CANADIAN JOURNAL of EMERGENCY NURSING

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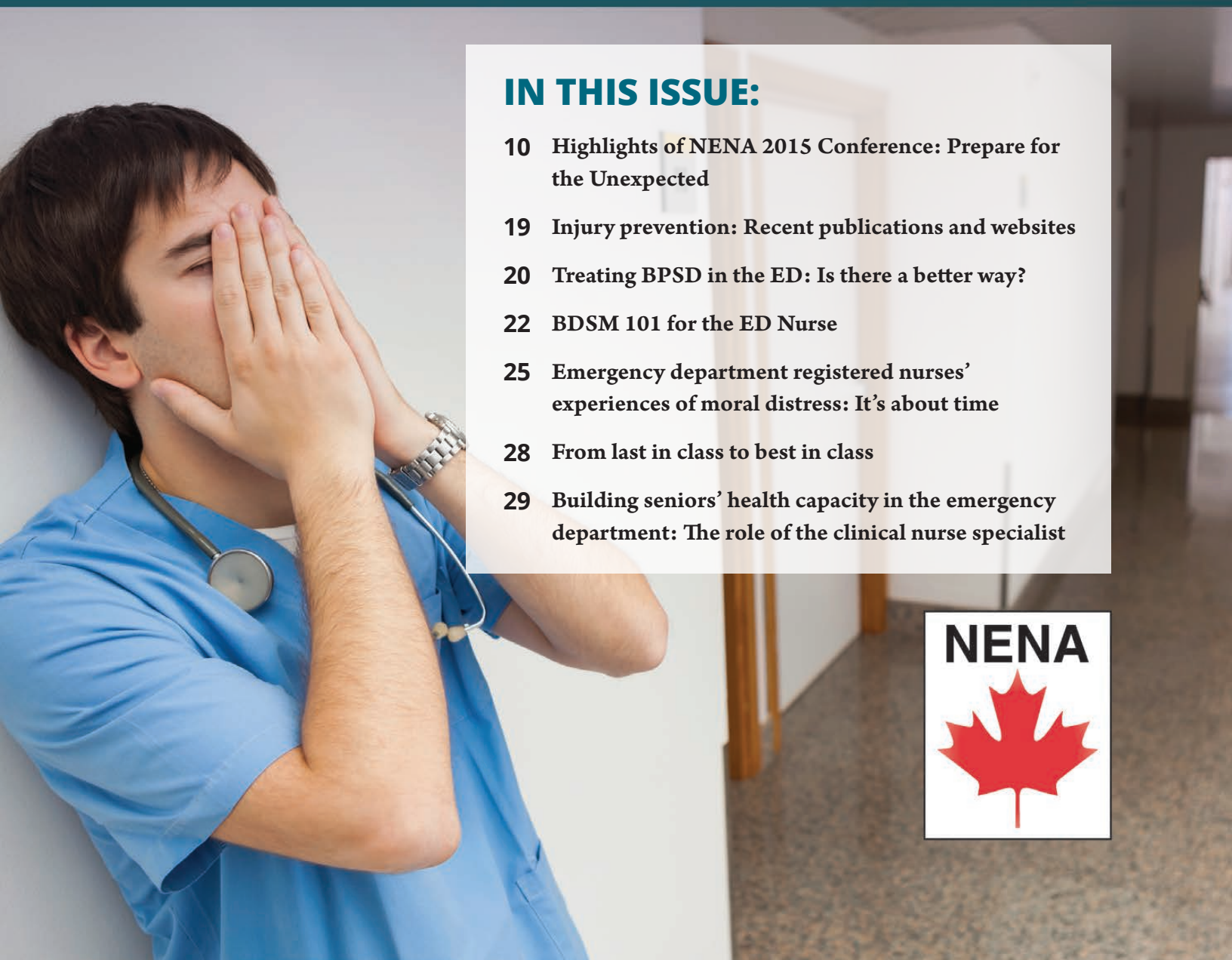

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NENA

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

CANADIAN JOURNAL of EMERGENCY NURSING

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Editorial staff

NENA elected officers

Provincial directors

Committee chairs

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President's message

It is my honour to deliver this, my first President's Message, to fellow NENA members. The National Emergency Nurses Association, NENA, sets the gold standard in Canada for issues related to care of the patient and their family in the emergency department. Thank you to each and every one of you for being a member.

NENA has undergone significant change in the past few years in order to comply with the new Canada Corporations Not-for-Profit regulations. We have now completed the mandated changes and are ready to move forward. Many thanks to past NENA Presidents Sharron Lyons and Janet Calnan for their many hours of work during the transition.

Under the new structure, the NENA Board of Directors consists of the president, past president or president-elect, secretary, treasurer, director of training/education and director of membership and recruitment. The members of the executive work with the President's Council – Provincial Council (provincial representatives), the National Course Administration Committee (NCAC), Triage Committee, the National Advisory Council (CJEN Editor and Website Coordinator) and a national conference chairperson. The Board of Directors and all members of the President's Council are assisted by our Financial Administrator, NENA's only part-time paid position. I would like to say thank you to each one of these members for their countless hours of dedicated service to NENA. Please do not hesitate to contact the Board of Directors with questions, concerns, suggestions, etc. Our contact information is listed on the website, **www.nena.ca**.

I must give a special thank you to Janet Calnan, immediate past president, for her guidance, mentorship and calm approach, as we transitioned to our new structure.

During my more than 40 years as an RN, I was fortunate to work with many people, two of whom became special mentors to the growth of my career. Two wise people, in different locations, who made it easy to enjoy going to work every day. What I learned from them is what I consider my "platform" for the next two years, as I serve as NENA President: "Patient care comes first". Our patients are the reason we do what we do where we do it every day. Of course, this includes family members, as well, and sometimes this is just not very easy to remember. Overcrowding, admitted patients in the ED, staffing challenges and violence in the workplace—you have heard it all and it is all true. But still we go to work every day and for that I say thank you.

The other lesson I learned from my mentors is the value of the people we work with. I was an administrator for many years and I knew my most valuable resource was the staff, for I could not deliver our mission "to provide care" without them.

Here again, as your president, it is the same. NENA's strength is in our members. Our voice is as strong as our members, our ability to influence change the same. So, thank you again.

I look forward to meeting as many of you as possible these next two years. (That is a hint to invite us to your provincial meetings, conferences, etc.). Please support your provincial meetings, education offerings and, of course, attend the NENA National Conference in Montreal, April 22–24, 2016.

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

2015 Poster Presentations

The NENA Board of Directors asked the 2015 Conference Committee to put out a Call for Poster Presentations to encourage nurses to use the NENA Conference as a platform to present their work. The posters could be research based, educational, and innovative or simply a problem that needed to be solved. The response may not have been overwhelming, however, the posters that were presented were very well received by the delegates. See list below.

Marissa Weiler, RN, ENC(C): *There is no 'I' in Team...or Emergency*

Laura Ebenspanger, RN: *Translating Emergency Knowledge for Kids (TREKK): A Social Networking Analysis of a National Pediatric Emergency Network*

Matthew Douma, RN, BSN, ENC(C), CNCC(C): *Double Barreled IO: A Feasibility Trial of Dual Interosseous Needles Inserted into a Single Porcine Humerus*

Matthew Douma, RN, BSN, ENC(C), CNCC(C): *Pumps, Pipes & Tubes: A Description of Common Nitroglycerin Infusion Delays & Overdoses*

Margaret Dymond, CNE: *A Behind the Scenes Look at the Door to Needle Times Process Improvement Initiative at the University of Alberta Hospital*

Ashley Murakami, RN, BN: *Improving Timely Patient Care using a Dynamic Intake Process in a Busy Urban Emergency Department*

Cheryl Swanson, Nurse Educator: *Flow Nurse" Role in our Emergency Department*

Communications report

As our profession becomes increasingly entrenched in the use of electronic media, one could easily wonder if the printed page is heading toward obsolescence. Why do I say this? My grandchildren are encouraged to use electronic tablets in the early grades of school; they are not taught penmanship. Electronic records are becoming the standard in every business and discipline, especially in health care. Human voice and contact have been usurped by gadgets and logins. I have a friend who is a patient at one of the continent's largest cancer treatment centres and all of their registration and paging is done with iPads and text messages—something, she says, is a struggle for the elderly patients who sit beside her in the waiting areas. Many of us no longer carry paperback books to travel, preferring the easy use of a Kindle or other device.

Despite understanding the manifold reasons for using electronic communication, some of us love to hold the real books and papers in our hands. There is something wonderfully amazing about the visual presentation of a paragraph or page with contrasting or complementary fonts and text sizes, the texture of the pages, the use of images and colour to support, highlight, or enhance the meaning of the passages in print. The slight discolouration in the margins of favourite pages in oft-used reference material, the way that documents and books fall open to the last page read, the ability to put a book down and return to it without signing in again—these things are delightful to me.

As I work with authors, advertisers, the NENA board and committee members, and our publisher to assemble another CJEN, I know that some people will never read it. Others will wait until it is available electronically on the website and download it to their computers for possible use in the future. For those who prefer to rely on characters on a screen—good for you!

For those readers, like me, who love to hold journalism in our hands, I offer you an opportunity to enjoy this Fall 2015 *Canadian Journal of Emergency Nursing* in print. Written by Canadians who may not share my love of the printed page, this journal carries the vision of nurses with whom NENA shares a bond of dedication to patient care. I trust you will find as much joy in reading this as I have in preparing it.

Thank you to all who submitted content to this journal. It is so much appreciated by all of us. The deadline for the spring edition is February 10. Guidelines for submission are available on the **NENA.ca** website.

Respectfully submitted,
Stephanie Carlson

Director of Membership & Promotion report

I am Pat Mercer-Deadman from Edmonton, Alberta, and I am proud to have been appointed to the NENA Board of Directors in the new and developing position of Director of Membership & Promotion. I have been an emergency nurse since 1983 and have maintained certification in emergency nursing with the CNA since 1998. I am the immediate past president of NENA-AB.

During my term of office, Alberta had great success in growing our provincial membership from 130 to more than 300. I look forward to introducing the provincial directors to some strategies that worked for Alberta, and to developing new initiatives to increase NENA membership and promote NENA within the provinces and across Canada. We need to be recognized as the **"voice"** of emergency nurses and the **"go-to people"** when the media need commentary on emergency nursing issues, whether it is Ebola, or emergency inpatients.

As part of my portfolio, I will make efforts to re-establish provincial associations, so that each province or territory is represented on the Presidents' Council, which reports to the Board of Directors of NENA. We need to increase the visibility of NENA, so that every nurse across the country who works in an emergency department, room, urgent care or outpost, knows who NENA is and what our goals are, and sees the value in membership.

Our organization needs to grow and serve you, our members, better. Let your voices be heard. I value feedback and suggestions from NENA members on what you would like to see from us, as an organization. Why did you join? What keeps you a member? Go to nena.ca and send me an email.

Some benefits of membership

- Looks good on a CV/resume
- Great for continuing competencies—provincially and for the CNA certification
- Bursaries—FREE money available provincially and nationally
- *Canadian Journal of Emergency Nursing* subscription, a chance to be published in a national publication
- Provincial newsletter where available
- Nena.ca our new and improving website
- Reduced rates for courses such as TNCC, ENPC & CTAS
- Access to NENA Position Statements and Standards of Emergency Nursing
- Annual NENA conferences and provincial conferences at reduced rates

I challenge each NENA member to spread the word and encourage your friends and co-workers to join NENA, **the** professional association of emergency nurses in Canada.

Pat Mercer-Deadman,
RN, ENC(C)

FOR IMMEDIATE RELEASE

Greater Accessibility to the National Guidelines for Anaphylaxis Management in Canadian Schools

Now Available in e-book, Flip-book and PDF Versions

OTTAWA, ON – September 15, 2015 – The Canadian Society of Allergy and Clinical Immunology, in collaboration with Food Allergy Canada (formerly Anaphylaxis Canada), the Allergy/Asthma Information Association, Allergy Quebec (formerly Association québécoise des allergies alimentaires), and the Canadian Allergy, Asthma and Immunology Foundation, is pleased to announce the availability of the *Anaphylaxis in Schools & Other Settings, 3rd Edition* resource in e-book and flip-book versions.

With more people accessing digital resources, important information on anaphylaxis will reach a greater number of Canadians. This is the latest initiative by our organizations to increase public education on potentially life-threatening allergies.

Originally released in PDF version in 2014, *Anaphylaxis in Schools & Other Settings* includes updated information on the effective management and treatment of anaphylaxis in school communities. The resource also includes the input of individuals from more than 15 national and provincial health and education and training organizations as well as parents.

"We are pleased to provide greater accessibility to this important resource for schools," said Dr. Sandy Kapur, President, Canadian Society of Allergy and Clinical Immunology. "By doing so, we hope to increase the understanding of anaphylaxis within school communities in order to safeguard both students and staff with potentially life-threatening allergies."

Anaphylaxis is a growing public health concern and the need for ongoing education and awareness is essential. While *Anaphylaxis in Schools & Other Settings* primarily refers to the school environment, many of the key recommendations and management strategies apply to all individuals at risk of anaphylaxis and are applicable to other settings.

For more information about the various versions of *Anaphylaxis in Schools & Other Settings, 3rd Edition* in English and French, go to **www.csaci.ca**.

About the Canadian Society of Allergy and Clinical Immunology (CSACI). The CSACI is the largest national professional medical specialty organization in Canada representing allergists, physicians, allied health professionals and scientists with special expertise in the management of allergic and immunologic diseases. The Society is also dedicated to improving the quality of life of people with allergies through research, advocacy, and continuing professional development and public education.

