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

Volume 29, Number 1, Spring 2006

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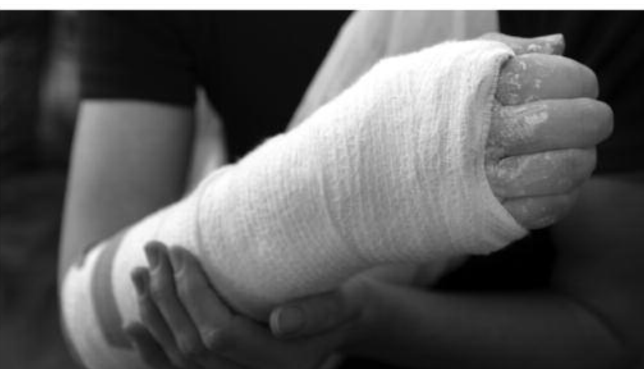

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outlook

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Editorial staff

Editor: Valerie Eden, valeden@hfx.eastlink.ca
Ideas@Work: Pediatrics: Judy Skanderup, sskander@eidnet.org
Research: Cathy Carter-Snell ccartersnell@mtroyal.ab.ca
Trauma Corner: Carole Rush Carole.Rush@CalgaryHealthRegion.ca
4N6RN: Sheila Early sheiladawn_early@telus.net

Editorial board

Donna Arsenault, NS
Christine Hartley, ON

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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 inquiries 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
Janice Spivey, 112 Old River Road, RR#2, Mallorytown, ON K0E 1R0
(H) 613 923-5539; (W) 613 548-2333;
fax: 613 923-5539; e-mail: Spiveyj@ripnet.com

Past 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

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: Jan.Calnan@viha.org

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) 902 473-3174;
fax: 902 473-5105;
e-mail: valeden@hfx.eastlink.ca

Provincial directors

British Columbia
Sharron Lyons, #308 7171 121 Street Surrey, BC V3W 1G9
e-mail: Sharron_Lyons@telus.net

Alberta
Judy Skanderup, RR#1, Tilley, AB T0J 3K0
(H) 403 377-2567; (W) 403 501-3220\
fax: 403 377-2849;
e-mail: sskander@eidnet.org

Saskatchewan
Bonnie Briere, 22 Hicke Bay Regina, SK S4R 7G5
(H) 306 543-0242; (W) 306 766-2731
fax: 306 766-2770
e-mail: bonnie.briere@rqhealth.ca

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
Ted Sellers, 396 Ormond Drive Oshawa, ON L1K 1J4
(H) 905 435-3413; (W) 905 576-8711 ext. 4439;
e-mail: t5isellers@rogers.com

New Brunswick
Nicole Raike, 309 Magnolia Avenue Sussex, NB E4A 2A2
(H) 506 433-6675; (W) 506-432-3231;
e-mail: craike@nbsympatico.ca

Nova Scotia
Tanya Penney, RR#1, Site 0 Box 9 Head of Chezzetcook, NS B0J 1N0
(H) 902 827-5058; (W) 902 792-2060
e-mail: Tanya.penney@cdha.nshealth.ca

Prince Edward Island
Tracey Norris, Box 925, Cornwall, PEI C0A 1H0
(H) 902-367-6733
e-mail: pei_ena@hotmail.com

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

Committee chairs

Awards/Bursaries
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: Jan.Calnan@viha.org

Professional Practice and Documents
Ted Sellers, 396 Ormond Drive, Oshawa, ON L1K 1J4
(H) 905 435-3413; (W) 950 576-8711 ext. 4439;
e-mail: t5isellers@rogers.com

Research
Tanya Penney, RR#1, Site 0 Box 9 Head of Chezzetcook, NS B0J 1N0
(H) 902 827-5058; (W) 902 792-2060
e-mail: Tanya.penney@cdha.nshealth.ca

Nominations
Tanya Penney, RR#1, Site 0 Box 9 Head of Chezzetcook, NS B0J 1N0
(H) 902 827-5058; (W) 902 792-2060
e-mail: Tanya.penney@cdha.nshealth.ca

National Course Administration Committee
Karen Latoszek, 115 Healy Road, Edmonton, AB T6R 1V4
(H) 780 430-6983; (W) 780 407-8616
e-mail: Klatosze@cha.ab.ca

Political Action Committee
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

Archives
Janet Calnan, 1500 Burnside Road West, Victoria, BC V9E 2E2
(H) 250 727-2795; (W) 250 727-4400;
fax: 250 744-5939;
e-mail: Jan.Calnan@viha.org

Outlook is the official publication of the National Emergency Nurses' Affiliation. Articles, news items and illustrations relating to emergency nursing are welcome. **Outlook** is published two times per year. Opinions expressed are not necessarily those of NENA, or of the editor. NENA reserves the right to edit information submitted for publication. The use by any means of an article, or part thereof, published in **Outlook,** is an infringement of copyright law. Requests for written consent prior to reprinting of any article, or part thereof, should be addressed to the editor.

President's message

Mark Twain once said, "Always do right. This will gratify some and astonish the rest." Doing right is like active NENA membership, a personally and professionally rewarding experience. As members, we must share the NENA passion and enthusiasm while we help to promote the many benefits of membership.

Active membership in NENA demonstrates a professional commitment to both quality emergency health care, and to a high standard of practice in emergency nursing throughout Canada. Involvement in NENA allows individual members to contribute to the quality and to participate in the future direction of their chosen specialty.

Emergency nurses utilize a broad knowledge base, many finely honed skills and advanced critical thinking. Emergency nurses must possess a scientific mind, technological know-how, a compassionate heart, healing hands and, equally important, the personal stamina to repeatedly come back and do it all again.

In October 1902, suffragette Susan B. Anthony said, "The nurses of today are making history, and the results of their work will influence nursing throughout the next century." If she were alive today, I think that Susan B. Anthony would say that the NENA members of the Canadian Triage and Acuity Scale's (CTAS) National Working Group (NWG), are truly making history and the results of their work and dedication will influence emergency nursing today and in the future, both across Canada and around the world.

Emergency nurses know that the primary purpose of triage in the emergency department is the timely evaluation and treatment of the ill and injured, accomplished by assigning each patient a triage category reflecting the urgency with which care is required. Historically on Napoleon's battlefields, Baron Dominique Jean Larrey, Bonaparte's chief surgeon, ignored the rank and distinction of the casualties. Instead, he prioritized care according to the severity of the injuries. This is the first known use of triage (from the French word "trier", to sort).

Today, triage assists us to determine patient needs, location of care, type of provider required, infection control protocols, patient and family education, assorted types of screening, as well assisting with patient flow through our emergency departments. NENA supports the standardized Canadian CTAS program as created and revised by the CTAS National Working Group for all emergency nurses across Canada. The combined adult and peds CTAS program is expected early in 2006 and NENA looks forward to facilitating the program rollout in every Canadian province.

Your NENA board of directors (BOD) deserves special recognition for the incredible work they are doing throughout the year on behalf of, and for the benefit of NENA members and all of Canada's emergency nurses. Not only do they meet for six nine-and-a-half hour days each year conducting NENA business at BOD meetings, but they also put in many hours in smaller group work sessions during these evenings. Their role does not end after the BOD meeting or annual general meeting, since each BOD member then goes home with a to-do list. This is when the many hours of computer, phone, e-mail and committee work begins. Your NENA BOD members donate huge amounts of time, talent and work throughout each year because they share a true passion for our profession of emergency nursing. With member support for the work of the NENA BOD and participation in NENA activities, the true professional spirit of NENA will continue to shine.

Remember what Mark Twain said and "continue to do right", both for yourselves and your patients. Celebrate all that we are and all that we do as Canada's emergency nurses!

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

From the editor

By the time you receive this issue of **Outlook** hopefully we will be enjoying spring weather as we prepare to meet at the National Conference in Ottawa. This year's theme is "Stayin' Alive" and it is one of those titles that can be interpreted in a number of ways depending upon how your day went or your shift….

