CANADIAN JOURNAL of EMERGENCY NURSING

JOURNAL CANADIEN des INFIRMIÈRES D'URGENCE

THE OFFICIAL JOURNAL OF THE NATIONAL EMERGENCY NURSES' AFFILIATION, INC.

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NENA

Guidelines for submission

Editorial Policy

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), on 8½" × 11" paper with adequate margins. Manuscripts longer than one page must be submitted in a disk format in Word Perfect or Word. Submissions are accepted via e-mail to the communication officer.

3. Author's name(s) and province of origin, a photo and a brief biographical sketch must be included.

4. Clinical articles should be limited to six pages.

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

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

Please submit articles to:
Stephanie Carlson, CJEN Editor,
email: communicationofficer@nena.ca

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

Deadline dates:
January 31 and September 8

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President's message

As I move into the year 2013, I feel like I have run a marathon! On talking to other members of NENA they, too, have the same feeling! That led me to look back on what had kept myself and the NENA board so busy!

Here are a few of the things NENA has been working on:

- The 2012 conference in Halifax was a success and the present conference team are well on their way to making 2013 "Wild and Spectacular".
- The Ontario crew, not to be left in the dust, has already started on the 2014 conference, which will be open to nurses from North and South America!
- The Honorary Life Membership program, (see "Letter to the President" on page 10) started in 2012 and we have been successful in finding some of the past hard-working nurses who laid the foundation of the National Emergency Nurses' Affiliation (see letter from Louise). We will be inducting several more members at the AGM in May.
- The International Exchange program (see "IEP" on page 14) is well underway and two U.S. nurses will be coming to Canada for a week.
- NENA has a board member on the Bystander CPR committee, as well as the overcrowding committee at CAEP.
- Another member is on the Accreditation Canada—emergency committee.
- With the release of the new 4th edition of ENPC and the TNCC rewrite underway, there is the need to raise money for translation. Thankfully, with the help of the AIIUQ and a special committee, work is underway to source out some funds.
- The job of combining the membership data from NENA and AIIUQ has turned out to be a bit more work than expected, and continues at this time.
- Work continues on the NENA bylaws and society changes required by Canada Corporation Act and will be discussed at the May board meeting, then taken to the AGM for discussion prior to finalization.

Personally, I have had the pleasure of attending several provincial and national conferences or workshops and I continue to draw energy from the people I meet at these events. Emergency nurses are truly exceptional people and they continue to face new challenges every day.

Sharron Lyons

Belief is truth held in the mind. Faith is a fire in the heart. Keep the faith.
— Author unknown

Communication Officer's Report

Welcome to the premiere edition of the *Canadian Journal of Emergency Nursing*! The change in the title of our journal is one more demonstration that nursing is constantly changing. It also reflects the desire to increase the profile of emergency nursing as a specialty.

If ever there was a time to enter emergency nursing, this is it. Many provinces are seeing greatly expanded scopes of practice for nurses with exciting opportunities in careers associated with emergency care of patients.

This will also be reflected in the NENA Conference in Vancouver in May, which will include sessions on a wide range of topics directly and tangentially related to care within emergency departments. Our conference committee has been hard at work for more than a year, planning and preparing to make this a must-do event. **http://www.interprofessional.ubc.ca/nena/**

Please consider contributing to the *Canadian Journal of Emergency Nursing*. We are already accepting submissions for the fall edition. The deadline for submission is September 10.

See you in Vancouver,
Stephanie Carlson

Elections for Treasurer

As treasurer, you are entrusted with the funds and securities of the corporation and you shall keep full and accurate accounts of all assets, liabilities, receipts and disbursements. …You are expected to prepare and deliver an accounting of all financial transactions at each board meeting. This is a four-year term with a mentorship by the previous treasurer and the expectation of mentoring the incoming treasurer at the end of your term.

American Nurses Association recognizes emergency nursing as a nursing specialty

Emergency nursing is now an official nursing specialty recognized by the American Nurses Association. The American Nurses Association (ANA) has rigorous criteria for specialty recognition, so this is a major accomplishment validating the unique aspects of emergency nursing practice. The ANA also accepted the revised Emergency Nursing: Scope and Standards of Practice, available for purchase later this year. To see the full release, go to **www.ena.org**.

News from the provinces

NENA-AB (ENIG) Report

This past fall and winter have been very busy for the executive of the Emergency Nurses' Interest Group (ENIG) of Alberta. We have met four times since September and have exchanged countless e-mails. Our main priorities have been to increase our membership, and to promote ourselves as the provincial division of the National Emergency Nurses' Affiliation Inc. (NENA). We have developed a brochure and poster, which we have distributed in both hard and electronic format to our members. We have visited almost a dozen smaller and rural hospitals with emergency services to give out brochures and NENA pins. This was received with great excitement and enthusiasm from the staff contacted.

Our Communications Officer, Jean Harsch, has been extremely busy with improvements to our newsletter and then, electronically distributing it to our membership, as well as mailing hard copies to all Alberta hospitals with emergency services. It is our hope that our newsletter will continue to improve and grow, and that with the increase in circulation, it will become a "go-to" publication for Alberta emergency nurses to connect them to educational opportunities provincially and nationally. We have developed a Facebook page that Jean posts on and maintains. Our next project will be to improve our website.

We have updated and revised our constitution/bylaws document to reflect allowing Licensed Practical Nurses (LPNs) to join our group as full members. LPNs are an important part of the emergency nursing team, not just in Alberta, but also across Canada. LPN involvement and membership in our group can only help us improve. Another revision to the constitution/bylaws is to change our name from ENIG to NENA-AB. We hope that this will visibly reinforce our connection to NENA and the importance of our provincial role in our national organization. We will put this new document to the membership for a vote at the Annual General Meeting (AGM), which will occur later this spring.

Our executive is busy planning, and we hope to combine an education and skills day with our AGM. December and January were extraordinarily busy for Alberta emergency departments with extremely high numbers of patients attending with the flu and Norovirus. Thankfully, the latest statistics show a significant decrease in these numbers, and we are hopeful we will not see a substantial increase when the "second wave" hits.

TNCC, ENPC and CTAS courses are ongoing throughout Alberta and at each opportunity, members of NENA-AB (ENIG) continue to promote our group and encourage our colleagues to become members. Our collective voice is much louder and carries more weight, with more members. This will make NENA-AB's goal to promote professional growth as emergency nurses much easier to accomplish! Thank you for continually rising to the challenges that are always a very real part of emergency nursing.

Pat Mercer-Deadman, RN, ENC(C)
President NENA-AB (ENIG)

British Columbia

What an exciting time for ED nurses across the province. Lots of exciting improvement work going on. Patient volumes continue to cause stress to departments everywhere. We just completed an education day in Whistler, attached to the St. Paul's Emergency Medicine Conference. Lots of good conversations and networking occurred. We will take the feedback and make next year even better.

I would like to share an exciting process that we have implemented in our emergency department in North Vancouver. Approximately a month ago, our acting manager Angeline Bierstee brought her incredible energy and enthusiasm forward to roll out a "continuous quality improvement board" in our department.

