

# CANADIAN JOURNAL of EMERGENCY NURSING

## JOURNAL CANADIEN des INFIRMIÈRES D'URGENCE

THE OFFICIAL JOURNAL OF THE NATIONAL EMERGENCY NURSES' AFFILIATION

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1. **Canadian Journal of Emergency Nursing** 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 **Canadian Journal of Emergency Nursing** editor. The author should retain one complete copy.
2. Manuscripts must be typed, double-spaced (including references), layout on 8 1/2" x 11" paper with standard margins. Manuscripts must be submitted in Word or Word Perfect and sent electronically to the communications officer at [communicationsofficer@nena.ca](mailto:communicationsofficer@nena.ca).
3. Author's name(s) and province of origin, a high-resolution 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. Plagiarized material will be rejected without explanation.

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 **Canadian Journal of Emergency Nursing**."

Please submit articles to:  
Stephanie Carlson, CJEN Editor,  
email: [communicationsofficer@nena.ca](mailto:communicationsofficer@nena.ca)

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

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



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### Canadian Journal of Emergency

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### Editorial staff

Editor: Stephanie Carlson,  
communicationsofficer@nena.ca

Kids' Corner: Sharron Lyons,  
sharron\_lyons@telus.net

Trauma Corner: Margaret Dymond,  
margaret.dymond@albertahealthservices.ca

4N6RN: Sheila Early,  
sdeconsulting@telus.net

Geriatrics Matters: Cathy Sendeki,  
communicationsofficer@nena.ca

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Stephanie Carlson,  
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Sherry Stackhouse, [bcdirector@nena.ca](mailto:bcdirector@nena.ca)

**Alberta:** *Emergency Nursing Interest Group of Alberta (ENIG)*  
Pat Mercer-Deadman,  
[abdirector@nena.ca](mailto:abdirector@nena.ca)

**Saskatchewan:** *Saskatchewan Emergency Nursing Group (SENG)*  
Alison Duncan, [skdirector@nena.ca](mailto:skdirector@nena.ca)

**Manitoba:** *Emergency Department Nurses Association of Manitoba (EDNA)*  
Marie Grandmont, [mbdirector@nena.ca](mailto:mbdirector@nena.ca)

**Ontario:** *Emergency Nurses Association of Ontario (ENAO)*  
Janice Spivey, [ondirector@nena.ca](mailto:ondirector@nena.ca)

**Quebec:** *Association des infirmières et infirmiers d'urgence du Québec*  
Carine Sauvé, [aiiudirector@nena.ca](mailto:aiiudirector@nena.ca)

**New Brunswick:** *New Brunswick Emergency Nurses Association (NBENA)*  
Erin Musgrave, [nbdirector@nena.ca](mailto:nbdirector@nena.ca)

**Nova Scotia:** *Nova Scotia Emergency Nurses Association (NSENA)*  
Michelle Tipert, [nsdirector@nena.ca](mailto:nsdirector@nena.ca)

**Prince Edward Island:** *Prince Edward Island Emergency Nurses Association (PEIENA)*  
April Mills, [peidirector@nena.ca](mailto:peidirector@nena.ca)

**Newfoundland & Labrador:**  
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Todd Warren, [nldirector@nena.ca](mailto:nldirector@nena.ca)

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**CEDIS:** Erin Musgrave,  
[ewooldridge2000@yahoo.com](mailto:ewooldridge2000@yahoo.com)

**CTAS/NWG:** Representative to the Board: Colleen Brayman,  
[colleen.brayman@interiorhealth.ca](mailto:colleen.brayman@interiorhealth.ca)

**National Course Administration Committee:** Margaret Dymond,  
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**NENA National Conference Chair 2014:**  
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**Nominations:** Michelle Tipert,  
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**Nursing Research:** Dawn Paterson,  
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[professionalpractice@nena.ca](mailto:professionalpractice@nena.ca)

# President's message

**W**ow, I can't believe that my year as president elect has passed and I have been in my new role as president of NENA for two months. Where did that year go? Am I ready?

I guess the best way to start this is to introduce myself and tell you a little bit about myself and what my goal is for these next two years.

I have been in nursing for more than 40 years and recently retired from full-time employment in a tertiary/trauma hospital in Victoria, B.C. For those of you who do not know where this is, I tell everyone it is an island in the Pacific! This always makes my friends in Saskatchewan mad. We get very little snow, but do get a lot of rain and they had to lengthen the time for the "walk" on our street lights due to the age population to which we cater. The city of the newly wed and nearly dead! Now it does not sound so great, does it?

In this emergency department I have held many roles over my 33-plus years (longer than some of my co-workers have been alive): clinical nurse, manager, educator, clinical leader and now back to my favourite role as clinical nurse and forensic nurse examiner.

I have seen many changes to our health care system from hand-writing on the requisitions/charts with their name and data, to computers generating labels and, now, in some hospitals, bar scans. Working alone in the ED on nights, having no triage system to now having CTAS taught across the country. Technology is everywhere and our patients are far more complex and living longer.

Due to this advancement, we, as emergency nurses, have had to keep up with this technology and become even greater critical thinkers. This is what we do best.

I was recently asked to speak at an ENA conference and to bring to the panel the emerging issues here in Canada. So, instead of putting down what I thought was the issue in my hospital, I asked nurses from across Canada (who are working in the trenches) about what they thought were the issues.

Guess what? They are the same across the country! The rural nurses had a slightly different perspective as to flow and wait times, but the larger cities were consistent in listing overcrowding and housing of inpatients in their ED as one of their greatest barriers to giving the care they want to. How many of us now hold ICU patients in our ED, the adolescent with mental health issues, the demented elderly patient who can no longer be cared for at home and whose family are burnt out? This is the same all across the country.

Retention of senior nurses in all EDs, regardless to their size or location, was another issue. How do you keep those senior experienced nurses in the ED who threaten to quit every time a new piece of technology is introduced? In some places these experienced nurses are being replaced by health care aides/LPNs/nursing assistants/paramedics.

NENA's goal is to support our emergency nurses across Canada in collaboration with our health care associates such as: Canadian Association of Emergency Physicians, Society of Rural Physicians, Canadian Nurses' Association, and


Forensic Nurses' Society of Canada, to name a few. These colleagues understand the complexities of our department and together we are developing position papers on such issues as overcrowding, education for nurses, domestic violence, human trafficking, and scope of practice for nursing required for the emergency department.

NENA wants to hear from you and welcomes your input. Together we can make a difference. One of the reasons we chose to be emergency nurses is that we are adrenalin driven, we like that fluctuation from minute to minute at an ever-changing pace.

But aside from what we can do to change the system, to challenge the status quo, to confront the injustices in our work lives, we need to remember why we do this. Virginia Henderson so aptly stated:

"The nurse is the consciousness of the unconscious, the love of life for the suicidal, the leg of the amputee, the eyes of the newly blind, the means of locomotion for the infant, knowledge and confidence for the young mother, a mouthpiece for those too weak or withdrawn to speak."

We are the eyes, ears, hands, feet, the backbone and muscle, heart and soul of emergency care.

Thank you for all you do. 



**Jan Calnan,**  
**NENA President**

## NENA has a new mailing address

For remittance of course fees and other fees, not including provincial membership dues, please use the following address:

National Emergency Nurses Affiliation Inc.  
PO Box 365  
Chilliwack, B.C.  
V2P 6J4

## 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 CJEN. 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, [communicationsofficer@nena.ca](mailto:communicationsofficer@nena.ca)

# Communication Officer's report

**M**y hospital issues me a cell phone because I am frequently on standby. My old phone was acting up and I was eligible for a new one, so our IT department set me up with Blackberry's latest.

As with most technology, there is a bit of a learning curve on these things and the IT person gave me the Coles Notes version of how to operate this new phone at the end of the day and suggested that I play with it until I became proficient. I did play, I didn't become proficient. I spent a portion of the evening ensuring that my contacts list had been moved, setting ringtone volume, trying to learn to navigate from one function to another.

The next morning, as I was entering the hospital with my phone in my left pants pocket, the cell rang. It took me a minute to figure out how to answer it, but after swiping and hitting it several times, I was successful. A voice said crisply, "This is 911. We received a phone call from this number. Are you okay?"

Mortified, I responded, "Yes. I'm sorry. I just got this phone yesterday and must've accidentally dialed." An accidental call to 911! Really? The phone was in my pants and I can hardly believe this.

The Voice asked, "We need to know, are you alright?"

I answered, "Yes. I am fine. I am so sorry."

The Voice asked a third time, "You are okay? You don't need any help?"


After reassuring the Voice, I went to work with renewed resolve to master the blasted phone.

That afternoon my boss asked how I liked my new phone and said he thought he might get one. I said that I was still learning and tried to show him some of the features, but gave up when I couldn't get beyond finding my email. I left for home shortly afterwards and, as I walked through the hospital I spoke to several people, discussing weather, kids, work, weekend plans and anything else that came up. I arrived outside in the hospital parking lot to find my phone beeping. I pulled it out of my pocket and discovered that I had made a video of the inside of my pocket, complete with muffled audio recording of my conversations.

This was a good reminder that it is crucial that we remain open to new things, to advancing technology, to different approaches to old problems. By being open, I don't mean open in a passive way, but in an energetic, embracing way.

*The World's knowledge was said to have doubled every century of human history before the 19th century. As technology was*

*further developed, it got faster. As of today, it is believed that it doubles once every year or so, but there is no real method of accurately measuring this* (Retrieved from <http://www.ask.com/question/how-often-does-the-world-s-knowledge-double>). I learned this from the uncertain fount of all accuracy and knowledge, of course, the internet. Whether or not this is correct, we are certainly changing in nursing and in the way we provide emergency care.

The *Canadian Journal of Emergency Nurses* is one vehicle for sharing some of that new knowledge, as is the NENA website. We welcome submissions to the journal and postings to the website. This fall journal has some fresh takes on old topics and we offer them with enthusiasm. I believe you will find in this journal more about the exciting field in which we work and about those nurses who, like you, are engaged in learning, growing, working, and extending the boundaries of care in exciting directions. 



**Stephanie Carlson**

# Treasurer's report


**H**appy Fall to each of you. I hope you had the opportunity to enjoy some time off during the summer. I am sure you will agree with me in saying that summer volumes continue to challenge our resources—I know my emergency department saw a significant increase in July and August total visits—while at the same time many staff members are away on vacation.

I would also like to take this opportunity to say thank you, as I transition out of my treasurer role on the NENA Board of Directors, and welcome Jane Daigle to the role. We have also engaged the services of Jim Lashkevich to assist us with financial and administration issues. Please watch for address changes for course fee submissions, memberships, etc.

It has been my privilege to work with an amazing group of ED nurses on the board, representing now more than 1,000 members across our country. I am fortunate to be beginning retirement, unsure what, exactly, my future will be, but starting with a journey across Canada.

NENA's financial status continues to be very stable. At each Board of Directors' meeting we review our financial picture, comparing current status to our working budget and adjusting, as necessary. Each meeting re-emphasizes how important our members are and how valuable the courses offered are to our members and other health care team members. Our financial statements are available for your review if requested.

The Board of Directors will meet for our fall meeting in Ottawa in November. A major focus of the work will be dedicated to the upcoming Canada Corporation Act changes.

Please, if you have questions, concerns, suggestions, etc., send them to me and I will take them forward. 



**Sherry Uribe**



# NENA Board of Directors' Meeting, Fall 2013

## British Columbia

As always there is lots happening in the western world of emergency nursing. B.C. is sitting with 172 paid members in NENA—exciting stuff, but room for lots more!

An interesting initiative is continuing to map all pediatric emergency care in our province, and determine levels of service and skills required of department staff. This will lead to standardizing pediatric ED care and sharing of resources. A final meeting this month should wrap up all of this hard work. Great work towards consistent pediatric care in B.C.