What does "Stayin' Alive" say to me? Well, it speaks to me of the flexibility, the adaptability, the energy and the commitment of so many emergency nurses. It speaks to me of the challenges that emergency nurses face daily. It speaks to me of longevity – what I hope for the younger nurses coming up through the ranks – that they remain in the specialty, that they continue to grow and develop their competency as emergency nurses and that they remain committed to being and working as an emergency nurse. It means that our veteran nurses will stay in the work force for a year or so more. Rather than retiring, they will stay to mentor these younger nurses.

It also means, for me, that we have educated nurses who are current with the latest in emergency health care. The health care environment continues to change rapidly. Nurses are challenged to remain current. This conference will explore and highlight new treatments, protocols and procedures impacting emergency care. We want to continue to provide best practice care or evidence-based care for our patients

"Stayin' Alive" also speaks to me of "staying the course" – that your national association continues to grow, evolve and be responsive to the needs of emergency nurses across Canada. I look forward to seeing you at the conference. Enjoy learning, enjoy meeting new friends or renewing old friendships. Learn lots! Have lots of fun! Celebrate being an emergency nurse and "Stayin' Alive"! See you in Ottawa.

Valerie Eden
Communication Officer

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 Ottawa, ON. 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 Tanya Penney. 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 Ottawa, ON.

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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 28, 2006, to:
Tanya Penney, RR#1, Site 0 Box 9
Head of Chezzetcook, NS B0J 1N0

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.

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The NENA bursary

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: ______________________

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Conference watch

CNA 2006 Biennial Convention

"Advancing Technology and Preserving Caring in Nursing" Saskatoon, June 18-21, 2006. Register at **www.cna-aiic.ca**

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**

14th Annual Scientific Assembly of International Association of Forensic Nurses

Vancouver, BC, at the Hyatt Regency, September 27-October 1, 2006.
The theme is Forensic Nursing: A Global Response to Crime, Violence and Trauma.
Check IAFN website for future information: **www.forensicnurse.org**

5th Annual Emergency Care Conference

Tackling Gridlock * Reducing Wait Times * Improving Service * Managing Risk
June 19-20, 2006, Marriott Yorkville Hotel, Toronto.

Call for abstracts for the ICN Conference and CNR

"Nurses at the forefront: Dealing with the unexpected" in Yokohama, Japan, May 27-June 1, 2007. Submission deadline is September 15, 2006. Submission form and guidelines may be found at **www.icn.ch/Conference2007.htm**

Innovations in Rural Chronic Care: The "Beulah Salts"

Senior healthcare conference at Exhibition Park in Lethbridge, AB, April 12-13, 2006.
For more information e-mail: **www.ruralinnovations2006.ca** or call (403) 388-6580.

1st National Health Emergency Preparedness Conference

"Preparing your Hospital for Disaster". May 29-30, 2006, at Hamilton Convention Centre, Hamilton, ON.
For more information and to receive a copy of the brochure contact: Leigh Norman, Continuing Health Sciences Education, Tel: (905) 25-9140 ext. 22958, fax: (905) 572-7090, or e-mail: **lnorman@mcmaster.ca**

2006 Healthcare Middle Management Conference

April 6-7, 2006, Renaissance Hotel, Downtown Toronto.

11th International Conference on Emergency Medicine

"Forward Thinking, Frontline Care" in Halifax, NS, June 3-7, 2006. See website **www.icem2006.com** for further details.

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Websites of interest

www.guidelinesforhealth.com
Guidelines for Your Health is a website that explains the evidence-based practices that many doctors follow in easy-to-understand language. The goal of the site is to provide reliable, usable information to help individuals better understand what their doctors are or aren't doing. As they become more informed, individuals can make better health care choices for themselves and their families.

Guidelines for Health is the result of a project called "The Best Evidence for Consumers", jointly sponsored by The Change Foundation and the Guideline Advisory Committee (GAC). The GAC promotes evidence-based health care in Ontario by assessing existing clinical practice and recommending guidelines that should be used by practising physicians. The GAC also develops and recommends appropriate strategies for guideline implementation and evaluation.

With the creation of this website, physicians and patients each have quick access to the same recommended clinical information in an appropriate language and format. Where the GAC logo appears, it verifies that the consumer education information contained on that page has been reviewed by the GAC and has been confirmed as consistent with GAC-endorsed clinical practice guidelines.

The Change Foundation and the GAC believe that aligning physician and consumer information will have a positive impact on compliance with the guidelines and influence consumer expectations.

For more information on Guidelines for Your Health or the Best Evidence for Consumers project, please contact Julie Gilbert.

jagilbert@changefoundation.com

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Quotable quotes

"Maybe it is true that life begins at 50, but everything else starts to wear out, fall out or spread out."
- *Phyllis Diller*

The cardiologist's diet advice: "If it tastes good, spit it out!"
- *Author Unknown*

"We would certainly slow the aging process down, if it had to work its way through government channels."
- *Will Rogers*

"Don't worry about avoiding temptation… As you get older, temptation will avoid you."
- *Winston Churchill*

"Be careful when reading health books, you might die of a misprint."
- *Mark Twain*

"Only Irish coffee provides in a single glass, all four essential food groups: alcohol, caffeine, sugar and fat."
- *Alex Levine*

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Book review

The hopelessly human nurse: Simple strategies for overhauling your lamp

Authors: Linda Bridge and Kathy Knowles
Published by Hopelessly Human Productions Inc., Lethbridge, AB
162 pages ill., ISBN 0-97360400X

Two Canadian women who have been practising nurses for more than 25 years wrote this great little book. The authors, as well as the illustrator, are or were emergency nurses. Like many of us who have said, "I could write a book…" they not only talked about writing a book, they actually did! In the foreword of the book, the authors state that they were waiting for someone else to change things until they realized that the change had to come from within and so their journeys began.

This book is divided into four sections with several small chapters in each section. The sections are: "Where's our lamp", "Polishing our lamp", "Our new wick" and "Shining it forward". The stories are personal and real stories that happened to real nurses. When you read it, you will nod your head empathetically as you will relate to each and every word the authors have written. Your stories will come bubbling to the surface as you realize you are "hopelessly human", too. Their lamps shine brightly as they describe their journey to find or perhaps to regain their passion for the art of nursing. Their hope is that we reaffirm that we are "hopelessly human", that we embrace it, call it our own and that we reclaim our passion for the art of nursing. It is one of those books that you will want to read again and again.

You can also visit their website: **www.hopelesslyhuman.ca**

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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

Journal writing 2006

Section editor's note: *This is written by a mother whose son was diagnosed with cancer, had an amputation and, to date, is doing well. The planning committee asked her to present at the annual ENIG fall conference. The room was packed despite everyone needing to check out and get going. I asked this mother to write something about her experience and here is what she said. I also asked her to include some pictures.*
Judy Skanderup

Hello - First, let me introduce myself and give you a bit of history about how our story made its way to these pages. Several months back, I was in the Alberta Children's Hospital with our 16-year-old son. It was one of many trips I've made to 'Emerg' over the years. As the nurse jotted down her intake notes, I began sharing a bit of medical history and was invited to share some of our story. Since I love telling stories about my family, I accepted. After a photo presentation to a small group of emergency nurses, I was invited to share some written thoughts for this journal.

Family - As a full-time mother to four, it's a hectic lifestyle and, over the years, I've seen my share of childhood mishaps, especially since all the kids have been active participants in numerous sports. There were skinned knees, split toes, fractures and sprains, all kinds of what I now call the routine injuries. In fact, after having gone through seven sets of stitches with the three oldest kids, when the fourth came along, as parents, we felt well-versed in the medical world.

Diagnosis - Little did I know that with our fourth child I would embark on such a serious medical journey. The little bit of background knowledge I had did not begin to prepare me for the new medical info and terminologies I would come to know. It didn't matter that I'd never chosen nursing as a career, I was about to get a lot of experience. Fate had determined cancer and the McRaes were about to become one. When our youngest son turned five he was diagnosed with Ewing's Sarcoma, bone cancer. The hospital became our new home, medicine became our new world, the medical staff became our new best friends and uncertainty was the only thing I could count on with any certainty at all. It was a very frightening time.

When I talk to people about our experience, I often refer to surviving and getting through as something I was going through. Even though it's our youngest son who was touched by cancer, truly every single person in the family goes through it. No one goes through unscathed. One person is AFFLICTED by the disease, but EVERYONE in the family is AFFECTED.