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For more information, please contact:
Louise Tremblay, CSACI Executive Director
Tel: 613-986-5869 / Email: info@csaci.ca

POUR DIFFUSION IMMÉDIATE

Plus grande accessibilité aux lignes directrices nationales en matière de gestion de l'anaphylaxie dans les écoles canadiennes

Maintenant offertes dans un livre numérique, un livre numérique feuilletable et en version PDF

OTTAWA, ON – 15 septembre 2015 – La Société canadienne d'allergie et d'immunologie clinique, en collaboration avec Allergies Alimentaires Canada (auparavant Anaphylaxie Canada), l'Association d'information sur l'allergie et l'asthme, Allergies Québec (auparavant Association québécoise des allergies alimentaires) et la Fondation canadienne d'allergie, d'asthme et d'immunologie, est heureuse d'annoncer la disponibilité de nouvelles versions de *L'anaphylaxie à l'école et dans d'autres milieux, 3e édition*, soit un livre numérique et un livre numérique feuilletable.

Puisque les gens utilisent de plus en plus les ressources numériques, de l'information importante relative à l'anaphylaxie atteindra plus de Canadiens et de Canadiennes. Il s'agit de la plus récente initiative de nos organisations pour favoriser l'éducation du public quant aux allergies pouvant mettre la vie en danger.

Initialement offert en version PDF en 2014, le document *L'anaphylaxie à l'école et dans d'autres milieux* comprend de l'information mise à jour sur la gestion et le traitement appropriés de l'anaphylaxie dans les milieux scolaires. Cette ressource a été revue et commentée par des personnes provenant de plus de 15 organisations nationales et provinciales s'intéressant à la santé et à l'éducation ainsi que par des parents.

« Nous sommes heureux de rendre cette importante ressource pour les écoles plus accessible », a dit Dr Sandy Kapur, président de la Société canadienne d'allergie et d'immunologie clinique. « Ce faisant, nous espérons que plus d'intervenants dans les écoles comprendront mieux l'anaphylaxie afin d'assurer la sécurité tant des élèves que du personnel vivant avec des allergies pouvant mettre leur vie en danger. »

L'anaphylaxie est un enjeu de santé publique de plus en plus préoccupant et les besoins en matière d'éducation et de sensibilisation sont sans cesse renouvelés. Bien que *L'anaphylaxie à l'école et dans d'autres milieux* fasse principalement référence à l'environnement scolaire, plusieurs des recommandations clés et des stratégies de gestion de l'anaphylaxie s'appliquent à toutes les personnes à risque d'anaphylaxie dans d'autres milieux.

Pour plus d'information relativement aux différentes versions de *L'anaphylaxie à l'école et dans d'autres milieux, 3e édition*, en anglais et en français, visitez le **www.csaci.ca**.

La SCAIC est la plus importante société professionnelle nationale de spécialistes médicaux au Canada qui représente des allergologues, médecins, professionnels paramédicaux et scientifiques ayant une expertise particulière dans la prise en charge des affections allergiques et immunologiques. La Société est aussi vouée à améliorer la qualité de vie des personnes qui souffrent d'allergies grâce à la recherche, la défense des intérêts, le développement professionnel continu et l'éducation du public.

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Pour plus d'information, veuillez vous adresser à :
Louise Tremblay, directrice du SCAIC
Tél. : 613-986-5869 / Courriel : info@csaci.ca

2016 NENA Conference—"Unleash the power of the ED nurse / Exploiter le pouvoir de l'infirmière à l'urgence"

National Emergency Nurses Association Annual Conference Montreal, Quebec April 22–24, 2016

The Association des infirmières et infirmiers d'urgence du Québec is proud to host and support the 2016 annual conference of the National Emergency Nurses Association in Montreal. We invite emergency nurses to draw on their experience and creative resources and bring a presentation to this conference. This is your opportunity to share innovative clinical projects and research in current topics in emergency nursing with an international audience. Simultaneous translation services will be available during this conference.

See you in 2016!

Steve Gagné, BSN, CNCC(C)
Responsable des relations externes à AIIUQ
NENA Conference Chair – Président de conférence 2016
Contact: Email 2016 Conference

Conférence de l'Association nationale des infirmières et infirmiers d'urgence Montréal, Québec 22 au 24 avril 2016

L'Association des infirmières et infirmiers d'urgence du Québec est fière d'accueillir et de supporter la prochaine conférence annuelle du NENA à Montréal. Sachant que les infirmières d'urgence sont reconnues pour être des professionnels créatifs et innovateurs, nous sollicitons votre savoir ou votre expertise afin que vous puissiez partager vos réalisations cliniques ou vos connaissances sur les sujets de l'heure. Veillez prendre note qu'un service de traduction simultanée sera disponible pour les congressistes.

Au plaisir de se voir en 2016

“Unleash the power of ED nurses / Exploiter le pouvoir de l’infirmière à l’urgence”

National Emergency Nurses Association Annual Conference
Montreal, Quebec
April 22–24, 2016

Conférence de l’Association nationale des infirmières et infirmiers d’urgence
Montréal, Québec
22 au 24 avril 2016

Prenez part au congrès annuel de l’Association nationale des infirmières et infirmiers d’urgence qui se déroulera à l’hôtel Omni de Montréal. Le comité organisateur se prépare actuellement à mettre sur un pied un programme unique qui aura pour objectif de regrouper les domaines de la pratique clinique d’une infirmière en salle d’urgence. La conférence portera sur le thème suivant : ***Exploiter le pouvoir de l’infirmière à l’urgence***. Dans le cadre de cette conférence, l’innovation, la spécialisation requise du champ de pratique, la potentialisation du rôle de l’infirmière, l’expertise clinique et le corpus de connaissances propre à notre spécialité seront au cœur des présentations et des ateliers.

Le comité scientifique vous invite à soumettre des abrégés qui portent sur différents aspects de la clinique, la gestion et la recherche. Nous encourageons les infirmières et les infirmiers travaillant dans divers milieux à soumettre des abrégés qui mettent en valeur des interventions infirmières, de nouveaux projets ou des projets qui sont présentement en cours, des résultats de recherche, des enjeux éthiques et légaux propre au milieu de l’urgence, des études de cas et des données issues de la littérature. Nous sommes à la recherche de sujet pouvant enrichir et approfondir les échanges que nous espérons entamés au cours de la conférence.

Réservez vos dates pour cet évènement.

N’oubliez pas de consulter régulièrement le site internet de la conférence pour toutes les informations clés et les annonces importantes. **http://nena.ca/conferences/nena-conference-2016/**

Highlights of NENA 2015 Conference: Prepare for the Unexpected

The 2015 Conference had a total of 254 delegates during the two-and-a-half-day event, with an additional 62 delegates attending the preconference CAMAN or Wound Management workshops.

The opening ceremonies of the conference were Thursday evening with the Board of Directors and guests being piped in, (#0850) by the Alberta Paramedic Guard of Honour. The Piper Andrew Fairservice was followed by the Honour Guard: Blaine Barody, Gerry Murphy, Gerry Gunderson and Eric Armsworthy.

There were greetings, including a video message from the national Minister of Health, Hon. Rona Ambrose. (#0855). Greetings from CNA were conveyed by Janet Calnan NENA President, NENA-AB President Shelley Pidruchney and Dr. Raj Sherman, former Liberal MLA and Emergency Physician. The evening keynote address was given by Detective Guy Pilon from the Edmonton Police Service on current street drugs.

The annual general meeting was followed by refreshments, appetizers and an entertaining game of *Family Feud* which numerous teams of conference attendants played, with boisterous audience participation. (#0881- 0882)

Friday and Saturday saw a total of 38 workshops and keynotes sessions. The speakers were all very well received with the evaluations showing 93% of participants felt the workshops were above average or excellent.

Our exhibitors and vendors received many delegates at nutrition breaks and lunches. A huge thank you to Stryker and Hill-Rom—these vendors loaned stretchers used during the skills lab breakout sessions. Moving the stretchers back and forth prior to the breaks was a great example of how easy this equipment is to move around obstacles and people. The moves went well for the most part although our pregnant resuscitation doll did get a bit hot (burst into flames)! The stretcher was saved (#0855), so Sharron could relax and breathe. Evaluations showed both exhibitors and delegates enjoyed the exhibit hall and would like more time to talk with the representatives. These comments have been forwarded to the 2016 conference team.

On Friday, seven poster presentations (#0904-0916) were on display and delegates were encouraged to drop by to speak with the presenters. This was a fairly new addition to the conference layout and NENA hopes to expand the poster session at future conferences. NENA welcomes and encourages participation from emergency nurses at future conferences.

A scavenger hunt at West Edmonton Mall was held as a social event and although it got off to a slow start, had 75 participants. Each person received a bag, map, coupon book and a list of questions and places they needed to find. There was a lot of shopping (hopefully delegates used the coupons in their book) (#0924) and socializing.

On Sunday, the final day of the conference, there were three excellent keynotes that included a very sincere presentation by Patrice Gordon on her personal experience with Ebola in Africa and at home in B.C. It was fabulously interesting and very touching.

Navkiran Tiwana and her team of volunteer student nurses did an excellent job of helping with last-minute registrations, requests from speakers and the organization, and running the registration desk. This also helped relieve the NENA Board of Directors and the conference committee so they could take care of other duties.

The conference committee were extremely pleased with Conference 2015 —Prepare for the Unexpected, and wish to thank everyone for their assistance and attendance. You made this conference a great success and we look forward to NENA Conference 2016 in Montreal.

Respectfully submitted,
Sharron Lyons, Conference Chair
Pat Mercer-Deadman, Conference Co-Chair

Coming soon!

Xarelto®
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Xarelto® is indicated for the treatment of venous thromboembolic events (deep vein thrombosis [DVT], pulmonary embolism [PE]) and prevention of recurrent DVT and PE.

For the treatment of VTE, Xarelto® is **not** recommended as an alternative to unfractionated heparin in patients with acute pulmonary embolus who are haemodynamically unstable, or who may receive thrombolysis or pulmonary embolectomy, since the safety and efficacy of Xarelto® have not been established in these clinical situations.

Xarelto® is not recommended for use in children less than 18 years of age.

Consult the Xarelto® Product Monograph at http://bayer.ca/xarelto for contraindications, warnings, precautions, adverse reactions, interactions, dosing, and conditions of clinical use. The product monograph is also available by calling 1-800-265-7382.

Reference: 1. Xarelto® (rivaroxaban tablet) Product Monograph. Bayer Inc. July 20, 2015.

Bayer HealthCare

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www.prneducation.ca

INFORMATION RELEASE

Canada's National Emergency Nurses Association (NENA) Developing Standardized Emergency Nursing Course Based on Core Competencies

Vancouver, BC – October 02, 2015 – The National Emergency Nurses Association (NENA) is pleased to announce that it is co-leading a project to develop a standardized emergency nursing course, to be delivered to nurses throughout Canada in both English and French and based on the NENA Core Competency document.

For many years, the Emergency Nurses of Canada have been requesting a Canadian-developed course to cover the core concepts of being an emergency nurse. They have requested that this program be based on Canadian emergency nursing standards, be delivered in both official languages, and subscribe to modern learning techniques that focus on the adult learner.

NENA has engaged a team of experienced emergency nurses from across Canada who are currently developing course content that will be a balance of online and attended classroom content. The classroom content will be structured in small group scenario format to focus on both the practical and critical thinking components of emergency nursing practice. In addition to the theoretical content, there will be certain practical skills reviewed that are specific to an emergency nurse's expected practice.

The course is being designed to benefit both new and experienced practitioners and is expected to be two days in length with an amount of online preparation beforehand. The distribution format will be similar to many other standardized courses—this being individual nurses, facilities or private teaching organizations able to become instructors/course coordinators and distribute the course in a way that meets the needs of their communities. It is anticipated that the course will be attended by Registered Nurses, Licensed Practical Nurses and other non-physician health care providers in the emergency department.

Ongoing support of the program and revisions to the course will be supported through the collection of a fee for every student who participates. It is the intention of the design and sustainment teams that the program be kept current with evolving research and practice changes to allow repeat students to further their learning when they re-attend upon expiry.

Interested nurses and organizations who wish to receive further information as it is released should register their information at **http://eepurl.com/bz-kiL**, by visiting one of the websites above, or by scanning the QR Code Here. The program has an anticipated release date of Spring 2016.

This project is a joint project between the National Emergency Nurses Association of Canada and prn Education—A part of Pacific Rim Nursing Consultants Inc.

www.nena.ca

www.prneducation.ca

COMMUNIQUÉ

L'association nationale des infirmiers/infirmières d'urgence du Canada (NENA) propose une formation en soins infirmiers d'urgence

Vancouver, C.-B. – le 2eme octobre 2015— L'association nationale des infirmiers/infirmières d'urgence du Canada (NENA) est heureuse d'annoncer qu'elle codirige le développement d'un cours de soins infirmiers d'urgence. Ce cours, basé sur les critères de compétence en soins d'urgence, sera offert aux infirmiers/infirmières partout au Canada, en anglais et en français.

Depuis plusieurs années, les infirmiers/infirmières d'urgence du Canada nous demandent une certification canadienne en soins infirmiers d'urgence. Ils veulent que cette certification soit construite selon les normes de soins infirmiers d'urgence canadiennes, qu'elle soit disponible dans les deux langues officielles et s'appuie sur des techniques modernes d'apprentissage.

