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A call to action for NENA members! CJEN needs you!

Our journal can only be as good as our submissions, and in this regard, I have fallen short in my role as Editor-in-Chief. In the spring of 2019 we did not receive enough high-quality submissions to allow us to publish an edition of the journal. This interruption in the journal forced us to focus our energy in its renewal. We spoke with the journal's major stakeholder groups and began to develop a plan. It is our unwavering goal to advance the journal to a world-class periodical that Canadian emergency nurses can be proud of, and this is our plan.

For authors, researchers and other content creators

We have heard that academic writing can be intimidating and that many people find APA "nauseating" (as a new grad in Calgary light-heartedly described the citation style to us). For novice authors who are NENA members, the CJEN editorial team is now offering its mentorship and support. We will partner with new authors and provide as much or as little support as is required, anywhere from creating article outlines to providing tools and templates for article layout and citation management. We will help novice authors go from idea to publication.

A concern for more established content creators has been CJEN's historically "closed" model of publishing. When I asked past authors to submit new work for the Spring 2019 edition, I was met with their disappointment that their previous work was not widely available to readers. They voiced frustration that it did not appear in internet search engine results (like Google and Google Scholar) and DOIs (digital object identifiers) were not issued. DOIs are important because they provide the creator a permanent unambiguous way to identify their work in grant applications, citation managers, article databases, etc. As one researcher put it, "when we put hundreds of hours into a study, including the time and energy of our participants, we have to choose the highest impact and most easily accessible publication option." To address these concerns, we have established partnerships with Canadian university librarians, and working with our publisher, Pappin Communications, to help us with individual article indexing and hosting. We have also secured www.CJEN.ca and www.canadianjournalofemergencynursing.ca as well, to secure our online presence. Authors, researchers and content creators, we have heard you and we are working hard to meet your needs.

For our readers

We heard from our readers who are also NENA members, that our print edition is important to you; but so is accessing CJEN content on your mobile devices and via social media. We were enthusiastically informed that if articles cannot be easily accessed at work, to support emergency care in its many forms, the utility of the authors' work is severely limited. For example, a nurse from Western Ontario wrote, "having CJEN editions [whole versions of the journal in pdf] archived in bulk on the NENA website, is totally unhelpful. It is impossible to find articles to support our work when they're stored like this." To address accessibility problem, we are adopting innovative methods of delivering content directly to Canadian emergency nurses. We have created a Twitter account, a Facebook page and established relationships with leading Canadian Free Open Access Medical Education (FOAMed) sites to help us promote and share content with our readers in mind.

In addition to issues of accessibility, concerns were voiced regarding the quality of our content, as well. A clinical nurse educator from New Brunswick shared, "too often the articles in CJEN are not well enough researched or written to responsibly contribute to our knowledge base." To address this, as we receive more submissions we will be simultaneously raising the bar regarding the quality of what we publish. Starting with this Fall 2019 edition, submissions undergo review by Canadian emergency nurses, as well as content experts (nurse and/or non-nurse) in the subject matter. Even content submitted in the past and being held for future publication is being re-reviewed through this lens.

Nurse leaders (n.b. every nurse is, at times, a leader)

For NENA members and leadership alike—we need to be a part of your professional networks. Please help us spread the word, CJEN is growing and becoming a modern, accessible peer-reviewed journal **AND** an online tool to connect and inform our community of practice. We want CJEN to be part of your emergency nursing education days, conferences and hospital quality improvement events. To fulfil this goal we need help connecting to more emergency nurses, emergency nursing leaders, academics and content creators. Find us online, interact with us, share our content and contribute to CJEN. Let us know about your emergency nursing training programs, Masters programs and continuing education days so we can be there (in-person or virtually). Together we will grow into something awesome.

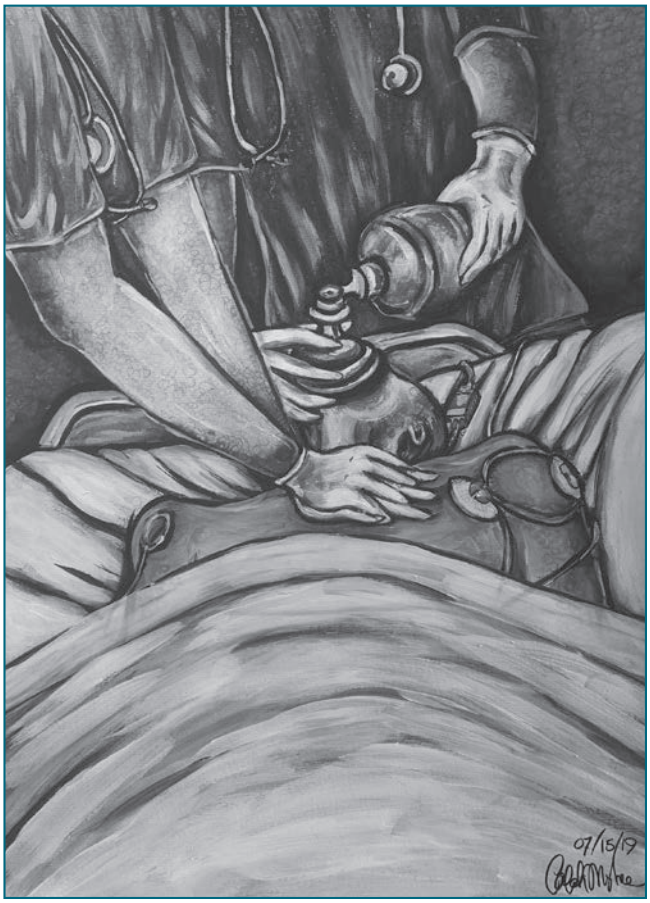
Thank you! from the
CJEN editorial team,
Matt, Heather, Chris and Carole

Cover image: *Helping Hands*

Calah Myhre, 4th-Year Nursing Student,
Grant McEwan University

As a nursing student, I have found making art to be a form of self-care in the face of high stress. Specifically, incorporating nursing into my art has facilitated self-reflection and, therefore, my growth. In addition to providing self-care, incorporating art into nursing has strengthened my therapeutic and professional relationships with my patients and interdisciplinary team members. As members of a caring profession, our passions have a place in our work and should be reflected in patient care, patient education, and professional development. In doing so, our care remains meaningful, we play to our individual strengths, and we promote innovative, "out-of-the-box" thinking.

There is a certain vulnerability in incorporating a personal element of oneself, such as their art, into one's professional life. This can be intimidating, particularly to a novice nurse. However, throughout my nursing journey I have learned that this vulnerability can be harnessed as a strength. This incorporation can communicate authenticity and may encourage others to also act on their attributes and bring forth their passions. From my experience, inspiring forward thinking is facilitated with an emotive component. People are more easily inspired to action when they feel passionate, which we can promote by leaning into our own passions within our profession. It is important to me to promote a nursing culture that embraces the perspectives that challenge the status quo and strive toward shared visions, while incorporating our individual passions. By embracing creativity and innovation, I believe that we can empower nurses to initiate change, become involved in policy, and become more visible as self-advocates.



A reference image was used for Calah's art, that can be found at https://www.healthline.com/

Calling all instructors

If your students have put the work into a presentation, a case study, a disease process, research, etc., encourage them to write it up into a brief article to be published in CJEN. Our editors will work closely with them to help in the process, and they can see their hard work in print, help to educate emergency nurses across the country, and add a publication to their resume—a win-win situation! Articles can be submitted to the editor at **editor@nena.ca**

Outbreaks—What's in a name?

By Nevio Cimolai

You are covering the afternoon shift in a community hospital emergency department. Five females have presented to the emergency department sporadically with clinical pyelonephritis over the same timeframe. Over the next few days, you overhear two casualty officers (emergency physicians) expressing the findings that all five patients suffered from Escherichia coli urinary infections.

Did you experience an outbreak?

Answer: possibly, but quite likely not.

Common urinary infections among females are usually sporadic infections in which the causative bacterium, most often *E. coli*, is acquired from the patient's own microbial flora. For some unlucky patients, the bacterium may ascend from the bladder to cause a kidney infection. The probability that a series of such infections so seen in the Emergency Department (ED) constitute an outbreak is extremely small. Had the females all been maintaining urinary catheters and residing in the same chronic care facility, or had the females all attended the same urological endoscopy suite in the previous few days, one might have thought otherwise regarding the possibility of an outbreak.

What is an infection outbreak?