Care - Carter received such great care. Compassionate people walked into our lives and left footprints forever etched in our hearts. Now, I often refer to these people, those frightening 52 weeks, and our completely interrupted and totally unpredictable life during the 18 rounds of chemotherapy, and yes, even the dreaded amputation surgery as "Hidden Treasures". For looking back, I've grown so much in so many ways. I've gained a wealth of knowledge, albeit about a

Carter at age 5 with Sox, the family dog.

Carter McRae and his family, prior to surgery.

subject I'd rather have never been introduced to, but definitely I'm wiser because of it. I have become life-long friends with those who were once complete strangers having been similarly touched by cancer, and have been enriched beyond belief as a result.

It's true, as a result of the required treatment, Carter now lives life as a leg amputee, but he has moved on and now, almost 12 years later, he remains cancer-free and inspires others with his determination and great attitude. He proved to us that he would continue to pursue sports with the same fervour and passion he displayed prior to surgery. Now an active amputee, his energy and time is divided between hockey and snowboarding in the winter and in summer he enjoys water skiing, wakeboarding and golf. He is a true sports hero who encourages others and we are truly proud of him. It's important to point out our son's current active lifestyle since emergency and medical staff rarely know the life led by patients once they leave the hospital corridor. It's important to understand that caring for your patient today can make such a difference in shaping their future.

Carter playing hockey following surgery.

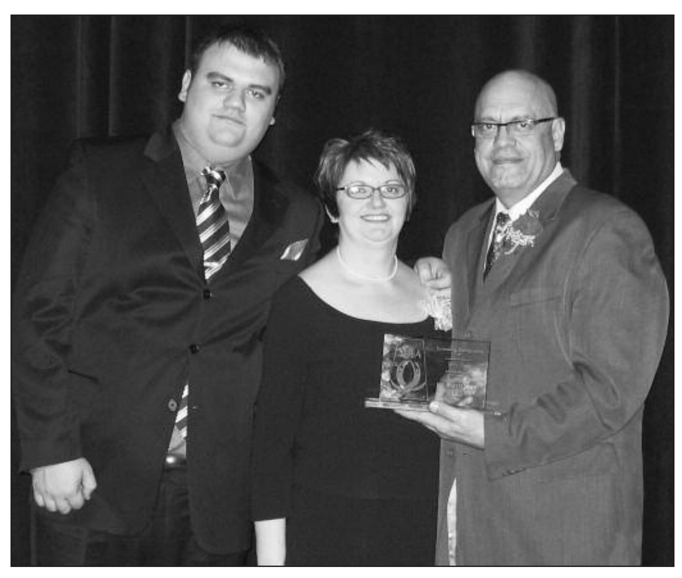
Future - I could share many stories of our medical experience, but there is one thing I want to be sure to urge each of you to reach for. Make a difference to the future by lending a hand today. I know it sounds very grandiose, but we can all make a difference. Just ask the family of Terry Fox. Did those who assisted Terry Fox in his lifetime ever imagine at the time the greatness to which they had contributed? So many medical and business people, family and friends, countless others assisted him along his way. Some more so after his death than during his marathon of hope – the effects of which are still inspiring today, 25 years later.

Medical staff, by going about daily tasks and aiding others as you do, perhaps without realizing the significance of it at the time, you just might be adding to someone's treasured memoirs. So many added to ours, so many touched our lives and helped shape our future. Not all patients will go on to accomplish greatness or be the likes of Terry Fox, but your career choice and the caring you show can shape the future, and to the family of the person for whom you are caring, your assistance makes a world of difference, no matter what they go on to do.

I hope you are forever encouraged to continue your great work in this industry and I thank those in the medical profession for helping our family grow into our present state, for allowing me to share with you a small part of our story and how we've been touched by medicine and, as a result, the hidden treasures we have come to know.

Sincere thanks,
Cindy McRae

outlook Bouquets



Congratulations to our own Jerry Bell for being awarded the Saskatchewan Excellence in Healthcare award. Jerry is seen here accompanied by his wife Cindy and his son Travis.

Welcome to Sharron Lyons, BC Provincial Director, Tracey Norris, PEI, Provincial Director, and to Tanya Penney, NS Provincial Director.

Goodbye and many thanks to Cynthia Bryanton, PEI, and Clay Gilrie, BC, for their leadership and their participation as provincial directors on the national board.

We wish God speed to Linda Jackson as she has been deployed to Afghanistan. While Linda is on deployment, Tanya Penney will become Provincial Director for NS.

Nursing Matters

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Nursing Matters *fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues.*

What is avian influenza (bird flu)?

Avian influenza or "bird flu" is an infectious disease, caused by the influenza A virus and occurring mainly in birds. Fifteen subtypes of the influenza A virus are known to infect birds, thus providing an extensive reservoir of influenza viruses' potential within bird populations. Of greatest concern is the H5N1 subtype, which circulates among birds worldwide, is very contagious among birds, and can be deadly, but which does not usually infect humans. "Human flu" viruses refer to those subtypes that occur widely in humans. There are only three known A subtypes of human flu viruses (H1N1, H1N2 and H3N2), and it is likely that some genetic parts of current human influenza A viruses came from birds originally (http://www.cdc.gov/flu/avian/gen-info/facts).

Why is H5N1 of particular concern?

Of the 15 avian influenza virus subtypes, H5N1 is of particular concern for several reasons. H5N1 mutates rapidly to acquire genes from viruses infecting other animal species. It has a high pathogenicity and can cause severe disease in humans. Birds that survive infection excrete the virus for at least 10 days, orally and in feces, thus facilitating further spread at live poultry markets and by migratory birds. The spread of infection in birds increases the opportunities for direct infection of humans. If more humans become infected over time, the likelihood also increases that humans, if concurrently infected with human and avian influenza strains, could serve as the "mixing vessel" for the emergence of a novel subtype with sufficient human genes to be easily transmitted from person to person. Such an event would mark the start of an influenza pandemic (http://www.who.int/csr/disease).

How does bird flu spread?

Infected birds shed the flu virus in their saliva, nasal secretions, and droppings. Susceptible birds become infected when they have contact with contaminated excretions or surfaces that are contaminated with excretions. It is believed that most cases of bird flu infection in humans result from contact with infected poultry or contaminated surfaces. In rare instances, limited human-to-human spread of H5N1 virus has occurred. However, transmission has not been observed to continue beyond one person.

Do bird flu viruses infect humans?

Bird flu viruses do not usually infect humans. However, H5N1 viruses are constantly changing and there is concern that they might adapt over time to infect and spread among humans. During an outbreak of bird flu among poultry (domesticated chicken, ducks, turkeys), there is a possible risk to people who have contact with infected birds or surfaces that have been contaminated with excretions from infected birds. In such situations, people should avoid contact with infected birds and contaminated surfaces, and should be careful when handling and cooking poultry.

What are the symptoms of bird flu in humans?

Symptoms of infection with H5N1 in humans have ranged from typical flu-like symptoms (fever, cough, sore throat and muscle aches) to eye infections, pneumonia, severe respiratory diseases (such as acute respiratory distress), other severe and life-threatening complications and death (http://www.who.int/csr/disease).

What are the infection control measures in health care settings?

(http://who.int/csr/resources/publications/influenza/Mask%20 Clarification10_11.pdf)

During an influenza pandemic, health care workers will be at increased risk of exposure to and infection by influenza viruses. In a pandemic situation, WHO recommends use of facemasks by health care workers exposed to persons considered infected by influenza virus.

Available evidence suggests that transmission of human influenza viruses probably occurs largely through exposure to respiratory large-particle (> 5 m in size) droplets. Therefore, the use of surgical masks is considered beneficial and is recommended for all health care workers working within three feet (one metre) of patients who are considered potentially infectious with pandemic influenza. Health care facilities also may recommend that health care workers use such masks when entering a room occupied by a patient diagnosed with pandemic influenza. Hand hygiene should also be performed immediately after discarding a used mask. (For more information visit: **http://www.who.int/csr/resources/publications/influenza/Mask%20Clarification10_11.pdf**

Is there a vaccine to protect humans from H5N1 virus?

