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

Volume 25, Number 1, Spring 2002

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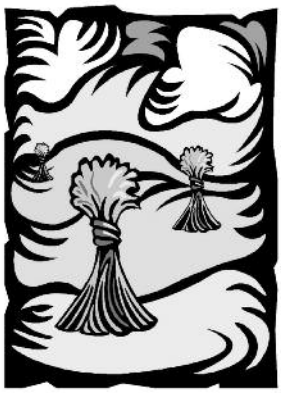
NENA

National Emergency Nurses Conference
Saskatchewan Emergency Nurses Group

Regina, Saskatchewan - May 2003

CALL FOR ABSTRACTS - "Emergency Nursing - A Kaleidoscope"

Presenters at this conference will encompass the many facets of emergency nursing. Abstracts are welcome from anyone who feels that they have topics relevant to emergency nursing.



Abstract Guidelines

Submit a short summary indicating: • title of presentation • contents of presentation • length of presentation • presenter(s) name, address, phone and fax number, and e-mail address • presenter's affiliation • audiovisual requirements—slide projector, overheads, data projector, TV/video

MAIL SUBMISSION TO:
National Conference Publicity Chairperson,
Emergency Department,
Pasqua Hospital, 4101 Dewdney Avenue,
Regina, Saskatchewan S4T 1A5

• Deadline for submission - September 1, 2002

NENA

Outlook
Conference watch

How to Take Care of Others and Ourselves - "The Feel Good Conference"
The New Brunswick Emergency Nurses Association Regional Conference, May 3-4, 2002, Moncton, NB
• Legal issues • Critical Incident Stress Management • Dealing with Stress • Sexual Assault Nurse Examiners • CTAS and Pediatrics • See new products • Many RN presenters

Sixth World Conference on Injury Prevention and Control
511 Place d'Armes, #600, Montreal, QC H2Y 2W7. May 12-15, 2002. For information telephone: (514) 848-1133 or visit the website at: www.trauma2002.com. E-mail: info@trauma2002.com

12th Annual Pediatric Update: Pediatric/Adolescent Nursing Essentials
Sponsored by Women's & Children's Health, Regina Health District
September 27-28, 2002, Delta Regina Hotel, Regina, Saskatchewan.
For information or to request a brochure telephone: (306) 766-4587 or (306) 766-4603
E-mail: Barb Beaurivage at bbeaurivage@reginahealth.sk.ca
Linda Chorney at lchorney@reginahealth.sk.ca

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
Pam Little: pamordon@telusplanet.net

Outlook
Websites of interest

- Linda MacCracken's Forensic website: www.telusplanet.net/public/hlmcc
- Johnson & Johnson website has initiated a huge campaign for nurses: www.jj.com/news_finance/434.htm

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Editorial staff:

For information on advertising, contact Heather Coughlin, Advertising Manager, Pappin Communications, The Victoria Centre, 84 Isabella St., Pembroke, Ontario, K8A 5S5, telephone (613) 735-0952, fax (613) 735-7983, e-mail heather@pappin.com. Our rate card is available online at our website: pappin.com

Send manuscript enquiries or submissions to:
Valerie Eden, RN, ENC(C), Outlook Editor, 34 Bow Street, Dartmouth, Nova Scotia, B2Y 4P6
e-mail: valeden@hfx.eastlink.ca

NENA elected executive

President
Anne Cessford, 12555 19th Avenue
Surrey, BC, V4A 9P1
(H) 604 541-7830; (W) *(pager)* 604 450-5876;
fax: 604 946-3086;
e-mail: acessford@telus.net

Past-president
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

Secretary
Janet Calnan, 1500 Burnside Road West,
RR#3, Victoria, BC, V8X 3X1
(H) 250 727-2795; (W) 250 727-4181;
fax: 250 744-5939;
e-mail: jancalnan@yahoo.ca

Treasurer
Jerry Bell, 10 Laval Drive
Regina, SK S4V 0H1
(H) 306 522-6295; (W) 306 766-2238;
pager: 306 565-5757; fax: 306 766-2770;
e-mail: jbell@accesscomm.ca

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

Provincial representatives

British Columbia
Sheila Early, 4-13964, 72 Avenue
Surrey, BC V3W 0M5
(H) 604 590-9315; (W) 604 585-5688
fax: 604 585-5679
e-mail: sheiladawn_early@telus.net

Alberta
Carla Policicchio, 4712 White Road
Edmonton, AB T6H 5M3
(H) 780 434-5119; (W) 780 472-5116;
fax: 780 472-5191; pager: 780 445-2083;
e-mail: cpolicic@cha.ab.ca

Saskatchewan
Bob Lawson, 314 Hansen Drive
Regina, SK S4X 3B8
(H) 306 543-3623; (W) 306 766-2362;
fax: 306 766-2770;
e-mail: lawson@accesscomm.ca

Manitoba
Angela Bachynski, 177 Saul Miller Drive
Winnipeg, MB R2V 3W4
(H) 204 334-6929; (W) 204 661-7362;
fax: 204 661-7232;
e-mail: abachyns@mts.net

