CANADIAN JOURNAL of EMERGENCY NURSING

JOURNAL CANADIEN des INFIRMIÈRES D'URGENCE

THE OFFICIAL JOURNAL OF THE NATIONAL EMERGENCY NURSES' AFFILIATION

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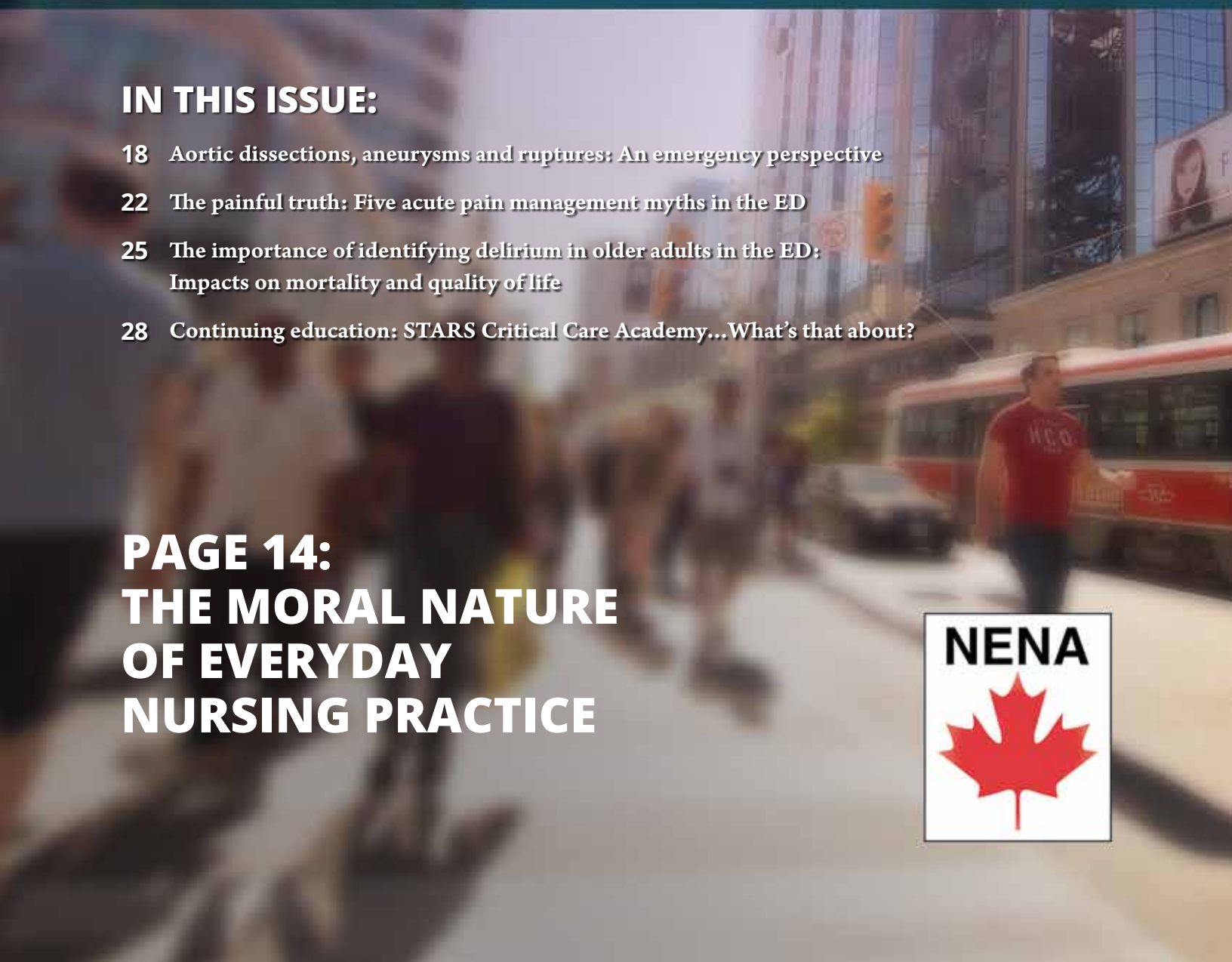

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NENA

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), layout on 8½″ × 11″ paper with standard margins. Manuscripts must be submitted in Word or Word Perfect and sent electronically to the communications officer at **communicationofficer@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 unless prior arrangements have been made.

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: **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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Editorial staff

NENA elected executive

Provincial directors

Committee chairs

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President's message

The season of spring brings new transformations of many kinds. As the temperature across our nation warms up and we shake off the winter blues and Mother Nature's last few months of freezing surroundings, our lives, as well as our surroundings are fresh and new. Spring is a time of new beginnings and we need to adapt to the changes in the environment, as well as in ourselves. What better impetus to change than spring.

As you have read in previous editions of our *Canadian Journal of Emergency Nursing (CJEN),* NENA must comply with new regulations under the Federal Not-for-Profit Corporations Act. Your NENA Board is adapting to the change of seasons and the change in requirements for professional groups with a major change in our structure and dramatic change in our direction. We are very confident that creating positive outcomes will freshen and renew our organization.

Your Board spent an entire day with a facilitator prior to our fall Board meeting in Ottawa, learning how to renew and create a progressive direction for NENA and its members. Following this session, we felt a new sense of purpose. We have developed a strategy in the months since then, and we will present it to you fully at the conference in Toronto and on the new website.

So, how are we demonstrating this new direction? Our first proposal is to change our name, National Emergency Nurses' Affiliation to National Emergency Nurses Association. Our intent with this change is to reflect a sense of unity and to communicate that we are not merely 10 separate affiliate groups, but ONE group—strong and purposeful, working together to create both standards and positive outcomes for emergency nurses.

Secondly, the Board has been convinced for some time that our organization needs a better way of communicating so that emergency nurses know what is happening across Canada. Patches to the old website, though many, have been inadequate. To that end we will be launching a new website on a new platform. We are optimistic that this will improve the ability of our members to acquire information and share ideas. Watch for its launch at the NENA conference.

Thirdly, the Board of Directors has been revising position statements, policies, and standards to reflect existing evidence-based practice. Many of you know that revisions are made biennially, but we are committed to revising all documents this spring and remaining current with Canadian standards and global research.

Finally, in moving towards the Federal Government's mandates for professional organizations such as ours, we have been redeveloping our bylaws. The bylaws' changes will align NENA with current recommended governance structure to promote transparency and streamline operation of not-for-profit groups. You will see the summation of our work when the new website becomes active and the new bylaws are presented for your vote.

We believe this collection of proposed changes and updates will better support and define our practice as emergency nurses. In clarifying our positions and consolidating our efforts more effectively, I am confident we will ultimately provide benefit to all emergency nurses and to our patients, as well.

Emergency nurses are open, creative, and innovative. We are not content to drift with the status quo. It is my belief that there is none better to consider how NENA should move forward than the membership.

As NENA members, you can ask, "How can I make a difference?" The answer is clear. Our members set the tone of this association; you make or break our team. It is your attitude that helps set the direction of our profession. So, SPRING into action, help us to help you, it's your choice.

See you all in Toronto April 27–29, 2014, at the NENA National Conference/Pan-American Conference "Connected by Caring Across the Americas".

Janet Calnan,
NENA President

Communication Officer's message

A team of website developers has been working since mid-November to completely redesign the appearance and function of the NENA website using cutting-edge technology. This team has taken all of the ideas and concerns of the membership and the board, and tried to incorporate our suggestions into an attractive and highly functional web presence for NENA. Some of the features members requested include: more intuitive search ability, streamlined organization to facilitate searches for contacts, course information, affiliate information, archived information and journals, position statements and other documents, working links to social media, and more functional registration/renewal and password reset processes.

Initially it was expected that current information and aspects of current design could be imported from the existing site, but that has proven impossible and designers are building from the ground up. This means that all members will have to enter the website at least once to re-enter their membership information and set a new password.

The NENA board will do extensive testing of the website to catch any details that may have been missed. The technical team will be immediately available to correct or add to the design if we find omissions or errors somewhere between planning and execution. Special thanks are due to NENA's Janet Calnan and Sharron Lyons and to Tim Feher of Mission to Vision Communications and his team for hours of work on this project. An April launch date is anticipated.

When I was first elected as communication officer, I had two goals: to build on the work of Val Eden, Colleen Brayman, and Pappin Communications to produce a quality print journal, and to make the website something of which we can be proud. I am looking forward to formally announcing completion of the new website at the AGM in Toronto.

Stephanie Carlson,
NENA Communication Officer

Treasurer's report

What a learning curve the last few months have been as the incoming treasurer. I have been busy becoming familiar with how things work in NENA, as well as acquiring a new accounting language. This role is a work in progress, as there is always something new to learn. As I become more familiar with this role in the future, I will have a more detailed report.

In my life outside of NENA, I work full-time hours in a casual position, and I enjoying spending my free time with my husband and our two daughters. I hope to see you in Toronto at the conference. If you ever have any questions, please feel free to contact me at **treasurer@nena.ca** and I will do my best to respond.

Sincerely,
Jane Daigle
NENA Treasurer

NENA AT WORK

Children and the dangers of miniature detergent packs

By Sharron Lyons, BC

I was working in the urgent care area of our emergency department when a parent presented with a three-year-old child who had blistering to his upper chest area and the fingers of one hand. The parents stated they did not know of any burns. However, earlier that day the child was in the laundry room playing with a detergent pack, when he put it in his mouth and bit it. The mom had wiped his chin and hand, but did not flush the areas or remove his shirt. She noticed the blisters a couple of hours later. The child was diagnosed with several small second-degree burns to his upper chest and two fingertips. Both parents were very upset they had failed to realize how dangerous these new detergent packs can be.

These dishwasher or laundry packets are small, brightly coloured and squishy, which makes them very attractive to children. The ingredients include powerful cleaning agents and may cause harmful health effects if ingested or left on the skin.

Consumers who use the miniature detergent packs should store them on a high shelf or in a locked cabinet or drawer. If a child does break or ingest one, flush the area immediately and call Poison Control for further advice.

Health Canada is aware of these types of incidents and has issued a warning to consumers and parents.

Bouquets

• Sharron Lyons has been appointed to be the Chairperson for the National Emergency Nurses' Affiliation (NENA) National Conference for 2015. Sharron was selected based on her long history as an emergency nurse and an active member with considerable experience in conference planning. Joining Sharron are these members who have expressed an interest in helping bring about yet another fantastic national conference.

Sharron Lyons: Sharron_lyons@telus.net
Shelly Pidruchney: shellyp55@shaw.ca
Navkiran Tiwana: navkiran@ualberta.ca
Jane Daigle: jd-06@hotmail.com
Pat Mercer-Deadman: pat_mercerdeadman@yahoo.com
Margaret Dymond: Margaret_Dymond@albertahealthservices.ca

Thank you to this great team, we look forward to hearing from all of you.

• **The following nurses won awards and bursaries in 2013**
Lori Quinn – British Columbia
Andree Lineker – British Columbia
NENA Newfoundland
Sherry Uribe – British Columbia

• Did you know that NENA gives lifetime memberships to nurses whose lives characterize exemplary emergency nursing and service to NENA and all emergency nurses? The following nurses are our honorary lifetime members.

