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

Volume 26, Number 1, Spring 2003

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President's message

"Diversity" is the one word that sums up and describes a competent emergency nurse for me. Emergency nurses care for individuals across the continuum of the lifespan, from prenatal to death. Individuals we care for arrive at our doors with varying degrees of acuity and disease processes. Their health care needs range from prevention, education, and promotion, to critical care and resuscitation.

Over the last few years, emergency nursing has changed dramatically. We are no longer a profession that assesses, stabilizes and directs the patient to an area for further treatment and/or definitive care. The emergency department has become the "be all and end all" of the health care system. Out of necessity, emergency nurses have broadened our realm and scope of care.

We attempt to care for admitted inpatients who cannot be placed on an inpatient unit and may be left for days on a stretcher in the emergency department. Numerous programs have been implemented to assist in getting patients out of hospital and back into the community quickly. However, when these programs meet the maximum number of patients they can take on, the patients return to the emergency department for their outpatient treatment. One just needs to look at the waiting rooms of our emergency departments, and chances are you will discover one large patient care area. People wait to get in, be assessed and reassessed by the triage nurse. It is almost as if we have accepted the overcrowding of emergency departments with admitted patients, and the obvious lack of resources, as the norm. If this is the case, then we have a great deal of work ahead of us! Emergency nurses need to change this way of thinking among ourselves, with the general public, and politicians if we are ever going to have an impact on the health care system of Canada!

There are numerous reports that have been written and presented to the government over the past year; Romanow, Kirby, CNAC, to name just a few. These reports speak in broad terms of receiving "timely access to quality health care." I have to ask: What is considered "timely access" for the emergency patient who waits for hours to enter a treatment area of the emergency department and then, if admitted, may wait for days for admission to an inpatient unit in the hospital? What is considered "quality care" for this same patient who is often unintentionally neglected, due to the busyness of the emergency department and lack of inpatient resources required to give the proper and needed care this patient deserves? Surely the care and/or lack of care that is being provided to these patients can qualify as "timely access" and/or "quality care."

So what can we do and, more importantly, what must we do? The possibilities are endless, but it will depend on how creative, motivated, and intent we as emergency nurses wish to be!

In this edition of **Outlook** you will find the joint position statement from the Canadian Association of Emergency Physicians (CAEP) and NENA on *"Access to Acute Care in the Setting of Emergency Department Overcrowding"*. This is the second such position statement on overcrowding published by our two organizations. I encourage members of NENA to familiarize themselves with its content and be creative in promoting suggested recommendations.

Emergency nurses must refocus the energy that we expend on the emotions and frustrations of overcrowding, and develop that energy into a positive proactive effort. Doing our best in overcrowded emergency departments will never be good enough! There is always a better way; our challenge is to find it! We need to be vocal beyond the walls of our institutions to ensure that we are heard! We must be persistent with our goal, keeping in mind that great achievements require time, they do not happen overnight. In so doing, emergency nurses **will** make necessary changes for the betterment of the health care of our patients, which will undeniably improve our own work environment and health!

I ask each of you take up the challenge and be proactive in promoting "timely access for quality health" for our patients and ourselves.

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

Did you know?

- That membership continues to grow and totals 1,407.
- That Judith Shamian, Executive Director, Office of Nursing Policy, Health Canada, acknowledged the successful completion of the core competencies in a letter to the board.
- That NENA and critical care nurses have collaborated to promote bike helmet safety by writing letters of support to various levels of government.
- That the first PEDS CTAS instructor course was held in Toronto in November 2002 with 47 people becoming successful instructors.
- That NENA has developed position statements on ambulance diversion and ambulance waiting in ER.
- That the verdict from the Ontario Ministry of Health's inquest into the death of Scott McCorkindale recommended that all ED nurses have the Trauma Nursing Core Course (TNCC).

Outlook contest winner

Congratulations to Lucy Rebello, an ED nurse at Kingston General! She is the lucky winner of the Outlook article contest, which means that Lucy will be able to attend the national conference in Regina, Saskatchewan in May. Way to go Lucy! A reminder to all potential article writers: Get those articles in and you might win your way to a national conference too.

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

From the editor

As you can see from the president's message and the second position statement published on overcrowding in the emergency department, we are all struggling with the same huge issue across the country. While there may be different local, regional, and provincial issues, this is one issue that is common to all of us. As you can see, there are many recommendations that have been suggested by the authors to help with the overcrowding problem in the emergency department. What kinds of things has your department attempted and continues to try in order to ease the burden of care? Write them down and submit them to this journal. Perhaps an idea that your department has tried is something that another ED might like to implement too. One of the things that emergency staff does so well is share information and ideas. Now is your chance to share some of those great ideas with others.

This is your journal and it is a vehicle for you to submit ideas, suggestions, stories and articles. Articles can be clinically based, research oriented, educational pieces or management strategies. All are welcome. It matters not whether you have written before.

What interesting books have you read or videos have you watched? What about interesting websites? Do you have any conferences coming up that you might want to advertise? Do you have any bouquets that you want to share about nurses with whom you work?

What about any community projects that you may have initiated or been involved in, like Gail Colosimo and her colleagues in Moncton, NB, who approached a local high school after a tragedy with underage drinking and provided the students with information about drinking (see p.7). Share those stories with other ED nurses.

This journal can only be as good as you want it to be. It needs to hear from you - it needs to hear your voice.

Yours in nursing,
Valerie Eden, RN, BN, ENC(C), MDE

Outlook Bouquets

Goodbye and hello

- We say a special thank you to retiring board members: **Sheila Early** (British Columbia); **Bob Lawson** (Saskatchewan); and **Angela Bachynski** (Manitoba) for their valuable contributions to NENA and to emergency nursing in Canada. We wish you well in all your future endeavours!
- We welcome new board members **Clay Gillrie** (BC), **Troy Sebastian** (Alberta), **Chris Norman** (Saskatchewan) and **Irene Osinchuk** (Manitoba), and we look forward to working with each of you over the next two years.

- To **Janet Spence**, an ED nurse who is employed at the Halifax Infirmary Emergency Department, who was awarded Nova Scotia Emergency Nurses Association's Member of the Year
- Emergency nurses are doing extraordinary things at and away from work every day! Ontario emergency nurse, 49-year-old Paula Jongerden, became the oldest female to successfully swim Lake Erie this summer. Her 55 km. swim began in Erie, Pennsylvania and finished in Long Point, Ontario. Money made from Paula's swim will be used to support habitat restoration and educational programs in the Long Point World Biosphere Reserve. Congratulations Paula! This further proves that emergency nurses are special, and there is a lot more to emergency nurses than nursing! *Proudly submitted by Janice Spivey, ENAO president*.
- To Melanie Rose who participated in the Wheels of Motion Marathon in the States from your friends and colleagues at Dartmouth General Hospital.

