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

Volume 30, Number 1, Spring 2007

In This Issue:

NENA

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President's message

Eleanor Roosevelt once said, "I cannot at any age, be content to take my place in a corner by the fireplace and simply look on." I believe that this great lady had the heart of a NENA member.

Emergency nursing never has been and never will be a profession for just anyone. Emergency nursing is a passion, not just a profession. It is no secret that the pace of emergency nursing today is relentless, just as the scope of our practice is ever broadening. One reason we each entered emergency nursing is the variety from minute to minute, day to day and patient to patient. What attracted us is what holds us in one of today's most challenging specialities in health care. We must continue to find new ways to infuse courage and commitment to caring into our practice, our education and our research.

As emergency nurses, we are professionals who are trusted by the public for whom we care, because of our ethical and high standards of practice. It takes dedication, commitment, energy and courage to be an emergency nurse today, more than ever before. As emergency nurses in Canada, we manage daily with increasing patient volumes, higher levels of acuity, growing complexity of care needs and extended lengths of stay of admitted patients in our departments.

As well as our countless responsibilities to our many patients, Canada's emergency nurses have many duties to ourselves; to maintain competence, to continue personal and professional growth and to contribute towards the advancement of our chosen profession. NENA is dedicated to facilitating the provision of high-quality education for all of Canada's emergency nurses, thereby serving our profession and all of its members.

Emergency nurses are not an unlimited resource. As NENA members, we are nursing leaders, charged with the responsibility to mentor and groom our profession's leaders of tomorrow. We must help to create and mould them, guide and support them, educate and encourage them, ultimately knowing that our shared knowledge and expertise will enable them to not only fly, but to soar.

Active participation in NENA, as well as involvement in various NENA initiatives, allows emergency nurses to contribute to the quality and to shape the future direction of emergency nursing in Canada. NENA's strength is derived from its visibility, recognition and membership. NENA members are both leaders and valued partners, working tirelessly to promote and advance a high standard of emergency health care for all Canadians.

NENA has been dedicated to quality emergency nursing care in Canada, since it was founded in 1982. NENA continues to meet its goals of "establishing educational programs for emergency nurses, promoting emergency nursing as a specialty in the nursing profession, developing standards in the practice of emergency nursing, and promoting and interpreting the role of the emergency nurse to other health care groups and to the community."

In order to ensure the maintenance of the integrity of our profession and our professional affiliation, we must all serve as ambassadors for NENA and emergency nursing.

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

From the editor

Always ready, always caring.

Nursing today, especially emergency nursing, is in a state of constant change. Initiatives such as Safer Health Care Now Acute Myocardial Infarctions, Medication Reconciliation, Central Line Infections, Correct Site, etc., new emerging or evolving sepsis pathways (and with this, often, the introduction of arterial line and central line monitoring in emergency), hypothermia post V-fib arrest, new ALS guidelines, new BLS guidelines, to name a few, have added more stress to an already chaotic environment, let alone the longer wait times, increasing acuity and increasing emergency visits. Within this dynamic state, I am continually awed, amazed and proud of the emergency nurse's ability to adapt, embrace and advocate for that which is of ultimate benefit to the patient, and to redirect and speak out to that which is not. We are the poster children of flexibility, adaptability, reliability, accountability and professionalism, and I encourage everyone to pat themselves, and each other, on the back as we continue to proudly move forward in this time of turmoil.

Be the change you want to see in the world – Mahatma Gandhi

Colleen Brayman, RN, BScN
Communication Officer

Highlights from the Fall 2006 BOD meeting

- Connections were made with Canadian paramedics and nursing students by the president in hopes of having better understanding of each other's group and to work collaboratively
- NENA president participated in the first International Congress of Nursing in Ixtapa, Mexico, and has now been invited to speak in Seville, Spain, in May 2007
- Revision of NENA's strategic plan was done with the focus being on NENA INC as the acronym:
  N: National Focus
  E: Education Focus
  N: Nursing Practice
  A: Affiliations
  I: Innovations in Research
  N: New Initiatives
  C: Communication

With this acronym in mind, the following questions were asked by the board:

1. What each of these means to us as a group?
2. What are we currently doing and how does it fit into the strategic plan? If it doesn't fit... should we be doing it?
3. What would we (NENA) like to do now and in the future?

- At each BOD meeting, there is discussion about the issues in each province that are concerns for emergency nurses. Issues discussed at this meeting were:
  - Geriatric specific issues
  - Rural dilemmas
  - Legal issues at triage
  - Customer services for emergencies
  - Wait times in EDs
  - Safe staffing
  - Retaining and recruiting staff
  - Resource sharing
  - Recruiting new members

- **Conferences**

Conference 2006:

- Total number of nurses present was 315
- Profit from conference was $52,000.00.

Conference 2007:

- St. John's Newfoundland at the Fairmont Hotel

Board meeting observer policy

NENA Policies & Procedures 5 . 6 . 0

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

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

Observer policy

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

- Theme for the conference is: Emergency Care: Rock Solid
- Conference will be May 5-7, 2007
- Course in Advanced Trauma Nursing II (CATN II) will be offered prior to the conference
- Forensic nursing course will also be offered prior to the conference.

Conference 2008:
- Preliminary plans for conference 2008 are under way
- Place will be Banff Park Inn, Banff, Alberta
- Dates have been confirmed for May 8-11
- No theme has been decided as of yet

- A conference planning package was finalized and is now ready for use by those provinces that will be having conferences. This package includes templates to be used for speakers and sponsors, how to get started, etc
- National Working Group for Canadian Triage Acuity Scale: A meeting was held November 24, 2006, in Toronto. At this meeting, the final package was completed and rollout was January 2007. OHA will disseminate its product in Ontario and NENA can roll out the other package across Canada.

Highlights for
Trauma Nursing Core Course
Courses / students taught May 1, 2006 to Nov. 1, 2006:

BC 9 / 117	AB 13 / 213
SK 13 / 68	MB 8 / 144
ON 30 / 515	QC 1/ 8
NB 1 / 14	NS 2 / 29
NL 7 / 78	NWT 1 / 5

New revisions to TNCC are:
- Disaster management with triage scenarios
- Airway and ventilation
- All chapters are being updated
- Special populations chapter on pediatric, geriatric trauma and obstetrics
- Surface trauma chapter contains burns and wounds/soft tissue injuries
- Brain trauma chapter awaiting new brain injury guidelines
- New Canadian content in Chapter 2: Epidemiology, biomechanics and mechanism of Injury
- NCAC reviewing chapters.

Skill station revisions:
- Trauma nursing process will be the only tested skill station along with a written exam
- Six new TNP scenarios
- Exposure moved to primary survey
- Airway and ventilation skill station taught only
- Spinal immobilization will be taught / demo only.

New course rollout: early 2007 written exam to be validated course expected fall 2007.

Emergency Nursing
Pediatric Course
Course and students taught May 1, 2006, to Nov. 1, 2006:

BC 9 / 138	AB 8 / 108
SK 2 / 22	MB 3 / 39
ON 13 / 178	QC 1 / 20
NS 1 / 12	

CATN II
- Currently there are three CD in BC and two in AB
- Course is going to Manitoba with the potential for two CDs.

Contracts
- Contract recently signed and good until 2008
- Cost of manuals and indirect fees remain the same
- Retained the grant fund to a maximum to $1,000.00 US
- CATN II contract now in place.

Web course application
Working on course application as an online process with the NENA webmaster.

Goals for such a process are:
- Seamless course application to ENA and NENA
- Automatic approval of instructors
- Generation of a list of courses and where they are located and how to access the course
- Access to course directors and instructors contact by all instructor faculty
- Ability to post news items and "course happenings newsletter/ updates to the web
- Instructor chat line.

Dr. Cass spoke to the BOD about disaster preparedness. Dr. Cass stated that his hope, by talking with the board, would have three goals:
1. Input from the leadership of NENA and identifying the goals, gaps and adding the nursing perspective
2. Promotion from NENA to their members, which, in the long run, will increase the nursing perspective
3. NENA to utilize the CEEP website to disseminate more information to its members.

Next BOD meeting May 3-5, 2007, in St. John's, Newfoundland.

outlook
Conference watch

Ontario Injury Prevention Conference 2007
June 3-5, 2007, at the Valhalla Inn, Thunder Bay, ON. Website: **www.oipc.org,**
Conference Secretariat: Firedog Communications, **stephanie@firedogpr.com**

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**

Annual report to the Canadian Nurses Association

Group
National Emergency Nurses' Affiliation (NENA Inc.)

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

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

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

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

Mission
To represent the Canadian emergency nursing specialty.

