outlook
the official journal of the National Emergency Nurses' Affiliation Inc.

Volume 25, Number 2, Fall 2002

In This Issue:

NENA

outlook
Conference watch

Emergency Nursing Conference
Sponsored by The Emergency Nurses Interest Group of Alberta
October 4-6, 2002, Delta Lodge at Kananaskis, Kananaskis Country in the Rocky Mountains.
For more information contact: Shelly Anderson: slarn@telusplanet.net or Pam Little: pamordon@telusplanet.net

Resolving Conflict in Health Care
An intensive, interactive conflict resolution workshop presented by mediate.calm
October 15-17, 2002, The University Club, Dalhousie University, Halifax, Nova Scotia. The full three-day workshop that was so successful in Toronto earlier this year is presented immediately prior to the three-day Medical Error Symposium at Dalhousie University. For more information visit and register on-line: www.mediatecalm.ca

Mind, Body and Soul - Supporting rejuvenation of all health care providers
October 17, 2002, 0900-1600 hours. Presented by NBENA Saint John Chapter, NBENA. Cost $30.00
For further information, contact: Lois Moore or Rose McKenna at (506) 648-6900 or rosemck@hotmail.com

10th annual EMS Development Symposium - EMS- Past, Present and Future
October 17-19, 2002, Saint John Regional Hospital, Saint John, NB
For further information contact: website: www.ahsc.health.nb.ca/ems, voice mail: (506) 642-3688 or fax: (506) 652-6430

The Second Halifax Symposium on Health Care Error
October 18-20, 2002, The University Club, Dalhousie University, Halifax, Nova Scotia. Sponsored and organized by Capital Health. For more information contact: Sherri Lamont, Symposium Coordinator: lamont@accesswave.ca

Pediatric Emergency Care 2002
A two-day conference for Atlantic Canadian front line health care providers: physicians, nurses, crisis/social workers, house staff and paramedics, sponsored by the Emergency Department Education Committee, IWK Health Care Centre
October 24-25, 2002, OE Smith Auditorium, IWK Health Centre, Halifax, NS. For more information contact: Erica Thomas (902) 470-8823, fax: (902) 470-7248, or e-mail: Erica.Thomas@iwk.nshealth.ca

2003 Nursing Leadership Conference
February 10-11, 2003, Crowne Plaza, Ottawa, Ontario
The Academy of Canadian Executive Nurses, the Canadian Association of University Schools of Nursing, the Canadian College of Health Service Executives, the Canadian Healthcare Association, the Canadian Nurses Association and the Canadian Public Health Association are pleased to issue this Call for Abstracts for the 2003 Nursing Leadership Conference. Nursing requires strong, consistent and knowledgeable leaders who can inspire others, are visible, have organizational awareness and can support professional nursing practice. Leadership plays a pivotal role in the lives of registered nurses and is essential to ensure quality professional practice environments and quality client outcomes, based on evidence. This two-day conference is organized into the following three streams and will provide the opportunities to hear, learn and share how nurse leaders are:
- Building Professional Practice Environments
- Building Primary Health Care
- Promoting Evidence-based Practice

Secretariat Contact Information:
2003 Nursing Leadership Conference, 50 Driveway, Ottawa ON K2P 1E2,
e-mail: nfreeman@cna-nurses.ca,
(800) 361-8404 (x219) or (613) 237-2133 (x219)

Emergency Nursing – "A Kaleidoscope"
National Emergency Nurses Conference, sponsored by Saskatchewan Emergency Nurses Group
May 3-4, 2003, Regina, Saskatchewan
For more information or to request a brochure contact: National Conference Publicity Chairperson, Emergency Department, Pasqua Hospital, 4101 Dewdney Ave., Regina, SK S4T 1A5

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President's message

The theme of this year's CNA Biennium was *diversity*, with one of the focuses being that of achieving a quality professional practice environment or, in simpler terms, a healthy work environment for one and all. Needless to say, such an environment will not appear on its own. It will take work, effort, and commitment by all to bring it to fruition.

As emergency nurses, we are all too aware of the stresses in emergency departments across the country – overcrowding, gridlock, ambulance diversions and the nursing shortage, just to name a few. Some days, it is so very overwhelming, and just too much to cope with. The atmosphere is one of negativity, with burn-out, exhaustion, and illness being the end results.

Emergency nurses can make a difference to our own work environment. The question is, though, how important is a healthy work environment to emergency nurses in Canada, and are we willing to take up the challenge?

Emergency nurses pride ourselves in being diverse. We are often the entry point for many to the health care system, the foundation of our institutions. If this is the case, then we **must** take up the challenge ahead of us. We cannot expect others to solve our problems if we do not accept responsibility, initiate change, and focus on the quality of our own work environment. We need to start from within and make the necessary changes that we can.

We need to focus on the problem one aspect at a time. It is really rather simple, as straightforward as the ABCs that we deal with each time we assess a patient. Here, however, our ABCs are **A**ttitude, **B**elief and **C**ommitment.

Attitude requires a positive outlook. Dwelling on the negative is so very draining. It wears and tears on us and, if allowed to, will spread and fester in a moment's notice. We must build on the positive, give a pat on the back for work well done by our peers and ourselves. It is surprising that positive recognition can be so very rewarding.

Belief is in knowing and believing that we can make a difference by changing our attitudes. Give it a try, focus on the positives and I am sure you, too, will see and experience a change for the better in your surroundings.

Commitment is ensuring that we come to work with a healthy, positive attitude. Make the commitment to yourself then, as an entire department, make the commitment to each other.

Emergency nurses are a dynamic group! Let's build on our strengths and together we can begin to make necessary changes to our own health and environment. Focus on one aspect at a time. When we succeed with this step, we will be ready to take the next step to ensure a quality professional practice environment and, at the same time, meet the numerous challenges we do every shift that we work.

Anne Cessford
RN, BA, BScN, ENC(C)

Certification report

Statistics

Number of nurses who have written the emergency certification examination ***(% difference between years)***

1994	301	
1995	233	*(-23%)*
1996	249	*(+7%)*
1997	273	*(+10%)*
1998	165	*(-40%)*
1999	162	*(-2%)*
2000	116	*(-28%)*
2001	192	*(+65%)*
2002	171*	

(applied to write)*

Total **1,691**

Total ENC(C)
The total currently certified ENC(C) nurses is 1,193 as of 2001.

	Due to recertify	Recertified	Renewal rate
1999	244	159	65%
2000	217	112	52%
2001	237	106	55%
2002	240	103 *(number applied to recertify)*	

Examination information

Next year's examination date is April 5, 2003.

Preparation guide

The **Preparation Guide** is now available and included in the cost of registering for the examination. The guide is also available through CNA publications department at sales@can-nurses.ca or 1-800-385-5881. The cost is $34.95 (CNA member) or $43.75 (non-member).

Committee structure

The committee is composed of emergency nurses from the following areas and with the following backgrounds:
Administration: Louanne Kinsella, NF
Helen Grimm, SK
Education: Meg McDonagh, AB
Catherine McDonald, BC
Clinical: Darlene Cogswell, NB
Audrey Dabreo, QC
Margaret Pook, ON

A committee meeting was not held in Ottawa this year, however, questions were reviewed and submitted to Suzanne Maize.

Summary

It has been an honour to work on this committee on behalf of NENA.

Marg Pook, RN, ENC(C)

Were you aware?

- That Health Canada, following reports of suffocation and strangulation of young children from entanglement in IV tubing or monitor leads while they were patients in hospital, has issued the following recommendations:
  1. All hospitalized children could possibly become entangled in a monitor lead or tubing and should be continuously observed by an adult or placed on a monitor.
  2. Consider treating hospitalized children with oral therapy or a heparin-locked needle if possible.
  3. Coil excess tubing when the child is unattended to prevent the infant/child from becoming entangled.
  4. Inform hospital staff, parents and other caregivers that young children are at risk of entanglement and strangulation by IV tubing, electronic leads, or cords of any sort. Health Canada asks that the recommendations be posted in a prominent spot for staff and that they be implemented in the interest of patient safety (http://www.hc-sc.ca).
- That a recent study done in Sarasota, Florida revealed that fabric stethoscope covers represent a potential infection control problem because they are used for long periods of time, are infrequently laundered, and are contaminated with pathogenic bacteria known to cause nosocomial infection (Milam, M.W. et al., 2001. Bacterial contamination of fabric stethoscope covers: the velveteen rabbit of health care? **Infection Control and Hospital Epidemiology, 22**, 653-655.).

Celebrate Emergency Nurses Week, October 6-12, 2002, and Emergency Nurses Day Wednesday, October 9, 2002

"Caring, Healing, Educating… one life at a time"

The 2002 annual report submitted to the CNA - National Emergency Nurses' Affiliation Inc. (NENA)

Historical Perspective

The National Emergency Nurses' Affiliation Inc. was formed in 1981.

General structure

There are nine active provincial groups along with independent members from Quebec.

The NENA board of directors meets twice a year, in the spring and fall. The spring board of directors meeting is held in conjunction with the AGM and an educational conference. Odd years are in conjunction with the national conference and even years with a regional conference.

Objectives

The mission of NENA is: "To represent the Canadian emergency nursing specialty".

The values of NENA are:
- All individuals have the right to quality health care
- Essential components of emergency nursing practice are wellness promotion and injury prevention
- Continuing education and professional development are fundamental to emergency practice
- Research guides emergency nursing practice.

The goals of NENA are:
- Strengthen the communication network
- Provide direction for clinical practice of emergency nurses
- Promote research-based practice
- Support and disseminate education.

Membership

As of February 13, 2002, there are 1,282 members of NENA.

Present special projects and activities (publications, research, conferences, certification, etc.)