Overcrowding and lack of resources continues to plague our emergency colleagues and challenges providers to find novel cost-effective solutions. Every site is challenged with how to do more with less, faster and more efficiently.

Sepsis continues to be a focal point in B.C. By the time our journal is out World Sepsis Day 2013 will have passed, but there are lots of valuable resources both on the B.C. Patient Safety & Quality Council website, as well as World Sepsis Day resources online and on Twitter and Facebook.

Our provincial executive is anxiously awaiting the outcome of the fall national meeting, which will determine our structure moving forward. Any B.C. members with questions about this upcoming activity should email me directly for more information and discussion. Our provincial AGM is scheduled for October 9 at 0900 online, and associated with an educational session. Details will be emailed closer to the date.



**Sherry Stackhouse**  
B.C. President

## Ontario

The Emergency Nurses Association of Ontario has embarked upon a new initiative that will see ENAO BOD members “travelling” education to members in various parts of Ontario. The provincial membership was polled seeking “ENAO members on the ground” in their areas. Sponsorship has been obtained to

facilitate educational evenings throughout Ontario. The local member will secure a facility, propose a topic pertinent to their current location and challenges, and will advertise the event throughout the EDs in their geographical area. ENAO will arrange for an appropriate speaker to meet the identified learning needs. Sponsors will provide funding for these free evenings, including transportation of at least one ENAO BOD member to attend each event, refreshments, prizes, and ENAO CECH hours will be granted. The goal of these “ed eves” is to promote NENA/ENAO exposure and membership, while continuing to serve Ontario’s emergency nurses.

New regulations came into effect in January 2013 regarding foreign-trained nurses seeking to obtain licensure in Ontario. The Ministry of Health and Long-Term Care, “in keeping with the need to protect the public”, has changed what constitutes an applicant’s “previous nursing experience”. The “safe nursing practice timeframe” now means that a foreign-trained nurse must have practised within the past three years, not five years, as previously required. According to the College of Nurses of Ontario, there are currently 21,000 applicants in the process of seeking to obtain Ontario nursing licensure.

Ontario’s new premier, Kathleen Wynne, was sworn into office in February of 2013. Ontario’s Minister of Health and Long-Term Care, Deb Matthews, remains in this position. ENAO is cautiously waiting and watching to see what Premier Wynne means by her announcement to “chart a new course for Ontario”, and the potential effects on Ontario’s EDs and the countless emergency patients we serve every day.

2013 marks the 10th anniversary of SARS. Many Ontario emergency nurses faced SARS head-on in their EDs, while many more across Ontario remained on high alert for the possibility that this nightmare would also arrive at our triage desks. We will never forget how the second wave surprised everyone, yet again. We respectfully remember two of our Ontario nursing colleagues, Nelia Laroza and Tecla Lin, who lost their lives to

SARS while selflessly caring for their patients. May the lessons learned protect all nurses in the future.

We are looking forward to welcoming emergency nurses from across Canada, the USA, and Central and South America to the NENA 2014 Pan American Conference being held April 27–29, 2014, in Toronto, Ontario. Hope to see you all there!



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

## Newfoundland and Labrador Membership

Fifty-eight and growing, we have seen more awareness and the existing members seem to like the options of the “anniversary date” membership year and the Paypal options. NENA NL is looking to increase membership in October by attending a “non-Nena” conference to promote NENA to a pediatric emergency nursing audience.



## Recent events

TNCC and CTAS have been continuing to put off regular provider and trainer courses.

ENPC will launch its first full course this fall.

NENA NL is attending the “Kids Rock” Paediatric Emergency Nurses Conference on October 4-6 in St. John’s, NL.

The next NENA Provincial Conference is tentatively being held in St. John’s, NL, in the spring of 2014.



### Publicity and communications

NENA NL nurses have been busy fundraising, so that members can avail of the necessary education and networking with other health care professionals, so they can bring the highest quality of care to those for whom they provide.

Honorary Lifetime Member Ms. Anne Casey received her award in a cake-cutting ceremony covered by the media. She was thoroughly, yet humbly impressed.

### Pressing issues and reform

The main areas of concern amongst emergency nurses across the Island seems to be the struggles with overcrowding and prolonged wait times compounded by short staffing. Nurses are feeling the strain of long hours, no breaks or insufficient breaks and the increased demand on the emergency room. This is also causing an increase in nurse abuse, as the demands of patient care have become unmanageable at times.

The Department of Health is currently implementing a new system of delivery of care in the emergency department in an attempt to resolve these and other issues.

### Goals and objectives

To elect a new executive at an AGM in the Spring of 2014.

Continue marketing NENA Inc. on a provincial level.

Hoping to send a 20-plus delegation to the 2014 NENA Conference in majestic Toronto!



**Thank you,  
Todd Warren, RN, NL  
Director  
Proud to be an ER  
Nurse**

## Nova Scotia

Warm greetings from Nova Scotia! Congratulations, NENA, on the name change and new look for the official journal of the National Emergency Nurses' Affiliation—from Outlook to the Canadian Journal of Emergency Nursing. The new name and look are outstanding! Speaking of outstanding, hats off to the organizing committee of the national conference, which took place in Vancouver May 29–31. We had several Nova Scotia emergency nurses who attended and all agree it was truly “Wild and Spectacular.” Well done! We are all looking forward to the Pan-American conference in Toronto next spring and are hoping to see many of the great emergency nurses we met in Vancouver there, as well as some new faces.

During the conference in Vancouver, Val Eden was announced as one of the first recipients of the NENA Honorary Lifetime Membership award. Val was recognized as a long-standing Nova Scotia member of NENA who is a past president and NCAC member. She has taught TNCC for many years and has helped other provinces get the program started. I had the honour of presenting Val with the award during the summer months. We are, indeed, fortunate and proud to have a NENA member in Nova Scotia who has made such a significant contribution to the advancement of emergency nursing.

Emergency departments in Nova Scotia are working hard towards complying with the standards developed by the provincial government's Health and Wellness plan for “Better Care Sooner.” The goal for all district health authorities to meet these standards is December 2014, which is fast approaching. Nova Scotia will be the first province to implement Provincial Standards in Emergency Care. The work towards this goal has presented some challenges, but many opportunities, as well.

The Halifax Infirmary Emergency Nursing Education committee is once again holding their annual education day on October 8, 2013, at the Bethune Ballroom, VG Site. This popular education day is always very informative and lots of fun. This year the theme is “Emergency Nursing Throughout the Ages.” A big shout out to the education committee for all the hard work they do to provide this excellent learning opportunity for emergency nurses.




**Michelle Tipert, RN,  
ENC(C)  
NS Provincial Director**

## Saskatchewan

Our membership has remained stable; currently at 76 members. It has been a while since we have had a general meeting or an education day, but we are hoping to organize something this fall.

Like all ER nurses, we struggle with wait times, no beds for admitted patients and staying current in our practice. Saskatchewan also has the added challenge of distance, as so much of our population is rural and far from tertiary care.

CTAS, TNCC and ENPC are offered regularly throughout the province.

Our provincial Health Quality Council has approached SENG for input on two upcoming projects: ED Waits and Acute Stroke Pathway. We are pleased to represent ER nurses on both of these projects. It is gratifying to see government reaching out to those of us on the front lines and realizing that our voice is important. 



**Respectfully  
submitted,  
Alison Duncan, RN,  
ENC(C)**

# A nursing student's experience in the emergency room


By Laura Marie Genge, BSc Psychology, BA English, BSN

To say I was nervous for my first shift in the emergency room would be a huge understatement. It was a familiar feeling from the first days of other clinical placements, so I thought I was getting used to it. However, on this morning I was actually sick to the point of vomiting. I remember walking to my shift, my mind racing with questions, "Am I good enough for this?" "What will I see?" "Am I even ready for all that I will see?" "Am I ready for my first code?"

As nursing students, I feel that we hold ER nurses in very high esteem. It is what many nursing students aspire to become. I thought then, and still think now, that it takes a special kind of person to work in the ER. Someone who knows how to handle life's most stressful moments. A person who can hold a huge body of knowledge in their head and come up with a tiny fragment in a heartbeat.

When I arrived for that first shift, my preceptor greeted me with a big smile and welcomed me to the ER. The first day was overwhelming. I thought I would drown in the tidal wave of information. Although I would like to say that I fell in love with the job there and then, it just didn't happen that way. Admittedly, I hated it at first. After my first few shifts I left the ER in tears. I felt incompetent. I was suddenly expected to remember information and execute skills that I had learned two years ago. I had no knowledge of how the unit was supposed to function. And, of course, I was terrible at inserting IVs.

However, as time went on I became more comfortable in my new surroundings. I learned the unit, how it ran, and which skills and information were required (I also quickly became an IV insertion master). It was a slow building love, but it has grown quite deep.

I will always cherish some of my experiences in that emergency room. Administering my first chest compressions was a moment that I will remember until the day I need them myself. These firsts have had a huge impact on me, but it was the ER nurses themselves who have left the most lasting impressions. They were true professionals, keen and kind, who brought a passion for helping others to every shift. What amazes me most is their zest for life outside of the job. They punch long, hard workdays, yet still find time for walks with partners, soccer games with friends, and training for marathons. This placement has reminded me to follow their great example and live life to the fullest, and to one day set such an example myself for a young nursing student taking their first tentative steps into the ER. 

## NENA AT WORK

### Letter to the membership

Dear NENA,


I am currently finishing my graduate studies in nursing. I am a typical emergency nurse... I like to have a million things going on at once and I like to have knowledge and awareness about as much as I possibly can! When I started this graduate program, I went in with a focus in education because I love teaching and sharing knowledge and experiences with others, growing as a nurse is an amazing experience that takes second place only to saving a life.

Within the first term of school, I quickly realized that I wanted to learn it all and experience as much as I could and, so, I quickly decided that I wanted to take

some extra courses and round out my program with research and leadership... so, that's exactly what I did for the next two years.

I am currently finishing the writing of my thesis. The topic is about understanding the dynamics of interdisciplinary teams in critical care and how team training/education impacts the team and, ultimately, improves patient outcomes and staff satisfaction. We all know that in emergency medicine we always pull together, working as a team to get the job of saving lives done. The reality is that we (nurses, physicians, social workers, respiratory therapists, etc.) train and learn in silos and are just

expected to function with high reliability in highly stressful environments while making decisions that have critical implications.

There is not a lot of research about this team forming/functioning process in critical care areas. My hope is that my research will prove that functionality of teams in critical care is a key component to providing excellence in care. By acknowledging team functionality, team training with interdisciplinary teams will become not only a recommendation at the frontlines, but possibly even part of health care curriculum. 

Sincerely,  
Lori Quinn




# NENA 2013 Annual Conference in Vancouver, B.C.

The annual conference of the National Emergency Nurses' Affiliation was held from May 29–31, 2013, in Vancouver, British Columbia. The topics were current and very relevant. It was difficult to choose from among the sessions because they were all interesting.

I have been in the nursing field for 30 years and despite my knowledge as a nurse having worked in emergency and as a CTAS instructor, I learned a lot and the workshops I attended will be very useful in my teaching. It was one of the best conferences I have attended.

Everything was well organized and the information or advertising booths were quite interesting. I enjoyed visiting them and received good information. I had the chance to meet and talk with many nurses from all provinces of Canada and struck up friendships.

I took a few vacation days to take the opportunity to visit the beautiful city of Vancouver. The Sky Train and the SeaBus were great discoveries for me! And as I like to climb mountains, I took the opportunity to climb one of them.

I want to thank the organizers who worked very hard to make this event a success! I hope to have the chance to attend the conference next year, which will be held on April 26–29, 2014, in Toronto, Ontario! 