"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****.*

Build your future by making history

Participate in one of the largest surveys of Canadian nurses ever

Now is a critical time in health care for nurses to be heard, and *Building the Future: An integrated strategy for nursing human resources in Canada* wants to hear from you.

More than 24,000 nurses from all three occupational groups (licensed practical nurses/registered practical nurses, registered nurses, registered psychiatric nurses) will be randomly selected from all parts of Canada to receive a survey later this spring.

If you receive one, please complete it and return it as soon as you can.

We need to hear from you about the challenges you face every day. Your direct input is critical in helping us provide concrete options to improve the work environment of nurses.

Recent high-profile studies and reports have placed emphasis on the major health human resources data dearth. Your completed survey will help fill the information/data gaps for all three nursing occupational groups. With your involvement, we can develop a long-term strategy to deal with issues, including the nursing surplus/shortage cycles that continue to plague your profession, and many other worklife issues.

While you may have answered some of these questions before, the sheer size of this sample will add strength to the findings. It is also the first survey to seek similar information from all three nursing occupational groups. Your responses will give us data that doesn't exist in any of the registrar or administrative databases.

Building the Future is a milestone project. It is the first national nursing study that is both endorsed and led by all the nursing stakeholder groups in Canada: professional nursing organizations, unions, employers, researchers, educators, physicians, provincial and territorial governments, Health Canada and Human Resources Development Canada. Together, we are committed to building a better future for nurses in Canada.

Help us make history. Look for our survey this spring.

Go to **www.buildingthefuture.ca** for news on when the survey will be distributed, and for more information on how to participate.

Community involvement

By Gail Colosimo, RN,
Moncton City Hospital, Moncton, NB

In September of 2002, shortly after beginning her first year at university, my daughter received word that a friend and classmate from high school had died due to complications of alcohol ingestion, possibly combined with drugs. It was a heartbreaking phone call to receive from her. Two days later, I met her at the bus stop. She came home to attend the funeral.

During the drive home, she told me about orientation week at the university, that the students were told daily of the dangers of drinking too much, and what they should do for anyone they were with who was inebriated. "Mom, kids in high school should know this stuff too." She felt that her friend's death could have been prevented. "It shouldn't have happened." "Mom, couldn't you do something - your group of emergency nurses, could they do something?"

Later that evening at work, I approached two co-workers who have been active in the work of the New Brunswick Emergency Nurses Association, both provincially and locally with the Moncton chapter. Nadine LeClair and Alison Bulmer agreed that it was a very worthwhile project. We have seen many young people brought to our emergency department with injuries suffered because they had been drinking.

My daughter, Melanie visited the school and spoke with several teachers and the principal about her idea on the day she arrived home. They were thrilled with her notion and very encouraging.

I contacted the principal and told him what we would like to do, with a summary of the information we wanted to give. Again, he was very receptive.

One of the most challenging aspects was to find a way to give the information without appearing to condone teenage drinking. Some universities address this topic as "responsible drinking", clearly not an acceptable approach for 14- and 15-year-olds. It was very important that the students and their parents understood our goal was to give information that might be needed should anyone make the decision to drink. It had to be understood that we were saying, "if this happens to someone you're with," not "when you are out with your friends." The most important point for them to grasp was that, if they ever found themselves in the position where someone had drank too much alcohol, that person should not be left alone.

The presentation was about an hour long and included information on the effects of alcohol, the dangers of combining drugs and alcohol, aspiration, alcohol and hypothermia, and drinking and driving. Following the presentation, we gave a demonstration of rescue breathing and the recovery position, involving the students. Hand-outs were also provided.

A short time was allowed for questions. The questions asked and some of the comments illustrated an interest and a good understanding of the important points.

Another of our concerns was the protection of confidentiality for the family of Melanie's friend. We felt that this should be protected above all else.

During one full day, we made four presentations to a total of approximately 130 students and a number of their teachers. The remarks afterward were very positive. All the teachers echoed the remark, "If this saves just one kid, it will have been worth it." We will probably never know whether we had an impact or not, but our sense of accomplishment and the hope that we did help someone is enough.

One of the goals of NENA and NBENA is to promote development of community partnerships in prevention education. It was an honour to have been given this opportunity to contribute to our community.

Outlook
Letter 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

Currently, we have a task force at Capitol Health Edmonton, Alberta, who are looking to tag triage scores to workload measurement and then compute a methodology to see how many FTEs you need and what type of skill set would be necessary. I have concerns about the use of the triage scores for this, as the patient in the ER can and does move between these scores throughout his/her stay in the ED. For example, a patient presents with abdominal pain at a scale of five. He may have slightly altered vital signs. He may then be triaged at three or four. Then, one hour later, he has acute back pain and his BP drops and he is now in Resus as a level one and is on his way to the OR as an AAA. His workload measurement would have been tagged to the three or four. My question is, what are the EDs across Canada doing or using for workload measurement, is anyone using triage scores and, if so, with what success in reflecting the nursing workload associated with acuity? Please send any information that you might have to: Karen Latoszek, 115 Healy Rd., Edmonton, AB T6R 1VR, e-mail: klatoszek@shaw.ca.

Karen Latoszek

Nova Scotia flight nurse and paramedic among the top in the world

Caroline McGarry-Ross, RN, ENC(c)
EHS LifeFlight Nova Scotia

Darlene Pertus has been a Nova Scotia emergency nurse for 13 of her 25 years in nursing, and she recently put that experience to the test in her role as flight nurse. Darlene and partner, Dale Traer (a critical care paramedic), competed in an air medical crew competition in the United States, putting Nova Scotia and Canada on the map!

The conference

This past November, the annual Air Medical Transport Conference (AMTC) was held in Kansas City, USA. While the conference is an annual event, this year was the first time the air medical crew competition became part of it, and three Canadian teams entered as well as a number of teams from the USA. With people attending from all over North America and as far away as China, teams were really under the microscope during their competition. After all, how a team performs directly reflects on the type of program they represent.

