outlook

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

Volume 34, Number 2, Fall 2011

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Guidelines for submission

Editorial Policy

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

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

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

Preparation of Manuscripts

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

2. Manuscripts must be typed, double-spaced (including references), on 8½" × 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:
Stephanie Carlson, Outlook Editor,
e-mail: communicationofficer@nena.ca

Deadline dates:
January 31 and September 8

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President's message

Stepping into the president's shoes is a bit daunting, especially when trying to fill the ones left by our Past-President Landon James.

The NENA Board of Directors worked hard on your behalf under Landon's leadership and my plan is to see that NENA continues that work and moves forward.

As I start my term as president of NENA, I have been in contact with other groups and organizations and continue to dialogue with colleagues such as Canadian Nurses Association (CNA), Canadian Association Emergency Physicians (CAEP) and Emergency Nurses Association (ENA).

Over the summer, I have also been talking to nurses and managers across Canada and I have asked them, "What do you see as the major problems facing emergency departments today?"

It is no surprise that overcrowding, boarding and staffing issues remain at the top of the list. However, many of them are now using words such as *burnout* and *frustration,* and a growing lateral violence and bullying among staff. This is a frightening situation, as I also heard the same while attending the ENA General Assembly and Conference in Tampa, Florida, in September.

It is common knowledge that the emergency nurse continues to work in a situation where the emergency department has become the "front door" of the health care system and the emergency staff are forced to be the gatekeepers. As the stress and frustration build, so does the resentment, as viable solutions do not appear to be in the near future.

Emergency nurses have always been leaders and I challenge you to develop some suggestions or ideas on how we, as emergency nurses, can take back our departments and make them positive, healthier places to work, regardless of the overcrowding and staffing issues.

As Henry Ford said, "Coming together is a beginning; keeping together is progress; working together is success". I believe nurses have the ability to do this and look forward to hearing from you.

Sharron Lyons
NENA President

Communication Officer's message

While in line for a morning dose of caffeine, I witnessed a most amusing, yet sobering, event. An elderly couple were seated in wheelchairs and headed together to the counter at the coffee/donuts shop in the lobby of our hospital. They somehow managed to get their wheels tangled and began struggling to separate. It was a visual cacophony of ineffective activity. At one point, one was trying to move forward and the other was struggling to move backwards. As they had two wheels locked, the effect was that the pair of them, as a unit, turned in a circle. Sharp words followed. Dollops of saliva spewed through toothless gums. There was some slapping of each other's hands and each one was hastily trying to gain traction with the hand wheels of their chairs. Eventually they sorted it out and ordered… separately.

It was one of those epiphanic moments when you know in a flash that you have seen the future of your marriage and your life. That was depressing.

Leaving that scene and going to the emergency department, I saw young nurses gently and compassionately caring for a confused and panicky senior in a hall bed (yes, we have hall beds in Saskatchewan, too) who was asking for the tenth time to talk to "the manager of this hotel." Another nurse was hastening to join a sea of green scrubs responding to a code in room one. A nursing student was listening attentively to a seasoned nurse explain a medication protocol in the med room. Despite the chaotic atmosphere and constant pressure to catch up, there were quick smiles, light-hearted remarks, and staff rushing to help each other.

It was another unexpected instant in which I felt that I had seen the future: emergency nurses caring for increasing numbers of patients with increasing acuity; nurses sharing knowledge; and nurses supporting each other.

And I knew in that moment that there is reason for optimism about the future of emergency nursing—not because of favourable changes in working conditions, not because of a different *manager of the hotel*, and not because of some new approach to resource management, but because of the character and resilience of the type of persons who choose to be emergency nurses.

Please join me in visiting with others who have chosen to be emergency nurses through the articles of Outlook. The pages of this journal are our forum for sharing who we are and what we do.

Stephanie Carlson
Communication Officer

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, **communicationofficer@nena.ca**

Treasurer's report

Another year has come and gone and there have been some wonderful developments within NENA, one being a very successful NENA conference held in Regina, as well as the hopeful joining of Quebec to our national body, and the beginning of some concentrated efforts towards our national conferences in the next few years.

NENA's finances have not had many changes in the past two years, but have remained stable and allowed the national body the ability to invest in conferences that will produce revenue and has allowed NENA to become more actively involved in the emergency activities that affect all of us at the front line.

Our last conference held in Regina was a great success and had an overall income of $27,000, which was shared between the provincial host and the national body.

Looking to the future suggests that the addition of Quebec to our national body will bring in added revenue. Quebec is a province that has a large population and a very active nursing community. The introduction of TNCC and ENPC to the province will be an added attraction for joining NENA and will really unite our country from coast to coast.

Our last area that has taken on both financial and time priorities has been our website. We realize that in order to bring information to our membership in a timely way, we needed to invest in our website and have made this a priority. We hope that our new look and functionality will bring an added capacity to serve our members well.

All in all from a financial perspective, NENA's funds in have matched NENA's funds out, and this is in keeping with our non-profit status and commitment to use our finances to serve the emergency nursing community.

This will be my final report for NENA, as I step down after our fall board of directors' meeting. My time with NENA has been wonderful—not only have I learned about the business of NENA, but also I have met some wonderfully dedicated emergency nurses who continually strive to represent emergency nurses across the country. Truly an inspiring group of people that I will never forget and a time of learning that I will cherish and reference in my ongoing career. Thank you, NENA board for all you do.

Sincerely,
Lori Quinn
NENA Treasurer

outlook
NENA at work

Experience in the Hands-On Procedural Cadaver Lab

During the Emergency Nurses Association Annual Conference held in Tampa, Fla., in September of 2011, I was fortunate enough to secure a place at the Vidacare Hands-on Procedural Cadaver Lab. Two of these popular sessions of approximately three hours each were provided by this strategic sponsor of the conference and filled up long before the start.

Led by esteemed employees of Vidacare, 14 generous individuals and families donated their bodies to medical science through the state board organization. Apparently this cadaver lab was the largest in attendance for Vidacare with 14 cadavers and approximately 250 participants! It was hardly distracting being in the lab with that many people, as our group of eight was mesmerized by the demonstrations and tactile interface of nearly no-risk procedures not limited to intraosseous access.

Our "emergency" interventions and procedures made so much more sense being able to see it from the outside and the inside. There was no comparison to studying anatomy of organs in jars or slides of cells. Pulling at the pericardial sac to feel how tough it is, seeing a humeral intraosseous infusion come through the subcavian vein and dissecting down to distorted asymmetric femoral anatomy were just a few of the things to note. In my 11 years of nursing, I have not attended such an informative educational session.

One would think there would be a terrible industry bias since Vidacare is the manufacturer for the EZ-IO device, but this was hardly the case. Many emergency departments have these devices already and some seem to be struggling with nursing scope of practice to be able to perform this procedure. Vidacare even has position statements by various organizations supporting nurse-initiated intraosseous access. I have never felt so supported in my practice and continuing education by a business. We should be so lucky one day if, perhaps, Vidacare would be fortunate to enrich our conferences with a cadaver lab.

Participants at the Hands-On Procedural Cadaver Lab during the Emergency Nurses Association Annual Conference.

Brian Lee
SbStJ, RN, ENC(C), CFRN

National Course Administration Committee (NCAC) Updates

ENPC 4th edition updates

All ENPC course directors should have received an email from ENA regarding the roll-out of the 4th edition ENPC course planned for fall 2012. ENPC course directors can continue to plan ENPC 3rd edition courses until at least fall 2012.

TNCC/ENPC course approvals

A general reminder to all ENPC/TNCC course directors that your courses cannot be approved unless you are current NENA members as of July 1, 2011. Course directors must ensure all instructors in your courses are also NENA members.

TNCC/ENPC courses

All courses must have a special reduced fee for NENA members and a higher non-member price.

CATN-11 courses

This course will be deleted as of December 31, 2011. ENA is working on a new revised program called "Advanced Clinical Education for Emergency Nurses."

Update on French translation of ENPC and TNCC course materials

ENPC 3rd edition course materials have been translated into French. The 6th edition TNCC course slides and exams are also available. Work continues on the 6th edition TNCC manual in a French version. If course directors require translated materials, they can email the NCAC chair at **chairncac@nena.ca**.

NCAC projects

The NCAC committee is working on a course approval process for TNCC/ENPC course applications through the NENA website and CTAS course approvals.

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The NCAC Committee, standing: Monique McLaughlin, Ann Hogan and Traci Foss-Jeans. Seated: Debra Bastone, Margaret Dymond and Colleen Brayman.

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Submitted by Margaret Dymond

outlook
NENA at work

Pilot project between B.C. and Washington State emergency nurses

An exciting pilot project between the **Emergency Nurses Association of B.C.** and the **Washington State Emergency Nurses Association** is underway. B.C. and Washington share a boarder and have several large cities that are only a few hours apart. Therefore, it was felt that the two groups could mutually benefit by working together on conference/education days.

This project will see each association mutually supporting the other with attendance at their provincial/state educational event. In 2011, British Columbia will host an education day with speakers from B.C. and Washington. Emergency nurses from both sides of the border will receive invitations to attend. In 2012, Washington will be the host and B.C. nurses will be invited to travel to the U.S. Networking with our colleagues to the south can only benefit all emergency nurses.