**Joseph Gaétan Arseneau Basque**  
Manager of the Staff Development Department  
Campbellton Regional Hospital, N.B.  
Vitalité Health Network


# Conférence Annuelle 2013 NENA à Vancouver en C.-B.

La conférence annuelle de l'Association Nationale des infirmiers et Infirmières d'Urgence s'est déroulée du 29 mai au 31 mai 2013 à Vancouver en Colombie-Britannique. Les sujets traités furent actuels et très pertinents. Les choix pour assister aux sessions furent difficiles car tous étaient intéressants.

Je suis dans le domaine infirmier depuis 30 ans et malgré mes connaissances comme infirmier ayant travaillé à l'urgence et aussi comme instructeur de l'échelle de gravité au triage, j'ai appris beaucoup et les ateliers que j'ai assistés vont m'être très utiles dans mes enseignements. Ce fut l'une des meilleures conférences que j'ai assistées.

Tout était bien organisé et les kiosques d'information ou de publicités étaient bien présentés et j'ai reçu de bons renseignements et c'était intéressant de les visiter. J'ai eu la chance de rencontrer et de discuter avec beaucoup d'infirmières de toutes les provinces du Canada et de créer des liens d'amitiés.

J'ai pris quelques jours de vacances afin de prendre l'occasion pour visiter la belle ville de Vancouver. Le « Sky Train » et le « SeaBus » furent de belles découvertes pour moi! Et comme j'aime beaucoup faire de l'escalade de montagne, j'ai profité de l'occasion pour escalader l'une d'elles.

Je veux remercier les organisateurs qui ont travaillé très forts pour que le tout soit une réussite! J'espère avoir la chance de pouvoir assister à la prochaine conférence qui se tiendra l'an prochain les 26 au 29 avril 2014 à Toronto en Ontario! 

**Joseph Gaétan Arseneau Basque**  
Chef du Service du Perfectionnement  
Hôpital Régional de Campbellton,  
N.-B.  
Réseau de santé Vitalité

## 2014 CNSA National Conference



**Canadian Nursing Students' Association/Association des étudiant(e)s infirmier(ère)s du Canada**

[www.cnsa.ca](http://www.cnsa.ca)

The 2014 National Conference of the Canadian Nursing Students' Association will be held in the heart of downtown Vancouver on January 22–25, 2014. More than 600 nursing students and nurses will gather from across Canada to develop nursing knowledge and leadership skills by participating in various educational keynote speaker sessions, as well as networking with peers. Students will be given the opportunity to learn about and explore different educational opportunities and expectations of future health care employers.

# Conference president's report

**W**ild and Spectacular was the theme for the National Conference held in Vancouver, B.C., in May 2013 and it truly was spectacular.

Although the weather was not that great, a little wet as per usual for the west coast, it did not dampen the spirit of the 310 registrants for this conference. These participants came from all across Canada including Nunavut, from as far east as Newfoundland/Labrador and of course from the west, the host province. We had guests from the United States, Scotland and England—that map had a lot of pins on it and was a highlight for many, as we could see where we all came from.

There were speakers on a number of subjects. One of the breakout sessions, clinical skills, was housed in the Medical Mobile Unit that sat outside


the main doors of the Bayshore. This was a hit for the delegates, as well as the staff from the Bayshore. We had many observers when they were driving it onto the lot at the hotel as it literally swallowed up the whole driveway. One hotel worker thought it was supposed to be a small truck—needless to say he was very shocked to see how big it was. CAEP used it after NENA and held their “Olympics” in there.

There were sessions for clinicians, administrators, research and education, with each day starting and ending with an inspirational speaker who made us laugh or made us cry, and we even had a superhero. Most of all, it made us proud of the work we do every day.

Being the Chair of this conference taught me a lot about what issues nurses face from across Canada and the U.S.

I know that I am grateful for the team I worked with and without them we could not have accomplished what we did. Evaluations were positive and we heard over and over again that it was the best conference they have gone to, so our mission was accomplished.

Although we did not make any money on the conference and, in fact, were in a deficit, NENA's mandate was to provide education to nurses and that is what we accomplished. Thank you to all who came and for all the support you gave.

Can't wait for the next one in Toronto, see you all there in 2014. 



**Jan Calnan, NENA President**



**Jerry Bell receives his honorary lifetime membership award**



**Conference hijinks 2013**



**Val Eden receiving her honorary lifetime membership award from Michelle Tipert**



**Fun-loving delegates in Vancouver**



**The mobile medical unit**



**Teaching in the mobile medical unit during the 2013 conference**



Conference guerillas at work 2013



Conference attendees



Enjoying the conference



## CJEN Bouquets

### Honorary Lifetime Members

Congratulations to each of those pioneering nurses who received NENA Lifetime Memberships. The committee evaluated the nominees carefully and awarded those nurses whose lives have made a difference to each of us.

### Lifetime Members

I commend the organizers of the AGM here last spring for recognizing NENA members who have contributed so much over the past many years to promote excellence in emergency nursing. No doubt this will be covered in Outlook, but the act of taking time to share some details of what has been done by nurses such as Jerry Bell, Carole Rush, Anne Cessford and so many others validates what we are all about. Emergency nursing and emergency nurses matter!

—Cathy Sendecki

### Bouquets for our Sponsors

While standing at the NENA Conference registration desk I was approached by

two elderly ladies from the U.S. asking what was going on. I explained who NENA was and the purpose of the conference. Both ladies were retired RNs and they stated the displays in the hallway looked very interesting. I invited them to take a walk around the display area to see what was new in 2013.

They were joined by their husbands and we all went to have a look. When we approached the HoverJack® Air Patient Lift equipment they asked how it was used. The HoverJack® representative explained how the slider worked and how the product can be used to safely lift patients from the floor if they have fallen. All four were amazed and the next thing we know one of the ladies has her husband getting down on the floor so they can see the product in action. He was raised to the level of the stretcher and moved onto the stretcher with very little effort. They were truly astonished and the husband said it was very smooth and comfortable. Then, to our surprise, the wife asked for the information to

take back to her home hospital. It turns out her husband had suffered a back injury and required surgery in 2012. It seems he was in excruciating pain and had to be moved from stretcher to x-ray table then on and off the CT Scan and then onto the OR table. For several days after surgery he was subjected to pain every time he needed to be moved.

They may not have been conference delegates, but they have contributed to the NENA goal of “spreading the word” on new promotions and products!

—Sheila Early

### Leader in forensic nursing

Congratulations to long-time NENA member, Sheila Early. She was elected president of the International Association of Forensic Nurses. She is the first president from outside the United States. This honour is a testament to her standing as a leader in forensic nursing worldwide. Kudos to you, Sheila.



# A review from Edinburgh

By Ray Middlemiss, BSc(Hons) Nursing

I was fortunate enough to attend the NENA Conference in Vancouver this year, and what an absolutely fantastic experience it was! It all began last year with a meeting with my Senior Charge Nurse to discuss my professional development for the coming year and the idea of attending an international conference was born. After a bit of research, thanks to Google, I discovered NENA 2013. After contacting President Sharron Lyons who assisted me greatly to attend the conference and with the support of my own department, I was all set to make the trip. Prior to arriving in Vancouver I also contacted three of the local hospitals to arrange a visit during my trip. I felt that this, combined with the conference, would allow me to make comparisons with my own department, and also potentially generate some new ideas to take home.


The department in which I work has an attendance of 113,000 patients annually (over the age of 13) and covers a population of 800,000. We are also the only adult emergency department within Edinburgh and the surrounding region. We, as with the rest of the U.K., work under the Government's four-hour Emergency Access Standard where no patients have to wait more than four hours from arrival to admission to a bed in the hospital, transfer elsewhere or discharge. Having done a bit of research on Canadian Quality Access Targets/Standards, it was interesting to talk to emergency nurses whilst I was at the conference and compare how these affect us and our patients. Also, by visiting the emergency departments of Vancouver General, St. Paul's and Lionsgate Hospitals I got a real insight into some of the comparisons and differences between us.

I found staffing is better within these departments than what we have within our ED and also other EDs in Scotland, given the comparison of volume of attending patients between departments. Until the start of the year we worked with 13 Registered Nurses on a dayshift and 12 on a nightshift. This has recently been increased to 16 on dayshift and 15 on nightshift (12.5 hour

shift pattern). Lengthy waits for patients to be admitted into the main hospital, both in Vancouver and with ourselves in Edinburgh, is a problem, albeit we have significantly improved under the four-hour Access Standard and lengthy waits are now, thankfully, infrequent—90% + of our patients meet the four-hour standard consistently. Physical space and overcrowding is an issue within our departments on both sides of the Atlantic—where every cubicle, wall and corridor space is utilized for attending to patients. Acuity and volume of patients continues to rise yearly thanks to the ageing population and ease of access to “emergency” care provided by our departments. It was great to visit these departments to realize we face a lot of similar issues and also to see how they work and develop their systems to combat these problems. As a result of my visit to these departments and from information gained from the conference, I have taken their lead and am currently developing a Rapid Assessment Zone within my ED. Due to the ever-increasing demand on our resources, lack of physical space and in order to provide a high level of patient care, we are continually looking at how we improve patient flow through the department, resulting in us becoming more streamlined and efficient.

The conference itself was phenomenal. The quality of speakers over the days was fantastic—some truly inspirational—and such a variety of subjects covered. I would have liked to attend all the talks. I tried to pick topics that had relevance to U.K. practice and systems. I attended talks that discussed things like nursing teams—how to recognize the strengths that each team member brings in order to develop high functioning teams, a must within the ED setting throughout the world; cognitive bias and its impact on quality in health care—focusing on human error in patient care, currently a major topic within the U.K.; caring for the elderly in the ED—again another major focus currently throughout the U.K. National Health Service with government targets being set

(as a result of these my department has successfully implemented Care Rounding into the department this year with great success); patients on the move—all about streaming patients in order to make departments more streamlined and improve patient flows, a familiar theme to any ED; and leadership and team building—all about change management. I also attended a practical session on cardiac arrest—it was interesting to see how the U.K. and Canada compare on their development and research of cardiac arrest care, as my department undertakes a lot of research on cardiac arrest patients. The final session of the conference was a very poignant presentation from an ED consultant entitled, “Why I Love Emergency Nurses”, sharing a few experiences and stories that he had with ED nurses over the years. But the purpose of his talk was to thank us all for being who we are and the difficult job we do each day—something that, no matter where we are in the world, we can all relate to. I know I do this job because I love it.

My whole trip to Vancouver was fantastic, meeting so many people from a variety of ED settings and being able to share and learn from each of them. I would like to thank everyone I met for being so welcoming. 

## About the author



Ray Middlemiss, BSc(Hons)  
Nursing, Deputy Charge  
Nurse, Emergency  
Department, Edinburgh  
Royal Infirmary, Edinburgh,  
Scotland, qualified in 2001

and commenced her career in Respiratory Medicine at Edinburgh Royal Infirmary. She travelled the world for two years with a year working within New Zealand in Rotorua Public Hospital in their General Medical Unit then worked in the Emergency Department of Auckland City Hospital. She returned to the U.K. in 2005 where she began working in the Emergency Department of Edinburgh Royal Infirmary where she remains today, being promoted to Deputy Charge Nurse in 2010.

# 10 reasons why you should attend a nursing conference

By Navkiran Tiwana, RN, BScN

I attended seven professional conferences during nursing school, three of which were at the national level. When I entered into the nursing profession, I didn't see anything outside the clinical or hospital aspect. Wait, there's more to this nursing thing? While working in the emergency department, I came upon the opportunity to attend the National Emergency Nurses' Affiliation conference in Vancouver in May. After spending the weekend in Vancouver with incredibly passionate registered nurses from all over Canada, I can say that I truly love the area of nursing that I have chosen. Emergency nurses are the most passionate, caring, and best multi-taskers I know.

I often get asked by family and friends, why do you go to conferences? Here's why...

## 1. Travel

Need I say more? Make a vacation out of your conference trip. Not only will you learn, you have the opportunity to explore (or re-explore) the beautiful city in which the conference is located.

