# outlook

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

Volume 35, Number 2, Fall 2012

## In This Issue:



NENA
30th ANNIVERSARY

# outlook
# Guidelines for submission

## Editorial Policy

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

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

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

## Preparation of Manuscripts

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

2. Manuscripts must be typed, double-spaced (including references), on 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, a photo and a brief biographical sketch 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

Please include a brief biography and recent photo of the author.

**Deadline dates:**
January 31 and September 8

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# President's message

2012 has been a very busy yet exciting year for me. As the NENA president I have had the opportunity to attend or take part in provincial, national and international meetings, conferences and focus groups. I have been able to give you, the Canadian emergency nurse, a voice at these functions while gaining considerable knowledge for myself. Now, as I try to pass on some of that knowledge, I share with you the following.

Emergency departments have become the front door of our medical system obliging emergency nurses to expand their knowledge to include issues previously addressed in different settings. It is difficult in a busy emergency department to take the extra time needed to deal with non-emergency issues, but nurses must continue to advocate for these patients regardless of the reason for their visit or their medical issue.

Many emergency departments face increasing workloads, overcrowding and long wait times making it a stressful work environment for both staff and patients. Our hospitals are putting programs into place to deal with patient-to-staff violence, but let's not forget about bullying, lateral violence and incivility between staff. You can be the one to start the change; whether you have been bullied or been the bystander, take action. To begin you can simply stand beside the target, or better yet, be courageous, speak up and help extinguish this type of behaviour.

NENA, along with many other nurses from the Canadian Network of Nursing Specialties (see CNA Associate and Affiliate Members and Emerging Groups has a new name, below), met for a one-day session on June 16, just prior to the CNA conference in Vancouver. The day included a wealth of information on everything from a talk on bullying, working with the media and getting your message out to the right people.

Some of the take-away points were:

- patients and families are our top priority
- RNs need to understand their populations
- RNs need to get into the boardrooms
- RNs need to take on the power, get out of the back seat
- RNs have the power to make change.

For NENA to accomplish some of these points, we need to build our membership and share our knowledge. I would like to encourage all nurses to attend the conference May 29–31, 2013, in Vancouver BC—***"NENA 2013—Wild and Spectacular"***. This is an excellent opportunity to gather valuable information, practise some hands-on skills and network with other nurses from across Canada and the U.S. What you learn can be taken back to your facility and shared with co-workers. I hope to see you in May 2013.

**Sharron Lyons**
**NENA President**

# Communication Officer's report

Thank you, each of you, who have contributed to this fall edition of the NENA Outlook. Your willingness to share and your investment of time and knowledge are a wonderful gift to your peers across the country.

Even as we are preparing this edition for the press, I want to remind NENA members that we will be publishing another edition in the spring. Spring seems very far away when we are only beginning to haul winter coats and mitts from storage places, but it will be here before we know it. The deadline for submissions for the next journal is January 31, 2013.

**Stephanie Carlson**

# Secretary's note

Hello everyone. I want to introduce myself to you. I am the interim secretary for NENA—my name is Dawn Paterson. Recently I have served on the board as the Alberta representative. I have met many of you in that position over the last few years and hope to meet more of you in my new position. Please feel free to contact me via the website if you need to direct anything my way.

**Thanks,**
**Dawn Paterson**

outlook
NENA at work

## CNA Associate and Affiliate Members and Emerging Groups has a new name!

The Canadian Nurses Association has a network of 43 national nursing specialty groups previously known as the *Associate and Affiliate Members and Emerging Groups* (AAE).

Earlier this year, CNA hosted a "name that network" contest for all nurses in Canada to come up with a new name for the network of national nursing specialties. CNA felt the new name needed to be more reflective of who these nurses are and the important work they accomplish. CNA received 73 suggestions, which were reviewed and narrowed down to a list of four potential names. The network members, of which NENA is one, then voted on the short list and the winning suggestion was announced at the June CNA Conference in Vancouver. The AAE will now be known as ***Canadian Network of Nursing Specialties***. Susana Styles, its author, won $300—congratulations, Susana.

# News from the provinces

## Ontario

The past six months have been very busy for the Emergency Nurses Association of Ontario (ENAO). The year-long celebration of ENAO's 40th anniversary culminated with a successful provincial conference "Compression for Compassion" held in Toronto in September. ENAO was honoured to receive recognition plaques from Toronto's Mayor, Rob Ford, Ontario's Premier, Dalton McGuinty, and Canada's Prime Minister, Stephen Harper.

The conference attendees were treated to an amazing line-up of speakers and presentation topics, all so pertinent to the emergency nursing specialty of today. Many exhibitors and corporate sponsors partnered with ENAO to create this incredible educational event for emergency nurses. The nurses learned about the latest products, services and pharmaceuticals available, while receiving countless and varied take-home gifts.

The ENAO 2012 conference planning committee did an incredible job of acquiring so many unique door prizes, which were awarded to attendees. The 50–50 draw was financially beneficial to both the winner and ENAO. ENAO is proud to have awarded two complimentary ENAO/NENA one-year memberships—one for the free ENAO booth draw and one for the sponsor passport draw.

ENAO was honoured to have special guests in attendance throughout our conference. Lucie Vachon, Nurse Consultant, CNA Certification Program, and Janet Calnan, NENA President Elect, both addressed the attendees. ENAO also happily welcomed emergency nursing colleagues from Nova Scotia, Alberta and British Columbia.

A historic event for ENAO happened during the 2012 Annual General Meeting, which took place during the ENAO conference. The members voted to dissolve the longstanding district set-up within ENAO's provincial structure. The members also voted to create two new ENAO Board of Directors' positions—education coordinator and member at large. The ENAO BOD hopes that an eight-member BOD will continue to serve the needs of all ENAO members and our emergency nursing colleagues throughout all of Ontario.

ENAO is now moving full steam ahead with our ongoing plans and preparations for our next turn to host the NENA conference in 2014. Stay tuned!

**Respectfully submitted,**
**Janice L. Spivey**
**ENAO President**

## Newfoundland and Labrador

**Membership:** Our numbers have been steadily increasing with the new trial format of registration—renewal on your own anniversary date, as opposed to the set "deadline" of June 30 yearly. Thus, our membership at this point is at 56 with 15 pending payment.

**Courses:** The province has offered education courses in TNCC and CTAS with the expectation of introducing ENPC (thanks Sharon Lyons for travelling to NL) provincially for the first time ever! Recent corporate decisions have made it difficult to deliver NENA courses, as they have instituted a province-wide "ban" with all staff being declined requests to travel outside their particular region for educational purposes (see conference information below).

**Conference:** We are relaunching a NENA conference October 19-21, 2012, in Corner Brook, NL. We had a strong launch of the conference in April and had a projected participation of between 125 and 150 participants. With recent government legislation that will limit the travel opportunities of emergency and, indeed, all nurses for education, our numbers look to be in the 40 to 60 range of expected participants. Due to this government "cutback" there have been a number of annual conferences from other health care provider groups cancelled. Despite the health authority's professional development ban, we are forging ahead and look to deliver the first conference in more than eight years to the province of Newfoundland and Labrador. Therefore, join us for our conference on "Disaster Preparedness: Are we ready?"