Both organizations have designated an individual to participate in the planning of this pilot project, which will be reviewed following the 2012 educational event.

News from the provinces

British Columbia: ENABC

I am happy to report a great beginning to our membership year 2011, with 102 renewals/new memberships to date. Thank you to our members for the continued recognition of the importance of being a member of ENABC/NENA.

ENPC and TNCC continue to be well-attended throughout the province and we look forward to delivery of the revised ENPC course in late 2012.

Exciting news in B.C. includes two brand-new emergency departments in Interior Health hospitals. Kelowna General Hospital is a busy "small city" hospital in which we see approximately 150 to 180 patients per day and, along with that, the same issues with delays, admits, staffing, etc., as are seen across Canada. To help with our old, tiny, crowded department, Kelowna General Hospital is preparing to move to a new emergency department. It is very similar to Vernon's tower with many of the new equipment and technologies. In preparation for the move to the new department, staff is busy trying different LEAN strategies to help create more proficient processes in the triage and trauma rooms. This is a big time of change and the staff is amazing. Staff at Vernon Jubilee Hospital have also been busy preparing and packing for the move to a brand-new emergency department in the VJH Polson Tower. Move-in day was September 25, 2011. The new emergency department, situated on the ground floor of the new tower, is four times larger than the old department. The tower includes state-of-the-art technology to assist in more efficient delivery of care. Some of the new equipment includes Vocera, a hands-free nurse-call communication system, Vernacare, a waste management system, a pneumatic tube system, a decontamination room and paired processing for triage and patient registration, just to name a few. Please check it out by searching VJH Polson Tower.

Challenges continue to be just that—challenging us with staffing shortages, overcrowding, holding admitted patients, sustaining care in small rural hospitals, etc., but several creative solutions have been developed and we look forward to hearing about them at our Fall Education Day in October.

Recognizing the challenges associated with planning a successful Education Day, ENABC has entered into a two-year pilot project with our colleagues in Washington State. They will attend the ENABC Education Day this year and a conference committee comprising members of both organizations will present at the 2012 conference in Washington State.

We look forward to the NENA 2012 Conference in Halifax and even more to our opportunity to host NENA 2013.

Finally, a thank you from me, as I finish my term as ENABC president, turning it over to Sherry Stackhouse. It has been a tremendous experience.

Thank you,
Sherry Uribe
ENABC President

Alberta: ENIG

I cannot believe the fall is already here and harvest has started early or late, if at all, depending on where in the province you are. Our fall is actually turning out to be our summer, which leads me to believe that our Indian summer is here now.

As Albertans and nurses in Alberta, we have been through many different disasters over the years. This year we almost lost a whole town and a hospital due to wildfires in the northern part of the province. I cannot tell how proud we are of our nurses who stayed by patients and moved them to safer areas at a minute's notice, knowing they may never be returning to their homes. The strength of our members never ceases to amaze me.

Alberta membership remains steady and, as an executive, we continue to come up with new ways to encourage membership. Throughout the province we continue to offer educational opportunities for our membership and at all times encourage non-members to join us.

Also, this spring Alberta Health Services started posting emergency department wait times on our public website in an ongoing effort to be transparent with the public. There are many views on this initiative, but we continue to wait for ongoing analyses of this initiative, which we hope will give us all important information from the public and how they decide to seek emergency care.

Lastly, in Alberta we are preparing for another election, so stay tuned for the next change in health care in Alberta. You can always count on surprises during the election year.

Dawn Paterson
ENIG President

Saskatchewan: SENG

Hello NENA members and welcome to the fall *Outlook*! For me, the fall has always felt like the start of a new year, a time for new beginnings. Here in Saskatchewan, we are having a new beginning of our own. My name is Raegan Gardner and I am pleased and honoured to be taking over the role of SENG president. The amazingly dedicated Mari-Elena Guerrero has completed her term as president and will be dedicating her time to pursuing her career as a nurse practitioner in rural Saskatchewan. On behalf of the members and executive of SENG, we cannot thank Mari-Elena enough for her commitment to propelling emergency nursing along an exciting path in our province. You will be greatly missed, but we are lucky to have you sitting next to us still as the past president!

Saskatchewan also had a very exciting spring, hosting the 2011 NENA National Conference. The conference was a great success and enough thanks cannot be said to the board and volunteers for all of their hard work! I truly look forward to representing the nurses of Saskatchewan on a national level and to making our voices heard! Thank you for this opportunity!

Raegan Gardner, RN, BScN, ENC(C)
SENG President

Ontario: ENAO

HAPPY 40th ANNIVERSARY, ENAO! ENAO was founded in 1971 and we are celebrating 40 years of representing the emergency nurses of Ontario in 2011. The "renewed" ENAO has an updated association logo, as well as a special 40th anniversary logo. ENAO has changed publishing companies and has acquired increased corporate sponsorship for our publications. Our "Name the New ENAO Publication" contest for members resulted in the transformation of the biannual ENAO newsletter into the *Journal of the Emergency Nurses Association of Ontario* (JENAO) with the expectation of publication three times per year. This celebratory year has also seen the creation of "ENAO Chronicles", ENAO's new electronic newsletter. The members who submitted the winning titles will both receive complimentary 2011–2012 ENAO/NENA memberships.

ENAO strongly supports CNA ENC(C) certification in our nursing specialty. The ENAO board of directors has proposed that CNA consider adding membership in a nurse's professional organization to the requirements to qualify to write the specialty certification exams. The NENA president has committed to discuss this proposal with the CNA Associates and Affiliates Group.

ENAO was involved throughout the creation of the Emergency Department Asthma Care Pathway (EDACP), which is now used in most Ontario EDs. This work is being adapted into a net learning program, which will be available on MacHealth through McMaster University. The Canadian Medical Association will be granting physician CEUs and ENAO will be granting nursing CECH hours to all who participate in this online educational course. Along with other key stakeholders, ENAO is currently a member of the steering committee for the creation of the Emergency Department Asthma Care Pathway—Paediatrics.

In the wake of SARS and H1N1, the Ontario Ministry of Health has recently established an Influenza Pandemic Working Group, whose mandate is to learn from the past in order to prepare for the future and the next pandemic. Recognizing the front-line position of emergency nurses, ENAO is honoured to have been invited to provide a representative to participate in this necessary and important work.

Jan Spivey
ENAO President

Nova Scotia and Prince Edward Island: NSENA and PEIENA

It has been a busy few months over here in the Maritimes. The former president has moved and I am stepping in to make sure things are kept in order. I am excited to say that there are two people who have expressed interest in stepping up to the president's position—one in PEI and one in NS.

We are facing the same challenges as the rest of the country: nursing shortages, overcrowding, long ED waits and the restructuring of nursing units (RNs, LPNs, CCAs). In Nova Scotia some of the walk-in clinics are having their hours decreased to help save money. This is going to impact on the care that people receive and it will increase the wait times in the ED.

On a positive note, the NENA conference is going to be Halifax next year! This is going to be a fantastic time, getting to experience Halifax's culture and spend time with other colleagues from across the country. I hope as many people as possible can come and experience Maritime hospitality.

Cate McCormick

NENA is turning 30 years old in 2012!

As the president-elect, I have been going through old boxes of NENA material and I have come across archives with interesting reading material.

Excerpt from NENA Vol. #1 Newsletter titled: **"Emerging"** 1982:

During the past two years, Emergency Nurses Group of B.C. and Emergency Nurses Association of Ontario have encouraged emergency nurses from across Canada to consider the concept of a national affiliation. At Interphase '81 in Vancouver, the concept became a more concrete idea and a steering committee was formed. Members were: Pat Kasprow, B.C., Chairperson; Bonnie Bates, Ontario, Vice Chairperson; Lorraine Wuori, B.C., Secretary; Louise LeBlanc, Ontario, Treasurer.

The next meeting was held in conjunction with the Ontario Assembly of Emergency Care in Toronto with representatives from British Columbia, Alberta, Ontario, Nova Scotia and New Brunswick in attendance. The steering committee consisted of the above executive members from B.C. and Ontario emergency nurses who then came up with draft objectives and proposed bylaws.

In May 1982, a national NENA meeting was held at Interphase '82 in Regina, at which time a national NENA executive was formed. Members voted in were: President—Bonnie Bates, Ontario; Vice President—Pat Kasprow, B.C.; Secretary/Treasurer—Donna Rae, Saskatchewan; Editor—Betty-Lou Kindleman, Alberta; Consultant for Emergency Nursing Standards—Gina Dingwell, B.C.; and NENA representative—Accreditation of Education Programs for Emergency Medical Attendants—Sandra Easton, Ontario.

Questions:

1. What did membership cost in 1982?
2. Who was the first group/company to approach NENA for endorsement?
3. With whom did NENA hold their 1983 annual meeting?

Find out the answers and see some of the suggested NENA logos in the next issue of *Outlook*!

Sharron Lyons
NENA President

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.

