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

Volume 29, Number 2, Fall 2006

In This Issue:

NENA

Take-home messages from the NENA 2006 conference:

1. If you feed emergency nurses, they will come.
2. The Canadian Chief of Defence is married to a nurse and likes chocolate chip cookies.
3. Morphine is better than Demerol, second only to white wine.
4. Slides of inflammation and infection don't spoil emergency nurses' appetites.
5. Kids may be small, but their hurts can be very big.
6. Some of our patients have "rocks in their heads".
7. Today's personally protected emergency nurses wear hot orange boots.
8. Stridor is caused by croup, croup and also caused by croup.
9. Tactical paramedics are backed up by three really big guys with guns.
10. Trauma patients remember their emergency nurse's voice and touch.
11. The greater the number of conference exhibitors, the better.
12. We need to listen to the voices when they tell us that our meds aren't working.
13. Lawyers are our friends.
14. Canada's Federal Health Minister is committed to ongoing collaboration with NENA.
15. Saskatchewan emergency nurses can really sing!
16. There is a "Golden Hour" for antibiotics in Sepsis.
17. Triage nurses should be issued a tazer.
18. The Canadian ER nurses clearing the C-spine trial is as exciting as winning chocolates.
19. Exercise will kill you!
20. We must leave our fever phobias at home!
21. It is very bad if you end up in K-land!
22. Both death and diarrhea are bad.
23. Love potion 8.5 can cause grievous bodily harm.

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President's message

NENA is continually working to assist our members and all emergency nurses across Canada. No issue is isolated to any one area or province.

To this end, your NENA board of directors had requested and successfully orchestrated a May 2006 meeting with Canada's federal health minister, the Honourable Tony Clement. Concerns expressed by NENA members from across Canada were shared with Mr. Clement.

The round table discussion included emergency overcrowding, the ongoing nursing shortage, wait times and patient safety, and nursing recruitment and retention. NENA suggested that Canada's federal government directly target increased finances toward the support of ongoing education and skill upgrading for all of Canada's emergency nurses. NENA also proposed that support services (MRI, CT scan, laboratory services, and homecare) provide expanded hours to at least six days per week in order to facilitate patient flow in Canada's health care system.

Mr. Clement shared NENA's concerns, voicing appreciation for our responsible and constructive suggestions for emergency health care in Canada. During his address to the NENA 2006 conference attendees, Canada's federal health minister publicly committed to an ongoing collaborative relationship with NENA.

May was a very busy month for NENA and its members. Your board of directors held a very productive three-day BOD meeting. Further affiliation business was also conducted during the NENA 2006 annual general meeting. Winners of several bursaries and one Award of Excellence, as well as the first NENA research grant were announced.

The NENA 2006 conference "Stayin' Alive" was a great success. Attendees from across Canada participated in a highly educational NENA event, incorporating assorted speakers covering a broad scope of pertinent topics, eating very well at meals and breaks, touring wonderful exhibits, and enjoying many entertaining and fun social events, along with taking advantage of unlimited networking opportunities while earning valuable certified education contact hours.

NENA supports the CTAS program created by the National Working Group (NWG) and remains committed to facilitating the rollout of this standardized triage program across all Canadian provinces and territories. The NENA members of the NWG continue to work tirelessly to make this a reality very soon.

As your NENA president, I had the honour of being invited to present "Canadian Trauma Care" at the first International ER Nursing Congress held in May 2006 in Ixtapa, Mexico. Carla Policicchio, NENA past-president, presented on CTAS and triage as well. During the same conference, I also participated in a panel symposium discussing issues faced by emergency nurses from around the world. The other participants were the emergency nursing presidents from Mexico, the Philippines, USA and Spain. Overcrowding, nursing shortages, recruitment and retention, and funding for ongoing education were global concerns.

The emergency nursing presidents from Spain and Mexico have created an alliance between their two countries with the goal of working together to better deal with issues faced by emergency nurses in the world's Spanish-speaking countries. As NENA president, I was honoured to be asked to serve as the international witness to the ceremony and document-signing, establishing this historic emergency nursing alliance. NENA is indeed highly regarded and recognized internationally.

The NENA membership should be aware of how proactive and committed your BOD is to becoming involved in health care issues affecting Canada's emergency nurses today and in the future. We have initiated a connection with the Centre for Excellence in Emergency Preparedness (CEEP) and Health Canada's Emergency Preparedness Division. These agencies are excited to have NENA's participation in emergency preparedness planning for Canada. Since emergency nurses are the gatekeepers to the Canadian health care system, it is essential that NENA be involved early and continuously.

We are now into the 2006-2007 membership year. I believe that many exciting challenges are in store for each of us in the upcoming months. Together, we will meet and overcome them for the benefit of the countless patients for whom we care. I urge every NENA member to encourage your friends and colleagues to also become NENA members so that they, too, may contribute to and benefit from all that NENA has to offer. I encourage every NENA member to become more active in "your" professional affiliation. The more members and the more involvement by those members, the louder NENA's collective voice for all of Canada's emergency nurses. Let us share together, in a personally and professionally rewarding NENA experience!

Janice L. Spivey, RN, ENC(C), CEN
NENA President

Calling all instructors

If your students have put the work into a presentation, a case study, a disease process, research, etc., why not encourage them to write it up into a brief article to be published in Outlook? Our section editors will work closely with them to help in the process, and they can see their hard work in print, help to educate emergency nurses across the country and add a publication to their resume – a win/win situation!

Articles can be submitted to the Communication Officer, Colleen Brayman, 337 Providence Avenue, Kelowna, BC V1W 5A5
(H) 250 764-9603; e-mail: **colleenbrayman@hotmail.com**

Introducing the President-Elect – Tanya Penney

I graduated from nursing in 1991 from St. Martha's Regional Hospital, initially practising in mental health. I began emergency nursing in 1997 in a small rural hospital, moving to the Dartmouth General ED shortly thereafter. In October 2005, I graduated from Dalhousie University with my BScN and I remain enrolled in courses in an eventual goal to attain my Masters.

At present, I am the Health Services Manager of the emergency department in Hants Community Hospital (Windsor, NS) as well as faculty within the Maritime School of Paramedicine (Dartmouth, NS). Teaching paramedic students presents a wonderful opportunity to establish working relationships with paramedics across the province; it allows me to appreciate their roles and knowledge while sharing nursing perspectives with them.

I have been on the NENA board of directors for one-and-a-half years now, representing Nova Scotia as Provincial Director. This has been an awesome experience! The folks who represent this country's emergency nurses are professional, knowledgeable, outgoing, dedicated and, above all, committed to the standards of practice of emergency nursing. I feel honoured to be participating as president-elect. The work of this organization is very important in establishing standards in research, education and practice. The mission and values of NENA speak to nurses nationally. Within our health care system today, emergency nurses are facing new challenges daily from British Columbia to Newfoundland. We need to applaud ourselves for our practice, professionalism and dignity in the face of adversity.

On a personal note, I live in rural Nova Scotia with my two sons (Zackary and Breton) who keep me busy as a softball/hockey/lacrosse mom!

I am very excited and look forward to this opportunity. Please do not hesitate to contact me if you have any questions, concerns, comments or suggestions.