There currently is no commercially available vaccine to protect humans against the H5N1 virus. However, vaccine development efforts are taking place. Research studies to test a vaccine to protect humans against H5N1 virus began in April 2005, and a series of clinical trials is underway.

Useful websites

http://www.who.int/csr/disease/avian_influenza/en/index.html
http://www.cdc.gov/flu/avian/gen-info/facts
http://www.hc-sc.gc.ca/dc-ma/avia/index_e.html
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How asthma education and follow-up can reduce the use of the emergency room

By Dora Lougheed, RN,
Alberta Childrens' Hospital, Calgary, Alberta

According to the BC Lung Association (2005), the World Health Organization has deemed asthma as a serious health problem affecting more than 150 million worldwide. Tough, Hessel, Green, Mitchell, Rose, Aronson, et al. (1999), suggested that asthma is the most common chronic respiratory illness on this continent and the majority of cases can be controlled. They say that the treatment of asthma in the emergency department signifies a failure of treatment and/or the control process while adding significant cost to the health care system.

The Canadian Lung Association (2005) states the most common chronic illness in Canada, asthma, affects an estimated 13 per cent of Alberta's children. The BC Lung Association (2005) says that every year in Canada there are 146,000 emergency room visits due to asthma attacks. In 2000/2001, the Calgary Health Region reported asthma as the number one cause for hospital admissions in the age group one to nine. In the same age group during 2002/2003, asthma accounted for 10.8% of admissions. During this same period, 22% of children seen in the Calgary Health Region's emergency departments had more than one emergency visit for asthma (Community Pediatric Asthma Education/Emergency referral manual, 2004). In the Calgary Health Region, asthma is the number one cause of emergency room visits and indicates poor asthma control.

Need for change

It is well-documented that follow-up can decrease the need for repeated emergency visits. How can we, as the emergency room team, promote asthma follow-up that will deter or decrease the need for use of the emergency department by asthma patients? Referring the family and patients to the asthma clinic is one solution, but referral to asthma specialists is often not necessary for simple cases of asthma and the wait is often greater than three weeks. Follow-up is best in the week post-exacerbation (Sin, Bell, Svenson, & Man, 2002). This article will explore how the implementation of follow-up clinics, both in the community and in the family doctor's office, can impact the asthmatics' use of the emergency department, as well as give hope to patients and families that, with controlled asthma, life can be lived normally with little restrictions.

Tough et al. (1999) found that parents or caregivers take children to the emergency department for asthma treatment more readily than adults would for their own treatment. These patients will come to the emergency room with an acute exacerbation of asthma, we treat them and then discharge them home with some brief teaching, suggestions of medication changes and recommend follow-up by the family physician. Studies have shown that most of the patients do not receive the follow-up for two reasons: they have busy lives and the crisis has passed, or they are unable to get an appointment within the week post-asthma attack (Zorc, Scarfone, Li, Hong, Harmelink, Grunstein, Jalal, & Andre, 2003). These patients and their families continue on with their lives until the next exacerbation of asthma and return to the emergency department.

In one study by Dales, Schweitzer, Kerr, Gougeon, Rivington and Draper (1995), it was suggested that prompt effective treatment by the family physician could reduce emergency hospital visits. This situation would be ideal, but the study by Dales et al. and a previous U.K. study proved that their asthmatic patients were poorly controlled and under-medicated. Simply treating the patients and returning them to the physician without changing the physicians' behaviours will not improve the situation of under-medication and lack of asthma education for the patient and physician. Ideally, this situation would be effective if the doctors were better educated in the treatment of asthma, would adhere to the guidelines for the diagnosis and management of asthma, and refer complex cases to an asthmatic specialist or a pediatrician. "The Canadian consensus report on asthma management is alone in recommending that a visit to an emergency department should prompt referral to an asthma specialist" (Dales et al., 1995, p.524).

The study by Sin et al. (2002) showed that early follow-up visits after an emergency room encounter had a significant reduction, by 25%, in emergency re-admission. They also cited Naylor et al.'s study suggesting that comprehensive discharge planning and intense follow-up further decreased the chance of re-admission. Sin et al.'s study showed that only 35% of patients had a follow-up visit with a physician within 30 days of their emergency visit. The National Asthma Education and Prevention Program advocates "the importance of ongoing preventive care and the importance of follow-up visits" (Zorc et al., 2003, p. 495). This article suggests that getting an appointment with or accessing a family physician is a difficult task.

The lack of family doctors across Canada is well-known and many families depend on walk-in clinics to access normal medical care, leading to inconsistent or inadequate medical care. The College of Family Physicians of Canada (MediResource, 2005) states the shortage of family physicians is prevalent in communities of all sizes, but the greatest hurt are the rural, northern and remote areas with patient/doctor ratios dropping faster in rural areas than city areas. They also say the lack of family doctors affects the medical care and coordination of patient care, which generally leads to the likelihood of longer wait times and decreased satisfaction with the health care that patients do receive. These families come to the emergency room, are triaged by the nurse and, depending on the severity of their asthma

attack, can wait, contingent on the availability of beds, hours for treatment to start. Once treatment has started, the patient can stay for hours. Normally this would be a good opportunity for teaching but, generally, the nurse and/or respiratory technician are too busy to spend quality time with the anxious patient and family. The most opportune time for teaching is within the first week immediately following the asthma exacerbation, when the patient has improved and the crisis has passed.

Plan for change

The Calgary Health Region and the Alberta Children's Hospital (ACH) sponsored an asthma education program project, called iCAN that was developed and trialed from 2001-2004. This project proposal was developed in response to the 1999 Asthma Accreditation Recommendations (Child Asthma Network, 2004). The major goal of the project was to provide standardization of asthma information and asthma management through education of family physicians, pharmacists, fire stations, elementary schools, daycares, and rural communities and to increase community awareness (Child Asthma Network, 2004). The outcomes of the program were promotion of follow-up education for the pediatric patient, post-emergency room visits, which could decrease emergency re-admissions, as well as increased confidence and continuity of accurate, up-to-date pediatric asthma care and information in the community and families caring for asthmatic children (Child Asthma Network, 2004).

The team developed two websites, **www.calgaryhealth.ca/ican**, the child asthma network that gives updated asthma information in both child- and adult-friendly form, and the teen website designed by teens for teens, **www.project-a.ca**. These websites remain today, as a legacy from the iCAN project, promoting asthma information and support. They also developed educational material that is still in circulation throughout the medical practices, school/daycare system, pharmacies, community health nurses, and hospital systems. The iCAN project maintains updated educational material both on the website and in the written material.

The project was so successful that it was given funding as a program as of June 2004, and has been receiving referrals since. The outcomes of the program were:

1. The asthma emergency visits decreased by 65%, and the asthma hospital stays decreased by 62%.
2. The family physicians, pharmacists, school/daycare staff, and community nurses all stated an increase in asthma knowledge.
3. The implementation of and increased access to medically accurate, consistent pediatric asthma information for patients and their families was invaluable.
4. Families felt they were more able to manage and control their child's asthma.

The program is called Community Pediatric Asthma Education Referral Service (CPAERS). The object of the program is to support patients and their families with education and spirometry, in their family doctors' and pediatricians' offices (Child Asthma Network, 2004).

The goals of the CPAERS are:

1. Facilitating a regional asthma care pathway, which incorporates both adult, pediatric and community providers, region-wide.
2. Developing standardization and dissemination of medically consistent asthma information.
3. Pilot a small number of referrals for asthma education from the emergency department.

The CPAERS emergency pilot program runs once a week with referrals from the emergency physicians, for patients who have had emergency room visits for asthma exacerbations.

The criteria for a referral from the emergency department are:

1. The child must have a diagnosis of asthma
2. Be an uncomplicated case of asthma
3. Patient should be seen within two weeks of the emergency room visit.
4. Deemed to be uncontrolled asthma by the emergency physician.

The team consists of a program manager, four half-time certified asthma educators (CAEs), and a pediatric asthma specialist who reviews the CAEs' reports and will field complex respiratory problems outside the educator's, pediatrician's, or family physician's roles.

