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

Volume 27, Number 1, Spring 2004

In This Issue:

Call for nominations: "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 Charlottetown, PEI. 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 Celie Walsh-Gallison. 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 Charlottetown, PEI.

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 April 27, 2004, to: Celie Walsh-Gallison, Suffold Road, RR#3, Charlottetown, PEI C1A 7J7 fax: 902 894-2927.

outlook

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

Volume 27, Number 1, Spring 2004

Outlook is the official publication of the National Emergency Nurses' Affiliation Inc., published twice annually by Pappin Communications, 84 Isabella Street, Pembroke, Ontario.
ISSN 1499-3627

Editorial staff

Editor: Valerie Eden, valeden@hfx.eastlink.ca
Ideas@Work: Pediatrics: Allyson Shephard, shephard@cheo.on.ca
Research: Cathy Carter-Snell ccartersnell@mtroyal.ab.ca
FN6RN: Sheila Early sheiladawn_early@telus.net

Editorial board

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. Rate card available at www.pappin.com

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

NENA elected executive

President
Carla Policicchio, 4712 Whitemud 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

Past-president
Anne Cessford, 12555 19th Avenue
Surrey, BC, V4A 9P1
(H) 604 541-7830; (W) 604 588-3369
fax: 604 585-5679;
e-mail: acessford@telus.net

Secretary
Janet Calnan, 1500 Burnside Road West, RR#3, Victoria, BC, V9E 2E2
(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 directors

British Columbia
Clay Gillrie, 106 West 12th Avenue,
Vancouver, BC, V5Y 1T7
(H) 604 874-8185; (W) 604 456-8021
e-mail: clay_gillrie@bcit.ca

Alberta
Troy Sebastian, Box 3480,
High Level, AB, T0H 1Z0
(H) 780 926-5557; (W) 780 841-3200;
e-mail: tsseb@telusplanet.net

Saskatchewan
Chris Norman, 2124 C Robinson St.,
Regina, SK, S4T 2P7
(H) 306 924-4200; (W) 306 766-2390
e-mail: Norman81@hotmail.com

Manitoba
Irene Osinchuk
495 St. Anthony Ave.,
Winnipeg, MB, R2V OS4
(H) 204 586-4547; (W) 204 787-3486
e-mail: iosinchuk@hsc.mb.ca

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@ripnet.com

New Brunswick
Alison Bulmer, 280 rue Centrale,
Memramcook, NB, E4K 3S4
(H) 506 758-3997; (W) 506 857-5353;
fax: 506 875-5360;
e-mail: abulmer@nb.sympatico.ca

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
(H) 902 629-1462; (W) 902 894-0130;
fax: 902 894-2927
e-mail: celie_gallison@hotmail.com

Newfoundland & Labrador
Joanne Collins
49 Ennis Avenue, St. John's, NFLD, A1A 1Y7
(H) 709 579-3133; (W) 709 777-6115;
fax: 709 777-8007;
e-mail: Joanne.Collins@nf.sympatico.ca

Committee chairs

Awards/Bursaries
Celie Walsh-Gallison, Suffold Road,
RR#3, Charlottetown, PEI, C1A 7J7
(H) 902 629-1462; (W) 902 894-0130;
fax: 902 894-2927
e-mail: celie_gallison@hotmail.com

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

Nursing Practice
Chris Norman, 2124 C Robinson St.,
Regina, SK, S4T 2P7
(H) 306 924-4200; (W) 306 766-2390
e-mail: Norman81@hotmail.com

Research
Clay Gillrie, 106 West 12th Avenue,
Vancouver, BC, V5Y 1T7
(H) 604 874-8185; (W) 604 456-8021
e-mail: clay_gillrie@bcit.ca

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

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: Triage - protecting patients and nurses

One of the most prevalent and frustrating issues identified by emergency nurses is the challenges and vulnerability of the role of the triage nurse. Efforts have been made over the last year to collaborate with the Canadian Association of Emergency Physicians (CAEP), and to develop a national position statement on the impact of overcrowding within emergency departments. The implications of emergency departments crowded with patients waiting for inpatient beds have resulted in severe reductions of emergency stretchers and exceedingly long waits. The impact on the triage nurse has been such that patients who require treatment are left for the triage nurse to reassess and re-prioritize to ensure that conditions do not change drastically in the waiting room and that the most ill remain to be seen first. Subsequently, the triage nurse has been placed in the most vulnerable and risky position of all emergency staff. How can we, as the National Emergency Nurses Affiliation and individual emergency nurses, assist our nurses and provide them with practice standards which may be utilized to establish standards within their own facilities, and at the same time provide national benchmarks they can use as references to address issues within their facilities?

The National Canadian Triage and Acuity Scales developed between CAEP, NENA, CPS (Canadian Pediatric Society), and Quebec Emergency Physicians, provides Canadian standards for emergency triage. Of great concern are the reassessment standards and the impact on workload. These reassessment times provide nurses with guidelines to ensure that patients, as they are waiting for extended times in our emergency waiting rooms, are being assessed and re-prioritized. Although this is placing a great deal of pressure on the triage nurse, we really need to look critically at the option of not doing the reassessments. Regular reassessments ensure that we are evaluating patients' status routinely and maintaining a safe environment for our patients. Realistically, it is also not without pressure, from a staffing standpoint. How can we, as advocates for our patients, promote safe emergency care and prepare for these challenges and pressures on our triage nurses?

To ensure that triage nurses are covered by their facilities, and maintaining expected standards of care, one of the first issues which needs to be addressed is to be sure that there is a policy for your institution that outlines the triage procedure. NENA also has developed national position statements on triage that can be utilized as a national benchmark. Through appropriate documentation, triage nurses can demonstrate due diligence in their practice. Next is to maintain current knowledge and skills in triage. The National Pediatric CTAS course is available to assist in this area. Revisions to the adult CTAS standards are underway and will include sections on the elderly, mental health, and obstetrics and gynecology. A working group comprised of CAEP and NENA representatives will be presenting the revisions at the national CTAS working group in Montreal in April, and an educational program which incorporates these additions will also be presented. Our ultimate goal will be the eventual amalgamation of both the pediatric and adult CTAS in one course. At this time, however, the Peds CTAS course is available and efforts are being made to ensure access to these courses.

Are the national standards an obstacle or are they a benchmark to assist us to promote and ensure adequate, safe care for our patients? I believe we cannot and should not lower standards because they are challenging to maintain, but rather should look upon them as a national reference by which our care will more than likely be measured, should our care be in question. As a result, we need to collectively work with our facilities to strive towards meeting these standards. We, as emergency nurses, can and will continue to work on issues which impact on the care of emergency patients, such as throughput, overcrowding, and prolonged waits. In the meantime, as professionals providing care, we need to focus on both ensuring that we are working with our facilities to clarify expectations through establishing triage policies and procedures, as well as continuously increasing our knowledge and skills as triage nurses. As your representatives, NENA, comprised of your provincial directors, will continue to work on national issues to support the challenges we are all facing daily. Continue to communicate your issues and concerns through your provincial directors to ensure that we, as a group, are collectively working on issues that make a difference to each of us daily.

Carla Policicchio,
RN, MA, BScN, ENC(C)

From the editor

It has been a rollercoaster of a ride over the past few months for me and for many of my colleagues, both personally and professionally. In September, Nova Scotia and in particular the Halifax area was hit hard by Hurricane Juan. The "storm of the century" changed forever the landscape of the city I have lived in for my entire adult life. While the degree of destruction saddened me, I was at the same time very proud of all the health care providers who worked in the local hospitals and who, at some cost to themselves and their families, came to work every day during the disaster. The "emergency community" lost a friend and colleague, John Rossiter, a paramedic who died during the height of the hurricane – doing a job that he loved.

The Christmas season coincided with the flu season and proved to be a monster as emergency departments were flooded with patients – many very sick patients. Our local emergency departments were overwhelmed with large numbers of admitted patients who stayed for days in the emergency departments waiting for beds, while those seeking care spent hours out in the waiting rooms. It was a small consolation that our situation here was not unlike what was being experienced across the country. Nurses at the Halifax Infirmary Emergency Department took action into their own hands by going public with their union. They held a press conference and explained their fears of providing care in a jammed emergency department. This prompted a public discussion about the ongoing pressures experienced in emergency departments across the province. More specifically, discussion between the government and the Capital Health District led to the implementation of the *10-point plan*.

Following Christmas, the paramedic and emergency family of Nova Scotia was dealt yet another blow as another veteran paramedic, John Wyllie, died in a tragic home invasion. It has been a rough few months for us. Yet, we continue to go to work and in tragedy, it has brought us closer together, united in a common bond of friendship.

The stresses of the past few months have certainly taken their toll on all of us. We continue to face challenges, yet we have learned valuable lessons about ourselves that keep us motivated to keep moving forward. Our experiences here in Nova Scotia are no different than the experiences of emergency nurses across the country. Share your stories with us – what have been your challenges and, more importantly, what did you do about them?

I encourage you to begin writing about those experiences and submit to this journal. We want to hear from you!

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

Board meeting observer policy

NENA Policies & Procedures 5 . 6 . 0

NENA board of directors' meetings are open to NENA members on a pre-arranged basis.

The objectives of open board of directors' meetings are to enhance the board's accountability to those who have an interest in the affiliation's affairs and to facilitate member understanding of the board's governance of the emergency nursing specialty.

Observer policy

- Those wishing to observe a NENA board of directors' meeting will contact the NENA president with their wish to do so at least 30 days prior to the board meeting when possible.
- Numbers of observers allowed will be at the discretion of the board.
- If the request is less than 30 days in advance of a NENA board of directors' meeting, it will be at the discretion of the NENA executive as to whether or not permission will be granted.
- All observers shall be identified at the beginning of the meeting.
- A review of observer expectations will be outlined at the start of the meeting and are as follows:
  - i. Observers, prior to the start of the meeting, must agree to confidentiality of matters discussed.
  - ii. Observers will not be allowed to attend in-camera sessions.
  - iii. All observers will have non-voting status.
  - iv. Observers may not enter into the discussion of the business of the board.
  - v. The observer may comment in writing to their official representative while the meeting is in progress.
  - vi. Observers cannot be elected to chair a standing committee.
  - vii. Observers will be placed in a row behind the table where the meeting is held, depending on the number of observers present.
  - viii. NENA, Inc. will not be responsible for any expenses incurred by the observer attending a NENA board of directors' meeting (i.e., meals, accommodation, travel, etc.).
  - ix. If any observer becomes disruptive, they will leave the BOD meeting immediately on the request of the president.

Outlook Bouquets

The board of directors expresses its thanks and appreciation to Anne Cessford who will be completing her role as past-president in July. During her term as president, Anne has worked tirelessly to develop partnerships with other national associations and to ensure that NENA's voice was heard nationally. We wish Anne all the best in her future endeavours.

To the emergency nurses at the Halifax Infirmary Emergency Department at Queen Elizabeth II Health Sciences Center in Halifax, Nova Scotia for having the courage to inform the public about the issues of overcrowding in the province's largest emergency department.

To emergency nurses throughout Nova Scotia who worked through Hurricane Juan and again through "White Juan". For those staff who stayed hours and hours past their regular shift, covering for the staff who couldn't get in to work. To the many staff who walked, skied, or used snowmobiles, sleds, or whatever in order to get to work. Their ingenuity and persistence were remarkable.

To Kate Mahon, Health Services Manager of Emergency and Critical Care Services, Children's Health Program at IWK Health Centre, Halifax, NS for acknowledging the work of the preceptors within the program by supporting membership in their professional associations.

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

Outlook 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) authorization to use the photograph of (subject's name) in the **NENA Outlook**.