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

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

Membership
As of March 2006, NENA has 720 members, distributed as follows:

British Columbia	111
Alberta	155
Saskatchewan	33
Manitoba	48
Ontario	247
New Brunswick	23
Nova Scotia	40
Prince Edward Island	9
Newfoundland & Labrador	44
Independent	9
International	1

Special projects and activities:
The NENA website continues to be increasingly interactive, resulting in more frequent site utilization by the members. The website contains a public section as well as members-only sections, accessible by an individual password. Member participation through affiliation polls has resulted in significant increases in member interest and involvement. Information that is both current and pertinent to emergency nurses is frequently updated on the NENA website, **www.nena.ca**

NENA has sent a letter of support to the Saskatchewan Minister of Health in response to his government's recent new legislation requiring the mandatory reporting to law enforcement agencies, of the presence of victims of gunshot wounds and stab wounds in emergency departments. A recent poll of NENA members concluded that, as well as our duty to respect an individual patient's right to privacy and confidentiality, Canada's emergency nurses believe they also have a responsibility to other patients, visitors, colleagues, our communities and society as a whole.

The NENA journal, **OUTLOOK**, continues to be published twice per year. All members are encouraged to make submissions and write articles for publication. NENA members benefit greatly from the expertise of **OUTLOOK** section editors for pediatrics, research, trauma and forensics in emergency nursing.

Emergency preparedness is an important issue for Canada's emergency nurses. NENA, having already established a connection with the Centre for Excellence in Emergency Preparedness (CEEP) and the Public Health Agency of Canada, has expressed interest in joint participation in ongoing initiatives and future program development. To this end, NENA and CEEP have committed to a continuing and collaborative working relationship. Recently, NENA representative Sharron Lyons from British Columbia participated in a national working group addressing pediatric specific issues in emergency preparedness.

NENA has long been working as a member of Canada's National Working Group (NWG) for the Canadian Triage and Acuity Scale (CTAS). Through much hard work, countless long hours and genuine dedication, NENA representatives Jerry Bell, Debbie Cotton, Valerie Eden and Carla Policicchio have actively participated in making NWG and NENA's dream a reality. At long last, a high-quality, made in Canada, both adult and pediatric, standardized TRIAGE program is about to be taught to every Canadian emergency nurse.

Events

The annual NENA conference "Stayin' Alive", which took place in Ottawa, Ontario, on May 4-6, 2006, was a huge success. While attendees arrived from every Canadian province and territory, the speakers and topics well covered the broad scope of the specialty of emergency nursing. The pomp and circumstance befitting a NENA conference were enjoyed by all, including a special visit by Canada's Chief of Defence, Major General Richard Hillier.

The three-day spring 2006 NENA Board of Directors' meeting was held immediately prior to the conference. At NENA's request, Canada's Federal Minister of Health, the Honourable Tony Clement, met with the NENA BOD. The issues of emergency overcrowding, wait times, nursing shortages, patient safety, recruitment and retention, as well as increasing financial support availability for ongoing specialty nursing education were discussed with the Minister. NENA recommended increasing the availability of support services (labs, CT scans, MRIs, home care and public health) in order to facilitate patient throughput in the Canadian health care system.

Health Minister Clement also addressed attendees at the NENA conference the following day, where he publicly committed to an ongoing working relationship with NENA.

NENA President Janice Spivey gave two presentations at the First International Emergency Nursing Congress in Ixtapa, Mexico, in May 2006, "Canadian Trauma Care" and "Issues Faced by Canadian Emergency Nurses". NENA Past-President Carla Policicchio also attended this conference and presented "Triage Issues in Canada" and "The Canadian Triage and Acuity Scale" (CTAS) to the international emergency nurses.

The NENA 2007 conference, Emergency Care: Rock Solid, will take place in St. John's, Newfoundland, May 5-7, 2007, with attendees expected from across Canada. This exciting NENA event on "The Rock" promises to provide attendees with high-quality educational opportunities, pertinent skill upgrading, exposure to various corporate exhibitors, valuable networking time, Puffins, lots of Screech and a down-home Kitchen Party!

The NENA president has been invited to present at the upcoming International Emergency Nursing Conference, being held March 15-17, 2007, in Seville, Spain. The presentations will be "Certification in Emergency Nursing" and "Prescribing: The Use of Nurse Practitioners in Canada's Emergency Departments". While proudly representing the specialty of emergency nursing throughout Canada, NENA is honoured to also be recognized internationally.

Issues of concern

Overcrowding, wait times, personal safety, the ever-increasing pace, patient volume and level of acuity, patient safety, emergency preparedness, as well as nursing recruitment and retention, all remain issues of concern for Canada's emergency nurses. NENA continues to participate actively to address these issues and any other concerns as they come to the forefront.

Janice L. Spivey, RN, ENC(C), CEN
NENA President
January 20, 2007

outlook
Bouquets

NENA wishes to express sincere appreciation to Mr. Dale Roberts, Therapeutic Specialist, ROCHE Pharmaceuticals, Saskatchewan, for his generous and selfless donation to the affiliation of much personal time, as well as his valuable industry knowledge and corporate expertise. Dale has been a longstanding friend of NENA and an active supporter of NENA national conferences for many years. During the past two years, Dale has also served the membership in the role of NENA Industry Representative. On behalf of the board of directors and the entire NENA membership, I extend our heartfelt gratitude to Dale Roberts.

Janice Spivey
NENA President

Letter to Saskatchewan Health Minister re: Gunshot wounds

January 20, 2007

The Honourable Len Taylor,
Saskatchewan Minister of Health,
2405 Legislative Drive,
Regina, Saskatchewan
S4S 0B3

Dear Minister Taylor,

On behalf of the Board of Directors of the National Emergency Nurses' Affiliation (NENA Inc.), I wish to extend our support to you, your health ministry and your provincial government on your recently passed legislation regarding the mandatory reporting of victims of gunshot wounds (GSWs) and stab wounds presenting to Saskatchewan emergency departments.

NENA, being the professional organization representing Canada's emergency nurses, had previously conducted a membership poll regarding the important and pertinent practice issue of GSWs. Many responding members aligned the possibility of GSW reporting with the situations of child abuse and assorted communicable diseases, both currently bearing mandatory reporting status. Your government has carried this situation one step further, to also include stab wounds in the emergency departments.

As emergency nurses, we have a duty to maintain confidentiality while respecting patients' rights to privacy. The majority of NENA poll respondents believed that as well as our responsibility to individual patients, emergency nurses also have a responsibility to other patients, visitors, colleagues, their community and society as a whole. The conclusion derived from the NENA poll is clear that public safety must be the priority in this very serious issue.

While it should be recognized that the role of the emergency nurse would be solely to inform law enforcement agencies, NENA recommends that all Canadians should be advised of this important legislation. The National Emergency Nurses' Affiliation commends the Saskatchewan government on their responsible actions.

Yours sincerely,

Janice L. Spivey, RN, ENC(C), CEN,
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Course happenings update – Spring 2007

We are pleased to announce that the Trauma Nursing Core Course (TNCC) revision is entering the first step of a two-step process. The first step will consist of rolling out the new course to **U.S. instructors only.** This process will begin in May with three national U.S. sessions planned with the final session occurring in July 2007.

The second step of the process will be updating the international instructors, of which Canada is a part. The National Course Administration Committee (NCAC) will be receiving a DVD along with printed material to review and, from there, a process will be agreed upon to facilitate the roll-out across Canada. We anticipate that this will start to occur in late summer, early fall. The roll-out of the new TNCC course must be completed by April 2008.

It is therefore **very important that all TNCC course directors and instructors are registered on www.nena.ca** with their information, such as mailing address and e-mail address. Bulletins will be posted on the NENA website, as well as e-mails sent individually to all TNCC instructors as the roll-out process begins. It will be very important to know who is current as a TNCC instructor. This is not a small undertaking as there are more than 300 TNCC instructors in Canada.

NCAC is also pleased to announce the partnership with Claire Thibault and a group of dedicated ENPC instructors out of MUHC Pediatric Network at McGill in Quebec, along with the support of ENA and NENA. They are proceeding with the French translation of the exam and slides with the next step to look at translating the ENPC manual. The long-term goal, once the TNCC revisions roll-out is complete, is to look at opportunities to translate this course as well. This is great news for our French-speaking colleagues across the country as it means more emergency nurses will be able to partake in these very valuable courses.

One last reminder is that all TNCC, ENPC and CATN II instructors must be members of NENA to teach. Remember provincial dues are paid on July 1, 2007, so make sure you mark it on your calendar and renew both your fees and update your information on **www.nena.ca**. Courses that do not have current NENA instructors cannot be processed.

Karen Latoszek
Chair, NCA

Editorial Policy

1. **Outlook** welcomes the submission of clinical and research articles, case studies, and book reviews relating to the field of emergency nursing.

2. Statements or opinions expressed in the articles and communications are those of the authors and not necessarily those of the editor, publisher or NENA. The foregoing disclaim any responsibility or liability for such material and do not guarantee, warrant or endorse a product or service advertised in this publication, neither do they guarantee any claim made by the manufacturer of such product or service.