Tania Agnot Johnston – Manitoba
Jerry Bell – Saskatchewan
Ann Casey – Newfoundland
Anne Cessford – British Columbia_
Val Eden – Nova Scotia
Karen Johnson – Ontario
Karen Latosek – Alberta
Linda McCracken – Alberta
Carole Rush – Alberta
Louise LeBlanc – Ontario
Gina Dingwall – British Columbia
Betty-Lou Kindleman – Alberta
Lorraine Wuori – British Columbia
Donna Rae – Saskatchewan
Sandra Easton – Ontario
Bonita Bates – Ontario
Patricia Kasprow – Ontario

Congratulations to each of you.

News from the provinces

BC report

We have 160 paid members. We are continuing to try to attract more nurses to join our national organization.

Two web-based education sessions have been offered in our efforts to make education more accessible. BCIT sponsored our fall session with faculty discussing "New nurse transition into the emergency department". This was followed by Dr. Noah Alexander reviewing "Targeted temperature management post cardiac arrest". We are very excited to continue partnering with organizations to offer free sessions for emergency nurses. Dr. Alexander's presentation can be viewed at **http://bcpsqc.ca/blog/knowledge/nena-targeted-temperature-management/** by any nurse in Canada, courtesy of the BC Patient Safety and Quality Council.

H1N1 has arrived in BC just as predicted, and continues to cause stress in many hospitals. Many care facilities continue to experience norovirus outbreaks that result in stressors again for emergency departments and inpatient units.

Our provincial ambulance service is ready to launch a new electronic health record throughout the province and we are anxious to have it up and running for a smooth and clear handover with our colleagues.

Our province lost a valuable member of our emergency community when Tim Jones passed away unexpectedly on January 19, 2014. He was recognized provincially and nationally for his work with search and rescue and as a paramedic. The response from the local community and provincial and national leaders speaks to his influence in his field. Remember to thank and acknowledge your colleagues before the unspeakable happens and it is too late.

Submitted by
Sherry Stackhouse,
President ENABC

Alberta report

Happy 2014 from the flu capital of Canada! No laughing matter as the ERs of our province struggle with the multitude of patients with the flu or "flu-like" symptoms. The struggle throughout our province continues to be to give our patients the best care possible in conditions over which we have little control. Isolating multiple patients in our departments is virtually impossible and we look for creative solutions to these dilemmas. Please forward any suggestions you have found useful in your province's facilities.

NENA-AB has had an increase of membership numbers from 138 in July 2012 to approximately 240, an increase that we are very pleased about. We continue to strive not only to increase our membership, but also to keep those who do join by maintaining their interest and involvement. In a province with more than 3,000 emergency nurses, we feel this is a priority goal for our group.

In September, we held our AGM in conjunction with a "free" for members education day. We had an attendance of 30, which I found to be disappointing, so we are now faced with how to increase attendance to our functions. The education topics all received very positive evaluations. Our AGM was successful in that we have secured a new secretary, treasurer and a president-elect who will assume the president position in July 2014. We also have had five volunteers to be "members-at-large". These members are from around the province, both in rural and urban settings, so they can be our eyes and ears to help us truly reflect the wishes of our entire provincial membership.

At the AGM we also introduced our revised constitution and bylaws that reflect our name change from ENIG to NENA-AB, as well as the welcoming of LPNs to join our group, with stipulation that they may not hold office.

Our newsletter is being sent out electronically to our members and a copy by post to each hospital in Alberta with emergency services. We are proud of this publication and continue to encourage submissions from our members.

We have given away two registrations with airfare to the NENA conference in April 2014, and we hope that this entices emergency nurses to join and reap the benefits of membership. One was given out at the AGM and one was raffled off at the Edmonton and area ER Nurses Night held on October 9. So far, there seems to be quite a number of Alberta nurses who are planning to attend in Toronto. There were more than 20 members who attended in Vancouver, so I am hopeful for a good turnout from our province. We are also excited with the initial planning for the 2015 NENA conference here in Edmonton.

Our goal of promoting the specialty of emergency nursing continues to be a challenge in light of the fact that our province seems to be set on the "de-skilling" of health care providers. This said, Alberta emergency nurses continue to rise to the challenges we face, giving our patients and their families the best care that we can.

TNCC, ENPC and CTAS courses throughout Alberta are ongoing and continue to have good attendance.

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

Manitoba report

Manitoba is an active part of NENA once again! The current board is looking forward to revitalizing EDNA and recruiting new members. We currently remain at 57 members.

Manitoba emergency nurses are awaiting the completion of the Sinclair Inquest, which will bring recommendations that will impact all of the ERs in the province. The inquest is due to wrap up in the spring. Our thoughts are with the ER nurses who have had to take the stand to testify. Another inquest is due to start in Manitoba shortly after the completion of the Sinclair Inquest. The media regularly

publishes information about the ongoing inquest or about the current state of the ERs.

Recently, the Winnipeg Regional Health Authority published the system targets relating to flow in emergency departments within the WRHA. The targets were for patients to receive the right care, in the right place, at the right time. The 2015 goals for WRHA emergency departments, as established by the board of directors are as follows:

- Treat and discharge 90 per cent of non-admitted emergency room patients within four hours
- Find a bed for 90 per cent of the emergency room patients who have been admitted to hospital within eight hours
- No patient, admitted to hospital or not, is to sit in an emergency department longer than 24 hours
- All ambulances are able to unload patients at hospitals within 60 minutes
- Ensure the number of non-emergency patients attending hospital emergency rooms does not exceed 20 per cent.

These targets will surely have great impact on how we do business in the ERs within the WRHA. All ERs are challenged to do more with less and to constantly be working "smarter".

Our challenges across the province are not unlike other provinces across Canada—overcrowding, ambulance offloads, lack of resources, lack of staff and physicians, and in the north and remote areas of the province, timely access to care. Much of Manitoba is still recovering from the impact of reducing the number of Regional Health Authorities from 11 to five RHAs 18 months ago. This restructured health care in our province dramatically.

The Manitoba premier has recently appointed a new Minister of Health, the Honourable Erin Selby. The "changing of the guard" inevitably brings new ideas and recommendations for the provincial health care system. These are challenging times for the emergency departments in the WRHA facing several inquests.

Emergency nurses are resilient! Despite the challenges of the ED environment, we continue to educate ourselves. TNCC is offered widely across the province with courses being run in some of the most remote areas. Despite the limited number of ENPC instructors in our province, four courses were run last year of the new 4th Edition. CTAS is also ongoing in all areas of Manitoba. The Advanced Emergency Nursing Course continues to be offered once a year to all ER nurses in the province whose level of experience is at a triage level. The WRHA Regional Emergency Program emergency orientation is also accessible to all provincial RHAs to educate new staff.

We are looking forward to spring in Manitoba, when the bitter cold has ended and the snow melts. With spring comes hope of new beginnings.

Looking forward to NENA's 2014 Pan-American Conference hosted by our neighbours to the east!

Respectfully submitted,
Marie Grandmont, RN, BN, ENC(C)
MB Provincial Director

Newfoundland and Labrador report

Membership: 50 members registered with 11 pending renewal.

Current events: A spring Provincial Conference has been slow moving and planning to get the nurses that spoke of the conference to become re-engaged. Awaiting a response, but will seek other interested parties within the next month to try to set a date in 2014! (Please respond if you want input.)

Janeway Hospital Paediatric Conference: Held in October 2013, was a huge success and will be hosted again in 2014 by the organizing committee in St. John's, NL. Congratulations to Jackie Connolly, BN, and committee.

Team Broken Earth: Dr. Andrew Furey and his highly motivated team of emergency staff continue to make relief missions to Haiti. (Please support: **www.brokenearth.ca**, Twitter: **@TeamBrokenEarth**.)

Courses: TNCC and CTAS continue to be delivered regularly. ENPC was introduced to the province in the fall of 2013 for the first time and will continue roll-out this spring. This course has gained momentum and other regions are looking to expand this course into their education requirements to work in the emergency department environment.

Challenges: The delivery of emergency medicine has undergone many changes as far as implementation and delivery, as they implement the Ottawa Model. This has been a very huge learning curve, but the outcomes are slowly becoming positive.

There is a great deal of uncertainty politically as to what will happen in the near future, as the province is currently addressing the resignation of the premier.

Executive: We would like to thank Cathy Fewer, RN, for her years of service to NENA Newfoundland and Labrador, as she steps down as treasurer and past president of our association. We would also like to welcome Vikki Bennett, BSN, RN, Clinical Educator of WMH Emergency, as she assumes the role of treasurer in the interim. We will be looking for expressions of interest for a new executive soon that we hope to coordinate with our next conference and AGM.

Framework: Undergoing changes in the organization as we keep in compliance with Canada Corporations Act for Not For Profit Groups. This is a national standard that may require some provincial changes going forward. Eagerly looking forward to the **new and improved website**!

Submitted by
Todd Warren

Nova Scotia report

Hello NENA members. It has been a quiet winter for NSENA. Membership has been steady with approximately 80 members. Work continues across the province, as the December 2014 deadline for implementing the provincial Standards for Emergency Care draws near. This initiative has produced great collaboration between health districts, as

we work at developing standardized policies and initiatives across the province. TNCC and ENPC courses have been occurring frequently, as ED staff across Nova Scotia strive to meet the education standards. Overcrowding and staffing issues continue to challenge many of our emergency departments.

As April approaches we are really looking forward to NENA's annual conference in Toronto, "Connected by Caring Across the Americas". It promises to be an exciting event and we look forward to meeting other emergency nurses from across Canada and the Americas. A big thank you to the organizing committee for the hard work they have done and will continue to do throughout the conference.

Respectfully submitted,
Michelle Tipert, RN, ENC(C)
NS Provincial Director

Ontario report

The Emergency Nurses Association of Ontario (ENAO) wishes all of our NENA friends and emergency nursing colleagues across Canada, a very safe and healthy New Year with only good things for all throughout 2014. Ontario continues to "enjoy" an old fashioned Canadian winter of ice, wind and snow.

Ontario course directors are now busy scheduling ENPC, TNCC and CTAS courses for the near future, following the holiday education hiatus. ENAO continues to facilitate a connection between our provincial colleagues and these valuable courses they are seeking. Brenda Lambert, Ontario's NCAC representative is constantly busy, ensuring that our emergency nurses are able to meet their individual learning needs. Thank you, Brenda!

Ontario is honoured to be hosting the NENA 2014 Pan-American Conference: "CONNECTED BY CARING ACROSS THE AMERICAS" in Toronto on April 27–29, 2014. We believe that we covered the broad scope of emergency nursing of today, with an incredible variety of topics, speakers, presentations, posters, research and exhibitors. Our social events and pre-conference workshop round out this incredible educational opportunity.

Plan to join your emergency nursing colleagues from North, Central and South America, while you relax, learn, play, network and socialize at this unique NENA conference. Hurry to take advantage of the special hotel conference room rate. Hope to see YOU in Toronto in April!

Janice L. Spivey
ENAO President

NENA AT WORK

International Exchange Program ends

In September 2012, NENA, Inc. and Emergency Nurses Association (ENA) Foundation entered into a collaborative relationship to pilot an International Exchange Program between the U.S. and Canada. The nurse from each country would host their colleague for one week in a "shadowing only" position. The exchange program offered emergency nurses the opportunity to experience and share nursing practice, education, research and cultural differences.

In 2013, the Canadian applicant presented the required documents and was ready to leave on her adventure. However, several roadblocks arose, making the exchange unachievable.

NENA Inc. would like to thank the ENA Foundation for everything they did to try to move the exchange forward and sincerely thank them for the offer of an ENA Conference registration for the Canadian participant. Karen Winkel attended the ENA Conference.