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Bouquets

- **Sheila Early.** Congratulations to Sheila Early of Surrey, B.C., for winning the Ruby Award, presented annually by Soroptomist International of the Tricities for her "tireless efforts on behalf of women and girls." She went on to win the Western Canada Award. Congratulations, Sheila.
- **MariElena Guerrero.** Thanks to Mar for her years of service to emergency nurses in Saskatchewan in many avenues. Raegan Gardner will join the NENA board as Saskatchewan Emergency Nurses' Group President.
- **Jan Spivey.** Congratulations to Jan Spivey for her selection to serve on the CNA ENC(C) exam committee for a six-year term.
- The ENAO Board of Directors wishes to acknowledge **Mr. Motsi Valentine,** ENAO Webmaster, for his creation of the new ENAO website **www.enao.me**. Motsi's tireless dedication, hard work and creativity over countless hours have produced an informative and professional new website for the "new ENAO" and the membership across Ontario.
- Thank you to **Mr. Humberto Laranjo** for entering the Name the ENAO Journal Contest and submitting the winning name for the new ENAO Journal, Journal of the Emergency Nurses Association of Ontario (JENAO). Bert wins a complimentary ENAO/NENA 2011–2012 membership. Congratulations, Bert!
- Thank you to **Ms. Yvonne Gayle** for her submission of the title "ENAO CHRONICLES," as was chosen to be the name for the new ENAO electronic newsletter! Yvonne wins a complimentary ENAO/NENA 2011–2012 membership. Congratulations, Yvonne!
- Thanks to **Sherry Uribe** for supporting emergency nurses in British Columbia and representing them on the NENA board. Welcome aboard to new B.C. Director Sherry Stackhouse.
- **Cathy Fewer.** Thank you, Cathy, for your contribution to emergency nursing in Newfoundland and Labrador. Cathy has passed her gavel to Todd Warren, new director.

The following persons were recognized publicly for their work and service to emergency care in Canada:

- In recognition of a career marked by service in pediatric emergency care, Lori Lonergan, right, won the Marg Smith Award for Excellence in Pediatric Emergency Nursing
- Colleen Brayman of British Columbia for an Award of Excellence in Emergency Nursing Education
- Paula Mayer of Saskatchewan for an Award of Excellence in Emergency Nursing Administration
- Denise Kudirka of Quebec for an Award for Commitment to Excellence in Emergency Nursing
- Claire Thibault of Quebec for an Award for Commitment to Excellence in Emergency Nursing
- Gary Pronych of Saskatchewan for an Award for Service to NENA and to Emergency Nursing
- NENA Bursaries were awarded to David Conroy of British Columbia and Heidi Krahn of Alberta

What was overheard at the NENA 2011 Conference

- Nova Scotia nurses union has approved a policy to have all nurses dress in black pants with a white top. Practical nurses will wear the same with a yellow armband.
- "Code White" training includes wearing riot gear and includes the riot training.
- Rural Saskatchewan emergency departments are closing, as their doctors are leaving. EHS and hospital security have started wearing "flak jackets."
- Ontario Lung Association is footing the bill for the roll-out of the provincial asthma protocol. As well, it has an on-line education package and is working on the pediatric protocol.
- B.C. interior is developing HART teams (High Acuity Response Teams) to work with the ambulance teams.
- People are making plans for NENA Conference 2012 in Halifax, Nova Scotia!

Awards of Excellence

Do you have an idol? Someone who helped you through that long day, evening, or night shift in ER?

Well, NENA wants to hear about them!

NENA is looking for applications for Awards of Excellence in emergency nursing. There is no limit to the number of awards that are awarded in four categories:

- Emergency Nursing Practice
- Emergency Nursing Research
- Emergency Nursing Administration
- Emergency Nursing Education

The application form is on page 26 of this issue.

National Emergency Nurses' Affiliation Conference 2011
Hosted by Saskatchewan Emergency Nurses' Group

Emergency Nursing!
Pioneering Change... Impacting the Future

April 29–May 1, 2011

ENA President Anne-Marie Papa.

The 2011 NENA Board of Directors.

Above, Landon James and guest, Valerie Pelletier of AIIUQ, on Pandemic Response. Below, Cate McCormick and Landon James at the NENA Board of Directors' meeting.

NENA and the Saskatchewan NENA 2011 Conference Committee wish to acknowledge and thank the sponsors who made the Regina conference successful. Without their support this conference would not have been possible.

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Transferring patients between facilities and the ED

By Cathy Sendecki

Some time ago, ENA appointed a committee to come up with a comprehensive process to improve the transfer of nursing home (NH) residents to and from the ED. As the NENA representative, I participated in a number of conference calls with colleagues in the U.S. Several Canadian nurses with an interest in improving the care of seniors sent sample forms.

Some I spoke with were less enthusiastic—"Why are you doing this again? I developed a form 10 years ago," and a non-nursing friend said bluntly, "How hard can it be?"

In our discussions some facts became very clear—in some small centres, a good process already exists. The staff may work together at times, the clients have been known in the community as they have aged, and communication is effective. While not directly transferable to urban settings, some aspects can be adopted. Some areas had developed successful measures that could easily be added to existing processes—dentures, hearing aids, glasses in a fanny pack, and a checklist for other items such as mobility aids.

But we had not developed the definitive transfer process and I observed at work the continuing conflicts: calls from the director of a facility to complain that we had "just sent them back without any documentation", and comments from ED nurses, physicians and paramedics criticizing a lack of information from "The Home." Clearly, most staff in both areas care about good care for these patients, but experience ongoing frustration.

Why?

Another perspective is outlined in *A Conceptual Framework for Understanding Interorganizational Relationships Between Nursing Homes and Emergency Departments: Examples from the Canadian Setting* by Rose McCloskey et al., www.sage publications.com, Policy, Politics and Nursing Practice, Nov. 2009, 10, 285–294.

Since 1960, the question of how to improve transfers between hospital and NH has been considered. This article outlines some aspects of the interorganizational relationships. How the staffs at ED and long-term care facilities view the work they do, the mandate of their organization, their perceptions of their counterparts, and their expectations of the other institution may all contribute to less than optimal communication and outcomes. The extent to which the ED staff view older adults in the health care system as potential "bed blockers" or perceive that "what you see is all they've got" (to quote Geriatrician Dr. Duncan Robertson) in terms of potential improvement and ongoing quality of life can also affect the decisions made to investigate and treat. Do we discount the intrinsic value of seniors due to our ageism?

Clearly there is more to a successful transfer than forms and official process.

Some tips from the geriatric emergency nurse perspective

- Have information in the ED available about local "nursing homes" and the services provided. The continuum from independent living in a seniors' building through residential or complex care is immense. A summary will help to clarify what care can be provided after discharge, and give direction as to how we can support the patient in the transition back to the facility.
- Communication: if more information is needed, call the staff. Ask to have any missing documentation faxed so you know how their meds have changed recently. Call before sending the resident back to deal with any questions. Can they obtain a new medication in time for the next dose? Would it help if we fax the prescription so it can be delivered? Or have the EP phone the pharmacy directly?
- When completing the transfer form back to the facility, include what investigations turned out negative. Copies of the results may be appreciated for follow-up with the GP within the next few days. We know we don't send someone back without doing ANYTHING, but we often don't clarify that we did—a CXR and blood work to R/O pneumonia or ACS with negative results.
- Be very clear about any change in medications—what did we give? When? What is the new prescription? Is anything to be discontinued? Keep a copy on the chart.
- What follow-up is needed? Under what circumstances is a return visit to the ED needed?

These measures add a little to the time needed to care for our patients, but they save time later and enhance future dealings with the staff of that facility. They will certainly contribute to improved care of our seniors.

About the author

Cathy Sendecki has worked in Burnaby Hospital ED since 1987. As Educator, in 2005 she worked with the Clinical Nurse Specialist for Acute Care of Older Adults to improve the care of seniors in the ED. What started as a three-month project by an ED nurse who did not see great areas for improvement, became a full-time position that continues to be fascinating and challenging. She appreciates the opportunity to assess patients with a geriatric and emergency "lens" to assist the emergency team to provide the best care to those seniors with complex presentations.

CPSI SHN Virtual Learning Collaborative: Canadian teams improving STEMI care together

By Dannie Currie, RN, MN, DHSA, Virginia Flintoft, MSc, BN, Chantal Bellerose, DtP, MSc, Doris Doidge, RN, MN, and Theresa Fillatre, RN, MHSA, CHE

"Timely reperfusion therapy is the most important determinant of better outcomes for patients suffering an ST-segment elevation myocardial infarction (STEMI). All health care professionals should work together to ensure that all Canadian STEMI patients receive reperfusion therapy in the most timely manner possible."
– Dr. Jack Tu, Senior Scientist, Institute for Clinical Evaluative Sciences and Faculty Lead for the CPSI-SHN Acute Myocardial Infarction Intervention.