## 2. Break free of routine

Not everyone who attends a conference has to be there. Yes, you have the option! You also have options of which presentations you attend. You can make your own schedule based on what piques your interest. There is always something for everyone. Plus, you don't have to answer call bells!

## 3. Education

We are dedicated to lifelong learning. There are and will continually be changes and advances in health care in terms of technology, medications, treatments, etc.

## 4. Exposure to new ideas

Sometimes, when you work in the same area in the same hospital for years and years, you begin to have closed-door thinking. You can break away from this by interacting with nurses from different provinces all over the country. Share your experiences with one another. Discuss common problems and know that you are not alone with your thoughts and opinions.

## 5. Network

Probably one of the best reasons to attend conference is a chance to meet people in your field of interest. Establish professional relationships and friendships with individuals who you meet.

## 6. Job opportunities

There are always opportunities for professional development or new jobs at conferences.

## 7. New perspective

Be in the know and learn more about emergency nursing. Learn about key issues and what you can do. Learn the new trends, ideas, concepts and ways of practising. Refresh on information that you previously learned.


## 8. Get inspired

Perhaps you're caught in a bit of a slump? There's a reason you picked emergency nursing as your field of practice. Conferences are a great way for you to reignite your passion for nursing and gain a fresh outlook on your career.

## 9. Leadership

Share the information you gain from conferences with your colleagues at work. There is also the opportunity to advance your nursing career by becoming part of nursing organizations at the local, national or international levels.

## 10. Licence renewal

You are doing yourself a huge favour when you attend a professional conference. What is your learning goal this year, or next? Can you apply what you gained and learned at a conference to it? The answer is probably yes! 

## About the author



Navkiran Tiwana is a registered nurse practising in the emergency department at the Grey Nuns Hospital in Edmonton, Alberta.

She received her BSN degree from the University of Alberta in June 2012. Before pursuing her passion in emergency nursing, she worked in the cardiac operating room. When she's not working, she enjoys cooking, volunteering, and travelling.

## The value of a bursary


I would like to begin by saying thank you to the NENA board for awarding me a bursary at the AGM in Vancouver in May 2013.

I have been a registered nurse for 39 years, involved in emergency nursing for almost 30 years. During that time I have been a front-line nurse, an ED manager and a director for acute services, which includes the emergency department. I have also had the privilege to be a member of the NENA Board of Directors, both as provincial director and currently as NENA treasurer.

I have worked in a number of different emergency departments, in Canada and the U.S., and one observation for me was how similar we are—regardless of location, size of ED—rather than how different we might think we are. Geography is obviously different, but patients, processes, and equipment are often the same.

Thinking that we are so similar, I used the bursary to assist me in attending the 2012 ENA General Assembly as an International Delegate, followed by the National Conference in San Diego, California. More than 3000 nurses

attended the conference from many countries around the world—an almost endless opportunity for networking and learning. In addition, I am a member of the 2013 Vancouver Wild and Spectacular conference planning committee, so used the opportunity to ask many questions and observe conference planning processes.

I hope those of you who attended the Vancouver conference agree that it was, indeed, a success. 

**Thank you,  
Sherry Uribe, MBA, RN, ENC(C)**

# Honorary Lifetime Member

## Purpose

- To recognize those individuals who have given extraordinary contributions to emergency nursing and NENA Inc. by providing a vehicle for public acknowledgment of their expertise, clinical practice, and service
- To promote a sense of history and continuity within NENA Inc.'s membership.

## Goals

- To publicly honour extraordinary service to NENA Inc. and Emergency Nurses across Canada
- To increase member awareness of NENA Inc.'s history
- To engage members in recognizing pioneers in Canadian Emergency Nursing.

**Honorary Lifetime Membership** shall be bestowed upon any individual who has displayed a unique interest in emergency nursing and who has demonstrated an outstanding contribution to the National Emergency Nurses' Affiliation or to the advancement of emergency nursing as a specialty.

### Honorary Lifetime Membership shall confer:

- Free membership to NENA Inc. for the life of the recipient or until withdrawal or resignation is requested by the recipient, provincial membership fees may still be required
- A medallion bearing the NENA Inc. logo and citing their status as an Honorary Lifetime Member
- Special recognition in NENA Inc.'s national publication following the announcement of their honorary status
- Recognition on the NENA Inc. website.

## Selection

- Any NENA Inc. member may nominate a candidate for Honorary Lifetime Membership by submitting a letter of recommendation to NENA Inc.'s Honorary Membership Committee
- Recipients must meet the criteria set by the Honorary Membership Committee and be approved by majority decision of voting NENA Inc. Board of Directors' members
- Recipients will be notified of their selection by mail or electronic means prior to public announcement
- The Chairperson of the Honorary Membership Committee shall forward names and addresses of recipients to the president for a congratulatory letter
- Recipients will be announced at the Annual General Meeting (AGM) each year and, where possible, the medallion will be presented in person
- When presentation at AGM is not possible, the provincial director in the province in which the recipient resides shall attempt to present the award in person.


- When personal contact is impractical, the provincial director shall mail the award to the recipient in a timely manner following the announcement
- For those recipients who are not members of NENA Inc., the NENA Inc.'s Honorary Membership Committee shall mail the medallion and a copy of the national publication in which their award is mentioned.

## Terms of reference

- NENA Inc. shall bear no financial responsibility for the recipient's accommodations or travel expenses to attend the conference or Annual General Meeting at which they will receive their medallion
- Honorary Lifetime Membership does not provide membership in any provincial affiliate organization
- Honorary Lifetime Members shall be registered on the website under "Honorary Lifetime Member" and will be responsible to ensure that contact information on the website is maintained for purposes of email contact.

## Guidelines for eligibility criteria

The nominee:

- Served as a member in good standing on either the NENA Inc. Board of Directors, one or more of its subcommittees (e.g. National Course Administration Committee, Canadian Triage and Acuity Score National Working Group) or a provincial group for more than one term
- May have served in more than one capacity and the terms may not have been consecutive
- Made a significant contribution to, or on the behalf of, NENA Inc.—e.g., significant role in the roll out of NENA-endorsed courses or active promotion of NENA Inc. 

November 2012 (revised April 2013)

## Thank you

On behalf of the National Emergency Nurses' Affiliation and the Vancouver 2013 Conference Committee, I would like to thank all the sponsors for their generous support of emergency nursing across Canada. Without your generosity, the 2013 conference would not have been the Wild and Spectacular event that it was. Feedback from participants was positive and as some said, "lit the spark once again" for them to deliver the best care for our patients.

Your dedication to emergency care has not gone unnoticed and we thank you.

**Janet Calnan**  
President NENA



# National Course Administration Committee (NCAC) TNCC/ENPC/CATN/CTAS Updates Fall 2013

By Margaret Dymond, NCAC Chair

## Instructor recognition program

NCAC will be acknowledging instructors who have shown dedication, commitment, and outstanding achievements through the NCAC–NENA instructor recognition program. These instructors will be acknowledged during the NENA AGM each year.

## 2013 TNCC and ENPC instructors hit 20+ years teaching!

Congratulations to the following TNCC/ENPC instructors who have been teaching for more than 20 years.

### TNCC

Carole Rush (AB)  
Brenda Wiggins (AB)  
Darlene Kidd (Ont)  
Tannia Agnot Johnston (MB)

### ENPC

Sherry Uribe (BC)

## TNCC 7th Edition course roll-out in Canada

ENA has published timelines regarding the revision of TNCC (7th edition). Canadian TNCC instructors can expect to update their instructor status starting February, 2014. Updated instructors can teach 7th edition courses in February 2014.

Information is posted on the ENA website at [ena.org](http://ena.org). Instructors will be receiving more information in the months to come.

## ENPC 4th Edition update

The ENPC 4th edition exam is currently under review due to feedback ENA has received from instructors and course participants.

## CATN revision update

The Course for Advanced Trauma Nursing (CATN) revisions for the 3rd edition course are almost completed. ENA expects to launch the 3rd edition

course in 2014. The course format will involve online modules and classroom face-to-face discussions. Information will be communicated to current instructors later in the year or early 2014.

## NCAC communication to Canadian instructors

NCAC publishes a newsletter twice a year. NCAC reps distribute the newsletter to instructors across Canada. The newsletter and course administrative manual is also located on the NENA website under the NCAC tab on the front web page.

ENA publishes a newsletter called *Course bytes*. If you would like an automatic email, send your request to [CourseBytes@ena.org](mailto:CourseBytes@ena.org).

## Course Directors TNCC/ENPC Course paperwork

- Please follow the posted course checklist for required paperwork to be sent to ENA. The final course roster needs to reflect the order the instructors are listed on the course evaluations to correctly identify the instructor evaluations.
- The exam scantron forms were updated two years ago. ENA has requested that only the up-to-date forms are used. The form number should be 103516-11. Please discard older versions of the scantrons.
- The only form sent to the NENA treasurer is Form C and NENA fees. Do not send any other paperwork to NENA.
- NCAC encourages course directors to keep a copy of all course documentation.

## Course applications and approvals

- Once course applications are received, ENA approves the course by checking that the course director and instructors have met the requirements for teaching.

This means the instructors must teach once every 18 months and have satisfactory instructor evaluations.

- NCAC reps receive a list of approved courses in Canada on a weekly basis. NCAC reps will check that all course directors are NENA members. NCAC reps do not receive a list of instructors listed by the course directors in the ENA course application. Course directors must ensure their instructors are NENA members.

## TNCC revisions 7th Edition planning

- Please review your current inventory of TNCC 6th edition manuals and courses. Updated instructors can be teaching in the 7th edition spring 2014 and materials for these courses will be available February 2014.

## Resources for directors—PowerPoint Presentation

- A PowerPoint presentation has been created to highlight the course application, approval process for courses, and course processes. Many changes have occurred over the years. This presentation will highlight quick pointers for course directors.

## Course fees: ENA fees and NENA Fees

- Please refer to the NCAC administrative manual for the required forms and course fees. Courses fees cannot be posted online. Each course director can request a copy of course fees and manual costs through their NCAC rep. The last update was November 2012.
- Course fees are required to be received within 30 days of the course.

## NENA membership required for all TNCC/ENPC/CTAS instructors

All instructors must have current NENA membership in order to teach courses. Instructors can go to the NENA website

to renew. If your NENA membership has lapsed, instructors cannot teach courses until their membership is renewed. If course directors are unsure if their instructors are current members, they can contact their NCAC rep for their province to check this information.

### CTAS


CPAS, the acuity scale based on CTAS, currently in use in the pre-hospital environment has been renamed "Pre-Hospital CTAS". Pre-Hospital CTAS does not replace CTAS currently in use for ED triage; rather its use in the pre-hospital environment furthers communications between pre-hospital professionals and the receiving ED as we both speak a common language when communicating about a patient's acuity.

CTAS instructor renewals are now past due (due July 1 each year). If you have

not yet renewed your instructor status please do so using the CAEP.ca website or by completing the renewal form and emailing to [admin@caep.ca](mailto:admin@caep.ca) or faxing to 613-523-0190. If further information is needed about the renewal process, please contact [admin@caep.ca](mailto:admin@caep.ca).

Very shortly, the security on the CTAS teaching materials will be updated. Following the update, those who have not renewed their instructor status will no longer have access.

As always, your suggestions, questions and comments about CTAS are welcomed. Please send inquiries to [ctas@nena.ca](mailto:ctas@nena.ca).

NCAC would like to thank all instructors, course directors, and instructor trainers for your hard work and commitment organizing and teaching courses. NCAC is your resource. Please feel free to contact us at the email addresses below. 

