outlook

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

Volume 32, Number 1, Spring 2009

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outlook
Guidelines for submission

Editorial Policy

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

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

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

Preparation of Manuscripts

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

2. Manuscripts must be typed, double-spaced (including references), on 8 ½" × 11" paper with adequate margins. Manuscripts longer than one page must be submitted in a disk format in Word Perfect or Word. Submissions are accepted via e-mail to the communication officer.

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

4. Clinical articles should be limited to six pages.

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

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

Please submit articles to:
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President's message

As we moved into March, most of us saw it come in like a lion, so hopefully it will go out like a lamb.

2007–2009 has been a busy time for NENA and, as I move aside to allow Landon to take the reins as president for the next two years, I am confident we are moving in the right direction as an organization, as well as a profession.

The strategic direction developed in 2007 encompasses all facets of emergency nursing—the board continues to align decisions with these directions such as the website initiative, recruitment and retention and communication that Landon speaks about in the president-elect's message. Communication is the key and it is exciting to see the present message board being used more frequently. Moving technology along will ensure a professional network that spans our entire country from east to west and north to south.

International liaisons have been a priority over the past two years. There have been discussions and meetings with the Emergency Nurses Association, particularly around collaboration. I have attended the annual ENA General Meeting for the past two years (Salt Lake City and Minneapolis) where I have had the opportunity to meet with the president, board and office staff. We welcomed the ENA president in Banff and hopefully will in Winnipeg as well. The World Congress of Emergency Nurses in Mexico in November 2008 revealed opportunities to discuss ED overcrowding as an emergency issue worldwide. The Royal College in England, while unfortunately unable to have a representative join us in April, sends its regards and looks forward to collaborating in the future.

I would like to take this opportunity, as my last message, to thank some people who have been instrumental to me. I first need to thank my better half Scot and my boys Zack and Breton who have endured teleconferences (stealing their Xbox 360 head set–which works as a great set for cordless phones!), e-mails, voicemails, and late-night telephone calls, as well as the times I have been away. The board of directors, who are a great group of people–Jan C. for keeping me on track during meetings, Jerry for his untiring work both fiscally and with CTAS, Jan S. for guidance as past-president, Stephanie for her wonderful work with the web and **Outlook**, Landon for his vision (and computer skills, especially Adobe formatting AFTER the meeting had ended), provincial directors for their work in individual provinces, and NCAC for the endless hours dedicated to CATN, TNCC and ENPC across the country. I want to reiterate that this group of individuals collectively works on behalf of EVERY emergency nurse in this country towards a gold standard of quality care through education, research and innovation.

I am inspired by the direction NENA has been taking and I am very proud to be a part of it. I look forward to my time as past-president and continuing for one more year in this wonderful work.

Take care and hope to see you in Winnipeg!
Tanya Penney, RN, BScN, ENC(C)

From the editor

I wasn't completely naive when I became NENA communication officer. I have done some editing work for organizations before and I have a few years of experience with life in general. I knew this position would be a big step. I was unprepared, however, for the learning curve that would be required.

The most significant thing I have learned is the power of words. I know that there is truth in the maxim, *the pen is mightier than the sword,* but I had always thought it applied to politicians and dissidents, never considering that it applies in little things and to regular people like me.

I want to make it clear that I do not routinely set out to wield my lingual member or pen for evil. I have learned inadvertently, however, that a careless word or phrase can do great damage to another nurse and to a professional relationship. This can be a particularly painful lesson when the professional relationship involves a degree of friendship as well, as it did in this case.

I was really fortunate, as the person whom I hurt confronted me with gentleness and respect and gave me an opportunity to explain my words. I won't use the word *apologize* to describe what I needed to do, as it suggests offering an excuse; and I was without excuse. I had to acknowledge my responsibility and say, "I'm sorry." I hate eating my words, but I have a greater loathing for the knowledge that my words had hurt someone.

In the wake of that experience, I have become very sensitive to the ease with which a hurtful comment can escape our lips and how often it happens that nurses speak in a way that is painful to hearers, whether family or patients or other nurses. Thoughtless comments, a sharp tone, a failure to really listen—these are the things that undermine team spirit on nursing units and diminish us as professionals.

Whether it is a triage nurse chiding a drunk, inattention when others are speaking at a staff meeting, or briskly passing off the geriatric patient to another nurse without a good report, there is always an opportunity to be discourteous. Pressure from overcrowding, short staffing, fatigue, and long-term pessimism has created a culture where our default style is abrupt, harried, and often insensitive.

That is why we need NENA. We have to support each other—not because it's noble, or gracious, or even because it's the right thing to do, although these things are true. We must do it because we, of all people, are best prepared to give encouragement to other nurses. Only emergency nurses understand emergency nursing; and NENA is emergency nursing.

See you in Winnipeg,
Steph Carlson, RN

President-elect's message

Happy winter everyone! Hopefully by the time this goes to print, we will all be starting to warm up a bit. Although not as cold as the rest of you, even out here in Vancouver we had our two feet of snow in a 24-hour period, which made us the laughingstock of the national news yet again! The last year as president-elect has been a busy one, as we have embarked on a couple of exciting projects that will carry over into the president position.

Website: The largest project that your board of directors and I have initiated is a large overhaul of the NENA website. We have chosen to change our website software completely and start from the beginning in its redesign. The exciting part is that our project team has been moving fast and furiously with this project and will do an "official" launch of the new site at the National Conference in Winnipeg. The website will gain functionality as time progresses, but we really feel it is important to get a basic site up and running as quickly as possible.

Recruiting and retention: There is strength in numbers! On the tails of our website launch, we will be focusing on recruiting new members into the organization and providing expanded services through the website for those of you who are already members. Stay tuned to the website to see what our plan is going to be moving forward.

The wheel: I figure that those cavemen who invented the wheel did a pretty good job. In fact, such a good job that we haven't seen the need to re-invent it! Why is it that in health care, we all try to re-invent the wheel so often? I have worked at multiple facilities all trying to develop a protocol for something that somebody else has already done. One of the great things about our new website will be the ability for members to collaborate and share resources, which should make all of our jobs easier and provide a more consistent level of service for our patients. Web collaboration and social networking is the future of the internet and our new website platform will be based around this concept. Even those of you scared of the internet will be excited about the new possibilities that NENA will be bringing forward.

Keeping in touch: Going forward, my plan is to maintain regular contact with the membership through the website and via e-mail. I also encourage you to keep in touch with NENA. We want to hear about your issues and what NENA can do for you and your emergency nursing professions. I encourage you to become active both nationally and within your province. Even so much as contributing an article to this journal contributes to your profession and adds to the nursing body of knowledge.

I can be reached at **presidentelect@nena.ca** and I encourage you to contact your provincial director as well at the addresses provided in this **Outlook Journal**. Remember, everyone's two hours of volunteer service add up over time!

Landon James, RN, BSN, MA, CEN

National Emergency Nurses' Affiliation Inc. board of directors' meeting highlights

The National Emergency Nurses' Affiliation board of directors met in Ottawa, Ontario, November 7–9, 2008.

Highlights from this meeting:

- T. Penney was contacted by Royal College of Nurses from England and they will be co-authoring a paper on the "Differences in ED nurses from Canada and England".
- Advertising rates for the OUTLOOK were accepted.
- There was discussion on how NENA can make the annual general meeting more interactive and have involvement from the membership. It was moved and approved by the board that the annual general meeting in spring of 2009 would have a café-type forum and that the questions for discussion will be issues raised from each of the provinces.
- Final profit from conference 2008 was $27,510.36. NENA received 50% + $2,000.00 seed money return for a total of $14,752.18 and ENIG received 50% for a total of $12,752.18.
- Conference 2009 will be in Winnipeg. The date for the AGM will be April 24, 2009, 12:30 p.m. to 2:30 p.m. and it will be a luncheon.