Introduction

Optimal patient outcomes using fibrinolytic therapy or primary percutaneous coronary intervention are dependent on the timeliness of reperfusion of the infarct-related artery (Levy, Terashima, & Travers, 2010; Lambert, Brown, Brophy, Rodes-Cabau, & Bogaty, 2010). Patient age, infarct location, symptom duration, pre-hospital care, triage level, timing of ECG, and geographical location of the patient are some of the factors that can impact timeliness of reperfusion. Delay in reperfusion therapy is associated with increased morbidity and mortality (Lambert et al., 2010; Nallamothu et al., 2007). A significant portion of patients (Nallamothu et al., 2007), estimated to be more than half (Atzema, Austin, Tu, & Schull, 2009), exceed recommended times to reperfusion (Tu, Khalid, Donovan, & Ko, 2008).

Health care professionals are faced with competing demands for their time, knowledge, energy and resources, while at the same time always seeking ways to improve care and close evidence and practice gaps. To improve patient safety, exploration and testing of new methods for connecting providers for learning is essential, while respecting the demands on their resources. However, distance, travel and accommodation costs, and time away from direct care are very real limitations. Therefore, using interactive technology to connect people with a common goal, to both content and improvement experts is a viable alternative to more traditional methods for bringing people together. The CPSI SHN AMI Virtual Learning Collaborative was designed to engage interested Canadian emergency department teams using the internet and telephone to create an interactive learning environment.

Canadian Virtual Learning Collaborative

Safer Healthcare Now! (SHN), the flagship program of the Canadian Patient Safety Institute (CPSI), invited Canadian health care teams to participate in a virtual learning collaborative to improve AMI care. The goal was to improve delivery of care so that all eligible patients receive fibrinolytic therapy or primary percutaneous coronary intervention (PCI) within 30 or 90 minutes of hospital arrival respectively. The collaborative participants were supported by a multidisciplinary planning committee, faculty and SHN staff to develop, adapt, and share best practices within their local environments. The focus was on understanding the local care delivery contexts, factors that impact timely administration of reperfusion therapy, testing change ideas that lead to improvement, and measuring performance. The AMI Virtual Learning Collaborative transitioned into a network of health care professionals focused on improving STEMI care, as was expected. A web-based community of practice (CoP) was used to share documents, presentations, team charters, change cycles, data collection tools and procedures. The CoP was open to all and provided access to recordings of sessions to other interested teams and organizations. Data submission on timely diagnostic ECG and reperfusion therapy, and other AMI care measures was encouraged. The SHN Central Measurement Team (CMT) and Safety Improvement Advisor (SIA) staff helped teams to embed data collection and interpretation into their improvement work. Teams were encouraged and coached in the use of run charts to make comparisons with baseline starting points. The use of run charts enabled teams to monitor their performance over time, as teams deployed their tests of change. Sharing of innovations, high impact change ideas and solutions to change barriers were exchanged during explicitly designed learning sessions. Additional conference calls on various AMI improvement topics were held and details can be found on the CoP.

The Virtual Learning Collaborative (VLC) was modelled on the Institute for Healthcare Improvement (IHI) Virtual Breakthrough Series (Boush, Provost, Gagnon, & Carver, 2006) methodology (Figure 1) and earlier work that had been tested and evaluated on a smaller scale by SHN Atlantic teams. The "Call to Action" was widely circulated in July and August of 2010 inviting potential teams to participate, and was followed by information sessions to help organizations make their participation decisions. Training sessions on "how to" use the web based tools to maximize interactivity were held in both English and French languages before the first "virtual learning session" occurred. All documents and support during and between learning sessions were offered in both English and French languages and presentations were offered in English with French language support as needed.

The design of the VLC included three-hour "virtual learning sessions'" using webinar technology. Content and improvement experts and SHN AMI faculty convened with enrolled

teams to foster a learning environment where didactic and applied knowledge were exchanged and expanded. Support was available during this time and included: team conference calls; faculty contact by phone or email; use of the web-based CoP; and ready access to SHN staff and the SHN CMT. CMT supports all SHN teams and serves as the central repository for SHN data through a contract between CPSI and the University of Toronto.

Teams from 21 organizations and nine provinces, from British Columbia to Nova Scotia, participated in the collaborative. Multidisciplinary clinical team members including nurses, physicians, cardiology technologists, and paramedics participated in 16 hours of virtual learning webinars. During these sessions teams shared their own work and benefitted from presentations by 12 volunteer experts on various content themes related to improving reperfusion therapy. Improvement methodology support was provided by SHN staff and the CMT.

Measurement

Measurement focused on three clinical care elements and participant experiences with the virtual learning environment. Specifically, teams were asked to submit data on (i) time to ECG from hospital arrival, (ii) time to thrombolytic agent administration from hospital arrival, and/or (iii) time to primary PCI from hospital arrival. The clinical measures were submitted to the CMT. The participant experience measures included a self-assessment of progress, and learning relationships within and between the teams. In addition, various aspects of satisfaction with the learning sessions and a final measure of the participant overall VLC experience were measured.

Results

Team self-assessment of progress on a five-point scale moved from 0 to 3 and within seven months indicating that, on average, the reporting teams believed they moved from "forming a team" to accomplishing a "50% improvement" on at least one goal. This is comparable to face-to-face collaborative team results over a similar timeframe. The intra-team self-assessment of collaborative work patterns revealed that 86% selected: "We are having productive team meetings and are accomplishing tasks between meetings" and 14% selected: "We are proud of our improvement work. There is mutual respect within our team, we are using the team members' strengths to focus on and achieve our AIM. We celebrate our successes." For inter-team relationships, 57% indicated that there was some activity related to their improvement work taking place with other collaborative teams.

Participant satisfaction with the VLC, based on 12 respondents to a survey indicated they were satisfied or very satisfied with the experience. The two areas of dissatisfaction cited were for team participation and "format and easiness to concentrate and devote time to VLC at the workplace" (Table 1).

All respondents to the survey agreed that the VLC provided opportunities for interaction, networking, sharing, and moving

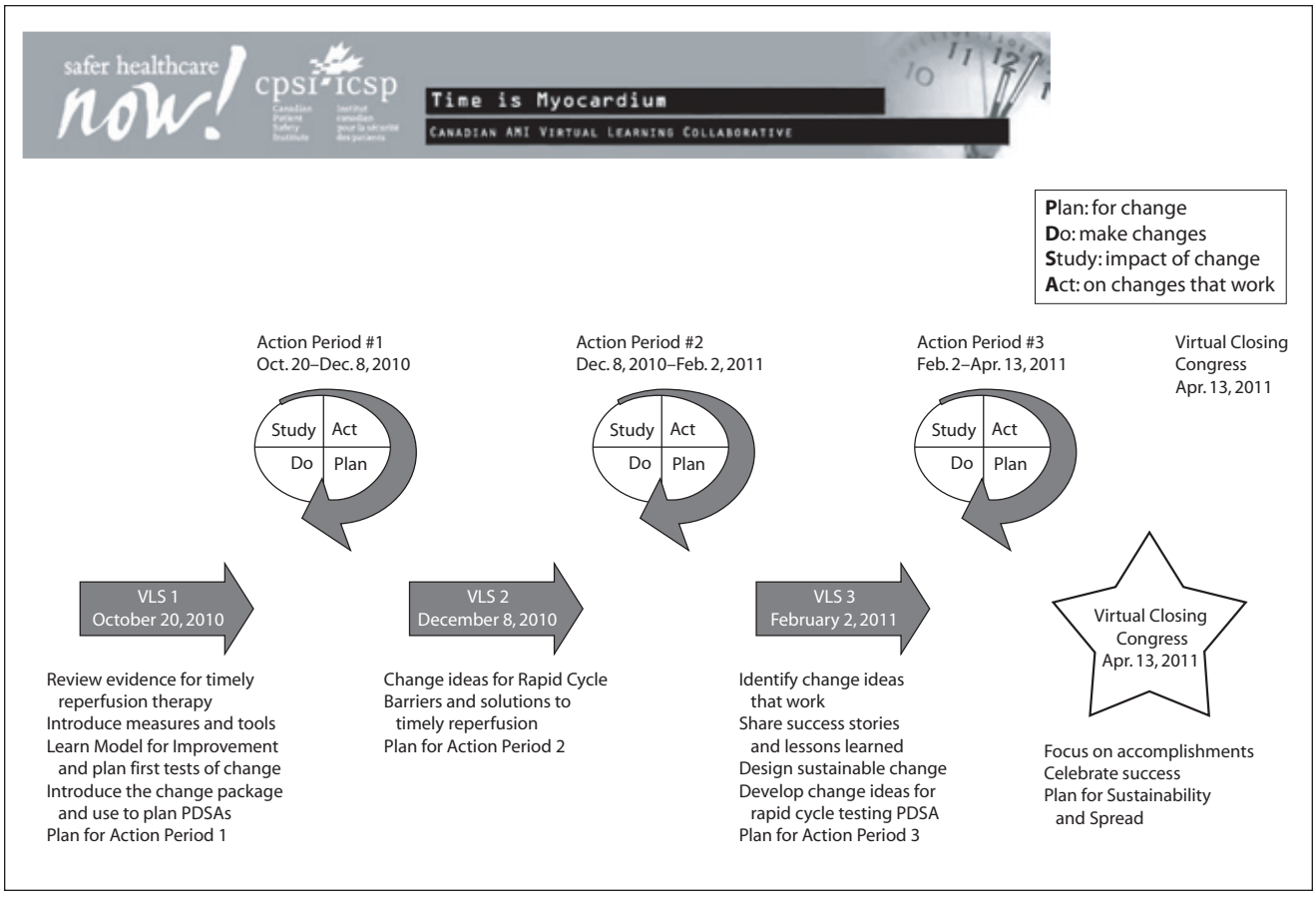

Figure 1.

forward with improvement work, and that access to and coaching from SHN SIAs and faculty were helpful to their quality improvement work. Seventy-five per cent indicated they had or planned to submit data (clinical measures) to the CMT while only 50% indicated they used the CoP (Table 2).

