CANADIAN JOURNAL of EMERGENCY NURSING

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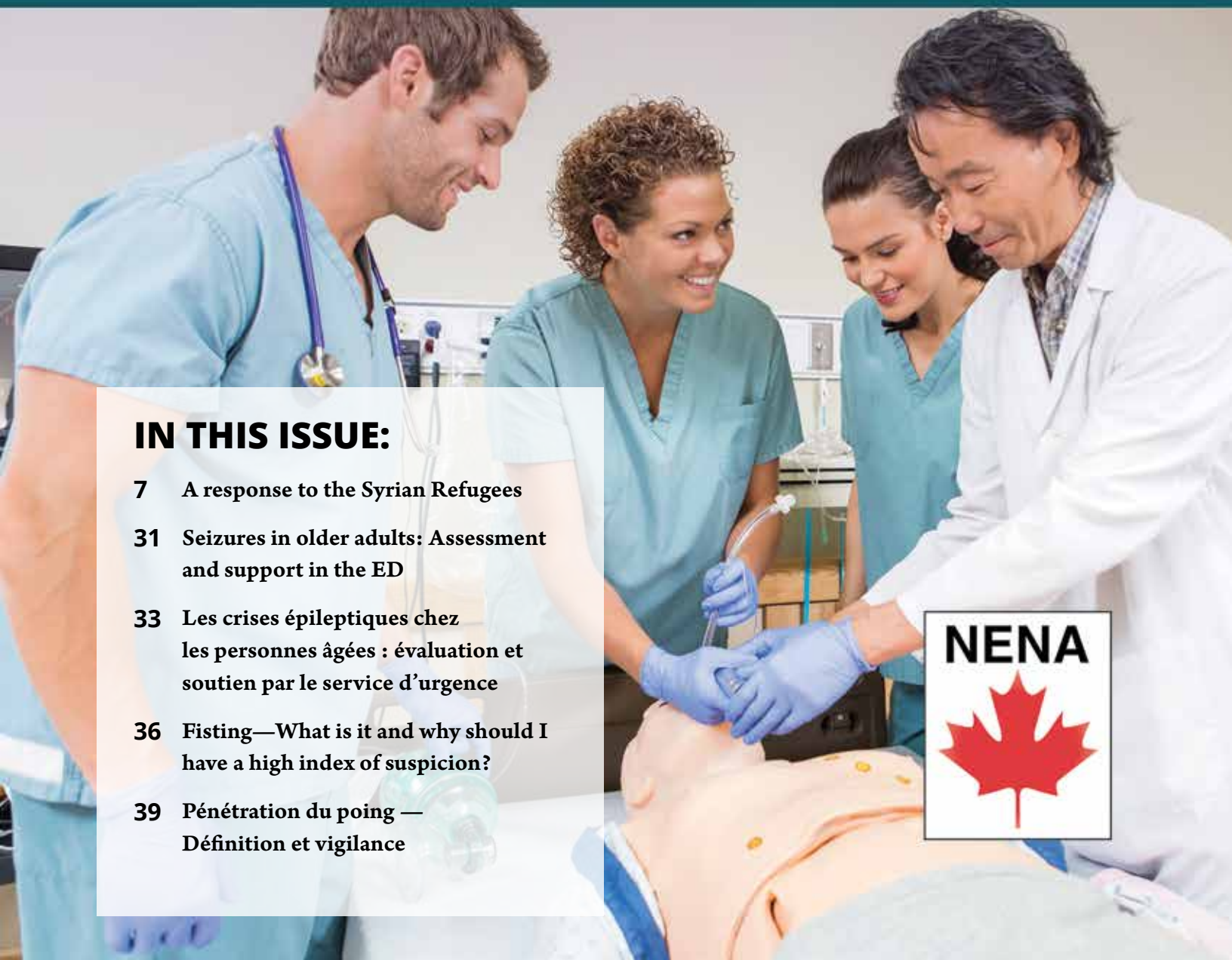

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Guidelines for submission

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:
Stephanie Carlson, CJEN Editor,
email: **communicationofficer@nena.ca**

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

Deadline dates:
January 31 and September 8

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President's message

Happy 2016 to everyone. Are you like me in thinking that, as you get older each year, time seems to go by just that much faster? Our fabulous CJEN Editor, Stephanie, sent a reminder to submit articles for the spring edition of CJEN, due by February 10. At the time, I thought that was a day far in the future, leaving me ample time to write this message. As I write this, it is already February and there is even a hint of spring in the air.

I hope that each one of you had an enjoyable holiday season, spent with friends and family during some well-deserved time off. Friends and family shared the time with us and all enjoyed.

And now we are back at work, doing what we do best—caring for our patients. I mentioned in an earlier article that my focus during my term as NENA President would be on patient-centred care. That is why we are here, that is what we do best and that is what our patients most appreciate from us. All of our health care team co-workers are important, as are the diagnostic tests, medications, etc. But we are there, at the bedside, 24/7, 365 days per year (366 days this Leap Year), influencing patient care because we provide the most care to the patient.

So important in providing quality care to our patients is education and, as you will read in other articles in the journal, NENA is thrilled to have partnered with prn Education in the development of EPICC (Emergency Practice, Interventions and Care - Canada). You will learn more when you receive and plan to attend the NENA National Conference in Montréal this April. EPICC will debut as a pre-conference offering in both French and English. Do not miss this opportunity to be part of something great.

I encourage you also to read about NENA Board of Director opportunities. We are searching for key people to serve in several executive positions, including President Elect, Treasurer, Director of Membership and Promotions, and Director of Training and Education. Nomination forms and position job descriptions are available on our website at **nena.ca** or you may contact me directly at **president@nena.ca** for more information.

Thank you for your continued membership in and support of NENA. I hope to see many of you in Montréal this April.

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

Le mot de la présidente

Bonne année 2016 à tous! Êtes-vous de celles et ceux qui, comme moi, trouvent que le temps file de plus en plus vite chaque année? Il a quelque temps, Stephanie, notre formidable rédactrice du *Canadian Journal of Emergency Nursing* (CJEN) nous a rappelé que la date de tombée pour le numéro de printemps était le 10 février. J'ai alors cru que cela me laissait tout le temps nécessaire pour rédiger ce message. Au moment d'écrire ces lignes, nous sommes déjà en février; on peut même sentir le printemps à nos portes.

J'espère que vous avez tous passé une agréable période des Fêtes, entourés de vos amis et de vos proches pour ces vacances bien méritées.

Et voilà que nous sommes de retour au travail, à faire ce que nous faisons de mieux – nous occuper de nos patients. J'ai mentionné dans un article précédent que mon mandat en tant que présidente de la National Emergency Nurses Affiliation (NENA) serait axé sur les soins aux patients. C'est pour cela que nous sommes ici, pour prodiguer aux patients ce qu'ils apprécient le plus de nous : nos excellents soins. Nos collègues du milieu de la santé sont tous importants, autant que les tests diagnostiques, les médicaments, etc. Nous sommes au chevet des patients 24 heures sur 24, 7 jours sur 7, 365 jours par année, ou plutôt 366 en cette année bissextile. Parce que nous intervenons aussi souvent auprès des patients, nous influons sur les soins qu'ils reçoivent.

La formation des infirmières et infirmiers est très importante pour la qualité des soins prodigués aux patients. En lisant les autres articles de la revue, vous constaterez que la NENA est emballée par son association avec prn Education pour l'offre de formation EPICC (Emergency Practice, Interventions and Care - Canada). Vous en apprendrez davantage à ce sujet lorsque vous recevrez l'information relative au congrès national de la NENA, qui se déroulera à Montréal en avril. Nous vous invitons à y assister. La formation EPICC sera présentée avant le début des conférences et sera offerte en français et en anglais. Ne ratez pas l'occasion de prendre part à cette activité ressourçante.

Je vous invite également à prendre connaissance des possibilités d'engagement au sein du conseil d'administration de la NENA. Nous sommes à la recherche de personnes clés pour occuper divers postes de direction, incluant celui de président désigné, de trésorier, de directeur des adhésions et des promotions et de directeur de la formation et de l'enseignement. Les formulaires de mise en candidature ainsi que la description des différents postes à pourvoir se trouvent sur notre site Web, à l'adresse **nena.ca**. Vous pouvez également me joindre directement à l'adresse suivante : **president@nena.ca** afin d'obtenir de plus amples renseignements.

Merci de votre adhésion continue ainsi que de votre soutien à la NENA. J'espère vous voir nombreux à Montréal en avril.

Cordialement,
Sherry Uribe, B.Sc., M.B.A., inf.aut., ENC(C)
Présidente de la NENA

Editor's commentary

Much discussion about nursing revolves around the patient: patient safety, patient-centred care, patient participation, patient teaching, patient satisfaction. Nursing is about patients. This past week I was on the periphery of an event that reminded me that nursing is also about nurses.

We have two acute care hospitals in Regina with emergency departments at each hospital. Each department has a slightly different clientele and a very different culture. My job enables me to work closely with staff at both hospitals. I wouldn't say that one is better than the other, but they are certainly different. There is a good deal of interaction between staff of the two departments. Some nurses work part-time or casual at both hospitals and we enjoy conjoint nursing education activities and socialization.

A nurse from one of the departments became gravely ill. This touched us all very deeply, as we have been concerned for him and for his sweetheart, who also works as an emergency nurse. He was seen by an emergency physician in the emergency department and whisked to an inpatient unit very quickly and then to the intensive care unit where he remained for several weeks with mechanical support.

Everyone from our executive director on down was involved somehow in tangible expressions of affection for both of our nurses. His manager stayed overnight at the hospital with family and managed somehow to carry on with her regular duties in emergency. When the email blast went out to meet at the hospital chapel to pray or "be there" for the family, the room filled and there was spill-out into the hall. Several staff maintained an intermittent vigil with the family and some offered care of their toddler, jockeying time around their work schedules. Staff from each department brought food to the family during his illness. Doctors provided food for staff and in many other ways showed their shared concern. Nurses from the departments at both hospitals asked to contribute to a collection to help with immediate needs. Some of the men cleaned sidewalks at the home following snowfalls. This isn't a complete list, but it demonstrates the level of engagement by staff.

It is with profound sorrow I add that this nurse did not survive his illness. We were all touched by his short life and we will all miss him very much. When the word came, it felt like a death in the family. The tears came. The questions came. The grief continues.

Yes, I am proud to say that nursing is about patients, but I can say also and with absolute certitude that nursing is about nurses. Goodbye, Louelle, we miss you.

Stephanie Carlson

NENA Awards, Bursaries and Grants available for 2016

Awards

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

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

Award nomination forms to be sent to **awards@nena.ca**. Deadline for submission is March 31.

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 annually for the support of ongoing education, with 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 1 each year, the number of bursaries to be awarded will be determined based on the number of registered members per province. One annual bursary will be available to the NENA Board of Directors and one bursary available collectively to an independent member.

One Margaret Smith Paediatric Memorial Bursary and one Debbie Cotton Memorial Bursary are also available annually.

Grants

A NENA Research Grant is available for application by a 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 or **awards@nena.ca** prior to March 31.

NENA congratulates all of our 2015 bursary recipients

Below are the essays by the 2015 NENA bursary recipients. NENA derives immense pleasure from presenting these awards, which assist active NENA members to participate in events that enable them to remain current in their practice of emergency nursing. The deadline for 2016 bursary applications is March 31, 2016. Eligibility requirements and instructions for application are included in this journal.

Attendance at the NENA Conference

I was fortunate enough to be one of the recipients of the 2015 NENA Bursaries. This bursary allowed me to attend the national conference this May in Edmonton, AB, where I felt like I had received an injection of knowledge, renewed passion and energy for emergency nursing!

I attended the pre-conference workshop on evidence-based practices for emergency wound care where I reviewed the principles of wound healing to better help me make the right choices when using the many new dressing products available. I updated my knowledge on many topics, including recent changes in caring for hypothermic patients, paediatric rashes and allergic reactions—knowledge that I can apply at the bedside to improve the quality of care I provide for my patients. I was inspired by the enduring passion that is so evident in AnnMarie Papa, as she shared many lessons on how to work more effectively with my ED team.

I now bring the knowledge and experiences I had at the conference forward to my studies, as I interact with nurses from across the country in the Advanced Critical Care/Emergency Nursing Certificate program – and hope to share the knowledge and passion I have for emergency nursing with the nurses entering the program who are at the beginning of their journey into the world of emergency!

Thank you sincerely for allowing me this opportunity.

Darlene Campana, RN, BSN, CEN

Attendance at the NENA Conference

Thank you very much for the NENA bursary I received this last year at the conference in Edmonton. This money helped to pay for lodging and registration for the NENA conference.

I find these conferences informative and very applicable to emergency practice. I have shared some of the knowledge gathered at the conference with the staff in our department.

The financial support from NENA is very much appreciated. Thank you again.

Kitty Murray, Clinical Nurse Educator, Victoria General Emergency Department

2015 Margaret Smith Bursary Recipient

BCEN Certification in Paediatric Emergency Nursing

In the summer of 2014, I studied for and obtained my BCEN certification in Paediatric Emergency Nursing. This certification was established in 2009 to verify the unique body of knowledge that is post basic in paediatric emergency nursing. I am one of the few British Columbians, let alone Canadians, to attain this certification after obtaining both Canadian ENC(C) and American CEN certifications.

I currently work full-time in a busy, combined adult/paediatric emergency department and teach TNCC and CTAS. Preparation for this certification has allowed me increased comfort and confidence in caring for sick children. It has also allowed me to become somewhat of a resource in the department.

The Margaret Smith Memorial Bursary has allowed me to recoup some of the costs for the preparation for this exam, texts, DVDs and travel to Seattle and, finally, the cost of the exam itself. There was no requirement for this certification in my current job. So, many say, why waste the money? Well, for personal satisfaction and, more importantly, to provide the best care possible.

Thank you.

Sincerely,
Laura B MacKinnon, RN, BScN, ENC(C), CEN, CPEN

Attendance at the IAFN Conference

Thank you for the bursary to attend the annual conference of the International Association of Forensic Nurses. My position as SANE coordinator in the Regina Qu'Appelle Health Region requires that I be knowledgeable about the latest research in forensic nursing, particularly sexual assault care. All adolescent and adult cases in our area are examined and treated in a collaborative process between nurse examiners and primary emergency nurses. Attendance at the conference of the International Association of Forensic Nurses not only provides the premier learning opportunity for nurse examiners, but it is also one of two opportunities to network with Canadian forensic nurses (the other is the annual NENA conference). I believe my attendance has a direct benefit on patient care and on the response to our patients in our two emergency departments.

Respectfully submitted,
Stephanie Carlson, RN, SANE-A, CFN

Attendance at the 2015 NENA Conference in Edmonton

We are very fortunate this year that the NENA conference is being held here in Alberta. I am very excited to have this opportunity to attend the NENA conference to gain knowledge and insight on a vast array of emergency topics. I am eager to learn about many topics such as: paediatric rashes, anaphylaxis and allergic emergencies, legality issues in nursing and changing the negative outcome of long ED wait times. All of these topcis apply to my job as a clinical nurse educator of the South Health Campus Emergency Department. I can definitely

relate to the long wait times and am eager to hear what the Jean-Talon Hospital has done to increase their safety and quality of care in their waiting rooms.

Attending conferences such as NENA's helps to advance my own knowledge and skills. I am able to take this knowledge and apply it to my practice. I can take the "pearls" I will learn from the conference and incorporate them into teaching our own staff and nurses across the zone, whether it is in emergency orientation or courses such as ACLS, PALS, CTAS or TNCC. I am looking forward to the NENA conference at the end of April. I am excited to see all that I will learn and take away from the conference.

Sara Nosworthy, Alberta

Deb Cotton Bursary to attend the ENA Conference in Orlando, Florida

The Emergency Nurses Association (ENA) has been offering the largest emergency nursing conferences in North America for many years. Traditionally, they offered two conferences per year; a leadership conference in the spring and a clinical conference in the fall. In 2001, I had the opportunity to attend the clinical conference and benefitted tremendously. I have never had the opportunity to attend the leadership conference, as it was held in the spring (similar timing to the NENA conference), although every year I would look at the conference brochure and wish I could attend.

This September (2015), ENA will integrate the leadership and clinical conferences into one outstanding six-day emergency nursing conference. The conference will be held in Orlando, Florida, a location that is more affordable for those of us on the East coast than travelling to most parts of Western Canada. The timing and location of the integrated leadership and clinical conferences this year provide me an excellent opportunity to attend.

Although the official program has not yet been released, ENA 2015 promises many opportunities to network with emergency nursing colleagues from across North America and around the world, hands-on learning labs and interactive demonstrations in addition to disaster drills. I am also looking forward to visiting the ED of the future exhibit to have a glance at emerging ED technology and promising operations practices.