3. Authors are encouraged to have their articles read by others for style and content before submission.

Preparation of Manuscripts

1. The original copy of manuscripts and supporting material should be submitted to the **NENA Outlook** editor. The author should retain one complete copy.

2. Manuscripts must be typed, double-spaced (including references), on 8 1/2" x 11" paper with adequate margins. Manuscripts longer than one page must be submitted in a disk format in Word Perfect or Word. Submissions are accepted via e-mail to the communication officer.

3. Author's name(s) and province of origin must be included.

4. Clinical articles should be limited to six pages.

5. Direct quotations, tables and illustrations that have appeared in copyrighted material must be accompanied by written permission for their use from the copyright owner, and original author and complete source information cited.

6. Photographs of identifiable persons, whether patients or staff, must be accompanied by signed releases, such as the following: "I hereby give (author's name) authorization to use the photograph of (subject's name) in the **NENA Outlook**."

Please submit articles to:
Colleen Brayman, Outlook Editor,
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Kelowna, BC V1W 5A5
e-mail: communicationofficer@nena.ca

Deadline dates:
February 20 and August 16

NO MOUNTAIN TOO HIGH
EMERGENCY NURSING

NENA
National Conference
May 8-10, 2008

NENA National Conference

May 8-10, 2008

Banff, Alberta

Emergency Nursing, No Mountain Too High

Where:

Banff Park Lodge
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
carole.rush@calgaryhealthregion.ca

Banff Tourist Information: **www.banff.ca**

Calgary Tourist Information: **www.aroundcalgary.com**

Come join your emergency nursing colleagues in the beautiful Canadian Rockies!

CALL FOR ABSTRACTS

NENA National Conference – May 8-10, 2008

Banff, Alberta

Emergency Nursing, No Mountain Too High

The National Emergency Nurses' Affiliation, Inc. (NENA) would like to announce a Call for Presentation Abstracts for the National Conference on May 8-10, 2008, in Banff, Alberta. Our conference theme is Emergency Nursing, No Mountain Too High. This is a terrific opportunity to share your research, clinical practices, knowledge and commitment to emergency nursing with colleagues from across Canada. Come and take an Alberta break to learn, network and experience the beautiful Canadian Rockies.

Guidelines for presentation abstracts:

1. Submissions:

- The deadline for submissions is June 30, 2007.
- Abstract selection is a peer review process by the NENA 2008 Conference Committee. Selections will be completed and acknowledged by October 1, 2007.
- Successful presenters must indicate their commitment to attend by October 30, 2007.

2. Format:

- Abstracts are to be written in English. The abstract is limited to 500 words or fewer describing the central theme of the presentation.
- Your abstract should include a title, purpose, summary of content and implications for emergency nursing practice in one of the following areas: clinical practice, education, innovative solutions to emergency care issues, case studies, research, injury prevention.
- A cover page must include the abstract title, the authors' names, credentials, current position, address for correspondence, e-mail address and phone number.
- Indicate your preferred presentation audience: plenary (whole group) or concurrent (smaller group).
- Abstracts to include authors past presentation experience including audience type and size.
- Abstracts must be submitted by e-mail in Microsoft Word to: **nena2008@telus.net**

3. Other information:

- Concurrent presentations will be 60 minutes in length, including questions.
- Plenary presentations will be 75 minutes in length, including questions.

Acknowledgement of receipt of any files or communication will be sent via e-mail soon after receipt. If you do not receive such acknowledgement, or if you need to communicate with us, please contact Rosemarie Enokson at (403) 251-1011 or e-mail **nena2008@telus.net**

The Alberta Children's Hospital move: What's changed and lessons learned from our new location

By Connie Abrey, RN, BN

The Alberta Children's Hospital in Calgary is now located in a new state-of-the-art facility. In September 2006, we left our old location – a space the Children's Hospital had occupied since 1952 – to move to a freestanding building in another quadrant of the city.

The new hospital boasts 'location, location, location'. Situated on the top of a hill, this colourful Lego-like building brightly contrasts against the blue prairie skies. There are several family-centred features, including family lounges, playrooms on every level, an art therapy centre and even a pet visiting room – all catering to our young patients and their families. Several landscaped areas on the property, appropriately named The Healing Gardens, have been developed to offer patients, families and staff some much-needed time away.

Preparation to move to the new site was no small feat. It took a collection of individuals, affectionately dubbed the Kids on the Move Team, to plan and facilitate the relocation.

I was fortunate to be part of this team and was hired as one of two nursing educators to plan an orientation program for all staff, volunteers, and physicians. My partner and I worked with others to create an orientation guide and facility maps, in addition to providing physical tours to more than 3,000 people. Staff participated in drills, mock scenarios and equipment training. Key code team responders also did preparatory training, testing code activation equipment, as well as the new paging and code elevator systems.

Other facets of the move preparation involved taking an inventory of the 10,000 items to be moved, as well as strategic move planning. Multiple staff members were involved in doing their department inventory. A designated move coordinator helped to facilitate and plan the six-week equipment move. In addition, each respective patient care area developed patient care contingencies, planning patient care delivery for either site (or patient transfer to an alternative site) for the days surrounding the planned patient move date.

Figure One. *Courtesy of Robert Lemermeyer*

What took months to plan finally culminated on a sunny September day, when 51 of the sickest inpatients were shuttled the five-kilometre distance by ambulance to the new site.

It has been a mere six months since the move and we continue to operate at our usual busy pace. While the move experience has become a faded memory for most of us, I cannot help but notice what has changed and what we now do differently as a result of this move. The following is a description of what, in my opinion, is different and how we have grown along the way.

1. The impact of physical relocation was greater than we expected.

Little did we know just how much this vast new space would influence and change how we work every day! Departments that used to be neighbours with one another now have changed work relationships. Those departments that formerly shared space, or even shared programs, are now more likely to be self-contained departments. Not only are they no longer co-located, but also they are likely situated on different levels in the building! This has required a change in how departments currently work and how they communicate with each other.

Even within the emergency department itself, there are changes related to this larger physical space. The cramped ED at the old site was a small, homey environment. The pitfall of that space was the obvious lack of patient privacy. Our new emergency space, which offers only single-patient rooms, now poses communication challenges of a different sort! As staff members are not as visible in our larger department, we have now

Figure Two.

become dependent on communication using wireless, voice-recognition technology to communicate to each other, within our own department, as well as interdepartmentally.

2. Despite the move, process change continues.
Moving to a new hospital was a significant event that departments tried to use to make process changes they believed would improve their department overall. Yet, despite best efforts at planning, not all aspects of workflow could be anticipated. Now that we are working in our new location, many more frontline staff members have become engaged in process change, resulting in a greater number of new ideas being generated. By incorporating frontline workers' suggestions and changes, patient flow issues continue to be addressed.

3. Plans are plans, and then there is reality.
Several hundred staff members were involved in the planning and design of the 750,000 square-foot building. If you have ever done a renovation or built a new house, you will know that certain design ideas do not always work out as planned. In the few months since the move, we have seen various changes made within the building. For example, various clinical areas have had the recent addition of closed-circuit camera surveillance to improve patient safety. Computers have been moved to be more user-friendly. As well, millwork counter tops and cupboards have been adjusted to be more ergonomic for staff.

4. Adapting to change varies among individuals.
Some of us thrive on change, while others find it uncomfortable or even frightening. While we may realize that change affects us all, not all individuals are affected equally by any given change. Some may embrace a new way of doing things and feel challenged and energized by the opportunity to learn something new, while others may not. We have seen many staff changes, shifts between departments, and even retirements since our relocation.

5. Adapting to change varies for families, too.
Despite being very family-focused in planning and designing the building, the facility move has been difficult for some of our families. For example, in the emergency department, we continue to refine our triage process. One day, families are expected to wait in the triage line, while the next week the same family may be required to use the take-a-number system that has just been implemented. During these adjustment periods, some family members comment that they feel confused or distressed. As families are our key stakeholders, we need to keep in mind how difficult such changes may be for them.

6. Further change is inevitable.
As with all aspects of health care, we continue to refine our patient flow and process and to make technological improvements with key patient safety issues in mind. But perhaps it is time to realize the driving force for further change may not be due to reasons of the relocation itself but, rather, the way we see and adapt to our regular health care demands. Health care is dynamic and, as such, we need to be responsive to the ever-changing needs within the system.

A new hospital is a rarity; few hospitals are being built from the ground up. This unique opportunity has allowed us to introduce some valuable changes. The Alberta Children's Hospital has been and continues to be a great place to work and our new space will allow us to continue to improve the care we provide for our patients and their families.

About the author

Connie Abrey is a staff nurse who works and enjoys the view from the emergency department at the new Alberta Children's Hospital.

For further information on the new facility, please visit: ***http://www.calgaryhealthregion.ca/ACH/***

Figure Three.