Every day we start with a "huddle" to review staffing concerns, patient ratios, unsafe assignments and any particular concerns with patients. We then move on to address issues in the department. Staff are encouraged to post concerns under the headings of safety, quality, people, cost or delivery. Each morning we address one or two concerns. Once the issues are solved, we move items over to the "achievement" section. Staff has a renewed sense of engagement and excitement that our department is moving forward. I would encourage staff to consider this kind of work to make department improvements in staff engagement, and patient and staff satisfaction. Research has shown that engaged staff results in happier patients. This is based on lean methodology and can be up and running in a couple of days!

Emergency nursing week is coming up—let us look for ways to celebrate our colleagues and the work that we do.

Sherry Stackhouse

Newfoundland and Labrador

Winter has set in here on the island and we have had our share of cold and snow. Emergency rooms are being bombarded with winter-related ailments. The flu season has left its mark with nursing units quarantined and EDs filled over capacity with inpatients. This is the norm now.

Other rural RNs have an "extended" nursing role that includes covering off an Acute Emergency Clinic after hours.

This role was shared by two RNs, as they also care for other LTC inpatients in the centre. The RN is often monitoring several acute patients for an out-of-facility MD. This has created an outpouring of demonstration, as we see a reduction of RN coverage, therefore decreasing the provision of good quality health care.

Ongoing issues: emergency departments continue to deal with over-crowding, extended wait times, limited general practitioner coverage increasing the patient volumes in EDs, increased acuity and increased staff abuse.

On a bright note, administrators are making attempts to improve flow within the emergency departments.

Membership: 64 active members

Events: October conference completed with a profit for the Province

- Health Authority introducing LEAN Healthcare model
- PEDS Conference to be held in St. John's in the spring of 2013.

Body participation: expressions of interest for next provincial conference

- Recruiting new executive interest. Goal: AGM 2013
- Partnered with paramedics in local Christmas Parade.

Education: TNCC, CTAS continue to be offered twice yearly.

- ENPC under review (promising feedback)
- Training new instructors for TNCC, March 2013.

Todd Warren, RN
NL Director

Canada's National Day of Remembrance & Action on Violence Against Women

Photo: Pat Kelln & John Johnson, Women, Information & Advocacy.

December 6, 2012

The 10th Annual Shoe Memorial in Vancouver, B.C.

I would first like to pass on two often-heard comments by pedestrians on December 6: "*It must be Dec. 6*" and "*Thank you so much for doing this*". I don't think I can convey my thanks any better than that. For without your hard work collecting shoes, the Memorial could not be built. Women in need appreciate the number of boots and walking shoes you collected.

Again this year we were able to commemorate each woman and girl killed in B.C. that we know of—869 deaths, 869 pairs of shoes. Though we spoke to fewer individuals, our goal of "remembering" those who have died needlessly is being fulfilled by our just being there. And not just in Vancouver. The number of Shoe Memorials in Canada continues to grow with Mississauga, Ontario, building its first. The shoes were donated to worthy charities following the event. To read more about the event go to: **www.shoememorial.com** or **http://metronews.ca/news/vancouver/468683/empty-shoes-at-vancouver-art-gallery-mark-women-murdered-by-domestic-violence/**

Journée nationale du souvenir et de l'action contre la violence faite aux femmes

10e journée annuelle de « Shoe memorial » à Vancouver

6 décembre 2012

Tout d'abord, j'aimerais vous mentionner des commentaires positifs que nous avons reçus des participants à la marche du 6 décembre. Je pense que ces messages accompagnent nos remerciements. Sans votre travail ardu pour la collecte de souliers, cette activité commémorative n'existerait pas. Les femmes dans le besoin apprécient toutes les bottes et les souliers amassés lors de cette journée.

Encore une fois, cette année, nous pouvons commémorer toutes les femmes et filles tuées en Colombie Britannique (869 décès, 869 paires de souliers). Tel que discuté, notre but est de ne pas oublier les êtres disparus et pas seulement à Vancouver. Cette activité prend de l'essor avec un premier événement à Mississauga en Ontario. À la suite de l'événement, les souliers ont été donnés à un organisme de charité. Pour en savoir plus concernant cet événement, vous pouvez consulter le site : **www.shoememorial.com** ou **http://metronews.ca/news/vancouver/468683/empty-shoes-at-vancouver-art-gallery-mark-women-murdered-by-domestic-violence/**

NENA awards, bursaries and grants available for 2013

Awards

Excellence in nursing and health care deserves recognition. By celebrating nurses' achievements in the four domains of practice, the understanding of nursing is expanded and a positive image is reinforced. The NENA Awards of Excellence Program enables nurses to honour colleagues for their outstanding contributions and for demonstrating excellence in relation to the Standards of Nursing Practice. Awards available:

- Award of Excellence in Emergency Nursing Administration
- Award of Excellence in Emergency Nursing Education
- Award of Excellence in Emergency Nursing Practice
- Award of Excellence in Emergency Nursing Research

Award nomination forms to be sent to **awards@nena.ca**

Bursaries

NENA recognizes the need to promote excellence in emergency care and, to this end, 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. On April 1 of each year, the number of bursaries awarded is determined by the number of registered members per province. One bursary will be available to NENA BOD and ONE collectively to an independent member. Applications must be submitted to your provincial president or **awards@nena.ca** prior to April 1, 2013.

Grants

The purpose of the NENA Research Grant is to encourage and to support nurses conducting nursing research in emergency. Research must be relevant to emergency nursing and may include practice, education or administration. The amount of money granted per year is $1,000.00. Application deadline is March 31. For more information on how to apply, go to **www.nena.ca**

Prix, bourses et subventions NENA disponibles pour 2013

Prix

Reconnaissance de l'excellence en soins infirmiers et en soins de santé. En célébrant les réalisations des infirmières dans les quatre domaines de pratique, nous renforçons l'image positive de la profession. Le Prix de l'excellence du NENA permet aux infirmières d'honorer leurs collègues pour leur contribution exceptionnelle, en lien avec les standards de politique en soins infirmiers. Prix disponibles :

- "Award of Excellence in Emergency Nursing Administration" (Administration)
- "Award of Excellence in Emergency Nursing Education" (Formation)
- "Award of Excellence in Emergency Nursing Practice" (Pratique)
- "Award of Excellence in Emergency Nursing Research" (Recherche)

Les formulaires doivent être envoyés à **awards@nena.ca**

Bourses

Le NENA reconnaît l'importance de promouvoir l'excellence des soins d'urgence et l'aide financière à ses membres. Le NENA offre annuellement des montants d'argent afin de maintenir un haut niveau des standards dans les soins d'urgence à travers le Canada. Toutes les directions d'équipe en soins d'urgence sont éligibles incluant le personnel infirmier, les directeurs et les formateurs. Les bourses seront déterminées par le nombre de membres enregistrés par province, au 1er avril de chaque année. Une bourse sera disponible à NENA BOD et une collective à un membre indépendant. Toutes les demandes doivent être envoyées à votre président provincial ou à **awards@nena.ca**, avant le 1er avril 2013.

Subventions

Le but des subventions pour la recherche du NENA est d'encourager et de supporter les infirmières qui dirigent les recherches en soins d'urgence. La recherche doit relever des soins infirmiers d'urgence et doit inclure la pratique, la formation ou l'administration. Le montant accordé par année est de 1 000 $. Date limite pour les demandes est le 31 mars. Pour plus de détails sur la façon de faire une demande, consultez : **www.nena.ca**

National Course Administration Committee (NCAC) TNCC/ENPC/CTAS Instructor Updates, Spring 2013

By Margaret Dymond

ENPC 4th Edition updates

All ENPC instructors should have received an email from ENA describing the process for updating your instructor status to teach the ENPC 4th edition course. The update process is all online. ENPC instructors are required to watch the online videos, preview four online modules, and complete the exam online. It is advisable that instructors secure a 4th edition provider manual prior to completing the exam. The deadline for an instructor to update is February 28, 2013.