My experiences at the 2013 Emergency Nurses Association Conference

In September, I received the opportunity to attend the ENA Annual Conference in Nashville, Tennessee. The conference consisted of three days of emergency nursing-focused educational sessions, with optional entertainment events in the evening. There was also a large exhibit hall showcasing new products, as well as employment opportunities for nurses. The conference was located in the Gaylord Opryland Resort and Convention Center, which was a fantastic venue in the heart of Nashville.

I found the conference very informative and relevant to my daily nursing practice as a registered nurse at the University of Alberta Hospital Emergency Department.

Throughout each day of the conference there were breakout sessions with various topics to choose from, allowing nurses to attend the topics that interested them most. I attended sessions on blood transfusions during traumas, pediatric shock management, sickle cell disease, and many other nursing topics.

I found the conference a great opportunity to connect with and learn from other emergency nurses from all over the continent. I left the conference feeling excited and energized about my career and profession as an emergency nurse.

I am so grateful for the opportunity to attend such an outstanding conference. It was a great experience that I will always remember, and I look forward to attending again in the future!

Karen Winkel, BScN, RN

NENA makes governance and bylaw changes to comply with federal Not-for-Profit Corporations Act and to enhance organizational development

The Board of Directors met in November 2013 to discuss changes to NENA's governance structure required by federal legislation. A subsequent board meeting approved a number of principles to bring NENA into compliance with the new federal act governing how non-profit organizations are governed, managed and accountable to their members.

In particular, the new legislation does not permit ex-officio appointments to non-profit boards of directors. The legislation requires that individuals and their commitment and skills (and not their positions or affiliations) be the determining factor for their successful election to a non-profit board of directors. The legislation also requires more transparency and accountability from boards regarding how they conduct business and are accountable to their members.

NENA also used the required bylaw revision exercise to evaluate the efficiency of its policy governance, the effectiveness of its business management structure, and its development vision for the future.

One of the key visions developed during the board exercise was that NENA will strive to provide health sector leadership, training support, policy advocacy, and membership growth to position NENA as the "gold standard" in Canadian emergency nursing. This vision will require significant growth within NENA and a continued dedication to becoming the national leader.

With the assistance of a non-profit management consultant, the board is currently preparing the specific bylaw revisions. Before its conference and annual meeting in April 2014, NENA will advise all members of these proposals and seek ratification of the new bylaws by its membership.

Remembrance Day in Ottawa

NENA board members join in Remembrance Day recognition of the lives sacrificed for our country at the Tomb of the Unknown Soldier, part of the National War Memorial in Ottawa.

National Course Administration Committee (NCAC) TNCC/ENPC/CATN/CTAS Updates: Spring 2014

By Margaret Dymond, NCAC Chair

TNCC 7th Edition course rollout in Canada

The January 2014 edition of Course Bytes (ENA course newsletter) has published timelines and important information regarding the TNCC instructor update process. All timelines are pertinent to Canadian instructors except for a few minor revisions. ALL Canadian TNCC instructors should complete the update process by September 1, 2014. TNCC courses in Canada must be in the 7th edition program as of September 1, 2014.

Timelines

- TNCC 7th edition manuals (if paid for) will be available to ship effective February 3, 2014
- Current 6th edition instructors will gain access to the 7th edition update materials and update exam, online starting Feb 24, 2014
- Updated 7th edition instructors can purchase the 7th edition instructor supplement as of Feb 24 , 2014
- TNCC 7th edition courses can be held by updated instructors as of Feb 24, 2014
- TNCC 6th edition courses can continue until Aug 31, 2014
- All current edition TNCC instructors must successfully pass the TNCC 7th edition instructor update by September 1, 2014.

Other information

- Canadian instructors should approach their respective employers for funding the 7th edition provider manuals and instructor supplements
- If you are a current 4th edition ENPC instructor, this TNCC instructor update process is similar to the 4th edition ENPC rollout in 2012
- Instructors should spend time reading the TNCC 7th edition manual before going online to do the modules and exam. The online modules will highlight the changes to the course. You are required to complete all online modules
- The exam is timed: you will have two hours to complete the exam. You will receive immediate feedback on any questions answered incorrectly. Pass mark is 80%. If you not achieve the 80% pass mark on the first attempt, you will have one more opportunity.

Information for course directors:

- Once TNCC course directors are updated, they will get access to the course forms, slides, and exams online on the ENA website.

Course directors for ENPC/TNCC

- A revised form for the fee structure is available on request. Please email **ncac@nena.ca** for your updated information. This information cannot be published on the NENA website
- A course director mentoring form is available with the course forms and is to be completed when current course directors mentor new course directors.

Course paperwork

- Please follow the post 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 properly reflect 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 forms 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.

NENA has a new treasurer. All NENA fees are to be sent to:

NENA Treasurer
National Emergency Nurses Affiliation
P.O. Box 365
Chilliwack, BC V2P 6J4

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. **Course directors must ensure their instructors are NENA members**
- Re-verification courses for ENPC 4th edition and TNCC 7th edition no longer exist. Course participants may challenge the course. This is a decision that the course director will make for these respective courses.

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.

ENPC 4th edition news

ENA course Ops is reviewing the current ENPC exams for content. If you would like to offer any feedback, please email your issue or concern to **ncac@nena.ca**. NCAC will forward your concern. ENPC instructors can also direct their feedback to ENA at **feedbackenpc@ena.org**.

French translation progress: ENPC 4th edition/TNCC 7th edition

Translation of both courses is underway. ENA will communicate the progress and anticipated launch of the translated materials in 2014. Until the translated

materials are available, TNCC and ENPC instructors who teach the program in French may use the existing translated materials for ENPC and TNCC.

CTAS News

CTAS National Working Group Workshop for CTAS Instructors
Saturday, April 26, 2014, Sheraton Centre, Downtown Toronto

The CTAS National Working Group is very pleased to offer a workshop for CTAS instructors as a preconference activity for the NENA Pan-American Conference 2014. This interactive session will include networking with other CTAS instructors from across Canada. Participants will have a chance to share ideas about innovative ways to deliver CTAS education through roundtable discussions of issues and suggestions. For more information or to register online, please go to: **http://nena.ca/**

Have a question about CTAS content? Have you found a great way to explain a CTAS concept? We'd love to hear from you! We are currently compiling questions and innovative teaching strategies to be shared at the workshop and your input is crucial. Please send your questions or comments to **ctas@nena.ca**

Geriatric Emergency Nursing Education (GENE)
ENA has launched the revised GENE course online. There are 17 interactive evidence-based modules on geriatric emergency nursing education. The cost in U.S. dollars for ENA members is $250.00 (U.S.) and for non-ENA members is $350.00 (U.S.).

- Live links to additional resources
- E-learning modules to test your knowledge
- Course narrative notes for greater retention.

Course for Advanced Trauma Nursing (CATN)
The revision process continues into 2014. ENA will announce the launch date when the revision process is completed.

Meet your NCAC representatives at the NENA Conference in Toronto, 2014
NCAC will be hosting a booth in the exhibit hall. We look forward to seeing you in Toronto.

NCAC contact information

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 to contact us at the email addresses below.

Generic email for NCAC: **ncac@nena.ca**

Margaret Dymond, Chair
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NENA Awards, Bursaries and Grants available for 2014

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, 2014.

Grants

The purpose of the NENA Research Grant is to encourage and 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**

First in the province to be delivering ENPC

Employee Development recently completed the delivery of a 12-week ICU/ER training program made up of participants from both Western Memorial Regional Hospital and Sir Thomas Roddick Hospital. As part of that program, we delivered a two-day Emergency Nursing Pediatric Course (ENPC) course. This is the first time ENPC has been offered here in Western Health. In fact, we are the only region in this province currently delivering ENPC.

ENPC is a training program offered nationally through NENA to improve skills and clinical competency required to care for the pediatric population, from the neonate to the adolescent. ENPC is based on a systematic model, including pediatric growth and development, and anatomical and physiological characteristics that help you identify appropriate interventions for the ill and injured child. ENPC helps you answer the question, "Are you ready to care for children in your emergency or pediatric ward?"

ENPC meets 12 of the 13 clinical and professional competencies, as specified in the Joint Policy Statement—Guideline for Care of Children in the Emergency Department (American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians, Pediatric Committee, Emergency Nurses Association Pediatric Committee, 2009). This includes triage, illness and injury, pain, airway, vascular access, monitoring, resuscitation, trauma, burn and mass casualty care, medication safety, and family-centred care. ENPC utilizes evidence-based information for nurses providing pediatric care.

Certification is good for four years upon successful completion of the program.

The instructors for this course included Debbie Cotton and Carrie Bent, both of whom had to be brought in from Nova Scotia in order to deliver this program, and myself, Maureen Doody.

Three of the nurses in attendance went on to complete the ENPC instructor course, providing us with our own pool of ENPC instructors for future courses. They were Rory Tatchell, Steve Connolly and Penny Janes.

We look forward to continuing to provide the nurses of Western Health with the opportunity to receive certification in ENPC.

Submitted by
Maureen Doody
Regional Education Coordinator
Critical Care
Course Director and ENPC Instructor

Reference

American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians, Pediatric Committee, Emergency Nurses Association Pediatric Committee (2009). Joint Policy Statement—Guideline for Care of Children in the Emergency Department. *Pediatrics, Official Journal of the American Academy of Pediatrics, 124*(4), 1233–43. doi:10.1542/peds.2009-1807.

ATTENTION CTAS INSTRUCTORS: CAEP is on the move!

Effective January 1, 2014, CAEP's address will be: 180 Elgin Street, Suite 808, Ottawa, ON K2P 2K3 (send CTAS course funds here).

Telephone, fax and email addresses will remain the same. For individual contact information, please visit **caep.ca**.

As always, your questions/concerns about CTAS are welcomed at **admin@caep.ca** or **ctas@nena.ca**.

Sheila Early, A nurse to know

By the Forensic Nurses' Society of Canada

Sheila Early is currently a Forensic Nursing Consultant in British Columbia and a Program Coordinator/Instructor at the BCIT Forensic Science and Technology department.

In 2004, Sheila developed the first Advanced Certificate in Forensic Health Care at BCIT; the first classroom-delivered certificate in Canada. She has been teaching sexual assault nurse examiner courses throughout Canada since 1996.

Sheila has been a Sexual Assault Nurse Examiner for 17 years and has testified in both Supreme and Provincial Courts in B.C., as an expert witness. Her background is in emergency nursing and she has been active in this role for 30 years. She travels internationally promoting forensic nursing in Europe and doing presentations on forensic nursing.

Sheila is currently President of the International Association of Forensic Nurses (IAFN). She has received numerous awards recognizing her work in forensic and emergency nursing, including:

- 2010: Achievement Award from the IAFN
- 2008: "One of 150 outstanding nurses in BC" from the government of British Columbia
- 2002: Award of Excellence in Nursing Practice by the College of Registered Nurses of BC
- 1997: Award of Excellence in Emergency Nursing Education by the National Emergency Nurses Affiliation.

Thrilled beyond words, Sheila Early was chosen by the members of IAFN to represent the organization for a three-year term as president elect for 2013, president for 2014 and past president in 2015.

Sheila isn't the only one who is thrilled. Susan Short, President of FNSC stated: "How clever are the IAFN members to vote in such a marvelous person? Sheila will do a great job. She brings a wealth of experience along with a real desire to share and work with others to see much accomplished. And I am so excited to see a Canadian as the first international president."