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

Deadline dates:
February 20 and August 16

Outlook
Conference watch

The Nuts and Bolts of ED Nursing

Come to the Island... for a weekend of "NUTS AND BOLTS" emergency nursing in Charlottetown, Prince Edward Island. May 14-16, 2004. Hosted by PEIENA (PEI Emergency Nurses Association). For further information contact Celie Walsh-Gallison, Conference chair @ (902) 629-1462, or e-mail: **nutsandbolts@isn.net**

Code Triage: National Triage Conference

Host: Vancouver General Hospital Emergency Department, June 11, 2004, Vancouver, BC. For further inquiries please contact Claude Strang: **cstrang@vanhosp.bc.ca**, or Monique McLaughlin: **mmclaugh@vanhosp.bc.ca**

Emergency Nurse Interest Group of Alberta, AGM & Conference

October 1-3, 2004, Kananaskis Resort and Conference Centre. For more info contact Pam Little: **pjlittle@ucalgary.ca**

Pediatric CTAS course

October 1, 2004, 0930-1700, Kananaskis Resort and Conference Centre. Contact: **judyskanderup@hotmail.com**

Partnerships, National NENA Conference

May 14-15, 2005, Kelowna, BC. For further information, contact Clay Gillrie: **clay_gillrie@bcit.ca**

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

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

1. Contest will be advertised in **Outlook**
2. Provincial representatives are encouraged to promote the contest among their membership.
3. Articles must be submitted directly from the author. Provincial newsletters forwarded to the communication officer for selection of items to include in **Outlook** will not be considered in the lottery. Please refer to the submission guidelines included with this issue.
4. Primary author's name will be entered into the draw (in the event of multiple authors).
5. Names will be entered into the draw beginning with the winter 2003 edition of **Outlook** and ending with the winter edition of 2005.
6. The communication officer will maintain a record of names entered into the lottery.
7. The NENA president will randomly draw the name of the winner.
8. The NENA president (or delegate) will notify the winner and will communicate with the winner to ensure conference registration, hotel booking at the convention rate, and travel arrangements are made at the most economical rate to the maximum value of $2,000.00.
9. The draw will occur in January prior to the national NENA conference to allow the winner to arrange their time off to attend. In addition, this allows time to obtain the best fares and booking of a hotel room at conference rates.
10. The winner of the lottery will have three weeks in which to accept their prize. In the event the winner is unable to claim their prize, a second name will be drawn. The prize is non-transferable.
11. The winner will make his or her own travel arrangements.
12. The winner's name will be published in **Outlook.**
13. The winner must be a NENA member at the time of submission.
14. NENA board of directors and **Outlook** section editors are exempt.
15. Articles are published at the discretion of the communication officer.
16. NENA board of directors has approved the contest rules.

The next National Emergency Nurses Conference is in British Columbia in 2005.

Outlook
Book reviews

Canadian Essentials of Nursing Research

Authors: Carmen G. Loiselle, PhD, RN, Joanne Profetto-McGrath, PhD, RN, Denise F. Polit, PhD, and Cheryl Tatano Beck, DNSc, CNM, FAAN
Published by Lippincott Williams & Wilkins, 2004
519 pages ISBN 0-7817-4281-1

My first question after reading this book is, where was it when I did my undergraduate research course? Nursing research is essential if we are to understand the diverse scope of our profession. We are all aware of the expectation and necessity of nursing research, particularly those of us in clinical practice who utilize the results of scientific study and thus promote evidence-based practice. Finally, here is a book that teaches us all how to read, understand, and translate research findings into practice. Each chapter defines the basic terminology that will be found in the specific chapter and concludes with summary points. I know that this book will be at my side as a reference to guide me through future readings of research papers.

In addition, the key benefit of this book is that it is Canadian-based. Finally, a book that promotes the numerous Canadian nursing research endeavours that have taken place in Canada. It is my hope that **Canadian Essentials of Nursing Research** will be the prime research text recommended and used in schools of nursing across this country!

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

Outlook
Tidbits & Trivia

- North American journalist, Suzanne Gordon, is quoted to say, "Nursing is the security component in the health care system. Nurses prevent the catastrophies. Nurses are the intelligence gatherers. Nurses keep patients safe."
- Toronto oncologist, Dr. Robert Buckman, is quoted to have said, "Bad news is any news that seriously and adversely affects a patient's view of his or her future. Good news is any news which importantly and positively affects anyone's view of their future."
- Ralph Waldo Emerson once said, "Life is an experiment. The more experiments you make, the better."
- You can tell a lot about a person by the way they handle three things; a rainy day, lost luggage, and tangled Christmas tree lights.
- You shouldn't go through life with a catcher's mitt on both hands. You need to be able to throw something back.
- Six critical life messages: I believe in you. I trust in you. I know you can handle it. You are listened to. You are cared for. You are very important to me.
- You know it will be a bad day in the ER when:
  - The off-going shift can't keep a straight face while giving report about the patient in Room 12.
  - Your first patient of the day insists there is no way she could be pregnant.
  - Your next patient screams at you, and you just can't remember ever hearing that many obscenities strung together.
  - Someone on the off-going shift wishes you a Q day.
  - The paramedics on the ramp are using mops to clean up their ambulance.
  - You have writer's cramp, and still have seven hours left in your shift.
  - The paramedics tell you that the arriving patient with a closed head injury, flail chest, and positive belly tap is in much better shape than the one still being cut out of the minivan.
  - You hear there is a flu epidemic travelling like wildfire through the local nursing homes.
  - And finally, the psychiatric patient's delusions are beginning to make sense.

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

Hurricane Juan

By Valerie Eden, Dartmouth, NS

"There's a hurricane coming this weekend," said my husband on Saturday morning. "We'd better put away the deck furniture and the barbecue in the garage. It's supposed to hit us on Sunday evening." And so it began. Like most Maritimers, I wasn't overly concerned about the hurricane. However, I did heed my husband's warning and, with the help of our two sons, we put away the furniture, the barbecue, plants and anything that could get blown away in the wind.

Sunday was overcast and windy. My husband and I went out and bought extra bottled water, fresh fruit, and milk. We checked our supply of candles, batteries, and flashlights. We made sure that our eldest daughter, who lives alone, was prepared. To be honest, a part of me believed that we were over-reacting.

That Sunday evening at about 1930 hours, my husband, who works for EHS (Emergency Health Services), was called into the Emergency Operations Center. I went to work as well. I am the manager of one of the local emergency departments, and I wanted to make sure that the staff were aware of the hurricane, that the disaster fan-out call list was near, and to also advise those staff leaving at midnight to take care and perhaps to head for home early, if possible. I also left word that the staff was to call me if they needed advice or if they had any concerns or questions.

We (my sons and I) watched the progress of the storm on TV. We decided that we would stay in my bedroom because it has a TV, and we would continue to watch the news for as long as the power held. We had our candles and flashlights at the ready. The wind began to blow harder, but it still didn't seem to be so bad. The telephone rang several times as my husband checked in to report on the progress of the storm, and the charge nurse in the ED called to inform me that the tertiary level ED had gone on alert and had asked that we empty out the ED – to admit any patients whom we were holding, and to be prepared to handle any injured people.

By 2330 hours, the wind had picked up considerably and it was raining hard. The power stuttered a couple of times and then the lights went. The eye of the storm was over the mouth of the Halifax harbour. Lying in bed listening to the rain and the wind outside, I could hear a humming sound between the wind gusts. I realized that it was the storm. That humming told me that this storm was different. It was at that point that I became more concerned about our welfare. I know that describing a storm humming sounds strange, but hum it did, and that is when I realized that this was a powerful hurricane. Just before the power went off, the newscaster stated that the high winds and rain would last only another 30 to 45 minutes. In my mind, I thought that meant that the second part of the storm would be less violent. Boy was I wrong – the second half of the storm was even fiercer. The winds were tracked at over 165 KPH. There were massive gusts that made the entire house vibrate. It felt like a giant was shaking the house. At one point, the air pressure changed in the house and I felt the roof lift. It was about then that I thought the boys were right and we should have stayed down in the family room in the basement. My husband called every hour or so. During one call, he told me that there was one death and that one of the ambulances in Halifax had a tree fall on it. One of the crew was trapped inside. Later on, he came home just to check on us – he told me that the paramedic had died. It was all so hard to believe.

The next morning, getting dressed in the dark and attempting to put makeup on by candlelight was interesting, to say the least. I packed a bag so that I could take a shower at the end of the day. Who knew when the power would be back on? The drive to work is usually short, but it took longer that morning due to downed trees, downed power lines and no traffic signals. The only good thing was there was very little traffic. School had been cancelled, people were stranded in their homes, their driveways blocked by downed trees or power poles. There was no power, so most businesses were not able to open either. Many streets were impassable because of downed trees.

The hospital was on generator power. The entire hospital except for the ED, which is on a separate generator, was dark with only dim emergency lighting. Emergency was hopping, though. Because the storm struck in the night and people were in their homes, there were few injuries as a result. However, later that day, we began to see patients with injuries directly related to the clean-up effort, as men fell out of trees and fractured bones, while others sustained lacerations from hatchets, machetes, etc., as they tried to hack their way through downed tree limbs. One elderly lady was admitted because the apartment building that she and her husband lived in had its roof blown off.

Initially, we saw a large number of people who were on home oxygen and needed new tanks. The companies, of course, did not have phone service and were unable to reach their customers anyway, because so many streets were impassable. Initially, we gave out several of our own tanks, until the head of respiratory caught wind of what was happening. We then collaborated with the ambulance service (EHS). We got names and addresses of patients requiring tanks; EHS provided the tanks and replaced them until the oxygen companies were able to take over their deliveries. We also treated patients who were on Home Care because the VON nurses could not get to them and there were a number of patients who needed medication refills. This was one of the lessons learned – that there are a large number of people in the community who have some kind of outpatient medical service.

Over the next two days, we saw an incredible number of people who would ordinarily go to their family doctors or to the medical clinics. However, their offices were closed due to power loss and the ED was the only game in town. One idea we tried that seemed to help was to have one of the family doctors who had hospital privileges come and work in the minor emergency treatment area. It allowed the emergency physicians to concentrate on the sicker patients, and we could maintain patient flow through the department. By Wednesday, most of the family physician offices were up and running and the volume of patients dropped off. The other big issue for us was supplying medications. With the pharmacies closed, how were people to get prescriptions filled? Our pharmacy department stepped in and filled prescriptions until the local pharmacies reopened.

It took nearly two weeks before all of the electricity was back on and the streets were passable. During that time, there were three more deaths as a result of burning candles. Hospital staff were amazing throughout the entire time – if they could manage to get into work, they did. Many of them left children and spouses at home with no electricity or telephone service. That went on for days. They dressed in the dark and made their way to the hospital with little thought for themselves. They were professional and dedicated throughout the entire time. For emergency staff, it was an especially difficult time because we had lost a colleague and a friend who died in the line of duty. Months later, the scars from the storm are still evident with many downed trees still in evidence; the parks are in ruins and buildings still under repair. However, the spirit of the people remains strong. For example, money has been raised to restore the parks to their former glory. As Maritimers, we are used to violent storms, but many of us were caught unprepared for a storm of this magnitude. One of the big lessons learned is that we will take weather warnings much more seriously in the future and take the proper precaution.

The first episode of psychosis – A crucial opportunity for recovery

By Sharon Mulder,
CMHA National Project Assistant,
Early Psychosis Intervention: From Awareness to Action

What is psychosis?

Psychosis is a serious, but treatable medical condition that reflects a disturbance in brain functioning. A person with psychosis experiences some loss of contact with reality, characterized by changes in their way of thinking, believing, perceiving and/or behaving. For the person experiencing psychosis, the condition can be very disorienting and distressing.

Psychosis is associated with a number of causes such as substance abuse or withdrawal, exposure to severe stress, and certain medical conditions or diseases. More often than not, psychosis signals the onset of schizophrenia or bipolar disorder.