The competition

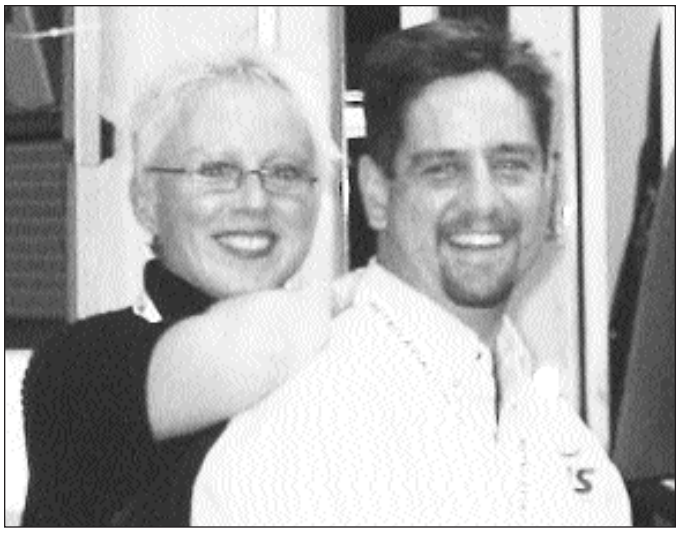
The competition portion consisted of giving each team two scenarios; one pediatric and one adult. The teams were told to be prepared for any kind of emergency such as trauma, medical, cardiac or obstetrics to be staged as an interfacility or a scene call. They were to perform the scenarios without use of calculators or drug reference cards, and would only be allowed a Broslow tape for reference. The teams were sequestered away from everyone to ensure fairness and were all given two identical scenarios. Once their turn came up, a team was put into the helicopter simulator with a 'Realistic Simulator Patient Mannequin*', wearing what they normally would be working in (flight suits, steel toed boots, and helmet). The helicopter simulator produced the real noise and vibration of rotors and, therefore, all communication between team members and patient had to be done through the internal microphones from their helmets. As you can imagine, assessment of patients in this environment poses special challenges, since such things as breath sounds and blood pressures cannot be heard. The scenarios lasted 30 to 50 minutes and were broadcast *live* to everyone in attendance at the conference! Four judges participated in the competition (two Canadian, two USA) and each is a medical control physician for a flight program in their area. The two Canadian judges were from the Alberta STARS program and the Ontario Sunnybrook program.

The Nova Scotia Lifeflight team

The Nova Scotia air medical team was comprised of a flight nurse, Darlene Pertus, and a critical care paramedic, Dale Traer. Darlene and Dale have worked together since the program's inception in 1995, and felt it was time to challenge themselves and see how they compared to other air ambulance programs. The pediatric scenario (30 minutes) was a scene call for a 20 kg male in status asthmaticus, and the second scenario (50 minutes) was an interfacility call for a 56-year-old with acute pancreatitis, renal failure, shock and ARDS. Throughout each scenario, they worked through an assortment of drugs and interventions using only their experience, knowledge, and teamwork as resources. Their hard work and dedication paid off, as they were awarded a very commendable and impressive *second place* in the competition!

Canadians fly above the rest

To the credit of air ambulance programs in Canada, the top three teams in the entire competition were Canadian (Bandage from Sunnybrook, LifeFlight from Nova Scotia, and STARS from Alberta). Special congratulations go out to Darlene and Dale, as well as the teams from Ontario and Alberta, for putting Canada 'on the map' internationally as *the* centre of excellence in air medical transport!



Darlene Pertus and Dale Traer of Nova Scotia.

** The "Realistic Patient Simulator Mannequin" is a training mannequin that responds physiologically to interventions such as drugs, chest tubes, airway interventions, and electrical therapy, etc. Computerized, it will even identify the drug given and the actual dosage that was delivered. It is an excellent learning resource.*

Trauma nurse recognized

Congratulations to Laura Wilding, Injury Prevention Coordinator, Trauma Services, The Ottawa Hospital (TOH) for receiving a certificate in recognition of her commitment and support of the P.A.R.T.Y. program. The award was presented by Dr. Jack Kitts (President and CEO of TOH) and Ms. Paula Doering (VP Clinical Program TOH) on behalf of Smartrisk and P.A.R.T.Y.

From left to right: Paula Doering, Laura Wilding and Dr. Jack Kitts

Remembrance Day - November 11, 2002

On behalf of National Emergency Nurses Affiliation (NENA), three Ottawa trauma services nurses placed a wreath, below, at the cenotaph during the Remembrance Day ceremony at the National War Cenotaph. Left to right: Laura Wilding, Joanne O'Brien and Susan Phillips.

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 be accompanied 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

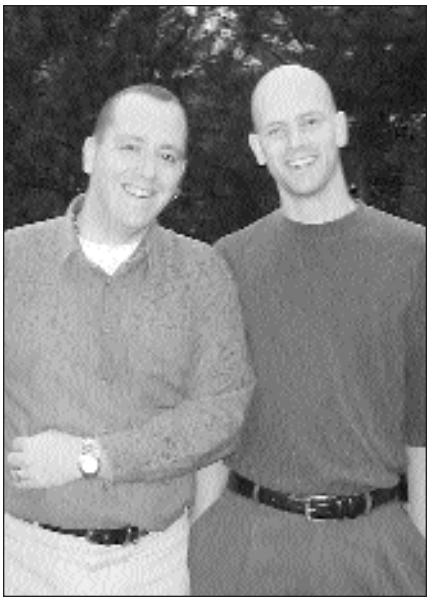
Meet your board members!

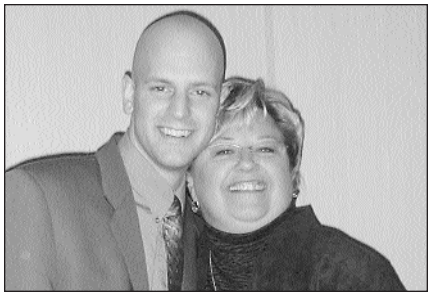
Below are pictures of board members from the fall board meeting in Toronto. This was a transition meeting in which retiring board members were orienting new board members to their roles. Thanks to Jan Spivey, photographer extraordinaire!

Carla Policicchio, president-elect, left, and Clavell Bolger of Newfoundland.

Above, from left: Gail Colosimo of New Brunswick, Debbie Cotton of Nova Scotia and Irene Osinchuk of Manitoba. Right, Anne Cessford, president.

Above left, from left: Bob Lawson, outgoing Saskatchewan representative, treasurer Jerry Bell, and Celie Walsh-Gallison of PEI. Above right, Jan Calnan, secretary, Valerie Eden, communications, and Celie Walsh-Gallison.





Clockwise, from bottom left: Chris Norman of Saskatchewan and Carla Policicchio. Jan Calnan and Valerie Eden. A group at the board table, with Jan Spivey of Ontario, Bob Lawson, Troy Sebastian of Alberta, Chris Norman and Carla Policicchio. Clay Gillrie, incoming representative for B.C. and Chris Norman.

Call for nominations - 2003 board of directors Secretary and treasurer

This is a call for nominations for the positions of secretary and treasurer for the NENA board of directors. These positions are two-year terms that begin July 1, 2003 and run until June 30, 2005. To help you determine whether you might be interested in such a position, it is only fair to provide some information on the time commitment that is required of anyone who holds a position on the board of directors. The board of directors meets twice yearly. The fall meeting is typically in November and is held in Toronto. The spring meeting is usually held in conjunction with either a national or regional conference. Board meetings are usually three days long. However, the spring meeting is longer and means more time away from home and work due to the AGM. This year, the election will be held in Regina, Saskatchewan during the annual general meeting in May 2003.