Website

The NENA Web Master joined the board meeting via a Web cast. During the Web cast, the board walked through the following processes:

Renewal process

- Payment by cheque
- Payment by PayPal

Membership management

- Set member applying
- Transaction receipts on member demographics (PayPal and cheque)

PayPal

- Overview of PayPal account
- Changing password and profile settings
- Payment reporting

Upcoming projects

- NCAC course applications
- NENA/NCAC website

Website will soon have a new look. A website development committee was developed with membership from the BOD and NCAC.

NCAC report

A joint meeting of NCAC and NENA happened on the third day and several processes were streamlined for the dissemination of NENA courses.

A PowerPoint presentation will be developed about the benefits of NENA mem-

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.
- Number of observers allowed will be at the discretion of the board.
- If the request is less than 30 days in advance of a NENA board of directors' meeting, it will be at the discretion of the NENA executive whether permission will be granted.
- All observers shall be identified at the beginning of the meeting.
- A review of observer expectations will be outlined at the start of the meeting and is as follows:
  - 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 at the request of the president.

bership and this presentation will be done at the beginning of all NENA-endorsed courses.

French translation (TNCC) has now been completed.

TNCC

- 2008/2009 contract with ENA has been signed.
- NENA received $1,771.00 grant monies from ENA for course taught.
- A Canadian Course Administration Manual will be developed and will include CATN.
- 6th Edition of TNCC has been rolled out and NENA/NCAC must have all instructors updated.

ENPC

- ENPC will be undergoing revisions.
- NCAC appointed a Canadian representative for the revisions. The revisions are anticipated to take three years.

CATN

- There are currently eight CATN course directors.

NENA board was given a copy of a recent report entitled: "Boarding of admitted patients in the emergency department. The incidence and impact of this practice—Final report". This research project represents a beginning attempt to examine the incidence and impact of holding or boarding admitted patients in the ED. The impact of this practice was examined in terms of outcomes for patients who are admitted to hospital, as well as those who are treated and then released from the ED. The data were collected between September 2005 and August 2006.

It is hoped that a synopsis of this report will be in a future edition of OUTLOOK.

NCAC at work

The NENA board of directors

International ER Congress 2008

The president of NENA, T. Penney, spoke at the 5th World Congress World Federation of Critical Care Nurses in Mexico City, November 12–14. J. Spivey, Director from Ontario, spoke as well, as an invited guest.

Workload measurement tools

It was recommended that the research committee conduct a survey of our membership via the web and see if there is any measurement tool being used in emergency departments across Canada.

Quebec/Prince Edward Island/Yukon/ Northwest Territories

NENA members from Prince Edward Island will be represented by Nova Scotia.

There was a teleconference in December with representatives from Quebec on developing an interest group in that province. Results will be discussed at the spring board meeting.

New position statements

New position statements were assigned to BOD members:

- New Grad in the ED
- Non-nursing staff in the ED
- Role of the NP in the ED
- Deferral of CTAS Level 5
- Internationally Educated Nurses

It is hoped that these position statements will be ready for approval at the spring 2009 meeting.

The following new position statements were added to the website:

- Family Violence
- Family/Primary Social Unit Presence during Resuscitation and Invasive Procedures
- Violence in the Emergency Department
- Nurse-Patient Ratios in the Emergency Department

Submitted by Jan Calnan

outlook
Canadian Perspectives

New Brunswick

"Riding the Wave of Change"

Plan now to attend the 2010 NENA Conference in St. John, NB. The conference will be held May 6–8, 2010, at the Hilton Hotel and Trade and Convention Centre. The call for abstracts will go out this spring. Contact Hiadee Goldie at **golhi@reg2.health.nb.ca**

Hiadee Goldie

Manitoba

Rural Solutions

In rural centres, emergency departments are being closed due to lack of physician and nursing coverage. Rural patients continue to seek care at the local facilities even when the ED is closed. Some regions have implemented policies and protocols that allow nurses to work to their full scope. The nurses are covered to triage, assess, treat and discharge CTAS level 4 and 5 patients. This has been somewhat controversial in rural Canada, but many rural nurses believe they have the skills, experience and knowledge to care for these patients safely.

Irene Osinchuk

Saskatchewan

Saskatchewan Emergency Nursing Group Meets with SaskHealth

NENA representatives met with a representative of the Minister of Health, nursing practice advisors from the SRNA, and Saskatchewan's Chief Nursing Officer in January to discuss issues of concern: limited resources in rural areas, bed shortages in inpatient units, admitted patients lounging in emergency departments and the shortcomings of overcapacity protocols, and non-nursing personnel filling in for registered nurses.

SUN/SaskHealth Partnership

Saskatchewan Union of Nurses and Saskatchewan Health have signed a partnership that describes a framework including dedicated funding to hire 800 registered nurses over the next four years. The agreement includes specific hiring targets and funding, which will provide motivation for health regions to meet the targets. This comprehensive plan includes means of retaining experienced nurses, improving nurse/patient ratios, increasing the use of nurse practitioners, a bridging program for LPN to RN, increased nursing school seats, and increased opportunities for full-time employment of new graduates. Hopefully some of these measures will address SENG's concerns for emergency care. Signed, Pollyanna

Stephanie Carlson

Calling all instructors

If your students have put the 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, Stephanie Carlson, Box 31E-RR1, Station Main, Regina, SK S4P 2Z1, ***communicationofficer@nena.ca***

outlook
Conference watch

World Association for Disaster and Emergency Medicine

World Conference on Disaster and Emergency Medicine will hold its biennial conference
Victoria, British Columbia, May 12–15, 2009.

This conference will host between 600 and 1,000 delegates from around the world, involving experts in public health, government, industry, military and civilian organizations. For further information and registration forms, brochure, submission of articles, etc., e-mail: **info@wcdem2009.org**

NENA Conference 2009

Dates for the conference will be April 23–25, 2009, in Winnipeg, Manitoba.
Theme: Global Changes…Emerging Times

Think febrile seizure? Think again...

By Susan Poole, RN, and Amanda Luffman, RN, BSN

The seizing baby was brought into our room with mom, dad, and grandma. We cut off his clothes, obtained vital signs, and connected him to our cardiac monitor while our paramedic student maintained the child's airway on high-flow oxygen. The babe's temperature was over 39 rectally, with an elevated heart rate between 180 and 200 bpm. He had laboured respiration and a normal Chemstrip of 9.1 mmol/L. The chest sounds were clear, and mom denied any recent cold or flu in the child. She stated her son just woke up with a fever after naptime and began seizing.

Our emergency physician immediately ordered rectal Valium and Tylenol after a Braslow weight was obtained. However, the child continued to seize. IV access was initiated twice, the child was suctioned, the respiratory therapists were called, and a urine bag was applied. Blood work was drawn and a Stat chest x-ray was completed.

We noted stridorous breathing in the child, and prepared for rapid sequence induction and intubation. After the respiratory therapist intubated the seizing child, we continued to push sedatives intravenously, administered Advil rectally, and started an infusion of Cefuroxime after noting an elevated white count of 18.4.

The child finally quit seizing for a short period of time. Nearly 45 minutes after he was brought in, we noted decorticate posturing. The child's parents had denied any prior trauma. After reassessment by the emergency physician, a Stat unenhanced CT of the head was ordered. The child began seizing again. We noted short runs of ventricular tachycardia (V-Tach) while attached to our transport monitor. We nervously prepared for defibrillation while our paramedic student continued bagging and we continued transporting our patient down the hallway to CT.

The CT was normal and we returned to the patient's room. We observed periodic short runs of V-Tach. The child produced 30 cc of urine, which was collected in a U-Bag; samples were sent to the lab. Urinalysis and C&S were initially ordered, but some quick thinking led to adding a triage urinalysis for toxicology.

As our shift ended, the babe was attached to a ventilator and the respiratory technician was drawing ABGs. Although we had done our best in caring for the child during our shift, neither of us slept well that night, wondering what would happen to the infant. Upon return the next morning, we found out the baby's urine had tested positive for cocaine, he had been ambulanced by helicopter to another facility, and social services had apprehended all other children in the family.