Outbreaks, as reported in the media, are rather glorified events and a large part of the impression made often relies on the large numbers of affected individuals. The severity of the infections may also attract attention. It is the public impact factor that strikes at the centre of how an outbreak may be perceived.

On a more scientific basis, a definition of "outbreak" is simple and pragmatic (Cimolai & Cimolai, 2012). Effectively, an outbreak may be declared when the number of infections over a given time period exceeds the number anticipated by historic knowledge. That is, past experience provides a normative baseline to which the current number of infections can be compared. It may be very clear in some circumstances that the numbers are well above those anticipated as the norm. At other times, the elevation in event frequency needed to assert an outbreak can be somewhat arbitrary. Small numbers of infections may especially be relevant in an outbreak setting when the baseline is typically none at all. For example, the occurrence of three nosocomial influenza infections on a single care ward would be considered an outbreak given that none would be seen at most times. Understanding what the norm should be could, at times, prove tricky, since even a low-grade endemic number of a specific infection may represent an ongoing outbreak. For example, food-borne infections with *Salmonella* might be identified sporadically in the community and measured over many months and, yet, the vector food and *Salmonella* strain may have been the same all along, thus indicating a smoldering form of outbreak. The timing during which the infections are identified can, thus, be a very brief or very extended timeframe.

When outbreaks occur on a large scale, the common epithet is the term 'epidemic'. The latter will generally apply to regional outbreaks. When outbreaks or epidemics are considerably broad in geographical terms, for example involving multiple continents, the term 'pandemic' is likely to be applied, although again the numbers of infection usually factors into calling the event a pandemic.

Confusing to some, are the potential over-riding concepts of microbial isolates and strains. An 'isolate' is just that—a given germ that was isolated in the laboratory. Each time a microbe is defined from the laboratory sample as having been present, one has obtained an isolate. Isolates of microbes in the laboratory may or may not have a common source. 'Strain' implies that there is some commonality among given isolates. That is, if several isolations of methicillin-resistant *Staphylococcus aureus* (MRSA) from clinical samples are genetically linked, they constitute samples of a common strain. In this era, there are very sophisticated methods to type isolates to determine if they are, indeed, common strains (Struelens, 2001). For example, in assessing new influenza isolates annually, variation in the laboratory isolates can be determined down to the level of their RNA code. Fingerprints of microbes can be defined nearly overnight with current laboratory methods. 'Clone' defines microbe isolates that have come from a common origin. Over time, the clone of microbes may remain genetically similar or there may be some slow genetic divergences that create variations on the behaviour of the germs or variations in how the fingerprints may change. In the outbreak setting, it is typical for the isolates in the laboratory to have a common strain profile—that is, they show clonality. Much less common is the potential for several strains to cause infections in the same outbreak. For example, in one scenario, the author and colleagues determined that a common environmental contamination in an intensive care unit was causing problems with multiple co-existing strains of *Serratia marcescens* (Cimolai, Trombley, Wensley, & Leblanc, 1997).

Different strains of a common germ may possess varying ability to create infection or varying ability to influence the severity of infection. For any given patient and infection, the severity will depend on both human and microbial factors. The medical and public impacts of infectious outbreaks are, thus, quite heterogeneous. An infectious disease may be modified by fluctuation in host susceptibility over time, and one can witness different degrees of infection intensity as the microbes mutate over time and modify their virulence factors.

The Emergency Department as a sentinel

Infections constitute a large proportion of perceived medical emergencies that present to the ED. Patients are becoming more likely to attend EDs for infectious problems as their access to medical invigilation becomes more compromised with the perceived slow access in primary community care. There is also the trend

in society that timeliness and perfection in medical care should be attainable and are basic human rights given the resources that medical services now command in government budgets. The infections that present to the ED, thus, often have an urgency factor and/or a severity factor. The latter make it more likely that infections seen in this setting could be part of an outbreak. This is why some provincial viral watch programs for seasonal influenza may use ED data as part of their surveillance processes.

Outbreak infections can be diagnosed in the ED solely on clinical grounds, for example, clinical influenza, or institutional post-operative infections. Results of laboratory samples from the ED may also provide evidence of commonality in the reports of microbial isolations. The latter, although perhaps at times evident to the ED personnel, is best screened for through a solid institutional infection control program. ED triage or other points of entry constitute an excellent focus for some of the infection control data collection.

The Emergency Department as source or vector

Apart from attending to patients whose infections may be part of an outbreak, could the ED activities serve as the source of the infection if not the mechanism by which infections may be passed to incoming patients or, for that matter, medical staff? There are very few, if any, environments in medical institutional settings where infections cannot originate or be transmitted. If anything, the ED is likely to be one of the more likely.

The emergency setting draws patients with perceived significant infections. The ED is not uncommonly crowded and, hence, reduces the physical distance between patients who are arriving infected, especially of concern for airborne respiratory infections. Patients may often wait for extended periods of time, which increases the chances of microbial contact. The paraphernalia in most current emergency rooms is considerable. The diversity of such inanimate objects has increased more than not. Keyboarding enhances the hand contact role for infection spread. Procedures in this setting also increase the potential for contact. Having multiple service providers over a short period of time increases physical transmissibility. Greater attention to non-infectious aspects of patient visits may detract from the infection control precautions otherwise more easily afforded when staff have the opportunity to be more focused on infection. Sanz et al. once published on the evidence that procedural objects, such as ultrasound probes could pose risk for transmission (Sanz, Theoret, Liao, Erickson, & Kendall, 2011). Risk of transmitting germs via the proverbial stethoscope route in the ED have often attracted attention (Núñez, Moreno, Green, & Villar, 2000; Jones, Hoerle, & Riekse, 1995).

As for all other medical venues, the ED will never be a sterile environment. Accordingly, the risks for the ED to act as vector or source can be more or less.

The emergency department as a helpful participant

To an outsider, the ED nurse is a gregarious type. He or she has a high competence profile, seeks an intense medical scenario, welcomes knowledge bases and acquisition, and is a great person to work with (Eldred, 1977). While obvious to many, some have sought to prove the latter with a measure of science (Kennedy, Curtis & Waters, 2014). The ED nurse is no less empathetic and compassionate than any other (Atkins & Piazza, 1987). What better person to have some role in the understanding of outbreaks and in the general realm of infection control?

Given the busy enterprise of emergency care, one wouldn't expect ED nurses to give extraordinary time to recognizing outbreaks, but any little insight in this regard is welcome from an institutional infection control service. Enforcing common infection control principles and overseeing them is nevertheless an important role. Who else in the ED will seriously take on that role? Ensuring appropriate triage related to the presenting infection, invoking methods of prevention and quarantine, post-visit disinfection, and advising on infection control generally may be in the purview of nursing care and/or commentary. It is up to the individual or the collective nursing management to ad hoc, or on a grander scale, determine how much emphasis can be afforded. While we seek perfection to prevent infection, we do not demand everlasting perfection, but rather seek reasonableness.

Attitudes and management

The example of MRSA will be well within most experienced ED nurse's domain. The last decade or more experienced a large resurgence and then decline in superficial and soft tissue infections with this category of bacterium (Cimolai, 2010). What was largely circulating then were some hypervirulent clones that caused, initially, considerable infection in the community and then, eventually, in acute care settings. The roles of the inanimate medical environment and the patient in maintaining the bacterium for spread was evident (Cimolai, 2008a). Also, unfortunately, for some medical personnel, they unknowingly participated in the spread of MRSA (Cimolai, 2008b). Why then would the problem reach such a proportion that legislators in some domains felt obligated to invoke solid mandates for the control (Cimolai, 2007a)?

Patients and medical personnel are humans. Their loyalty to preventing infections is affected by many different variables. Even during outbreak situations, some are simply fed up with the effort that must be directed toward prevention. It may pose a nuisance during an otherwise pre-occupied existence. How many patients and personnel avoid handwashing if not only for the distraction that it may seem? ED nurses are well-positioned to act as intervenors. They can improve the status quo with practical teaching and purposeful example. ED nurses are in a position to simplify infection prevention while maintaining effectiveness. When there is a counter-culture to appropriate behaviour, they can lead the way back to an expected norm with their positivistic attitudes (Cimolai, 2007b).

Key points

1. The ED can be the focus for infection spread and for outbreak recognition. An outbreak can be proposed when the number of infections over a given time period exceeds the anticipated number.
2. The ED has the onus to integrate with effective institutional infection control programs.