NENA collabore avec une équipe d'infirmières d'urgence expérimentées de partout au Canada qui sont en train de développer le contenu d'une formation qui possèdera un bel équilibre entre l'apprentissage en ligne et en classe. Le format d'enseignement utilisé en classe sera des ateliers en petit groupe afin de se concentrer sur les composantes de la pensée pratique et critique de la pratique des soins infirmiers d'urgence. En plus du contenu théorique, certaines compétences pratiques seront révisées en fonction des besoins de la pratique des professionnels infirmiers en salle d'urgence.

Cette formation s'adresse autant le nouveau personnel infirmier qu'aux professionnels plus expérimentés. Ce cours sera d'une durée de 2 jours avec un apprentissage en ligne au préalable. Le format du programme sera semblable aux autres cours standardisés - ce qui permettra aux professionnels infirmiers, aux institutions et aux organismes d'enseignement privé de devenir des instructeurs / directeurs de cours et de l'enseigner d'une manière qui répond aux besoins de leur communauté. Cette formation sera offerte aux infirmières, aux infirmières auxiliaires et autres professionnels (sauf les médecins) qui travaillent en soins d'urgence.

Le soutien continu et les révisions du programme seront inclus dans les frais d'inscription de chaque participant. Considérant l'évolution et les changements rapides de la pratique en soins d'urgence, notre objectif est d'avoir une équipe qui maintiendra à jour le programme afin de permettre aux participants de renouveler leur apprentissage lors de l'expiration de leur certification.

Les infirmiers/infirmières et les organisations qui souhaitent recevoir plus de renseignements sur l'évolution de ce programme sont priés de soumettre leurs coordonnées grâce au lien suivant **http://eepurl.com/bz-kiL**, en visitant l'un des sites ci-dessous, ou en scannant le code QR ci-joint. Le programme devrait débuter au printemps 2016.

Cette formation est un projet conjoint entre L'association nationale des infirmiers/infirmières d'urgence du Canada (NENA) et prn Education (une filiale de Pacific Rim Nursing Consultants Inc.).

Director of Training report

By Margaret Dymond

Thank you to all TNCC, ENPC, and CTAS instructors who continue to offer courses throughout Canada. There have been some changes over the summer to Emergency Nurses Association (ENA) fees and the business address for TNCC and ENPC course paperwork. The information was communicated to all TNCC and ENPC course directors through a newsletter from ENA called "Course Vitals" (formerly Coursebytes) and in the Spring 2015 newsletter from your NCAC representative. NENA fees for courses have not increased.

Course fees

The course fees (indirect to ENA) and direct fees to NENA are required to be sent within 30 business days of the course completion date. Course directors will receive notices from ENA if the indirect fees are overdue. For NENA-related courses, course directors will receive an overdue notice from the financial officer for NENA. All course directors should ensure your contact information is up to date for ENA and NENA for ease of communication.

What the Canadian course fees are used for

NENA is a not-for-profit organization and is internationally recognized for its work in emergency nursing. In order to operationalize NENA's business, funding is required. The two main sources of income to run the organization are generated through NENA membership fees and course fees from TNCC, ENPC, and CTAS. NENA plans its budget based on these main sources of funding. All NENA board members and committee members (NCAC, triage [CTAS], president's council, website coordinator, CJEN editor) are volunteers. They are not paid for their work on NENA-related business. The income generated from collection of fees is to support attendance of NENA officers and related committees for meetings and travel expenses, supporting a national emergency nursing conference annually, publication twice annually of the *Canadian Journal of Emergency Nursing (CJEN),* French translation of NENA documents (position statements, standards of practice), and to support ongoing maintenance of the NENA website. NENA has one paid employee—the accountant who is paid through these funding sources. This funding also supports NENA members with the provision of bursaries to qualified members in pursuit of educational programs/courses related to emergency nursing. NENA provides research grants to qualified NENA members pursuing research in the field of emergency nursing. These are examples of a few special projects NENA is involved with and can support NENA members with these opportunities based on funding received from the membership and course fees. In many areas of Canada, NENA members will enjoy a reduced registration fee for courses, conferences, and workshops. Becoming a NENA member and taking NENA-sponsored courses helps operationalize the business of NENA and promote our nursing specialty in Canada.

Special projects: Canadian Emergency Nursing Certification ENC(C) resources

Canada has a well-recognized certification program for emergency nurses. This recognition is noted internationally. The goal in the next few months will be to provide resources to emergency nurses in Canada to prepare to write the Canadian certification exam. These resources will be available via the NENA website. Qualified NENA members pursuing emergency nursing certification can apply for a NENA bursary in support of emergency nursing certification.

The Canadian nursing certification program is transitioning from a paper to computer-based exam. Applications and/or renewals for certification will be deferred to winter/spring 2016. RNs who need to renew this fall will be given an extension to renew their certification to the end of 2016. The CAN website will have up-to-date information on this new process for certification.

CTAS report

A huge thank you to the many CTAS instructors who took the time to complete the survey and provide their input to the CTAS National Working Group in preparation for the upcoming CTAS revision. It is anticipated that the revised CTAS will be released in late 2016.

We continue to build a bank of CTAS cases (like the ones in the CTAS course). If you have any cases you are willing to contribute, please email them to **ctas@nena.ca**. Contributions are greatly appreciated.

The CTAS Administration Manual was last revised in January 2015 and is available to all instructors on the website where the CTAS Instructor Materials are housed. You will find it under the heading Course Documents for Instructors/Documents pour les instructeurs pour ETG en francais.

Colleen Brayman has completed her term as the CTAS National Working Group, Western Representative and we are grateful to her for her many contributions to CTAS over the years. We are pleased to welcome Thora Skeldon as the new CTAS National Working Group Representative from the western provinces. Thora may be reached via email at **ctas@nena.ca**.

Erin Musgrave
CTAS and CEDIS Chair

News from the provinces

British Columbia

Currently 199 members. All our information has moved from the provincial site to the B.C. page of NENA. We continue to work on our B.C. page and make the information relevant to members.

B.C. is again sponsoring five nurses for the conference, this time in Montreal! Details will be released shortly on the application process. Our executive meets monthly via teleconference to support emergency nurse activities within the province.

Flu came and went in B.C. and we are now ramping up for the next season. The Health Authorities are continuing to promote peer immunizers so that staff can be immunized easily while at work. Ebola continues to be a topic, as departments continue to have to report training numbers and update supplies according to Ministry of Health changes. Standard guidelines from Ministry of Health improved training across the province and the reporting structure ensured that any suspect patients entering B.C. were identified.

TNCC/ENPC/CAMAN/ACLS/PALs and CTAS (including Instructor Courses) continue full steam in many areas of the province. Please email if you are having trouble accessing a course in your area.

PRN education continues to offer a new course, "Advanced Care in Emergency Departments, ACED" with courses in October, November and December. We are very pleased to see the rural sites included.

As well, this entrepreneurial group offers a monthly podcast that all ED nurses should be checking out. **http://prneducation.ca/pages/nursem**

WEDOC will be in Winnipeg next year—stay tuned for announcements re the pre-conference workshop.

The Association of Registered Nurses of B.C. continues to reach out and strengthen links with the specialty groups, and we look forward to the ongoing support of emergency nurses.

ENABC is providing support for a provincial wide education day at St. Paul's Hospital on November 23, 2015. More information to follow shortly.

Our AGM follows the education day and we are actively recruiting for treasurer, education officer and ENPC officer.

Fentanyl overdoses are occurring in pockets around the province and this is being tracked at the provincial level. Within one health authority, a small number of volunteers were tested and found to have fentanyl in their system, and were not aware that the drug they purchased contained this medication. Some EDs and community sites are participating in the narcan-to-go program and many others are also being asked to look at this program. For more information **http://towardtheheart.com/naloxone/**.

If BC nurses have questions, or concerns, please reach out to your executive.

Respectfully submitted,
Sherry Stackhouse

Alberta

Greetings from Alberta. What a beautiful, hot summer our province had, as we are leading up to the fall season.

Our province would like to thank the nurses from across our country , and a few from the United States, for attending the NENA 2015, Prepare for the Unexpected, conference in Edmonton. The attendance made it a sell out, and the speakers were enjoyed by all. I must say what an incredible experience it was to assist to organize and host such an event for our nurses.

Alberta has 320 members at present. We are continuing to have great success with our membership drive. Our provincial newsletters are emailed out to all our members, as well as every emergency and urgent care centre in Alberta to promote our organization, as well as mailing out the *CJEN* to every emergency department.

At present, we have 109 nurses certified in emergency this year from the CNA, according to NurseONE stats.

The Alberta executive is planning our fall AGM and conference. Due to our wonderful attendance from last year in Red Deer, this year we are using the same location, and planning to increase our conference to two days. At our AGM, we will be having an election for president elect and for the position of secretary.

Last year we decided to increase the amount of our provincial bursaries to up to $400. Four members applied and qualified for bursaries. Congratulations to each of them.

TNCC, and ENPC courses continue to run all over our province, including instructor courses.

A new challenge placed by Alberta Health Services on our emergencies is to reduce our EMS wait to no longer than 90 minutes before the patient is placed into nursing care, to get the paramedics back out on the street. How will this help us place our patients in the full waiting room within the four-hour window on top of that?

We are readying for the next round of flu season or Ebola or MRSA, or whatever this year may bring us, to be prepared as best we can be.

Submitted by
Shelley Pidruchney,
RN, BScN
Alberta Provincial Director

Manitoba

The air and leaves have begun to change in Manitoba indicating fall is upon us. As Manitobans prepare for the changing of the season, emergency nurses continue their dedicated work in emergency departments across the province.

PTSD is a rising concern for nurses in Manitoba. The exposure nurses have to trauma and critical incidents can have lasting effects on their mental health. This is particularly true for emergency nurses given the nature of our work.

One in four nurses consistently experiences PTSD symptoms. The Manitoba Nurses Union has recently published a study on PTSD in nursing. On June 18, 2015, Sandi Mowat, MNU President, presented recommended amendments to Bill 35 – The Workers Compensation Amendment Act: Post Traumatic Stress Disorder Presumption, to the Standing Committee on Legislative Affairs. Sandi Mowat will be speaking to the Emergency Department Nurses Association of Manitoba on Thursday, November 19, regarding PTSD. Stay tuned for registration.

The Manitoba Government has imposed a new Provincial Healthcare Violence Prevention policy. This program must be implemented by January 2016. A provincial violence prevention working group has received feedback from stakeholders within the five regional health authorities to develop implementation strategies and education. This will include screening and identification of individuals who present to emergency departments across the province. We expect the true data of the incidents of violence or potential for violence in EDs across the province will become apparent quickly.

Manitoba emergency nurses face another inquest into the death of a patient who was discharged from the emergency department by taxi. Heather Brennan was discharged from a Winnipeg emergency department in the late evening and collapsed on her doorstep in the cold. Once again, emergency nurses, physicians, and representatives from the Winnipeg Regional Health Authority have testified during the inquest. Currently, the recommendations from the Sinclair Inquest are being examined by emergency directors, as well as Manitoba Nurses Union representatives to determine implementation strategies specific to emergency. Work has been ongoing in emergency departments across the Winnipeg Regional Health Authority for the last several years in anticipation of many of the recommendations.

Ebola preparedness is ongoing in several Winnipeg hospitals despite the reduced threat. Scientists who are associated with the Federal Virology Lab in Winnipeg have been travelling to affected countries in Africa. A specific unit at the Health Sciences Centre has been designated for potential Ebola patients should the need for quarantine arise.

TNCC, ENPC and CTAS courses continue to run throughout the province. TNCC and ENPC courses are scheduled throughout northern Manitoba in The Pas, Flin Flon, Gillam and Thompson for the remainder of 2015. TNCC is currently offered in all regions of Manitoba. A TNCC instructor course is currently being planned for November.

Premier Greg Selinger of the NDP party was reelected this past spring with the Honourable Sharon Blady continuing on as Minister of Health for the province of Manitoba.

Manitoba will be hosting the Western Emergency Department Operations Conference in Winnipeg in April 2016. We hope to see many NENA members travelling to Winnipeg to attend!

Respectfully submitted,
Marie Grandmont, RN, BN, ENC(C)
Manitoba Director Emergency Department Association of Manitoba

Ontario

There are currently 147 ENAO/NENA members in the province of Ontario.

TNCC, ENPC and CTAS courses continue to take place regularly throughout Ontario. ENAO is grateful to all of our dedicated instructors, who so generously donate their time and expertise in order to provide this valuable education to our emergency nurses. Ontario is also fortunate that several of our instructors also travel significant distances, thereby facilitating good access to these important courses across all of Ontario.

As her two terms on the National Course Administration Committee (NCAC) come to a close, ENAO wishes to recognise and thank Ontario member Brenda Lambert for her dedication and service in the promotion and facilitation of valuable education courses across our province.

The ENAO Board of Directors has committed to the printing of additional copies of each edition of the *Journal of the Emergency Nurses Association of Ontario* (JENAO), which is published twice each year. As an immediate and personal acknowledgement, a copy of the latest *JENAO* is immediately mailed out to welcome "new" members.

ENAO continues to offer three different monetary awards annually to assist qualifying members with the ever-increasing costs of ongoing education and skills advancement. A draw for a complimentary one-year ENAO/NENA membership is sponsored by ENAO at various educational events throughout Ontario, thus actively promoting membership growth.

ENAO's liaison relationship with various Ontario groups changes, as some projects are completed and new work begins. Our participation with the Ontario Neuro Trauma Foundation over several years has resulted in standardised provincial guidelines for patients having traumatic brain injuries (TBIs).