**Ongoing issues:** As we hear from our colleagues across the country, we seem to have similar concerns regarding delivery of care, as we struggle with increased wait times, boarded admitted patients in the emergency department, and staff abuse related to public uncertainty and frustration.

We are also currently being subjected to a province-wide ban on travel relief and financial support for professional development. The health authorities (four within our province) have been directed by government to refrain from granting education relief for these events. They will only honour core competencies education. We expect to see long-term reduction in staff motivation for continuing education and an impact on morale, as nurses feel they have no support. Ultimately, this will be reflected in patient care because staff will have difficulty remaining current with trends.

**Positive note:** I would like to thank my colleagues in nursing, paramedicine and ERPs who have helped my conference committee remain positive and for your encouragement to persevere as compassionate caring health care staff who continue in this career because it's a calling and not a job.

We are lucky to have had Hurricane Lesley visit the province with only minor mishap, but it reflects the need for disaster preparedness. As we tend to get these events more frequently, there is a need for a more comprehensive coordinated response from all parties. Like TNCC and ENPC, we need a systematic approach that is universal to all across the island.

**Thank you,**
**Todd Warren**

## British Columbia

Wow—the summer has flown by and on the coast we are preparing for cooler nights and lots of rain.

Emergency departments organized the first International Sepsis Day on September 13. The B.C. Safety and Quality Council has been providing educational materials and links to Twitter discussions from around the world. Any B.C. site can still join the sepsis network, so look to get involved.

Our 2013 NENA conference planning committee has been madly working behind the scenes putting together a show-stopping event.

Bouquets of flowers and red wine to Jan Calnan, Darlene Campana and Kitty Murray. The island women are a force to be reckoned with. This is an event not to miss.

It is never easy organizing educational events, and thanks go out to a group of professionals who are essentially volunteering time at the St. Pauls emergency medicine conference in Whistler, B.C., to promote and increase nursing presence at emergency conferences. Monique McLaughlin, Landon James, Claude Stang, Katie Procter, Sheila Turris, Sheila Finamore, Deb Scott, Camille Ciarnello, Lori Baker, Tracy Northway, Brent Woodley, Susanne Moadebi, and Dr. Doug Brown have contributed to a jam-packed event. My heartfelt thanks to you all.

TNCC, CTAS, ENPC, CAIMAN and ACLS classes are happening all over the province, and we have another collaboration with Washington State—in Seattle this year—for our fall education day. Please email if you have any questions regarding these courses.

Continue to provide the excellent emergency care that you do, in all the various settings in which you have chosen to work.

**Sherry Stackhouse**
**ENABC President**

## Québec: AIIUQ

L'AIIUQ est très fière des développements qui sont actuellement en cours pour que l'affiliation au NENA soit concrète pour les membres. Nous travaillons actuellement à attacher les ficelles des structures administratives qui sont nécessaires et essentielles sur les liens avec le site internet et tous autres détails. Nous avons très hâte de débuter les discutions avec les autres provinces, nos nouveaux partenaires, pour participer au développement continue de la pratique des infirmières d'urgence. Dans nos activités de l'automne, nous avons notre congrès annuel qui aura lieu dans très peu de temps, soit le 3-4 octobre prochain, sous le thème: «Les soins d'urgence, un milieu propice au développement professionnel». Nous sommes aussi impliqués dans un groupe de travail, avec le ministère du Québec, qui élabore des recommandations sur la prévention des infections dans les salles d'urgence. Ce sera un plaisir de partager ces recommandations avec les intéressés lorsque les travaux seront terminés… Et nous continuons d'offrir à nos infirmières de la formation continue sur différents thèmes intéressants, évaluation respiratoire, triage et autres. Notre défi de l'année sera de trouver des moyens pour augmenter notre membership!

**Carine Sauvé**
**President AIIUQ**

## Nova Scotia

Fall greetings from Nova Scotia! It's hard to believe the summer has passed by so quickly! We started it with a bang here in Nova Scotia, hosting the national NENA conference in May, in Halifax—"30 Years of Navigating the Depths of Emergency Nursing." It was a fabulous conference from all the wonderful educational sessions and brilliant presenters to the connections/friendships made and the party at Murphy's on the Waterfront! A huge thank you to all those who attended and a big round of applause to the organizing committee for all the hard work in making the conference such a great success! We certainly hope that you will all come back to visit us again and hope to see you at the next national conference in Vancouver!

Work continues across the province preparing for the Emergency Department Standards that the Department of Health and Wellness is hoping to have in place by 2014. We are seeing more TNCC and ENPC courses happening throughout the province, as nurses prepare to meet the education standards to work in Nova Scotia's emergency departments. We have also seen the development of some Collaborative Emergency Centres (CECs) in the province. These centres are located in the more rural areas of the province and are open 24 hours a day, seven days a week. During the night the centres are staffed with a registered nurse and/or a paramedic working under the direction of a medical oversight physician through Emergency Health Services.

We are planning a provincial meeting of NSENA this fall, as we strive to become a stronger support and advocate for emergency nursing in Nova Scotia.

**Michelle Tipert**
**NSENA President**

## Alberta: ENIG

My name is Pat Mercer-Deadman, and I am pleased to be the president of the ENIG of Alberta and the Alberta Director for NENA. I have been a member of ENIG since 1994. I truly love emergency nursing and believe wholeheartedly in what ENIG and NENA stand for. This said, I have a huge learning curve with these new roles, but feel "up for the challenge".

As summer quickly is becoming fall, I have been busy thinking of ways to increase our membership and engage our members. We have more than 3,000 emergency nurses in our province and yet the membership with ENIG has always been less than 200. With this statistic in mind, it is my personal priority to substantially increase our membership. We are developing a brochure and a poster to advertise our group and are looking at ways to contact all the ER nurses in the province. I hope to get a personal e-mail out to each RN who has identified themselves as working in emergency through CARNA, by year's end. We are in the

planning stages of education days for the fall and the spring, as well as making our newsletter, ER STAT, more substantial and informative.

ENIG executive continue to not only promote our group, but also encourage emergency nurses of Alberta to join in so our voices can be heard on political issues that arise, not only in Alberta, but also on the national front through NENA.

ENIG's philosophy is to improve standards of emergency nursing practice, to promote growth professionally, to improve communication among emergency health care providers, to act as a resource on emergency nursing and to be a voice for issues affecting emergency nursing.

**Pat Mercer-Deadman**
**Alberta Director**

## outlook
## Bouquets

**TNCC's 20th anniversary**
Bouquets to visionary NENA members from past years. This year marks the 20th anniversary of Trauma Nursing Core Course (TNCC) in Canada. NENA developed and implemented the TNCC for national and international dissemination as a means of identifying a standardized body of trauma nursing knowledge.

The TNCC (Provider) is a 16- or 20-hour course designed to provide the learner with cognitive knowledge and psychomotor skills. Nurses with limited emergency nursing clinical experience, who work in a hospital with limited access to trauma patients, or who need greater time at the psychomotor skill stations are encouraged to attend courses scheduled for the 20-hour format.