3. The ED nurse is a competent and enterprising individual who can facilitate the surveillance and application of effective infection control.
4. The ED nurse is a pragmatic individual who can assist in steering appropriate attitudes and management to prevent infections.

Today, you, Nurse Chloe, are working in the ED triage of a very busy hospital. Two parents and three children are attending with complaints of what they perceive to be severe respiratory infections. They are recent immigrants to Canada, but have returned from a short visit to a country in the Middle East this last week. The mother volunteers a concern that some relatives told them of local infections overseas that resembled SARS.

What do you do?

The Great Canadian Outbreaks was published with the intent of providing a more public view of outbreaks (Cimolai, 2018). Ten short stories were created to illustrate historic Canadian episodes in broad scope and with a pan-national perspective. In particular, topics such as enterohemorrhagic E. coli and 'hamburger disease', smallpox, tuberculosis, MRSA, SARS, listeriosis, pandemic influenza, blood-borne transfusion infections, Q fever, and pseudo-outbreaks are themes for prose that is of mixed fact and fiction. Some may be very familiar with some of the names, topics, and places of this medical history.

About the author

Nevio Cimolai, MD, FRCP(C), is a practising physician and academic university professor. His career has included general practice, specialty practice, basic science and clinical research in several fields, medical administration and public health service, medical publication and editorial support, and curriculum development and reform. He has taught both undergraduate and postgraduate students in medical fields as diverse as nursing, medical technology, primary medical school, and postmedical graduate education. His former postgraduate teaching program was awarded the highest commendation from the Royal College of Physicians and Surgeons of Canada, and he has personally been awarded for undergraduate teaching excellence. He has provided lectureships and organized symposia on local, national, and international levels. He maintains specialty interest in medical microbiology and clinical infection and has published books and book chapters on basic science microbiology, medical microbiology, infectious diseases, public health, and infection control. He has provided more than 400 oral and written publications in the scientific and clinical fields.

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Research Review

By Heather McLellan

Citation

Harley, A., Johnston, A., Denny, K., Keijzers, G., Crilly, J., & Massey, D. (2019). Emergency nurses' knowledge and understanding of their role in recognising and responding to patients with sepsis: A qualitative study. *International Emergency Nursing, 43*, 106–112. https://doi.org/10.1016/j.ienj.2019.01.005

Background

Sepsis is a time-sensitive clinical event. Rapid recognition, key physical finding and escalation of intervention are crucial for successful management. The role that the emergency department (ED) nurse plays in these events may not be universally clearly understood.

Purpose of the study

To examine the understanding of experienced emergency department nurses of their role in responding to patients with sepsis, as well as of the resources and tools available to them.

Research approach and methods

The researchers used a descriptive qualitative design with semi-structured interviews to explore the experiences of the participating ED nurses. This research design choice is appropriate for summarizing the perceptions and experiences of a group of individuals, in this case experiences of ED nurses caring for sepsis patients.

Setting and sample

The study recruited emergency department trained RNs working in a large public tertiary teaching facility in Australia. The RNs were recruited by invitation from the principal investigator (PI) at employee meetings. The RNs self-selected by contacting the researcher and expressing interest in participation. Face-to-face semi-structured interviews were conducted and recorded for analysis. Qualifications for participation were that the nurses were currently employed in the area and had recent experience working with sepsis patients.

Questions in the interview guide were developed based on research recommendations in existing literature. Interviews were read and coded and the findings were organized into themes. To ensure rigour, the data were reviewed multiple times by the research team, as well as being independently reviewed by researchers with different clinical backgrounds.

Findings

The study included 14 RNs who met the criteria and agreed to participate. The experience levels of these nurses ranged from six months to 25 years. Post-analysis the research team identified six themes including contribution of the organization, appreciation of knowledge, appreciation of clinical urgency, appreciation of the importance of staff supervision, awareness of the importance of staff experience, and awareness of the need to seek advice. Within these broader themes specific supports and barriers were identified.

Barriers inhibiting recognition and response to indicators of sepsis included high volumes of patients, patient flow through the department, lack of recognition of sepsis flags, and minimal use of screening tools. They also noted that the lack of recognition of acuity and lack of experience for junior nurses delayed escalation of intervention. Supports noted included use of a deterioration detection tool and provision of sepsis-specific education, although retention of that training was lacking.

Recommendations from this study included education and preparation of ED nurses to use sepsis screening tools, and that development of a nurse-driven sepsis pathway might improve response. There is also indication that staffing support that would allow adequate time for a thorough assessment of each patient would improve both recognition and response.

The researchers noted that the delay between caring for the patients with sepsis and participating in the interviews may have biased responses, and that conducting the research within the clinical area where staff are fatigued, still have patient care responsibilities or are distracted, also may have had a negative impact on the quality of the data.

Commentary

This qualitative study identified barriers to nurses' recognition and response to markers of sepsis and the important role they both play in successful management of sepsis from the perspective of the nurses providing the care. Many of the findings articulate well with other qualitative and quantitative research. Padilha et al. (2011) also noted the challenges for nurses in recognition of sepsis and the improvement in patient outcomes when nurses identify sepsis markers early in the disease process. One qualitative study identified a marked improvement in recognition of sepsis and escalation of intervention when focused sepsis-specific education was coupled with repeat performance of tool use (Tromp et al., 2010). They further identified the importance of nurse-driven protocols aligned with sepsis care guidelines that support nurses in collaboratively escalating treatment.

Kleinpell, Schorr and Rauen (2014) note that the physical assessment skills of the nurse are the key to identifying sepsis early and go on to note that education of nurses and provision of tools are also crucial components to improving patient outcomes.

One important point to note with this study is that while ethical approval was obtained, it is not clearly evident how confidentiality of the interview recordings was maintained. Under the heading of "rigour" the authors note that there was independent review of the transcripts by researchers with different clinical and research backgrounds to verify thematic findings, but the steps taken to maintain confidentiality are not outlined.

Key Messages

- Knowing and recognizing the indicators of sepsis is a crucial role for ED nurses.
- Access to and training in the use of sepsis identification tools and nurse-driven protocols support recognition of sepsis indicators and escalation of intervention.
- Reduction of barriers improves nurses' confidence in working collaboratively to rapidly accelerate sepsis management.

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Translating clinical experience into action: Developing an educational protocol to improve intimate partner violence screening by Emergency Department nurses

By Thea Herzog and Geoffrey Maina

Background

The World Health Organization (WHO) describes intimate partner violence (IPV) as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship." IPV affects millions of people around the world. "Worldwide, almost one-third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime" (World Health Organization [WHO], 2012, 2013). IPV is also associated with higher rates of chronic health issues such as PTSD, mental health problems, poor cancer outcomes, and increased risk to HIV infections (Beydoun, Williams, Beydoun, Eid, & Zonderman, 2017; Coker, Follingstad, Garcia, & Bush, 2017; Dillon, Hussain, Loxton, & Rahman, 2013). Additionally, risks of further victimization (e.g., sexual assault, and IPV in other relationships), and elder abuse (Teresi et al., 2016; Gerber, Wittenberg, Ganz, Williams, & McCloskey, 2008; Young-Wolff et al., 2013) challenge nurses working in emergency units to support IPV screening and stop the long-term impact of IPV.

Intimate partner violence is a major social and health issue in Canada. The Department of Justice estimates that the annual cost of caring for victims of IPV is $7.4 billion (Zhang, Hoddenbagh, McDonald, & Scrim, 2013). In 2016, more than 93,000 cases of IPV were reported in Canada. Women are most affected by IPV and constitute 79% of the reported IPV cases. Further, 37% of violent crimes are acts of IPV (Andresen & Linning, 2014; Burczycka & Conroy, 2018). Women aged 25–34 years report the highest rates of IPV, at 650 per 100,000 (Sinha, 2013).

Saskatchewan has the fourth highest IPV rates in Canada, at more than twice the national average (Sinha, 2013). During 2005–2015, the province reported 57 domestic homicide victims from 48 events (Ministry of Justice, 2017). In 2018, the police service for Prince Albert, Saskatchewan's third-largest city, received 2,614 "domestic calls for service" related to family disputes (C. Rudderham, personal communication, April 2, 2019). During the same year, Prince Albert police services responded to 278 calls for IPV-related assaults (T. Dunlop, personal communication, April 10, 2019).