NENA and Canadian Association of Emergency Physicians (CAEP) boards of directors met in November 2001 to discuss common issues and prioritize the issues identified. Priorities for action were identified under three categories:

Improved communications
- web page links
- sharing of board minutes

Present projects to continue
- Canadian Triage Acuity Scale (CTAS)
- emphasis on the pediatric component
- Canadian Emergency Department Information System (CEDIS)

New projects
- pediatric CTAS education project
- violence in the workplace
- re-look at the overcrowding position statement

The policy and procedures have been reviewed and revised along with the position statements. There has been the addition of three new position statements, which are:
- Use of non-registered nurses as health care providers in the emergency department
- Family presence during resuscitation and invasive procedures
- Procedural sedation in adults and children in emergency departments.

The core competencies for emergency nursing have been developed and published and will soon be distributed to all NENA members.

In May 2002, the NENA AGM was held in conjunction with a regional conference in Moncton, New Brunswick. The theme of the conference was "Caring for Others, Caring for Ourselves".

Issues of concern

• New untrained RN staff; • Vacancies; • Retention; • Nurse:patient ratios; • Non-RNs in the emergency department, skill mix; • Overcrowding; • Emergency department vs. systems problems; • Potential violence/security risks

Date: April 1, 2002

National trauma committee report

Well, it's hard to believe fall is upon us and, for some of you it means busy work and course planning, whereas for others it means structure and process. Whichever emergency nurse you happen to be, the national trauma committee wishes you all a safe and happy fall!

The Trauma Nursing Core Course (TNCC) is well on target for this year with 1,700 nurses signed up to date. We expect to exceed, or at least match, last year's numbers of 1,845 participants. The Emergency Nursing Pediatric Course (ENPC) is also on target with 522 nurses registered to date, almost meeting last year's number of 645. The Course in Advanced Trauma Nursing (CATN) is slightly down with no upcoming courses scheduled to date.

Thank you to the instructors who believe in offering educational opportunities to all emergency nurses.

A reminder to all instructor trainers from central and eastern Canada that the national trauma committee is accepting applications up until October 15 for four vacant positions that currently exist, two positions from the east (NFLD, NS, NB, PEI) and two positions from central (Ontario, Quebec). The appointments would be made at the November meeting of the NENA board and the first meeting of the committee would be late November or early December. It is important that instructor trainers know of the commitment needed to assume these positions on behalf of your provinces, however, the reward of networking within this committee is tremendous. Please consider submitting your names! All submissions should be directed to the NTC chair. Address and e-mail address are below.

The NTC has developed a process to manage complaints regarding courses and we welcome feedback from all emergency nurses who have taken one of the trauma courses and who have positive suggestions re improvement, or who have a concern over quality of teaching.

New administrative manuals will be sent to all instructors by the end of September. If you do not receive your copy, please contact the NTC committee member for your area, or the current chair. To this end, we request all instructors of any NENA program to resubmit their full mailing address, e-mail if available and home number either by e-mail or letter to the NTC Chair, 20 Power Street, Grand Falls-Windsor, NF A2A 2T6, or e-mail: pwalsh@cwhc.nf.ca

This will help update the database and make communications more effective.

Contract negotiations have also begun with the US for the trauma programs for 2003 so feedback from any emergency nurse, but particularly instructors, would be extremely helpful in ensuring we negotiate on your behalf.

Pat Walsh, Chair,
National Trauma Committee,
NENA

NENA 2000-2001 year-end financial report

INCOME	**Actual**	**Budget**	**Variance**
Fundraising	$814.00	$100.00	$714.00
Advertising	$113.06	$100.00	$13.06
Grants	$1,000.00	$2,400.00	($1,400.00)
Sponsors	$2,000.00	$0.00	$2,000.00
Indirect Fees: ENPC	$12,250.00	$8,520.00	$3,730.00
Indirect Fees: TNCC	$48,889.41	$17,880.00	$31,009.41
Indirect Fees: CATN	$3,000.00	$1,200.00	$1,800.00
Interest Income	$3.57	$0.00	$3.57
Investment Income	$470.45	$0.00	$470.45
Member Fees	$21,160.00	$23,140.00	($1,980.00)
Misc. Income	$21,678.48	$0.00	$21,678.48
TOTAL INCOME :	$111,378.97	$53,340.00	$58,038.97

EXPENSES:	**Actual**	**Budget**	**Variance**
Awards		$0.00	$0.00
Advertising	$1,198.41	$0.00	($1,198.41)
Bank Charges	$241.83	$100.00	($141.83)
Board Meetings	$22,393.31	$17,700.00	($4,693.31)
Bursaries	$2,750.00	$3,500.00	$750.00
CNA Fees	$200.00	$214.00	$14.00
Committee Meetings	$9,438.41	$5,500.00	($3,938.41)
Gifts	$242.60	$100.00	($142.60)
Interest Paid	$0.00	$0.00	$0.00
Legal	$391.84	$100.00	($291.84)
Liaison Meetings	$1,672.06	$0.00	($1,672.06)
Office Expense	$11,798.09	$5,450.00	($6,348.09)
Programs		$12,052.00	$12,052.00
Promotions	$1,481.30	$3,075.00	$1,593.70
Public Relations	$7,777.92	$3,600.00	($4,177.92)
Reimbursements: ENPC	$4,370.00	$3,000.00	($1,370.00)
Reimbursements: TNCC	$16,749.41	$5,960.00	($10,789.41)
Reimbursements: CATN	$750.00	$400.00	($350.00)
Misc			$0.00
TOTAL EXPENSES:	**$81,455.18**	**$60,751.00**	**($20,704.18)**
INCOME/LOSS POSITION:		**$29,923.79**	

Revised Position Statements, Standards and new Core Competencies are available for purchase by non-NENA members for $20.00 per document. For orders of 20 copies or more, 15% will be reduced from the total cost. Just make sure that you note this when you place your order. Send orders to Jerry Bell, 10 Laval Drive, Regina, SK S4V 0H1

Did you know?

- That work has started on developing a national orientation and preceptor program
- That position statements on ambulance diversions and the responsibility of patients on stretchers waiting placement in the ED are currently being drafted
- That core competencies are complete and are being sent out to all members
- That NENA standards, core competencies and position statements with an accompanying letter have been sent to federal and provincial health ministers, CNA, CAUSN, ACEN, Federal Chief Nursing Officer and all provincial regulatory bodies
- That the Peds CTAS educational program has been developed and will roll out this fall

Outlook

NENA biography

Anne Cessford, RN, BA, BScN, ENC(C)

Anne Cessford is a registered nurse with a BA in psychology and a BScN from the University of Windsor, Ontario (1979). She has been involved in the specialty of emergency nursing since 1988 and has held numerous positions in emergency nursing as a staff nurse, clinical educator, triage nurse, manager, and patient service coordinator. Anne is presently a clinical resource nurse in the emergency department of Surrey Memorial Hospital in Surrey, BC where she also works as a sexual assault nurse examiner.

From 1997 to 2000, Anne was president of the Emergency Nurses Group of BC (ENGBC) and chair of the Canadian Nurses Association National Emergency Nursing Certification Examination Committee. She has been president of the National Emergency Nurses' Affiliation, Inc. since July 2000.

In her role as president of NENA, Anne's main goal has been to support and promote the specialty and profession of emergency nursing with the focus on communicating with the membership and our partners in health care.

As involved as Anne may be with NENA, her number one priority and passion in life is her husband, Jamie, and their three fantastic, teenage children.

Outlook

Letters to the editor

*This will be a new feature for **Outlook**. I would encourage all of you to send in your letters, questions, tips, ideas. Many of our issues and the problems that we face daily are the same, whether you work in Victoria, BC or Grand Falls, NFLD.*

The sharing of information is powerful. Trying to develop a new policy, looking for a new form? Request it here. This is your journal. It is a vehicle for communication for all of us. Use it.

Please send your letters, etc., to: Valerie Eden, 34 Bow Street, Dartmouth, NS B2Y 4P6, or e-mail at: valeden@hfx.eastlink.ca

Further to your article in the Spring 2002 copy of **Outlook**, I would like to send a bouquet to my daughter, Allyson Shephard. She has accomplished much in her short career. Graduating from Ottawa University in 1996, she began working at the emergency department at Childrens' Hospital of Eastern Ontario (CHEO). Following two years of working in emergency, she was instrumental in developing and implementing the new trauma program in CHEO, which she now manages.

Allyson is a member of ENAO and has made a number of presentations at ENAO conferences. She is an instructor for TNCC and provides lectures in the emergency program at Algonquin College. At present, she is completing her Masters degree in nursing.

Allyson has been an inspiration to me. She encouraged me to accept a team leader position that I am finding very challenging after working 24 years in emergency at the Queensway-Carleton Hospital.

Allyson is a great asset to nursing and she will continue to advance the very best of what it means to be a professional nurse.

Wendy Shephard

The Ontario report: FYI across the country

The Registered Nurses Association of Ontario predicts that by 2011, Ontario will need to recruit 60,000 to 90,000 nurses. With current trends continuing, Ontario can only expect 40,000 to 50,000.

The College of Nurses of Ontario statistics indicate the following:
57.5% RNs work in hospitals
13.4% RNs work in the community
12.6% RNs work in long-term care
16.1% work in assorted other fields.

The average age of an Ontario RN is 44 in spring 2002.

51.6% RNs work full-time.
36.2% RNs work part-time.
11.7% work casual.

There are currently 106,305 RNs licensed to practice in Ontario, only 82,788 of them are working in nursing.

The Ontario Hospital Association President, David MacKinnon, was quoted as saying, " Fewer Ontario nurses are handling sicker patients who need longer hospital stays, in fewer acute care beds!"

A recent study done by **The Toronto Star** produced no surprises. "Weekends can be Hell in the ER", was the headline. Public holidays continue to top the list for high-volume days. The seven-year, province-wide study concludes what ER nurses have always known; demand peaks on weekends and holidays when doctors' offices are closed. The year's busiest week is always between Christmas and New Year. The study also went on to say: "The emergency department is the barometer of how the whole health-care system is functioning. If things aren't working well elsewhere, the pressure is felt in the ER." No news to emergency nurses!