Several notifications have been sent through ENA and NCAC to all ENPC instructors regarding the up and coming changes to the course. Only 4th edition ENPC courses are being approved, so instructors who have not completed their update cannot teach ENPC.

E-course OPS

There are many advantages to applying for courses online: view your courses, invoices, order manuals, cancel courses. Course directors for 4th edition ENPC courses will also register participants to enable access to the pre-course modules through E-course OPS.

Course approvals

A two-step process is required for course approvals. Course directors should apply through e-course OPS for their courses. ENA approves that these course directors and instructors are current to teach. NCAC ensures all instructors are NENA members by checking the NENA membership list. NCAC is looking forward to future enhancements to E-course OPS that will permit viewing the instructors, as well as the course.

TNCC updates

The 7th edition TNCC revision process is underway. The new course format is expected early in 2014.

TNCC re-verification courses

ENA will still approve the TNCC 6th edition re-verification courses, but contact hours cannot be awarded after December 31, 2012.

Non-RN health care providers taking TNCC or ENPC

Non-RN health care providers who work in an emergency setting can participate in the written and skill station testing of both the ENPC and TNCC provider courses. The non-RN health care worker who attends a provider course will receive a certificate of attendance with the appropriate number of contact hours, but will **not** receive a verification card or verification status.

Course Bytes

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

CTAS update

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

Course updates

NCAC publishes a newsletter twice annually, which is posted on the NENA website and through email. If your email addresses change, please notify us at **ncac@nena.ca**. Your NCAC rep can also email you an update to the Canadian course administration procedures.

NCAC members

All queries regarding TNCC/ENPC/CTAS can be sent to **ncac@nena.ca**

Margaret Dymond, Chair: **margaret.dymond@albertahealthservices.ca** or **chairncac@nena.ca**
Ann Hogan, Eastern Canada Rep: **Ann.Hogan@horizonnb.ca**
Brenda Lambert, Central Canada Rep: **Lambertbrenda17@gmail.com**
Monique Mclaughlin, Western Rep: **monique.mclaughlin@vch.ca**
Denis Bouchard, Quebec Rep: **bouchardsante@gmail.com**
Erin Musgrave, CTAS rep: **Erin.Musgrave@horizonnb.ca** or **ctas@nena.ca**

Letter to CTAS instructors

Dear CTAS Instructors,

After much great feedback from all of you, the CTAS NWG has revised CTAS (incorporating all of your suggestions—please keep them coming) and we are pleased to announce the new CTAS teaching materials are now ready to download on the CAEP website. Please delete older versions, as they are no longer current and can no longer be used.

The new materials have been saved with an expiry date of July 1, 2013. This coincides with the renewal of CTAS Instructor and NENA memberships and is to ensure all CTAS Instructors are using the most up-to-date materials vetted by the CTAS NWG, NENA and CAEP. What this means is that as of July 1, 2013, the materials will become corrupt and you will not be able to use them until you have renewed both of your memberships, and have taught at least one course per year.

As some of you have noticed, accessing CTAS is now easier and more user-friendly.

Any current instructor can access the materials by logging into the CAEP Communities website. If you have not yet renewed your CTAS Instructor membership and/or NENA membership, please do so as soon as possible so you can access the new materials.

A few highlights of the provider course revisions are:

- The elimination of "steps" within the modifiers. There are now only 1st order modifiers and 2nd order modifiers
- More definitions added, e.g., timeline for acute pain versus chronic pain
- Adult fever is now > 38°C to be in line with sepsis protocols
- CVA-like symptoms now go to 4.5 hours
- New CEDIS complaint and modifiers, "Newly born" has been added to Module 3
- New evidence-based paediatric vital sign charts
- Addition of Paediatric Hypertension chart
- The delivery of content in Modules 2, 3 and 4 has changed slightly for clarification
- Removal of redundant/repeated slides
- Enhanced Instructor Notes to help answer some of the more common questions/controversies
- Added animation to the case studies in order of modifiers to consider
- The Participant Manual has been updated to reflect all changes.

We have also revised the Administration manual to better act as a resource guide to instructors and instructor trainers. In order for the CTAS NWG and NENA and CAEP to really support the instructors and ensure credibility and consistency of ongoing courses, we are changing the instructor development, instructor courses, and instructor trainer processes. Along with this, we will be developing a chat site for instructors and holding several webinars throughout the year to discuss challenges, clarify content, etc. We urge you to read this manual and destroy any old copies (it will be available shortly on the CAEP website). Please note that a few of the forms can now be filled in and submitted electronically.

The following highlight some of the changes:

Instructor development changes:
Potential instructor candidates will be asked to submit a letter of intent, along with their CV to **ctas@nena.ca** for approval to become an instructor. Once approved, they will attend an instructor course, submit the appropriate paperwork and fees, and then co-teach at one course with an instructor trainer. To maintain your instructor status you must teach a minimum of one course per year.

Instructor course changes:
The instructor course will now be the full CTAS course taught from an "instructor's point of view", incorporating course paperwork, etc., as well. Requests for an instructor course must be made prior to the course to **ctas@nena.ca** with the name of the instructor trainer, and instructor candidates included. It is no longer the "see one–teach one" process.

Instructor trainers changes:
In order to maintain your instructor trainer status, you must teach a minimum of two provider courses per year.

Sincerely,
Colleen Brayman and Tom Chan,
Co-Chairs of the CTAS NWG

If you have any questions, please feel free to contact the CTAS NWG at **ctas@nena.ca** and/or Gisele Leger at **admin@caep.ca**

Thank you,
Gisele Leger, Administrative Assistant
Canadian Association of Emergency Physicians
104-1785 Alta Vista Drive
Ottawa, ON K1G 3Y6
Tel: 613-523-3343 ext. 10
Fax: 613-523-0190

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, **communicationofficer@nena.ca**

Taking your career "out there"

By Christina Mavinic, RN, BSN, RN-C

Snow is falling lightly and the sun is low on the horizon. My dog and ever travelling companion Lola is asleep on the carpet. It's 4 p.m. and I sit here staring out the window, watching the Arctic tundra freeze up and fall prey to the start of another long winter. I find myself wondering… "How did I get here?" One of two RNs servicing the tiny remote outpost of Old Crow, Yukon. There are 250 amazing people living off the land to a large extent, and warmly opening their hearts and lives to me… a relative stranger, who has been given the opportunity to spend a period of time amongst their community learning their practices and enjoying their lands.

I'm into travel nursing, something I knew I wanted to do from the very first term I spent in the BCIT nursing program. When I was a little girl, about 11 years old, I went on my first backcountry hiking trip with Girl Guides of Canada and some VERY adventurous leaders. I read a quote shortly before I left from a now famous person named J.R.R. Tolkien. *"Not all those who wander, are lost."* I thought to myself, I like that. I like it a lot. This saying has become a motto for my life.