The face of IPV in the Emergency Department

Victims of IPV have significantly higher rates of visits to the ED than the general population (Hofner et.al., 2005). Between 18-25% of women presenting in the ED are victims of IPV (Robinson, 2010). They present with problems that are directly or indirectly related to IPV (Kothari & Rhodes, 2005; Rhodes et al., 2011). For example, they may have broken bones or bruises, but they may also have vague complaints that are not obviously associated IPV, such as headaches or abdominal pain (Hoffman, 2013), or they may appear in distress or be flagged for having frequent visits to the ED.

Because victims of IPV often have their first contact with nurses and the healthcare system in an ED, this is an ideal setting for nurses to screen for IPV. However, many EDs across Canada, including Victoria Hospital in Prince Albert, do not mandate IPV screening. Also, healthcare providers are unable or resistant to screen for all the clients seeking care in the EDs. For example, Gutmanis and others found that nurses and physicians in Ontario screen only 5-25% of patients presenting to EDs for IPV (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007). This low IPV screening rate is attributed to nurses' lack of time and to their feelings of inadequacy, helplessness or discomfort with how to manage IPV (Catallo, Jack, Ciliska, & MacMillan, 2013; DeBoer, Kothari, Kothari, Koestner, & Rohs, 2013). A lack of knowledge of or experience with caring for clients experiencing IPV can also impact their interactions with these clients (Gutmanis et al., 2007). Clients may also be in denial that they live in an abusive relationship. Therefore, healthcare provider screening can create awareness of the existence of partner violence in a client's life (Giesbrecht, 2012).

Personal experience working as an RN in an ED

As a nurse working in the ED in Prince Albert for five years, I (T.H.) have cared for a significant number of women in crises who showed signs of experiencing IPV. Although women of all ages are affected by IPV, most of the clients I have cared for range from 16–29 years old. Most of these clients are not economically independent and feel trapped in a violent relationship. Others do not know the resources available within the city to support them, such as safe shelters or crisis services. Often, alcohol and substance use within a relationship is a significant factor that masks IPV in majority of women seeking care with symptoms of IPV. Therefore, correctly identifying and screening for IPV takes patience and diligence.

Currently, Victoria Hospital has no strategy for screening for IPV in the ED. Since screening for IPV is a sensitive endeavour for both nurses and clients, it is critical that ED teams are thoroughly equipped with knowledge and skills to identify, screen and intervene for vulnerable clients (Sundborg, Saleh-Stattin, Wändell, & Törnkvist, 2012). Because of the lack of resources and support, such as protocol and processes to screen for IPV, nurses feel frustrated and inadequate to provide safe care to these patients. In staff meetings, nurses have frequently voiced a need for capacity building to screen and intervene for IPV. In response to these identified needs, I decided to create an educational tool to aid in IPV screening in the ED.

Creating an educational poster for nurses working in ED setting

The creation of the IPV educational poster was grounded in critical social theory, allowing the gap between research and practice to be bridged (Sundborg et al., 2012). The following steps were used to create this poster.

Conducting a brief literature review and situational analysis of IPV in Prince Albert: The literature review provided information on the definition and manifestations of IPV and strategies for screening for it. Discussions with local partners and stakeholders involved in service provision and care, yielded statistics on the prevalence of IPV in the community.

Drafting of the poster: Information gathered from the literature review and situational analyses were summarized into key brief statements under the following subheadings: definition of IPV; local statistics; manifestation; and, intervention strategies. Copyright-free images representing IPV and ED settings were included to provide interest and a balance between text and graphics. IPV screening questions (Davis, Parks, Kaups, Bennink, & Bilello, 2003) were also included in the poster, and brief intervention steps were illustrated in a flow diagram.

Seeking and receiving feedback on the draft IPV educational poster: The draft poster was presented to 12 nurses working in the ED, including a unit nurse manager, a unit nurse educator, and nurses with diverse ED experiences. Nurses were initially surprised by the statistics on IPV in the city and appreciated the poster's utility in raising awareness about IPV. They commended the poster's simplicity and aesthetic properties, believing that it can act as a reminder to screen and intervene. They suggested that having community support services and contacts listed on the tool would help them connect clients to these valuable resources, especially during after-hour shifts. The nurses also suggested that the "community supports" section of the poster be bolded and summarized to be more concise. They encouraged introducing this tool to other hospital departments and printing it onto pocket cards for RN use.

Refining and launching the IPV educational tool: Following extensive consultation with the nurse manager, nurse educator, and front-line nurses in the ED, the tool was refined to include the feedback provided. As per the RNs' suggestions, copies of the IPV educational tool were posted on the walls of the exam room, staff room and triage room to serve as constant reminders to the nurses to screen and intervene for clients suspected of experiencing IPV. During the launch of the tool, the nurse educator recommended that pocket-sized cards with information on local resources be printed and handed to clients suspected to be at risk for IPV (see Appendix 1 and 2 for the poster and pocket-sized cards respectively).

Discussion

Through personal experience, as a nurse in an ED in Prince Albert, and through numerous conversations with other RNs, it was determined that ED nurses frequently encounter clients suspected of being affected by IPV. However, no resources were available in the hospital to help nurses accurately screen or support these clients. Thus, this poster was developed as an easy-to-use educational resource to support nurses in providing effective IPV screening and care.

The process of developing this nursing intervention began with conducting a literature review and then a situation analysis with stakeholders providing services to victims of IPV. The literature review revealed that ED nurses feel inadequately prepared or supported to facilitate care of clients who disclose IPV (DeBoer et al., 2013). A lack of a private space in the ED and insufficient time to develop rapport with the clients were also identified as barriers to screening (Catallo et al., 2013). Conversations within the ED are ongoing to eliminate these barriers.

Information on common manifestations of IPV was obtained from the review and included in the educational poster. Local stakeholders provided statistics of IPV in the community. The use of local statistics on IPV made the resource contextually relevant and validated clinical observations that IPV was a major health issue likely affecting many clients presenting in the ED.

Seeking RNs' input in the development of the IPV educational tool ensured that it was informative, relevant, easy to use and appropriate for raising awareness and supporting RNs in the care of clients experiencing IPV (Fay-Hillier, 2016). Nurses identified with the assessment that there was a need to screen for IPV. They also expressed willingness to use this educational resource to screen their clients and to encourage the clients to use the available supports and services.

According to Ulbrich and Stockdale (2002), building self-efficacy of healthcare providers in screening for IPV and increasing their knowledge of community supports and referral processes help to address IPV within the healthcare setting and in the community. They also reported that increased comfort and awareness of staff last up to six months following educational intervention.

In this project, having the nurse educator provide feedback during the development phase was critical because she helped

with the design and offered to include the tool when orienting new RNs to the department. The nurse manager was supportive of the intervention, but senior nurses cautioned against making IPV screening a universal practice. They believed screening all clients would become tedious and time consuming and, thus, decrease staff morale and eventually reduce support for the intervention.

Despite the challenges ED nurses might face in caring for IPV victims, they have a duty to provide safe and compassionate care to all clients (Canadian Nurses Association, 2017). The Registered Nurses' Association of Ontario (2005) recommends that RNs screen "females 12 years of age and older" by asking cued questions such as, "Have you ever been hurt or threatened by someone?" (p. 9, 63). Where knowledge and skills deficits exist, RNs are expected to grow in competence and provide evidence-informed practice including identifying, screening, and intervening for victims (Canadian Nurses Association, 2017). In this project, while we recognize that men, too, can be victims of partner violence, screening for IPV among men was not within the scope of this project. The statistics reflect prevalence of IPV victims are females. When screening men, social and cultural climates require a degree of sensitivity. It is imperative to be aware of these realities.

Educating RNs to recognize signs of IPV and effectively screen for it are the first steps towards improving care for clients experiencing IPV (Ahmad, Ali, Rehman, Talpur, & Dhingra, 2017; Williams, Halstead, Salani, & Koermer, 2016). For the sustainability of the screening practice in the ED, it is important that the ED Manager and Nurse Educator provide support such as sharing statistics of partner violence screening on a regular basis.

Implications for emergency nursing practice

This project provides several practical lessons. First, the process of designing this educational tool showed that in settings where peer and managerial support exists, there is goodwill to implement desired changes to improve client outcomes. In our case, with nursing unit manager support, front-line workers advocated for the healthcare needs of clients experiencing IPV. Creating this educational poster is an example of nurses working collaboratively and drawing on their clinical experiences to identify and respond to clients' needs.