**Web changes**
Bouquets to our Webmaster, Gary Pronych, who has developed the web capability for the change in the membership year. NENA members and potential members may now join or renew lapsed memberships at any time of the year and know that their memberships are valid for a full 12 months. This hasn't been without headaches and a few problems, but Gary has struggled to make it work. Next spring we will see another major change when we go to online voting for the open executive officers, secretary and treasurer. We believe these two changes are major advances for NENA and a good service for all members. For people who are non-computer literate, there is a tendency to expect that some of these web-based actions are easy to accomplish with a mere change of a code or key stroke. In fact, things that would be simple to do with pen and paper and a good filing cabinet can be remarkably complex in the computer world. Thank you, Gary, for all your work.

The ENAO BOD wishes to recognise and thank the ENAO 2012 conference Co-Chairs, Humberto Laranjo and Motsi Valentine for all of their time and efforts in creating an awesome educational opportunity for emergency nurses in Ontario and beyond.

Thank you for your service to outgoing NENA Board members Cate McCormick, Lori Quinn, Raegan Gardner. Thank you to Valerie Pelletier for representing AIIUQ during the arrangements required to facilitate joining NENA.

Welcome to Jan Calnan, newly elected President Elect. Jan has many years of experience on the NENA board as secretary.

Welcome to Dawn Paterson, who is the new NENA Secretary.

Welcome to Carine Sauvé, who is the AIIUQ President.

Welcome to Lydia Sousa, who is the Saskatchewan Provincial Director.

Welcome to Pat Mercer-Deadman who is the new Alberta Provincial Director.

Kudos to the Halifax Conference Committee for hosting an amazing event and valuable conference and a huge THANK YOU to our corporate sponsors of all levels for enabling NENA to host a national conference. There are other volunteers, too many to mention, whose untiring work in the details made the conference appear effortless.

Congratulations to British Columbia's Mandy Hengeveld, Northern Outpost Nurse and Lion's Gate Hospital ER RN, who won a trip to the NENA conference from ENABC.

Bouquets of flowers and red wine to Jan Calnan, Darlene Campana and Kitty Murray. The Island women are a force to be reckoned with. Our 2013 NENA conference planning committee has been madly working behind the scenes putting together a show-stopping event.

Thanks to a group of professionals who are essentially volunteering time at the St. Paul's Emergency Medicine Conference in Whistler, BC, to promote and increase nursing presence at emergency conferences. Monique McLaughlin, Landon James, Claude Stang, Katie Procter, Sheila Turris, Sheila Finamore, Deb Scott, Camille Ciarnello, Lori Baker, Tracy Northway, Brent Woodley, Susanne Moadebi, and Dr. Doug Brown have contributed to a jam-packed event. My heartfelt thanks to you all.
Sherry Stackhouse

A big thank you to Traci-Foss Jeans for all her dedication and tireless efforts to make the Emergency Nurses of NL a well-educated and competent group of professionals. We thank you so much. My personal thanks, as she encouraged me to be the NL Director. I am truly thankful, as she provided me with a conch to have my voice heard.
Todd Warren, NL Director

National Emergency Nurses Affiliation
National Conference 2012

# 30 Years of Navigating the Depths of Emergency Nursing

May 3–5, 2012
Halifax, Nova Scotia

The National Emergency Nurses' Affiliation would like to thank all the companies that sponsored our annual educational conference "Thirty years of Navigating the Depths of Emergency Nursing", held in Halifax, Nova Scotia, May 3–5, 2012. This sponsorship was sincerely valued, and without the support, the NENA conference would not have been such a success.

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1. Davis K and Lachenbruch CA. A Comparison of Two Powered Transport Features in Reducing Biomechanical Stress During Stretcher Maneuvering Tasks. Hill-Rom Services Inc., July 2011. Based on data collected from University of Cincinnati Ergonomics Laboratory, 2010.
2. A total of 672 trials were conducted representing weights of 0 (empty), 200 lbs, 500 lbs and 700 lbs. Specific tests performed include: pushing a straight distance, pushing up and down a ramp and pushing around a corner.



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National Emergency Nurses Affiliation
National Conference 2012

# 30 Years of Navigating the Depths of Emergency Nursing

May 3–5, 2012
Halifax, Nova Scotia

Colleen Brayman and Sherry Stackhouse

Sharron Lyons and Valerie Pelletier

Mari-Elena Guerrero and Sharron Lyons

Carol Legare and Marie Grandmont

Above: The signing agreement for union of AIIUQ and NENA

2012 Conference committee: Heather Peddle Bolivar, Jennifer Clarkson, Jane Daigle, Sherry Uribe, Sandra Bosma, and Cate McCormick.

Jan Spivey and Sharron Lyons

Sherry Uribe

Kitty Murray and Sharron Lyons

Pat Mercer-Deadman, Dawn Paterson, Landon James, and Val Eden

Erin Musgrave and MariElena Guerrero

Dawn Paterson and Sharron Lyons

Above and right: Bedbugs presentation

Sharron Lyons and Landon James

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Vancouver, one of the world's most spectacular cities, welcomes the members of NENA, as host city of the 2013 National Emergency Nurses Conference.

The city of Vancouver is renowned for its incomparable natural beauty and cultural diversity.

Whether you are a staff nurse or manager in an emergency department, an administrator, prehospital, flight, pediatric or trauma emergency nurse, an emergency clinical nurse specialist, nurse practitioner, student or educator, you can benefit from this National Emergency Nurses Conference.

No matter your level of experience, or the size of your emergency department, this conference is for you and it will contribute to your professional growth.

As we all know, the pace of emergency nursing varies from slow to hyper drive, and it can change within minutes.

Patients may be housed in your hallways and cubby holes due to overcapacity in your facilities, which adds to the stress of our work life, as we struggle to ensure all patients receive excellent and compassionate care.

Our nursing specialty encompasses caring for patients of all age groups and conditions, from delivering babies and resuscitating trauma arrests to administering medication.

Emergency Nurses are "Wild and Spectacular"—the theme for the Conference 2013.

**So if you answer yes to any of these characteristics of emergency nursing, then we will have something to offer you in Vancouver on May 29–31, 2013.**

- Do you like variety and complexity? This conference has it.
- Do you have the ability to shift gears and accelerate your pace as needed?
- Do you have good observation, assessment, and prioritization skills?
- Do you have multitasking ability?
- Do you have good interpersonal and customer service skills?
- Do you have stamina (as there is great shopping in Vancouver)?
- Are you an assertive patient advocate?
- Can you maintain calm amidst a chaotic environment?
- Do you have the ability to think fast and on your feet?
- Do you have a good sense of humour (this is essential)?
- And last of all, do you want to have fun?

If you answer yes to any of these characteristics, then this conference is for you!

We hope that this conference will find something for all of these characteristics and we can show the world that we are "Wild and Spectacular".

You can never know too much about emergency nursing, so NENA offers this continuing education opportunity that will be involving, comprehensive, and very rewarding.

So please mark May 29–31, 2013, on your calendars, and come join the fabulous team of conference planners that I have working with me—the Emergency Nurses Association of British Columbia, your host provincial group, and NENA, and let's be Wild and Spectacular.