Trauma and anticoagulants – A potentially dangerous combination

By Carole Rush, RN, MEd, CEN

An 88 year-old gentleman was transferred by EMS to an urban emergency department (ED) from an urgent care centre outside the city. The patient complained of dizziness during venipuncture at the urgent care's outpatient laboratory and was found to have a heart rate (HR) of 30/minute and a blood pressure (BP) of 112/60 mm Hg. Further history at the urgent care revealed the patient was taking warfarin for sick sinus syndrome and was having his INR level checked. The patient denied syncope, but had sustained a ground-level fall three days prior. A 12-lead ECG revealed sinus bradycardia with first degree AV block. The patient's heart rate subsequently increased to 60/minute. Cervical spine x-rays at the urgent care revealed a possible C1-C2 abnormality and major anterior soft tissue swelling of the neck. Spinal immobilization was initiated prior to transfer.

Initial emergency department presentation and management

The patient presented to triage with a hoarse voice. His inability to speak had increased in the past five minutes. He was immediately triaged to a trauma bed with an urgent page to emergency medicine and trauma surgery. Vital signs on arrival were: BP 160/90, HR 60, RR 24 and temperature of 36ºC. Significant physical assessment findings included the use of accessory respiratory muscles, muffled speech, pain on swallowing and a large hematoma extending from his anterior neck to his upper chest. Portable cervical spine and chest films were completed and the patient was transferred to radiology for a CT scan of head and neck. No acute spinal or head injury was found on CT. The patient was positioned with the head of bed at a 45° angle, which helped decrease his work of breathing.

Lab results	
Significant Urgent Care Lab Results	**Significant ED Lab Results**
INR = 7.9 (Outpatient lab result the day before presentation to Urgent Care)	Hemoglobin = 127 g/L Hct = 0.39 L/L INR = 1.9 Random Digoxin Level = Less than 0.4 mmol/L Creatinine = 140 umol/L

Bronchoscopy revealed anterior non-obstructive swelling above the epiglottis, with normal vocal cords and trachea down to the level of the carina. Pulmonary and trauma services agreed the patient was at a lower risk of upper airway obstruction unless his bleeding progressed. The priority was to correct the patient's coagulopathy.

Correction of coagulopathy

This gentleman had been advised to stop his warfarin and Aspirin after his INR was known to be 7.9 the day prior to presentation at the urgent care centre. Vitamin K 2 mg was given by mouth at the urgent care prior to transfer. Further correction of this patient's coagulopathy involved the administration of two units of fresh frozen plasma (FFP) in the ED.

Further history

An extensive cardiac history including infiltrative cardiomyopathy and tachyarrhythmias was found through this patient's previous medical records. This patient had a recent hospital admission for tachycardia with new medications prescribed and had been experiencing subsequent bradycardia. Current medications included digoxin, amiordarone and Aspirin.

Outcome

This patient was admitted to the trauma ward under "high observation" for 48 hours and received another two units of FFP for continued management of coagulopathy.

Follow-up on discharge to include very close monitoring of INR level and signs and symptoms of further bleeding episodes. (My injury prevention voice would say that fall prevention education and initiatives would also be a good idea!)

Teaching points

Warfarin is a common anticoagulant prescribed for a range of medical conditions including arrhythmia, prosthetic heart valves, deep vein thrombosis (DVT) and pulmonary embolus (Medline Plus Drug Information, 2007). Some studies show a 70% risk reduction in large and fatal ischemic strokes in patients with atrial fibrillation who take prophylactic warfarin (Hughes, & Earnest, 2003). However, this medication is not without risk. The warnings included with a prescription of warfarin from the pharmacy are extensive. A group of neurologists in Cincinnati found that in patients

over 80 years of age, the rate of brain hemorrhages associated with warfarin increased more than tenfold (Reinbert, n.d.). There needs to be a balance between preventing ischemic stroke and the risk of bleeding. Blood pressure must also be managed to decrease the risk of bleeding. Not all patients will significantly benefit from warfarin therapy.

The International Normalized Ratio (INR) or Prothrombin Time (PT) can be used to assess both bleeding and clotting tendencies. Most laboratories report PT results that have been adjusted to the INR (Lab Tests Online). Warfarin affects the INR directly and indirectly, through interactions with other patient medications and herbal preparations such as cranberry products, garlic, Ginkgo biloba, ginseng and St. John's wort (Medline Plus Drug Information). Table One outlines recommended INR ranges and duration of warfarin therapy for a number of medical conditions.

Treatment of bleeding in patients who are on warfarin therapy focuses on withholding the drug and other blood thinners such as Aspirin, and the administration of vitamin K and fresh-frozen plasma. Warfarin inhibits clotting factors II, VII, IX and X, which are all vitamin K-dependent; reduction of the INR level with vitamin K requires at least four to six hours (Altmin, 2003). With significant bleeding that requires immediate reversal of anticoagulation, fresh-frozen plasma is required because it contains all the vitamin K-dependent coagulation factors (Altmin).

The INR of this patient was decreasing from the initial high of 7.9 post-injury to 1.9 on arrival to the ED, through the action of withholding warfarin and the administration of vitamin K.

So, even a minor mechanism of injury such as a ground-level fall can produce potentially life-threatening complications in patients who are anticoagulated. Ask the question about blood thinners on all trauma patients!

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Table One. INR ranges and duration of warfarin therapy
(Vancouver Coastal Health Pharmaceutical Sciences)

Indication	Target INR	Duration of Therapy
Low intensity therapy		
Prophylaxis of hip surgery	1.6 – 2.3	Until patient is ambulatory and/or p to 4-6 weeks
Moderate intensity therapy		
Treatment of DVT or PE • Due to reversible risk factors • Idiopathic • ≥ 2 episodes, cancer	2.0 – 3.0	 3 months 6-12 months (may consider indefinite) Indefinite
Cardioversion for atrial fibrillation	2.0 – 3.0	3 weeks prior and 4 weeks post cardioversion
Tissue heart valves	2.0 – 3.0	3 months post surgery
Mechanical aortic valve	2.0 – 3.0	Indefinite
Acute anterior myocardial infarction (MI)	2.0 – 3.0	3 months post MI (with ASA 81 mg daily)
High Intensity Therapy		
Mechanical mitral valve (Hughes & Earnest, 2003) (or aortic valve with atrial fibrillation)	2.5 – 3.5	Indefinite Long term use recommended if meticulous INR monitoring is standard; target INR range 2.5 – 3.5 without concomitant aspirin or 2.0 – 3.0 with aspirin

A bruise by any other name would be... An ecchymosis?

By Stephanie Carlson, RN, SANE-A

The topic of the session was *Domestic/intimate partner violence injury documentation – Do's and don'ts* (Lewis-O'Connor, 2006). The speaker possessed a PhD. The audience was a multinational audience of nurses. In a lecture about documenting injuries, a group of more than 100 forensic nurses could not reach a consensus on how to document each of the injuries described. The one thing upon which everyone agreed at the end of the session was that this is a topic that needs further clarification.

A prudent writer would explore this topic alone rather than inviting exposure to criticism for trying to clarify descriptions that are generally understood. Experience suggests, however, that many emergency nurses struggle with the documentation of injuries. Perhaps some terms are not really generally understood. It might be useful to review the more common injuries that emergency nurses see and explore terminology.

Emergency nurses are familiar with the acronym T-E-A-R-S. Crowley (1999) identifies the words represented as "tears, ecchymoses, abrasion, redness, and swelling" (p. 88). Although there are other mnemonics, this seems to be the most widely used; therefore, it was selected as the basis of an exploration of wound definitions.

T: tears (laceration) or tenderness (Giardino, Datner, Asher, Girardin, Faugno, & Spencer, 2003, p. 182). This is generally used to remind nurses of lacerations, probably the most common of all injuries and usually requiring sutures. It is not unusual for emergency nurses to mistakenly chart an injury from a sharp object as a laceration (Assid, 2005). Lacerate means "to tear or rend roughly" (Webster, 2001). Lacerations are injuries that are caused by impact with a blunt object and result from "tearing, ripping, crushing, overstretching, pulling apart, bending and shearing soft tissues (Besant-Matthews, 2006, p. 195). They can range from the fairly tidy open wound, as when wall meets toddler forehead, to a messy, grossly irregular gash caused by closing a door on a finger. On close inspection, jagged edges and bridging across the wound margins may be visible, particularly at the ends of the wound. Bridging refers to the existence of small bands of tissue, which indicate an incomplete separation of the two sides of the wound. There is often discoloration in the area from the impact that caused the laceration. The key is the mechanism of injury – lacerations are caused by blunt force trauma.

A cut or incision, on the other hand, is caused by either sudden or steady impact with a sharp object – a knife or glass or sharp metal, for example. The man who arrives at the emergency department with a blood-soaked kitchen towel wrapped around his hand and reporting that he was washing dishes (lucky wife) when a glass broke in his hand, has an incised wound. These injuries are characterized by clearly defined edges without bridging. Some physicians will call a nurse to task for charting incision and the agency may prefer incised wound or cut; in any event, it is not a laceration.