When I attended the prior ENA clincial conference, I had the opportunity to participate in a cadaver lab, which not only increased my knowledge of anatomy, but also allowed me to gain experience with inserting the EZ IO and utilizing Glidescope technology. Both the EZ IO and Glidescope are now utilized in our ED and I was fortunate to be familiar with them when they arrived. It was also advantageous for me to meet other TNCC and ENPC instructors from across the U.S. to hear their challenges in offering the programs and to learn tips and tricks that have been utilized and enrich our TNCC and ENPC course offerings. Given the recent updates to both TNCC and ENPC, I welcome the opportunity to network with other instructors.

Most of all, what I remember from the prior ENA conference was the passion and excitement for emergency nursing shared by the group of more than 3,500 nurses. It was truly inspiring and I want to experience that again.

Thank you,
Erin Musgrave, MN, RN, ENC(C), Triage Coordinator, Horizon Health Network/Réseau de santé Horizon, New Brunswick

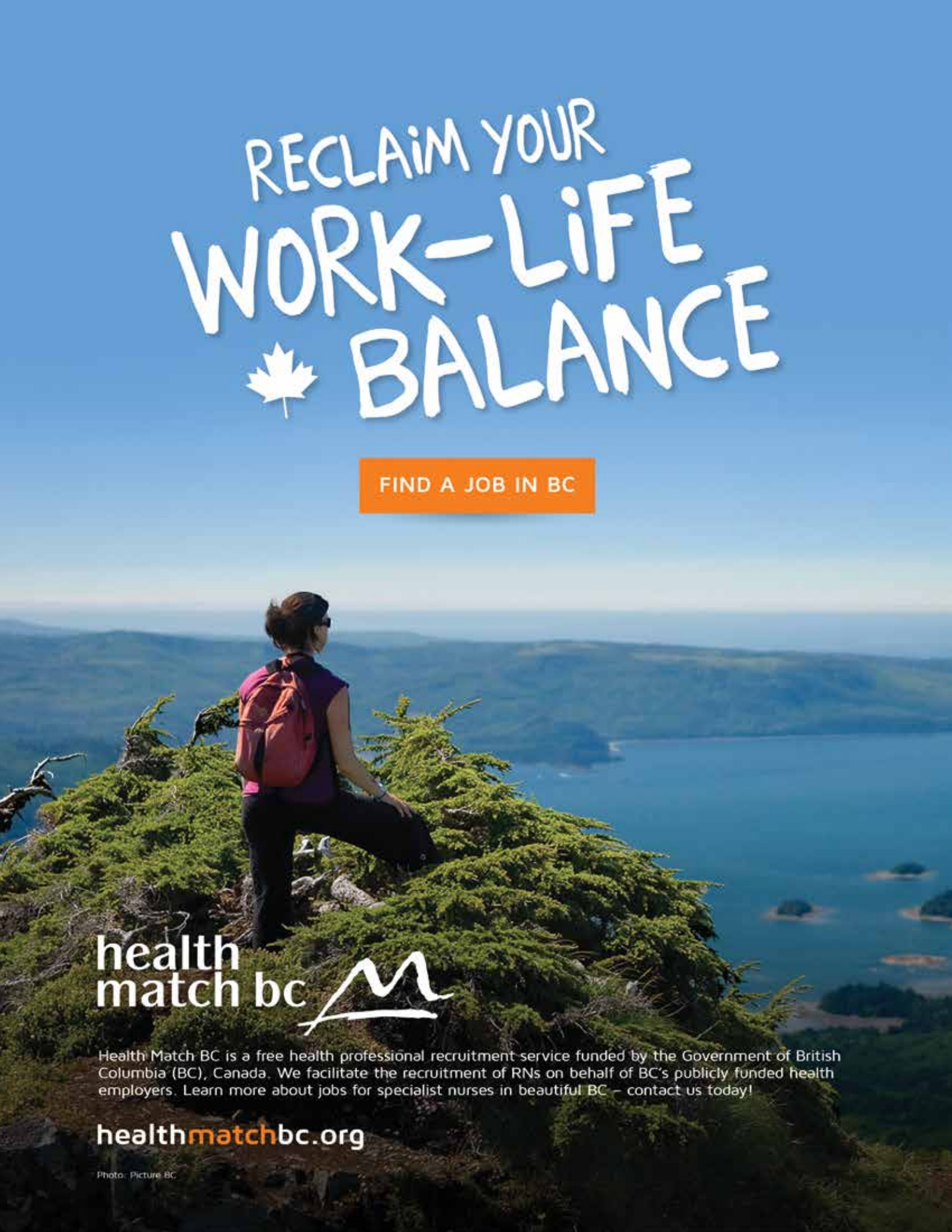
A response to the Syrian Refugees

By Haidee Goldie, RN, ENC(C), Manager St. Joseph's Community Health Centre, Saint John, New Brunswick

The St. Joseph's Community Health Centre (CHC) has been partnering with the YMCA New Comers Connection to provide assistance and guidance for providing a medical assessment. Termed a Post Arrival Health Assessment (PAHA), it provides access to immunizations through public health and access to mental health clinicians and other specialists, as needed. The CHC has been providing one clinic a week since December 7, and twice weekly since January 19. Public health and mental health clinicians attend these clinics.

The PAHA is a document developed to help clinicians identify acute/chronic medical conditions, and recognize if the client will need immediate access to a primary care provider. This assessment is being completed with each family member by a registered nurse who has volunteered their time to provide the service. Primary care providers within the Saint John area have also volunteered to provide ongoing care for these clients. Through the assessment, the need for immunizations is recognized and a referral is made to public health who will then provide the service. Mental health clinicians are available to provide care if a need is identified, whether it is a one-time appointment or an ongoing service of support. Each PAHA assessment takes approximately 30 minutes/adult and 15 minutes/child. Interpreters are provided through the New Comer Connections or the Translation Line may be used. Ideally, interpreters make the process much more streamlined, but there is a cost that is incurred. Appointments for the families are booked on specific clinic dates through the YMCA. All referrals that have been identified are made by one lead person to ensure less confusion and to ensure the appointments are booked with the appropriate person and contact has been made. The contact at the YMCA ensures that the patient is aware of the appointment time and that an interpreter is available. At the end of each clinic day all of the volunteers spend time in case management. This allows the volunteers time to go over the assessment and discuss any referrals with the team lead.

These clinics would not be possible without the volunteers and the Community Health Centre that provides manpower and equipment to the clinics.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MEET WITH HEALTH MATCH BC

National Emergency Nurses Association Conference (NENA)
April 21-24, 2016 | Montreal, Quebec

Director of Training and Education report

By Margaret Dymond, RN, BSN, ENC(C)

The role for the Director of Training and Education, NENA Board of Directors, has expanded over the last one to two years. This winter, the job description is being finalized in order that NENA members understand the position and duties of the role.

The position duties highlights:

- Monitors courses (TNCC, ENPC, CTAS) including tracking information, costs, effectiveness, and feedback
- Analyzes and evaluates courses for strengths and areas of improvement to promote delivery of courses
- Regularly connects with NCAC chair, triage working group (CTAS), EPICC working group
- Acts as a liaison for education-related opportunities with the NENA BOD and interested groups
- Acts as a resource for emergency nursing certification to NENA members seeking certification, CNA, and other interested groups
- Develops educational tools to assist emergency nurses prepare for the emergency nursing certification exam — Canada
- Provides input into the operational activities of NENA: financial, educational, policies and procedures.

NENA is actively pursuing many opportunities to increase the organization's awareness provincially, nationally, and internationally. The Director of Training and Education is a member of the Canadian Concussion Consortium and the International Committee for the Advancement of Procedural Sedation.

The Canadian Nurses Emergency Nursing certification program is actively working on the exam process and switching the exam to an electronic format. Starting in the fall of 2016, the exam will be computerized.

There has been interest from other countries in the Canadian emergency certification program. A recent pilot project between the Dubai Health Authority (DHA) and the Canadian Nurses Association certification is on going, with two Canadian nursing specialties rolling out in the DHA—emergency nursing and nephrology.

The next generation of NENA educational activities includes the creation and dissemination of the Emergency Practice Interventions and Care – Canada with prn Education. The course will be simultaneously rolled out in English and French.

Le compte rendu de la directrice de la formation et de l'éducation

Par Margaret Dymond, inf. aut., BSN, ENC(C)

Le rôle du directeur/de la directrice de la formation et de l'éducation au sein de la National Emergency Nurses Affiliation (NENA) a évolué au cours des deux dernières années. Cet hiver, la description du poste sera finalisée, ce qui permettra aux membres de la NENA de comprendre le statut et les fonctions de la personne occupant ce rôle.

Principales responsabilités du directeur/de la directrice de la formation et de l'éducation :

- Superviser les cours Trauma Nursing Core Course (TNCC), Soins infirmiers pédiatriques d'urgence (CSIPU) et Échelle de triage et de gravité (ÉTG) canadienne, en surveillant notamment l'information, les coûts, la pertinence et les rétroactions;
- Analyser et évaluer les cours en faisant ressortir leurs forces et leurs lacunes afin d'en améliorer la promotion;
- Travailler étroitement avec le président/la présidente du National Center for Alternative Certification (NCAC) de même qu'avec les groupes de travail relatifs à l'ÉTG canadienne et à Emergency Practice, Interventions and Care — Canada (EPICC);
- Assurer la liaison entre le conseil d'administration de la NENA et les groupes à la recherche de formations;
- Agir en tant que personne-ressource pour la certification des infirmières et infirmiers membres de la NENA, de l'Association des infirmières et infirmiers du Canada (AIIC) et d'autres groupes intéressés;
- Élaborer des outils pédagogiques afin de mieux préparer le personnel infirmier d'urgence à l'examen de certification en soins infirmiers d'urgence — Canada;
- Participer aux activités opérationnelles de la NENA — finances, éducation, politiques et procédures.

La NENA cherche activement à saisir diverses occasions d'augmenter la reconnaissance de l'organisation à l'échelle provinciale, nationale et internationale. Le directeur/la directrice de la formation et de l'éducation est membre du Canadian Concussion Consortium et de l'International Committee for the Advancement of Procedural Sedation.

Les responsables du programme de certification de Canadian Nurses Emergency Nursing travaillent activement au processus d'examen de certification afin d'en faire une version électronique. Celle-ci sera disponible à compter de l'automne 2016.

Le programme canadien de certification des soins infirmiers d'urgence suscite de l'intérêt à l'extérieur du pays. Un projet de formation pilote réalisé conjointement par l'Autorité de santé de Dubaï et l'AIIC consiste à enseigner actuellement à Dubaï deux spécialités infirmières reconnues au Canada.

Les prochaines activités pédagogiques de la NENA comprennent la création et la diffusion de la formation EPICC, réalisées par prn Education. Le cours sera offert simultanément en anglais et en français.

2016 is going to be an EPICC year!

By Landon James, RN, MA

The National Emergency Nurses Association (NENA) and the prn Education group have collaborated on an exciting venture to develop a bilingual course based on the NENA core competencies. After an exhaustive search for the right name, it has been named the Emergency Practice, Interventions and Care – Canada (EPICC) Course. This unprecedented course will use mixed instructional methods such as pre-course online modules, classroom and small-group case studies, as well as psychomotor skill stations. Videos, games and formative evaluation techniques will challenge the beginner and seasoned emergency nurses' ways of thinking, translating and applying knowledge to practice. The course was developed keeping in mind evidence-based adult learning principles.

The task of meeting a tight timeline of one year from July 2015 to July 2016 was given to the EPICC Project Development Team, which included Landon James, Monique McLaughlin, Brian Lee, Denis Bouchard and Mélanie Marceau. We are fortunate in both our civilian and military areas in Canada to have many experts (both English and French) in the fields of clinical emergency nursing and emergency nursing education from which we drew our expert content developers. These academically and clinically qualified content developers were asked to author case studies encompassing a mixture of many challenging competencies. These case studies were then exchanged to be peer reviewed. The EPICC Project Development Team was impressed by how recent relevant research contributed to the quality of the case studies.

The Project Development Team met in Vancouver in October 2015 for an intensive four-day review of the content. Filming the videos for the online portions in the Mobile Medical Unit (a legacy from the 2010 Olympics) and a test course schedule were some of the other tasks completed. Fortunately the weather in Vancouver cooperated.

The Project Development Team then hosted two test group courses that were held in Vancouver and Montréal in November 2015. Notable emergency nursing education leaders were gathered, volunteering their time to lend invaluable constructive feedback to the curriculum, development and delivery of this course. It was an energized, respectful and motivating environment that helped to clarify the objectives for the course. It was humbling to be challenged and given such enthusiastic support by respected nursing leaders to continue to be open and innovative in the delivery of education.

The EPICC Project Development Team gathered once more, this time north of Montréal in January 2016 to incorporate the critical feedback from the test groups and come up with the "final" product. It was another intense four days holed up in a cabin in the Laurentians (thank you Denis). But we did manage to enjoy some of the winter weather in Quebec (on snowshoes nonetheless).

The next step is to do the "dress rehearsal" both in Vancouver and in Montréal. We will be teaching the first EPICC courses in February and March 2016 with emergency nurse participants. We are excited to "show off" national bilingual Canadian expertise in the combined work of the project developers, content developers and the course reviewers.

The first formal public course will be delivered as a pre-conference offering to the NENA National Annual Conference in Montréal where we "Unleash the Power of the ED Nurse." For anyone who would like to keep up with the course development, blog, FAQ and updates, you can visit us at: **http://prneducation.ca/pages/epicc**

Let's make 2016 an EPICC year!

Canadian emergency course previewed in Vancouver

By Jean Harsch, RN, ER, CNE, Grey Nuns Community Hospital Emergency Department, Edmonton, AB

On February 13–14, I had the privilege of joining with 23 others (staff nurses, clinical nurse educators, and managers) to participate and evaluate the new Emergency Practice, Interventions and Care - Canada (EPICC) course.

We began our introduction to the course by doing the EPICC online modules before we gathered in Vancouver. These modules present foundational physiology and pathophysiology, some common emergency presentations through readings, podcasts and YouTube videos. Initially, I felt these modules were quite basic and I was concerned that the course would be more entry level. But, I was wrong.

In Vancouver, the 24 of us were split up into four groups of six. We worked through common emergency presentations using simulations where we each got to function in different roles (physician, triage nurse, team leader, staff nurse, respiratory therapist). During the debriefing and group discussions the theory behind the actions/treatment was confirmed and clarified.

The principle that simulation/hands-on learning is the most effective adult learning approach was patterned for us and the experience effectively drove the concept home.

Though the creators of the EPICC course are still ironing out all the details for the Montréal conference, I found this course to be an effective and exciting way to teach and challenge higher-level learning and critical thinking. We experienced the cases through different eyes and challenged ourselves to know the medical and nursing treatment. As a result of this experience, I am changing how I present my training and orientation in our emergency department. I believe that no matter what your role is in the ER, EPICC can positively influence your practice.

NENA—A grandiose vision

By Jean Harsch, RN, ER, CNE, Grey Nuns Community Hospital Emergency Department, Edmonton, AB

Because NENA represents a group of nurses who are masters of assessment, of creativity and of flexibility, I desire that NENA would be their voices in the local, national and international political, social and medical arenas.

Politically: I want NENA to be assertive in pursuing provincial and federal governments to address the need for a bigger vision to accommodate the bulging emergency departments. We need to meet with hospital administrators to discuss their plans for addressing these issues and plan with them to see with a bigger vision how to solve the problem not just for today, but also for the future. We need to have a vision, a suggested plan and get out there and speak about it with the media. We need to promote and participate with any discussion groups that are happening.

We need to increase our visibility so that the political world and the general public know who we are and hear what we stand for, using advertisements in magazines, strategically planned media interviews/statements. Definitely having a presence at as many nursing conferences as we can, so we can promote what we believe. Having and presenting our vision or position on how Canadians can own their health care and health responsibilities and possibly reduce the number of ER visits. Health promotion.

Socially: I want NENA to be actively involved and present when local, national or global disasters occur. What if we got on board with a disaster planning/emergency preparedness nursing training program? What if we equipped our nurses to go out into the world to meet the needs of the countries or places that need disaster intervention? What if the answer to the question "who do we call" wasn't ghost busters but it was NENA? What if, when the Canadian government was preparing to send disaster relief/medical relief, they would have on their list of resources NENA? Who better to enter into the world of chaos and extreme medical emergency than our emergency nurses? What if we had on our website registration for those nurses who could be deployed within 24–48 hours to places of need? What if when people saw our logo they would recognize us as a group of nurses who not only meet the needs of people in local hospitals, but they would also recognize us as a group of nurses who are involved and present globally.