ENAO members recently took part in a survey originating from Toronto's Sick Kids Hospital relating to palliative paediatric patients in the event of a future pandemic. We look forward to soon publishing the results of this survey, as well as the Paediatric Palliative Pandemic Planning Guide once it has been completed.

ENAO is proud to be an invited member of the steering committee for the development of an e-CTAS program with the planned use throughout Ontario's emergency departments. Funding for this important program is generously being provided by Cancer Care Ontario (CCO). The end product is anticipated to be similar to a computer program that is currently in use in the province of Alberta. This work is so relevant to ENAO, since emergency nurses perform all triage within Ontario.

In keeping with our mandate to facilitate educational opportunities within Ontario, ENAO is busy planning our next biennial provincial conference, which will take place on **September 27–28, 2016, in Belleville, Ontario.**

By the time this ENAO provincial report appears in *CJEN*, the 2016 conference Call for Abstracts for speakers and posters will have gone out throughout Ontario and across Canada. Would you like to be a speaker? Have you done research that you would like to share as a poster presentation? I encourage you to mark your calendars, save the dates, request time away from work or plan a vacation while you take part in this exciting educational event in 2016 in Ontario. Hope to see you there!

Yours in emergency nursing,
Janice L. Spivey, RN, ENC(C), CEN
ENAO President

PEI

Hopefully everyone had a fantastic summer .The fall is off to a fast start and we head back into the education groove. PEI is a small province, so membership is small. However, we are doing well with approximately 25 active members. The challenge of recruiting new members and retaining members is always an ongoing priorty for the PEI group. We continue to try to create incentives and offer priorty seating at workshops to our members. Although the national fee did increase for NENA, we are trying to keep the PEI registration fee low, so our member numbers do not start to fall.

As with many emergency departments, staffing is an ongoing issue. This makes it very hard to allow employees to attend the workshops that are necessary to keep one's coverage up to date. PEIENA continues to offer TNCC biannually and CTAS monthly. The registration numbers are low and we find this discouraging. We will make every effort to support our members in any way we can and offer them priorty seating when applicable.

PEIENA will be sponsoring the following fall workshops: Seasonal and Specialty Emergencies (October 13, 2015), Trauma Laboratory Day (November 18, 2015), Emergency Intermediate Coronary Care (November 20, 2015), and The Emergency Respiratory Workshop (November 26, 2015). All these workshops will provide an excellent opportunity to learn and share up-to-date information for the emergency staff and to other disciplines who also have a keen interest in emergency care.

Our treasurer (Donna Gallant) has recently retired and we wish her all the best in her retirement. We will be seeking new candidates for this position.

Model of Care will be completed in the next few months, so we will be waiting to see what changes will be implemented in our emergency departments. Change is always a challenge. PEIENA will offer support where needed.

We hope everyone has a calm and snow-free winter! We look forward to the next conference in Montreal and have started to plan for Conference 2017. PEI will be hosting and we look forward to the challenge of being your host.

Respectively submitted,
Sharon Hay, PEIENA Director

New Brunswick

New Brunswick totally missed spring and summer did not arrive until August! Where has the summer gone?

Education

TNCC is offered in both languages throughout the province on an ongoing basis. Trauma New Brunswick with Horizon Health Network and Vitalite' support this initiative. ENPC is offered two to three times per year in Saint John and Moncton. CTAS is offered around the province in French and English, as needed.

NBENA continues to promote emergency nursing as a speciality, challenging and encouraging ER nurses to write their certification exams. CNA is changing the process for certification in 2016. Examinations will be computer based. Applications will be received online and examinations will be written in the fall between September 19 and October 7, 2016. This should provide more opportunity for nurses to complete their certification.

Simulation! We are starting another season of simulation in southern NB! We continue to provide education to RNs, LPNs and MDs in our rural hospitals through case-based simulation. It is great to see such positive outcomes from the collaboration between MDs, RTs and nursing! The emphasis this fall will be "A Systematic Approach to the Sick Patient". At the Saint John Regional Hospital, the level one trauma centre in New Brunswick, bi-weekly in-situ simulations occur followed by structured debriefing. Education through simulation improves skills, communication and processes.

New Brunswick Health Authorities, Horizon Health Network and Vitalite' with the Department of Health in collaboration with University of New Brunswick and Universite' de Moncton support a provincial Critical Care Nursing Program, which offers two streams—emergency care and critical care. The program is three months in length and is offered four times per year. It provides opportunity for continued professional development to nurses across the province in both French and English. This initiative has been in place since 2002 and is an excellent example of collaboration to provide a need.

Work environment

Front-line nurses continue to struggle with admitted patients filling their emergency departments. Providing quality care for these acute admissions, as well as the patients presenting to our emergency departments is very challenging and stressful. Ambulance offload times are increasing as a result. Emergency nurses deal with these issues every day! Our nursing leaders are working closely with hospital administration to come up with a plan to address these situations.

Nuclear: On November 17–18, 2015, the Saint John Regional Hospital Emergency Department will be involved in a full-scale mock nuclear disaster. Point Lepreau Generating Station, located 40 km from Saint John, is the only nuclear generating station east of Ontario. This generating station has been in operation since 1981 with a refurbishment completed in 2012. The mock disaster will be the first since refurbishment. Involved in the mock disaster will be Point Lepreau staff, multiple departments from all levels of Government, Saint John Regional Hospital Emergency Department, Red Cross and Horizon Health. There will also be observers from the United Nations and Homeland Security from the U.S.

A terrific amount of education and training has been taking place over the last four months. Staff is anticipating two days of learning, as the casualties that would present from a nuclear accident are not something that you hope to ever see in your lifetime. Stay tuned for the spring addition of CJEN to read about lessons learned from this event.

Hiadee Goldie RN, ENCc, SANE-A
Emergency Nuclear Preparedness Educator

Membership: In the last year we have recruited 19 new nurses to NBENA! In total we have 52 members. We continue to promote membership at all educational courses! NBENA is sponsoring an ER nurse who is a member to attend the 2016 NENA conference in Montreal. We hope to see a large number of NB nurses attend!

As NENA's voice grows, hopefully we can increase awareness of the problems faced by ER nurses. These issues impact patient care! These issues impact nurses! Emergency nurses make a difference!

Looking forward to the 2016 NENA conference!

Respectfully submitted
Debra Pitts, RNBN, ENC(C)
NENA-NB Director

Nova Scotia

Hello to all from Nova Scotia. I would like to first off say how excited I am to be taking over the role of director for NSENA. I look forward to collaborating with everyone across our province and the country. The fall is always a busy time here in Nova Scotia for emergency nursing education. The QEII Emergency Nursing Education Committee held its education day on October 23 this year, and as well the IWK Education Committee is having its education day on November 20. Both of these events are held in Halifax and I know they will shine in the topics that will be presented. I have been lucky enough to attend both of these events yearly and they are sure to never disappoint, so if you can make it, I highly suggest going. My goal for NSENA is to increase our membership and hopefully work across our beautiful province to bring education to all of our emergency nurses, and strong working bonds. Although we may be small in numbers, we are mighty and together we can bring the best possible care to our communities. I look forward to the future and working with everyone in NENA.

Respectfully submitted,
Mary Spinney, BScN, RN, ENC(C)
Director NSENA

TRAUMA CORNER: TNCC INSTRUCTORS

Injury prevention: Recent publications and websites

Distracted driver: An evidence-based review

EAST.org is a website that provides up-to-date guidelines on trauma management. A review of the distracted driver was published in July 2015. The review below is a summary of these findings.

A) Driver distractions contribute significantly to motor vehicle collisions (MVCs) across all age groups.

B) Cell phone use and texting cause significant distraction to motorists across the population. Their ubiquitous use in society has increased their role in MVCs.

C) Novice and teen drivers are less prepared to deal with the demands of driving; their use of cell phones while driving and subsequent morbidity and mortality are, therefore, higher than other groups of drivers.

Visit **https://www.east.org/education/practice-management-guidelines/distracted-driver-an-evidencedbased-review** to see the complete review or download a copy.

Submitted by
Margaret Dymond
NENA Director of Training

Canadian Injury Prevention Resource

Parachute is pleased to announce the release of the *Canadian Injury Prevention Resource* (CIPR). Made possible with valuable support and financial resources from the Public Health Agency of Canada, the CIPR culminates the work of more than 60 authors, and the vision and collaboration of Canadian Collaborating Centres on Injury Prevention (CCCIP).

The CIPR is built to reflect the Canadian experience around injury prevention and is relevant to individuals and practitioners invested in injury prevention. The resource answers important questions like, "How is injury related to income?" or "What is the approach to injury prevention in Canada?" among many others.

This resource is FREE of cost and is publicly available to anyone interested in learning more about the field of injury prevention.

Visit **www.parachutecanada.org/cipr** to download your copy.

Submitted by
Ann Hogan
National Course Administration Committee Chair

Treating BPSD in the ED: Is there a better way?

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

Introduction

As an emergency nurse, you develop a sense of atmosphere without knowing all the details. You can feel, as you enter the department, the buzz of several emergencies being dealt with at once, or the anticipation of a case just called in by the paramedics. As a Geriatric Emergency Nurse (GEM), I am removed from much of that immediate urgency, but the awareness remains.

Recently, I was aware of this ambient tension when a senior from a long-term care facility was sent to us with Behavioural and Psychological Symptoms of Dementia (BPSD). On hearing of the imminent arrival, there were, in addition to making sure I knew of this priority, anxious concerns about the facility accepting the patient back, the need to avoid a lengthy hospital admission, and the need to call the case manager in the community. All this before the patient arrived!

In contrast, when the department anticipated an unknown number of casualties from a chemical exposure, the "buzz", while intense, felt controlled and focussed. Staff was delegated to obtain necessary information on appropriate decontamination procedures, procurement of antidotes, and availability of ICU beds. How is it that one patient stresses several experienced emergency practitioners, while anticipation of several casualties only sets into motion the necessary preparations?

Dementia is a significant progressive disease in the senior population. In 2011, 747,000 Canadians, nearly 15% of our population 65 years of age and older, were living with Alzheimer's disease and other dementias. The risk for dementia doubles every five years after the age of 65, with implications for health care, as the population ages (Alzheimer Society of B.C.). Dementia typically affects cognition, function and behaviour. The behavioural changes experienced by more than 90% of persons with dementia are the most difficult of the symptoms to manage.

Behavioural and Psychological Symptoms of Dementia, commonly abbreviated to BPSD, refers to the non-cognitive symptoms of dementia. These can result from neurotransmitter changes of the disease, as well as impairments of communication and challenges of the environment. For example, it is not uncommon for a person with dementia to believe others are entering her home and taking items that she can no longer find, and these people frequently suspect spousal infidelity. Changes in her environment, such as being moved from home to hospital, as well as difficulty hearing and seeing, may further overwhelm her understanding and ability to cope, resulting in agitation and aggression. Other manifestations include behaviours such as wandering or hoarding, which can be difficult for family members or other caregivers to deal with, but seldom result in visits to the ED.

Our case

Mr. R. was diagnosed with mixed Alzheimer's and vascular dementia seven years ago. Until 18 months ago, he lived with his wife in the home they had built as they started their family. With their son, daughter, and families providing meals, transportation, and housecleaning, the couple were able to fulfil their desire to stay together in the home they loved, but when Mrs. R. fell and died a few months later of complications, Mr. R. struggled. His family noted he was unable to heat the meals they left and spilled his medications, but he would not consider any help. He suspected his children of stealing his possessions, and believed strangers lived in the basement, also misappropriating items (nearly all of which were located by family when they visited). He began to call his daughter many times each day , forgetting they had just spoken. When the calls became frequent in the early morning hours and he began calling the police, the family made arrangements for him to be moved to a care facility. Mr. R. had refused any home health supports, including Adult Day Programs, and when, after a wait of several months, he was moved to the facility, the sudden change in location and the multitude of staff and residents were profoundly upsetting. He could not remember anyone telling him anything about this change and he wanted no part of it.

No one in his family, exhausted from several months of intense caregiving, as well as their ongoing work responsibilities, was prepared for this reaction. Afraid to take him out for fear he would not be accepted back in the facility, and unsure what to do, they left to avoid upsetting him further.

When Mr. R. hurled a lamp at a frail woman unsteadily walking by with her walker the staff were taken aback, not anticipating such an outburst. As Mr. R. concentrated on finding a way out, the staff called emergency services. Because Mr. R. had been managed at home by his family, his physician had not known of any need to prescribe medication for his agitation, nor was she available at this time.

The paramedics were able to talk with Mr. R., convincing him they were there to help him, and providing him with one-on-one attention. He walked with them to the ambulance.

Mr. R. was not expecting the ED to be his destination. Calm on arrival, within minutes he reacted with fear, aggression, and attempts to leave.

Best practices for care of persons with dementia and BPSD often emphasize the importance of anticipating and avoiding overwhelming situations. Many persons with advanced dementia reside in long-term care facilities, and the benefits of this approach are clear in helping those with dementia live as comfortably as possible. Generally the staff know the preferences of each resident, plan for appropriate types of activity, avoid demands that the resident finds overwhelming, and provide a safe, secure environment. When such an approach is not

sufficient, and the resident responds with aggression, emergency responders are called to provide care and to transport the individual to the ED.