Tidbits, trivia, & truisms

• I have learned that sometimes what my patient needs most is a hand to hold and a heart to care.
• The Fugu fish, also known as the Blowfish or Puffer fish, is a delicacy in Japan. A pinch of tetrodoxin (fugu fish poison) is 1,250 times more deadly than cyanide and is enough to kill 30 people. Chefs must take intensive courses and pass exams to be licensed to prepare Fugu dishes.
• You don't stop laughing because you grow old, you grow old because you stop laughing.
• Confidence never comes from having all the answers, it comes from being open to all the questions.
• Sterilize: what you do to your first baby's pacifier by boiling it and to your last baby's pacifier by blowing on it.
• If four out of five people suffer from diarrhea, does the other one enjoy it?
• Whatever happened to Preparations A through G?
• If we say something is "out of whack", what's a whack?
• If it's true that emergency nurses are here to help others, then what exactly are the others here for?

Remember...

Emergency nurses are always there for others, providing the best of care.
You reassure and comfort with the many nursing skills you share.
You make a major difference in everything you do.
All of us are thankful for that special person, "You".

From an emergency patient.
• Caring is such a large part of being an emergency nurse. In order to keep on doing what you do for others, never forget to care for yourself !!!

Submitted by Janice L. Spivey, RN, ENCC, CEN, ENAO President

Confessions from the Communication Officer - the NENA website

As you are aware, NENA has a website that, for several months recently, has been inactive and then disappeared altogether due to a combination of unfortunate factors. Just prior to my appointment to the role of communication officer, the board of directors had approved a recommendation to have the website redesigned in an effort to make it more visually pleasing and user-friendly. The person who had been asked to redesign the website had agreed to do the work. In the meantime, the company that held the domain name for the website had sent out a renewal notice by e-mail. However, no one received this renewal notice and the website disappeared. The IT people at the Ottawa Hospital were unsure of what had happened to the site and so, after several weeks of e-mails and phone calls, the confusion over the site was sorted out.

The domain name has been reinstated. Unfortunately, the person who had agreed to redesign the website was unable to do the job in the end and we have had to find another company to do the redesign. We have found a company that is willing to take on the job. At the time of writing, the company is doing a mock-up of a new web page.

I wanted to update you and I also wanted to apologize for any inconvenience that the disappearance of the website has caused for any members.

Valerie Eden
Communication Officer

New Brunswick report - the 2002 regional conference

The regional conference of 2002 was held in Moncton, NB, hosted by the New Brunswick Emergency Nurses Association. The title was "Caring for Others, Caring for Ourselves." Emergency nurses most often are the first contact people have with the health care system. It is often a critical event for them, whether perceived or actual. We must be prepared to meet their needs, both physical and emotional, and to support the family and loved ones. Today's environment of staffing shortages, overcrowding and general lack of resources has compounded the stress on the ER nurse. In order to care for others, we must take care of ourselves. Our goal was to acknowledge some of the issues and offer some strategies that might help in the workplace.

The conference opened with a smash hit, "Survive!!!ER", presented by Sheila Early and Ruth Ringland. It was a sometimes comic and other times thought-provoking look at situations common to ER departments and coping strategies that might be used. Other topics were: "Critical Incident Stress Debriefing" by Rev. R. Maund, "Pediatric CTAS" by Carla Policicchio, "Telecare and Emergency Services, Partners in Quality Care" by Lois Scott, "ATV Trauma" by Heather Oakley, "Adolescent Behavioral Disorders" by Dr. S. Sadiq, "Sexual Assault Nurse Examiners" by Janet Calnan and Sheila Early, and "Staff/Manager Relations" by Carla Policicchio. These topics on Friday were followed by the NENA Annual General Meeting. It was a full and rewarding day.

Saturday began with a presentation by Joan Lutes, "Multidisciplinary Roles in the ER", a look at the changes the nursing profession has seen over the years and now, and the inclusion of other health care providers such as pharmacists, discharge planning, psychiatric nurses, and volunteers. Other presentations were: "Non-urgent patients: Why do they seek ER care?" by L. Scott, "Family Presence During Resuscitation" by Dr. M. Allen, and "Legal Issues in ER" by Joan Allain, all

NENA's "Win a trip to the national conference" contest rules

NENA Inc. will biannually sponsor a NENA member's attendance at the national conference/AGM, for an article published in **Outlook.** The winner will be chosen by lottery.

1. Contest will be advertised in **Outlook**
2. Provincial representatives are encouraged to publish the contest among their membership.
3. Articles must be submitted directly from the author. Provincial newsletters forwarded to the communication officer for selection of items to include in **Outlook** will not be considered in the lottery. Please refer to the submission guidelines included with this issue.
4. Primary author's name will be entered into the draw (in the event of multiple authors).
5. Names will be entered into the draw beginning with the winter 2001 edition of **Outlook** and ending with the winter edition of 2003.
6. The communication officer will maintain a record of names entered into the lottery.
7. The NENA president will randomly draw the name of the winner.
8. The NENA president (or delegate) will notify the winner and will communicate with the winner to ensure conference registration, hotel booking at the convention rate, and travel arrangements are made at the most economical rate to the maximum value of $2,000.00.
9. The draw will occur in January prior to the national NENA conference to allow the winner to arrange their time off to attend. In addition, this allows time to obtain the best fares and booking of a hotel room at conference rates.
10. The winner of the lottery will have three weeks in which to accept their prize. In the event the winner is unable to claim their prize, a second name will be drawn. The prize is non-transferable.
11. The winner will make his or her own travel arrangements.
12. The winner's name will be published in **Outlook.**
13. The winner must be a NENA member at the time of submission.
14. NENA board of directors and **Outlook** section editors are exempt.
15. Articles are published at the discretion of the communication officer
16. NENA board of directors has approved the contest rules.

The next National Emergency Nurses Conference is in Saskatchewan in 2003.

followed by another superb session, "Stress" by Mrs. A. Lepage, a family therapist who kept her audience captivated with her humorous reflections on human behaviour.

Thank you to all those who attended and made our conference the success it was. One of the comments on an evaluation form said it very well, "Excellent conference, great opportunity to network with excellent, motivated, dedicated emergency nurses!!"

Thank you to all the presenters. We appreciate the time and the effort you gave. Comments, again received with the evaluations, say it well, "Excellent speakers! Great topics! Great reminders!" and, "Excellent. All the speakers were incredible. I have not been to a conference where every session was led by dynamic speakers. All very informative."

We would also like to thank the conference's major sponsor, Hoffman-La Roche, as well as other corporate sponsors whose support and recognition are so important.

As president of the New Brunswick Emergency Nurses Association and chairperson of the planning committee, I wish to thank those who put so much thought and effort into the planning of this conference. There were many hours devoted to the preparation of this event and your dedication is very much appreciated! Thank you to Nancy Ashley, Alison Bulmer, Patti Davis, Nancy Douthwaite, Carol Frizzell, Karen Gallup, Nadine LeClair, and Jeannine Michaud.

One comment was especially appreciated by the conference planning committee and might encourage anyone who is contemplating a conference in the near future, "This was my first NBENA conference. I wish to compliment the committee on their hard work. You've done an excellent job. The conference was interesting and informative. The opportunity to choose topics of personal interest showed insight into your diversified membership…."

outlook Bouquets

- **Eileen Denomy**, for her appointment to the Certification Advisory Committee
- **Lucy Rebello**, for being a strong patient advocate
- **Retiring NENA Board Directors**, for their work, their time and their energy
- **Marg Pook**, for her work on the Certification Committee
- **The Planning Committee of the NB Emergency Nurses Conference**
- **Members of Saint John Chapter NBENA** - Sue Benjamin, Haidee Goldie, Lynn Thom and Nicki Hamburg for achieving certification in emergency nursing

"Bouquets" is dedicated to celebrating the achievements of NENA members. If you would like to send a bouquet to a NENA member, contact the communication officer, Valerie Eden, 34 Bow Street, Dartmouth, NS B2Y 4P6 (H) 902 461-1897; (W) 902 465-8340; fax: 902 465-8435; e-mail: ***valeden@hfx.eastlink.ca****.*

Outlook

Position statement

Family presence during resuscitation and invasive procedures

Issue

In most cases, the family is the patient's primary support system. Family members are frequently not given the opportunity to remain with the patient during invasive procedures, including resuscitation efforts. Families and patients may be separated for reasons such as the perception of being overwhelmed and/or intimidated with the situation and concern on the part of the individuals performing the procedure in the presence of non-medically oriented individuals.

NENA position

NENA supports the option of family presence during invasive procedures and/or resuscitation efforts.

NENA acknowledges that a support system, (i.e.) social worker and/or pastoral care, must be in place for the family member(s) during invasive procedures and/or resuscitation efforts.

NENA supports further research related to the presence of family members during invasive procedures and/or resuscitation and the impact it has on family members, patients, and health care professionals.

Rationale

Every emergency patient is a member of a family system with the family being defined as a person(s) who has an established mutual relationship with the patient.

The family system is the major source of support for the individual during times of stress and crisis. Studies have indicated that the most important needs identified by family members of critically ill patients are:

- To be with the patient
- To be helpful to the patient
- To be informed of the patient's condition
- To be comforted and supported by family
- To be accepted, comforted, and supported by health care personnel
- To feel that the patient was receiving the best possible care

Family presence during resuscitation efforts allows the patient and the family to support each other and facilitate the grieving process by bringing a sense of reality to the treatment efforts and the patient's clinical status.

References

Eichhorn, Dezra J. et al. (2001). Family presence during invasive procedures and resuscitation: hearing the voice of the patient. **American Journal of Nursing, 101, (5)**, 48-54.

Emergency Nurses Association. (1998). **Position Statement: Family Presence at the Bedside during invasive procedures and/or resuscitation.**

Lester, J.S. (1986). Needs of relatives of critically ill patients: a follow-up. **Heart and Lung, 15, (2)**, 189-193.

Meyers, T.A. et al. (2000). Family presence during invasive procedures and resuscitation. **American Journal of Nursing, 100, (20)**, 32-43.

Molter, N. (1979). Needs of relatives of critically ill patients: a descriptive study. **Heart and Lung, 8**, 332-339.