Ontario
Janice Spivey, 112 Old River Road, R.R.#2,
Mallorytown, ON K0E 1R0
(H) 613 923-5539; (W) 613 548-2333;
fax: 613 923-5539;
e-mail: Spivey@recorder.ca

New Brunswick
Gail Colosimo, 1336 Gorge Rd.
Stilesville, NB E1G 1J4
(H): 506 384-9708; (W): 506 857-5353;
e-mail: gcolos@hotmail.com

Nova Scotia
Debbie Cotton, PO Box 34
Judique, NS B0E 1P0
(H) 902 787-2780; (W) 902 867-4106;
fax: 902 863-6455;
e-mail: cotton@ns.sympatico.ca

Prince Edward Island
Celie Walsh-Gallison, Suffold Road,
RR#3, Charlottetown, PEI C1A 7J7
e-mail: celie_gallison@hotmail.com

Newfoundland & Labrador
Cavell Bolger, PO Box 1621, Stn. B
Happy Valley, Goose Bay
Labrador, NFLD A0P 1E0
(H) 709 896-2216; (W) 709 897-2361;
fax: 709 896-4130;
e-mail: c.b.bolger@nf.sympatico.ca

Committee chairs

Certification
Margaret Pook, 319 Linsmore Crescent
Toronto, ON M4J 4M1
(H) 416 425-0832;
e-mail: mawp@sympatico.ca

Nursing Practice
Bob Lawson, 314 Hansen Drive
Regina, SK S4X 3B8
(H) 306 543-3623; (W) 306 766-2362;
fax: 306 766-2770;
e-mail: lawson@accesscomm.ca

Research
Carla Policicchio, 4712 White Road
Edmonton, AB T6H 5M3
(H) 780 434-5119; (W) 780 472-5116;
fax: 780 472-5191; pager: 780 445-2083;
e-mail: cpolicic@cha.ab.ca

Nominations
Debbie Cotton, PO Box 34
Judique, NS, B0E 1P0
(H) 902 787-2780; (W) 902 867-4106;
fax: 902 863-6455;
e-mail: cotton@ns.sympatico.ca

National Trauma Committee
Patricia Walsh, 20 Power Street
Grand Falls/Windsor, NFLD A2A 2E1
(W) 709 292-2482; (H) 709 489-4164;
e-mail: pwalsh@cwhc.nf.ca

President's message

Since the Fall 2001 edition of **Outlook**, much has happened within NENA and the world at large. These past few months have been a time for all to reflect upon what is truly important in our lives, and this has given us "permission" to take action if needed.

My career in emergency nursing started as a staff nurse, which, I believe, is the starting point for the majority of us. From here I had a brief venture in education, and over the past three-and-a-half years I have been involved in management.

During the 14 years of my emergency nursing career, I have learned a great deal – professionally, in finding what I believe my "niche" to be, but more importantly, on a personal note, I have finally learned to prioritize what Anne, the person, needs, and that I must come first, before any position or job!

On that note, I recently put job satisfaction as my number one priority ahead of any other variable that one can encounter at work, aside from safe patient care! In so doing, I have returned to the bedside in the emergency department of Surrey Memorial Hospital (the busiest emergency department in British Columbia). As much as I have enjoyed management, and I do hope to return one day, I need to feel good at the end of the day. After all, this was the reason I went into nursing – to be able to make a difference, to touch and positively impact the lives of others.

There are many challenges that a registered nurse faces in an emergency department today. The acuity of the patients, along with the numbers that enter, have increased dramatically over the past few years. Continual and ongoing education is essential to ensure that all who enter are cared for with competence and knowledge. In returning to the bedside, my learning curve will be steep – there is so much to know and learn! I pray that I will be able to meet the challenges ahead of me.

So what is my message? Take a deep look inside, find out where your own job satisfaction lies. Appreciate and value **all** emergency nursing positions. Access the resources that are offered you through your manager/administrator, staff nurse, educator and/or researcher! Most importantly though, be happy in what you do and, in so doing, you will not only be a better nurse, you will be a more content and fulfilled individual.

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

The NENA election process

By Debbie Cotton

Two years ago, at the annual general meeting (AGM) in Winnipeg, the NENA board of directors was tasked with reviewing our current voting procedures, and to offer suggestions regarding possible changes to the process. Specifically, we were asked to investigate the possibility of either using proxy votes or mail–in votes.

The election process for the executive requires written nominations that are submitted to the chairperson of the nominations committee. The bylaws for the affiliation state that nominations are allowed from the floor prior to the election that is held at the annual general meeting. The election is held at the AGM and the successful candidates are announced at that time.

Several specialty nursing groups were contacted regarding their voting processes. Their responses varied. Some groups used the same process as NENA, with mail-in nominations and a call for nominations from the floor at the AGM, with voting in person at the AGM. One group used proxy voting. The votes must be signed and mailed into the national office two weeks prior to the AGM. This process would limit the nominations from the floor and would be costly. One group only elected the executive from the board of directors.

We also spoke to ENA staff, because they used e-mail voting last year. The cost is prohibitive at $20,000.00. Discussions with the company used by ENA revealed that the cost would be similar for our association. The cost results from inputting the data.