Over the past seven years I have done multiple work contracts with various government and private agencies all over B.C.'s remote northern and coastal areas, as well as the entire Yukon Territory. I have started to venture into Nunavut and other areas of the Arctic this past year. Along with these remote nursing experiences, I have taken my skills with me on various high-altitude mountain trips, looking after teams of climbers in the remote corners of our planet. I've also been fortunate enough to provide volunteer and disaster response nursing services in Africa and Haiti.

My "real" job is as an emergency department nurse at Lions Gate Hospital in North Vancouver. I love the combination of a fast-paced urban trauma centre, with all the services and supplies I could dream of and remote outpost clinics that test my skills and resourcefulness. People often ask how I got into the lifestyle of nursing that I have chosen. The answer to that question is definitely a combination of things. The presence of extremely supportive, as well as motivational people along the way, play a huge role in my choices.

After finishing my BSN, I quickly began pursuing my emergency nursing specialty and my remote nursing certification. After a few years of dedicated study and a steep learning curve, I began to feel more confident and comfortable working in remote and isolated areas.

Why the nomadic and wandering lifestyle? People have asked me what I'm running from… to which I often answer, I'm not running from anything. In fact, I'm running to something; the amazing experiences and people that have enriched my life beyond my wildest dreams. Looking after tragically sick children in Haiti, and wondering if they will survive after I leave them with the Haitian health care system, knowing I've done everything in my limited power to help them. Trying to help my friends breathe, rehydrate and remain calm in the mountains when they are suffering the ravaging effects of altitude on their physiology. Using a translator to understand the symptoms a First Nations elder in the northern Yukon is experiencing and trying to treat her while incorporating her traditional beliefs and medicinal practices. Learning to enjoy various preparations of fish, berries, meat and other local fare as thank yous and offerings at community feasts, while taking in the gorgeous raw landscape on which these peoples are surviving. With every contract, volunteer aid trip and adventure comes a new desire to see what's around the next corner. As I bridge my passions for the extraordinary with my desire to settle and have a family, I find that the path is a little less clear. Nevertheless, where there's a will there's a way! (My mother always said). So, now I look forward to many more years of nursing, travelling, exploring and growing with a family that is as eager to see what's next as I am!

Dwell in possibility!

NENA AT WORK

Letter to the President

Good evening Sharron,

Please accept my sincere appreciation for the wonderful surprise of the NENA Honourary Lifetime Member and your letter. It was extremely touching to receive such recognition. I always felt that it is the members we honour as they continue to belong to our organization and who have the courage to represent our specialty on the world stage.

Yes, a lot of great moments were achieved over the years, but nothing could have happened without the hard work of the board and NENA's members. I was extremely fortunate to be a part of the board with many great leaders. To see the growth over the years is a pure joy. To see the collaboration with other professionals, how can we not succeed to expand our specialty? To be seen and looked to for our skills, knowledge and most of all our spirit, passion, and love of emergency nursing is AWESOME!

I greatly miss my role in emergency nursing, but will forever stay involved in any way I can. Great NENA leaders have come before me and after me, and I am forever grateful to have been part of such incredible leadership.

Once again thank you, Sharron. Take care and bonne chance.

Love, Louise Leblanc

Streaming in the emergency department: An innovative care delivery design

By Sherri Morrish, RN, MSN

Emergency departments (EDs) in urban settings are experiencing extreme challenges such as overcrowding, long wait times, and patient dissatisfaction (Kelley, Bryant, Cox, & Jolley, 2007). Emergency department overcrowding is defined as a situation in which ED function is impeded by the fact that the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure exceeds the physical or staffing capacity of the department (Forero et al., 2010). The literature on ED overcrowding, which comes primarily from the United Kingdom and Australia, demonstrates that the problem represents an imbalance between the supply of resources and demand for service. Moreover, this supply-demand imbalance is influenced by a complex web of internal and external factors (Darrab et al., 2006; Devkaran, Parsons, Van Dyke, Drennan, & Rajah, 2009; Kelley et al., 2007). Internally, there are factors such as the difficulty of inpatient discharges; externally, there is a lack of family physicians and walk-in clinics, limited hours of clinics that do exist, an aging population, and the closing of small rural hospitals. Overcrowded EDs are linked to a higher risk of poor outcomes, including increased wait times, patient dissatisfaction, staff frustration, and patient mortality (Darrab et al., 2006; Forero et al., 2010; Kwa & Blake, 2008). This situation leads researchers and health care leaders to look for solutions, as they examine the flow of patients into and out of emergency departments.

That flow begins at the triage desk, and the triage nurse's decision about the patient's acuity. This decision is made within the framework of the Canadian Triage and Acuity Scale (CTAS), which is used in many countries as a system to assign a level of acuity to all patients who arrive at triage (Bullard, Unger, Spence, & Grafstein, 2008). Patients are scored on the CTAS from Level 1 (most acute) to Level 5 (least acute). Level 1 patients should be seen immediately by a physician upon presentation at the emergency department. Examples of a CTAS Level 1 is a patient in full cardiac arrest or severely injured. Level 2 patients include those having an acute heart attack, sepsis, active suicidal thoughts, or severe shortness of breath. Level 3 patients display such things as depression, headaches, abdominal pain, and potential miscarriage. Levels 4 and 5 include extremity fractures, sutures, coughs and colds, and back pain. Many factors influence CTAS scoring, and health care providers using the CTAS must be experienced and well trained.

In many emergency departments, care delivery for Level 1 and 2 patients takes place immediately by trauma-trained physicians and nurses. Levels 4 and 5 require straightforward care, and they are often seen in a minor treatment clinic (MT) or fast-track clinic (FT) located near or in the main ED. Level 3, moderately acute ambulatory patients, still pose a challenge for efficient, effective care delivery, and many potential solutions for overcrowding have focused on this level. One solution, in particular, and the focus of this study is a special unit within the ED for these moderately acute ambulatory Level 3 patients.

Several names have been given to such units, including "streaming units" and "rapid assessment zones (RAZ)." For the purposes of this study, we will refer to them as streaming units. Streaming units redesign the flow of moderately acute ambulatory Level 3 patients through the ED in order to decrease wait times without decreasing the quality of care (KGH Streaming Project Material, 2007-09). These streaming units are embedded in a separate area within a functioning urban ED, but are often viewed as a parallel system with dedicated staff and resources. In this way, they are similar to fast-track (FT) and minor treatment (MT) clinics, which are located within (or very near) the main ED and care for patients with urgent, but less-serious conditions (Finamore & Turris, 2009; Quattrini & Swan, 2011). Both FT/MT and streaming units function by moving patients in and out of chairs and only putting them in exam rooms for assessment and treatment (Interior Health Authority, 2010; Kwa & Blake, 2008; Ieraci, Digiusto, Sonntag, Dann, & Fox, 2008). This process results in improved patient flow and shorter wait times (Quattrini & Swan, 2011). By redirecting selected patients out of the main ED, stretchers are also more readily available for patients in need of urgent care (Interior Health Authority, 2010).

In order to understand the complexities of streaming unit care delivery, I used a qualitative, descriptive approach: the single case study approach. Case studies can answer the "how" and "why" questions when the focus is an under-studied, contemporary phenomenon within a real-life context (Yin, 1994). Case studies rely on multiple sources of evidence. I used semi-structured interviews and departmental documents as my data sources.

Ethics approval was obtained independently through the University of British Columbia (UBC), as well as the Interior Health Authority (IHA) in the summer and fall of 2011. A total of 15 semi-structured interviews were done including the three key informants over a two-week period, starting January 15, 2012, and finishing on January 28, 2012.