Outlook

Guidelines for submission

Editorial Policy

1. **Outlook** 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 **NENA Outlook** editor. The author should retain one complete copy.
2. Manuscripts must be typed, double-spaced (including references), on 8 1/2" x 11" paper with adequate margins. Manuscripts longer than one page must be submitted in a disk format in Word Perfect or Word. Submissions are accepted via e-mail to the communication officer.
3. Author's name(s) and province of origin must be included
4. Clinical articles should be limited to six pages.
5. Direct quotations, tables and illustrations that have appeared in copyrighted material must beaccompanied by written permission for their use from the copyright owner and original author and complete source information cited.
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) to use the photograph of (subject's name) in the **NENA Outlook**.

Please submit articles to:
NENA Outlook Editor, 34 Bow Street
Dartmouth, NS B2Y 4P6
valeden@hfx.eastlink.ca

Deadline dates:

February 20 and August 16

Outlook

Position statement

Use of non-registered nurses as health care providers in the emergency department

Issue

Nationally, emergency departments have begun to implement alternative staffing options to include the use of non-RN health care providers. Non-RN health care providers may include: licensed practical nurses (LPNs), nursing assistants, emergency department technicians, emergency medical technicians (EMTs), and paramedics. The inclusion of non-RN health care providers within the staffing mix of an emergency department does not promote comprehensive emergency care. There is evidence which supports that a higher ratio of RN staffing is directly related to improved patient outcomes, lower mortality rates, and reduced costs. The impact of the use of non-RN personnel within emergency departments can influence the quality of care, patients' perceptions of satisfaction with care, pain management, preventable complications, patient education, and length of stay. Since research does not exist identifying reliable staffing ratios or staffing formulas which would ensure optimal quality of care, the promotion of alternative staffing options could therefore negatively impact patients in the emergency department.

NENA position

Emergency departments are increasingly challenged with high complexity, high acuity, high volume of patients within a dynamic environment, which necessitates rapid assessment and intervention by an emergency nurse. All patients seen in the emergency department should be assessed, care initiated and evaluated, and be appropriately educated by a registered emergency nurse.

NENA believes that the provision of emergency care requires the knowledge, expertise, and advanced preparation of registered nurses to ensure optimal quality of patient care. Patients are entitled to receive specialized nursing care including ongoing assessment and treatment by nurses educated in emergency management. Increasing pressures within emergency departments require appropriately skilled registered nurses. The scope of practice and education of the emergency nurse is directly related to patient outcomes.

NENA believes that budgetary constraints and, at times, limited supply of emergency nurses, should not be used as rationale for inappropriate delegation to non-RN health care providers or substitution of registered professional nurses in the emergency setting.

NENA believes that registered professional nurses are accountable for the quality of care in the emergency department and the delegation of care activities to non-nursing personnel. Patient outcomes and safety are compromised as the number of non-RN health care providers increases.

NENA believes that all patients seen in the emergency department deserve comprehensive, professional care by educated and trained registered nurses. Patients' status change quickly and require the knowledge and skill of a registered emergency nurse to quickly and appropriately assess and intervene.

References

Emergency Nurses Association (1999). **The use of non-registered nurse (non-RN) caregivers in emergency care.** Des Plaines, IL: Author.

Gerber-Zimmermann, P. (2000). The use of unlicensed assistive personnel: An update and skeptical look at a role that may present more problems than solutions. **Journal of Emergency Nursing, 26(4)**, 312-317.

Gerber-Zimmermann, P. (2001). The emergency department of the future – The challenge is in changing how we operate. **Journal of Emergency Nursing, 25(6)**, 480-488.

Pisarcik Lenehan, G. (1999). ED short staffing: It is time to take a hard look at a growing problem and strategies such as standard nurse-patient ratios. **Journal of Emergency Nursing, 25**: 77-78.

Outlook

Websites of interest

- **www.nursesreconnected.com** - a popular site with a large database that assists nurses in locating lost classmates and friends
- **http://nursezone.com/** - the largest community website that is exclusively dedicated to nurses. It is an online community with articles, columns written by experts, international news, updates on the latest in nursing and health care innovations, continuing education, contact hours and links to other sites.
- **www.nurses.com/nurse-zine/** - a site that offers the latest news, product offerings and industry updates. Sign up for the free newsletter that is delivered to your inbox twice per week.
- **www.healthcarecommission.ca** - a series of discussion papers that have been prepared by independent health researchers, experts, and academics with different ideological and philosophical perspectives. Four papers were released on August 2, 2002 with other releases planned for later this year. The results of the commission's research agenda, along with information gathered through the commission's far-reaching and comprehensive program, will provide the groundwork for the commission's final report and recommendations.

The NENA Bursary

NENA recognizes the need to promote excellence in emergency care, and, to this end, financial aid 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 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 registered members per province for that NENA fiscal year i.e.:

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 is to be available to NENA board of directors members and one collectively to an independent member per year.

Successful candidates can only receive a bursary once every three years.

NENA Bursary 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/ chairperson.....5 points

Candidates with certification in emergency nursing and/or involved in nursing research will receive an additional five points.

If two candidates receive an equal number of points, the committee will choose the successful candidate. All decisions of the bursary committee are final.

Each application will be reviewed once per spring board meeting.

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

Candidates must have completed Forms A, B and C. (**Outlook** page 14) The provincial director may forward applications at the spring board meetings.

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

Eligibility
- Current RN status in respective province or territory. (Proof of registration required.)
- Active member in NENA Inc. for at least **two** consecutive years. (Proof of membership required.)
- Presently working 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. Photocopies of provincial registered nurse status and NENA registration

Provincial representative responsibilities:

a. Completes bursary candidate's recommendation form "C"
b. Ensures application forms are complete before submission
c. Brings to board of directors meeting all completed applications

Selection process

The standing committee for bursary disbursements will:

1. Review all applications submitted by provincial representatives and award bursaries based on selection criteria.
2. Forward names of successful candidates to the board of directors for presentation.

NENA Bursary Winners

Congratulations to the following members who were awarded $250.00 bursaries at this year's AGM:

- Ruth Ringland, British Columbia
- Tracie Jones, British Columbia
- Helen Grimm, Saskatchewan
- Selina Godfrey, Ontario
- Doris Splinter, Ontario
- Janice Gilmour, Ontario
- Gabrielle Ross, Ontario
- Therese Lauziere, Nova Scotia
- Margaret Colbourne, NFLD/Labrador
- Celie Walsh-Gallison, Board of Directors

NENA Bursary application form "A"

Name: _____ Date of Application: _____

Address: _____

Phone numbers: work (_____) _____ - _____; home (_____) _____ - _____; fax (_____) _____ - _____

E-mail: _____

Place of employment: _____

Name of course/workshop: _____

Date: _____ Time:_____ Length of course: _____

Course sponsor: _____Cost of course: _____

Purpose of course: _____

Credits/CEU's: _____ ENC(C) Certified: ❑ Yes ❑ No

Previous NENA Bursary: ❑ Yes ❑ No Date: _____

Please submit a proposal of approximately 200 words stating how this educational session will assist you and your colleagues to provide an improved outcome for the emergency care user: Attached?: ❑ Yes ❑ No

Ensure photocopies of provincial RN registration and provincial Emergency Nurses Association are included with your application: Attached?: ❑ Yes ❑ No

NENA Bursary application form "B"

I acknowledge that _____ (name of applicant) is currently employed in an emergency care setting. This applicant should receive monies for _____ (name of course).

Reason: _____

Other comments: _____

_____

Signed: _____ Position:_____

Address: _____

NENA Bursary application provincial directors' recommendation form "C"

Name of bursary applicant: _____ Province: _____

Length of membership with provincial emergency nurses group: _____

Association activities: _____

_____

Do you recommend that this applicant receive a bursary? ❑ Yes ❑ No

Reason: _____

Provincial director signature: _____ Date: _____

The NENA Awards of Excellence

Annual awards of excellence in: emergency nursing practice, emergency nursing research, emergency nursing administration, and emergency nursing education

Excellence in nursing and health care deserves recognition. By celebrating nurses' achievements in the four domains of practice, the understanding of nursing is expanded and a positive image is reinforced. The NENA Awards of Excellence program enables nurses to honour colleagues for their outstanding contributions and for demonstrating excellence in relation to the standards of nursing practice.

Following is the criteria and nomination process for NENA Awards of Excellence.

Selection process

An awards committee of NENA is appointed by the board and reviews all the nominations to determine that the criterion for each award has been met. Based on this review, the committee makes recommendations to the NENA board of directors. Awards are given to successful candidates in each category at the NENA annual general meeting.

The NENA awards committee bases its review of nominations for awards solely on the documentation submitted for each candidate. Candidates stand the best possible chance of recommendation to the board of directors for an award if the supporting materials clearly show outstanding contributions as specified.

All nominations must be submitted to a provincial representative on the NENA board of directors by January 31 in the year of the annual general meeting. The representative will forward this information to the awards committee chairperson.

Preparing a nomination package

1. Review a copy of the candidate's resume or curricula vitae (CV). Use it as a guide in putting together the nomination. A current copy of the resume or CV should be included as part of the submission. Information on the resume should include, but not be limited to: professional association involvement, professional development, education, posters, presentations, etc.

2. There must be a minimum of two letters of support from colleagues or associates of the candidate that will strongly support the nomination. Select people who have knowledge of the candidate's exceptional achievements and/or people who provide varying perspectives about the candidate's outstanding qualities (e.g. peers, employers, students, patients, other health professionals, other organizations).

3. Provide the contacts with a copy of the appropriate award criteria and ask them to: indicate why they support the candidate and how the candidate is exceptional; give specific examples indicating how the candidate meets the various criteria for the award; indicate their positions, professional relationship (etc.) with the candidate.

4. Develop a summary. Using the candidate's resume and letters of support, prepare a summary of the candidate's achievement and highlight how the candidate meets the award criteria.

5. Complete and submit a nomination form with the package.

6. Forward all submissions to the provincial director by January 31 of each year. Incomplete or late applications will not be eligible for consideration. Successful candidates will be presented with awards at the annual general meeting. In order to facilitate the process of the applications, the nominator will involve the nominee in the submission and verification of information.