The CAE assigned to the emergency pilot program is a half-time position with 0.2% devoted to the emergency referrals and 0.3% to the physicians' office referrals. The CAE sends all of her reports to the asthma specialist and then they are sent to the family physicians. Any concerns the CAE has, such as querying changes in medications or methods of medication delivery, are communicated to the family physician both in writing and by phone. The CAE will also suggest and arrange patients' visits with a pediatrician for asthma management for those who don't have a family physician following them.

Conclusion

The CPAERS has enabled and empowered asthmatics and their families to take control of their health and well-being, by the mere act of placing information at their fingertips and making available a program that will give continuity of practice in the health care system and community. Usher (1989) emphasizes that as long as the medical professionals, the patients and caregivers share the power and responsibilities, this will promote health. The iCAN website is helping to re-orientate the individuals, community groups, health professionals and health service towards a health care system that contributes to the pursuit of health and well-being, and not just the prevention or curing of health problems. In 1992, the Canadian Nurses Association found that a review of 35 major commissions and Canadian health care task forces revealed three common goals: more emphasis was needed on disease prevention and health promotion, focus on community-based care alternatives, and to increase accountability among the stakeholders (Starzomski, 2002). In one year, the iCAN project showed that consistent information and management of asthma disease in pediatrics could decrease the episodes of asthma exacerbation and decrease the use of the emergency department.

In summary, the iCAN project was very innovative and thorough in its approach to dealing with the gaps in child asthma awareness and management. The project showed that proper,

consistent management, access to up-to-date asthma information, and increased knowledge and confidence in families regarding asthma management can and did decrease the need for use of emergency departments.

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About the author

Dora Lougheed has been nursing for 30 years! The first 10 years of her career were spent in intensive care trauma units and emergency, both teaching and rural, around B.C. In 1989 she returned to Vancouver and went to work in the B.C. Children's emergency department. In 2004 Dora moved to the Alberta Children's Hospital where she now works half time in the recovery room and picks up casual shifts in the emergency and asthma clinic. She began working on her degree in 2002, when she realized that she had a need to expand into other areas beyond bedside care, and will finish in April 2006. As Dora says, "This journey has been very interesting and enlightening for me. More enlightening than I could have ever imagined possible, and well worth the journey."

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Alcohol and head injury: A continuing dilemma

By Carole Rush, RN, MEd, CEN

Case presentation

A 44-year-old male presents to an urban emergency department (ED) after falling down 12 stairs. He was found by friends, in bed with a scalp laceration and another pool of blood at the foot of the stairs. Patient history included frequent alcohol ingestion. At the time of presentation, the patient smelled of liquor. The scalp laceration was sutured, and the patient was discharged home. Two days later, the patient presents to an urgent care facility with complaint of increased headache, event amnesia, balance disorder, photophobia and hyperacousis. No focal motor neurological deficits were noted on exam. Since the urgent care facility does not have a CT scanner, the patient was transferred to another urban ED for a CT scan of the head. The CT revealed a right parietal skull fracture and small subdural hematoma. After consultation with neurosurgery, the patient was admitted for observation for two days and again discharged home. He returned again to the urgent care facility five weeks later with post-concussive symptoms of continual headache and mood swings. He was again transferred to the urban ED for a follow-up CT scan.

This case raises a few issues. The one I will focus on is the strong connection between alcohol use and head trauma. Patients continue to "fall through the cracks" when it is assumed that their main problem is alcohol intoxication and the **possibility of more severe head injury is not adequately addressed**. There are a few practices that I would like to discuss.

Careful initial assessment

A through history and physical exam are necessary with patients who are seemingly "only intoxicated" (Marx, 2003). There may or may not be evidence of acute trauma. Patients need to be undressed and examined, as evidence of a fall or assault can otherwise be missed. Patients who habitually ingest alcohol may not be the best historians. The question of "recent trauma" should be extended to include the past several weeks and any friends or family of the patient in the history who may reveal additional traumatic incidents that the patient may not remember.

Serial evaluations and the trending of assessment findings will help differentiate between ethanol intoxication and head injury. As blood ethanol levels decrease, level of consciousness should improve, speech should become clearer, and general motor power should increase. The trend of Glasgow Coma Scale scores will help illustrate these findings. The Glasgow Coma Scale is a simple tool to use and trend, yet does not replace a full neurological examination (Shepard, 2004).

The question of blood ethanol levels

Not all EDs are able to obtain blood ethanol levels. When available, it is recommended that an initial blood ethanol level be known, with serial blood ethanol levels if there is a debate over the reason for a patient's continued altered mentation or lack of improvement in level of consciousness.

Blood ethanol concentrations vary according to sex, size, body composition, previous exposure to ethanol, whether it is taken with food, and whether drugs that affect gastric emptying are used (Shepard, 2004). Ethanol is eliminated predominantly by liver metabolism at a rate of 15 mg/100 ml per hour. Metabolism is accelerated in heavy drinkers unless they have liver damage, when it may fall to less than a quarter of normal (Shepard). So, the bottom line is that patients should sober up over time spent in the ED, and any delays should be further investigated. There are many possible explanations for patients with a decreased level of consciousness. Table One lists the differential diagnosis for altered mentation.

The question of CT head for all intoxicated patients

A head CT is not available in all EDs at all times. Many intoxicated patients with a questionable or suggestive history of trauma will receive a CT scan if available. The question becomes whether to transfer an intoxicated patient for a CT head.

Physicians can refer to the Canadian CT Head Rule (Paton, 1994). One study reported a sensitivity of 100% for detecting abnormal CT scans in head injured patients with any one of seven findings: headache, vomiting, age >60 years, drug or alcohol intoxication, deficits in short-term memory, physical

Table One: Differential diagnosis for altered mentation (Marx, 2003)

Traumatic	Metabolic	Toxicologic	Infectious	Neurologic
Intracranial hemorrhage	Hypoglycemia	Other alcohols	Meningitis Meningoencephalitis	Postictal state
Hypotension secondary to hemorrhage	Hepatic encephalopathy	Other toxins	Brain abscess	Alcohol withdrawal
	Hypoxia	Disulfiram (Antabuse®)-ethanol reaction	Sepsis	Wernicke-Korsakoff syndrome

evidence of trauma above the clavicles, and seizure (Jin & Bullard, 2002). Strict following of this rule would then indicate the need for a CT scan of an intoxicated patient.

Final point

Patients who ingest ethanol are at risk for minor, moderate and severe head trauma. Most people presenting with mild head injuries will not have any progression. However, up to three per cent of mild head injuries progress to more serious injuries (Shepard, 2004). ED staff must continue to have a high index of suspicion for concomitant trauma in patients who present with intoxication.

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Additional information/ Resources on alcohol use and trauma

The Centre for Disease Control and Injury Prevention in the U.S. has announced that **The Journal of Trauma: Injury, Infection & Critical Care** has recently published a special issue of proceedings from the groundbreaking conference, "Alcohol and Other Drug Problems among Hospitalized Trauma Patients: Controlling Complications, Mortality, and Trauma Recidivism." In 2003, the CDC's Injury Center convened this interdisciplinary meeting of government organizations, trauma surgeons, advocates, and substance-use treatment researchers. The proceedings discuss recent studies and recommendations for implementation of brief screening and intervention strategies within the emergency and trauma care settings for patients who might have drug or alcohol problems.

Trauma surgeons, nurses, addiction counsellors, psychologists, public health officials and others on the front lines of trauma care will find this special supplement essential for developing interventions to prevent injury caused by alcohol and drug-related problems.

Website
http://www.cdc.gov/ncipc/pub-res/alcohol_proceedings/alcohol_proceedings.htm
You can view or download sections of the supplement at **http://www.cdc.gov/ncipc/Spotlight?JrnTraumaSupl.htm**

E-mail any questions or comments to **ncipcdirinto@cec.gov**, and type "Trauma/Substance Use" in the subject line of your message.

"Alcohol, Trauma and Impaired Driving, 3rd Edition" document released through The Centre for Addiction and Mental Health and MADD. The 3rd edition is more comprehensive and has more international research to place the Canadian experience of impaired driving and alcohol-related trauma into context. The document is intended as a resource for health care researchers, lawmakers, media and anyone interested in current trends on alcohol-related trauma.

