I was worried that people would blame me," (15%), and "I didn't realize that I had been assaulted," (15%) (see Figure 1), while top reasons identified for not reporting to the police were: "I didn't want to tell anyone," (20%), and "I didn't think it would help," (19%) (see Figure 2). Number of assaults experienced was not significantly associated with reporting the assault(s) to the police [OR 3.08 (0.22, 173.74)]. The odds ratio for collection of forensic evidence could not be collected due to zero cell counts.

Discussion

This study provides quantitative evidence that residents of the Sea to Sky Corridor have experienced sexual assault. As the first research of its kind, these results provide baseline information to build further research into sexual assault in the corridor. These results suggest that one in four people in the corridor have experienced sexual assault (39% of women and 12% of men), and of these individuals, roughly half had experienced more than one assault. Many demographic factors that are often associated with experiencing sexual assault, such as identifying as a visible minority (Boykins, Alvanzo, Carson, Forte, Leisey, & Pilchta, 2010), were not associated with experiencing sexual assault in this analysis. However, over-representation of certain demographics likely biased these results.

Approximately one-eighth of assaults had occurred within the past 12 months, suggesting that sexualized violence is an ongoing problem in the area. However, only two percent of survivors reported having forensic evidence collected post-assault, and less than 10% identified having reported their assault(s) to the police. These numbers imply that survivors of assault are not accessing services post-assault that can help connect them with medical help and support systems, and which are often vital to prospective criminal investigations. Concerns over blame, an unwillingness to report, and concerns over whether reporting would benefit the survivor mainly prohibited seeking forensic evidence collection and police involvement. These outcomes suggest that survivors do not feel that the benefits of these services outweigh the potential negative outcomes from reporting or seeking medical attention.

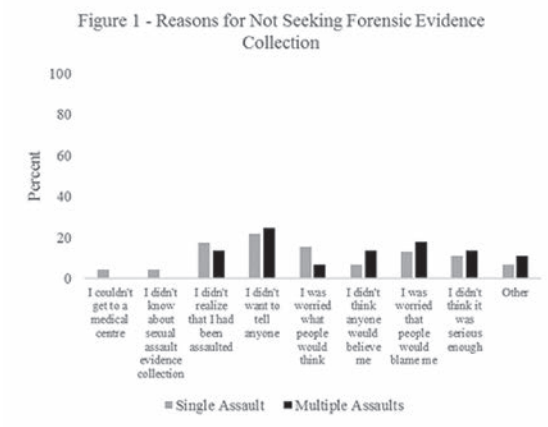
Research to action

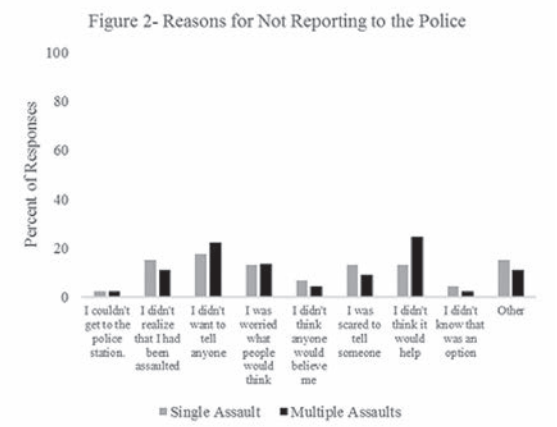
Knowledge translation occurred throughout several phases of this research in partnership with community groups and the local health authority. In summer 2015, the Howe Sound Women's Centre (HSWC), a long-time advocate for sexual assault survivors in the corridor, secured funding to hire a Sexual Assault Response & Prevention Coordinator. Concurrently, a nurse practitioner from Vancouver Coastal Health, the local health authority, reviewed the findings from the Sea to Sky Sexual Health Survey in response to calls for funding for forensic nursing staff at the Squamish General Hospital. At a meeting hosted by the HSWC in Fall 2015, the full results of the Sea to Sky Sexual Health Survey, including all age groups, were presented to stakeholders. Sheila Early, a forensic nursing professor from the British Columbia Institute of Technology, also presented on building an effective forensic nursing program with community engagement. At this meeting, it was announced that the Sea to Sky Corridor's first forensic nurse had been trained, and would be offering forensic nursing services at the Squamish General Hospital.

One year post-implementation of the program, in an interview with the HSWC, Kristine Good, the Program Supervisor of Public Health and Prevention for Squamish, Whistler, and Pemberton described the benefits seen from the corridor's forensic nursing program, and its impact in "reduc[ing] local barriers for victims… [as] a key component of recovery" (Howe Sound Women's Centre Society, 2017). The program, in collaboration with continued efforts by HSWC, also generates awareness of the services in the community. The HSWC also aims to continue to provide support for survivors by providing competency training for professionals and stakeholders in the community. In addition to these sessions, they are currently working to secure further funding to continue these efforts.

Limitations

There were several notable limitations to this research. The survey population was not representative of the ethnic distribution of the Sea to Sky Corridor. Future research in this region aiming





to include a more representative sample should make special considerations for engagement. Additionally, the research was not able to include individuals who identify outside the gender binary (i.e., as neither a woman or a man) due to a lack of responses from this population. Further research specific to this population is recommended. Although the research attempted to be representative of the entire Sea to Sky Corridor, there was a lack of participation from individuals living outside of Squamish and Whistler, the two largest communities in the corridor. Therefore, this research cannot be generalized for the entire area, although it can help inform future research specific to the communities in the corridor. Finally, as research on sexualized violence and/or sexual assault is not standardized (Sexual Violence Research Initiative, 2006), varying use of terms and definitions, in addition to diverse experience of sexualized violence by sub-populations, reduce the generalizability of such research. The definition of sexual assault used includes all levels of assault, as defined by Statistics Canada, which may differ from other definitions of sexual assault used in research.

Conclusion

The Sea to Sky Sexual Health Survey represents an effective collaboration between researchers and community stakeholders to translate research to action. Armed with independent local data, the determined efforts of stakeholders resulted in the implementation of forensic nursing services in the Sea to Sky Corridor. The advances made in the corridor's response to sexualized violence over the past two years show great potential in improving the response to survivors, and hopefully in reducing the incidence of sexualized violence in the corridor. It is the researchers' hope that such efforts can be replicated in other communities to strengthen community-based responses to sexualized violence and, ultimately, to decrease the incidence of such violence in Canada.

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Several key stakeholders have worked tirelessly for years to improve the services available for sexual violence survivors in the Sea to Sky Corridor, most notably the Howe Sound Women's Centre Society. The supervising researcher for the Sea to Sky Sexual Health Survey, Dr. Megan Bulloch, Quest University Canada, is a former board member for the HSWC, and continues to act as a researcher and advocate for this issue in the corridor. Her work with the HSWC and her knowledge of sexual assault in the Sea to Sky Corridor inspired this project.

About the author

Tamara Dudley is a graduate student with the School of Population and Public Health at the University of British Columbia. She is working with the Gender and Sexual Health Initiative at the BC Centre for Excellence in HIV/AIDS for her thesis work exploring the how determinants of health are shaped by place for women living with HIV/AIDS. Her undergraduate thesis, Challenging Perceptions of Sexual Victimization and Consent: Investigating Sexual Assault and Service Use in the Sea to Sky Corridor, formed the basis for this article.

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