Yours in emergency nursing,

Tanya Penney, RN, BScN, ENC(C)

From the editor

As you are reading this, it means that I was able to shake off the "deer in the headlights" syndrome enough to submit something for publication (and I apologize now for any deficiencies, as compared to previous publications and beg your forgiveness). I have recently taken over the position of Communication Officer from Val Eden – big shoes for me to fill – and am on a huge, but exciting, learning curve.

Let me introduce myself. I graduated from an Edmonton RN program in 1985, and obtained my BScN in 2001 from the University of Alberta. I worked in NICU for my first four years after graduation (in Edmonton, Ottawa and Vancouver), then transferred to PICU at the University of Alberta Hospital (UAH) where I worked for the following 12 years – the last five of which were on the Pediatric Transport Team. Lastly, for the past five years I have been a Clinical Nurse Educator in Emergency at the UAH and this is where my journey with NENA began. I am married and have four children, which keeps my life very busy and has taught me that sleep is not all it is cracked up to be! We just recently moved to Kelowna, and once I am registered there (darn, this FORCED me to take the summer off…), I hope to continue working in emergency.

I am excited about this opportunity to work closely with the NENA executive, board of directors and membership, and would appreciate any input, suggestions, and future submissions sent my way. I look forward to working with you to continue to make this a class one publication.

Colleen Brayman, RN, BScN
Communication Officer

Outlook
Conference watch

The 5th World Conference on Breast Cancer

June 4-8, 2008, at the Winnipeg Convention Centre, Winnipeg, MB. For more information contact:
World Conference on Breast Cancer Foundation. Duane Eagles, Marlene Finn, Rachel Gillooly
Tel. (905) 384-1848, E-mail **mail@wcbcf.ca,** website: **www.wcbcf.ca**

President's address

NENA AGM – May 4, 2006, Ottawa, Ontario

NENA is your professional affiliation. Your BOD works hard year-round, representing the NENA membership. I encourage you to contact any of the BOD members about issues in your areas or ideas you may have to further the work of NENA.

NENA continues to make TNCC and ENPC available across Canada. The BOD has been working with course directors to facilitate better availability of the CATN II course as well.

NENA continues to represent you as an active member of the CTAS National Working Group, striving towards the rollout of the standardized CTAS program across Canada.

In the past six months, NENA has established contact with the Canadian Nursing Student Association and the Paramedic Association of Canada in the hopes of future collaboration between our groups.

Shortly, a NENA representative will be meeting with the newly formed Canadian working group for the Centre for Excellence in Emergency Preparedness. Since emergency nurses work on the front lines of health care, NENA feels it is appropriate to participate in the planning and preparation for future threats to public health in Canada.

NENA has many wonderful documents available for use in your daily practice. Consider writing an article for **Outlook**, this is your professional journal. The NENA website is always changing. Watch for more member polls and other exciting additions.

On behalf of the NENA BOD, I would like to thank the Emergency Nurses Association of Ontario for hosting the NENA 2006 Conference. Liz Rodovich and her committee have done a commendable job!

I wish you all three totally fulfilling days of "Stayin' Alive". Thank you for your attendance, and I hereby adjourn the NENA 2006 Annual General Meeting.

Janice L. Spivey, RN, ENC(C), CEN
NENA President

Bursary and award winners

Special congratulations

- to Edwina Campbell (Prince Edward Island), pictured at right, recipient of the NENA Award of Excellence in Nursing Practice.
- to the following NENA bursary winners: Kathy Kennedy (British Columbia), Stephanie Carlson (Saskatchewan), Lisa Powell (Manitoba), Tanya Norris (Prince Edward Island), Cate Knowlton (Nova Scotia), Tanya Penney (Nova Scotia), Stacey Sowerby (New Brunswick), Irene Osinchuk (board of directors), and Rose Jacobson, who was awarded the Margaret Smith Pediatric Bursary.
- to BOD members Janet Calnan and Janice Spivey who recertified their ENC(C).
- to BOD member Tracey Norris and the other 217 Canadian nurses who achieved their ENC(C).

Letter to rural physicians

February 13, 2006

Dr. Trina Larsen Soles,
President – Society of Rural Physicians of Canada,
PO Box 1170,
Golden, BC V0A 1H0

Dear Dr. Larsen Soles,

Many Emergency Nurses practise in rural settings in every province across Canada. The National Emergency Nurses' Affiliation (NENA) representing these professionals is one of the five organizations that comprise the Canadian Triage and Acuity Scale (CTAS) National Working Group (NWG).

The NENA TRIAGE position statement indicates: "Triage is a dynamic process. Patients' conditions can change, therefore continual reassessment of the patient is imperative."

Since the implementation of the CTAS 5 deferral position taken by the SRPC, several issues have become apparent that need to be addressed. Significant medico-legal issues have been identified that directly impact the emergency nurses involved with this deferral process. The NENA board of directors is committed to providing support and assistance to Canada's rural nurses as they face their unique challenges. NENA certainly recognizes the challenges within the rural facilities, however, as a result of the medico-legal issues identified, we believe it is important to collaborate with the Society of Rural Physicians to eliminate these issues.

NENA believes:

- All emergency nurses should receive standardized training in both adult and peds CTAS through Canada's NWG CTAS program.
- A hospital must have a written policy in place accepting full responsibility for any expected deferral actions by the emergency nurse relating to Level 5 patients.
- A written policy regarding Level 5 patients must clearly outline the liability if triaged away from the emergency department.
- Any hospital supporting the deferral of Level 5 patients must provide a hospital record for the purpose of permanent documentation of this occurrence.
- A physician must be notified and thus involved in any decision to triage a Level 5 patient away from the emergency department.

NENA looks forward to the further discussion and debate of this important emergency health care issue by our two organizations.

Yours sincerely,

Janice L. Spivey, RN, ENC(C), CEN
NENA President
112 Old River Road, RR2,
Mallorytown, ON K0E 1R0
E-mail: president@nena.ca

CNA annual report

Group
National Emergency Nurses Affiliation (NENA)

Historical perspective
The National Emergency Nurses Affiliation was formed in 1981. As NENA has grown and developed, nine provinces have become part of the affiliation. We also have several independent members in Quebec, the territories and internationally.

General structure
There are nine active provincial interest groups, each led by a provincial director, as well as the independent members in NENA. The NENA board of directors (BOD) comprises an executive (president, past-president or president-elect, secretary, treasurer and communications officer) as well as the nine provincial directors. The NENA BOD meets for three days twice each year.

NENA has several operating committees: Professional Practice & Documents Committee, Nursing Research Committee, Political Action Committee, Nominations Committee, Bursaries & Awards Committee and the National Course Administration Committee (NCAC).

NENA holds an annual emergency nursing conference that rotates across Canada. Each province hosts this national education initiative in turn. The NENA annual general meeting is held in conjunction with the annual conference.

Mission
To represent the Canadian emergency nursing specialty.

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

Goals
- Strengthen the communication network.
- Provide direction for clinical practice of emergency nurses.
- Promote research-based practice.
- Support and disseminate education.

Membership
As of March 2006, NENA had 912 members, distributed as follows:

British Columbia	222
Alberta	178
Saskatchewan	48
Manitoba	75
Ontario	167
New Brunswick	40
Nova Scotia	89
Prince Edward Island	14
Newfoundland & Labrador	72
Independent	7

Special projects and activities
The NENA website is becoming more interactive, resulting in more frequent site utilization by the members. The website contains a public section as well as members-only sections, accessible only by an individual password. Information that is both current and pertinent to emergency nurses is frequently updated on the NENA website **www.nena.ca**.