We then investigated the potential of mail-out via business return mail. The cost would be $425.00/year plus the mail-out and $0.57 for each returned ballot.

To attempt either a proxy vote or mail-in vote, there will be a cost incurred. The bylaws for the association would have to be changed to reflect the change in process. This would necessitate drafting the changes, sending the changes out to the membership, and voting upon the changes at the next AGM.

These results will be reported at the AGM to provide a platform for further discussion with the membership.

In Memoriam

It was with sadness that we learned of the recent death of Joe Hare as the result of a cardiac arrest at the age of 50 years. Many of us knew Joe from his work as a sales representative for thrombolytic intravenous drug therapy. We often would see him at nursing conference trade shows across Canada. He was a great friend of emergency nurses. He valued education and would often ensure that emergency nurses were able to attend a workshop or a conference. He valued nurses' opinions and their experience. He was energetic, enthusiastic, thoughtful and a lot of fun to be around. He will be missed. Our sympathies go to his wife and children.

Call for nominations - 2002 board of directors "president-elect" and "communication officer"

Are you interested in serving on the board of directors? Then read on - this year there are two available positions. The president–elect position is a one-year term preceding the presidential role, and the communication officer position is a two-year term. Both positions would begin following the annual general meeting in Moncton, New Brunswick. The board of directors meets twice yearly. Both meetings are three days in length. Typically, the spring meeting, though, is held in conjunction with a regional or national conference, so time away from home is usually longer.

As president-elect you are a vital member of the board. You would be expected to assume the role of president if the current president were to resign. Other duties include: reviewing and revising (as needed) the policy manual, position statements, bylaws and preparing achievements and actions in the strategic plan. There may be other duties that would be assigned to you by the president.

As communication officer, you are expected to ensure the production and dissemination of the "**Outlook**" journal every six months. You will liaise with provincial communication officers to encourage members to submit articles, pictures, tips, etc., to the journal. You will establish and maintain a credit rating with a printing firm for the production of "**Outlook**". You will ensure that all invoices for the production of the journal are correct and are submitted to the NENA treasurer for payment. You will also maintain a liaison with NENA webpage designers to ensure updated information is displayed, and you will act as a contact resource for affiliation members who wish to use the website services. You will also assist with national and regional conferences by acting as a liaison between the conference committee and the board of directors.

Two NENA members must nominate candidates and the nominee must be a NENA member in good standing. A nomination form has been included for your use. Please forward completed nomination and curriculum vitae to Debbie Cotton. Her address is listed on the nomination form. Nominations for these positions may also be made from the floor at the AGM. Announcement of successful candidates will be made following the election at the AGM in Moncton.

Outlook

Nomination Form

NENA executive position

Positions:

- Communication Officer
- President-elect

We, the undersigned voting members of NENA, do hereby nominate:

_____

for the position of

_____

on the NENA executive.

_____

(nominee) is in good standing with NENA.

1. Name: _____

Date: _____

Signature of nominator: _____

2. Name: _____

Date: _____

Signature of nominator: _____

I, _____,

do hereby accept this nomination for the position of

_____

on the NENA executive.

Signature: _____

Date: _____

Please return this letter of intent and CV, by May 2, 2002, to: Debbie Cotton, P.O. Box 34, Judique, NS, B0E 1P0, Fax: 902 863-6455

Board highlights

The NENA board of directors meeting was held November 9-11, 2001 in Toronto. This is a brief synopsis of the meeting.

NENA forum

This is a section in the meeting in which board members explore common issues and needs of nurses across the country. During the general discussion period, board members identified several common issues that are currently facing emergency nurses in Canada. From the issues that were identified, three were prioritized as being most urgent:

- new untrained staff
- replacing RN staff with multi-skilled workers, such as paramedics and/or LPNs
- overcrowding and apathy (intertwined with above)

The BOD then broke into two groups to develop recommendations and/or actions.

1. New untrained staff
- develop a national orientation plan and education tool
- develop core and advanced competencies
- develop a mentor and preceptor program
- collaborate with Canadian Association of University Schools of Nursing (CAUSN) and other provincial emergency nursing programs to educate nursing students about NENA Standards of Nursing Practice and Position Statements
- promote NENA education requirements

2. Non-RN health care providers

- develop a position statement
- send position statement to federal and provincial health ministers, CNA, Federal Nursing Union, Provincial Nursing Associations and Unions.
- produce a media release.