As secretary, you are expected to carry on the affairs of the corporation under the supervision of the officers of the board. You are expected to attend all meetings and to record all votes and minutes from these meetings. You will ensure that all board members will receive board meeting minutes in a timely fashion and, as well, you are responsible for producing the incorporated minutes. You will set the agenda for the board meetings in collaboration with the president. There may be additional duties that would be assigned to you by the president.

As treasurer, you are entrusted with the funds and securities of the corporation and you shall keep full and accurate accounts of all assets, liabilities, receipts and disbursements. You will be responsible for depositing all monies, securities and other valuable effects in the name and to the credit of the corporation. As well, you will be responsible for the disbursement of such funds. You are expected to prepare and deliver an accounting of all financial transactions at each board meeting. You will be expected to submit an annual accounting to the membership at the AGM. There may be other duties assigned to you by the president.

Two NENA members must nominate candidates, and the nominee must be in good standing. A nomination form has been included here for your use. Please forward completed nomination and curriculum vitae to Celie Walsh-Gallison. Her address is listed on the nomination form. Nominations for these positions may also come from the floor during the AGM. Announcement of the successful candidates will be made at the AGM in Regina.

outlook

Nomination Form

NENA executive position

Positions:

- Secretary
- Treasurer

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 April 28, 2003, to: Celie Walsh-Gallison, Suffold Road, R.R. #3 Charlottetown, PEI, C1A 7J7

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. (included with this issue of **Outlook**) 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.

outlook
The NENA bursary

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 (included with this issue) 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

Access to acute care in the setting of emergency department overcrowding

A joint position statement of the Canadian Association of Emergency Physicians and the National Emergency Nurses Affiliation.

Introduction

Canadian emergency departments often deal with more sick patients than there are staffed stretchers in which to treat them. Acutely ill people overflow into hallways and waiting rooms, ambulances are diverted from hospital to hospital looking for an emergency department that will accept incoming patients and, after arriving, paramedics often cannot offload patients onto an emergency stretcher. Sick patients endure prolonged waits in emergency department waiting rooms and face unacceptable delays in care.

Emergency department overcrowding has been described, defined and studied for over two decades in the literature. Despite a range of initiatives and management strategies, it is worsening and it remains the most serious issue confronting Canadian emergency departments. The ultimate consequence of overcrowding is a lack of access to timely and appropriate care for the sickest patients in our system – those described in levels one, two and three of the Canadian Triage and Acuity Scale (CTAS). This document reviews emergency department overcrowding and makes recommendations aimed at resolving this crucial patient care issue.

Definition of overcrowding

Several criteria have been used to help define overcrowding; these include ambulance diversion, staffing, availability of beds and emergency department volumes (Lynn & Kellerman, 1991; Schull & Redelmeier, 2002; Kollek, 1990; Graff, 1999). Overcrowding should not be defined in terms of the number of patients in a department, but rather on the ability to provide necessary patient care. Therefore, ***emergency department overcrowding*** is best defined as a situation in which the demand for emergency services exceeds the ability of a department to provide quality care within acceptable time frames (Lynn & Kellerman).

Based on this definition, it is clear that emergency department volumes are not the primary determinant of overcrowding and that overcrowding is actually a form of 'access block.' It is also important to clarify that 'non-urgent' patients do not contribute substantially to overcrowding (Dickinson, 1989). Although they comprise a significant proportion of patients who come to emergency departments, they do not occupy acute care stretchers, they require little or no nursing care, and they typically have brief treatment times. These "non-urgent" patients consume a small fraction of emergency department resources, generate minimal incremental costs (Richardson & Hwang, 2001), and do not displace sick patients who need emergency care. The American College of Emergency Physicians report on overcrowding states that, "non-urgent emergency department use simply leads to overcrowding in the waiting room, not overcrowding in emergency department treatment areas" (American College of Emergency Physicians, 2002).

The history behind overcrowding

Emergency department overcrowding was described in the early 1980s. Several causative factors were identified, including an aging population, rising infectious disease rates (particularly the AIDS epidemic), substance abuse, psychiatric illness, the effects of poverty on health, as well as hospital bed and staffing shortages (Kollek; Gallagher & Lynn, 1990; Lynn). In the early 1990s, strategies to address overcrowding were developed (Lynn & Kellerman; Lynn; Lynn & Yeh; American Association of Emergency Physisicans, American Hospital Association, 2002; Feferman & Cornell, 1989), but most hospitals took little or no action. In situations where there were more sick patients than hospital beds to accommodate them, it was cheaper and easier to house supernumerary patients in the emergency department than to devise appropriate inpatient solutions, so this became an accepted practice for almost all Canadian health care facilities. Sadly, the term "corridor patient" became part of the medical lexicon, and overcrowding became the emergency department's problem rather than the institution's problem.

In the mid to late 1990s, Canadian health care restructuring and regionalization reached its peak. Economic pressures and a philosophical shift away from acute care led to hospital bed closures and increasing numbers of patients held in emergency departments. In Ontario alone, there was a 22% decrease in acute care beds and a jump in occupancy from 85.6% in 1994/95 to 93% in 1999/2000 (Ontario Hospital Association, 2000). With an aging population, fewer hospital beds and fewer emergency departments, the remaining emergency departments dealt with rising patient volumes and acuities (Fatovich, 2002). By the mid to late 1990s, overcrowding was the most significant problem facing emergency care providers. Several key organizations tried to address the overcrowding issue, including CAEP (Canadian Association of Emergency Physicians) and NENA (National Emergency Nurses Affiliation), ACEP (American College of Emergency Physicians), and the emergency section of the Ontario Medical Association (Drummond, 2002).

Overcrowding and quality of care: Double standards

When a hospital has more sick patients than there are beds to accommodate them, one possible solution is to distribute supernumerary patients between the emergency department and the appropriate inpatient care areas. This would bring all of the

institutional resources to bear and allow nursing units throughout the hospital to share the patient care load and "triage" care to patients who need it the most. But the default position in Canadian hospitals is to build a firewall that contains most or all of the supernumerary admitted patients in the emergency department. Only emergency resources are brought to bear and the "access block" is much more severe than it needs to be.

This practice is only possible if a series of "double standards" are enforced. For example, most administrators feel it is unsafe to manage even one or two "hallway patients" on inpatient units; yet they accept the practice of managing 10 or 20 patients in emergency department hallways. They believe that adding one or two supernumerary patients (a five to 10% workload increase) to an inpatient ward imposes unacceptable stress on inpatient staff, but that adding 10 or 20 such patients (a 50 to 100% workload increase) to the emergency department does not (Lynn). No hospital administrator would allow 20 off-service medical patients to be admitted to a 20-bed surgical unit, or allow stable admitted patients to occupy all of the hospital's critical care beds; yet, it is common practice to fill all of an emergency department's acute care stretchers with admitted off-service patients. The end result of this series of double standards is that inpatient units are protected from overcrowding stresses, that emergency departments shoulder a disproportionate burden, and that standards of care for patients in emergency departments fall far below those seen elsewhere in the hospital. To change this, hospitals must adopt a philosophy of equally shared responsibility for patient care. Until decision-makers view emergency departments as equal to other departments, give emergency department staff the same considerations as inpatient staff, and provide emergency department patients the same rights as other patients, the crisis in emergency department access and quality will continue.