### NCAC Contact Information

Generic email for NCAC: [ncac@nena.ca](mailto:ncac@nena.ca)

Margaret Dymond, Chair: [margaret.dymond@albertahealthservices.ca](mailto:margaret.dymond@albertahealthservices.ca) or [chairncac@nena.ca](mailto:chairncac@nena.ca)

Ann Hogan, Eastern Canada (NB, NS, PEI, NL) Rep: [Ann.Hogan@horizonnb.ca](mailto:Ann.Hogan@horizonnb.ca)

Brenda Lambert, Central Canada (ON) Rep: [Lambertbrenda17@gmail.com](mailto:Lambertbrenda17@gmail.com)

Monique Mclaughlin (BC, AB, SK, MB, YK, NT, NUN) Western Rep: [monique.mclaughlin@vch.ca](mailto:monique.mclaughlin@vch.ca)

Denis Bouchard, Quebec Rep: [bouchardsante@gmail.com](mailto:bouchardsante@gmail.com)

Erin Musgrave, CTAS rep: [Erin.Musgrave@horizonnb.ca](mailto:Erin.Musgrave@horizonnb.ca) or [ctas@nena.ca](mailto:ctas@nena.ca)

## NENA 2014 Pan-American Conference

In response to several requests from various countries for NENA to host an international emergency nursing conference in Canada, NENA is proud to invite emergency nurses and other allied health care providers to attend the NENA 2014 Pan American Conference "CONNECTED BY CARING ACROSS THE AMERICAS".

The presentation topics have been selected to cover the broad scope of emergency nursing. Speakers have been confirmed from across Canada, as well as the U.S., Mexico, Peru, Brazil, Chile and Spain. Emergency Nurses are expected to attend from North, Central and South America.

The Sheraton Centre Toronto Hotel is the chosen conference venue, in an ideal downtown location, close to endless shopping and countless tourist attractions, as well as easily accessible by train, subway, bus, car or airport shuttle.

Plan to attend this unique NENA educational event with your friends and colleagues.

**Janice Spivey**

**NENA Conference 2014 Chair, [janicespivey@live.ca](mailto:janicespivey@live.ca)**



# Canada Corporations Act and NENA Inc.

The new Canada Corporations Act has been implemented. As a result, all not-for-profit organizations in Canada must ensure their bylaws and structure meet the requirements of the new Act. Any changes to present bylaws and governance will need to be voted on by the entire NENA membership and then be filed with Corporations Canada before October 17, 2014.

NENA Inc. must make some changes to its bylaws with one of the most important being the structure of the Board of Directors and how directors are voted in.

Although I have referred to this change in several memos over the last 12 months, the Board of Directors had not had a chance to really discuss the issues until the May 2013 meetings. At that time the directors were presented with three suggested options and it became apparent these options could not be discussed adequately in the time allotted. Therefore, a one-day session has been added to our November meeting and an expert in the field of governance and professional association management will assist the board with finding a solution. He will also facilitate the discussion and input from board members towards an agreement.

The board will focus on emergency nursing, their needs and expectations, and ensuring a sustainable future for NENA Inc. while complying with the new Act.

If you would like more information about the rules under the Canada Not-for-profit Corporations Act go to their website at: [www.corporationscanada.gc.ca](http://www.corporationscanada.gc.ca) or contact [President@nena.ca](mailto:President@nena.ca) or [Pastpresident@nena.ca](mailto:Pastpresident@nena.ca)



**Sharron Lyons, NENA  
Past President**

## CJEN editorial policy

NENA's Canadian Journal of Emergency Nursing 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 CJEN editor. The author should retain one complete copy.
2. Manuscripts must be typed, double-spaced (including references), layout on 8 1/2" x 11" paper with standard margins. Manuscripts must be submitted in Word or Word Perfect and sent electronically to the communications officer at [communicationsofficer@nena.ca](mailto:communicationsofficer@nena.ca).
3. Author's name, credentials, a brief biography, and province of origin must be included. A high-resolution 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 CJEN".

### 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, on 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 CJEN SUBMISSIONS

Submission dates for article publication in the NENA CJEN 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.*



# Test yourself: “Infection control true/false review”

1. Nurses are the only licensed health care professionals responsible for overseeing the infection control practices of their colleagues. T / F
2. Consequences of failure to follow accepted standards of infection control include subjecting oneself, co-workers, visitors and patients to increased infection risk. T / F
3. The mode of transmission for Tuberculosis (TB) is airborne. T / F
4. Hand-washing / hand antisepsis is the least important strategy in the prevention of the spread of infection. T / F
5. Use of a waterless antiseptic agent is the preferred method for hand hygiene when hands are not visibly soiled. T / F
6. Sharps disposal containers, self-sheathing needles and leak-proof specimen containers all contribute to the prevention of infection transmission. T / F
7. Isolation gown use is designed to prevent airborne transmission. T / F
8. Appropriate mask use is designed to prevent airborne transmission. T / F
9. Teaching patients proper cough or sneeze etiquette is extremely helpful in controlling the spread of influenza. T / F
10. In order to prevent the spread of infection, gloves must be sterile. T / F
11. Gloves must be changed between patients, to prevent infection spread. T / F
12. Surgical scrubs are considered acceptable personal protective attire. T / F
13. Particulate respirators are required for all types of isolation. T / F
14. In order to be effective, personal protective equipment (PPE) must fit properly. T / F
15. Hand washing and aseptic technique will prevent the spread of most bacterial and viral infections in health care settings. T / F
16. Appropriate cleaning, disinfection and sterilization of equipment and furniture are vital to breaking the infection chain of transmission. T / F
17. HIV screening of health care workers is mandatory in Ontario. T / F
18. When using a chemical disinfectant, only the surfaces in direct contact with the solution will be disinfected. T / F
19. Hepatitis B vaccine protects health care workers against all types of hepatitis. T / F
20. Special room ventilation (i.e., negative pressure) is required for patients with certain known or suspected airborne infections (i.e., TB). T / F
21. There is no vaccine to protect against Hepatitis C. T / F
22. Hands must be washed prior to putting gloves on and after glove removal. T / F
23. MRSA is a streptococcal infection. T / F
24. Clostridium Difficile, first described in 1893, is a Gram +, spore forming, anaerobic bacillus, with 70 % of the C-diff strains producing exotoxins. T / F
25. VRE, a Group D Streptococcus, which was first identified in 1988, is now the fourth most prevalent organism causing nosocomial infection. T / F

## Information resources

- Canadian Institute of Health Information (CIHI) website ([www.cihi.ca](http://www.cihi.ca))
- Center for Disease Control website ([www.cdc.gov](http://www.cdc.gov))
- Hepatitis Foundation International ([www.hepfi.org](http://www.hepfi.org))
- Public Health Agency of Canada (PHAC) website ([www.phac-aspc.gc.ca](http://www.phac-aspc.gc.ca))
- World Health Organization (WHO) website ([www.who.int/research](http://www.who.int/research))

- True / False QUIZ Answers**
- 1. False
  - 2. True
  - 3. True
  - 4. False
  - 5. True
  - 6. True
  - 7. False
  - 8. True
  - 9. True
  - 10. False
  - 11. True
  - 12. False
  - 13. False
  - 14. True
  - 15. True
  - 16. True
  - 17. False
  - 18. True
  - 19. False
  - 20. True
  - 21. True
  - 22. True
  - 23. False
  - 24. True
  - 25. True

# Caber and Kim

By Kim Gramlich, MA

When the call came in, Caber and I were attending our team graduation from the Pacific Assistance Dogs Society (PADS). A 15-year-old teenager had been attacked in North Delta while walking through a local park on a beautiful sunny afternoon. Her day's plan had been simple—meet some friends and watch a football game. But nothing would be the same after her friends heard Laura's screams and ran to try to help. They found her badly beaten and unconscious body lying on the forest floor. From that moment forward their lives would never be the same. The following day Laura died of her injuries. A family and a community were devastated.

The shock that our first major deployment was to be in response to a homicide sat heavy with me. My canine partner, Caber, had spent the past two-and-a-half years training to become an assistance dog. After he passed all the necessary tests he was more than prepared for what was to come his way. I, on the other hand, had just been trained in how to handle an assistance dog properly. Caber seemed self-assured and confident, but was I prepared to deploy him with a community devastated by pain and loss? I had worked in victim services for many years and knew the job like the back of my hand, that wasn't the problem. The problem was that Caber was the first victim services Trauma K9 in Canada, and I was unsure about how my clients would receive my somewhat unconventional partner.

I was the passionate voice behind the idea, so why the hesitation? A year previously I attended the National Organization for Victims Assistance conference in Scottsdale, Arizona. Like all good conference attendees, I chose a variety of workshops intended to open my horizons and expand my knowledge of the field—the most intriguing of which was a workshop called “Crisis Response Canines”. As I sat through the workshop I literally buzzed with excitement over the concept of working alongside a helping canine (yes, I see myself working alongside Caber, not the other way around). I listened to Anthony Pagliuca, from the Scottsdale Police Crisis Intervention Unit, talk about his amazing dog, Fozzie. Anthony told story after story of Fozzie's interventions with people affected by crime and trauma. The audience cried (myself included) at the heart-wrenching ways Fozzie had positively impacted people suffering from life-altering trauma. I thanked Anthony for his wonderful presentation and received a fabulous kiss from Fozzie, not realizing the full impact these two would have on my future.

After leaving Scottsdale vibrating with anticipation, I calmed myself down and decided to wait six months before doing anything about the idea brewing within. I spent that time researching animal-assisted intervention, dog assistance schools and the cost of the initiative I wanted to propose. When it was all said and done, my interest had not waned. I was ready to cross my fingers and pitch the idea.

I quickly garnered the support of my Chief, Jim Cessford. Chief Cessford is the longest serving Police Chief in Canadian history, and for good reason. He is visionary, he is a leader and he doesn't let an opportunity pass him by. With his support, I made a similar presentation to our police board. Questions about liability, insurance, costs, commitment and succession planning were raised. Of all the questions asked, the most important one was “what does the dog do?” Although I had some idea, it would be Caber who would ultimately prove the value and role he would play.



With management support in hand, the next big step was to get a dog! I applied to PADS and eventually met Ron Tymrick, Director of Client Services, for an interview. It was clear he was a little unsure about my proposition. Ron listened carefully and asked great questions about the role of the dog, the nature of our clients, the environment the dog would work in and what the dog would be exposed to. It became clear that PADS had never placed a dog to work in a capacity like victim services. I explained how our work was somewhat unusual. We intervene immediately after the trauma has taken place. This can mean we attend the scene of the crime, the hospital, the victim's home or even the roadside. We meet our clients when their pain, hurt, anger, shame, embarrassment, grief and loss are at an all-time high. Essentially, we intervene at the worst time in a person's life. We attend to victims of sexual assault, domestic violence, robbery, home invasion, homicide and every imaginable trauma in between. We see raw emotion—the kind that tears at the hardest of hearts.

Ron listened, but he also talked. Ron told me about the other clients that PADS already served. He told me how the organization had been placing service dogs with people with disabilities for more than 23 years. They accompany their clients everywhere: to work, on public transit, to doctor's appointments and to school. They turn lights on in the morning, help pull back the covers,



open the bedroom door and the cereal cupboard. These amazing dogs pick up the smallest dropped items and pull wheelchairs up steep ramps. Among the million other remarkable things they do, PADS dogs provide companionship to people who have been dealt hard knocks in life. Imagine having the most loving and non-judgmental partner with you 24 hours a day... and you have imagined a PADS dog.

Fortunately, I didn't scare PADS off and they generously agreed to be the organization to provide us with our Trauma K9. PADS brought six beautiful yellow and black Labrador retriever dogs to my office for a "site visit". When it was all said and done, a certain yellow lab named Caber seemed to be the front-runner. They say that PADS dogs choose you, you don't choose them. Nothing could be more true. Caber was unfazed by every test given to him and, most importantly, he captured our hearts immediately.

Caber was (and is) an extremely low-energy dog. He calms instantly in new environments and around new people. His large amber eyes seem to reach in and pull at your heartstrings. He is curious about emotion and never reacts negatively to wailing, crying or even screaming. He wants nothing more than to be petted and warm your feet. Most importantly, Caber seems to have a sixth sense. He senses and spontaneously moves to be with the person who seems to need him the most. I can't tell you how many times this has drawn tears from those who meet him.