However, at the time of the first episode of psychosis it is important for the person to receive a thorough medical assessment to explore possible reasons for the experience.

What is 'first episode psychosis' and why is it so important?

While psychosis can evolve into chronic forms, the first time the condition occurs it is referred to as 'first episode psychosis'. There is mounting evidence to indicate that appropriate and timely interventions at this juncture *significantly increase* the chances for *faster, fuller recovery*.

Benefits of early detection and appropriate treatment include:

- faster and more complete recovery
- improved capacity to maintain self-identity and self-esteem
- improved capacity to maintain life course
- reduced disruption of educational and vocational pursuits
- reduced disruption of family and social relationships
- reduced likelihood of hospitalization
- reduced risk of suicide.

Yet, while research indicates that the longer the duration of untreated psychosis, the poorer the outcomes, studies often report delays of a year

or more before treatment begins. Appropriate interventions in the early stages of psychosis are a crucial step towards the prevention of mental illness.

Who is most likely to experience a first episode of psychosis?

Psychosis can happen to anyone, but symptoms of psychosis most often begin between 16 and 30 years of age. Both males and females can be affected. Males tend to experience symptoms a few years earlier than females. Persons with a family history of serious mental illness are at increased risk of developing psychosis. Psychosis affects up to three per cent of the population.

Why is psychosis an important issue for emergency nurses?

Psychosis sometimes emerges gradually over time and the early symptoms are dismissed as 'typical teenage behaviour'. Other times, the symptoms appear very suddenly with the onset of an acute psychosis. The acute phase is characterized by the presence of positive symptoms such as delusions, hallucinations, and thought disorder.

Individuals presenting with an acute episode of psychosis are often first assessed through hospital emergency departments.

And so emergency nurses can play an important role in a number of ways. They can:

- recognize the symptoms of a psychotic episode
- set the stage for the young person's recovery by demonstrating a positive, optimistic attitude
- communicate respectfully with the young person and their family to begin the development of collaborative partnerships.

Emergency nurses are in a key position as gatekeepers to the formal care system in recognizing the signs and symptoms of psychosis and supporting the first steps toward recovery.

Know what you are seeing

During the acute phase, typical psychotic symptoms emerge.

Hallucinations are perceptual experiences for which there is no corresponding external source. The most common types are auditory hallucinations, with other types including visual, tactile and olfactory.

Delusions are beliefs that are unjustified, often bizarre and not shared by the other people in the person's culture. Common types of delusions are religious delusions, persecutory delusions, and grandiose delusions.

Thought disorder refers to a pattern of vague or disorganized thinking. A person may have difficulty concentrating, following a conversation, or remembering things.

Hallucinations, delusions, and thought disorder are typically referred to as 'positive symptoms', but 'negative symptoms' such as decreased motivation, energy, and interest, and blunted affect are also common in the acute phase.

Co-morbid conditions such as depression, obsessive compulsive disorder, anxiety disorders, substance abuse, or personality disorder might also be present. Again, because the underlying causes of psychosis can be complex, comprehensive medical assessment is always required.

Increased awareness of the signs and symptoms of psychosis by emergency nurses is essential for early detection and effective treatment.

What is appropriate treatment?

Early identification followed by comprehensive, individualized treatment strategies that incorporate the use of low-dose anti-psychotic medications with education and psychosocial interventions can promote full recovery from psychosis. As most young people experiencing psychosis for the first time are living in the family home, family engagement and support through the assessment, treatment, and recovery process are critical. Treatment strategies are aimed at allowing the individual to maintain their daily routines as much as possible.

What is happening in your province?

Over the past decade, recognition of the importance of the early phases of psychosis to the subsequent course of the illness, and of the need to develop effective interventions, has grown at an ever-increasing rate in Canada and around the world. Most major Canadian cities now have a clinical site which can be a source of information and also a possible referral point. The websites of two Canadian clinics are listed in Appendix One and updated information on community initiatives across Canada will be available at **www.cmha.ca**.

Appendix One

Learn more...

The Canadian Mental Health Association's early psychosis intervention project has been raising awareness and catalyzing action on early psychosis intervention across Canada. Funded by Health Canada, this project has created a series of pamphlets and other resources that are available to assist organizations such as yours. To order or download resources go to **www.cmha.ca** and click on the 'Education' link.

The information in this document has been taken from materials developed from the CMHA project and the following websites:

- Early Psychosis Prevention and Intervention Centre (EPPIC), Melbourne, Australia. Available at **www.eppic.org.au**
- Early Psychosis Intervention Program (EPI), Fraser Health Authority, British Columbia. Available at **www.psychosissucks.ca**
- The Prevention and Early Intervention Program for Psychoses (PEPP) London, Ontario. Available at **www.pepp.ca**

For more information contact Sharon Mulder, CMHA National Project Assistant, phone: (204) 878-9239, e-mail: **slsm@escape.ca**.

Emergency department overcrowding: Waiting for disaster

By Susan B. Noseworthy,
BSc, MHSA (c),
Dalhousie University,
Halifax, Nova Scotia

Introduction

Emergency department (ED) overcrowding is both an international and national problem. In Canada, concerns of overcrowding are becoming more and more of the "norm", and faced by our EDs on a daily basis. Canadian EDs provide essential and critical services to roughly nine million Canadians a year (Schull et al., 2002) and this number is expected to rise in the future, especially with the expected increase of the aging Canadians. At such large patient volumes, ED overcrowding is evident within our current health care system. ED overcrowding is thought to be associated with many adverse effects and, if overcrowding persists in Canadian EDs, there is cause for concern about poor outcomes and compromised levels of quality care. Essentially, without addressing this issue, ED overcrowding has the potential to create an enormous hazard to public safety.

This paper focuses on a review of the Canadian-based literature on ED overcrowding, and its purpose is to define ED overcrowding and to establish that it is a serious problem facing the Canadian health care system. After presenting the definition of this problem, its major causes and effects will be discussed. Another important aspect of ED overcrowding that is becoming increasingly controversial is the legal and ethical issues involved in providing ED health care. These concerns will be discussed in relation to both physicians and hospitals. To conclude this literature review, potential overcrowding solutions, strategies, and recommendations will be identified and discussed. These recommendations will be directed to both hospital administrators and the government, the individuals who have an impact on this trend of ED overcrowding, since many causal factors lie outside the ED and beyond ED staff control. The ED human resource issues, in relation to the causes and effects in ED overcrowding of professional staff shortages and staff morale respectively, will not be discussed. Although these issues are important in relation to ED overcrowding, they are not included in this discussion.

The topic of ED overcrowding is familiar to most Canadians and is recognized as a major Canadian health care issue, however, there are several limitations with the research conducted in this area. First of all, the research in this area is limited as a result of many factors, mainly the lack of a clear definition of ED overcrowding. In combination with a lack of a clear definition is the notion that many of the studies conducted to date focus on single institutions and there is no data or conclusions on this topic from a nationwide perspective. Not only are the studies conducted from single institutions, but the causes and effects of ED overcrowding are based on very little quantitative analyses. Rather, they are based on consensus statements, staff surveys, or self-reports that may be extremely biased or grounded on uneducated or false assumptions. There is little hard evidence on this subject and, as a result, overcrowding is not clearly understood. The lack of information and, in particular, quantitative information, has limited the development and application of systems-wide quality improvement measures (Schull et al, 2002).

Likewise, of the few studies and publications that have been released which look at the causes of ED overcrowding, none have been prospective. Without these types of studies, it is impossible to prove with certainty that any specific factor may be a definite cause of ED overcrowding. A more scientific approach to evaluating this problem, and providing a clear and precise definition to this problem, may help close the gaps between the individual opinions that are currently available to provide more rigorous evidence of the problem (Schull et al., 2002).

The final limitation encountered during this literature review is that most of the limited work already done in this area is based on United States ED overcrowding. Since the scope of this paper excludes a review of ED overcrowding in other jurisdictions, the research findings from studies in the United States would not be considered. The rationale behind excluding these other studies is that the definition, causes and effects, and

viable solutions to ED overcrowding differ greatly from region to region, even across Canada and, therefore, make it hard to generalize across regions. Accordingly, materials focusing on the ED situation in other countries would offer little guidance in finding a remedy to the Canadian problem.

What is emergency department overcrowding?

Emergency department overcrowding is defined as a "situation in which the demand for service exceeds the ability to provide care within a reasonable time, causing physicians and nurses to be unable to provide quality care. It can be measured by monitoring patient waiting times, including the time from registration to physician exams, time to be seen by a consultant, and the time necessary to move admitted patients to appropriate inpatient beds" (CAEP, 2002). ED overcrowding can occur at any time and create unpredictable workloads characterized by peaks and valleys resulting from patient volumes and acuity, causing huge frustrations for ED staff and patients (CAEP and NENA, 2003). The result is often a decrease in the quality of health care, increased public health hazards, and diminished patient outcomes.

ED overcrowding has not just been a phenomenon of recent years, but has been around for decades. It has developed into a chronic crisis and is an issue confronting health care systems around the world, and Canada is no exception. Overcrowding was initially reported in the early 1980s, and was thought to be a "result of several factors including an aging population, rising infectious disease rates (particularly the AIDS epidemic), substance abuse, psychiatric illness, the effects of poverty and hospital bed and staffing shortages" (CAEP and NENA, 2003). By the early 1990s, many strategies were proposed to address this issue of ED overcrowding, yet most acute care facilities took little time to implement such suggestions, as many institutions felt the costs of implementing such initiatives would be far greater then keeping the ED patients in-house (CAEP and NENA, 2003). Because of these inactions on the part of many Canadian hospitals, ED overcrowding became a common problem recognized all across Canada. "By the mid to late 1990s, the era of restructuring and regionalization in the Canadian health care system hit its peak. This was a direct result of the recession that created tremendous economic pressures and closed large proportions of acute care beds, leading to a major upsurge of ED overcrowding during this period. By the time the late 1990s hit, ED overcrowding was the largest issue facing ED health care providers" (CAEP and NENA, 2003). Since then, this phenomenon has not subsided; rather, it is becoming worse. Today, ED overcrowding can be considered an epidemic in emergency departments nationwide.

Although this topic of ED overcrowding is continuously described and defined as the most serious issue confronting Canadian EDs, it is a multi-factorial problem caused by a combination of both internal and external, yet interrelated, factors. Most of these factors are external to the ED and, therefore, beyond its control. This has led to the belief that ED overcrowding is primarily a "systems problem" reflecting bottlenecks throughout the entire health care system, rather than an issue isolated within the EDs themselves. However, most hospitals maintain policies and procedures that constrain overcrowding to the ED as much as possible and, as a result, eliminate the motivation for anyone outside the ED to solve the problem (CAEP and NENA, 2003).

As concluded by Drummond (2002), ED overcrowding remains poorly understood by government, managers, administrators, and leaders of organized medicine, despite the 'chronicity' of the problem, combined with an impressive international literature base. "As a result of the widespread reports of overcrowding, multiple countries have raised doubts about the capacity of emergency services to ever provide dependable and rapid emergency care" (Schull, 2002).

Causes of emergency department overcrowding

ED overcrowding, as previously stated, is not the result of a single factor, but is rather a combination of interrelated factors. A major limitation in determining the causes of ED overcrowding is that prospective studies are needed to determine such causes. Without such studies, it is hard to make any definitive conclusions as to the actual causes of the overcrowding. Some of the most frequently suggested causes of ED overcrowding are described below:

The lack of beds for admitted patients in the hospital is thought to be a significant contributing factor to ED overcrowding. The lack of hospital bed availability is considered by many individuals as one of the greatest causes of overcrowding. However, this is considered to be a commonly-held "belief", since there is little data demonstrating this effect (Forster et al., 2003).