Sheila is a registered nurse, with four decades of experience under her belt. She has practised as a nursing administrator, nurse clinician, and nurse educator in both emergency and forensic nursing. Currently, Sheila is the Program Coordinator/Instructor for the BCIT Forensic Science and Technology Program—Forensic Health Sciences option.

Sheila has known many firsts in her career such as:

- She founded the first sexual assault nurse examiner program in British Columbia starting the process in 1992 (currently known as the Forensic Nursing Services at Surrey Memorial Hospital)
- She performed the first medical forensic examination by a B.C. nurse examiner in February 1994, and remained a practising nurse examiner until 2007
- She developed the curriculum for the first Advanced Certificate in Forensic Health Sciences (classroom delivery) in Canada (2005) at BCIT
- She provided the initial education for sexual assault nurse examiners in five provinces and one territory.

Sheila's immense experiences as a nurse clinician in emergency, a legal nurse consultant for both criminal and civil legal matters, and as a forensic nurse have provided her with the expertise to assist health care in the investigation of inquiries/complaints, as well as consulting on issues relating to violence and trauma.

Sheila has lived in Surrey, B.C., for the past 25 years with her husband Peter. They have two daughters and sons-in-law, and four grandchildren.

IENJ reminder

NENA members will continue to receive a 35% discount on a one-year subscription to the **International Emergency Nurses Journal** (IENJ) in 2013–2014. NENA members who are interested need to subscribe directly to IENJ and state they are a NENA Inc. member. They will then receive their yearly copies directly upon publication, as well as access to the journal and forthcoming articles online.

The moral nature of everyday nursing practice

By Hudson T. Andrews, RPN, BSc, MSc, CFRC

Introduction

The number and complexity of ethical issues in health care are increasing at a faster rate than what many of our institutions can handle. When we couple this with increasing public awareness and subsequent governmental pressure for greater accountability on the part of all health care workers, we can sometimes feel overwhelmed.

Medical science can now genetically engineer pigs so that we may later take out their organs and transplant them into humans, resulting in lower incidences of host rejection. Doctors can now perform surgery on someone who is hundreds or thousands of miles away, by using fibre optics and robotics. We can precisely measure the cortical reactions to such interventions as chemotherapy or electroconvulsive therapy (ECT).

Education has attempted to keep up through an uneven pace, but morality is floundering. Many corporations in the private sector, as well as service agencies in the public sector, are hiring ethicists to help them cope with the conundrums of the 21st century.

It is, therefore, extremely important that nurses stay current and insist that clients/patients, their significant others and all health care providers be included in ethical decision-making.

Ethical professionalism

It could be said that the doctors and medical assistants who were responsible for human experimentation during the Nazi holocaust, were professionally socialized—but were they ethical? May Lifton (1986) conducted an exhaustive study of this phenomenon and developed the concept of "embodied self"—a process of taking our human self and joining with a "professional self"; being careful to include unity of awareness of self with others.

But caring nursing implies even more. Over time, three essential elements have emerged:

- Caring principles related to practice
- Nurse-patient relationships
- Everyday ethics.

Principles of Biomedical Ethics

There are four traditionally accepted principles that govern ethical medical decision making:

1. Principle of Respect for Autonomy: the right of self-determination
2. Principle of Beneficence: a duty to do or promote good, to contribute to the welfare of others
3. Principle of Nonmaleficence: to "do no harm"—not putting others in harm's way
4. Principle of Justice: fairness and treating others equally.

Caring

The concept of caring is now well accepted as central to the nursing profession's ethical base of practice. Predominating themes include a commitment to values, attitudes and actions that restore or maintain a person's dignity, humanity and well-being.

Caring acknowledges our own and another's humanity and inherent vulnerability; whether it be of physical, emotional or spiritual pain or crisis.

Caring is manifested through words and actions that convey concern and that respond to needs that require relieving suffering, maintaining dignity and searching for meaning or understanding of experience(s).

Caring results in greater patient well-being by the preservation of dignity, engendering a greater sense of meaning or understanding of self and life experiences for both nurse and patient (Lubkin, 1995).

Relationships

It is only within the therapeutic relationship context that caring can take place (Parker, 1990). Participation leads to a thorough understanding of a patient's very particular and highly personal story or situation. The development of a mutual, genuine and caring relationship is seen as a primary ethical responsibility of nursing (Lubkin, 1995).

Ethicists, both in health care and otherwise, have agreed that a natural by-product of a therapeutic relationship is the effective way it prevents ethically problematic situations from arising—simply put: you would not normally harm a friend (Reich, 1991).

Everyday ethics

A primary characteristic of caring and relational ethics is the emphasis on the moral nature of the experience of everyday practice (Lubkin, 1995). The problem with focusing strictly on standards of practice or on a code of ethics is that it tends to accentuate the problems or breaches of ethics. In contrast, caring and relational ethics focus on understanding what is to be moral every day and in all activities. From an ethical perspective, being moral and practising ethically means working hard to recognize and nurture the best potential in self and others (Lubkin, 1995).

Nurses get into difficulty

Despite good intentions and a solid grounding in ethical considerations, nurses (as well as every other discipline) continue to breach ethical practice. There are many reasons for this, but we will discuss just a couple of issues here, namely "judgement" and "adversity".

Judgement and relativism

As nurses, we are indoctrinated (socialized) to the need of remaining non-judgemental. This is truly noble, but not always very practical. Humans are, by nature, prejudicial. As the term implies, we pre-judge people and situations regularly—it is the way we psychologically size up and prepare for interactions or actions.

As professionals it is, therefore, incumbent upon us to reserve acting on judgements or, certainly, refrain from verbalizing such, until we have more data and until we can therapeutically align ourselves with the other person or situation. But we must, ultimately, make (what we term to be) "clinical judgements." The inference here is that such decisions are professionally motivated. Some nurses are caught up in what they perceive to be "grey areas." It is here that problems arise. The grey area usually exists for the observer or perpetrator, but rarely for the victim of any situation. To have been hurt or damaged in some way is tangible and concrete—not nebulous in some fashion.

It deserves thorough examination and thoughtful consideration but, as nurses, we must ultimately choose which values we hold dear. These beliefs (e.g., code of ethics) must then be clearly articulated and WHOLLY SUPPORTED by all, to maintain their relevance and import. When confronted with an ethical dilemma, weigh the issue, decide on a moral conclusion or judgement—THEN STICK TO IT and defend it!

Adversity

One factor that has been identified leading to professional misconduct is that nurses are sometimes ill prepared for adverse situations that befall them.

A million pages of chronicles, a million metres of documentary film and daily newscasts are there to tell us that human life is punctuated by adversity. It is peculiar then that so many of us are caught off guard. We actually know full well that, when times are good, we should build up assets against the possibility of their turning bad. But then, considering human nature, our basic instincts lead us to believe that serious trouble never really comes to us—and we try to dodge it when it inevitably does. This attitude seems to be especially pervasive in modern western societies (Royal Bank, 1993).

The economic events of the past number of years may have had a sobering effect on many, but not on the mass media. Though filled with stories of other people's woes, tragedy and strife, the media conveys the impression that human beings actually can live relatively trouble-free. This is especially true in the TV fictionalized world. The denizens portrayed are nearly always well-fixed financially, have rewarding jobs, exude good health, are physically attractive, and fall easily into loving relationships. The underlying message is that, if you are not happy, healthy, and relatively prosperous yourself, your life is not measuring up to the norms of society. The danger is that people may be subliminally persuaded that fictional sitcoms or dramas really do illustrate a feasible way of life. While there can be no denying that there is plenty of happiness among humans, it is anything but constant and universal.

So, since such vicissitudes cannot be avoided or denied, what can be done? First, avoid the "why me" syndrome—the feeling that you have somehow been singled out for a special dose of misery. We can never develop a sense of proportion about our own circumstances if we persist in measuring them against mythical standards. Many persons are very unhappy simply because they conclude that others are better off than they are. Perspective provides us with the strongest of all defences, especially against self-pity. It may even provide us with the ability to laugh at our own folly—a powerful antidote to subjectivity.

Samuel Johnson on Calamity

Johnson claimed that "when any calamity has been suffered the first thing to remember is: how much has been escaped. Among what has survived, you might find, are things like personal integrity and the love of our peers—the things that really matter!"

"Lots of folks confuse bad management with destiny", the American humorist Kin Hubbard observed.

Bad things happen to good people, but, unfortunately, it is far too common that people blame problems on others rather than themselves. When things go wrong it is tempting to blame "the system", politicians, the boss, head nurse or director. This may bring some fleeting psychological relief, but serves no lasting purpose. The energy spent in blaming others would be better used in trying to dig ourselves out of our own predicaments.

The aforementioned fallacy can lead to fatalism; the notion that external forces are responsible for our troubles. If you truly believe that the powers-that-be are intrinsically blind or hostile to your interests, it logically follows that it is futile to try to do anything about your own case. Since trouble has a way of regenerating itself, the chief effect of fatalism is to open the door to more trouble.

It will help to accept adversity as a necessary evil. Some of the noblest acts of humankind have come from stern social trials. Shakespeare spoke of "the uses of adversity" in which he suggests that great triumphs are often accomplished through sheer frustration and toil—that adversity provides the needed resistance to generate creative tension. The rules of sports deliberately add difficulty to tasks that might otherwise be too easy.

By successfully handling adversity, a person is likely to be better equipped to handle prosperity when things turn out well again. If tribulation brings a better sense of who you are, it certainly shows you who your real friends are.

Adversity helps to develop a view of life characterized by empathy and charity—traits most desirable in the ethical, caring nurse.

About the author

Hudson T. Andrews, RPN, BSc, MSc, CFRC, has worked in health services, education and forensic sciences for more than 40 years.

After a career as a paramedic, he pursued education as a Registered Psychiatric Nurse at BCIT in 1983. He then completed bachelors and master's degrees in psychology and forensic sciences, along with health care administration components, at Pacific University, California (1987, 1997 respectively). He also attended the Recovery Institute (San Francisco) and obtained a credential in addictions assessment and counselling.

Andrews was employed as a clinician in the field of Forensic Psychiatry until he was recruited by Douglas College to teach in the Health Sciences Faculty in 1988. He was at Douglas until 2012. He now teaches selected courses at the British Columbia Institute of Technology (Burnaby, B.C.) in the Forensic Sciences Faculty, as well as at other post secondary institutions.

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Aortic dissections, aneurysms and ruptures: An emergency perspective

By Pat Mercer-Deadman, RN, ENC(C)

The goals of this (research article) presentation are to review aortic dissections, aneurysms and ruptures, review the anatomy and physiology of the aorta, discuss differing presentations and the challenges faced with diagnoses in the emergency department. This article will highlight the importance of our nursing assessments and our ability to direct physicians and diagnostics appropriately, thereby positively influencing patient diagnosis, treatments and outcomes.

The aorta is the largest blood vessel in the body. It is usually about one foot in length and one inch in diameter. It originates in the left ventricle of the heart and extends down the length of the abdomen, ending in a bifurcation into the common iliac arteries that supply blood to the legs.

The aorta functions to distribute oxygenated blood to the entire body through systemic circulation.

