

outlook

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



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In This Issue:

President's message	4
From the editor	4
NENA at work: Highlights from the Spring 2007 Board of Directors' and Annual General Meeting	5
Board meeting observer policy	5
NENA at work: Canadian Association of Emergency Physicians and National Emergency Nurses' Affiliation commend report recognizing emergency department overcrowding as significant problem in Canada	7
NENA at work: CEEP Report	8
Bursaries and Award of Excellence	8
Call for nominations: "president-elect" and "communication officer"	9
Bouquets	10
Conference watch	10
NENA National Conference 2008, Banff, Alberta	11
NENA National Conference 2009, Winnipeg, Manitoba	12
Kids' Corner: What do you say to the parents of a crying baby?	13
Kids' Corner: New rules boost children's safety	14
Trauma Corner: Case study — Traumatic amputation	15
Trauma Corner: The Trauma Nursing Core Course: 21 years and six editions later!	20
Rural Realities: An unforgettable experience in Iqaluit	22
Manager's Moment: The effects of emotionally intelligent leadership behaviour on emergency staff nurses' workplace empowerment and organizational commitment	24
Manager's Moment: An ambulatory waiting room expedites the processing of CTAS 3 patients in a busy emergency room	25
Care of the acutely ill elderly in ER: Growth of the role of geriatric ER nurses	27
The NENA Bursary	29
The NENA Bursary application form	30
The NENA Award of Excellence application form	31



We've broken ground on our New Wing. *Break new ground in your career.*

This is an exciting time to join Trillium, as we enter a new phase in our commitment to transform the health care experience. Work has begun on a new wing that will integrate creative architecture, the best clinical practices, state-of-the-art technology and patient-centred care. This physical transformation, which will allow for new and enhanced services and programs in many areas, is one more way in which Trillium continues to re-invent itself as an innovator.

As an acute care hospital with comprehensive community-based programs and several regional programs – Advanced Cardiac, Stroke, Sexual Assault/Domestic Violence, Neurosurgery and Mental Health, Trillium provides a uniquely diverse health care environment. As the portal into all patient care areas, the Emergency department is a key component and partner in Trillium's integrated patient care delivery journey. Operating 24/7, the full-service Emergency department at our Mississauga location is a 42-bed unit with 10 Clinical Decision Unit beds, and one of the busiest ERs in Canada. We are also home to the first hospital-affiliated urgent care centre in the west-end Greater Toronto Area, and the first separate paediatric area in an emergency department in Ontario.

Serving more than 130,000 patients annually, the most of any hospital in Canada, our **Emergency Services** is setting benchmark standards in patient access and flow by working together in ways that are pace-setting. **Emergency RNs** find here many opportunities to gain experience in a wide variety of areas – all within a highly collaborative workplace that includes a 24-hour Crisis Support Team and a Medical Emergency Team, promotes both personal and professional growth, and encourages decision-making as close as possible to the point of care.

For more information on our two-site organization, located just minutes from downtown Toronto, and both current and upcoming ER Nursing opportunities, please **visit us online to apply** or fax your resume, in confidence, to **Human Resources, Trillium Health Centre**, at 905-848-5598.



www.trilliumhealthcentre.org

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 ½" × 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:

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Deadline dates:

March 15 and September 15



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President's message



I always laugh when people say September's here – “back to the old grind”. Well, when you work in an emergency department, there is NO

back to the grind – we are always in the grind! I do hope, however, that everyone was able to take some time off over the summer to rejuvenate.

Over the past year, the NENA board of directors has been looking at strategic planning. This plan took shape in November 2006. I submit the outline to you for your opinion and criticism. (It would be impossible for me to submit all the discussions that have occurred surrounding these initiatives). I would love to hear your comments and suggestions about the plan itself, as well as where do you see NENA in the next year? Five years? Please e-mail president@nena.ca.

I will endeavour to take this feedback for inclusion in the strategic plan to the board table in the spring. Following that meeting, I will share the plan in its entirety on the website and in the next **Outlook**.

The use of the acronym NENA INC seemed fitting, as well as comprehensive.

N – Nationally Focused

This direction is self-explanatory – NENA represents Canada, supporting each provincial body.

E – Education

As nurses, we inherently recognize the need for education – both initially as well as ongoing. Courses such as TNCC, ENPC, and CTAS that are NENA-driven are included here, as well as our orientation packages. Within this section there has also been significant discussion surrounding degree-based education and new graduates beginning in critical care areas.

N – Nursing Practice

NENA supports safe, competent, and responsible nursing practice through standards of care, position statements and guidelines.

A – Affiliations

Who do we need to work with to provide optimal patient care? Not only those colleagues who are present in our day-to-day practice, but also the decision-makers, policymakers, and groups that are looking at disaster planning,

injury prevention, etc. For example, paramedics, police, physicians, trauma groups, national emergency response teams and the Canadian Nursing Association.

I – Innovations in Research

Nursing-initiated research within the emergency field is supported financially annually by NENA through an annual grant.


N- New Initiatives

Emergency nursing is an ever-changing profession in an ever-changing practice environment. What are new ways of providing support to emergency nurses?

C – Communication

What communication tools do we currently use – website and **Outlook**; can we improve on these? Are they effective? Is there another means of communication that we can be utilizing?

As I said, this is but an outline of a year's worth of work. Please take the time to provide some feedback.

“Change – The most powerful waves begin as a single drop.” 

Tanya Penney, RN, BScN, ENC(C)
NENA President


From the editor



Fall is an interesting word for this time of year. It is during this time that many of us “fall” back into our “business as usual” routines, with kids returning to school,

summer vacation finished, and the return of regular rotations and wind-up of summer hours. It is also the time that

we can “fall” into the humdrum that the anticipation of long winter months often brings. But fall is also a season in which we are surrounded by beautiful tapestries and amazing palettes. Fall brings a sense of renewal and anticipation of what the future holds. Fall is often a time of change and forward momentum after a summer lull. It is in this spirit that this edition of **Outlook** is published. Herein you will find a collection of interesting articles that highlight various new initiatives and adven-

tures in the various populations we serve. There is also the call for nominations for the positions of president-elect and communication officer, and I would highly encourage everyone to think about embracing the opportunity that either of these positions presents. Take this time to not “fall” back to the routines of the past, but rather reach out to new experiences in the future. 

Colleen Brayman, RN, BScN
Communication Officer

Highlights from the Spring 2007 Board of Directors' and Annual General Meeting

NENA Highlights


- BOD has created a new strategic plan.
- BOD looking at initiatives to increase the exposure of NENA and, thereby, increase membership.
- Website continues to expand and be interactive.
- NENA is maintaining liaisons with several groups such as CAEP, CEEP and PHAC, and is actively participating in emergency preparedness.
- NENA is increasing its exposure internationally through a collaborative relationship with ENA in the U.S.
- NENA is being recognized further from home with the NENA President having given two presentations this March at the International Emergency Nurses Congress in Seville, Spain.
- Having met with Canada's federal Health Minister a year ago, the NENA BOD is committed to inviting him to meet annually with NENA, so that, together we may address the issues and concerns of Canada's emergency nurses.

Board meeting observer policy

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

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

Observer policy

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

NENA
Policies & Procedures
5 . 6 . 0

- NENA is continuing to actively support Canada's rural and remote nurses as they struggle with many issues and challenges surrounding the potential delay or deferral of CTAS level 5 patients away from the EDs.
- NENA has sent a letter of support to Saskatchewan's Justice Minister and Attorney General for their province's recent enactment of the Bill regarding mandatory reporting to police of GSW and stab wound victims in the EDs.
- NENA is proud to have been one of the five groups making up the CTAS National Working Group on the long-awaited rollout of the combined adult and pediatric CTAS program across Canada.
- At the meetings, the board awarded Dale Roberts, NENA Industry Rep, a plaque of appreciation as he completed his term of service to NENA in this valuable role. The board has welcomed Debbie Seminovich of Edmonton to the two-year term as NENA Industry Representative. D. Seminovich was introduced.

NCAC

- K. Latoszek was appointed to chair of NCAC for another term.

TNCC

- TNCC is entering the first step of a two-step rollout process.
- First step – roll out the new course to the U.S. instructors in three update sessions from May through June.

- Second step – to update all international instructors. This process will be starting in October 2007, and we have until October 2008 to complete this process across the country.
- NCAC will be provided with seven copies of the DVD and other related materials. ENA has asked that the chair of NCAC review the DVD and materials first, then relay any questions either with a conference call or communicate via e-mail to clear them up. Once done, chair will be able to update the six committee members with their information. This would qualify them to update the balance of instructors in their areas. This will still ensure consistency across the updates.
- The current course can be taught until April 1, 2008. All TNCC course directors are encouraged to use up all current 5th edition TNCC provider manuals and order only as needed for any upcoming courses. *Please note*

that only the revised course materials will be available from ENA after April 30, 2008.

- Chair compiled NCAC feedback on all chapters and sent back to ENA, who were to send feedback to the TNCC Revision Workgroup for consideration.
- NCAC did revise the Canadian content of the Biomechanics/Mechanism of Injury chapter, but has not seen the final draft before it went to print.
- TNCC number of students from April 1, 2006, to March 31, 2007, is 1,097.
- TNCC number of instructors from April 1, 2006, to March 31, 2007, is 231.

ENPC

- ENA sent an e-mail on February 22, 2007, that the PALS renewal process is no longer an option with ENPC.
- ENPC courses in Nunavut have been facilitated by the team of instructors from Manitoba.

- French translation of exam is complete and NENA and ENA have documents.
- Working with McGill School of Translation to do slides, which are in the process of completion.
- 2007 current ENPC instructors are 116.
- ENPC number of students from April 1, 2006, to March 31, 2007, is 429.

CATN II

- Course directors now in British Columbia, Alberta and Ontario.
- Indirect fee for NENA back into effect July 2007.
- Canada has conducted more CATN courses this year than U.S. *219 students were taught.
- Working to take CATN into Montreal with Ontario instructors and Alberta.
- Have now done three national conferences.

Bursary and Awards of Excellence

Bursaries:

Manitoba – Jan Kozubal

Newfoundland & Labrador –

Joanne Collins

Board of Directors – Bonnie Briere

Award of Excellence:

Award of Excellence recipient for Excellence in Nursing Practice for 2006 was awarded to Edwina Campbell of Prince Edward Island.