Secondly, this project shows that front-line nurses do not have to have leadership positions to initiate change in their workplace. In this case, nurses served as patient advocates by taking ownership of the issue and using therapeutic communication skills to screen for clients suspected of experiencing IPV. By encouraging front-line nurses to be problem solvers, nurse managers and leaders can create a culture of patient advocacy. When nurse managers foster a culture of collaboration and leadership with front-line nurses, nurse-client relationships are optimized (Canadian Nurses Association, 2017; Hegney et al., 2019).

Third, when front-line nurses are proactive by addressing gaps in care, they can affect broad and far-reaching changes in healthcare practice and policy. For example, in our situation, because victims of IPV present in various clinical settings, encouraging other hospital units to use the IPV education poster will likely lead to departmental collaboration and a re-examination/re-evaluation of treatment approaches and referral protocols. We, therefore, anticipate that new policy and referral protocols will be created to advance the needs of clients experiencing IPV.

Finally, this project demonstrates the importance of keeping current with the literature in order to enhance client outcomes. In our case, reviewing the literature on the challenges that RNs face when screening for IPV and presenting the findings to decision makers can lead to an evaluation of our approaches to care in the ED. For instance, studies have identified a lack of private spaces to interview clients as a barrier to screening for IPV. In order to create a safe space where clients can freely disclose their experiences to the RNs, our department has offered a private interview room for this purpose.

Conclusion

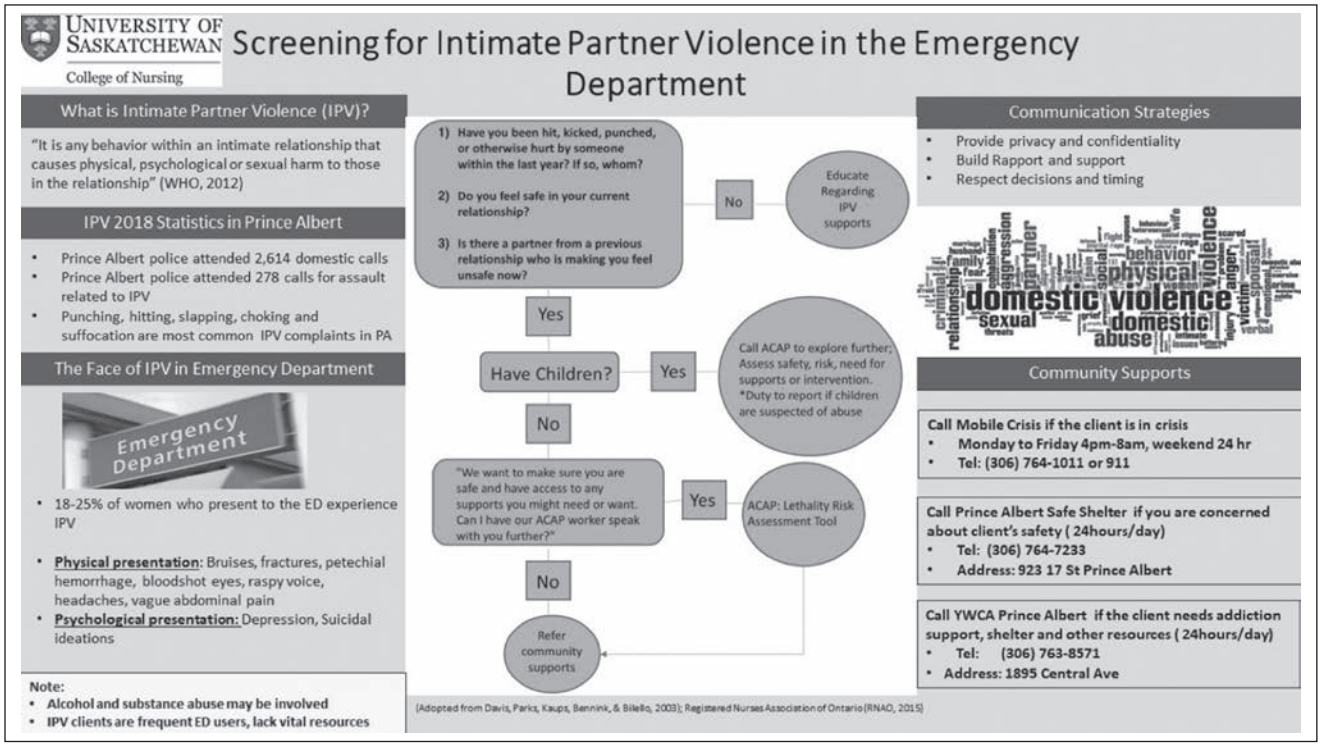
Additional research is needed to evaluate the success of this educational poster. The next steps include a two-pronged approach: 1) evaluating how often the education tool is used by RNs to screen for IPV, and for changes or client outcomes such as numbers of referrals to community agencies; and 2) expanding the IPV screening process to other units in Victoria Hospital.

Take-aways

- The purpose of this practice improvement project was to develop an intimate partner violence (IPV) education screening aid for nurses in ED.
- Nurses feel inadequately prepared to screen and care for IPV clients.
- The primary outcome for this practice improvement project was an IPV screening education tool for nurses working in ED.
- Key implications for emergency nursing practice from this project are: a) when ED nurses are involved in the co-creation of education tools for improving screening for intimate partner violence, ownership of the process and the product is enhanced; b) nurses are also keen to use the tool to improve screening and patient care.

About the author

Thea Herzog, MN, RN, completed her BSc Kin, BSN and MN at the University of Saskatchewan. This article was completed in partial fulfillment of her MN requirements. She currently works as an emergency nurse in Prince Albert, Saskatchewan. In addition to emergency nursing, Thea's topics of interest include domestic violence, women's health, rural nursing, and health prevention.



Appendix 1. IPV poster

Appendix 2. IPV pocket card

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Mettre son expérience clinique à profit : Développer un outil éducatif pour améliorer le dépistage de la violence entre partenaires intimes par les infirmières des services d'urgence

Par Thea Herzog et Geoffrey Maina

L'Organisation mondiale de la Santé (OMS) décrit la violence entre partenaires intimes (VPI) comme « tout comportement au sein d'une relation intime qui cause un préjudice ou des souffrances physiques, psychologiques ou sexuelles aux personnes qui sont parties à cette relation ». La VPI affecte des millions de personnes, partout dans le monde. « Au niveau mondial, près du tiers (30 %) des femmes qui ont eu des relations de couple signalent avoir subi une forme quelconque de violence physique et/ou sexuelle de la part de leur partenaire intime au cours de leur vie (Organisation mondiale de la Santé [OMS], 2012, 2013). Ce fléau est également associé à une augmentation des problèmes de santé chroniques comme les TSPT, les problèmes de santé mentale, les cancers persistants et un risque accru des infections par VIH (Beydoun, Williams, Beydoun, Eid et Zonderman, 2017; Coker, Follingstad, Garcia et Bush, 2017; Dillon, Hussain, Loxton et Rahman, 2013). En outre, les risques de victimisation récurrente (ex. agression sexuelle et VPI dans d'autres relations) et la maltraitance des aînés (Teresi et al., 2016; Gerber, Wittenberg, Ganz, Williams et McCloskey, 2008; Young-Wolff et al., 2013) exigent des infirmières des services d'urgence qu'elles contribuent au dépistage de la VPI et limitent ses impacts.

La violence entre partenaires intimes constitue un enjeu social et de santé important au Canada. Le ministère de la Justice estime à 7,4 milliards de dollars le coût annuel des soins aux victimes (Zhang, Hoddenbagh, McDonald et Scrim, 2013). En 2016, plus de 93 000 cas de VPI ont été signalés au Canada. Les femmes sont les plus touchées puisqu'elles représentent 79 % du nombre total de cas. De plus, 37 % des crimes violents se déroulent entre partenaires intimes (Andresen et Linning, 2014; Burczycka et Conroy, 2018). Les femmes de 25 à 34 ans sont les plus durement touchées, avec 650 cas pour 100 000 personnes (Sinha, 2013).

La Saskatchewan arrive au quatrième rang des provinces canadiennes pour les cas de VPI, avec plus du double de la moyenne nationale (Sinha, 2013). De 2005 à 2015, 57 homicides familiaux pour 48 événements ont été signalés (ministère de la Justice, 2017). En 2018, le service de police de Prince Albert, troisième plus grande ville de Saskatchewan, a reçu 2 614 appels d'intervention relativement à des disputes familiales (renseignements obtenus de C. Rudderham, 2 avril 2019). Pendant la même année, le service de police de Prince Albert a répondu à 278 appels relativement à des agressions entre partenaires intimes (renseignements obtenus de T. Dunlop, 10 avril 2019).