A diagnosis of febrile seizure had boldly flashed across our minds when the infant was initially brought in, especially with the child's elevated temperature. However, we began to question our original assumption as the treatment proved ineffective and other signs such as decorticate posturing emerged. When the CT of the head was normal, we began to think outside the box and question, "What more could be occurring?"

As the child's urine came back positive for cocaine, we both learned firsthand the valuable lesson: *never assume anything, while expecting and being prepared for everything*.

Had an adult patient come into our department with the same presentation as this child, acute drug ingestion would have crossed our minds more readily, while ingestion of cocaine in this age group is not the norm (Havlik & Nolte, 2000). With cocaine-related diagnoses increasing, emergency nurses should be prepared for anything (Regina Qu'Appelle Health Region Addictions Services, 2006). As noted by Brubacher and Hoffman (1997), children may be exposed to cocaine through accidental ingestion, second-hand smoke inhalation of crack cocaine, or intentional poisoning by family members. Because symptoms of cocaine toxicity can also include hyperthermia and seizures, we must not automatically assume febrile seizures (Brubacher & Hoffman, 1997).

Our second lesson learned in this case was to *always trust our instincts*. Never hesitate in reporting your findings and make suggestions to the physician. We communicated everything to our emergency physician, who was very receptive and listened to our concerns. In this case, suggesting to him the need for a urine triage may have saved the life of this child.

References

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About the authors

Susan Poole and Amanda Luffman are emergency nurses at Regina's Pasqua Hospital.

Sex trade workers: Special considerations in providing sexual assault care

By Elizabeth A. Scoffield, RN

Introduction

While certain areas of sexual offences in North America have been fairly well researched through victim surveys and police agency reporting, there remains a dearth of information about sex trade workers (STWs) who have been sexually assaulted. For instance, one study commissioned by the Canadian Centre for Justice Statistics examined 24,350 sexual assaults reported to Canadian police in 2002, classifying the victims according to a multitude of characteristics such as sex and race. However, it failed to delineate STWs who had been sexually assaulted, as "sex trade" was not recognized in the area of "occupation" (Kong, Johnson, Beattie, & Cardillo, 2003).

Similarly, a study of 1,488 sexual assaults reported to police in British Columbia between 1993 and 1994 failed to illustrate STW proportions because it did not include occupation as a qualifying characteristic (Ministry of Attorney General, 1997). Lowman and Fraser conducted a retrospective examination of Vancouver-based news media from 1964 to 1993 in order to understand this particular issue, but were unable to find any mention of violence toward prostitutes until 1975 (1995, p. 14), despite the fact that, during this time period, B.C.'s RCMP reported 47 cases of sexual assault on STWs, and the Vancouver Police Department recorded 22 similar assaults during a two-year period alone (Lowman & Fraser, 1995, p. 14).

While researchers have repeatedly identified common barriers to gathering information regarding STWs and sexual assault, such as failure to report and substance abuse, all too often sexual assault service providers fail to recognize and incorporate these circumstances when dealing with this unique population. What follows is an examination of why, in particular, STWs are more vulnerable to sexual assault than other groups, and how sexual assault service providers such as health care and legal professionals can integrate this information into providing a more tailored approach when dealing with this challenging subset.

Risk factors and failure to report

A study by the United States National Task Force on Prostitution showed that 32% of female STWs have had a customer attempt to rape them and 26% have been a victim of a completed rape (as cited in Rape Crisis Services, n.d.). The fact that STWs are at an increased risk for sexual violence is even more disconcerting given the link between sexual assault of STWs and murder. For example, the Homicide Survey conducted by Statistics Canada found that 184 out of a total of 6,714 homicides occurring between 1991 and 2001 in Canada were preceded by a sexual assault toward the victim, and that 27% of these victims were STWs (as cited in Kong et al., 2003, p. 5). Street prostitutes are at an even greater risk for violence because they are more likely to be targeted by men with the intention of violence or a combination of sex and violence, because they are easily visible, and because the offender knows that they are unlikely to be caught or prosecuted. In fact, 80% of the prostitutes murdered in British Columbia between 1975 and 1994 worked on the streets Canadian Medical Association, (2004), and according to a Colorado study of 1,969 women who were deceased from 1967 to 1999, prostitutes were nearly 18 times more likely to be murdered than women of similar age and race (Potterat et al., 2004).

Compared to other subgroups, STWs are much less likely to report a sexual assault to either health care or law enforcement groups. One contributing factor is that reported sexual assaults are cleared by police at a much lower rate than other violent offences. Kong et al. examined 27,094 sexual offences declared "founded" by police in 2002 and found that the clearance rate was only 44%, compared to 50% for other violent crimes (2003, p. 9). STWs are also less likely to report sexual assaults to police because they feel that they are not taken seriously; that many people in society have the attitude that STWs cannot really be victimized because they sell sex, or that the sexual assault of an STW is merely an "occupational hazard" (Substance Abuse). In one study, researchers found that 33% of STWs who were sexually assaulted did not report their victimization to police because they believed that the police would not be able to help them, and a further 18% felt that the police would not choose to help them even if they could (Kong et al., 2003, p. 6). Compounding the situation is the fact that "communicating" laws force STWs to conduct business hastily and in remote locations (Canadian Medical Association, 2004), and make it even less likely that STWs, particularly youths, will report a sexual assault for fear of going to jail (Lowman & Fraser, 1995, p. 14).

Many researchers have identified co-morbid diagnoses commonly found in STWs, such as acute and chronic post-traumatic stress disorder (PTSD), substance abuse, generalized anxiety disorder, mood disorders, and acute suicidality, which can impact their ability to seek out and complete sexual assault care (Farley, 2004; Campbell, Ahrens, Sefl, & Clark, 2003; Kurtz, Surratt, Inciardi, & Kiley, 2004, p. 357). For instance, one study by Farley et al. found that two-thirds of 854 female STWs in nine countries had symptoms of PTSD at a severity comparable to treatment-seeking combat veterans (as cited in Farley, 2004), and in a 1999 study, Norton-Hawk reported that between 68% and 80% of women prostituted in order to support their drug habit (as cited in Rape Crisis Services of Greater Lowell, n.d.).

Being "high" further compounds the risk of sexual assault because it impairs an STW's judgment (Lowman, 2000; Rape Crisis Services), as well as reduces their ability to maintain control of a situation (Kurtz et al., 2004, p. 376). Furthermore, substance use makes reporting and prosecuting sexual assaults more difficult because of problems with memory and fear of criminalization for using illegal substances (Rape Crisis Services of Greater Lowell).

Recommendations for care

By far, the most important point that providers of sexual assault services need to remember when dealing with STWs is that working in the sex trade is not a choice. The word "choice" implies that there are options from which one can choose and, as Farley (2004) points out, "The conditions that make genuine consent possible are absent from prostitution: physical safety, equal power with customers and real alternatives". The only difference between prostitution and other types of personal violence is the exchange of money for the abuse (Farley). Having said this, once a therapeutic relationship has been established, all victims of sexual assault should be asked about sex trade activity, especially more than once, since, according to Schwartz, an initial denial of prostitution is not unusual (as cited in Farley). Farley recommends asking questions such as "Have you ever exchanged sex for money, drugs, housing, food or clothes?" or "Have you ever worked in the sex industry: for example, dancing, escort, massage, prostitution, pornography or phone sex?". Once identified as an STW, sexual assault service providers can then move on to screening for co-morbid issues such as substance abuse, homelessness, and mental health issues, as well as provide tips for reducing victimization. Kurtz et al. (2004, p. 380) have identified strategies for reducing risk that sexual assault service providers can relay to STWs such as conducting the sexual act in the most public place possible, sharing information about "bad dates", carrying weapons, not carrying money or drugs on them while working, and delaying drug use until after work in order to increase their judgment and ability to maintain control. Unfortunately, the latter may be difficult for the STW, since many require intoxication in order to perform the sexual act (Kurtz et al., 2004, p. 381).