**Janet Calnan**

outlook
NENA at work

# Discourses at triage

**By Lucy Cross, RN, BSN**

Discourses are intimately tied to practice and, if unpacked and exposed, reveal truths. Defined as groups of ideas or patterned ways of thinking within wider social structures, discourses help uncover what is largely taken for granted in practice to create an awareness of what is hidden. There are discourses embedded in the practice focus we use to triage in the emergency department (ED), specifically the use of two standardized texts—The Canadian Emergency Triage and Acuity Scale (CTAS) and the Canadian Emergency Department Information System (CEDIS)—which construct and produce triage. CTAS and CEDIS are largely physician-driven data collection endeavours supported by the National Emergency Nursing Affiliation (NENA), as a means to provide potential economic benefits and improve future targeted health care funding to best meet identified population health care needs.

I propose that discourses reveal how these two texts influence triage outcomes for the patient and the triage nurse. The discourses embedded in the triage texts are: a dominant medical discourse, a political and economic discourse and a relational discourse. Other discourses include a discourse of disclosure, a moral and ethical discourse, and a discourse of obligation. We "act" in our discourses and, to some degree, we choose our discourses. Being aware of the underpinnings of practice and the hidden discourses we inadvertently participate in, can create insight into relational tension and power imbalances that triage can create. Being aware of this can, in itself, create space for learning new truths. While the standardized CTAS and CEDIS texts influence triage decision-making attempts to ensure consistent care and patient safety, the nurse can be aware of the hidden discourses he/she participates in and the implied choices embedded within. An awareness of how the emergency nurse is affected by hidden discourses is key to creating change and fostering personal and professional growth.

# National Course Administration Committee (NCAC) TNCC/ENPC/CTAS Instructor Updates

**By Margaret Dymond**

## ENPC 4th Edition Updates

All ENPC instructors should have received an email from ENA describing the process for updating your instructor status to teach the ENPC 4th edition course. The update process is all online. ENPC instructors are required to watch the online videos and write the test after viewing the videos and update information. It is advisable that instructors secure a 4th edition provider manual to preview the course material prior to completing the online videos and exam.

Instructors are being asked to secure funding for the new provider manual with their employer. Some funding is available through your emergency nursing provincial organizations. An application is available and proof that your employer denied your request for funding is required. Funding is not available for the instructor manual.

The 4th edition manuals can be purchased through the ENA.org website or through ENPC course directors.

NCAC regional reps have emailed all instructors in their zone regarding the update requirements. If you have not received any notification, call your regional NCAC rep.

## E-course OPS

The online application process for ENA courses has been available to all Canadian course directors for a year through the ENA website. A demonstration video is available for course directors to preview. There are many advantages to applying for courses online—view your courses, invoices, order manuals, and/or cancel courses. Further enhancements coming: entering student rosters and marks online. No more paper!

## Course approvals

A two-step process is required for course approvals. Course directors should apply through e-course OPS for their courses. ENA approves that course directors and instructors are current to teach. NCAC ensures all instructors are NENA members by checking the NENA membership list. Generally your NENA membership expires June 30 every year.

## TNCC updates

The 7th edition TNCC revision process starts this fall. This process normally takes two to three years to complete.

## Course Bytes

This is a great newsletter published by ENA where TNCC/ENPC instructors can get up-to-date information on courses. If you would like an automatic email, send your request to **CourseBytes@ena.org**

## CTAS update

The 2012 CTAS course revisions are available through the CAEP website in a secured manner. Only current CTAS instructors will have access to the course materials. Course materials expire every year. CTAS instructors are required to ensure their instructor status is current (teach one course every 12 months) and be a NENA member. Instructors who have lapsed in either their instructor teaching requirement or NENA membership will not have access to the teaching content. Questions or queries can be sent to **ctas@nena.ca**.

## NCAC positions available

NCAC currently has two vacancies: One NCAC rep for Quebec, and one CTAS rep. Information can be sent to interested parties at **chairncac@nena.ca**.

**Back row: Monique McLaughlin, Traci Foss-Jeans and Debra Bastone. Front row: Margaret Dymond and Ann Hogan.**

## Course updates

NCAC publishes a newsletter twice annually. Instructors are sent the information via email. If your email address changes, please notify us at **ncac@nena.ca**. Your NCAC rep can also email you up-to-date Canadian course administration procedures.

## NCAC members

All queries regarding TNCC/ENPC/CTAS can be sent to **ncac@nena.ca** or through the NCAC members below.

Margaret Dymond, Chair
**margaret.dymond@albertahealthservices.ca** or **chairncac@nena.ca**

Ann Hogan, Eastern Canada Rep
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# We must be prepared to collaborate and respond, cont'd.

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

In the last edition of *Outlook*, I shared my experiences as an invitee at the January 2012 Emergency Preparedness And Response (EPR) Forum in Edmonton, Alberta. When emergency preparedness and planning has never been more crucial or timely, the theme of the forum, "Strengthening Collaboration Between Public Health, Health Care and Emergency Management" could not have been more appropriate.

Dr. Theresa Tam, Director General, Centre for Emergency Preparedness and Response, Public Health Agency of Canada, served as the forum's master of ceremonies. At the end of day one, she left us with this thought: "Significant and ongoing financial and human support are both essential in order to achieve and maintain an appropriate standard of emergency preparedness, as would be required to mount an effective response to a future disaster." Dr. Tam's words, with our many thoughts about all that we had heard this day, accompanied by our feelings regarding all of the pictures we had seen, stayed with us throughout that cold (-32 degrees) Edmonton night, as we eagerly anticipated day two.

The first plenary session, "Building Awareness and Preparedness: The Benefit of Zombies" was presented by Dr. Ali Khan, U.S. Assistant Surgeon General and Director, Office of Public Health Preparedness and Response, Centers for Disease Control and Prevention. He talked about how the CDC's novel idea to use social media (Twitter, Facebook, blogs) had played a critical role in informing the public during recent emergencies. Dr. Khan described the value of social media in helping to manage rumours and negate false information, while it served as an excellent way to request help.

Dr. Khan concluded his presentation with, "Relating to the current popularity of Zombies in books and movies, if you are generally well equipped to deal with a Zombie apocalypse, you will be well prepared to deal with a tornado, hurricane, nuclear accident or pandemic."

The second plenary session reviewed the German experience with the E-coli outbreak in Hamburg in May 2011. Dr. Christina Frank, Deputy Head, Unit for Gastroenteric Infections, other Zoonoses and Imported Infections, Robert Koch Institute, Germany, described the processes and lengthy investigation from outbreak declaration to the ultimate determination that the E-coli source was sprouts that had arrived in Germany as seeds for local planting from another country. It was surprising that the source for the E-coli was fresh vegetables, not undercooked meats or raw milk, as is more common. The victims were found in clusters, having eaten at the same restaurants and salad bars or at the same catered parties. The investigation revealed that many of them did not even remember there were sprouts in their salads! We learned that this outbreak ultimately resulted in 4,000 cases of E-coli in total, two-thirds of the victims were female, and there were 53 deaths. Following an eight- to nine-day incubation period, there was one case of E-coli seen in a Canadian who had recently travelled to northern Germany. It was concluded that all of the sprouts had come from the same German sprout farm, which had imported all of their sprout seeds from Egypt.