Portait de la VPI à l'urgence

Les victimes de VPI consultent beaucoup plus souvent à l'urgence que la population générale (Hofner et al., 2005). Entre 18 et 25 % des femmes se rendant à l'urgence subiraient ce type d'agression (Robinson, 2010). Elles présentent toutes sortes de problèmes reliés à ce type de violence (Kothari et Rhodes, 2005; Rhodes et al., 2011) : fractures osseuses, ecchymoses, mais aussi d'autres symptômes qui ne sont pas directement associés à la VPI, comme des maux de tête ou des douleurs abdominales (Hoffman, 2013). Ces femmes peuvent aussi montrer des signes de détresse ou être remarquées en raison de leurs visites fréquentes à l'urgence.

Bien souvent, le premier contact des victimes de VPI avec une infirmière et le système de santé se fait lors d'une consultation à l'urgence, ce qui en fait le contexte idéal pour un dépistage par l'infirmière. Cependant, dans plusieurs services d'urgence du Canada, dont l'Hôpital Victoria à Prince Albert, le dépistage de la VPI n'est pas systématique. De plus, les intervenants de la santé sont incapables ou réticents à dépister toutes les patientes qui consultent à l'urgence. Par exemple, Gutmanis et collaborateurs concluent que les infirmières et médecins de l'Ontario dépistent seulement 5 à 25 % des patientes qui se présentent à l'urgence après avoir subi de la VPI (Gutmanis, Beynon, Tutty, Wathen et MacMillan, 2007). Ce faible taux de dépistage serait attribuable au fait que les infirmières manquent de temps et se sentent incompétentes, impuissantes et inconfortables à gérer ce type de cas (Catallo, Jack, Ciliska et MacMillan, 2013; DeBoer, Kothari, Kothari, Koestner et Rohs, 2013). Le manque de connaissance ou d'expérience en matière de soins aux victimes de VPI peut également nuire aux interactions avec les patientes (Gutmanis et al., 2007), qui peuvent nier le fait qu'elles vivent une relation malsaine. Le dépistage réalisé par les intervenants de la santé peut alors aider les patientes à prendre conscience des agissements violents de leur partenaire (Giesbrecht, 2012).

Expérience personnelle d'une infirmière autorisée dans un service d'urgence

En tant qu'infirmière travaillant à l'urgence de Prince Albert depuis 5 ans, j'ai (T.H.) pris soin de plusieurs femmes en crise

qui montraient des signes de VPI. Des femmes de tous âges sont victimes de VPI; cependant la plupart des patientes dont je me suis occupée avaient entre 16 et 29 ans. La plupart sont dépendantes financièrement et se sentent piégées dans la relation violente. Certaines ne connaissent pas les ressources disponibles dans leur milieu, comme les refuges ou les services offerts en cas de crise. Bien souvent, la consommation d'alcool et de drogue est un facteur important qui dissimule la VPI chez la plupart des femmes qui consultent avec des symptômes liés. Identifier ce type de violence demande donc patience et attention.

À l'heure actuelle, l'Hôpital Victoria ne dispose d'aucune stratégie de dépistage des cas de VPI à l'urgence. Étant donné qu'il s'agit d'une tâche délicate pour les infirmières et les patientes, il est essentiel que les équipes du service d'urgence possèdent les connaissances et compétences nécessaires pour identifier et dépister ces cas de violence et intervenir auprès des personnes vulnérables (Sundborg, Saleh-Stattin, Wändell et Törnkvist, 2012). En raison du manque de ressources et de soutien (absence d'un protocole et de processus de dépistage de la VPI), les infirmières se sentent frustrées et inaptes à fournir des soins sécuritaires à ces patientes. Lors des réunions du personnel, les infirmières ont souvent exprimé le besoin d'améliorer les capacités de dépistage et d'intervention en matière de VPI. Voyant ces besoins, j'ai décidé de créer un outil éducatif pour faciliter le dépistage à l'urgence.

Préparer une affiche éducative pour les infirmières des services d'urgence

La conception de l'affiche éducative sur la VPI est basée sur la théorie sociale critique, laquelle permet de raccorder la recherche à la pratique (Sundborg et al., 2012). Les étapes suivantes ont été suivies pour produire cette affiche :

Réaliser une brève revue de la littérature ainsi qu'une analyse situationnelle de la VPI à Prince Albert : La revue de la littérature a permis de mieux définir la VPI, ses signes ainsi que les stratégies pour la dépister. Grâce aux discussions avec les partenaires locaux et les intervenants impliqués dans la fourniture des soins et services, des statistiques sur la prévalence de la VPI dans la communauté ont pu être compilées.

Réalisation de l'affiche : Les renseignements recueillis après la revue de la littérature et les analyses situationnelles ont été résumés dans de brefs énoncés clés portant les sous-titres suivants : définition de la VPI, statistiques locales, signes et stratégies d'intervention. Des images libres de droits représentant la VPI et le milieu des urgences ont été intégrées pour capter l'attention et créer un équilibre entre le texte et le visuel. Les questions sur le dépistage de la VPI (Davis et al., 2003) ont été intégrées à l'affiche, et une courte démarche d'intervention a été illustrée par un organigramme.

Demander et recevoir des rétroactions sur l'affiche proposée : La première version de l'affiche a été présentée à 12 infirmières du service d'urgence, dont une infirmière gestionnaire, une infirmière formatrice et des infirmières cumulant diverses expériences à l'urgence. Elles ont d'abord été surprises par les statistiques de VPI recensées dans la ville et ont apprécié l'utilité de l'affiche pour sensibiliser les gens à cette réalité. Elles ont salué la simplicité et l'apparence de l'affiche, estimant qu'elle peut servir à rappeler l'importance de dépister et d'intervenir. Ces infirmières ont suggéré d'indiquer les coordonnées des services de soutien communautaire sur l'affiche, afin qu'elles puissent facilement les donner aux patients (particulièrement utile hors des heures régulières). Elles ont également proposé que la section *Soutien à la communauté* sur l'affiche soit mise en gras et présentée de manière plus concise. Elles étaient d'avis que cet outil devrait être distribué dans d'autres services hospitaliers et imprimé sur des cartes de poche pour les infirmières autorisées.

Finaliser et lancer l'outil éducatif sur la VPI : Après des consultations poussées avec l'infirmière gestionnaire, l'infirmière formatrice et les infirmières de première ligne de l'urgence, l'outil a été ajusté en fonction des commentaires reçus. Conformément aux suggestions des infirmières autorisées, des reproductions de l'outil éducatif sur la VPI ont été affichées aux murs de la salle d'examen, du local du personnel et de l'aire de triage pour rappeler en tout temps aux infirmières de dépister la VPI et d'intervenir auprès des potentielles victimes. Au lancement de l'outil, l'infirmière responsable de la formation a suggéré que des cartes de poche contenant les renseignements sur les ressources locales soient imprimées et remises aux patientes potentiellement à risque de VPI (voir les annexes 1 et 2 pour l'affiche et les cartes de poche, respectivement).

Discussion

Mon expérience en tant qu'infirmière à l'urgence de Prince Albert et les nombreuses conversations que j'ai eues avec d'autres infirmières autorisées me permettent de conclure que les infirmières des services d'urgence interviennent souvent auprès de personnes susceptibles de subir de la VPI. Cependant, aucune ressource n'était disponible dans l'établissement pour aider les infirmières à dépister ou soutenir adéquatement ces patientes. Cette affiche, qui se veut un outil éducatif facile à utiliser, a été conçue pour aider les infirmières à fournir un dépistage et des soins efficaces en matière de VPI.

Le processus de développement de cette intervention infirmière a débuté avec une revue de la littérature, puis une analyse de la situation avec les personnes qui offrent des services aux victimes de VPI. La revue de la littérature a révélé que les infirmières des services d'urgence ne se sentent pas suffisamment préparées ni soutenues pour organiser la prise en charge des patientes qui dénoncent la violence vécue au sein de leur relation (DeBoer et al., 2013). Le manque d'espaces privés à l'urgence et le manque de temps pour développer une relation de confiance avec les patientes ont aussi été identifiés comme des obstacles au dépistage (Catallo et al., 2013). Des conversations avec le personnel de l'urgence sont en cours afin de trouver des solutions aux obstacles énumérés.