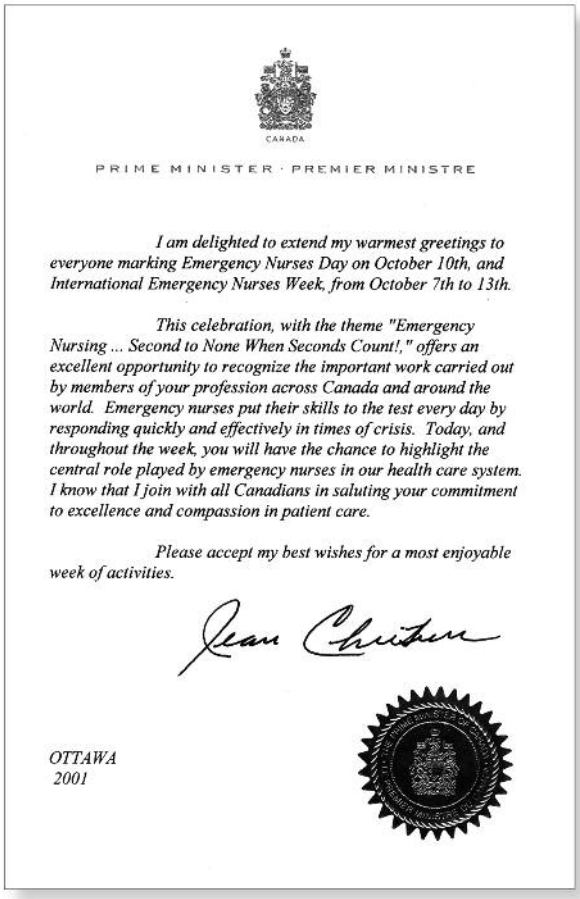
Emergency Nurses Day

Provincial directors reported on various activities held in the provinces – ranging from letters and tokens of appreciation from provincial and national associations, radio announcements, and media releases, to balloon baskets to departments. Calgary region hosted a wine and cheese party for nurses, and Edmonton had sites performing skits with the winner taking home a plaque. Great ideas!

President Ann Cessford sent letters to the federal Minister of Health and the Prime Minister who both responded. Two provinces, Saskatchewan and Nova Scotia, had proclamations declared by their respective ministers of health.

National Triage Working Group

NENA continues to actively participate in the working group. Pediatric Canadian Triage and Acuity Scale (CTAS) was completed and published in the fall issue of the **Canadian Journal of Emergency Medicine** (**CJEM**). There is continuing work on the educational package for Peds CTAS by various members of the national working group. The next national triage working group meeting will be at the Canadian Association of Emergency Physicians (CAEP) meeting in Hamilton in April 2002. Posters and postcards are available for purchase at the CAEP office.



CANADA

PRIME MINISTER · PREMIER MINISTRE

I am delighted to extend my warmest greetings to everyone marking Emergency Nurses Day on October 10th, and International Emergency Nurses Week, from October 7th to 13th.

This celebration, with the theme "Emergency Nursing ... Second to None When Seconds Count!," offers an excellent opportunity to recognize the important work carried out by members of your profession across Canada and around the world. Emergency nurses put their skills to the test every day by responding quickly and effectively in times of crisis. Today, and throughout the week, you will have the chance to highlight the central role played by emergency nurses in our health care system. I know that I join with all Canadians in saluting your commitment to excellence and compassion in patient care.

Please accept my best wishes for a most enjoyable week of activities.

Jean Chrétien

OTTAWA
2001

CEDIS (Canadian Emergency Department Information System) Working Group

This is another collaborative working group with CAEP. The objective for this working group is to develop a comprehensive national ED data set that meets the informational needs of Canadian EDs. This data set will enable regional, provincial and national comparisons for evaluation, quality improvement, and research applications, both in rural and urban settings.

CAEP/NENA meeting

The highlight of the board meeting was the first-ever combined meeting of the NENA and CAEP boards. Both presidents provided an overview of their respective associations. Most of the meeting was spent looking at ways the two associations can work together. Through a brainstorming session, the members identified specific areas of collaboration and common processes.

The boards identified opportunities for improved communication between the two associations through sharing board minutes and web links, continuing our present collaborative projects (CTAS and CEDIS), and two additional projects - more work around overcrowding, and violence in the workplace.

The New Brunswick Emergency Nurses Association, St. John chapter

Editor's note: *When I learned that this chapter had recently formed, I thought it would be a great idea to interview the president to find out how and why they organized, and to share this with you. Way to go Saint John!*

In May 1999, eight nurses from the Atlantic Health Science Corporation in Saint John, New Brunswick piled into a van and drove all the way to St. John's, Newfoundland to attend the national emergency nurses' conference. While they acknowledge that it was a very long drive, they were inspired by the nurses whom they met and the information they gained from the conference. They realized that we have a common goal to improve emergency nursing through education and through networking with other emergency nurses.

Planning for the new chapter began in the latter part of 2000, and it officially came into being January 2001. Members of the executive are: president, Hiadee Goldie; vice-president, Tammy Lawson; secretary, Rose McKenna; treasurer, Lois Moore. Although notices had gone to other emergency departments in the region, the 27 members come primarily from the Atlantic Health Sciences Corporation. While Hiadee Goldie (president) realizes that the issues for the rural EDs may differ from the tertiary referral centre, she firmly believes that ED nurses in that region could be so much stronger if all the ED nurses within the region were members of the chapter. She believes that by joining forces, rural and urban nurses would better understand the pressures that each faces on a daily basis.

The goals of the chapter are to educate nurses through inservices provided at the monthly meetings, promoting the Trauma Nursing Core Course (TNCC), fundraising to send nurses to conferences (with the understanding that they bring back fresh ideas and concepts and share the information with the rest of the members), problem-solving issues in the department, and celebrating their successes as nurses.

