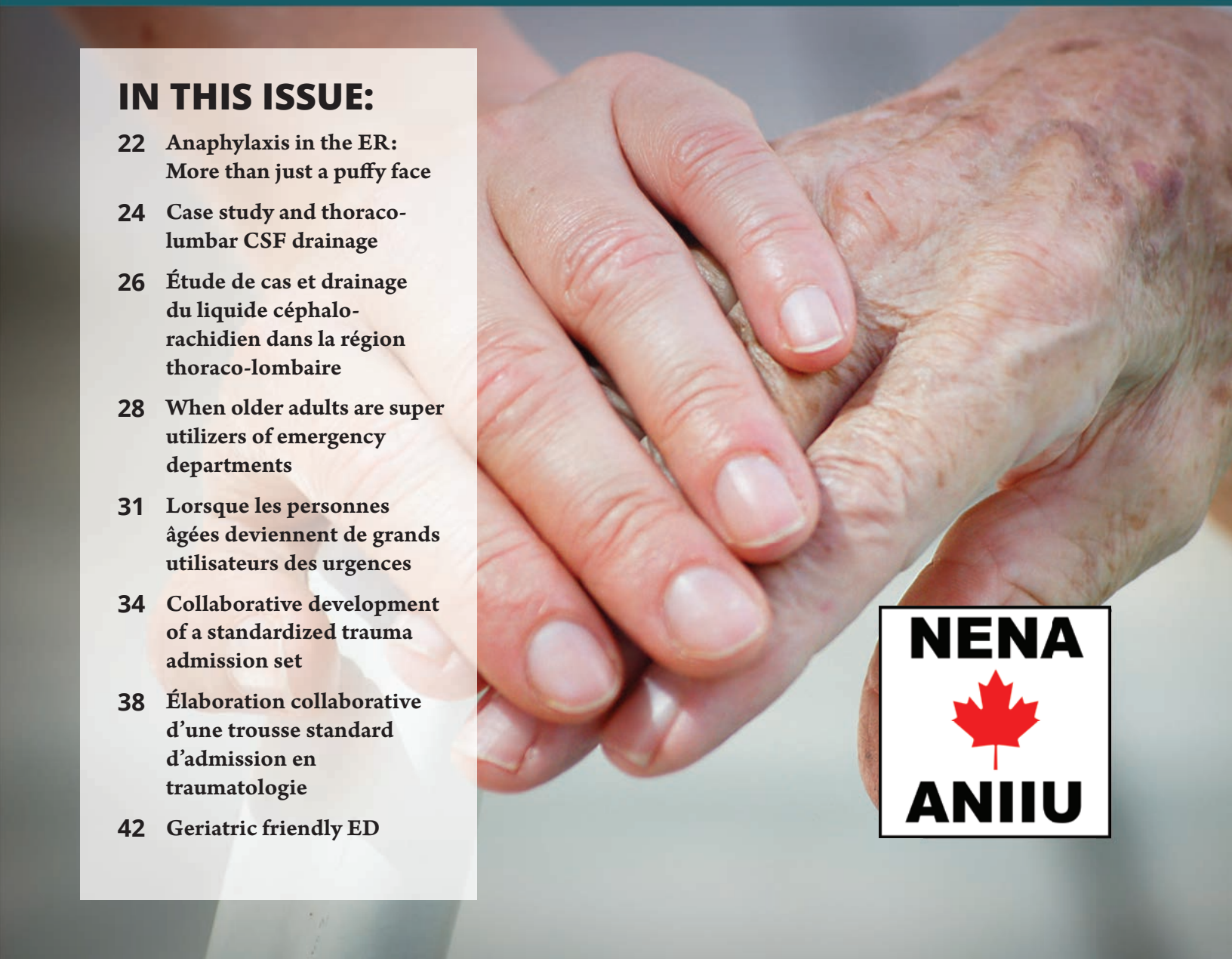
CANADIAN JOURNAL of EMERGENCY NURSING

JOURNAL CANADIEN des INFIRMIÈRES D'URGENCE

THE OFFICIAL JOURNAL OF THE NATIONAL EMERGENCY NURSES ASSOCIATION

ISSN 2293-3921

VOLUME 39, NUMBER 2, FALL 2016



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NENA

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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:
communicationofficer@nena.ca

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

Deadline dates:
January 31 and September 8

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Canadian Journal of Emergency Nursing is the official publication of the National Emergency Nurses Association, published twice annually by Pappin Communications, 84 Isabella Street, Pembroke, ON K8A 5S5. ISSN 2293-3921. Indexed in CINAHL.

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Send manuscript inquiries or submissions to: communicationofficer@nena.ca

CJEN is the official publication of the National Emergency Nurses Association. Articles, news items and illustrations relating to emergency nursing are welcome. **CJEN** is published twice per year. Opinions expressed are not necessarily those of NENA, or of the editor. NENA reserves the right to edit information submitted for publication.

PUBLICATIONS MAIL AGREEMENT NO. 41147033. RETURN UNDELIVERABLE CANADIAN ADDRESSES TO:
National Emergency Nurses' Association, P.O. Box 365, Chilliwack, B.C. V2P 6J4

Fall greetings, NENA members

Are you as surprised as I am that it is November 2016 already? It is so true that as each month or year passes, the next one seems to go even more quickly.

I do hope you each had a chance to enjoy a bit of summer—at the lake, beach, mountains or even just enjoying time at home. My husband and I are fortunate to call the Sunshine Coast in BC home—the name alone ensures a steady stream of summer visitors—definitely true this year.

But here we are, continuing to provide the quality care and expertise of care to all those who come through our doors. The same, yet different, every day.

The same is true for NENA—our history and traditions are strong while at the same time, we change in order to meet the needs of all of you, our members. This is what I want to talk to you about with this message.

As you know, NENA went through significant change, resulting in a Letter of Continuance from the Canadian Government, necessary in order to comply with the rules of the Canada Corporations-Not for Profit Act, which came into law October of 2014. A five-member executive was formed, consisting of president, past/elect president, secretary, treasurer and director of education. Assisting the executive was the newly formed President's Council, composed of provincial representatives, NCAC and triage committee members, communications officer and Webmaster. We soon realized, however, that membership is a key strategy, thus the appointment of director of membership and promotion.

We were not done yet, as it became obvious that an executive of six was simply too small a group to complete the work necessary to keep NENA strong. You have received information recently describing the proposal and selection process used to appoint six additional directors at large, each of whom has written a short biography included later in this journal.

It is my great pleasure to announce the following NENA Directors at Large, their home province and their area of geographic responsibility, ensuring we touch base with all members.

Directors at Large
Geographic Area of Responsibility
Janice Spivey, Ontario
Steve Gagné, Quebec
Marie Grandmont, Manitoba
Debra Pitts, New Brunswick, Nova Scotia, Prince Edward Island
Ashleigh Malarczuk, Newfoundland/Labrador
Melanie Fecteau, Northwest Territory, Yukon, Nunavut

Please join me in welcoming these Directors to the NENA Board of Directors. Over the next several months, we will be meeting to discuss governance and representation models. Be assured we will keep you informed of decisions/changes made.

In addition to all the work described above, please know that your Board of Directors continues to work on many other projects—launch of EPICC courses throughout Canada, ENPC/TNCC contracts, liaisons with CNA, CAEP and ENA, budget management and many others. Please do not hesitate to contact me if you have questions, concerns, suggestions, etc. **president@nena.ca**

I would also like to introduce Wendy Atkinson, new Financial Administrator for NENA. We would not be in the secure financial position we are today without the help of Jim Lashkevich, financial administrator for several years. Jim has decided to retire and was instrumental in recruiting Wendy to take over the role. Wendy lives near Chilliwack, BC, ensuring easy access to Jim, as she learns the role.

In closing, please look at the Save the Date information included in this edition—NENA 2017 is in Charlottetown, PEI, next June. It is Canada's 150th birthday, so what better place to host our conference. I hope to see many of you there—it promises to be great.

Take care, be safe and let us know how we can help.

Sherry Uribe, MBA, BSc, RN, ENC(C)
NENA President

Treasurer's report

My name is Kitty Murray. I am a clinical nurse educator at Victoria General Hospital in beautiful Victoria, BC. My husband and I have four grown children and two lovely grandchildren. I began my term as treasurer in July of this year.

I want to say thank you to Sharron Lyons (interim treasurer) and Sherry Uribe (past treasurer) for helping me with all the various accounting and policy questions. I would also like to thank Wendy Atkinson, our accountant, for doing the brunt of the accounting work and keeping our NENA finances in order.

Currently, we are working on taking over the administration of the EPICC courses, which were jointly developed by prn education and NENA. There were some financial costs to NENA in developing this course, but as they are starting to run, we are seeing some revenue. The rest of NENA finances remain fairly stable, which enables us, as an organization, to continue to fund education and other activities that support emergency nursing practice. I look forward to continuing to serve as your treasurer and am proud to be a member of NENA.

Kitty Murray
NENA Treasurer

CJEN Editor's report

Welcome fall and welcome emergency nurses to the Canadian Journal of Emergency Nursing. This is my last opportunity to speak in this column and I plan to take full advantage to thank all of the many persons who have contributed during my tenure as editor of this journal.

Most readers have little awareness of the many hands that collaborate to bring a journal from nothing to your mailboxes. The most difficult aspect of the task is soliciting for content. Each of the provincial presidents and each of the section editors begin scanning the horizon well in advance of publication for authors who are willing to contribute and topics of import. Emergency nurses tend to be busy people and finding a nurse with extra time is difficult. Often submissions arrive requiring clarification and, of course, we like to include a photo and brief bio of each author. I found out quickly that nurses do not like to send pictures of themselves.

Once content begins to roll in, the task of editing begins with section editors reviewing each item and discussing with the authors. Simultaneously the provincial presidents provide reports on the activities of their provinces—trends in emergency care, provincial high points and issues. Officers on the board also submit reports to keep members informed of NENA activities.

When all of the content is assembled, it is sent electronically to our publisher where proofreaders work their magic. One of their most important services is ensuring that cited sources are accurate and catching plagiarized material. I was shocked the first time we caught blatant unattributed use of material; I suspect it was unintended. Anyway, I chose to give the author the benefit of the doubt.

The CJEN editor works with layout and design staff to organize content in a way that it is most readable and attractive for readers. We also work together to select an image for each cover. This is my final opportunity to thank Heather and Sherri of Pappin Communications for their invaluable help with this task. When we changed the appearance of the journal several years ago, it was their guidance that led to the development of the more professional appearance.

You may notice a generous amount of advertising in each journal. Those advertisers undergird the cost of publication and distribution of the journal twice a year. Without those agencies and vendors this journal would be a PDF in your email.

Thank you to each and every contributor to the journals through the years, many from outside our discipline of emergency nursing. Thank you to the section editors: Sheila Early (Forensic Nursing), Cathy Sendecki (Geriatrics Matters), Sharron Lyons (Kids' Corner), and Carole Rush and Margaret Dymond (Trauma Corner), whose work as section editors has been invaluable through my tenure as editor.

NENA is seeking a permanent CJEN editor but, in the interim, Marie Grandmont from Manitoba and Tayne Batiuk from Saskatchewan have risen to the task for this fall edition. Thank you, ladies.

Respectfully submitted,
Stephanie Carlson

Director of Membership and Promotion's report

Pat Mercer-Deadman is from Saskatchewan and graduated from the Misericordia Hospital School of Nursing in Edmonton in 1981. She has been an emergency nurse since 1983, working in Edmonton and England. Pat has had her Emergency Nursing Certification-Canada through the CNA since 1994. A member of NENA since 1994, Pat was the President of NENA-AB from 2012–2014 and the NENA Conference 2014 Co-Chair. Pat is passionate about emergency nursing and NENA, and developed the Director of Membership and Promotions position for NENA. Pat serves in this position now until June 30, 2017. Along with emergency nursing, Pat works part-time in recovery room at the Northern Alberta Vascular Centre at the Grey Nuns' Hospital in Edmonton and has developed a keen interest in aortic vascular patients, especially with their presentations and care in the emergency department.

Pat Mercer-Deadman
NENA Director of Membership

Website Coordinator's report

In April 2015, I took on the role of website support for NENA. You may recall we experienced a significant problem in the fall of 2015 when our email server became inadvertently blacklisted by Microsoft and its subsidiaries. Because of changes to our hosting company, the solution for the blacklist problem required changing hosting companies, a process that took about a month and resulted in delays to (and dropped) emails among many of our members. Thank you for your patience as we worked through that situation.

With the blacklisting problem resolved we proceeded to grow the site into a more bilingual platform with the addition of French and English language versions of the Position Statements in the Documents section. We also increased the website's provincial content and optimized its communication capacity. Currently the Board of Directors (BOD) is in the process of establishing a website representative among the executive to interface between the membership, the BOD, and the web support team to ensure the site continues to strengthen its profile as an educational and professional resource among the emergency nursing community. Looking ahead, website issues for the consideration by the BOD include: updating the design of the site, increasing the information outflow from the site, and making better use of forum functionality on the site.

Regards,
Norman Carter-Sim, RN, BScN, MHInf(Candidate), Dip. ER Nursing, Dip. Comp. Sys. Tech., Dip. Traditional Chinese Med.
NENA Website Coordinator

Secretary's report

Dear NENA members,

I am honoured to be your current NENA Secretary. I have been an RN for 31 years now and if I could do it all again, I would. I love nursing! I started my career in the Neonatal ICU in Edmonton, but eventually transferred to a position which spanned 12 years in the pediatric ICU. During that time I had the extreme privilege of being a part of the first physicianless Pediatric Critical Care Transport Team in Canada and all of the amazing education that came with this opportunity. From PICU I moved to a large, tertiary, trauma centre emergency department in Edmonton and become a Clinical Practice Educator. This was my first encounter working with an adult population; I was so scared of these "big people" and emergency—it was intimidating and a big learning curve! I stayed in that ED in the educator role for five years before my family made the decision that we could handle Alberta winters anymore (I know – wimps) and moved to the beautiful wine and lake region of Kelowna, BC. I continued in the ED as a Clinical Practice Educator for another five years before returning to the transport world. I am currently the Program Leader for ground, hospital integrated, high acuity response teams (we have four bases in total) and continue to be closely tied to the ED.

I started my introduction by saying that I have the honour of working with NENA, because although I have had an amazing nursing career so far (basically womb to the tomb), some of my most rewarding, memorable and humbling experiences have been with NENA. I became the Communication Officer in 2006, and worked with the NENA publication known then as "Outlook". I took a brief leave from NENA, but returned as the CTAS National Working Group (NWG) representative on the National Course Administration Committee (NCAC) in 2010. I transitioned into the CTAS NWG Co-Chair over the following five years. During this term I was extremely privileged to meet nurses and physicians across Canada, teaching CTAS across numerous provinces, and internationally; Florida, Turks and Caicos, Costa Rica, Hungary, Barbados, Saudi Arabia and Portugal. I was profoundly affected through this; watching RNs become empowered to take ownership of the triage process in a country where there had not previously been access. We shared many tears and hugs with this victory.

At the end of my experience as CTAS NWG, NENA was transitioning into a new era and I wanted to see where this could take this amazing organization. I was elected into the secretary position soon after. My advice to emergency nurses is to "GET INVOLVED". If I had never taken the leap to become involved in NENA, I would not have experienced the amazing people, energy, enthusiasm and dedication that I have on a national level.

Colleen Brayman, RN, BScN

Director of Education's report

The summer has been busy with educational activities related to dedicating resources for those emergency nurses seeking studying materials for the certification exam and the release of NENA's emergency nursing foundations course —EPICC.

Resources for the Canadian Emergency Nursing Exam prep course

This is an online program accessible through the **openlearning.com** website. A systems-based program has been set up with a question and answer format. The PowerPoint show poses a question with the answer and rationale on the next slide. Canadian emergency nurses can access this program following these steps:

1. Go to **openlearning.com**
2. Create a student account
3. Log in and search for "Canadian emergency nursing exam prep course" and select course
4. Click on "Join course"
5. Click on "Videos and activities". The modules now show up for you. The modules are loaded in a PDF PowerPoint format. The tool bar at the top has a "View" choice. Select "Read" or "Full screen"
6. This program is free for the launch year and open to NENA members.

Enhancements to the program will be ongoing with a NENA certification design team. Thank you to all who have participated in the program to date.

Canadian emergency nurses exam - prep course in Dubai, October 2016

Canadian Nurses Association (CNA) and The Dubai Health Authority (DHA) in partnership with NENA are sending two Canadian emergency nurses to deliver a three-day education session in preparation for the Canadian emergency nursing certification exam later in 2016 for the Dubai Health Authority. Efforts are underway to develop a template for an emergency nursing certification face-to-face prep course in Canada for those educators wanting a resource to deliver a prep course for their own emergency nurses preparing to write the Canadian emergency nursing specialty exam in 2017.

Educational resources added to the NENA website under education "Learn More":

1. Links to Allergy education information for nurses, parents, and schools
2. Links to the Canadian Concussion Consortium

Emergency Nurses Pediatric Course 5th edition working team

NENA has a representative on the ENPC 5th edition revision working team. The team is now progressing through development of a 5th edition ENPC course and program development. Stayed tuned for more news in future editions of CJEN, NENA NCAC reps, and ENA.

Submitted by
Margaret Dymond

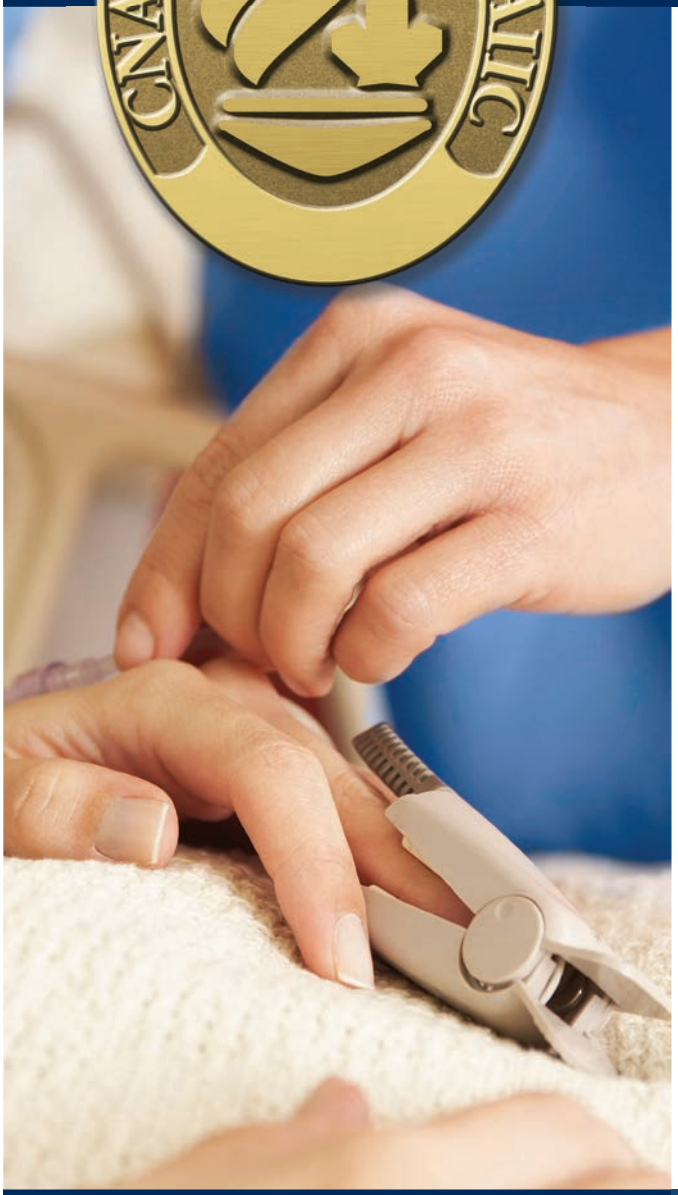
Calling all instructors

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, **communicationofficer@nena.ca**

Care to Be the Best

CNA Certification in Emergency Nursing



"The National Emergency Nurses Association encourages all its members to obtain CNA certification in emergency nursing, as it promotes expertise in the field and helps RNs keep current with current emergency nursing knowledge. Numerous studies have shown that the presence of nurses with their ENC(C) credential contributes to better patient outcomes."

Sherry Uribe
President, National Emergency Nurses Association

Did you know over 1,100 emergency RNs across Canada now have their national ENC(C) certification designation?