"Over the past five years, it has been noted that the number of hospital beds in Canada has been reduced by almost 40%. Although some of these beds have been converted away from acute care to home care and long-term care beds, there has been and continues to be a problem admitting patients away from the ED in a timely fashion" (CAEP and NENA, 2001). This, in turn, "prevents ED physicians and nurses from accomplishing their primary mission, providing emergent and urgent care to communities" (CAEP and NENA, 2003), as stretchers are being occupied by patients awaiting hospitalization.

In one study done by Forster et al. (2003), titled *The Effect of Hospital Occupancy on Emergency Department Length of Stay and Patient Disposition,* investigators conducted a retrospective review of administrative databases of two 500-bed, academic acute care hospitals to examine whether hospital occupancy is associated with admitted patients' length of stay in the ED, as well as determining whether hospital occupancy was associated with physician referral for admission. Results of this study show that the total number of beds in the hospital decreased from 610 in 1993, to 432 in 1999 for cost-saving purposes and that the daily hospital occupancy was 89.7%. Accordingly, the ED length of stay (LOS) was found to be significantly associated with hospital occupancy. A 10%

absolute increase in occupancy reflected a 5% increase in patient ED LOS before being admitted into a hospital bed. However, hospital occupancy levels that exceeded 90% contributed to the majority of the increased ED LOS. It was also determined that physicians do not alter their level of referrals for admission based upon hospital bed availability.

This increased occupancy as a result of fewer inpatient beds is typically a result of restructuring. In a 2001 study conducted by Schull et al. called, *Emergency Department Overcrowding Following Systematic Hospital Restructuring,* investigators attempted to determine the effect of restructuring through a time series analysis of monthly overcrowding from 1991 to 2000 in EDs in Toronto, Ontario. During this 10-year time period, complex hospital restructuring started in 1997, which consisted of ED closures and mergers, increased ambulatory and community care programs, and major hospital bed cutbacks occurred (Schull et al., 2001). Hospital bed closures were, however, a continuous occurrence throughout the entire study period.

Results of the study by Schull et al. (2001) showed that before restructuring, moderate to severe overcrowding was not increasing and occurred roughly 10% of the time and that, during restructuring, both severe and moderate overcrowding began to increase significantly at a rate of 0.4% monthly (30% of the time). This finding held even after controlling for ED utilization (total ED visits did not predict overcrowding) and demographics. It was also noted that during each year of the restructuring period, the occupancy rate in hospitals increased and exceeded 90% and peaked at 96% in 2000.

We can therefore conclude, based on the above results, that the higher the hospital bed occupancies, the greater the LOS is in the ED for admitted patients. A British study identified in CAEP and NENA, 2003, acknowledged the fact that "at rates above 85%, risks become discernable and above 90% the system is subject to a regular bed crisis". Following the study that determined the effect of hospital restructuring on ED overcrowding, it was found that when occupancy rates typically exceeded 90%, overcrowding was present 30% of the time. In our health care system, many acute care hospitals are constantly restructuring and are continuously operating at occupancy levels greater than 90%. Therefore, without changes that will eliminate the lack of inpatient beds, the negative effect hospital occupancy rates have on ED overcrowding is unlikely to dissipate.

Lack of access to primary care, physicians, nurse practitioners, or specialists and diagnostic services are also major factors contributing to ED overcrowding in Canada. Many Canadians do not have access to a family physician or nurse practitioner, and access to these individuals is limited. Another concern is that waiting times to seek specialist care, as well as for tests and procedures, are so long that many Canadians feel they have no other choice but to seek ED care. As an individual's condition worsens, they see the ED as a "safety net" that will provide the specialist consultations, CT scans, ultrasounds and other diagnostic and laboratory tests on the spot, thereby providing quick results as opposed to waiting for weeks or months to access these tests via regular outpatient services (CAEP and NENA, 2003). Drummond (2002) notes that the lack of, or delay in, on-call specialist consults are an integral component of emergency care. Typically, there are substantial wait times involved in attaining a specialist consult in the ED, and many times it takes multiple attempts before the specialist arrives, during which time the ability to provide rapid urgent and emergent care is compromised. There are also huge delays involved in waiting for diagnostic and laboratory services testing and result acquisition in the ED because not all hospitals provide 24-hour-a-day services. As a result, patients remain on stretchers, utilizing resources while they wait for a diagnosis, and thus contributing to overcrowding.

"Bed-blockers", otherwise known as Alternative Level Care (ALC) patients, require "chronic care, chronic complex care, transition care, respite care, and palliative care" (CAEP and NENA, 2003). Because of the health of many of these individuals and the corresponding lack of home care, community care and long-term care available to these patients in the community, many have no choice but to remain in acute care facilities where they occupy a bed that could be used by patients waiting to be admitted from the ED. According to the article published by Drummond (2002), hospitals reported that the number of beds these patients occupy is upwards of 20 to 25 per cent. Although ALC patients do not require the high levels of care and specialty services that are offered in acute care facilities, they remain there, consuming a large proportion of the resources that could otherwise be used to alleviate the problem of ED overcrowding and facilitate patient flow. Ultimately, it becomes much more costly to provide chronic care in an acute care setting.

The increased complexity and acuity of patients are important factors thought to contribute to ED overcrowding. With the increasing age of the population, the ED is seeing many individuals with complex conditions and chronic diseases such as AIDS, mental illness, diabetes, and cardiovascular disease, just to name a few. Patients such as these require many different and complex assessments using advanced diagnostics and lab tests (CAEP and NENA, 2001). Often, these complex treatments do not warrant hospitalization, but require patients to remain in the ED while they receive sometimes lengthy assessments and procedures. Such assessments expand the scope of practice of emergency medicine since physicians acquire the responsibility for outpatient follow-ups and developing patient management plans, and contribute to an increased patient LOS where they occupy a stretcher, inhibit patient flow through the ED, and contribute to overcrowding (CAEP and NENA, 2001).

Recently discharged inpatients also contribute to the increased complexity and acuity of patients who are entering EDs, and have the potential to act as a source of ED overcrowding. The impact that these patients actually have on ED overcrowding was investigated in a 2001 retrospective, observational study by Baer et al. This study looked at all patients presenting to the ED within seven days of inpatient discharge from the hospital. They were identified as "returns." With the increased focus on decreasing the LOS of inpatients following surgical procedures or various illnesses, many patients are typically released after a

predetermined LOS, providing there are no complications. For these patients, the ED is seen as a "safety net" following their release from the hospital, yet patients presenting to the ED utilize many resources that cannot be used for other patients requiring care.

Results from this study show that only a small percentage of patients returned to the ED (~3%), but this is a very complex group of patients. These patients spent more time being evaluated and treated than other patients in the ED. The returns were also more than twice as likely to be admitted into the hospital as other patients (47% versus 19% respectively). In conclusion, it was found that the resources needed to evaluate and to treat these patients are relatively high when compared with those of the "average" ED patient (Baer et al., 2001) and contribute to ED overcrowding.

Increased volume of patients presenting with non-urgent problems is also thought to be a major contributor to ED overcrowding. What is not recognized is the fact that large volumes of non-urgent patients do not cause overcrowding and that this is a well-known myth of the Canadian health care system. "Although non-urgent patients occupy a large amount of space in the ED, particularly in the waiting room, they actually consume a very limited proportion of the ED's resources - i.e., stretchers and nurses. These patients add very little to incremental costs and do not displace patients who need emergency care" (CAEP and NENA, 2003). In fact, efforts that will seek to move these non-urgent patients to other health care settings will not alleviate the current problem of ED overcrowding. Rather, they will simply transfer costs from one health care institution to another (CAEP and NENA, 2001).

The effects of ED overcrowding

The conditions of Canadian emergency departments have been deteriorating over the past couple of decades and, with health care restructuring and reform becoming more the norm, ED overcrowding is expected to continue as a serious health care problem. The definite effects of ED overcrowding are understudied in the literature, yet many health care professionals and members of society are continuously dealing with adverse outcomes of this phenomenon on a regular basis.

The effect ED overcrowding has on the care of admitted patients as a result of their increased LOS is unknown. There are only a few studies that relate quality of care to the duration of ED stays. These studies have found that prolonged ED stay is associated with decreased patient satisfaction due to the increased delays in the treatment of pain and suffering. However, there are no studies evaluating outcomes of this care (Forster et al., 2003). As ED overcrowding inhibits patient flow into and out of the ED, the backlogs of ED patients face increased waiting times before they even see a nurse or physician. "Many individuals wait for extended hours in a stretcher or chair before they can be admitted into the hospital, receive appropriate treatment, testing, or specialist care. As a result, patients' pain and suffering in physical, mental, and emotional health is delayed beyond acceptable limits" (CAEP and NENA, 2001). ED overcrowding also causes huge dissatisfaction among patients waiting for care for extended periods of time, meaning that more and more individuals are leaving the ED before they can receive the care they need. All of these consequences are totally unacceptable to both ED physicians and nurses, whose goal is to provide emergent and urgent care within appropriate time limits, but who are too busy and are constrained by limited resources to attend to the patients who need them.

Prolonged waiting times mean patients experience prolonged periods of pain and suffering before hospitalization, treatments, and procedures are available. This has created a renewed interest in patient safety and the increased risk of medical errors that can occur as a consequence of inadequate patient care. Overcrowded EDs are environments with enormous potential for medical error because of the delays in providing patient care, the intensity of decision-making, the pressure to move patients out quickly, the lack of observation and monitoring when patients are cared for in hallways and waiting rooms, and increased stress on caregivers as their scope of practice continuously increases (Drummond, 2002). Although much of the evidence for this is anecdotal, there is a growing concern that ED overcrowding will lead to increased medical errors in the future. Another factor contributing to the increased risk of medical error is the fact that the specialty of emergency medicine is concentrated in providing fast emergent and urgent care and is often much different than other disciplines of medicine. With an increased proportion of patients receiving their care completely within the ED, and with admitted patients being held in the ED for extended periods of time, emergency physicians are having to expand the levels of care they provide and, at times, this is beyond their scope of practice, and has the potential to contribute to a greater number of medical errors that adversely affect patient outcomes.

Another one of the most obvious adverse effects of ED overcrowding, particularly in urban centres, is ambulance diversion. Ambulance diversion, otherwise known as "redirect consideration" and "critical care bypass", has a large impact on the quality of health care provided to Canadians, and its incidence is increasing. "Redirect consideration" is a request that the ambulance dispatch centre send all critically ill patients to another ED because, at such time, the resources in the ED are being stretched, but another critically ill patient could be accommodated if necessary. "Critical care bypass" occurs when the hospital cannot admit even one more critically ill patient without compromising the care of patients already in the ED; the ED is closed to the ambulance (Upfold, 2002). "The negative consequences of these directions include increased transport times of critically ill patients, increased possibilities of poor clinical outcomes, limitations on system-wide response times, discontinuity of care and, of greater concern, is that paramedics, upon the declaration of 'redirect consideration', need to assess the patient's condition to determine whether it will permit longer transport to another facility" (Drummond, 2002). Overall, patients should never be denied access to the ED for an urgent or potentially critical problem, as this is against the Canadian health care systems values (CAEP and NENA, 200l).

Ethical and legal issues surrounding ED overcrowding

The issue of ED overcrowding has elicited quite a debate as to whether it is reasonable, legally and ethically, to hold a physician or hospital liable in negligence for failing to treat, or for inadequately treating an individual in need of emergency care due to ambulance redirect, critical care bypass, patient overcrowding, lack of personnel, equipment or both (Walker, 2002).