In the emergency department, the initial goals of treatment are to provide safety for this patient, other patients, staff and others, and to allow examination to determine if medical causes, including delirium, are contributing to this behaviour. Thus, we need to provide necessary physical and medical restraint with ongoing monitoring and management of symptoms and side effects. A calm, positive approach with decreased stimulation may help. Attention to any reversible causes of discomfort may also decrease this patient's reaction. Offering food or fluid, toileting or changing wet incontinence pads may help, but we need to anticipate the need for medication.

Initial medical management includes administration of an antipsychotic and, often, a benzodiazepine. Appropriate medications include Haloperidol 0.25-0.5 mg po or IM q 2-4 h prn, to a maximum of 2 mg. or Loxapine 2.5-5 mg po or IM q 2-4 h prn, to a maximum of 10-25 mg. Lorazepam 0.5-1 mg sl, po or IM q 2-4 h prn in addition to the antipsychotic may allow a reduced dose of each medication. For patients with Parkinson Disease (PD) or Dementia of Lewy Body Disease, Quetiapine 12.5-25 mg bid prn is a safer choice of antipsychotic but, if not available, lower doses of other antipsychotics could be used with careful monitoring for side effects including worsening of parkinsonian symptoms.

When the patient has settled sufficiently, a thorough physical examination is needed to identify any medical conditions, injuries, or lesions that need treatment. Constipation or a urinary tract infection could be contributing to this change in behaviour. It will be difficult to absolutely determine if delirium is a factor, so we must treat for this until we can be confident it is not present. The above medications are indicated but, as with other medications for seniors, "start low and go slow" if ongoing delirium is suspected.

A review of the patient's current medications is needed to identify any that could be contributing to the behaviour, such as anticholinergics. Any recent changes should also be noted, as well as what regular medications need to be continued, for example, analgesics or medications for PD.

At this point, it may be necessary to contact the patient's facility to obtain further collateral information. Not surprisingly, information that was conveyed during the emergency may not have been complete. At such times, emotions tend to be strong: the patient is reacting in fear; staff there are overwhelmed with trying to contain this resident, as well as keeping all others safe; the perception in the ED is sometimes less than collegial toward the facility staff; and the ED staff may be feeling overwhelmed in trying to improve this person's symptoms.

We need to clarify which behaviours need our attention. For example, there may have been a recent history of increasing paranoia or hallucinations that requires further assessment. Nursing staff at the long-term care facility will need reassurance that there is a medication regimen to address the safety issues that precipitated this visit. It is unlikely to be a successful discharge if this patient is sent back immediately following the initial doses of medication. On the other hand, a complete refusal to consider taking this person back is rarely in the patient's best interests.

Having given appropriate medications and provided the best environment and comfort we can in the ED, we anticipate the patient is no longer so agitated and aggressive. Indeed, by the time the medication is effective, the patient may be over-sedated for a period. Initiate fall and injury prevention measures, such as non-slip socks and hip protectors; adjust the height of the bed to the patient's knee level; assist to toilet regularly; and encourage regular nutrition and fluid intake.

Ongoing care will generally include medical therapy for several weeks following an acute episode of BPSD. Atypical antipsychotics offer some benefit to many of these patients, but also carry risks including sedation, increased falls, stroke and death. Anti-depressant medications may be effective in reducing symptoms of anxiety, depression and agitation. Most of these patients are not able to comprehend their situation adequately to give or refuse consent, so appropriate substitute decision-makers must be identified and informed of risks and benefits of proposed therapies. As some symptoms of BPSD may decrease with progression of dementia, the need for ongoing medication must be re-evaluated at intervals, initially after six weeks and subsequently every few months. For patients such as Mr. R. whose symptoms were precipitated by a move, short-term medication and ongoing non-pharmacological measures may be sufficient.

As with many conditions for which seniors come to the ED, we do not provide the definitive treatment. Rather, we ensure safety, assess for reversible conditions and treat these. We consider the comorbidities involved in the individual's care and refer to the patient's primary care provider or hospitalist for ongoing care, as needed. As part of the ongoing care team, we contribute to the safety and comfort of some of our most vulnerable patients, those experiencing BPSD. By responding compassionately and knowledgably to their needs, we help to calm them and reduce the stress in the ED.

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BDSM 101 for the ED Nurse

By Linda Reimer

Fifty Shades of Grey (2011) by E.L. James, although not the first book on the market that explores the world of BDSM, has been the most popular, selling more than 100 million copies and being the most popular e-book ever downloaded. It was marketed as erotica fantasy for women and has been translated into more than 50 different languages. The sequel, *Grey* (2015), released this summer, has already sold more than a million copies and tells the same story from the perspective of the dominant Christian Grey.

Following the release of the first book in 2012–2013 the sex toy industry recorded a 8% increase in sales while home renovation and hardware stores sent out memos to their staff explaining how to respond appropriately to customers' requests for cable ties, rope and duct tape and outlines how managers were to keep a close eye on stock to ensure that it didn't become depleted ("Sex toy injuries rocket", February 2015).

Meanwhile, in the fall of 2014 in Toronto, a very popular national broadcasting radio host and Canadian celebrity was let go from his job for what he stated in a Facebook post was consensual rough sex. This story continued to evolve, eventually translating into four counts of sexual assault and one count of choking for Mr. Ghomeshi, to which he pleaded not guilty.

"In dozens of Canadian bedrooms, consensual couples are choking each other, verbally abusing one another and even striking each other with closed fists" (Hasselback, 2014).

What are the implications of these stories to health care providers and how can we counsel patients who may be exploring the BDSM scene? Can we distinguish between acting out a fantasy and assault? Can we care for patients who seek medical care for injuries in an informed, non-judgmental manner?

Initially we need to learn the language. BDSM stands for bondage and discipline/dominance and submission/sado-masochism and refers to erotic play and sexual acts that revolve around taking or relinquishing control. There is a continuum of activities that would be considered part of the BDSM realm. The National Coalition for Sexual Freedom (Moore, Pincus, & Rodemaker, 2014) offers these definitions:

Bondage: The practice of restraining individuals through the use of rope, chain, cuffs made for that purpose, or other devices or materials. The purpose can be to render the person immobile, to make the person accessible, or for the purpose of display, which might be intended to cause humiliation.

Discipline: The practice of controlling behaviour using rules and punishment. Punishment can be both physical, like spanking, and emotional, like humiliation.

Domination: When someone is granted control or authority in a scene, situation, or relationship. Dominants are usually referred to with a capital letter (e.g., You, D/s, Master, M/s).

Submission: When someone grants control or authority in a scene, situation, or relationship. Submissives are usually referred to with a lowercase letter (e.g., i, D/s, slave, M/s).

Sadism: Being sexually excited by the consensual application of force and infliction of physical or emotional pain in a scene, situation, or relationship.

Masochism: Being sexually excited by the consensual receiving of force and infliction of physical or emotional pain in a scene, situation, or relationship. Sometimes known as a "pain slut."

Prevalence of BDSM activities in Canada, reported in the Durex Global Sex Survey of 2005, indicate that 8% of adults have tried sado-masochism and 33% have used masks, blindfolds or other forms of bondage (compared to 20% worldwide). A CBC article from 2015 states that 10% of adults in North America have tried some form of BDSM and that 5% regularly engage in it.

Older data often quoted in BDSM literature states that *The Canadian Journal of Human Sexuali*ty reported that 65 per cent of university students interviewed for a 1999 study by Janus had entertained sexual fantasies about being tied up, and as far back as 1953 a study conducted by the Kinsey Institute, found that 55 per cent of females and 50 per cent of males had experienced an erotic response to being bitten.

"BDSM is intended to be a mutually pleasurable interaction between two people, in which any pain or stimulation that is consented to is welcomed by that person and is experienced as a form of pleasure" (Moore, Pincus, & Rodemaker, 2014).

Not everyone who incorporates BDSM play into their sexual experiences is a part of the BDSM "community". The community is a loose term for individuals who participate regularly in the BDSM scene. They may have a power differential relationship with one person and/or participate in parties at which they meet others who are interested in BDSM play or fantasies.

What is the difference between BDSM play and assault? The key is the issue of consent. Those who participate in the BDSM scene regularly outline the principles around consent using the guide "safe, sane and consensual" or "risk-aware consensual kink". Specifically, "safe" means being knowledgeable about the techniques and safety concerns involved in what is being done in the scene and acting accordingly. "Sane" means knowing the difference between fantasy and reality and acting accordingly. "Consensual" means respecting the limits imposed by each participant at all times. The use of a "safe word", agreed upon beforehand, ensures that each participant can end his or her participation with a word or gesture (LLC Statement on SM vs. Abuse, 2003).

Consent is negotiated ahead of any acting out within a scene, is very detailed and is ongoing. Hard and soft limits are discussed in advance. Hard limits are the acts that the individuals absolutely will not do or participate in and soft limits being those they may consider under the right circumstances. Using alcohol or drugs while acting out a scene is discouraged so that participants are able to stay alert and safe.

Some groups feel it is important to distinguish what BDSM is not. It does not involve violence, coercion or an activity that is non-consensual (The Sex Information and Education Council, 2012).

Consent in BDSM play is to be explicitly (and some say enthusiastically) expressed and it is important to note that consent can be withdrawn at any time (Luksic, 2015). This is the case in non-BDSM sexual encounters, as well. This may seem obvious, but it is also important to point out that one cannot give consent if not capable of doing so. A circumstance in which someone is passed out or is highly intoxicated is an example.

At this point in Canada, consent to activities that cause bodily harm is still a grey area. However, decisions are based on the premise that one cannot consent to something that will cause serious harm to the self. The pivotal criminal case on this issue is the 1991 Supreme Court of Canada decision R. vs. Jobidon in which the court determined consent cannot be used to excuse situations where adults intend to cause serious harm to one another.

The Ontario Court of Appeal ruled in R. vs. Welch (1995) that, "when the activity in question involves pursuing sexual gratification by deliberately inflicting pain upon another that gives rise to bodily harm, then the personal interest of the individuals involved must yield to the more compelling societal interests, which are challenged by such behaviour" (Hasselback, 2014). In other words, it is not in the best interest of society for the courts to agree that one can consent to physical harm in a sexual scenario.

Is it possible for those who participate in BDSM to have their rights violated? A study was conducted by the National Coalition for Sexual Freedom (2014) in which a survey was posted online asking members who identified as participating in the BDSM culture to respond to questions about consent violations. Almost one third (29%) reported that their pre-negotiated limits and/or safe word had been violated. Of those, one in three involved manipulation or coercion and one in four said a predator attacked them. Nearly one in three said the consent violation was caused by an accident, miscommunication or lack of skills or knowledge.

The largest percentage of participants said they were non-consensually penetrated (29%), only 2.7% reported the violation to police, and 7% reported having an injury that required medical attention while 0.5% reported receiving a serious physical injury that was life- threatening or serious enough to cause dysfunction in an organ or limb.

Injuries from BDSM play can range from superficial such as bite marks, bruises, welts to burns, lacerations, nerve damage and perforation to life-threatening and death. There may be a delay in seeking medical treatment due to embarrassment regarding how the injuries were obtained and risk of stigma. Maintaining a non-judgmental approach will ease the patient's discomfort in disclosing important details that may be relevant to a health care provider's assessment and treatment.

A search of the literature reveals case histories of injuries from vaginal and anal fisting such as perforation, lacerations, peritonitis and hemorrhage (Cohen, Giles, & Nelson, 2004). Other reported injuries include foreign body insertion in the rectum (for erotic purposes) including medical and surgical management (Caliskan, Makay, Firat, Karaca, Akgun, & Korkut, 2011).

Jay Wiseman (who has health care training and experience) is often recognized as a leader and educator within the BDSM world (*SM 101: A realistic introduction*, 2000), outlines five threatening moves that can put a participant of BDSM at serious risk of harm or death. He refers to them as "the bad five". They are self-bondage, chest punching, ball-kicking, gun-play and breath play. The one area that seems to be disputed in the BDSM world is the issue of breath play, which involves strangulation and suffocation during a sex scene.

Some of the allures of breath play are that the receiver describes sensory distortions, hallucinations and euphoria due to the anoxia. The "choking game" amoung teenagers and non-fatal strangulation in domestic violence literature outlines the dangers associated with a lack of oxygen to the brain. The risks associated with breath play include cardiac arrest, brain damage from anoxia and ischemia, stroke, seizure, aspiration and death (Toblin, Paulozzi, Gilchrist, & Russell, 2008). Denying the brain oxygen in any form should be considered very dangerous and not a game or play.

While there is little data on the prevalence, BDSM activities are probably more common than identified in the scholarly literature. It appears that with the immense popularity of *Fifty Shades of Grey* books and movies, more individuals are experimenting. While incorporating a blindfold or light spanking into a relationship brings inconsequential risk, there are many more concerns around the aggressive and potentially dangerous forms of BDSM activities. This is especially true in circumstances in which the participants are using drugs or alcohol, are not properly educated or not practising in a safe, sane and consensual manner. Having knowledge of BDSM language and activities, consent issues and the potential dangers will enable emergency room staff to ascertain a thorough history from patients presenting with injuries related to these activities and provide timely interventions. It also affords an opportunity for individuals who felt violated by the experience or who did not consent to connect with a forensic nurse or social worker.

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Emergency department registered nurses' experiences of moral distress: It's about time

By Kevin Reedyk and Monique Sedgwick

Causes of moral distress in nurses have been widely studied and reported in both qualitative and quantitative capacities (Elpern, Covert, & Kleinpell, 2005; Maiden, 2008; McCarthy & Deady, 2008). While there is remarkable consistency as to the primary causes of moral distress in the literature (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Glasberg, Eriksson, Dahlqvist, et al., 2006; Redman & Fry, 2000; Zuzelo, 2007), the areas of focus for researchers in this regard have been almost exclusively outside of the emergency department (ED). The purpose of this paper is to begin to fill this gap by presenting the findings of a qualitative study where the experience of ED nurses' moral distress were explored.