Patients may arrive with penetrating wounds such as a puncture wound, a piercing injury, such as being jabbed by the end of a wire or the tine of a meat fork. A stab wound is an incision or a cut that is deeper than its length (Hoyt, 1999), usually caused by a thrust of a sharp object. It might also be caused by impalement, such as falling upon a pointed rock. A penetrating wound enters the body, but doesn't pass through, while a perforating wound enters and leaves the body via a specific exit point, such as a gunshot wound.

E: ecchymosis (bruising) (Giardino, Datner, Asher, et al., 2003, p. 182). The acronym TEARS, though useful and succinct, promotes the understanding that ecchymosis and bruise are synonymous. An ecchymosis is the same as a bruise – or is it? This word is, in fact, the most troublesome of all wound descriptions.

If we first attempt to determine what a bruise is, we find it is a lay term, appropriately used interchangeably with contusion. Bruises or contusions, "black and blues" (Hoyt, 1999), are "mechanical injuries (usually caused by a blow) resulting in hemorrhage beneath unbroken skin" (Crowley, 1999, p. 203). One definition of a contusion is "an injury, as from a blow with a blunt instrument, in which the subsurface tissue is injured, but the skin is not broken; a bruise" (Dictionary.com, 2006).

Common injuries		
Description	Mechanism of Injury	Typical Appearance
Abrasion	Horizontal compression with scraping of outer layers of skin	Superficial shearing of skin, often pushing skin to the terminus of the injury
Amputation	Separation of a part from the body	Complete removal of a body part
Avulsion	Tearing or cutting away of a body part	Skin flap or removal of tissue
Bite mark (Describe by appearance)	Crushing bruise(s) or laceration(s) or abrasion(s) caused by teeth	Related to the source of the bite. Human bite marks may appear as single or opposing u-shape bruises with or without lacerations. Animal bites are more likely to include punctures or lacerations, sometimes complete avulsions.
Bruise	Blunt force impact resulting in blood vessel leakage under surrounding tissue	Unbroken skin with discoloration ranging from reddish-purplish to yellow-green
Contusion	Blunt force impact resulting in blood escaping from vessels into surrounding tissue	May include redness and swelling, bruising Organ contusion will not be visible
Ecchymosis	Trauma, direct blunt impact, or idiopathic	Purplish regular or irregular shaped hemorrhagic areas under the skin
Erythema	Increased pressure to the skin, thermal injuries, allergic reactions	Redness or flushing, blanches with pressure
Hematoma	Blunt force impact	Confined mass of blood
Incised wound	Sharp force trauma, e.g. wounds from impact with knives, glass, shards, sharp metal	Clean, tidy break in the skin, without bridging
Laceration	Blunt force trauma, e.g. falls, blows from non-sharp implements or fists	Break in the skin, usually with somewhat jagged edges, possibly with obvious bridging of tissue between wound margins
Ligature mark	Something tied around the neck or other body part with applied pressure	Circumferential or near circumferential marks, often with bruising and laceration or abrasion of skin surface and subcutaneous layers. Seen with hanging, strangulation, or restraints
Pain	Any type of injury	Physical suffering caused by a body disorder
Pattern injury	Any forceful contact, e.g., belt buckle, rope, hand	Possesses features or shape pinpointing the object or surface that caused the injury
Penetrating injury	Sharp/blunt object or projectile	Enters the body but does not exit the body
Perforating injury	Sharp/blunt object or projectile	Enters the body and passes through
Petechiae	Rupture of capillaries associated with strangling, trauma, or excessive vomiting	Pinpoint hemorrhages less than 3 mm diameter; do not blanch
Puncture	A hole or perforation	A punctuate lesion in the surface of skin or mucous membrane
Purpura	Pathology	Purple non-blanching lesions, blood leaking under the skin
Stab	Soft tissue injury by a relatively pointed weapon pointed inward by a thrust-like force or by impalement	Usually deeper than it is long and may have bruising around the wound margins
Stellate (adj.)	Impact wound which pierces the skin	Central impact area with outward spokes, star shape injury
Tenderness	Any type of injury	Sensitivity to pressure or movement

Giardino, Datner, and Asher (2003) describe a contusion as injuries "…characterized as areas of tenderness, with or without swelling or redness from the impact of blunt forces against the body, and may be the result of being slapped, punched, or impacted with an object." (p. 490). Bruises/contusions are tender and/or painful and generally have fairly regular borders. The patient will often recall a causative injury. The key is that bruises or contusions are caused by trauma.

Taber's Cyclopedic Medical Dictionary (2001) defines an ecchymosis as "A bruise…superficial bleeding under the skin or a mucous membrane" (p. 301). Stedman's Medical Dictionary (2005) states that an ecchymosis is "A purplish patch caused by extravasion of blood into the skin, differing from petechiae only in size (larger than 3 mm diameter)" (p. 448). An ecchymosis, according to Hoyt (2006) is a "hemorrhagic, reddish-purple spot or rash that is induced from an underlying hematological condition… often noted in older adults as their capillaries are fragile…" (p. 266). She lists several non-trauma causes of ecchymoses.

So is an ecchymosis a bruise? Is a bruise an ecchymosis? Bickley and Szilagyi (2003) say that an ecchymosis is "blood outside the vessels; often secondary to bruising or trauma; also seen in bleeding disorders" (p. 106). Contusions/bruises are the result of trauma. Ecchymosis is a description of what exists and may include contusions or any extravasion of blood out into skin or mucous membranes apart from injury directly to that area (Taber's, 2001, p. 659).

One way to remember this is to think of "raccoon eyes" and Battle's sign. No direct trauma occurs at the sites of discoloration so they cannot be considered contusions. Raccoon eyes are "periorbital ecchymoses" (Schwartz, 2002, p. 751) and Battle sign is "ecchymosis behind the ear caused by basilar skull or temporal bone fractures" (Schwartz, p. 751) or a "mastoid process ecchymosis."

Another word that describes discolored lesions is purpura. Purpura is defined in Taber's Cyclopedic Medical Dictionary (2001) as "Any rash in which blood cells leak into the skin or mucous membranes, usually at multiple sites. Purpuric rashes often are associated with disorders of coagulation or thrombosis. Pinpoint purpuric lesions are called petechiae; larger hemorrhages into the skin are called ecchymoses." These lesions do not blanch (Schwartz, 2002, p. 139).

Petechiae are small reddish-purplish hemorrhages of small capillaries under the skin, less than 3 mm in diameter (Giardino, Datner & Asher, 2003) or, according to Jarvis (2000), "less that 2 mm…and do not blanch" (p. 253). Petechiae may result from blunt trauma or from increased intravascular pressure, as in the case of severe vomiting or strangulation.

One other word that we see often in emergency departments is hematoma, described by Giardino, Datner, and Asher (2003) as "a localized mass of blood that is relatively or completely confined within an organ, tissue, space, or potential space, and which is usually or partly clotted" (p. 700). Porth (2002) defines a hematoma as "a large area of local hemorrhage" (p. 1322). A hematoma deep inside the body will not be seen, although it may be tender and should be noted in charting as an area of tenderness. A surface hematoma will be obvious by swelling, as in a "goose egg."

A: Abrasion (Giardino, Datner, Asher, et al., 2003, p. 182). Perhaps, after lacerations, the next most common wounds seen in emergency are abrasions. Crowley defines abrasion as, "Excoriation or circumscribed removal of superficial layers of skin or mucous membrane; a scraping away of a portion of the surface" (p. 203). These are caused by a combination of parallel moving contact and compression against a surface with resulting friction. The wound will suggest the direction of the injury; it is not unusual to see the tissue lifted in the opposite direction of the force applied against the skin.

R: Redness (erythema) (Giardino, Datner, Asher, et al., 2003, p. 182). Erythema is a reddened area of the skin caused by dilation of the capillaries. Erythema includes pressure marks (the forearm resting on the edge of the table) and flushed areas. The distinct difference between erythema and ecchymoses is that erythema will blanch when pressure is applied. It is usually not sharply defined and usually not tender, although it may feel warm to the touch.

S: Swelling (edema) (Giardino, Datner, Asher, et al., 2003, p. 182). Documentation should include any swelling or deformity. Charting should reflect location, extent, discoloration, if present, and sensation. It is often useful to compare the injured site to the corresponding site on the opposite side of the body to determine the extent of edema present.

It is inappropriate to try to date an injury in documentation; it should be sufficient to note its color, shape, or quality without trying to guess how old it is. In fact, the chart should record only what is observable. Nurses may quote the patient or his/her companions to clarify or explain a description, but should avoid conjecture.