Award of Excellence in Emergency Nursing Practice

This award recognizes NENA members who excel in clinical care/nursing practice. The nurse must be providing direct care for the clients in an emergency-type setting.

I. The candidate must excel in all major categories of practice:
   1. Nursing knowledge
   2. Clinical decision-making
   3. Professional accountability and responsibility
   4. Application of research
   5. Interpersonal relationship and communication skills

II. Supportive documentation must demonstrate outstanding performance in relation to the majority of the standards of nursing practice:
   1. Specialized body of knowledge
   2. Competent application of knowledge
   3. Provision of a service to the public
   4. Code of ethics
   5. Self-regulation
   6. Responsibility and accountability

III. Important considerations:
   1. Consistently demonstrates excellence as a professional nurse
   2. Consistently demonstrates responsibility for professional development
   3. Participates in the activities of professional organization
   4. Actively demonstrates innovative and progressive ideas in nursing
   5. Acts as a role model and mentor
   6. Contributes directly or indirectly to improving the quality of emergency nursing care in one's province/nation

Award of Excellence in Emergency Nursing Education

This award recognizes a NENA member who excels in emergency nursing education. The candidate must be providing nursing education in an emergency care setting.

I. The candidate must show outstanding performance in a majority of the following areas:

1. Lecture, demonstration, discussion, clinical or lab instruction Demonstrates and utilizes the principles of adult learning
2. Consultation, including tutoring, advising and thesis supervision
3. Program, curriculum or course design and development
4. Innovative teaching methods
5. Educational planning and policy-making
6. Production of educational material (study guides, instructional materials and resources, audiovisual, text books.)

II. Supportive documentation must demonstrate outstanding performance in relation to the majority of the standards of nursing practice:

1. Specialized body of knowledge
2. Competent application of knowledge
3. Provision of a service to the public
4. Code of ethics
5. Self-regulation
6. Responsibility and accountability

III. The candidate must also meet all of the following general criteria:

1. Consistently demonstrates excellence as a professional nurse
2. Consistently demonstrates responsibility for professional development
3. Participates in the activities of professional organization
4. Actively demonstrates innovative and progressive ideas in nursing
5. Acts as a role model and mentor
6. Contributes directly or indirectly to improving the quality of emergency nursing care in one's province/nation
7. Encourages and supports life-long learning
8. Demonstrates good communication skills

Award of Excellence in Emergency Nursing Research

This award recognizes a registered nurse who excels in nursing research. In an effort to encourage nursing research, this category is not restricted to emergency nurses, nor is the research restricted to emergency nursing, but the findings may be transferable to the advancement of emergency nursing.

I. The candidate must show outstanding performance in a majority of the following areas and competent performance in the remaining areas of nursing research.

1. Research with a clinical focus and demonstrated practical application
2. Contribution to the development of nursing research as a principal investigator or research assistant, or a member of a committee receiving grant proposals, or as a member of a nursing research committee
3. Acts as a role model, mentor and a consultant to foster the development of beginning researchers
4. Evidence of external peer review evaluating the outcomes of completed research
5. Contributor to the communication of nursing research findings through presentations at conferences, public speaking engagements, consultations and publications
6. Obtains funding for nursing research based on peer review

II. Supportive documentation must demonstrate outstanding performance in relation to the majority of the standards of nursing practice:

1. Specialized body of knowledge
2. Competent application of knowledge
3. Provision of a service to the public
4. Code of ethics
5. Self-regulation
6. Responsibility and accountability

III. The candidate must also meet all of the following general criteria:

1. Consistently demonstrates excellence as a professional nurse
2. Consistently demonstrates responsibility for professional development
3. Participates in the activities of professional organization
4. Actively demonstrates innovative and progressive ideas in nursing
5. Acts as a role model and mentor
6. Contributes directly or indirectly to improving the quality of emergency nursing care in one's province/nation

Award of Excellence in Emergency Nursing Administration

This award recognizes a NENA member who excels in the administration of emergency nursing. The candidate must be in a management position in an emergency setting.

I. The candidate must excel in a majority of the following areas and show competent or better performance in the remainder.

1. Planning and implementing effective and efficient delivery of nursing services
2. Participating in the setting and carrying out of organizational goals, priorities and strategies
3. Providing for allocation, optimum use of, and evaluation of resources such that the standards of nursing practice can be met
4. Maintaining information systems appropriate for planning, budgeting, implementing, and monitoring the quality of nursing services
5. Promoting the advancement of nursing knowledge and the utilization of research findings
6. Providing leadership that is visible and proactive
7. Evaluating the effectiveness and efficiency of nursing services
8. Empowering staff through participatory management

II. Supportive documentation must demonstrate outstanding performance in relation to the majority of the standards of nursing practice:

1. Specialized body of knowledge
2. Competent application of knowledge
3. Provision of a service to the public
4. Code of ethics
5. Self-regulation
6. Responsibility and accountability

III. The candidate must also meet all of the following general criteria:

1. Consistently demonstrates excellence as a professional nurse
2. Consistently demonstrates responsibility for professional development
3. Participates in the activities of professional organization
4. Actively demonstrates innovative and progressive ideas in nursing
5. Acts as a role model and mentor
6. Contributes directly or indirectly to improving the quality of emergency nursing care in one's province/nation
7. Recognizes contributions and celebrates successes
8. Promotes emergency nursing standards

NENA Award of Excellence application form

Forward all submissions to the provincial representatives by January 31 of each year. Incomplete or late applications will not be eligible for consideration. Successful candidates will be presented with awards at the annual general meeting. In order to facilitate the process of the applications, the nominator will involve the nominee in the submission and verification of information.

Award of Excellence in: _____

Nominee: _____ Address: _____

_____ Postal Code: _____

Phone: work (_____) _____ - _____; home (_____) _____ - _____; fax (_____) _____ - _____

E-mail: _____

Employer: _____ Current position: _____

Nominator: _____ Address: _____

_____ Postal code: _____

Phone: work (_____) _____ - _____; home (_____) _____ - _____; fax (_____) _____ - _____

Letter of support (1) from: _____

Letter of support (2) from: _____

Signature of nominee: _____

Signature of nominator: _____ Date: _____

Awards of Excellence

Do you have an idol? Someone who helped you through that long day, evening, or night shift in ER? Well, NENA wants to hear about them! NENA is looking for nominations for Awards of Excellence in emergency nursing. There is no limit to the number of awards that are awarded in four categories: Emergency Nursing Practice, Emergency Nursing Research, Emergency Nursing Administration, and Emergency Nursing Education.

Changing how we care for kids: Research in a pediatric ED

By Rhonda Correll, RN, HBScN
Emergency Medicine Clinical Research Coordinator
Children's Hospital of Eastern Ontario, Ottawa, Ontario

Many years ago, before I would ever have dreamed that I would end up specializing in research within the emergency department (ED), I worked on a general medicine ward of a pediatric hospital. I received a call one night from a nurse working on a nearby surgical ward. Due to a shortage of beds, they had been required to accept an admission of an infant with croup who was not doing very well. The nurse asked if one of our nurses who was more experienced working with croup could come and look at this patient. I went over and sure enough the child was quite distressed. We called the physician responsible for that patient and, after examining the child, he wrote an order for IM dexamethasone. I had never heard of giving decadron for croup and questioned him about it. He replied that this was a new treatment and he had just read about some research that had been done which showed it was highly effective. We administered the medication and I was really impressed by the dramatic improvement in the child. When I think back, this was the first time I made a connection between research and how it changes the way we care for kids. Soon after that, I transferred to the ED where I became involved with research, working as a research assistant for several years, and then moving into my present role as the emergency medicine clinical research coordinator.

Over the past 10 years, the amount of research within our ED and certainly EDs all across Canada has escalated, bringing about many changes in practice. In our hospital, ED-based studies have looked at respiratory conditions such as asthma, croup and bronchiolitis. These studies are responsible for many changes in practice, including the use of inhaled budesonide and oral decadron in the treatment of croup (Klassen, Craig, Moher, Osmond, Pastercamp, Sutcliffe, Waters & Rowe, 1998) and the increased use of inhaled racemic epinephrine in infants with bronchiolitis (Menon, Sutcliffe & Klassen, 1995). Complex care of children with asthma in the ED has been significantly impacted and improved by research findings over the years (Sung, Osmond & Klassen, 1998; Plint, Osmond & Klassen, 2000). The suturing of lacerations in small children was often a traumatic event involving needles and painful freezing. Studies looking at the use of glue to replace sutures in face lacerations of children (Osmond, Quinn, Sutcliffe, Jarmuske & Klassen, 1999) have eliminated the need for sutures on simple facial lacerations. As a triage nurse, it is a great satisfaction to be able to tell an anxious child with a simple chin laceration, "We should be able to just glue that back together...no needles!"

Recently, a study examining the use of cool mist in the treatment of croup showed that it was not effective in resolving croup symptoms (Neto, Kentab, Klassen & Osmond, 2002). This particular study is a perfect example of the value of evidence-based practice. We always assumed that treating children with cool mist within the ED improved their croup symptoms despite the fact that there was no evidence to support this practice. This study resulted in the cessation of the use of mist sticks within our ED. While mist sticks are in no way invasive, they were time-consuming to set up and instruct families how to use and, generally, the child with croup who is already feeling anxious disliked having the cool mist blowing into their face.

This kind of care-altering research is continuing in our ED. Presently, there are a number of studies underway within our ED which, when completed, will provide evidence that will undoubtedly alter our treatments and improve the already great care we give to our patients with common ED ailments such as gastroenteritis, ottitis media, wrist fractures, and pain resulting from musculoskeletal injuries. It is an exciting time for emergency department-based research and it is great to see so many emergency department nurses becoming involved in research which changes how we care for kids!