Eight of the teams reported on the percentage of patients receiving thrombolytic agents within 30 minutes of hospital arrival and six teams reported on the percentage of patients with an ECG within 30 minutes.

One team's success story

The Cape Breton Regional Hospital (CBRH) is a 326-bed acute care facility in Nova Scotia. On average, the emergency department sees 85 patients monthly requiring an ECG, of which four patients on average are diagnosed as presenting with STEMI. The AMI-VLC interdisciplinary team was led by the nurse manager and included representatives from medicine, cardiology technology, nursing, and quality improvement professionals. The director of nursing served as the team's executive sponsor. Baseline data verified an opportunity for improvement in

Table 1.

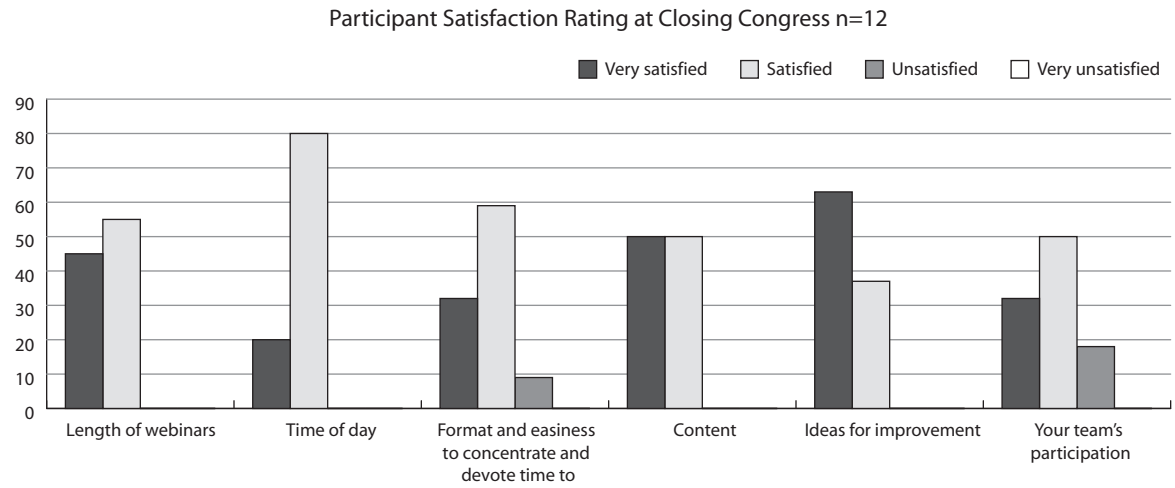

Table 2.

Topic	% Yes	% No
The Collaborative allows for interaction, networking and sharing of challenges and solutions	100%	0%
The Collaboration was successful in helping us move forward with STEMI improvement work	100%	0%
SIAs and faculty experts were helpful in assisting our team work and improvement	100%	0%
The Collaborative allowed easy access to quality improvement and STEMI experts	90.0%	10.0%
The VLC presented strong evidence to increase awareness and help prioritize timely reperfusion as an improvement project in our organization	83.3%	16.7%
The Collaborative documents such as the shared tools, change package and Community of Practice (CoP) website are useful resources	83.3%	16.7%
Would you like this Collaboration to reconnect and follow up in three months from now to explore improvements, new learnings and accomplishments?	83.3%	16.7%
The AMI Virtual Learning Collaborative helped us to establish an interdisciplinary improvement team	81.8%	18.2%
The Collaborative allowed us to dedicate time and to concentrate on improvement in the work to be done	75.0%	25.0%
Did you use the change package?	72.7%	27.7%
Have you submitted AMI improvement data or will you submit some in the near future?	73.0%	27.3%
Did you use the CoP?	50.0%	50.0%

the percentage of STEMI patients receiving an ECG within 10 minutes and lytics within 30 minutes of hospital arrival or first medical contact.

The team focused on how to improve patient care by initially mapping their processes for a typical episode of care, maintained a patient-centred perspective, and identified and tested change ideas using the Plan Do Study Act (PDSA) Cycle in their emergency department. PDSA cycles and tests of change included: (1) synchronizing clocks and equipment; (2) programming the triage phone to speed dial the ECG department; (3) using a whiteboard to identify the location of the patient in the ED; (4) placing an ECG machine within the department; (5) modifying care documentation forms to enable performance data collection; (6) designating ECG as first priority designated medical function for all patients with chest pain; (7) meeting regularly to review team performance and shape continuous improvements to close their practice gaps. Over a period of seven months, the percentage of STEMI patients receiving an ECG within 10 minutes of arrival or first medical contact improved from baseline of 34% to 95.2%, and the percentage of patients receiving lytics within 30 minutes of arrival improved from the baseline of 61.5% to 95.2%.

Factors contributing to this team's success include: using a patient-centred team approach; use of data coupled with PDSA cycles to guide their improvements; as well as the willingness of team members to change their practice and embrace full participation in the AMI Learning Collaborative. The hospital has now established 100% as their target for obtaining ECGs within 10 minutes and administering lytics within 30 minutes of hospital arrival for STEMI patients.

What did we learn?

Holding sessions to teach people how to use the interactive technology before the learning sessions worked well and is viewed as an essential component of the engagement process. The performance gap between current and best practice for the teams that did submit data was similar to what has been reported in the literature and other SHN quality performance data. The virtual learning environment is a viable alternative for participants who are separated by geography, time and other resources. Participant progress and satisfaction was similar to "in person" learning collaboratives.

The use of virtual methodology augmented with coaching support resulted in a learning network similar to "in-person" learning collaboratives in which experts and care providers with a common goal were effectively brought together to improve quality of care and patient safety. From the host (CPSI SHN) perspective, the human resources required in preparation and execution of this virtual collaborative were greater than preparation time for in-person sessions, but for participants was less expensive and required less time away from direct care. With further experience with the virtual methodology and refinements to preparatory processes, it is anticipated that preparation and execution resource intensity will decrease somewhat.

How could we improve?

Participating team members need to be provided with protected time from their executive sponsors to participate in the learning sessions and concomitant action periods. Pre-collaborative work should include establishing baselines and making an explicit commitment to ongoing measurement and data submission. Teams would benefit from explicitly assigning role responsibility to a member to monitor and report team process and outcome measures to the team, their executive sponsor, and to their quality monitoring body. The question about making measurement and data submission an absolute requirement for participation and learning in future collaboratives is being examined. The additional effort required by participants to stay engaged and demonstrate sustainable results may be offset by holding more learning sessions for shorter lengths of time, and over a longer duration.

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Why all emergency departments should have ED nursing journal clubs, not just physician journal clubs

By June Tavenor-Brake, RN, BN

I am a registered nurse in the emergency department (ED) at the Health Sciences Centre, one of only two adult EDs here in St. John's, Newfoundland. The physician group we work with covers both EDs, but the nursing staff is exclusive to each site. The ED physicians hold a monthly journal club as a means of keeping up to date with current practice and research. The doctors rotate who hosts the event, and food and drink are provided. Each month, they invite two nurses from each ED to also attend the event. Earlier this year, I was selected to join.

Prior to the event, I had access to the research articles, which were critiqued and presented by one of the residents in the emergency medicine residency program at Memorial University of Newfoundland. At the event, the research methodologies were scrutinized, the authors themselves were critiqued for any conflicts of interest, and the findings were thoroughly debated. At the end of the evening, there was a general consensus reached about whether the studies presented sufficient evidence to alter or improve current practice.

I had a great time at the journal club, largely because I am somewhat of a research nerd, but also because I love getting involved in debates and conversations that are actually going to improve patient care. As ED nurses, we can all tell stories of how we "just knew" that the patient needed something, but without evidence we were unable to convince the physician to order a specific test, or try a certain medication. Inspired by the open dialogue of the physicians' journal club, I decided this was a great opportunity to organize the ED nurses, take a critical look at nursing literature, and really start examining our practice. Perhaps we could even find evidence to support our "gut instincts" when faced with a resistant physician in the future.

So, I decided to start the ED Nursing Journal Club. The first challenge I encountered was making the nurses feel as though this was not going to be like nursing school, where we had to know how to read stats, or know how to search CINAHL, and so on. To counteract this, I decided I would do the first "critique and presentation." Participants would have to simply read the articles I emailed to them and show up. I did all the leg work on critiquing the research methodologies. As an added strategy, I also emailed a short article I found in *JEN*, about a two-step approach to critiquing nursing research. We still reference this article from time to time.