Perverse allocation of acute care resources

When most or all of a department's stretchers and nurses are diverted to the care of admitted patients, emergency nurses and physicians find it difficult or impossible to address their primary mission of providing emergent and urgent care to their communities. Newly arriving patients cannot be placed in (already full) treatment areas; paramedics cannot unload their patients and respond to emergencies in the community (Schull, Szalai, Schwartz & Redelmeier, 2001); and patients who should be assessed and treated are 'blocked' in waiting rooms. Consequently, few Canadian emergency departments can meet the nursing and physician evaluation time objectives specified in the Canadian Triage Acuity Scale (CTAS) guidelines.

Delays in timely nursing and physician care lead to delays in diagnosis, treatment and disposition, which have been associated with adverse outcomes and deaths in many Canadian emergency departments (Schull & Redelmeier; Redelmeier, Blair & Collins, 1994). Accumulation of undiagnosed, untreated people in waiting rooms increases the workload of triage nurses, who must constantly re-triage waiting patients to detect critical deteriorations and to ensure the sickest patients get the first available treatment space. Time spent re-triaging interferes with primary duties and creates an environment that is in itself an impediment to safe patient care. Care provider stress leads to burn-out and loss of skilled people. Patient dissatisfaction leads to verbal and physical abuse. Sadly, one death in a Canadian emergency department was directly related to a family member's frustration with access to care. The chaotic situation in Canadian emergency departments is a recipe for medical error.

These factors have given rise to the ironic and dangerous situation that exists today, where the sickest patients in the system — those who have not yet been evaluated or stabilized — are left in waiting room chairs and on ambulance stretchers in hallways, while the most stable patients — those already diagnosed and treated, and those awaiting placement in the community — have access to higher quality care in staffed inpatient beds. Although logic suggests that patients with the greatest need for acute care interventions should have first priority for hospital resources, institutions seem to have accepted a system where exactly the opposite occurs. This perverse model of allocating acute care resources can be described as "normalization of deviant behaviour."

Overcrowding reduces access to emergency evaluation and treatment, but an often-overlooked aspect of the problem is the decreased and inappropriate care provided to patients who require hospitalization. Emergency departments were designed to provide immediate lifesaving care as well as assessment, diagnosis, and treatment of medical and surgical urgencies and emergencies. They were not intended to function as inpatient care units. In the emergency department, patients lie on hard stretchers — not beds. They are held in large open rooms where the lights never go off, where the noise never stops, and where normal sleep is impossible. They generally lie in full view of medical personnel, other patients and, in many cases, the public. There may be one bathroom for every 20 to 30 patients. Comfort, dignity, privacy and confidentiality are foreign concepts — especially when there are additional patients crammed into waiting rooms, hallway spaces and between existing stretchers.

Why previous solutions have failed

Illness and injury are neither constant nor predictable. Peaks and valleys in patient acuity and volume are the rule rather than the exception. When more patients arrive requiring urgent and emergent care, it is the emergency department's responsibility to cope with this input variability and provide the necessary care. Similarly, when more patients require inpatient care, it is the hospital's responsibility — not the emergency department's responsibility — to provide this. Although it is generally acknowledged that overcrowding is a system problem rather than an emergency department problem, most hospitals maintain policies and procedures that contain

overcrowding in the emergency department as much as possible. These policies eliminate motivation on the part of anyone outside the emergency department to solve the problem — hence they guarantee failure. As long as 'policy firewalls' artificially focus overcrowding pressures in emergency departments, there will be little impetus for meaningful, system-wide change to solve this key access problem. The negative impact of overcrowding on patient care must be the motivator to create an overall institutional acceptance that this workload must be shared.

Management strategies

Numerous strategies targeting emergency department overcrowding have been developed over the past 15 years (Lynn & Kellerman; Graff; American College of Emergency Physicians; Lynn; Lynn & Yeh; American Association of Emergency Physicians, American Hospital Association; Feferman & Cornell; Drummond). These have had a mitigating effect on the problem, but they do not counter the impact of hospital and bed closures, and our aging, increasingly complex emergency department patient population. Appendix A lists several strategies that will improve access to care, maximize quality of care, and help maintain patient dignity.

Within the emergency department, it is important to optimize internal processes, reduce avoidable admissions and shorten ED lengths of stay. However, because the core of the problem is poor access to inpatient hospital beds, the most effective strategies will be those that improve inpatient utilization and focus on moving the 'right patient' to the 'right bed' within a reasonable timeframe. It is essential that all stakeholders participate in implementing the necessary strategies, since this is beyond the capability of the emergency department. Responsibility for successful implementation ultimately lies with the hospital administrations, regional health boards and government.

Alternate level of care (ALC) patients

Health care restructuring and regionalization have dramatically decreased the number of acute care beds over the past decade, forcing many hospitals to target unrealistic occupancy rates of over 90%. A recent British study looking at occupancy rates has shown that "at rates above 85%, risks become discernable and above 90%, the hospital system is subject to regular bed crisis" (Bagust & Posnett, 1999).

ALC patients include those requiring chronic care, chronic complex care, transition care, respite care and palliative care. These patients have a large impact on hospital occupancy rates and frequently block access to acute care beds. While they do not require the specialty services and high-level care provided in acute care institutions, they cannot be discharged home and, when all appropriate community beds have been occupied, they must, by default, stay in the acute care setting. Furthermore, when these patients present to emergency departments, there is often no option but to admit them to the hospital. Because of the number of these patients and their required lengths of stay, they consume a disproportionate amount of acute care resources and have a large impact on the delivery of acute care. If ALC patients could be placed in appropriate community settings, the issue of emergency department overcrowding would be minimal in most acute care hospitals.

The solution to this problem is to ensure that there is an adequate number of ALC beds outside the walls of acute care institutions. This is perhaps the most looming factor in the overcrowding problem, and it will increase dramatically over the next decade as the population ages and their care needs increase. Consequently, health care planners must assign a high priority to quantifying and resolving the extent of ALC needs in Canadian communities.

The Canadian Association of Emergency Physicians and the National Emergency Nurses Affiliation have developed this position statement regarding overcrowding in Canadian hospitals:

Access to acute care in the setting of emergency department overcrowding

Access to emergency care

Hospital emergency departments must be capable of providing access to appropriate assessment and treatment within timeframes specified by the Canadian Triage Acuity Scale (CTAS). Appropriate assessment and treatment requires, at minimum, an available stretcher, a qualified nurse, and the equipment and supplies necessary to deal with conditions requiring urgent and emergent intervention.