Award of Excellence recipient for Excellence in Nursing Administration 2006 was awarded to Helen Grimm from Saskatchewan.

Elections:

Janet Calnan: Secretary

Jerry Bell: Treasurer

Tanya Penney: Incoming president was installed.

Next Annual General Meeting of NENA Inc. will be held in Banff, Alberta, May 8, 2008. 



The NENA Board of Directors develops its new strategic plan at the Spring 2007 meeting in St. John's, Newfoundland.

Calling all instructors

If your students have put their work into a presentation, a case study, a disease process, research, etc., 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
e-mail: communicationofficer@nena.ca

Canadian Association of Emergency Physicians and National Emergency Nurses' Affiliation commend report recognizing emergency department overcrowding as significant problem in Canada

The Canadian Association of Emergency Physicians (CAEP) and the National Emergency Nurses' Affiliation (NENA) welcome new research on emergency department overcrowding released by the Canadian Agency for Drugs and Technologies in Health (CADTH), an independent, not-for-profit organization that provides evidence-based information about health technologies. CAEP and NENA commend the report for recognizing that emergency department overcrowding continues to be a frequent and significant problem across Canada.

According to a survey of emergency department directors across the country, 85% state that a lack of beds was a major or serious cause of overcrowding and more than half say that it increases the risk of poor patient outcomes.

CAEP and NENA concur with the report's finding that emergency department (ED) overcrowding is a "system-wide problem with multiple causes". They go on to emphasize that the principal cause of overcrowding and wait times in emergency departments is the lack of beds on hospital wards and in intensive care units.

"Adding bed capacity is the key to addressing overcrowding and wait times in emergency departments," says Alan Drummond, emergency physician and spokesperson for CAEP. "14 million Canadians visit emergency departments every year and timely access to medical care is of great concern to our patients. Overcrowding can be solved, but it requires looking beyond the emergency department to a system-wide solution and to increasing acute care hospital beds and adopting appropriate bed utilization strategies."

Drummond explains that Canada has seen a 40% decrease in overall hospital bed capacity due to government funding cuts over the last 10 years. Furthermore, it is estimated that of the remaining hospital beds, 10% are occupied by patients who would be better served in nursing homes, convalescent care or at home with appropriate community supports. Hospital and bed closures, coupled with an aging and increasingly complex patient population have created an overcrowding crisis in emergency departments across the country. International studies show that emergency department overcrowding rarely occurs when bed occupancy rates approach 85%, but consistently occurs when occupancy is greater than 90%. Most hospitals in Canada currently operate on 95% bed occupancy rates.

"All Canadians are entitled to a high standard of emergency health care and it is imperative that this issue become an immediate priority for our federal government," says Janice Spivey, President, National Emergency Nurses' Affiliation. "The Canadian health care system cannot continue in its present overcrowded state and system-wide interventions are needed now."

Spivey adds that bed capacity throughout the system must be increased to assist with the emergency department backlogs. Coverage by support services must also be expanded in order to facilitate acceptable patient flow through the health care system and attention must be directed towards the achievement of safe staffing levels across Canada.


As a first step to addressing the overcrowding issue in emergency departments, CAEP and NENA are calling for governments and health care providers to work together to establish a

framework of definitions, standards and measurable indicators that will be critical to implementing an overcrowding reduction strategy. It is also critical that ED overcrowding be integrated into provincial and federal wait time reduction strategies being addressed through the 10-year accord on health care in order to restore patients' confidence in Canada's health care system.

About CAEP

The Canadian Association of Emergency Physicians (CAEP) is a national advocacy and professional development organization representing 1,750 of Canada's emergency physicians. CAEP's mission is to provide leadership in emergency health care with a goal to enhance the health and safety of all Canadians.

About NENA

The National Emergency Nurses' Affiliation represents 912 members across Canada and believes that all individuals have the right to quality health care. Its mission is to represent the emergency nursing specialty in Canada and to enhance wellness, health promotion and injury prevention. 

For more information, please contact:

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



Report to: Board of Directors – NENA
Date: November 9, 2006
From: Sharron Lyons – Emergency Nurses’ Group of British Columbia

Centre for Excellence in Emergency Preparedness – Pediatric Disaster Working Group

In the spring of 2006, Janice Spivey asked me to sit on the Pediatric Disaster Working Group on behalf of NENA. In July 2006, a telephone conference call was held and work began on a tool designed with pediatrics in mind. Following is a brief report. For more information on CEEP, go to www.ceep.ca.

Committee members: A. Karwowska, H. Sandvik, S. Lyons, M. Salvadori, D. Kollek, D. Hutton, J. Marrone, G. Neto


Overview: The Centre for Excellence in Emergency Preparedness (CEEP) is a non-profit organization whose main goal is to facilitate and maintain optimal Canadian health emergency preparedness by providing expert consensus based on evidence and best practice. This includes development of a series of tools for responders at all levels to help prepare them for a disaster situation. Throughout recent conferences and in speaking with colleagues, CEEP realized that the pediatric population was an “orphan group” in disaster planning, as well as one of the harder groups to adapt tools for because of such specific needs. In realizing this, Dr. Kollek sought out professional help from those participating in the working group to come together and look at how we can define a tool or syllabus for health care facilities that will be specific to pediatric disaster planning.

Format and content of tool:

- Tool will need to be used at various levels of health care.

- It will need to be easy to understand, comprehensive and detailed.
- Should be in checklist format.
- Pediatrics will need to be defined by age (Dr. Kollek suggested 16 years as cut-off).
- Protocols for pediatric disaster treatment areas, design on space set-up and how to secure and temperature-control this space.
- Guidelines for who would supervise these treatment areas.
- Bare-bone needs for pediatrics patients’ care: basic pediatric assessment skills (suggested all emergency departments have ENPC), IV skills, psychosocial support, APLS course.
- A list or network of specialists from across Canada will be required, i.e. pediatric ID, nephrologist, cardiac, etc.

Closing remarks

- This project may incur costs and the committee will seek means to cover the funding needed to achieve our goals.
- Other expertise will be approached to join the group, i.e.: pediatric triage, public health, EMS, psychology.
- The next meeting will take place in the fall and, hopefully, a face-to-face meeting in 2007. 

Bursaries and Award of Excellence

Bursaries

Manitoba — Jan Kozubal
 Newfoundland/Labrador — Joanne Collins
 Board of Directors — Bonnie Briere

A special congratulations to



Award of Excellence for Excellence in Nursing Practice for 2006 was awarded to Edwina Campbell of Prince Edward Island.



Award of Excellence for Excellence in Nursing Administration for 2006 was awarded to Helen Grimm from Saskatchewan.


the Award of Excellence winners

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 Banff, AB. 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 a completed nomination and curriculum vitae to Sharron Lyons. 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 Banff, AB. 

Outlook

Nomination Form

NENA executive position

Positions:

- Communication Officer
- President-elect

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

_____ for the position of

_____ on the NENA executive.

_____ (nominee) is in good standing with NENA.

1. Name: _____

Date: _____

Signature of nominator: _____

2. Name: _____

Date: _____

Signature of nominator: _____

I, _____, do hereby accept this nomination for the position of

_____ on the NENA executive.

Signature: _____

Date: _____

**Please return this letter of intent and CV, by April 15, 2008, to:
Sharron Lyons, #308, 7171 121 St.
Surrey, BC V3W 1G9
e-mail: nominations@nena.ca**



outlook

Bouquets

✿ The following NENA members have served the emergency nurses of their respective provinces and all of Canada in their roles as provincial directors on the NENA board of directors: Tracey Norris, P.E.I., Cavell Bolger, Newfoundland and Labrador, Alison Duncan, New Brunswick, Ted Sellers, Ontario, and Bonnie Briere, Saskatchewan. They should be commended for their generous donations of immeasurable time, assorted talents and much hard work during their terms of office. While the NENA membership extends its sincere gratitude to these dedicated professionals, the NENA BOD is honoured to have had the privilege of working and serving with each of them. We wish them many future successes as they move on to other challenges.

Janice Spivey **NENA Past-President**

✿ On behalf of the emergency nurses across Canada, we would like to thank Jan Spivey for her absolute dedication to her position as president of NENA. She donated immense amounts of time and energy to numerous individuals, groups and organizations across Canada, the United States and internationally while in her position. She will continue to represent emergency nurses across Canada in her new role as past-president.

Tanya Penney **NENA President**

✿ **Mr. Frank Stramaglia, Product Manager TNKase,**
Ischemia & Vascular Access Business Unit, Hoffmann-La Roche Limited,
2455 Meadowpine Blvd., Mississauga, ON L5N 5L7

Dear Frank,

On behalf of the National Emergency Nurses' Affiliation (NENA Inc.), I would like to express our sincere appreciation to Hoffmann-La Roche for your April 20, 2007, cheque in the amount of \$15,000.00 payable to the NENA 2008 Conference. The ongoing and generous financial support of the national NENA conferences by Hoffmann-La Roche facilitates the provision of exciting educational opportunities for all of Canada's emergency nurses.

NENA is fortunate to continuously partner with our lead conference sponsor, Hoffmann-La Roche in the creation of high quality annual professional events. We look forward to an ongoing, mutually beneficial partnership.