NENA Inc., 2004-2005 year-end report

INCOME	**Actual**	**Budget**	**Variance**
Fundraising	$2,126.00	$4,200.00	$2,074.00
BOD Mtg Recoup	$2,087.64	$4,000.00	$1,912.36
CTAS – Indirect Fees CAEP	$785.00	$0.00	($785.00)
Grants		$0.00	
Indirect Fees: ENPC	$21,150.00	$22,410.00	$1,260.00
Indirect Fees: TNCC	$49,165.00	$49,080.00	($85.00)
Indirect Fees: CATN	$0.00	$720.00	$720.00
Interest Income	$331.53	$200.00	($131.53)
Member Fees	$37,355.00	$31,980.00	($5,375.00)
Advertising	$5,202.19	$3,000.00	($2,202.19)
Misc. Income	$4,151.98	$0.00	($4,151.98)
TOTAL INCOME:	**$122,354.34**	**$115,590.00**	**($6,764.34)**

EXPENSES	**Actual**	**Budget**	**Variance**
Awards	$201.42	$200.00	-$1.42
Advertising		$100.00	$100.00
Bank Charges	$319.28	$300.00	-$19.28
Board Meetings	$37,146.17	$21,400.00	-$15,746.17
Bursaries	$2,150.00	$6,600.00	$4,450.00
Professional Fees	$214.00	$250.00	$36.00
Committee Mtgs.	$20,349.44	$32,000.00	$11,650.56
Gifts	$388.00	$200.00	-$188.00
CTAS Reimbursement	$235.00	$0.00	-$235.00
Legal	$809.72	$300.00	-$509.72
Office Expense	$4,241.19	$10,800.00	$6,558.81
Programs	$6,055.63	$5,000.00	-$1,055.63
Promotions	$1,382.02	$4,080.00	$2,697.98
Public Relations	$13,522.63	$20,480.00	$6,957.37
Reimbursements: ENPC	$7,360.00	$7,270.00	-$90.00
Reimbursements: TNCC	$17,330.00	$15,880.00	-$1,450.00
Reimbursements: CATN	$240.00	$240.00	$0.00
Misc.	$361.53	$0.00	-$361.53
TOTAL EXPENSES:	**$112,306.03**	**$125,100.00**	$12,793.97

INCOME/LOSS POSITION:	**$10,048.31**
SAVINGS ACCOUNT:	**$22,133.32**

NENA has conducted two membership polls through our website in the past year. The first poll related to potential legislation requiring mandatory reporting to police about the presence of a person with a gunshot wound in an emergency department. The majority of NENA respondents agreed with the Ontario government in their new law, that the responsibility for general public safety outweighed individual patient confidentiality. NENA also conducted a poll regarding potential emergency nursing research in Canada. These results are yet to be compiled.

The NENA journal, **Outlook**, continues to be published twice per year. All members are encouraged to make submissions and write articles to be published in **Outlook**.

NENA is working to establish a liaison with the Paramedics Association of Canada. Since emergency nurses work so closely with paramedics, there is the potential for collaborative opportunities between our two groups.

NENA has initiated a connection with the Canadian Student Nurses Association (CSNA), offering human as well as informational resources to this group, many of whom will become Canada's emergency nurses of tomorrow.

Emergency preparedness is an important issue for emergency nurses. NENA has established a connection with the Centre for Excellence in Emergency Preparedness and the Public Health Agency of Canada, expressing interest in participation in ongoing initiatives and program development.

NENA Inc., 2005-2006 unaudited year-to-date budget report

INCOME	**Actual**	**Proposed**
Advertising	$3,780.00	$4,000.00
BOD Mtg Recoup	$5,304.31	$3,000.00
CTAS – Indirect Fees	$5,135.00	$2,000.00
Grants	$1,886.14	
Fundraising	$2,070.94	$8,200.00
Indirect Fees: ENPC	$17,930.00	$25,650.00
Indirect Fees: TNCC	$54,790.00	$52,650.00
Indirect Fees: CATN	$600.00	$3,240.00
Interest Income	$96.05	
Member Fees	$23,654.25	$28,520.00
Misc. Income	$2,507.84	$0.00
TOTAL INCOME:	**$117,754.53**	**$127,260.00**
EXPENSES	**Actual**	**Proposed**
Bank Charges	$459.82	$300.00
Board Meetings	$14,688.16	$27,595.00
Bursaries		$6,300.00
Professional Fees	$214.00	$500.00
Committee Mtgs.	$20,824.96	$26,500.00
CTAS Reimburse CAEP	$0.00	$0.00
Gifts	$40.00	$400.00
Interest Paid		
Legal	$30.00	$1,800.00
Liason Meetings	$3,497.85	$2,000.00
Misc.	$2,140.00	$0.00
Office Expense	$9,790.52	$10,900.00
Programs	$0.00	$8,500.00
Promotions	$80.00	$5,085.00
Public Relations	$21,573.75	$22,000.00
Reimbursements: ENPC	$6,120.00	$8,550.00
Reimbursements: TNCC	$16,290.00	$17,550.00
Reimbursements: CATN	$0.00	$1,280.00
TOTAL EXPENSES:	**$95,749.06**	**$139,260.00**
INCOME/LOSS POSITION:		**$22,005.47**

As a member of Canada's National Working Group for the Canadian Triage and Acuity Scale (CTAS), NENA is working to facilitate the rollout of the revised CTAS program that combines both the adult and pediatric components. The purpose of the new CTAS program is to establish a standardized triage process in every Canadian emergency department. Many Canadian paramedic groups have also adopted the CTAS program into their assessment protocols, clarifying communication with receiving hospitals. NENA Past-President Carla Policicchio presented CTAS at an international interdisciplinary conference in Montreal in June of this past year.

Events

The NENA 2006 conference "STAYIN' ALIVE" took place in Ottawa May 4-6, with attendees from across Canada. The three-day NENA BOD meeting was held prior to the conference. The NENA BOD requested a meeting during the week with Canada's newly elected health minister, Mr. Tony Clement.

The NENA President, Janice Spivey, was invited to present "Canadian Trauma Care" at the first International Emergency Nursing Congress in Ixtapa, Mexico, in May of this year. During this conference, the NENA president also participated in a panel symposium on emergency nursing issues with the emergency nursing presidents from Mexico, Spain and the U.S. A networking meeting was held as well for all visiting international emergency nursing presidents. NENA's Past-President, Carla Policicchio, also attended this conference. She presented CTAS to the international emergency nurses.

Issues of concern

Overcrowding, wait times, personal safety and nursing recruitment and retention remain issues of concern for all of Canada's emergency nurses. NENA continues to participate actively to address these and any concerns as they come to the forefront.

Janice L. Spivey, RN, ENC(C), CEN
NENA President
March 20, 2006

Memories from the first International ER Nursing Congress – Ixtapa, Mexico, May 2006

NENA President Janice Spivey and NENA Past-President, Carla Policicchio were both invited to do presentations at this wonderful emergency nursing international educational event held in Ixtapa, Mexico. After two flights each, we managed to find each other in the monstrous Mexico City airport for our final flight into Ixtapa!