Appropriately, one of the following concurrent sessions considered the question, "Food Borne Illness in Canada: Are We Ready?" Mark Samadhin, Outbreak Management Division, Centre for Food-Borne, Environmental and Zoonotic Infectious Diseases, Public Health Agency of Canada, reminded us that people travel all over the world daily and, as a result of international travel, so does food. Busy as we all are, we tend to buy more ready-to-eat foods such as prepackaged salad or meats, and we don't tend to wash these items. FYI, Canada's 2008 Listeriosis outbreak was determined to have an extensive three to 70 days incubation period.

The next concurrent speaker was Dr. John Lynch, Executive Director, Food Safety and Consumer Protection Directorate, Canadian Food Inspection Agency (CFIA). Food safety in Canada is regulated by the Food and Drugs Act and its management is shared between the CFIA and Health Canada, who are responsible for organizing any Canadian food recalls. It is estimated that every year, 11 to 13 million Canadians suffer from illnesses caused by food-borne bacteria in various degrees of severity. These federal agencies must perform an intricate balancing act between facilitating international trade, while protecting Canadians and the Canadian agriculture industry.

During our next plenary session, we met Peter Workman, Environmental Health Consultant, Nunavut Department of Health and Social Services. As background information, we learned that the territory of Nunavut has a total population of 33,000 people, and 85% of them are Inuit. Health and Social Services for the territory includes 25 health centres, two regional health facilities, and one hospital, which is located in Iqaluit. There is a 40% vacancy

rate in permanent full-time health care positions, and there is no intensive care capability. In 2011, there were 100 reported cases of TB in Nunavut.

In his presentation, "Hazard Specific Planning: North of 60 Degrees", Peter Workman described the circumstances in October 2011 that followed, when "the ANIK F2 satellite experienced a technical anomaly." This loss of all satellite service resulted in no cell phone, regular telephone or internet service in 56 communities across the Arctic. There could be no flights between communities, or in and out of the territory, except MEDEVAC flights by special permission, using an RCMP alternate communication system. During the 17 hours that it took to "reboot" the satellite and restore vital services, the biggest health care challenges were blood supply for transfusion, drug supply, laboratory specimens requiring shipping and valuable links to a variety of specialists.

Thus, ended the very intense morning of day two of the EPR Forum.

Wayne Dauphinee, Executive Director, Pacific Northwest Border Health Alliance, opened the next plenary session titled, "Surge Capacity: Meeting the Emergency Health Needs of Canadians". We learned that there are three requirements during any surge situation—stuff, staff and structures. The "stuff" includes all of the supplies and equipment. The "staff" must be both appropriate to the situation and sufficient in number. The structures are all of the beds and stretchers required to meet the needs of a surge event.

Chris Smith, A/Executive Director Emergency Management Unit, British Columbia Ministry of Health, shared pictures of B.C.'s Mobile Medical Unit (MMU) from the 2010 Vancouver Olympics, which has since become a valuable addition to B.C.'s emergency preparedness plan. He spoke about the need to develop a practical approach to emergency situation licensure, in order to facilitate cross-province use of health care professionals. Current discussion is happening with the provincial Colleges of Physicians & Surgeons, as well as the Colleges of Nurses. Stay tuned!

Jean-Francois Duperre, Director, Office of Emergency Response Services, Centre for Emergency Preparedness and Response, Public Health Agency of Canada, was our next speaker. We were reminded that Canada's National Emergency Stockpile System (NESS) was established in 1952 for the purpose of stockpiling beds and supplies, including entire field hospitals. There are 11 NESS warehouses throughout Canada and the current stockpile "has a book value of $300 million". NESS is currently being reviewed, as it must be updated to align with the current risk environment and associated requirements. Some outdated equipment will not meet today's standard of care, a shelf life review of many items (i.e., gloves, masks, pharmaceuticals) is necessary, there must be maintenance and upgrading of high-tech medical equipment (i.e., ventilators, x-ray machines), and all of these are accompanied by high costs.

The final plenary session was "The Crystal Ball: For What Challenges Should Canada be Preparing?" Peter Brander, Executive Director, Office of Emergency Preparedness, Health Canada, stressed the importance of ongoing collaboration between all levels of government, including federal, provincial, regional and municipal, in order to maximize preparedness.

Dr. Brian Schwartz, Director of Emergency Management Support, Ontario Agency for Health Protection and Promotion, stressed that many emergency preparations are fine-tuned based on past situations and all of the lessons learned. He urged that Canada conduct more proactive planning for various possible future scenarios.

Jeff Maihliot, Senior Policy Analyst, Critical Infrastructure and Strategic Coordination, Public Safety Canada, encouraged group discussion from forum attendees about ways to most effectively coordinate joint planning and preparation for the future challenges, which will most certainly be faced by Canada and our Canadian health care system.

In Dr. Theresa Tam's closing remarks, she strongly encouraged the creation of future and regular forums such as the one in which we had all just participated. She emphasized the value of the sharing of best practices between organizations, while recognizing the importance of including any and all anticipated participants throughout the entire planning, preparation and execution phases.

It was an incredible experience for me to represent emergency nurses at this EPR Forum. I am excited that Canada's emergency nurses have been recognized at very high levels to, indeed, be key stakeholders in the emergency planning and preparation for Canadians. From our frontline position in emergency health care, we have so much valuable knowledge and countless suggestions to contribute to this critical and ongoing planning. I am confident that emergency nurses will be on the invitation list for future forums!

## 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**

# Presenting complaint: Dizziness

**By Cathy Sendecki**

Some time ago, I realized we were seeing a lot of seniors with the presenting complaint of "dizziness", a term covering a host of symptoms. The range of possible causes is extensive and sometimes difficult to identify. Relief in the ED is often incomplete, and the patient leaves with many questions, a hesitant gait, ongoing discomfort, and anxious relatives. I wanted to know more about this constellation of symptoms, and how to help the patient deal with this complaint. If you identify with these concerns, here is some of what I've learned:

## Some definitions

**Syncope** is a transient loss of consciousness with a loss of ability to maintain postural tone due to global cerebral hypoperfusion. One example would be "church syncope" brought on by standing following a prolonged time seated or kneeling.

**Presyncope** includes the same symptoms including loss of postural tone without loss of consciousness. There is a sense of impending faint or "blacking out."

**Vertigo** describes the illusion of movement, often spinning, or the sensation of falling, and is often accompanied by nausea.

**Disequilibrium** is a sense of unsteadiness, a feeling that a fall is imminent.

The vestibular nucleus in the brain stem receives information from the ears, eyes, and joints (proprioception). When these inputs cannot be correlated, the sensation of vertigo often results. As with so many conditions in seniors, there will frequently be more than one contributing cause, and brief episodes of acute vertigo may be followed by an ongoing sensation of disequilibrium. Presbyastasis, or multisensory disequilibrium of aging, while not a sudden change, will add to the changes experienced by seniors now challenged with acute dizziness.