Yours sincerely,

Janice Spivey, RN, ENC(C), CEN, NENA Past-President
112 Old River Road, RR2, Mallorytown, ON K0E 1R0



outlook

Conference watch

The 2007 Canadian Injury Prevention and Safety Promotion Conference, **"Evidence to Action: Injury, Violence and Suicide Prevention"**

November 11-13, 2007, at Westin Harbour Castle, Toronto, ON. Website for more information:

www.injurypreventionconference.ca, Conference Chairperson: Shelley Callaghan at purpledog@sympatico.ca

NENA National Conference 2008

May 8-10, 2008 at Banff Park Lodge, Banff, Alberta. Website for more information: www.nena.ca,

Conference Chairperson: Carole Rush at carole.rush@calgaryhealthregion.ca

NENA National Conference 2009

April 30-May 2, 2009 at the Delta Winnipeg, Winnipeg, Manitoba. Website for more information: www.nena.ca,

Conference Chairperson: Irene Osinchuk at iosinchuk@hsc.mb.ca



NENA

National Conference

May 8-10, 2008

Emergency Nursing, No Mountain Too High

Where:

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Banff, Alberta

www.banffparklodge.com

When:

Pre-Conference Educational Sessions

May 6-7, 2008

Conference

May 8-10, 2008

Check the NENA website at www.nena.ca for continuing updates about the conference

Conference Chairperson: Carole Rush
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EDNA of Manitoba will be hosting
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April 30–May 2, 2009
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When:

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April 30–May 2, 2009

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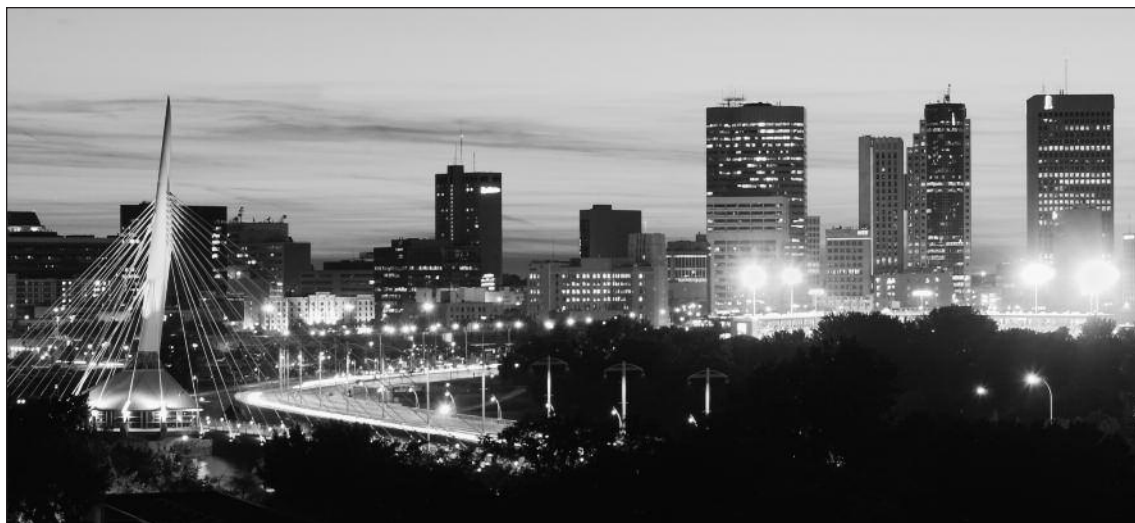


Photo courtesy of Destination Winnipeg Inc./Ken Miner Photography


What do you say to the parent of a crying baby?

By Marilyn Barr

Many new parents and caregivers feel that a crying baby means they are doing something wrong. Understanding early infant crying, especially inconsolable crying, as a normal and healthy part of infancy can greatly reduce the stress in anyone who cares for a child.

Prevent SBS British Columbia is set to begin a province-wide prevention campaign for shaken baby syndrome called the **Period of PURPLE Crying®**. This program was developed by Ronald G. Barr, MDCM, FRCPC, and the National Center on Shaken Baby Syndrome, USA.

From more than 25 years of research, Dr. Barr and other scientists have concluded that early infant crying, including inconsolable crying or colic is a normal part of early infant development. More recent research has also shown that the frustration over this early infant crying is the main trigger for shaken baby syndrome. This link provides the opportunity to educate parents about the normal characteristics of infant crying and the danger of shaking a baby. The prevention program will be implemented in maternity hospitals and community health units throughout B.C. The 10-minute DVD and 11-page booklet are to be distributed free of charge to all new parents during their hospital stay.

So, what can you tell a frustrated parent who comes to the emergency room? Let them know that it's okay to be frustrated with a crying baby. That it's not their fault, and they did the right thing to come and get their infant checked. That all babies cry and need to be comforted but, if a parent has done everything they can, it's always an option to put the baby down in a safe place and walk away for a few minutes to calm down. No baby has ever died from crying, but hundreds are injured every year when a caregiver gets frustrated and lashes out violently. Parents and caregivers need to know and understand the dangers of shaking a baby and how this abuse usually occurs out of frustration over early infant crying. If the baby is healthy and growing, then he/she is probably just going through the **Period of PURPLE Crying®**. It will come to an end and your baby will be fine, there is nothing you are doing wrong, or that your baby is doing wrong. It's just normal. 

About the author

Marilyn Barr is the Director of Prevent SBS British Columbia and also the Founder and Executive Director of the National Center on Shaken Baby Syndrome, USA.



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New rules boost children's safety

**Ministry of Children and Family Development
Ministry of Public Safety and Solicitor General**

B.C. children will be better protected in the event of a motor vehicle crash with changes to child passenger safety regulations that make booster seats mandatory, said Linda Reid, Minister of State for Childcare, and Iain Black, MLA for Port Moody-Westwood.

"When children are put in adult seatbelts too soon, they are at much greater risk during crashes," said Reid. "This regulation change, combined with an increased booster seat awareness campaign, will reduce injuries and save lives."

Starting July 1 next year, booster seats will be mandatory for all children at least 40 pounds until they are 4'9" tall or age nine. Other changes to Motor Vehicle Act regulations dealing with child restraints include: children over one year old and between 20-40 pounds will need to be secured in a child seat, regardless of who is driving the vehicle; and infant seats must be used until the baby is at least one year of age and 20 pounds. The seat must also be rear facing and not placed in front of an active frontal airbag.

"New rules were needed because B.C.'s laws around child restraints are 22 years old and out of step with current research," said Black. "Booster seats reduce the risk of fatality by 71 per cent and the risk of serious injury by 67 per cent. It only makes sense to make these changes on behalf of all B.C. children."

Black has worked over the past year with the Ministry of Public Safety and Solicitor General to make amendments to child restraint laws, including holding extensive consultations with parents and other stakeholders.

Additional changes to MVA regulations also remove a number of exemptions. All drivers, not just the child's parents or guardians, will now have to use child restraints, as will drivers of rental vehicles, out-of-province vehicles and passenger vans. Failure to comply with these new regulations will result in a \$109 fine.

"Car crashes are the leading cause of injury and death for children in B.C.," said Solicitor General John Les. "An average of 860 children aged 5-9 are seriously injured every year and five are killed. Yet, currently only about 18 per cent of kids in B.C. use booster seats. We're making changes to enhance booster seat use because, quite simply, it is the responsible thing to do."

To create awareness and increase booster seat use in B.C., the government has also announced that the British Columbia Automobile Association Traffic Safety Foundation will receive a \$250,000 one-time grant to support its Provincial Booster Seat Public Education Strategy.


"Booster seats save lives," said Allan Lamb, executive director for BCAA TSF. "This new funding will improve our ability to get the message out to all parents in B.C. about the regulation change and the importance of booster seats."

Currently, Ontario, Quebec and Nova Scotia and 39 states in the U.S. all have booster seat laws.

Media contact: Cindy Rose

*B.C. Ministry of Public Safety and Solicitor General
250 356-6961*

*Karen Murry,
Ministry of Children and Family Development
250 356-1639*

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Awards of Excellence

Do you have an idol? Someone who helped you through that long day, evening, or night shift in ER? Well, NENA wants to hear about them! NENA is looking for nominations for Awards of Excellence in emergency nursing. There is no limit to the number of awards that are awarded in four categories: Emergency Nursing Practice, Emergency Nursing Research, Emergency Nursing Administration, and Emergency Nursing Education.

Case study — Traumatic amputation

By Elizabeth Brennan, RN, BScN, Trauma Nurse, Abigail Hain, RN, MScN, CNCC(C), ICU Nurse Educator, Alanna Keenan, RN, MScN, Trauma APN, Jo-Anne O'Brien, RN, MScN, ENC(C), Trauma Coordinator, and Laura Wilding, RN, BScN, ENC(C), Injury Prevention Coordinator, The Ottawa Hospital, Civic Campus

Introduction

At approximately 2200h, on a summer evening, EMS received a call to respond to a motorcycle crash. Jim (pseudonym used), a 52-year-old motorcycle driver, was T-boned by a truck at highway speed. At the scene he was found supine on the grass, in no respiratory distress and GCS of 15. His left leg was mangled with a complete above-the-knee amputation and a laceration in the left femoral region. He was complaining of severe pain 10/10. The paramedics arrived on the scene and established their priorities: airway, breathing, circulation, and external hemorrhage control. Paramedics then applied large pressure dressings to the open wounds in an attempt to control bleeding from the amputated limb. Two large bore IVs were started and Jim was transported by land ambulance to the emergency department (ED) of a community hospital. The amputated limb was placed in a blanket at the scene and transported with the patient.

Case progression — Community emergency department

Fifty minutes post-injury, Jim arrived at the community hospital. His initial assessment revealed: A) airway patent, B) breathing spontaneously, but moderately distressed, C) pale, traumatic amputation left leg, vital signs: BP 84/60, HR 150, RR 23, and oxygen saturation 100% on supplemental oxygen, and D) GCS 15. Three litres of normal saline and eight units of uncrossed matched blood were rapidly administered as well as tetanus toxoid, Ancef and analgesia. Once stabilized, Jim was transferred to the regional trauma centre for definitive care.

Case progression — Arrival at the regional trauma centre

Two hours post-injury, Jim arrived in the ED of the regional trauma centre. Initial assessment revealed: A/B) RR 44, decreased air entry, C) systolic BP never greater than 80

mmHg, and D) increasing agitation. Therefore, Jim was intubated. In an effort to control bleeding from the left stump, orthopedics applied an auto tourniquet at 245 mmHg. Cuff pressure requires a physician order and needs to be high enough to completely suppress arterial circulation and control hemorrhage, yet low enough to minimize the risk of neuromuscular injury. Volume was administered in the ED using crystalloid, Pentaspan and blood products (see Table One). When transfusing units of PRBC it is critically important to also administer coagulation products to maintain the balance of plasma, proteins and coagulation factors. In addition, Recombinant Factor VII a (rFVIIa), Phenylephrine, and Calcium Gluconate were administered to control bleeding, increase BP and replace electrolytes depleted due to large amounts of blood transfusion. The left leg was stabilized with a Thomas Splint. Jim remained hemodynamically unstable throughout his ED stay despite indication of responsiveness to treatment (BP 110/60 and HR 110).