We hit the ground running on arrival at our hotel. A late-night dinner meeting was waiting for us with the emergency nursing presidents from Mexico, Spain, the U.S. and the Philippines. There was no time for jet lag as the first session of the three full days of conference began at 0700 hours the next morning.

International university translation students had been hired by the conference committee to serve as Spanish/English interpreters. Carla and I each had our own interpreters throughout our entire stay in Mexico, so language was no problem.

The conference included speakers from around the globe. The varied presentations covered traumatic hand wounds, TNCC in Latin America, domestic violence, clinical records in the ED, organ donation, forensic nursing, universal precautions, snake bites and spider stings, severe hand injuries, adolescent ODs, Avian Flu, violence in the ER, resuscitation management, nosocomial infections, peds asthmatic crises, prehospital care for children, legal aspects of emergency care, child and elder abuse, and transportation of the multiple trauma victim. Carla did presentations on CTAS and triage, while I presented Canadian Trauma Care and Issues of Concern for Canadian ER Nurses.

Emergency nurses attended from throughout Mexico, the U.S., Peru, most countries of South and Central America, Portugal, Spain, the Philippines and Canada. During the conference days and evenings, we met with attendees from around the world and found that emergency nursing issues are totally global. The international emergency nurses were so eager for information about their Canadian counterparts and shared much about their lives and concerns with us.

While much education was packed into the long conference days, there was some downtime. A wonderful Mexican feast, complete with decorations and entertainment, happened one evening. Groups of ER nurses from around the world requested to have pictures taken with their new Canadian colleagues. A tour of Ixtapa and surrounding area, including the ambulance base was provided for all out-of-country attendees. A private tour of the Ixtapa Naval Hospital was also arranged for Carla, myself and the other international emergency nursing presidents.

Prior to the close of the conference, a ceremony was held to formally create the alliance between the Mexican and Spanish emergency nurses and their associations. It was an honour for me to represent NENA, having been asked to serve as international witness to this historic event for emergency nursing.

The Asociacion Mexicana de Enfermeria en Urgencias (Mexican Association of Emergency Nurses) and its President, Mr. Gerardo Jasso Ortega, have expressed sincere appreciation to Canada's National Emergency Nurses' Affiliation (NENA) for their support of this huge conference venture. With international recognition and many new emergency nursing friends worldwide, this is a proud day for NENA!

Janice Spivey
NENA President

Left to right: Domingo Arteaga, Sociedad Espanola de Enfereria de Urgencias y Emergencias, Spain, Janice Spivey, National Emergency Nurses Affiliation, Canada, Gerardo Ortega, Asociacion Mexicana de Enfermeria en Urgencias, Mexico, Nancy Bonalumi, Emergency Nurses Association, U.S.

outlook

NENA at work

NENA BOD with Canada's federal health minister, the Honourable Tony Clement, at the NENA 2006 national conference held in May in Ottawa. Front row (left to right): NENA executive: Jerry Bell, Valerie Eden, Tony Clement, Janice Spivey, Janet Calnan Back row: NENA board of directors: Sharron Lyons, Karen Latoszek, Irene Osinchuk, Leslie Olson, Judy Skanderup, Tanya Penney, Bonnie Briere, Tracey Norris, Ted Sellers, Cavell Bolger, Alison Duncan.

outlook

Bouquets

A special thank you:

On behalf of the NENA board of directors and the entire NENA membership, I wish to extend sincere appreciation to Valerie Eden and Carla Policicchio. These two dedicated NENA members have served the affiliation tirelessly and proudly.

Valerie has fulfilled several roles on the NENA executive over many years, including president and, most recently, as communications officer and OUTLOOK editor. She continues in her role on the CTAS National Working Group.

Carla has fulfilled her term as NENA president and continues to actively represent NENA as a member of the CTAS National Working Group.

The NENA membership has benefited greatly from the incredible time, energy, talents and commitment to emergency nursing in Canada, by these two special ladies.

– Janice L. Spivey, NENA President

"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, Colleen Brayman, 337 Providence Avenue, Kelowna, BC V1W 5A5. (H) 250 764-9603;
e-mail: ***colleenbrayman@hotmail.com***

American Heart Association's new guidelines to pediatric resuscitation

By Colleen Brayman, RN, BScN

The International Liaison Committee on Resuscitation, a consortium of many of the world's resuscitation council's representatives, and the American Heart Association (AHA) published the *Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care*. In 2002, reviews (both literature and expert) began to identify, review and evaluate evidence pertaining to resuscitation and draft or revise treatment recommendations, which resulted in the *2005 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations* published in November 2005. The biggest changes were to the delivery of basic life support (BLS) and an increased emphasis on the importance of chest compressions. The following is a brief summary of changes to the **health care provider** guidelines pertaining to pediatric resuscitation:

a) Newly born applies specifically to an infant at time of birth, Newborn/neonate refers to infants from birth to discharge from hospital. Infant refers to the time from discharge from hospital to one year of age, and child is from one year of age to onset of puberty.
b) BLS sequence should be varied according to the cause of arrest:
   - Call First (get Automated External Defibrillator [AED]) if the arrest was witnessed, therefore probable shockable rhythm arrest
   - Call Fast (start CPR x 5 cycles or about two minutes) in unwitnessed arrest, therefore probable asphyxia arrest (International Liaison Committee on Resuscitation, 2005).
c) If the health care provider is unable to adequately open the airway using a jaw thrust on the trauma victim with suspected C-spine injury, the head tilt-chin lift technique should be used (Marett, 2006).
d) When intubating, either cuffed or uncuffed tubes are acceptable for infants (except newborns) and children and cuffed may be preferred, although a caution is stated about pediatric intubations (Marett, 2006).
e) Lone health care provider compression-to-ventilation ratio is 30:2 in all age groups, except the newborn. Two-rescuer health care providers compression-to-ventilation ratio is 15:2 in all age groups, except the newborn, and they should rotate the compressor role every two minutes. Emphasis is placed on the importance of adequate compressions. Push hard, push fast, minimize interruptions in chest compressions; allow full recoil of the chest and do not hyperventilate (International Liaison Committee on Resuscitation, 2005).
f) Once an advanced airway is established, compress at a rate of 100/minute and ventilate, without pausing to give the breath, at a rate of eight to 10/minute (International Liaison Committee on Resuscitation, 2005).
g) The two-thumb technique of giving compressions is stressed in two-rescuer infant CPR, and either the one-hand or two-hand technique is acceptable in children.
h) AEDs that are able to recognize pediatric rhythms and attenuate shock doses are acceptable to be used on children ≥ one year of age. Standard AEDs are recommended for children ≥ eight years of age or 25 kilograms.
i) For shockable pulseless rhythms, a single shock (initially 2 J/Kg, 4 J/Kg for subsequent shocks) is delivered, immediately followed by CPR beginning with compressions, for five cycles or about two minutes before completing a pulse check (International Liaison Committee on Resuscitation, 2005).
j) De-emphasis of drug delivery via the ETT route and increased emphasis on IV/IO route.
k) High-dose epinephrine is no longer recommended (Marett, 2006).
l) The importance of adequate ventilations at a rate of eight to 10 breaths/minute is emphasized in profound shock and/or post-arrest states.
m) For children who remain comatose upon return of spontaneous circulation, considerations should be made to inducing hypothermia (32°C to 34° C) for 12 to 24 hours (Marett, 2006).