The second challenge was getting the nurses interested. Like all EDs in Canada, we are faced with staffing issues, overcrowding, increasing numbers of admitted patients, and sicker patients. Why would they want to take their off time to meet and talk about the things that frustrate them at work? So, the research I chose for the first meeting of the journal club was centred around nursing burnout and fatigue, and the differences between critical care nurses and med/surg nurses. I thought that at least this would help my colleagues feel as though nursing research could be helpful as support when we complained to management about working conditions, and what some of the implications could be if things did not change.

Hoping that I had met my two biggest challenges, I set the date, decided to host the event at my home, put up a poster in the break room with directions to my house, and hoped for the best. The day of journal club, we were hit with a storm. One nurse who lived close showed up, but obviously the event was a bust. So, I rescheduled in two weeks' time to ensure I still captured the "side of the schedule" that would have been planning to come to the original event. Two nurses, a nurse practitioner, and myself sat down with potluck and wine and discussed the articles. Although this small group may have seemed like an indication that this project would not work, this was not the case. One of the nurses, in particular, who attended is well liked among our colleagues, and she spent the next few shifts bringing up our discussion to everyone else. The other participant and nurse practitioner were also excited about our discussion, and whenever we worked together over the next few months, we would see examples of scenarios we had discussed, and relate it back to the research.

Next, I decided I would target someone I thought would draw a crowd. One of our new graduate nurses is exceptional, and just lovely to work with. So, I approached him to see if he would be interested. I figured that he would be someone to whom others would want to listen. I'm not sure if I coerced him, but he agreed. I decided to host again because I did not want to put too much pressure on him, and at this journal club meeting, we had a total of five participants. I was gaining slow momentum, but I felt like I was starting to get some attention. Of particular interest from this event was the decision by the nurse practitioner to have a "holding area" for patients who were waiting for blood work or ultrasounds, etc., thereby improving her patient flow of CTAS 4 and 5 patients. Now I had the managers' attention.

For the third, and most recent meeting, I decided to go big. I recruited the most experienced and most popular nurse in our ED to choose the articles to discuss, and I encouraged her to come to me with any research-related problems. I started a

Facebook group and invited all of my colleague "friends" to join. I also included the ED residents, staff physicians, and paramedics to join. Then I created an event for this group, inviting everyone. I even had friends from my previous ED in Toronto ask if they could attend via "Skype". Unfortunately, I did not know how to organize this in time. I advertised in our department and the other ED, and required an RSVP because I was going to have the event catered, albeit BYOB. The date was set, I was going to host again, and now I had "confirmed" attendees. I booked a caterer, secured a small amount of financial backing from our "recycling fund" at work, and decided I would absorb the rest of the cost personally, because I really wanted this to work! Fingers were crossed. The event totalled one nursing student, 12 nurses, and four paramedics. The discussion, guided by the articles, could have continued for hours. We learned more from the paramedics than we expected, and the paramedics stated that there were now several new ways they were going to approach patients. At the end of the evening, everyone asked when the next event would be held, and at whose house. Success!

In planning our upcoming event, I asked if anyone was interested in hosting, and several people volunteered. I approached one of my colleagues and close friend to choose a topic and find the articles, and she agreed. I have been unsuccessful in finding a regular source of funding to cater the journal club, so this one is planned as a potluck. One of the paramedics is also a nursing student, and has had several inquiries from nursing students who are interested in ED nursing if they can attend. They have also been requesting to join the Facebook group! The current tally on "attendees" as per Facebook is eight, with an additional 10 "maybes". This does not include those ED nurses who are not Facebook users, but have stated to me that they are coming. I am also hoping to take advantage of Skype, and perhaps include ED nurses from other locations, such as my former colleagues in Toronto, and other EDs where some of our nurses have worked in the past. Many nurses who are unable to attend have requested I send them the articles.

My colleague who is reviewing the articles this month is going to address family presence in the ED, and decided to do an informal survey of the nurses, paramedics, and doctors in the department using a tool from the literature. This strategy has opened dialogue about the topic even before the event, and prompted a locum physician to email our manager some literature that "changed the way he practises" when it comes to family presence during invasive procedures and resuscitation. Several of the staff physicians have also requested the articles, and plan to attend. You don't see the physician journal club sparking this kind of interprofessional debate.

In conclusion, all EDs in Canada should have an ED nursing journal club in addition to any physician journal clubs, because nurses are the ones who spend the most time with patients and their families, we collaborate with all professions, we coordinate care and information with all professions, yet our knowledge and experience is still under-utilized. All ED nurses have issues, and may resort to lunchroom venting, so why not organize ourselves, our thoughts and our research evidence, and invite the other ED care providers to hear what we have to say. And also listen to what they may have to say. It will improve our collaboration, the care we all deliver, and just may make our working environment better places, even within the chaos of the ED.

Lessons learned:

- Stay positive. If you want to champion a project such as this, it is up to you to keep the momentum strong.
- Remove the idea that this is going to be work!
- Involve key people, and keep approaching naysayers, because their involvement can turn the tide. Each ED has its own culture, so only you know who these people are.
- Consider interprofessional involvement, because we may be complaining about another group only to learn that a simple "did you know" conversation can change practice and attitudes.
- Everyone loves food, but secure funding BEFORE booking a caterer!

If anyone has any experience or suggestions as to how I can improve or build on this project, I encourage you to contact me personally.

About the author

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Staying out of court: Your documentation could be the key

By Paula Mayer, RN, LNC, and Chris Mayer, RN, LNC

Paula and Chris Mayer of Mayer Legal Nurse Consulting presented recently in Regina at the NENA conference. After our presentation an ER nurse asked: "What are the chances of me being involved in a lawsuit, being an ER nurse in rural Saskatchewan? Seriously, there aren't any lawsuits in Saskatchewan, are there?" We were not at all surprised by these questions, as it is a common misconception among nurses in our part of the country that lawsuits don't happen here. It is obvious from our observations of the documentation of ER nurses we have worked with, and now supervise, that litigation is not considered in daily practice.

The short answer is that there is a very good chance of being named in a lawsuit. The number of medical malpractice claims, while not excessively high compared to our neighbour to the south, is expected to rise over the next several years. In 2010 in Canada, there were 930 lawsuits initiated. In the state of Massachusetts alone that same year, there were more than 10,001. So, while the legal risks of ER nursing in Canada are much lower than in the U.S., that risk still does exist.

Adverse events can occur anywhere, and poor outcomes are not limited to any specific type or size of hospital, nor are they limited by geography. Medical malpractice claims arise when a patient seeks to recover previous levels of functioning after suffering damages sustained while under the care of a health professional.

There is another question that comes up frequently when speaking with ER nurses from across Canada: how do I protect myself from a lawsuit?

Things like:

- being familiar with and following facility policies
- establishing relationships with your physicians, fellow team members and patients
- maintaining current ACLS, TNCC, ENPC or PALS, and CTAS
- earning your CEN-C certification
- taking pride in your work as an ER nurse
- remaining current with best practice
- and knowing how to use the equipment you work with.

These are all important factors in maintaining your standard of practice.

But if we had to pick one common thread in all the medical malpractice cases I've studied, we would have to say the single most important way to protect yourself as a nurse lies in your documentation. Timely, accurate, concise, detailed documentation is something your patient has a right to. Your documentation serves as a tool for communication amongst team members. It provides a reference for future care providers. It can protect you in a lawsuit or board review. In fact, case law has been set from the Supreme Court of Canada that states, "Failure to adequately maintain charts by the nurse is a distinct ground of negligence" (Joseph Brant Memorial Hospital vs. Koziol, 1978). These are all very good reasons to take a look at your documentation practices and see where you can improve.

We started our careers in the United States and from day one we learned to document properly without question, because litigation is a more prevalent part of health care there than in Canada. Documentation was a lifesaver for us early in our careers. Here is one example from our experience. Paula was an ER nurse with less than three years of experience working in the U.S. when she had an adverse event with a patient that profoundly influenced the direction of both our careers. This adverse event threatened her licensure, her job, our future plans, and she could very well have faced litigation. Her documentation alone is what saved us from all these life-altering consequences. This case impressed upon us early in our careers the importance, the absolute necessity of proper documentation in nursing practice. So, we are making it our mission to impress this upon our fellow nurses and to help them avoid the inevitable consequences of poor charting practices. Litigation is not something Canadian nurses give a great deal of thought to on a daily basis, because the incidence of lawsuits is lower. Lower. Not nonexistent. That is the important definer for those who do not consider litigation a possibility.

In our current roles as managers of two emergency departments we see evidence of poor documentation all of the time. Even though we have provided our nursing staff with education, inservicing, presentations and verbal reminders of the importance of documentation, when we do chart audits we find again and again failures to:

- document assessments
- document pain scale ratings
- reassess and document responses to interventions meant to manage pain
- document incidents that occur with patients
- document repeat vital signs
- label monitor strips and affix them to the chart
- document events that occur with the patient.