Literature review

Hamric, Borchers, and Epstein (2012) provide the most detailed breakdown of the causes of moral distress in nurses. They classify the causes as rooted in one of three areas: clinical situations; factors internal to the provider; and factors external to the provider or situation.

Elpern, Covert, and Kleinpell (2005) indicate moral distress is particularly problematic for nurses who practise in critical care. However, the most closely related specialty nursing practice area, the ED, is virtually absent from the literature on the topic of moral distress.

Background

The ED is a dynamic area necessitating staff and physicians to think, speak, and work in terms of minutes and hours, as opposed to other areas of nursing where care is often planned and provided based on days and weeks (Fernandez-Parsons, Rodriguez, & Goyal, 2013). This study was conducted in a western Canadian province. All levels of ED care were represented from major urban level I trauma centres, regional referral hospitals, and rural EDs.

Research design

A narrative inquiry research design was used to explore registered nurses' (RNs) narratives on sources of moral distress while working in ED settings. Narrative inquiry involves determining common themes from stories collected to enable presentation of the findings in the context of which they were discovered (Riessman, 2008). Ethical approval was obtained from the University Human Subjects Research Committee (Protocol #2013-050).

Sample

With the assistance of the provincial regulatory body, participants were invited to participate in the study via email and/or telephone. Prior to agreeing to participate in the interview, the purpose of the study, along with participant rights were explained. Twelve RNs agreed to be interviewed (10 female and two male RNs). Their overall nursing experience ranged from eight to 36 years with emergency department experience ranging from seven to 20 years.

Data generation

Individual qualitative interviews lasting 60 to 120 minutes were completed primarily via Skype with others occurring face-to-face at locations of the participants' choosing. All of the interviews were recorded. Once no new information emerged from the interviews, recruitment of additional participants was discontinued. Examples of questions asked during the semi-structured interview included: Can you remember a particular situation that comes to mind from your work related to this definition of moral distress? And, are you able to describe reasons the right thing could not be done in this scenario? No participants withdrew from the study.

Data analysis

All interviews were transcribed verbatim and assigned pseudonyms. An inductive production of categories and themes was used. Initially, coding was undertaken by reading and re-reading the text and highlighting words and sentences. This was followed by relating theoretical ideas to the text, interpreting the text, and making interconnections between the codes. Lastly, notes were made of the relationship between the codes, the research questions, and the literature. Rigour was maintained with the aid of a research project supervisor reviewing transcripts and preliminary analysis, as well as providing feedback.

Results

"It's about time" emerged from data analysis as the essence of the participants' experience of working in the ED setting and the predominant cause of their moral distress. This theme is supported by three categories: (i) 'futile care': details the participants experiences of providing aggressive treatment to patients not expected to benefit from that care; (ii) 'between a rock and a hard place': describes decisions and choices the participants had to make regarding patient care; and (iii) 'one-stop shopping': details participant descriptions of how the ED is used as a primary care clinic by many patients.

Futile care: A focus in the ED environment is to prolong life with the most stress-inducing event being dealing with death and dying (Jonsson & Halabi, 2006). Participants in this study expressed frustration with providing what they felt was futile care. Indeed, several participants mentioned instances of caring for palliative patients who presented to the ED seeking comfort measures, but who were, ultimately, subjected to multiple invasive interventions. In many of these cases, unclear goals of care or an unwillingness on the part of the patients' family or

the health care team to hold back on potentially physically and psychologically invasive interventions resulted in moral distress. Chloe gave an example of a time when she felt they were actually torturing a patient by providing futile care:

> *I just felt sick, we put in a central line, a chest tube, all the poking and prodding. This poor man didn't have long to live and we were using all these resources to try and save him. I felt like it was torture (Chloe).*

In cases of trauma, participants indicated that patients' families expected that the health care team would undertake every intervention regardless of whether or not it was futile. There was speculation from some participants that this expectation was related to the sudden and unexpected nature of the situation in which they found themselves. Other participants indicated that for the health care team there was a correlation between the age of the patient and the length of time and invasiveness of interventions initiated.

> *Last week we had a stabbing. So, in those cases, it's typically younger people who are involved in violence and they get stabbed. They come into our department, you're thinking they're probably going to die from these injuries. In these cases, the whole world shows up, you get trauma team, ER, fire, EMS, police, housekeepers, everyone's in there watching. And eventually, it's "We're gonna crack the chest open and we're gonna try and save this guy's life." You lose perspective and you've got to keep in mind that this is a person, you're doing something very, very invasive, and you could be doing something very painful, it could be unsettling for their family to see this. And the outcome is almost always that they are going to die … but we've got to treat this person. The right thing to do would be to treat them more in a comfort care scenario. Allow the family in, have less intensity and less gawking at them and their insides and outsides as they die (Phil).*

Between a rock and a hard place. Physical bed management within the ED resulted in participants feeling caught between a rock and a hard place. For example, participants unanimously agreed that getting patients to a treatment space and closer to the point of physician assessment could be a source of moral distress. In fact, the increase in the number of patients who accessed ED impacted the degree of moral distress the participants experienced, since many EDs in which they were working were not designed to accommodate large increases in patient visits.

> *I can't remember the exact numbers they had set up for, but we are far surpassing these numbers [with] upwards of 250 people a day, that's two-fold what was expected for our staffing levels. The resources that we have are just not there (Ben).*

Eleven of the 12 participants also identified that the inability to move patients who were admitted to the hospital to the appropriate nursing unit was problematic. These patients occupied a bed in the department, which delayed assessment and treatment of patients waiting to be seen. In this situation, the ability to complete their work efficiently and effectively was impaired and contributed to the degree of moral distress they experienced.

The last situation that created moral distress for several participants was when they felt the right thing to do for their patients would be to spend more time with them but, due to competing demands, they could only spend a minimal amount of time with the patient before they had to move on to the next assessment or task. Rose stated succinctly, "We can't tie an old man to a chair, keep the light on in emergency, give him the Morphine and call that good nursing care!"

One-stop shopping. Many participants indicated that they experienced moral distress due to patients' use of the ED as a family care clinic. For these participants, having high volumes of non-urgent cases come into the department meant they were unable to attend to the needs of higher acuity patients. Jessica commented on the inappropriateness of placing less-urgent patients in high-acuity patient treatment areas:

> *In our intake area, we have patients who are less sick and patients who are appropriate and those who aren't. The other day I was having a frustrating day and they were sending me patients who didn't belong there. I had to call back three times because they were sending me patients who just didn't belong there.*

Ben was very direct with his assessment of emergency department use, stating:

> *The first thing people do is come running to emergency for the silliest of things. Nausea and vomiting for two hours and we give them Zofran instead of sending them home… Emergency is a one-stop shop now, you get your blood work, your radiology, and you get your results.*

Discussion/Implications

Participants in the study confirmed the existence of morally distressing situations while working in the ED. In other studies conducted in other acute care areas, one of the sources of moral distress is provision of care to patients who are not expected to benefit from that care, also known as futile care (Elpern, Covert, & Kleinpell, 2005; Lawrence, 2011). In keeping with the findings of these studies, the participants in this study also experienced moral distress in situations where futile care was provided. So, while open, honest and transparent communication among all team members is needed in all patient care situations, it is imperative in situations where futile care may be given. Once goals of care have been confirmed, the team must include appropriate and achievable outcomes in their bedside discussion with the patient and/or family involved throughout the course of patient care (Chapman, 2009).

Participants also identified triage situations and a lack of available and appropriate treatment spaces as causing moral distress. Management and administration are called upon to ensure there are sufficient treatment spaces, as well as policies and guidelines in place related to what defines an appropriate treatment space.

The call for higher levels of hospital administration to provide additional support in morally distressing situations for nurses is reiterated in a number of studies (Corley, Elswick, Gorman, et al., 2001; Pauly, Varcoe, & Storch, 2012). Examples of additional support required in EDs include formal debriefing processes, availability of pastoral care, and individual counselling services

for staff members. Each of the participants indicated they have access to an employee assistance program. However, willingness or interest in utilizing these services was not unanimous.

Timely patient disposition from triage also has implications for ED bed management. Ongoing widespread public education related to appropriate use of health care options is needed to reduce the overall number of patients presenting to emergency departments. While many EDs in the province have transition teams ensuring adequate follow-up care post ED presentation, there are many existing community services that patients are often unaware of that would eliminate the need for the patient to present to the ED in the first place. Essentially, referrals to home-care are effective from ED, but accessing these resources prior to presenting to ED benefits both patients and staffing resources while simultaneously reducing the number of ED visits.

Limitations

The findings of this study need to be considered within the study's context. To that end, it is possible some potential participants may have opted not to participate because they perceived moral distress in their work environment as 'normal.' Others may have felt powerless to change the status quo and so elected not to participate. Others may have elected not to participate due to the potentially sensitive nature of the topic and concern for the emotion and impact the interview might have. While the sample size of 12 participants is appropriate for a study of a specialized area, it is possible that the findings are not representative of the larger demographic. More specifically, the relatively small representation of participants working in rural sites leaves the possibility that the findings do not represent the experiences of rural registered nurses as thoroughly as the urban participants' experiences.

Conclusion

Increasing patient acuity and patient volumes are creating a situation where 'it's about time' results in moral distress for nurses working ED. It is imperative then, that RNs arm themselves with the ability to recognize moral distress and communicate the need for support with their leaders and management. Similarly, organizations must effectively communicate with frontline nurses while providing them with the necessary direction and resources to mitigate these situations.

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Monique Sedgwick, PhD, RN, has worked in nursing and nursing education for more than 30 years. In the last 25 years, she has developed an avid interest in ethics and ethical issues that nurses are confronted with on a daily basis. This interest has expanded into her teaching ethics to both undergraduate and graduate nursing students.

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From last in class to best in class

By Real LeGoueff, MD

In 1989, I was working at the Lamèque Hospital. Faced with enormous difficulties regarding the urgent transfer of patients, I started studying the situation. Studies showed that the transfers took as much time as they did during the First World War.

Following these disastrous results, I started working with the government to implement an air ambulance service in New Brunswick. A meeting took place between Raymond Frenette (Health Minister at the time), Gastien Godin (*Association des pêcheurs professionnels acadiens* [APPA]) and myself. In February 2015, 26 years later, I ran the study again to see if anything had changed.

Delays and traumas

Delays reduce chances of survival. The main cause of traumas is car accidents, which are also the main cause of death among young people and an important cause of death among people of all ages in New Brunswick. These accidents are very costly in medical terms, so working to resolve delays and prevent traumas is justified economically.

Ideal solution

Specialized hospitals face four problems: access, location, distance and transfer wait times. There are two ultra-specialized hospitals in New Brunswick (Moncton and Saint John); it would be preferable to have more, but that requires a minimum population. However, everyone should have equal rights to access. That is the problem in New Brunswick.

In the beginning

Realizing its unenviable situation, New Brunswick got to work and in 1991 an air ambulance service was proposed. PEI and NS were originally partners, but the partnership ran into problems; PEI could not participate due to budget constraints, while NS opted for a helicopter. The NB air transfer service (using an airplane) came into being in 1996.

Transfers

There are currently two ways to be transferred in New Brunswick—by land or by air ambulance. The efficiency of the system relies on a global approach. In 2013–2014, NB's 134 ambulances made an impressive 96,492 transfers, while the air ambulance made 499.

Trauma network

In 2010, a 24-hour toll-free telephone line was established, allowing for the triage, referral and coordination of trauma cases that could then be transferred to the right establishment at the right time. The referral system is so effective that few patients have to be transferred more than once.

Global system

In order to optimize treatment, New Brunswick set up a system where every step of the way is managed, starting from the moment the accident happens. As soon as the ambulance arrives, the patient is evaluated and treatment is begun; the patient is then referred to the appropriate hospital. Twenty hospitals are part of the network: 12 are not specialized, six are somewhat specialized and two (Moncton and Saint John) are very specialized. If an inter-facility transfer is needed, doctors have access to a trauma line through the referral system, which allows them to contact a trauma specialist who will help refer the case to the appropriate hospital.

Continued medical education

The quality of ambulance services at ANB is upheld through refresher courses to its personnel. ANB also gives CPR courses to the public. Few people survive cardiac arrest outside of a hospital by reason of passersby's' ignorance. A witness can make all the difference in the world by giving a simple cardiac massage while waiting for the ambulance.

Traumatology

The New Brunswick Traumatology program oversees everything concerning traumatology. It collaborates with the Department of Health, Horizon and Vitality networks and ANB in order to pursue its goals of excellence, prevention, education and research. It also aims to prevent falls among young children, falls among seniors and traumas connected to alcohol and risk behaviours among young people. The program also maintains a provincial trauma register whose data leads to the improvement of many trauma components.

Conclusion

It's important to be critical, but we must also give credit where credit is due. The important point is not to have an air ambulance service, but to maintain a coordinated whole, where each step of the way is optimized in order to provide the best possible care to the patient. NB aimed for a cohesive approach in order to ensure quick access to hospitals. There is still no specialized hospital in the North, and the distance to reach the ones in the South is the same as in 1989. But this is mitigated by a modern approach to access to specialized care. From last in class, New Brunswick is now best in class in terms of traumatology. Distance is now no match for the efficiency of the system. It appears that the choice of a global trauma network represents the height of the underlying trauma philosophy. NB could hardly have made a better choice.