Access this document at **http://www.madd.ca/english/research/real_facts.pdf** or through the MADD web site: **www.madd.ca**

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

Letter of support (1) from: ______________________

Letter of support (2) from: ______________________

Signature of nominee: ______________________

Signature of nominator: ______________________ Date: ______________

***Rest Up! Save Your Neck** brochure is reprinted with permission.*

"Rest Up! Save Your Neck" is a national awareness campaign, focusing on educating drivers about the ideal adjustment of their vehicle headrests to help prevent whiplash and soft-tissue injuries.

Emergency nurses are encouraged to check the position of their headrest, and pass this information on to the public. More information can be found on the Insurance Bureau of Canada's website: **www.ibc.ca**

Headrest Positioning Study

IBC commissioned a study to assess the level of headrest adjustment across Canada in seven provinces, British Columbia, Alberta, Ontario, New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador, during June and July 2002. A total of 7,571 drivers and 1,090 passengers were videotaped as they approached intersections and in stop-and-go traffic.

Data collected from this study indicate that too many Canadians are failing to take precautions to protect themselves against soft-tissue injuries. This failure is extremely costly for Canadian consumers, insurance companies and their policyholders.

By taking the time to properly adjust the headrests in your car, you will not only be preventing injury to yourself, but also to your family. So next time you get into your vehicle, remember to Rest up! **Save your Neck**.

Insurance Bureau of Canada

Insurance Bureau of Canada (IBC) is the voice of companies that insure the homes, cars and businesses of Canadians. Member insurance companies provide about 90% of the private property and casualty insurance sold in Canada.

Rest up! **Save your Neck** is a national awareness campaign, focusing on educating drivers about the ideal adjustment of their vehicle headrest to help prevent whiplash and soft-tissue injuries.

This brochure provides information on how to properly adjust your headrest, key findings from IBC's headrest positioning study, and costs associated with soft-tissue injuries.

To learn more about IBC, visit the website at www.ibc.ca.

Insurance Bureau of Canada — Bureau d'assurance du Canada

Rest Up! Save Your Neck.

Taking time to properly adjust the headrest in your vehicle can help reduce soft-tissue, whiplash-related injuries by as much as 40%.

Soft-tissue injuries are those that do not involve bones or organs. It is estimated that 80% of insurance claims following motor vehicle collisions result from soft-tissue injuries. Insurance companies spend approximately $4 billion annually to help people recover from these soft-tissue injuries.

Good headrest adjustment depends first on the design of the headrest, and second (in many instances) on the diligence of drivers and passengers in making necessary adjustments. About 75% of headrests in vehicles are adjustable, rather than fixed.

How Can I Adjust My Headrest?

Having your headrest properly adjusted is as easy as **1, 2, 3!**

1. The centre of the headrest should be slightly above the top of the ear.
2. The top of the headrest should be at least as high as the top of the head.
3. Ideally the distance between the headrest and the back of the head should be between five and ten centimeters (two to four inches).

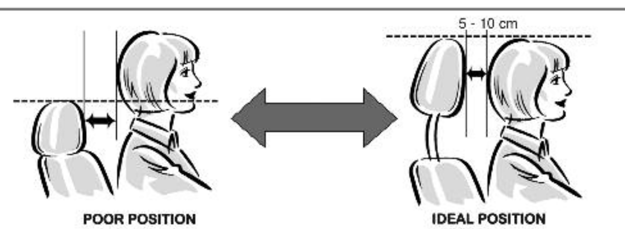
Headrest Adjustment

IBC's headrest study has revealed the following:

- Only 14% of Canadians have their headrests ideally adjusted.
- Drivers of large cars and light trucks have the poorest record, with only 22-23% having their headrests ideally adjusted.
- Drivers of SUVs and small cars have the best rate of adjustment.
- 23% of Canadian women have their headrests ideally adjusted.
- Only 7% of Canadian men have their headrests ideally adjusted.
- Female drivers are three times more likely than male drivers to have ideally adjusted headrests.
- Drivers in New Brunswick and Prince Edward Island have the worst adjustment rates.
- Drivers in Alberta and British Columbia have the best adjustment rates.

How do Drivers in Your Province Measure Up?
Percentage of drivers with ideally adjusted headrests

BC 18%
AB 16%
ON 13%
NL 15%
PEI 8%
NS 12%
NB 7%



Mini-evaluation of triage accuracy

By Glenn Donnelly, RN, ENC(C), BScN, MN, PhD, Assistant Professor, College of Nursing, University of Saskatchewan & Nurse, Emergency Department, Pasqua Hospital, and Jerry Bell, RN, ENC(C), Clinical Development Educator, Emergency & Emergency Medical Services, Regina Qu'Appelle Health Region, and Undergraduate Student, College of Nursing, University of Saskatchewan

Key words: triage, emergency assessment

Introduction

Triage is defined as "a sorting process utilizing critical thinking in which an experienced registered nurse assesses patients quickly on their arrival in the emergency department. This is achieved by assessing and determining the severity or acuity of the presenting problem, processing patients into a triage category and determining and directing patients to appropriate health resources" (National Emergency Nurses Affiliation & Canadian Association of Emergency Physicians, 1998). Triage is one of the most challenging responsibilities of the emergency room nurse. Safe, effective patient care begins with triage assessments for which the emergency room nurse is accountable.

Little is known about the accuracy and reliability of current triage methods. A study by Brillman, Doezema, Tandberg, Sklar, Davis, Simms, and Skipper (1996) examined agreement among observers with regard to the need for emergency department care and ability to predict at triage the need for admission to the hospital and compared these findings with admission rates after medical evaluation and management. The results showed great variability among physicians, nurses and a computer program with regard to triage decisions. Comparison of the three groups' triage decisions with actual data after medical evaluation and management showed that none of the three performed well in predicting which patients required admission. Based on these findings, the investigators called for validated and standardized triage methods. Pain is most frequently the symptom that brings patients to the hospital emergency department. Puntillo, Neighbor, O'Neil, and Nixon (2003) studied nurses' initial assessment of pain with subsequent triage. They found that there was considerable underestimation of pain in both triage and clinical areas, which has great potential to have negative effects if appropriate treatment is not initiated. Kilner (2002) examined theoretical triage decision-making amongst pre-hospital emergency personnel, physicians and nurses. From this study, there is little difference in the accuracy of triage decision-making between the professional groups, with physicians and nurses scoring marginally better than paramedics. The rates of over-triage are high, posing the risk of overwhelming available resources. Under-triage rates are also high, with potentially life-threatening conditions going unrecognized.

The triage system evolved as an efficient way to separate patients requiring immediate medical attention from those who could wait. Frequently, the question is asked, "How accurate are our triage assessments?" In an effort to determine how effective emergency nurses were in triaging patients that presented to emergency, this mini-evaluation was conducted in the two tertiary care hospitals in a western Canadian city.

Method

Cases from the Canadian Emergency Department Triage and Acuity Scale: An Educational Program for Registered Nurses were presented in four sets of 18, 19, 23 or 24 cases. The emergency room nurses were to assess the information provided and make a determination of which triage category to place the patient in the case. The triage categories developed by the National Emergency Nurses Affiliation (NENA) and the Canadian Association of Emergency Physicians (CAEP) are used as standards in this mini-evaluation.

All questionnaires were completed on electronic scan sheets anonymously and the scoring sheets were coded only as to which hospital they were from.

Results

Thirteen respondents at one hospital completed the survey, and only two at the other hospital chose to participate. Response rate was not calculated.

Findings

Overall, the number of cases assessed correctly according to the triage standards set out by NENA and CAEP was 53.5%. The number is further broken down into the percentage within each category that was assessed correctly.

Resuscitation	Emergent	Urgent	Less-Urgent	Non-Urgent
55.3%	47.52%	58.62%	54.83%	51.28%

In doing the analysis of the data, a further question was asked, "If patients presented in the case study were not assessed to the correct triage category, then which category were they placed in?"