Hypothermia in trauma

Jim was admitted to ED with a temperature of 35.6°C, which remained low post-op (35.8°C), despite the Level 1 fluid warmer and blanket warmers. Hypothermia is defined as a core temperature from 35°C (mild) to below 32°C (severe). Jurkovich, Gresser, Luterman, and Curreri (1987) identified that up to 50% of trauma patients are hypothermic, which contributes significantly to morbidity and mortality, and that patients with temperatures less than 32°C are unlikely to survive. Hypothermia initially delays clotting factor activity, which contributes to prolonged clotting times and subsequent prolonged bleeding times (Watts, Trask, Soeken, Perdue, Dols, & Kaufmann, 1998; Cochrane, 2001). Persistent hypothermia can also contribute to increased platelet clumping potentiating the risk for consumptive coagulopathy and subsequent hemorrhage.

Both the ED resuscitation and the OR may increase the severity of the hypothermia. Trauma nurses must be vigilant in monitoring vital signs and ensuring that patients are kept warm. Inadequate tissue perfusion may prolong hypothermia, as an increase in metabolic heat production may be impossible during traumatic shock. Interventions such as administration of sedation and anesthesia will decrease the patient's metabolic rate, resulting in decreased heat

production and a lower core temperature. Anesthesia eliminates all shivering reactions, however, the body relies on shivering to increase heat production by up to five times normal. Anesthetic agents may also cause vasodilation, which will increase heat loss. Environmental interventions must be optimized to prevent hypothermia.

Case progression — To the OR

Jim remained hemodynamically unstable and hypoperfused when transferred to the OR, despite aggressive management of his hypovolemic shock. Upon arrival at the OR, the vascular team noted a large expanding left groin hematoma and became suspicious that the patient's continuing hemodynamic instability was related to an arterial bleed in the left femoral artery. Surgery was postponed in favour of a CT scan. In CT scan, the team continued to aggressively fluid resuscitate Jim for ongoing bleeding and hypotension. Despite additional blood product and crystalloid infusion (see Table One), Jim remained tachycardic (HR 120) and hypotensive (BP 80/60).

Traditional assessment in hypovolemic shock

Valuable assessment parameters available to the RN caring for a patient who is in profound hypovolemic shock include HR, BP (including pulse pressure), urine output, the patient's general colour, capillary refill and level of consciousness (LOC).

Tachycardia is the first sign of hypotension in hemorrhagic shock. Sympathetic stimulation will increase the heart rate to compensate for a decrease in stroke volume (the volume of blood ejected with each beat of the heart). Keep in mind that cardiac output (CO) = HR (heart rate) × SV (stroke volume). In early hypovolemia, the increased heart rate will be sufficient to maintain the cardiac output within normal limits. In hypovolemic shock, up to 30% of total blood volume can be lost before hemorrhage becomes clinically evident (American College of Surgeons Committee on Trauma, 2004). It is critical that aggressive fluid resuscitation be initiated with tachycardia. Delaying fluid resuscitation until the patient becomes hypotensive may mean they have lost a significant volume of blood and that end organ perfusion may be severely compromised before resuscitation is begun.

Decreased blood volume in hypotensive shock causes decreased circulation to the organs, and will result in diminished organ function. A decrease in urine output is one of the early signs of hypovolemic shock, as perfusion to the kidney is quickly reduced in order to preserve blood flow to the brain and other vital organs. A decrease in LOC and agitation can also be ominous signs of hypoperfusion. This may indicate inadequate cerebral perfusion and subsequent hypoxia to brain cells, despite the body's attempt to shunt blood to the brain. Jim had been intubated on arrival to the ED due to increasing agitation, decreased air entry and tachypnea. It is recommended that all patients with severe traumatic injury be intubated prior to transfer from the community hospital, as their status can quickly deteriorate en route (American College of Surgeons Committee on Trauma, 2004).

Jim's narrowed pulse pressure of 20 mmHg is a cardinal sign of ongoing hypovolemic shock (McQuillan, Von Rueden, Hartsock, Flynn, & Whalen, 2002). In the hypovolemic patient, pulse pressure (systolic BP minus diastolic BP) will narrow to below the normal of 40 mmHg, as sympathetic compensatory mechanisms vasoconstrict blood vessels to maintain the diastolic pressure. This mechanism acts to increase diastolic pressure which, in turn, increases venous return, and produces an increased preload to the right side of the heart. The increased volume of blood returning to the heart will increase cardiac output, resulting in a clinically improved blood pressure (McQuillan et al.)

Perfusion deficit in hypovolemic shock

Porter and Ivatury (1998) emphasize that compensated shock can persist after the clinical signs of uncompensated shock have been corrected. In other words, a patient's vital signs and pulse pressure may return to a near normal state following resuscitation, but sympathetic compensation masks ongoing tissue hypoperfusion.

Additional assessment parameters that reflect tissue perfusion also include acid base status, including base deficit, lactate and ScVO₂ ((American College of Surgeons Committee on Trauma, 2004; Barquist, Pizzutiello, Burke, & Bessey, 2002; Shulman, 2002). The trauma RN should ensure all hemodynamically unstable trauma patients have an arterial line initiated in ED. This will allow for easy access to blood taking and will simultaneously allow for direct, continuous monitoring of the patient's systolic, diastolic and mean blood pressure values.

Table One – Crystalloid/plasma expander/colloid and blood product utilization						
Fluids	Pre-hospital	ED	CT	OR	ICU	Total
Crystalloid	2L	4 L	2L	4L	8L	20L
Pentaspán		2 L				2L
PRBC	8U	7 U	6 U	14U	8U	43U
FFP		5U		5U	7U	12U
Platelets				5U	5U	10U
Cryoprecipitate					5U	5U

Prior to transfer to the OR, Jim's hemodynamic status had improved noticeably (BP 110/60 and HR 110). However, his acid base status demonstrated he remained seriously hypoperfused, and in a state of metabolic acidosis:

PH 7.08 CO₂ 34 O₂ 500 HCO₃ 10 base deficit -19

Metabolic acidosis is common in hypovolemic shock as a result of inadequate tissue perfusion and anerobic metabolism. Severe refractory metabolic acidosis usually reflects inadequate resuscitation from long-standing shock or ongoing bleeding (American College of Surgeons Committee on Trauma, 2004). Base deficit may be useful in determining the severity of the acute perfusion deficit and can be used as an approximation of global tissue hypoperfusion. The severity of the base deficit has been correlated with the adequacy of fluid and blood resuscitation and mortality in trauma (Porter & Ivatury, 1998; Barquist et al., 2002). Rutherford et al. (1992) found that a base deficit of -15mmol/L or greater in a hemorrhagic trauma patient is associated with significantly increased mortality.

Lactate is a byproduct of anaerobic glycolysis and can also be useful in the assessment of global perfusion in hemorrhage (Abramson, Scalea, Hitchcock, Trooskin, Henry, & Greenspan, 1993). A normal lactate level is 2mmol/L or less. When a patient is hypoperfused, oxygenation to tissues is inadequate. This lack of oxygen requires energy (ATP) to be produced by anaerobic metabolism, which results in the production of lactic acid (lactate). Increased levels of lactate may indicate insufficient oxygenation due to hypoperfusion. Scalea et al. (1994) found that 80% of multisystem trauma patients in their study had elevated serum lactate levels and decreased mixed venous oxygen saturation despite normal HR, BP and urine output.

Case progression – In the OR

CT revealed left common femoral vein and left distal profound femoral artery injuries, which were ligated in the OR. A hematoma was evacuated and a hemovac drain was placed. The surgical team also revised the above-knee amputation.

In the OR, Jim's blood work revealed a prolonged clotting time: INR 3, PTT 39 and Hgb 82. Jim also had a critically elevated potassium level of 6.2 mmol/L, leaving him vulnerable to lethal cardiac arrhythmias. This elevation in serum potassium was likely a reflection of two physiologic responses: tissue damage and metabolic acidosis. With traumatic injury to skeletal muscle, the muscle breaks down, and potassium is released into the bloodstream, resulting in increased serum levels. In metabolic acidosis, an increase in hydrogen ions causes the ions to move into the cells. In a compensatory movement, potassium, the body's main intracellular cation, will move out of the cell to try to maintain the polarity of the intracellular fluid which, in turn, elevates serum potassium levels. Jim was given 10

units of humulin regular insulin as well as a bolus of 50% Dextrose and then started on an infusion of D5W. The insulin causes glucose to move into the cell and it will pull some of the serum K with it, dropping the critical serum K level and removing the risk of arrhythmia from hyperkalemia. Active resuscitation continued in the OR as Jim received further blood product, crystalloid and rFVIIa (see Table One).

Case progression – To the ICU

Jim's hemodynamic status deteriorated immediately post-op on his arrival to the ICU. His admission vital signs demonstrated uncompensated hypovolemic shock: HR 130, BP 75/50, pulse pressure of 25mmHg and a temp of 35.8. His ABGs (PH 7.33, CO₂ 45, O₂ 220, HCO₃ 22, base deficit -2.3, and lactate 6 mmol/L) reflected an improved perfusion status in comparison to his pre-OR status. However, his sustained hypotension and Hgb of 39, INR 1.7, PTT 87, as well as overt signs of bleeding from his stump and operative site demanded immediate fluid and blood resuscitation by the ICU team. Orthopedics was called stat and the surgical team attempted exploration of the bleeding site in the ICU. The level 1 fluid warmer was deployed to transfuse additional crystalloid and colloid products while cryoprecipitate and platelets were also given through a separate line (these products should not be warmed when transfused [The Ottawa Hospital, 2002]). A third dose of rFVIIa, Factor X and transemic acid were added to the resuscitation. Phenylephrine was infused briefly when the team was unable to detect a blood pressure. Vasopressors are not routinely recommended for the hypovolemic patient as they may worsen perfusion (American College of Surgeons Committee on Trauma, 2004), however, when optimal fluid resuscitation is insufficient to maintain cardiac output, vasopressors may be used temporarily.