Alberta	**109**	British Columbia	**116**
Manitoba	**61**	New Brunswick	**54**
Newfoundland & Labrador	**50**	Nova Scotia	**114**
Northwest Territories	**15**	Ontario	**551**
Prince Edward Island	**11**	Quebec	**53**
Saskatchewan	**61**	Yukon/Nunavut	*

* Information suppressed to protect privacy (1 to 4 candidates)

What distinguishes CNA-certified nurses

- Advanced clinical expertise with a commitment to lifelong learning
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What employers of certified nurses are saying

- Certification confirms an RN's enhanced competency and specialized knowledge
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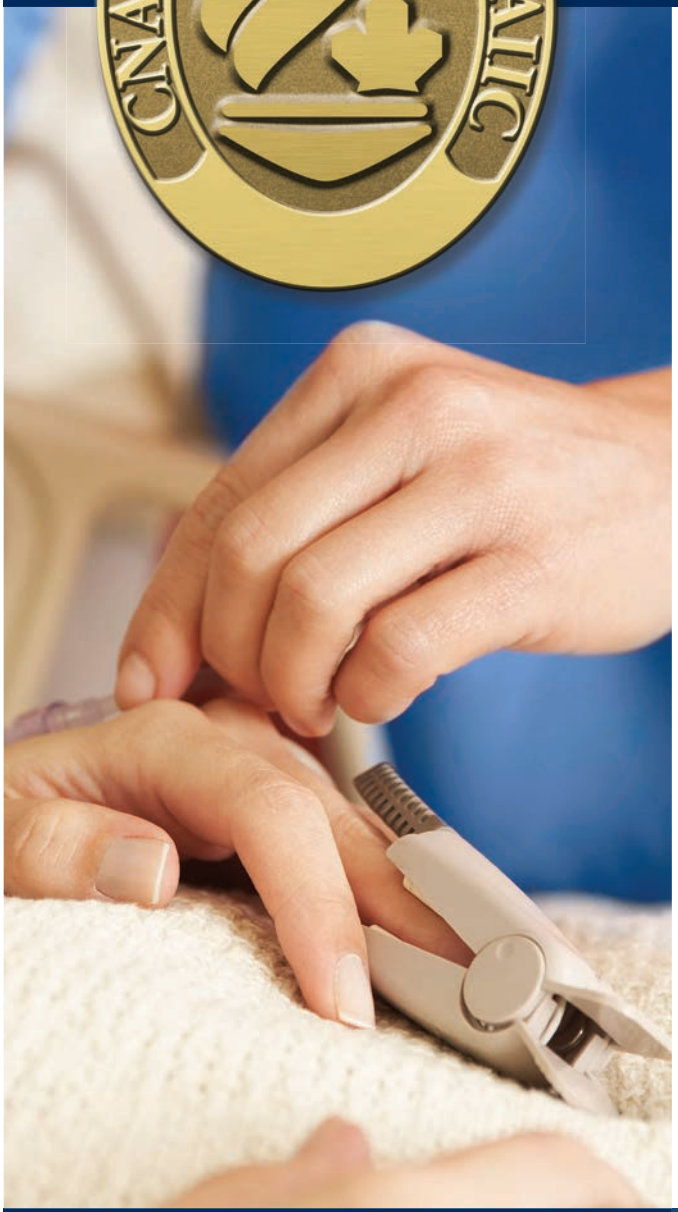
Certification infirmière de l'AIIC en soins d'urgence



« L'Association nationale des infirmières et infirmiers d'urgence encourage tous ses membres à obtenir la certification de l'AIIC en soins infirmiers d'urgence, puisqu'elle fait la promotion du savoir-faire dans le domaine et permet aux infirmières et infirmiers autorisés de maintenir à jour leurs connaissances en soins infirmiers d'urgence. De nombreuses études démontrent que les infirmières ou infirmiers titulaires de la désignation CSU(C) contribuent à de meilleurs résultats cliniques chez les patients. »

Sherry Uribe
Présidente, Association nationale des infirmières et infirmiers d'urgence

Saviez-vous que plus de 1 100 infirmières et infirmiers spécialisés en soins d'urgence de tout le Canada sont maintenant titulaires de la désignation nationale CSU(C)?

Alberta	**109**	Colombie-Britannique	**116**
Manitoba	**61**	Nouveau-Brunswick	**54**
Terre-Neuve-et-Labrador	**50**	Nouvelle-Écosse	**114**
Territoires du Nord-Ouest	**15**	Ontario	**551**
Île-du-Prince-Édouard	**11**	Québec	**53**
Saskatchewan	**61**	Yukon et Nunavut	*

* Information supprimée pour protéger la confidentialité (1 à 4 candidat(e)s)

Qu'est-ce qui distingue le personnel infirmier certifié par l'AIIC?

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- Un dévouement envers les soins fondés sur des données probantes et la sécurité des patients

Qu'en disent les employeurs du personnel infirmier certifié?

- La certification confirme les compétences renforcées et les connaissances spécialisées d'une infirmière ou d'un infirmier autorisé
- La certification permet de recruter et de maintenir en poste les meilleurs infirmiers ou infirmières
- Compter du personnel infirmier autorisé certifié au sein de notre effectif favorise non seulement des soins sûrs et de grande qualité, mais rehausse aussi la culture en matière d'éducation

Pour obtenir plus de renseignements, visitez obtenircertification.cna-aiic.ca

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AIIC

NOUVELLES DATES POUR LES EXAMENS

Passez l'examen informatisé 2017 entre le 1er et 15 mai.

Soumettez votre demande en ligne du 2 janvier au 1er mars 2017.

Nota : Dès l'obtention de la certification, votre désignation CSU(C) est valide pour une période de cinq ans.


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Photo: Destination BC/Blake Jorgenson

NENA Director at Large bios

Janice Lynne Spivey, RN, ENC(C), CEN

Hello/bonjour NENA members and all Canadian emergency nurses. It is both a personal and professional honour for me to have been recently appointed to serve as one of the six new Directors at Large on the expanding NENA Board of Directors.

I have been licensed to practise nursing in Ontario since 1973, as well as having been licensed to practise nursing in New York State, U.S. since 1997. All but my first five years of practice (medicine and CCU) have been in emergency nursing with several years that have included both ED and PACU experience.

I have been privileged to serve as the President of the Emergency Nurses Association of Ontario (ENAO) for several terms, as well as having served as your NENA President. I am ENC(C) certified in Canada by CNA, having just renewed my national certification for the fifth time. I am also CEN certified in the United States.

I have chaired ENAO provincial and NENA national conferences. I am a long-time ACLS and CTAS Instructor. I have previously or am currently serving on various provincial and federal emergency health care working groups and committees.

I have presented on emergency nursing "topics/issues" at various national and international emergency nursing conferences in Canada, U.S., Mexico, Spain, Peru and Brazil. I have been invited to be a speaker at the 2017 international emergency nursing congress in Costa Rica.

I am currently working as an emergency nursing expert for law firms, judges and juries across Ontario, as well as serving as an emergency nursing expert for the College of Nurses of Ontario (CNO). I also continue to serve on the CNA Emergency Nursing exam development committee.

It is a privilege, honour and pleasure for me to serve Canada's Emergency Nurses on the NENA Board of Directors.

Marie Grandmont, RN, BN, ENC(C)

Hello NENA members!

I am pleased to begin my new role serving on the NENA Board of Directors as a Director at Large. I am currently the Director for the Emergency Department Nurses Association of Manitoba and have held that position since 2013. I have been a NENA member since 1994.

I have been a nurse for 25 years, graduating from the Misericordia School of Nursing in 1991 and began work there on a medical floor. After two years, I moved to Dawson Creek in northern British Columbia where I began my emergency career working very briefly in the emergency department. This is where my passion for emergency nursing began and I have been hooked since. After returning home to Winnipeg in 1994, I was fortunate to get a position in the emergency department at Concordia Hospital where I continued to work for almost 21 years. I worked both at the bedside and as the ED Educator during my time at Concordia Hospital. In the last year, I have held a position as a Regional Nurse Educator for the emergency program for the Winnipeg Regional Health Authority, where my role has shifted to academic, teaching new emergency nurses.

I completed my Bachelor of Nursing from the University of Manitoba in 2009. I hold a Certificate in Adult Education through St. Francis Xavier University in Nova Scotia, a Certificate in Emergency Nursing from Red River College in Winnipeg, my CNA Certification in Emergency Nursing for the last 19 years, which I have maintained through continuing education. I teach TNCC, ENPC, CTAS, BLS, ACLS, and Non Violent Crisis Intervention (NVCI). I am a course director for TNCC & ENPC, as well as an Instructor Trainer for TNCC. I am also an ACLS Instructor trainer with the Heart and Stroke Foundation of Manitoba.

I look forward to bringing a provincial voice to the national table, representing hard-working nurses who work in emergency departments across the country. Keep up the excellent work that you do!

Debra Pitts, RN, BN, ENC(C)

I graduated from the Saint John School of Nursing in 1977. Over the next 10 years I worked in a variety of areas including medicine, cardiovascular and thoracic surgery, and the intensive care unit. In 1986 I landed a job at Saint John Regional Hospital (SJRH) in the emergency department (ED).

Lifelong learning being a hallmark of nursing, I continued to learn, taking advanced assessment courses, ACLS and triage. In the '90s at the SJRH, I was part of the clinical team that validated the current CTAS course that was endorsed by CAEP and accepted nationally. In 2002 I took a provincially accredited critical care course, which gave me credits toward my Bachelor of Nursing (BN). I graduated in 2006 from UNB Fredericton with my BN while I continued to work in the ED. I wrote my certification exam in 2006, renewed by continuous learning in 2011, and plan to renew November 2016. In 2007, I and five other senior nurses hopped in a van, drove to Antigonish, NS, and participated in the CTAS instructor course, which was facilitated by Val Eden and Deb Cotton. This was the beginning of my role as an educator in the ED. Currently, my role is Nurse Educator for the Emergency Program at Horizon Health Network, Saint John area. My area includes three rural hospitals, one urgent care centre and the SJRH, a level 1 trauma centre. I instruct/teach BLS, ACLS, CTAS, TNCC, and ENPC.

I love emergency nursing, advocating for my patients and I care to be the best. I support the vision to promote education, certification in emergency nursing and making our voice the one to turn to for emergency nursing in Canada… **NENA.ca**—log on today!

Mélanie Fecteau, RN ENC(C), I.A. CSU(C) Clinical Coordinator Emergency Department/Clinicienne de l’unité des Soins d’Urgences, Acting Clinical Coordinator ICU/Clinicienne de l’unité des Soins Intensifs

Frenchie from Québec, I graduated in Nursing in 1998 in Rivière-du-Loup. I worked in Ottawa as a front-line emergency nurse and in 2003 I decided to go for an adventure and moved to the Northwest Territories (NT) (first in Inuvik and now in Yellowknife). I am an emergency nurse. I did some flight nursing in the North and was able to travel in all of the NT and Nunavut (NU) (Kitikmeot) communities. I have been the Clinical Coordinator for the emergency department in Yellowknife, NT, since 2010 (I took a two-year break to go back into nursing only… but since July of this year I am back into my Clinical Coordinator position). I am also an instructor for all the critical care certifications given in-house, for ACLS, PALS and BLS Heart and Stroke. Some may say that I am a workaholic… but my real passion is travelling… Happy to be part of the BOD for NENA and to be able to expand NENA developments into Northern Canada, in our hospitals, as well as community outpost nursing. Expanding NENA nursing knowledge to all areas of emergency nursing in the North is an area that I am extremely interested in.

Thanks, Merci, Mársı , Kinanāskomitin , Mahsi’ , Quana , ᖅᑯᔭᓐᓇᒦᒃ, Quyanainni, Mahsi’ , Máhsı , Mahsı

Steve Gagné, RN, BSN, CNCC(C)

Je suis actuellement membre du conseil d’administration de l’Association des infirmières et infirmiers du Québec et depuis les dernières semaines, j’ai le privilège de siéger sur le Comité des directeurs de notre association canadienne.

Je suis un infirmier clinicien depuis vingt ans. J’ai pratiqué les soins infirmiers d’urgence à l’Hôpital Juif de Montréal et depuis 2009, je suis conseiller en soins infirmiers pour l’installation Jean-Talon du CIUSSS du Nord-de-l’Île-de-Montréal. En plus de mon rôle au centre hospitalier, j’entretiens un partenariat avec l’Université de Sherbrooke afin de superviser des étudiantes en stage et d’assister à certaines tâches d’enseignement. Je suis également formateur CTAS et j’ai eu l’opportunité de me promener à travers le Québec afin de dispenser cette formation.

J’assurerai une représentation à la nouvelle structure nationale de cette association professionnelle. Je tenterai de communiquer la réalité de la pratique clinique au Québec, mais également je tenterai d’être la voix de chaque infirmière francophone de ce pays.

Malgré les temps difficiles et chaotiques, continuez l’excellent travail que vous faites !

Ashleigh Malarczuk, MN, RN, ENC(C)

I am a registered nurse and very happy to be included on the NENA Board of Directors. I currently live and work in rural northern Alberta as a Clinical Nurse Educator. I am passionate about education and have been involved in teaching many courses to nurses and other members of healthcare teams for several years. I look forward to helping promote emergency nursing.

CTAS National Working Group Update

Work continues on the CTAS content revision and development of enhanced education materials. Release of the new materials is expected in early 2017. More information will be available for CTAS instructors prior to the release of the new materials.

Contributions of case studies, (formatted like the case studies in the existing course) would be appreciated and can be sent to **ctas@nena.ca**

Information about becoming a CTAS instructor is available at: **http://www.caep.ca/resources/ctas/how-become-ctas-instructorinstructor-trainer**

A listing of upcoming CTAS courses is available at: **http://www.caep.ca/CTAS_Courses**

Erin Musgrave & Thora Skeldon
CTAS National Working Group Chairs

NENA Awards, Bursaries and Grants available for 2016–2017

Awards

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

Awards available are:

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

Award nomination forms are to be sent to **awardsbursaries@nena.ca**

Deadline for submission is annually March 31. Awards/Bursaries are announced at the annual NENA conference.

Bursaries

NENA recognizes the need to promote excellence in emergency care and, to this end, will provide financial assistance to its members. NENA will budget for a predetermined amount of monies (up to $400) for the support of ongoing education within the mandate of facilitating a high standard of Emergency patient care throughout Canada.

All members of the emergency nursing team are eligible for consideration including staff nurses, managers, educators and nurse practitioners.

On April 1st annually, the number of bursaries available to be awarded will be determined based on the number of registered NENA members in each province. One annual bursary will be available to the NENA Board of Directors and one bursary will be available to the registered Independent NENA members.

There is one bursary each for the Margaret Smith Paediatric Memorial Bursary and the Debbie Cotton Memorial Bursary, each with a value of $500.

NEW—There are five bursaries each for $100 for NENA members writing their Emergency Nursing Certification of Canada [ENC(C)] through the Canadian Nurses Association (CNA) and five bursaries each for $100 for NENA members re-certifying their ENC(C) whether through continuous learning or the exam.

Deadline for these bursaries are annually March 31 and September 1.

Grants

A NENA Research Grant is available for application by a NENA member/members participating in current research related to emergency nursing in Canada.

Completed applications accompanied by all required documentation must be submitted to your provincial president and/or **awardsbursaries@nena.ca** on or before the deadline date.

Vince Navamete, RN, Regina, Saskatchewan

Sarah Groom, RN, and Tess Comeau, RN, Charlotte County Hospital, St. Stephen, NB

ANIIU Des prix, bourses et subventions disponibles pour 2016/2017

Des prix

L'excellence en infirmiers et soins de santé mérite reconnaissance. En célébrant les réalisations des infirmières dans les quatre domaines de pratique, la compréhension des soins infirmiers est élargi et une image positive est renforcée. Le programme des prix d'excellence d'ANIIU permet aux infirmières d'honorer leurs collègues pour leurs contributions exceptionnelles et pour démontrer l'excellence en ce qui concerne les normes de pratique des soins infirmiers.

Les prix disponibles sont:

- Prix d'excellence dans l'administration des soins infirmiers d'urgence
- Prix d'excellence dans l'éducation des soins infirmiers d'urgence
- Prix d'excellence dans la pratique des soins infirmiers d'urgence
- Prix d'excellence dans la recherche en soins infirmiers d'urgence

Les formulaires de candidature d'attribution doivent être envoyés à **awardsbursaries@nena.ca**

Date de tombée annuelle pour la soumission est 31 mars

Bourses

L'ANIIU reconnaît le besoin de faire la promotion l'excellence des soins d'urgence et donc fournira l'assistance financier à ses membres. L'ANIIU planifiera une quantité prédéterminée de l'argent dans le budget, jusqu'à 400$, pour le soutien de l'éducation continue dans le mandat de faciliter un haut niveau de soins aux patients en cas d'urgence partout au Canada.

Tous les membres de l'équipe de soins infirmiers d'urgence sont admissibles aux fins d'examen, y compris le personnel infirmier, les gestionnaires, les éducateurs et les infirmières praticiennes.

Annuellement, le 1 avril, le nombre des bourses disponibles pour être attribué sera déterminé en fonction du nombre de membres inscrits de l'ANIIU dans chaque province Une bourse annuelle sera disponible au Conseil d'administration de l'ANIIU, et une autre bourse annuelle sera disponible pour les membres indépendants inscrits de l'ANIIU.

Il y a une bourse chacun pour la bourse Margaret Smith Paediatric Memorial et de la bourse Debbie Cotton Memorial. Chaque bourse a une valeur de 500$.

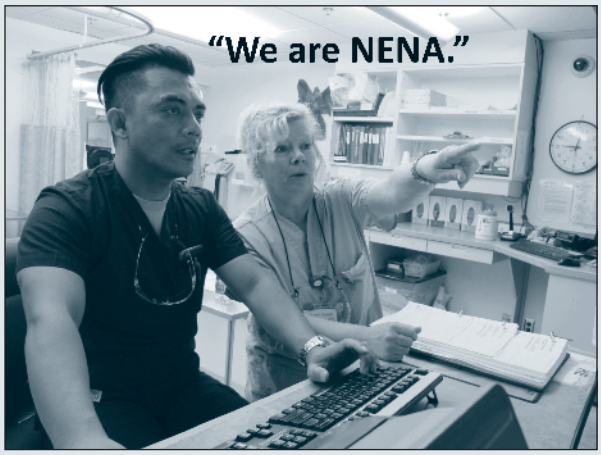
NOUVEAU—Ce sont cinq bourses, chaque pour 100$, pour les membres écrivent leurs Certifié(e) en soins d'urgence (Canada) [CSU(C)] avec l'AIIC. Ce sont aussi cinq bourses, chaque pour 100$, pour les membres renouvellent leurs CSU(C).

Les dates de tombée annuelles de ces bourses sont le 31 mars et 1 septembre.

Subventions

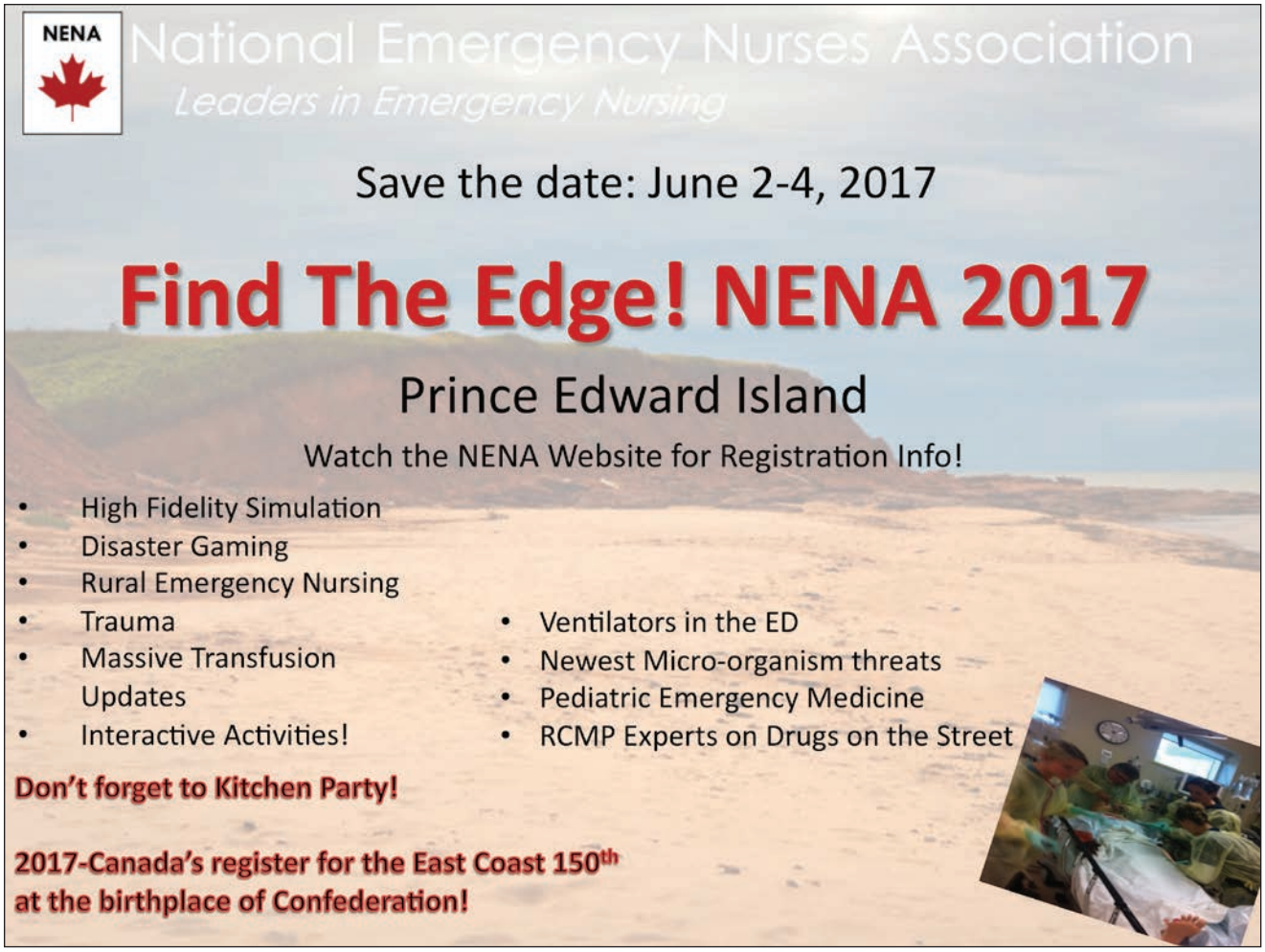
Une subvention de recherche annuelle de l'ANIIU est disponible pour tout membres participent en recherche courante en relation aux infirmiers d'urgence au Canada.

Les demandes remplies accompagnées de tous les documents requis doivent être soumis à votre président provincial et/ou **awardsbursaries@nena.ca** à, ou avant la date tombée.



Vincent del la Cruz, RN, and Arlene Graham, RN, Regina, Saskatchewan

Sheila Swerid, RN, Regina, Saskatchewan



NENA Conference 2017

Fellow Emergency Nurses,
NENA-PE is delighted to be hosting the NENA 2017 National Conference. The theme is 'Finding the Edge'. Emergency nurses were challenged to present abstracts containing cutting edge topics in emergency care. Indeed, the challenge was accepted and the conference committee has an amazing choice of presenters. The conference presenters will give insight into our diverse nursing practice and ignite (or re-ignite!) enthusiasm and love of the best job in the world.