Meanwhile, participants in Lowman and Fraser's 1995 (p. 14) survey of Vancouver STWs further suggested that the best way to minimize violence against street STWs would be to provide safe and affordable housing, food, money, and daycare, and 85% of the STWs identified the need for increased detox units. As front-line care providers, sexual assault nurse examiners, emergency room nurse, social workers, and victim's services organizations can be instrumental in providing assistance in these areas. Another study conducted by Zweig, Schlichter, and Burt (2002, February, p. 168) found that the most commonly cited barrier to care for STWs was the fact that STWs felt that the "system" tends to blame them for their victimization and, thus, takes them less seriously than others. Again, interacting with the STW with an attitude of acceptance and non-judgment is one of the greatest tools for empowerment that the sexual assault care provider can utilize.

Summary

It is clear that sexual assault and violence toward STWs is a complex social and criminal issue whose solution is way beyond the scope of this discussion. Yet, one cannot ignore that there are special considerations for STWs who are sexually assaulted, such as concomitant social problems, as well as societal views about their "occupation" that affect their likelihood to initiate and follow through with investigation and treatment. It is especially important that sexual assault care providers provide appropriate after-care for STWs because, as Kurtz et al. (2004, p. 379) point out, "they are a loosely knit collection of people" who, unfortunately, do not belong to any community that can provide them with support. Therefore, it is critical that sexual assault care providers be aware of these particular challenges and incorporate them into their interactions with members of this special population. It is only through non-judgmental and empathic care by the health and legal systems that STWs can develop strategies to minimize the impact of victimization and the risk for re-victimization.

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About the author

The author, Elizabeth A. Scoffield, RN, has been a critical care nurse for 23 years, working in emergency for the past 17 years. She is currently employed as a sexual assault nurse examiner at Surrey Memorial Hospital and is a staff nurse in the Emergency Department and a Site Leader at Royal Columbian Hospital. Elizabeth is pursuing her BSc in criminology at Simon Fraser University.

Information from NENA's Course Administration Committee (NCAC)

Information on NCAC's terms of reference can be found on NENA's website, **www.nena.ca**, under "Committees", under "NCAC".

New contracts for TNCC/ENPC/CATN-II

New contracts have been signed with ENA for TNCC/ENPC and CATN-II. **The contracts remain in effect until October 2010.**

Highlights since our last contract include:

- Paying for manuals upfront. **All course applications with book orders, and individual book orders received on or after January 1, 2009, will require full payment to ENA prior to shipment.**
- Amounts for indirect fees remain unchanged for TNCC and ENPC.
- CATN-II indirect fees are built into the cost of the participant manual.

ENA has since announced price increases for its provider manuals for all orders received by fax/e-mail on or after June 1, 2009.

Course directors can e-mail NCAC at **ncac@nena.ca** for specific information on the financial details for TNCC, ENPC and CATN-II courses if they do not have the current information.

Credit card information to ENA

When submitting credit card information, please be clear about the way in which you wish to be charged if paying for both books and indirect fees. If you wish ENA to charge your credit card for both books and indirect fees, you must enter separately one amount for books and one amount for indirect fees per the following example:

I have listed my credit card information. Please process a charge in the amount of $___ for books, and $___ for indirect fees.

NENA indirect fees

Indirect fees payable to NENA remain constant: $30 Canadian per student for TNCC, ENPC and CATN-II courses. There are no NENA indirect fees for instructor courses.

Course directors, PLEASE include the appropriate paperwork when sending your indirect fees to the NENA treasurer. There is an ongoing problem with cheques being sent to the NENA treasurer without the appropriate information (course number, number of participants, course director, province course was held).

Reminder re. instructor candidate monitoring guidelines

Just a reminder that when monitoring instructor candidates (IC) for TNCC/ENPC, they must be monitored 1:1 by an instructor trainer (IT) or designate. If an IT is not present at your course to monitor the IC, a senior instructor may be designated to do so. Please indicate on your course application to ENA which experienced instructor will be assigned to monitor your IC.

New instructor cards

All current ENPC and TNCC instructors should now have or will soon receive new instructor cards. There is now only one instructor number for both courses. If you are an ENA member, your instructor number will be your membership number. If you have not yet received your new instructor card you may check on the status of your card by contacting ENA Course Operations at (800) 900-9659 extension 4120 or e-mail at **courseops@ena.org**.

Please ensure you provide your new number to the course director when teaching.

Course numbers have changed

Course numbers are now shorter. The last two digits, previously used to represent the probable number of participants, have been eliminated.

Previous: TP20081002-54A-24
Now: TP20081001-54A

Please continue to use the course number "originally" assigned to the course—even if it is in the old format.

French translation exams

If you have French-speaking participants at your course, the course director may request an electronic copy (PDF format so no alterations can be made) of the ENPC and TNCC provider course exams and answer keys. As with all exams, the course director must ensure exam security. Send your request to the NCAC chairperson at **chairncac@nena.ca**.

Instructor courses

NCAC endorses the dissemination of courses throughout the country and encourages the development of new instructors. If you require an instructor course in your area, please send a letter of intent, outlining the rationale for more instructors, to NCAC members at **ncac@nena.ca** prior to requesting your course.

Mechanism of injury lecture

Though mechanism of injury is discussed in each chapter of TNCC, NCAC suggests that the information in the previous lecture is so valuable that you may still wish to incorporate it into your course as a lecture.

Some instructors are currently doing this and already have prepared material. Should you wish to receive the "Mechanism of Injury" PowerPoint for your 6th edition TNCC courses, simply e-mail **ncac@nena.ca** with your request. The file is quite large, so please provide an e-mail address that will be able to accommodate a large file, or the lecture may have to be burned to a CD and mailed to you.

ENPC reverification course

ENA has developed and is now offering a one-day ENPC reverification course.

Components of this course include

- Pre-test (can also be used as the pre-test for provider courses)
- Condensed lectures
- Triage discussion
- Testing in Management of Injured and Ill
- Post-test

The course was piloted at B.C. Children's Hospital and Alberta Children's with overwhelming success. The key to this success was the familiarity with ENPC and having pediatric emergency experience.

NCAC recommends this course ONLY for those nurses who have taken ENPC multiple times OR work in a pediatric emergency setting.

All nurses registering for the ENPC reverification course must be current ENPC providers.

TNCC 6th edition exam

ENA has issued a recent Course Bytes dedicated to recommendations around the 6th edition exam. Please visit **http://www.ena.org/catn_enpc_tncc/CourseBytes/default.asp** for the most current information.

Copyright information

Remember that all information contained in ENPC, TNCC and CATN-II is a copyright of ENA and requires permission for use. Pneumonic such as "CIAMPEDS" or "A-I" cannot be used in other courses or educational sessions without ENA's written permission. You may request permission by sending your request to Maureen Howard at **mhoward@ena.org**.

Meet with NCAC

NCAC will be meeting prior to the NENA conference in Winnipeg. We are planning an instructor meeting and educational session in conjunction with the conference. When plans are finalized, they will be posted on the NENA website and sent via e-mail to instructors.

Vacant positions for fall 2009

NCAC will be looking to fill two vacancies on the NCAC board for fall 2009—one in the central region (Manitoba, Ontario & Quebec) and one in the Atlantic provinces (Nova Scotia, New Brunswick, Prince Edward Island, Newfoundland and Labrador).