This is only a brief summary of pediatric recommendations, and further explanations to the evidence behind these recommendations as well as recommendations to the resuscitation of adults and newborns are addressed in the *2005 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science with Treatment Recommendations*. Copies of these guidelines can be found on the AHA website, **www.americanheart.org**, and in **Circulation** (2005), 112.

AHA and collaborating organizations will be developing and delivering comprehensive training material in the very near future, so stay tuned.

References

American Heart Association in Collaboration with International Liaison Committee on Resuscitation. (2000). Guidelines 2000 for cardiopulmonary resuscitation and emergency cardiovascular care. **Circulation, 102**(suppl.), I-1-I-384.

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Tips for promoting injury prevention in your practice!

By Carole Rush, RN, MEd, CEN, Injury Prevention Specialist and Emergency Staff Nurse, Calgary Health Region

The overall focus of emergency care is assessment, diagnosis and treatment. Injury prevention is not usually a big part of clinical practice. While nurses and physicians are focused on the knowledge and skills needed to successfully and efficiently treat the patient, there may be some "teachable moments" to help patients avoid a future injury. Injury prevention strategies also include initiatives to reduce injury severity, such as helmets and seat belts — the device does not prevent the crash, but reduces the severity of injury should a crash occur.

Injury prevention does work, but over time. Safe Kids Canada released their report, *Child & Youth Unintentional Injury: 10 Years in Review 1994-2003* during Safe Kids Week June 5-11, 2006. The overall injury death rate among children from birth to age 14 declined by 37% between 1994 and 2003. The overall rate of injury hospitalizations from birth to age 14 declined 34% during that same period. The three leading causes of injury-related death are motor vehicle collisions (17%), drowning (15%) and threats to breathing (11%) such as suffocation, choking and strangulations. Falls account for nearly half (44%) of all injury-related hospital admissions, and occur at home, school and on playgrounds. Although the results are encouraging, the report reminds us that injury rates continue to be unacceptably high, and injury is an important public health issue. There is still plenty more that needs to be done.

Emergency nurses are a key target audience to become involved in injury prevention efforts in their hospitals and out into their communities. We are credible sources, see the consequences of injury and, hopefully, subscribe to the theory that most injuries are preventable.

Here are some suggestions for promoting injury prevention messages in your practice:

Clinical practice

- History-taking and triage questions: Include questions about safety devices such as restraints, helmets, wristguards, etc., appropriate to the patient situation. If patients hear us ask those questions, they may get the message that these items are important.
- Discharge teaching: Try to include injury prevention information in your discharge teaching, where appropriate. It may not be appropriate to discuss helmets right away with the family of a critical head-injured patient; a "teachable moment" may be promoting helmets and wristguards to a skateboarder who presents with a fractured clavicle.
- Include injury prevention literature in your waiting areas on topics such as child passenger restraints, helmets/protective gear for a variety of sports, driving distractions and fall prevention for older adults. See Table One for sources of injury prevention literature.
- Show safety/injury prevention videos on your waiting room televisions (although I know it will be tough to compete with the hockey game. Perhaps more success in children's hospital waiting rooms).

Educational presentations/ TNCC/ENPC courses

- For local current injury data, talk with your trauma registry staff, if your facility collects trauma data. All health regions collect what is called "corporate data" and include information on emergency department visits and hospitalizations. Provincial trauma data is usually available through the Ministry of Health.
- Include examples of injury prevention initiatives in your community, e.g. PARTY program*, Emergency Nurses CARE**, where appropriate in your course. Many of these programs have informational pamphlets and displays that could be at your course. Many of these programs rely on volunteers; participants may want to become more involved in these programs on a local level.
- Have a display table of injury prevention resources at your TNCC/ENPC course. Participants will be able to learn more about these subjects, and also get ideas for which resources they could use in their emergency department waiting rooms and minor treatment areas (See Table One).

** For information on the HEROES and PARTY programs, contact SMARTRISK Foundation at **www.smartrisk.ca***
*** For information on the Emergency Nurses CARE program, contact the Emergency Nurses Association **www.ena.org** and click on "Injury Prevention / ENCARE"*

Opportunity for media coverage

- Media may approach your hospital/ emergency department for commentary on a specific injury case. Following your media policy, it may be deemed appropriate to promote messages that could help prevent a similar incident/tragedy in the future. For example, if the patient was not wearing a seatbelt or helmet and it is deemed that such a device likely would have reduced the injury severity, then providing a reminder to the public is appreciated.

Table One. Key Canadian agencies for injury prevention and control	
Agency name	**Website for Data, Resources, Handouts**
Agriculture Canada (Farm Safety Surveillance System and Injury Prevention)	www.agr.gc.ca
Block Parents of Canada	www.blockparent.ca/english/main.html
Canada Safety Council	www.safety-council.org
Canadian Association for Suicide Prevention	www.thesupportnetwork.com/CASP/main/html
Canadian Association of Poison Control Centres	www.napra.org/practice/Toolkits/Toolkit6/poison_control.html
Canadian Centre of Occupational Health and Safety	www.canoshweb.org
Canadian Centre on Substance Abuse	www.ccsa.ca
Canadian Firearms Centre	www.cfc.gc.ca
Canadian Institute of Child Health	www.cich.ca
Canadian Institute of Health Information (CIHI) – National Trauma Registry	http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=home_e
Canadian Parks and Recreation Association (Playground Safety)	www.cpra.ca
Canadian Pediatric Society	www.cps.ca
Canadian Public Health Association	www.cpha.ca
Canadian Red Cross Society	www.redcross.ca
Fire Prevention Canada	www.fiprecan.ca
Health Canada – Seniors Injury Prevention (Aging and Seniors Section)	www.phac-aspc.gc.ca/seniors-aines/pubs/injury_prevention
Health Canada (Many divisions and departments with Injury Prevention Information)	www.hc-sc.gc.ca (Home page)
Lifesaving Society of Canada	www.lifesaving.ca
MADD Canada	www.madd.ca
Public Health Agency of Canada Includes Emergency Preparedness, Child, Adult and Seniors' Injury Prevention	www.phac-aspc.gc.ca/new_e.html
Rick Hansen Man in Motion Foundation (Spinal Cord Injury Prevention)	www.rickhansen.com
SAFEKIDS Canada (Unintentional injury prevention for children, Birth-14 yrs)	www.sickkids.ca/safekidscanada
Safe Communities Foundation	www.safecommunities.ca
Statistics Canada (Injury hospitalization & mortality data)	www.statcan.ca/
St. John Ambulance (First Aid training and prevention of injuries)	www.sja.ca
ThinkFirst Foundation (Head and spinal injury prevention)	www.thinkfirst.ca
Transport Canada (Road, rail, air, marine)	www.tc.gc.ca/en/menu.htm
War Amps of Canada	www.waramps.ca

- If your emergency department is seeing an increase in a specific type of injury, e.g. scooter-related injuries, trampoline injuries, it may be appropriate to approach the media (again following your media policy and working through your communications department) and suggest they do a story.