A. Resuscitation category

For those cases that correctly should have been assessed as "resuscitation" 34.04% were assessed as "emergent" while 4.25% were assessed as "urgent."

Resuscitation	Emergent	Urgent	Less-Urgent	Non-Urgent
61.70%	34.04%	4.25%		

B. Emergent category

For those cases that correctly should have been assessed "emergent", 3.96% were categorized in the higher category of "resuscitation" while 34.65% were assessed as "urgent," 12.87% were "less urgent" and .99% were "non-urgent."

Resuscitation	Emergent	Urgent	Less-Urgent	Non-Urgent
3.96%	**47.52%**	34.65%	12.87%	.99%

C. Urgent category

For those cases that correctly should have been assessed "urgent," 13.79% were assessed at the higher category of "emergent," while 22.41% were categorized at "less urgent," and 3.44% were categorized as "non-urgent."

Resuscitation	Emergent	Urgent	Less-Urgent	Non-Urgent
	13.79%	**58.62%**	22.41%	3.44%
*1.7% of the responses were invalid.				

D. Less than Urgent category

For those cases that correctly should have been assessed as "less-urgent," 1.61% were assessed as "emergent" and 14.52% were assessed as "urgent," with the remaining 29.03% assessed as "non-urgent."

Resuscitation	Emergent	Urgent	Less-Urgent	Non-Urgent
	1.61%	14.52%	**54.83%**	29.03%

E. Non-Urgent category

For those cases that correctly should have been assessed as "non-urgent," 33.33% were assessed as "less-urgent," 12.82% were assessed as "urgent" and 2.56% were assessed as "emergent."

Resuscitation	Emergent	Urgent	Less-Urgent	Non-Urgent
	2.56%	12.82%	33.33%	**51.28%**

Limitations

1. A major limitation of this mini-evaluation was that the validity of the cases and their assigned triage level was not established or documented.
2. There is no information about the triage nurses who completed the study question with regards to the numbers of years of experience, age, education level, triage training etc.
3. The small number of respondents (n=2) at one site make it difficult to make inferences about the differences between the two sites.
4. The results of this mini-evaluation represent a snapshot only of the work of the triage nurses. The assessment may yield more useful data if it was done at multiple times over a longer period of time.
5. The method uses hypothetical cases and does not reflect the context in which triage nurses assess acuity. Therefore, the findings of this mini-evaluation have to be considered in that light. A more rigorous design would provide more robust findings.

Discussion

Although the majority of cases were triaged correctly according to the triage standards, the cases that were not categorized correctly tended to be the next lower level of triage, with the exception of the "non-urgent" cases, which, for the most part, were triaged to the next higher category. This result could lead to the assumption that triage nurses in this sample population have not "fine-tuned" their triage skills or that the categories do not have clear limits. Clinical judgment at the very best always has an element of subjectivity. Another consideration is that the triage categories take into account the context within which the patient presents. These contextual variables may have an impact on what triage category the nurse places the patient.

This exploratory study provided the department with the impetus to re-examine the triage process. There is recognition that triage processes and standards need to be examined using a quality improvement philosophy, which could lead to further adaptation and refinement of our existing triage process. Clearly, moving from three categories of triage – emergent, urgent and non-urgent – to the five-level Canadian Triage and Acuity Scale (CTAS) has provided an opportunity to more appropriately direct the flow of patients in a busy emergency department. The training provided for triage nurses needs to be re-examined with the view of developing the triage nurses' role and competencies. Training in history-taking and physical assessment are two areas that would provide triage nurses with added skill. Additionally, formal triage training utilizing the principles and standards of the Canadian Triage Acuity Scale (CTAS) could potentially improve the outcome of reliability and accuracy of triage decisions.

As this small-scale study was conducted with a group of triage nurses who have had little formal training in triage methods, it would be instructive to repeat the study following formal training in triage using the Canadian Triage Acuity Scale (CTAS) model.

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What's happening to our children? A closer look at global sexual exploitation

By Tara Lamb, RN, Burnaby General Emergency Department, Burnaby, BC

Section editor's note: *While taking the BCIT Forensic Nursing course instructed by Sheila Early, Tara was inspired to write a paper on the issue of global sexual exploitation of children. Since writing the paper, Tara plans to volunteer her nursing skills, knowledge and compassion in Thailand at a camp that protects 420 Akha children from sexual exploitation. Tara plans on reporting her experience once she returns.*

The commercial sexual exploitation of children is a global issue. It's estimated that millions of children across the globe every year are being sexually exploited in forms such as prostitution, trafficking, and pornography for personal profit, and at the expense of the victim's own health and well-being. The purpose of this article is to create discussion, awareness, and insight amongst readers and to establish advocacy, prevention and protection of children. In this article, I will describe the forms of sexual exploitation and discuss who is being victimized, as well as depict the offenders. Factors that increase the incidence of child exploitation/abuse within established and developing countries will be identified. Also, this article will illustrate the psychological, physiological, and social impact that sexual violence has on children. In conclusion, the roles of forensic science and nursing and how they contribute to the eradication of sexual exploitation is discussed. Cross-continental measures are being taken to prevent and protect any child from being subjected to this trauma. Lastly, identification of efforts to support and reintegrate children who have already been sexually exploited is discussed.

Sexual exploitation is defined as a "fundamental violation of children's rights and comprises sexual abuse by a person and remuneration in cash or kind to the child or to a third party or person. In addition to suffering all the consequences of sexual abuse, the child (male or female) is treated as a commodity, and the child's body is sold to an abuser for the abuser's sexual pleasure" (Barnitz, 2001). A form of sexual exploitation, child prostitution, is described as minors engaging in sexual activities with adults (Lynch, 2006). Sexual contact with a minor in the form of coercion, exposure, touching and/or sexual intercourse is a criminal offence in most countries. However, the consequences and seriousness of the crime vary globally (Lynch, 2006). Child trafficking is an offence in which children are being coerced, bought, sold or kidnapped into the sex trade to become sexual slaves (NBC News Dateline, 2005). "Human trafficking also means the giving or receiving of payments and benefits to achieve the consent of the person having control over another person for the purpose of exploitation, which includes prostitution, forced labour or services, slavery and servitude" (Berondo, 2005). Child pornography can be defined as "any visual or print medium depicting sexually explicit conduct involving children… [that involves] sexually explicit behaviour [in the form of] sexual intercourse, bestiality, masturbation, sadomasochistic abuse and lewd exhibition of the genitals and pubic area" (Lynch, 2006). New technologies such as the internet, digital cameras, and mobile forms have increased the distribution of child pornography (UNICEF, 2005). The internet has also made child sexual exploitation easily "accessible, anonymous, and affordable" (Duguay, 2005).

Children of all ages are at risk for sexual exploitation for many reasons such as poverty, inequality, discrimination, violence, criminality, lack of education and employment opportunities, mental illness and disabilities, substance abuse, victim accessibility (the internet), rural and urban growth, lack of laws and enforcement, societal views (children do not have HIV/AIDS) and traditions (child marriage), family dysfunction, political instability and war, tourism, and new technologies such as the internet (UNICEF, 2001). Other issues such as "force, trickery, bribes, threat[s] and lies" (UNICEF, 2005) also are involved in deceiving parents and luring children into the world of sexual exploitation. In established countries such as North America, factors such as substance abuse, violence, prior/ongoing sexual abuse, dysfunction with their own family, lack of educational and employment opportunities, victim accessibility via the internet and, in some regions, poverty are influential in the increased incidence of sexual exploitation (UNICEF, 2005). Within developing countries, all of the above root problems are influential in the incidence of sexual exploitation, poverty being at the forefront as it bears weight on most other factors. Sex tourism and victim accessibility via the internet are the newest, and vastly growing forms used by the offender to come in contact with the victim (UNICEF, 2005). "While it is unknown exactly how many children have been abused worldwide in cyberspace, the scale of the problem could be measured from the millions of child pornographic pictures that can be found on only one computer" (Assavanonda, 2005). Using chil-

dren to make pornography causes physical and psychological harm. "It also creates… [risk] for other children [to be exploited] through the normalization of images of sexual violence and a mainstream packaging of children as sexual commodities ready for consumption" (Assavanonda, 2005).