The aorta is divided broadly into four parts: the ascending aorta, the aortic arch, the thoracic descending aorta and the abdominal descending aorta. The branches of the ascending aorta supply the heart, the branches from the aortic arch supply the head, neck and arms. Branches of the thoracic descending aorta supply the chest (except for the heart and the respiratory zone of the lungs) and branches of the abdominal aorta supply the abdomen and its organs. The common iliac arteries supply the legs and pelvic area.

Ascending aorta: This portion supplies blood to the heart through the right and left coronary arteries.

Aortic arch: Has three main branches—the brachiocephalic trunk (this feeds the right side of the head, neck, right chest wall and arm), the left common carotid and the left subclavian artery, which feeds the left side of the head, neck, left chest wall and left arm.

Thoracic descending aorta: This portion of the aorta feeds the intercostal and subcostal arteries and the left bronchial arteries. These vessels supply blood to the esophagus, mediastinum, pericardium and the diaphragm.

Abdominal descending aorta: This portion begins at the diaphragm and feeds the lumbar and renal arteries, suprarenal and visceral arteries and, therefore, supplies blood to the diaphragm, stomach, intestines, liver, spleen, pancreas and the reproductive organs.

The aorta, like all arteries, has several layers that are further divided into: intima, media and adventitia. A weakening of the arterial wall can occur anywhere and on any layer, though the majority of the time it is the intimal layer. This weakening develops into an aneurysm or the vessel wall sustains a tear and there is bleeding between the layers... a dissection. The location determines the type, i.e.: aortic arch tear, thoracic aneurysm or abdominal aortic aneurysm (AAA).

An aneurysm, by definition, is a sac formed by the dilation of the walls of the artery, a ballooning. They may be "berry-like" or "spindle-shaped" fusiform, which are the ones most likely to form with a dissection.

With an aneurysm or dissection, blood is diverted from circulation into an expanding mass or hematoma, which, depending on the location, creates an obstruction and decreases flow to the area or organs with associated symptoms. The dissection decreases circulating volume, decreasing cardiac output and decreasing end-organ perfusion, as a result. This diversion of blood can extend up or down the aorta and, if it goes "up"-retrograde, may result in blood in the pericardium and a resultant cardiac tamponade.

Aortic dissections are a diagnostic challenge. It is important to have a high index of suspicion to increase the accuracy of your diagnosis. According to some of the research used on this project, approximately 38% of dissections are missed and possibly up to 50% are initially diagnosed as some other condition and not correctly identified until autopsy. Aortic dissections are two to three times more common than abdominal aortic aneurysm ruptures and, that being said, are still relatively uncommon.

Aortic dissections are classified in two common ways:

Debakey

Debakey Type I: begin at the ascending aorta and extend through the aortic arch to the descending aorta—these are the most lethal classification and are the most common in patients who present and are less than 65 years of age.

Debakey Type II: involve the ascending aorta.

Debakey Type III: involve the descending aorta only and may be classified further as IIIa: above the diaphragm and IIIb: extending below the diaphragm.

Stanford Classification

Type A: Involve ascending and descending aorta—these have a higher mortality rate with rates sited as approximately 75% within two weeks of diagnosis if left untreated. The majority of these patients present with severe chest pain.

Type B: Involve the descending aorta only and patients are most likely to have back pain and have a 50% chance of death within the first 48 hours without treatment.

Once a dissection is classified, our nursing care and assessments can be tailored specifically. For example, a patient with a Debakey Type II dissection would be assessed and reassessed for developing cardiac tamponade, or with a Type III, would be observed for

decreased urinary output or sensation/movement of lower limbs if the dissection is extending distally down the aorta.

The type of classification used is less important than the accuracy of the assessment, so that you know if the dissection involves ascending or descending aorta and, with that, know what nursing interventions may be required and what management strategies should be used for best patient care. Unfortunately, in emergency, the "classification" is not usually known prior to deterioration of the patient, so it is of not much use to us.

Risk factors for the development of aortic dissections, aneurysms and ruptures are the same for all. Hypertension and a smoking history are the primary factors. Other factors include: atherosclerosis, hyperlipidemia, genetic disorders (Marfan's syndrome, Ehlers Danlos Syndrome and other connective tissue disorders), stimulant use (cocaine, meth) family history of AAA, trauma with sudden deceleration, cardiac surgeries, cardiac catheterization, pregnancy (increases the risk x 3) arteritis, syphilis, TB and more.

Aortic "disease" is three times more common in men, more common in black people than white people, and 75% of presenting patients are between 40 and 75 years—with the majority over 60 years of age. Women have worse outcomes than men, and this is most likely due to the fact that they are frequently misdiagnosed or the diagnosis is delayed. Aortic dissection should be considered a differential diagnosis in any pregnant woman with complaints of chest pain and shortness of breath.

Timely diagnosis of aortic conditions is challenging because of the variety of presentations, and the mimicking of other conditions. The clinical symptoms and presentations depend on which area of the aorta is affected. This, in turn, can confuse the clinician, delaying not only the diagnosis, but also the appropriate treatment. These patients can present with any variety of symptoms, including undifferentiated shock and cardiac arrest.

The classic triad of symptoms: abdominal pain, hypotension and pulsatile abdominal mass is only present in 25% to 50% of patients. A "swooshing" or bruit may be heard over the abdominal aorta. Our patients may present with symptoms consistent with MI (more specifically an inferior MI, as the majority of dissections and aneurysms tend to be on the right side of the aorta and may occlude the right coronary artery). They may present with congestive heart failure symptoms—shortness of breath, stroke, pulmonary embolism, right pleural effusion renal colic or cholecystitis. Symptoms could be consistent with diverticular complaints, or neurological complaints or deficits. Differentiating dissection from Acute Coronary Syndrome and MI are extremely important, as anticoagulation and or cardiac catheterization for dissecting patients could prove to be lethal. Common misdiagnoses include: ACS, musculoskeletal pain, pneumonia, pericarditis, and GI pain, to name but a few. Patients with retroperitoneal ruptures may present with bruising to flank, scrotum, or perineum. Typically, our patients present with sudden onset of chest and/or abdominal pain, which may or may not radiate through to their back. They may or may not have differing BPs in each arm, with 20 mmHg or more being significant. This, too, will be reflective in pulse deficits. Realistically, this can only be found roughly 30% of the time. Twenty per cent of the population has significant differences in right and left BP with the dominant arm having higher BP. There are NO laboratory studies that are definitive in the diagnosis of aortic disease, though multiple studies reviewed show an elevated D-Dimer of greater than 500 μg/dl in patients with aortic dissection (this is not an opinion that is supported or endorsed by the vascular surgeons with whom I spoke while researching this presentation).

Diagnostic tests are based usually on the patient's presentation in emergency.

CT scans are the preferred radiological exam with greater than 90% accuracy, though the CT does not show the degree of involvement of the branch vessels.

Chest x-rays in patients with cardiac or respiratory symptoms generally (50%) will show a mediastinal widening with a dissection. For this reason, it must be done in patients with MI diagnoses prior to thrombolytic therapy. This said, the absence of mediasinal widening does not rule out a dissection of the aorta.

Transesophogeal echocardiography (TEE) is useful if the patient is hemodynamically unstable, and cannot be moved. It has the sensitivity of up to 100% in diagnosing a high dissection with an intimal flap, aortic regurgitation or extension of dissection into the coronary arteries Type A dissections. The disadvantage with this is that it must be done by someone with the skills to perform TEE.

Ultrasound, especially done at the bedside in the ER, is very helpful for diagnosis of rupture in showing blood in the abdomen.

MRI is more sensitive than CT scans, but impractical in the ER setting, as they are much more time consuming and the patient is inaccessible.

In emergency, we will see patients with symptoms produced by acute dissections or aneurysm ruptures, and these can be acute or chronic. "Chronic" is diagnosed when symptoms are ongoing for two or more weeks. Chronic dissections may be stabilized with medical therapies and then may become acute, as the dissection progresses or extends, and this may be what brings the patient into emergency. History taking is vitally important with any abdominal or chest pains, especially if the patient is older than 60 years of age, has hypertension and other risk factors, such as a history of smoking—even if they quit "years ago".

Elective repairs of aortic aneurysms are done based on the size and location. For Stanford Type A, surgery is indicated for sizes of 5 cm or greater and for Stanford Type B for sizes of 6 cm or greater. For a presentation of an "acute" nature in a patient with a Stanford A dissection, surgery is highly recommended, as ruptures of this type have an extremely high mortality rate.

Medical management before surgical repair on an elective basis is aimed at decreasing the blood pressure and lowering the heart rate with beta blockers (Esmolol, Labetalol). This is the first-line therapy for emergency patients where aortic dissection is suspected. Beta blockers decrease the left ventricular contractile force and will decrease the pressure through the false lumen between the aorta wall layers.

If our patients present with an aortic dissection and hypertension, research recommends the use of a Nitroprusside drip with beta blockers, and that it is titrated to lower and maintain the systolic blood pressure at 100 to 120 mmHg with a target heart rate of 60 beats per minute. Beta blockade is to be achieved before the Nitroprusside drip is started to decrease the likelihood of reflex tachycardia, which could occur if they aren't started first. Calcium Channel blockers can be used if, for whatever reason, beta blockers are contraindicated. Pain should be controlled with titratable opioids (i.e., morphine), which will also decrease the sympathetic tone.

Early and aggressive attention to hemodynamic stability in the emergency department can give patients with acute aortic dissection or aneurysm rupture the best possible chance for successful surgical intervention.

With aortic aneurysm ruptures, risk factors are the same as with aortic dissections. Thoracic aortic aneurysms are less common with 80% of the ruptures of the aorta occurring below the level of the renal arteries.

Initial ER assessment and treatment is again focused on hemodynamic stabilization, but with ruptures the patient will most often present with hypotension, which may be profound.

Resuscitative efforts focus on A, B, Cs, at least two large bore IVs with infusion of crystalloids and blood products, with transfer to the operating room as soon as possible for surgical repair either done endovascularly or open abdominal approach. Preoperatively, patients need the usual ICU blood work, ECG, CXR, Foley, N/G, arterial line, and CVP line, all of which can be done in the OR if time is of the essence. The aim in the resuscitative efforts is to improve/maintain end organ perfusion prior to and during surgery, as opposed to a "target" blood pressure. **It is important to keep in mind that fluid overload could result in compromising the patient by disruption of the clotting cascade or dislodgement of a clot.**

In emergency, with patients who have abdominal pain and fit the risk factors for potential aortic "disease", ALWAYS suspect the worst. Perform serial assessments and evaluations of their condition. Be extremely vigilant with elderly women who have these symptoms and risk factors—these patients are often under-diagnosed and under-treated. Women often are vague and underplay the severity of their complaints, as with MIs.

Acute abdominal pains with abnormal vital signs should be a CTAS 2 and, ideally, have physician assessment within 15 minutes. This said, hypotension can be an ominous sign, as well as extreme hypertension. Errors with diagnosis may occur in upwards of 60% of aortic aneurysm and aortic dissection patients.

Dr. H. Cox from the Grey Nuns Edmonton recommends that any patient with hypertension that is not controlled with medication should be screened with a CT scan (elective) for an aortic aneurysm.

The classic triad for AAA is: abdominal pain, pulsatile abdominal mass, and hypotension. Remember though, that less than 50% of patients have the pulsatile mass and that hypotension is a late sign and is a sign that could indicate poor prognosis.