Medically: I desire that NENA would not only be the go-to association for questions regarding emergency intervention, but also that we would be actively investigating and promoting best practice for nursing in the ED. What if the way emergencies ran their departments was based on NENA recommendations—and I don't mean they have some documents that they looked at once upon a time but really never followed—but what if we were considered the experts, so that when they wanted to institute new policies or programs they would just automatically say, "Well, let's see what NENA recommends." What if accreditation was based on NENA standards?

We already do and are involved in some of this and so much more than this. We have the greatest resources… our ER nurses from all over Canada and the representatives from 10 provinces and soon our territories, too. I want for the NENA team to have the biggest, most grandiose vision of what we are capable of… and then let's do it, and let's do it together. All of us feeding the vision with ideas and dreams and all of us fleshing it out.

NENA—Une vision grandiose

Article rédigé par Jean Harsch, inf. aut., ER, CNE, service des urgences du Grey Nuns Community Hospital, Edmonton, AB

La National Emergency Nurses Affiliation (NENA) regroupe des infirmières et infirmiers passés maîtres dans l'art d'évaluer, de créer et de s'adapter. Je souhaite que la NENA les représente sur les scènes politique, sociale et médicale, et ce, à l'échelle locale, nationale et internationale.

Scène politique : Je souhaite que la NENA parvienne à convaincre les gouvernements, tant provinciaux que fédéral, de la nécessité d'élargir leur vision afin d'améliorer la situation dans les salles d'urgence, qui débordent. Nous devons rencontrer les administrateurs des centres hospitaliers afin de discuter avec eux des plans envisagés pour régler les problèmes de nos services d'urgence. En travaillant conjointement avec les administrateurs, nous parviendrons à une vision « améliorée » du problème et trouverons des solutions durables. Nous devons exposer notre vision et notre plan d'action dans les médias. Nous devons également promouvoir la tenue de groupes de discussion sur le sujet et y participer, aussi souvent que possible. De plus, nous devons accroître notre visibilité par l'entremise de publicités dans des revues et d'une planification stratégique d'entrevues accordées aux médias. De cette façon, le milieu politique ainsi que le reste de la population sauront qui nous sommes et ce que nous cherchons à accomplir. Aussi souvent que possible, il importe d'assister aux congrès s'adressant au personnel infirmier, afin de promouvoir notre message. Nous devons amener les Canadiens à prendre soin de leur santé. Notre vision et notre position quant à la manière de les responsabiliser

doivent être partagées. Cela pourrait réduire le nombre de visites à l'urgence. C'est ce qu'on appelle faire la promotion de la santé.

Scène sociale : La NENA doit s'engager activement et être présente lorsque des catastrophes locales, nationales et internationales surviennent. Pourquoi ne pas élaborer un programme de formation visant à préparer les infirmières et infirmiers à agir en cas d'urgence? Pourquoi ne pas équiper nos infirmières et infirmiers afin qu'ils voyagent de par le monde pour répondre aux besoins de populations affligées par les catastrophes? Pourquoi le numéro à composer en cas d'urgence ne serait-il pas celui de la NENA? Et lorsque le gouvernement du Canada se prépare à fournir de l'aide aux sinistrés et du secours médical, pourquoi la NENA ne ferait-elle pas partie de ses ressources? Personne d'autre que nos infirmières et infirmiers d'urgence n'est mieux placé pour faire face au chaos et aux situations d'extrême urgence médicale. Les coordonnées du personnel infirmier pouvant être déployé dans un délai de 24 à 48 heures dans des zones sinistrées ne pourraient-elles pas se trouver sur notre site Web? Notre logo ne pourrait-il pas être associé non seulement à un groupe de personnes prenant soin de patients dans les hôpitaux locaux, mais aussi à un groupe d'infirmières et d'infirmiers engagé et présent à l'échelle planétaire?

Scène médicale : La NENA doit non seulement être la référence pour des questions relatives aux interventions d'urgence, mais elle doit être bien renseignée sur les meilleures pratiques de soins infirmiers d'urgence, en plus de les promouvoir. Pourquoi les services d'urgence ne suivraient-ils pas les recommandations de la NENA? Et je ne parle pas de documents auxquels on jette un œil de temps à autre, sans vraiment suivre les recommandations. J'entends par là que si nous étions considérés comme des experts, les recommandations de la NENA pourraient être prises en considération dans la mise en place de nouvelles politiques ou de nouveaux programmes. On penserait automatiquement : « Eh bien, voyons ce que la NENA recommande ». Pourquoi l'accréditation du corps infirmier ne se baserait-elle pas sur les normes établies par la NENA?

Nous sommes déjà engagés dans certains de ces projets, et bien plus encore. Nous disposons des meilleures ressources : en font partie nos infirmières et infirmiers qui travaillent dans les urgences du Canada, ainsi que nos représentants des dix provinces et bientôt des territoires du pays. Je souhaite que l'équipe de la NENA ait la vision la plus large, la plus grandiose de ce que nous pouvons accomplir… Et si on la réalisait tous ensemble? Et si chacun de nous nourrissait cette vision, avec ses idées et ses rêves, afin de l'enrichir… ?

NENA Membership report

- A NENA information sheet was sent out as a pdf to all NENA Executive and NENA Directors for their use in promoting NENA in a variety of ways (handouts, orientation, and "welcome" packages to NENA). This brochure will be translated into French and will be posted on the website for any member to use for promoting NENA.
- Ongoing work is taking place to have a NENA brochure. This will be sent out to the Executive and the President's Council for dissemination and printing. We will include one in each conference bag at 2016 in Montreal. Remember there is a discount on copy and printing through Staples and the reference number is **8152350834**. This is a Level 2 Business Discount giving 20% off Printing and Copying though any Staples across Canada. **This number is on our website for all members of NENA to use.**
- NENA has NENA RN pins available for any provincial group to purchase. They come in lots of 100 and will be sold to the provinces at cost ($0.97 each plus shipping). Just contact me to arrange for your pins.
- NENA also has 500 pens (red with stylus at the end), which will be used for promotion in the conference bags.
- We are ordering travel mugs—which we will sell at Conference 2016 in Montréal.
- I have also inquired about NENA warm-up jackets and hope to hear from Aloft as to what these will look like with the NENA logo. We hope to have some samples at the NENA conference in Montréal, as Aloft will be there with a booth.
- Our membership numbers for November 6–December 31, 2015:
  51 new members
  42 renewing members
- Total NENA membership as of January 27, 2016, is **2,460**. This is up from last year and we want to continue to grow across country. Any ideas you may have for doing this will be gladly received and considered. Our provinces must grow to increase the national number. We all need to do our best to promote NENA as the Leader in Emergency Nursing and be the voice of our specialty.

A job description has been developed for the position of Director of Membership and Promotion on the NENA Board of Directors. An election for this position will occur at the AGM in Montréal, April 2016. This position will then become permanent and have a term of two years.

Submitted by
Pat Mercer-Deadman, RN, ENC(C)
NENA Director of Membership and Promotion

Canadian Emergency Nursing Certification in Dubai, United Arab Emirates

By Margaret Dymond, RN, BSN, ENC(C), and Michelle Tipert, RN, ENC(C)

The Canadian Nurses Association (CNA) certification program is becoming recognized on the international stage. Early in 2015, CNA and the Dubai Health Authority (DHA) began discussions on bringing the Canadian emergency nursing certification and the nephrology certification programs to qualified nurses in the DHA. The National Emergency Nurses Association (NENA) Canada was approached by CNA to become involved in the emergency nursing certification process with the DHA and develop/disseminate an action plan for exam preparation for DHA emergency nurses.

Background

The CNA sponsors 20 RN nursing specialty certifications in Canada. The emergency nursing certification has existed since 1994. As of July 2015, 1,198 emergency nurses in Canada were certified and have earned the professional designation of Emergency Nurse Certified Canada – ENC(C). The DHA is adopting the Canadian emergency and nephrology nursing certification programs.

Canadian emergency nursing certification process

The CNA emergency nursing certification process involves preparation several months in advance. The RN candidate must apply and meet all the essential qualifications of the certification program. These include 3,900 hours in emergency nursing practice in the past five years, or a combination of education hours and experience—2,925 hours in practice in the past five years and a formal post-basic course in the specialty more than 300 hours in length. An endorsement from a supervisor in the specialty is required.

The CNA website has posted resources for emergency nursing certification exam preparation. The resources include a blueprint of the expected knowledge and content to study, the core competencies and the weight/percent of exam questions based on the competency, bibliography, recommended methods of preparation (forming study groups), and access to nurseONE. A practice exam is available for the applicant to review areas of strength and areas of potential review and study.

CNA, NENA, and DHA collaboration: Emergency nursing certification

CNA and DHA negotiated an agreement to bring the Canadian emergency nursing certification program to Dubai. The first step was to determine the eligibility and number of nurses in the DHA who would be qualified for the emergency nursing certification program. NENA was tasked to assign two certified emergency nurses in Canada to develop an emergency nursing exam preparation program to be hosted in Dubai, UAE.

The exam preparation program was designed based on the exam blueprint and the 20 core competencies for emergency nursing. The plan was to develop a two-day program and deliver this program twice. Core competencies with more weight over the number of exam questions were longer sessions. The goal of the prep sessions was to offer an

Table 1: Topics presented in Dubai

Time	Topic - System
20 mins	Patient Assessment Review
45 mins	Respiratory Emergencies
90 mins	Cardiovascular Emergencies
45 mins	Musculoskeletal/Integrumentary Emergencies
30 mins	Medical Emergencies: Haematology/Immunology
30 mins	Endocrine Emergencies
30 mins	ENT/Ocular Emergencies
20 mins	Mental Health Emergencies
15 mins	Environmental Emergencies
45 mins	Neurologic Emergencies
30 mins	Gastro-intestinal Emergencies
30 mins	Genital-urinary Emergencies
30 mins	Obstetric/GYNE Emergencies
45 mins	Paediatric Emergencies
30 mins	Toxicology Emergencies
20 mins	Triage
60 mins	Trauma

overview of the subject matter, what areas the RN candidate felt they had a strong knowledge base in, and in what area(s) they needed more review. The method of delivery selected for the prep sessions was using PowerPoint and interactive lecture-style presentations. See Table one for the exam preparation content.

Ready, set, GO!

The main challenge of the project was the short timeline to develop the exam preparation program. It was challenging and exciting all at the same time. The program was developed over a period of one month, and sent to the DHA for screening and acceptance of program content. The main learnings of the collaboration of CNA, DHA, and NENA were ensuring the content delivered would meet the needs of the emergency nurses in the DHA, understanding the impact of the content and the unique culture(s) in the Middle East. Learning the dynamics of the DHA, health and disease patterns in Dubai was key in core content development.

Dubai: Nursing conference, emergency nursing certification prep course, tour of Dubai hospitals
First emergency nursing conference – Dubai, UAE, December 10, 2015
The DHA conference committee invited the two certified emergency nurses from Canada to be keynote speakers at the first emergency nursing conference they hosted. More than 17 speakers delivered the sessions. The keynote presentations by the emergency nurses from Canada included *CTAS: 16 years and counting* and *Polytrauma*.

Canadian emergency nursing exam preparation sessions (December 11/12, and 13/14, 2015)
Two hundred and twelve emergency nurses attended the first session and 98 nurses attended the second session. The challenge for the DHA was ensuring the emergency nurses could attend while still staffing the emergency departments in DHA hospitals.

The main goal of the sessions was to provide content to prepare for writing the emergency nursing certification exam. Some nurses attended for an educational opportunity and were not intending on writing the certification exam. The attendees of both sessions were highly motivated to learn and engaged with the presenters.

Dubai emergency nursing prep class, December 12, 2015
Exam session review and tour of the Dubai hospitals
The last day of the project was to offer a session on tips and tricks when preparing and writing a multiple-choice exam. This session involved an informal approach and answering any questions the emergency nurses had in regard to further study and exam preparation. One Canadian nurse met with the emergency nurses and one Canadian nurse met with the nephrology group. In both sessions, the nurses received a practice exam and answer sheet, a blueprint of the core competencies, and tips for further studying efforts.

The tour of the DHA hospitals involved a visit to a DHA trauma facility and a new paediatric hospital. Our learnings included that DHA hospitals use CTAS as their triage scale, offer evidence-based practice methods of health delivery, and focus on a family-centred care approach. Families are present for all treatments/procedures if it is their desire to do so, including resuscitation procedures. It was a unique experience to visit a paediatric centre in the "just ready stage" for its grand opening and state-of-the-art equipment and care pathways. The nursing staff was receiving their orientation in preparation for opening day and their first paediatric patients and families.

Next steps for Canadian emergency nursing certification in Dubai

The emergency nurses in Dubai have indicated an interest in a webinar prior to the exam writing date to meet with the two Canadian nurses and review prep session content. The exam is scheduled for March 11, 2016. Two representatives from CNA certification program will travel to Dubai in March for the exam roll out and follow through.

Summary

It was an honour to be selected and represent the Canadian Emergency Certification Program, NENA, and the Canadian emergency nursing specialty in Dubai. The Canadian certification program is growing and receiving international interest.

Many thanks to all the DHA staff, Roxanne Nematollahi, PhD, RN, ACNP, Specialist Career Development—DHA, CNA certification program, Lucie Vachon and Patricia Elliott-Miller, Margarita Pardo (CNA) who made the PowerPoint presentations look so great, Gord Boal (CNA) for all the great advice, and NENA for supporting the project.

For Canadian nurses considering certifying or re-certifying in emergency nursing

Go to the **CNA.ca** website and search under professional development. The description of the Canadian certification specialty programs is located here with information on eligibility and the application process. Select emergency nursing for information on certification and study material.

Dates for the next exam: September 19–Oct 7, 2016. The exams will be electronic.

Online application process April 11–July 1, 2016.

About the authors

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New emergency nursing book by Canadian-trained nurse hits the shelves

By Jeff Solheim, MSN, RN, CEN, TCRN, CFRN, FAEN

Editor's note: *Jeff Solheim is a familiar name to those nurses who have faithfully attended NENA conferences. We are happy to announce to our readers that this friend of NENA has recently published a book.*

"The emergency department (ED) is truly a cross-section of society. Every person ultimately becomes ill or is injured and, especially after regular business hours, there is only one place for individuals to meet their acute health care needs—the emergency department. At any given time, an ED may have patients from every end of the social spectrum from a very influential person such as a politician or sports figure to a homeless, impoverished individual who is virtually alone in this world. In the ED, the very rich sit next to the very poor, the acutely ill may arrive simultaneously with the minimally ill and people who would never interact with one another outside of the ED may find themselves side by side. It is against this backdrop that the emergency nurse works every shift" (Walker-Cillo, Semonin-Holleran, & Solheim, 2016, p. 361).

These are the words that open chapter 14 of a brand new book dedicated solely to the profession of emergency nursing released January 13, 2016. The title of the book, published by Sigma Theta Tau International is *Emergency Nursing: The Profession, The Pathway, The Practice*.

I had the distinct privilege of serving as lead author on this project. When I was first approached by Sigma Theta Tau in 2014 to write a book about emergency nursing, I was somewhat reticent. How many books are already published in the emergency nursing realm? What more could I add to this body of knowledge? But, as I considered the project, I could not think of a single book I had ever read dedicated solely to the profession of emergency nursing. A book about who we are as a profession, where we came from, where we work and what makes us unique in the vast field of nursing. It was against this backdrop that I agreed to take on the project.

I certainly did not take on this project alone. I was joined by 17 other great minds in emergency nursing who authored chapters as varied as "Unique Roles of the Emergency Nurse" and "Risk Management and Quality Issues Affecting the Emergency Nurse". The book starts with a foreword written by one of the most recognized names in emergency nursing—Susan Sheehy—original author of *Sheehy's Manual of Emergency Care*. Other familiar names grace the pages of the book like Renee Semonin-Holleran, former editor-in-chief of the *Journal of Emergency Nursing*, and Rebecca McNair, Founder and President of Triage First. But several first-time authors also make their debut in the book.

The book is divided into three distinct sections. The first section is a about emergency nursing as a profession and career. There are chapters on the history of emergency nursing; traditional and unique roles that emergency nurses play both in and out of the hospital setting; an overview of the educational preparation of the emergency nurse with hints on educational paths to take to reach specific career goals, professional aspects and responsibilities of carrying the title of "emergency nurse" and a chapter dedicated solely to self-care of the emergency nurse. In this chapter, the author gives tips on exercise regimens and diets that are especially well suited for the physical demands that emergency nurses face regularly. There are also sections on maintaining emotional and spiritual well-being, preventing burnout and surviving shift-work.

The second section is all about the place many emergency nurses call home—the emergency department. There is an overview of types of emergency departments, locations within the emergency department and key players that frequently work along-side the emergency nurse. This section also contains a chapter dedicated solely to a role that is unique to emergency nursing—triage.

The third chapter of the book is about the practice of emergency nursing. There is an overview of common challenges that nurses face every day and numerous chapters about challenging patients that nurses work with regularly. Laurel Grisbach did a phenomenal job of writing about legal pitfalls emergency nurses face and how to avoid those pitfalls.