Building seniors' health capacity in the emergency department: The role of the clinical nurse specialist

By Angela Chan and Judy Smith

Mackenzie Health is a community hospital, located in the Greater Toronto Area, just north of Toronto. It opened in 1963 and is in the process of development of a second hospital site, to be opened in 2018. The hospital has 491 operational beds, with 355 budgeted acute care inpatient beds. The remaining beds are long-term care beds operated by an external partner. The emergency department served approximately 90,000 patients in 2013. Fourteen per cent of these patients were over the age of 75 years, with 26% requiring admission to an acute care bed. On any given day approximately 260 seniors are admitted to acute care, with 180 in either the medicine or surgery program. The hospital is recognized as a regional leader in domestic abuse and sexual assault, chronic kidney disease and as a district stroke centre.

In 2003, Mackenzie Health (formerly York Central Hospital) was one of eight hospitals selected to participate in a pilot project sponsored by the Regional Geriatric Program (RGP), of a Geriatric Emergency Nurse (GEM). The RGP provided base funding for one full-time equivalent Advanced Practice Nurse. A Clinical Nurse Specialist (CNS) was selected. The original goals of the project were: 1) improve care to the seniors within the emergency department, 2) build capacity with the staff, and 3) develop and implement a new model for seniors. In 2009, the organization received funding for a second GEM and trialed Nurse Practitioners in this role. In 2011, the role reverted to Clinical Nurse Specialists. The Clinical Nurse Specialists spend most of their time in professional development and organizational leadership, research and educational activities with less time in direct patient care, while the nurse practitioners spend most of their time in direct patient care. The GEM CNS(s) spend 60% of their time with direct clinical patient consultation, 30% in the professional development, organization leadership and capacity-building activities, and 10% of their time building capacity with external community partners. These advanced practice nurses have all reported directly to professional practice with a matrix to the operational director of the emergency medicine program. This reporting model has been a strength in advancing the care of seniors. One example of this strong relationship is the work being accomplished with the advanced practice nurse team to support seamless transitions of care across the continuum for seniors with complex medical issues.

GEMS as capacity building agents: Professional practice adopted the Strong Model of Advanced Practice (1996). This model identifies five program pillars: clinical practice, collaboration, education, research and leadership, and five program components: clinical services, community partnerships, program evaluation, ambassadors and program development. These pillars and components mesh with the Canadian Nurses Association framework for Clinical Nurse Specialists.

The clinical practice role of the GEMs currently includes: Targeted consultation support and management recommendations for seniors over the age of 75 within the emergency department, referrals to inpatient and outpatient advance practice nurse-led services and community resources, ongoing communication with primary care physicians, case finding of high-risk seniors and identification of the geriatric syndromes and follow-up post discharge telephone calls to high-risk seniors.

The research component of the roles involves engaging in quality improvement initiatives (both within the department and across the organization), development of research and funding proposals with a senior friendly lens, dissemination of their work externally, and the utilization of nursing research to support the implementation of best practices in the care of seniors in the emergency department and across the organization.

The education component is built on their existing Master's preparation, professional development (both GEMs are certified coaches in Gentle Persuasive Approach in Dementia Care®), have specialty certification from the Canadian Nurses Association, as either gerontological or emergency nurses. This background allows them to develop and implement various knowledge translation activities for both patients and staff, including health literacy materials developed specifically for the senior. One of the successes of this component is dedicated time during unit-specific orientation to discuss the unique care needs of the senior with a focus on the complexity and necessity of discharge planning.

The collaboration component internally is the interprofessional team within the emergency department. This includes physiotherapy, speech language pathology, social work, dietitians, respiratory therapist, crisis team and the medical team. External partners include Community Care Access Centre case managers, hospice palliative team, Behavioural Support Ontario, Integrated Psychogeriatric team, local retirement homes, and the Alzheimer's Society through the First Link initiative. The emergency department team, including the GEMs participated in the organization's attainment of Accreditation Canada's Stroke Services Distinction award. Recently they have added Health Links. Another valuable collaboration is the Central Local Health Integration Network GEM nurses group and the provincial GEM network through the Regional Geriatric Program email service.

The leadership component of the role includes being project managers for the Senior Focused Best Practices in Hospital strategy in collaboration with the CNS Seniors' Health. In addition, they are leads for the development and implementation of Clinical Best Practice Guidelines from the Registered Nurses Association of Ontario (RNAO). These roles are corporate roles involving the dissemination of knowledge translation activities across the organization. The GEM nurses have ongoing participation in lean events that impact the seniors and on the various committees charged with the development of the new emergency department at the new hospital.

Hardwiring strategies for success

In 2013, Mackenzie Health was awarded designation as an RNAO Best Practice Spotlight Organization with the successful implementation of 21 best practice guidelines. Through this journey, many systems and processes were developed for use across the organization. One of the first tools developed was the launch of a learning management system to facilitate on-line learning. This platform allows staff to complete modules and quizzes, either in the department or from home. The Senior Friendly strategy was able to modify other systems and processes to successfully implement change and best practices not only in the emergency department, but also across the organization. One example is the development of visual cue ID tags for delirium screening and mobility.

In collaboration with front-line nursing staff, an electronic website was developed by the GEMs to address the needs of nurses in the emergency department in relation to caring for seniors with complex needs. Examples of the topics include: normal aging, geriatric domains, geriatric assessments, and information of community resources. Interactive approach to information sharing include: videos, modules, and discussion forums. Interprofessional team members contributed their expertise in fields such as speech language pathology, physiotherapy, occupational therapy and geriatrics. This e-resource is made available 24/7 for ED nurses to access and is updated on a monthly basis to reflect emerging and changing needs of the department.

The GEMs requested an upgrade to the existing department tracking board to include a GEM column, with drop-down options for staff to use, allowing for flagging of high-risk seniors as early as triage, and another flag indicating that GEM has assessed the patient. The GEM nurses have developed their own documentation record for use in their focused assessments. It was built to align with the inpatient assessment tool, which avoids duplication in charting.

Unit based metrics

With the paper-based health record currently being used in the department, all quality-based metrics are manually collected. Currently, completion of the Triage Risk Screening Tool (TRST), Confusion Assessment Method (CAM), Preadmission Baseline Functional, and Falls Risk Screening are being audited and being presented via a unit-based score card that is reviewed at the Daily Huddle Board. These metrics are being monitored by the various project leads.

Lessons learned

Several lessons were learned based on previous corporate quality improvement projects. Adopting the Senior Friendly Hospital framework from the Regional Geriatric Program was an easy fit. Systems and processes were already developed to support policy development, patient education, and knowledge translation activities. Building the Senior Friendly lens into all facets of the care delivery model and the environment is the role of the GEM nurses. The leadership team has been open to addressing some of the concerns related to safety of the senior by the purchase of safety socks in various sizes, purchasing of two wheeled walkers and canes and the installation of a fridge to provide nutritional support to the patients.

Challenges

As we reflect on our current journey with various GEM leaders several challenges were identified.

When the organization began the RNAO BPSO candidacy journey in 2010, several staff volunteered to join the unit-based knowledge translation teams. These teams completed a Champion Workshop sponsored by the RNAO, but were engaged in the roll out of only two of the Best Practice Guidelines—*Prevention of falls and fall injuries in the older population, and Screening for delirium, dementia and depression in the older adult.* The Champion Workshops were only delivered in-house during the first year of the journey and not repeated until this winter. As emergency staff moved on, their positions on the team were not replaced. Knowledge translation teams spark enthusiasm within the department and these content champions aid in the hardwiring of standard work.

Many organizations experience similar challenges as the department experienced, that of staff turnover and complexities of workload.

Another challenge for staff was the differentiation of emergency patients versus the admitted holding patients. Screening tools, patient education and metrics were developed for various projects across the organization utilizing the electronic documentation system as their platform. However, the emergency remains paper based. This meant paper tools needed to be developed, manual metrics and often omission of patient information across the continuum of care. The inpatient care teams on the clinical units often did not know where in the paper chart to find baseline screenings.

Summary

In summary, organizational support for implementation and knowledge translation is a key. The department has been able to maintain external funding for the two full-time GEM nurses. The senior strategy is supported by the Board, endorsed by the executive leadership team and embraced by the operations team for the emergency medicine program. Celebration of successes either within the department at Daily Huddles, or across the organization, through our monthly professional practice report and yearly professional achievements book provide opportunities for all members of the team to shine in the spotlight. Hardwiring best practices into standard work and monitoring these practices through chart audits and direct observations

ensure that all patients receive an exemplary patient experience. The final key to our success was building on lessons learned from past initiatives, and the utilization of existing systems, processes and structures. As evidence-based practices change, so, too, will our seniors' best practices within the emergency department.

About the authors

Angela Chan, RN, BScN, MN, GNC(C), graduated from Ryerson University with her undergraduate nursing degree in 2007. She then obtained her Master's of Nursing degree at the University of Toronto where she also completed a collaborative degree in Gerontology in 2011. Angela has previously worked as a clinical instructor at Centennial College, and a staff nurse at Toronto General Hospital. Currently, Angela is an Advanced Practice Nurse for Geriatric Emergency Management in the Emergency Department (ED). Angela provides advanced gerontological expertise in the care of the frail elderly who present to the ED with complex issues related to decline and loss of independence. In addition, Angela builds capacity through educating nurses across the organization to ensure that frail seniors at risk receive the best evidence-based care possible to improve their health outcomes and well-being. Angela is also the co-lead for the Management of Hypertension best practice guideline and has worked collaboratively with key stakeholders to enhance care of adults with hypertension. Along with the senior's health team, Angela continues to lead best practices initiative to foster a senior's friendly environment across Mackenzie Health.

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Judy Smith, RN, BScN, MEd(DE), ENC(C), GNC(C), has been an emergency nurse for more than 35 years, with experience as a front-line nurse, patient care coordinator, clinical educator, interim manager and as a GEM nurse. Currently she is a CNS—Seniors Health. Judy has worked with the Canadian Nurses Association to develop exam questions for the Emergency Nurses Certification process. She is currently a TNCC and ENPC instructor, as well as a coach for GPA. Judy has been an expert panel member for the RNAO in the development of the Healthy Workplace BPG—Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational, and systems outcomes, released in April 2013. She is also a reviewer for the Advanced Clinical Fellowships. Judy has presented both posters and oral papers, locally, provincially and internationally. Judy is currently the lead for the two best practice guidelines related to delirium, dementia and depression, working collaborative with interprofessional teams across the organization to provide a safe environment for seniors.

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Interview with Judy Waldman

Introduction

Judy Waldman, RN, MN, NP(C), is the president of the Forensic Nurses' Society of Canada

Website: **http://forensicnurse.ca/**
Email: **president@forensicnurse.ca**

She provides counselling services specializing in trauma and post traumatic stress, sexual assault and abuse, child abuse, interpersonal violence, adolescent issues, and compassion fatigue through Judy Waldman Counselling

Website: **www.judywaldmancounselling.com**
Email: **info@judywaldmancounselling.com**

1. What are your current professional roles?
Currently I am working professionally part-time at Women's College Hospital for the Sexual Assault and Domestic Violence Treatment Centre (SADVTC) while I complete the Primary Care Nurse Practitioner Program at the University of Toronto. My role includes both acute care and follow-up care of sexual assault and domestic violence survivors. I am certified as a Sexual Assault Nurse Examiner (SANE-A) for adults and adolescents and as a SANE-P for pediatrics. I also have a private counselling practice, Judy Waldman Counselling, in which I offer trauma-based and general counselling for youth and adults, as well as consultation and training.

2. You have a varied nursing background. Can you tell us how you came to be doing what you are doing?
Prior to encountering forensic nursing, my nursing experience was solely in psychiatry. After graduating, I worked for the Clarke Institute of Psychiatry, which eventually became the Centre for Addiction and Mental Health (CAMH) in Toronto, before moving to New York City where I worked in the Psychiatric Emergency Department at Bellevue Hospital. Upon returning to Toronto I began working at the Hospital for Sick Children in the Mental Health and Eating Disorders Unit. Shortly thereafter I accepted a position on the Crisis Response Team. Although my interest in this team was in the role of responding to mental health crises in the emergency department for the psychiatry team, along with this role came the role of responding to sexual assault cases for the Suspected Child Abuse and Neglect (SCAN) Program. This is where I first learned of and what initially sparked my interest in forensic nursing and led me to studying forensic nursing at Mount Royal College and continuing to work with the SCAN Program and eventually the SADVTC for many years.

3. Tell us about your role as President of the Forensic Nurses' Society of Canada?
The Forensic Nurses' Society of Canada was created in 2007, as an organization for Canadian forensic nurses to network and address uniquely Canadian forensic nursing issues. The primary goal of FNSC is to promote comprehensive evidence-based forensic nursing practice. We also provide a network for forensic nurses to share information and connect with one another. As the president of the current term, my role includes leading a fantastic executive team that provides services for members such as sharing of resources, offering educational sessions such as webinars to support forensic nursing practice, operating a website on which we have just recently opened a members-only area, and promoting forensic nursing standards and the field of forensic nursing science to governments, industry and the public.

I believe strongly in the philosophy that violence is a preventable health care issue and that collectively nurses and particularly forensic nurses can play a role in preventing the negative consequences of violence. My personal goals as president are to strive to become a more politically active organization and raising social awareness of the issue of violence in our society, and to build the organization as a stronger, recognizable Canadian resource not only for forensic nurses, but also for the public and other governmental and non-governmental agencies.