Currently, there is no case law concerning this issue and in many cases, resolutions regarding such issues remain in the hands of the judicial system, say the authors of several articles who take opposing views in this debate (Kollek, 2002; Upfold, 2002; Walker, 2002). Many argue that it is unethical for EDs to go on critical care bypass and refuse a critically ill patient, regardless of ED overcrowding and lack of resources, according to the physicians' and hospitals' "duty of care" principle.

According to Upfold (2002), physicians owe a duty of care to their patients, but in general this exists only when there is a pre-existing professional relationship with the patient. Essentially, they can refuse to provide emergency care when this relationship is non-existent. However, as an emergency physician, such a relationship is rare. Typically, emergency physicians have a contractual relationship with the community and, as a result, there is a duty, and the community has the right to rely on the care being available when needed. By going on critical care bypass or ambulance redirect, the potential for patient harm is foreseeable and is in breech of the physicians' duty of care, upon which they may be held liable (Upfold, 2002).

The flip side of this coin is the notion that the reason physicians and hospitals employ ambulance diversion is because ED overcrowding has created a situation in which resources, both human and physical, are so stretched that having one more critical patient in the ED may put themselves and other patients in the department at harm (Kollek, 2002). Physicians in this situation have a duty to all patients who enter the ED, and accepting one more critically ill patient may put more than one other patient at risk, due to limited resources. It is thought to be unreasonable and unethical to hold physicians liable for not delivering adequate care to patients they never get to see because of ambulance diversion, or whom they see too late because of patient backlog, often without adequate diagnostic tools. These are all adverse outcomes as a response to ED overcrowding, a health system issue, not an issue controllable by physicians in the ED. Hospital cutbacks have created an environment where emergency physicians cannot reliably deliver the standard of care that is legally and ethically expected of them (Kollek, 2002).

Whether physicians, hospitals, or the government are held responsible for such actions is currently determined by the justice system. However, both sides of the story have debatable legal and ethical issues that surface every day, many directly as a result of ED overcrowding.

Conclusions and recommendations

Because ED overcrowding is recognized as a problem resulting from numerous interrelated and multi-factor causes that rest outside the ED, it is unlikely that quick fixes in the ED will alleviate this crisis situation currently seen across the country. It is apparent to the specialty of emergency physicians that a long-term solution will require concerted efforts and strong lobbying to influence the government and hospital administrators so that they understand the issues behind and seriousness of this national crisis. "The community and government must identify ED overcrowding as a high priority heath concern and acknowledge that the prolonged waiting in EDs by admitted patients is unacceptable" (CAEP and NENA, 2001). Once a partnership develops between such bodies, action must be taken to help resolve or, at a minimum, facilitate a change in the trend of ED overcrowding. This is a serious issue that requires the development of standards of care for patients, so that negative outcomes can be avoided, as well as financial and philosophical support from the government (CAEP and NENA, 2001).

It must also be recognized that putting money alone in the ED to alleviate the problem of ED overcrowding in Canadian hospitals is not enough. If this is the approach that government and hospital administrators take in recognition of this problem, the solution will not be enough. As previously discussed, ED overcrowding is a whole-system issue and it requires multiple factors to be assessed and addressed simultaneously in order to contribute significantly to eliminating or at least reducing the problem. To put money back into the ED to increase the number of beds that are available or simply re-open previously closed beds is only one part of providing patient care in the ED. There is currently a lack of emergency human resources that are required to handle the increased bed capacity. Staff are overworked already. More diagnostic services, treatments, and procedures will also need to be completed on the increased volume of patients. Opening beds leads to a much greater amount of expenses and resources that are required outside the ED (CHSRF, FCRSS 2000). There are multiple things that can currently be done to facilitate change in this area. However, we present four major recommendations that can be made to the government and hospital administrators to help alleviate this problem for the long term.

1. Address the lack of beds. Set priorities on increasing long-term care beds first.

The lack of beds for admitted patients in the ED needs to be resolved. Currently 20 to 25 per cent of inpatients occupying beds are "bed blockers"/ALC. Usually, these patients are in an acute care facility simply because they have nowhere else to go, and this is a significant contributor to increased ED LOS and overcrowding. A key government intervention at this point would be to increase the number of long-term care beds, such that ALCs can move out of the acute care beds they currently occupy and into a setting that is more appropriate for them. This will alleviate ED overcrowding, improve patient outcomes, and save money for the government by having ALC patients receiving their chronic care in an institution more

suited for them. As previously mentioned, it costs far more to have an acute care bed occupied with chronic care patients who should be somewhere else.

2. Increase community care across the country, starting with increased home care services.

It should be recommended to the government to increase the levels of community care, particularly home care in communities all across Canada. This is another way to get bed-blockers out of acute care facilities and into a more appropriate setting where they can receive the level of care that they require. Such an approach helps facilitate patient flow within hospitals and removes admitted patients from the ED into inpatient beds. This will free up resources for other patients waiting in the ED, thus decreasing overcrowding.

3. Hire nurse practitioners for inpatient wards to facilitate more efficient discharge of patients.

Another recommendation that could be made is to allow for nurse practitioners to enter health care facilities, where they can do the large quantities of paperwork required by physicians before inpatients can be discharged from the hospital. Often times, patients are ready to go home but physicians and residents are so busy that the papers for discharge are not filled out until half a day or so after the eligible time of discharge. At times, where shorter inpatient visits are suggested and enforced, such time delays in discharge mean that inpatient beds are unnecessarily occupied when they could have removed a patient awaiting admission from the ER. Nurse practitioners in the hospital can perform such a role and would be important in reducing ED overcrowding by facilitating patient flow. Nurse practitioners can also play a role in the emergency department, providing non-urgent care, however it is unclear how this would alleviate the issue of overcrowding.

4. Define parameters of a Canadian Emergency Department Information System (CEDIS) and facilitate its implementation nationwide.

The final recommendation that may be necessary to help ease the pressures of ED overcrowding in Canada would be the implementation of an information system. Specifically a CEDIS that tracks waiting times, patient volumes, admission rates, other relevant ED data, benchmarks, performance indicators, and other necessary quantitative data. This will help identify system inefficiencies and help facilitate studies that can establish causative factors and definitive effects of ED overcrowding and patient flow. In the submission by CAEP to the Romanow Commission, they "identified the importance of implementation of ED information systems across the country, that will develop standard performance reports that facilitate inter-institutional and inter-regional comparisons". As well, the working group composed of CAEP, NENA, and the CEDIS national working group also agreed upon the standard data elements that would be necessary for such a system to provide them with both quality improvement and clinical research (CAEP, 2002).

The recommendations provided here focus on eliminating, or at least reducing some of the major problems inhibiting efficient patient flow from an entire health care system perspective. These are best accomplished through the government, both federal and provincial, health authorities, and hospital administrators. Changing the internal workings of the ED to fix overcrowding would be ineffective at this point in time, as the problem rests almost entirely outside the ED. Without actions in the near future, ED overcrowding will continue to contribute to poor patient outcomes, and we may contribute to even greater disasters in the future.

References

Baer, R.B. et al. (2001). Recently discharged inpatients as a source of emergency department overcrowding. **Academic Emergency Medicine, 8**(11), 1091-1094.

Branswell, H. (2001). Speedy restructuring of Toronto's hospitals cause ER overcrowding: Study. **Canadian Press Newswire**.

Canadian Association of Emergency Physicians (CAEP). (2002). The future of emergency medicine in Canada: Submission from CAEP to the Romanow Commission. **Canadian Journal of Emergency Medicine, 4**(6), 431-438.

Canadian Association of Emergency Physicians and National Emergency Nurses Affiliation (CAEP and NENA). (2003). Access to acute care in the setting of emergency department overcrowding. **Canadian Journal of Emergency Medicine, 5**(2), 81-86.

Canadian Association of Emergency Physicians and National Emergency Nurses Affiliation (CAEP and NENA). (2001). Joint position statement on emergency department overcrowding. **Canadian Journal of Emergency Medicine, 3**(2), 82-85.

Canadian Health Services Research Foundation (CHSRF)/Fondation Canadienne de la Recherche sur les Services de Santé (FCRSS). (2000). More money would put an end to emergency room crunches. **Myth Busters**.

Drummond, A.J. (2002). No room at the inn: Overcrowding in Ontario's emergency departments. **Canadian Journal of Emergency Medicine, 4**(2), 1-11.

Estey, A. et al. (2003). Understanding the causes of overcrowding in emergency departments in the Capital Health Region in Alberta focus group study. **Canadian Journal of Emergency Medicine, 5**(2), 87-94.

Forster, A.J. et al. (2003). The effect of hospital occupancy on emergency department length of stay and patient disposition. **Academic Emergency Medicine, 10**(2), 127-133.

Kollek, D. (2002). Emergency department overcrowding. **Canadian Medical Association Journal, 167**(6), 626-a.

Schull, M.J. et al. (2001). Emergency department overcrowding following systematic hospital restructuring. **Academic Emergency Medicine, 8**(11), 1037-1043.

Schull, M.J. (2002). Urban emergency department overcrowding: Defining the problem and eliminating misconceptions. **Canadian Journal of Emergency Medicine, 4**(2).

Upfold, J. (2002). Emergency department overcrowding: Ambulance diversion and the legal duty to care. **Canadian Medical Association Journal, 166**(4), 445.

Walker, A.F. (2002). Emergency department overcrowding [The author of the review article responds:]. **Canadian Medical Association Journal. 167**(6), S626-627.

Ethical decision-making in practice: A triage decision

**By Sandie Drew, RN, BTSN,
Victoria, BC**

The experience I would like to discuss occurred three years ago and it impacted me greatly, prompting me to question my decision-making processes surrounding it. I initially believed it to be a purely clinical decision, but reflection suggested that it may be equally an ethical one. I am interested in seeing how the two processes work together and wanted to see if I would have altered my decision after examining it from an ethical framework.

At the time, I worked in the busy emergency department of a community hospital (I suppose that "busy emergency department" is redundant; they are all busy these days). The department was in the process of a complete renovation and, for the previous few months, we had been trying to cope with approximately 75% of our regular number of stretchers and considerably less space. Waiting times were being extended for all acutely ill patients for up to five hours.

I was assigned to the triage desk for four hours on a Saturday evening. Approximately half of the stretchers in emergency were filled with admitted patients for whom there would be no ward beds until at least the following day, and all the other stretchers were in use. The nurse going off shift gave me a report regarding a patient who was registering at that time, who had overdosed on Tylenol roughly six hours prior to her arrival. At that moment, a middle-aged woman presented at my desk with midsternal chest pain, radiating to her left shoulder for the past two hours.

Both women had the potential for severe negative consequences with delayed treatment. A bed became available in 15 minutes, and I gave it to the younger woman, who quickly received treatment. The woman with chest pain was not taken into the department for another 90 minutes, and did, in fact, have an anterior myocardial infarction.

My first step in this process was to identify the actual problem from an ethical perspective. I had two patients who both needed prompt access to the emergency department. Due to limited resources, I had to place a higher priority of care on one or the other. These were my only two alternatives available; to prioritize neither was not an ethical option.

This could be classified as an ethical dilemma since it is not solvable, but resolvable. However, Wocial (1996) goes on to describe my conflict in terms of moral distress:

Moral distress occurs when a person is prevented from acting on their individual conscience to exercise their moral choice. In this case, one believes they know the right thing to do, but power structures, such as institutional constraints, prevent them from acting on their moral choices (p. 152).

Both alternatives are equally undesirable, but I believe I did have some influence over this decision, and wanted to explore the decision I made in terms of my own values.

Because this type of resource allocation problem is becoming more frequent, I wanted to be certain I was practising from a "good" ethical standpoint.

Two of my personal values that come into play here are those of health and fairness. These are both in accordance with the Canadian Nurses Association Code of Ethics (1999), and are a central part of my ethical decision-making. Rodney and Starzomski (1993) state: "The moral agency of health care professionals is enshrined in the high standards of behaviour demanded by specialized knowledge and skills. Traditionally, professional morality is viewed as protecting the individual patient interests and enhancing the status of the profession" (p. 25). I also value my skills and knowledge as a professional, and believe I have a moral duty to my patients.