This book was written with numerous readers in mind. Nursing students and non-emergency nurses interested in emergency nursing will gain a plethora of information about the field, whether they are suited for this work and how best to navigate into a career in emergency nursing. For nurses who are new to emergency nursing, I cannot think of a more consolidated resource to learn about all things emergency nursing in just over 400 pages. And for emergency nurses who have been in this field for a while already, this book will help infuse a new enthusiasm for the career path you have chosen. (Are you looking to spice up your career a bit? Make sure to peruse chapter three entitled "Unique Roles of the Emergency Nurse" and learn about all kinds of opportunities like cruise-ship nursing, disaster relief nursing and camp nursing amongst others that emergency nurses are suited for and how to get involved in these different prospects.)

I hope you are as excited as I am about this new product that is written exclusively about us and for us, as emergency nurses. Let me bring this article to a close by reprinting a few of the words that I originally authored for the preface of this book:

A colleague of mine who works as a registered nurse on an inpatient surgical unit made an interesting observation one evening while we

were enjoying dinner together. She pointed out that when you ask many nurses what they do for a living, they will respond by saying that they are an "RN" or a "nurse". She went on to comment that she observed when you ask a nurse who works in the emergency department what they do for a living, they are much more likely to identify themselves as an "emergency nurse". She asked me why it is that emergency nurses seem to feel the need to identify the area of nursing they are employed in rather than simply their career choice as a nurse. This was not something I had given serious thought to before this conversation, but I began to pay more careful attention and found there to be some truth to this statement. While emergency nurses remain an integral part of the nursing field, there seems to be a certain sense of pride to working in the emergency department and emergency nurses frequently identify themselves as both a "nurse" and with their place of employment—the emergency department. (Solheim, 2016).

The book *Emergency Nursing: The Profession, The Pathway, The Practice* can be purchased as a hard copy or an electronic copy by accessing the following web address: https://www.nursingknowledge.org/emergency-nursing-the-profession-the-pathway-the-practice.html

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Research is not the enemy… a New Brunswick emergency department perspective

By Jacqueline Fraser

As emerg nurses, we all know that time is of the essence. We all have the experience of performing a head-to-toe assessment, starting an IV , administering meds, getting the equipment ready for the MD, mentoring new staff, **and** being the support person for the patient and family… Then those dreaded words are spoken…. "I suppose we could enroll this patient into the trial". However, in one New Brunswick Emergency Department (ED), these words are not so dreaded.

The Saint John Regional Hospital (SJRH) ED is an academic tertiary centre that sees approximately 56,000 people a year. Five years ago, the SJRH ED commenced its research program. One of the primary goals was to create a multidisciplinary culture that encompasses research.

It is scary to be a research coordinator. As an outsider, it can be difficult to work with rotations that are so closely knitted. To be on the receiving end of comments like "Oh great…what do they want us to do now?" I have been fortunate (and grateful) to have never had such negative experiences.

It has been a lot of work to garner support, but our department has grown to be open to the concept of research. To date, we have had nurses screen patients for studies, follow study protocols, assist in data collection, be a representative on research teams, and review manuscripts.

I think there are three main factors why research has been well received.

The ***first*** factor is (and most important) the recognition of impact on clinical staff time and workload, as the ED is hectic and spare minutes are precious. Any investigator-initiated research protocols are streamlined to be efficient and have minimal impact on clinical staff.

The ***second*** factor is choosing projects that impact the department. Projects that examined care and processes in our department have been well received. A great example was when we examined lab turnaround times. Clinical staff felt there was a slow turnaround from lab specimen collection to result and was directly impacting clinical care. We conducted a prospective study that reviewed lab times for two different specimen tubes; results confirmed turnaround times were taking longer than an hour. The lab then reviewed internal processes and implemented many changes post. Staff are also curious about results of a study they participated in, so knowledge translation is also imperative.

The ***third*** and ***core*** factor is support. Administrative and departmental support has been key in our program development… but clinical staff support can make or break a research program. Support from staff is imperative for patient enrolment, study procedures, research ideas, and advice.

Research is not the enemy. It has given us our current practice and allows us to examine ways to improve process and care. So, next time you see the research team, surprise them with a "*What's going on in research*" instead of the possible "*What now*?" Trust me… it will make their day!

About the author

Jacqueline Fraser, RNBN, ENCC, ER Research Coordinator, Horizon Health Network, Saint John Regional Hospital

Bouquets

- It is with sadness that we say "goodbye" to Jane Daigle as NENA treasurer. Jane stepped down for unanticipated personal reasons. Thank you, Jane, for all your work for NENA and its members.
- Bouquets and thank you to Sharron Lyons who has offered to step in to complete Jane Daigle's term as NENA treasurer.
- Bouquets to Marie Grandmont and Colleen Brayman for their work in updating the NENA position statements and documents following the last NENA Board meeting in November.

NENA 2016
MONTRÉAL

21 AU 24 AVRIL 2016 | **21 TO 24 APRIL 2016**

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INFORMATION

SITE WEB / *WEBSITE :* HTTP://NENA.CA/CONFERENCES/NENA-CONFERENCE-2016/
COURRIEL / *EMAIL :* CONFERENCE2016@NENA.CA
LIEU / *VENUE :* HÔTEL OMNI MONT-ROYAL, 1150, SHERBROOKE OUEST, MONTRÉAL, QUÉBEC, CANADA, H3A 2R6

Traduction simultanée disponible pour chaque séance. / *Simultaneous translation available for each session.*

Le détail du contenu de chaque séance sera disponible prochainement. / *The detailed content of each session will be available soon.*

PROGRAMME DU PRÉ-CONGRÈS / *PRE-CONFERENCE PROGRAM*

FORMATIONS OFFERTES EN FRANÇAIS ET EN ANGLAIS / *COURSES OFFERED IN FRENCH AND ENGLISH*
PAUSES SANTÉ ET DÉJEUNER INCLUS / *NUTRITION BREAKS AND LUNCH INCLUDED*

EMERGENCY PRACTICE, INTERVENTIONS AND CARE – CANADA (EPICC)

(places limitées / places limited)

WEDNESDAY APRIL 20, 2016 **08 H 30 À 16 H 30**
THURSDAY APRIL 21, 2016 **08 H 30 À 16 H 30**

For many years, the Emergency Nurses of Canada have been requesting a Canadian-developed course to cover the core concepts of being an emergency nurse. The EPICC course is being designed to benefit both new and experienced practitioners and is expected to be two days in length with an online preparation beforehand.

The purpose of the course is to provide a standardized approach to the emergency department patient with a variety of presentations. In addition to discussing presenting complaint pathophysiology and standardized treatment, a focus will be placed on rapid plans of care, follow-up assessments and formats to communicate clinical data to other nurses and health care professionals.

For more information : http://prnc.ca/EPICCInfo.pdf

DON D'ORGANE / *ORGAN DONATION*

JEUDI, 21 AVRIL 2016 **08 H 00 À 16 H 00**

L'annonce de mauvaises nouvelles à des familles en état de choc est presque une activité quotidienne pour les professionnels de la santé qui travaillent dans les services d'urgence au Canada. La façon de communiquer avec ces familles peut avoir un grand impact sur la qualité des soins et dans le cheminement du deuil de ces familles. C'est pourquoi le NENA et l'AIIUQ, en collaboration avec Transplant Québec, vous offrent une journée de formation complète pour développer vos habiletés à communiquer avec ces familles qui vivent des moments très difficiles.

Le but de la formation est de développer les compétences nécessaires afin d'intervenir adéquatement auprès d'une famille en situation de crise tel qu'un décès inattendu, une maladie subite avec pronostic sombre, un deuil traumatique, un décès neurologique ainsi qu'en situation de don d'organes et de tissus.

PROGRAMME DU CONGRÈS / *CONFERENCE PROGRAM*

JEUDI, 21 AVRIL 2016 / *THURSDAY APRIL 21, 2016*

16 H 00 – 20 H 00 INSCRIPTION / *REGISTRATION*

18 H 30 – 19 H 00 CÉRÉMONIE D'OUVERTURE / *OPENING CEREMONY*

19 H 00 – 20 H 00 SESSION PLÉNIÈRE / *PLENARY SESSION*

DONNÉES PROBANTES ET PRATIQUES EXEMPLAIRES : RÉFLEXION SUR LA MONTÉE DU VIDE EN SCIENCES INFIRMIÈRES.

Catégorie : Pratique clinique

Dave Holmes, RN, PhD
Full professor in the School of Nursing
University Research Chair in Forensic Nursing
University of Ottawa, Ontario, Canada

20 H 00 – 20 H 45 ASSEMBLÉE GÉNÉRALE ANNUELLE DU NENA / *NENA ANNUAL GENERAL MEETING*

20 H 45 – 22 H 00 RÉCEPTION DE BIENVENUE / *WELCOME RECEPTION*

VENDREDI, 22 AVRIL 2016 / *FRIDAY APRIL 22, 2016*

07 H 00 – 08 H 30 INSCRIPTION / *REGISTRATION*
PETIT-DÉJEUNER CONTINENTAL / *CONTINENTAL BREAKFAST*

08 H 30 - 09 H 30 SESSION PLÉNIÈRE / *PLENARY SESSION*

PUT ME IN COACH, I WANT A HAT TRICK! UNDERSTANDING THE DYNAMICS OF CONCUSSION

Category: Trauma

AnnMarie Papa, RN, DNP, CEN, NE-BC, FAEN, FAAN
Clinical Director, Emergency, Medical & Observation Nursing
Hospital of the University of Pennsylvania, USA

09 H 30 - 10 H 30 SESSION PLÉNIÈRE / *PLENARY SESSION*

YOU GAVE THAT A CTAS 4?

Category: Clinical practice

Landon James, RN, M.A.
Urban ED and rural critical care transport nurse
British Columbia, Canada

Monique McLaughlin, RN, M.Sc., NP
Nurse Practitioner
Vancouver General Hospital,
British Columbia, Canada

10 H 30 – 11 H 00 PAUSE SANTÉ / *NUTRITION BREAK*
SALON DES EXPOSANTS / *EXHIBIT HALL*
SESSION PAR AFFICHE / *POSTER SESSION*

11 H 00 – 11 H 30 SÉANCE SIMULTANÉE 1 / *CONCURRENT SESSION* 1

A. MIEUX COMPRENDRE L'UTILISATION DES CONTENTIONS DANS UN CONTEXTE D'URGENCE PSYCHIATRIQUE : L'EXPÉRIENCE DES PATIENTS ET DU PERSONNEL INFIRMIER

Catégorie : Recherche

Dave Holmes, RN, PhD
Full professor in the School of Nursing
University Research Chair in Forensic Nursing
University of Ottawa, Ontario, Canada

B. FAMILY PRESENCE AT BEDSIDE DURING RESUSCITATION IN THE EMERGENCY DEPARTMENT

Category: Quality of care & safety practice

Danièle Lamarche, RN, M.Sc.(A), CDE, CNMS(C)
Clinical Nurse Specialist
McGill University Health Centre,
Montréal, Quebec, Canada

Cynthia-Ann Ulley, RN, BSN
Emergency Nurse Clinician
McGill University Health Centre,
Montréal, Quebec, Canada

11 H 30 – 12 H 00 SÉANCE SIMULTANÉE 2 / *CONCURRENT SESSION 2*

A. AUTO-APPRENTISSAGE : FORMATION CONTINUE PROMETTEUSE

Catégorie : Qualité et sécurité des soins

Isabelle Simard, inf., M.Sc.
Conseillère cadre aux activités cliniques
Institut universitaire de cardiologie et de pneumologie de Québec, Canada

Elisabeth Robert, inf., B.Sc.Inf.
Chef de service du département des urgences
Institut universitaire de cardiologie et de pneumologie de Québec, Canada

B. DELIRIUM IN THE EMERGENCY DEPARTMENT: THE EMERGING EPIDEMIC

Category: Clinical practice

Mohamed El Hussein, RN, PhD
Associate Professor, School of Nursing and Midwifery
Mount Royal University, Calgary, Alberta, Canada

Joseph Osuji , RN, PhD
Associate Professor, School of Nursing and Midwifery
Mount Royal University, Calgary, Alberta, Canada

12 H 00 – 13 H 00 DÉJEUNER / *LUNCH*
SALON DES EXPOSANTS / *EXHIBIT HALL*

13 H 00 – 14 H 00 SÉANCE SIMULTANÉE 3 / *CONCURRENT SESSION 3*

A. LES CRITÈRES D'ORIENTATION PATIENTS À L'URGENCE. LES BONS SOINS, AU BON PATIENT ET AU BON ENDROIT.

Catégorie : Pratique clinique

Jennifer Boisclair, B.Sc.Inf., CSU(C)
Conseillère en soins infirmiers
CHU de Québec – Université Laval, Québec, Canada

Jolène Provost, inf., M.Sc.
Conseillère en soins specialisés
CHU de Québec – Université Laval, Québec, Canada

Christian Garneau, B.Sc.Inf., CSU(C)
Conseiller en soins infirmiers
CHU de Québec – Université Laval, Québec, Canada

Dr Pierre Hamel, MD
Urgentologue
CHU de Québec – Université Laval, Québec, Canada

B. CARE AND RESPECT FOR ELDERS IN EMERGENCY (CARE) PROGRAM

Category: Quality of care & safety practice

Donna Naugler, RN
Discharge Planning Nurse
Queen Elizabeth II Health Sciences
Charles V. Keating Emergency and Trauma Centre,
Halifax, Nova Scotia, Canada

Nikki Kelly, RN, M.Sc.
Nurse practitioner
Queen Elizabeth II Health Sciences
Charles V. Keating Emergency and Trauma Centre,
Halifax, Nova Scotia, Canada

14 H 00 – 14 H 30 SÉANCE SIMULTANÉE 4 / *CONCURRENT SESSION 4*

A. EMERGENCY NURSE'S ROLE IN THE IDENTIFICATION OF FRAGILITY FRACTURE IN A FRACTURE LIAISON SERVICE.

Category: Clinical practice

Josée Delisle, inf., M.Sc.
Infirmière clinicienne spécialisée
CIUSSS du Nord-de-l'Île-de-Montréal, Montréal, Québec, Canada

B. AUDIT DE TRIAGE : RÉSULTAT DE LA MOBILISATION D'UNE COMMUNAUTÉ DE PRATIQUE EN SOINS D'URGENCE.

Catégorie : Qualité et sécurité des soins

Mélanie Marceau, inf., M.Sc., MPES
Infirmière clinicienne
CIUSSS de l'Estrie-CHUS, Sherbrooke, Québec, Canada

Joannie St-Pierre, inf., M.Sc
Conseillère cadre en soins infirmiers
CISSS de Lanaudière, Québec, Canada

PROGRAMME DU CONGRÈS / *CONFERENCE PROGRAM*

14 H 30 – 15 H 00 PAUSE SANTÉ / *NUTRITION BREAK*
SALON DES EXPOSANTS / *EXHIBIT HALL*
SESSION PAR AFFICHE / *POSTER SESSION*

15 H 00 – 16 H 00 SÉANCE SIMULTANÉE 5 / *CONCURRENT SESSION 5*

A. L'INFIRMIÈRE LEADER EN TRAUMATOLOGIE, UNE EXPERTISE RECONNUE — *Catégorie : Traumatologie*

Annie Canuel, RN, B.Sc., M.Sc.(cand.)
Conseillère en soins infirmiers
CHU Sainte-Justine, Montréal, Québec, Canada

B. NO CAPES NEEDED — *Category: Leadership & management*

Allen Fasnacht, RN, MSN, NE-BC
Clinical Director, Emergency, Medical and Behavioral Health Nursing
Penn Medicine, Pennsylvania, USA

16 H 00 – 16 H 30 SÉANCE SIMULTANÉE 6 / *CONCURRENT SESSION 6*

A. STRATÉGIES VISANT L'UTILISATION DE L'ÉCHO-GUIDANCE POUR L'INSERTION DE CATHÉTERS INTRAVEINEUX — *Catégorie : Pratique clinique*

Marie-Audrey Roy, inf. M.Sc
Conseillère en soins spécialisés
CHU de Québec – Université Laval, Québec, Canada

Geneviève Roch, inf. Ph.D
Professeure agrégée à la Faculté des sciences infirmières
Université Laval, Québec, Québec, Canada

B. EVIDENCE-BASED TRANSITION TO PRACTICE SUPPORT FOR NEW GRADUATE NURSES IN THE EMERGENCY DEPARTMENT — *Category: Leadership & management*

Michelle Lalonde, RN, PhD
Assistant professor in the School of Nursing
University of Ottawa, Ontario, Canada