Clearly, Caber was the right dog got the right job. But what about the other end of the leash? I was still nervous about deploying Caber. Although I'd received tremendous support, I had also spoken with people who thought my idea was ridiculous. Was I about to become the "crazy dog lady"? More importantly, would introducing Caber to clients be seen as disrespectful or unwelcome? My motto had always been "do no harm" and I was committed to providing the most effective and helpful support possible.

PADS dogs are not normal family pets. They are highly trained assistance dogs that are granted public access by the province. There are specific requirements in how they are handled. You could say I was also a little nervous that somehow I would mess up a \$30,000 dog!

Caber and I had only just begun to know one another when the homicide happened and we were thrust into our new role. We anxiously attended Laura's school where an assembly was held in the gymnasium geared towards calming a terrified community. Caber and I stood on the sidelines, watching 250 faces filled with confusion and fear. The Mayor, Chief of Police and Superintendent of Schools each spoke. Unbeknownst to me, Caber and I were to be introduced next. As we walked to the centre of the gymnasium, all eyes fell upon Caber and half of them spontaneously filled with tears. I have never seen anyone or anything elicit such instant and raw emotion as Caber did in that moment. I was shocked at the response and terrified at what I, one victim services worker, could do for this room filled with hurting people. I quickly realized there was little I needed to do. You see, a loving dog brings out healthy emotions in people. A loving dog helps you understand what you are feeling and makes it okay for those emotions to come to the surface. Research even



shows that merely looking at a dog can cause a surge of oxytocin, the “love hormone”. To those of us accepting, dogs make us feel nurtured, not unlike that of a mother’s love.

Caber spent the remainder of that day providing comfort and affection to hundreds of students and teachers. But, little did we know, our biggest test was still to come. The following day was the first official day back to school after the homicide. Laura’s teachers were worried about how to honour her memory and address the painful void her absence had left. And so, an idea was born. I was asked if Caber could attend each and every one of Laura’s classes and sit by her desk in her absence. Caber gently and lovingly sat at the feet of each of Laura’s desks, as we travelled through her timetable. His non-threatening presence provided a calming and cathartic source of comfort for the students. At any given time 10 to 15 teenagers surrounded Caber. Through him, they talked about their pain and loss in a healthy way. As for me, my Trauma K9 had effectively rendered me useless! I calmly sat on the sidelines watching, as Caber worked his magic. He comforted the students in a way that I could not, despite all my years of experience and training. The greatest compliment Caber received is one I have heard from many clients since... several teens said, “He was exactly what I needed”.

Since Caber’s first deployment he has provided support to more than 500 victims of crime and trauma. At my side, we have given presentations to more than 3,500 people across Canada and the United States about the tremendous impact of assistance dogs. Caber was the first Trauma K9 of his kind in Canada and we are proud to say there are three other dogs working in a similar capacity today... and hopefully many more to come.




Today, Caber is breaking new ground again. In victim services we work with clients from the moment a crime happens all the way through the criminal justice system. It seemed a perfect extension of his work that Caber also provides support to clients when they go to court. As such, Caber is now also the first Courthouse Dog in Canada. In a pilot project with the Surrey Crown Counsel (sincere thanks to Winston Sayson and Paul Sandhu for their leadership and support), Caber has attended

several Crown Counsel interviews with anxious victims who are preparing for court. It is our hope that Caber will soon be sitting with his clients and providing comfort while they testify in the courtroom.

This initiative began in an effort to provide a new means of support to vulnerable victims of crime and trauma. But Caber has made this project so much more. Among the many things he has taught me, I now truly understand the value of embracing people for who they are and accepting where they stand. You see, when Caber meets a client, there is a deep and powerful bond that is created almost instantly. This bond occurs because Caber creates instant trust with everyone he meets. He doesn’t care about the colour of your skin, the job you do, the choices you make or where you came from. He provides loving care and support to anyone and everyone. We could all learn a lesson or two from a dog.



## PADS

To learn more about assistance dogs, please visit [www.pads.ca](http://www.pads.ca). To learn more about courthouse dogs, please visit [www.courthouse dogs.org](http://www.courthouse dogs.org). To learn more about Caber, please visit [www.deltapolice.ca](http://www.deltapolice.ca) and please enjoy this video about Caber at <http://youtu.be/jDHRqNIF-BU> (sincere thanks to Justice Canada for their support). 

## About the author



*Kim Gramlich, MA, is the Coordinator of Victim Services for the Delta Police Department serving Ladner, Tsawassen and North Delta in British Columbia. Kim has worked and volunteered in the field of Victim Services for over 17 years. She has her Bachelor’s degree in Psychology and a Master’s degree in Leadership and Training. Kim, her husband, Rob, and their Trauma K9, Caber, live in Langley, British Columbia.*

Email: [kgramlich@deltapolice.ca](mailto:kgramlich@deltapolice.ca)

Phone: 604-940-5007

# Sport-related concussion care in the emergency department: What every ED nurse needs to know

By Ann Hogan, BScN, RN, ENC(C) Trauma Coordinator, New Brunswick Trauma Program

Each year thousands of Canadians sustain a brain injury. Concussion is the most frequent type of brain injury<sub>1</sub> (Echlin et al., 2010) seen in the emergency departments (ED). Health care professionals typically see patients during the acute phase of injury and must determine what type of brain injury the patient may have sustained. It is important that emergency nurses play a role in educating patients about what to expect after the diagnosis of concussion once discharged from the ED.

Types of brain injuries include:

- Concussion or mild traumatic brain injury (mTBI)
- Cerebral contusion
- Tearing or laceration of the brain
- Cerebral hematoma
- Intracerebral, subdural, or epidural.

Forty per cent of head injuries in children and youth aged 10 to 19 years treated in emergency departments are concussions sustained while playing ice hockey, rugby, football, baseball, soccer, ringette and lacrosse (Parachute, 2013). Much debate has occurred over the last several years regarding concussion diagnosis and care. In November 2012, the 4th International Conference on Concussion in Sport was held in Zurich, Switzerland (Parachute, 2013). Revisions and updates of earlier recommendations from this conference include the Concussion Recognition Tool (CRT), the Sports Concussion Assessment Tool V3 (SCAT3™) (McCrory et al., 2013; BMJ Group, 2013) and the Child SCAT3™ (McCrory et al., 2013; BMJ Group, 2013) for ages five to 12 years. Parachute, a Canadian charitable organization, which united Safe Communities Canada, Safe Kids Canada, SMARTRISK and ThinkFirst Canada into one strong national injury prevention organization, has composed a concussion “toolkit.” This toolkit has many resources developed by professionals to support the care of patients who have suffered a sport-related concussion (see helpful links at end of article).

## Definition

Any blow to the head, face or neck, or a blow to the body that causes a sudden jarring of the brain inside the skull, may cause a concussion (McCrory et al., 2013).

The exact mechanism of injury is unknown but it is believed that rotational acceleration “jiggle” of the brain within the skull causes concussion. Concussion is not due to bleeding, contusion or laceration/tear of the brain. It is thought that it is a biochemical injury. More research is required.

## Diagnosis

Firstly, one must rule out risk of cerebral bleed or contusion. Glasgow Coma Scale range 13–15. The clinician must depend on the history of the event, including mechanism of injury

(MOI), time of injury as well as physical and cognitive assessments and history of previous concussions. Signs and symptoms vary. Concussion cannot be seen on CT head scans. It is important for the nurse to ask questions about possible symptoms rather than depending on the patient to know what is important to tell. Nurses should become familiar with the Sport Concussion Assessment Tool 3 (SCAT3™) (McCrory et al., 2013; BMJ Group, 2013) and Child SCAT3™ (McCrory et al., 2013; BMJ Group, 2013) for 5–12 years old.

Common symptoms include:

- Confusion to date, time, one’s location and trouble remembering what happened before or after the injury
- Difficulty concentrating
- Easily distracted
- Inappropriate emotions in relation to environment (e.g., laughing, crying, anger)
- Physical complaints:
  - headache, dizziness, feeling dazed
  - feeling rattled or stunned
  - seeing stars, flashing lights
  - double, blurry, or loss of vision
  - ringing in the ears
  - stomach ache, pain and/or nausea
  - difficulty sleeping (sleeping less or more than usual)
  - poor co-ordination and balance
  - having a blank stare (glassy-eyed)
  - slurred speech
  - slow responses to questions and directions.

## Treatment

- Complete physical and cognitive rest in the first 24 to 48 hours while symptomatic is recommended. In other words... No TV, texting, computers, radio, reading or physical activity—complete rest
- Referral to health care professional trained in return-to-play assessment based on guidelines (Purcell, 2012; BMJ Group, 2013).

Graduated Return to Play (RTP) protocol (Parachute, 2013) following a concussion follows a stepwise process. The athlete continues to proceed to the next level if asymptomatic at the current level. Each step usually takes 24 hours. Therefore, an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise (double the time needed in children five to 12 years old). If any postconcussion symptoms occur while in the RTP program, then the patient should drop back to the previous symptomatic level and try to progress again after another 24-hour period of rest. <http://www.parachutecanada.org/downloads/programs/activeandsafe/returntoplayguidelines.pdf>

## Complications

Eighty to ninety per cent of concussions resolve in seven to 10 days. However, recovery time may be longer in children and youth (Parachute, 2013).

**Post Concussion Syndrome (PCS)**—The Mayo Clinic's definition of Post Concussion Syndrome describes it as a complex disorder where a variable combination of post-concussion symptoms (e.g., headaches, dizziness) can last for weeks and sometimes months after the injury that caused the concussion (Parachute, 2013; McCrory, et al., 2013).

**Second Impact Syndrome (SIS)**—The Mayo Clinic's definition of Second Impact Syndrome describes rapid swelling of the brain, which sometimes can be catastrophic if the person afflicted suffers a second head injury before the symptoms from the first have gone away. Although this condition is rare, it can lead to death (Parachute, 2013; McCrory, et al., 2013).

**Chronic Traumatic Encephalopathy (CTE)** due to repetitive concussions. Symptoms over time include intellectual decline, balance impairment, slurred speech, tremor (Parachute, 2013; McCrory, et al., 2013).

## Prevention

Prevention is complex. Awareness is essential. Prevention needs to include education, environment, enforcement, and engineering. Primary prevention includes education surrounding respect of the rules of the game by athletes, parents, coaches and officials, especially no hits to the head or hits/pushes from behind. A safe environment such as the sports field or ice rink is important in decreasing the risk of injury. Rules of the game need to be enforced without pressure from fans, players and coaches on officials to overlook dangerous play (Parachute, 2013; McCrory, et al., 2013).

Secondary prevention includes recognition of the signs and symptoms by athletes, parents, coaches and officials and, most importantly, full support by all to "when in doubt, sit (them) out". Short-term pressure of winning the big games can overshadow the health and well-being of the athlete. With improper care and or advice the athlete can be susceptible to long-term symptoms such as headaches, difficulty concentrating, dizziness and nausea (i.e., post-concussion syndrome or the more serious Second Impact Syndrome where there can be significant brain swelling potentially leading to death) (Parachute, 2013; McCrory, et al., 2013).