In gathering information, I began with these nursing skills, knowledge, and clinical reasoning. Although patients presenting with overdoses frequently overstate the amounts they took, the symptoms the young woman displayed indicated that she was probably telling the truth about swallowing 50 tablets. I knew that she would require medication very soon to prevent liver damage,

plus her level of consciousness was decreasing. The older woman had pain which could very well have been pain of cardiac origin. She had no cardiac or gastrointestinal history, and her vital signs were within normal limits.

I chose not to use a utilitarian framework for this discussion. Its emphasis is on the consequences of the action, and since this is a retrospective exercise, I know that both patients recovered from their illnesses. It is more the duties and responsibilities to patients that I wished to explore, and how they relate to my own values. In using the deontological perspective, I will examine the dilemma from each of the four principles: autonomy, beneficence, nonmaleficence, and justice.

In reflecting on the principle of autonomy, I discovered that although I gave each of them ongoing information, it might not have been complete enough for them to make fully autonomous choices. The younger woman's level of consciousness may have interfered with her ability to understand the consequences of what I was telling her. I accepted her consent as implicit by the fact that she stayed for treatment. The second patient, although informed of the potential wait, was not given alternatives. I could have told her she could go to another facility, but I did not believe that to be in her best interests. This may have been paternalism on my part, but there were also risks in giving her that choice. If she had gone elsewhere, would she have been treated more quickly? Might she have suffered a cardiac arrest en route? I do not believe I could have answered those questions for her, so I did not give her that choice.

Nonmaleficence is the principle I struggled with the most. There was potential for doing harm to each patient by choosing the other. I believed that I had a duty to provide safe and optimal care to **both** patients, but the context in which I was working prohibited that. I will discuss context more thoroughly later. Here was where my moral distress lay; my own personal and professional values of being able to help my patients to maintain their health conflicted with the needs of the entire department. Storch (1992) discusses the concept of the nurse having multiple obligations "to patients, to families, to physicians, to colleagues, and to employing institutions"(p. 261). I certainly felt the weight of these differing obligations; to my two patients, the other ones in the waiting room, those being treated in the department, as well as to the already-overworked staff.

The question became "did I do harm?". Unfortunately, I have no way of knowing how much my patient's infarct extended while she was waiting. I certainly caused her distress, although I checked with her frequently to keep her informed and to reassess to the best of my limited ability.

The principle of beneficence, I believe, was upheld. I did not refuse treatment, in fact I did my best to accelerate it for both patients. I reassured them and provided opportunity for questions and information, in order to care for them as best I could.

Justice was the principle I most wanted to examine. Did I base my choice on my own personal values, or professional ones? There are different aspects to this principle that need to be looked at, beginning with the concept of distribution according to effort or merit. Both patients actively sought treatment. My personal moral belief of the sanctity of life was certainly in the back of my mind regarding a young woman who would attempt to take her own life. However, I recognize that my professional ethic to care for someone in such distress overrode that. She was certainly responsible for the health predicament she was now experiencing….or was she? I did not have enough information on her background to be able to judge that; i.e., did she have a longstanding mental illness? Nor did I have enough background on the older woman to base my decision on this. Was she a smoker or an alcoholic? On reflection, I cannot honestly say that I have **never** taken this difference into account, but it was not a factor in this instance. Nor did I base it on either's actual or potential social contribution. This seems irrelevant to my nursing practice.

Equal-share distribution was probably more in the minds of my patients than mine. Although in Canada we pride ourselves on the concept of universality, the current constraints on the system make this difficult to maintain. I see this frequently in the emergency, where patients' expectations of how we can care for them are so very different from our realities. For example, it is no longer feasible to keep someone in hospital for investigation of gall bladder disease. These are now being done as outpatients, despite the pain that they are having. Both of my patients ultimately received an equal share of care and treatment, but perhaps not as quickly as they expected.

The distribution according to need is difficult, both clinically and ethically, to examine. Both my patients and myself agreed that they needed to be seen by a physician. However, as Maddox (1998) states, "this is complicated by the fact that individuals may perceive their need differently than their health providers or health plans. When providers advocate for an individual, the professional justification of need may be conflicted" (p. 6). The dilemma occurred when I tried to establish whose need was greater. This conflicted with my own need to advocate for both patients. In this instance, I believe I looked at it from a "distance-ethic" perspective. McGillivray describes it this way:

In cases of conflict, the overriding principle is determined by relevant data specific to each case from a position of impartiality, observing four criteria: 1) the moral objective must be realistic, 2) no morally preferable alternative is available, 3) the least infringement possible must be sought, and 4) the agent must act to minimize the effects of infringement (p. 2).

It is from this framework that I believe I actually made my decision for this dilemma. The moral objective was to address the health needs of both my patients within the

constraints of the department. The morally preferable alternative of having both patients seen immediately was not available. My data collection told me that the young girl had a high likelihood of severe liver damage if not treated very soon. The older woman may have been cardiac, but also may have been gastrointestinal by her symptoms. With my limited information, my clinical judgment was that she was the more stable of the two, hopefully causing the least infringement. I attempted to minimize the effects of the wait with frequent reassurance and reassessment.

Although the process of "close-up" ethics would appear to be the gold standard for nursing care, its emotional nature makes this type of resource allocation decision more difficult. I was aware of the need to avoid the chaos that would ensue by acting on everyone's individual values, and also governed by my obligations to all the patients who were directly or indirectly in my care. I was also cognizant of the needs and values of my colleagues. The "society" that I was acting for was the emergency (and the whole institution), and the patients and staff who were a part of it that shift. I responded to both patients in a compassionate manner by honestly outlining my constraints, and explaining how I would do my best for each of them. By doing this, I was also fostering a trusting relationship. By using my knowledge and skills, I acted in a competent manner in accordance with the code of ethics, and maintained the best care possible in the circumstances.

The context of this dilemma is probably its major component. The limitations of the department created a situation where I was unable to act on what I thought was right. The understaffing, renovation of the department resulting in fewer available stretchers, and an increase in the number of acutely ill patients that shift all played an important role at the organizational level. The societal belief that we are all entitled to health care on demand is an example of the context at the macro level. Although I value access to health care when it is needed, I understand that realities and expectations may be different, and this creates a conflict for me.

The micro context is more difficult to examine. I had an equal duty to each patient, and my relationship to each was the same. Because that relationship was limited by my triage role, I had little knowledge of each patient's personal context regarding their illness. The older woman was fearful, which may have added to her symptoms and/or outcome. Did she have relatives who had died from heart attacks? Had she had prior negative experiences in hospital? Due to her drowsiness, I was unable to gain much context from the young woman, either. I did not know if she had asked to come to hospital, or was found by friends and brought there without explicit consent. Was this a reaction to a stressful event, or the result of a longstanding depression? Although I do not believe these pieces of information would have ultimately changed my decision, they could have improved my care for them in the interim while I was waiting for a bed.

In trying not to look at this problem retrospectively, I recognize that my decision could have had a negative impact on either patient. If my personal values regarding suicide had weighed more heavily, this young lady might have sustained irreversible liver damage. I could also have considered the younger woman's potential for societal contribution, as opposed to the older one's. If I was a less experienced practitioner, I might have delayed the older woman's treatment even longer, based on her lack of cardiac history or associated symptoms. Alternatively, if I had taken the older woman in first, her outcome (decreased pain, quicker reperfusion) might have actually improved her outcome.

Using the deontological approach has proved difficult in this problem, because outcome is clearly an important aspect. When determining the allocation of limited resources for these two patients, I found that, from this framework, either would have been essentially an ethical decision. It gave me little direction as to which would be the better of the two choices. However, it did allow me to examine my own moral and ethical beliefs, and understand how they affected the decision that I made. It is clear now that this was not only a clinical decision, but also an ethical one. After looking at all of the perspectives in this discussion, I believe I would not change the decision I made. However, I still resent the context that made this decision necessary.

The pressures of limited resources in the hospitals are not going to go away soon and, therefore, need to be examined from an ethical "eye" by all nurses. Changes will have to be made at all levels, micro, meso, and macro, and nurses have a huge responsibility in this. Sometimes, though, there are no "right" answers, and I believe that with the guidance of resources like the code of ethics, we can only make the best of the choices that are open to us.

References

Canadian Nurses Association. (1999). **Code of Ethics for Registered Nurses.** Ottawa, ON: Author.

MacGillivray, J. (1994). Allocating Health Care Resources [Electronic version]. **Bioethics Bulletin, 6**(4), 1-5. Retrieved March 15, 2001 from http://www.ualberta.ca/~ethics/bb6-4res.htm

Maddox, P.J. (1998, December 31). Administrative Ethics and the Allocation of Scarce Resources [Electronic version]. **Journal of Issues in Nursing**, 1-13. Retrieved March 15, 2001 from http://www.nursingworld.org/ojin/topic8-5.htm

Omery, A. (1989). Values, moral reasoning, and ethics. **Nursing Clinics of North America, 24**(2), 499-508.

Rodney, P., & Starzomski, R. (1993). Constraint on the moral agency of nurses. **Canadian Nurse, 89**(9), 23-26.

Storch, J. (1992). Ethical Issues. **Canadian Nursing Faces the Future: Development and Change** (2nd ed.). 259-270

Wocial, L.D. (1996). Achieving collaboration in ethical decision-making: Strategies for nurses in clinical practice. **Dimensions of Critical Care Nursing, 15**(3), 150-159.

High voltage teamwork

By Carleen Ridley, BScN, RN, MBA
Operations Director,
Emergency Patient Service Unit,
Children's Hospital of Eastern Ontario, Ottawa

"Attention please"... bang! At the sound of the starter's gun, the 160 paddlers in eight dragon boats begin paddling feverishly towards the finish line, 500 metres away. The sounds of the drummers in the front of each boat, beating their drums and screaming commands, increase the intensity of excitement felt amongst the teams. Approximately two minutes and 35 seconds later, the first boat will cross the finish line, a test of true teamwork. By the end of the day, 180 different teams will have taken to the water to test their ability to work together towards a common goal.

The Ottawa Dragon Boat Race Festival is part of a larger Chinese cultural tradition that goes back 2,400 years. It began as a fertility rite performed in southern China to ensure bountiful crops. The race was held to avert misfortune and encourage the rains needed for prosperity. The object of their worship was the dragon. Also known as Poet's Day, it commemorates the death of Qu Yuan, a poet and Minister of State during the Chou Dynasty. Qu sacrificed himself by drowning in a tributary of the Yangtze River to protest against a corrupt government. When local fishermen realized Qu had disappeared into the river, they raced out in their boats to save him, beating drums to scare off fish which they thought would eat his body. The scene of the fishermen racing out to save Qu Yuan is re-enacted every year in the form of dragon boat races (**www.dragonboat.net**).

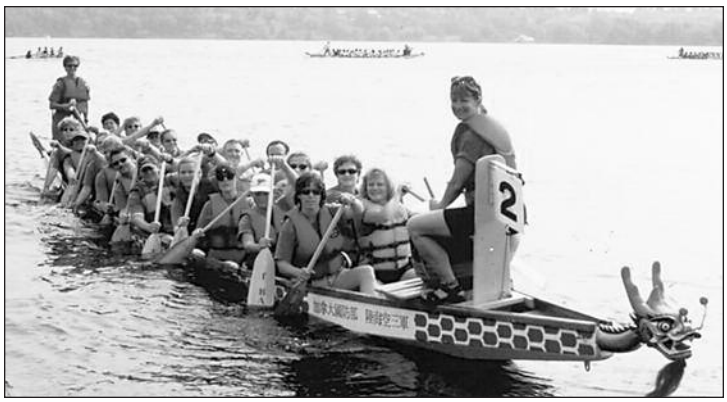
Our "CHEO Defibrillator Paddles" team participates in the annual Ottawa Dragon Boat Race Festival. Our team is comprised of all disciplines from the Children's Hospital of Eastern Ontario Emergency Patient Service Unit: nurses, patient service assistants, patient service clerks, child life specialists, physicians, poison information specialists, and nurse practitioners. Our multidisciplinary team comes together with a shared vision.