18 H 00 ACTIVITÉ SOCIALE / *SOCIAL EVENT*

Cocktail dînatoire, visite de l'exposition permanente à Pointe-à-Callière et spectacle multimédia *Signé Montréal* réalisé par Moment Factory / *Cocktail reception, tour of the Pointe-à-Callière permanent exhibition and multimedia show* Yours Truly, Montréal *created by Moment Factory*

SAMEDI, 23 AVRIL 2016 / *SATURDAY APRIL 23, 2016*

07 H 00 – 08 H 30 INSCRIPTION / *REGISTRATION*
PETIT-DÉJEUNER CONTINENTAL / *CONTINENTAL BREAKFAST*

08 H 30 – 09 H 30 SÉANCE SIMULTANÉE 7 / *CONCURRENT SESSION 7*

A. VÉCU DES INFIRMIÈRES DE LA PRÉSENCE DE LA FAMILLE DU PATIENT EN SALLE DE RÉANIMATION À L'URGENCE — *Catégorie : Pratique clinique*

Dominique Labbée, inf., M.Sc
Professeure en soins critiques
Université du Québec à Chicoutimi, Québec, Canada

B. A PRIMER FOR SOCIAL MEDIA FOR ED NURSES
#DIGITALFOOTPRINT#GOINGVIRAL#NETWORKING#CONFUSED — *Category: Clinical practice*

Landon James, RN, M.A.
Urban ED and rural critical care transport nurse
British Columbia, Canada

Monique McLaughlin, RN, M.Sc., NP
Nurse Practitioner
Vancouver General Hospital,
British Columbia, Canada

PROGRAMME DU CONGRÈS / *CONFERENCE PROGRAM*

09 H 30 – 10 H 00 SESSION PLÉNIÈRE / *PLENARY SESSION*

THE CANADIAN TRIAGE AND ACUITY SCALE (CTAS) 2016 COURSE CHANGES: A PREVIEW — *Category: Clinical practice*

Erin Musgrave, RN, MN, ENC(C)
Triage Co-ordinator in the Emergency Department
of The Moncton Hospital
Horizon Health Network, New Brunswick, Canada

Thora Skeldon, RN, BSN
Rural Nurse Clinical Educator
Alberta Health Services, Canada

10 H 00 – 10 H 30 PAUSE SANTÉ / *NUTRITION BREAK*
SALON DES EXPOSANTS / *EXHIBIT HALL*
SESSION PAR AFFICHE / *POSTER SESSION*

10 H 30 – 11 H 00 SÉANCE SIMULTANÉE 8 / *CONCURRENT SESSION 8*

A. EVIDENCE-BASED HUMOUR: A TEACHING STRATEGY TO UTILIZE COMPLEX CONCEPTS IN THE EMERGENCY DEPARTMENT — *Category: Clinical practice*

Mohamed El Hussein, RN, PhD
Associate Professor, School of Nursing and Midwifery
Mount Royal University, Calgary, Alberta, Canada

Joseph Osuji, RN, PhD
Associate Professor, School of Nursing and Midwifery
Mount Royal University, Calgary, Alberta, Canada

B. EXPLORING NURSES' PERCEPTIONS OF HELPFUL STRATEGIES FOR ADAPTING TO A LINEAR MODEL UNIT — *Category: Leadership & management*

Demetra Koutroumbas, B.Sc., M.Sc.(A)
Clinical nurse
Kingston General Hospital, Ontario, Canada

Amanda McTeague, BA, M.Sc.(A

Danièle Lamarche, RN, M.Sc.(A), CDE, CNMS(C)
Clinical Nurse Specialist
McGill University Health Centre,
Montréal, Quebec, Canada

Pierre Chassé, RN, M.Sc.N.
Nurse Educator
McGill University Health Centre,
Montréal, Quebec, Canada

11 H 00 – 12 H 00 SÉANCE SIMULTANÉE 9 / *CONCURRENT SESSION 9*

A. ÉVALUATION ET TRAITEMENT DE LA DOULEUR PÉDIATRIQUE, DE L'URGENCE À L'UNITÉ DE SOINS — *Catégorie : Pédiatrie*

Maryse Grégoire, inf., M.A.
Conseillère cadre clinicienne
CIUSSS de l'Estrie-CHUS, Sherbrooke, Québec, Canada

B. HEALTHY WORKPLACES: STAND UP FOR SAFETY! — *Category: Quality of care & safety practice*

AnnMarie Papa, RN, DNP, CEN, NE-BC, FAEN, FAAN
Clinical Director, Emergency, Medical & Observation Nursing
Hospital of the University of Pennsylvania, USA

12 H 00 – 13 H 30 DÉJEUNER / *LUNCH*
SALON DES EXPOSANTS / *TRADE SHOW*

13 H 30 – 14 H 30 SÉANCE SIMULTANÉE 10 / *CONCURRENT SESSION 10*

A. THE WACKY WORLD OF WEED – THE HEALTH IMPLICATIONS OF RECREATIONAL AND MEDICINAL MARIJUANA USE — *Category: Clinical practice*

Monique McLaughlin, RN, M.Sc., NP
Nurse Practitioner
Vancouver General Hospital, British Columbia, Canada

Landon James, RN, M.A.
Urban ED and rural critical care transport nurse
British Columbia, Canada

B. CRITICAL INCIDENT STRESS AND ITS IMPACT ON EMERGENCY NURSES – REALLY? *Category: Clinical practice*

Sharron Lyons, RN
Clinical nurse
BC Children's Hospital, Vancouver, British Columbia, Canada

14 H 30 – 15 H 00 SÉANCE SIMULTANÉE 11 / *CONCURRENT SESSION 11*

A. TRIAGE NURSES: POWERFUL OR POWERLESS DECISION MAKERS? *Category: Research*

Gudrun Reay, RN, PhD
Assistant Professor at the Faculty of Nursing
University of Calgary, Alberta, Canada

Jim Rankin, RN, NP, PhD
Professor and Nurse Practitioner at the Faculty of Nursing University of Calgary, Alberta, Canada

B. 3 CAS CLINIQUES OU 3 CASSE-TÊTE *Catégorie : Pratique clinique*

Philippe Boisvert, MD, CCMF(MU)
Médecin d'urgence, Hôpital Jean-Talon CIUSSS du Nord-de-l'Île-de-Montréal
Professeur d'Enseignement Clinique Faculté de médecine, Université de Sherbrooke

15 H 00 – 15 H 30 PAUSE SANTÉ / *NUTRITION BREAK*
SALON DES EXPOSANTS / *EXHIBIT HALL*
SESSION PAR AFFICHAGE / *POSTER SESSION*

15 H 30 – 16 H 30 SÉANCE SIMULTANÉE 12 / *CONCURRENT SESSION 12*

A. SEPSIS – TIME IS LIFE *Category: Clinical practice*

Sherry Stackhouse, RN, BSN
ER clinical nurse
Lions Gate Hospital, North Vancouver,
British Columbia, Canada

B. L'INTÉGRATION DE L'IPSPL À L'URGENCE UNE VALEUR AJOUTÉE. EUTOPIE OU RÉALISTE ? *Catégorie : Pratique clinique*

Valérie Huot, inf., M.Sc., IPS-PL
Infirmière praticienne
CISSS des Laurentides, Québec, Canada

Renée Charpentier, inf., M.Sc.,
Conseillère cadre en soins infirmiers
CISSS des Laurentides, Québec, Canada

DIMANCHE, 24 AVRIL 2016 / *SUNDAY APRIL 24, 2016*

07 H 30 – 08 H 30 PETIT-DÉJEUNER CONTINENTAL / *CONTINENTAL BREAKFAST*

08 H 30 – 10 H 00 SESSION PLÉNIÈRE / *PLENARY SESSION*

LES DONS D'ORGANES : L'ÉTAT DE LA SITUATION *Catégorie : Pratique avancée*

Dr Pierre Marsolais, MD, FRCP
Interniste et intensiviste
CIUSSS du Nord-de-l'Île-de-Montréal, Montréal, Québec, Canada
Professeur agrégé de clinique à la Faculté de médecine de l'Université de Montréal, Québec, Canada

10 H 00 – 10 H 30 PAUSE SANTÉ / *NUTRITION BREAK*

10 H 30 – 11 H 30 SESSION PLÉNIÈRE / *PLENARY SESSION*

WHERE TNCC ENDS – WHAT'S NEW IN TRAUMA? *Category: Advanced practice*

Monique McLaughlin, RN, M.Sc., NP
Nurse Practitioner
Vancouver General Hospital, British Columbia, Canada

Landon James, RN, M.A.
Urban ED and rural critical care transport nurse
British Columbia, Canada

11 H 30 – 12 H 00 CÉRÉMONIE DE FERMETURE / *CLOSING CEREMONIES*
ANNONCE DE LA CONFÉRENCE DU NENA 2017 / *ANNOUNCEMENT OF NENA CONFERENCE 2017*

INSCRIPTION / *REGISTRATION*

EN LIGNE : nena2016-fr.eventbrite.ca / ***ONLINE:*** *nena2016.eventbrite.ca*
PAIEMENTS ACCEPTÉS / *ACCEPTED PAYMENTS* : VISA, MASTERCARD, AMEX

Votre inscription et votre paiement doivent être reçus avant le 17 avril 2016 pour vous assurer d'avoir le support matériel nécessaire au congrès. / *Your registration and payment must be received by April 17th, 2016 to ensure that the course materials are ready for you at the conference.*

FRAIS D'INSCRIPTION / *REGISTRATION FEES*

CONGRÈS / *CONFERENCE**	AVANT / *BEFORE* 20 MARS 2016 / *MARCH 20, 2016*	ENTRE LE / *BETWEEN* 21 MARS ET 17 AVRIL 2016 / *MARCH 21 AND APRIL 17, 2016*
MEMBRES DU NENA / *NENA MEMBERS*	**475$**	**575$**
NON-MEMBRES / *NON-MEMBERS*	**575$**	**675$**
ÉTUDIANTS / *STUDENTS***	**300$**	**350$**
TARIF POUR 1 JOURNÉE / *ONE DAY RATE*	**300$**	**350$**
PRÉ-CONGRÈS / *PRE-CONFERENCE*		
EPICC	**375$**	**400$**
DON D'ORGANE / *ORGAN DONATION*	**125$**	**150$**
ACTIVITÉ SPÉCIALE / *SPECIAL ACTIVITY*		
POINTE-À-CALLIÈRE, *SIGNÉ MONTRÉAL*	**100$**	**110$**

En cas d'annulation, nous devons recevoir une confirmation écrite. Des frais de traitement de 75$ seront déduits de votre remboursement. Aucun remboursement après le 1er avril 2016 - substituts acceptés. / *We must receive written notification of your cancellation. A $75 processing fee will be deducted from registration refund. No refunds after April 1st, 2016 - substitutes accepted.*

*Les frais d'inscription pour le congrès incluent le matériel nécessaire au congrès, les appareils de traduction simultanée, les petits-déjeuners, les pauses santé, les déjeuners et une activité sociale le jeudi en soirée. / *Conference fee includes conference materials, simultaneous translation devices, breakfasts, nutrition breaks, lunches and a social activity on Thursday evening.*

** Le tarif étudiant nécessite une preuve d'inscription à temps plein. Merci de bien vouloir soumettre une copie de votre carte étudiante par courriel au conference2016@nena.ca au moment de votre inscription. / *Student rates require proof of full-time enrolment. Please submit a copy of your student ID with your registration by email to conference2016@nena.ca*

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HÔTEL OMNI MONT-ROYAL
1150, SHERBROOKE OUEST, MONTRÉAL, QUÉBEC, CANADA, H3A 2R6 - TÉL. : 514-284-1110

En tant que participants au congrès du NENA, vous avez droit à un tarif préférentiel pour votre chambre d'hôtel. Réservez vos nuitées avant le 21 mars 2016 pour bénéficier du tarif spécial en visitant le lien suivant.

http://www.omnihotels.com/fr-ca/hotels/montreal-mont-royal/meetings/national-emergency-nurses-association

Note that for all room reservations, as participants you are entitled to a discount. Book your nights before March 21, 2016 by visiting the following link to receive your special rate!

http://www.omnihotels.com/hotels/montreal-mont-royal/meetings/national-emergency-nurses-association

Provincial reports

Alberta

Alberta emergencies are staggering under the impact of flu season and our emergency nurses are working relentlessly. All over Alberta the emergency departments are groaning under the weight of increased EIPs and prolonged wait times for admitted patients to be moved out of the ER and into appropriate inpatient wards.

NENA-AB reports a membership of 308 nurses. Thanks to our regional representatives we, the NENA-AB executive, are gaining a clearer picture of the needs, educational opportunities and changes occurring all over Alberta in our emergency departments.

Our Southern Rural area is continuing with a bi-annual Rural Education Program for new staff, they are officially trialing a new Emergency Assessment and Treatment Record, and they are rolling out Sepsis Standing Orders. Because rural communities do not have the privilege of a SARTE team they have been working on updating a clinical pathway for sexual assault. Some of their greatest challenges centre around managing mental illness in rural centres.

Many of our ERs are working through accreditation standards like how to implement "Falls Risk" assessments and "Medication Reconciliation." This process brings rural and urban ERs together, as they collaborate on forms and policies.

TNCC, ENPC, PALS and ACLS courses are rolling out all over Alberta.

Our quarterly newsletter is being crafted in anticipation of it hitting email boxes in early March. Our new Communications Officer, Navkiran Tiwana, will soon be stepping into her new position to take over the newsletter responsibilities.

The NENA-AB executive is working, with the input of interested members, on the details of our new budget item that is designed to offer financial assistance to NENA members responding to national and/or international disaster sites. The finishing touches are being added to our information brochures and to our renewal thank you postcards sporting our new NENA-AB logo pins.

We are also, at present, working through the details of our annual conference and AGM. October 21, 2016, will be the date for our annual "Meet in the Middle" conference in Red Deer. Last year's was well attended and we are anticipating another great conference in the fall. At our 2015 conference two of our members won the draw paying for their attendance to the Montréal 2016 NENA Conference: Unleash the Power of ED Nurses, and I hope to see many other NENA-AB members in Montréal, April 21–24.

"Let us touch the dying, the poor, the lonely and unwanted according to the graces we have received and let us not be ashamed or slow to do the humble work."
Mother Teresa

Jean Harsch,
President NENA-AB

Manitoba

Spring is predicted to come early on the Prairies, although it seems hard to comprehend given that I am writing this on a cold February day. As Manitobans prepare for the changing of the season, emergency nurses continue their dedicated work in emergency departments (EDs) across the province.

The Manitoba government has imposed a new Provincial Healthcare Violence Prevention policy. This program was due to be implemented by January 2016. A provincial violence prevention working group has received feedback from stakeholders within the five regional health authorities to develop implementation strategies and education. This will include screening and identification of individuals who present to emergency departments across the province. Implementation has been held back due to the recognition that some of the screening tools we use for identifying patients may, in fact, serve to escalate violence. We expect that the true data of the incidents of violence or potential for violence in the EDs across the province will become apparent quickly.

Emergency department flow within Manitoba has made national news, as data that was recently released from the Canadian Institute for Health Information (CIHI) indicated several hospitals within the Winnipeg Regional Health Authority had the worst wait times in the country. A Flow Improvement Initiative led by the VP and CNO of the WRHA has been established to refocus WRHA's activities to achieve measurable improvement in patient flow and access over the next months.

Rural facilities across the province continue with struggles to staff emergency departments with physician coverage. During these times, rural 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 and 'keep the doors open'. They initiate care through Nurse Initiated Standing Orders to patients who present in order to manage their care until there is physician coverage. Rural emergency nurses continue to be the backbone of the rural health care system within the province of Manitoba.

Sandi Mowat, President of the Manitoba Nurses Union, spoke to the Emergency Department Nurses Association of Manitoba on Thursday, November 19, 2015, regarding Post Traumatic Stress Disorder. A group of 15 nurses braved the traffic during the first snowfall of the year to join us for Sandi's presentation. The MNU has recently published a study on PTSD in nursing. The exposure nurses have to trauma and critical incidents can have lasting effects on their mental health and the study showed that one in four nurses consistently experience PTSD symptoms. Given the nature of our work, emergency nurses are at particular risk for developing PTSD. On June 18, 2015, the MNU President presented recommended amendments to Bill 35—The Workers Compensation Amendment Act: Post Traumatic Stress Disorder Presumption, to the Standing Committee on Legislative Affairs.

Winnipeg is hosting the Western Emergency Department Operations

Conference on April 28–29. The objectives of the conference are to discuss the fundamental issues to be addressed at the system level to improve emergency department clinical workflow. It is an opportunity to identify the successes and lessons learned by all individuals working to improve emergency care. We are looking forward to our emergency colleagues across Canada attending this conference.

TNCC, ENPC and CTAS courses continue to be offered in all areas of the province, including many northern communities. A CTAS instructor course was recently offered in Winnipeg and a TNCC instructor course was offered this past October.