"Compared to younger persons, dizziness is more common, more pronounced, has more causes, is less likely due to a psychological cause, and is more incapacitating" (Davis, 1994). How common? According to some studies, approximately 40% of over-65-year-olds report that feelings of dizziness or unsteadiness diminish their quality of life, and it is a frequent reason for persons over the age of 75 to seek medical attention.

Etiology can be medical, otologic, central or psychogenic, bearing in mind that for older adults there may be more than one source. In approximately one-third of patients, no cause will be found.

## Medical

In our primary and secondary assessment, we are likely to identify changes in blood pressure, either ominously high, or too low. During the physical examination, infectious processes such as pneumonia or gastroenteritis can be identified, as well as signs of dehydration. Basic lab work will assess for anemia, elevated WBC, electrolyte abnormalities, hypoglycemia or UTI. A review of medications is indicated, to identify recent changes, particularly in antihypertensives, beta blockers and other cardiac meds. Although it can present a challenge, it is important to know what the patient has actually been taking, including prescription and over-the-counter medications, as well as any alternative remedies. Assess for recent use of Gentamicin or high doses of Furosemide. If the patient is on Phenytoin, serum levels may need to be checked.

An ECG will reveal ongoing dysrhythmias and a history of palpitations or chest discomfort will alert us to look further for cardiac causes. A CT scan may be ordered, as with the ECG, it is important to identify abnormalities, and a negative test can give some reassurance that this is not an ominous event.

Postural versus measurement may help to account for symptoms—the BP and pulse need to be measured with the patient lying, then standing, over a period of three minutes, with an assessment of symptoms. A drop of more than 20 mm Hg systolic, or 10 mm Hg diastolic, or HR increase of more than 20 beats/min. indicates orthostatic hypotension, which may or may not be symptomatic.

While medical causes may herald significant morbidity, such as a patient who presents with "dizziness" and is found to have a hemoglobin in the 60s, the most common causes relate to inner ear problems.

## Otologic

Three significant sources of vertigo are vestibular neuritis, labyrinthitis, and benign paroxysmal positional vertigo (BPPV). These conditions tend to come on suddenly, often accompanied by nausea, and sometimes vomiting. BPPV is postulated to be due to otoconia—tiny crystals that become dislodged from the vestibular area of the ear and enter one of the semicircular canals. Also called otoliths or canaliths, these crystals normally help the brain to sense gravity. If they become dislodged, the vestibular centres of the brain sense this as a change in the body's position. The typical history is of intense brief vertigo upon sudden changes in body position. In the past, it was felt that impingement on the vertebral arteries caused dizziness in some patients who looked up, for example, to find an item on a high shelf. Current evidence indicates this is a rare mechanism of dizziness—more likely the symptoms are related to BPPV.

Vestibular neuritis refers to an inflammation of the vestibular nerve, which carries balance signals from the inner ear to the brain. Inflammation can convey a sense of movement when no actual movement is occurring. This can follow a URI or viral infection. It may be due to decreased circulation to this area. A typical presentation of vestibular neuritis is the patient who wakes up to the sensation of spinning, has difficulty walking, and the symptoms have lasted a few hours.

Labyrinthitis refers to swelling and inflammation of the labyrinth of the inner ear, sometimes due to bacterial or viral infection, although the cause is not always known. Symptoms are similar to vestibular neuritis, but temporary hearing loss, distortion, or tinnitus generally occurs. Almost always, only one ear is affected, and the symptoms of vertigo occur as the brain is receiving incongruent impulses from each ear, as well as visual input.

The incidence of Meniere's disease increases with age. This is characterized by bouts of vertigo with hearing loss, ringing in one ear, and a sensation of fullness, due to fluid imbalance in the inner ear. Otologic vertigo tends to be recurrent.

## Central

Central causes, within the brain, tend to be of more gradual onset, and the associated symptoms are usually less intense. The cause of the symptoms may be more ominous than with peripheral vertigo, e.g., tumours (primary or metastatic). Balance may be significantly impaired, to the extent that the patient has difficulty sitting or standing. Finger-to-nose and heel-shin tests may be abnormal. Such presentations are more common in middle-aged persons than the elderly, although vertigo due to brainstem or cerebellar abnormalities may be more intense than in younger patients. A TIA or CVA in the posterior circulation may present initially as vertigo, occasionally accompanied by headache. Symptoms often include dystonia, ataxia, weakness and numbness in the perioral area or elsewhere.

## Psychogenic

While symptoms are less likely to be psychogenic in seniors than younger patients, depression or anxiety may present as dizziness. Understandably, the sudden onset of vertigo can be a source of anxiety.

The symptoms of dizziness or vertigo, even if not caused by a serious condition, are incapacitating for seniors who are prone to serious injuries due to falls. If they remain in bed to avoid falls, they risk significant deconditioning after only a few days. If they live alone, they will have difficulty with preparing meals and other daily activities. The fear of falls can cause seniors to limit their activities and, therefore, social contacts, all of which diminish their enjoyment of life and contribute to declining health.

Interventions will, of course, depend on the underlying causes of the dizziness. Medical causes may be most readily identified and treated. The treatment of central causes of dizziness, once identified, are well established. If TIA or CVA is diagnosed, appropriate management and follow-up to maximize cardiovascular health are needed.

Of the otologic syndromes, BPPV is most effectively treated with otolith repositioning exercises, such as Epley manoeuvres. Cervical spine fragility may necessitate modifications. Medications offer little relief. Patients may feel worse in the morning, as the otoliths tend to clump as the patient sleeps—with activity during the day, these particles become more dispersed and the symptoms subside.

Vestibular suppressant medications may be prescribed to decrease nausea and to lessen the sensation of movement. Meclizine (Antivert) may be prescribed. It has antihistamine and anticholinergic properties, which carry the risk of side effects, particularly falls, constipation and urinary retention. Lorazepam or other benzodiazepines may suppress the central response in the vestibular area, and may be prescribed for symptom management and relief of anxiety, but must be balanced against the risk of falls and mental changes.

Medications may alleviate the distressing symptoms initially but, over time, the central nervous system will accommodate the ongoing changes in stimuli in a similar fashion to becoming accustomed to new eyeglasses. Thus, medications should be taken for only a brief period, for example, up to five days. Beyond this time, they will delay the process of vestibular compensation.

Vestibular rehabilitation therapy is an exercise program designed to promote this compensation. This includes assessment by a qualified physiotherapist, occupational therapist or other professional, and exercises for the individual to do at home to promote safe activity involving movement of the head and visual stimulation.

When no cause is found, empirical trials of medications and vestibular rehabilitation therapy may be helpful.

Discharge teaching should focus on protection from injury during the acute phase, as well as the need to follow up with the primary care provider.

Advise these patients to get up from bed slowly, sit for one to two minutes, and exercise the feet and lower legs to stimulate venous return to prevent postural hypotension.

- move slowly when symptomatic
- do not lie flat, but elevate the head slightly
- do not drive or climb up on a chair or ladder, or engage in other activities where poor balance could be disastrous until symptoms have resolved.
- ongoing attention to fall prevention may be the "new normal".