A common misnomer about sexual offenders/exploiters is that they are all pedophiles: "adults who are only sexually attracted to children and will commit abuse to fulfill their own desires" (UNICEF, 2005). Many offenders are not pedophiles but, instead, have sex with children because of availability, curiosity, and/or they do not question or care about the age of the child. The majority of the offenders are males who live "respectable lives" per se, which is an added factor as to why the offenders are not readily recognized within your community (UNICEF, 2005).

The psychological, physiological, and social impact left from sexual violence can be lifelong and life-threatening. Psychological effects such as self-blame, low self-esteem, decreased self-worth, anxiety, aggression, fear for one's own life or their own family's life, depression, post-traumatic stress disorder, and suicidal ideation and attempts are very common amongst children (Lynch, 2006). Within every type of abuse, the offender uses manipulation to victimize which, in turn, creates distrust for others, and a sense of insecurity and isolation for the victim (United Nations Economic and Social Commission for Asia and the Pacific, 2005). Physiological effects include, battery (roughly handled, bruises, fractures etc.), genital trauma, the transmission of sexually transmitted infections (HIV/AIDS and hepatitis are increasing at a phenomenal rate, especially in developing countries), pregnancy, malnutrition, substance abuse/dependency, and eating disorders (Lynch, 2006). There is also an increased risk of death associated with sexual exploitation. The societal impact stems from the psychological effects of low self-esteem and self-worth that can facilitate withdrawal from society. A societal view of someone who has been sexually abused varies from country to country but, in general, is not 100% supportive of the victim being innocent in the occurrence. There is a component of blame towards the victim. For example, someone (usually the perpetrator) may say that the children wanted to be prostitutes or that they chose this lifestyle in order to make money. There are other societal views that may recognize exploitation/abuse as a crime, but then contradict themselves by labelling the individual as unworthy. An example of this is in India, if a woman/child has been raped, they are deemed not a virgin and are considered unworthy of marriage. These individuals are either committed to a single life with their parents or, in extreme cases, have been murdered to honour the family name (Lynch, 2006).

In 1996, sexual exploitation amongst children was recognized for the first time globally at the World Congress. This provided a "landmark opportunity for representatives of governments and private organizations to learn about the problem and begin to consider interventions" (Barnitz, 2001). Representatives from 124 countries decided to develop a standardized plan to provide a global definition of sexual exploitation, enhance local and international law enforcement, and provide awareness, education and advocacy amongst the public. The congress also encouraged youth participation in the action plan, as well as considering root problems that could facilitate the occurrence of abuse. The main point established at the 1996 World Congress of great importance was that this is not an issue that can be addressed independently within each individual country (Barnitz, 2001). Five years later, the second World Congress was held to review progress of objectives made previously, identify gaps and new roadblocks, and enhance political and global commitment to the fight against sexual exploitation. At this gathering, there were 3,050 participants, which included 136 government delegates, non-government organizations, private sector organizations, and 100 youth. This turnout alone is significant as it shows global awareness has increased, and that many countries are ready to protect the children. The downside of the second World Congress was that information regarding the overall impact of the 1996 initiatives to combat the sexual exploitation of children was limited and vague. Sexual exploitation has been around for hundreds of years and there has never been a set plan of action to attack this problem. Therefore, as frustrating as it is, change can only occur as fast as the issues are brought forth and addressed.

Within every facet of society, forensic science is intertwined. In addition to public involvement, professional bodies such as health care professionals, law enforcement, the judicial system and science need to come together as one to acknowledge, intervene, and eliminate sexual exploitation. It would be ideal to have law enforcement patrolling in droves looking for sex offenders or victims. However, the reality is that this is not completely possible. Public awareness worldwide is also a valuable tool that is not utilized enough. There are many other professions within our communities, such as teachers, that are involved with children, sometimes more often than one's own family, that need to be educated in prevention, recognition and intervention. Public, global and governmental efforts need to be made to enhance the importance of education and retention of children within the school system. Within this, global issues such as poverty and individual family necessities need to be evaluated to determine the causes of why children do not complete their education. Educating children also empowers them to recognize high-risk situations, which will aid in protection and prevention (Barnitz, 2001). It is beneficial for children to complete school so they are eligible for higher paying jobs later in life, which reduces their risk to be vulnerable at the hands of an offender. Another aspect of education is to encourage and support parents in receiving a higher education to decrease the need for children to work, and aid in supporting their family (Barnitz, 2001). In many developing countries, non-government organizations such as UNICEF are directly involved with children in crisis. This is an optimal opportunity to evaluate the health and well-being of the child and intervene. It has been estimated that in established and developing countries, a child who is sexually exploited will come in contact multiple times with health care professionals, especially within emergency departments and specialty areas. Therefore, this may be the only opportunity to identify the instance of sexual

violence (Lynch, 2006). Specifically within health care, the nurse's role is to develop a relationship with the patient in which they feel safe enough to divulge information. From this, accurate documentation of injuries is recorded and follow-up interventions can be initiated (social work, shelter, etc.). Advocacy for the patient and removal of the individual from the situation, along with reinforcement that the victim has the right to be safe and free from harm is also a necessary intervention (Lynch, 2006). Within established countries, the victim can be placed in the Witness Protection Program if future safety is an issue, and services such as counselling, therapy and financial benefits are considered (but unfortunately not always awarded). In all established countries, child welfare options are accessible, and advocacy groups such as non-government organizations (UNICEF), as well as orphanages, are options for placing the child in a safe environment. For the reintegration process, it was recognized at the first and second World Congress that more public and social support needs to be established to aid in getting children appropriate care, as well as preventing further exploitation. It was recognized at the 1996 World Congress that youth participation was vital in the war against exploitation to promote protection of their rights, and to facilitate youth as peer communicators and counselors (Barnitz, 2001). More recently within the travel industry, a Code of Conduct has been developed by UNICEF and distributed by airlines to provide information to travellers about sexual exploitation. Brochures and in-flight films educate them that sexual exploitation is illegal, punishable and morally and ethically wrong (End Child Prostitution, Child Pornography and Trafficking of Children, 2004). This information also educates them to identify and report any suspicious behaviour to authorities. Factors in prevention/protection also include increasing prison sentences for criminals of sexual crimes and providing more rehabilitation treatment for offenders. Currently, the rehabilitation treatment programs in some parts of North America are optional when, unquestionably, this should be a mandatory requirement for offenders. Globally, law enforcement has become more established with legislation. An example of this is Bill C-15A that seeks to combat global cyber crime and convict offenders in other countries (Foreign Affairs Canada, 2004). Recently, North American legislation has been established to convict offenders in their own country that have committed a sexual crime in another. During the last G8 summit, humanitarian aid to poverty-stricken countries was increased. Although not directly allotted to the fight against sexual exploitation, the financial aid will address root risk factors and, hopefully, have an indirect effect. More recognition and intervention of sexual exploitation needs to be brought to the forefront. Its personal, social and economical effects on society are just as detrimental as any other cause for which there is public advocacy. Recovery and reintegration of victims includes "strengthen[ing] the capabilities of social service and health personnel (including non-government organizations) in countries to assist young victims of sexual abuse and exploitation" (United Nations Economic and Social Commission for Asia and the Pacific, 2004), prevention, recognition and intervention being key.

In summary, due to the dynamic nature of child sexual exploitation and its prevalence in every country around the world, a global plan has been established to raise awareness and continuity in prevention, protection, support and reintegration for children. There also needs to be global continuity so perpetrators are punished accordingly for their crimes. Due to the financial status of many developing countries, a global approach is the only way to assist in the quest to prevent sexual exploitation from occurring. In every country, root problems can differ and other issues such as substance abuse, street youth, family support and structure needs to be evaluated and resolutions initiated. With the start of recognition and intervention at the 1996 World Congress, identification amongst some countries has been made that will hopefully lead to more prevention, protection and support for children. Although sexual exploitation is a global issue, many countries, some of which have the highest rates of child sexual exploitation, still refuse to recognize this is a problem. Within the World Congress, it has been recognized that constant re-evaluation of the global plan is necessary to maintain progress in combating this despicable crime.

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