Not all the meetings are about serious issues, they have fun and try to include the spouses as well. For example, the group plans to go curling with their spouses, and an invitation has been extended to the rest of the department.

One of the chapter's greatest successes to date has been the legal liabilities conference. Over 175 nurses attended this one-and-a-half day conference sponsored and organized by the chapter. The group was pleased with the outcome, the feedback they received, and the skills they developed in organizing a conference for a large number of people.

If there are any nurses in the region who would like to become members or get more information on the chapter, please call Hiadee Goldie (w) 506-648-6900 or (h) 506-738-8939 or e-mail Hiadee Goldie@msn.com. In Hiadee's words: "I would like to encourage emergency room nurses to get involved in their association. We are a professional group of people and we should stand up and be heard, whether it is in our own departments, our hospitals or with the government. Also it's a lot of fun!"

NENA Position Statements and NENA Standards may be purchased for $20.00. Please contact Jerry Bell, NENA treasurer, for further information.

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

Attention - position statement and core competencies

Be on the look-out for newly revised position statements and newly developed core competencies. They will be coming to a mail box near you over the next two months. They will also be available for purchase for $20.00.

Legal implications

Check out the **ED LEGAL LETTER**, Volume 13(1), January 2002. The title article is "Errors at triage - don't get off on the wrong foot." Although this is an American article, the cases that are presented for review are enlightening reading for any of us who triage patients. Traditionally, lawsuits resulting from improper or inadequate triage were framed as medical malpractice, and for those patients who died, wrongful death. With increasing frequency, patients who are injured by the triage process are bringing forward lawsuits.

It's worth reading and posting in your ED triage areas.

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Position statement

Procedural sedation in adults and children in emergency departments

Issue

The emergency nurse is increasingly involved in the administration of a variety of medications to adults and children for the purpose of procedural sedation in the emergency department setting.

Procedural sedation involves producing an analgesic and sedative state without loss of consciousness for the patient via the administration of medications for therapeutic, diagnostic and surgical procedures.

The administration of medications by oral, rectal, intranasal, inhalation, intramuscular and intravenous routes for procedural sedation creates a potential increased risk for the patient's safety.

NENA position

NENA believes it is in the scope of practice of an emergency nurse to manage the care of a patient before, during, and after administration of medications for procedural sedation, after appropriate education and training is completed.

NENA believes that each emergency department utilizing procedural sedation must develop policies and procedures:

- Guidelines for use of procedural sedation in emergency, including nurse-patient ratio of one-to-one during and after the procedure
- Procedure for procedural sedation, including physician managing sedation, physician performing procedure, nurse caring for patient and other roles as needed (eg. respiratory therapist) which are clearly defined and developed as a multidisciplinary team.
- Documentation tool for documentation of patient status before, during and after procedure, including discharge criteria
- Criteria for discharge of patient
- Patient/parent discharge information, including observation guidelines post-procedure, resource telephone number, and list of medications administered to the patient
- Protocols for managing potential complications or emergency situations arising from the administration of procedural sedation medications
- Pharmaceutical tools to assist nursing staff for administration of agents for sedation
- Drug profiles, including side effects, adverse effects, complications, reversing effects
- Dosage and weight charts
- Peak actions and duration of actions
- Administration protocols.

NENA believes that emergency nurses caring for patients undergoing procedural sedation should complete a standardized education and practical competency package as developed by the facility. This process would enable the emergency nurse's knowledge, skills, and abilities to care for a patient undergoing procedural sedation to be evaluated.

NENA believes there must be a process for evaluation of both the competency of the nursing care provided, and the overall process of administration of procedural sedation in the emergency department, through quality improvement or risk management initiatives.

Rationale

Procedural sedation in the emergency department can be a safe, therapeutic intervention for adults and children undergoing a variety of procedures. Recognition of the potential risks and complications of procedural sedation, with proactive management of patient care, will ensure the best possible outcomes for patient care before, during and after the procedure.

References

Emergency Nurses Association Position Statement. **Conscious Sedation**. Developed 1992, and revised and approved by the ENA Board of Directors, July 1998.

Ip, U., & Saincher, S. (2000). Safety of pediatric sedation in a Canadian Emergency Department. **Canadian Journal of Emergency Medicine**, January 2000, pp 15-20.

Kost, M. (1999). Conscious sedation – guarding your patient against complications. **Nursing 99**, April 1999, pp 34-39.

Nelson Kaj, M.S., Walters, Capt. V.E., & Watkins, L.M. (1996). Competency verification for conscious sedation. **Journal of Emergency Nursing**, April 1996, pp 116-19.

Ringland, R., & Early, S. (1997). Conscious sedation: documenting the procedure. **Journal of Emergency Nursing**, December 1997, pp 611-17.

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Bouquets

- **John Trickett**, for his leadership as chair of National Trauma Committee over the past three years.
- **Pat Walsh,** for assuming the chair of National Trauma Committee.
- **Bev Mullin**, for receiving a community volunteer action award for her work with the foodbank in Halifax, NS.
- **Johnson & Johnson,** for its wonderful advertising for nurses.