The provincial election is scheduled for April of 2016. Given that health care is a politically driven environment, we anticipate changes in the way we do business if a new political party is elected. We await the results.

Stay tuned for an EDNA newsletter to be emailed to all Manitoba NENA members. In the meantime, stay warm Manitoba ED nurses. Spring is on the way.

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

New Brunswick

February is here… we have more daylight hours! Winter, so far, has treated us well compared to last year.

Education

TNCC is offered in both languages 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 speciality, challenging and encouraging ER nurses to write their certification exams. CNA is changing the process for certification in 2016. Examinations will be computer based. Applications will be received online and examinations will be written in the fall between September 19 and October 7, 2016. This should provide more opportunity for nurses to complete their certification.

Education through simulation continues in southern NB! We continue to provide education to RNs, LPNs and MDs in our rural hospitals through case-based simulation. It is great to see positive outcomes from the collaboration between MDs, RTs and nursing! Bi-weekly in-situ simulation at the Saint John Regional Hospital, the level one trauma centre in New Brunswick, continues followed by structured debriefing. 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.

In the fall issue of CJEN, we mentioned that a mock nuclear disaster that was taking place in November in Southern New Brunswick. Follow-up evaluations of the mock nuclear disaster emphasized the importance of practice and review of the plan, as well as the need for improved communication processes. Nuclear response training should be part of orientation to the emergency department and reviewed annually.

Work environment

Emergency nurses continue to struggle with over capacity in the emergency departments around the province. Acutely ill patients wait in the ED for placement within the hospital. Inpatient beds are filled with alternate level of care patients waiting for placement in care facilities… the problem continues. The administration of the health authorities continues to work to improve the situation… the government changes, progress to solve this problem is slow.

As seasoned emergency nurses, we cope with the challenges. It is very difficult to retrain our novice nurses to work in this environment. Providing quality care for these acute admissions, as well as the patients presenting to our emergency departments is very challenging and stressful.

Membership

In the last year, our membership has increased to 61 members. We continue to promote membership at all educational courses! NENA NB is sponsoring two ER nurses to attend the 2016 NENA conference in Montréal. We hope to see a large number of NB nurses attend!

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

Looking forward to the 2016 NENA conference!

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

Nova Scotia

Greetings to emergency nurses across our country and beyond from Nova Scotia. NSENA has had a quiet winter, but has continued to grow and maintain our membership. We are looking forward to the conference in Montréal. Plans to organize a provincial education day for NSENA remain in the works. The province is undergoing changes in its delivery of health care as the Department of Health and Wellness announced at the end of January that it will be restructuring and moving some of its programs to the Nova Scotia Health Authority and IWK.

Development of standard care directives for emergency departments around the province continues, as well, at the provincial level. These care directives include cardiac care, stroke care, pain, fever

management and tetanus administration to name a few. Ongoing education continues with TNCC, ENPC, CTAS and ACLS courses as emergency department nurses must have and maintain this education in order to work in the ED, as per the provincial education standards. Of course, we also look forward to the QEII Emergency Department Nurses Education Day that takes place in the fall, along with IWK Pediatric Education Day. Both sessions provide great learning and are always lots of fun.

Last, I would like to mention that our past president of NSENA, Michelle Tipert, was fortunate to have the opportunity to go to Dubai, UAE, on behalf of CNA and NENA along with Margaret Dymond, NENA's Director of Education and Training, to deliver a prep course for CNA's Emergency Nursing Certification exam. Michelle tells me it was a wonderful experience to be a part of this international project.

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

Ontario

Hello from the Emergency Nurses Association of Ontario (ENAO) to all NENA members and all of Canada's emergency nurses!

ENAO is currently concentrating much of our time and efforts towards the creation of the 2016 biennial ENAO provincial emergency nursing conference. This educational program will include an amazing variety of very talented speakers, each providing pertinent learning updates with inspiring information and sharing.

The ENAO 2016 Conference will take place at the Travelodge Hotel in beautiful Belleville, Ontario, on September 27–28, preceded by a planned early registration and cash bar "welcome" on the evening of September 26. A variety of sponsors and exhibitors will be supporting this educational initiative by demonstrating their newest technologies, and providing pertinent information about the latest in research and best practices. As with every ENAO event, we will be sponsoring a draw for a one-year complimentary ENAO/NENA membership.

Wherever you may live in Canada, September is a wonderful time of year to travel with colleagues, friends and family. Why not plan to travel to Belleville, Ontario, this September to participate in some excellent ongoing education, while enjoying the scenic views and many activities on the shore of the Bay of Quinte?

ENAO continues to participate on the e-CTAS Steering Committee that is working to facilitate the development of an e-CTAS program, for use throughout all Ontario emergency departments. ENAO is proud to have our president serving as an invited member of this committee. Much planning and travel throughout Ontario has also been taking place under the expert leadership of ENAO/NENA member Joy McCarron. Joy and her Clinical e-CTAS Working Group have been instrumental in moving this important project closer to becoming a provincial reality. Thank you, Joy.

The results of an earlier survey that was circulated to all ENAO members have been compiled and recently incorporated into a wonderful CBRNE resource. This important research was conducted by a group of dedicated professionals from Toronto's Sick Kids Hospital and the completed work has now been published. The document provides guidelines and shares much valuable information regarding The Care of the Paediatric Palliative Patient in a Disaster. This work is available on the ENAO website (**www.enao.me**) and on the website of The Centre for Excellence in Emergency Preparedness – CEEP (**www.ceep.ca**).

ENAO extends congratulations to longtime ENAO/NENA member and NENA Honourary Lifetime Member Karen Johnson in her new role as the NCAC representative for Ontario. We are fortunate to be able to benefit from Karen's dedication and commitment to the promotion and provision throughout Ontario, of the valuable NENA–endorsed courses. Thank you, Karen.

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

Prince Edward Island

Hello to all from PEI. We hope everyone is having a fantastic winter. Our membership continues to fluctuate between 20 and 29 members. Our chapter tries to promote/advertise PEIENA any time we can. We do this through our courses, team huddles, workshops, flyers and word of mouth. We also offer incentives such as cheaper courses for members, prizes to the members during emergency nurses week, and special bursaries for members only.

As with most emergency departments, staffing is an ongoing issue. The constant struggle with properly educating new staff and placing the appropriate staff in an appropriate area of the department has been very demanding for the manager, clinical leader and the clinical educator. On January 21, 2016, it was announced that the major hospital in PEI (Queen Elizabeth Hospital) has adopted and will incorporate an all-RN Model of Care in its emergency department. This is a result of Health PEI and the Collaborative Model of Care Team. This means in April the emergency department will no longer staff LPNs. Several RN jobs will soon be posted and hopefully filled to meet the demands of this new model. There are mixed emotions over this announcement. The changes will take place in April and ongoing evaluation will be taking place.

PEIENA continues to sponsor workshops such as The Emergency Respiratory and Forensic Workshops. We also support ACLS, PALS, Basic Coronary Care and the Critical Care Course. We continue to teach TNCC twice yearly (spring and fall) and CTAS monthly. We have two new ENPC educators who will complete their training in May and we hope to offer our first ENPC course in fall 2016. PEIENA also continues to support those interested in becoming CNA certified.

We held our annual meeting in February. The role of provincial director, treasurer, and secretary were up for election. The recruitment process found some very suitable candidates. We look forward to these changes and hope to assist the new council, as they take on these new roles.

The work environment in the emergency department has been difficult and will

prove to be an adjustment, as the new model is incorporated. This transition, along with the high acuity of patients and increased number of admissions, will be a challenge. There has been great support from administration/managers throughout the process.

Another struggle for our emergency departments is the increase in mental health patients. Measures that have been put in place to assist with the increase include mandatory training for all staff to be more familiar in dealing with all types of mental health problems. It is included in the orientation to all new staff and offered to the remaining staff as a short course. Security in the hospitals has been increasing its knowledge in this area, as well, and, thus, we will better be able to provide the safest, most effective care for the patient, caregivers/family and staff.

PEI has also recently appointed a new Health Minister (Hon. Robert L. Henderson). PEIENA will continue to be vocal and be recognized as an essential part of the health planning for the emergency departments on PEI.

The PEIENA has also started to plan for the 2017 NENA National Emergency Conference and looks forward to the challenge of being a host to the rest of Canada for such a terrific conference.

Have a great winter and see you at the Montréal Conference in April 2016.

Respectively submitted,
Sharon Hay, RNBN, ENC(C),
PEIENA Director

Canadian Forensic Nurses Association name change

Dear colleagues at the NENA,

At the start of this new year, we would like to formally announce to all of our fellow Canadian nurses, forensic nurses and colleagues at the National Emergency Nurses Association that the Forensic Nurses' Society of Canada has officially changed our name to the Canadian Forensic Nurses Association. We feel this name better reflects our unique Canadian perspective and our goals as an organization.

CFNA
CANADIAN FORENSIC NURSES ASSOCIATION

Please pass this great news on to your colleagues and other stakeholders in the many areas of forensic nursing and encourage forensic nurses to join us in strengthening our organization and collective voice.

We look forward to continuing to work in collaboration with the NENA to advance the profession of forensic nursing and address forensic healthcare issues.

Over the next few months we will endeavour to complete all the necessary formal changes on our website and written materials. We thank you for your patience in that regard.

Sincerely,

Judy Waldman, RN, MN, NP-PHC, SANE-P, SANE-A
President
Canadian Forensic Nurses Association

CTAS report

By Erin Musgrave, MN, RN, ENC(C)

CTAS 2016 revision work continues. It is anticipated that the revised hybrid on-line/in-person course will be ready for release in late 2016. If you have any CTAS case studies you are willing to contribute (formatted similar to cases within the current course) it would be greatly appreciated. Please send them to **ctas@nena.ca**

A reminder that the CTAS instructor renewal fee is due by July 1. To remain an instructor you must have paid the renewal fee, have a current NENA membership, have taught at least one course in the prior year (two courses for instructor trainers), and have continued employment in an emergency nursing-related environment. Complete details are available in the current CTAS Administrative Manual available online in the CTAS Instructor area of the CTAS (CAEP) website.

Questions about CTAS course content or the process to become an instructor? Please contact **ctas@nena.ca**. Questions about payment of course fees, course approvals? Please contact **ctas@caep.ca**

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

Seizures in older adults: Assessment and support in the ED

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

The incidence of new onset seizures increases after the age of 60. According to Ontario data, nearly 25% of new cases of epilepsy occur in this age group (Epilepsy Ontario, 2012). The prevalence of seizures increases from 5.3 per 1,000 population aged 46–64 to 6.9 after the age of 65 (Theodore, 2006). This increase, in conjunction with the growing population of aging "boomers", means we can expect to treat more seniors with this diagnosis. Some aspects of seizures in this population are unchanged from what is experienced by younger adults, but there are some specific concerns to be appreciated with older adults.

Seizures occurring at any age can be classified as partial, also termed focal, or generalized, and further delineated as simple or complex. Complex seizures are accompanied by a change in level of consciousness (LOC) ranging from unawareness of the episode to a prolonged post-ictal period of drowsiness or altered LOC. During simple seizures, the person remains aware during the event. Another consideration in understanding seizures is that they may be provoked or epileptic. Provoked or reactive seizures occur in response to an abnormality, for example metabolic abnormalities such as hypoglycemia or hyponatremia, uremia or hepatic encephalopathy, alcohol or benzodiazepine withdrawal, central nervous system (CNS) infection such as encephalitis, or with the use of some medications. Provoked seizures may be caused by a structural abnormality such as a tumour or subdural bleed. The term "epilepsy" generally refers to two or more unprovoked seizures occurring more than 24 hours apart. In seniors, the majority of new onset epileptic seizures are due to a previous stroke. New onset seizures are also associated with degenerative neurological conditions such as Alzheimer's disease, but in approximately half of the cases, a cause is not found.

As with many conditions, older adults often present atypically. Partial seizures are most common in older adults and are less likely to progress to generalized motor activity, as the neural connections of older adults are not as readily stimulated as those in younger subjects. In younger adults, an aura may be identified. This is less likely in older adults, although some note dizziness or poorly defined muscle cramps prior to these episodes. Seizures may present as episodic confusion, drowsiness or clumsiness rather than overt motor symptoms. Unusual sensations of movement, especially to the face, may be reported by patients; one described the sensation "of my nose being tweaked." The post-ictal phase is often prolonged, lasting from several hours up to two weeks (Abdulla, & Austin, 2013). Todd's Paralysis, characterized by unilateral weakness, is also more frequent with older adults, usually following partial or generalized seizures. These symptoms mimic a stroke, but resolve within 48 hours.

Convulsive and nonconvulsive status epilepticus may occur. Convulsive status epilepticus is treated as for younger adults, with a benzodiazepine such as Lorazepam to stop the seizure, and anti-epileptic medication to provide ongoing stabilization. In older adults, comorbidities often affect the outcome. For example, cardiac function may be adversely affected by prolonged seizure activity and hypotension may result from medications given. Non-convulsive status epilepticus (NCSE) can occur in elderly patients who may present with confusion, psychosis, lethargy or even coma. This may also present as a more focal disturbance such as aphasia or neglect. The majority of cases of NCSE occur with acute medical conditions such as organ failure, drug toxicity, and alcohol or benzodiazepine withdrawal. Acute or remote stroke or dementia may also contribute (Boggs, 2016).

Clearly, seizures can be difficult to identify in the older adult population. Is the mental clouding due to delirium? Are the myoclonic movements described by companions associated with a vasovagal episode? Is the aphasia due to a TIA? Are tremors due to fever? Or could seizures account for the changes? Understandably, the diagnosis of a seizure disorder in this population is often delayed, up to two years (Abdulla, & Austin, 2013). One source cites 15% of conditions initially diagnosed as strokes being found, on further investigation, to be seizures (Huff, 2002).

Of course, the identified acute illness requires treatment, but unusual or ongoing symptoms may require further investigation. In the ED, appropriate blood work includes electrolytes, glucose, magnesium, renal and liver function tests. An ECG is needed, with monitoring of those with ongoing concerns about cardiac status. A CT head scan will help to identify acute structural changes or previous strokes. If seizure activity persists, an electro-encephalogram (EEG) may help to elucidate the cause, but in older adults, the results tend to be non-specific and an EEG done when seizure activity is not present will often not be diagnostic. Magnetic Resonance Imaging (MRI) may provide more information, but is seldom available during the ED presentation. History is vital, but not always available. Was this a witnessed episode? Have similar symptoms been observed before? Are there signs commonly associated with generalized seizures such as incontinence or bites to the lateral aspect of the tongue or inner cheek?

Treatment will depend on the cause and severity of the seizures, the effect on the patient's quality of life, and the side effects of the required medications. Medication is generally prescribed for epileptic seizures, as this is effective for approximately 70% of these patients. Anti-epileptic medication may be prescribed for provoked seizures until the causative abnormality is resolved, for example infectious encephalitis.

As with many conditions in older adults, the ED visit may not provide the definitive diagnosis. Some conditions such as an intracranial bleed may be ruled out; other investigations are needed to rule out or identify others, such as Holter monitoring to detect cardiac dysrhythmias. If the patient has had a single identified seizure of unknown cause, medication will not likely be prescribed. If further seizures occur and are affecting the patient's quality of life, medication is indicated and is generally effective in preventing further seizures.

The choice of medications for treating epilepsy in older adults must include appreciation of the anticipated side effects. Lower doses than those prescribed for younger adults may be effective in controlling seizures, and doses should be titrated to effect rather than serum levels. First generation anti-epileptics such as Phenytoin and Carbamazepine are often sedating. For seniors with some cognitive impairment or gait instability, these medications may make day-to-day life much more difficult. They may increase hepatic clearance of other medications being taken, thereby decreasing their effect. Second-generation medications such as Gabapentin and Lamotrigine are better tolerated and have fewer drug interactions, but are more costly. For patients with Alzheimer's disease, Levetiracetam may be better tolerated, but long-term results are not yet known. Long-term use of anti-epileptic medications is a risk factor for osteoporosis; adequate calcium and Vitamin D are recommended.

ED nurses can contribute to obtaining an accurate history and by maintaining an index of suspicion for seizure activity. Does the medication reconciliation include benzodiazepines? Are there concerns with compliance resulting in withdrawal? Are there new prescriptions such as Tramadol, Ampicillin, or tricyclics that may lower the seizure threshold?

We need to help these patients and those caring for them with safety issues. If this person is not allowed to drive, what alternatives are available? A referral to an occupational therapist may be indicated, or information about available modes of transportation. Personal alarms may be helpful, as some are programmed to activate if the wearer falls, or does not indicate at intervals that he is, in fact, well. These patients are at increased risk of drowning in even a shallow amount of water and need to have adequate supervision for their safety when bathing or swimming. They need to avoid falls from heights such as ladders, particularly as more severe injuries are likely with increasing age, and patients should be counselled about injury prevention measures such as hip protectors. Helmets are available to decrease the likelihood of head injury. Some manufacturers of hip protectors also offer head protectors with accessories such as a sun hat or toque to cover the appliance.