To apply for one of the vacant positions, please send the following to Carole Rush, NCAC Chairperson, at **chairncac@nena.ca** by September 1, 2009:

- Current TNCC, ENPC provider card with evidence of instructor-trainer status

OR

- Copy of CATN-II course certification with evidence of course director status

AND

- Copy of current resume/CV highlighting the **selection criteria** items for NCAC and copies of continuing education courses taken, emergency certifi2cation status (see selection criteria in this newsletter)
- Letter of support/endorsement from your provincial chapter of NENA
- Cover letter indicating your rationale for becoming a member of NCAC

NCAC members and contact information

To reach all NCAC members simultaneously, please e-mail **ncac@nena.ca**

Chairperson:
Carole Rush, Calgary, AB
carole.rush@albertahealthservices.ca

Western Canada Reps:
Colleen Brayman, Kelowna, BC
Colleen.Brayman@interiorhealth.ca

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hogaan@reg2.health.nb.ca

National Emergency Nurses Affiliation, Inc. National Course Administration Committee

Committee Candidate Selection Criteria Scale

Blinded Candidate Identification:

ESSENTIAL CRITERIA

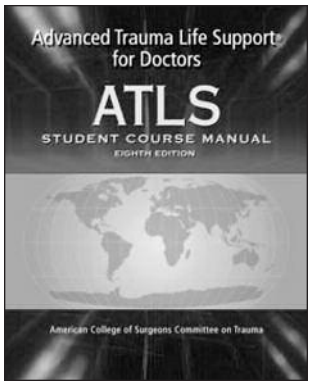
- All NCAC members will be Instructor Trainer (IT) in either ENPC/TNCC or a Course Director of CATN II
- Is a current member of NENA and the provincial emergency nursing association
- Able to work with Microsoft Word and the internet
- Have access to a computer and e-mail accessibility
- Able to travel to meetings twice per year and participate in committee work

PREFERRED CRITERIA

Criteria	Points Earned
Provincial Endorsement	2
Committee involvement National	1
Committee involvement Provincial	2
Completion of BScN	1
Evidence of relevant Emerg. Nursing	1
ENPC Instructor	1
TNCC Instructor	1
CATN II Provider	1
Dual TNCC/ENPC Instructor Trainer	2
Emergency Nursing Experience:	
0–5 years	1
6–10 years	2
11 or > years	3
Total Points Earned:	———

Revised: March 05

Book review: Advanced Trauma Life Support for Doctors: ATLS® Student Course Manual, 8th Edition



American College of Surgeons Committee on Trauma (numerous contributors)
American College of Surgeons, Chicago, IL, October 2008
366 pages
ISBN 978-1-880696-31-6
$100 + $16 shipping to Canada (USD)

Reviewed by Carole Rush, RN, MEd, CEN, FAEN

This manual can now be ordered online outside of taking an ATLS® Provider course. Layout is similar to the TNCC Provider Manual, 6th edition (2007). Chapters include:

- Initial Assessment and Management
- Airway and Ventilatory Management
- Shock
- Thoracic Trauma
- Abdominal and Pelvic Trauma
- Head Trauma
- Spine and Spinal Cord Trauma
- Musculoskeletal Trauma
- Thermal Injuries
- Pediatric Trauma
- Geriatric Trauma
- Trauma in Women
- Transfer to Definitive Care

Numerous Appendices for additional resources:

- Injury Prevention
- Biomechanics of Injury
- Trauma Scores
- Sample Trauma Flow Sheet
- Tetanus Immunization

Some lectures that are part of the core content of the TNCC 6th edition course are optional lectures in the ATLS 8th edition course—*Ocular Trauma*, *Disaster Management/Triage Scenarios* and *Trauma Care in Underdeveloped Areas Following Catastrophes*.

As trauma care is multidisciplinary, it is helpful to know what our physician colleagues are studying in their trauma course. Most ATLS courses allow a few nurses to audit in exchange for their services as a patient in the teaching/testing scenarios.

TNCC instructors will find this manual helpful to enhance their knowledge on core trauma content and to answer questions from participants where the information is not in the TNCC Provider manual. There are more than 100 colour images throughout the manual to provide visual understanding of the injuries and trauma care concepts. The summaries at the end of each chapter are a concise way of reinforcing the key points.

The DVD with skills from the course demonstrated in video segments is a unique feature of this manual. These video segments can be reviewed to enhance one's own understanding of the skill, and could be used as a teaching adjunct in nursing orientation and continuing trauma care education. The DVD can be viewed on either a PC or Macintosh computer with certain system requirements.

Skills demonstrated in a simulated environment include:

- Initial Assessment & Management
- Airway & Ventilatory Skills in both adult and pediatric patients, including LMA and gun elastic bougie
- Vascular Access Skills including venous cutdown and pediatric intraosseous
- Surgical Skills
  - Cricothyroidotomy
  - Pericardiocentesis
  - Chest tube insertion
  - Diagnostic Peritoneal Lavage
- Head & Spine Injury Skills
- Extremity Injury Skills
  - Traction splint
  - Pelvic sling
- Ultrasound: FAST Technique

Although the ATLS® course is international with 47 countries providing the course to their physicians, the injury statistics and resource information in this manual is predominantly from the United States.

Purchase information

American College of Surgeons, Committee on Trauma:
www.facs.org

Web page to order manual:
https://web2.facs.org/timssnet464/acspub/frontpage.cfm?product_class=trauma

The attitudes and activities of registered nurses towards health promotion and patient education in the emergency department

By Michelle Taggart, RN

Abstract

Emergency department (ED) registered nurses (RNs) can help empower patients toward greater well-being through health promotion and patient education (HPPE). The ED is often an individual's first and only access to the health care system, and is seen as an under-used setting for HPPE. To investigate RNs' current attitudes and activites about educating patients in the ED, 223 Canadian ED RNs were surveyed using an adapted web-based questionnaire. The attitudes of ED RNs and their current HPPE activities were examined, as was the relationship between level of nursing education and these attitudes. Results showed that perceived importance is the major variable to explain HPPE. A relationship also exists between fewer barriers and feeling more comfortable providing HPPE to patients. More comfortable ED RNs are more likely to see the importance of HPPE. A relationship between perceived effectiveness of HPPE and the frequency of HPPE was found. In general, ED RNs believe that HPPE is important, but need to perceive that what they are providing is effective.

Introduction

In Canada, between 4 and 5 million adults are without a family physician, with a significant portion of those individuals seeking medical advice at emergency departments (ED) (Bailey, 2007; Canadian Broadcasting Corporation, 2008). As a result, all types of patients come through the ED doors and an incredibly varied array of health issues are addressed by ED staff. Nurses are at the forefront, helping and caring for those patients. In a health care system that is clearly over-extended, where patients often present to the ED with non-urgent concerns, ED registered nurses (RNs) can help to empower patients to take control of their own lives through health promotion and patient education.

Literature review

The ED has long been under-used as an area for health promoting practices, although it is definitely a suitable setting for these kinds of activities (Bensberg, Kennedy, & Bennets, 2003). According to Allender and Spradley (2001), one role of the nurse is "to encourage the full development of a self-care attitude" (p. 363), and nurses can empower patients by educating them about health promotion strategies. Specifically, ED RNs are in an ideal position to promote health through education. ED RNs see a variety of patients, both men and women, ranging in age, ethnicity, and socioeconomic background. Many patients are never admitted, a large number of them being discharged home with non-acute illnesses. Often, the ED is the only place of contact with the health care system (Wei & Camargo, 2000).

Casey (2007) found there is a need for a solid nurse-client relationship in order to empower patients, as well as health education at the appropriate educational level. Whitehead, Wang, Wang, Zhang, Sun, and Xie's (2008) focus was mainly on promoting healthy lifestyle changes, with health education the most common way to do so. Wingard (2005) recommended that health education be simple and understandable so as not to overload the patient and/or the family. A skills training program prior to discharge of surgical patients has worked well and can be cost efficient (Rifas, Morris, & Grady, 1994). Is there a chance that model would be suitable for ED discharges? Emerson (2003) looked at education of patients regarding heart disease in the ED, and considers it is reasonable for RNs to discuss lifestyle issues related to heart disease with their patients. Patients who are most suitable for teaching are those who are stable, less anxious, and awaiting an admission or consult.