Have you lost your passion for emergency nursing? Are you a new grad struggling in a busy environment? An educator or nursing leader who wants to connect with front-line nursing? This is the conference to attend.

Don't forget to register for the East Coast Kitchen party! An evening with emergency nursing peers in a fun and engaging environment, and one never knows where a lobster may show up!

2017 is the 150th anniversary of Confederation. Charlottetown is the birthplace of Confederation and there will be a lot of activities in the province. Watch the NENA website for special activities and links to the celebrations.

We have some great topics planned including Ventilators Made Easy for ED Nurses, What's New for the Hemorrhaging Patient, Disaster Plans Gone Well-Tales from the Boston Bombing, New Techniques and Theory in Trauma, Pediatric Emergencies, Various Mental Health Topics, Medical Simulation, Disaster Gaming, Rural Emergency Nursing, and more! We have an expert from the Chief Public Health Office, Experts in Disaster Medicine, Royal Canadian Mounted Police, Nursing Leaders, Frontline Nurses, Educators and Physicians and a few surprises!

Watch the NENA website for the registration materials and register early if you are interested in one of the limited simulation seats.

See you in June!

April Mills, BScN, RN, ENC(C)
NENA Conference Chair 2017
NENA-PE Director of Education

Provincial reports

Hello from BC!

Fall has crept in with crisp air and buzzing emergency departments. Volumes continue to increase and congestion remains an ongoing issue.

With rising congestion, ambulance offload wait times have hit the radar in a big way for many communities. Many EDs in partnership with our BC Ambulance partners have been tasked with finding creative solutions for offloading our ambulance patients in a more timely fashion. While incredibly challenging at times, we know the payoffs are also incredible when we can get our paramedics back to the streets where they need to be.

Fentanyl has sustained its position as a leading health crisis in BC with numbers of deaths continuing to mount, as the year progresses. In response, many EDs have started or are trialing Take Home Naloxone programs. This crisis has challenged personal belief systems and our society stigmas around issues of homelessness and mental health, but has also crept into the centres of our homes, affecting our children, friends and families. Kudos to all the ED nurses who are meeting this difficult challenge head on.

Electronic Medical Records have been rolled out successfully in many BC EDs, including EDs across Island Health and now Interior Health. Vancouver Coastal and Providence Health are also now working towards a similar model.

Our ENABC board looked forward to a shared conference with our Washington ENA partner that has, unfortunately, been cancelled, so we are now working towards alternate plans for our annual AGM.

Work also continues in recruitment of members and emerging ideas for the year. The board has several positions turning over this fall. We are so grateful for all the work our outgoing board members have done and are looking forward to welcoming our new board!

Kind regards,
Cassi Gray, BSN
ENABC President

NENA-Alberta

As we move into the cooling season of autumn our 324 members continue to be represented at the provincial level by nine regional representatives. These regional reps have done a remarkable job of keeping the NENA-AB executive informed of the needs and accomplishments of Alberta emergency nurses and they faithfully spread the information about NENA to their respective areas. Most emergency departments are moving into the fall getting ready to gear up for continued educational opportunities for the staff, such as ENPC, TNCC, ACLS, and PALS, plus a variety of conferences around Alberta.

Our annual AGM/Meet in the Middle Conference will happen in Red Deer (pretty much the middle of Alberta) on October 21. Our theme this year is "Change with the Times" with presentations on Changing Perspectives—a nurse speaks about being a patient; Leaders as Change; Sexual and Gender Minorities in Healthcare and skill stations in the afternoon. We are all looking forward to nurses from all over Alberta coming together.

The NENA-AB executive is excited to present at the AGM our proposal for a "Disaster Relief Fund" and the plan to "Adopt a Village" in a developing country where our own NENA-AB nurses are already present. Our vision is that NENA-AB would have an expanding appreciation for global nursing and healthcare.

November 21–23 will be our first EPICC "train the instructors" and EPICC course. We have had an overwhelmingly enthusiastic response from the membership resulting in a full course and a waiting list. PrnEducation will be giving us support and leadership as we do our first round of training the instructors. We invited nurses from all areas of Alberta to be part of the instructor training so that we will have a good base of instructors in all areas of the province. We are very excited for the launch of EPICC in Alberta.

I feel honoured to be the voice of such a dynamic and committed group of nurses that make up NENA-AB.

Respectfully,
Jean Harsch
Provincial Director
NENA-AB

Greetings from Saskatchewan!

My name is Tayne Batiuk and I am the current President of the Saskatchewan Emergency Nurses Group (SENG). I am really excited to be part of this group, as we are working on revitalizing it once again after being dormant for a number of years. We have an active working group of emergency nurses from the province who are committed to being part of this initiative, and to seeing SENG grow in membership so that nurses from across Saskatchewan can link together to discuss challenges, concerns and successes of our members! We are really excited to have the opportunity for our Education Day and Annual General Meeting (AGM) here in Regina, on October 20, 2016. We have an exciting line up of topics and speakers for this session and are looking forward to getting together with emergency nurses for a day of learning and networking. As fall begins, we start to see increasing numbers of requests for courses for TNCC, ENPC, ACLS, PALS and CTAS. There continues to be much interest from our membership in ongoing education initiatives.

Some of the major governmental initiatives for this year include looking at barriers to reduce challenges to moving patients through the emergency department (ED). There is commitment from government to try to address things like mental health and addiction gaps, as well as hospital overcrowding, through a more systems-based approach. The concern of lengthy ED wait times, bed blocking, and high capacity are not new knowledge to ED nurses, however, there is interest from the province in attempting to work to assist with change going forward.

One of the most exciting educational opportunities on the horizon is the introduction of the new Advanced

Certificate of Emergency Nursing that is being offered through Saskatchewan Polytechnic! This program is for registered nurses who want to expand on their current knowledge base and skill set to be able to work with varying health issues in the high-paced world of the ED. This program takes place over 15 weeks. It begins with 10 weeks of online theory courses building on current knowledge base regarding necessary concepts. Following the theoretical components is one full week of lab simulation scenarios, followed by four weeks of clinical practicum. The online theory portion of the emergency nursing program allows for the practical application of knowledge and technical skills in a simulation lab preparing the nurse for the practicum clinical experience. There will be four intakes each academic year for registered nurses to apply.

Emergency nursing is thriving in Saskatchewan, and we will commit to continue to invigorate and enhance SENG to meet our current members' needs and attract even more members to join.

Tayne Batiuk,
President
SENG

Emergency Department Nurses Association of Manitoba

The winds of change are happening in Manitoba, as fall breezes in and the leaves on the trees change colour. Emergency nurses across the province continue their dedicated work making a difference for patients 24/7 no matter what the weather or the season.

After many years of NDP leadership, a new Progressive Conservative government was elected in Manitoba in April this year. During the provincial election campaign, the new government was clear that an immediate priority would be to undertake a sustainability and innovation review to improve the efficiency and effectiveness of the health system in Manitoba and to identify opportunities for improvements to ensure the long-term viability of the system into the future.

Last month, the government issued a Request for Proposal to identify an external consultant to undertake this review. The review will assess spending against three criteria: economy, efficiency, and effectiveness. In the first phase of the review, the consultant will establish a framework for evaluating spending and will consult with leaders within the health system to assist in identifying opportunities for improvement. A number of areas will be identified through this first phase for further investigation. In phase two, those areas of further investigation will be the focus. The consultant will provide concrete recommendations with implementation plans, timelines and estimates of the savings projected as a result of successful implementation. This process will undoubtedly bring some significant changes to segments of our current healthcare system in Manitoba.

Rural facilities across the province continue to struggle to staff emergency departments with physician coverage. During times that lack physician coverage in these rural EDs, ambulances are diverted to other rural or urban centres where there continues to be physician coverage. Emergency department nurses become the sole providers of care during this time. They initiate care through Nurse Initiated Standing Orders to patients who present in order to manage their care until there is physician coverage. Many facilities no longer have telephone access to a physician providing 'remote direction' to nurses during those times when there is no physician on site, therefore sporadic closure of several of the Interlake-Eastern RHA facilities has been necessary during those times. Nurses must assess patients who present during these hours of closure and call 911 if necessary. Rural emergency nurses continue to be the backbone of the rural healthcare system within the province of Manitoba.

The Winnipeg Regional Health Authority (WRHA) continues to work on targets for patient flow and wait times in the ED. According to the CIHI data, the WRHA continues to lag behind the EDs across the country in terms of these indicators. The WRHA senior leadership is committed to working towards goals to change this; incorporating regional, site, and program level operating plans and addressing fundamental system-wide issues that affect emergency department workflow.

Susan Alcock, RN, BScN, Manitoba Stroke Strategy Acute Care Coordinator, has established TeleStroke-Hyperactute in Thompson, The Pas, Dauphin and Brandon. TeleStroke brings the stroke expert to the patient in rural and remote areas of Manitoba by accessing the neurologist via TeleHealth. The goal is to establish TeleStroke-Hyperacute at every rural hospital in Manitoba that has a CT scanner. Implementation of hyperacute stroke care has been made possible by developing stroke protocols and providing education for medical and nursing staff.

Holly Bekkering, RN, BN, presented to EDNA members in June for the spring meeting on "Stress in Emergency Nursing' held at the College of Registered Nurses of Manitoba. The spring meeting was available to rural members via WebEx and Teleconference lines to enable attendance without travel. Stay tuned for a fall meeting. Publicity for EDNA meetings is sent out to members via email through the NENA Webmaster. If you have not been receiving email notification of spring and fall meetings, please contact **mbdirector@nena.ca**

TNCC, ENPC and CTAS courses continue to be offered in all areas of the province, including many northern communities. TNCC will now be offered six times per year, as part of the WRHA Emergency Orientation for nurses new to emergency practice. ENPC will be offered twice per year within the WRHA. TNCC courses continue to be offered frequently in many of the RHAs throughout the province thanks to the dedicated course directors and instructors in all areas of Manitoba. Thank you for all of your hard work and commitment to educating emergency nurses ☺

The Emergency Department Nurses Association of Manitoba will be host to the NENA conference in Winnipeg in spring 2018. We will be looking forward to seeing you in Prince Edward Island for the next NENA conference in June 2017.

In the meantime, stay warm Manitoba Emergency Nurses! Winter is around the corner…

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

ENAO

Hello from Ontario to all of Canada's emergency nurses! The ENAO Board of Directors and ENAO 2016 conference committee have been completely involved with creating a 2016 educational event for emergency nurses that will meet and surpass their current learning needs. The excellent variety of speakers and topics will include the ED patient experience, Organ Donation & Recovery, chronic pain patients' treatment consequences, infectious disease challenges on our horizon, the challenges of working with refugees, ED overcrowding still? YES, bleeding disorders, best practices in blood collection, young stroke patient successes and the legal chronicles of a nurse accused.

TNCC, ENPC, ACLS and PALS continue to be readily available throughout our province. While the administration of CTAS courses in Ontario will change somewhat this fall, this important education for ED nurses will remain accessible and consistent with Canada's national standards for triage education and practice.

Yours in Emergency Nursing,
Janice L. Spivey, RN, ENC(C), CEN
ENAO President

NENA-NB

Where did summer go? It seems to fly by a little more quickly every year.

As I write this note, I reflect that the busy season is starting, but it seems to be starting a little earlier this year… sick patients, the elderly, waiting more than 24 hours to be transferred to an inpatient room. EMS calls in, our stretchers are full, patients are pulled out into the hallway and new patients go into the room for assessment… on it goes. Providing quality care for acute admissions, as well as the patients presenting to our emergency departments is very challenging and stressful.

How and when are we going to fix the overcapacity issues in our facilities? The talk is of patient-focused care… The overcrowding is not only an ED problem, it goes deeper. It is more complex than we realize. We need the government at the table, speaking with primary health care providers, understanding that nurses and nurse practitioners, through collaboration and teamwork, can ease the burden on the health care system, provide patient-focused care and improve the health of patients.

Education

TNCC is offered throughout the province on an ongoing basis. Trauma New Brunswick with Horizon Health Network and Vitalité 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, as well as CTAS instructor courses as needed.

NENA NB continues to promote emergency nursing as a specialty, challenging and encouraging ER nurses to write their certification exams.

Education through simulation is starting back after the summer break. Education is provided to RNs, RTs, LPNs and MDs in our rural hospitals through case-based simulation. It is great to see positive outcomes from the collaboration between MDs, RTs and nursing! Education through simulation improves skills, communication and processes.

New Brunswick Health Authorities, Horizon Health Network and Vitalité with the Department of Health in collaboration with University of New Brunswick and Université 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 program is open to the novice nurse who wants to work in the emergency or critical care area. Applications are received through UNBCEL and Université de Moncton. This initiative has been in place since 2002 and is an excellent example of collaboration.

Membership

Our membership has increased to 62 members. We continue to promote membership at all educational courses! We have 54 nurses in NB who hold their ENC(C).

NENA NB is sponsoring two ER nurses to attend the 2017 NENA conference in Charlottetown, PEI. 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 2017 NENA conference!

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

SANE Programs in Horizon Health in NB

The Sexual Assault Nurse Examiner Program is a nursing-based approach to caring for victims of sexual assault and intimate partner violence. The program is part of the emergency department and provides care to all ages. The primary purpose is to ensure consistent, uninterrupted care and supportive treatment to the victim and their families. Horizon Health has established programs in Moncton (2004), Saint John (2006), Fredericton (2014), and Miramichi, which opened a program this year.

A Sexual Assault Nurse Examiner (SANE) is a registered nurse who has received special training so that she/he can provide comprehensive care to sexual assault victims. Saint John has nine SANE, Fredericton and Moncton both have six SANE and Miramichi has five SANE. Training for more SANE positions has been scheduled for October 2016 for Fredericton, Saint John, Moncton, and Miramichi.

With the development and implementation of the programs across Horizon, a new standardized approach is being taken. Policies and procedures are being developed at all locations and levels. The support of hospital

administration and staff facilitates the success of these programs by assisting with the legal and medical protocols. The Sexual Assault Response Team (SART) is a community-based team that coordinates the response to victims of sexual assault. The team may be composed of SANEs, sexual assault victim advocates, law enforcement, prosecutors, social workers, and any other professional with a specific interest in assisting victims of sexual assault. SART teams are playing an important role by supporting the development of the SANE programs in Saint John and Fredericton.

The SANE program is open 24 hours a day in Fredericton and Saint John, with Miramichi and Moncton planning to achieve 24/7 coverage by early 2017. The program has reduced the workload for the emergency department physicians, has decreased treatment delays, and has created a safe environment for victims. Emotional, physical and psychological care is provided, while completing medical and forensic examinations. Fredericton works in collaboration with the Fredericton Sexual Assault Crisis Centre. An advocate from the centre is notified when a patient presents to the emergency department. They provide support and comfort during the examination and throughout the process. Saint John pediatricians are active in providing support and additional resources for pediatric cases. The SANE role advocates for the patient by presenting them with information, while giving them the power to decide how they wish to proceed. All patients have an option to receive medical and/or forensic care and they decide whether they report to police. Our commitment to providing best patient care will continue to grow with program development.

Laura Astle, BN, RN, Interim Sexual Assault Nurse Examiner Coordinator for Fredericton and Saint John

NSENA

Hello from beautiful Nova Scotia. We hope that everyone had a lovely summer and we are looking forward to getting back into the swing of routine and education that the fall brings for our province. The QEII Emergency Nursing Education Committee is holding its education day on October 21 this year, along with the IWK Education Committee having its pediatric education that day, as well. Both of these events are held in Halifax and I know they will excel in their topics presented. I have been lucky enough to attend both of these events yearly and they are sure to never disappoint. This year I will be attending the QEII education day and we plan to draw from our NSENA members who are attending the education day to cover the cost of registration for the NENA Conference 2017 in PEI. We are very excited that the conference will be on the east coast this year and hope to have many in attendance. NSENA is looking forward to what hopefully will be an exciting year in the world of emergency nursing and working towards building a healthy community amongst our emergency nurses in the province.

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

NENA-PE (formerly PEIENA)

Prince Edward Island is the host for the NENA 2017 Conference. Yeah! We are very enthusiastic about the conference that will be held at the Rodd Charlottetown on June 2-4, 2017. Strategically dated during the spring lobster season? Perhaps! Springtime is beautiful in PEI, and it will be especially fun in 2017, the 150th Anniversary of Canada. Where else to celebrate than at the birthplace of Confederation? NENA-PE members are very enthusiastic about hosting our Canadian colleagues, showing off our beautiful landscape and hopefully recruiting you to our East Coast Kitchen Party, a social event during conference days.

Change seems to be the theme for this biannual report from NENA-PE members. PEI emergency departments have undergone a model of care transition. Leaders have chosen a registered nurse primary care model with support from pharmacy technicians, the cardio-respiratory departments and, in some facilities, dedicated persons for stocking and a re-focus on the basics of nursing care. The RNs struggled with the loss of the team nursing model. The members believe they have risen to the challenge and have been continuously learning and refining the art of primary nursing in the emergency observation units.

TNCC, CTAS, ACLS, NVCI, Basic Coronary Care, and BLS-C continue to be offered on a regular basis. Provincial workshops will be offered this fall including a Trauma Laboratory Day, a Forensic and Health Law Study Day, a Specialty Workshop and the Emergency Respiratory Workshop. Mental Health First Aid will be offered specifically for emergency care providers, including nursing, security, respiratory therapists and ECG technologists.

Earlier this year, the province elected to provide standardized scoop stretchers and pelvic binders for the emergency departments and EMS units. The transition from long spine boards for transport was smooth. The standardization has made for simpler training exercises, as education resources with EMS can be shared and continuity of care transition is simplified.

Our departments have made some amazing gains, including standard processes for the automatic delivery of blood products during hemorrhage, revision of trauma team activation plans, a provincial project for early recognition of sepsis and a provincial plan for medical simulation. At the heart of the changes has been our strong and dedicated nursing staff.

NENA-PE members can't wait to meet more of our nursing friends at the 2017 conference. Lots to see and do in PEI—come early or stay late—there may be a whale or a sandy beach awaiting your attention!

Respectfully,
Dawna Ramsay
Provincial Director NENA-PE

Interview with Jan Calnan

Janet Calnan, RN, BSN, ENC(C), is currently Coordinator of the South Island (SI) Forensic Nursing Services Program within Island Health, B.C. She is also an instructor in Forensic Health Sciences Option at the British Columbia Institute of Technology. Janet has decades of experience as an emergency nurse and forensic nurse at her facility. She has held many offices in the Emergency Nurses Association of B.C. and National Emergency Nurses Association (president from 2012–2016), as well as being a founding member of the Canadian Forensic Nurses Association (2007). Her dedication to the specialities of emergency and forensic nursing has made her an outstanding role model for both new and experienced nurses in both fields. In the following interview she gives us an insight into her most interesting and challenging career.

What are your current professional roles?

Currently, I work part-time as the Forensic Nurse Program Coordinator for the South Island (Vancouver Island Health Authority). I also hold a casual position for the Emergency Department at Victoria General Hospital, where up until two years ago I worked full-time as a clinical nurse leader (CNL).

I know you have been an emergency nurse for decades, what took you to emergency and kept you in emergency nursing?

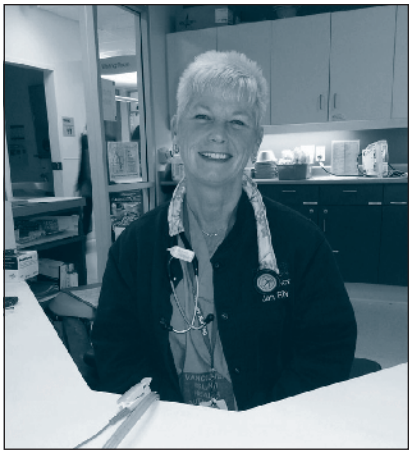
I have always loved emergency nursing. I was very involved in high school with St. John's Ambulance and I guess that was the starting point of my journey in emergency care. When I was in nursing school we had to do a two-month rotation through the emergency department and that is where I was hooked, I knew then that was where I wanted to work. Of course in the 1970s the nurses who worked in the ED had to retire before there was ever a vacancy. There was no issue in those days of retention, so I graduated and worked in medical/surgical units for a few years before I could 'get in the door.' Having those years as a med/surg nurse only made me better as an ED nurse. I love the variety, the chaotic environment and the unpredictability of the ED, no two days are ever the same. I love to critically think and use all of my knowledge to bring the best care to the patient. I want to give them the kind of care I would want my family to have if ever they were patients in the ED.

You have a varied nursing background; can you tell us how you came to be doing what you are doing now?

I have been an instructor for St. John's Ambulance and was a member for many years and also volunteered as a nursing assistant in a nursing home prior to going into nursing. After my graduation from St. Joseph's School of Nursing I went to the Fraser Valley in the province of B.C. and worked on the orthopedic floor and then returned to Vancouver Island, worked in a variety of floors such as urology and EENT. I finally got into emergency nursing in 1980 after many years of waiting and, while there, I held many positions such as clinical nurse, charge nurse, nurse manager, educator and finally clinical nurse leader before I retired in 2013 from full-time. I then went back to the ED as a clinical nurse on a casual basis. Two years ago a position came up in the Victoria area for a Coordinator of the SI Forensic Nurse Examiner (FNE) Program and I was successful in getting this position. I had been a FNE since 1999 and was helping the coordination of the program 'off the side of my desk' for the last 10 years, so took this position and am there to date. Forensic nursing and emergency nursing are a natural fit. I love being able to meld the legal portion and medical portion together and teaching other staff members to think forensically in everything they do.