Otologic vertigo tends to recur, so measures to lessen future episodes are important, for example:

- prevent dehydration
- avoid substances that can affect circulation, such as caffeine, alcohol, tobacco
- fatigue, illness, or stress can contribute.

Follow-up should also include correction of vision and hearing problems, adjustment of medications that may be contributing, and fall prevention strategies, such as use of a cane.

This has been an interesting topic to research, both in the literature, and in talking with seniors who deal with ongoing dizziness and vertigo. I hope this information will be helpful, especially as you are assessing and teaching seniors how to deal with this common illness, making the symptoms less incapacitating.

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## 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 our 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.*

# Does providing a wait time for ER patients in the waiting room improve patient satisfaction?

**By Karen Hill, RN, CNE, Cowichan District Hospital, ER/ICU/PAR**

February 20, 2011

In this article, I have referred to the patient, with the understanding that family is **always** considered inclusive with the patient.

**As gatekeepers to the hospital, we begin shaping the patient's experience in a positive way!**
Patients presenting to ER are prepared to tell their story... allow them to tell this story. The rule of thumb according to the "Strangers in Crisis Workshop" is to let the patient speak uninterrupted for 90 seconds. You will get a more accurate story and the patient feels that they have been heard.

Triage nurses use the CTAS assessment standards set out by CAEP and NENA. Triage has the important role of explaining to the patient the next sequence of events they can expect. Triage nurses do this all the time, for example, patients will see a nurse and a physician, and may have some tests done. The triage nurse then advises those patients waiting to return to triage if their condition changes. Further, the triage nurse monitors the possible progression of illness for patients waiting.

What seems to have the biggest impact on a patient's waiting room experience, however, is the question, "How long am I going to wait?"

These are the two questions patients ask:
1. How long do I have to wait?
2. Why am I waiting?

Patients want to be provided with an estimated wait time. The wait time provides them with baseline information about what they can expect. If a reason for the wait is also provided, patient satisfaction is even more positive!

**How do we give patients the information that they really want?**
Some examples of reasons for wait times might be: a high number of in-patient admissions, only one physician currently available, or very sick patients for whom the physician is currently caring.

By offering this "snap-shot" information on waiting, the patient is really being told, "We care," thereby reducing anxiety/stress levels and supporting the patient to feel more valued and in control.

Patient follow-up surveys currently examine left without treatment (LWT), or left without being seen (LWBS) reasons. Perhaps willingness to wait (WTW) reasons should be evaluated.

**Accreditation Canada recommends that:**
1. Triage staff informs patients in the waiting area of wait times for assessment and treatment.
2. Triage staff advises patients to return to triage if their condition changes.
3. Triage staff monitors possible progression of illness for patients waiting in the ER.
4. Triage staff explains the anticipated sequence of events, locations where services will be provided and by whom, at the time of registration.

Here is the most challenging piece: it is not just the ER waiting room. This same service is needed when the patient is placed in the streaming chairs, because this is really an extension of the waiting room. On the CDH-ER "patient satisfaction survey results" for July 2010 to Sept. 2010 category: **reason for waiting explained – the score result was extremely low.**

The ER staff within the Health Authority has expressed concerns about providing approximate wait times to patients. Specifically, if a patient feels the wait seems too long, they might leave without treatment.

I encourage everyone to remember that it is an estimated wait time with updates provided to the patient as situations change. Open communication promotes good public relations and a more positive emergency room experience.

The triage nurses at Cowichan District Hospital Emergency do a great job! The nurses show a caring, professional approach. Despite very busy times when patients may not be able to be re-assessed in a timely manner, have long line-ups, ambulances waiting, no breaks; the triage nurse is still there providing care to the best of his/her ability. This shows a true commitment to the community!

## Resources

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VIHA. (2010). *Results of patient experience in the Emergency Department at CDH, BC* (July 2010–Sept. 2010).

# Pediatric injury prevention in the emergency department

**By Lisa Widas, RN, BSN**

Injuries are a common cause for pediatric emergency department visits, and are the leading cause of death in children. As many of us are aware, most injuries are preventable. Emergency nurses are an integral part of injury prevention, especially with the pediatric population. Emergency nurses provide patient education daily for our pediatric populations, and injury prevention education can help reduce future injuries or injury severity. Finding that "teachable moment" for kids and families about injury prevention is paramount.

Here are some tips that you can give to parents and children in your emergency department to help keep children safe this fall and winter, or you can post them for reading in your waiting room.

## 10 tips to keep your child safe this fall/winter

1. **Road safety**. It only takes a second to forget to look both ways when crossing a road. Remind children, that even when they see a car and think the car sees them, to make eye contact with the driver and be *certain* that they are seen, even in a crosswalk.
2. **Car seats.** Staged car seats (rear-facing, forward-facing, booster) are intended to protect your child during a collision. Ensure you are familiar with provincial/national regulations and that your seats are installed correctly.
3. **Cycling on the road**. Children, until they are about 10 years old, do not have the capacity to process all the information required to ride a bicycle on the road (street signs, speed of traffic, side streets, shoulder checking, etc.). Ride with them or have them stay on bike paths.
4. **If it has wheels, wear a helmet**. Helmets can significantly reduce the risk of brain injury for all ages when worn appropriately. Start early—children should wear a helmet when on wheeled devices, even tricycles. A fall from as little as two feet can result in significant trauma to a child's brain.
5. **Winter sports**. An adult should check winter sports areas for things such as ice thickness where outdoor skating and hockey are popular. Other hazards such as trees or roads need to be considered for tobogganing or skiing/snowboarding. Always keep to designated areas.
6. **Snowmobiles**. The Canadian Pediatric Society does not endorse children under the age of six riding as passengers on snowmobiles as they "…do not have the strength or stamina to be transported safely…" (Canadian Pediatric Society, 2004). They also recommend that children younger than 16 years do not operate snowmobiles.
7. **Be aware of choking hazards and poisons at home or away**. Many homes that you visit may not be childproofed. Be aware of choking hazards that are within an infant or toddler's reach. Also be aware of medications in other's homes, or in purses or bags placed on the floor.
8. **Hot water will burn**. Children often reach for mugs or bowls of hot liquid on tables and counters. If near a child, use a mug with a tight lid, or drink hot liquids away from small children. Keep pots/kettles/soup bowls and cords out of reach of young ones. Tap water set at 60°C can burn an infant's skin in one second. Turn your hot water tank down to 49°C, and mix with cool water when running a child's bath.
9. **Fireplace safety**. The glass of a gas fireplace can cause a third degree burn on contact. A fireplace gate could help keep a child away from the glass and safe from these severe burns.
10. **Autumn and winter holidays**. Fireworks and sparklers can cause significant burns (a sparkler can burn as hot as 700°C and will not go out even when doused in water). Remember, when decorating your home for the winter holidays, to childproof decorated areas especially for electrical cords and candles.

Let's all work together to keep our children safe this fall/winter.