Kelley and Abraham (2007) found that, overall, nurses believe it is part of their role to provide health-promoting advice to their patients. However, very few actually do so on a regular basis. McBride (1994) omitted ED RNs from her study; she felt that they do not have regular contact with their patients like acute care nurses do and, therefore, need to be studied separately. Bensberg, Kennedy, and Bennets (2003) did, however, study ED RNs in relation to health promotion and patient education. They looked at barriers to its provision: lack of time, lack of patient and staff interest, fewer staff numbers, and an increased acuity of medical conditions were most common. Nevertheless, they encouraged discharge teaching in the ED, stating it leads to patient empowerment. Cross (2005) conducted the only study that could be found addressing the attitudes of ED RNs towards health promotion specifically. She concluded that more research is required not only of ED RN attitudes, but also regarding health promotional activities in order to highlight barriers to its provision.

The study

This study investigates relationships among the frequency of providing health promotion and patient education to adult patients by RNs in the ED. In particular, perceptions of effectiveness and its importance were explored, as well as comparisons made regarding demographic characteristics, and perceived barriers.

The research questions for the study were:

1. What are the attitudes and activities of ED RNs regarding the offering of health-promoting advice in the ED?
2. What relationships do age, level of education, years of experience as an RN, years of experience as an ED RN, and perceived importance have with the frequency of providing health-promoting advice?
3. What relationships do age, level of education, years of experience as an RN, years of experience as an ED RN, and perceived importance have with the perceived effectiveness of providing of health-promoting advice?

Definitions

Health promotion refers to supporting individuals to make healthy choices, and **patient education** is providing the information and rationale for one to do so. According to the World Health Organization:

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By doing so, it increases the options available to people, to exercise more control over their own health and over their environments, and to make choices conducive to health" (World Health Organization, 1986, p. 3).

Methodology

The study was approved by the University of Victoria Human Research Ethics Board, covering all health regions across Canada. Data were collected using a convenience sample of ED RNs, mainly through the National Emergency Nurses Association (NENA) membership. An e-mail was sent out to NENA members by NENA executive on behalf of the researcher. Participation in this study was voluntary and responding to it implied consent.

The questionnaire was adapted from Yeazel, Lindstrom, and Center's (2006) Preventive Medicine Attitudes and Activities Questionnaire (PMAAQ), then tested on a pilot group of ED RNs at Foothills Medical Centre in Calgary, Alberta. The modified PMAAQ consisted of 17 questions divided into three sections. The first eight questions related to the demographic characteristics. In the second part of the survey, eight questions were posed. The topics related to overall prevention behaviours, weight management, tobacco cessation, hypertension management, perceived effectiveness of providing health promotion advice, perceived importance of providing health promotion advice, comfort when providing health education, and perceived barriers to health promotion. Each of these questions is further divided into items related to each scale, for a total of 76 items. The third portion of the survey included a comments section.

(In general, how important is it for ED registered nurses to provide health education to their patients about the following?)

Individual Item Scores for Perceived Importance Scale (measured on 4-point scale)

Item	Mean	Std Dev
Alcohol Consumption	3.17	0.87
Safe Sex Practices	3.15	0.92
Illicit Drug Use	3.22	0.86
Exercise	2.88	0.99
Healthy Diet	2.90	0.99
Tobacco Use Cessation	3.12	0.94
Weight Reduction	2.81	0.98
Seatbelt Use	3.51	0.76
Stress Management	2.86	0.91
Injury Prevention	3.43	0.80
Violence Prevention	3.28	0.84
Sun Exposure	2.72	0.97
Hypertension Management	3.43	0.76
Depression Management	2.99	0.87
Helmet Use	3.50	0.78
Total	3.14	0.69

(Regardless of whether you see the patients again or not, as an ED RN, how effective do you feel you are in changing your patients' behaviour with respect to the following?)

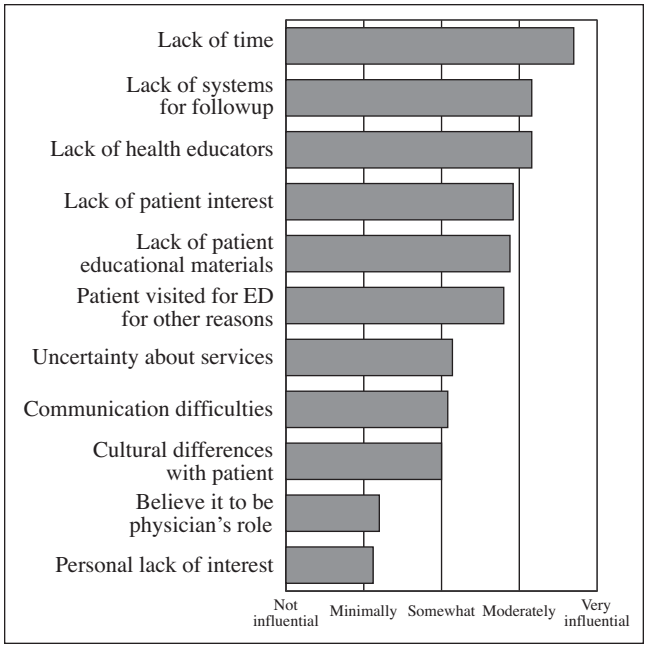
Individual Item Scores for Perceived Effectiveness Scale (measured on 4-point scale)

Item	Mean	Std Dev
Alcohol Consumption	1.33	0.60
Safe Sex Practices	1.69	0.75
Illicit Drug Use	1.30	0.52
Exercise	1.52	0.63
Healthy Diet	1.60	0.68
Tobacco Use Cessation	1.55	0.73
Weight Reduction	1.34	0.58
Seatbelt Use	2.22	1.05
Stress Management	1.61	0.70
Injury Prevention	2.15	0.98
Violence Prevention	1.71	0.81
Sun Exposure	1.67	0.86
Hypertension Management	2.31	0.87
Depression Management	1.71	0.76
Helmet Use	2.20	1.04
Total	1.70	0.54

Data were unanalyzed using SPSS, Version 16. Frequencies and descriptive statistics were calculated for the demographic data, as well as for individual items in each of the scales: overall prevention behaviour, weight management, tobacco cessation, hypertension management, perceived effectiveness, perceived importance, personal comfort, and reported barriers. The first four scales were summed to create one scale: combined prevention behaviour, and was used for further analysis rather than including the four individual scales. Pearson's correlations were calculated among years of experience as an RN, years of experience as an ED RN, and age with the various subscales in the survey. Correlations were also calculated among nursing activities (combined prevention scale) and attitudes (effectiveness, importance, comfort, and barriers) in providing health-promoting advice. Multiple regression analysis was performed with the frequency of giving health advice (combined prevention scale) as the dependent variable and demographic characteristics (age, level of education, experience) and perceived importance as the independent variables. Another analysis was conducted to examine the effect of personal comfort and reported barriers on the prevention scale. Regression analysis was also conducted with perceived effectiveness as the dependent variable and demographics, importance, barriers and comfort as independent variables. A final regression equation was calculated with personal comfort as the dependent variable and demographics and barriers as independent variables.

Findings

The sample consisted of 223 ED RNs from across Canada. Participants ranged in ages between 24 and 63 years (M = 42.2; SD = 9.07). Ninety-one per cent (91%) of respondents were female. The participants' years of experience as an RN ranged from 1 to 42 years (M = 18.4; SD = 9.89), and their years of experience as an ED RN ranged from 0 to 40 years (M = 12.8; SD = 8.74). Almost 65% of the respondents had basic nursing education. The remainder had completed post-RN speciality courses, mainly specific to the ED environment (22.9 %), or graduate studies (8.1 %). One respondent had her PhD in nursing.



Perceived Barriers by the ED RN to Health Promotion and Patient Education Provision (N=223)

Attitudes were measured through the following scales: perceived effectiveness, perceived importance, personal comfort, and reported barriers to the provision of health promoting advice.

ED RNs found themselves to be most effective at changing their patients' behaviour when it comes to blood pressure management (41.3% *moderately* or *very effective*), but were found to believe they are only *minimally* or *somewhat effective* at changing their patients' behaviour when it comes to alcohol consumption (92%) and illicit drug use (93.7%). Overall, most respondents reported that they were *minimally effective* to *somewhat effective* at providing health-promoting advice to their patients.