Tell us about your latest project: the Victoria Sexual Assault Clinic in Victoria

One of my visions in the last 17 years as a FNE/SANE nurse is to better serve the patients who have suffered from sexual violence. As you know, there are many barriers to this group of patients coming to the ED or reporting and so the Victoria Sexual Assault Centre with collaboration from Vancouver Island Health Authority (VIHA), and local



police departments were able to open a freestanding Sexual Assault Clinic (open 24/7). Now patients no longer have to go to sit in an emergency department (must be medically cleared by FNE) and here they will be met by a FNE and a volunteer from the Victoria Sexual Assault Centre. The patient will receive care and treatment, counselling and police contact can be provided if they so desire. Sort of like a one-stop shop. We are part of the Victoria Community Response Centre.

How do you think emergency nursing links with forensic nursing today in Canada?

I think that forensics and emergency are linked together as we try to mesh the legal and medical systems together. Forensics is not just sexual assault, but we see forensic patients every day in the ED such as MVCs, assaults, gunshot wounds, elder abuse, and child abuse. We need to think forensically.

You work with vulnerable populations, what inspires you to do so?

I want the vulnerable patients to know someone cares and is listening to them. I want to treat people like I would like to be treated. Everyone deserves care and respect.

What do you like most about being a nurse?

I love caring for people and making a difference in their lives. In emergency nursing, we make a difference one patient at a time.

What is your favourite "down time" activity?

I like to garden, sometimes pulling those weeds can be very cathartic.

Anaphylaxis in the ER: More than just a puffy face

By Teri Fahner, RN, BScN

In the emergency department nurses will encounter a variety of conditions requiring urgent and immediate interventions. One of these situations is anaphylaxis, which is defined as "a serious allergic reaction that is rapid in onset and may cause death" (Kim & Fischer, 2011). For those nurses who are working in the emergency department, it is of utmost importance that they can quickly and thoroughly assess and identify when anaphylaxis is occurring in order to deliver effective and timely treatment for their patients. Anaphylaxis is a term that "is often reserved to describe immunological, especially IgE-mediated reactions. A second term, non-allergic anaphylaxis, describes clinically identical reactions that are not immunologically mediated. The clinical diagnosis and management are, however, identical" (Lockey, 2012). With this description in mind, it is imperative that nurses working in emergency departments are capable of properly recognizing anaphylaxis and preparing for immediate and appropriate intervention.

Most nurses would be capable of recognizing anaphylaxis if it presents with the most common manifestations, which are "cutaneous symptoms, including urticaria and angioedema, erythema (flushing), and pruritus (itching). Patients also describe a sense of impending doom" (Kim & Fischer, 2011). The reactions occur quickly and are unpredictable, the symptoms "typically develop within minutes after exposure to the offending allergen, but may occasionally occur as late as one hour post exposure" (Kim & Fischer, 2011). It is important to be aware that in recent years there have been adaptations to the criteria that identify anaphylaxis, as well as recognizing that the most crucial area of focus for the proper diagnosis lies in the patient history (prnEducation, 2015).

When assessing a patient with a potential case of anaphylaxis in the emergency department, the acknowledgement of thorough history is paramount; "history is the most important tool to establish the cause of anaphylaxis and should take precedence over diagnostic tests" (Kim & Fischer, 2011). When retrieving the history, nurses must include clinical appearance and exposure encountered before the incident, as well as patient activity preceding the event, such as exercise or sexual activity.

There are three categories into which anaphylaxis falls in terms of diagnostic criteria. The first of these is exposure and airway problems. These are typically caused by an injection source of exposure (prnEducation, 2015). This is the category of anaphylaxis that is the most common and also "includes involvement of the skin, mucosal tissue, or both" (Kim & Fischer, 2011). This criterion is the common presentation, which involves, but is not limited to the typical angioedema leading to throat tightness, tongue swelling, and hives. The second category that is included in the diagnostic criteria is "the impact of two or more body systems after the likely exposure to an allergen" (prnEducation, 2015). There are five body systems that are included in this category. These body systems include integumentary, respiratory, gastrointestinal, cardiovascular, and other, which includes anxiety and the sense of impending doom (prnEducation, 2015). The third category that contributes to the diagnostic criteria is "reduced blood pressure after exposure to a known allergen for that patient. A blood pressure is considered reduced when it is >30% decrease in systolic blood pressure from the normal patient measurement" (Kim & Fischer, 2011). With the knowledge of these categorizations in mind, it is paramount that nurses are aware of the patient history and understand that a patient may have no respiratory or cutaneous involvement whatsoever in the presence of anaphylaxis. It is of great significance that the nurse can identify the recent exposure to the known or potential allergen in order to rapidly and adequately treat.

Once the diagnosis of anaphylaxis has been established, the prompt initial treatment is essential as "even a few minutes delay can lead to hypoxic-ischemic encephalopathy or death" (Simons et al., 2013). The patients' airway, breathing, and circulation must be assessed quickly and immediate interventions provided as necessary. The drug of choice for the initial treatment of anaphylaxis is epinephrine, and "epinephrine should be given immediately to any patient with a suspected anaphylactic episode...even if the diagnosis is uncertain since there are no contraindications to the use of epinephrine" (Kim & Fischer, 2011). Epinephrine should be given intramuscularly in the lateral thigh. This is the route of choice as "it allows for more rapid absorption and higher plasma epinephrine levels...it can be given every five to 20 minutes, as necessary, if no improvement" (Kim & Fischer, 2011). The administration will not stop the anaphylactic episode from occurring. However, it will provide supportive measures to the body by restoring cardiovascular support, stopping respiratory and airway swelling, and stopping fluid shifts, ultimately resulting in the prevention of the development or worsening of distributive shock caused by anaphylaxis (prnEducation, 2015). It has also been found that "In actual studies of individuals who have died as a result of anaphylaxis, epinephrine was under-used, not used at all, or administration was delayed" (prnEducation, 2015). The administration of this medication is absolutely paramount in the management of anaphylaxis and favourable outcomes for the patient.

During the initial treatments of anaphylaxis, antihistamines are not recommended to be used instead of epinephrine. They are

not intended for the reason that "they do not relieve life-threatening respiratory symptom or shock, although they decrease urticaria and itching" (Simons et al., 2013). Nurses should be mindful that antihistamines can be provided for the treatment of cutaneous symptoms and second-line treatment related to these symptoms. However, it will not be useful in preventing distributive shock and respiratory compromise, amongst other life threatening complications. "Intravenously administered H_1-antihistamines can also cause hypotension" (Simons et al., 2013), which is not favourable during anaphylactic episodes as "massive fluid shifts can occur rapidly in anaphylaxis due to increased vascular permeability" (Kim & Fischer, 2011). Understanding that there is a likelihood of substantial fluid shifts and hypotension is also an indication that the nurse can anticipate the initiation of intravenous access, preferably with a large bore catheter, and the administration of fluid for intents of resuscitation. In order to prevent adverse effects of fluid shifts and hypotension, nurses should also "ensure that patients are lying supine with their legs elevated, except if they have shortness of breath or vomiting...do not allow the patient to stand abruptly, as the fluid shift is a likely cause of cardiovascular collapse in the patient experiencing anaphylaxis, which is the second most common cause of death, following airway swelling" (prnEducation, 2015).

After patients have been treated for anaphylaxis, the patient must be observed and monitored for a period of time in order to ensure that the likelihood of a biphasic, or rebound, reaction is less. It is stated that "experts have recommended observing patients for four to six hours following an anaphylactic reaction, with prolonged observation times for patients with severe or refractory symptoms" (Kim & Fischer, 2011). It is also important to note that individuals who have experienced anaphylactic reactions should be given epi-auto injectors, ideally more than one in the event that they experience another exposure to the responsible allergen in the future.

Anaphylaxis is a medical emergency that has a rapid onset and requires immediate attention. It is categorized by three different criteria and the involvement of the respiratory and integumentary systems are not absolute. It requires the immediate administration of intramuscular epinephrine accompanied by intravenous fluids, and secondary treatment using antihistamines, if necessary. The nurse also needs to ensure close observation for biphasic reactions, as well as patient education regarding the risk of future anaphylactic episodes. It is seen in the emergency department and nurses must have preparation and knowledge to accurately recognize when it is occurring and be able to anticipate its management in order to achieve optimal patient care and outcome.

About the author

Teri Fahner, RN, has been living with her family in and around Edmonton, Alberta, and working as a Registered Nurse at the Grey Nuns Hospital in the emergency department since graduating in 2012. She has also worked in a rural hospital in both emergency and acute care. Teri has developed a passion for working with those individuals who are acutely and/or critically ill and frequently developing and learning ways to enhance their outcomes. On days off Teri enjoys spending time with friends and family.

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Case study and thoraco-lumbar CSF drainage

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

Mr. D. is a 78-year-old farmer from rural Alberta, who presented to the emergency department (ED) Wednesday, March 30, 2016, with mid thoracic/scapular pain that began suddenly while he was out doing chores. The pain is severe and unrelenting. He developed transient paralysis of both legs, but, on occasion, just the left leg. These episodes of paralysis came and went approximately every 15 minutes and lasted 5–10 minutes. There was no impairment of sensation. Mr. D. has a known 5 cm abdominal aortic aneurysm (AAA) and he is brought to the Grey Nuns ED. The Grey Nuns in Edmonton is the vascular centre for northern Alberta. Other than the known AAA, Mr. D is healthy, has no history of hypertension and does not take any medications. He quit smoking approximately 30 years ago.

Mr. D. described his pain as 5/10, which was not substantially relieved with three doses of Morphine 2.5 mg IV.

On CT-angio, a dissection of his aorta was seen, extending from his left subclavian all the way down to his abdominal aortic aneurysm. This was classified as a Crawford II, with dissection and bleeding between the walls of the aorta. The doctor told Mr. D. that this was *not* repairable by surgical intervention. The doctor advised the patient that based on this, he would have an Anesthesiologist come and insert a thoraco-lumbar cerebral spinal fluid (CSF) drain to relieve the increased pressure on the spinal cord that was being caused by the dissection. The paralysis is caused by ischemia to the spinal cord. By draining off some CSF, there would be additional space for the spinal cord and circulation to it would be improved (Cheung, 2013).

At the Grey Nuns ED, the Anesthesiologist inserts this drain and brings all the necessary equipment including the "kit" with the manometer and monitoring tubing and cable. The Anesthesiologist requires assistance by the ED staff and supplies for this procedure including hats, gowns, masks and gloves and possibly the chlorhexidine swabs. This CSF drain must be inserted under strict aseptic conditions (Fedorow et al., 2010).

A 14-gauge needle is most often used to insert the Silastic® catheter to drain the CSF and is usually put in through the L3-L4 or L4-5 space and threaded up to the T12-L1 space. For insertion, the patient is in the same position as for a lumbar puncture, either lateral decubitus with knees flexed to the chest and chin down, or the patient is sitting up leaning over an over bed table with the back bowed outward. Once the catheter is in place, it is sutured in and a three-way stopcock is attached with the tubing and manometer. The insertion site is covered with a sterile clear occlusive dressing. The tubing is either primed retrograde with the patient's own CSF or with sterile preservative-free normal saline. This tubing must be clearly labelled with a "No Injections" label. A pressure bag or heparin must *never* be used for this procedure. There may be a sterile bag attached or the system closed with sterile caps. A set amount of CSF is decided upon and removed by the physician. The patient with a CSF drain is ideally monitored in an ICU for close observation of the CSF pressure and the patient's blood pressure. The CSF monitor is "zeroed" and the transducer is kept at the phlebostatic axis (level with the right atrium). This is important, as the patient is usually positioned with the head of the bed elevated, but not more than 30 degrees. Usual CSF pressure parameters are 10–12mmHg. However, during this procedure, CSF pressure is to be kept below 15 mmHg (Federow et.al, 2010). The patient's blood pressure (BP) is monitored carefully to maintain a mean arterial pressure (MAP) of greater than 80 mmHg with consideration of the reason for the drain. The aim is to maintain the patient with normal blood pressure. Monitoring of the CSF pressure is continuous and the removal of CSF is usually intermittent (Cheung, 2013).

There are risks with this procedure: meningitis, fistulation, epidural hematoma, subarachnoid hemorrhage and possibly uncal herniation if too much CSF is removed too quickly. Headache is a common side effect. The literature suggests that no more than 10–15 ml of CSF be removed in any one-hour period (Federow et.al, 2010).

Contraindications for the thoraco-lumbar CSF drain are: trauma, active infection, aortic rupture, pre-existing paraplegia, or past spinal surgery.

These drains are sometimes used with elective repair of thoracic aortic aneurysms and are inserted usually one day preoperatively. These drains may also be used for the treatment of post-operative or traumatic dura fistula with a CSF leak, diagnostic tests for hydrocephalus, to decrease intracranial pressure (ICP) with craniotomies, and as adjunct therapy in the management of traumatically brain-injured patients (Federow et al., 2010).

Documentation is, as with any other procedure, making note of the amount and description of the CSF, and the patient's condition during and after the procedure.

Neurovital signs are monitored and documented at least hourly with particular attention to limb strength and movement if done to relieve pressure on the spinal cord.

The CSF drain is usually removed after approximately 72 hours, may be left longer in certain instances, but never more than five days due to potential infection.

The thoraco-lumbar drain is removed by the Anesthesiologist or a specially trained ICU nurse. The patient's clotting times are checked prior to removal. The patient should be positioned as for the insertion (this increases the space between the vertebrae,

making withdrawal easier) and the catheter is removed with a steady constant withdrawal. The tip of the catheter is visualized and charted "tip intact", as with the removal of an arterial line (American Association of Neuroscience Nurses, 2011).

Now back to Mr. D:
The Anesthesiologist removed 12 ml of CSF and the patient was admitted to ICU where he was attached to the CSF monitor. He was kept in ICU for three days at which time he had no recurrence of the paralysis and his pain had subsided. Mr. D. was kept on the ward for an additional 2–3 days at which time beta blockers were administered to lower his BP. This resulted in syncope, as he was not previously hypertensive. Therefore, the medication was discontinued. Mr. D was discharged and resumed his normal activities.

In mid-May, the doctor scheduled Mr. D. for a follow-up CT-angiogram, which showed no furthering of the dissection and no recurrence of his symptoms. He still has the 5 cm AAA, which will be monitored by CT scan approximately every six months for future elective repair.

Acknowledgements

This was a very interesting presentation and case. I would like to thank Dr. Garret Winkelaar, Vascular Surgeon, and Dr. Raveen Bhalla and Dr. Craig Needham from Anesthesia at the Grey Nuns Hospital in Edmonton, Alberta, for their expertise in the care of Mr. D. and for the knowledge they imparted to me during that time and for this article.

About the author

Pat Mercer-Deadman has been an emergency nurse since 1983 and has her emergency nursing certification through the Canadian Nurses Association since 1999. Pat works on a casual basis in emergency and has a part-time position in the recovery room at the Grey Nuns in Edmonton, Alberta. It is here that she has developed a special interest in aortic vascular patients. She has developed a presentation on Abdominal Aortic Aneurysms, Dissections and Ruptures in the Emergency Department and has presented this both locally and nationally. This presentation was published in the Canadian Journal of Emergency Nursing (CJEN) Spring 2014.

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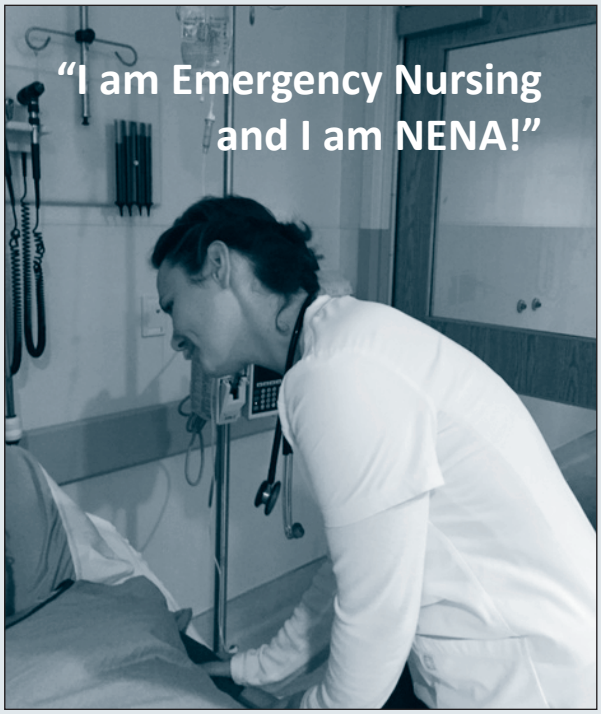

Stacy Anderson, RN, Saint John Regional Hospital, Saint John, NB

Étude de cas et drainage du liquide céphalo-rachidien dans la région thoraco-lombaire

Pat Mercer-Deadman, inf. aut., ENC(C)

Le mercredi 30 mars 2016, monsieur D., un fermier de 78 ans d'une région rurale de l'Alberta, se présente aux urgences en raison d'une douleur scapulaire et thoracique ayant commencé de manière soudaine alors qu'il s'affairait à des tâches extérieures. La douleur est intense et continue. Il souffre de la paralysie de Todd dans ses deux jambes, mais il arrive que seule sa jambe gauche soit affectée. Les épisodes de paralysie apparaissent environ toutes les quinze minutes et durent de cinq à dix minutes. Aucune perte de sensation n'est ressentie. Monsieur D. présente un anévrisme de l'aorte abdominale (AAA) de cinq centimètres, et il est transporté aux urgences de Grey Nuns, le centre hospitalier en cardiologie d'Edmonton, dans le nord de l'Alberta. Outre l'AAA, monsieur D. est en bonne santé, n'a aucun antécédent d'hypertension et ne prend aucun médicament. Il a cessé de fumer il y a environ trente ans.

Monsieur D. décrit sa douleur comme étant à 5 sur 10, et les trois doses de morphine 2,5 mg administrées par voie intraveineuse ne suffisent pas à soulager considérablement sa douleur.

L'angiographie a permis de voir une dissection de son aorte, allant de la sous-clavière gauche jusqu'à son AAA. Selon la classification de Crawford, il s'agissait d'un cas de type 2, caractérisé par une dissection de l'aorte et des saignements entre ces parois. Le docteur Winkelaar a expliqué à monsieur D. qu'une intervention chirurgicale ne pourrait *pas* le soigner et l'a avisé que pour cette raison, un anesthésiste viendrait lui poser un drain pour retirer le liquide céphalo-rachidien (LCR) localisé dans la région thoraco-lombaire et ainsi soulager la pression croissante exercée sur la moelle épinière par la dissection. La paralysie est provoquée par l'ischémie dans la moelle épinière. En drainant une partie du LCR, la moelle épinière aura davantage d'espace et la circulation y sera améliorée (Cheung, 2013).

Aux urgences de Grey Nuns, l'anesthésiste installe un drain, ayant à sa portée tout l'équipement nécessaire, y compris la « trousse », qui comprend le manomètre ainsi que la tubulure et les câbles requis pour l'observation. Pour effectuer cette procédure, l'anesthésiste a besoin de l'aide du personnel des urgences et du matériel suivant : bonnets, blouses, masques, gants et (possiblement) tampons de chlorhexidine. De strictes conditions d'asepsie doivent être respectées lors de la pose du drain (Fedorow et coll., 2010).

Il est fréquent d'utiliser une aiguille de 14 CC pour introduire un cathéter Silastic® dans le but de drainer du LCR, et le cathéter est généralement posé entre les segments L3-L4 ou L4-L5 pour remonter jusqu'au segment T12-L1. Lors de la pose, le patient est placé dans la même position que pour une ponction lombaire, c'est-à-dire en décubitus latéral avec les genoux pliés sur la poitrine et le menton baissé, ou en position assise, penché au-dessus d'une table de lit, le dos bombé vers l'extérieur. Une fois le cathéter installé, il est suturé sur place et un robinet à trois voies est attaché à la tubulure et au manomètre. Le site d'insertion est couvert d'un pansement occlusif transparent et stérile. La tubulure est purgée avec soit le LCR du patient, soit une solution physiologique salée stérile et sans agent de conservation. Il doit clairement être indiqué « aucune injection » sur cette tubulure. Il ne faut *jamais* utiliser de perfusion ou d'héparine pour cette procédure. Un sac stérilisé peut être attaché à la tubulure, sinon elle peut être fermée par un bouchon stérile. La quantité de LCR à écouler est définie et le médecin s'occupe du drainage. Idéalement, le patient est sous observation aux soins intensifs pour permettre de surveiller étroitement sa pression artérielle et la pression du LCR. Le moniteur du LCR est mis à zéro, et le transducteur est maintenu sur l'axe phlébostatique (au niveau de l'oreillette droite). Cette étape est importante, puisque le patient est normalement allongé dans un lit dont la tête est inclinée, mais dont l'angle est au maximum 30 degrés. Les paramètres habituels de la pression exercée par le LCR sont de 10 à 12 mmHg. Toutefois, au cours de cette procédure, la valeur de la pression du LCR doit être maintenue sous 15 mmHg (Fedorow et coll., 2010). La pression artérielle du patient est observée attentivement pour maintenir la pression artérielle moyenne au-delà de 80 mmHg, en tenant compte du drain. Le but est que le patient conserve une pression artérielle normale. La surveillance de la pression du LCR est continue, et l'écoulement du LCR est, en général, intermittent (Cheung, 2013).

Cette procédure présente des risques : méningite, fistulisation, hématome extradural, hémorragie méningée et, possiblement, un engagement cérébral si une trop grande quantité de LCR est enlevée trop rapidement. Les maux de tête sont un effet secondaire fréquent. La littérature indique qu'un maximum de 10 à 15 ml de LCR peut être drainé au cours d'une période d'une heure (Fedorow et coll., 2010).

Les contre-indications entourant la pose d'un drain pour écouler le LCR dans la région thoraco-lombaire sont : traumatisme, infection active, rupture aortique, paraplégie préexistante ou chirurgie rachidienne antérieure.