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## Summary: Points to ponder and share with patients and families

(Parachute, 2013; McCrory, et al., 2013)

- A human brain is not fully developed until age 25. Children and youth more susceptible to concussions
- Helmets can reduce the risk of more serious brain injuries, like a bleed or contusion, but do not prevent concussions
- Concussion symptoms do not always show up right away. They can occur up to 48 hours following an incident
- Concussions can occur without direct impact to the head
- Recognizing signs and symptoms and proper care of a concussion can help in the recovery and prevention of further injury or even death
- Only 10% of all concussions involve loss of consciousness
- Important to provide patients and families with written information to take home. Follow-up with a health care professional trained in return to play assessment is highly recommended. 📄

### Helpful links

- Concussion Clinical Toolkit: [www.catonline.com](http://www.catonline.com)
- Parachute – concussions: [www.parachutecanada.org/injury-topics/topic/C9](http://www.parachutecanada.org/injury-topics/topic/C9)
- Parents' Guide to Dealing With Concussions: [www.parachutecanada.org/downloads/resources/ParentsGuide\\_concussions\\_May27.pdf](http://www.parachutecanada.org/downloads/resources/ParentsGuide_concussions_May27.pdf)

## About the author



Ann Hogan, BScN, RN, is the Trauma Coordinator with the New Brunswick Trauma Program at the Saint John Regional Hospital (SJRH), a level 1 trauma centre in Saint John, NB. Over the past 29 years, her experience includes obstetrics, pediatrics and emergency

nursing, as well as her present position in trauma. She is an instructor in ACLS and RITDC, as well as an instructor trainer in TNCC and ENPC and is the Eastern Representative on NENA's National Course Administrative Committee (NCAC). Ann is also president-elect for the Interdisciplinary Trauma Network Committee (ITNC) part of the Trauma Association of Canada. As an advocate for injury prevention she is on the Canadian Collaborating Centre for Injury Prevention committee (CCIPC), as well as part of the leadership team for the Atlantic Network on Injury Prevention (ACIP). Sport concussions are of special interest, as she is also a national certified level 2 coach in basketball and soccer. Ann can be reached at [Ann.Hogan@HorizionNB.ca](mailto:Ann.Hogan@HorizionNB.ca)

- McCrory, P., Meeuwisse, W.H., Aubry, M., Cantu, B., Dvorak, J., Echemendia, R.J. ... Turner, M. (2013). Consensus statement on concussion in sport. 4th International Conference on Concussion in Sport held in Zurich, November 2012. *Br J Sports Med*, 47, 250–258.
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# CATT—A concussion toolkit for health practitioners

By Dr. Shelina Babul

## BC Injury Research & Prevention Unit

Concussion, also known as mild traumatic brain injury (mTBI), has received enormous attention both in the media and the scientific literature. Concussion continues to be an under-recognized, under-diagnosed and under-treated medical condition requiring both physical and mental rest to recover.


CATT, the new Concussion Awareness Training Toolkit for Health Practitioners, was developed with the goal of improving patient care throughout the province. The short- and long-term effects of concussion can vary from person to person and can greatly affect quality of life. The long-term effects of concussion are often not recognized early enough to prevent post-concussion syndrome and permanent brain damage. A significant percentage of professional hockey and football players, as well as high school athletes, with previously reported concussions or other head-related injury were found to have reported an impact on their social and professional lives including difficulties at work, attending school, playing sports and other simple activities such as riding stationary bicycles or lifting weights (Ackery, Provvidenza, & Tator, 2009).



Figure 1: [www.cattonline.com](http://www.cattonline.com)

Based upon established international principles, the aim of CATT is to standardize concussion recognition, diagnosis, treatment and management. CATT features a learner-directed online training module supplemented with diagnostic tools (SCAT3, Child-SCAT3) and links to clinical resources, patient handouts, journal articles, related websites and concussion videos. CATT is available online at [www.cattonline.com](http://www.cattonline.com)

CATT is currently undergoing a two-pronged evaluation. Part 1 of the evaluation is looking at changes in knowledge, attitudes and practices among physicians and nurses following completion of the CATT tutorial and access to the tools and links. Part 2 of the evaluation looks at changes in family experiences when attending the emergency department at the British Columbia Children's Hospital with a head-injured child. Results will be available in late fall 2013.

Good concussion management may decrease the risk of brain damage and potentially reduce health care costs related to long-term health issues. Phase 2 of CATT for coaches, parents and athletes is currently in development. 

## Acknowledgement

CATT was developed by Dr. Shelina Babul in collaboration with a team of injury prevention researchers and emergency doctors and nurses based out of BC Children's Hospital. Funding for this initiative is provided by Child Health BC, the BC Children's Hospital Foundation and the BC Ministry of Health.

## About the Author



Dr. Shelina Babul has been with the BC Injury Research and Prevent Unit for the past 13 years and is involved in various injury prevention strategies and initiatives. She focuses primarily on sport and recreational evidence-based research development, with a particular specialization in the recognition, treatment and prevention traumatic brain injury/concussion. She is a Clinical Assistant Professor in the Department of Pediatrics, UBC, an Investigator with the Child & Family Research Institute, Chair of the BC Concussion Advisory Network (BC CAN), and Co-chair of the BC Sport and Recreation Injury Prevention Advisory Committee.

## Reference

Ackery, A., Provvidenza, C., & Tator, C. (2009). Concussion in hockey: Compliance with return to play advice and follow-up status. *Can. J. Neurol. Sci.*, 36(2), 207-12.

# MedRec starts in the ED: Challenges and benefits for our seniors

By Cathy Sendeki, BSN, RN, and Shauna Holmes, BSN, RN

**G**eriatric emergency nurse clinicians often encounter medication reconciliation (MedRec) challenges. They include duplicate containers of antihypertensive tablets not taken “because I didn’t want to upset my doctor by telling him they make me light-headed” but prescriptions diligently refilled; vital medications taken at half-doses because the patient could not afford both medication and adequate food; and various mysteries when medications found at home by the paramedics are quite different from those listed on a recent discharge summary.

Accreditation Canada Required Organizational Practices (ROPs) now include Medication Reconciliation. What does this mean for ED nurses? There is limited time in the emergency department setting to obtain information on medication use. Such time constraints can lead nurses to ask questions related to the required practice including: how can we take time to phone their pharmacies, or check all their pill bottles? Why would this be a nursing responsibility when physicians are ordering the meds? When a patient is unsure of what medications she is on, “You know, the little blue and white pill I take for my heart,” would a pharmacy technician not be better suited to this role? Is this MORE paperwork for the already time-pressured ED nurse?

## What is it?

MedRec is a systematic and comprehensive review of all the medications a patient is taking. This provides the medical professional with an opportunity to ensure that all medications being added, changed, or discontinued are carefully assessed and documented. It is meant to ensure accurate communication at care transition points. Examples would include events such as when a patient enters a hospital, transfers to another service or provider, or is discharged home.

Taking a best possible medication history (BPMH) is a foundational part of MedRec. BPMH involves interviewing the patient and family, or care partners, and using one other source to obtain information on the drug name, dosage, route and frequency of prescription and non-prescription medications. BPMH will only be required at the time of the decision to admit, so clearly this level of detailed history will not be required for every ED patient.

MedRec was first introduced as an Accreditation Canada ROP in 2006. ROPs are evidence-based practices that, when implemented, reduce the risk to patients and help improve the quality and safety of health services. When developing the MedRec ROPs, Accreditation Canada examined detailed literature reviews of peer-reviewed research and examined best-practices organizations use to mitigate medication errors. In addition, Accreditation Canada gathered a domain-specific group of experts.

## Why is this needed?

MedRec reduces the potential for medication discrepancies such as omissions, duplications, and dosing errors, which can potentially lead to adverse outcomes. When properly done at

time of discharge, MedRec helps to prevent readmissions to emergency departments that are caused by drug interactions, over-/under-doses, and other potentially harmful side effects. These readmissions can be very stressful to patients and families, and can be expensive to the health care system. It is estimated that the total cost of preventable, drug-related hospitalizations in Canada is about \$2.6 billion per year.

Considering that seniors typically take multiple medications, the risk of errors is increased in this population. In 2011, the first members of the baby boomer generation turned 65. Of people aged 65 years and over, 69% reported taking five or more medications. Nearly 10% were taking at least 15 medications. Not surprisingly, the number of medications taken increases with age. Seniors in Canada take four times more over-the-counter (OTC) medications than any other age group. OTC medications or samples distributed by family doctors rarely appear on Pharmanet searches.

## How best to obtain this information?

The “gold standard” is to have the medication history obtained by a clinical pharmacist, clearly not possible in most situations. Whatever medication-related documentation is done as the patient encounters any care transitions, it needs to start with an accurate list of what the patient has been taking prior to admission. Patient involvement is vital because a patient’s actual medication use may differ greatly from what is shown in their records.

Particularly with seniors, the initial discussion often involves some assessment of cognition. Establishing a rapport can help patients and their care partners have a frank and open discussion about what they feel are barriers to medication compliance. Some patients may disclose they have not been taking medications as prescribed because of financial constraints, or because they may not have understood what to take. Some may have deliberately chosen to continue with medications previously prescribed by their GP rather than changes made by the hospital physician because they know and trust their GP. Certainly in the ED, where we assess pertinent negatives as part of a thorough assessment, we may need to question why this patient is not taking medications for a known condition for which medication is indicated.

## Challenges and opportunities

As part of consultations the Canadian Patient Safety Institute (CPSI) conducted in 2011, MedRec was identified as one of the top three patient safety priorities in every jurisdiction by health care leaders across Canada. Despite this, MedRec ROPs continue to be some of the ROPs with the lowest compliance rates across Canada. Lack of human and fiscal resources, limited technology, and insufficient professional and government direction

have all been cited as contributors to the lack of MedRec implementation and compliance with this critical ROP. Key factors for success, identified by pioneers of MedRec implementation in Canada, include strong leadership support, physician champions/leaders, information technology support, and a comprehensive staff education plan. Without these supports being established, the medical profession can expect to see ongoing issues with MedRec implementation.

In our standard practice we are already laying the foundation of MedRec. Although we may not get all possible information about medications as part of the initial assessment, we are looking for all information relevant to the patient presentation. A possible head injury elicits questions about anticoagulant use; increased shortness of breath prompts assessment of recent changes in diuretics and so on. By utilizing our resources, and looking for ways to build on this initial information, we are on the road to establishing a strong base for MedRec, and increasing our patients' safety.


Some ideas:

- Watch for high-alert medications such as anticoagulants; Insulin and sulfonylureas such as Glyburide® with the risk of prolonged hypoglycemia; opioids, and medications with a narrow therapeutic window, including Digoxin and Phenytoin.
- Patients discharged within the last 30 days need to be a high priority for MedRec. An American study published in 2012 looked at recently discharged patients and found 56% had a discrepancy in medications within 48 hours of discharge. The readmission rate at 30 days post-discharge was approximately 14% of those experiencing medication discrepancies compared to 6% of those who did not.

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- Encourage accurate medication information to be brought by patients, family members, care partners and emergency health services. Even if we do not immediately need to know all this information, clearly it is needed by other team members to provide safe care.

While this article does not answer all the questions raised, perhaps it will give support, as we all work to achieve this required practice. Medication Reconciliation will require more work by some team members, but not necessarily an inordinate amount by ED nurses. We can, as always, advocate for meaningful ways to increase patient safety through accurate assessment and ongoing education to help them and, when necessary their care partners, make the best decisions about medication management. 

## About the authors



Cathy has worked at Burnaby Hospital Emergency Dep't since 1987, in the past several years as Geriatric Emergency Nurse Clinician, as part of the Older Adult Program. Particular interests include working with persons with dementia and their care partners and embracing the challenges of dealing effectively with Elder Abuse. She enjoys being a grandma.



Shauna Holmes has worked as a staff nurse in Burnaby Hospital Emergency Department for the past five years where she is an active member on the Practice Council. Her interest in contributing to this magazine was sparked by attending the recent NENA conference in Vancouver. When not at work she enjoys running around with her children and learning to cook different foods from all over the world.