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Evidence-based nursing: Blending the art and science

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Abstract

In this introductory article in the research section, an overview is provided of evidence-based practice and its potential value to emergency nurses. Nursing has been described as consisting of both art and science. This definition of science in nursing has caused some controversy in relation to evidence-based practice. Some view science in the traditional natural science view in which only randomized controlled trials count as evidence. This leaves out a substantial portion of research findings in nursing which contribute significantly to health care and best practices. In this article, the concept of evidence-based practice is explored and related to the art and science of nursing. Strategies to increase evidence-based practice are then suggested.

In the past decade, there has been a noticeable increase in literature concerning evidence-based practice and research utilization by nurses. There is inconsistency in the use of the terms "evidence" and "research utilization". To the medical community, "evidence-based practice" has generally been limited to implementing results of randomized controlled trials, also called RCTs. The Health Information Research Unit (HIRU) at McMaster University, which is closely linked to a large international research network known as the Cochrane Collaboration, has defined evidence-based practice more narrowly. It defines evidence-based health care as "the explicit, conscientious and judicious consideration and use of the best, most up-to-date research evidence to guide health care decisions". This is a restrictive definition which should be used cautiously in health care. Randomized controlled trials are limited in nursing, mainly due to the types of questions we ask, as well as the limits on some aspects of our autonomy. Most of our research is correlational or quasi-experimental, or uses qualitative methods. Restriction to evidence from RCTs would exclude an increasingly rich base of evidence nurses have amassed.

Health care professionals require a wider definition of evidence-based practice, one which includes not only quantitative data, but also qualitative and non-research-based evidence. While qualitative research data has been excluded by many medical evidence-based practice definitions, it is an extremely important source of information and evidence for health care professionals. In the past, research using qualitative methods was seen as a "stepping stone" leading to quantitative research methods. This is now unfounded, as many research questions are suited only to qualitative research and the findings can stand on their own. Examples may include studies of what the experience of loss has meant to families of trauma patients, what it feels like to be unable to breathe for patients with lung disorders, and what is involved in providing comfort in emergency. There have been concerns with the ability to generalize qualitative findings to other settings or populations, including issues of reliability and validity. It is now recognized that qualitative research can also be rigorous, considering aspects such as credibility, fittingness, applicability, confirmability, and auditability. The utility of qualitative research findings beyond the study setting may also be enhanced if supported by other similar findings in similar studies. This can be done through a process called "metasynthesis" for qualitative data, or "meta-analysis" in quantitative studies. Groups of health care researchers have formed into specialty groups to perform systematic reviews of related research in various specialty groups. The most well-known of these is the Cochrane Collaboration group. They have, until now, exclusively conducted systematic reviews of randomized controlled trials, but are currently exploring ways to include systematic reviews of qualitative research findings as well.

Other non-research-based forms of evidence may also be important. We may also have evidence of the effectiveness of our interventions through sources such as experience, quality assurance data, descriptive reports, patient satisfaction questionnaires or individual observations/critical thinking by the practitioner. Evidence has also been critical in the development of clinical practice guidelines. It is important to remember that the guidelines must be flexible enough to allow for diversity of evidence. A guideline must be able to be adapted in relation to clients' unique needs and the nurse's observations. The nurse must also be able to explain the basis of the evidence used to change the guideline. We all recognize that no one patient presents in the same manner as another and all respond somewhat differently to the same treatment. It has been argued that a more flexible definition of evidence is also required due to the fluid/changing nature of knowledge. Even if an RCT is the

appropriate research design for a question, it takes time to develop and implement, and the findings do not stand on their own. As knowledge changes, it is not possible to keep pace with an equal amount of generalizable RCT findings. Furthermore, RCTs only reflect one aspect of our science and not our art.

The art and science of nursing

Art is described as consisting of learned skills which have become creative and beautiful, whereas science is knowledge which has been systematically obtained and formulated. Watching an expert nurse weave measures into their care while attending to physiologic and social alterations in the client's condition is truly an art. Understanding and explaining this art, or generalizing it to broader contexts for more consistent or effective care, requires scientific observation and exploration. Traditionally, science has been seen as consisting of quantitative empirical knowledge (positivism), although other forms of systematic investigation are also important. Examples include interpretive science in which scientists seek to understand phenomena, and critical science in which the phenomena are explained and theories are developed to support change toward or away from the outcome. At least four different types of knowledge have been described, all of which are interrelated and interdependent. The four include: empiric knowledge, observing the actions of the nurse on the client (aesthetics or the art), knowledge of self (personal), and morality (ethics). This implies that empirical science is therefore only one way of gaining knowledge, and that science and art cannot be separated.

We need to be able to explain not only the quantitative aspects of our practice, but also the qualitative or social aspects of our client interactions. How can we argue for more time with clients outside tasks if we cannot demonstrate the importance of our interactions with them? If we have not explored their perceptions of our touch, our tone of voice, our efforts to comfort, how do we know the effectiveness of our care? This is evaluated on a daily basis by each nurse with individual clients. An understanding of these aspects facilitates the development of the art in novice practitioners, provides a framework for theory development and practice guidelines, and justification for both our art and our science. So how do we increase the evidence base for our practice?

Increasing evidence-based nursing practice

In order to increase evidence-based practice (EBP), we need to know about current research findings and observations, understand our own practices and contributions, and to communicate with each other about these. Two key aspects which will increase EBP include increased utilization of existing research and formation of partnerships to promote further research and documentation.

Research utilization is only a piece of EBP, but is critical. Much research goes unnoticed and practices do not change, even if published or presented at conferences. Nursing practice has been described as based on "tradition, rituals, or hunches rather than scientific knowledge or research". In a study of practices in one US state, it was found that while the majority of protocols were referenced, very few were research-based. It is unlikely that this state is atypical of other North American hospitals. In studies of nurses' knowledge of published research-based changes in practice, up to 70% were either unaware of the changes or had implemented six or more in their practice.

Research utilization has been defined as "the use of research findings to change or validate practice" (Fitzimmons et al., 1995). In this context, we are including qualitative and quantitative findings. How the prevalence of research utilization is measured is quite variable, however. Some only measure changes made to practice as a result of research findings. It may be argued that the review of research is equally important. Many times, we review and interpret data and find it not suitable for practice changes, or for a particular patient circumstance. If changes are not made due to lack of sufficient evidence or generalizability of results, it is argued that this is an important aspect of research utilization.

Major reported barriers to research utilization by nurses include: (Carroll et al., 1997; Pettengill et al., 1994; Funk, Champagne, Wiese, & Tornquist, 1991; LeMay, Alexander, & Mulhall, 1998; Kajermo, Nordstrom, Krusebrant, & Bjorvell, 1998; Walsh, 1997; Kajermo, Nordstrom, Krusebrant, & Bjorvell, 2000; Walsh & Walsh, 1998):

- aspects of the organization - inadequate time to implement the new ideas, lack of authority to make the changes, inadequate facilities to implement, lack of support from administration, lack of support from other disciplines; workload; already experiencing too much change; lack of a culture which supports or understands research culture; and dominance of medical research and practice.
- aspects of the presentation - use of research jargon, unclear statistical explanations
- aspects of the research - accessibility of research findings, publications or computer databases, small sample sizes and/or lack of replication of studies, findings not generalizable or applicable to user's setting;
- aspects of the nurse – attitudes toward research, inconsistency between practice beliefs and research findings, inadequate time to locate or read the research, limited skills in critiquing research reports, inflexibility to change, lack of support from other nurses, limited professional relationships with colleagues/team members to support their research searches or implementation.

A large study of factors affecting Alberta nurses' research utilization revealed that experience and nursing school were the two most frequently used knowledge sources. These knowledge sources may be dated and potentially non-evidence based. Literature (texts and journals) was ranked in the bottom five sources of knowledge. The role of experience is supported by a qualitative study in the

area of decision-making by nurses. Experience may either be a positive influence predicting information use, or be negative in terms of increasing bias or potential for disbelief of research findings. If a particular method has worked for many years, why should the nurse believe it has to now be changed?

It has been shown that education is an important component of increased research utilization, but not just formal education. Inservice education was found to increase awareness of research findings and was found to influence utilization. This may be linked to the immediacy of our needs as adult learners to apply findings to clinical practice. It is also important for us to increase the breadth of our research methods and range of inquiry to reflect the diversity of our practice. Much of our work is not quantifiable with a randomized controlled trial, but we see the clinically significant impact our work has on our patients. We need to also document and communicate our findings with colleagues. Clinical practitioners are urged to publish and communicate their observations, questions, and nursing wisdom and to facilitate research. With the reality of cutbacks and "doing more with less", however, this seems like a daunting task. At one time, there was a real push in nursing to educate staff on how to conduct their own research. This is no longer a reasonable expectation in such times of workload issues. What is possible, however, is ensuring that the research which is conducted is relevant to practice and that you find out the results. This suggests forming partnerships with nurses with specialized skills or additional resources in research, clinical skills or access to additional resources.

Nurses with additional training in research methods, philosophy and theory development may include nurse specialists, nurse practitioners, or those in academic institutions. These nurses have much to contribute to exploring, observing, and documenting the art and science. They also usually have access to resources and often have dedicated time to teach or conduct research. Unfortunately, often we see them as living in an "ivory tower" and producing seemingly irrelevant work that is of no immediate clinical utility, or is not easily interpreted by the clinical staff. Partnerships between these nurses and clinical staff are critical bridges to build to increase our evidence base. Academic staff need to be aware of relevant issues and how to communicate their results in a format that is more immediately applicable. Academic researchers gain tenure in part by publishing in prestigious research journals rarely read by practitioners, using technical jargon. They are now being challenged to publish a second publication in the practice journals in a format that directly highlights the applicability of the results to practice. Some universities in Canada, such as University of Alberta, are seeking to establish "chair" positions for specialty clinical areas, such as neuroscience, emergency, critical care or medical/surgical nursing. The chair would be responsible for furthering research, theory, and practice in the specialty area and would have at least two scholars working with them – a research scholar and a clinical scholar. The research scholar would work predominantly on research and theory development with some responsibilities in the clinical specialty area. In a parallel manner, there would also be a clinical scholar who would work predominantly in the clinical area, with some research or teaching responsibilities. These positions are aimed at understanding and explaining nursing practice in these areas, and conducting research which is relevant to the practice. It is also a vehicle to communicate the findings in a timely manner to clinical staff and the community. These nurses can also seek support from funding and political agencies to further promote change.