Ces drains sont parfois utilisés pour les chirurgies électives d'anévrismes de l'aorte thoracique et sont généralement posés une journée avant l'opération. Ces drains peuvent aussi être utilisés pour les pertes de LCR survenant à la suite d'une opération

ou d'une fistule durale post-traumatique, pour les tests de diagnostic d'une hydrocéphalie, pour diminuer la pression intracrânienne lors d'une craniotomie, et pour le traitement auxiliaire des patients ayant un traumatisme crânien (Fedorow et coll., 2010).

Comme pour toute autre procédure, la documentation consigne la quantité de LCR écoulé et la description du liquide, ainsi que l'état du patient pendant et après la procédure.

Les signes neurologiques et vitaux sont surveillés et consignés au moins toutes les heures, en accordant une attention particulière à la force et aux mouvements des membres lorsque la procédure vise à réduire la pression exercée sur la moelle épinière.

Généralement, le drain est enlevé au bout d'environ 72 heures, mais il peut être conservé plus longtemps selon les circonstances, sans toutefois être laissé en place plus de cinq jours en raison du risque d'infection.

Le drain thoraco-lombaire est retiré par l'anesthésiste ou une infirmière aux soins intensifs ayant suivi une formation spéciale. Le temps de coagulation du patient est vérifié avant le retrait du drain. Le patient doit être dans la même position que lors de la pose du drain (cela augmente l'espace entre les vertèbres, ce qui facilite le retrait), et le cathéter est enlevé d'un geste continu et régulier. L'extrémité du cathéter est examinée, et (le cas échéant) il est inscrit au dossier que « l'extrémité est intacte », comme dans le cas du retrait d'un cathéter intra-artériel (American Association of Neuroscience Nurses, 2011).

Revenons au cas de monsieur D. L'anesthésiste a fait écouler 12 ml de LCR, et le patient a été admis aux soins intensifs, où il a été branché à un moniteur de LCR. Le patient est resté aux soins intensifs trois jours, pendant lesquels aucune paralysie ne s'est manifestée; la douleur avait aussi baissé. Monsieur D. est resté à l'hôpital pour deux ou trois jours supplémentaires, et il a reçu des bêtabloquants pour diminuer sa pression artérielle. Puisque le patient n'a jamais été hypertendu, la prise de ce médicament a entraîné une syncope. Pour cette raison, le médicament a été cessé. Monsieur D. a été autorisé à quitter l'hôpital et a repris le cours normal de ses activités.

À la mi-mai, le docteur Winkelaar a fait un suivi auprès de monsieur D., et l'angiographie effectuée a montré que la dissection est stable et qu'aucun symptôme n'a réapparu. Comme monsieur D. a encore un AAA de 5 cm, il devra passer un tomodensitogramme aux six mois pour surveiller son AAA en cas de future chirurgie élective.

Il s'agissait d'un exposé et d'un cas très intéressants. J'aimerais remercier le docteur Garret Winkelaar, chirurgien vasculaire, ainsi que le docteur Raveen Bhalla et le docteur Craig Needham, tous deux anesthésistes au centre hospitalier Grey Nuns d'Edmonton, en Alberta, pour leur expertise dans les soins prodigués à monsieur D. et les connaissances échangées tout au long de la prise en charge de ce cas et pendant l'écriture de cet article.

Au sujet de l'auteure

Pat Mercer-Deadman est infirmière aux urgences depuis 1983 et a obtenu, en 1999, son certificat en soins infirmiers d'urgence auprès de l'Association des infirmières et infirmiers du Canada. Elle travaille occasionnellement aux urgences et travaille à temps partiel en salle de réveil au centre hospitalier Grey Nuns d'Edmonton, en Alberta. C'est à cet endroit qu'elle a développé un intérêt particulier pour les patients atteints de problèmes vasculaires aortiques. Elle a monté une présentation sur les anévrismes de l'aorte abdominale, les dissections et les ruptures aux urgences, et l'a donnée à l'échelle locale et nationale. Cette présentation a aussi été publiée dans le Journal canadien des infirmières d'urgence (CJEN) au printemps 2014.

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When older adults are super utilizers of emergency departments

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

The definition of 'super utilizers' of the emergency departments (ED), sometimes referred to as 'frequent flyers' varies, from those who visit four or more times a year (Grover, 2009), to those having 20 or more annual visits (Champion, 2015). These individuals account for less than 4% of overall ED visits (Soril, 2013), but most ED nurses soon get to know a few patients in their area who visit much more than this, some every few weeks for ongoing needs, some every few days. This can be a frustrating experience for the patient, who may disclose a perception of declining empathy although their symptoms continue. Even when the patient feels well supported during the ED visit, the lack of progress in resolving their issues can be worrisome and tiring. For staff, there can be frustration, as we are unable to resolve the chronic issues that plague this patient, or even provide significant relief. There may also be a feeling that these persons are abusing the system by coming frequently to the ED rather than seeing their GP, or waiting to see a specialist. There may also be concerns that the ambulance system is being misused to bring someone relatively stable to the ED, causing delays for more urgent cases.

The literature has identified adults who visit EDs generally suffer from at least one chronic illness (Champion, 2015). They may have issues with transportation, housing, or mental illness; and contrary to the perceptions of ED physicians and nurses, these people are often high users of other services, as well as the ED. Often, psychosocial issues and substance misuse contribute to their health care needs (Grover, 2009).

Repeatedly, studies reveal that 'super utilizers' perceive the hospital to provide superior care to that available elsewhere, such as an office visit (Champion, 2015). As care providers, we recognize that something may be seriously wrong on this visit, and when the history is not known, comprehensive examinations may expose these patients to the risk of excessive radiation and discomfort, as well as cost to the system (Grover, 2009).

Some measures to improve the outcomes for super utilizer patients and the ED have been developed. For example, in Vancouver, a program has been developed in which a case manager works with these patients to integrate crisis intervention, supportive therapy, and ongoing care, with attention to housing and other social needs (Pope, 2000). In Saskatoon, housing and other social determinants of health have been addressed to provide "upstream" support to prevent the need for ED visits (Meili, 2013). In other areas, individual care plans have been developed as interdisciplinary health care providers and the patient work together to identify needs and interventions. Little information is available to identify if these approaches result in fewer ED visits, but more consistent care is provided.

The situation for older adults who frequent EDs is often complicated by changes of aging. Issues of mobility and transportation, housing, poor nutrition, and increasing burden of chronic illness may become more prevalent with age. In some instances, cognitive decline plays a significant role. It is difficult to ascertain why someone has come when the patient can describe only vague complaints of uncertain duration. Often, our instructions to follow up with a family physician do not result in a decrease in ED visits.

As a Geriatric Emergency Nurse Clinician, I am consulted when seniors are perceived to be visiting our ED frequently. This may be on the second or third visit in as many days, or it may be for someone who has been coming monthly for years and today that person is here during my shift. As with so many scenarios involving seniors, the range of presentations is broad. Early in my career, one elderly man who lived alone near the hospital came to the cafeteria for dinner several nights a week. Then he began to stop by the ED at times. He was vague as to how he was managing at home, and didn't want to bother his niece, his only local family. My mentor at that time stated such patients often "know something is wrong", and therefore make contact with the ED. In the case of this gentleman, when he gave us permission to contact his niece, she was eager to help, and arranged adequate food and support.

For many, there is not such a positive outcome. Some of these patients have evidence of cognitive impairment, but they are able to manage with some support in the community, and often remember how to call an ambulance. This may go on for months or even years, and can be frustrating for paramedics, who are called frequently, and the ED staff. The cycle tends to end when a crisis occurs, requiring admission to hospital or their cognitive impairment worsens and arrangements are made for ongoing care.

The occurrence of mental health conditions, as well as physical illness affecting many of these patients can complicate their management. In my experience, the mental health concerns are not generally so acute as to warrant an emergency referral to psychiatry, but outpatient referrals may be forgotten or rejected. Even when some of these patients have been seen by psychiatry, they eschew ongoing care.

Despite these barriers to care, these people come to us. What can we realistically offer?

- As always, accurate assessment: Why is this person coming so often? Are these visits for management of pain following compression fractures? When the patient can give only vague information, seek collateral information from family or friends. Identify who can investigate further: social work or home health may be able to identify needs and interventions. Involve the patient's family physician if there is one, so the ED and other healthcare providers are giving consistent care.
- Intervene as appropriate: Considering history to avoid unnecessary duplication of examinations, but with consideration for complexity of needs.
- Make a concise history and care plan readily available so physicians and staff have necessary information for each visit: For example, one patient with COPD has been given Prednisone and, at times, Lorazepam; both caused delirium. Now that this information is available on every visit, she has had a more stable course.
- Provide printed instructions on discharge, in a font large enough for this patient to read.
- Consider the possibility of a history of trauma: Defined as "experiences that overwhelm an individual's capacity to cope." This may occur at any time, from early life to a later time, and may be a single incident or an ongoing situation. Trauma is common, as 76% of Canadian adults report some form of trauma exposure in their lifetime (B.C. Centre of Excellence for Women's Health, 2013). While most people are resilient, and develop healthy ways of coping, illness, exhaustion or overwhelming events at a later time may cause a recurrence of an earlier response.

While an in-depth discussion of trauma informed practice is beyond the scope of this article, there are aspects of this approach that may benefit these patients and can be incorporated into the practice of emergency nurses. Trauma-informed practice is addressed most frequently in the setting of mental health practice, but we, in the emergency care community, need to consider how we can incorporate the principles into our practice. For example, a trauma-informed approach places "priority on the individual's safety, choice, and control" (B.C. Centre of Excellence for Women's Health, 2013).

Four aspects to consider are:

1. Trauma awareness: increased knowledge about the prevalence and effects this may have on our patients, as well as on us.
2. Safety and trustworthiness: provide consistent care, clear information about the options for care, ensure informed consent. For example, refer to home health only if the patient agrees.
3. Provide opportunities for choice: this may be limited during the ED visit but, where possible, this gives the patient some control of their situation, for example, give information about how to contact home health if they need to change the time of the appointment.
4. Assist patients to identify and build on their strengths. This approach can also enable us to gain a better understanding of what this person is dealing with.

As an illustration

Mrs. P. is an 88-year-old widow, living alone in an apartment. In the past, she had accompanied her husband on his hospital admissions, but since his death a few months ago, she has had several ED visits. She has frequently experienced chest pain, and has come to hospital by ambulance. The paramedics sometimes report concerns about medication management, noting tablets spilled on the floor. On each visit, investigations reveal no cardiac cause for her symptoms and she is discharged. She is instructed to see her family physician, but returns to the ED before making an appointment. She is offered a home health referral, but declines, as she has fallen behind in her housework and doesn't want "strangers to see my home like this."

On one visit, the emergency physician and nurse speak with her to discuss that despite several visits, her health continues to be a concern, explaining that while no acute illness is present, she requires ongoing support. Her care for her late husband is acknowledged and she is encouraged to accept help now for herself. A home nursing visit is recommended, and the Quick Response Case Manager comes to the ED to speak with her before discharge, gaining her consent for a home visit. An appointment with her physician is also made before she is discharged. Printed instructions are reviewed with her before she goes home. These measures are outlined in a care plan, which is flagged on subsequent visits.

Over the next several weeks, Mrs. P. makes a few more visits to the ED. She is again reassured, and the importance of ongoing follow-up is emphasized. When she comes to the ED again near the anniversary of her husband's death, the staff realize she had not come for some time and acknowledge that she has done well with their support.

As a final note, we need to accept that, as ED practitioners, we may experience frustration when caring for 'super utilizers.' Sometimes we can identify definitive strategies to provide relief for the presenting symptoms, but there are times we will not achieve this. We can feel professional satisfaction in knowing we have done a thorough assessment and addressed relevant issues. We may need to refer to other disciplines, and we may continue to see this patient often. We may be the safety net for these vulnerable patients, ensuring they have the best possible care while they struggle with complex needs.

About the author

Cathy Sendecki, BSN, RN, GNC(C), has worked at Burnaby Hospital Emergency Department since 1987, in the past several years as Geriatric Emergency Nurse Clinician, as part of the Older Adult Program. Particular interests include working with persons with dementia and their care partners and embracing the challenges of dealing effectively with Elder Abuse. She enjoys being a grandma.

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Tidbits & Trivia Fall 2016

Submitted by Janice L. Spivey

- The American Association of Retired Persons (AARP) June/July 2016 magazine reported that older feet are less sensitive to heat, so our "senior" patients may not realize how hot the beach sand is until it has already done its damage, which could include second and third degree burns, according to Shriners' Hospitals' David Greenhalgh, MD. The risk of injury is greater for diabetics or vasculopaths, who have decreased sensation in their feet. Surf shoes or sandals are recommended and cool (not cold) soaks for red feet, with medical care for blister formation.

  Supported by:
  Wickremaratchi, M.M., & Llewelyn, J.G. (2006). Effects of ageing on touch. *Postgrad Med J*. 2006 May; 82(967), 301–304. doi:10.1136/pgmj.2005.039651

- The Stanford University School of Medicine recommends that to cool down after a workout, we should try chilling our hands. Cooling the palms has been found to help to circulate blood and pull heat from the body.

  Supported by:
  Berkeley Wellness. October 1, 2012. *"Cool Hands."* Retrieved from http://www.berkeleywellness.com/fitness/exercise/article/cool-hands

- Researchers at the University of Auckland, New Zealand have found that honey reduces healing time significantly when applied to wounds because of its antibacterial and anti-inflammatory properties.

  Supported by:
  Jull, A.B., Rodgers, A., & Walker, N. (2009). Honey as a topical treatment for wounds (Review). *The Cochrane Library 2009*, Issue 4. Retrieved from https://researchspace.auckland.ac.nz/bitstream/handle/2292/7841/cd005083.pdf?sequence=3

- Did you know that according to the Canadian Association of Retired Persons (CARP), the first recorded use of Cannabis as medicine was in China in 2737 BC? It was recommended to treat gout, rheumatism, malaria and constipation.

  Supported by:
  Rose, S.D. (2013). *Traditional Chinese medicine: How marijuana has been used for centuries.* Northwest Leaf: the patient's voice. Retrieved from http://www.thenorthwestleaf.com/pages/articles/post/traditional-chinese-medicine-how-marijuana-has-been-used-for-centuries
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Lorsque les personnes âgées deviennent de grands utilisateurs des urgences

Cathy Sendecki, B.Sc.inf., inf. aut., CSIG(C)

Les « grands utilisateurs » des urgences sont définis de diverses manières, allant de personnes qui visitent les urgences quatre fois ou plus par année (Grover, 2009) à personnes qui s'y présentent vingt fois ou plus par année (Champion, 2015). Ces individus représentent moins de 4 % de tous les visiteurs des urgences (Soril, 2013), mais la plupart des infirmières en urgence finissent rapidement par reconnaître des patients de leur région qui s'y présentent très fréquemment, certains pouvant visiter les urgences à quelques semaines, voire quelques jours, d'intervalle pour des besoins récurrents. Cela peut s'avérer une expérience frustrante pour le patient qui perçoit une baisse d'empathie envers lui malgré la présence continue de ses symptômes. Même si le patient se sent bien entouré lors de ses visites aux urgences, l'absence de progrès dans la résolution de ses problèmes de santé peut aussi être préoccupante et épuisante. Pour les membres du personnel que nous sommes, cette situation peut également entraîner des frustrations lorsque nous sommes impuissants face aux problèmes chroniques qui affligent le patient ou même incapables de soulager ses douleurs. Nous pouvons aussi parfois avoir l'impression que ces personnes abusent du système de santé en se présentant aux urgences au lieu de consulter leur omnipraticien ou d'attendre un rendez-vous avec un spécialiste. En outre, on peut se demander si le système ambulancier est mal utilisé dans ces situations, transportant des personnes dont l'état est relativement stable au détriment des cas plus urgents.

La littérature montre qu'en général, les adultes qui se présentent aux urgences sont atteints d'au moins une maladie chronique (Champion, 2015). Ils peuvent être aux prises avec des problèmes de transport, de logement ou de santé mentale et, contrairement aux perceptions des urgentologues et des infirmières en urgence, ces personnes sont souvent de grands utilisateurs d'autres services, en plus des urgences. Bien souvent, des problèmes psychosociaux et le mauvais usage de substances contribuent à leurs besoins en matière de soins de santé (Grover, 2009).

À maintes reprises, des études ont démontré que les grands utilisateurs considèrent recevoir de meilleurs soins à l'hôpital que partout ailleurs, notamment en clinique (Champion, 2015). En tant que professionnels de la santé, nous constatons, lors de ces visites, qu'il y a quelque chose d'anormal, et lorsque les antécédents des patients ne sont pas connus, les examens généraux passés par ces derniers peuvent les exposer de manière excessive à de la radiation et à de l'inconfort, en plus d'engendrer des coûts pour le système (Grover, 2009).

Certaines mesures visant à améliorer la situation des grands utilisateurs et des urgences ont été mises sur pied. À Vancouver, par exemple, il existe un programme faisant participer un gestionnaire de cas auprès de ces patients dans le but de favoriser les interventions en cas de crise, les thérapies de soutien et des soins continus en fonction des besoins en matière de logement et de tout autre besoin social (Pope, 2000). À Saskatoon, les déterminants sociaux de la santé (y compris en matière de logement) ont été abordés pour fournir aux patients du soutien en amont dans le but de prévenir les visites aux urgences (Meili, 2013). Dans d'autres régions, des plans de soins individuels ont été élaborés afin que les professionnels de la santé de diverses disciplines et le patient travaillent ensemble pour cerner les besoins et établir des interventions. Très peu de données sont disponibles pour déterminer si ces approches ont fait diminuer les visites aux urgences; toutefois, il en découle des soins plus homogènes.

Le vieillissement vient souvent compliquer la situation des personnes âgées qui fréquentent les urgences. Les problèmes liés à la mobilité, au transport, au logement, à la malnutrition et aux maladies chroniques deviennent plus fréquents en vieillissant. Dans certains cas, le déclin cognitif joue un rôle important. Il est difficile de déterminer pourquoi une personne est venue à l'hôpital lorsqu'elle décrit de vagues maux d'une durée incertaine. Bien souvent, nos consignes voulant que le suivi se fasse auprès du médecin de famille n'entraînent pas une diminution du nombre de visites aux urgences.

En tant qu'infirmière en gestion des urgences gériatriques, j'entre en jeu lorsque des personnes âgées semblent se présenter souvent à nos urgences. On vient me consulter après la deuxième ou la troisième visite d'un patient en autant de jours, ou encore lorsqu'un patient étant venu aux urgences chaque mois pendant des années est finalement aux urgences pendant mon quart de travail. Comme les scénarios possibles entourant les personnes âgées sont multiples, les signaux sont eux aussi variés. Au début de ma carrière, un homme âgé qui habitait seul et non loin de l'hôpital venait souper à la cafétéria quelques soirs par semaine, puis il s'est mis à visiter les urgences à l'occasion. Il parlait très peu de comment il prenait soin de lui à la maison et il ne voulait pas déranger sa nièce, la seule personne de sa famille qui demeurait dans les environs. Mon mentor de l'époque m'a appris que de tels patients « savent souvent qu'il y a quelque chose d'anormal », ce qui explique leurs visites aux urgences. Dans le cas de cet homme, lorsqu'il nous a donné la permission

de communiquer avec sa nièce, elle s'est montrée empressée de l'aider et a veillé à ce que lui soient offerts des services adéquats de nutrition et de soutien.

Pour beaucoup, cependant, l'issue est loin d'être positive. Certains de ces patients montrent des signes de troubles cognitifs, mais peuvent tout de même demeurer autonomes en utilisant des services de soutien de leur collectivité; souvent, ils arrivent à se rappeler comment demander une ambulance. Cette situation peut durer des mois, voire des années, et peut être frustrante pour les ambulanciers paramédicaux, souvent sollicités, et pour le personnel aux urgences. Habituellement, ce cycle se termine après qu'une urgence nécessite l'admission du patient à l'hôpital ou lorsque les troubles cognitifs se dégradent et que des dispositions sont prises pour la prestation de soins continus.

La présence de problèmes de santé mentale et de maladies physiques chez bon nombre de ces patients peut compliquer leur prise en charge. Selon mon expérience, les inquiétudes en matière de santé mentale ne sont généralement pas assez graves pour mener à une recommandation urgente d'hospitalisation en psychiatrie, mais il arrive que les recommandations de patients externes soient oubliées ou rejetées. Et même si certains de ces patients ont déjà été suivis par un psychiatre, ils ne sont pas forcément retenus pour des soins continus.

Malgré ces barrières limitant les soins, ces personnes viennent à nous. De façon réaliste, que pouvons-nous faire pour elles?

- Effectuer, comme toujours, des évaluations rigoureuses. Pourquoi cette personne vient-elle si souvent? Ces visites pour gérer la douleur font-elles suite à une fracture par compression? Lorsque le patient donne des renseignements vagues, il faut chercher à obtenir des renseignements supplémentaires auprès de la famille ou d'amis. Il faut aussi déterminer qui peut pousser l'enquête : les services sociaux ou les services de soins à domicile pourraient être en mesure de cerner des besoins et des interventions. Le médecin de famille du patient, s'il en a un, devrait être impliqué pour que le personnel des urgences et les autres professionnels de la santé prodiguent des soins cohérents.
- Intervenir de façon appropriée : tenir compte des antécédents pour éviter la duplication inutile des examens, tout en considérant la complexité des besoins.
- Répertorier les antécédents et les éléments du plan de soins de manière concise pour que les médecins et le personnel aient facilement accès aux renseignements importants lors de chaque visite. Par exemple, une patiente atteinte d'une MPOC a reçu de la prednisone et, parfois, du lorazepam; ces deux médicaments ont causé des crises de délire. Depuis que cette information est disponible à chaque visite, l'état de santé de cette patiente est plus stable.
- Fournir des consignes imprimées, lors d'une sortie d'hôpital, dans une police suffisamment grande pour que le patient puisse les lire.
- Envisager la possibilité d'antécédents de traumatisme (expériences qui surpassent les capacités de la personne à gérer ses émotions). Cela peut survenir à tout moment, dans l'enfance ou plus tard dans la vie, et il peut s'agir d'un événement isolé ou d'une situation récurrente. Les traumatismes sont fréquents; 76 % des Canadiens d'âge adulte déclarent avoir vécu un quelconque événement traumatisant dans leur vie (B.C. Centre of Excellence for Women's Health, 2013). Même si la plupart des individus sont résilients et développent des moyens sains de se protéger, la maladie, l'épuisement et des événements bouleversants peuvent faire réapparaître des réactions antérieures.