Access to hospital care

Emergency departments are loud, brightly lit environments where patients lie on hard stretchers with limited privacy or dignity, poor access to bathroom facilities, and with little or no opportunity for sleep. These are not reasonable or humane conditions for sick people. Patients requiring hospital admission should not be held in emergency departments, hallways or waiting rooms for more than six hours.

Improving acute care access

Institutions that cannot provide these defined levels of access to emergency and hospital care must implement strategies that focus on moving inpatients to appropriate hospital beds within six hours. Strategies to move non-urgent patients out of the emergency department will not have a meaningful impact on overcrowding or access to care.

Match care level to need

To gain the maximum health benefit from our overstretched acute care system, it is essential to match patient need to level of care. Denying ill and injured patients access to emergency or hospital care because acute care beds are occupied by alternate level of care (ALC) patients is both costly and dangerous. Hospitals should modify their policies and procedures to assure that acute care resources are provided on a priority basis to patients who need them the most. Governments and health authorities must provide sufficient community resources and ALC beds to care for patients who no longer require acute hospitalization. Community resources should be provided on a priority basis to patients who need them the most.

APPENDIX A: Potential strategies to deal with overcrowding

Control input wherever possible:

1. Create regional or provincial bed access management to assure that inter-hospital transfers are directed to hospitals that have the capacity to manage the patient requiring transfer.
2. Develop pre-hospital care policies to divert level two and three patients to appropriate nearby hospitals during periods of severe overcrowding.

Avoid unnecessary admissions:

1. Support ED-based programs that reduce the need for hospitalization (e.g., outpatient IV antibiotics; outpatient anticoagulation for venous thromboembolism; ED procedural sedation for appropriate minor operative procedures).
2. Create 12- to 24-hour rapid diagnosis and treatment units that aggressively investigate, treat and discharge patients who would, in the past, have been admitted to hospital. These units may be based in emergency departments.
3. Increase emergency department access to diagnostic tests when these tests preclude the need for inpatient investigation.
4. Assign a discharge coordinator for the emergency department.
5. Establish multidisciplinary ED-based rapid response teams to coordinate community supports and enable discharge of patients who will not benefit from hospitalization (e.g., the frail elderly).
6. Nurture closer liaisons with primary care providers to assist with patient disposition.
7. Develop information systems to facilitate the transfer of valuable patient information from the community to the ED and from the ED to the community.

Enhance the flow of sick patients from the emergency department to the ward:

1. Assign top priority to emergency admissions.
2. Distribute supernumerary (i.e., "hallway") patients equally between all wards, including the emergency department.
3. Institute "daily quota" beds. If there are an average of 10 admissions per day, inpatient units should assure that 10 daily quota beds are available to accommodate the expected admissions.
4. Designate "flex beds" that can be used by different services based on daily need.
5. Establish "admission units" during peak daytime hours. Such units, physically separate from the emergency department and staffed by ward nurses, would accept and hold admitted patients from the ED until their assigned inpatient bed is ready. This decompresses the ED and reduces the need to admit off-service when the "right" bed will be available later the same day.
6. Allow direct admission to the floor for stable patients being transferred from another facility when a bed is open on the floor.
7. Invoke a "30-minute rule" for transfer to the floor when a bed is assigned.
8. Automatically assign patients to "off-service beds" when defined ED thresholds are reached.
9. Establish acceptable consultation timeframes to avoid disposition and treatment delays.
10. Electronically capture key process times, including time to ED stretcher; time to physician; time to disposition decision; consultation delay; length of stay for admitted and discharged patients.

Executive summary

- emergency department overcrowding can be defined as: a situation in which the demand for emergency services exceeds the ability to provide care within a reasonable timeframe, causing physicians and nurses to be unable to provide appropriate and timely quality care.
- emergency department overcrowding is a critical problem in the health care system.
- emergency department overcrowding has been escalating for more than a decade despite numerous attempts to resolve it. Hospital restructuring, regionalization and bed closures have all exacerbated the problem.
- the main cause of emergency department overcrowding is the practice of holding admitted patients in the emergency department when inpatient beds are full or unstaffed.
- holding admitted patients in the emergency department for several days has, for unexplainable reasons, become routine practice.
- this routine practice can be described as the "normalization of deviant behaviour", as this practice has become the norm with the impact on patient care being contrary to what the health care system is intended to provide.
- emergency department overcrowding is directly associated with access to patient care in that:
  - it blocks access to quality care for patients presenting to the emergency department
  - it impedes and blocks access to quality care for patients being treated and assessed in the emergency department
  - it has a significant negative impact on and blocks access to appropriate care for patients admitted to the hospital who must stay in the emergency department
  - it results in a loss of patient dignity, privacy, safety and confidentiality when they are examined, treated and admitted into the emergency department hallways
- well-defined emergency department overcrowding management strategies have been developed and must be implemented.
- the deficiency of long-term care resources outside of acute care facilities is the single most important factor in blocking acute care beds
- hospitals, health care authorities and governments must come to the realization that emergency department overcrowding and access to care is a quality of care, patient safety, patient dignity, privacy and confidentiality issue which is a joint responsibility.
- while long-term solutions are developed, hospitals must share the workload and burden to minimize the impact of access to patient care in the setting of emergency department overcrowding.

11. Identify and open over-census beds when specified emergency department thresholds are surpassed. This may necessitate opening temporarily closed beds, using non-traditional spaces like sunrooms, conference rooms and auditoriums, or adding beds to existing rooms.

Optimize inpatient acute care lengths of stay

1. Assign a utilization coordinator for the hospital.
2. Ensure there is a most responsible physician (MRP) accountable for every admission.
3. Identify length of stay (LOS) benchmarks for key case-mix groups, establish LOS targets, and measure performance.
4. Estimate expected LOS for patients at the time of admission.
5. Begin discharge planning at the time of admission. This includes a discharge notification process.
6. Electronically monitor key discharge processes, including time from discharge to bed availability and time from bed availability to transfer.

Provide alternate levels of care for alternate level of care (ALC) patients

1. Lobby for appropriate availability and utilization of community subacute and ALC beds.
2. Move patients who are "just waiting" (e.g., for investigations, for a ride home) out of hospital areas that are staffed for acute care.
3. Designate a discharge lounge and suitable waiting areas.
4. Match care provided to care required. Do not occupy acute care beds with patients who do not need them. Move ALC patients to defined units or holding areas where staffing levels and care resources provided match what the patient requires.

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Nursing Management Strategies - Questions and answers reveal the secrets to successful nursing management

Author: Polly Gerber Zimmerman
Published by Hanley & Belfus, 2002, 243 pages ISBN 1-56053-529-6

This is a small book that is packed full of information for new nurse managers and for more experienced managers as well. The foundation of the book is to provide information on common issues and topics that concern nurse managers. The book has six sections entitled: management role differences; planning and organization; staffing; directing and controlling; meeting standards; and related topics. Within each section there are chapters that discuss such topics as management and leadership styles, managing budgets, recruitment and retention, coaching and mentoring, ethics, and managing your career. I especially liked the chapter on managing generation X employees. This chapter reviews the characteristics of the generation X nurse, and the differences between generation X and the baby boom nurses. It also explains how best to communicate to the generation X nurse. In the chapter on recruitment and retention, see what the author has to say about recruiting Canadian nurses.