Forty-five minutes after his arrival in ICU, Jim was transferred back to the OR for exploration of the femoral artery and vein. The vessels were noted to be boggy, oozing, and were subsequently ligated. Before returning to the OR, ABG samples taken in the ICU provided evidence of worsening tissue perfusion: PH 7.31, CO₂ 45, O₂ 220, HCO₃ 22, and base deficit -3.7. The worsening base deficit and the lower PH indicate tissue hypoperfusion despite administration of fluids, blood products, clotting factors and vasopressors. This change in base deficit, which occurred over the 45-minute resuscitation in ICU, demonstrates the usefulness of trending a base deficit in conjunction with vital signs and urine output in the hemorrhagic patient.

Coagulopathy in trauma

Exsanguination accounts for 38% of all hospitalized deaths of trauma patients (Sauaia, Moore, Moore, Moser, Brennan, Read, & Pons, 1995), and is the second leading cause of mortality in trauma (second only to head injury). Many trauma patients threatened by hemorrhagic shock and exsanguination develop some degree of coagulopathy due to

large amount of fluids, hypothermia, acidosis and multi-transfusion syndrome (Martinowitz, Holcomb, Pusatein, Stein, Onaca, Friedman, Macaitis, et al., 2001). Coagulopathy is defined as the inability to establish hemostasis with resultant excessive bleeding. Coagulopathy coupled with acidosis and hypothermia, often referred to as the lethal triad, significantly increases the risk of mortality in the hemorrhagic trauma patient (Mikhail, 1999).

Hemostasis in bleeding is achieved by the activation of a complex clotting cascade that comprises the intrinsic (plasma activated) and extrinsic (tissue activated) pathways. Chemical factors are released by damaged tissue and a platelet plug is formed to temporarily seal the hole in the blood vessel. Fibrin is eventually produced and crosslinks to anchor platelets in place to achieve a stable clot (Morton, Fontaine, Hudak, & Gallo, 2005). In massive hemorrhage and subsequent resuscitation, clotting factors may be diluted by massive fluid resuscitation or over-consumption. As well, both acidosis and hypothermia affect platelet function by inhibiting the enzymes that activate platelet aggregation, thus preventing stable clot formation (Mikhail, 1999; Klemcke, Delgado, Holcomb, Ryan, Burke, DeGuzman, et al., 2005; Reiss, 2000).

A promising therapy for hemorrhage in trauma patients has recently emerged — Recombinant Factor rVIIa, which complexes with Tissue Factor in the extrinsic pathway and leads to the activation of fibrin via the common pathway. Boffard et al. (2005) conducted a large multicentre international study of 301 trauma patients with both blunt and penetrating trauma. The amount of red blood cell transfusion was reduced with rFVIIa treatment. Many trauma centres are adding these pharmacological approaches to their management of hemorrhagic shock. Jim received Factor rVIIa in the ED, the OR and in the ICU for ongoing bleeding, as well as Factor X and tranexamic acid in the ICU.

Jim received significant fluid resuscitation in the first 24-hour period post-injury, as illustrated in Table One, as well as Factor X and tranexamic acid in the ICU. Thirty-six hours post-admission hemostasis was obtained. However, Jim continued to have ongoing instability due to complications related to his injuries: acute lung injury and sepsis.

During his stay in the ICU, Jim showed evidence of sepsis and septic shock, which were treated aggressively with fluid, vasopressors, antibiotics and surgical revisions. Jim returned to the OR for incision and drainage of his left thigh stump four times before his discharge from ICU.

Progress towards rehabilitation

Seventeen days post-admission to the ICU, Jim was transferred to the trauma unit. He progressed very well and did not experience any complications. He was subsequently discharged to his community hospital to await healing of his stump prior to admission to the rehabilitation centre.

Unfortunately, because of Jim's initial hemodynamic instability, ongoing bleeding and sepsis, the revisions of his stump resulted in decreased preservation of limb length. The goal in amputation is to optimize stump length for a more ideal prosthesis and improved walking capacity, while maximizing tissue integrity and healing. Jim's prosthesis was optimized and his physical and psychological needs were addressed during rehabilitation. Several months later, Jim returned to visit the staff of the trauma unit, walking independently and ready to face new challenges!

Motorcycle injuries — An ounce of prevention...

Motorcycle sales in Canada have more than tripled in the past few years (Canada Safety Council, 2005). The typical rider in Canada has increased in age (46 years), and they are buying more powerful and expensive machines. With this increase in popularity comes the potential for increased injury. Motorcycles typically offer very little protection for the rider. The fatality rate for motorcycle riders involved in a collision is 34 times greater than for those riding in a car, and the risk of serious injury is about eight times greater (National Highway and Traffic Association's National Centre for Statistics and Analysis, 2005). Other factors that contribute to the risk of injury while riding motorcycles include: speeding, impairment by drugs or alcohol, invalid licensing, and neglecting to wear a helmet. Typical injuries seen are to the head, arms and legs. With this increased risk of injury, there is a clear role for injury prevention.

So, what can you do? The ED may provide a unique opportunity to implement injury prevention information to motorcyclists (Blanchard & Tabloski, 2006), but what can you teach to patients in order to prevent future injury? Here are some important points to cover with your patients:

Get trained: Take a course on how to operate this powerful machine safely. Courses such as The Canadian Safety Council's *Gearing Up* teaches riders how to pick the right bike for their needs, and to learn about speed control, balance and breaking, basic traffic behaviour, urban riding tactics, and emergency driving techniques. Driver education has been shown to reduce injury and collision rates (Savage, 2001).

Drive sober: Alcohol is a factor in nearly one-third of all collisions involving motorcycles (Canada Safety Council, 2005). Motorcycles require more skill and coordination to operate than a car, so even small amounts of drugs or alcohol affect your ability to operate the bike safely.

Wear the gear: Protective clothing and equipment is key. Long-sleeved jacket and pants should be worn and should be made of a strong, durable fabric such as leather. This will offer more comfort when riding and serves to protect against abrasion. Bright colours allow other drivers to see you more readily. Pants should not be flared to avoid getting caught in the gears, foot pegs or starter. Gloves are recommended for all seasons. Proper footwear, such as leather boots, protects the

ankle, foot and lower leg, which are commonly injured in collisions involving motorcycles. Perhaps the most important piece of gear is the helmet. In 1996, 41% of motorcyclists killed in Canada were not wearing a helmet (Canada Safety Council).

Conclusion

Jim's case exemplifies the importance of the trauma care continuum, from pre-injury to rehabilitation, with all health care providers working together to return the patient to optimal family and work life. Trauma nurses are reminded that key assessment parameters beyond the traditional vital signs and pulse pressure measurements, such as acid base status (including base deficit, lactate levels and uses of ScVO₂ monitoring) can lead to the early identification of the under-resuscitated trauma patient. This case review also highlights complications in the trauma population: hypothermia, hypovolemic shock and coagulopathies. Emergency nurses have a key role in the identification and management of these potential complications as early aggressive identification and treatment plays a critical role in the patient's morbidity and significantly impacts their eventual health status. ❏

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The Trauma Nursing Core Course: 21 years and six editions later!

By Carole Rush, RN, MEd, CEN, Member of NENA
National Course Administration Committee (NCAC)

Brief history of the Trauma Nursing Core Course1

The Trauma Nursing Core Course (TNCC) was conceptualized, designed and first disseminated by the Emergency Nurses Association (ENA) in the United States. The membership of ENA expressed a need to the board of directors for a special trauma course for nurses. A National Task Force was formed in 1983 and met for a full year of discussions regarding such a course. The task force did look at other existing trauma courses for nurses, but none were available across the U.S. The Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLD) courses were also examined. The Basic Trauma Life Support (BTLS) course was not widely available at that time and was not examined. The decision was made to go ahead with the development of a new course. Throughout the year of discussions, the task force made some decisions:

- This course would be designed to meet the learning needs of nurses
- A broad-based educational philosophy would be used
- A similar educational model as ATLS with a combination of lectures and skill stations would be used
- ENA had the expertise within the organization to develop the course materials
- The course would be taught by nurses.

A new committee was then formed to write the manual and other materials for the course. A pilot course was conducted in San Antonio, Texas, in spring 1986; the pilot group included nurses who had not been part of either the original course task force or committee.

The first TNCC was held for 64 participants in the fall of 1986 in Hawaii as a combined provider-instructor course. Faculty for the course was the nurses who authored the manual, along with experienced emergency nurse educators who assisted with the skill stations. There were many barriers to course dissemination across the U.S. It took four years for the course to be offered in most states.

The TNCC has a large audience of military nurses and is used as one of the major trauma training programs for both reserve and active duty military nurses.

International dissemination of TNCC to date

Negotiations between ENA and NENA regarding the Canadian dissemination of TNCC were held from 1990 to 1992. The first Canadian TNCC was held in Calgary in October of 1992. Each province was invited to send two nurses who would participate in a combined provider/instructor course, and then go on to disseminate the course to their respective provinces. Not all provinces immediately embraced TNCC but, gradually, the course has been offered in all provinces and territories. A team of TNCC instructors from Manitoba travelled to Nunavut earlier in 2007 to disseminate the TNCC provider course!

As of Fall 2007, TNCC is available in the following countries: United States, Canada, United Kingdom, Australia, Sweden, The Netherlands, Norway, Mexico, South Africa, United Arab Emirates and Portugal. Remember the TNCC provider and instructor status is recognized in these countries should you decide to do international nursing!

Keeping the TNCC current

The Emergency Nurses Association is committed to keeping all their courses current. They try to maintain a schedule of updating each course every five years, although the time needed for content update, focus testing, publishing and course rollouts can alter this schedule. The TNCC fifth edition was published in 2000, so it will be seven years until the sixth edition is available.

TNCC 6th edition changes

With each TNCC revision, the workgroup looks closely at past courses, the current course and receives solicited feedback from TNCC instructors. Course content for both lectures and skill stations is kept current through reviews of the literature and best practice evidence. New case studies are designed for the skill stations. All material has been focus-tested with TNCC instructors in the United States. Members of NENA's NCAC committee were given the opportunity to review revised chapters, provide feedback, and to contribute Canadian injury data where appropriate.