Bien qu'un examen approfondi de la pratique axée sur les traumatismes dépasse la portée du présent article, les patients pourraient bénéficier de certains aspects de cette approche, lesquels pourraient être ajoutés aux pratiques des infirmières en urgence. La pratique axée sur les traumatismes est principalement utilisée en santé mentale; toutefois, nous, la communauté des soins d'urgence, devons réfléchir à comment nous pourrions intégrer ces principes dans notre pratique. Une approche axée sur les traumatismes, par exemple, « priorise la santé, les choix et la maîtrise de l'individu » (B.C. Centre of Excellence for Women's Health, 2013).

Les quatre aspects à considérer sont :

1. La sensibilisation au sujet des traumatismes : améliorer les connaissances sur la prévalence des traumatismes et les effets qu'ils peuvent avoir sur les patients et sur nous.
2. La sécurité et la confiance : offrir des soins cohérents et des renseignements clairs sur les options de traitement, et s'assurer du consentement éclairé des patients (par exemple, utiliser les services de soins à domicile seulement si le patient est d'accord).
3. La possibilité de faire des choix : cela peut être difficile aux urgences, mais lorsque c'est possible, offrir des choix aux patients leur permet d'avoir un peu de contrôle sur leur situation (par exemple, leur expliquer comment communiquer avec les services de soins à domicile s'ils souhaitent changer l'heure de leur rendez-vous).
4. Montrer aux patients comment trouver et améliorer leurs forces : cette approche peut aussi nous permettre de mieux comprendre la situation du patient.

À titre d'exemple

Madame P. est une veuve âgée de 88 ans qui habite seule en appartement. Par le passé, elle accompagnait son mari chaque fois qu'il était admis à l'hôpital, mais depuis son décès, il y a de ça quelques mois, elle a visité les urgences à plusieurs reprises. Elle souffre souvent de douleurs à la poitrine et a été transportée à l'hôpital en ambulance. Les ambulanciers soulèvent parfois leurs préoccupations au sujet de sa prise de médicaments, voyant les comprimés éparpillés sur le sol. Lors des visites, les examens ne révèlent aucune cause cardiaque à ses symptômes, et elle est donc autorisée à sortir. Elle a été avisée de consulter son médecin de famille, mais avant même d'avoir pris un rendez-vous, elle retourne aux urgences. Il lui a été recommandé d'utiliser les services de soins à domicile, mais elle refuse, puisqu'elle est en retard dans son ménage et ne souhaite pas que des inconnus voient son domicile dans cet état.

Lors d'une visite, l'urgentologue et l'infirmière ont discuté avec elle pour lui expliquer que malgré ses nombreuses visites, sa santé continue d'être inquiétante, et qu'elle a besoin de soutien même si elle n'a aucune maladie grave. On reconnaît qu'elle s'est bien occupée de son mari, et on l'encourage à accepter de l'aide à

son tour. Il lui est recommandé qu'une infirmière lui rende visite à domicile, et le gestionnaire de cas de l'équipe d'intervention rapide est venu aux urgences pour discuter avec madame P. afin d'obtenir son consentement pour les visites à domicile avant qu'elle ne soit autorisée à quitter l'hôpital. Un rendez-vous avec son médecin est également pris avant son départ, et on passe en revue avec elle les consignes imprimées avant de la laisser partir. Ces mesures sont inscrites dans un plan de soins, lequel sera consulté lors des prochaines visites.

Au cours des semaines suivantes, madame P. s'est présentée aux urgences encore à quelques reprises. Elle est à nouveau rassurée, et l'importance d'un suivi continu est soulignée. Lorsqu'elle s'est présentée aux urgences à nouveau, cette fois près de l'anniversaire du décès de son mari, le personnel a réalisé qu'elle n'était pas venue depuis un certain temps, et elle a reconnu qu'elle se porte mieux depuis qu'elle a de l'aide.

En conclusion, nous devons accepter, en tant que professionnels de la santé aux urgences, qu'il se peut que nous vivions des frustrations lorsque nous avons à notre charge de grands utilisateurs. Il arrive parfois que nous réussissions à établir des stratégies pour soulager les symptômes apparents, mais à d'autres occasions, cela nous est impossible. Nous pouvons toutefois éprouver une satisfaction professionnelle en sachant que nous avons effectué des examens approfondis et avons traité les problèmes reliés. Il se peut que nous ayons besoin de consulter d'autres disciplines, et il se peut aussi que nous continuions de voir régulièrement ces patients. Nous représentons peut-être un filet de sécurité pour ces patients vulnérables, mais nous devons nous assurer qu'ils reçoivent les meilleurs soins possible, surtout lorsqu'ils ont des besoins complexes.

Au sujet de l'auteure

Cathy Sendecki, B.Sc.inf., inf., GNC(C), a travaillé à Burnaby Hospital Emergency Department depuis 1987, dans les dernières années comme infirmière clinicienne gériatrique d'urgence, dans le cadre du Programme des aînés. Ses intérêts particulier comprennent travailler avec des personnes atteintes de démence et de leurs partenaires de soins et d'embrasser les défis de traiter efficacement les abus envers les aînés. Elle aime être une grand-mère.

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Collaborative development of a standardized trauma admission set

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Abstract

Patients with severe injuries require the complex integration of care between medicine, nursing, and allied health services. Increasing patient volumes, clinic visits, and a regional directive to improve patient flow have added pressure for all members of the trauma team from the emergency department to the wards and to the outpatient clinics. With increasing workload, concerns emerged regarding the lack of consistency in practice. The decision was made to develop a process to standardize and improve the admission process for trauma patients. After a lengthy collaborative process, an assessment booklet, order set and medication administration record (MAR) were developed and implemented in a large tertiary care facility.

Introduction

Patients with severe injuries require the complex integration of care between medicine, nursing and allied health services. The injuries represent extremely common causes of preventable morbidity and mortality, and these patients are especially prone to developing complications (Hemmila et al., 2007; Reicks, Thorson, Irwin, & Byrnes, 2010). This, coupled with care teams composed of various levels of expertise within each discipline and a fast-paced teaching facility, increases opportunities for delays in diagnosis, missed injuries, limited resources, errors in care, and communication issues.

Background and problem

At our inner city, tertiary care facility, more than 2,600 patients annually present to the emergency department with a Canadian Trauma and Acuity Scale (CTAS) score of 1–3 and, of these, more than 700 patients are admitted to the trauma unit. This does not include the "off service" patients who are admitted from the emergency department to other surgical wards within the facility, or those who are seen by the trauma team, but admitted under other surgical services with single organ system injuries. While it is the Acute Care Trauma Service ("Gold") Team that assesses all major traumas brought into the emergency department, many other specialties are involved in the care of the patient, based upon patient needs.

Concerns with the lack of consistency in practice began to emerge from nursing and allied health professionals during team discharge rounds. Handwritten orders by physicians used unclear or contradictory terms such as "VSR" (vital signs routine), or "C-Spine Precautions - AAT" (activity as tolerated). Pharmacists reported the need for frequent clarification of medication orders, consultants reported being called too early or too late, patients and families conveyed receiving mixed messages from all members of the team, and nurses expressed a desire for more consistent expectations, rather than relying on the experience or preference of the prescriber. At the same time, the physicians were exploring a process to standardize their assessments of trauma patients. A small team, led by a trauma surgeon and clinical nurse specialist (CNS), was assembled with the goal to improve trauma care, communication, patient safety and patient care outcomes, while reducing frustration among and between members of the trauma team, patients and families.

Analysis and resolution

Clear, effective communication between and among healthcare professionals and patients is fundamental to providing quality patient care, particularly within the often chaotic setting of a busy emergency department. Through a review of medico-legal cases involving trauma patients over a six-year period, the Canadian Medical Protective Association (CMPA, 2016) identified communication problems at all points of the patients' care resulting in critical patient information not being shared. Poor communication flow may be due to a number of issues; the failure to review pre-hospital records; poorly communicated trauma history or important clinical information; a lack of coordination of care between physician specialties; delays in assessing patient deterioration; lack of communication with the patient and family; and inadequate or delayed reporting of diagnostic imaging reports. Absent or inadequate documentation posed additional communication gaps, creating doubts about the thoroughness of assessments, with lack of discharge instructions, and illegible notes being particularly problematic (Canadian Medical Protective Association, 2016).

Increasingly, attention is being paid toward standardizing the care of trauma patients. Standardized templates and continuous quality improvement strategies for assessment, order entry and documentation can simplify the care process, improve accuracy of assessments, improve patient safety, and benefit patient care outcomes (Barnes, Waterman, MacIntyre, Coughenour, & Kessel, 2010; Biffl, Harrington, & Cioffi, 2003; Reicks et al., 2010; Schedler & Neely, 1996; Zamboni et al., 2014). Missed injuries have been described as "the trauma surgeon's nemesis" (Enderson & Maull, 1991). Likewise, pharmacists and nurses often find incomplete, illegible, and disorganized patient care orders that can in turn potentially lead to delays, errors, and sloppy, inefficient practices.

The two-part solution

To improve the trauma admission process, a two-part trauma suite composed of two separate, but related documents, was designed to standardize care of trauma patients. The first component, the assessment booklet, was developed to ensure capture of essential details of the patient's admission and as a teaching tool to remind prescribers of important admission components. The second component was a standardized order set with corresponding medication administration record (MAR). In addition, previously developed companion documents, such as spinal precautions, venous thromboembolism, patient controlled analgesia, smoking cessation, and alcohol withdrawal protocols, were referred to within the new standardized order set.

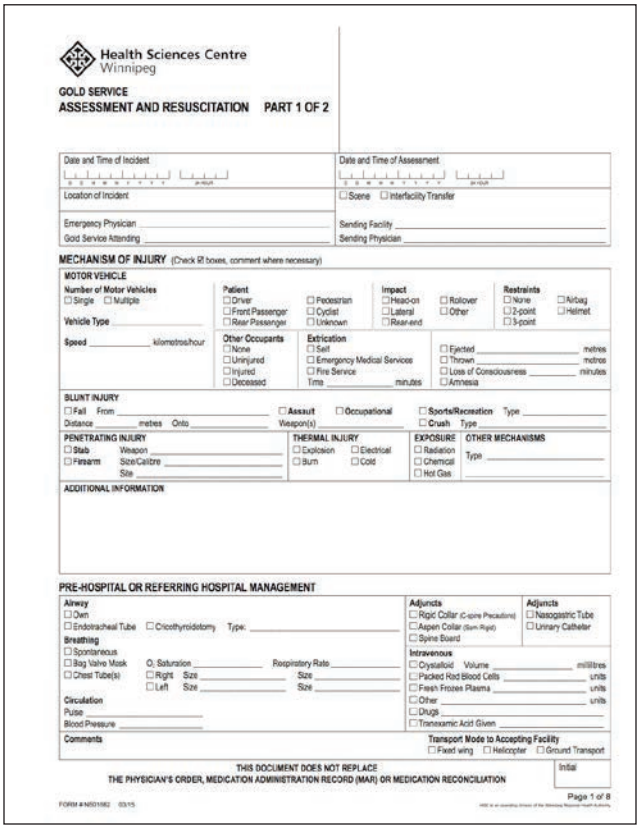
The assessment booklet is composed of a five-page initial assessment, followed by a three-page tertiary survey, and is completed by the trauma service team, on all trauma patients whether admitted or not. The primary survey follows the Advanced Trauma Life Support (ATLS) guidelines as outlined by the American College of Surgeons (American College of Surgeons, 2016) and is designed to recognize and immediately treat any life-threatening problems before proceeding to the secondary, head-to-toe examination facilitating diagnosis of all injuries before formulating a definitive management strategy (Figure 1). The tertiary survey is intended to minimize the risk of missed injury (Biffl et al., 2003; Hajibandeh, Hajibandeh, & Idehen, 2015), identify incidental imaging finding that require further follow up and ensure adherence to established protocols (such as deep venous thrombosis prophylaxis and tetanus administration for all trauma patients). All injuries after the initial resuscitation and any operative interventions are reviewed, and a comprehensive review of the medical record, the patient, and a re-evaluation of the primary and secondary surveys and all investigations (especially final imaging reports) are required (Figure 2).

The second component of the trauma suite is the standardized order set and corresponding MAR. Standardized admission orders have been found to be beneficial in reducing omission of orders, improving thoroughness of orders, organizing patient care needs, communicating best practices, increasing efficiency of order transcription, and reducing transcription errors (Figure 3). Additionally, they have the potential to serve as an educational tool to modify practice, and can be used to facilitate computerized order entry (Elder, Lemon, & Costello, 2015; Harvey, Carol, 1990; Wentworth & Atkinson, 1996). The final component of the process was the development of a corresponding medication administration record (MAR) to reduce the risk of transcription errors.

The process

An initial draft of the order set was developed by the trauma surgeon and shared with the trauma physician team. The CNS then assembled a team of nursing educators from the trauma unit and emergency department, the trauma unit clinical resource nurses, pharmacists, physiotherapists, dietitians, social workers, and occupational therapists to review language within the order set to ensure it reflected the correct professional vernacular, was clear and based in evidence.

Prior to implementation, the trauma unit nurses assessed vital signs "routinely", which ranged anywhere from 1–12 hours, basing their information upon what was handed down from senior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GOLD SERVICE
ASSESSMENT AND RESUSCITATION PART 1 OF 2

Date and Time of Incident
Date and Time of Assessment
Location of Incident
Scene Interfacility Transfer
Emergency Physician
Gold Service Attending
Sending Facility
Sending Physician

MECHANISM OF INJURY (Check ☑ boxes, comment where necessary)

MOTOR VEHICLE
Number of Motor Vehicles: Single Multiple
Vehicle Type
Speed kilometres/hour
Patient: Driver, Front Passenger, Rear Passenger, Pedestrian, Cyclist, Unknown
Impact: Head-on, Lateral, Rear-end, Rollover, Other
Restraints: None, 2-point, 3-point, Airbag, Helmet
Other Occupants: None, Uninjured, Injured, Deceased
Extrication: Self, Emergency Medical Services, Fire Service, Time minutes
Ejected metres, Thrown metres, Loss of Consciousness minutes, Amnesia

BLUNT INJURY
Fall From metres Onto
Assault Occupational Sports/Recreation Type
Distance metres Weapon(s)
Crush Type

PENETRATING INJURY
Stab Weapon
Firearm Size/Calibre
Size

THERMAL INJURY
Explosion Electrical
Burn Cold

EXPOSURE
Radiation
Chemical
Hot Gas

OTHER MECHANISMS
Type

ADDITIONAL INFORMATION

PRE-HOSPITAL OR REFERRING HOSPITAL MANAGEMENT

Airway
Own
Endotracheal Tube Cricothyroidotomy Type:
Breathing
Spontaneous
Bag Valve Mask O2 Saturation Respiratory Rate
Chest Tube(s) Right Size Size
Left Size Size
Circulation
Pulse
Blood Pressure

Adjuncts
Rigid Collar (C-spine Precautions)
Aspen Collar (Sum Rigid)
Spine Board

Intravenous
Crystalloid Volume millilitres
Packed Red Blood Cells units
Fresh Frozen Plasma units
Other units
Drugs
Tranexamic Acid Given

Adjuncts
Nasogastric Tube
Urinary Catheter

Comments

Transport Mode to Accepting Facility
Fixed wing Helicopter Ground Transport

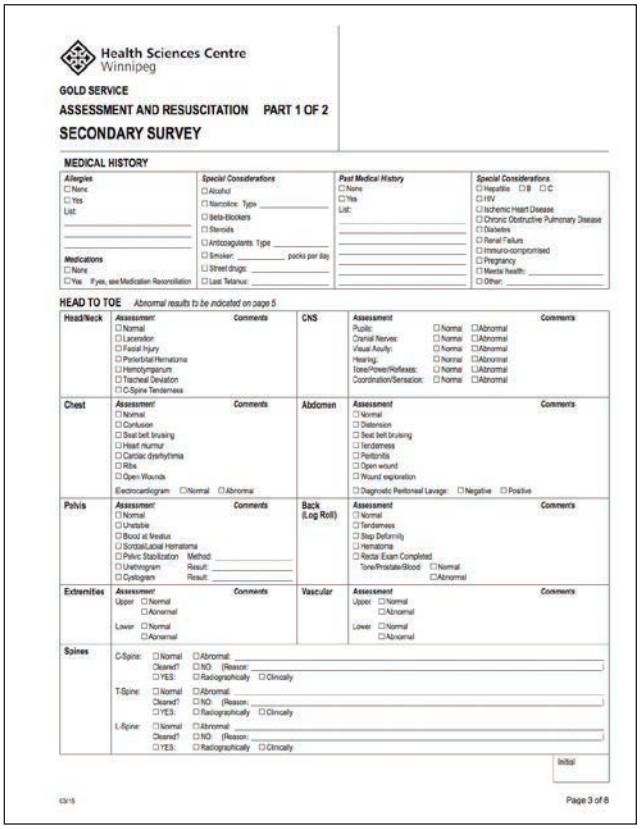
THIS DOCUMENT DOES NOT REPLACE
THE PHYSICIAN'S ORDER, MEDICATION ADMINISTRATION RECORD (MAR) OR MEDICATION RECONCILIATION

Initial

FORM # MD01882 03/15

Page 1 of 8

Figure 1.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GOLD SERVICE
ASSESSMENT AND RESUSCITATION PART 1 OF 2
SECONDARY SURVEY

MEDICAL HISTORY

Allergies
None
Yes
List:

Special Considerations
Alcohol
Narcotics: Type
Beta-blockers
Steroids
Anticoagulants: Type
Smoker: packs per day
Street drugs:
Last Tetanus:

Past Medical History
None
Yes
List:

Special Considerations
Hepatitis B C
HIV
Ischemic Heart Disease
Chronic Obstructive Pulmonary Disease
Diabetes
Renal Failure
Immuno-compromised
Pregnancy
Mental health:
Other:

Medications
None
Yes If yes, see Medication Reconciliation

HEAD TO TOE Abnormal results to be indicated on page 5

Head/Neck — Assessment: Normal, Laceration, Facial Injury, Periorbital Hematoma, Hemotympanum, Tracheal Deviation, C-Spine Tenderness; Comments
CNS — Assessment: Pupils, Cranial Nerves, Visual Acuity, Hearing, Tone/Power/Reflexes, Coordination/Sensation (Normal, Abnormal); Comments
Chest — Assessment: Normal, Contusion, Seat belt bruising, Heart murmur, Cardiac dysrhythmia, Ribs, Open Wounds, Electrocardiogram (Normal, Abnormal); Comments
Abdomen — Assessment: Normal, Distension, Seat belt bruising, Tenderness, Peritonitis, Open wound, Wound exploration, Diagnostic Peritoneal Lavage (Negative, Positive); Comments
Pelvis — Assessment: Normal, Unstable, Blood at Meatus, Scrotal/Labial Hematoma, Pelvic Stabilization Method:, Urethrogram Result:, Cystogram Result:; Comments
Back (Log Roll) — Assessment: Normal, Tenderness, Step Deformity, Hematoma, Rectal Exam Completed, Tone/Prostate/Blood (Normal, Abnormal); Comments
Extremities — Assessment: Upper (Normal, Abnormal), Lower (Normal, Abnormal); Comments
Vascular — Assessment: Upper (Normal, Abnormal), Lower (Normal, Abnormal); Comments
Spines — C-Spine: (Normal, Abnormal; Cleared? NO (Reason:); YES: Radiographically, Clinically); T-Spine: (Normal, Abnormal; Cleared? NO: (Reason:); YES: Radiographically, Clinically); L-Spine: (Normal, Abnormal; Cleared? NO (Reason:); YES: Radiographically, Clinically)

Initial

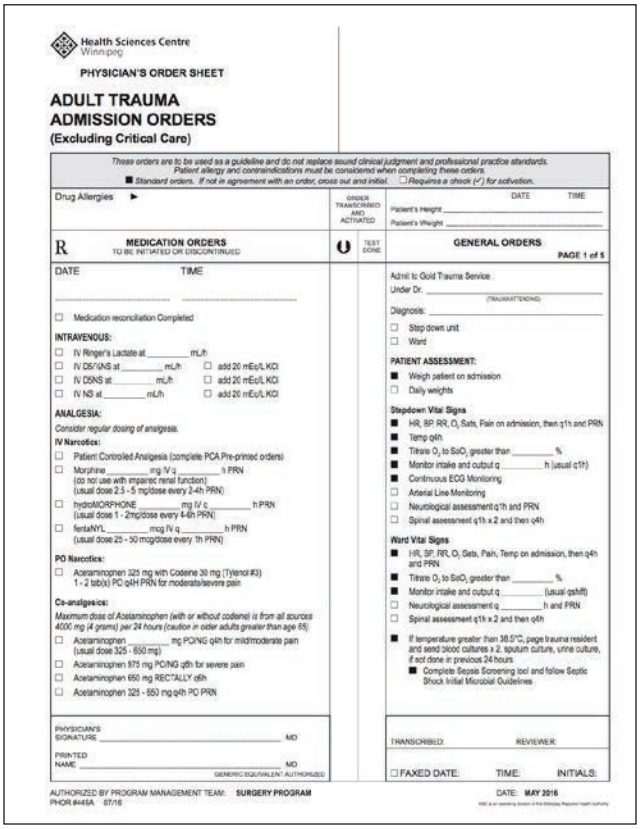
03/15

Page 3 of 8

Figure 2.

nurses, rather than evidence. Standardized expectations for nursing assessment based on TNCC (Trauma Nursing Core Course) guidelines from the Emergency Nurses Association (Emergency Nurses Association, 2016) were included within the order set to ensure regular, hourly focused assessment of the patient while in the step-down unit, and every four hours upon admission to the ward. Improving pain management became another area of opportunity to improve practice, as patient satisfaction surveys conducted at our facility identified 80–90% of patients reporting moderate to severe pain during their admission. Analgesic orders were added based upon best evidence for pain management for the trauma patient. A bowel protocol, stress ulcer and venous thromboembolism prophylaxis, antiemetics, dietary orders, and orders for genitourinary care, spinal clearance, laboratory and radiographic investigations, as well as defined activity orders were added to the document. All generic names, 'colloquial' language, and abbreviations were removed; medications were listed using 'tall-person' (sic. Tall man) lettering (ISMP, 2016), with standard dosages included among the choices to be selected. Pre-existing standardized PCA (patient controlled analgesia) and spinal precautions, sepsis, and smoking cessation orders were referred to. A parallel process was occurring to address alcohol withdrawal, so the decision was made to exclude this from the order set.