It was found that most respondents believed that the provision of health-promoting advice to their patients and families is a *moderately important* to *very important* role of the ED RN. Specifically, ED RNs found it *moderately* or *very important* to focus on seatbelt use (87.4%), helmet use (87.0%) and injury prevention (86.1%). Of lesser importance were weight reduction (60.9%), stress reduction (60.5%), and sun exposure (57.0%).

Seventy-seven point two per cent (77.2%) of respondents *somewhat* or *strongly agree* with the statement: I feel comfortable discussing illicit drug use with patients, and 70.9% of respondents *somewhat* or *strongly agree* with the statement: I feel comfortable discussing sexual health practices with patients. On the other hand, 66.8% of respondents answered that they *somewhat* or *strongly disagree* with the statement: Most patients try to change their lifestyles if I advise them to do so.

Lack of time was the most frequently reported perceived barrier, rated as *moderately* or *very influential* by 92.8% of respondents. The next two most frequently reported barriers were having a lack of health educators (rated *moderately* or *very influential* by 78.5% of respondents) and having a lack of support systems for patient follow-up (rated as *moderately* or *very influential* by 74.0% of respondents). The least-reported barrier was the RNs' personal lack of interest in health promotion and patient education. It was rated *not influential* by 40.4% of respondents.

Health promotion activities were measured individually through four scales: overall prevention behaviour, weight management, tobacco cessation, and hypertension management. The combined prevention behaviour grouping incorporated all four scales into one.

It was found that, on average, respondents reported providing health-promoting advice to their patients and families less than *half of the time*, and they were very *rarely* found to provide health-promoting advice regarding weight management to their overweight and obese patients who visited the ED. Respondents more commonly advised their patients to quit, however were found *rarely* to refer them to a program, provide the tobacco users with self-help materials, or prepare them for withdrawal symptoms. There was a range of answers but, on

average, hypertension management activities were done about *half of the time*. Referrals to the patients' general practitioner and encouragement to continue with their prescribed medication routine were the most common activities reported by ED RNs in relation to hypertension management.

Demographic characteristics were found to have little relationship with the ED RNs' frequency of providing health-promoting advice. Weak, but statistically significant correlations were noted among years of experience as an RN, years of experience as an ED RN, and age with the activities of providing health-promoting advice. No relationship was found to correlate with any of the attitudes examined.

In the regression analysis, it was found that age, education, and experience alone were not significant predictors of the overall combined prevention score (frequency of ED RNs providing health-promoting advice). However, adding the importance category made the overall regression equation statistically significant. The variables explained 24.1% of the variance of frequency of providing health-promoting advice. As well, when analyzed together, the perceived comfort and perceived importance of offering health promotion advice were found to explain 27.2% of the variance of the frequency of providing health-promoting advice.

There was no correlation between the demographic characteristics or reported barriers and perceived effectiveness in providing health-promoting advice. However, it was found that there were statistically significant correlations between perceived effectiveness of the provision of health-promoting advice and combined prevention behaviours (r = .518; p = 0.01), perceived importance (r = .388; p = 0.01), and personal comfort (r = .312; p = 0.01).

In the regression analysis, it was found that perceived importance explained the perceived effectiveness of health-promoting advice, when demographic characteristics were controlled. This equation explained 17.7% of the variance of perceived effectiveness.

Discussion

Perceived importance is the single most significant variable in explaining the frequency of health-promoting advice. Still, while a large number of ED RNs believe that health promotion and patient education are important, it does not necessarily get carried out in practice. ED RNs are faced with barriers to providing health-promoting advice. They also need to feel that the health-promoting activities they are providing are effective and not a waste of their time. ED RNs who are more comfortable with its provision are more likely to see it as an important aspect of the nursing role. Once they feel that they are actually making a difference in their patients' lifestyle, there is a greater likelihood that health promotion and patient education will occur more frequently.

Limitations

For one, this study's focus is on adult populations only. It would be interesting to compare health promotional activities in adults with those in child populations. Secondly, a convenience, not random sample was obtained with NENA nurses. One could argue that there is bias with nurses who are members of NENA, and that those who are willing to participate in a survey are more likely to be motivated toward health-promoting activities. Thirdly, in review of the comfort scale, it appears that the last three questions are not measuring personal comfort. Therefore, these questions should be redone should this study be repeated. Finally, the instrument adapted for this study was based on a questionnaire designed for primary care physicians, not emerge nurses. GPs tend to see their patients again and often deal with more chronic issues. ED RNs tend to see their patients just once, usually during an acute crisis. Therefore, the instrument may not have captured all the aspects of health promotion important for ED RNs.

Conclusion

This study reports findings from ED RNs regarding their attitudes and activities towards health promotion and patient education within an adult population. The findings show that, overall, ED RNs believe that health-promoting activities are important, but need to feel that what they are providing is effective. It was reported that barriers, most reportably time, make it difficult for ED RNs to provide health promotion and patient education. There is a relationship between overcoming these barriers in practice and feeling more comfortable providing health-promoting advice to patients. ED RNs who are more comfortable are also more likely to see the importance of health-promoting activities. Feelings of importance are the most important predictor of providing health-promoting advice. The level of education of the ED RNs was not found to significantly predict health-promoting attitudes, and no relationship was found between years of experience as an ED RN and the perceptions of effectiveness in providing health-promoting advice.

The results of this study have implications for nursing policy and practice, suggesting that believing that health-promoting activities are important may increase the frequency of ED RNs providing health-promoting advice. Current emergency departments can be transformed into ones that support health promotion and patient education. Health-promoting activities should become an expectation of employment, reinforced at initial hire, orientation, and annual recertification. ED RNs already agree that health-promoting activities are important, now they need to become comfortable through practice. With the necessary support, resources, and training available, these ED RNs will be more comfortable and effective in their role as a patient educator. A culture of health promotion within EDs needs to be encouraged. If policy change elicits a trend toward regular health promotion and patient education provision as a socially acceptable norm, then other ED RNs will follow suit. Still, barriers to health promotion and patient education must be kept in mind when developing new policies.

It may also be valuable in EDs, particularly in larger centres, to create a new position for an RN to specifically offer health promotion and patient education regularly. The patient education nurse would be someone who has the time to spend

with patients and their families while in the waiting room or while in the department waiting for test results, providing them with information about their health, tailored to their needs. In smaller hospitals, the staff nurse educator could supply ED RNs with the appropriate education and suitable resources for them to provide health promotion and patient education. While it is still the role of every RN to provide health-promoting advice to her patients, this new role may assist in overcoming some barriers.

Recommendations for future research include examining the qualitative data for prominent themes and patterns, exploring other variables not included in the study such as ED RNs' knowledge of health promotion and patient education topics, and the evaluation of implemented programs of health promotional activities in the ED. A study of the overall effectiveness of health promotion and patient education in EDs that looks at outcomes and rates of return to the department would be worthwhile.

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About the author

Michelle Taggart is a registered nurse at the Foothills Hospital in Calgary, Alberta. She carried out the above research for her thesis in completion of her Master's of Nursing, Advanced Practice Leadership through the University of Victoria.

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Clinical tip: Hypothermia

By Elizabeth Hextall

On a cold January day, our ER treated the fourth patient with hypothermia (core temp 27°C) of the winter. To infuse warm solution into the bladder, we applied principles borrowed from intra abdominal pressure monitoring. We hung a litre of NS put through a Hotline warmer with a stopcock on the end of the IV tubing. The sampling line on the Foley catheter has a clear link design so the stopcock (or IV tubing) connects directly. We then clamped (using plastic forceps) the drainage tubing to the catheter bag and infused 500 ml warm NS into the bladder and let it dwell 20 minutes.

Then we closed the stopcock connected to the sampling port, unclamped the drainage tubing and let the saline drain into the catheter bag. Once drained, we reclamped the drainage tubing and infused more warm saline to repeat the process.