"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****.*

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 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 being 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 10) 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 candidates 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 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: _____

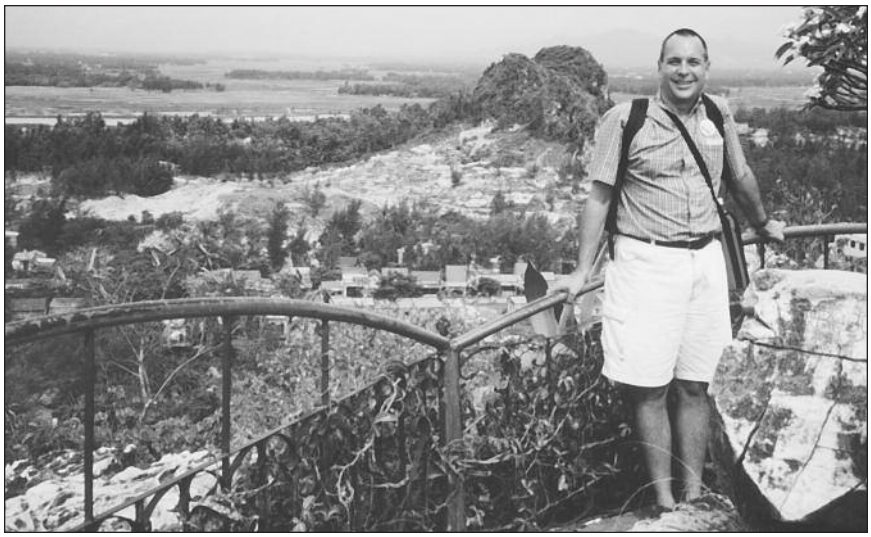
Operation Smile - Vietnam 2001

By Greg Samson, RN, ENC(c)

One of the advantages of being a pediatric emergency room nurse is the opportunity to travel to developing areas of the world as a participant in an international medical mission. Such an opportunity was extended to me when I travelled to Can Tho, Vietnam earlier this year with Operation Smile (OS).

Operation Smile is an international, private, not-for-profit volunteer medical services organization. Each year, OS provides reconstructive surgery and related health care to indigent children at 30 different mission sites involving 20 countries. Each international team of 30 to 40 volunteers consists of doctors, nurses, speech pathologists, and other volunteers. They are brought together for two weeks at a mission site for surgeries including cleft lip and palate repair, burn revisions, and other reconstructive surgeries. As many children as safely possible are seen during five to six days of surgery.

I joined the mission after a 28-hour flight, followed by a five-hour bus trip to Can Tho in the Mekong Delta. The first aspect of the mission was three days of screening, during which 240 patients were assessed for surgery. The families huddled in the shade of every nook and cranny along the hospital to escape the 38ºC heat of the sun, as they waited for their turn to be screened by the nurses and doctors of OS. The difficult task of selecting the patients who are candidates for surgery was the responsibility of the team leaders. The final surgery lists were posted on Saturday, a day of anticipation and mixed emotions for the families discovering either that their child had been chosen for surgery, or that they were to return home and hope that next year their child would be chosen. Those children with more unique or complex problems could not be operated on due to lack of facilities or equipment within the country.



Author Greg Samson in Danang, Vietnam, with China Beach in the background.

Sunday, my sixth day, I was off to relax. A group of us from the OS team got up at 0400 to go to the floating market on the Mekong River. During this seven-hour long trip, we were able to see how the people of Vietnam are one with the river. In the late afternoon, after a long nap, my roommate and I rented a motorcycle with a driver for two hours at a cost of 30,000 dong ($3.00 Cdn.) to drive around the city and see the sites of Can Tho.

Monday, day seven, began early, up at 0530 to arrive at the hospital for 0700. Surgery began at 0730 with the first

Above left, one part of the hospital in Can Tho. Right, patients try to avoid the 38˚ heat while awaiting screening.

patients arriving in post-op by 0900. There were five surgical teams, so a child left the OR every 30 to 45 minutes and then remained in the recovery room until awakening, enabling them to move to the post-op area down the hall. In post-op, three nurses worked together to provide care in three small rooms, each containing three or four cots with wooden slats on them. The hospital only had straw mats to place on the cots for the comfort of the expected 40 to 45 patients each day. Each cot had two to three patients at a time, depending on the child's size. All children were supposed to arrive in post-op with an IV infusing. However, some of the children were able to pull out their IVs despite their elbow restraints. As post-op filled up during the day, the temperature reached the mid-40s. The rooms were noisy with the sounds of children crying and their family members trying to talk with them through the windows. The pace continued until we finally returned to our hotel at 2130. This was our schedule for five days straight.