After several months of revisions and edits, the order set and MAR were circulated to direct care providers from nursing, medicine, and all allied health disciplines to provide "outside eyes". Drafts of the documents were tested by direct care providers using actual patients and amended based upon errors, inconsistencies, or difficulties identified. After more than 15 iterations, the documents were sent thru the facility approval process.



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PHYSICIAN'S ORDER SHEET

ADULT TRAUMA
ADMISSION ORDERS
(Excluding Critical Care)

These orders are to be used as a guideline and do not replace sound clinical judgment and professional practice standards. Patient allergy and contraindications must be considered when completing these orders.
■ Standard orders. If not in agreement with an order, cross out and initial. ☐ Requires a check (✓) for activation.

Drug Allergies ►

ORDER TRANSCRIBED AND ACTIVATED

DATE TIME

Patient's Height
Patient's Weight

R MEDICATION ORDERS
TO BE INITIATED OR DISCONTINUED

DATE TIME

☐ Medication reconciliation Completed

INTRAVENOUS:
☐ IV Ringer's Lactate at _____ mL/h
☐ IV D5/¼NS at _____ mL/h ☐ add 20 mEq/L KCl
☐ IV D5NS at _____ mL/h ☐ add 20 mEq/L KCl
☐ IV NS at _____ mL/h ☐ add 20 mEq/L KCl

ANALGESIA:
Consider regular dosing of analgesia.
IV Narcotics:
☐ Patient Controlled Analgesia (complete PCA Pre-printed orders)
☐ Morphine _____ mg IV q _____ h PRN
(do not use with impaired renal function)
(usual dose 2.5 - 5 mg/dose every 2-4h PRN)
☐ hydroMORPHONE _____ mg IV q _____ h PRN
(usual dose 1 - 2mg/dose every 4-6h PRN)
☐ fentaNYL _____ mcg IV q _____ h PRN
(usual dose 25 - 50 mcg/dose every 1h PRN)

PO Narcotics:
☐ Acetaminophen 325 mg with Codeine 30 mg (Tylenol #3)
1 - 2 tab(s) PO q4H PRN for moderate/severe pain

Co-analgesics:
Maximum dose of Acetaminophen (with or without codeine) is from all sources 4000 mg (4 grams) per 24 hours (caution in older adults greater than age 65)
☐ Acetaminophen _____ mg PO/NG q4h for mild/moderate pain
(usual dose 325 - 650 mg)
☐ Acetaminophen 975 mg PO/NG q8h for severe pain
☐ Acetaminophen 650 mg RECTALLY q6h
☐ Acetaminophen 325 - 650 mg q4h PO PRN

PHYSICIAN'S SIGNATURE _____ MD
PRINTED NAME _____ MD
GENERIC EQUIVALENT AUTHORIZED

U TEST DONE

GENERAL ORDERS
PAGE 1 of 5

Admit to Gold Trauma Service
Under Dr. _____
(TRAUMATTENDING)
Diagnosis: _____
☐ Step down unit
☐ Ward

PATIENT ASSESSMENT:
■ Weigh patient on admission
☐ Daily weights

Stepdown Vital Signs
■ HR, BP, RR, O_2 Sats, Pain on admission, then q1h and PRN
■ Temp q4h
■ Titrate O_2 to SaO_2 greater than _____ %
■ Monitor intake and output q _____ h (usual q1h)
■ Continuous ECG Monitoring
☐ Arterial Line Monitoring
☐ Neurological assessment q1h and PRN
☐ Spinal assessment q1h x 2 and then q4h

Ward Vital Signs
■ HR, BP, RR, O_2 Sats, Pain, Temp on admission, then q4h and PRN
■ Titrate O_2 to SaO_2 greater than _____ %
■ Monitor intake and output q _____ (usual q8hr)
☐ Neurological assessment q _____ h and PRN
☐ Spinal assessment q1h x 2 and then q4h

■ If temperature greater than 38.5°C, page trauma resident and send blood cultures x 2, sputum culture, urine culture, if not done in previous 24 hours
■ Complete Sepsis Screening tool and follow Septic Shock Initial Microbial Guidelines

TRANSCRIBED: REVIEWED:
☐ FAXED DATE: TIME: INITIALS:

AUTHORIZED BY PROGRAM MANAGEMENT TEAM: SURGERY PROGRAM DATE: MAY 2016
PHOR 8445A 07/16

Figure 3.

Led by the trauma surgeon, the assessment booklet was developed based on a review of existing documents from centres across Canada and the United States, modified to fit our own unique local needs, and tested by residents. After review and input by the facility forms committee, the document was ready for implementation. The decision was made to roll the entire trauma suite out, as a package once the order set and MAR approval process was complete.

Implementation

Final copies of the new documents were ordered and a plan to provide global education was developed. The nursing educators provided individual orientation of the trauma suite to the unit staff. Posters and information about the impending changes were placed in high-traffic staff areas. On the "GO LIVE" date, an interdisciplinary Grand Rounds was presented to those involved in the care of the trauma patients. Focused support and reinforcement to use the documents was provided by the attending physicians and the educators. Education for the rotating trauma residents was provided by the trauma team physician assistant and the CNS for trauma. After the Grand Rounds presentation, editorial changes were made to both documents, as typos and small inconsistencies were identified by those in attendance despite copious revisions and multiple "eyes" on the documents.

Discussion

One month post implementation, a brief survey was circulated to staff who indicated the orders were clear, expectations were easy to understand, and fewer calls to clarify orders were made. Staff identified the MAR as the biggest area of concern and reported nearly missing medications, and not having enough space to document medication administration. Thus, a decision was made to suspend the use of the MAR until it could be revised.

There have been occasional 'glitches', but these have been quickly corrected. The documents are inconsistently used on new admissions arriving to the ward from the ICU or operating room. However, improvements have been noted with completion of the assessment booklets, including the tertiary survey on the ward.

Three months following implementation, the plan is to audit the use of the assessment booklet, and to measure the fidelity of the order set. Chart audits will be done to identify if staff are caring for patients based upon the new order set, or on their previous practice. A follow-up patient satisfaction survey will be conducted to determine if improvements have been made to pain management, and measures related to length of stay, DVT prophylaxis, and identification of missed injuries will be evaluated to identify any impact from standardization. Outcomes will be circulated to help staff understand the impact of their practice, and a regular audit process will be established to help sustain practice improvements. Finally, the new MAR will soon be ready for testing and review.

Conclusion

The trauma suite was developed to combine a standard assessment and a standard order set in order to improve the care of the trauma patient. Anecdotally, clearer expectations for assessment,

investigations, and treatment have helped to reduce the need for clarification, delays in treatment, length of stay, and improved multidisciplinary communication, ultimately improving the care and outcomes of the trauma patients.

Acknowledgements

The authors wish to acknowledge the considerable contribution of the medical, nursing and allied health professionals who helped to develop and support the collaborative effort of the implementation team.

About the author

Asha Pereira is the Clinical Nurse Specialist for Trauma at the Health Sciences Centre in Winnipeg, MB, and a Doctoral Candidate at the University of Wisconsin, Milwaukee. She has more than 25 years of experience as a nurse in numerous capacities; as a direct care provider, nurse educator, researcher, director and CNS. She is a past-president of the Canadian Association of Critical Care Nurses (CACCN), a member of the Sigma Theta Tau International (STTI), Golden Key Society and numerous professional organizations.

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Élaboration collaborative d'une trousse standard d'admission en traumatologie

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Résumé

Les polytraumatisés nécessitent une intégration complexe des soins médicaux, infirmiers et paramédicaux. Cependant, le volume croissant de patients et de visites en clinique, combiné à une directive régionale d'accélérer le roulement des patients, a amplifié la pression exercée sur tous les membres de l'équipe de traumatologie, que ce soit en salle d'urgence, dans les unités d'hôpital ou en consultation externe. Avec cette charge de travail alourdie sont nées certaines inquiétudes concernant des incohérences dans la prestation des soins. Il a été décidé d'entamer une démarche dans l'objectif de normaliser et d'améliorer le processus d'admission des patients en traumatologie. À la suite d'un long travail collaboratif, trois outils ont été conçus et instaurés dans un grand centre de soins tertiaires : un livret d'évaluation, un ensemble de modèles d'ordonnances et un registre d'administration des médicaments (RAM).

Introduction

Les polytraumatisés nécessitent l'intégration complexe des soins médicaux, infirmiers et paramédicaux. Les lésions traumatiques sont causes très courantes de cas de morbidité et de mortalité évitables, et les patients qui en souffrent sont particulièrement sujets à complications (Hemmila et coll., 2007; Reicks, Thorson, Irwin et Byrnes, 2010). À cette réalité s'ajoute celle de la cadence effrénée d'un établissement d'enseignement et celle d'équipes de soins dont les membres possèdent un niveau d'expertise hétérogène pour une discipline donnée; il en découle un risque accru de diagnostics tardifs, de blessures non détectées, de limitation des ressources, d'erreurs de soins et de problèmes de communication.

Contexte et problématique

Chaque année, plus de 2 600 personnes se rendent aux urgences de notre établissement de soins tertiaires urbain et obtiennent un score de 1 à 3 sur l'Échelle canadienne de triage et de gravité; parmi ceux-ci, plus de 700 patients sont admis à l'unité de traumatologie. Ce nombre n'inclut pas les patients admis de la salle d'urgence au bloc opératoire de l'établissement, ni ceux qui sont vus par l'équipe de traumatologie, mais admis au bloc opératoire et dont les blessures se restreignent à un seul système d'organes. Bien que l'équipe de traumatologie et de soins de courte durée évalue tous les cas de traumatismes majeurs du service des urgences, beaucoup d'autres spécialités s'impliquent dans les soins au patient, selon ses besoins.

Certaines préoccupations face au manque de cohérence dans les soins ont commencé à faire surface chez le personnel infirmier et paramédical lors des réunions interdisciplinaires de planification des congés. Des ordonnances écrites à la main par les médecins contenaient des termes confus, voire contradictoires, comme « signes vitaux réguliers » ou « immobilisation cervicale – activité selon tolérance ». Autres constats : les pharmaciens devaient fréquemment clarifier une prescription, les intervenants étaient appelés trop tôt ou trop tard, les patients et leurs proches recevaient des messages ambivalents de la part de l'équipe soignante, et les membres du personnel infirmier désiraient que les attentes envers eux soient uniformisées (plutôt que d'avoir à s'adapter au prescripteur selon son expérience et ses préférences). De leur côté, les médecins exploraient des façons de normaliser leur évaluation des patients en traumatologie. Une petite équipe dirigée par un chirurgien-traumatologue et une infirmière clinicienne spécialisée (ICS) s'est ainsi formée dans le but d'améliorer les soins en traumatologie, la communication, la sécurité des patients et les résultats cliniques tout en mitigeant la frustration ressentie par le personnel soignant ainsi que par les patients et leurs proches.

Analyse et résolution

Une communication claire et efficace entre les professionnels de la santé et avec les patients est essentielle à une prestation de soins de qualité, surtout dans le milieu souvent chaotique d'une salle d'urgence achalandée. L'Association canadienne de protection médicale (ACPM, 2016) a procédé à une revue de dossiers médico-juridiques (compilés à l'intérieur d'une période de six ans) impliquant des patients en traumatologie dans le but de cerner les problèmes de communication qui surviennent à divers moments dans le processus de soins et qui empêchent la transmission de renseignements importants. Un flux de communication inadéquat peut avoir diverses origines : non consultation des rapports préhospitaliers, de l'historique du patient ou d'autres renseignements cliniques, mauvaise coordination entre les spécialités médicales, retards dans l'évaluation de la détérioration de l'état du patient, communication insuffisante avec le patient et ses proches, rapports d'imagerie diagnostique inadéquats ou tardifs, etc. Des registres manquants ou incomplets ont causé des lacunes supplémentaires, entraînant des doutes quant à la rigueur des évaluations de même des consignes de sortie insuffisantes (le caractère illisible des notes manuscrites étant particulièrement problématique) (ACPM, 2016).

On prête de plus en plus d'attention à la standardisation des soins en traumatologie. Les gabarits standards et les stratégies d'amélioration de la qualité des évaluations, des ordonnances et de la documentation peuvent simplifier le processus de soins, affiner l'exactitude des évaluations, assurer la sécurité des

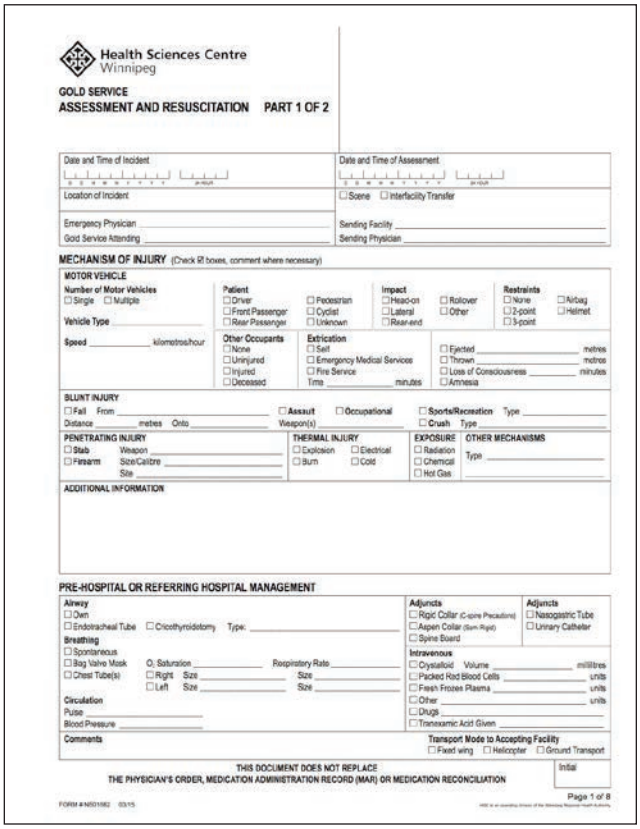
patients et produire de meilleurs résultats cliniques (Barnes, Waterman, MacIntyre, Coughenour et Kessel, 2010; Biffl, Harrington et Cioffi, 2003; Reicks et coll., 2010; Schedler et Neely, 1996; Zamboni et coll., 2014). On désigne parfois les blessures non détectées comme le « fléau des chirurgiens-traumatologues » (Enderson et Maull, 1991). De même, les pharmaciens et infirmiers doivent souvent composer avec des ordonnances incomplètes, désorganisées ou illisibles pouvant mener à des retards, à des erreurs et à des pratiques approximatives et inefficaces.

Une solution bipartite

Afin d'améliorer le processus d'admission en traumatologie, deux documents assortis ont été créés pour favoriser l'uniformisation des soins traumatologiques. Le premier, un livret d'évaluation, a pour but d'assurer la consignation des renseignements d'admission du patient et sert d'outil pédagogique et d'aide-mémoire relativement à l'admission. Le deuxième document consiste en un ensemble de modèles d'ordonnances accompagné du registre d'administration des médicaments (RAM) correspondant. Par ailleurs, le nouvel ensemble de modèles d'ordonnances fait référence à des documents connexes déjà en usage (portant sur l'immobilisation vertébrale, la thrombo-embolie veineuse, l'analgésie contrôlée par le patient, l'abandon du tabagisme et les protocoles de sevrage alcoolique).

Le livret d'évaluation est rempli par l'équipe de traumatologie pour tous les patients examinés (admis ou non) et contient cinq pages sur l'évaluation initiale, suivies de trois pages sur l'évaluation tertiaire du patient. Conformément aux lignes directrices en soins avancés de réanimation traumatologique (ATLS) rédigées par l'American College of Surgeons (American College of Surgeons, 2016), l'évaluation primaire vise à reconnaître et traiter tout problème potentiellement mortel. Vient ensuite l'évaluation secondaire, qui consiste en l'examen du patient de la tête aux pieds pour répertorier et identifier toutes ses blessures, puis on formule une stratégie de gestion du cas (Figure 1). L'évaluation tertiaire vise à minimiser le risque de blessures non détectées (Biffl et coll., 2003; Hajibandeh, Hajibandeh et Idehen, 2015), à recenser des découvertes fortuites à l'imagerie qui nécessitent un suivi et à assurer le respect des protocoles établis (p. ex. traitement prophylactique des thromboses veineuses profondes et administration d'un antitétanique à tous les polytraumatisés). Après la réanimation initiale et une éventuelle intervention chirurgicale, toutes les lésions sont réexaminées. On procède obligatoirement au réexamen exhaustif du patient, de son dossier médical, des évaluations primaires et secondaires, ainsi que des rapports d'imagerie et autres demandes de consultation (Figure 2).

Le deuxième des documents assortis est un ensemble de modèles d'ordonnances accompagné du RAM correspondant. Des ordonnances d'admission normalisées contribuent à diminuer le risque de leur omission, à en améliorer la rigueur, à organiser les besoins des patients en matière de soins, à communiquer les pratiques exemplaires, à augmenter l'efficacité de la transcription des ordonnances et à réduire les erreurs de transcription (Figure 3). Elles représentent en outre un potentiel pédagogique pour parfaire les pratiques et peuvent faciliter la saisie informatique des ordonnances (Elder, Lemon et Costello, 2015; Harvey et Carol, 1990; Wentworth et Atkinson, 1996). Le dernier élément du processus était la création d'un RAM en vue de minimiser le risque d'erreurs de transcription.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GOLD SERVICE
ASSESSMENT AND RESUSCITATION PART 1 OF 2

Date and Time of Incident
Date and Time of Assessment
Location of Incident
Emergency Physician
Gold Service Attending
Scene Interfacility Transfer
Sending Facility
Sending Physician

MECHANISM OF INJURY (Check fit boxes, comment where necessary)

MOTOR VEHICLE
Number of Motor Vehicles: Single Multiple
Vehicle Type
Speed kilometres/hour
Patient: Driver, Front Passenger, Rear Passenger, Pedestrian, Cyclist, Unknown
Impact: Head-on, Lateral, Rear-end, Rollover, Other
Restraints: None, 2-point, 3-point, Airbag, Helmet
Other Occupants: None, Uninjured, Injured, Deceased
Extrication: Self, Emergency Medical Services, Fire Service, Time minutes
Ejected, Thrown, Loss of Consciousness minutes, Amnesia metres

BLUNT INJURY
Fall From Distance metres Onto
Assault Occupational Sports/Recreation Type
Weapon(s) Crush Type

PENETRATING INJURY
Stab Weapon
Firearm Size/Calibre Site

THERMAL INJURY
Explosion Electrical
Burn Cold

EXPOSURE
Radiation
Chemical
Hot Gas

OTHER MECHANISMS
Type

ADDITIONAL INFORMATION

PRE-HOSPITAL OR REFERRING HOSPITAL MANAGEMENT

Airway
Own
Endotracheal Tube Cricothyroidotomy Type:
Breathing
Spontaneous
Bag Valve Mask O2 Saturation Respiratory Rate
Chest Tube(s) Right Size Size
Left Size Size
Circulation
Pulse
Blood Pressure

Adjuncts
Rigid Collar (C-spine Precautions)
Aspen Collar (Sum Rigid)
Spine Board
Intravenous
Crystalloid Volume millilitres
Packed Red Blood Cells units
Fresh Frozen Plasma units
Other units
Drugs
Tranexamic Acid Given

Adjuncts
Nasogastric Tube
Urinary Catheter

Comments

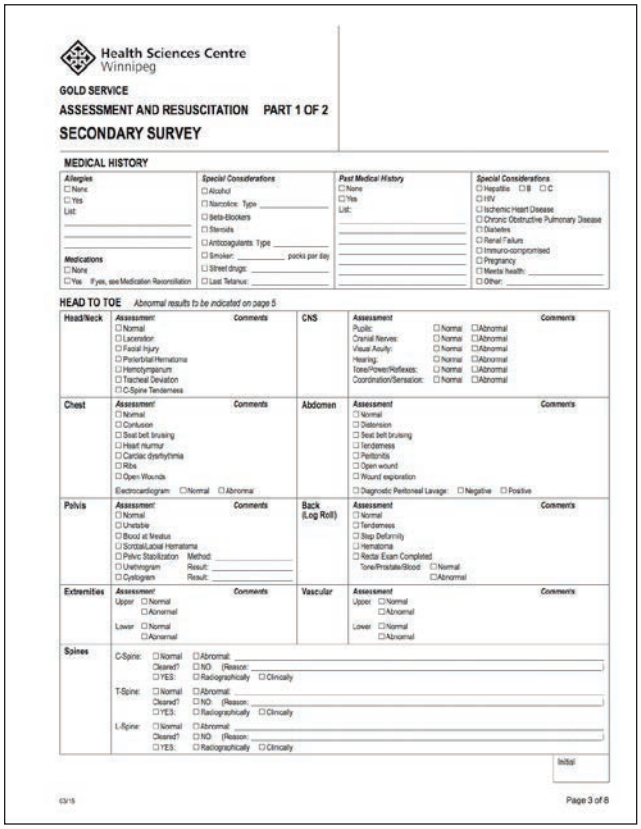
Transport Mode to Accepting Facility
Fixed wing Helicopter Ground Transport