Updated lectures from 5th edition:

- Epidemiology, Biomechanics, and Mechanism of Injury (with new Canadian content)
- Initial Assessment

- Shock
- Brain and Cranial Trauma
- Thoracic Trauma
- Abdominal Trauma
- Musculoskeletal Trauma
- Spinal and Vertebral Column Trauma

New lectures (or new combinations of topics):

- Airway and Ventilation
- Ocular, Maxillofacial and Neck Trauma
- Surface Trauma (combination of wounds and burn care)
- Special Populations (combination of trauma in pregnancy, pediatric trauma and geriatric trauma)
- Transitional Care (combination of stabilization and transport content and new content on the critical care of the trauma patient in the emergency department)
- Disaster Management with Triage Scenarios

Skill stations for the 6th edition:

Testable Skill Stations:

- Trauma Nursing Process (new cases)

Skill stations that are taught but not tested:

- Airway and Ventilation (new cases)
- Spinal Protection, Helmet Removal and Splinting

Rollout of 6th edition of TNCC in the United States

A total of three sessions were held at the ENA Office in Chicago from May through July 2007. Representative instructors from all states were invited to attend one of the sessions and are now in the process of updating all the TNCC instructors in their respective states. One of these sessions was videotaped and will be made available on DVD to other countries to assist with their instructor update process.

Timeline of dissemination of 6th edition to Canada

As NENA has a contract with ENA to disseminate TNCC in Canada, the update process for Canadian TNCC instructors will be conducted through the NENA Course Administration Committee (NCAC). Plans are underway for NCAC to be updated at their biannual meeting November 2-5 in Toronto. NCAC members are to then arrange for update sessions and

order materials for the TNCC instructors in their respective provinces. These update sessions will likely be one day in length. Canadian TNCC instructors have until October 1, 2008, to complete an update session in order to teach the TNCC 6th edition provider course.

The members of NENA NCAC (Table One) will be responsible for facilitating TNCC instructor updates in their respective provinces and territories; these individuals may not necessarily conduct all of the updates, but can be contacted for details of the sessions. Current TNCC instructors may attend an update in any location across Canada.

Continued offering of TNCC 5th edition courses in Canada

Canadian TNCC course directors may decide to continue to offer the TNCC 5th edition provider course if there is the demand for TNCC training before the TNCC 6th edition course is available in their area. ENA will have TNCC 5th edition course materials only until April 30, 2008. There will be no reimbursement for TNCC 5th edition materials; course directors are recommended to call others in their area to use up stock of 5th edition materials before ordering more from the ENA office.

Info for TNCC instructors

For current TNCC instructors in Canada, you will be required to attend an update session, which will likely be one day in length. At this update session, the TNCC 6th edition changes will be reviewed and discussed. All instructors must complete the examination criteria for the TNCC provider 6th edition:

- Achieve 80% or greater on written examination
- Successfully complete the Trauma Nursing Process skill station
- Demonstrate teaching the following stations: Airway and Ventilation, Spinal Immobilization and Helmet Removal

Prices for TNCC 6th edition materials:

Available after October 1, 2007

TNCC Provider manual (6th edition): \$45 U.S. funds plus shipping.

TNCC Instructor’s Supplement (4th edition): \$47.50 U.S. funds plus shipping.

TNCC CD of slides and paperwork and new Trauma Nursing Process DVD: First copy complimentary for Course Directors.

Table One. Members of NENA’s National Course Administration Committee		
Province/Territory	Name of NCAC member	E-mail Address
British Columbia and Yukon	Landon James	lndon.james@shaw.ca
Alberta, N.W.T. and Saskatchewan	Karen Latoszek and Carole Rush	karen.latoszek@capitalhealth.ca carole.rush@calgaryhealthregion.ca
Manitoba and Ontario	Kathy Woloshyn and Louise LeBlanc	kwoloshyn@exchange.hsc.mb.ca lleblanc@tsh.to
Quebec, Nova Scotia, New Brunswick, P.E.I., Newfoundland and Labrador	Debbie Cotton and Pat Walsh	cotton@ns.sympatico.ca PWalsh@cwhc.nl.ca

It has yet to be decided who will pay for the new course materials for current TNCC instructors. Options include the instructor, their employer or the provincial affiliations of NENA. Provinces may decide to bulk-order materials for all their instructors.

Info for instructor trainers

If you run a TNCC 5th edition instructor course, the instructor candidates must be monitored in a 5th edition provider course. So, unless your area has an immediate need for TNCC instructors, it is recommended that you wait to hold a TNCC instructor course until after you have completed your TNCC 6th edition update. You may want to further familiarize yourself with the 6th edition by teaching one provider course before scheduling an instructor course. Participants of your TNCC 6th edition instructor course must first recertify their TNCC provider status to the 6th edition requirements.


Documents available to download from ENA website: www.ena.org, click on TNCC from left-hand side menu:

- TNCC and ENPC Administrative Procedures October 2007 Revision (U.S. document but can be referenced until Canadian equivalent is available)
- TNCC and ENPC Administrative Procedures October 2007 Revision: Explanation of Changes and Clarifications

- Corrections for the TNCC 6th Edition Provider Manual
- List of Equipment for TNCC 6th Edition Provider course skill stations

Info for TNCC providers

If you hold a current TNCC provider card, it will still be valid for four years after your last course. If you need to renew your provider status, you may wish to wait until the TNCC 6th edition course is available in your area.

Canada has enjoyed 15 years of TNCC and looks forward to many more years of this unique course for nurses! 

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Websites for more information

Emergency Nurses Association at www.ena.org

National Emergency Nurses Affiliation at www.nena.ca (information on TNCC 6th edition should be available in December 2007).

Outlook

Rural Realities

An unforgettable experience in Iqaluit

By Erica Battran, RN, BA, ENC(C),
Rhose Q. Galia, RN, BScN, Sean Mattingly,
RN, CEN, EMCA, and Kevin Peters, RN,
The Ottawa Hospital

As we flew over Nunavut descending into Iqaluit our first vision was the vast frozen tundra with small communities dotted randomly. Nunavut has 26 communities spread across nearly two million square kilometres of undeveloped space. Iqaluit is the largest community in Nunavut as well as the capital city. We arrived on an early December afternoon. In December, you can expect five hours of daylight between 1030-1530h. By July, daylight hours will average about 18 or 19 hours/day. The average temperature in December is -25°C during the daytime but, by evening, you can expect it to drop down to -43°C! Despite the extreme temperatures, we were warmly welcomed and Rhose Ghalia, our host, gave us a quick walking tour of the capital city. Although the Arctic capital is home to a diverse mix of people, Inuit make up 60% of Iqaluit's population. Iqaluit is located in the

southeast part of Baffin Island, and was formerly known as Frobisher Bay. Even though it's located on the remote Arctic tundra, Iqaluit aims to be every inch a capital city, with the amenities and quality of life to rival any in Canada. The city has five schools, four hotels, three gas stations, two arenas and a swimming pool. The Iqaluit airport runway is 2,621 metres long and an alternative landing site for the U.S. Space Shuttle! The economy, based mainly on government, has expanded rapidly since the city became the territorial capital in 1999. The city's infrastructure is developing at a steady clip, trying to catch up with population growth, despite the harsh climate and challenges that many of us would consider near impossible. As well as being Canada's newest and most northerly capital, Iqaluit is also Canada's fastest growing community with a population of approximately 7,000 people.

Almost every Nunavut community has a health facility. Iqaluit has a hospital, while other communities have a health centre. The Baffin Regional Hospital in Iqaluit has 34 beds. It has an

adult and a pediatric ward, a combined emergency and outpatient department and is open 24 hours a day. It is a fully functional community hospital. It handles most local health care needs and serves patients brought in from smaller Baffin communities. The hospital is fully equipped to care for all patients. They have a two-bed trauma resuscitation bay complete with fluid warmers and ultrasound and a fully operational pediatric area upstairs. The space constraints and problems of transferring patients to an admitted bed on the floors or critical areas are familiar to all of us in emergency departments across the country and these challenges are no different for the staff at Baffin Regional Hospital. The hospital is located on top of the hill where it has a clear view of the RCMP headquarters, which is right next door to one of the popular bars. Thursday promises to be busy when the shipment of alcoholic beverages comes in and brings alcohol-related excitement!


We travelled to Iqaluit after receiving an invitation to come and instruct The Trauma Nursing Core Course (TNCC) for the first time in Iqaluit. This endeavour was also made possible with the support of the Iqaluit Government and The Ottawa Hospital Trauma Services. The team of instructors was composed of clinical nurses from the Ottawa Hospital Emergency Department. Rhose Galia, an emergency nurse from Baffin General Hospital, initiated our big adventure and was also our local coordinator. She took the lead because she felt many nurses had never had the opportunity to participate in the course before and felt it was important. Unfortunately, opportunities for continuing education and training are few for our northern colleagues.

Half of the nurses who had participated in the course came from communities of 500 to 1,500 people and travelled five to eight hours to come to Iqaluit. All were experienced emergency nurses. These nurses staff the small community health centres and are equipped to treat all emergencies and illnesses. Nurses are on duty at health centres during regular business hours on weekdays and on call for emergencies 24 hours a day. Challenges in the smaller communities include lack of resources and manpower. One of the most striking things that was brought to our attention was the resourcefulness of the registered nurse. Sometimes the care required exceeds the resources of the outpost and its staff, creating an increased urgency for transfer. The nurse may often have to use anything available while waiting for a physician who may be several hours away on a fixed wing. One nurse relayed his experience of having to call in a family member to assist with CPR while he established IV access. Another spoke of the injuries sustained to a patient as a result of an unprovoked polar bear attack. Patients requiring more serious medical attention are flown to Baffin Regional Hospital.

The majority of adult patients requiring tertiary trauma care are referred to The Ottawa Hospital, which is approximately 1,250 air miles south. Baffin Regional Hospital also transfers patients to Montreal and Winnipeg. Injured children are transferred to pediatric trauma centres.