As such, I have had the opportunity to attend press conferences, become more involved with the Canadian Nurses Association and promote the FNSC at conferences and events locally and internationally, provide input on public health resources related to violence and health, and publicly speak to forensic nursing issues. This year, our membership has grown significantly and I hope to continue with that momentum for the next year.

4. You work with vulnerable populations. What inspires you to do so?
I have always felt a desire to assist the least advantaged of society. I hold strong democratic values of equality, justice and respect for all creatures, and I have an aversion to social injustice and feel that, as a person who is strong enough to be the voice for those who are voiceless, one must be that voice.

Everybody has equal value as members of society. I believe that, as a society, we must care for the disadvantaged and those who cannot care for themselves or who need assistance through times in their lives to assure protection for equal access to liberties, rights, and opportunities.

The thing about those who are vulnerable is that they are vulnerable through no fault of their own, but through marginalization and other life circumstances such as childhood trauma, war or conflict, and societal circumstances such as oppression, poverty, discrimination, racism, persecution and inequality .

What inspires me the most are those people themselves; I see so much strength and resilience in people who have gone through

so much in their lives. In our culture, vulnerability is associated with weakness but, in many ways, vulnerability is a great strength. Every day I get strength and learn from my clients. I see so much potential and value in people, which is often stifled by society.

Finally, it is rewarding to feel that, even if it is only in a small way, you have made a difference in someone's life.

5. Nursing today faces many challenges. What would you change in nursing education to prepare nurses for those challenges?

I believe that two of the greatest challenges facing nursing education today are nursing in an advanced technological world and the effects of relying too heavily on evidence-based guidelines and protocols. I feel that the emphasis on economic factors both in education and health care policy is often in opposition to the imperative of client-centred care.

What I mean by this is that nursing is getting further and further away from the bedside and the patient through the use of machinery and technology and nurses are losing the skills of 'being with' patients and providing intimate care that is so closely associated with good assessment skills and psychological benefits for the patient. Furthermore, teaching modalities themselves are technologically driven with more and more courses online, which often, unfortunately, lose the social and interactional aspects of nursing.

Relying strictly on evidence-based medicine (EBM), while providing valuable standards and guidelines, may limit an RNs clinical judgment. I find that education focuses heavily on evidence-based medicine and clinical practice guidelines that, if adhered to strictly, fail to consider the individuality of patients or specific populations. EBM often has a gender and cultural bias and takes a reductionist approach that does not prioritize patient suffering or subjective experiences and may discount traditional practices that cannot be demonstrated by randomized control trials or 'gold standards'.

Nurses need to be taught to think critically about guidelines and think intuitively from experiences and from practice consensus in conjunction with following EBM guidelines. Sometimes we need to consider our 'gut' feelings. Adhering to guidelines without clinical thinking does not take into consideration the lived experiences of the patient or the context in which they live.

So, how do we teach and learn those important skills from a distance? Most of these abilities come from experience and so I feel that the education of nurses should include a strong mentorship component in which experienced nurses can impart some of these valuable skills. While online education is convenient, I feel that a good deal of nursing education must be taught in a small, live, group setting whereby students and experienced nursing instructors can share their experiences and witness the hands-on practice of the expertise of senior nurses.

I feel educational institutions should provide a greater emphasis on and respect for the psychological aspects of caring for diverse cultural populations in nursing. There has been an emphasis lately on trauma-informed care and the health and psychological effects of adverse childhood experiences and I believe nursing education must join this initiative.

6. What do you like most about being a nurse?

The thing I like most about being a nurse is that your day is never the same. Particularly in the fields I have chosen, psychiatry and forensics, but in general, as a nurse, you always have to be prepared for anything and think on your feet. Nursing also provides for many diverse learning opportunities and career paths.

7. What is your favourite "down time" activity.

It is hard to say exactly what my one favourite "down time" activity is, but my favourite activity for relaxing and relieving stress is getting into nature; hiking, camping and canoeing (with my two dogs, of course). I also swear by the therapeutic benefits of yoga practice and gardening (in season).

Thank you so much for doing this.

Sheila Early
Immediate Past President
International Association of Forensic Nurses 2015

CNA Certification Program announces new developments

Dear colleagues,

The CNA Certification Program has an exciting year ahead, as we prepare for many new initiatives in 2016.

First, we are pleased to welcome Patricia (Pat) Elliott-Miller as executive lead for the certification and professional development division. Pat, a master's-prepared RN, is a results-oriented executive nurse leader who has delivered best-in-class innovative practices through a range of administrative, academic and clinical roles. Most recently, she was the vice-president of patient care and chief nurse executive at the Children's Hospital of Eastern Ontario. Pat has a sound understanding of our certification program and the opportunities and needs all RNs have for continued professional development.

Second, CNA is working with our testing company, Assessment Strategies Inc. (ASI), to begin delivering the 20 certification specialty examinations as computer-based tests. ASI has entered into a multi-year partnership with Pearson VUE that will give candidates access to their network of proctored test centres across Canada.

Another exciting development is that the certification application and eligibility processes will be entirely online starting in 2016.

Important timelines:

- CNA and ASI will collaborate over the next few months on making the transition from paper- to computer-based exams.
- Applications/renewals will not take place this fall. We expect the online application process to open in late winter/early spring and will provide specific dates once they are confirmed.
- The first computer-based exams will take place in fall 2016. Eligible candidates will be able to write their certification exam between **September 19 and October 7, 2016**.
- To ensure that all certified RNs who are due to renew by April 2016 continue in good standing, CNA has extended the **renewal expiry deadline to the end of 2016**. Doing so will also allow RNs to renew using the new online process.

Stayed tuned to the CNA website in the coming months for webinars with helpful information about online applications and how the 2016 computer-based exams will work. We look forward to the exciting developments ahead for CNA's certification program.

Sincerely,
Anne Sutherland Boal, RN, BA, MHSA
Canadian Nurses Association

Du nouveau pour le Programme de certification de l'AIIC

Chers collègues,

Le Programme de certification de l'AIIC se prépare en vue de plusieurs nouvelles initiatives captivantes pour 2016.

Tout d'abord, nous sommes heureux d'accueillir Patricia (Pat) Elliott-Miller à titre de chef administrative de la division de la certification et du perfectionnement professionnel. Mme Elliott-Miller, infirmière autorisée détenant une maîtrise, est chef des soins infirmiers orientée sur les résultats qui a présenté des pratiques innovatrices de premier ordre par l'intermédiaire d'une gamme de rôles administratifs, universitaires et cliniques. Elle était la vice-présidente des services aux patients et chef des soins infirmiers au Centre hospitalier pour enfants de l'est de l'Ontario. Elle a une solide compréhension de notre programme de certification, des occasions qui se présentent à tous les infirmiers et infirmières autorisés et de leurs besoins en matière de perfectionnement professionnel permanent.

D'autre part, l'AIIC travaille avec Stratégies en évaluation Inc., la société spécialiste des examens, pour commencer à informatiser les 20 examens de certification dans des spécialités. Stratégies en évaluation inc. a conlu un partenariat de plusieurs années avec Pearson VUE qui donnera accès aux candidats à son réseau de centres d'examen sous surveillance au Canada.

Nous sommes aussi très emballés d'annoncer que les processus de demande d'inscription et d'admissibilité à la certification se feront entièrement en ligne dès 2016.

Dates limites importantes :

- L'AIIC et Stratégies en évaluation inc. uniront leurs efforts au cours des prochains mois pour faire en sorte que les examens sur papier soient informatisés.
- Les demandes d'inscription/de renouvellement n'auront pas lieu cet automne. Nous prévoyons que le processus de demande en ligne soit en fonction à la fin de l'hiver ou au début du printemps et nous fournirons les dates précises dès que le tout sera confirmé.
- Les premiers examens informatisés auront lieu à l'automne 2016. Les candidats admissibles seront en mesure de passer leur examen de certification entre le **19 septembre et le 7 octobre 2016**.
- Pour veiller à ce que tout le personnel infirmier autorisé devant renouveler sa certification d'ici avril 2016 soit en règle, l'AIIC a repoussé la **date limite de renouvellement à la fin de 2016**. Ainsi, les infirmières et infirmiers autorisés auront la possibilité de renouveler leur certification au moyen du nouveau processus en ligne.

Au cours des prochains mois, le site Web de l'AIIC présentera des webinaires renfermant des renseignements utiles sur les demandes en ligne et sur le fonctionnement des examens informatisés en 2016. Nous sommes très heureux de l'évolution captivante du Programme de certification de l'AIIC.

Sincèrement,
Anne Sutherland Boal, inf. aut., B.A., M.G.S.S.
Association des infirmières et infirmiers du Canada

BOUQUETS

SHEILA EARLY MAKES CANADA LOOK GOOD

IAFN was represented at the WHO Global Campaign for Violence Prevention Meeting by Sheila Early, a long-time NENA member and editor of the forensics section of CJEN. This event was held Sept. 22–23, 2015, in the WHO Executive Boardroom in Geneva, Switzerland. The scope of the 7th Milestones Meeting included child maltreatment; youth violence; intimate partner violence; sexual violence, and elder abuse.

CTAS INSTRUCTORS

A huge thank you to the many CTAS instructors who took the time to complete the survey and provide their input to the CTAS National Working Group in preparation for the upcoming CTAS revision. ~ Erin Musgrave

PEIENA RECOGNIZES DONNA GALLANT

Special tribute to our friend and co-worker DONNA GALLANT who has spent tireless hours promoting NENA/PEIENA. She has had several positions in our chapter and continues to show interest in all aspects of emergency nursing. Donna recently retired and has stepped down as Treasurer of PEIENA. We wish her happiness and good health in her retirement. You will be missed. Thank you, Donna, for everything you have contributed to NENA. ~ PEIENA

HONOURARY LIFETIME MEMBER

Bouquets to Sharron Lyons who was awarded an Honourary Lifetime NENA Membership.

Sharron joined NENA and ENABC (Emergency Nursing Association of BC, formerly Emergency Nurses Group of BC) in 2000. Her early involvement included teaching ENPC (2nd edition) throughout the province of BC, where she has continued to be a leader.

In 2005, Sharron became the president-elect for ENGBC and became the president in 2006. She continued to hold that position until the fall of 2009. During her term, she was instrumental in updating the provincial bylaws. Due to the changes in the Registered Nurses Association of BC, it was necessary for ENABC to disaffiliate as a professional practice group under the new College of Registered Nurses of BC, and to become a non-profit group. This is when ENGBC changed its name to ENABC.

In 2010, Sharron became the president-elect for NENA, and served as the president from 2011–2012 and past president in 2013. During this time AIIUQ joined NENA, the first French translation of the ENPC Manual occurred, negotiations with ENA with regards to translating TNCC and future editions of ENPC was ongoing and, once again, she was instrumental in changing bylaws. As a result of Corporations Canada changes to all federal societies, the entire structure and roles of the NENA Executive and Board of Directors changed, including membership and the web page.

During her time as the NENA President, Sharron represented Canada at the ENA Board Meeting and was one of the first five international members to be given voting rights.

Since finishing her term as NENA President, Sharron has served as the NENA Conference Chair on both the 2014 and 2015 conferences, and continues to be a strong leader in ENPC.

BOUQUETS FOR NENA BURSARY WINNERS

The following nurses received NENA bursaries: Darlene Campano, British Columbia; Stephanie Carlson, Saskatchewan; Kitty Murray, British Columbia; Erin Musgrave, New Brunswick; Sara Nosworthy, Alberta; Mary Spinney, Debbie Cotton Bursary; Laura MacKinnon, Marg Smith Bursary

SENG HAS A NEW PRESIDENT

Saskatchewan Emergency Nurses Group has been struggling for the past year, and Tayne Batiuk of Regina has agreed to serve as president until a provincial election can be scheduled. Thank you, Tayne.

The NENA Board of Directors asked the 2015 Conference Committee to put out a Call for Poster Presentations to encourage nurses to use the NENA Conference as a platform to present their work. NENA asked that the posters be research based, educational, and innovative or simply a problem that needed to be solved. The response may not have been overwhelming, however, the posters that were presented were very well received by the delegates. Conference attendees were treated to some excellent and attractive materials. Kudos to those nurses who showcased their excellent work: Marissa Weiler, RN, ENC(C), *There is no 'I' in Team... or Emergency;* Laura Ebenspanger, RN, *Translating Emergency Knowledge for Kids (TREKK): A social networking analysis of a national pediatric emergency network;* Matthew Douma, RN, BSN, ENC(C), CNCC(C); *Double Barreled IO: A Feasibility Trial of Dual Interosseous Needles Inserted into a Single Porcine Humerus;* Matthew Douma, RN, BSN, ENC(C), CNCC(C), *Pumps, Pipes & Tubes: A Description of Common Nitroglycerin Infusion Delays & Overdoses;* Margaret Dymond, CNE, *A Behind the Scenes Look at the Door to Needle Times Process Improvement Initiative at the University of Alberta Hospital;* Ashley Murakami, RN, BN, *Improving timely patient care using a dynamic Intake process in a busy urban emergency department;* Cheryl Swanson, Nurse Educator, *"Flow Nurse" role in our Emergency Department.*

Calling all instructors

If your students have put the work into a presentation, a case study, a disease process, research, etc., encourage them to write it up into a brief article to be published in CJEN. Our section editors will work closely with them to help in the process, and they can see their hard work in print, help to educate emergency nurses across the country and add a publication to their resume—a win/win situation!

Articles can be submitted to the Communication Officer, Stephanie Carlson, **communicationofficer@nena.ca**