THIS DOCUMENT DOES NOT REPLACE
THE PHYSICIAN'S ORDER, MEDICATION ADMINISTRATION RECORD (MAR) OR MEDICATION RECONCILIATION

Initial

Page 1 of 8

Figure 1.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GOLD SERVICE
ASSESSMENT AND RESUSCITATION PART 1 OF 2
SECONDARY SURVEY

MEDICAL HISTORY

Allergies
None
Yes
List:

Special Considerations
Alcohol
Narcotics: Type
Beta-blockers
Steroids
Anticoagulants: Type
Smoker: packs per day
Street drugs:
Last Tetanus:

Past Medical History
None
Yes
List:

Special Considerations
Hepatitis B C
HIV
Ischemic Heart Disease
Chronic Obstructive Pulmonary Disease
Diabetes
Renal Failure
Immuno-compromised
Pregnancy
Mental health:
Other:

Medications
None
Yes If yes, see Medication Reconciliation

HEAD TO TOE Abnormal results to be indicated on page 5

Head/Neck — Assessment / Comments
Normal
Laceration
Facial Injury
Periorbital Hematoma
Hemotympanum
Tracheal Deviation
C-Spine Tenderness

CNS — Assessment / Comment's
Pupils: Normal Abnormal
Cranial Nerves: Normal Abnormal
Visual Acuity: Normal Abnormal
Hearing: Normal Abnormal
Tone/Power/Reflexes: Normal Abnormal
Coordination/Sensation: Normal Abnormal

Chest — Assessment / Comments
Normal
Contusion
Seat belt bruising
Heart murmur
Cardiac dysrhythmia
Ribs
Open Wounds
Electrocardiogram: Normal Abnormal

Abdomen — Assessment / Comment's
Normal
Distension
Seat belt bruising
Tenderness
Peritonitis
Open wound
Wound exploration
Diagnostic Peritoneal Lavage: Negative Positive

Pelvis — Assessment / Comments
Normal
Unstable
Blood at Meatus
Scrotal/Labial Hematoma
Pelvic Stabilization Method:
Urethrogram Result:
Cystogram Result:

Back (Log Roll) — Assessment / Comment's
Normal
Tenderness
Step Deformity
Hematoma
Rectal Exam Completed
Tone/Prostate/Blood Normal Abnormal

Extremities — Assessment / Comments
Upper Normal Abnormal
Lower Normal Abnormal

Vascular — Assessment / Comment's
Upper Normal Abnormal
Lower Normal Abnormal

Spines
C-Spine: Normal Abnormal
Cleared? NO (Reason:
YES: Radiographically Clinically
T-Spine: Normal Abnormal
Cleared? NO: (Reason:
YES: Radiographically Clinically
L-Spine: Normal Abnormal
Cleared? NO (Reason:
YES: Radiographically Clinically

Initial

03/15

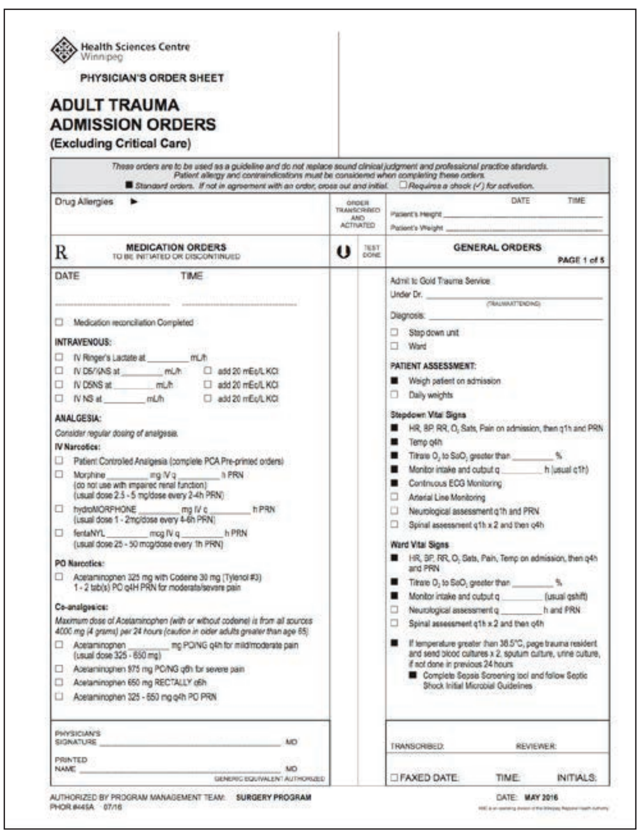
Page 3 of 8

Figure 2.

Le processus

Une première ébauche de l'ensemble de modèles d'ordonnances a été élaborée par le chirurgien traumatologue et présentée à l'équipe de médecins traumatologues. L'ICS a ensuite mis sur pied une équipe multidisciplinaire (infirmiers enseignants des unités de traumatologie et d'urgence, infirmiers-ressources en soins cliniques de l'unité de traumatologie, pharmaciens, physiothérapeutes, diététistes, travailleurs sociaux et ergothérapeutes) pour veiller à ce que le langage utilisé dans les modèles soit clair, factuel et conforme au vocabulaire professionnel reconnu.

Avant la mise en œuvre, le personnel infirmier en traumatologie vérifiait les signes vitaux « régulièrement » – ce qui pouvait être interprété comme des intervalles allant de 1 à 12 heures, selon les instructions du personnel infirmier en chef et non selon les données probantes. Des attentes normalisées vis-à-vis de l'évaluation infirmière, basées sur les directives du TNCC (Trauma Nursing Core Course) de la Emergency Nurses Association (Emergency Nurses Association, 2016), ont été incorporées dans l'ensemble de modèles d'ordonnances pour assurer qu'une évaluation du patient en unité de soins intermédiaires soit effectuée chaque heure, et qu'une évaluation soit effectuée aux quatre heures après l'admission en traumatologie. La gestion de la douleur était un autre domaine de pratique perfectible : les sondages sur la satisfaction des patients de notre établissement ont révélé que 80 à 90 % des patients auraient éprouvé une douleur modérée à aiguë au moment de l'admission. Des ordonnances d'analgésique ont été ajoutées à l'ensemble (conformément aux données probantes sur la gestion de la douleur en traumatologie), de même qu'un protocole sur l'évacuation des selles, des protocoles de prophylaxie des thrombo-embolies veineuses et des ulcères de stress,



Health Sciences Centre Winnipeg

PHYSICIAN'S ORDER SHEET

ADULT TRAUMA ADMISSION ORDERS
(Excluding Critical Care)

These orders are to be used as a guideline and do not replace sound clinical judgment and professional practice standards. Patient allergy and contraindications must be considered when completing these orders.
■ *Standard orders. If not in agreement with an order, cross out and initial.* ☐ *Requires a check (✓) for activation.*

Drug Allergies ►

ORDER TRANSCRIBED AND ACTIVATED

DATE TIME
Patient's Height ______
Patient's Weight ______

R MEDICATION ORDERS
TO BE INITIATED OR DISCONTINUED

DATE TIME

☐ Medication reconciliation Completed

INTRAVENOUS:
☐ IV Ringer's Lactate at ______ mL/h
☐ IV D5/½NS at ______ mL/h ☐ add 20 mEq/L KCl
☐ IV D5NS at ______ mL/h ☐ add 20 mEq/L KCl
☐ IV NS at ______ mL/h ☐ add 20 mEq/L KCl

ANALGESIA:
Consider regular dosing of analgesia.
IV Narcotics:
☐ Patient Controlled Analgesia (complete PCA Pre-printed orders)
☐ Morphine ______ mg IV q ______ h PRN
(do not use with impaired renal function)
(usual dose 2.5 - 5 mg/dose every 2-4h PRN)
☐ hydroMORPHONE ______ mg IV q ______ h PRN
(usual dose 1 - 2mg/dose every 4-6h PRN)
☐ fentaNYL ______ mcg IV q ______ h PRN
(usual dose 25 - 50 mcg/dose every 1h PRN)

PO Narcotics:
☐ Acetaminophen 325 mg with Codeine 30 mg (Tylenol #3)
1 - 2 tab(s) PO q4H PRN for moderate/severe pain

Co-analgesics:
Maximum dose of Acetaminophen (with or without codeine) is from all sources 4000 mg (4 grams) per 24 hours (caution in older adults greater than age 65)
☐ Acetaminophen ______ mg PO/NG q4h for mild/moderate pain
(usual dose 325 - 650 mg)
☐ Acetaminophen 975 mg PO/NG q6h for severe pain
☐ Acetaminophen 650 mg RECTALLY q6h
☐ Acetaminophen 325 - 650 mg q4h PO PRN

PHYSICIAN'S SIGNATURE ______ MD
PRINTED NAME ______ MD
GENERIC EQUIVALENT AUTHORIZED

TEST DONE

GENERAL ORDERS
PAGE 1 of 5

Admit to Gold Trauma Service
Under Dr. ______
(TRAUMATTENDING)
Diagnosis: ______
☐ Step down unit
☐ Ward

PATIENT ASSESSMENT:
■ Weigh patient on admission
☐ Daily weights

Stepdown Vital Signs
■ HR, BP, RR, O_2 Sats, Pain on admission, then q1h and PRN
■ Temp q4h
■ Titrate O_2 to SaO_2 greater than ______ %
■ Monitor intake and output q ______ h (usual q1h)
■ Continuous ECG Monitoring
☐ Arterial Line Monitoring
☐ Neurological assessment q1h and PRN
☐ Spinal assessment q1h x 2 and then q4h

Ward Vital Signs
■ HR, BP, RR, O_2 Sats, Pain, Temp on admission, then q4h and PRN
■ Titrate O_2 to SaO_2 greater than ______ %
■ Monitor intake and output q ______ (usual qshift)
☐ Neurological assessment q ______ h and PRN
☐ Spinal assessment q1h x 2 and then q4h

■ If temperature greater than 38.5°C, page trauma resident and send blood cultures x 2, sputum culture, urine culture, if not done in previous 24 hours
■ Complete Sepsis Screening tool and follow Septic Shock Initial Microbial Guidelines

TRANSCRIBED: REVIEWER:
☐ FAXED DATE: TIME: INITIALS:

AUTHORIZED BY PROGRAM MANAGEMENT TEAM: SURGERY PROGRAM
PHOR #445A 07/16
DATE: MAY 2016

Figure 3.

et plusieurs autres ordonnances (antiémétiques, diète, soins génito-urinaires, immobilisation vertébrale, analyses radiographiques ou de laboratoire, activités permises au patient). Les noms génériques, abréviations et termes familiers ont été retirés; les noms de médicaments ont été rédigés avec le lettrage « tall man » (ISMP, 2016), accompagnés des doses standards parmi les choix à sélectionner. Le document renvoie à des modèles d'ordonnances standards existants sur l'analgésie contrôlée par le patient, l'immobilisation vertébrale, les infections et l'abandon du tabagisme. En parallèle, un processus similaire quant à la gestion du sevrage alcoolique était en cours; c'est pourquoi on a préféré ne pas y faire référence dans l'ensemble de modèles d'ordonnances.

À la suite d'un travail d'édition et de révision de plusieurs mois, l'ensemble de modèles d'ordonnances et le RAM ont été distribués aux fournisseurs de soins infirmiers, médicaux et paramédicaux pour profiter de leur regard neuf. Les documents ont été testés par des prestataires de soins directs auprès de véritables patients et modifiés selon les erreurs, incohérences ou autres failles relevées. Après plus de 15 versions, les documents assortis ont été soumis au processus d'approbation par l'établissement.

Conçu principalement par le chirurgien-traumatologue, le livret d'évaluation s'est basé sur les documents en usage dans des centres canadiens et américains dont le contenu a été adapté à nos besoins avant d'être testé par les médecins résidents. Après examen et rétroaction du comité des formulaires de l'établissement, les documents étaient prêts à être intégrés à la pratique. Il a été décidé d'implanter l'assortiment complet une fois que l'ensemble de modèles d'ordonnances et le RAM seraient approuvés.

Mise en œuvre

Une fois les exemplaires finaux des nouveaux documents achevés, un plan d'éducation global a été défini. Le personnel infirmier enseignant a initié le personnel de l'unité de traumatologie à la nouvelle documentation. Des affiches placées dans des lieux passants présentaient les changements à venir. Le jour de la mise en œuvre, le personnel impliqué dans les soins en traumatologie a assisté à une séance scientifique interdisciplinaire. Un soutien ciblé et du renforcement ont été donnés par les médecins traitants et les enseignants relativement à l'utilisation des documents. L'adjoint médical et l'ICS de l'équipe de traumatologie s'occupaient de mettre au courant les résidents en rotation. Après la séance scientifique, des modifications ont été apportées aux documents, car malgré les nombreuses révisions, des coquilles et des incohérences mineures ont été repérées par les personnes présentes.

Discussion

Un mois après la mise en œuvre, un bref sondage a été mené auprès du personnel, lequel a indiqué que les ordonnances et les attentes étaient claires, et que moins de demandes de clarification avaient été nécessaires. Toutefois, le RAM posait problème : le personnel avait parfois presque passé à côté de certains médicaments, et le document n'offrait pas suffisamment d'espace pour préciser la modalité d'administration d'un médicament. L'usage du RAM a conséquemment été suspendu jusqu'à sa révision.

Il y a eu quelques accrocs rapidement corrigés. Les documents sont utilisés de manière inconstante pour les patients nouvellement admis en provenance de l'unité de soins intensifs ou du bloc opératoire. Néanmoins, l'usage du livret d'évaluation a engendré des améliorations, notamment dans l'évaluation tertiaire faite à l'unité.

Trois mois après la mise en œuvre, nous prévoyons vérifier l'usage du livret d'évaluation et mesurer la fidélité de l'ensemble de modèles d'ordonnances. La vérification des dossiers médicaux servira à voir si le personnel soigne les patients conformément au nouvel ensemble de modèles d'ordonnances, ou s'il a conservé ses anciennes habitudes. Un sondage de suivi sur la satisfaction des patients sera mené pour jauger l'éventuelle amélioration de la gestion de la douleur; les mesures relatives à la durée de l'hospitalisation, à la prophylaxie des thromboses veineuses profondes et au repérage de blessures non détectées seront évaluées pour déterminer si la standardisation a influencé ces aspects. Les résultats seront diffusés auprès des membres du personnel afin qu'ils prennent conscience des répercussions de leur pratique sur les patients, et un processus de contrôle régulier sera établi afin d'assurer la pérennité des améliorations. Une nouvelle version du RAM sera bientôt prête à être testée.

Conclusion

Les documents assortis sur l'évaluation traumatologique ont été créés dans le but de combiner une démarche évaluative normalisée et un ensemble de modèles d'ordonnances standards afin d'améliorer les soins en traumatologie. Il semblerait, sur une base anecdotique, que des attentes clarifiées en matière d'évaluation, d'examens médicaux et de traitement aient diminué les demandes de clarification, les retards de traitement et la durée de l'hospitalisation tout en améliorant la communication interdisciplinaire, ce qui, ultimement, mène à de meilleurs soins et à de meilleurs résultats chez les patients traités pour des traumatismes.

Remerciements

Les auteurs remercient les membres du personnel médical, infirmier et paramédical pour leur importante contribution au travail collaboratif de l'équipe de mise en œuvre du projet.

À propos de l'auteure

Asha Pereira est l'infirmière clinicienne spécialisée en traumatologie du Health Sciences Centre de Winnipeg (Manitoba). Elle est également candidate au doctorat à l'Université du Wisconsin, à Milwaukee. Elle a acquis plus de 25 ans d'expérience comme infirmière dans le cadre de nombreux postes : prestataire de soins directs, infirmière-enseignante, chercheuse, directrice et ICS. Elle a tenu le rôle de présidente de l'Association canadienne des infirmiers/infirmières en soins intensifs (ACIISI) et est membre de nombreuses organisations professionnelles, dont Sigma Theta Tau International (STTI) et la Golden Key Society.

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Geriatric friendly ED

By Jennifer D. Kostyshyn, RN, BN

As Canada's population continues to age, emergency departments must adapt to continue to deliver appropriate, competent, and compassionate care. Recognizing this, the emergency department in St. Boniface Hospital in Winnipeg, Manitoba, has spent the past year working towards developing a more elder-friendly emergency department.

In partnership with the St. Boniface Hospital Geriatric Program, an assessment of the physical space in the emergency department reassessment unit was conducted to look for opportunities of improvement for our older adult population. This assessment highlighted a lack of handrails leading towards the washroom, limited bedside seating, poor lighting, and insufficient signage. We also found unnecessary clutter in hall spaces and that our curtains were multicoloured and heavily patterned. Beyond our physical space, we also noted that there was a lack of mental and social stimulation for some of our longer-stay patients. Paired together, these physical and mental barriers put our older adult population at a higher risk for delirium and falls.

A team of frontline staff, emergency department leadership, volunteer services, and our hospital's geriatric program collaborated on transforming us into an elder-friendly emergency department. We changed the lighting so that it was softer and more ambient, changed our curtains to a uniform, solid colour, and installed handrails and new signage. We also conducted a successful quality improvement initiative on increasing our falls risk screening in the emergency department. Frontline staff developed a 'falls wall' that acts as a visual reminder of falls prevention, as well as houses falls risk signage, wristbands, anti-slip socks, and falls-prevention equipment such as assistive devices. This is also an area where falls-prevention resources for patients, families and staff are kept.

We also partnered with St. Boniface Hospital Volunteer Services to increase social and mental stimulation in our reassessment area where patients tend to have more prolonged stays. We now have volunteers playing gentle music in the evenings, providing art at the bedside, bringing in pet visitors, and offering library book and movie options for our patients. We also developed therapeutic activity kits (TAKs) to assist with stimulation and distraction for our patients with dementia, delirium, and/or responsive behaviours. Staff also donated fabrics and materials for our volunteer services department to make therapeutic touch blankets that are gifted to our patients with advanced dementia.

It is important to continually adapt our care to the population we serve. As our older adult population continues to rise, emergency departments should continue to work towards implementing elder-friendly practices to provide appropriate, competent, and compassionate care.

In response to an aging population and demands for a more elder-friendly ED, our emergency team took on a project to look at our environment, our attitudes and ways we could change to assist the delivery of care. Highlights of our discoveries included dim lighting, lack of proper seating at bedside, no hand rails for patients to walk to washroom and poor signage to locate washrooms. To assist with the changing of our attitudes we had multiple staff members attend a Responsive Behaviours workshop and then roll out the information to colleagues. This, in combination with the implementation of completing the fall risk screening in the electronic patient record, has increased our awareness and helped to change minds in our staff. Besides the physical well-being and safely factors, we also notice that due to the long stays in the reassessment unit, our patients were lacking mental and social stimulation and orientation of time and place. In response to this, we involved our volunteer services who provide weekly and daily services including music, pet therapy, book lending and visits. We installed TVs in the common area and encourage frequent rounding to provide for direct care and reorientation. We have developed TAKs to assist those with responsive behaviours and touch blankets for those who may never return home. To educate and provide easy access to tools we have developed a "falls wall" in three areas of our department that house our bedside flags, wristbands and antislip socks. The "falls wall" area also contains an educational component and highlights our successes in the department.

About the author

Jennifer D. Kostyshyn, RN, BN, graduated from the University of Manitoba with her Bachelor of Nursing in 2010. Jennifer has worked the past six years in the emergency department at St. Boniface Hospital in Winnipeg, Manitoba. Jennifer works as part of a dynamic team advocating for patient safety and team work. Jennifer enjoys sharing knowledge and inspiring new nurses with university and college preceptorship programs. She is also an avid member of the St. Boniface Emergency Department TeamSTEPPS initiative and is planning on completing graduate studies in the healthcare field.

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The NENA Bursary

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

Applications must be submitted prior to the spring Board of Directors meeting of NENA for review by the standing committee for Bursary disbursements.

On April 1 of each year, the number of bursaries awarded will be determined by the number of current registered members per province [for that NENA fiscal year]:

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

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

Successful candidates may receive a Bursary once every three years.

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

1. Number of years as a NENA member in good standing

2 years	1 Point
3–5 years	2 Points
6–9 years	3 Points
10 + years	5 Points

2. Involvement in Emergency Nursing: (associations/groups/committees)

Provincial member	1 point
Provincial chairperson	2 points
Special projects/committee/ provincial executive	3 points
National executive/NENA chairperson	5 points

3. Candidates with certification in Emergency Nursing and/or involved in Emergency Nursing research will receive an additional 5 points.

If two candidates receive an equal number of points, the committee will choose the successful candidate.

All decisions of the NENA Bursary Committee are final.

Each application will be reviewed once at the spring board meeting.

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

Candidates must have completed Forms A, B and C (available on the NENA website: **www.nena.ca**). The provincial director may forward applications at the spring board meetings following electronic notification to committee.

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

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

Application process:

Candidates must complete and submit the following:
a. NENA Bursary application form "A".
b. Bursary reference form "B"
c. 200-word essay
d. Photocopy of provincial RN status.

Provincial Director responsibilities:
a. Completes bursary candidates' recommendation form "C"
b. Ensures application forms are complete *before submission* to Bursary chair.
c. Brings to Board of Directors meeting all appropriately completed applications.

Selection process:
The standing committee for NENA bursaries will:
1. Review all applications submitted by provincial directors and make recommendations to award bursaries based on the NENA selection criteria.
2. Forward names of approved candidates to the NENA Board of Directors for presentation by the President.

Jenn Myles, RN, and Danielle Smith, RN, Saint John Regional Hospital, Saint John, NB

Erin Spencer, RN, Regina, Saskatchewan