My research was guided by the following research question: What structures and processes are most influential for successful outcomes in one urban ED streaming unit with respect to management of moderately acute ambulatory triage Level 3 patients? I used document analysis and interviews with staff, managers, and physicians, as well as analyzing department documents in order to obtain multiple data sources in hopes of gaining a rich understanding of one streaming unit.

Patient care is what mattered the most to those who were interviewed. "We want to treat people kindly and give good patient care." The physical space of the streaming unit, despite being small and cramped, only really mattered to staff when patient care and patient flow were interrupted and access to care was delayed. "It's fast-paced. Do I really want people to be in chairs? Not really, but when you balance it… do you want them to still be in the waiting room waiting or would you rather them be in a chair treating them… you need balance." Care delivery, to nurses and doctors, went beyond assessment and treatment of the patient; it included comfort, such as a warm blanket, having family present when space allowed, timely access to diagnostics, and offering a meal when appropriate. It involved spending time with patients, including one-on-one time. As one doctor put it: "I don't think streaming should take away from the amount of bedside time I have with my patients."

Communication—with each other and with patients—matters to staff. In fact, communication is a key ingredient to success for hospital X's streaming unit staff. For example, timely reassessment by physicians is important, and staff needs to update doctors on patient status and get them back to the streaming unit. Unit clerks play a key role in the communication chain and often "see and know all" that is going on within this busy area. Communication is also important to patients. They need and want to understand this new way of receiving care, and explaining the streaming unit protocol made patients more satisfied and reduced complaints. "We often see children first. The nursing staff sees most of the patients first, so they set the charts up with who is first. I don't look at the times, I take the first chart. We don't get a lot of pushback from patients. The nurses do a really good job of explaining to patients why you may not be seen before someone else."

Changing the way each staff member views emergency department care delivery matters. Care is going to "look different—it's not going to be tucked in and the most comfortable way to give care for nurses or patients. But the other side is not giving care at all." Not all staff like the streaming unit. As one informant said, "Buy-in is so important. Some staff members really enjoy it, the challenge of it, and there are others who just have a brick wall up against it. They skulk back." It is not for everyone, but over the past five years, as health care providers have learned how the streaming unit works, acceptance has grown. "I think in terms of utilizing the few examination beds we have to the greatest potential. It is a clever way to optimize the use of a few beds for many patients."

Teamwork matters. Hardworking staff members who strive to maintain the integrity of the stream and its flow improve the success of the system, as well as general staff morale. Working with the "rules" of the area allows care to be moved along smoothly, with everyone working as a team for best patient outcomes. Sharing power amongst the team is important, whether it is expressed as doctors changing linens or unit clerks and nurses seeking out MDs in other parts of the emergency department. Everyone pitches in to make it work.

For the streaming unit, understanding and following pre-determined processes allows for timely care delivery. Although these processes were originally outlined by the project team, many key stakeholders have since provided input on which processes are working and which need revisions. There have been no quick fixes using a teamwork approach. As the unit has evolved, changes are still documented and decided upon with a team approach. The tools and resources work because of inclusive approaches to revising and refining them. "There has to be a clear process; paper and charts, DI, lab, etc… so things can run smoothly each time."

Finally, staff thinks of the future. At the time of this research, a new emergency department was being built, which offers hope to those who will work there. It is a state-of-the art facility, but brings a new set of challenges. Staff members are confident, however, that they can overcome the issues put before them. According to the MD key informant: "The new space is a zone unto itself. As far as I know, it's the first streaming area built specifically for that. In any department in the world, quite frankly. So, it's a massive area. We were blown away… we are building for the future." At the time of this study, the facility had not yet opened, but an RN was clearly optimistic: "It addresses all the structural issues we have now. Although there is anxiety from members of the staff, they are hopeful that these will, once again, be reviewed, adjusted, and supported through a team approach, as part of the change process." Staff also spoke of the new department in very positive terms.

Implications for overcrowded urban emergency departments

In the literature, streamlined care for moderately acute ambulatory Level 3 patients has been presented as a stand-alone unit or as a combined unit for lower acuity (Levels 4 and 5) patients and Level 3 patients (Darrab, et al., 2006; Devkaran, Parsons, Van Dyke, Drennan, & Rajah, 2009; Ieraci, Digiusto, Sonntag, Dann, & Fox, 2008; Kelley, Bryant, Cox, & Jolley, 2007 & Kinsman, et al., 2008). This case study has shown what works well for hospital X's emergency department: three, interrelated ED services in close proximity to each other.

Innovative and streamlined emergency department care for moderately acute ambulatory Level 3 patients has arrived at hospital X. According to the key informant MD: "I believe this is just my line; this is the best thing that has happened to ED medicine. At least in my career. I think that every physician who has been around before and after would say that… It's the single most important thing in our department." Another RN key informant stated: "When did we know we were having success? Honestly, it was on day one. When I left that day, I didn't have 25 charts sitting there that were CTAS 3s that had not been seen. There were none. There was no one in the waiting room. We used to have 20 to 30, so we knew we picked the right project. We knew we would have to tweak it, but we knew we would never go back. This would be the way we would deal with ambulatory patients".

Emergency departments with long wait times for their moderately acute ambulatory Level 3 patients should consider the possibility of a streaming unit.

Hospital X's emergency department was chosen purposively as a research site due to its successful and long-running streaming unit. This site has pioneered streaming in British Columbia's Interior Health Authority. However, due to time limitations as a graduate student, the methodology was limited to two data collection approaches. Potential bias was limited by not researching in the site I work in, by taking field notes and doing reflective journaling, and by being aware that the purpose of this research was not to compare sites in any way.

A single-site case study lacks generalizability. Therefore, a multi-site case study analysis of emergency departments with different types of streaming units will help us understand the key elements necessary for successful implementation of a streaming unit. For example, studying a combined minor treatment/streaming unit with separate or stand-alone streaming units would be worthwhile. Looking at these ideas from quantitative, as well as qualitative methodologies would enrich the understanding of such units. Finally, I would like to see a pre-post intervention design or time series design to complement qualitative findings from document and interview analyses. I would also envision repeating this same study at hospital X in one to two years, following the opening of their new ED including their 50-chair, 12-bed streaming unit. This unit was built exclusively for streaming and includes all the key features staff felt were missing in the setting as it was studied for this research.

From this research, it is clear that streaming is improving care, patient outcomes, and staff satisfaction in hospital X's emergency department. This innovative care delivery design for moderately acute ambulatory patients is challenging the traditional paradigm of ED care, bringing positive changes in a complex health care environment. Timely care for ED patients through such innovative models as a streaming unit can save lives (Devkaran, Parsons, Van Dyke, Drennan, & Rajah, 2009).

About the author

I have been an RN for 20 years, graduating with a diploma in 1993, a BSN from Thompson Rivers University in 2005, and my Master's in Nursing from UBC Vancouver in 2012. I completed research and a thesis on ED flow (with a focus on ambulatory CTAS 3 patients) and improving access to ED care. Our health authority refers to our unit as "streaming"—that is, streamlining care of ambulatory, triage 3 patients. I completed a qualitative, descriptive study with 15 staff interviews at one hospital.

I am the Clinical Practice Educator (CPE) in the Emergency Department at Royal Inland Hospital in Kamloops, B.C. Our busy, tertiary ED sees close to 60,000 patients per year of combined adult and pediatrics.