For most older adults, a new diagnosis of a seizure disorder means they and their loved ones need to adapt to one more chronic illness. Our attention to their physical and emotional care in the ED and their education and support as they engage in their ongoing care can make a real difference in how well they manage. These patients will need to work closely with their primary caregivers; adjustments to medications may be needed, but they can be reassured that good results can generally be expected and, if side effects are intolerable, a different regimen may be better. Unfortunately, for many people, further cerebrovascular insults will occur and neurodegenerative diseases such as Alzheimer's disease will worsen, but symptom management and safety measures can help to maintain the best possible quality of life.

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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Les crises épileptiques chez les personnes âgées : évaluation et soutien par le service d'urgence

Article rédigé par Cathy Sendecki, B.Sc.inf., inf. aut., SCIG(C)

L'incidence des crises épileptiques augmente chez les personnes après l'âge de 60 ans. Selon des données obtenues en Ontario, presque 25 % des nouveaux cas d'épilepsie se produisent dans ce groupe d'âge (Epilepsy Ontario, 2012). La prévalence des crises augmente de 5,3 par 1 000 sujets âgés de 46 à 64 ans après 65 ans (Theodore, 2006). Cette augmentation, combinée avec la population croissante et vieillissante des *bébés boomers*, signifie qu'on doit s'attendre à traiter davantage de patients âgés ayant reçu ce diagnostic. Certains aspects des crises épileptiques parmi cette population demeurent les mêmes que ceux constatés chez les jeunes adultes, mais quelques enjeux spécifiques méritent notre attention en ce qui concerne les sujets âgés.

On peut classifier les crises d'épilepsie survenant à tout âge comme partielles – on les appelle également « focales » ou « généralisées » –, et on les définit plus précisément comme « simples » ou « complexes ». Les crises complexes s'accompagnent d'un changement du niveau de connaissance allant de l'ignorance de l'épisode à une période postictale prolongée de somnolence ou à une altération du niveau de connaissance. Pendant une crise d'épilepsie simple, la personne reste consciente. Un autre élément à prendre en considération pour comprendre ces crises est qu'elles peuvent être provoquées ou épileptiques. Les crises provoquées ou réactionnelles font suite à des anomalies, par exemple à des anomalies métaboliques comme une hypoglycémie ou une hyponatrémie, une urémie ou une encéphalopathie hépatique, un sevrage d'alcool ou de benzodiazépines, une infection du système nerveux central (SNC) comme une encéphalite ou l'utilisation de certains médicaments. Les crises d'épilepsie provoquées peuvent être causées par une anomalie structurale comme une tumeur ou un saignement sous-dural. Le terme « épilepsie » fait généralement référence à deux ou plusieurs crises provoquées survenant à plus de 24 heures d'intervalle. Chez les personnes âgées, la majorité des nouvelles crises sont dues à un ancien accident vasculaire cérébral. L'apparition récente de crises épileptiques est également associée à une affection neurologique dégénérative comme la maladie d'Alzheimer, mais dans environ la moitié des cas, la cause demeure inconnue.

Comme pour de nombreuses maladies, les personnes âgées atteintes sont souvent atypiques. Les crises partielles sont plus fréquentes chez les sujets âgés et risquent moins de progresser vers une activité motrice généralisée, car les connexions neurales des personnes âgées ne sont pas aussi facilement stimulées que celles des sujets plus jeunes. Chez les jeunes adultes, on peut déceler une aura. La chose est moins probable chez les sujets âgés, même si certains notent des étourdissements ou des crampes musculaires mal définies avant un épisode. Les crises peuvent se présenter sous forme de confusion épisodique, de somnolence ou de maladresse plutôt que sous forme de symptômes moteurs évidents. Un sentiment de mouvement inhabituel, particulièrement au visage, a été rapporté par des patients; certains l'ont décrit comme « si on leur pinçait le nez ». Le stade postictal est souvent prolongé, allant de plusieurs heures à deux semaines (Abdulla et Austin, 2013). La paralysie de Todd, caractérisée par une faiblesse unilatérale, est également plus fréquente chez les sujets âgés, survenant habituellement après des crises épileptiques partielles ou généralisées. Ces symptômes ressemblent à ceux d'un accident vasculaire cérébral mais rentrent dans l'ordre en l'espace de 48 heures.

L'épilepsie peut se présenter sous forme convulsive et non convulsive. On traite l'épilepsie convulsive comme celle des sujets jeunes, avec des benzodiazépines comme le lorazépam pour arrêter les crises, et une médication antiépileptique pour stabiliser le patient. Chez les sujets âgés, les maladies concomitantes influent souvent sur les résultats. Par exemple, le fonctionnement cardiaque peut être considérablement touché par l'activité d'une crise d'épilepsie prolongée, et une hypotension peut résulter de la médication administrée. L'état de mal épileptique non convulsif peut survenir chez les personnes âgées, qui peuvent présenter une confusion, une psychose, une léthargie et même un coma. Elle peut également se présenter sous forme d'un dérangement plus partiel tel une aphasie ou un manque d'intérêt. La majorité des cas d'état de mal épileptique non convulsif surviennent lors d'une affection médicale aiguë comme le dysfonctionnement d'un organe, la toxicité médicamenteuse et le sevrage d'alcool ou de benzodiazépines. Un accident vasculaire cérébral aigu ou isolé ou une démence peut également y contribuer (Boggs, 2016).

Il est manifeste que les crises épileptiques sont difficiles à déceler chez les sujets âgés. L'obnubilation est-elle causée par le délire? Les mouvements myocloniques décrits par les personnes qui accompagnaient le patient sont-ils associés à un malaise vasovagal? L'aphasie est-elle causée par un accident ischémique transitoire? Les tremblements sont-ils dus à la fièvre? Ou une crise épileptique pourrait-elle expliquer ces changements? On peut comprendre que le diagnostic de troubles épileptiques dans ce groupe de personnes soit souvent tardif et puisse même aller jusqu'à deux ans plus tard (Abdulla et Austin, 2013). Une source

mentionne que 15 % des patients chez qui on avait diagnostiqué un accident vasculaire cérébral avaient, après un examen plus approfondi, reçu un diagnostic de crises épileptiques (Huff, 2002).

Évidemment, la maladie aiguë, une fois diagnostiquée, nécessite un traitement, mais les symptômes inhabituels ou continuels peuvent nécessiter un examen plus poussé. Au service d'urgence, les analyses sanguines appropriées comprennent les électrolytes, le glucose et le magnésium, de même que des tests de fonctions rénales et hépatiques. On doit demander un électrocardiogramme et surveiller les patients qui sont source de préoccupations constantes quant à leur état cardiaque. Un tomodensitogramme de la tête aidera à déceler les changements structuraux ou les anciens accidents vasculaires cérébraux. Si l'activité d'une crise persiste, un électroencéphalogramme (EEG) aidera à en expliquer la cause, mais chez les adultes âgés, les résultats tendent à être non spécifiques, et un EEG réalisé en l'absence d'une crise active pourra rarement servir à la diagnostiquer. L'imagerie par résonance magnétique (IRM) peut fournir plus de renseignements, mais n'est pas souvent disponible au moment de la crise au service d'urgence. Les antécédents médicaux sont essentiels, mais pas toujours accessibles. Y avait-il un témoin lors de l'événement? Des symptômes similaires ont-ils été observés dans le passé? Y a-t-il des signes fréquemment associés aux crises épileptiques généralisées comme de l'incontinence ou des morsures de la partie latérale de la langue ou de l'intérieur des joues?

Le traitement dépendra de la cause et de la gravité des crises, des répercussions sur la qualité de vie du patient et des effets secondaires des médicaments requis. On prescrit généralement une médication dans les cas de crises épileptiques, parce qu'elle est efficace chez environ 70 % de ces patients. Une médication antiépileptique peut être prescrite contre les crises épileptiques provoquées jusqu'à ce que l'anomalie en cause soit résolue, par exemple dans le cas d'une encéphalite infectieuse.

Comme c'est le cas pour de nombreuses maladies chez les personnes âgées, une visite au service d'urgence peut ne pas déboucher sur un diagnostic final. Certaines affections comme un saignement intracrânien pourraient être écartées; il faut procéder à d'autres examens pour éliminer ou diagnostiquer d'autres maladies, par exemple un suivi à l'aide d'un moniteur Holter pour détecter la dysrythmie. Si l'on a relevé une crise unique, mais de cause inconnue chez un patient, la médication ne sera probablement pas nécessaire. Si d'autres crises surviennent et nuisent à la qualité de vie du patient, la médication est indiquée et sera généralement efficace pour prévenir l'apparition d'autres crises.

Le choix de la médication dans le traitement de l'épilepsie chez les personnes âgées doit englober l'évaluation des effets secondaires prévus. Des doses plus faibles que celles prescrites aux jeunes adultes peuvent être efficaces pour maîtriser les crises, et, en ce sens, la dose devrait être ajustée en fonction de l'effet thérapeutique recherché plutôt que des taux sériques. La première génération d'antiépileptiques, comme la phénytoïne et la carbamazépine, est souvent sédative. Chez les personnes âgées atteintes de déficit cognitif ou d'une anomalie de la démarche, ces médicaments peuvent compliquer la vie quotidienne. Ils peuvent augmenter la clairance hépatique d'autres médicaments administrés et, ce faisant, diminuer leur efficacité. La deuxième génération de médicaments, comme la gabapentine et la lamotrigine, est mieux tolérée et comporte moins d'interactions médicamenteuses, mais elle est plus coûteuse. Chez les patients atteints de la maladie d'Alzheimer, le lévétiracétam peut être mieux toléré, mais on ne connaît pas encore ses effets sur une longue période. L'utilisation à long terme des médicaments contre l'épilepsie est un facteur de risque pour l'ostéoporose; on recommande donc un apport adéquat en calcium et en vitamine D.

Les infirmières du service d'urgence peuvent contribuer à l'obtention des antécédents médicaux exacts et au maintien de l'indice de suspicion en matière d'activité des crises épileptiques. La comparaison des médicaments inclut-elle les benzodiazépines? Y a-t-il des préoccupations quant à l'observance du traitement et présence d'un sevrage? Y a-t-il de nouveaux médicaments comme le tramadol, l'ampicilline ou les tricycliques qui pourraient abaisser le seuil des crises?

Nous devons aider ces patients et leurs proches à assurer leur sécurité. Si ces patients ne sont pas autorisés à conduire, quelles sont les solutions de rechange offertes? Aiguiller le patient vers un ergothérapeute peut être utile, ou encore l'informer sur les modes de transport à sa disposition. Les alarmes personnelles peuvent être pratiques, car certaines sont programmées pour se déclencher si le porteur fait une chute ou s'il n'indique pas, à intervalles réguliers, qu'il se porte bien. Ces patients présentent un risque accru de chute et de noyade, ne serait-ce que dans une petite quantité d'eau et doivent recevoir une supervision appropriée pour nager ou se baigner en toute sécurité. Ils doivent éviter les chutes, par exemple d'un escabeau, parce que le risque de blessures graves augmente avec le vieillissement, et on devrait conseiller les patients sur les mesures de prévention des blessures comme les protecteurs de hanches. Des casques peuvent être conseillés pour diminuer le risque de blessure à la tête. Certains fabricants de protecteurs de hanches offrent également des casques protecteurs avec des accessoires comme un chapeau de soleil ou un bonnet pour couvrir l'appareil.

Chez la plupart des patients âgés, un nouveau diagnostic de troubles épileptiques signifie qu'ils devront, comme leurs proches, s'adapter à une autre maladie chronique. L'attention que nous portons à leurs soins physiques et émotionnels au service d'urgence ainsi que l'éducation et le soutien prodigués à mesure qu'ils avancent dans leurs soins continus peuvent améliorer réellement la façon dont ils maîtrisent leur maladie. Ces patients devront collaborer étroitement avec leurs fournisseurs de soins primaires; il pourrait être nécessaire de modifier leur médication, mais ils doivent être rassurés : ils pourront généralement s'attendre à de bons résultats, et si les effets secondaires sont

intolérables, un traitement différent pourra améliorer leur état. Malheureusement, pour de nombreuses personnes, d'autres agressions vasculaires cérébrales surviendront, et des maladies neurodégénératives comme la maladie d'Alzheimer s'aggraveront, mais la prise en charge des symptômes et les mesures de sécurité pourront aider au maintien de la meilleure qualité de vie possible.

Au sujet de l'auteure

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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Fisting—What is it and why should I have a high index of suspicion?

By Susan Short, RN, SANE-A, Forensic Nurse Examiner, British Columbia

Introduction

This article will define the sexual act of fisting; review the anatomy and physiology of the vaginal and anorectal areas; characterize sharp versus blunt force injuries; and highlight selected case studies. Fisting is also known as 'handballing' or 'fist fucking', 'brachiovaginal' or 'brachioproctic' insertion. Fisting can cause laceration or perforation of the vagina, perineum, rectum, and/or colon, with the potential for death.

The late 1960s/early1970s is when fisting first appeared on the homosexual club and party scene. Crisco was a common lubricant until other commercially prepared lubricants were available. Unprotected fisting may have been a causative factor in the transmission of HIV due to the micro-lacerations from penetration in the anal area. In the 21st century it has become more commonplace in heterosexual intercourse.

Accordingly it is useful to learn about this sexual practice.

Fisting definition

Fisting is a sexual act that involves using the whole hand to penetrate the body. People engage in both vaginal fisting, inserting the hand inside the vagina, and anal fisting, inserting the hand into the anorectal canal. The label fisting is deceptive, as the hand may not be made into a fist, if ever, until it has been fully inserted.

Two techniques recognized as the most commonly practised are the duck and the praying hands.

With the first technique, the fingers are extended and arranged to be overlapping; the thumb is positioned against the palm/base of the fingers. In this formation it resembles a bird's beak and is often called the 'silent duck' or 'duck billing'. The hand is then slowly inserted into the orifice of choice. Once insertion is complete, the fingers either naturally clench into a fist or remain straight.

The second technique is considered advanced and for the more experienced fistees. The hands are placed palm to palm, resembling a position of prayer. The hands are turned parallel to the floor with fingers again pointing to the orifice of choice for insertion.

Typically, fisting does not involve forcing the clenched fist into the vagina or rectum. In more vigorous forms of fisting, such as "punching," a fully clenched fist may be inserted and withdrawn slowly.

Anatomy and physiology

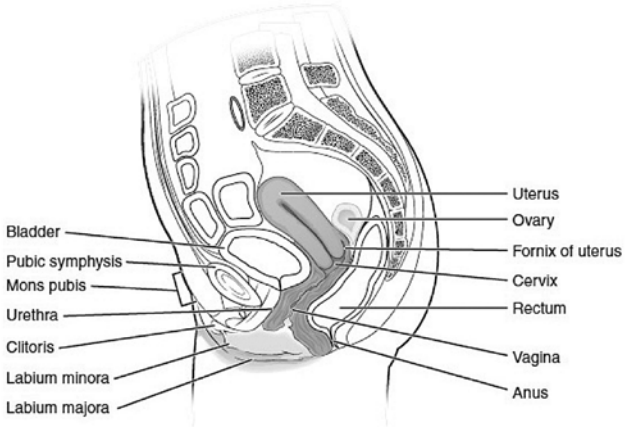

Figure 1. Vagina
https://commons.wikimedia.org/wiki/File:Female_Reproductive_Lateral.JPG
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The vagina is a thin-walled fibromuscular tubular structure that extends from the cervix to the vulva and measures 7–10 cm in length. The inner walls of the vagina are covered with rugae, which are ridges of tissue that allow for stretching and expansion. Normally, the vaginal walls are collapsed and in contact except at the upper end where the cervix keeps them separate. The elastic structure of the vagina allows it to stretch in both length and diameter to accommodate the penis and fetus. Glands near the opening of the vagina secrete mucus to keep the surface moist.

The vagina does change anatomically in response to stimuli. A person can be sexually aroused by a variety of factors, both physical and mental, which causes a number of physiological responses to occur in the body. These responses in the female can include vaginal lubrication, engorgement of the external genitalia and internal enlargement of the vagina.