The format used is question and answer, with the answers written in point form, which makes for easy reading. The information is concise and includes valuable pearls, tips, memory aids, bulleted lists, and tables for quick review. The bibliography is extensive.

While this has been written by an American author with an American audience in mind – hence the chapters on managed care and regulatory issues, there is much information that is germane to any manager, new or old, from any country.

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

Budgeting concepts for nurse managers (Third Edition)

Author: Steven A. Finkler
Published by W.B. Saunders, 2001, 431 pages ISBN 7216-7802-5

I wish that I had known about this book when I became a manager six years ago. While I learned about budgeting, variance analysis, and FTE requirements through on-the-job experience (and much trial and error), this book would have helped to provide me with the additional knowledge, tools, and techniques to help me understand the concepts as well as increase my skill in budgeting for a busy emergency department.

The goal of this book is to improve the budgeting skills of new and veteran managers. The information covers a wide range of budgeting skills, and is directed toward the first-line manager who has the immediate responsibility of planning and controlling his/her unit budget. There are also chapters that address benchmarking and productivity that will be of interest to mid-level and top nurse executives.

The concepts discussed in the book are relevant for many health care settings such as hospitals, clinics, home care agencies, and hospices, to name a few.

The format of the book makes for easy reference if you are interested in a specific concept, because chapter outlines are provided in the table of contents. Each chapter has identified goals and at the end of the chapter there is a summary and implications section for the manager. Each chapter identifies additional reading as well as a suggested reading list at the end of the book. A glossary is provided at the back of the book that provides definitions for unfamiliar terms. The appendix contains formulas, sample budget sheets, and worksheets.

While the world of budgeting might seem like foreign territory, this book has been written at a level that assumes no previous financial experience, and it explains concepts clearly using actual situations that managers encounter. This book could assist you in improving your communication with your finance department and improve your ability to participate in the yearly budgeting process.

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

Outlook Conference watch

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

Emergency Nurses Interest Group of Alberta (ENIG)
AGM and Emergency Nursing Conference, October 3-5, 2003, Delta Lodge, Kananaskis
• There will be a Peds CTAS workshop on October 3 prior to conference. For more information contact: Shelly Anderson: mygang@sprint.ca, Pam Little: pamordon@telusplanet.net, or Troy Sebastian: hiopd@nwhsr.com

The Nuts and Bolts of ED Nursing
Regional Emergency Nursing Conference, May 2004, Charlottetown, PEI
For further information, contact: Celie Walsh-Gallison: celie_gallison@hotmail.com

Grampa the good ghost

Over the years, working in a busy, pediatric tertiary emergency department, I was always amazed at the great artistic talent of so many of my nursing colleagues. Displayed in tole painting, knitting, memory books, and now poetry, so many emergency nurses have a deeply creative side. These nurses surely bring this creativity to the art and science of their nursing practice every day.

The poetry submission for this edition's pediatric section comes from Gary Bussiere from the Children's Hospital of Eastern Ontario (CHEO). Gary has worked in the CHEO ED for nine years. For the last three years, Gary has been a member of the ED's clinical leadership team in his role as clinical leader. The child-friendly and family-focused manner with which Gary approaches his day-to-day nursing life is clearly evident in his children's poem, entitled Grampa the Good Ghost. Enjoy!

By Gary Bussiere

It was a time of the day, a time I feared the most:
In my bed, in the darkness, in the land of the ghosts.
I'd say all my prayers, bid my Mom and Dad 'night;
Then they'd close the door and would turn out my light.
Well, it wouldn't be long after Mom and Dad parted,
That the room would get scary, and the haunting had started.

Bad little creatures that would screech, fly, and swing,
Drop onto my bed, and do scarier things.
They would climb up my curtains, and jump from the lights,
And leave me half frozen with a bad case of frights.

No night was special, they came and went as they pleased,
They taunted, they name called, they laughed and they teased.
I'd call to my parents, they'd turn the lights on,
And just like a miracle, these creatures were gone.

They'd try to convince me these creatures weren't real,
To cut out this foolishness, it was no big deal.
But the moment they left me, and went back to sleep,
These creatures, by hundreds, from the walls they would seep.
They would start out again, having fun in the dark,
And my room became one big amusement park.

This went on for years, from darkness to dawn,
And then in the morning, with sunrise, be gone.
I tried everything that I knew then, to chase,
All the creatures away, but they'd laugh to my face.
One evening my fear had not quite reached its peak,
When in walked a ghost, with a smile, cheek to cheek,
His dark hair was flaked with white all around,
And he did not float; his feet walked on the ground.

He proceeded to walk through my room, around my bed,
To safety, deep under my covers, I fled.
I felt the bed sink as he sat by my side,
And I dug down deeper, to hide, and I cried.

Don't be nervous, the ghost said, and started to laugh,
Think of funny animals, for instance, giraffes.
Think of your fun, with your friends at the park,
Don't think of your fear as you lay in the dark.
This advice comes from many, I won't try to boast;
Bestowed upon you by your Grampa, the Ghost.

Every night, just prepare as you get ready for bed,
Think of fun, laugh and dreams, everything that I've said.
Smiling's the best, oh these creatures can't take,
A happy young child, that won't cower and shake.

Just laugh when they come, and these creatures won't stay,
For a happy young child, puts an end to their play.
One thing to remember, while you are so young,
That Grampa protects you, when darkness has come.

Not all Grampas are ghosts, some you see everyday,
Some you talk on the phone with, some live far away.
Ghosts don't exist, they're only in your mind,
And that all fades away, with the passage of time.

Case study: 17-year-old motorcycle driver hit by a truck

By Susan Phillips, RN, MScN, ENC(C), and Jo-Anne O'Brien, RN, MScN, ENC(C)

Introduction

At approximately 16:00, Jim, a 17-year-old male, is hit by a truck while riding his motorcycle. He is transported, by ambulance, to the emergency department (ED) of a community hospital. Jim arrives in the ED at 17:00. Initial assessment reveals: A. airway patent; B. breathing spontaneously, but with decreased air entry to bases; C. no obvious external bleeding and vital signs are BP 99/52, HR 110, RR 18, and T 38.3° C (no oxygen saturation recorded); D. alert and oriented. The only major findings during secondary assessment are a fractured left femur and tibia. Treatment at the community hospital includes O_2 by nasal prong, IV access, and a Thomas splint on the left leg. The decision is made to transfer Jim to a regional trauma centre.*

Jim arrives at the trauma centre approximately 18 hours post-injury (delay in transfer due to bad weather). Jim is alert and breathing spontaneously (on room air) when he arrives at the ED of the trauma centre. He is pale and denies chest pain. At this point his oxygen saturation is 80%, BP 115/60, HR 108, RR 24 and T 37.9°C. His skin is warm and dry, but petechiae are noted on his chest. His left leg remains stabilized with the Thomas splint. During the course of his stay in the ED, Jim's HR ranges between 106 and 179 bpm while his BP remains stable. His oxygen saturation increases to 97% after three hours of 100% O_2 by non-rebreather mask. Both ICU and anesthesia are consulted for assessment due to his low oxygen saturation. The decision is made to admit Jim to the trauma unit – an intermediate care unit with cardiac and hemodynamic monitoring capabilities – rather than the ICU. Prior to admission, Jim is sent for a CT scan of his chest. He is finally admitted to the trauma unit six hours after his arrival in the trauma centre.