Opportunity for continuing education

- SmartRisk has developed "The Canadian Injury Prevention and Control Curriculum" to provide practitioners with an understanding of the theory and practice of injury prevention and control, including the tools needed to develop and implement effective programs.
- Workshops are planned this fall for around Ontario and hopefully will be offered across Canada in the future. Topics covered will include:
  - The epidemiology of injury
  - The principles of injury control
  - The basic injury data systems
  - Applied research and planning methodology
  - Program development, implementation and evaluation

For more information about this workshop, and a brochure/registration form, please contact SmartRisk at (416) 977-7350 or by e-mail: **learning@smartrisk.ca**

Opportunity to support national injury prevention strategy

- SmartRisk is the coordinating organization for Canada's injury prevention strategy
- They launched the report *"Ending Canada's Invisible Epidemic: A Strategy for Injury Prevention"* in October 2005
- We can all support this national injury prevention strategy through a letter campaign to members of both provincial and national governments
- SmartRisk has drafted a number of letters to key government officials
- We are encouraged to use our own words and personal examples and adapt the letters as we see fit
- For further information on this National Injury Prevention Strategy, please contact:

Peter O'Neill
Vice-President, Operations
SMARTRISK
(416) 596-2721
poneill@smartrisk.ca

Download a copy of the report and find letters to key government officials at ***www.injurypreventionstrategy.ca***

Thank you for your support of injury prevention!

For further information, Carole can be reached by e-mail: ***carole.rush@calgaryhealthregion.ca***

Reference

Safe Kids Canada. (2006). **Child and youth unintentional injury: 10 years in review 1994-2003**. Toronto: Author.

Forensic nursing education

By Sheila Early, RN, BScN, SANE-A
Section Editor

Forensic nursing is emerging as an entity in the Canadian health care system and this column has highlighted several articles on forensic nursing in the past with emphasis on some of the roles of the forensic nurse such as sexual assault nurse examiner and death investigator, and the implications of forensic aspects of health care in the emergency department.

This column will provide a brief overview of educational opportunities in Canada for those nurses wanting to enter into the realm of forensic nursing/forensic health care.

One only has to do a "google search" to discover that educational opportunities in forensic nursing in Canada are extremely limited. This is even after decades of registered nurses working in such areas as sexual assault care, child abuse/maltreatment, death investigation, forensic psychiatric nursing, forensic correctional nursing and legal nurse consulting.

Mount Royal College in Calgary, Alberta, offers online courses in forensic studies – Advanced Specialty Health Studies, an 18-credit program that can be taken full- or part-time and includes the following courses:

- Forensic History, Risk Populations and Issues
- Forensic Psychiatry and Correctional Populations
- Victims of Violence
- Forensic Science
- Expert Witness Testimony
- Crime Scene Investigation and Evidence
- Sexual Assault Examination and Intervention Theory
- Sexual Assault Examination and Intervention Practicum

See website: **http://www.mtroyal.ca/healthcomm/ashs/fore/index.shtml**

British Columbia Institute of Technology in Burnaby, BC, has an Advanced Specialty Certificate in Forensic Health Care within the Centre for Forensic and Security Technology Studies that has been offered as classroom studies since January 2005.

This part-time, 30-credit study program includes the following courses:

- Criminal Law 1: Legal Procedures
- Criminal Law 2: Legal Evidence
- Science, Technology and the Law
- Forensic Interviewing 1
- Introduction to Forensic Science
- Introduction to Forensic Health Sciences
- Management of Victims of Trauma, Violence and Crime
- Wound and Blunt Force Trauma Assessment, Documentation and Evaluation
- Sexual Assault Nurse Examiner Core Education – Theoretical Aspects
- Forensic Photography
- Sexual Assault Nurse Examiner Core Education – Practical Aspects for Health Care Professionals
- Sexual Assault Nurse Examiner Core Education – Practical Aspects for Non-Health Care Professionals

See website: **http://www.bcit.ca/study/programs/525hascert**

Seneca College in Toronto, Ontario, is the newest educational institution to offer courses within their Forensic Health Studies Certificate Program that requires six courses to complete. Courses offered are:

- Introduction to Forensic Health Science
- Introduction to Criminal Law: Procedures and Evidence
- Management of Victims of Trauma, Violence and Crime
- Wound and Blunt Force Trauma Assessment, Documentation and Evaluation
- Forensic Interviewing
- Science, Technology and the Law
- Sexual Assault Nurse Examiner Core Education – Theoretical Aspects

See website: **http://www.senecac.on.ca/healthsc/forensichealthstudies/index.htm**

Centennial College in Toronto, Ontario, offers a Forensic Mental Health Certificate with three courses required for completion. Courses are:

- Introduction to Law & Mental Health (Forensic Nursing) MNTL-418
- Advanced Law & Mental Health Nursing for RNs MNTL-419
- Law & Mental Health Nursing Practicum for RNs MNTL-420

See website: **http://www.centennialcollege.ca/future/schs_ce_rn_forensic.jsp**

There have been offerings of stand-alone courses in forensic nursing/forensic health care at University of Calgary, Calgary, AB, and University of Saskatchewan, Saskatoon, SK, as well.

This brief overview is meant to highlight the need for educational opportunities for the specialized body of knowledge that differentiates forensic nursing from other nursing specialties to become more readily available to nurses in Canada.

Please send any comments/ideas/suggestions on forensic nursing to:
Sheila Early, RN, BScN, SANE-A
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sdeconsulting@telus.net or call (604) 590-9315.

New trends in diabetes care

By Lorraine Samis, RN, CDE

There are many new advances in the field of diabetes care. Not only are there new insulin, new insulin delivery devices, advanced blood glucose meters, and lower targets for lipids and blood sugar levels, but also there is much discussion about prevention. It is challenging for staff that works directly in diabetes care to keep up with the changes, let alone nursing staff working in other specialties! The basic cornerstones of diabetes care, nutrition and physical activity, still exist. More emphasis is being placed on weight loss and obesity. Obesity is increasingly recognized as a health epidemic and a modifiable risk factor for diabetes and cardiovascular disease.

Blood glucose meters

The glucose monitoring industry has conducted significant studies in the past year, and there are more than 20 meters on the market. Some meters require as little as 0.3 microlitres of blood. Most meters can obtain a result within five to 15 seconds and have a memory system, but manual recording by clients is still beneficial. Some meters have a computer chip in them that can graph values, store insulin dose values, and program in carbohydrates and minutes of exercise. A few meters will allow patients to test "alternative sites" rather than relying on fingers (i.e., forearm, thighs and lower thumb area), though testing sites other than fingers is not advised when patients are checking for hypoglycemia. We are all waiting for the "non-invasive meter." Reports are that we may see this in 2006. There already is a "glucowatch" available in the U.S. that has a sensor pad that picks up readings, but self-blood glucose monitoring is still suggested. Initial pricing on this non-invasive technology will be prohibitive for many.

Lancing devices all have a depth setting and are much kinder than they used to be. There is even a preloaded lancing device on the market making testing easier for the person with diabetes.

Oral agents for Type 2 diabetes

There are many new medications available for people with diabetes. We are seeing a decrease in the use of old standbys such as Diabeta® and Diamicron®. The following chart taken from the Canadian Diabetes Association's (CDA) 2006 pamphlet identifies the available oral agents, the recommended dosing and indicators for use (Figure One). We know that compliance is improved if we can simplify the regimen, so many companies are starting to combine two different types of oral agents together. An example of this is Avandamet® (a combination of Avandia® with Metformin®).