On a side note, studies done in Charlotte, NC, and published in the *American Journal of Emergency Medicine* (Pierce & Courtney, 2008) found PEA to be the most prevalent cardiac arrest rhythm in patients with ruptured AAA. The article suggested that patients presenting in ER with PEA arrest, with a suspected aortic dissection, may benefit from an emergency pericardiocentesis to relieve a cardiac tamponade that may have resulted from an ascending aorta dissection. This said, a true acute aortic dissection is instantly fatal in the pre-hospital setting.

Case presentations

- 48-year-old male to ER with altered mental status and seizure, right neck pain, left hemiparesis and ST depression proceeds to have Vfib arrest—resuscitation is not successful. COD determined to be hemopericardium and right carotid artery dissection.
- 62-year-old female to ER with abdominal pain, altered mental status, syncope and ECG showing ST depression and then ST elevation. Proceeded to have Vfib arrest. COD determined to be aortic dissection to coronary arteries and hemopericardium.
- 48-year-old female to ER with headache and seizure, had Vfib arrest in ER. COD aortic dissection. She had no complaints of chest or abdominal pain, only neurological symptoms.
- 45 patient charts were reviewed from GNH ER… 75% of patients had history of smoking and 12/45 female, 4/45 under 60 years and all were female. Many of these patients presented with back pain, but only two reviewed had pain described as "ripping".
- 63-year-old male: non-smoker Hx ^cholest ^BP presented with cardiac-type chest pain, sent to GNH for CT to R/O PE and was Dx with AAA. At the rural site, had been worked up for cardiac with enzymes, ECG CXR, Nitro and Lovenox… o/a remained with ^BP 158/90R & 167/80 L (patient had discontinued own antihypertensives three weeks prior to ER). Was eventually diagnosed with Type B aortic dissection, spent four days in ICU on Labetalol and Nitroprusside and then was discharged home after 10 days with oral antihypertensives.
- 74 year-old male: sent to ER for back pain (sent by chiropractor), investigations shown to have AAA.... was discharged home and readmitted two weeks later for elective EVAR of 5.9 cm infrarenal AAA.
- 67-year-old male: into ER with c/o general weakness, numbness to legs that began approx 1.5 hours before he presented to ER (2000hr). He was able to move all his limbs and did have abdo and shoulder pain. Hx ^BP. The next morning CT showed dissecting aortic aneurysm from RCA to RT femoral artery with blood in pericardium, but no tamponade though a small rt hemothorax. He was transferred out to the U. of A., but the outcome was POOR.
- 68-year-old male: had sudden onset of rt flank and back pain and collapsed in WR after a one-hour wait for a room—was triaged as renal colic-type pain (3). Once in ER was seen to be mottled from the waist down with weak femoral pulse… had a STAT CT and was to the OR in less than 45 minutes… diagnosed with Juxtarenal AAA rupture... discharged home after 12-day hospitalization… did have ^BP and hx of smoking.
- 29-year-old female: EMS to ER with chest pain radiating to neck, jaw and arm approximately 1000 hour. Pain described

as 10/10 squeezing, there was no SOB, no diaphoresis, BP left 136/79 rt 108/74 CXR done, then CT were non-diagnostic of PE so augmented CT done at 1545. This showed ascending aortal dissection from root of aorta upwards. Patient was started on Labetalol to lower BP and was transferred STAT to U. of A. at 1630 where the dissection was repaired and the patient did well post operatively.

- 32-year-old male: CTAS 2 presented with chronic back pain for five to six years with increased intensity for a "few days". He was sent for L-S spine x-rays by chiropractor and then on to ER for suspicion of AAA. The back pain was lower back to right lower quadrant and down the anterior thigh. He had no abdominal pain. With further history he had a positive family history of AAA (dad and two paternal aunts). He was a non-smoker, but had significant HTN and was noncompliant with medication. No other medical history. With abdominal palpation he was found to have a pulsatile mass. CT revealed a 7.4 cm infrarenal AAA which he had elective surgical repair for three days after his ER presentation. He did well and was discharged from hospital five days post-op.
- 33-year-old male (Chinese heritage): presented to the tertiary centre with 26-hour history of chest/epigastric/back pain with hematuria. He was sent to the ER with suspected renal colic by the GP. In ER he had a lot of pain and systolic BP of 230. He had a syncopal episode in the ER waiting room and had a seizure. He was then sent for CT of the head and chest. Diagnosis was made of Type A dissection. His BP was stabilized with Labetalol ad he was sent to the "vascular" centre. BP was now 130/68 and his hgb was found to have dropped from 158 to 114. His prior history was HTN noncompliant with medication and smoking. An augmented CT was done and showed a dissection that extended down the descending aorta (T5 down to the common iliac arteries) and also a large right-sided hemothorax. Prior to surgery he had pedal pulses, which were palpable on the left and not on the right (even with Doppler). Right femoral pulse was only obtainable with a Doppler. This patient was sent STAT to the OR for thoracic EVAR repair. The next morning in ICU he was found to have no movement or sensation below T6 and was diagnosed with paraplegia secondary to ischemia of the Artery of Adamkewicz. He was discharged to a rehabilitation facility and the case is now in litigation, so further information is not available.

I hope this presentation has been useful in reminding us of the importance of our nursing assessments and having a high index of suspicion, and remembering that depending on the location of the dissection or rupture, symptoms can vary greatly. Timely diagnosis and maintaining end-organ perfusion are of utmost importance for our patients with aortic disease, be it dissection or rupture.

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The painful truth: Five acute pain management myths in the ED

By Adrienne Olszewski, RN, BA, BScN, Kathryn Kennedy, RN, MSN, Amy Kary, RN, MSN, Dawn Binns, RN, MSN, Ian Fingler, RN, BScN, CCN(C)

Adequately treating acute pain is an ethical obligation by the entire health care team (Butcher, 2005). Many barriers exist that create challenges to effective pain management in the emergency department (ED). Inconsistencies in practice occur for a variety of reasons, including inadequate knowledge, especially in pharmacological techniques (Butcher, 2005). At times, shared practices of health care delivery are maintained based on repetition and belief rather than evidence and new information in the ED. This article serves to review some of the common practice myths related to the treatment of acute pain management in the ED. Current evidence will be discussed to deconstruct these myths and promote best practice.

Myth #1: Giving analgesia to a patient with abdominal pain will interfere with getting accurate diagnosis

When pain is perceived as everlasting and unresolvable, it can further aggravate and exaggerate the pain with which a patient presents (Gallagher, 2004). If analgesia is delayed, the central nervous system has an opportunity to go into "wind up" mode due to nerve fibres being repeatedly stimulated (Butcher, 2005). A literature search found that for those patients presenting to the ED with acute abdominal pain, delaying the administration of opioids does not interfere with diagnosis and sometimes enhances its accuracy (Pace & Burke, 2008). In another study of patients who received intravenous morphine for acute abdominal pain, physical examination findings were not masked and there was no change of diagnostic accuracy found (Thomas et al., 2003).

The diagnosis of causes of abdominal pain occurs through a variety of tests and physical assessment. We are no further ahead if a patient's pain level is so severe that these diagnostic tests cannot be performed. Providing timely analgesia should be a principle goal of emergency staff when caring for patients with abdominal pain.

Myth #2: Neonates and infants do not require analgesic

It is now well understood that neonates and infants feel pain (Taddio & Katz, 2005; Wilson-Smith, 2011). However, in the ED, this population's pain perception and need for analgesia are often underestimated or overlooked. While the study of pain in this age range is complex and many factors are at play, there is accumulating evidence that failing to treat pain in neonates can cause long-term alterations on their pain responses later in life (Taddio & Katz, 2005).

Neonates and infants commonly present to the ED with complaints relating to pain, or may undergo painful treatments, as part of their emergency care. There is no doubt assessing pain level of preverbal patients is challenging. Being armed with an appropriate resource such as FLACC (Faces, Legs, Activity, Cry, and Consolability) Pain Assessment Tool, pain intensity can be assessed effectively (Manworren & Hynan, 2003). This tool provides ED nurses a means to determine pain scores out of 10 and pain should be managed accordingly. It has been suggested when a FLACC pain scale is six or greater, analgesia is required (Manworren & Hynan, 2003).

Some common barriers to effective pharmacological pain management often stem from fear of administering analgesic to neonates and infants and the invasiveness of some necessary routes of administration. While there are some considerations for pharmacological pain management in the age group, they should not be the reason that treating pain is neglected. It is true: neonates have greater sensitivity to numerous analgesics, but this only demands careful choice of technique and close monitoring with administration (Wilson-Smith, 2011). If IV access is not necessary for a neonate or infant, intranasal drug administration can be considered (Regan et al., 2013). Also, a variety of topical anesthetic creams, vapo-coolant sprays, and lubricants are available and commonly used in pediatric patients when an invasive procedure is anticipated (Wilson-Smith, 2011).

A variety of simple, non-pharmacological methods effective in pain prevention or reduction in neonates and infants receiving a painful procedure are recommended in the literature. Stroking a baby's skin and rocking them while having a painful procedure has shown to decrease the pain response (Wilson-Smith, 2011). Decreased pain response is also shown when the infant is non-nutritive sucking on a pacifier (Liaw, Yang, Blackburn, et al., 2010; Yilmaz & Arikan, 2010) or breastfeeding (Wilson-Smith, 2011; Yilmaz & Arikan, 2010). Giving a neonate or infant sweet glucose or sucrose oral solution a few minutes before a painful procedure has also shown to elicit a less-pronounced pain response (Wilson-Smith, 2011; Yilmaz & Arikan, 2010). Many of these strategies would be simple for nurses to do themselves or in collaboration with the parent or guardian when a painful procedure is anticipated. Neonates and infants feel pain, and with the use of an age appropriate pain assessment tool, an ED RN can assist in the recognition, prevention, and treatment of pain in these delicate patients.

Myth #3: Geriatric patients do not require analgesic as often because they complain of pain less

There are many barriers to effective pain management in geriatric patients despite the availability of many suitable pain control options. It has been shown that the elderly population is the most frequently under-dosed (Terrell, Heard & Miller, 2006). Chronic or concurrent illness in the elderly complicates pain management in the ED. There are barriers the health care team can address in practice, which can aid in effectively treating pain in older persons: under-reporting pain, communication difficulties, and under-treatment (Tracey & Morrison, 2013).

Under-reporting pain by the elderly patient is due to loss of autonomy or depression. Geriatric patients can become depressed due to their quality of life and inability to function and may suffer longer than necessary. Depression can alter the perception of pain and result in an inability to cope. They may have a lack of understanding of their diagnosis and feel that pain is a normal part of aging. Some may further feel embarrassment about using devices or medications to relieve pain or emotional stress (Tracey & Morrison, 2013). Recognition of the potential for depression should influence an ED nurse's pain assessment in this population.

Difficulty communicating pain may be a result of cognitive impairment. It can be challenging to assess pain levels with a cognitively impaired elderly patient. However, even mild to moderate dementia patients are capable of reporting pain using a number of validated tools (Hwang & Platts-Mills, 2013). Family members and caregivers can also be utilized, asking for their impression of the patient's comfort level. At times it is necessary to rely on more objective findings during the physical assessment.

Due to concerns about the use of analgesic medications with older patients, pain may be under-treated (Tracey & Morrison 2013). It becomes important to take into account elderly patients' liver and renal function and what current medications they might be taking. The adverse effects of daily medications coupled with current renal and liver functions may alter the amount or type of analgesic given. It is recommended that patients be reassessed frequently when initiating or adjusting any of their medications. When considering analgesia for older adults a reasonable starting dose may be 30%–50% of that recommend for a younger adult (Tracey & Morrison, 2013).