## Reference

Canadian Pediatric Society. (2004, November 1). *Position Statement: Recommendations for Snowmobile Safety*. Retrieved from http://www.cps.ca/en/documents/position/snowmobile-safety

## About the author

*Lisa Widas has been Manager, Trauma Program, BC Children's Hospital, since 2003. The Trauma spectrum includes injury prevention, pre-hospital, acute care and rehab. She is also experienced in Pediatric Emergency and Intensive Care and as an Emergency Nursing Pediatric Course Instructor. She has been an active ENABC member since 2005. Lisa is also the current president of the Interdisciplinary Trauma Network of Canada, a subgroup of the Trauma Association of Canada. She keeps balance in her life by working half-time to allow for time with her husband and their triplet girls.*

# Call for nominations: "secretary" and "treasurer"

Are you interested in serving on the board of directors? Then read on—this year there are two available positions. The secretary and treasurer positions are two-year terms. Both positions would begin following the annual general meeting in Vancouver, British Columbia. 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 secretary, you are expected to carry on the affairs of the corporation under the supervision of the officers of the board. You are expected to attend all meetings and to record all votes and minutes from these meetings. You will ensure that all board members will receive board meeting minutes in a timely fashion and, as well, you are responsible for producing the incorporated minutes. You will set the agenda for the board meetings in collaboration with the president. There may be additional duties that would be assigned to you by the president.

As treasurer, you are entrusted with the funds and securities of the corporation and you shall keep full and accurate accounts of all assets, liabilities, receipts and disbursements. You will be responsible for depositing all monies, securities and other valuable effects in the name and to the credit of the corporation. As well, you will be responsible for the disbursement of such funds. You are expected to prepare and deliver an accounting of all financial transactions at each board meeting. You will be expected to submit an annual accounting to the membership at the AGM. There may be other duties assigned to you by the president.

Two NENA members must nominate candidates for office and the nominee must be a NENA member in good standing. Nominations will be accepted until six weeks prior to the Annual General Meeting in May 2013. Reminders will be sent to the membership electronically well before the deadline for nominations. Nominations will not be accepted from the floor. A nomination form has been included for your use. Please forward a completed nomination and curriculum vitae to the Nominations Chairperson, whose name and contact information appear on the nomination form.

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Nomination form

# NENA executive position

## Positions:

- Secretary
- Treasurer

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 January 15, 2013, to:**
**Jan Spivey, 112 Old River Road, RR2, Mallorytown, ON K0E 1R0**
**e-mail: nominations@nena.ca**


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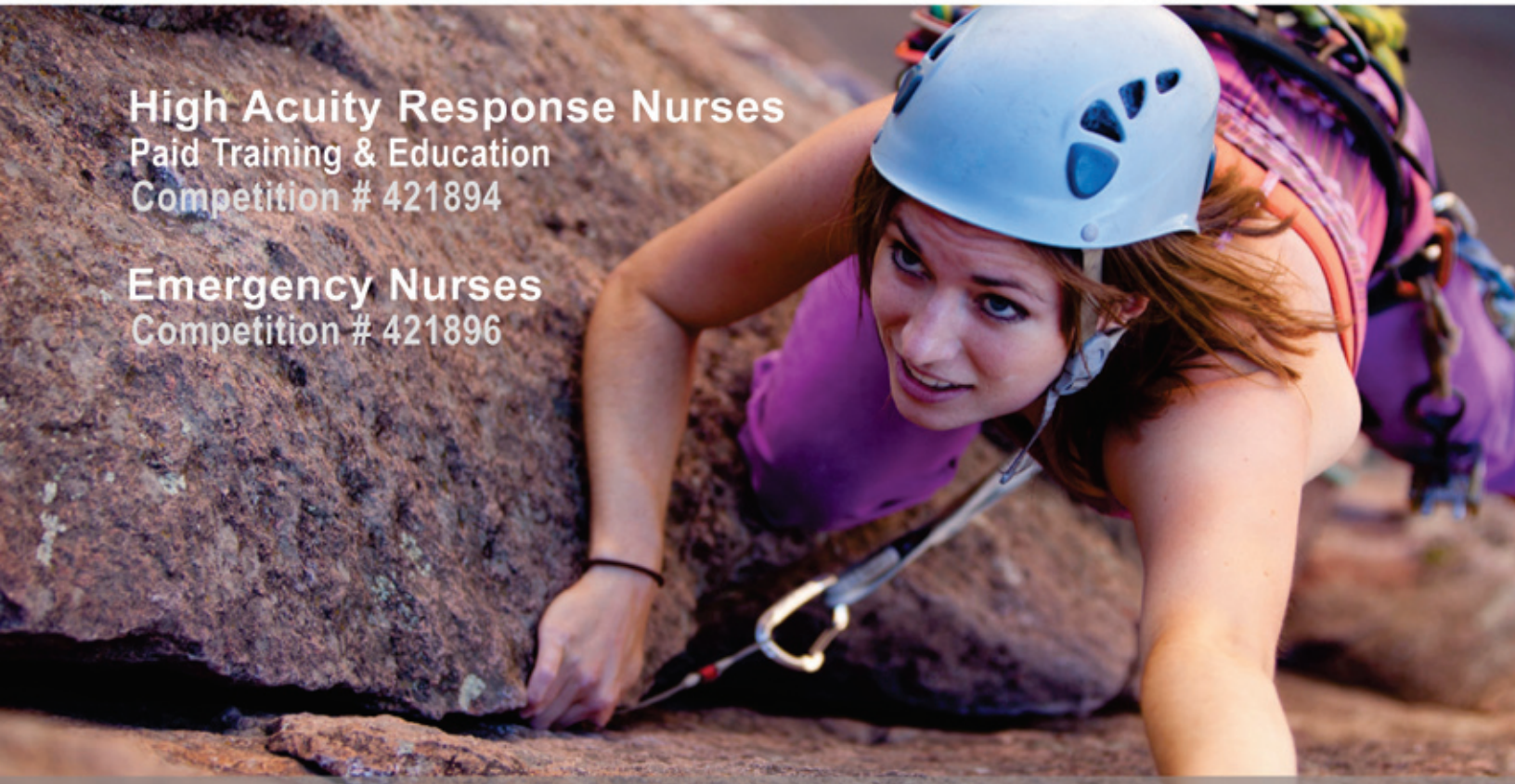

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# The NENA Bursary

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

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

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

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

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

## NENA Bursary application process

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

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

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

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

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

Each application will be reviewed once per spring board meeting.

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

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

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

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

## Application process

**Candidates must complete and submit the following:**

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

**Provincial representative responsibilities:**

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

**Selection process**

The standing committee for bursary disbursements will:

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

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NENA at work

# NENA Bursary application form "A"

Name: _____ Date of Application: _____

Address: _____

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

E-mail: _____

Place of employment: _____

Name of course/workshop: _____

Date: _____ Time:_____ Length of course: _____

Course sponsor: _____ Cost of course: _____

Purpose of course: _____

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

Previous NENA Bursary: ❑ Yes ❑ No Date: _____

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

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

# NENA Bursary application form "B"

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

Reason: _____

Other comments: _____

_____

Signed: _____ Position:_____

Address: _____

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

Name of bursary applicant: _____ Province: _____

Length of membership with provincial emergency nurses group: _____

Association activities: _____

_____

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

Reason: _____

Provincial director signature: _____ Date: _____

# NENA Award of Excellence application form

Forward all submissions to the provincial representatives by 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: _____