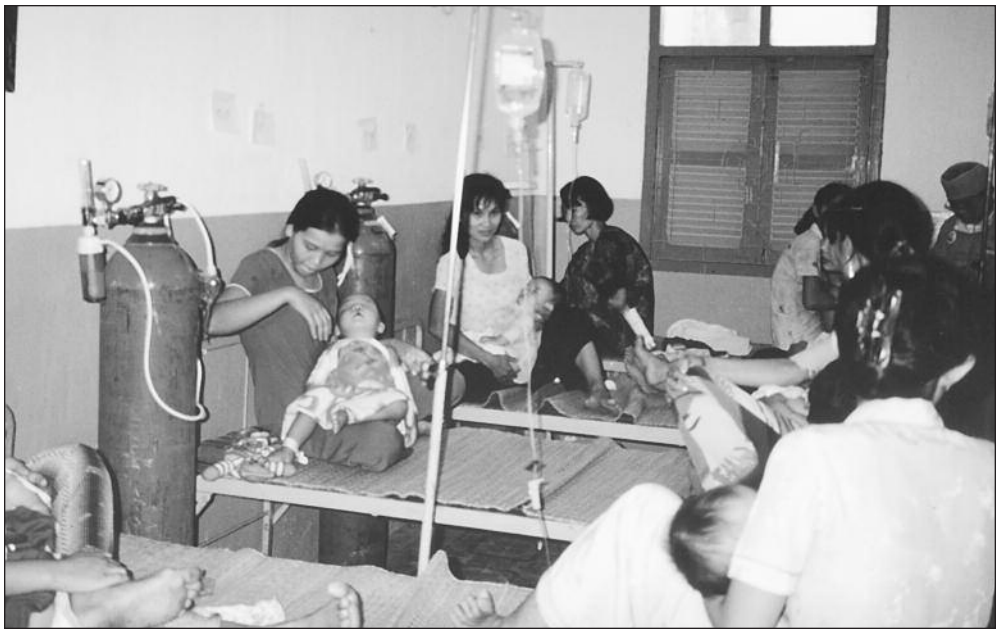
On Friday, day 11, the final cases were done in the morning. A total of 168 children and their families have had their lives changed forever. The smiles on the children's faces make every moment of the gruelling week worth it.

Friday afternoon the team worked together to clean, prepare, and pack all the medical equipment for shipping back to the USA, before returning to Ho Chi Min City. One doctor and I stayed in Can Tho to do follow-up post-op Saturday, Sunday and Monday. One hundred and ninety follow-ups were done in nine hours of return clinic visits, three hours each morning. Lips and palates were checked and dressings on burn revisions were changed. A few children would require follow-up the next week with a plastic surgeon in Hanoi in northern Vietnam. OS provided transportation for these patients for their follow-up.

After working 14 days, I took a week to travel around southern and central Vietnam. The country is beautiful and the people of Vietnam are very resourceful and hard-working. I found visiting the various sites that experienced heavy fighting 30 years ago, during the war, rather overwhelming. It is so hard to believe that this country was virtually destroyed by bombs and Agent Orange during the war. As I walked through the streets of the towns and cities, the children were particularly friendly to westerners they saw. Their favourite word is 'hello' and I could not help but smile and say hello back to them when it rang out from the children along the street. When they realized I was Canadian, they welcomed me with open arms.

Every mission has different qualities and features, but two things are constant: the dedication and commitment of the team members, and the appreciation of the children and their families. The key word with OS is flexibility, as each day is never the same as the day before. Although the mission is challenging, it is always rewarding. The smile on a child's face, when they give you a hug and kiss before they go home with a new outlook on life, leaves a lasting impression on your heart.

It was an honour to be chosen as a member of Operation Smile, whose ongoing goal is "Changing lives...one smile at a time."



Top photo: Empty beds in the post-op room. Above: The first day post-op with recovering patients, two to a bed.

Forensic nursing

By Sheila Early, RN, BScN

Forensic nursing in Canada is an evolving specialty which is currently usually included under the umbrella of emergency nursing or psychiatric nursing. However, forensic nursing can be part of all nursing, be it intensive care nursing, pediatric nursing, psychiatric nursing, emergency nursing, and so on.

Here are some examples of forensic nursing interventions within a variety of settings, which may help nurses to recognize the broad nature of forensic nursing:

- A five-year-old child is admitted to ER with a broken leg, parent says child fell from a ladder. X-rays show the fracture is spiral in nature. The orthopedic technician who is called to set up Buck's traction asks the child what happened. Child says, " Daddy did it". This is a potential child abuse case and all documentation regarding this child will be viewed as evidence.
- A 20-year-old female is admitted to ICU unconscious with unknown etiology. An astute intensive care nurse, who also is a sexual assault nurse examiner, realizes the potential loss of forensic evidence and oversees the assessment of the patient and documentation of findings as the patient's condition is critical. Observations made and documented at this time are crucial to what becomes a homicide investigation.
- A code is called in a hospital, a patient has fallen in a stairwell and is critically injured at the bottom of the stairs. A Code Blue ensues which is not successful. The surrounding area is cleaned of blood stains before police arrive. Crucial evidence is lost.
- A new, single mother on maternity does not want to look at her newborn child. She eventually tells her primary nurse this child is the result of a sexual assault she did not report to police.
- A patient is admitted to the OR for a gunshot wound to the abdomen. When he awakes, the removed bullet is in a container at his bedside as a souvenir. The bullet is no longer admissible as evidence in the police investigation.
- A medication incident occurs in which a patient receives a lethal dose of analgesic because of a faulty intravenous pump. The primary nurse does not secure the pump in a way that it cannot be tampered with. Crucial evidence is lost.
- The coroner's office is investigating an MVA with a fatality. The investigator is a forensic nurse death investigator who is a former emergency nurse.