Instead, we are finding that presenting complaints are documented briefly ("cough times a week" and other such brief and cursory descriptions). Physical assessment findings are documented barely at all. Chronological events occurring (to x-ray, ambulated to BR to void, physician in to assess) are not documented at all. When Paula first started doing these audits, triage levels were not being assigned at all, despite having provided all her staff with CTAS training. After a great deal of feedback most of the nurses are now assigning

triage levels, but that's only one aspect of charting in one ER. The question in our minds is: What is happening in other ERs around the country?

Don't look at our ER nurses and think they're so much different than other ER nurses. They are not. We have worked in three other emergency departments in Canada and found the exact same problem. All of the medical malpractice cases we've studied in our work as Legal Nurse Consultants have one consistent theme: ER nurses across Canada are consistently falling below the standard of care when it comes to documentation. This leaves all of us vulnerable to litigation.

We're not suggesting that you practise defensive nursing, where litigation becomes the reason you do everything. We're simply suggesting that you document the good care you're providing, in such a way that any layperson off the street could pick up your chart and figure out what is going on with your patient. It could one day save your licensure and/or your career. It did ours.

References

CanLII. (1978). *Joseph Brant Memorial Hospital vs. Koziol*. (1978) 1 S.C.R. 491.

Wallace, Dr. G. (2011). *CMPA Risk Management Education, Clinical Risk, Negligence and Claims Management in Health Care*. Toronto, ON: Osgoode Hall Law School, York University.

About the authors

Paula Mayer and Chris Mayer are partners in Mayer Legal Nurse Consulting.

Paula is the manager of Canora Hospital in the Sunrise Health Region in Canora, Saskatchewan. She has been an RN for 18 years, with a wealth of experience in ER. She won a NENA Award of Excellence in ER Administration in 2011 for her quality improvement work in her ER and throughout her health region. Paula has been studying health law and risk management at Osgoode Hall Law School at York University in Toronto. She is a member of LNCAC.

Chris is the manager of Kamsack Hospital in the Sunrise Health Region in Kamsack, Saskatchewan. He has been an RN for 18 years, with a wealth of experience in ER. He is a member of the ER QI committee in the health region, and former chair of the ER QI subcommittee. He is a member of LNCAC.

Paula and Chris presented at the 2011 NENA Conference on "Medical Legal Risks of Emergency Nursing."

Check out their website at ***www.Mayerlegalnurseconsulting.com****, or email at* ***info@mayerlegalnurseconsulting.com****, or call 306-590-8980. They are available for seminars and presentations on legalities in nursing.*

outlook

NENA at work

Expression of interest

This is your opportunity to be a part of the NENA team, as we create our 2013 National Conference Committee.

We will be filling the positions of conference chairperson and seven committee members.

The 2013 conference will be held in British Columbia, in the spring of 2013 (exact dates and location to be determined by the committee). This committee, led by the chairperson, is charged with planning the 2013 NENA National Conference. Committee members will be responsible for conference theme and design, conference registration, calling for and reviewing abstracts, selection and confirmation of topics and speakers, introducing/coordinating speakers at the conference, accommodation and catering arrangements, obtaining conference sponsorships, coordinating vendor display arrangements and other tasks, as identified.

Members of this committee are encouraged to attend all scheduled planning meetings, as this is crucial to the success of the conference. Most meetings will be conducted through the use of teleconference, Skype, live meeting, etc.

Selection of the committee will be based on the following criteria, but not limited to:

- NENA member
- previous provincial activity
- previous conference planning experience preferred
- at least one member from host city or close to it
- in person meetings not required, but may occur if deemed necessary
- commit to participation x two to three years
- must attend the conference and be in host city for week prior to conference
- resume/curriculum vitae must be sent with application
- references may be requested at a later date.

We invite NENA members to submit their applications using the above criteria and telling us why we should choose you to be on the committee. Members from across the country are encouraged to apply.

Deadline for applications is January 31, 2012.

Applications to be submitted to **secretary@nena.ca**. *NENA relies on its members to shape the direction of our affiliation. Your contributions are invaluable, and we thank you for all of your support.*

An alternate perspective

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

Recently, I sustained an injury during the performance of my role as an emergency nurse. Medical assessments, discomfort and diagnostic investigations determined that I would be unable to perform my regular duties for an indeterminate period of time.

Many phone calls, emails, discussions and meetings took place over a couple of very short days. I found myself in a totally unfamiliar situation, with the overwhelming sense of having lost any control. And I was in constant pain!

Many parties were involved in determining what to ultimately do with me. These included my ED nurse manager, an occupational health nurse, the hospital's WSIB administrator, my union representative, my assigned WSIB case worker, my family physician, WSIB's assessment physician, my physiotherapist and myself.

The proposed plan was for me to work in the infection control department. They were short two infection control practitioners (ICPs), thus had many duties within their busy department that could be delegated to an injured worker. The modified duties and flexible hours were intended to accommodate my discomfort, physiotherapy and functional limitations during my rehabilitation. I had, however, gone from 12 hours to eight-hour shifts, resulting in my being at work more days weekly than usual.

I was warmly welcomed to the infection control department by the director, the manager, the physician head, all of the infection control practitioners and the surveillance assistants, each expressing appreciation for whatever assistance I would be providing. On my arrival in infection control, I needed orientation and training to my many new roles and the assorted aspects of my interim job. It quickly became clear that I was totally unfamiliar with the true inner workings of this department and the huge scope and responsibilities of my new colleagues. I had never even been in their part of the hospital previously!

I quickly settled into my "home away from home" within my own hospital. I learned so much in a very short time in order to perform all of my new and varied roles. My duties changed weekly and sometimes even daily, as determined by the immediate needs and priorities of the hospital and, thus, those also of the infection control department.

Over several months, I conducted frequent hand hygiene audits of all inpatient floors and departments throughout the hospital, as had been mandated by the provincial government. This surveillance included the use of alcohol-based hand rub or the performance of hand washing pre and post exposure to each individual patient and their immediate environment. The separate contact precautions audit monitored the use of alcohol hand rub or hand washing, as well as proper use of isolation gowns, gloves and masks in all rooms containing patients who had been identified as requiring these precautions and practices. Of course, it was also required that all data, as obtained, be input into the computer in a timely manner.

I also conducted environmental services audits of the furniture in patient rooms or ED cubicles, as well as the bathrooms in every unit and on every inpatient floor throughout the hospital. My shifts were staggered during daytime, evening and weekend hours. "Potty patrol" consisted of me doing an environmental (cleaning) audit of every commode chair found, while on "pump patrol", I audited intravenous pumps both in use and "clean, ready for use". The process for these various audits involved the application of invisible Glow Germ lotion to pre-designated locations on specific furniture (bedside table, over bed table, side rails) and pre-selected surfaces (sink, toilet seat, toilet handle, bathroom door knob, as well as commode seats [upper and lower surfaces] and handle bars) within all patient rooms. This Glow Germ application was followed by me doing a scan with an ultraviolet light over the same areas in a minimum of 25 hours from application. Since the environmental services department is a vital partner in the control, transmission and prevention of infection within the hospital, it was essential to evaluate the housekeeping practices.

Three months into my time as a modified worker in the infection control department, I was seconded to the occupational health department for two weeks. H1N1 had come to Ontario, and it had taken priority within the hospital and over my placement in the infection control department! My new role allowed me to assist with the administration of the H1N1 vaccine injections, as well as the dispensation of Tamiflu antiviral, as it was being offered to all hospital employees.

When I was not working in the H1N1 clinic, which had been set up in our staff wellness centre, I met many other colleagues with my "travelling H1N1 vaccine and Tamiflu road-show". My cart was loaded with vaccine, antiviral, consent forms and Halloween treats. Once again, I found myself discovering many unfamiliar areas within our hospital. All departments appreciated having this health and safety initiative brought directly to their staff, thus eliminating time away from their units due to the long line-ups in the wellness centre.

In an attempt to understand the increasing transmission of VRE throughout my hospital, I was next asked to conduct patient mobility audits for the infection control department. This process included me conducting a personal interview with every current patient (if they were awake and they agreed, were coherent, and were able to communicate) who had tested positive for VRE. The patients responded to specific questions from me about whether they had ambulated independently out of their room in the past 48 hours, did they ambulate independently off their unit ever, had they been instructed in hand hygiene for entering or leaving their room, and any general infection control comments they wished to share.

All data were compiled and reviewed, along with any general comments shared by patients and their families. This VRE audit led directly to a change in practice throughout my hospital, resulting in the restriction of VRE patients to their individual rooms. This practice now seems like a "no brainer" with the audit data supporting the travel by some patients out of their isolation rooms, off their units, down the elevators, and into the cafeteria, cafe or gift shop. Although VRE information pamphlets were created for patients and visitors, this new "rule" did meet with some resistance from some patients.

I also frequently assisted the infection control practitioners by performing the daily isolation rounds throughout our hospital. This "walk about" involves the verification that all patients requiring isolation precautions actually do have the necessary signage notification and the appropriate PPE supplies stocked outside their rooms in order to facilitate proper infection control practices. As a registered nurse, it has been easy for me to often conduct spontaneous "point of care" infection control education with patients, visitors and hospital colleagues, whenever the opportunities arose, wherever I was throughout the hospital.