I have been married for 20 years and have two lovely daughters: Anna, 14, and Victoria, 7.

CJEN Bouquets

Ottawa, Tuesday, March 5, 2013 — The Canadian Nurses Association (CNA) is recognizing 30 registered nurses (RNs) for their outstanding contribution to nursing and health care with Queen Elizabeth II Diamond Jubilee medals. The recipients from across the country were selected by provincial/territorial nursing colleges and associations and awarded their medals in a ceremony that included Health Minister Leona Aglukkaq, CNA president Barb Mildon and CNA CEO Rachel Bard.

"Congratulations to all the recipients of the Queen Elizabeth II Diamond Jubilee Medal," said the Honourable Leona Aglukkaq, Minister of Health. "Your outstanding contributions in nursing have earned you this great honour and set a fine example for others in your profession to follow. Please accept my best wishes for your continued success in serving Canadians and the health-care profession in such an exemplary manner."

Among the recipients are Heather Jewers and Landon Graham James. Ms. Jewers, an RN in Nova Scotia for 38 years, is currently an assistant professor at St. Francis Xavier University. With her specialty certification in palliative care nursing, she has provided education services to nurses, other health care professionals, patients and families as a nurse consultant with St. Martha's Regional Hospital in Antigonish. Mr. James, from British Columbia, began his career 15 years ago as an emergency room nurse. During that time he has led two different emergency departments and volunteered countless hours for the St. John Ambulance brigade and the National Emergency Nurses' Affiliation of Canada. As a leader in education, he's brought emergency education to nurses in previously under-served communities throughout B.C. and the Northwest Territories.

Queen Elizabeth II Diamond Jubilee Medal awarded to nurses across Canada

On March 5, 2013, 30 registered nurses from across Canada received a medal in honour of the Queen Elizabeth II Diamond Jubilee. The medals honour Canadians who have dedicated themselves to the service of their fellow citizens, their community and their country. Among those recognized for their outstanding contribution to nursing and health care is Past President Landon James. Landon truly represents the best in nursing leadership, commitment and passion in the profession of nursing. Congratulations to all the recipients: Theresa Agnew, Pam Archibald, Elsie Duff, Wendy Duggleby, Lisa Guidry, Natalie Hache Losier, Landon Graham James, Leah Jamnicky, Heather Jewers, Heather Johnson, Heather Keith, Janet Lapins, Patrice Lindsay, Lenora Marcellus, Donna Mendel, Thelma Midori, Mary Morris, Donna Murnaghan, Bernadette Pauly, Brenda Poulton, Sandra Reilly, Josephine Santos, Barb Shellian, Tracey Taulu, Anna Tumchewics, Ardene Vollman, Ruth Walden, Karen Wall, Beverly White and Lorraine Wright.

International Exchange Program (IEP)

The National Emergency Nurses' Affiliation has been invited to participate in the ENA Foundation International Exchange Program (IEP), which includes a collaborative relationship between ENA Foundation and the National Emergency Nurses' Affiliation (NENA Inc.). The emergency nurses will gain intercultural competence through integration into their host institution and host culture while exploring the international dimensions of emergency nursing. The emergency nurses involved in the exchange would plan to host an emergency nurse from the visiting country for a period of one week.

The IEP offers emergency nurses the opportunity to experience and develop collaborative international relationships to improve emergency nursing practice, education, research and cultural competence. The IEP also presents an opportunity to compare different health care delivery models and to develop process improvement plans to address challenges faced by emergency nurses everywhere.

The ENA Foundation IEP provides a scholarship for ENA members for airfare and incidentals up to USD $1,000.00 for the one-week exchange. NENA Inc. members will be given a scholarship of $1,000.00 Canadian for airfare and incidentals for their one-week exchange.

How does the International Exchange Program work?

The program allows for two (2) successful applicants per year to be matched with an emergency nurse from the U.S. To help in this process, NENA will collaborate with provincial directors and hospitals from across Canada to assist emergency nurses with identifying those interested in participating in the IEP. Participants will make arrangements to host an emergency nurse from the U.S. on a reciprocal basis.

Scholarships available

A total of two scholarships will be available in 2013. Each scholarship will be of a maximum value of $1,000.00 to defray transportation costs. Accommodations will be provided by the respective host. Scholarship applications for 2013 are available.

For further information or questions, contact **president@nena.ca**

International Exchange Program—Requirements

An applicant must

1. Be a current member of NENA
2. Provide a copy of a current, unrestricted Canadian registered nursing license
3. Provide a letter of support from their emergency department director/manager
4. Agree to participate in the development of an article for publication in the *Canadian Journal of Emergency Nursing* (CJEN)
5. Be willing to host or arrange for hosting of the colleague from the exchange country in return
6. Have a valid Canadian passport
7. Have valid medical health, travel or worldwide liability insurance.

Guidelines

- International exchange participants will shadow a hosting emergency nurse while in Canada
- Any contact with patients while in the host country will be under the direct supervision of clinical staff in the host country. Participants will have no direct responsibility for patient care while in the host country
- Participants will abide by the policies of the host hospital while in the exchange country
- Participants are expected to facilitate the professional hosting experience of the visiting exchange nurse
- Participants are expected to plan how they will host their colleague from the exchange country
- Participants will be ambassadors for Canadian emergency nursing and NENA Inc. while in the exchange country
- Participants will be expected to write a summary article (500 words) or engage in an interview with NENA Inc. Editor to share the impact of the exchange program
- Applicants are responsible for making arrangements for proper international travel, health care and liability insurance
- Travel must be completed by December 31, 2013.

Review process

The president of NENA and two members of the NENA board will review and score applications. Applications will be evaluated on factors such as the completeness of the application, preparation for hosting an international colleague and the extent to which they have prepared their employer for the exchange.

Disclaimer

NENA is not liable for any health-related and nurse-patient (professional) issues in the framework of the International Exchange Program.

For information or questions, contact: **president@nena.ca**

International Exchange Program—Application

First Name:_____ Last Name: _____

Mailing address: _____

_____

E-mail address: _____

Place of work: _____ Position held: _____

NENA Member: ❑ Yes ❑ No

Describe your professional/clinical goals (bullet points are acceptable):_____

_____

_____

_____

Describe your personal goals (bullet points are acceptable):_____

_____

_____

_____

Will you host the exchange emergency nurse at your home? ❑ Yes ❑ No

If no, whose home? _____

Checklist

Copy of current registered nursing licence
Letter of support from emergency department director/manager
Copy of valid Canadian passport/if driving across border Enhanced Drivers' Licence
Copy of medical coverage for travel

Submit application forms and accompanying documents to: president@nena.ca

Serendipity leads forensic nursing to the Yukon

Sheila Early

According to Wikipedia, serendipity refers to "the accident of finding something good or useful while not specifically searching for it" or "a happy surprise". A chance meeting with Deborah Crosby at the 2011 International Association of Forensic Nurses (IAFN) Scientific Assembly in Montreal led to such a happening. Deb is the nurse in charge of a primary health care centre in Carmacks, YT, serving a population of more than 500 people. She is a member of both NENA and IAFN. She has also worked as a sexual assault nurse examiner in Ontario. She approached me after attending a session on nurse examiner programs, which I co-presented. She was interested in the most current practices in the forensic nurse examiner role, as she often is called on to perform examinations in her centre. She asked if it would ever be possible to have a nurse examiner course delivered in the Yukon. We both went on our way. However, I was impressed with her enthusiasm and desire to improve the services provided to those who have sexual violence in their lives.