# Upstream thinking about victims of intentional violence: The wisdom of Forensic Nurse Examiners

By Rose Marie Doyle, RN, BN, MScN

What comes to mind when you meet or hear about a Forensic Nurse Examiner (FNE)? If your response did not include prevention, you're not alone. The FNEs within British Columbia's Fraser Health (FH) maintain that health care professionals and the public at large have diverse perceptions about their responsibilities, ranging from equating FNE's work with death, CSI, or corrections, to one of complete topic avoidance. Some wrongly assume it is depressing work, placing the nurse examiner at risk for developing *immunity to human suffering*. In reality, the International Association of Forensic Nurses (2009) broadly defines forensic nursing as the practice of nursing globally where health care and legal systems intersect. Moreover, a goal of forensic nursing is prevention of intentional violence (IV). This article highlights an exemplary group of nurses whose practice has meaning for nursing care across the lifespan, both locally and globally. In a capacity-building project, these FNEs shared their wisdom, acquired from trauma-informed care and their humanity. Their perceptions helped me understand the breadth of their prevention initiatives, the rewards and challenges they experience, and the relevance of their work to all health care providers.

## Prevention of intentional violence

According to the director of the Forensic Nursing Services (FNS), these unique nurses are "dedicated, professional, heroes, educated, flexible, patient-centred, and quality driven" (Personal communication Martha Cloutier, June 20, 2013). FNEs are both hopeful and empowered by their comprehensive prevention responsibilities. While addressing sexual violence is their major responsibility, FNEs are concerned about the broader issue of IV. Lynch (2011) states that pure primary prevention refers to "preventing the event from happening at all" (p.16). FNEs take a proactive approach by engaging in formal and informal teaching that is individualized to the target population (e.g., the patient, family, various community groups such as students and law enforcement). Although women and girls are more likely to be survivors, FNEs conduct speaking engagements with all genders, addressing topics such as sexual health, reducing the risk of exposure to violence, and identifying persons at risk for violence and those at high risk for offending.

Lynch (2011) states that secondary prevention involves "prompt detection, treatment and management" (p.16). In FH, victims of intentional victimized violence may access the Surrey Mobile Assault Response Team (SMART); one of the first services provided is transport to the emergency department. An FNE arrives within 45 minutes to provide forensic care (FH, n.d.a). SMART addresses the safety concerns of women and girls who have been victimized by supporting them to make critical and often time-sensitive medical and legal decisions immediately following an assault. SMART emergency response workers receive

comprehensive training in the assessment of risk and the development of safety plans, which mitigate any ongoing threat to the safety of recent survivors of violence (Surrey Women's Centre, n.d.). This timely, respectful and competent care lessens the sequelae of violence for the victims (Dole, 2011). Having an established multidisciplinary initiative enables the FNE in remaining patient-centred.

Tertiary prevention "seeks to limit impairment, increase the quality of life, and prolong life" (Lynch, 2011, p.16). FNEs believe this necessitates a broad responsibility for preventing secondary re-victimization by changing the cultural norm of IV. Survivors of IV are at risk for being re-victimized when further exposed to violence, as well as when subsequently undergoing invasive procedures such as a gynecological examination (Dole, 2011). As part of their everyday lives and in their nursing employment outside of FNS, FNEs seize any opportunity to clarify myths and realities of gender bias and inequalities, and sexual relations. Dole (2011) states that "many men and women do not understand boundaries or the definitions of sexual violence" (p. 405). FNEs believe that gender-based violence requires a collective effort by social, health, law enforcement, justice and government agencies to adopt a broad view of violence as a *social*, not personal issue. FNEs hold strong beliefs that everyone has a responsibility to act non-violently, and avoid being a bystander to any type of violence.

Dole (2011) cited several studies whereby men and women have misconceptions regarding what constitutes IV. In one research study, a majority of college men did not perceive acquaintance rape as sexual violence. Similarly, men who were sexually assaulted often avoided reporting the offence because they erroneously believed they should have been able to protect themselves. FNEs have observed instances whereby young, educated men failed to realize that an unconscious woman, under the influence of drugs (e.g., GHB) or alcohol, cannot consent to a sexual relationship. They address this issue by disseminating knowledge on trauma-informed practice to other professionals across the health region. Indirectly, FNEs enhance the quality of life for survivors by raising awareness regarding the need for a collective effort. They believe many professionals including police, child protection workers, health care providers, teachers, daycare workers, lawyers and judges lack the requisite knowledge for preventing IV. Adopting a trauma-informed practice gives survivors permission to share their stories, which, ultimately, may prolong their lives. While knowledge is a necessary resource, tertiary prevention must be ongoing for a substantial behavioural change whereby all Canadians, particularly vulnerable populations such as Aboriginal peoples, survival sex workers, transgendered persons, new immigrants, and those living with disabilities have their voices heard and are safe from IV.

## Forensic Nursing Services

Forensic Nursing Services (FNS), located at Surrey Memorial Hospital and Abbotsford Regional Hospital and Cancer Centre is a unique Canadian program, and operates within Fraser Health (FH), one of Canada's largest health authorities, in conjunction with community agencies. FNS provides care for victims of intentional violence (IV), most of whom are women and girls. IV, also known as domestic abuse, includes sexual assault, yet, despite the high prevalence rate, many Canadian victims have no access to a forensic nursing examination (Fraser Health, n.d.c). In some areas, the role of a Forensic Nurse Examiner (FNE), formerly referred to as Sexual Assault Nurse Examiner, is to provide care for sexual assault victims. However, FNEs in FH have more extensive responsibilities.

These FNEs perform a forensic exam, make decisions regarding medication administration and diagnostic testing, collect evidence, create a medical-legal report, may testify as an expert witness, provide follow-up care and appropriate referrals. The FNEs collaborate with police and community agencies, such as Surrey Women's Centre (SWC) whose mission is to end violence against women and girls. SWC's SMART (Surrey Mobile Assault Response Team) helps survivors navigate the complex medical, legal and social service systems, and provides counselling, thereby addressing the immediate and long-lasting impact of violence with a paramount focusing on increasing safety.

Many Canadians are unaware that human trafficking is both a domestic (i.e., it occurs within Canada) and a global issue. In association with B.C.'s Office to Combat Trafficking of Persons, FNEs address this criminal activity as a health care issue and are developing a toolkit to train and assist FH emergency department staff to recognize and respond to the signs of human trafficking and sexual exploitation (Nagel, 2013). The FNEs' foci include working with stakeholders to build a cohesive team to combat the crime from multiple perspectives, developing prevention strategies, and improving health care for those being trafficked.

FNE coordinators, all of whom are nurse examiners, envision a future whereby all FNEs in Canada will perform to their full scope of practice in accordance with jurisdictional professional standards of practice. They believe that RNs working in areas such as the operating room, emergency department, and corrections have an opportunity to expand their knowledge and improve outcomes for IV survivors by becoming members of a "uniquely Canadian organization" (Forensic Nurses' Society of Canada, 2013). Moreover, they believe that intentional violence is a health care issue that must be included in curricula of all health care programs.

As exemplary lifelong learners, FNEs share best practice resources with internal and external colleagues, meet monthly for educational and debriefing sessions, and attend workshops. Educational topics include conducting a forensic examination, identifying biomarkers of human trafficking, documentation and preparing to testify, and preventing vicarious trauma. For this reason, the Director of FNS foresees B.C. serving as a model for ensuring forensic services are accessible to all urban and rural Canadians.

## Rewards and challenges faced by Forensic Nurse Examiners

FNEs work in a high-stress environment where it may take hours to obtain informed consent from a patient who has shared a horrific experience of IV. In addition to being on call and providing forensic care for four to 12 hours per patient, FNEs are required to submit a medical-legal report within 24 hours and must be prepared to testify as an expert witness (Fraser Health, n.d.b). Although stressful, FNEs find this work rewarding; fulfilment arises out of knowing they make a difference. Critically important, FNEs are skilled in remaining non-judgmental and unbiased in their care. Strategies they use to ensure retention of this skill include ongoing education and self-evaluation, staying mindful of their well-defined scope of practice, working in concert with SMART and other allied service providers, having a view of compassion for all, and debriefing with FNE coordinators.

Despite having role clarity and experiencing rewards, FNEs are at risk for vicarious trauma. To mitigate this they are exemplary in self-care and refine it over time. FNEs acknowledge and attend to their vulnerabilities by taking time for themselves, seek out appropriate people for support, diversion and debriefing, and practise healthy coping strategies, ranging from embracing nature to engaging in spiritual practices. One indicated that imagery helps in that when she removes her lab coat after providing forensic care, she *sheds the case* at the same time. Above all, FNEs have a positive world view, believing that there is more good than evil in the world. Several indicated that snuggling with their children and grandchildren reinforces this belief.

## Relevance to health care providers


A sense of powerlessness among health care providers may impede progress toward changing the culture of IV. If reducing violence is deemed external to one's control, an attitude of apathy and tolerance is conveyed. FNEs believe that fear and not knowing how to speak out against violence may underlie such inaction. By engaging in ongoing education on the exploitation of vulnerable people, FNEs are role models for adopting an internal sense of control. Although the numbers need to increase, some health care providers and the public have learned how to recognize blatant and subtle portrayals of violence, including exploitation of women and minorities in the media, movies, magazines and TV. They encourage their loved ones to use the Internet for non-injurious purposes, avoid dining in facilities with sexualized dress codes for servers, and recognize when advertising and sexist jokes denigrate women. Having an internal sense of control over violent behaviour is key to reducing and, ultimately, eliminating violence.

There is an element of forensic nursing in all nursing practice settings. While not all registered nurses have a desire to become FNEs, each one has a responsibility to support the quest for changing the cultural norm of IV. The statistics on IV are staggering:

- Females are six times more likely to be sexually victimized than males, and
- Up to one in three men have experienced sexual abuse (Canadian Centre for Justice Statistics, 2008).

Dole (2011) states that survivors of sexual assault “who present with discordant symptomatology are often waving a red flag and asking to be heard” (p. 399). Given the statistics, all health care providers need to be on the alert for red flags. She indicates that “health care professionals feel they are too busy and state that histories of sexual assault or abuse are not a priority. Unfortunately, this omission often represents a missed opportunity to assist patients in beginning the healing process by telling their story” (p. 404).

In conclusion, as registered nurses employed in practice, education, research or administration, we must be mindful that each patient/client or health care professional with whom we interact may have a current or remote personal experience with IV, the sequelae of which may be long lasting and possibly life-limiting. This capacity-building project has taught me that we could enhance our professional and personal lives by asking ourselves:

- Might my actions or inactions cause a (potential) survivor to feel re-victimized?
- What resources might be appropriate to offer a (potential) survivor?
- How can I incorporate IV prevention into my personal life and professional practice? 

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## About the author



Rose Marie Doyle, RN, BN, MScN, has been a nurse educator for 30 years, practising in Alberta, Ontario, and British Columbia, and currently is a faculty member in the BSN program at Kwantlen Polytechnic University (Langley, B.C.). Her teaching expertise is in caring for adults in acute care and community settings. Professional interests include primary health care, quality workplace environments

for nurse educators, and capacity building. A relatively new area of interest is how forensic nursing is embedded in nursing students' everyday clinical practice. Forensic Nurse Examiners have enabled her to expand on that understanding and, therefore, gratitude is extended to Fraser Health's Forensic Nursing Services' Director Martha Cloutier, Coordinators Larena Dodd, Lynn Gifford, and Susan Short, and all nurse examiners who shared their wisdom, and are helping to make Canada a safer place.

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## Call for papers: Special issue

### Call for papers—Forthcoming Special Issue— Major Trauma Care International Emergency Nursing invites submissions

We are pleased to inform our authors and readers that *International Emergency Nursing* has been selected for coverage in Thomson Reuter's® products and services and will receive its first Impact Factor in 2014.

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Guest Editors: Associate Professor Kate Curtis and Professor Rob Crouch, OBE

Globally, trauma remains a major cause of death and morbidity for those under the age of 40 years old. Recent advances through research, learning from combat resuscitation and new approaches to the organization of trauma services have significantly improved outcomes from major trauma.

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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 **CJEN**). 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. 



---

## 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: \_\_\_\_\_

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