Many of the traumatic injuries seen in Baffin Regional Hospital, such as falls and assaults, are familiar to emergency nurses, but animal maulings (especially polar bears) and hypothermia are some of the unique challenges facing a single nurse at an outpost community health centre. Off-road vehicle injuries are also common. Between February 2006 and February 2007, 50% of patients transferred to The Ottawa Hospital had received injuries related to off-road motorized vehicles. Although cars and trucks are becoming more popular, the typical mode of transportation is snowmobiles in the winter and ATVs in warmer weather. It is typical for snowmobiles to travel on the gravel roads (roads are not paved as the climate is too harsh on asphalt), but seldom did we see passengers (children and adults) wearing helmets. Mothers use their Inuit parka or "Amauti" to carry young infants and babies on their back while driving. At first we assumed that this was an isolated situation, but quickly realized that was not the case. The federal government provides subsidies for each family to purchase a snowmobile, however, helmets are not included in this. The price of a helmet ranges from \$100 to \$500. You can also travel by taxi anywhere in town. The only catch: they pick up other customers as they go, until the cab is often chock-full. Seatbelts are not required if the vehicular speed is under 40 kph!


The TNCC course was hugely successful, in large part because the participants were so enthusiastic. As instructors, we learned as much as we taught. Feedback from participants was that TNCC was long overdue and very applicable to their working situation. It provided them with a standardized approach to trauma care in order to identify life-threatening injuries and initiate care while waiting to access the amenities of a larger community. One of the participants stated that it was "important to understand the restraints of the resources in our world as northern nurses," while another stated the course was "long-awaited and should be available to any emergency nurse or community health nurse working in a northern setting."

Sean, Kevin and I would again like to thank all of the participants because it is thanks to them and their enthusiasm that this course was so successful and our first northern experience such an unforgettable one. We would also like to take this opportunity to thank Rhose for taking the initiative to bring TNCC to the north. We would welcome the opportunity to teach again in the north any time and hold the highest respect for those of you that manage with the demands of an isolated community. 

The effects of emotionally intelligent leadership behaviour on emergency staff nurses' workplace empowerment and organizational commitment

By Carol Young-Ritchie, RN, MScN, ENC(C),
Dr. Heather K. Spence Laschinger, RN, PhD,
Carol Wong, RN, MScN, PhD(candidate)

Abstract

The purpose of this study was to test a model examining the relationships among emergency nurses' perceptions of supervisor emotionally intelligent leadership behaviour, structural empowerment and affective organizational commitment using Kanter's theory of structural power in organizations. The current and projected shortage of nurses challenges health care administrators to consider strategies to enhance retention and recruitment, especially in specialty units particularly vulnerable to turnover. Nurse leader behaviour can have a significant impact in creating quality workplaces for nurses (Canadian Nursing Advisory Committee, 2002). Kanter (1977, 1993) asserts that having access to strong interpersonal relationships, information, support, resources, and opportunities empowers employees to accomplish meaningful work. As a result, employees have greater satisfaction with their work and the organization. A predictive, non-experimental design was used to examine the proposed relationships. A random sample of 300 emergency staff nurses working in acute care hospitals in Ontario was drawn from the provincial registry list. Participants were asked to complete the Emotional Competency Inventory (HayGroup, 2006), the Conditions for Work Effectiveness Questionnaire-II (Laschinger, Finegan, Shamian, & Wilk, 2001) and the Organizational Commitment Questionnaire Affective Subscale (Meyer, Allen, & Smith, 1993). The final sample consisted of 206 nurses (response rate = 73%). Through path analysis, the fully mediated hypothesized model was supported ($\chi^2 = 2.3$, $df = 1$, $CFI = .99$, $IFI = .99$, $RMSEA = .08$) with all paths significant. Perceived emotionally intelligent leadership behaviour had a strong direct effect on structural empowerment ($\beta = .54$) which, in turn, had a strong direct effect on affective commitment ($\beta = .61$). Results of this study provide support for Kanter's theory highlighting the importance of leadership behaviour influencing working conditions for nurses as well as organizational effectiveness. 

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An ambulatory waiting room expedites the processing of CTAS 3 patients in a busy emergency room

By Valerie Potts, RN, BN, Annamarie Fuchs, RN, MN, Brian Lang-Hodge, MD, FRCPC, Randy Junck, MD, FRCPC, Penny Richey, RN, BScN, Debbie Westman, RN, BScN, and Calvin Janzen, RN, BScN, Emergency Department, David Thompson Health Region, Red Deer, Alberta

The Canadian Association of Emergency Physicians and National Emergency Nurses Affiliation (2007) launched a national awareness campaign highlighting that emergency departments throughout Canada are reporting overcrowding and excessive or unreasonable wait times for emergency care. This is placing patients at risk. Many issues related to emergency department overcrowding have external roots that impact the management of the emergency department. The most common setback is a lack of timely access to inpatient beds for admitted patients (CAEP, 2007; NENA, 2003).

At present, at Red Deer Regional Hospital Centre, there is a bed utilization committee working actively on different strategies related to improving access to inpatient beds. This article offers a solution to managing capacity challenges within the emergency department while mitigating the risk with extensive wait times that are seen, particularly with CTAS level 3 patients. Formation of an “ambulatory waiting room” may, in fact, be an innovative and effective way to improve patient flow and manage wait times within emergency departments across the country.

Prior processing of emergency patients

All emergency patients are triaged according to the Canadian Triage Acuity Scale, which offers a guideline for appropriate lengths of time patients should wait before being assessed by a physician. Consistently, our emergency department was meeting guidelines for CTAS I, most often for CTAS II, but guidelines are seldom met for CTAS III. CTAS IV and V guidelines are only met when the Fast-Track area is open.

Generally, if no treatment space is available after a patient has been assessed by the triage nurse and assigned a triage level, the patient is sent to the main waiting room to sit on a chair. Standard reassessments are to be done and documented on each patient as they wait. The observational period continues until there is a treatment space available in the main emergency department.

Improving patient flow

In 2005/2006, Red Deer health care facility participated in a nation-wide collaborative to improve patient flow throughout the emergency department. A one-year commitment to work on a variety of different strategies to improve patient flow and wait times using the “Plan-Do-Study-Act” (PDSA) improvement model was made. Frontline care providers were involved and played an integral role in helping to identify opportunities for improvement.

The emergency department at Red Deer Regional Hospital manages, on average, 60,000 emergency visits per year, with 42% of visits to the emergency department triaged at CTAS III. These patients require urgent care with CTAS guidelines suggesting physician assessment within 30 minutes of arrival. This patient population experiences the longest waits at triage before being moved into an emergency room for assessment. Wait times of more than three hours are not uncommon for patients classified as a CTAS III. Vertesi (2004) performed a retrospective cohort study on all CTAS levels in an emergency department that sees about 50,000 patients per year. Results of this study demonstrated wait times for 10% of emergent patients (CTAS II and III) were greater than 3.3 hours to reach a treatment area. Many of these patients require a stretcher for examination by the emergency physician. Often, emergency doctors are available to see patients, but unable to assess patients because there are no available stretchers.

Formation of an “ambulatory waiting room”

With a goal to find creative and innovative ways to expedite care for CTAS III patients within our resource capacity, plans were made to increase patient flow by moving patients between stretchers and chairs in an ambulatory waiting area located within the main department. One of our treatment areas was transformed into an “ambulatory waiting room” with eight chairs (enabling one room to hold eight patients) and an adjacent room with a stretcher for examinations. One additional emergency nurse was assigned to this treatment area 24 hours a day.

A critical element guaranteeing the success of this project, with respect to realizing shortened times to physician assessment, was the movement of stable emergency department patients in and out of the ambulatory waiting room. Once any patient in the

entire department is stable and appropriate to wait on a chair, that patient is moved to the “ambulatory waiting room”. Patients in this area are generally waiting for blood work to be drawn or for results, x-rays or results, specialist consults, physician reassessment, a bed on an inpatient unit, transportation home, or other treatments. This process promptly and consistently frees up acute-care stretchers, keeping ahead of patients queuing at triage, particularly the CTAS level 3 patients. The idea is to improve patient flow by mobilizing resources to manage patient activity and acuity in the main emergency department instead of using patient observation areas in the waiting room at triage.

Wait times for CTAS III before and during the trial

Improving patient flow is an extremely important challenge. Reviewing wait times for CTAS III patients the week before and during the trial strongly supported our recommended change in clinical practice internal to the emergency department.

This table shows that the average time for CTAS III patients to be assigned to a treatment area from triage prior to the initiation of ambulatory waiting room trial was 88 minutes (1 hour and 22 minutes). During the two-week trial, this time was decreased to an average of 24 minutes. The average time for CTAS III patients from arrival at triage until assessment by ER physician was 122 minutes (two hours and two minutes) prior to the trial. During the two-week trial, this time was decreased to 55 minutes. The final time measured was the average total time spent in the emergency department until disposition (decision to admit or discharge). Prior to the trial, the average time to disposition was 292 minutes (4 hours and 52 minutes). During the two-week trial, this time was decreased to 246 minutes (four hours and six minutes). The longest wait time at triage for a CTAS III patient before being moved to a treatment area noted the week prior to starting the ambulatory waiting room trial was 10 hours and three minutes. Again, during the two-week trial, the longest wait at triage was two hours and 35 minutes. These data demonstrate a significant decrease in wait

times for emergency patients, which met our goals to improve the safety of our emergency department while managing patient flow in a more efficient fashion.

Discussion

Potential for continued improvement in all wait times was evident from the results of this trial. It is now an ongoing process at the Red Deer Emergency Department. Implementing an ambulatory waiting room has increased the likelihood that patients receive timely access to appropriate care and move safely and efficiently through the system without unnecessary and unproductive delays. This innovative change in clinical practice has continued to decrease wait times for all emergency patients. Furthermore, since implementing this process, higher acuity CTAS II patients are no longer waiting in our triage area, as acute care stretchers for critically ill patients are readily accessible.

Patient satisfaction increased and no complaints associated with wait times were received during this two-week trial. Prior to implementation, the organization received one to three complaints per week specifically related to prolonged waits in the emergency department. The emergency department surveyed a number of patients who were treated in the ambulatory waiting room and found that the majority of patients treated responded with overall satisfaction with the care they received. Moreover, many expressed that they believe it is important that wait times for emergency care are reduced.