When charting injuries such as lacerations and cuts, documentation should include the size of each injury and its location in relation to body landmarks, i.e., "4 cm above the left ante cubital fossa". The use of drawings or printed body diagrams is an excellent means of recording location precisely. Injuries and lesions should be documented by location, size and color. Areas of swelling and sites of deformity should be noted. If a nurse is uncertain of the correct term for an injury, he/she is certainly safe in charting an accurate description of what she sees, such as "a swollen, tender 3 cm by 6 cm reddish-purple, non-blanching, circumscribed area midline 2 cm above the xiphoid process." Alterations or deficits in sensation and changes in strength and range or motion should likewise be identified.

Although the genesis of this article was a meeting of forensic nurses, all nurses can appreciate the importance of accurately recording the nature and extent of injuries. This is especially true for emergency nurses whose initial descriptions will become the baseline by which to plan and evaluate future care. The documentation of injuries is an opportunity for emergency nurses to let charting excellence reflect the expertise and skill that they bring to their profession.

About the author

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New combined adult and pediatrics CTAS course

National CTAS Working Group, represented by the Canadian Association of Emergency Physicians, L'Association des medecins d'urgence du Québec, National Emergency Nurses Association, Canadian Pediatric Society and Society of Rural Physicians of Canada

Background information

Over the past six years, the Canadian Triage and Acuity Scale National Working Group (CTAS NWG) has collaborated and worked very hard to develop consensus to support and promote CTAS as the national standard. CTAS NWG consists of representatives from the Canadian Association of Emergency Physicians (CAEP), the National Emergency Nurses Association (NENA), l'Association des Médecins d'Urgence du Québec (AMUQ), the Canadian Paediatric Society (CPS), and the Society of Rural Physicians of Canada (SRPC). Committee members also worked on developing Pediatric CTAS in 2001, the CEDIS presenting complaint list in 2003, and the Adult CTAS revisions in 2004. To support nurses to more accurately apply CTAS, an adult, pediatric and, most recently, a combined teaching package has been developed to ensure that a high-quality, consistent educational experience can be provided to nurses across the country and internationally.

Evolution of combined program

Several years ago, the Ontario Hospital Association embarked on a project to evaluate and standardize triage across the province. In an effort to ensure integrity of CTAS and to ensure that another triage process was not introduced to the country, Ontario members of the CTAS NWG approached the OHA with a proposal to work with them to develop a CTAS-based teaching package. This teaching package would be licensed to OHA to teach nurses in Ontario. Along the way, there were project delays that led to delay in the development of the education package. However, after much discussion, many meetings and a lot of work, the combined education package was developed.

It is important to note that the new adult/pediatric combined CTAS educational package remains under copyright to CAEP and the CTAS NWG. However, the OHA has the right to use the materials to provide province-wide training to their emergency nurses. The one significant positive is that CTAS will remain the national standard without a competing triage scale in the country's most populous province.

Moving forward

To be able to continue the work of ongoing review and revision, developing and maintaining an updated list of CTAS instructors, providing the teaching materials for instructors and students, responding to feedback from nurses and physicians across the country, and continuing to meet annually, income needs to be generated to offset expenses primarily borne by CAEP and NENA. CAEP will be responsible to organize the meetings and teleconferences, maintain on-line access, and help with the distribution or teaching materials. NENA will be responsible for informing its members, maintaining a current instructor list, and promoting and assisting in the delivery of CTAS educational courses across the country. To do so, the following charges will be made for CTAS education. CTAS NWG expenses and income will be monitored to determine whether these charges can be modified.

**It is hoped and expected that all instructor and most student fees will be paid for by their employers.

1. New CTAS instructor – $90 registration when becoming a certified instructor. This provides the instructor with access to instructor and student teaching materials and course organization materials.
2. Ongoing instructor fee – $20 annual fee to ensure that we are able to maintain a list of active instructors to support educational requests. In return, not only will all new educational materials be passed along, but also instructors will receive e-mail summaries of ongoing CTAS NWG plans and activities to help keep them current and the triage leaders in their regions.
3. Student fees – $20 registration fee for every student taking a CTAS course, whether they are nurses, paramedics, physicians, or other caregivers. This will allow us to maintain a record of student numbers by region. There is no annual fee as this is not a certification program, purely an educational one.
4. CTAS posters and pocket cards, based on order form, revisions, and user interest.

To become an instructor

An emergency nurse who wishes to become an instructor must meet certain prerequisites, which are:

- Must be a current NENA member
- Attends the specific provider course that will be taught as an instructor, i.e., adult and/or pediatrics
- A minimum of two (2) years of emergency/triage experience
- Current and/or previous experience in teaching TNCC, ENPC, PALS, ACLS or other emergency program is an asset
- Attends the "how to organize a course" following the provider course
- Submits initial $90.00 registration fee

Program materials

The program materials are located on the CAEP website under **Policies/Guidelines,** and click on CTAS and follow directions

E-mail **jlafreniere@caep.ca** to submit request for password. Your status as a NENA member and as an instructor must be verified prior to being awarded a password. You will be asked to fill out a form and to submit your registration fee to CAEP office.

Significant changes to programming and to program delivery such as the changes that have occurred with the development of the combined CTAS program and the housing of materials on-line can lead to glitches and hiccups in the system. This can happen no matter how detailed the plans may be. NENA thanks you for your patience as we move along this journey and we continue to work together to ensure a smooth transition in teaching the combined program to Canadian emergency nurses.

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, Debbie Westman, RN, BScN, and Calvin Janzen, RN, BScN,
Red Deer Emergency Department,
David Thompson Health Region, Alberta

The primary role of the hospital emergency department is to serve as a "safety net" for the delivery of urgent and emergent care to Canadians 24 hours a day (Derlet & Richards, 2002). The Canadian Association of Emergency Physicians (2007) and the National Emergency Nurses Affiliation 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 (CAEP, 2007; Derlet & Richards, 2002; Cessford, 2005).

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. In our facility, 13% of patients may be admitted while the remaining 87% are discharged or transferred out of the emergency department to other facilities or other levels of health care. This article offers a solution to managing capacity challenges within the emergency department while mitigating the risk with extensive wait times, 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, based on patient acuity. Consistently, our emergency department is meeting guidelines for CTAS I, and 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. The Fast-Track area is a separate physical space staffed by two health care providers and a physician. This space is dedicated to less-urgent and non-urgent patients.

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. Typically, reassessments are to be completed every 60 minutes for a CTAS III patient. The observational period continues until there is a treatment space available in the main emergency department.

Improving patient flow

The Red Deer health care facility is participating 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. Front-line care providers are involved and play a crucial 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. These patients experience the longest waits at triage before being moved into an emergency room for assessment, waiting significantly longer than CTAS guidelines recommend. Wait times of more than three hours is not uncommon for patients classified as a CTAS III. Vertesi (2004) performed a

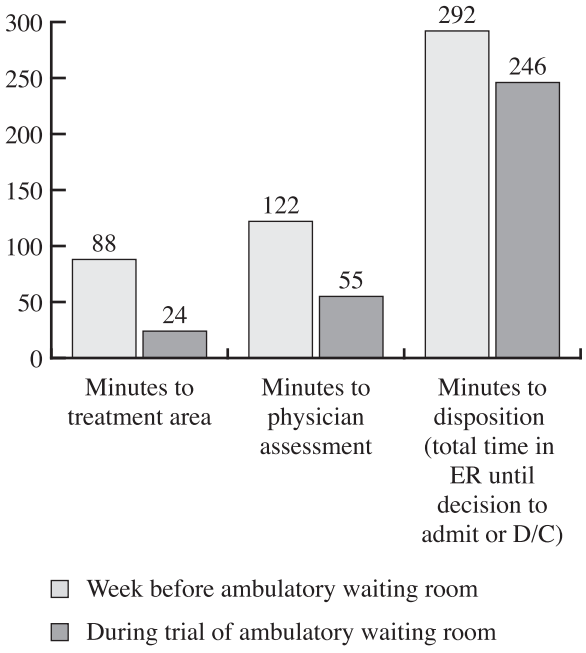

Figure One. Before and during ambulatory waiting room trial (CTAS 3 patients)

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 then 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 23 hours a day.

A critical element guaranteeing the success of this project, with respect to realizing shortened times to physician assessment, is 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 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 III patients. The idea is to improve patient flow and illustrate how it can be achieved by mobilizing resources to manage patient activity and acuity in the main emergency department instead of to patient observation areas in the waiting room at triage. By focusing our efforts on assessing and treating patients as early as possible, there is the potential to create a safer environment.

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.

Figure One shows that the average time for CTAS III patients to be assigned to a treatment area from triage prior to the ambulatory waiting room 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

change in process. During the two-week trial, this time was decreased to 55 minutes. The final time measured was the average total time in the emergency department until disposition (decision to admit or discharge). Prior to the change in process, 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 the ambulatory waiting room was 10 hours and 3 minutes. Again, during the two-week trial, the longest wait at triage was 2 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

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 decreased wait times for emergency patients. The ambulatory waiting room trial was so successful it is now an ongoing process at the Red Deer emergency department. Discussions are underway to support the increase in resources that were required to make this a success. 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 period. Additionally, in the months since the trial, no patient complaints regarding wait times have been received. 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. Qualitative feedback included suggestions for improvement such as more chairs, more comfortable chairs, a TV, and more up-to-date magazines.