Following the objective collection of the large volumes of data from each audit, an assessment of the percentage of compliance is determined. The risks of infection transmission to our patients, our families and ourselves are extremely high. The countless audits that I have performed accurately reflect all of our compliance with infection control protocols, while also identifying opportunities where we all need to improve.

I have met many hospital employees and have been in various areas of our hospital that were previously unknown to me, including the office of the president and CEO. I have witnessed and learned so much about the diverse working lives and countless challenges of so many varied health care professionals and allied personnel in all patient care areas of my hospital. I admire each of them in their countless and equally important roles.

While carrying out my various modified duties over several (10) months, I gained a new and extensive understanding of the infection control department and the hugely demanding roles and responsibilities of the infection control practitioners. Throughout my tenure, everyone in the infection control department served as mentors, guides and knowledgeable resources for me. I have developed a genuine respect and admiration for these dedicated professionals and the important jobs they perform, all in a very busy and short-staffed department. It is no surprise that the work and assistance by this modified worker were so greatly appreciated!

I had found myself in need of a temporary work "home". Infection control long-term, and occupational health short-term, both needed assistance. Together, my injury and recovery time became a positive experience for all. It has been a genuine pleasure and a personal honour for me to meet, to learn from and to work with all of these dedicated professionals during my lengthy rehabilitation. I am told that my shoulder is "at maximum recovery or 90%" and that I can always expect to have "some discomfort and limited use."

I do, however, find myself in the most fortunate position of having many new and respected friends in the expansive world of health care. I have taken all that I have learned or have come to better understand while I was "away", back to my emergency department and my colleagues there. I learned so much and I was treated so well, but it is so good to be home!

About the author

Jan Spivey job shares as a staff RN in the ED of Kingston General Hospital, works as a Legal Nurse Consultant for Wise Owl Legal Nurse Consulting, is the current President of the Emergency Nurses Association of Ontario, is a member of the NENA Board of Directors and a Past President of NENA, is a member of the Medical Advisory Committee for PHAC—Emergency Preparedness Division, serves on the Board of Directors of the Centre for Excellence in Emergency Preparedness, is a member of the ED Asthma Care Pathway Steering Committee for the Ontario Lung Association, serves on the Hospital Associated Infections Working Group for the Ontario Southeast LHIN, is a member of the PHAC Medical Receivers Working Group, and has been recently appointed by CNA to serve on the Emergency Certification Exam Committee, Eastern Region.

outlook
Kids' Corner

Management system coming

Memo to: **Course directors** of ENPC/TNCC

eCourseOps are developing a new course management system!

In response to your feedback, ENA has been working with a course director focus group, consisting of your peers, to develop an online course management system, which will facilitate the scheduling and management of ENPC and TNCC. Some key features of Phase 1 of the new online system:

- Direct entry of online course applications, resulting in an immediate course number
- "Cut and paste" an existing course into a new course application
- Pay open invoices online, or reprint your invoice whenever you need to
- View full history of your courses and invoices
- Reschedule the course dates, or cancel a course
- Report the actual number of students after the course completion.

During the ENA conference in Tampa, Florida, I attended one of the demonstrations of the system. For someone who is technically challenged, I found it very easy to work with and look forward to the launch. A demo should be available on the ENA website in the next couple of weeks for course directors to trial.

Sharron Lyons

Policy guidelines for OUTLOOK article submission

Approval date November 2009

Past revision date November 2007

Next revision date November 2011

Editorial policy

NENA *OUTLOOK* welcomes the submission of clinical and research articles relating to the field of emergency nursing care and articles of human interest related to emergency nursing and emergency nurses.

Statements or opinions expressed in the articles and communications are those of the author(s) and not necessarily those of the editor, publisher and/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.

Authors are encouraged to have their articles read by others for style and content prior to 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), and formatted to fit on 8 ½" × 11" paper with 2.5 cm margins. Manuscripts may be submitted in electronic form.
3. Author's name, credentials, a brief biography, and province of origin must be included. A digital image is desirable.
4. Clinical articles should be limited to six typed 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) permission to use the photograph of (subject's name) in the NENA *OUTLOOK*.

Letters to the editor

Letters raising a point of current interest or commenting on an article should be no longer than one typewritten page. The editor reserves the right to accept, reject, or excerpt letters without changing the views of the writer. The author of an article will have an opportunity to respond to unfavourable comments.

Board meeting highlights

Highlights of NENA Board of Directors meetings will be submitted by the NENA secretary to keep the membership informed. President's report will be submitted annually.

Research studies/abstracts

Readers are encouraged to submit abstracts of research studies that would be of interest to emergency nurses. A research abstract is a brief description of the problem, the design and method, and the important findings of a study. If taken from the research literature, the abstract must include the title, author(s), publication, volume, page numbers, and year of publication. Abstracts must be submitted on computer disc, and/or in an electronic format, in Word Perfect or Word, IBM compatible.

Case study/ clinical articles

Readers are encouraged to submit actual emergency situations with valuable educational potential, descriptions of procedures in emergency care, samples of patient care guidelines, and/or triage decisions.

Future events

Information regarding meetings of interest to emergency nurses may be submitted. NENA-sponsored events will be identified.

Book reviews

Emergency nursing books, specifically books on the CNA's bibliography for certification, will be reviewed. Solicitation from book publishers or donated books for review will be accepted.

Nena *OUTLOOK* submissions

Submission dates for article publication in the NENA *OUTLOOK* are to be set by the Communications Officer and dictated to publishing deadlines.

Please note: Nursing special interest groups may advertise upcoming conferences and seminars free of charge.

Call for nominations: "president-elect" and "communication officer"

Are you interested in serving on the board of directors? Then read on—this year there are two available positions. The president-elect position is a one-year term preceding the presidential role, and the communication officer position is a two-year term. Both positions would begin following the annual general meeting in Halifax, N.S. The board of directors meets twice yearly. Both meetings are three days in length. Typically, the spring meeting, though, is held in conjunction with a regional or national conference, so time away from home is usually longer.

As president-elect you are a vital member of the board. You would be expected to assume the role of president if the current president were to resign. Other duties include: reviewing and revising (as needed) the policy manual, position statements, bylaws and preparing achievements and actions in the strategic plan. There may be other duties that would be assigned to you by the president.

As communication officer, you are expected to ensure the production and dissemination of the Outlook journal every six months. You will liaise with provincial communication officers to encourage members to submit articles, pictures, tips, etc., to the journal. You will establish and maintain a credit rating with a printing firm for the production of Outlook. You will ensure that all invoices for the production of the journal are correct and are submitted to the NENA treasurer for payment. You will also maintain a liaison with NENA webpage designers to ensure updated information is displayed, and you will act as a contact resource for affiliation members who wish to use the website services. You will also assist with national and regional conferences by acting as a liaison between the conference committee and the board of directors.

Two NENA members must nominate candidates and the nominee must be a NENA member in good standing. A nomination form has been included for your use. Please forward a completed nomination and curriculum vitae to Sherry Uribe. Her address is listed on the nomination form. Nominations for these positions may also be made from the floor at the AGM. Announcement of successful candidates will be made following the election at the AGM in Halifax, N.S.

outlook
Nomination form

NENA executive position

Positions:

- Communication Officer
- President-elect

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

_____

for the position of

_____

on the NENA executive.

_____

(nominee) is in good standing with NENA.

1. Name: _____

Date: _____

Signature of nominator: _____

2. Name: _____

Date: _____

Signature of nominator: _____

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

_____

on the NENA executive.

Signature: _____

Date: _____

Please return this letter of intent and CV, by April 15, 2012, to:
Sherry Uribe, RR 5, S10 C7
Oliver, BC V0H 1TO
e-mail: nominations@nena.ca

NENA Award of Excellence application form

Forward all submissions to the provincial representatives by April 20 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: _____

NENA Bursary application form "A"

Name: _____ Date of Application: _____

Address: _____

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

E-mail: _____

Place of employment: _____

Name of course/workshop: _____

Date: _____ Time:_____ Length of course: _____

Course sponsor: _____Cost of course: _____

Purpose of course: _____

Credits/CEUs: _____ ENC(C) Certified: ❑ Yes ❑ No

Previous NENA Bursary: ❑ Yes ❑ No Date: _____

Please submit a proposal of approximately 200 words stating how this educational session will assist you and your colleagues to provide an improved outcome for the emergency care user: Attached?: ❑ Yes ❑ No

Ensure photocopies of provincial RN registration and provincial emergency nurses association membership are included with your application: Attached?: ❑ Yes ❑ No

NENA Bursary application form "B"

I acknowledge that _____ (name of applicant) is currently employed in an emergency care setting. This applicant should receive monies for _____ (name of course).

Reason: _____

Other comments: _____

_____

Signed: _____ Position:_____

Address: _____

NENA Bursary application provincial director's recommendation form "C"

Name of bursary applicant: _____ Province: _____

Length of membership with provincial emergency nurses group: _____

Association activities: _____

_____

Do you recommend that this applicant receive a bursary? ❑ Yes ❑ No

Reason: _____

Provincial director signature: _____ Date: _____

The 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.

See the nomination form on page 27.

outlook
NENA at work