Staff morale increased, as they were involved with the initial planning phase and implementation of the new process. Staff members expressed that they are able to provide their patients with quality care that is both safe and efficient. Front-line staff members are now responsible for the continuing management of the ambulatory waiting room. All emergency physicians supported the change in clinical practice. In order to remain ahead of the queues, it is essential to keep the ambulatory waiting room open 24 hours a day. This has made the department safer by using utilization strategies and quality improvement methodology to move patients throughout the department more efficiently.

Conclusion

An “ambulatory waiting room” within the main emergency department is an innovative and effective way to improve patient flow internally for any emergency department. New ideas and strategies for change must be encouraged, and working together towards solutions based on sound methodology, while recognizing the unique needs and challenges of individual emergency departments will facilitate the creation of a positive and safer health care environment. ☑

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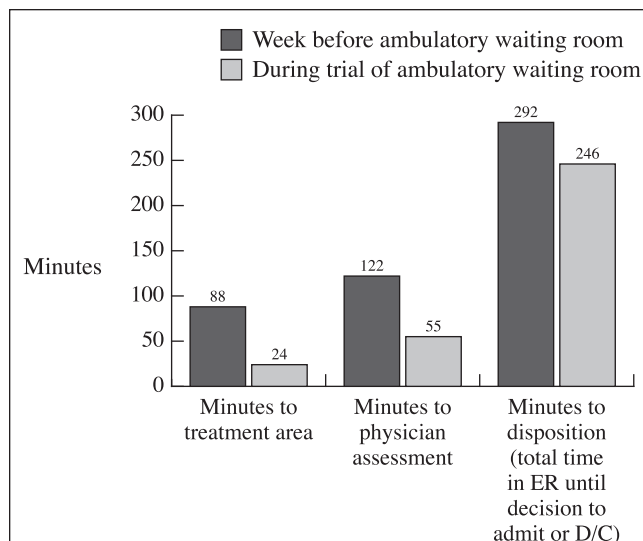


Figure One. Before and during ambulatory waiting room trial (CTAS 3 patients)

Care of the acutely ill elderly in ER: Growth of the role of geriatric ER nurses

By Cathy Senddecki, RN, BSN, ENC(C)

The majority of emergency departments in Canada are facing the increasing problems of ER congestion and inability to transfer admitted patients in a timely manner to in-patient beds. Additionally, with the population aging, there are greater numbers of older adults needing to access emergency room services. Burnaby Hospital is no different than the rest of Canada.

We are a community hospital of 267 beds, with more than 51,000 ER visits annually. The population demographics reflect the need to be elderly-friendly:

- The total volume of older adults seen in our ER is the highest in Fraser Health
- Residents 70 years and older use approximately 70% of the total bed days at Burnaby Hospital (BH)
- In 2005, those 75 and older had an ER admit rate of approximately 37%, while the average admit rate for all ages was closer to 15%.

Just over two years ago, BH committed to improve the care of older adults treated in the ER, with a two-part plan: education for all ER nurses, and a nurse in ER dedicated to the care of our geriatric patients.

GENI Program: Education and networking

The Geriatric Emergency Network Initiative (GENI) program is led by Marcia Carr, CNS for Acute Geriatrics in Fraser Health who worked collaboratively with the B.C. Acute Care Geriatric Nurse Network (ACGNN) CNS Collaborative and interdisciplinary health professional colleagues. The focus is on unique aspects of elderly assessment and proactive care planning from the perspective of ER nurses that is presented by the GENI Faculty. The Faculty includes a geriatrician, clinical nurse specialists, pharmacists, community social workers, PT, OT, clinical ethicist, geriatric emergency nurse (GEN) and nurse educators. The curriculum was designed and developed specifically with ER nurses as the target audience. Great care was taken to reflect ER nursing practice including role, functions and workload. Given that geriatrics and geriatric psychiatry are clinical practice specialties requiring specialized knowledge, skills and abilities, and the recognition that ER is also a specialty area with its own specialized set of requirements, the goal of GENI has been to provide the applicable geriatric/geropsychiatric knowledge,

skills and abilities that an ER nurse can implement into their day-to-day practice. For example, we need to assess falls as a symptom that requires investigation of root causes, treatment plan follow-up and risk reduction to prevent another fall, as well as assessing for injuries related to this episode.

A personal “epiphany”

As clinical nurse educator, I prepared a case study of an elderly patient who presented in the ER with abdominal pain. A short while earlier, the mother of a close friend had been to an ER. As my friend recounted the long wait, and the perception that her mother’s experience was being ignored, I listened with a new focus. For example, this woman had stated, “I know I have a bladder infection, but I’ve never felt such pain.” She felt the ER staff had disregarded her statements, concentrating on her shortness of breath and history of COPD. How could we work with her to start the necessary care, respecting her experience, even as we used our specialized knowledge to assess her?

The demonstration project: The journey starts

When we planned a four-month demonstration project of a geriatric emergency nurse (GEN), I volunteered to take that position. It was not a hotly contested role, and I was accepted at once! Other hospitals had developed this position, and had been able to reduce the number of admissions, as well as improve the quality of care. My orientation included a day with community care staff, including a home care nurse and a case manager, which gave me some insight about the challenges and supports available in the community. A further two days with nurses in this role at Vancouver General Hospital and Peace Arch Hospital, the first two B.C. ERs with GENs, helped me to feel more confident in starting this role.

What soon became apparent was that many of those 75+ year-olds coming to ER were acutely ill. They could not be successfully discharged from the ER with increased home support. The focus of the GEN rapidly evolved into identifying needs and starting a proactive care plan that would be used during the patient’s admission, and alerting community care to anticipated needs upon discharge. For example, a woman whose presenting complaint is abdominal pain with a weight loss of 8 kg in the past six months, has fallen three times in the past two days, and is now disoriented to place and date. She is diagnosed with pneumonia. The

GEN is able to identify that the patient is highly likely experiencing a delirium, which requires careful and clear care planning. The GEN ascertains what services are currently in place and discusses with the spouse and other family members the patient's usual level of functioning. If this patient was generally alert and active two months ago, and has become increasingly less active, with less social interaction, the health care team providing care over the next several days can work toward restoring this patient to her previous level, rather than immediately considering the option of facility placement. A referral to the registered dietitian is needed. Providing the family with information about delirium can help them to deal with this sudden and profound change in her mental status. Assessment of concurrent chronic illness, recent changes in medications, and concerns of family members can add important information needed for optimal care. The GEN can bring to the attention of the health care team the need for a depression assessment once the patient is medically stable. The case manager, who has assessed this patient in the past year at home, may contribute a valuable perspective. A referral to the geriatrician proactively facilitates the assessment of concerns with her overall medical status including cognition. Although her admission diagnosis is pneumonia, there is considerably more complexity to this patient.

At the end of four months,

- The GEN had seen a total of 592 patients (23.5% of all > 75-year-olds); of those, 50% were admitted to hospital
- The focus was on those with complex care needs
- The average LOS of patients who had been assessed by the GEN and admitted through ER was 11.5 days, compared with 15.4 for those of the same age group admitted through ER, but not seen by the GEN.


The journey continues

Now, more than two years later, the role has grown. Working relationships have developed, and some benefits include:

- Increased communication between community care, the GEN, and acute care, and LTC facilities. For example, when a home care physio finds her client experiencing increasing pain and diminished activity post-hip surgery, and sends him to ER, she can call the GEN and explain her concerns. The GEN is aware of these when assessing this patient, and can advocate for appropriate investigations and treatment. Similarly, when a patient with repeated visits to ER is found, again, to have no acute condition, the GEN is able to speak with the case manager to discuss what home support interventions may be possible to help this patient feel secure at home. By the same token, the GEN may help to uncover an acute illness that was presenting atypically.
- More comprehensive information for the health care team providing ongoing care, including physician, therapy, nursing, nutrition, social work, and discharge planning services.

- Referrals to a community pharmacist to visit patients soon after discharge to assess their medication regimen, their understanding of their medications, and prepare a medication calendar for their use.
- Opportunities to communicate the ER experience to other areas of the health care system. Those whose background doesn't include the controlled chaos of ER may not appreciate the constant busy, bright environment that contributes to delirium in older adults. We need to work together to establish new options for care.
- This role is a resource for staff, particularly ER nurses. For example, an elderly patient was receiving inadequate control of her pain, and her nurse felt frustrated in providing comfort. After discussing options with the GEN, the primary nurse got an order for a stronger opioid, and a referral was made to the clinical pharmacist. When the GEN checked the following day, the patient reported she was finally comfortable.

Future directions may include referring patients to a seniors' health clinic that is being developed, or making referrals for falls assessment in the community. Another aspect is to analyze statistics of patients admitted to determine other factors that may need to be addressed earlier in the hospital stay to accomplish shorter admissions with optimum outcomes.

In looking back on the experience of having an ER nurse to do specialized assessments and plans for care of older adults, it is apparent that this is an extension of what emergency care has always been about: identifying unmet needs and working creatively to find solutions. We saw gaps in communication between different areas of health care, and have been instrumental in improving this, both in listening and giving information. We have been able to work more closely with others who specialize in geriatric care, with benefit to both groups and, most importantly, to our patients and their families. 

Acknowledgement

With special acknowledgement to Marcia Carr, RN, BN, MS, GNC(C), NCA, for her assistance in preparing this article.

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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 years1 point
 - 3-5 years2 points
 - 6-9 years3 points
 - 10 + years5 points

2. Involvement in emergency nursing associations/groups/committees:

- Provincial member1 point
- Provincial chairperson2 points
- Special projects/committee
 - provincial executive3 points
- National executive/ chairperson5 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. 

outlook

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: _____

NENA Award of Excellence application form

Forward all submissions to the provincial representatives by January 31 of each year. Incomplete or late applications will not be eligible for consideration. Successful candidates will be presented with awards at the annual general meeting. In order to facilitate the process of the applications, the nominator will involve the nominee in the submission and verification of information.

Award of Excellence in: _____

Nominee: _____ Address: _____

_____ Postal Code: _____

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

E-mail: _____

Employer: _____ Current position: _____

Nominator: _____ Address: _____

_____ Postal code: _____

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

Letter of support (1) from: _____

Letter of support (2) from: _____

Signature of nominee: _____

Signature of nominator: _____ Date: _____



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