What do you suspect may be causing Jim's respiratory distress?

Discussion

If you suspect fat embolism as the cause of Jim's respiratory distress, you are correct! Fat embolism is defined as the presence of fat globules in the lung parenchyma and peripheral circulation, resulting in acute respiratory distress. Fat embolism syndrome (FES) is defined as acute respiratory deficiency due to decreased alveolar diffusion of oxygen (Hager & Brncick, 1998).

The literature reports that the incidence of FES can range from 0.5% to 2.2% of all cases that involve long bone (femur, humerus, tibia) fractures, but this statistic will increase if there is more than one fracture, especially if one is a pelvic fracture (Hager & Brncick). Fat embolism may occur in other forms of trauma including massive soft tissue injury, severe burns and liposuction, as well as in non-traumatic conditions such as diabetes and pancreatitis (Walsh, 2002). FES may occur from within one hour after injury up to 72 hours later, with the average time of occurrence being 12 to 24 hours (Hager & Brncick).

This is significant for the ED nurse who may believe that fat embolism is a post-admission complication. It is essential to have a high index of suspicion and intervene early (Walsh).

Hypoxia is the hallmark symptom of FES (Walsh). Other symptoms of a respiratory nature include tachypnea, dyspnea, productive cough, hyperventilation, moist crackles, pulmonary edema, hemoptysis, and cyanosis. A chest x-ray may reveal a classic snowstorm or ground glass appearance. This respiratory failure will result in an increased cardiac workload (reduced cardiac output and hypotension) and alveolar collapse. Other symptoms that may develop include cardiac

* *a pseudonym was used to protect the identity of the patient*

arrythmias (specifically RBBB, inverted T waves, prominent S waves in lead I, prominent Q waves in lead III, and depressed ST segments), vague chest pain, restlessness, a rapid spike in temperature and decreased urine output (Hager & Brncick; Walsh). Drowsiness and coma are later signs (Walsh). Neurological (cerebral dysfunction) and dermatological (petechiae) symptoms may also be evident in FES (Walsh).

Diagnosis is considered definite if all three of the following criteria are present within 72 hours of a traumatic fracture:

- Unexplained dyspnea, tachypnea, arterial hypoxia with cyanosis and diffuse alveolar infiltrates on chest x-ray
- Unexplained signs of cerebral dysfunction such as confusion, delirium or coma
- Petechiae over the upper half of the body, conjunctiva, oral mucosa and retinae (Walsh; Prazeres, 2002). Bear in mind, however, that petechiae appear only in 50 to 60% of patients, usually within 24 to 48 hours, and can disappear after a few hours (Hager & Brncick).

Another classic sign is a rapid temperature spike (38 to 40° C) with no obvious precipitating cause (Walsh).

Diagnostic tests

Arterial blood gases will provide an early indication of hypoxemia. The patient will exhibit respiratory alkalosis at first, due to their tachypnea and dyspnea, and then they will progress to respiratory acidosis as their PaCO2 increases and their PaO2 decreases. Complete blood count may reveal a decrease in hemoglobin by three to five grams and a platelet count of less than 150,000/ml. Platelets may drop as low as 50,000/ml (Hager & Brncick).

Management

Prevention and early recognition are the keys to managing FES. Early stabilization and immobilization of fractures will also reduce the incidence and are essential (Hager & Brncick). This is especially pertinent for the ED nurse who has a key role in ensuring that any suspected fracture is immobilized correctly and any movement is minimized. If any splints are removed during assessment, the injured extremity should be immobilized/re-splinted afterwards. If we know which patients may be at risk, we can provide adequate oxygenation and ensure adequate fluid resuscitation to flush the fatty acids through the system and prevent renal failure (Hager & Brncick).

Baseline vital signs, including temperature and oxygen saturation, must be documented. Ongoing monitoring of vital signs and neurological status are essential for all patients at risk. Any abrupt change in behaviour or mental status may be the first sign of deterioration in the patient's condition (Walsh).

Treatment includes oxygen and frequent ABGs. If the PaO_2 cannot be maintained above 60 mm Hg, the patient may need to be mechanically ventilated with PEEP. Some patients will be managed well with noninvasive positive pressure ventilation (Hager & Brncick).

While some feel that the mortality from isolated FES is as low as 10% (Prazeres), if it occurs with other sequelae such as acute respiratory distress syndrome, pneumonia, congestive heart failure or coma, then the outcome is less likely to be positive and may be fatal in up to 87% of patients (Hager & Brncick).

Jim's course in hospital

Jim's course in hospital was not smooth. A chest x-ray on day two post-admission suggested a grade two acute respiratory distress syndrome (ARDS). There are four phases of ARDS which range from mild physical symptoms and a normal chest x-ray (Grade 1) to severe alternations in lung compliance resulting in difficult ventilation (Grade 4) (Horn & Lewis, 1991). He was subsequently transferred to the ICU when his oxygen saturation dropped to 75% and his PaO_2 was 82. In the ICU, intubation was considered but Jim was maintained on BiPAP.

Jim was also transfused after repeat bloodwork revealed his hemoglobin had dropped from 100 (on arrival) to 70. He was started on Fragmin for DVT prophylaxis. Jim was also noted to have weakness of his extensor hallucis longus in his left foot, paresthesia to the sole of his left foot, and he was unable to dorsiflex the great toe.

Once Jim's condition stabilized (on day 14), he was taken to the operating room for intramedullary fixation of his left femur and left tibia. Post-op he was seen by physiotherapy and occupational therapy. Jim's respiratory status gradually improved, but he developed neuropathic pain in his left foot as the result of a nerve injury. Twenty-two days after his admission to the trauma centre Jim was transferred back to his community hospital for rehabilitation.

Conclusion

Complications from fractures can occur at any time post-injury. Early recognition and stabilization of lower extremity injuries will minimize the risk of trauma patients developing pulmonary or other complications. Emergency nurses, in both community hospitals and trauma centres, have a key role in assessment and intervention of trauma patients to reduce the risk of complications.

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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/CEUs: _____ 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 director's 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: _____

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

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