Understanding the psychological needs of geriatric patients can aid in obtaining a more accurate assessment of their pain. An evaluation of physiological and pharmacological considerations will lead to more safe and effective pain management for elderly patients in the ED.

Myth #4: An antiemetic medication should be administered prior to an opioid analgesic

The most commonly used analgesic in the ED setting is an opioid, as an initial attempt for general pain management (Todd et al., 2007). Due to potential side effects of the opioid analgesic, an antiemetic such as dimenhydrinate is usually given in the event of nausea and/or vomiting (Talbot-Stern & Paoloni, 2000). Common practice has been to administer an antiemetic prior to an opioid agent for this reason, but the result is further delay of analgesic for actual pain due to the potential for nausea and vomiting. Literature has shown that nausea and vomiting occurs in less than 6% of patients post-opioid administration (Talbot-Stern & Paoloni, 2000). Therefore, this is no evidence for the co-administration of a prophylactic antiemetic with opioid analgesic (Thomas, 2013). Often, doctors will order the two drugs concurrently in order to anticipate the potential indication for an antiemetic post opioid administration, not as a prophylactic dose, but common practice has become the opposite.

Myth #5: Opioid dependent patients do not require more pain medications than those who are not dependent

Emergency nurses often care for those addicted to or dependent on opioids. Patients who frequently use opioids can experience a condition known as hyperalgesia, in which an abnormally heightened pain sensation is noted and characterized by a decreased pain threshold (Morgan & White, 2009). Mehta and Langford (2006) provide clinical evidence showing opioid-addicted patients are less able to tolerate pain and require larger doses of analgesia due to higher cross-tolerance. Analgesic response is diminished at the pain receptors when opioids are taken repeatedly, creating a medication tolerance (Laroch, Rostaing, Auburn & Perrot, 2012). Hyperalgesia combined with medication tolerance will have the opioid-addicted population in constant and often uncontrolled pain. Despite tolerance and hyperalgesia, the etiology of the pain warrants true investigation while pain is managed in the emergency department. Therefore, opioid-dependent patients do require larger or more frequent doses of pain medication in this context while investigations are completed.

Implications for practice

This article examined the common myths associated with pain management in the emergency department context. Regardless of the myth addressed, the overall theme was to examine some commonly held misconceptions or questionable practice routines around pain management in the ED. Given pain management is the number one factor with which patients evaluate their satisfaction in emergency department care (Todd et al., 2007), continued reflection around common practices and review of current evidence will result in increased patient satisfaction and best practice for pain management in the ED.

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The importance of identifying delirium in older adults in the ED: Impacts on mortality and quality of life

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

Introduction

In my work as a Geriatric Nurse Clinician I have the opportunity to work with some of the most vulnerable patients who present to our ED, and the time to do a detailed assessment. This includes understanding the patient's cognition and function prior to this presentation, and what changes may have occurred, as I assess for the presence of delirium. With my background as an ED nurse, I fully realize the limitations on time for most ED staff to assess such information, yet, as I learn more about delirium, I am increasingly convinced of the vital importance of early detection and intervention to decrease the associated morbidity and mortality for older adults.

Much literature addresses the development of delirium in hospitalized patients, and interventions to promote recovery. This important work is beyond the scope of this article. Here, the emphasis is on some recent studies that look at delirium on presentation to the ED, how ED nurses can contribute to an accurate diagnosis, the importance of distinguishing the presence of delirium, and ways we might improve emergency care for this population.

Definition

Delirium is defined as a "disturbance of consciousness with reduced ability to focus, sustain, or shift attention… not better accounted for by a pre-existing, established or evolving dementia… develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day."

Delirium may be classified as hyperactive—most easily diagnosed, as the patient is restless and unable to retain explanations; hypoactive—often missed, as the patient is drowsy and quiet, not obviously registering pain or distress; or mixed, when behaviour fluctuates between these two states. All forms tend to have alternating periods of relative understanding and attention. Often medical illness accounts for these changes, but in approximately 10% of cases, no cause is identified.

The patient may experience visual changes, hallucinations or illusions. For example, one woman perceived the bedside curtains as waterfalls. Generally, patients are fearful of these perceptions, later describing an awful experience in which they felt no one was helping them; thus they react with fight or flight. Although persons of any age can develop delirium with sufficient insult such as illness and toxicity, in the ED setting it is often seen in older adults. It is identified as a medical emergency.

Importance in the ED

What is particularly important about this emergency in a setting of total emergency care? While airway, breathing and circulation are generally intact, disability is evident with altered level of consciousness (LOC): decreased consciousness and/or periods of hypervigilance occur. Delirium is an unstable condition that will generally progress without appropriate interventions.

Prognosis

Delirium has been noted for the past 2,500 years. From the beginning, it was noted to carry a high mortality rate, and survivors often developed dementia and functional deficits. Persons who already had dementia were at greater likelihood to develop delirium, and acceleration of their dementia was likely to follow. These observations have been confirmed in recent studies. In the last century delirium was recognized as a temporary condition, which would often resolve with appropriate care. Many patients regained their premorbid functioning. More recent studies following patients post-discharge note those who have had delirium often experience ongoing short-term memory deficits, disorientation and inattention. Not only is the mortality rate high during the acute phase, it continues to be increased for six to 12 months following discharge, approximately 30% at 12 months. Patients with delirium have longer admissions for the same underlying diagnosis. Prolonged delirium is associated with a greater degree of residual cognitive impairment and loss of function. In fact, functional decline is often so great that persons who were fairly independent before developing delirium require significant assistance, even transfer to a long-term care facility after the illness and delirium have resolved.

The economic implications have been compared to diabetes, the mortality rates similar to acute coronary syndrome (ACS) or sepsis.

Risk factors, precipitating events

Etiology and pathology of delirium are not fully understood, but changes in neurotransmitters and in cerebral metabolic activity have been implicated; changes in EEG waves have been identified. The presence of delirium involves a combination of risk factors and insults. Predisposing factors include:

- age over 70 years
- cognitive impairment including dementia or previous CVA
- visual or hearing impairment

- use of multiple medications
- severe comorbidity such as several chronic illnesses
- malignancy
- previous episodes of delirium.

Events precipitating this episode may include:
- a new disease process, such as ACS or CVA
- infection, particularly urinary tract, lungs, skin, GI
- hypoxia
- dehydration
- electrolyte imbalance
- change in status of a chronic disease such as diabetes
- pain
- new medication
- alcohol or drug toxicity or withdrawal
- constipation
- urinary retention.

Relocation, sleep deprivation, medication changes including analgesics, under- or over-stimulation, physical restraints and indwelling catheters may all be implicated as iatrogenic factors. While some of these stressors may be unavoidable, they will contribute to the development and continuation of delirium.

Delirium often not diagnosed

Why is this emergency condition so often missed? It has been estimated that 10% to 30% of older adults present to the ED with delirium. Many more will develop symptoms during their admission. One recent study cites the diagnosis being missed in the ED 75% of the time, and found that if delirium was not diagnosed in the ED, it was less likely to be identified once the patient was admitted. If it was diagnosed in the ED, it was more likely to be treated appropriately throughout the admission. When delirium was present but not diagnosed in the ED, and the patient was sent home, the mortality rate over the next six months was nearly 31%. If delirium was diagnosed and the patient was discharged, the mortality rate was closer to 12%, similar to that of patients without delirium.

Delirium is a clinical diagnosis; signs are often subtle. Patients who are in delirium are generally not able to give an accurate description of their symptoms and onset. Ascertaining their baseline involves getting information from family members, caregivers, or previous charts, all of which take time.

As delirium is a sudden change characterized by fluctuations in LOC, any screening tool used needs to discern these hallmarks. The widely accepted Confusion Assessment Method is used to detect acute onset and fluctuating course, inattention, and either disorganized thinking or altered LOC. Other causes of cognitive impairment, such as dementia or depression tend to show a steadier pattern of impaired cognition over two weeks to several years. Accurate diagnosis of delirium can a take time, particularly if we do not have a clear picture of this person's baseline, what changes have been observed, and over what period of time. One test that is sometimes recommended is to have the patient recite the last six months of the year in reverse order—this is an indication of the person's attention, but will be of use only if he could name the months prior to becoming ill.

Challenges and opportunities

As this is a serious condition that is shown to be improved by early detection and intervention in the ED, we need to have a high level of suspicion for its presence and consistently assess for delirium. If in doubt, treat as for delirium; we may help to prevent its development.

One study, emphasizing the similarity of management of ACS and sepsis to that needed for delirium, has outlined a two-step approach, with initial assessment at triage to identify those who need more in-depth assessment by a physician. This was shown to be effective when the triage assessment was positive for cognitive impairment, but did not identify patients at risk by history. Thus we may be able to establish delirium at triage, but a negative screen there does not preclude its presence; it only means we must continue to be vigilant in assessing for it during ongoing examination. We need to consider those at high risk, and obtain accurate histories from caregivers and family members. Ask specific questions about previous function and recent changes: does she cook? Have you noticed any changes in her thinking in the past few days? Has his behaviour changed? What have you noticed? Has he experienced acute confusion (delirium) with previous illness? Ask about visual changes; while not diagnostic of delirium, they may be an early indication of its development and are a sign of mental changes to be monitored.

Communicate

When delirium is identified, communicate your concerns to others on the health care team. To say, "of course he's confused, he has dementia," is not good enough. Nursing assessment is important; advocate for an accurate diagnosis: "there has been a change in this patient over the past three days and he screens positive for delirium on the CAM tool." Ensure those who assign beds know this patient is a priority for transfer to a unit, out of the busy ED. Share the diagnosis with other staff caring for the patient.

Management

Management of delirium in the ED includes identification and management of possible causes. While one problem may be the culprit, in approximately half of the cases, more than one factor is responsible. As well, further risks such as dehydration may develop once the initial illness has become established. Attention to prevention of iatrogenic factors is needed.

Management of symptoms of hyperactive delirium can be extremely challenging, as patients may be fearful, combative, inclined to get up, but at risk for falls and wandering due to weakness and impaired cognition. Non-pharmacological interventions should be tried first, to avoid side effects of medications: attention to comfort, including toileting, presence of someone familiar to the patient, good lighting, ensuring the patient can hear, addressing the patient by name, avoiding jargon and giving instructions one step at a time can help the patient cooperate with what is needed. In some cases, sedation may be necessary to accomplish investigations. Haloperidol 0.5–1 mg as a starting dose, to maximum of 1.5 mg in 24 hrs is recommended, although for patients

with Parkinson's disease this is contraindicated; a low dose of short-acting benzodiazepine may be needed. Physical restraint is likely to increase agitation and fall risk but, as a short-term measure, careful least restraint measures may be needed, for example, to maintain an intravenous line for necessary fluid and medication.

Disposition

In most cases, admission to hospital will be needed for treatment of the underlying condition, or for diagnosis when this is not clear in the ED. Relocation is a risk factor for delirium; simply being kept in an unfamiliar environment can precipitate acute confusion in demented patients. If adequate treatment and safety can be provided for the patient at home, the patient will benefit from the familiar environment. If admission is required, regular visits and support from family and friends can promote safety, comfort and recovery.

The first step to help patients recover from delirium is to make the diagnosis. I believe emergency nurses can contribute with increased awareness and attention to subtle, but identifiable changes.