The clinical nurse has equally important responsibilities. People who practise the art and science directly with the clients need to identify their information needs and questions and communicate these to the academic nurses and funding agencies. Much of what nurses do is taken for granted or is not explored due to time and energy constraints. We speak of the essential nature of nurses in emergency practice, but many areas have paramedics and aides working in emergency. How do we identify our unique contributions and establish our professional identity? A patient knows when they have "good nursing", but have we shown it or defined it? Current nursing workload measures tend to rely on observable tasks and measurable outcomes. So how do you define the question? One of the most valuable sources this writer has found is the staff lounge! When staff complain of the impact of a change on their care, or the poor function of a piece of equipment imposed due to budget cuts, these are potential research questions. When they share "tricks of the trade" with new graduates, these are wonderful examples of the art of nursing wisdom which need to be shared and established in the evidence-based literature. A common example is exploring what it is that nurses notice when they identify a client is "going sour" despite a lack of significant changes in physiologic indicators. Independent interventions such as distraction techniques for pain, or effectiveness of comfort measures with grieving family, also need exploration. We also need to question our practice "standards". What is the reason behind having every patient take off their underwear for surgery, even for throat surgery? Why do we insist on sterile technique for endotracheal suctioning when there is no evidence linking poor technique to nosocomial pneumonia, and we use clean technique for tracheostomy suctioning (entering the same lungs)? Using staff as a base for questions underscores the vital need to have links between researchers and clinical areas. Partnerships can also be formed between clinical staff, with or without academic staff, to share research findings. Journal clubs are one way in which nurses can share findings. A number of relevant journals are monitored monthly, one per nurse, and nurses meet monthly to present, critique and discuss articles they feel are relevant to their practice.

Conclusion

Nursing consists of both science and art. These are interdependent and both are necessary to expert practice. Any definition of EBP we accept in nursing has to reflect both aspects of our practice, and seek to explain both the empirical

aspects of nursing as well as our essence. Clinical practice guidelines need to reflect evidence from both natural and social science. Limiting ourselves to empiric evidence will only limit our value and diminish the important effects we know we have daily with our clients. Our challenge is to raise questions, seek literature, stimulate research and communicate our wisdom and research findings with each other. This is best achieved through partnerships and research utilization.

This column is devoted to the research utilization aspect of EBP. We will use a broad definition of evidence and hopefully serve to facilitate increased awareness of issues in critical appraisal of research findings using examples in the emergency literature. Future topics include discussions of research methods (qualitative and quantitative), statistical methods, systematic reviews, research funding and resources available. It is also hoped that the columns will stimulate discussion in your area and generate a means to compile our collective wisdom and research questions. The author of this column welcomes e-mails, calls and questions at the contact information provided. When possible, some of these will appear (hopefully with answers) in the subsequent issues of the journal. It is the hope that, through increased communication about research methods and findings in this column, we can begin some discussion of research questions, research priorities and begin to form networks of people with similar interests and diverse skills. Through these partnerships we may begin to blend the art with science in a culture of evidence-based practice.

About the author

Cathy Carter-Snell is pleased to join the **Outlook** team as a research editor. She is a certified emergency nurse, currently coordinating two distance education programs at Mount Royal College, Calgary (the Advanced ACCN Emergency Nursing program and the Forensic Studies program). She is also a sexual assault nurse specialist, working with two teams in Alberta. Cathy is also completing her PhD studies at University of Alberta, focusing on post-traumatic stress and acute stress disorders. Her dissertation work is on early detection in emergency of physiologic variables and event variables which increase risk for later development of these stress disorders in sexually assaulted women. Cathy encourages other nurses to communicate with her to share research or practice questions, information or contacts. She hopes to help build our capacity for research, networks and knowledge in emergency nursing. She can be reached by e-mail **ccartersnell@mtroyal.ab.ca** or at work (403)240-6679.

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Injury is no accident

**By Julian B. Young, BA, CRIM, MPA
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As is evident from the injury statistics presented by Dr. Tallon, injury causes incalculable human suffering each day in Nova Scotia. But, did you know that 95% of all injuries and the events that lead to their occurrence are caused by predictable circumstances? This suggests that we need to change how we view the problem of injury. One way we can accomplish this is to stop calling injuries "accidents".

The **British Journal of Medicine** states that "an accident is often understood to be unpredictable — a chance occurrence or as *an act of God* — and therefore unavoidable" (Vol 322, pp. 1320, June 2001). By continuing to refer to injury-causing events as accidents, we perpetuate the myth that injuries just happen and there is nothing that can be done to prevent or control them.

The Nova Scotia Trauma Program has begun a campaign to encourage people, particularly the media, health care professionals, emergency services personnel, injury prevention organizations, and academic researchers to stop referring to events such as those described in the box, as *accidents*!

Furthermore, we believe that these groups have a professional obligation to stop perpetuating the myth that trauma is an *accident*. By removing the term *accident* from our injury vocabulary, we will be able to shift our focus to the factors that cause injuries and the strategies we can adopt to prevent them from happening in the first place.

Where can you start? Try not to use the word "accident" when describing injury-causing events in patient charts, case presentations, research papers, or prevention programs. Instead, use terms such as motor vehicle collision (MVC), industrial injury, car-pedestrian collision, and unintentional fall. Although this request may sound strange, the Nova Scotia Trauma Program is one of a growing number of organizations seeking to ban the "A" word.

Tragic, but no accident...

- When an impaired driver crashes her car and is ejected from the vehicle, her resulting death is no accident!
- When a young child, who is not wearing a helmet, smashes his ATV into a tree, the debilitating brain injury he sustains is no accident!
- When an elderly man trips on a crack in a poorly maintained sidewalk, the broken hip he receives is no accident!
- When a worker, who fails to secure herself with a safety harness, falls 30 feet from scaffolding at a construction site and sustains severe spinal cord injury, it is no accident!

Injury is no accident: An awareness campaign

During the past year, the Nova Scotia Trauma Program, along with many of our partners has been actively engaged in a campaign to educate the media, public, trauma stakeholders regarding inappropriate usage of the word "accident". Why, you might ask? An accident is an event which takes place without one's foresight or expectation; an event which proceeds from an unknown cause; an event without an apparent cause; is unexpected; is unexplained; is an act of God or the result of fate or bad luck.

When it comes to describing injuries, the facts make it clear that the word accident is misleading and not an appropriate description. Indeed, 95% of all injuries result from predictable and preventable circumstances. A good example of this is motor vehicle collisions. It is not an accident when someone who has been drinking crashes head-on into another vehicle. It is not an accident when someone decides to drive too fast for road or weather conditions and hits a tree. It is not an accident when someone is ejected from a vehicle because they were not wearing a seatbelt.

On the surface, this debate may seem trivial and may appear to be just another argument about political correctness. However, the Nova Scotia Trauma Program along with many others believes that without a change in the use of language around injury, efforts to prevent it will continue to be hampered. As long as people believe that injuries cannot be controlled (as implied by the word "accident"), they won't stop to think about the risks in their lives and the ways they can mitigate them. We believe that over time, changing the way people perceive injuries will have a positive impact on our collective efforts to prevent them.

The Nova Scotia Trauma Program asks that you consider striking the word "accident" from your vocabulary of injury. For suggestions regarding alternative language, please visit the trauma program's website: www.gov.ns.ca/health/ehs

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Canadian Triage and Acuity Scale - Rural implementation

Introduction

The Canadian Triage and Acuity Scale (CTAS) was developed by the Canadian Association of Emergency Physicians (CAEP) in 1998 and published as **Implementation Guidelines for the Canadian ED Triage and Acuity Scale**. The objectives of the CTAS scale were to "more accurately define patients' needs for timely care and to allow emergency departments to evaluate their acuity level, resource needs and performance against certain operating objectives."

The CTAS national working group believes that Canadians living in rural communities are entitled to the same level of emergency medical care as urban residents.

Since the publication of the document, many Canadian emergency departments, both urban and rural, have adopted its recommendations. Patient flow has been altered so patients are seen by a triage nurse upon first entering the department. Nursing staffs have been trained in its application.

Triage by nursing staff, when applied as per the CTAS document, can be very helpful in sorting and prioritizing patients waiting for care.

Problems have arisen in sparsely staffed rural emergency rooms (ERs) when trying to implement this system. Some institutions have provided inadequate training to their nursing staff for proper implementation. Physician resources have been strained trying to accommodate the timeframes suggested in the document for non-urgent problems. This has led to friction between physicians and ER nursing staff, and increased job dissatisfaction among rural physicians, many of whom balance ER work with family practice, hospital inpatient care, obstetrical deliveries, etc. In some communities, the demand for strict adherence to quick response times could result in a loss of medical services, i.e. physicians may leave town. The CTAS document states, "The time responses are ideals (objectives) not established care standards." However, hospital administrators in many rural communities have demanded physician response within the timeframes indicated by the document, despite the lack of evidence to support any 'time to physician' recommendations. Hopefully research will uncover such data.

In order to address these issues, the following recommendations are intended to assist in the implementation of the CTAS guidelines in rural health care facilities.

Recommendations

1. The CTAS definitions and descriptions of triage levels one to five be accepted by rural as well as urban ER. *See part 6 of the CTAS: "Triage in Rural Emergency Health Care Facility."*

2a. Nursing staff should be trained in the use of the CTAS.

2b. Nursing staff should be involved in the implementation and monitoring of protocols and medical directives.

2c. Rural hospitals must have adequate RN staffing to ensure timely triage for all patients.

3. ER nursing staff should be trained to provide initial resuscitation including CPR, starting IVs and defibrillation and be familiar with ACLS standards. A pediatric assessment course such as ENPC is desirable.

4a. Ambulance services and emergency departments should use a common triage scale to reduce the risk of misunderstandings leading to inadequate mobilization of personnel.