Insulin and insulin devices

There is renewed energy across the entire treatment spectrum to use insulin earlier and more intensively (CDA, 2006). Currently, all insulin is produced synthetically. Premixed insulins are still popular with the rapid-acting insulins used extensively. In Canada in 2005, new insulin, Lantus®, was introduced that did not have "peak" times. Since this new "peak-less", long-acting "basal insulin" hit the market, we have seen many clients switch. A second company released similar insulin, Levemir®, in 2006 making the much-used combos of intermediate insulin (N) and regular insulin (R) at breakfast and at supper out of date.

Regular or short-acting insulin

Humulin R® or *Novolin Toronto®* reach the blood stream within 30 to 60 minutes after injection, peak from two to four hours and are effective for five to eight hours.

Rapid-acting

Humalog® or *Novo Rapid®* begin to work 10 to 15 minutes after they are injected, peak in about one hour and continue to work for four to five hours. People inject just before a meal or, occasionally, after a meal. These are considered mealtime insulins.

Intermediate-acting insulin

Humulin N® or *Novolin NPH®* generally reach the blood stream in one to three hours, peak in five to eight hours and are effective for up to 18 hours.

Long-acting insulin

Reaches the blood stream in three to four hours and is effective for 22 to 26 hours. It does have a peak action and can be absorbed at different rates.

Extended long-acting

Lantus® or newly released *Levemir®* have continuous peak-less action that mimics natural basal (background) insulin secretion. This insulin is clear in appearance and should not be mixed with any other types of insulin. It starts to work in 90 minutes and the duration is about 24 hours.

Inhaled insulin

Similar to asthma puffers, the insulin aero-chambers should be released this year. They will be used to replace short, fast-acting insulin to cover meals.

The majority of people on insulin who have visited a diabetes education centre in the past few years will use an insulin pen. This device has a 3ml cartridge of insulin inserted into a pen-like device with a disposable needle-tip screwed on. Needles are getting shorter and finer. The most common is the 8mm (short) needle, which is 31G, but the trend is to move to the 6mm 32G (mini) needle. A few patients with diabetes still use the old 12mm 29/30G. Adiposity and patient preference are considerations in choosing a needle size.

As previously mentioned, the trend is to initiate insulin therapy earlier in those with Type 2 diabetes. Most may be started on bedtime insulin using intermediate insulin or long-acting insulin. The goal is to lower the morning sugars so that oral agents can control the daytime sugars. If this approach is not successful, then daytime insulin needs to be added.

As Haire-Joshu (1996) states, "Insulin pumps are far more utilized than in the past, especially for children" (p. 218). There

Figure One. Oral agents for Type 2 diabetes		
Name/Dosage/mg Diamicron®, 40-160 mg (usually BID) or Diamicron®, MR (usually OD) (glicazide)	Class • • •	Comments • 1 Usually once or twice daily dosing with meals • 2 Less risk of lows – preferred to glyburide in elderly • 3 Shown to decrease blood stickiness
Diabeta®, 2.5-20 mg daily (usually BID) (glyburide) – modified release		• 4 Usually once or twice daily dosing with meal
Amaryl®, OD 1 - 4 mgm tablets 1 - 8 mm dosing (glimepride)		• 5 Usually once daily dosing with meal • 6 Less risk of low blood sugar • 7 Weight neutral +improves after meal insulin
Gluconorm®, (repaglinide) 0.5-1 mg, 2 mg, max daily 16 mg (with meals)	• •	• 1 Rapid onset short duration • 2 Take right before a meal • 3 If you miss a meal – do not take tablet • 4 Weight neutral • 5 Interacts with some drugs treating fungal and bacterial infections • 6 Can be combined with metformin & TZDs. Gluconorm's effects last 4 hours
Starlix®, (nateglinide) supplied 60, 120, 180 mgm 360 mlg – 540 mgm		• 1 Starlix effects last 2 hours.
Glucophage®, 500-2500 mg (BID or TID) (metformin)	• 2 biguanide • 3 Used to treat excessive glucose release by the liver and improves insulin resistance	• 4 Useful in obese, high cholesterol individuals • 5 Given 2-3 times a day with food • 6 Can be used in combination with other oral agents and insulins • 7 Avoid with active heart disease, kidney or liver disease • 8 Stomach side effects may occur initially – loose stools, metallic taste in mouth • 9 May lower side effects if using brand name • 10 Does not cause weight gain, low risk of low blood sugar when used alone
Avandia®, 2-8 mg (OD or BID) (rosiglitazone)	• • • •	• 1 Used alone or in combination therapy • 2 Taken once or twice daily • 3 Side effects: upper respiratory tract infection • 4 If you develop shortness of breath, edema, nausea and vomiting, yellowing of skin, contact doctor • 5 Can cause weight gain and fluid retention • 6 Do not use with some heart conditions
Actos®, 15-45 mg (OD) (pioglitazone)		• 7 Used alone or in combination therapy, side effects as above • 8 Taken once daily only • 9 May increase HDL, lower Trigs
Prandase®, 25-300 mg daily (acarbose)	• 1 alpha-glucosidase inhibitor • 2 Used to slow absorption of carbohydrates and decrease after meal blood sugar	• 1 Take with meals at first bite of food • 2 Start at low dose and increase slowly to minimize stomach symptoms such as gas and stomach discomfort, can be used in combination with all oral agents and insulin • 3 May affect absorption of some drugs • 4 Very low risk of low blood sugar when used alone • 5 If low blood sugar does happen, treat with 3 glucose tablets
OD – Once a day	BID – Twice a day	TID – Three times a day

are several pumps on the market. Insulin pumps can be programmed to release a basal amount of insulin and a bolus dose on an as-needed basis (usually meal coverage).

User-friendly, most pumps can be programmed with about the same amount of difficulty as programmed wristwatches and contain alarms for malfunctions and dosage ceilings. Subcutaneous access is achieved by a small flexible plastic catheter (inserted with a needle). The catheter may be used for two to three days before it is replaced. Usually, fast-acting insulin is used in a pump. Pumps offer light control that mimics what a pancreas should do, giving motivated patients the benefits of flexibility. Initially reserved for Type 1 diabetes, pumps can now be used in Type 2 as well.

One risk for pump users is diabetic ketoacidosis (DKA) if, for some reason, the tubing gets kinked or disconnected by accident. Pumps retail for about $500.00 and clients can also expect to pay approximately $1,200.00 in tubing costs. Some private insurance companies offer coverage for these costs.

Ongoing diabetes research in this area continues to be exciting. We can look forward to pump companies integrating with continuous glucose monitoring that displays real-time glucose readings while incorporating trend graphs every five minutes.

Nutrition therapy

The traditional standards of nutrition therapy in diabetes still exist: lower sugar, lower fat, following Canada's Food Guide, portion control and timing of meals. Counting calories per day diet is seldom used anymore (i.e. 1,200 calories). The new buzz words are glycemic index (GI) and carb counting.