Senge (1990) describes a shared vision as more than an idea. "It is, rather, a force in people's hearts, a force of impressive power. It may be inspired by an idea, but once it goes further – if it is compelling enough to acquire the support of more than one person – then it is no longer an abstraction... Few, if any, forces in human affairs are as powerful as a shared vision" (Senge, 1990, p. 206).

It is this shared vision that pulls our team together, and the excitement is the glue that brings us back year after year to compete together towards this vision. It is vital for an organization to create this excitement and commitment amongst team members in order for teams to work together to experience something larger than themselves (Hemsath & Yerkes, 1997). Dragon boating fosters this team development, allowing our team to grow together towards a shared vision which serves to raise our team functioning to a higher level, both at work and at play.

Paddling a dragon boat is much like developing a team; it is more than just collecting 20 paddlers, one steers person and one drummer together in a boat and encouraging them to all paddle towards the finish line. There is strategy and synchronous technique involved. There is commitment and challenge. There is belief that together great things can be accomplished. In teamwork, all members surge forward together and the outcome depends on the synchronous force of the group. The same is true with dragon boating. All paddlers must paddle at *precisely* the same time and with the same technique to maximize their outcome. One paddler out of sync can cause the whole boat to stall out during the middle of the race. In unison, the sheer power enables the boat to actually be raised in the water and propelled forward with less resistance. Each paddler must be acutely aware of his or her teammates and must focus exclusively on what is happening within his or her own team, ignoring the furore of the other teams only metres away. It is this focus and commitment that forms the teamwork that enables teams to cross the finish line together.

Although our team is not known for its particular athletic prowess, we have managed to attain higher heights every year and actually took the bronze medal last year in the Heath Care Challenge Cup. The slogan for the Ottawa Dragon Boat Race Festival is fitting – *22 hearts, one soul on fire*. Our secret for success on and off the water: high-performance teamwork!



References

Hemsath, D., & Yerkes, L. (1997). **301 ways to have fun at work**. San Francisco: Berrett-Koehler Publishers Inc.

Ottawa Dragon Boat Race Festival. (2004). **The dragon boating tradition**. Website: www.dragonboat.net.

Senge, P.M. (1990). **The fifth discipline: The art and practice of the learning organization.** New York: Doubleday Dell Publishing Group.

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 bursary per year will be available to an independent member.

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

3. 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

**By Coralee Boileau, RN,
Children's Hospital of Eastern Ontario
(CHEO), Ottawa**

This poem was written when I worked on the infant unit after I had cared for two palliative care infants. I watched them slowly deteriorate and their families suffer, and it made me wonder what they would say if they could express their love for their parents, to ease the pain of the whole family unit.

I have been nursing since 1999. I began my career as an RPN. I worked for one year on a pediatric surgical unit at CHEO, followed by two years on an infant medicine unit. I then went back to school to become an RN and have worked in the emergency department at CHEO for one year.

I love the little rewards the most about pediatric nursing. No matter how hard the day is, or how traumatic the illness or injury, in emergency there is always a smile or a hug from the resilience of children that make all the hardships so very worthwhile.

The Unheard Voices of Angels

Mommy I can hear you
Why are you crying?
Is it my time to go?

Who are these people?
What are they saying?
Mommy I have to know...

Mom, I'm too young yet
Only a baby,
please won't you speak to me.

Haven't we been here?
Not all that long ago,
please Mom stay near to me.

For I think I am leaving
I feel Him call to me
but I don't know how I will go.

It's getting so hard to breathe
please hold me closer.
Mommy, I love you so.

But He says that He needs me
to join His other children
and it feels so warm and right.

Mom, look at the golden wings!
They fit me so perfectly...
Mommy, you'll be alright.

I promise I'll wait for you
way up in Heaven.
I'll be your angel eye.

I know now I'm leaving,
He's holding me closely.
Tonight I will learn how to fly.

Correlation is not causation

By C. Carter-Snell, RN, MN

In a recent news release, a link was announced between increased antibiotic use and the development of breast cancer (CBC staff, 2004). While researchers were careful in the article to reinforce that cause and effect have not been established, this was not clear in subsequent television and radio reports about the research. All too often, we hear of "links" or "associations" between variables and begin to consider this proof that one causes the other. Many health research studies involve testing for associations between variables and are referred to as correlational studies. Patients may bring in articles and ask about the studies, or we may be looking for information to support our practices. Either way, we need to be familiar with the meaning of studies discussing associations or links between variables. The purpose of this article is to explore the concept of correlation, describe correlational studies, and then to discuss the criteria required for establishing causation.

Correlation

Correlation is the extent of a relationship which is found between two or more variables. If one variable always changes in direct relationship to another, this is referred to as a "perfect" correlation. Numerically, a perfect correlation is written as 1.0 in a statistical report. It may be -1.0 or +1.0 depending on the direction of the relationship. A positive correlation, or a value between 0 and +1.0, means that as the level of one variable increases, the other variable also increases. A negative correlation is also known as having an inverse relationship. This is expressed as ranging from 0 to -1.0 numerically and means that as one variable increases, the other variable decreases.

Correlations are sometimes described as being weak or strong. There is not an absolute value required for a strong or weak relationship, however. It depends on the type of variables and the implications of the relationship. For instance, if deciding between two types of blood pressure machines, a positive correlation of 0.70 is not very strong and you would not want to switch machines. In contrast, if looking at variables with less precise measures such as psychosocial measures of stress, or quality of life, a lower correlation would be acceptable. For this type of variable, a correlation of 0.70 would be fairly high (Loiselle, Profetto-McGrath, Polit & Beck, 2004). In Table One we see a strong positive relationship, with one variable increasing as the other increases. Note in Table One that the scores are represented in the table as dots on the scatterplot. The arrow represents the "regression line" of the data, or the slope of the line which is the best fit to the data.

The type of test used for correlation depends on the level of data being used. Spearman's rank order correlation (rho) is an example of a test used for association between variables which are nominal or ordinal in nature. Nominal variables are those in which the characteristic is either present or absent (e.g., obese or not obese). Ordinal variables have different levels of the characteristic, but there are not equal intervals between them. Examples would be thin, average, and obese, or the use of a scale from one to five (a Likert scale). This is a nonparametric form of correlation.

A common test used to determine correlation with more precise levels of data is Pearson's r or Pearson's correlation coefficient. This test is used for interval level data in which there are equal intervals between each value, such as the number of kilograms a person weighs. Pearson's r is also used for ratio level data, meaning there are equal intervals and an absolute zero or absence of the characteristic, such as the amount of weight gain or the amount of food eaten. It is important, though, that even at this level of precision, the data be "normally distributed", otherwise nonparametric correlation must be used (Greenhalgh, 1998). Normal distribution refers to ensuring there is a wide range of data, with the bulk of the data forming a bell-shape curve on a graph (otherwise known as a normal curve). A normal curve is difficult to obtain when subjects are not randomly selected or assigned to groups.

It is possible to look at the relationship between more than two variables. One such test is called multiple regression. Multiple regression has sometimes been explained as similar to correlation. There is a similarity with correlation in that both look at relationships between variables and both have regression lines, looking for the best fit of the data around this line. The difference with multiple regression is that there is a dependent or target variable identified. The remaining independent variables are then combined in different ways until the combination is found which best predicts the target variable. This implies causation, but it is still not established (Greenhalgh, 1998).

Study design and correlational studies

Research designs are of three main levels: experimental, survey, or exploratory-descriptive. These are summarized in Table Two. Note that correlational designs appear in the survey design category.

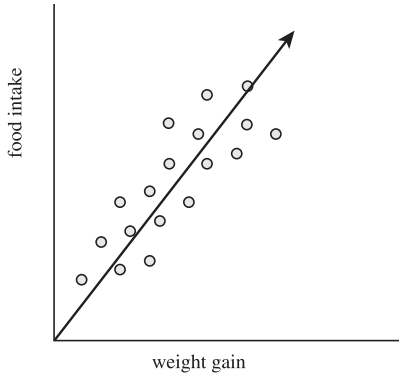
In order to understand why correlational designs cannot establish causation, we need to first explore the requirements for experimental designs. An experimental design has three major criteria (Greeno, 2002):

- there is random assignment of the subjects to one of two or more groups
- at least one of the key variables is manipulated or used in varying levels

- there is an attempt to control factors which may cause alternate explanations for the results (called confounding or extraneous variables)

Within the experimental design category there is sometimes further classification. A "true" experimental design is considered one in which there is both random selection of the subjects and random assignment to groups, in addition to the manipulation and control of extraneous variables. This level of design is most commonly found in laboratories and is difficult in health care research. If only random assignment to groups is used, and random selection is not possible, some researchers refer to this as a "Quasi-experimental" design. According to Greeno's categories, however, it would still be within the experimental category. The significance of this difference is in the risk for alternate explanations for the results. If the sample is randomly selected and randomly assigned, then it is assumed that the differences in individuals will be randomly distributed between the groups. If all the available subjects are used (a "convenience" sample) and they are only randomly assigned, you could end up with all the unusual cases in one group and confuse the interpretation of the results. An example is a research study on suctioning nosocomial pneumonia in endotracheally intubated patients (Carter-Snell & Sheehan, 1989). All patients who had recently been endotracheally intubated were included in the study (lack of random selection) but randomly assigned to one type of suctioning or the other. As it happened, all of the patients who vomited during intubation ended up in the same group and that group had a slightly higher pneumonia incidence. Instead of attributing this to the suctioning method, it well could have been the irritation and aspiration behind this difference.

Table One: Correlation table for food intake and weight



In survey research, nothing can be manipulated or changed, but you may discover a relationship of interest. Examples of descriptive research designs include the case report, case-series report, cross-sectional studies, surveillance, and correlational studies (Grimes & Schulz, 2002). A correlational study design is used to explore the relationship between two or more variables when there is not very much data to support causal relationships (Brink & Wood, 1998). Data is obtained, usually from large samples in the field, and then variables are examined for relationships. There is no ability to randomly assign members to groups, nor is any variable manipulated. One of the largest and longest correlational studies is the Nurses' Health Study (Linton, 2004) at Harvard University. It has been running since 1974 with nurses sharing their health, fitness, medical, and personal variables. These have provided directions for key studies involving variables which may affect risk for heart disease, breast cancer, and many other diseases. This study has played a significant role in raising questions among researchers and being the drive behind subsequent randomized controlled trials.

Table Two: Types of research designs

Level of Design	Type of Study
I. **Exploratory-descriptive** • used to explore data or theories with little prior data	• Descriptive • Exploratory
II. **Survey designs** • Statistically analyze relationships	• Comparative • Correlational
III. **Experimental** • used to test theory	• Descriptive • Exploratory

In exploratory-descriptive research there is very little data available, or very few studies which explore a relationship. An example of the descriptive design is the census data. An exploratory design has the least controls and usually includes the use of qualitative methods to explore small samples indepth. Examples include ethnographic or grounded theory studies. Historical research is another example of exploratory-descriptive research.

Causation and correlational studies

Three major criteria have been described as necessary before inferring cause (Cook & Campbell, 1979). These include: covariation between cause and effect; the occurrence of the cause before the effect; and the use of control to rule out other possible causes for the effect. This notion of causality is consistent with the experimental design, not the correlational design. If one manipulates the cause, it should follow that the effect is also manipulated. According to this definition of causation, therefore, only experimental designs would be suited to establishing causation.