Staff morale increased, as they were involved with the initial planning phase and during implementing the new process. Staff members said 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. A special committee for the ambulatory waiting room has also been formed to help facilitate the processes necessary to guarantee consistent use of the ambulatory waiting room and to provide for recommendations for change as the emergency department continues to experience the challenge of increasing volumes.

All emergency physicians supported the change in clinical practice. Additionally, the majority of physicians support the use of the room by encouraging the movement of patients to the ambulatory waiting room while the occasional ER physician may be reluctant to have emergency patients sitting on chairs within the department. 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 our 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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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**

Leadership in nursing: A frontline perspective

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

While there is no shortage of nursing leadership courses, books, seminars and conferences, they all seem to focus on leadership at a managerial level. No complaints here, a manager who can only manage but not lead, will ensure contracts are followed, employees are paid and policies updated but, without vision and leadership, their nurses, their units, hospitals and districts will never move forward. So, hurrah to the trend of combining management and leadership. But what about the front-line leaders?

What about those front-line nurses, who, day in and day out, make small consistent and valuable changes to our units? Why is it that a value has been placed on higher learning, implying that Master's-prepared nurses are naturally leaders in their field, yet little recognition has been placed on front-line nurses who, through volunteer committees, continuing specialty education, and even the writing of incident reports, can lead to and create change? Sometimes you just have to put down the binoculars and get in close to really see what is going on. One by one, and step by step, these frontline nurses are leading us forward through the ever-changing health care maze.

In World War 1, nursing was still in its infancy. It was a time when only single women could work, and women had a muffled voice in the political and military arenas and, yet, nearly 3,000 Canadian nurses joined the war effort. Three thousand! That is a phenomenal number, even by today's standards when we have 126,000 nurses practising in Canada. Following the lead from World War I, 4,480 Nursing 'Sisters' enlisted in World War II.

Every single one of those nurses was a leader, showing the world that they were not just for working in hospitals and were not "too frail" to look after the badly wounded in less than ideal conditions. If you ever get the chance to read books about nurses in any of the wars, you will be surprised at the connection and the sense of pride you feel. It will help you to re-ground yourself and remember why you became a nurse in the first place. Why? Because, despite being miles from the luxuries of home, and often working in deplorable conditions, they dug in, worked really hard and made a significant difference. They charted a new path for all nurses and we have all followed gratefully in their footsteps.

I remember one book in which a nurse commented that once the area near the field hospital was bombed, "I rounded up my 100 patients and moved them to the mess hall where it was much more sturdy" (Rees Aikens, 1998). She didn't wait for direction or policies to be written, she simply did what had to be done and got on with it. That's true raw leadership and we still see it every day in hospitals across Canada.

Faced with completely different challenges, the emergency nurses of today dig in, work real hard and make a difference too. I see leadership when I watch experienced nurses patiently guiding new staff through the rhythm of the unit, speak with nurses who sit on one or more committees freely giving their time and ideas to try and improve things, and when I meet nurses from medicine and surgical floors who have left the comfort of being "senior" on their own floor to venture into the unpredictable and sometimes hostile world of ER.

The dates have changed, the hospitals are fancier and technology is both a friend and foe, helping us improve care while often simultaneously distancing us from caring. But we haven't changed. Nurses, frontline nurses especially, are still the type of nurse leaders we hear about from WW1. Leaders who will venture into unchartered territory, will welcome and mentor new staff, will look at the system failures from a ground-level perspective and a critical eye and will create changes that will help us muddle through this emergency mess we find ourselves in coast to coast.

I tip my hat to the nurses who have furthered their studies, earning their Master's and PhD degrees and moving into serious research and high-level management positions. I am proud of you. I am proud to be a nurse, period. But I am most proud of my colleagues. They inspire me, push me to do better, learn more and come up with better solutions.

They know, as I do, that sometimes, despite the less than ideal conditions, the best place to be is in the trenches…standing shoulder to shoulder with some of the finest Canadians I know.

About the author

Caroline is a flight nurse with EHS LifeFlight in Nova Scotia, and works casual in emergency at the QEII hospital. She has been an RN for more than 23 years, spending four in the military and four in the reserves.

Interesting reading

Rees Aikens, G.M. (1998). **Nurses in battledress.** Halifax: Cymru Press.

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http://archives.cbc.ca/IDC-1-71-855-4975/conflict_war/women_ww2/clip8 (Video clip)

Partnering for patients: Home care nurse in the emergency department

By Valerie Potts, RN, BN, Gwen Doran, RN, Annamarie Fuchs, RN, MN, Brian Lang-Hodge, MD, FRCPC, Sue Harcus, RN, BScN, Lori Sparrow, RN, BScN, and Dawn Nickorick, RN, Emergency Department and Home Care, David Thompson Health Region, Red Deer, Alberta

Finding solutions to address the emergency overcrowding crisis due to the ongoing pressures of inpatient bed shortages are crucial. Emergency departments throughout Canada are reporting overcrowding and excessive wait times placing patients at risk (Canadian Association of Emergency Physicians, 2007; National Emergency Nurses Affiliation, 2004). Patients requiring admission are backlogged by a lack of inpatient beds (Canadian Association of Emergency Physicians, 2007). Older medical admitted patients are often the source of the most significant backlog.

At Red Deer Regional Hospital Centre, there is a bed utilization committee working actively on various strategies related to improving access to inpatients beds. One of those initiatives during 2006 was to establish a six-week improvement trial related to an idea presented by an emergency physician who suggested an innovative program that would allow a home care nurse to assess older patients in the emergency department. The theory behind this trial was to establish whether or not older patients actually required admission for management of chronic health care needs, or if management and support could be offered in the community. Ultimately, the goal was to offer a process for early intervention for older clients who present to the Red Deer Emergency Department. Early assessment has the opportunity to reduce unnecessary admissions to hospital and to offer clients access to a variety of health care services of which they may not have been otherwise aware.

Six-week trial

The Red Deer Emergency Department staff partnered with key members of home care for a successful six-week pilot project. One of two home care nurses was situated in the emergency department on a full-time basis for the trial period and provided assessment and recommendations for delivery of care options to any older patient who presented during regular working hours (Monday-Friday, 0800-1700). Two hundred and sixty-eight older medical clients were assessed by the home care nurse. Forty-six per cent of the patients who were assessed were discharged with the appropriate home care supports.

Qualifications and role of the home care nurse

Each of the two home care nurses who participated in this trial were staff members with expertise in home care. They were not only familiar with all of the home care services available in the health region, but were also able to access these services promptly and efficiently. Professional autonomy permitted the home care nurses the ability to make suitable and timely placement decisions.

When situated in the emergency department, the home care nurse was accessible and visible ensuring prompt and efficient intervention. Verbal referrals were made to the home care nurses by frontline staff, ER physicians, charge nurses, the ER case manager and case coordinators from home care. The home care nurse was able to see anyone in the emergency department (no official order or referral was required), however, priority was given to older patients over the age of 60. On a regular basis, the home care nurse would also check the ER tracker (electronic white board) to identify patients over the age of 60, or any other patients for reasons indicating that an assessment by the home care nurse may be appropriate. Assessments were completed on an average of 8.6 patients per day. The home care nurse had a cell phone, which enabled her to make and receive phone calls readily. The home care nurse was able to coordinate home care and community support services directly from the emergency department.

Examples of home care services provided

1. Support clients to remain independent and in their own homes as long as possible.
2. Provide services at home to clients who would otherwise require admission to hospital.
3. Arranged assessment for assisted living, supportive living and other residential care streams of living to clients.
4. Provide services that support people who are nearing the end of their life, and their families, at home or in a hospice.
5. Client focused communication between the home care case coordinators in the community and the emergency department caregivers.
6. Provide information to the client's home care case coordinator about the assessment completed by the home care nurse in the emergency department.
7. Arranged home care follow-up on admitted patients through community liaison coordinators (discharge planners) to reduce hospital stay.
8. Arrange direct referrals to rehab, MS Society, dietitians, Alzheimer Society, diabetic clinic, and other community resource groups.
9. Arrange home care based on the following needs: housing, personal care, meals, respite, medications, and mobility issues.
10. Encourage clients and ER physicians to access home parenteral therapy (HPT), wound care, and other existing community-based programs that are already available in the emergency department through home care.

Home care philosophy

Home and community care services promote well-being, dignity and independence of clients. Clients and families are given the information required to make their own decisions about lifestyle and care. Home care believes clients have the right to make their own care decisions.