Glycemic index measures the increase in blood glucose after a certain food is eaten. Different types of carbohydrate foods have different effects on blood glucose levels. A lot of starchy foods have a high glycemic index. People with diabetes are encouraged to choose food with a lower glycemic index, for example, choosing stone ground whole wheat versus white bread.

Carbohydrate counting is a way of counting how much sugar and starch are in a meal. A registered dietitian will set up target carb amounts for each meal and snack based on lifestyle and medication. Sources of carbs are starches, fruit and some vegetables, milk and yogurt, sugars and sweets.

Physical activity

Exercise is a key component of management. A minimum of 30 minutes of regular moderate physical activity per day is recommended. For most, walking is the answer and building up to 45 to 60 minutes per day is beneficial. Some choose to use a pedometer. Here, the goal of 10,000 steps a day is recommended. Resistance training such as lifting weights three times a week is also recommended.

Target values

The following table highlighting the recommended blood glucose targets for people with diabetes was taken from the Canadian Diabetes Association's (2003) clinical practice guidelines.

Complications

Improving quality of life and preventing complications are goals of diabetes care. There are strong links between diabetes and cardiovascular disease. Current research (CDA, 2003) stresses the importance of adhering closely to targeted levels for blood pressure, lipids and blood glucose control. Aspirin therapy is also recommended for people with diabetes. As well, exercise stress tests are being completed for these people to rule out cardiac complications. Regular dental and eye exams are a must, daily foot inspection with early and appropriate interventions is being stressed.

Identifying and dealing with stress is a key in management. We also look at sleep deprivation and its effect on blood glucose values. There are strong links between diabetes (CDA, 2003) and sleep apnea and more research is being done in this area.

Research

There is a vast amount of research being conducted all over the world in the field of diabetes. Canadian and Albertan

	AIC*	**Blood glucose level after meals**	**Blood glucose level after two hours after meals**
Target for most people with diabetes	7.0% or less	4.0-7.0 mmol/l	5.0-10.0 mmol/l
Normal range	6.0% or less	4.0-6.0 mmol/l	5.0-8.0 mmol/l

**A glycosylated hemoglobin or A1C test is a test that tells us about a patient's blood glucose levels over the past three months and should be done every three to four months.*

Targeted blood pressure for people with diabetes is <130/80. For those people with kidney damage, the targeted blood pressure is < 125/75.

Total cholesterol < 4.5 mmol/l is recommended with HDL > 1 mmol/l and LDL < 2.5 mmol/l. Triglycerides < 1.5 mmol/l with a Ratio < 4 mmol/l

Annual monitoring for kidney function (serum urea, creatinine), urine microalbumin and albumin creatinine ratio as well as creatinine clearance need to be completed. Regular kidney function tests are crucial for both Type 1 and Type 2 diabetes. Referrals to a nephrologist are done early if needed.

researchers are certainly leading the way, not only in Canadian trials, but international trials as well. Edmonton is world-renowned for pioneering the islet cell transplants. Still in the research stage, fewer than 90 procedures have been performed in the province. Research is also being completed on prevention, understanding Type 2 diabetes, new drugs to combat complications and weight loss, as well as drugs to treat neuropathy.

Two new injectable drugs released recently in the U.S. will be interesting to watch. Byetta® is a prescription for those with Type 2 diabetes who take oral medication. It enhances insulin secretion in the presence of high blood glucose. It is available in pen delivery and is taken one hour before meals. Symlin® is an injectable prescription for Type 1 or 2 diabetics who take insulin. It enhances the way insulin works and is taken just before the meal. As well, research is ongoing in the areas of: links between schizophrenia and diabetes, dealing with depression in diabetes, and herbal and vitamin mineral therapy (CDA, n.d.).

In conclusion, the field of diabetes is ever-changing. These are fewer "norms" than we have seen in the past and each person's care is tailored to them. As with every disease process, you see motivated and educated clients and others that place diabetes on the back burner until a health event "hits" them.

We know that few people with diabetes are actually seen in specialized centres due to lack of resources and waiting lists. The family physician is increasingly being asked to deal with these complicated clients.

Diabetes is a chronic disease with co-morbidities. Health system transformation is underway around the world. Multidimensional care is crucial in chronic disease management. Healthy lifestyle and prevention is the key. National strategies for public health change are crucial.

About the author

Lorraine is a graduate of the Holy Cross School of Nursing in Calgary. She coordinates the Diabetes Education Centre in Brooks, Alberta, in the "Living Healthy Program" of the Palliser Health Region. Lorraine has been a certified Diabetes Educator since 1992. Lorraine was honoured with the National Diabetes Educator of the Year Award in 1999.

Lorraine devotes a tireless amount of effort to diabetes education for all patients in our region. There has been a significant impact on the volume of people with diabetes needing to access information through the emergency department since Lorraine took on this educator position. We are only seeing patients who are in crisis or, as Lorraine mentions in her article, have been non-compliant in their care.

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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

The NENA Bursary

NENA recognizes the need to promote excellence in emergency care, and, to this end, to provide 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 receive a bursary only 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.)
- Working at present in an emergency setting which may include:
  - Emergency department
  - Nursing station
  - Pre-hospital
  - Outpost nursing
  - Flight nursing

Application process

Candidates must complete and submit the following:

a. NENA Bursary application form “A”
b. Bursary reference form “B”
c. 200-word essay
d. Photocopies of provincial registered nurse status and NENA registration

Provincial representative responsibilities:

a. Completes bursary candidate’s recommendation form “C”
b. Ensures application forms are complete before submission
c. Brings to Board of Directors meeting all completed applications

Selection process

The standing committee for bursary disbursements will:

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

NENA Bursary 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: _____

The Right To Play And To Be Happy

By this certificate know ye that

National Emergency Nurses' Affiliation

is a lifetime member in good standing in

The Society of Child-Like Persons

is hereby and forever entitled to walk in the rain, jump in the puddles, collect rainbows, blow bubbles, stop along the way, smell the flowers, go barefoot, watch the moon and stars come out, hum a tune, say hello to everyone, hula hoop, sing in the shower, have a merry heart, act silly, get new sneakers, dance as if no one is watching, share a smile, fly a kite, laugh and cry for the health of it. You will feel happy, give up worries, stay innocent, say the magic word, see things differently, whistle, doodle and draw. You will fall down and you will get up. You can talk with the animals, stay up late, take naps, daydream, play with toys, learn new stuff, enjoy a caring clown, listen to music, tell stories, make new friends and do anything else that brings more happiness, celebration, grace, communication, health, love, creativity, relaxation, self esteem, courage, balance, spontaneity, beauty, peace, and energy to the above named member and to other human beings on this planet. Furthermore, the above named member is hereby officially authorized to frequent amusement parks, beaches, mountaintops, swimming pools, picnic areas, birthday parties, circuses, cookie shops, ice cream parlours, theatres, aquariums, zoos, farms, museums, toy stores and other places where children of all ages come to play and thereby is forevermore encouraged to always remember the fun motto of The Society of the Child-Like Persons:

"It is never too late to laugh and have a happy childhood."

Live, love, life...laughing!

Certified Laughter Leader
"Nomee" Care Clown
HA HA Unit

CARE CLOWNS ON ROUNDS
HA HA UNIT

May 6, 2006

Judy Romeroy
Certified Laughter Leader
"Stitches" Care Clown
HA HA Unit

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