4b. Ambulance services should notify receiving hospitals of CTAS level one and two patients as early as possible.

4c. ER staff should then notify on-call physicians promptly of all CTAS level one and two patients coming by ambulance, prior to their arrival in the ER.

5. On-call physicians should be accessible at all times (by phone, pager, etc.), both so they can be called in as required, and so they can give direction to ER nurses prior to their arrival.

6. The timeframes recommended by the CTAS document are reasonable times to **physician-directed care** (in the absence of evidence). Physician-directed care could include:

- Care provided directly by the physician in person
- Telephone advice
- Care provided by nursing staff in accordance with medical directives agreed to in advance by the physician. See below for more information.

7. The CTAS makes no reference to obstetrics. Because of the wide variation in obstetrical preparedness between rural ERs, each institution may wish to prepare guidelines for such emergencies. There are very few examples of such protocols available to this committee; hospitals with such protocols are encouraged to submit them for publication on the Society of Rural Physicians of Canada (SRPC) website.

Protocols

The SRPC-ER committee has developed a protocol (medical directive) for CTAS level five patients presenting to the ER. Implementing this medical directive should allow rural and remote ERs to continue to provide a high standard of care to their patients while reducing the number of untimely visits to the ER by rural physicians. This is not intended to be a vehicle to solve overcrowding in urban ERs.

An example of an acceptable medical directive for CTAS level four patients in rural and remote hospitals is under development.

A number of rural hospitals have already developed a variety of medical directives so that physician-directed care can be initiated by nursing staff prior to the arrival of the physician. These vary in their detail and in the range of problems addressed. In some rural communities, it may be necessary to implement more detailed or less detailed protocols than the one in this document. Examples of these are available on the SRPC website: http://www.srpc.ca/. They can be

downloaded and modified to accommodate local circumstances.

Communities with functioning protocols are invited to submit them to the SRPC-ER committee so they can be shared with others. Over time, it is expected that these will form a comprehensive repository of well thought-out and produced medical directives from across the country, and perhaps beyond.

The CTAS is currently undergoing review. The SRPC is now represented on the CTAS working group. Please send comments or suggestions for improvement to your SRPC representative on the CTAS working group.

SRPC-ER working group members

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Karl Stobbe

CTAS level five protocol

CTAS level five includes conditions that may be acute, but non-urgent, as well as conditions which may be part of a chronic problem with or without evidence of deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or referred to other areas of the hospital or health care system.

CTAS level five patients may be triaged by the registered nurse to receive care at a more appropriate time or place if all the following criteria are met, i.e. criteria (a) to (e) inclusive, without contacting the on-call physician:

a) The patient is six months of age or older.
b) Vital signs are deemed satisfactory by the nurse, and temperature is 35-38.5°C (38.3°C for age > 60 years)
c) The patient is assessed as CTAS level five.
d) After the nursing assessment, there is no clinical indication that the patient may require urgent physician attention.
e) In borderline cases, or where the nurse is unsure, telephone consultation between the nurse and physician has determined that the problem is non-urgent.

When a "non-urgent" patient meets all of the criteria specified above, the patient will be advised that they have been assessed using a set of approved guidelines to determine the urgency of need for medical care and that their problem has been assessed as non-urgent at this time.

The nurse may carry out nursing intervention if appropriate, or advise the patient to seek health care services later, e.g. family physician's office, walk-in clinic, make an appointment, or return when the physician will be present in the ER. Always advise the patient that if s/he has further problems or if the condition worsens, to call the hospital or return to the emergency department. May use "patient letter" - see attached.

Facilities may develop standardized treatment protocols for nursing care and symptom relief. For examples go to http://www.srpc.ca/

Documentation/reporting

Documentation should follow the same process as all other ER visits, and should include the CTAS level, nursing assessment, any nursing interventions, and discharge instructions. These should be reviewed by the on-call physician early the next day and any suggested changes be initiated by the physician and communicated to the nurse involved. Follow-up by the physician would be documented on the same outpatient form.

Evaluation/ monitoring/audit

Ongoing monitoring is essential to ensure that the directives are effective and safe. Keeping a log of the patients triaged to receive care at a later time or in another location, and any changes in care initiated by the physician, will allow hospitals to monitor the effectiveness of the protocol and institute any necessary changes to improve the process. Monitoring, auditing, and ensuring the protocols are kept up-to-date is the joint responsibility of the physicians and hospitals.

Responsibility for care

Care provided by nursing staff under a medical directive remains the responsibility of the on-call physician. It is the responsibility of the physicians providing on-call services to the community to ensure that protocols and medical directives constitute good medical care and that they remain up-to-date. It is the responsibility of the hospital to ensure that nurses have adequate training to implement the medical directives and to monitor that they are being followed.

Patient letter:

Insert facility name, mailing address and phone number

Dear Patient:
The emergency department is intended for those patients who require medical attention on an emergent or urgent basis. You have been assessed by a nurse who uses a set of approved guidelines to determine the urgency of need for medical care. Your problem has been assessed as non-urgent at this time.

We recommend that you take the following action:

- Make an appointment to see your family doctor.
- Return to the hospital at _____ AM/PM.

If you have any further problems or if your condition worsens, please call the hospital or return to the emergency department.

Dr. _____ ; time; ER medical director; date; ER physician on-call

The Best That I Can Be

If I could be the very best,
the best that I could be,
There are very special qualities
that you would see in me.

I'd be the nurse that others
Would feel free to call upon,
When my patients or my colleagues
find it hard to carry on.

So let me care and let me share
My knowledge and my skill,
and I will stand beside you
as this will be my will.

I can also take a step back
so you may have your turn.
Through skill and observation,
I know we both can learn.

And as I "nurse" my patients,
I know that you will see,
care and understanding,
the qualities in me.

I will be the very best
That I can be,
As I stand beside the bedside
and anticipate their needs.

You will see the warmest smile,
and hear the softest voice.
You will feel me truly present,
as this will be my choice.

A gentle touch, a silent tear,
to let you know I care,
or just to be beside you,
the unspoken word we share.

If you feel the need to talk,
you know that I will hear,
Your accomplishments, contentments
your failures or your fears.

May your choices be the best for you,
and if you need a hand,
Let my expertise and
judgment guide you,
as this I know they can.

May I be the nurse remembered,
the best that I could be
When I stood beside your bedside,
you saw the best in me.

By Karen Johnson, RN, BHScN, BTSN (ER/CC), ENC(C), MEd

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Advocacy and the mental health client

**By Lucy Rebelo, RN,
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Before nurses can encourage client advocacy, it is important to understand what it means to advocate. According to the **Oxford Dictionary** (1998), an advocate is defined as: "a person who pleads for another," and "a person who supports or speaks in favour" (p.18). In order for the emergency nurse to plead for and support the mental health client in crisis, she must possess the knowledge regarding mental health issues and skills necessary to identify the client in crisis.

Emergency nurses are front line health care providers and an essential part of their role includes maintaining nursing skills and knowledge. By seeking opportunities to enhance skills and knowledge through the use of observation, exposure, experience and education, nursing can progress to a higher level. An advanced clinical fellowship awarded by the Registered Nurses Association of Ontario (RNAO) became the vehicle for enhancing my role as client advocate. I recently completed this fellowship experience, generously supported by my nurse manager and director.

A re-evaluation of my nursing role and the challenges faced by nurses working in a busy emergency department, in the context of this fellowship experience, prompted the realization that providing the best care possible involves taking on an active role of client advocate. Nurses are in a position to be advocates. The nurse as an advocate must not only consider the client, but the other team members as well. The dilemma is, are we as nurses ready to take the challenge? I believe the only answer to this is yes!

As a result of the severity of most mental health disorders, it is often difficult for the client to process the information given to them. This becomes problematic for nurses, "many of whom perceive themselves as lacking the skills and expertise to provide appropriate care and treatment to this client group" (Wand & Happell, 2001, p. 166). Mental health clients and their illnesses are multifaceted. Unlike the patient with abdominal pain or a broken limb whose care and treatment is clear, the mental health patient often presents with a litany of concerns. It has become the responsibility of the health professional to decipher these concerns. For nurses to assist with the care of clients in crisis, however, familiarity with clients' concerns is

crucial. Knowledge of these concerns provides an opportunity to educate and this, in turn, allows for informed decision-making by clients.

Learning is a critical element of mental health nursing. Nurses who take advantage of learning opportunities and take steps to increase their exposure to mental health clients develop a greater understanding and a more positive attitude toward this particular client population (Brinn, 2000, p. 32). Developing a better understanding of client issues, concerns, and challenges will only serve to enhance the advocacy role that nurses inherently practise on an ongoing basis.

Nurses are not alone in their efforts to be advocates. They can refer to the Nursing Code of Ethics and Nursing Practice Standards for guidance in their everyday practice. **The Canadian Standards of Psychiatric and Mental Health Nursing** (1998) states that, "the nurse uses sound judgment in advocating for safe, competent and ethical care for clients and colleagues even when there are system barriers to enacting an advocacy function (Standard VI, 9). System barriers can consist of feelings of helplessness, frustration and disrespect towards the client by the nurse. **The Canadian Code of Nursing Ethics** (2002) under "values" suggests, "Nurses respect the inherent worth of each person they serve and advocate for respectful treatment of all people."

By acknowledging our uneasiness towards mental health clients, we take the first step in developing an understanding of our limitations. Recognizing those limitations is a prerequisite to seeking out learning opportunities. According to Brearley (as cited by Duxbury, 1996), "if skills in communication, empathy, information-giving and relationship-building are developed and used by nurses, clients will benefit by feeling more in control of their own destiny" (p. 36).

In conclusion, nurses play a vital role in providing client support and education. In this way, we acknowledge that it is necessary to promote ourselves as advocates. For advocacy to be effective, however, nurses need to possess the skills and knowledge required to care for mental health clients in crisis. Continuing educational experiences through participation in nursing fellowships, or through reading articles in professional literature, should stimulate discussion of the needs of mental health clients and the special role of nurses as client advocates.

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