Through Deb, I was linked with Dr. Anne Williams, a medical practitioner in Whitehorse, Yukon. Dr. Williams is part of a Sexual Assault Response Committee (SARC), a community-based multidisciplinary committee committed to working to develop a community response to sexual violence. To make a long story short, in September 2012, Janet Calnan (NENA President Elect) and I went to Whitehorse and delivered the British Columbia Institute of Technology (BCIT) Nurse Examiner Adult/Adolescent Core Education: Theoretical Aspects course. The 45-hour, three-credit course was delivered over six days with 13 registered nurses attending from various areas of the Yukon. A nurse practitioner from Manitoba also attended the course. Jan and I also did a four-hour workshop for medical practitioners on child maltreatment and adult/adolescent updates in sexual violence. In less than a year, this first-ever course in the territories came to fruition. A "happy surprise" indeed! Our gratitude goes out to the SARC committee for this wonderful educational opportunity.

The course was held at the beautiful Kwanlin Dün Cultural Centre on the banks of the Yukon River where we were able to watch master carvers carving a totem pole. We were also featured on CBC radio, CBC TV "Northbeat" and in the Whitehorse Star newspaper. The goal of these media events was to create community awareness and support for the SARC committee as it moves forward with its response to sexual violence plan.

We were also able to visit the Whitehorse General Emergency Department and then another serendipity moment... the emergency physician on duty was one of the Regina Pasqua Hospital Emergency Department interns from my days there as an ER nurse!

Deb also acted as our tour guide both in Whitehorse and on a day trip to Kluane National Park and Reserve, which took us through spectacular scenery mile after mile on the Alaska Highway. The highlight was Sheep Mountain, where Deb's eagle eye spotted flocks of Dall sheep... on Sheep Mountain! The Kluane Lake, which is the largest lake in the Yukon, offered colours that were ever changing and made you hold your breath in awe.

This is the short story of how two long-standing NENA and IAFN members (who also happen to be two of the four co-founders of the Forensic Nurses Society of Canada [FNSC]) were able to bring forensic nursing concepts to the Yukon. The SARC committee is moving forward with the last steps to implement the coordinated response to patients who present for care following sexual violence.

Our thanks go out to many: Deborah Crosby for her unwavering desire to bring a nurse examiner course to the Yukon; to Dr. Anne Williams for her time, energy and support, which led to making this course actually happen; to Kwanlin Dün Cultural Centre for its lovely facility; to Christina Sim, street nurse with Kwanlin Dün, for her coordination of the course logistics; to every course attendee; and special thanks to Janet Calnan, my co-instructor.

Reference

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One nurse's story

Assuming… wow, did I just start with that word? That is the one word that I never use, as an emeregency room nurse but, for this next question, I feel it's safe. I assume that, as a nurse, in general, the single most asked question you get is, why did you want to become a nurse? Am I wrong in this assumption? I think not. My thought on this is that most nurses don't have one concrete answer, but have more of a time of arrival. You see, nursing is not a job or career, but a true calling. I seldom ask people why they chose their profession when they say they are teachers, lawyers or doctors and seldom hear others ask why of these other types of professions or occupations. This is because most people can see themselves doing some other person's work, but I have heard no one tell me they would love to do my work. They do tell me often that, "I could never do your job, it takes a special kind of person". Nurses do not see it, because it is who we are. I did not choose to become a nurse, I was born a nurse.

My arrival took a little time, as I practised my craft of caring long before formal training. I was the shy, cautious boy who always seemed more sensitive to the needs of those around him. I picked the kid on the playground who no one wanted on their team. Although a "jock", somewhat popular, I always had a group of friends who were not so popular and "nerdy". Little did I know that would equate to "Rulers of the Universe" 30 years later. But I am proud to say that I put it in writing in my grad bio in high school that my biggest "pet peeve" was "people who put down others". Looking back, it made sense.

At 14, I first became engaged by my calling, with a feeling of bewilderment and pure adrenalin. Walking to soccer practice one vibrant summer day, I had the misfortune of witnessing a pedestrian-automobile collision. An elderly gentleman (at least to me at 14) was walking across the street and was struck by an oncoming truck causing the gentleman to fall to the street and strike his head off the curb. I was walking right by this scene and without pause ran to the man's side, pulled my jersey from my bag, and applied pressure to his freshly bleeding and opened scalp. The police and ambulance services arrived within minutes (two hours to me) and whisked the man away, and the police went on to speak to the driver of the truck. I stood alone for a brief moment and vividly remember the feelings and thoughts that went through my body. "Wow! That felt amazing, hope he is okay, wow! I saved someone, I feel warm all over, wow. I love this feeling!"

From there, it was on to high school, where I became more of a "jock" attaining the honour of being appointed the male athlete of the year. Of what significance is this? Well, you trying telling your guidance counsellor in 1985 that you are thinking about becoming a nurse after high school. I remember being told something like, "You wouldn't be good at that, you are a great athlete, you should be a gym teacher." Must have had something to do with the stigma of homosexuality and it being a pre-requisite, I suppose. Well, I enrolled in university not knowing what I was going to do. Struggled and had fun, because deep down inside I knew what it was for me to do. So, I dropped out of school for a few years and worked a little on my self-confidence, and then, at 25 years of age, I thought, "Well, who the heck has the right to hold me back from the thing in life I am meant to do?" I enrolled in the Salvation Army Grace School of Nursing in 1992 with the goal of honing my "jagged wings" of caring and polishing them up for the next chapter of this journey.

Now, I am proud to say that "I am a registered nurse" working for more than 18 years on the front lines, mostly in the emergency room. I still get asked often why I became a nurse. The truth is, at the risk of sounding quirky, in the words of Lady Gaga, "I was born this way!"

Thank You
Todd Warren, RN
NENA Inc., NL Director

Communicating with patients who have dementia

By Cathy Sendecki, BSN, RN, GNC(C)

Communicating with patients with dementia in the emergency department (ED) can be challenging; getting and giving information effectively often takes longer than with cognitively intact individuals. These patients may have a diagnosis of dementia, or we may identify this in the ED.

Dementia is an umbrella term for a variety of brain disorders, with symptoms including loss of short-term memory, judgment and reasoning, and changes in mood and behaviour. Brain function is affected to the extent the person loses abilities to function in everyday activities, but the needs for identity, attachment, inclusion, and comfort are preserved. Alzheimer's disease is the most common form of dementia. In general, dementia is a progressive condition. This article refers to those with moderate to severe dementia.

In 2011, it was estimated that approximately 9% of Canadians aged 65 years and older had dementia. By 2031 that number is expected to double. Although individuals younger than 65 can develop dementia, it is more prevalent with increasing age. The risk for dementia doubles every five years after the age of 65. Overall, more women than men are diagnosed with dementia.

How can we provide effective, timely, respectful care to these patients?