The core temp increased one degree within minutes following bladder infusion. Prior to bladder instillation, the patient had warmed intravenous infusing and our Blanketrol had been applied. The biggest bonus of infusing saline into the bladder this way is that the warmth of the solution is controlled, and it frees up a pair of hands to do other nursing tasks. The down side is that you have to have more than one Hotline warmer in your ER…

About the author

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Clinical nursing experience in the emergency department

By Tayne Batiuk, RN, BSN

An outbreak of MRSA/VRE and subsequent closure of the 4D nursing unit forced the University of Saskatchewan College of Nursing to seek alternate sites for clinical experience. Fortunately, the two emergency departments were able to accommodate the Year III students. Although the course intents are levelled for care of patients admitted to a hospital unit, we believe that with adequate supports and supervision, junior students can acquire some of the competencies required in an emergency department. Normally in the University of Saskatchewan BScN program, emergency is a fourth-year experience. The College of Nursing is currently working with the Regina Qu'Appelle Health Region to increase the numbers of students receiving that experience.

In the last weeks of March 2008, a small number of nursing students from the Nursing Education Program of Saskatchewan (NEPS) were able to have clinical experience in the emergency department (ED) of the Pasqua Hospital. Each clinical group consisted of approximately five to eight students and their clinical instructor. Students were paired with staff nurses in both the ED and the Reassessment Unit (RAU) and remained in the ED for the full 12-hour shift. The students were in the last two weeks of their third year of nursing school and were preparing for their final fourth year practicum.

This experience was invaluable to the students, as the opportunities to heighten and enhance clinical skills, both new and established (i.e., IV initiation, catheter insertion, assessments, vital sign monitoring, ECG interpretation, etc.) were plentiful, as opposed to sporadic occasions on the ward on which they had initially spent their rotation. Proficiency in assessment skills was gained as students performed head-to-toe assessments on each patient, as per ED protocol. Students felt that they also gained confidence from the repetition of such skills.

The students were not allowed to administer medications during the shift, which was appropriate given the pace and unfamiliarity of the ED itself, and the difference in workings/routine of the ED, as opposed to the ward (med/surg) in which the students had been in the previous weeks.

The ED is a unique and appealing area for nursing students. Motivation to work in the ED is often the unknown presentation of the clients who are served there, the continuous pace that one does not often experience on the ward, the constant turnover of clients (thus, never losing interest), and the potential to continuously practise skills and learn new procedures and protocols. As a clinical educator, I support clinical experience in the ED as it provides a stimulating environment from which students gain both competence in skill and confidence in self, and are able to apply theory to practice. There is also transference of knowledge from senior staff to students, assisting in growth of the student on an academic and professional level.

Below are some comments from student journals regarding their ED experience. They were aware when they wrote the journals that excerpts might be used in future regarding this subject. I have edited some of their comments for space, and have not attached names to the comments for reasons of confidentiality:

"I think that it was a good opportunity being able to see just the path patients go through to get to the ward if they come through emergency. The experience of going to the ER helped us, as students, identify more with the patients."

"It was a really good place to be and I feel that, as third-year students, we have several skills that would provide as valuable in that type of setting, especially with catheters, dressings, assessments, intravenous starts. I liked the staff – they were all very friendly and helpful explaining and walking us through things."

" I was amazed at how well the team worked together to get everything set up and organized. It was amazing to see a team work like that and how they were constantly giving support and encouragement to each other the whole time."

"I feel that if this had happened at the beginning of the rotation, it would have been really stressful. I feel that getting to know your patients and doing the research along with the concept maps is important for the first few weeks. Plus, we also got to build up our confidence and skills before going to the fast-paced environment that is in the ER."

"I believe it is of great benefit and advantage for third-year clinical students to experience the ER department. The opportunities to practise skills such as: IV insertion, catheter insertion, and assessments are countless, and although these opportunities can present themselves on the wards, there is no guarantee."

"The assessments alone, which are crucial to perfect as a nurse, are different because in the ER there is no diagnosis for patients right away, so it is up to the skills of the nurse to incorporate the chief complaint, past history, medications the individual is on and all known information to formulate or guide their assessment. On the unit, the diagnosis is known and assessments focussed accordingly. By spending time in the ER, I gained a better understanding of the nurse's role in emergency practice and was exposed to new opportunities. Emergency nursing and the inner workings of an ER department are very different than ward nursing. There are differences in charting, protocols and in pace of the day."

In addition to teaching nursing students, Tayne Batiuk works in Regina's Pasqua Hospital Emergency Department and is enrolled in the MSN program at the University of Saskatchewan.

Who's your hero?

By David F. Baehren, MD

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For a generation or two, we have lamented the loss of role models in society.

As parents and individuals, we naturally seek out others we would like to emulate. Sadly, a serious search through the popular culture leaves us empty-handed and empty-hearted. Thanks to a long list of legal and moral shenanigans, many entertainers, politicians, and athletes long since abdicated this momentous position of responsibility.

We usually look afar for heroes and role models and, in doing so, overlook a group of professionals who live and work in our midst: nurses.

And not just any kind of nurse: the emergency nurse. There are plenty of people involved in emergency care, and no emergency department could function without all of these people working as a team. But it is the emergency nurse who shoulders the weight of patient care. Without these modern-day heroes, individually and collectively, we would be in quite a pinch.

This unique breed of men and women are the lock stitch in the fabric of our health care safety net. Their job is a physical, emotional, and intellectual challenge.

- Who helped the paramedics lift the last 300-pound patient who came in?
- Who took the verbal lashing from the curmudgeon giving admitting orders over the phone?
- Who came to tell you that the guy you ordered the nitro drip for is taking Viagra?

The emergency nurse has the thankless job of sitting in triage while both the long and the short buses unload at once. With limited information, they usually send the patient in the right direction while having to fend off some narcissistic clown with a zit on his butt. They absorb the penetrating stares from weary lobby dwellers and channel all that negative energy to some secret place they only tell you about when you go to triage school.

Other kinds of nurses serve key roles in health care and attend to their patients admirably. However, few function under the gun like emergency nurses do.

It is the emergency nurse who cares for the critical heart failure patient until the intensive care unit is "ready" to accept the patient. The productivity of the emergency nurse expands gracefully to accommodate the endless flow of patients while the rest of the hospital "can't take report." Many of our patients arrive "unwashed." It is the emergency nurse who delivers them "washed and folded." To prepare for admission a patient with a hip fracture who lay in stool for a day requires an immense amount of care—and caring.

Few nurses outside of the emergency department deal with patients who are as cantankerous, uncooperative, and violent. These nurses must deal with patients who are in their worst physical and emotional state. We all know it is a stressful time for patients and family, and we all know who the wheelbarrow is that the shovel dumps into.

For the most part, the nurses expect some of this and carry on in good humour. There are times, however, when the patience of a saint is required.

In fact, I believe that when emergency nurses go to heaven, they get in the fast lane, flash their hospital ID, and get the thumbs-up at the gate. They earn this privilege after being sworn at, demeaned, spit on, threatened, and sometimes kicked, choked, grabbed, or slugged. After this, they go on to the next patient as if they had just stopped to smell a gardenia for a moment.

Great strength of character is required for sustained work in our field. The emergency department is a loud, chaotic, and stressful environment. To hold up under these conditions is no small feat. To care for the deathly ill, comfort suffering children, and give solace to those who grieve their dead takes discipline, stamina, and tenderness. To sit with and console the family of a teenager who just died in an accident takes the strength of 10 men.

Every day emergency nurses do what we are all called to do, but find so arduous in practice. That is: to love our neighbours as ourselves.

They care for those whom society renders invisible. Emergency nurses do what the man who changed the world 2,000 years ago did. They look squarely in the eye and hold the hand of those most couldn't bear to touch. They wash stinky feet, clean excrement, and smell breath that would give most people nightmares.

And they do it with grace.

So, here's to the emergency nurse. Shake the hand of a hero before your next shift.

About the author

Dr. Baehren lives in Ottawa Hills, Ohio, and practises emergency medicine. He is the author of "Roads to Hilton Head Island." He welcomes your feedback at ***DFBaehren@ameritech.net***

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