There are some who argue that correlational studies can in fact be used to determine causality as long as certain criteria are met. Examples of these were developed by the US Surgeon General in the 1960s and were subsequently updated (Reynolds, 1999):

- consistency - whether the association appears in multiple studies at similar levels
- strength - the size of the association
- specificity - the appearance of the association mainly when the causal variable is present
- temporality - occurrence of the probable causal variable before the association
- coherence - the ability to explain the association with known facts

Reynolds (1999) disputes the ability to use these criteria causally, citing the case of the over 100 correlational studies on smoking and low birthweight babies. He presents a review of the research in which it was found that mothers who smoke also have higher caffeine intake as well as increased likelihood of narcotics and other illicit drugs. Each of these could explain the

low birthweights. As noted by Greeno (2002), giving up any of the conditions of the experimental design removes our ability to make causal inferences.

Conclusion

Although there are some who would like to use correlational studies to imply causation, we have seen here that these types of studies would not meet the criteria for causation. When we hear words like "linked to" or "associated with", we know that the researchers were using correlational research in some form. We then know to expect that there may be many other unknown factors which could be alternate explanations for the association. An often-told legend in statistics is used to illustrate the error in this thinking. Years ago, researchers were investigating the factors associated with the development of malaria. They discovered there was a strong association between the amount of rainfall in tropical zones and the incidence of malaria. They believed that the malaria parasites were carried in the rainfall. This was reinforced when researchers noted that those who wore protective clothing against the rain had a decreased incidence of malaria. This type of thinking excluded other possibilities which may explain why these two factors were linked. It was not until much later that they realized it was the Anopheles mosquitos that actually carried the parasites and transmitted the disease with their bite. The mosquito population would, of course, increase in times of high rainfall, and those who wore protective raingear would also be less likely to be bitten by mosquitos. Let's look beyond the rain in our interpretation of the research and try to find the mosquitos!

References

Brink, P.J., & Wood, M.J. (1998). Introduction (Chapter 1). In P.J. Brink, & M.J. Wood (Eds.), **Advanced design in nursing research** (2nd ed., pp. 3-20). Thousand Oaks: Sage.

Carter-Snell, C.J., & Sheehan, G. (1989). Comparison of two suction techniques for intubated ICU patients [Abstract]**. Proceedings of the Twenty-eighth Interscience Conference on Antimicrobial Agents and Chemotherapy** (p. 116).

CBC Staff. (2004). US Study suggests antibiotic, breast cancer link. **CBC News**. Retrieved February 20, 2004 from http://www.cbc.ca/stories/2004/02/16/antibiotic_bcancer040216

Cook, T.D., & Campbell, D.T. (1979). Causal inference and the language of experimentation. In T.D. Cook & D.T. Campbell (Eds.), **Quasi-experimentation: Design & analysis issues for field settings**. Boston: Houghton Mifflin Company.

Greenhalgh, T. (1998). Statistics for the nonstatistician - II: "Significant" relations and their pitfalls. **Student BMJ, 6**, 156-159.

Greeno, C.G. (2002). Major alternatives to the classic experimental design. **Family Process, 41**(4), 733-736.

Grimes, D.A., & Schulz, K.F. (2002). Descriptive studies: What they can and cannot do. **Lancet, 359**(9301), 145-149.

Linton, M. (2004, January 9). Nurses' health study a landmark. **C-Health, Toronto Sun.** Retrieved March 3, 2004 from http://www.canoe.ca/Health0109/04_linton-sun.html

Loiselle, C.G., Profetto-McGrath, J., Polit, D.F., & Beck, C.T. (2004). Analyzing quantitative data. In C.G. Loiselle, J. Profetto-McGrath, D.F. Polit, & C.T. Beck (Eds.), **Canadian Essentials of Nursing Research** (pp. 329-380). Philadelphia: Lippincott.

Reynolds, C. (1999). Inferring causality from relational data and designs: Historical and contemporary lessons for research and clinical practice. **The Clinical Neuropsychologist, 13**(4), 385-395.

Outlook

Trauma corner

'Brain death' in Vancouver!

By Caroline McGarry-Ross, RN, ENC(C), Halifax, NS

From April 9-11, 2003 Vancouver hosted a Canadian forum with one main goal: to bring experts from many fields together in order to develop a new Canadian protocol for assessing and diagnosing the patient with brain (versus cardiac) death. The forum was officially called "Severe Brain Injury to Neurological Determination of Death", and NENA was invited to send three emergency nurses from across Canada to participate. Provincial associations were contacted and requested to forward interested and appropriate names for selection. By some divine intervention, my name was selected, and so it was that I found myself attending this conference along with two other ER nurses: Clay Gillrie from British Columbia, and Francoise " Frankie" Verville from Saskatchewan.

Now one would think that five days in downtown Vancouver at the posh Fairmont Hotel Vancouver (all expenses paid by the conference) would be a treat. And, in many ways, it was. The catch was that I had to actually *participate* in this conference (versus attend and just look interested, which is something I can do well...) and it was on a subject that I had managed to avoid for years: how best to identify and diagnose the patient with brain death. You see, a couple of negative experiences in emergency and ICU had left me with a rather uncomfortable feeling about the whole process and that, coupled with a nagging spiritual concern for patients who became donors, simply meant avoiding such situations as much as possible. That is where the divine intervention comes in; clearly the good Lord decided it was high time I learned much more about this. And so, with some hesitation about it all, as well as Air Canada's ability to get me there, off to Vancouver I went.

On day one of the conference, we did the obligatory introductions and I found myself surrounded by quite an esteemed (and very cerebral) group from all over Canada. Indeed, there were neurosurgeons, neurologists,

emergency physicians, intensivists, pediatricians, a neonatologist, a statistician, donor coordinators, a representative from the Department of Health and a select number of ICU and emergency nurses (just to add some common sense and balance to the group, I'm sure). They had assembled quite a remarkable group of professionals, and the best part was we were divided into small working groups. (Oh yeah, I felt like contributing my squeaky little opinion amongst that crew!) Needless to say, I did end up contributing my thoughts, just as we all did, because we had a superb facilitator who was very clear about one thing: we had just two-and-a-half days to achieve our goals and *everyone* was expected to contribute.

Throughout those two-and-a-half days the conference organizers and facilitator succeeded in bringing this varied and opinionated group of experts to a consensus on a number of key things. Namely:

- Appropriately identifying the criteria for determining brain death,
- Identifying criteria of patients who should be assessed for brain death,
- Identifying which practitioners are best capable of diagnosing brain death; and
- Identifying a guideline for the optimal care of the patient with brain death.

It was a very dynamic and interesting process and there were times when clinical expertise combined with the emotional aspect of this discussion (and the *occasional* inflated ego) led to some very heated debates! To their credit, the organizers encouraged these debates and were very sincere that all aspects be discussed and considered. A presentation by the statistician pointed out to everyone, especially the organ coordinators, that our way of comparing potential organ donors to actual donors was deeply flawed and inaccurate. Thus, comparisons of provinces against each other, or of Canada versus the USA or European countries, are, to date, invalid.

Dr. Wijdicks, Professor of Neurology at the Mayo Clinic, presented on the evolution of the (relatively outdated) Harvard definition of brain death, developed in 1968. He was clearly impressed and excited at this Canadian initiative and stated we are "setting the new standard for Harvard and the world". It is expected that it will take approximately one year for the approval process for these proposals to be completed.

It was a real eye-opener to be a part of this whole process. I felt very fortunate to be invited to participate in these discussions and very impressed with the degree of passion shown by the physicians there. As if to allay my fears (and others'), the organizers were adamant that the conference focus solely on defining brain death and the optimal care of the patient with it. Deciding who then qualifies as a donor and the whole process of retrieval and donation were not to be discussed.

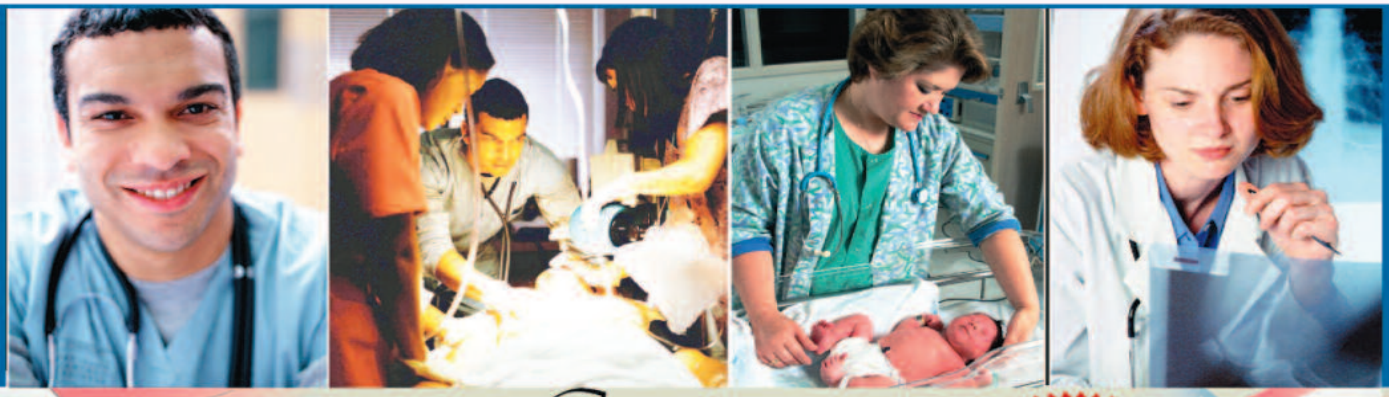
At the close of the conference, as debates were finished, notes taken, and thank you's made, Dr. Philip Belitsky, Coordinator Transplant Services QEII Halifax, stood up to speak. In his soft voice and unassuming manner, he thanked everyone profusely for attending and contributing to this conference. He stated he was the only person there who could be seen as being in a potential 'conflict of interest' position. After all, his world deals with retrieving organs and transplanting them, should he really be at a conference that looks to define a condition that will, in some cases, allow the patient to become an organ donor? He concluded his thoughts beautifully by stating there is no conflict of interest when we all share the same goals: to provide optimum care to *all* patients, regardless of where they may be in that continuum of life and death.

And so it was, on the long flight home, that I found myself realizing that I no longer felt uncomfortable about organ donation. A key piece of the puzzle had been solved, knowing that any patient diagnosed with brain death would have had it done using a non-biased, current, and nationally-accepted standard, with the only focus being optimal care of that patient and not their potential to be a donor. Divine intervention had worked; I finally felt I could speak to a family about either issue and not feel a conflict of interest.

Now... if I could only find a conference in Hawaii...

NENA revised position statements

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.



CRYTZER ENGLAND GROUP·INCORPORATED

formerly HRS

BRINGING CANADIAN RN'S to the U.S. for FREE!

VISIT BOSTON, ORLANDO & OTHERS U.S. CITIES!

ARE YOU

- **A CANADIAN RN?**
- **INTERESTED IN RELOCATING TO THE U.S.?**
- **INTERESTED IN SPEAKING WITH MULTIPLE U.S. HOSPITALS AT A UNIQUE INTERVIEW EXPO?**

THEN CALL TODAY AND YOU COULD BE ON YOUR WAY TO AN INTERVIEW EXPO IN THE U.S. ... WITH FREE AIRFARE & HOTEL!!

Don't miss one of the following events:

Jan. 24-27, Orlando, FL
June 5-8, Orlando, FL
September 25-28, Boston, MA

Call **877.722.SHOW**
or **405.722.SHOW**
or visit us at

www.interviewexpo.com

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 membership 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: _____