- Once we have established that the patient is hemodynamically stable, we need to know if he has any change of mentation from baseline. If a caregiver is present, she may be able to describe any recent changes, or indicate if this is his usual behaviour.
- Although we may be inclined to speak with the patient's companion, remember to speak first to the patient. Although his short-term memory may be poor, he may be very attuned to emotions and non-verbal cues, and will generally appreciate being greeted as any adult, by name, rather than a term of endearment.
- A calm, friendly approach can be the start of a cooperative interaction.
- Ensure the patient knows you are speaking to her. Hearing or vision may be impaired. Be visible, with the light on your face, rather than behind you. Establish eye contact.
- Observe for signs of understanding. If necessary, try restating the message. If at all possible, have a quiet, calm environment, so the patient is not overwhelmed by noise and other stimuli.
- Short, simple statements will be easier to understand: "Does your arm hurt?", as you touch one arm, rather than asking "What happened?"
- Ask one question at a time, or give directions one step at a time. Ask questions with a yes or no answer, or two choices.
- Give the patient time to respond. Prepare him when a new topic is introduced. Tell him what he can do, not what he cannot do.
- Use names of persons or things, not pronouns.
- If this patient is no longer able to understand speech, she may understand gestures. Speak in an encouraging tone.
- The patient with dementia generally is aware of what she feels now, and cannot recall dealing with this in the past, nor what she has been told a few minutes ago. Reminding her, "don't you remember? I just told you not to touch your IV; you told me you wouldn't" will convey displeasure rather than helpful information. On the other hand, going back a few minutes later to offer more fluids or another spoonful of crushed medication in applesauce may be surprisingly successful.
- Avoid trying to convince her she is wrong; focus and acknowledge the feeling expressed, for example frustration, and help her to deal with this.
- Distraction and redirection may help, perhaps physical activity, which also provides an opportunity for assessment of mobility.
- Emergency nurses are adept at assessing non-verbal cues—use this skill as you assist a patient to move, or compare ease of movement in the uninjured limb to the painful area.
- While the patient may not be able to describe pain, or even respond to questions about pain, a change in behaviour when the painful area is touched, or reluctance to move in certain ways provide clues.

A comprehensive guide, *Pain Assessment in the Patient Unable to Self-Report*, by Kunz et al., 2009, is available online at **www.aspmn.org**. The *Pain Assessment in Advanced Dementia Scale (PAINAD)*, available at **www.healthare.uiowa.edu** and other sources, is useful when ongoing pain and management are issues.

Not long ago, I was reminded of some of these challenges and opportunities: I went to see a woman in her late 80s who had come a few hours earlier by ambulance. The notes indicated she had gastrointestinal symptoms, and could not remember ever feeling as bad as she did this morning. I expected to find a woman in distress with pain, nausea and dehydration. To my surprise, she was sitting up on the stretcher, smiling, her nearly finished IV infusing well. By this time, she had no more symptoms, and described to me that she had been brought to hospital

by mistake. Her only concern now was to go home. I assured her we could help her with this request. Once we found she was tolerating her oral fluids, obtained a urine spec, and started her on antibiotics for a UTI, we were able to arrange her discharge, with a referral to Home Health to ensure she had appropriate support to manage well.

Caring for seniors with dementia is not often this simple, but the reward is in finding which techniques help us to make contact with the person, and communicate that we are doing our best to help.

About the author

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

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Identifying emergency-sensitive conditions for the calculation of an in-hospital standardized mortality ratio specific to emergency care

By Simon Berthelot, MD, CFPC(EM), FRCPC, Eddy S. Lang, MD, CFPC(EM), CSPQ, Hude Quan, MD, PhD, Henry T. Stelfox, MD, FRCPC, PhD, On behalf of the Panel on Emergency-Sensitive Conditions (PESC)

Introduction

The *Canadian Institute for Health Information* (CIHI) provides annual *Hospital Standardized Mortality Ratios* (HSMR) for each Canadian hospital. As a first step to developing an ED HSMR variant, we identified diagnosis groups (DGs) where high-quality emergency department (ED) care would be expected to reduce in-hospital mortality (emergency-sensitive conditions).

Methods

We used a two-step approach to identify emergency-sensitive conditions:

1. Using a modification of the RAND/UCLA Appropriateness Methodology, a multidisciplinary national panel of emergency care providers and managers (n=14) serially rated DGs included in the CIHI HSMR (n=72) according to the extent that ED management potentially decreases mortality.
2. The DGs selected by the panel were sent to members (n=2,507) of the *Canadian Association of Emergency Physicians* and the *National Emergency Nurses Affiliation* for evaluation. Using an electronic survey, they were asked to agree or disagree (binary response) with the panel classification.

Results

The expert panel rated 37 DGs (e.g., sepsis) over three rounds of review as having mortality potentially reduced by ED care. In addition, panelists identified 40 DGs (e.g., stroke) where timely ED care was critical, 43 DGs (e.g., atrial fibrillation) where ED care could reduce morbidity and 47 DGs (e.g., bacterial meningitis) not included in the Canadian HSMR, as diagnoses whose mortality could be decreased by ED care. Of the 37 DGs selected by the panel, 32 were rated by more than 80% of survey respondents (n=719) to be emergency-sensitive conditions for mortality. The level of agreement was above 68% for the five remaining DGs.

Conclusion

We identified 37 DGs representing emergency-sensitive conditions that will enable the calculation of an in-hospital standardized mortality ratio that is more relevant to emergency care.

Department(s) and institution(s) to which the work should be attributed

Department of Community Health Sciences, University of Calgary, Division of Emergency Medicine, University of Calgary, Institute of Public Health, University of Calgary.

Call for nominations: "secretary" and "treasurer"

Are you interested in serving on the board of directors? Then read on—this year there are two available positions. The secretary position is a two-year term. Due to policy revisions, the term of treasurer will be four years. Both positions would begin July 1st, following the announcement of election results. The board of directors meets twice yearly. Both meetings are three days in length. Typically, the spring meeting, though, is held in conjunction with a regional or national conference, so time away from home is usually longer.

As secretary, you are expected to carry on the affairs of the corporation under the supervision of the officers of the board. You are expected to attend all meetings and to record all votes and minutes from these meetings. You will ensure that all board members will receive board meeting minutes in a timely fashion and, as well, you are responsible for producing the incorporated minutes. You will set the agenda for the board meetings in collaboration with the president. There may be additional duties that would be assigned to you by the president.

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

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

NENA executive positions

Positions:

- **Secretary, Two-Year Term**
- **Treasurer, Four-Year Term**

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

_____

for the position of

_____

on the NENA executive.

_____

(nominee) is in good standing with NENA.

1. Name: _____

Date: _____

Signature of nominator: _____

2. Name: _____

Date: _____

Signature of nominator: _____

I, _____,

do hereby accept this nomination for the position of

_____

on the NENA executive.

Signature: _____

Date: _____

Please return this letter of intent and CV, by April 17, 2013, to:
Jan Spivey, 112 Old River Road, RR2, Mallorytown, ON K0E 1R0
e-mail: nominations@nena.ca

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: _____

NENA Award of Excellence application form

Forward all submissions to the provincial representatives by April 20 of each year. Incomplete or late applications will not be eligible for consideration. Successful candidates will be presented with awards at the annual general meeting. In order to facilitate the process of the applications, the nominator will involve the nominee in the submission and verification of information.

Award of Excellence in: _____

Nominee: _____ Address: _____

_____ Postal Code: _____

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

E-mail: _____

Employer: _____ Current position: _____

Nominator: _____ Address: _____

_____ Postal code: _____

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

Letter of support (1) from: _____

Letter of support (2) from: _____

Signature of nominee: _____

Signature of nominator: _____ Date: _____

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