Practice points

- Consider the likelihood of delirium in older patients, and screen consistently
- Ensure adequate oxygenation
- Assess medications taken, and recent changes, particularly those with anticholinergic effects such as Diphenhydramine (Benadryl), Dimenhydrinate (Gravol) or tricyclics
- Assess carefully for infection; these patients are generally not good historians, so check for UTI, joint swelling and warmth, skin breakdown, GI or pulmonary source, throat infection or other abnormal findings
- Look for signs of dehydration, particularly dry oral mucosa and "sticky" gums
- Check for and treat constipation
- Seek collateral information from family or other caregivers; ask for specific information about mental changes and changed behaviours
- Remember there may be several contributing conditions, and attention to a number of small needs can bring improvement
- Assume pain is contributing until proven otherwise; a trial of regular dosing of a mild analgesic may improve comfort and promote sleep. When a source of pain is known, even if the patient does not identify it, provide appropriate analgesic. Although opioids may contribute to delirium, untreated pain is a more significant contributor. Hydromorphone is generally preferable to morphine, as the metabolites are less likely to accumulate and worsen delirium
- Do all you can to prevent the development of delirium. Avoid precipitating and perpetuating factors when possible. Don't make it worse! Remove Foley catheters when they are no longer needed, e.g., when patient stabilizes and accurate measurement of output is not necessary. Get patients out of bed for short periods at least three times a day. If swallowing screen is negative, give fluids frequently; request order for IV if needed
- Encourage family presence; they are familiar in the unknown, and can identify early subtle changes, helping in accurate assessment. Educate them about delirium so they understand the importance of their presence and assistance.

About the author

Cathy Sendecki has worked at Burnaby Hospital Emergency Department 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.

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Continuing education: STARS Critical Care Academy…What's that about?

By Christine Maxwell, RN, BN, ENC(C)

I remember very clearly the feeling of writing my last nursing exam. It was a feeling of relief, joy, sense of accomplishment… I was finished and, at the time, I believed "school" would be a thing of the past. Little did I know at that time that my career would encourage me to pursue knowledge, continue to learn and challenge myself.

The first challenge arose when I decided to change my career path from palliative care nursing into emergency nursing. That first year was a steep learning curve. It was overwhelming to say the least. Many days were filled with self-doubt, the occasional day of triumph and many, many days of learning. Learning a multitude of new skills, new tasks, new knowledge, new medications, new coping mechanisms and, somewhere in that year, a deep appreciation and passion for emergency/critical care nursing was sparked.

Fast-forward five years into my emergency nursing career and the learning and challenging continues. In those five years I have achieved certifications in ACLS, PALS, TNCC, ENPC and also received my designation as a certified emergency nurse, ENC(C). I have attended many conferences and education days in the hopes of acquiring new knowledge, best practices and meeting fellow nurses who share the same desire to learn more. I have found in my own practice that continuing education improves confidence in your work. It allows you to increase the level of care you provide for your patient by using best practices and acquired new knowledge and also can create more effective communication between health care disciplines involved in patient care. I have come to understand that when you know better, you do better. Education allows us to do better.

Looking for my next challenge, I stumbled across the STARS (Shock Trauma Air Rescue Society) Critical Care Academy program. It is a certificate course offered through the accredited University of Calgary. I applied for the program and was a successful applicant. I was now looking at a 16-week, intensive program geared towards critical/emergency care. Entering the program, I knew that I would gain something, and it is now safe to say that I didn't understand how much I would advance my training, skills and critical thinking. Looking back, it is difficult to put into words the impact this program has had on me, as a nurse and health care provider.

Each week entailed new readings, assignments and postings to complete—all geared around critical thinking and emergency/critical transport care. A residency week during the middle of the course at one of the STARS bases provided many "light bulb" moments and exposure to new skills and knowledge. Each morning we had lectures from cardiologists, intensivists, obstetricians and emergency physicians. Afternoons were immersed in skill labs and simulations with "Stan" the mannequin. Some days Stan would die, some days he would survive. Each simulation presented valuable learning moments, trained you how to focus on the important information and how to effectively communicate with your team. Teams were comprised of a nurse and paramedic duo. This allowed us to gain a better sense and understanding of each other's role and encouraged us to combine our skills to the greatest effect. "Stan" was getting the best of both worlds and teamwork was of essence in this critical care environment for success to occur. It was incredible watching our team evolve. As communication improved we became more effective, and as we became more effective "Stan" faired better. We decided on the course of action/treatment, differential diagnosis and interpreted labs, ECGs and x-rays as a team. Camaraderie is of great benefit in the emergent care environment. The simulations were by no means easy—they were based around real calls STARS has responded to in the past and success brought a great sense of accomplishment to our team. Skills labs included interpretation of x-rays, percutaneous trans tracheal ventilation, cricothyrotomy, inserting TVP, intubation and many more interesting skills. Although all of these skills are not in our scope of practice as RNs, they were taught so that we could be better support systems for the physicians and staff having to complete the procedures. We would be able to prepare for possible complications and offer suggestions, if needed. I have also found that the knowledge gives you more confidence in assisting with these procedures and the continuing care of the patient once they are completed.

Near the end of the program, we all completed a flight practicum at one of the STARS bases. I had the opportunity to gain hands-on experience with some of the best in the critical care transport field. I witnessed firsthand the skill, intelligence and experience of the nurses and paramedics of STARS. During my three shifts, we were called out for four missions of varying emergencies, including a pre-eclamptic emergency, a sepsis, a central cord shock syndrome and a resuscitated traumatic cardiac arrest. The experience was phenomenal and positive in every aspect. The team was supportive, allowed for many, many questions to

be asked, and also promoted my learning when not on flights. The program, complete with the practicum, made it very evident that education is highly valued amongst the STARS organization and has proved to be the best educational experience I have had to date in my career.

Overall, this program has given me a chance to network and collaborate with 13 other incredible academy students compromised of ICU and ER nurses, paramedics and a GP from across Alberta, Saskatchewan and Manitoba. It has provided me with a greater depth of critical care knowledge and increased respect for my colleagues. I really am changed for the better. The level of knowledge, experience, dedication and commitment of the instructors and classmates has left an everlasting impression. Everyday I will strive to be better, do better and teach better. I encourage those who have a few years of emergency nursing experience and are interested in advancing or improving your critical care practice to apply for this program… you will not be disappointed. To learn more about this program, please go to **www.stars.ca**.

About the author

Christine Maxwell, BN, RN, ENC(C), is a registered nurse, practising for the past five years in the emergency department of the Grey Nuns Hospital in Edmonton, AB. She received her nursing diploma from Grant MacEwan in 2007 and her degree in 2011 from the University of Athabasca. When not at work, she enjoys travelling, spending time with family and her newest addition… training to run a half marathon.

BOOK REVIEW

Forensic Nursing: Evidence-Based Principles and Practice

Authors: Rose E. Constantino, Patricia A. Crane, Susan E. Young

Publisher: F.A. Davis Company, 2013,
ISBN 978-0-8036-2185-5

One of the newer books on forensic nursing, this text addresses the science of forensic nursing from the perspective of evidence-based principles applied to practice settings. The authors state their goal in writing the text is "to provide a roadmap to forensic nurses nationally and globally as they continue to make a difference in their specific area of practice" (page vii). There are 30 contributing authors for this text including one Canadian: Catherine J. Carter Snell, RN, PhD, SANE-A, ENC-C.

The text is divided into four units with each unit having several chapters on the unit topic. Each chapter begins with a list of competencies and key terms relevant to the chapter. Case studies are included throughout the text, focusing on providing the reader with the opportunity to gauge their knowledge in relation to the content for each chapter. At the end of each chapter is an evidence-based practice question with selected references to answer the practice questions posed by the authors. There are chapter review questions in the form of multiple choice questions, as well.

Unit titles are:

1. Introduction to Forensic Nursing Practice
2. Forensic Nursing in Interpersonal Violence
3. Forensic Nursing in Special Areas of Practice
4. Forensic Nursing in Collective Violence

After reviewing the textbook, I found it to be a very well written, coordinated text reflecting current practices for the forensic nurse and others in clinical settings. It is not a text filled with photographs of injuries and crime scenes—in fact, there are very few photographs in the entire text. There is a very nice timeline of events in forensic nursing's history, dating from 1948 to the present (page 6).

Chapters of interest to emergency nurses

Chapter 9: "Violence: Sexual Assault and the Forensic Nurse" describes the role of the sexual assault nurse examiner, the effectiveness of the role and legal outcomes. The chapter describes the assessment techniques of a forensic examination, the physical examination process and evidence preservation and collection.

Chapter 16: "Evidence: Forensic Nursing in the Emergency and Acute Care Departments" is of particular interest to the emergency nurse. It covers the development of health care-based violence intervention programs and sexual assault nurse examiner/forensic nursing programs within the ED. It identifies screening issues and barriers to conducting assessments in busy EDs. There are two assessment tools provided in this chapter. One is for abuse assessment screening and the second is Jacquelyn C. Campbell's danger assessment for women and men. The types of injuries commonly seen in the ED are described (abrasion, avulsion, bruises, laceration, cut, ecchymosis, patterned injury, petechiae, slap injury, firearm injury, bite mark and strangulation). There is a short section on the importance of documentation, as well.

Chapter 18: "The Forensic Nurse and Human Trafficking". This chapter highlights an aspect of violence that has not been prominent in forensic nursing until the last decade. Human trafficking is a global issue. Health care providers including first responders, nurses and physicians must understand the dynamics of human trafficking in order to provide the best care for victims of human trafficking. The chapter provides a background on human trafficking, trafficking definitions, risks and causes of human trafficking, identification of the trafficked person, and health concerns of trafficked victims, as well as planning interventions, interventions and implications for nurses as first responders. A simple set of screening questions is also provided.

Respectfully submitted,
Sheila Early, RN, BScN
President International Association of Forensic Nurses

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: _____

Conference notices

Western Emergency Department Operations Conference (WEDOC 2014)

May 1–2, 2014, Sutton Place Hotel, Edmonton, AB
To receive more information and to be contacted when registration is open, please email us: **cpd.info@ubc.ca**

Objectives:

- Review system-wide interventions such as P4P, accountability frameworks, benchmarks to address ED overcrowding
- Further develop the Western Canadian network in emergency medicine and operations
- Identify opportunities for collaboration and information sharing

Pre-conference workshop: CAEP: Toxicology Roadshow (Wednesday April 30)

1st Global Conference on Emergency Nursing and Trauma Care

September 18–21, 2014, Dublin, Ireland. Website: **www.globaledconference.com**
Secretariat: Charlotte Alman Elsevier, Email: **c.alman@elsevier.com**

Synopsis: The conference is for anyone involved in the delivery, development and organization of emergency nursing, trauma care, paramedical and medical sciences in both the developed and developing world.

ENA Proudly Announces the New Online GENE Course

GENE is a comprehensive eLearning program designed to provide the best evidence-based care for older adults. Elderly patients often present a unique set of challenges for emergency professionals. This extensive course gives nurses the tools to assess special needs in older adults, to recognize atypical presentations, and to coordinate care that will help improve patient outcomes.

The Geriatric Emergency Nursing Education Course includes:
Live links to additional resources, eLearning modules to test your knowledge, course narrative notes for greater retention, 17 interactive modules, up to 15.21 credit hours, and geriatric evidence-based data. For group pricing or more information, contact: **gene@ena.org** or 847-460-4055

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.