Les renseignements portant sur les signes courants de VPI proviennent de la revue de la littérature et ont été ajoutés à l'affiche. Des intervenants locaux ont partagé des statistiques de VPI dans la communauté. L'utilisation de ces renseignements a rendu la ressource pertinente d'un point de vue contextuel et permis de valider les observations voulant que la VPI soit un enjeu de santé majeur affectant de nombreuses patientes qui consultent à l'urgence.

La contribution des infirmières autorisées a permis de concevoir un outil éducatif instructif, pertinent, facile à utiliser et approprié pour sensibiliser et soutenir les infirmières qui accueillent les victimes (Fay-Hillier, 2016). Au cours de l'évaluation, les infirmières ont formulé la nécessité de dépister la VPI. Elles ont aussi exprimé leur volonté d'utiliser cette ressource éducative pour dépister leurs patientes et les encourager à faire usage des ressources disponibles.

Selon Ulbrich et Stockdale (2002), accroître l'efficacité personnelle des intervenants en santé dans le dépistage de la VPI et approfondir leur connaissance des ressources communautaires et des processus d'orientation aide à aborder la problématique dans les milieux de soins et dans la communauté. Ils ont aussi rapporté que le sentiment d'être plus à l'aise et sensibilisé perdure jusqu'à 6 mois après l'intervention éducative.

Durant la phase de création de ce projet, les commentaires de l'infirmière formatrice se sont avérés déterminants, puisqu'elle a contribué à la conception de l'outil et offert de l'intégrer dans la formation des nouvelles infirmières autorisées dans le service. L'infirmière gestionnaire était en faveur de l'intervention, mais les infirmières d'expérience étaient d'avis qu'en faisant du dépistage de la VPI une pratique systématique, le processus deviendrait fastidieux et prendrait beaucoup de temps, ce qui risquerait d'affecter le moral du personnel et, éventuellement, le soutien à l'intervention.

Malgré les difficultés auxquelles les infirmières des services d'urgence doivent faire face au contact de victimes de VPI, elles ont le devoir de prodiguer des soins sûrs et compatissants à tous leurs patients (Association des infirmières et infirmiers du Canada, 2017). L'Association des infirmières et infirmiers autorisés de l'Ontario (2005) recommande que les infirmières autorisées dépistent les « patientes de 12 ans et plus » à l'aide de questions comme : « Avez-vous déjà été blessée ou menacée par quelqu'un? » (p. 9, 63) Lorsque les connaissances et les compétences sont insuffisantes, on s'attend à ce que les infirmières autorisées élargissent leur savoir et adoptent une pratique fondée sur les données probantes comprenant l'identification, le dépistage et l'intervention (Association des infirmières et infirmiers du Canada). Même si nous reconnaissons que les hommes peuvent eux aussi être victime de violence entre partenaires, le dépistage de la VPI chez les hommes n'était pas l'objet de notre démarche. Les statistiques montrent que les femmes sont plus souvent victimes de VPI que les hommes. Le dépistage chez les hommes exige une certaine sensibilité à l'égard des facteurs sociaux et culturels. Il faut absolument demeurer conscient de ces réalités.

Éduquer les infirmières autorisées à reconnaître les signes de VPI et à la dépister efficacement constituent les premières étapes vers l'amélioration des soins offerts aux patientes qui subissent ce type de violence (Ahmad, Ali, Rehman, Talpur et Dhingra, 2017; Williams, Halstead, Salani et Koermer, 2016). Pour la constance de la pratique de dépistage à l'urgence, il est important que l'infirmière gestionnaire et l'infirmière formatrice du secteur offrent du soutien, comme le partage de statistiques concernant le dépistage de la violence entre partenaires, sur une base régulière.

Implications pour la pratique des soins infirmiers d'urgence

Ce projet a apporté plusieurs leçons pratiques. Premièrement, le processus de conception de l'outil éducatif a confirmé que dans les milieux où le soutien des pairs et de la direction est présent, il existe une volonté de mettre en œuvre les changements souhaités pour améliorer le sort des patientes. Dans le cas présent, avec l'appui des gestionnaires d'unités de soins infirmiers, les intervenantes de première ligne ont défendu les besoins en matière de soins de santé des victimes de VPI. La création de cette affiche éducative est un exemple de collaboration entre infirmières qui se servent de leur expérience clinique pour cerner les besoins des patientes et y répondre.

Deuxièmement, ce projet démontre que les infirmières de première ligne n'ont pas à occuper des postes de direction pour amorcer des changements dans leur milieu de travail. Ici, la prise en charge infirmière des patientes – et de leur problématique, par le fait même – et l'utilisation de la communication thérapeutique ont permis de dépister de potentielles victimes de VPI. En encourageant les infirmières de première ligne à résoudre les problèmes, les infirmières gestionnaires et les dirigeants peuvent créer une culture de défense des patientes. Lorsque les infirmières gestionnaires favorisent une culture de collaboration et de leadership avec les infirmières de première ligne, les relations infirmière-patient sont optimisées (Association des infirmières et infirmiers du Canada, 2017; Hegney et al., 2019).

Troisièmement, lorsque les infirmières de première ligne sont proactives et remédient aux lacunes des soins, elles peuvent inspirer des changements de grande envergure dans la pratique et les politiques entourant les soins de santé. Dans ce cas-ci, par exemple, puisque les victimes de VPI se présentent dans différents milieux cliniques, encourager d'autres unités de soins hospitaliers à utiliser l'affiche éducative sur la VPI favoriserait certainement la collaboration dans les départements, ainsi que la révision ou la réévaluation des approches thérapeutiques et protocoles d'orientation. Nous prévoyons donc que de nouvelles politiques et protocoles d'orientation seront créés pour répondre aux besoins des victimes de VPI.

Finalement, ce projet souligne l'importance de se tenir au courant des publications afin d'améliorer le sort des patientes. Dans notre cas, la revue de la littérature portant sur les défis auxquels se heurtent les infirmières autorisées lors du dépistage de la VPI et la présentation de ces constats aux décideurs peut motiver l'évaluation de nos approches en matière de soins à l'urgence. Par exemple, les études ont relevé le manque d'espaces privés pour évaluer les patientes comme un obstacle au dépistage de la VPI. Afin de créer un milieu sécuritaire où les patientes peuvent parler de leur expérience à l'infirmière, notre département a offert des salles de consultation privées à cette fin.

Conclusion

Plus de recherche est nécessaire pour mesurer l'impact de cette affiche à visée éducative. Les prochaines étapes prévoient une approche en deux volets : 1) évaluer la fréquence d'utilisation

de l'outil par les infirmières autorisées dans le but de dépister la VPI, ainsi que les changements ou les retombées pour les patientes comme le nombre de personnes guidées vers les agences communautaires; 2) étendre le dépistage de la VPI à d'autres unités de soins de l'Hôpital Victoria.

À retenir

- Ce projet d'amélioration de la pratique visait à développer un outil éducatif de dépistage de la violence entre partenaires intimes (VPI) à l'intention des infirmières qui travaillent à l'urgence.
- Les infirmières ne se sentent pas suffisamment préparées pour dépister et soigner adéquatement les victimes de VPI.
- Le projet a débouché sur une affiche facilitant le dépistage de la VPI pour les infirmières des urgences.
- Les principales répercussions pour la pratique des infirmières des urgences dans le cadre de ce projet sont : a) lorsque les infirmières des urgences participent à la création d'outils éducatifs visant à améliorer le dépistage de la violence entre partenaires intimes, l'appropriation du processus et du produit est renforcée; b) les infirmières sont désireuses d'utiliser l'affiche produite.