Forensic nursing courses are appearing in secondary colleges in Canada in some provinces.

Opportunities for online forensic nursing/health courses in both US and Canada are expanding.

Sexual assault nurse examiner programs are now available in five provinces: British Columbia, Alberta, Manitoba, Ontario and Nova Scotia.

Forensic psychiatric units are present in several provinces as well. Nurses work as death investigators in several provinces.

Legal nurse consultants review charts and evaluate standards of nursing care in civil matters.

The future of forensic nursing is endless and, as nurses are evaluating their current roles in health care, this is one more opportunity for nurses to move forward and grow within the scope of nursing practice. One word of warning: Forensic nursing is contagious! It will lead you down paths you never knew existed.

Hypothermia, the cold reality

By Terri Garven, Regina, SK

Hypothermia can occur during any season, but is more dramatic in presentation during our winter weather. The following is a summary of the treatments often utilized in the management of the hypothermic patient.

Initial therapy for all patients includes removing all wet garments, protecting from heat loss, maintaining horizontal position, avoiding rough movement, monitoring core temperature and cardiac rhythm.

Mild Hypothermia 34–36° C

- Passive rewarming
- Active external rewarming (see Table One)

Moderate Hypothermia 30-34° C

- Passive rewarming
- Active external rewarming truncal areas only (see Table One)

Severe Hypothermia <30° C

- Active internal rewarming (see Table One)

Potential complications

Ventricular fibrillation

"Fragile, handle with care." It has been reported that physical manipulation of hypothermic patients can precipitate V-Fib. (For example, intubation, insertion of a NG tube, etc.)

"Afterdrop"

A continued drop in the patient's temperature when cold blood from the periphery is mobilized" (AHA Guidelines, 2000). This is believed to be caused by active external rewarming. Be alert to the potential.

Table One:

Passive Rewarming	Active External Rewarming	Active Internal Rewarming
Blankets	Warm blankets	Warm IV fluids
Warm room	Warm bath	Warm, humidified oxygen
	Bair Hugger	Instillation of warm fluids by NG and CBI
		ECMO (by-pass)

Hyperkalemia

Known to occur in hypothermia. Watch for it! Lab values? ECG changes include: peaked T's, widened QRS and prolonged PRI. Treatment is the same as for all hyperkalemia patients.

Being alert to the treatment modalities and potential complications allows you to manage your patient with confidence in the face of a crisis.

Previously published in EmERg with the Saskatchewan Emergency Nurses Group newsletter January, 2002

Reference

The American Heart Association in collaboration with the International Liaison Committee on Resuscitation (ILCOR). **Guidelines 2000 for cardiopulmonary resuscitation and emergency cardiovascular care: An international consensus on science.** American Heart Association 2000.

Chicken Soup for the Nurse's Soul

Jack Canfield, Mark Victor Hansen, Nancy Mitchell-Autio, RN, Lee-Ann Thieman, LPN
Health Communications, Inc.
Deerfield Beach, Florida, 336 pages

I am sure that there were many of you who received this as a gift for Christmas. My copy of this book was a gift from my stepdaughter. This is a wonderful book about nurses and nursing. Between the covers, there are over 100 true stories that reflect the true essence of nursing – caring for another human being. The stories reveal the strength, compassion, integrity and the smarts that it takes for nurses to survive in today's system. This book has something for novice nurses and seasoned veterans. It is a funny, sad, thought-provoking and exhilarating read. Just what you need after another tough shift. So, thanks Jennifer, for the great book and, oh yeah, can you pass the kleenex?

Reviewed by Valerie Eden, RN, BN, ENC(C), MDE

AACN Procedure Manual for Critical Care

4th Edition
Edited by Debra Lynn-McHale and Karen Carlson
W.B. Saunders Company, 2001
940 pages ISBN 0-7216-8268-5

Finally, a procedure manual that answers not only the "**HOW**" but the "**WHY**"! The fourth edition of the **AACN Procedure Manual for Critical Care** provides the novice to the experienced nurse with a step-by-step outline of procedures, along with the rationale for the actions and any special considerations.

At a time of rapidly changing technology and increased pressure on nurses to remain current, the concise and organized delivery of the material is an asset to providing quality patient care. The emphasis on patient and family education and patient preparation for the procedures reflects the increasing autonomy of patients in care decisions. In addition to ongoing assessment and interventions, each procedure concludes with both expected and unexpected outcomes.

Perhaps the most intriguing element is the inclusion of levels of research for clinical practice which will guide us in evidence-based practice and identify areas needing further research. It will quickly become such a valuable resource in your department, you'll wonder how you did without it!

Reviewed by Joy Durand, BScN, RN

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