During this trial, the ER case manager was partnered with the home care nurse on duty. Together, they endeavoured to put the patient's needs first, always assessing each situation on an

individual basis. The home care nurses were particularly knowledgeable about the needs of older patients and the services available to them, thereby educating emergency staff when admitting older patients with chronic medical problems about options for management in the community, more specifically, suggesting increased risk that once admitted to an inpatient bed the older adult frequently becomes dependent on the health care system – often ending up in a long-term care facility, which is not a desired outcome for older clients wishing to remain independent (Palmisano-Mills, 2007).

Patients with admission orders

Out of the 268 patients who were seen during the trial period, the home care nurse assessed 115 admitted medical patients waiting on emergency stretchers for inpatient beds. The home care nurse was able to discharge 33% of these patients by putting services in place to support patients in the home. A plan for home care was initially discussed with the patient and patient's family, and then this plan was presented to the admitting physician.

Emergency physicians

All emergency physicians evaluated the project as "excellent" in the satisfaction survey. Most specifically, this process allowed the efficient and safe discharge of older patients from the emergency department. Emergency physicians were able to send patients home who would have otherwise been admitted to an inpatient bed. Having an experienced home care nurse as part of the emergency team was of particular importance to the success of this trial. She was particularly credible with respect to her knowledge regarding accessible resources in the community and her expertise in managing the care of this patient population and their family members.

The home care nurse also assessed 93 "possible" admissions and was able to discharge 34% of these patients. These were patients with health care needs whom emergency physicians indicated that, if no other reasonable service options were readily available to support them, an admission to an inpatient bed would be necessary. Information regarding home care services was given to patients who had never sought home care support in the past. For new clients not requiring admission, home care services were arranged directly in the emergency department, potentially reducing subsequent emergency visits.

Discussion

This innovative project helped highlight one of the many issues that lead to emergency department overcrowding. The possibility of avoiding admissions or frequent ER visits by educating a certain patient population about the variety of services available outside of emergency care or inpatient admissions has benefits for system-wide improvements while offering patient-centred care alternatives. The home care nurse was able to coordinate support services directly from the emergency department. This process offered a more seamless integration of service delivery. This project prevented unnecessary medical admissions enabling elderly clients to be discharged home safely with the appropriate homecare supports. Ultimately, this project helped improve the wait times for medical admissions while supporting more streamlined patient care for older adults.

Conclusion

Development of successful interventions to prevent further health decline of older adults who are discharged from the emergency department is essential (Hastings & Helflin, 2005). More seamless and integrated services are needed. Collaboration and integration between home care and emergency staff will produce positive outcomes for older adults while decreasing medical admissions. The initial success of this pilot project was evident and clearly warrants further consideration. This partnership was tailored to local needs and designed to integrate to the services that are available within the David Thompson Health Region. The principles behind this pilot project have the potential for success in any emergency department across Canada. The problem of "overcrowded emergency departments" is one of national concern. New and innovative ideas and strategies for change must be considered.

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Changing the Moment: A dedication to nurses

Thank you for *Changing the Moment.* Thank you for being a Nurse.

In millions of ways Nurses like you have been
Changing the Moment for countless men, women and children ever since time began.
Now it's not only the marvelous skills you have acquired,
which play such a vital role in the healing process of those in your care;
It's the above and beyond time and attention given;
it's the soft word spoken, the gentle reassurance and encouragement shared
when anxiety, fear and sometimes despair engulf us.
It's the cup of tea, the magic of a smile, it's the gentle touch of a hand
that gives hope when hope itself is almost gone.

These are the things that in so many wonderful ways *Change the Moment* for others
and though the eventual outcome may never change,
it may lighten a burden that just seconds before seemed too heavy to bear.
You do these things consciously, you do them spontaneously,
And we thank you for all of them.

But what about you, the Caregiver?
Who *Changes the Moment* for you when in spite of your best efforts,
the bottom falls out of your day?
Modern nursing is a high pressure occupation generally carried out at full-run,
and outside of family and intimate friends,
you have to rely on each other for support and understanding.
Sometimes a smile, a word or a humorous remark is all it takes to set things right,
sometimes non-judgmental listening and bridge-building are required.

Few people outside your profession will ever understand
the emotional roller coaster you ride
when you are front row centre to life coming in, life going out
and the myriad of humanities' illnesses in-between.
It is imperative then that you also use that power within you, that gift of healing,
to comfort and support each other.

Examples of people *Changing the Moment* for others can be found in all the religions,
cultures and professions in the world.
One example from the Bible….
Weary and weak from the beatings he had just received, Jesus was forced to carry a heavy wooden cross to his own execution,
his followers (out of fear) keeping a safe distance away.
As Jesus staggered up the hill, his face covered in perspiration and blood,
Veronica, with great courage and wonderful compassion, stepped out of the crowd
and wiped the face of Jesus with a towel.
Veronica knew she was never going to change the outcome,
but she was determined to *Change the Moment*.
The courage and compassion that Veronica showed that day,
along with uncompromising care and dedication,
have long been the hallmarks of the nursing profession.

So, from that new life just beginning, knowing instinctively
you will give it warmth, care and protection;
to the person seeking comfort as they prepare to take that final journey;

I say to you again…
Thank you for *Changing the Moment*
Thank you for being a Nurse.

Terry McGarry, 2004

Terry has a daughter who has been an RN for more than 23 years. He has a passion for writing and has published a number of works including a dedication to police officers and another to firemen. If interested in a copy of his work, please contact him at: ***ttmcgarry@yahoo.com***

The NENA Bursary

NENA recognizes the need to promote excellence in emergency care and, to this end, to provide financial aid to its members. NENA will set aside a predetermined amount of monies annually with the mandate of providing a high standard of emergency care throughout Canada. All sections of the emergency nursing team are eligible for consideration including staff nurses, managers and educators.

Applications must be submitted prior to the spring Board of Directors meeting of NENA for review by the standing committee for bursary disbursements. On April 1 of each year the number of bursaries awarded will be determined by the number of registered members per province for that NENA fiscal year i.e.:

1-99 members - 1 bursary
100-199 members - 2 bursaries
200-299 members - 3 bursaries
300-399 members - 4 bursaries
400-499 members - 5 bursaries
500-599 members - 6 bursaries
600 + members - 7 bursaries

One bursary is to be available to NENA Board of Directors members and one bursary per year will be available to an independent member.

Successful candidates can receive a bursary only once every three years.

NENA Bursary application process

Each candidate will be reviewed on an individual basis and awarded a number of points as set out below:

1. Number of years as a NENA member in good standing
- 2 years.....1 point
- 3-5 years .....2 points
- 6-9 years .....3 points
- 10 + years .....5 points

2. Involvement in emergency nursing associations/groups/committees:
- Provincial member.....1 point
- Provincial chairperson .....2 points
- Special projects/committee
  - provincial executive .....3 points
- National executive/ chairperson.....5 points

3. Candidates with certification in emergency nursing and/or involved in nursing research will receive an additional five points.

If two candidates receive an equal number of points, the committee will choose the successful candidate. All decisions of the bursary committee are final.

Each application will be reviewed once per spring board meeting.

Preference will be given to actively involved members of NENA and those actively pursuing a career in emergency nursing. Those members requesting assistance for emergency nursing certification, TNCC, ENPC, CATN, as well as undergraduate or post-graduate studies that would enhance emergency care will also receive preference.

Candidates must have completed Forms A, B and C (included with this issue of **Outlook**). The provincial director may forward applications at the spring board meetings.

Any incomplete forms will be returned to the provincial director for correction if possible.

Eligibility
- Current RN status in respective province or territory. (Proof of registration required.)
- Active member in NENA Inc. for at least **two** consecutive years. (Proof of membership required.)
- Working at present in an emergency setting which may include:
  - Emergency department
  - Nursing station
  - Pre-hospital
  - Outpost nursing
  - Flight nursing

Application process

Candidates must complete and submit the following:

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

Provincial representative responsibilities:

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

Selection process

The standing committee for bursary disbursements will:

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

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: _____

Live, Work ... the Best of Both

Vancouver Coastal Health (VCH) is focused on three integrated components of health care: Acute, Community and Primary Health. VCH operates 102 health care centres in 17 municipalities, including BC's largest hospital and one of Canada's largest research institutes. Our specialties include Trauma, Neurosciences, Bone Marrow Transplants, Burns and Plastics, Solid Organ Transplant, Public/ Community Health and Mental Health. Our talented, dedicated health care teams characterize the cultures and lifestyles of our coastal mountain communities and the city of Vancouver.

Our diverse geographic area offers you a unique choice of practice settings — from bustling tertiary care centres to smaller, rural hospitals — VCH has it all!

If urban living is for you, consider North Vancouver, Richmond or Vancouver. These are cosmopolitan cities with an abundance of cultural and recreational activities at your doorstep. Further up the coast of British Columbia, the stunning surroundings of communities like Sechelt, Squamish, Pemberton, Powell River, Bella Bella and Bella Coola will tempt you.

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