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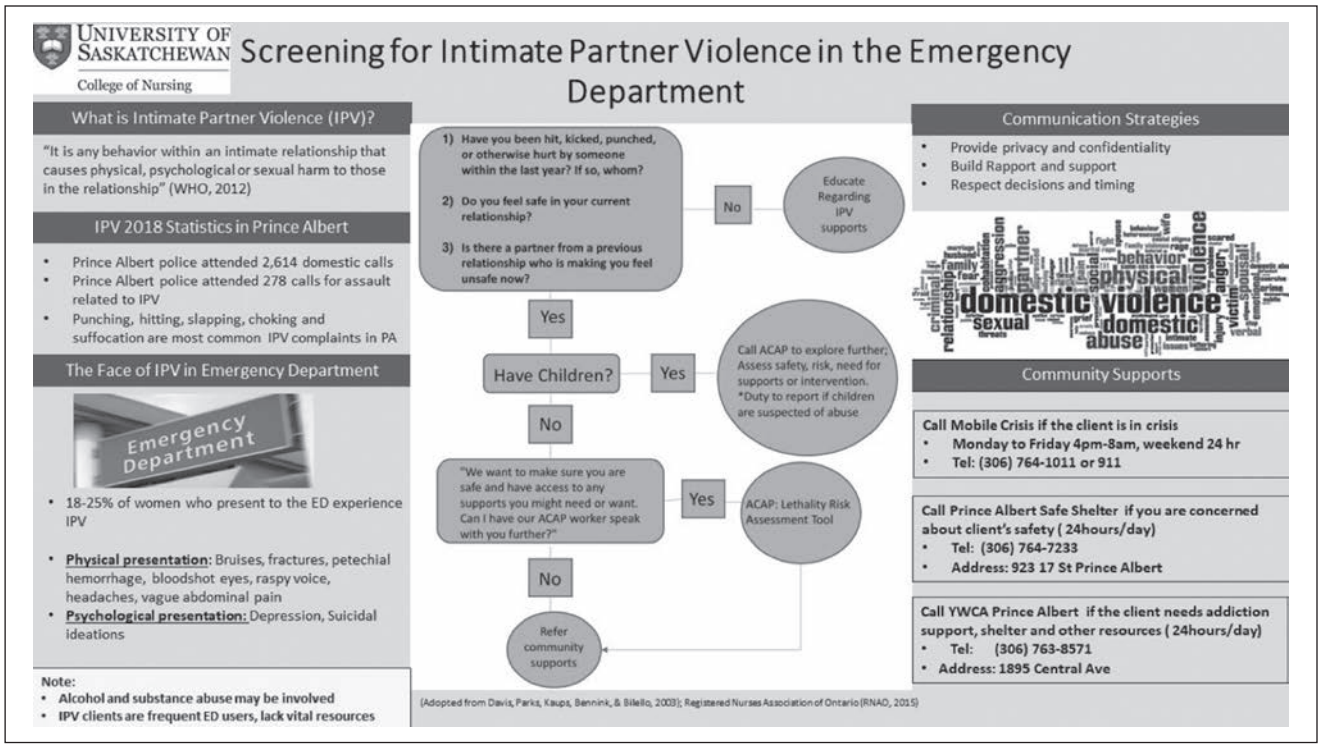

Annexe 1. L'affiche de VPI

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Appendix 2. Carte de poche de VPI

Guidelines for Authors

The Canadian Journal of Emergency Nursing (CJEN), is distributed to members of the National Emergency Nurses Association, to individuals, and to institutions interested in emergency nursing. The journal is published biannually.

The editorial board invites submissions within the four domains of emergency nursing: clinical care, education, leadership and research. Topic areas of emergency nursing we encourage submissions on include: transport, forensic, northern, rural and Indigenous nursing. Arts-informed scholarship and expressions are also welcome. If you are a novice writer, NENA member, and you have an important emergency nursing story, our editorial staff will be happy to partner with you to get your manuscript published.

The journal is indexed in online scientific journal databases and provides a forum for:

- new clinical practices
- clinical case studies
- research papers
- practice improvement papers
- scholarly projects
- reviews
- arts-informed scholarship
- letters to the editor
- short reports or profiles of:
  - an outstanding emergency nurse, department or program
  - a newsworthy event
  - an ally to Canadian emergency nurses.

CJEN will publish manuscripts related to emergency nursing by non-nurse authors, but priority will be given to the Canadian emergency nurses.

Manuscripts submitted to the CJEN must include the following:

- A cover letter stating:
  - the work has not been published and is not under consideration for publication elsewhere
  - acknowledgement that the submission will undergo computerized analysis for plagiarism
  - the contact information of up to 3 potential peer-reviewers or any requests not to have a certain individual contacted to provide peer-review
- Permission from the copyright holder for any previously published material.

Manuscripts submitted for publication must follow the following format:

1. Title page with the following information:

- Author(s) name, and credentials, title/position
- Place of employment/affiliation
- If there is more than one author, co-authors' names, credentials, titles/positions should be listed in the order that they should appear in the published article
- Indicate the primary person to contact and address for correspondence
- Provide five key words for indexing

2. A brief abstract is required for original research, systematic reviews and meta-analyses, of the article on a separate page of 150–250 words. The abstract should provide the context or background for the study and should state the study's purpose, basic procedures (selection of study participants, settings, measurements, analytical methods), main findings (giving specific effect sizes and their statistical and clinical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations, note important limitations, and not over interpret findings. Clinical trial abstracts should include items that the CONSORT group has identified as essential.

3. Acknowledgements

- Other contributing individuals and sources of research funding should appear in an acknowledgment section.

4. Body of manuscript (approximate maximum):

- Length, including tables, figures, and references:
  - new clinical practices = 8 pages, 2 tables or figures
  - research papers = 20 pages, 6 tables or figures
  - practice improvement papers = 12 pages, 4 tables or figures
  - scholarly projects = 12 pages, 2 tables or figures
  - reviews = 16 pages, 2 tables or figures
  - arts-informed scholarship = 8 pages, 2 tables or figures
  - letters to the editor = 4 pages, 1 table or figure
  - clinical case studies = 8 pages, including tables and figures

Additional specific guidelines for Clinical Case Studies. Case Studies should be written in a similar format to include the following:

- Initial patient presentation
- Relevant history
- Relevant physical exam findings
- Relevant diagnostics
- Case progression
- Final case outcome
- Discussion/Teaching points
- References.

Graphics that will enhance the case study are encouraged (e.g., photos, diagrams, diagnostics).

Authors must receive, and submit, the appropriate permission from the source(s) to use such images in the final publication. Information or graphics that uniquely identify the patient may only be included if written permission for publication in CJEN is received from the patient.

Case studies usually document the management of one patient, with an emphasis on presentations that include care given in an emergency/urgent care/pre-hospital setting and involving emergency nurses and/or nurse practitioners and /or emergency pre-hospital providers. Other features that will be of interest to the reader include cases:

- that are unusual, rare or where there was an unexpected response to treatment
- where new diagnostic tools were used
- that inform readers of new treatment and management options, including relevance to emergency care practice.

5. Implications for nurses

- Provide a separate page with three to five important points or clinical/research implications relevant to the paper. These will also be published with the paper and possibly in NENA social media (e.g., newsletters, Facebook, Twitter).

6. Copyright

- Manuscripts submitted and published in the CJEN become the property of NENA.

7. Submission

- Submit manuscripts electronically as a Word document to the editorial office and NENA national office (editor@nena.ca).
- Submit a signed Author Declaration. All authors must declare any conflicts of interest and acknowledge that they have made substantial contributions to the work and/or contributed substantially to the manuscript at the time of acceptance.

8. Review process and timelines

- All manuscripts are reviewed through a blinded, peer review process.
- Accepted manuscripts are subject to copyediting.
- Expected timeline from submission to response is approximately 8 weeks.
- Papers can be accepted as is, accepted with minor revisions, sent back for revisions and a request to resubmit, or rejected.
- If a paper is rejected, that decision is final.
- Once a manuscript is accepted, time to publication is approximately 3–6 months.

Canadian Journal of Emergency Nursing Preferred Style

- Format: double spaced, 2.5 cm margins on all sides. Pages should be numbered sequentially including tables, and figures. Line numbering should be used as well.
- Prepare the manuscript in the style as outlined in the American Psychological Association's (APA) Publication Manual 6th Edition. An exception from APA is the spelling (should be current "Canadian" use where applicable).
- Use only generic names for products, devices and drugs.
- Suggested format for research papers is background, methods, findings/results, discussion, and conclusion.
- The CJEN supports the SAGER guidelines and encourages authors to report data systematically by sex or gender when feasible.
- Tables, figures, illustrations and photographs must be submitted each on a separate page after the references. Illustrations should be computer-generated or professionally drawn. Images should be in electronic form and high resolution. The CJEN is only printed in black and white copy. If you want to publish a photograph of people you must include a consent from them. CJEN will not reimburse the author for any costs incurred for permission to use a graphic for publication.

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Note

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