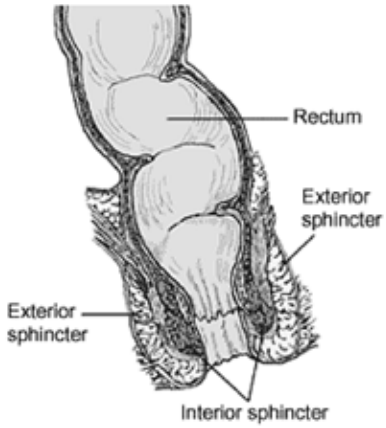

Figure 2. Anorectum
https://upload.wikimedia.org/wikipedia/commons/7/75/Anorectum.gif
Public domain

The anorectal area is the outlet of the gastrointestinal (GI) tract. The anal section is lined with skin that has no hair or sebaceous glands and merges with the rectal mucosa approximately 4 cm within the canal.

Innervation of the rectum is by autonomic nerves, but the anus and anal canal have numerous somatic sensory nerves. The sphincter muscles of the anus are quite sensitive and also are composed of numerous nerve endings. They facilitate pleasure or pain during anal intercourse. For the male, the pleasurable sensation is due to the contact with the prostate gland through the anal wall. For the female, the indirect stimulation of the clitoral nerve endings through the anal wall achieves the same outcome.

Injuries—Sharp versus blunt force

Sharp force trauma

Injuries produced by pointed objects or objects with sharp edges. These are characterized by a relatively well-defined traumatic separation of tissues, occurring when a sharp-edged or pointed object comes into contact with the skin and underlying tissues. These are commonly known as cuts or incisions.

Blunt force trauma

Injuries resulting from an impact with a dull, firm surface or object. Individual injuries may be patterned (e.g., characteristics of the wound suggest a particular type of blunt object) or non-specific. Blunt force trauma may cause contusions or bruises and lacerations.

Lacerations are often confused with cuts. The differentiation is based on the appearance of the separated tissues. With a laceration there is tissue bridging such as seen when there is tearing or pulling apart the tissue. The edges of the injury are not as well defined as in a cut.

Principles of why blunt force injuries occur

The amount of kinetic energy transferred and the tissue to which the energy is transferred will determine the severity of the injury.

The characteristics of the blunt object and the surface that is in impact will also determine severity. Impacts involving a large surface area—either with regard to the impacting object or with regard to the tissues being impacted—will result in a greater dispersion of energy over a larger area and, therefore, less injury to the impacted tissues.

The composition, or plasticity, of the tissues impacted also affects the resultant injuries.

Another factor is the amount of time that the body and the impacting object are in contact. A longer period of contact allows kinetic energy to be dissipated over a prolonged period, resulting in less damage to the tissues than an equally forceful impact with dispersion of energy over a brief period.

It has been simply said "an injury occurs when the force applied to a body surface exceeds the ability of that surface to stretch." (Lecture notes, Sheila Early, BCIT Forensic Program, circa 2005).

Selected case studies

Case 1

In 1989, Fain et al. wrote that the death of a 16-year-old female occurred in relation to a fisting incident. The male involved in the event did admit to having his entire fist and most of his forearm in the female's vagina. The autopsy findings include an 8 cm vaginal laceration that was surrounded by a contusion. It was located posterior to the cervix and extended through the posterior vaginal wall. Also present was a bladder and rectum contusion that extended into the rectal musculature without laceration. There were also numerous smaller lacerations on the lateral surface of the vaginal walls. Within the wall of the female's abdominal cavity there was 75–100 cc of blood. There were also two pubic hairs collected that were matched to the male in question. The cause of death was attributed to shock from blood loss due to 8 cm vaginal laceration.

Case 2

Cohen et al. (2004) described the following case of a 39-year-old male who presented to the ER 14 hours post consensual anal fisting. The male gave a history of ketamine use, which included him snorting and inserting it rectally. He reported that during fisting, he heard a 'pop', and his partner stopped the activity. Rectal bleeding did start following, but it was the increasing abdominal pain and bloating that brought him to the hospital. He presented with a distended abdomen and guarding of the left lower abdomen. A chest x-ray revealed free air under his diaphragm. A laparotomy revealed 550 ml of blood in his peritoneal cavity and a 1 cm full thickness laceration of the lower sigmoid colon.

Case 3

Anorectal penetration by forearm that resulted in a rectal perforation is the last case. Delacroix et al., in 2011, described the following case. A 16-year-old female patient presented to the ER with complaints of vaginal bleeding, rectal incontinence and chest pain. She also indicated that she had lethargy, epigastric pain, nausea and vomiting and rectal pain. She gave history of ingesting a large amount of alcohol and engaging in vaginal and anal intercourse with a male. Although she could not recall all the events of the day, she did insist that there was only penile penetration. Also of note is that the patient was intoxicated when presenting to the ER. She also had been diagnosed with a major depressive disorder with psychotic features and was on appropriate medications. On examination in the ER, an anal inspection revealed a superficial laceration at the anterior aspect, no active bleeding and intact sphincter tone. A vaginal speculum exam revealed no vaginal lesions, and a small amount of menstrual-type blood in the vault. A forensic examination was done; the speculum examination was deferred, as it had already been done. The findings were bleeding from the vagina and rectum; redness and a laceration to the left thigh; bilateral edema to the labia minora; and a laceration to the posterior fourchette (area just outside of the vaginal opening). The patient was kept in the ER overnight for observation. In the morning her condition had deteriorated and a CAT scan of her abdomen revealed free air and fluid in the abdominal cavity. An exploratory laparotomy was done. The anus was noted to have erosion and a laceration; the abdomen had large quantities of fecal matter and fluids with resulting diffuse peritonitis and the rectum had a linear tear. The tear was sutured and the patient received a colostomy, which was reversed nine months later to ensure healing of the tear occurred.

Clinical considerations

A high index of suspicion with fisting must be encouraged due to the potential serious consequences if these injuries are not identified.

We should bear in mind that regardless of whether the sexual activity was consensual or non-consensual, our patient may have difficulty verbalizing what has happened, and they may not remember the details, even in the absence of inebriation. With the disclosure of fisting activity, take into account that there is an increased risk of perforation. Combine that knowledge with the patient complaining of anal and/or vaginal bleeding, abdominal pain and/or genital injuries, and act accordingly.

About the author

Susan Short has been a registered nurse for 25 plus years with the majority of her career in the emergency department. She has specialized in forensic nursing and is currently the Coordinator of the Fraser Health program at the Abbotsford Regional Hospital, BC. Susan was the first student to complete the BCIT Advanced Specialty Certificate in Forensic Science Technology – Forensic Health Sciences Option, with Distinction. Building on that certificate, she has completed the courses for a BCIT Bachelor of Technology in Forensic Science. Susan has also been teaching for BCIT since 2006. She is the past president of the Canadian Forensic Nurse's Association and a lifetime member of the International Association of Forensic Nurses.

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Pénétration du poing — Définition et vigilance

Article rédigé par Susan Short, infirmière autorisée, infirmière examinatrice spécialisée en agressions sexuelles - adultes et adolescents, infirmière médico-légale examinatrice, Colombie-Britannique

Introduction

Le présent article définira la pratique sexuelle qu'est la pénétration du poing, passera en revue l'anatomie et la physiologie des régions vaginale et ano-rectale, caractérisera les traumatismes pénétrants et les traumatismes contondants, puis présentera quelques études de cas choisies. La pénétration du poing est aussi appelée « *fisting* » ou insertion brachio-vaginale ou brachio-rectale. Elle peut entraîner une lacération ou une perforation du vagin, du périnée, du rectum ou du côlon et potentiellement causer la mort.

La pénétration du poing a fait son apparition vers la fin des années 1960 et le début des années 1970 dans les clubs et la vie nocturne des homosexuels. L'huile Crisco était couramment utilisée comme lubrifiant jusqu'à l'arrivée sur le marché des lubrifiants commerciaux. La pénétration du poing non protégée peut avoir contribué à l'étiologie de la transmission du VIH à cause des microlacérations résultant de la pénétration dans l'anus. Elle s'est répandue dans les relations hétérosexuelles au cours du 21e siècle.

Il est donc pertinent de se renseigner sur cette pratique sexuelle.

Définition de la pénétration du poing

La pénétration du poing est un acte sexuel dans lequel il y a pénétration de la main en entier à l'intérieur du corps. Il est possible de pratiquer tant la pénétration vaginale, c'est-à-dire l'insertion de la main dans le vagin, que la pénétration anale, c'est-à-dire l'insertion de la main dans le canal ano-rectal. Le terme « pénétration du poing » est trompeur, étant donné que la main n'est pas nécessairement, voire jamais, serrée en forme de poing avant d'avoir été complètement insérée dans le vagin ou l'anus.

Deux techniques sont reconnues comme les plus courantes : la main en canard et les mains en prière.

Dans la première technique, les doigts sont allongés et placés de manière à se chevaucher; le pouce est placé contre la paume ou à la base des doigts. Dans cette position, la main ressemble à un bec d'oiseau, d'où l'image souvent employée de « canard silencieux » ou de « bec de canard ». La main est ensuite insérée lentement dans l'orifice désiré. Une fois l'insertion complète, les doigts se serrent naturellement pour former un poing ou demeurent étirés.

La seconde technique est considérée comme avancée et réservée aux pratiquants expérimentés. Les paumes sont jointes dans une position qui rappelle la prière. Les mains sont ensuite tournées parallèlement au plancher et les doigts pointent vers l'orifice choisi pour l'insertion.

En règle générale, la pénétration du poing n'implique pas de forcer l'entrée du poing déjà fermé dans le vagin ou le rectum. Dans les formes plus vigoureuses, comme le « coup de poing » (*punching*), le poing totalement fermé peut être inséré puis lentement retiré.

Anatomie et physiologie

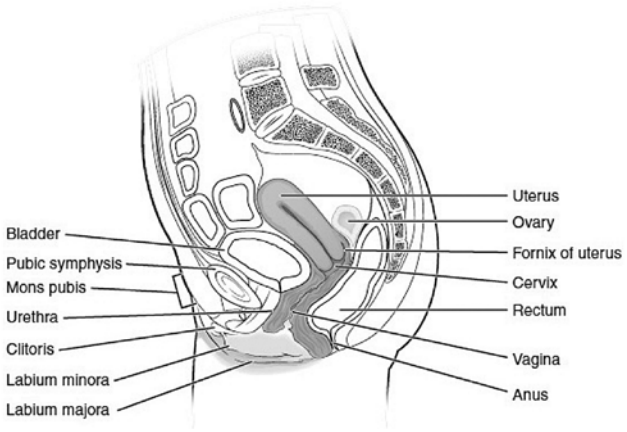

Figure 1. Vagin
https://commons.wikimedia.org/wiki/File:Female_Reproductive_Lateral.JPG
Partage dans les mêmes conditions – Image créée par CFCF

Le vagin est formé d'une structure tubulaire fibromusculaire à parois minces qui s'étend du col à la vulve et mesure de 7 à 10 cm de longueur. Les parois internes du vagin sont couvertes de saillies, qui sont en fait des replis de tissu permettant l'étirement et l'expansion. Normalement, les parois du vagin sont affaissées et se touchent, sauf à l'extrémité supérieure, où elles sont séparées par le col. La structure élastique du vagin lui permet de s'étirer tant en longueur qu'en diamètre pour accommoder le pénis et le fœtus. Des glandes situées près de l'ouverture sécrètent du mucus pour garder la surface humide.

La structure anatomique du vagin change en réponse aux stimuli. Plusieurs facteurs, tant physiques que mentaux, peuvent entraîner un état d'excitation sexuelle, ce qui déclenche tout

un nombre de réactions physiologiques dans le corps. Chez la femme, ces réactions comprennent, entre autres, la lubrification vaginale, l'engorgement des parties génitales externes et l'élargissement interne du vagin.

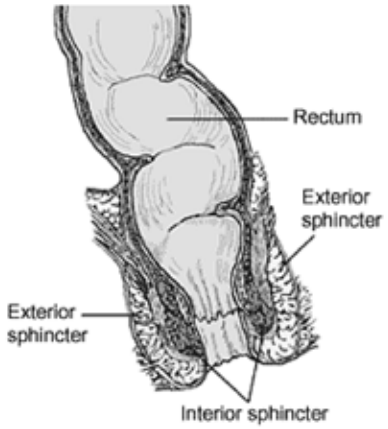

Figure 2. Région ano-rectale https://upload.wikimedia.org/wikipedia/commons/7/75/Anorectum.gif
Domaine public

La région ano-rectale est située à la sortie du tractus gastro-intestinal. La section anale est recouverte de peau et dépourvue de poils ou de glandes sébacées; elle rejoint la muqueuse rectale à environ 4 cm à l'intérieur du canal.

Le rectum est innervé par des nerfs du système nerveux autonome, alors que l'anus et le canal anal contiennent de nombreux nerfs sensoriels somatiques. Le sphincter de l'anus est très sensible et il contient lui aussi de nombreuses terminaisons nerveuses. Ces dernières renforcent le plaisir ou la douleur ressentis pendant les relations anales. Pour l'homme, la sensation de plaisir est due au contact avec la prostate à travers la paroi anale. Pour la femme, la stimulation indirecte des terminaisons nerveuses clitoridiennes à travers la paroi anale produit le même résultat.

Blessures – force pénétrante ou contondante

Traumatisme pénétrant

Il s'agit de blessures causées par des objets pointus ou à bord coupant. Elles sont caractérisées par une séparation traumatique des tissus relativement bien définie et elles surviennent lorsqu'un objet pointu ou coupant entre en contact avec la peau et les tissus sous-jacents. On les désigne généralement par les termes « coupures » ou « incisions ».

Traumatisme contondant

Il s'agit de blessures résultant d'un impact avec une surface ou un objet dur et émoussé. Les différentes blessures peuvent présenter un motif (c'est-à-dire des caractéristiques suggérant l'utilisation d'un type particulier d'objet contondant) ou être non spécifiques. Les traumatismes contondants peuvent entraîner des contusions ou des ecchymoses et des lacérations.

Lacérations et coupures sont souvent confondues. La différence réside dans l'apparence des tissus atteints. En cas de lacération, les tissus demeurent liés en partie, comme c'est le cas lorsqu'il y a déchirement ou séparation tissulaire. Les bords de la blessure ne sont pas aussi bien définis que dans le cas d'une coupure.

Principes expliquant la cause des blessures contondantes

La gravité de la blessure est déterminée par la quantité d'énergie cinétique transférée et le type de tissus en cause.

Les caractéristiques de l'objet contondant et de la surface de contact influent également sur la gravité de la blessure. Si la surface est étendue, qu'il s'agisse de l'objet portant le coup ou des tissus touchés, l'énergie sera plus dispersée, ce qui diminuera la gravité de la blessure.

La composition ou la plasticité des tissus influent aussi sur la gravité des blessures résultantes.

La durée du contact entre le corps et l'objet constitue un autre facteur déterminant. Plus le contact est prolongé, plus l'énergie cinétique se dissipe sur une longue période, ce qui cause moins de dommages aux tissus qu'un impact de force équivalente, mais dont la dispersion d'énergie s'effectue sur une courte période.

Pour résumer, « une blessure survient lorsque la force appliquée sur une surface corporelle excède la capacité de cette surface à s'étirer » [traduction] (notes de conférence, Sheila Early, programme d'études médico-légales du British Columbia Institute of Technology [BCIT], circa 2005).

Études de cas choisies

Cas nº 1

En 1989, Fain et collègues ont rapporté le décès d'une femme de 16 ans survenu à la suite d'un incident de pénétration du poing. L'homme concerné a admis avoir introduit son poing en entier ainsi que la majeure partie de son avant-bras dans le vagin de la femme. Les conclusions de l'autopsie font montre d'une lacération vaginale de 8 cm entourée d'une contusion. La blessure, rétro-cervicale, s'étendait jusqu'à la paroi vaginale postérieure. La vessie et le rectum présentaient aussi une contusion sans lacération atteignant la musculature rectale. L'autopsie a aussi révélé de nombreuses petites lacérations sur la surface latérale des parois vaginales. La cavité abdominale contenait entre 75 et 100 cc de sang. Deux poils pubiens ont été recueillis; ils appartenaient à l'homme en question. La cause du décès a été attribuée au choc dû à la perte de sang causée par la lacération vaginale de 8 cm.

Cas nº 2

Cohen et collègues (2004) décrivent le cas d'un homme de 39 ans qui s'est présenté aux urgences 14 heures après un acte consensuel de pénétration anale du poing. L'homme a dit avoir déjà pris de la kétamine, qu'il insérait par voie rectale. Pendant la pénétration du poing, il a rapporté avoir entendu un « pop »; son partenaire a alors mis fin à l'activité. Le rectum s'est mis à saigner, mais c'est la douleur abdominale croissante et les ballonnements qui l'ont conduit à l'hôpital. Il présentait une distension abdominale, ainsi qu'une défense abdominale dans le quadrant inférieur gauche. Une radiographie thoracique a révélé la présence d'air libre sous le diaphragme. Une laparotomie a montré quant à elle la présence de 550 ml de sang dans la cavité péritonéale, ainsi qu'une lacération très profonde de 1 cm dans le côlon sigmoïde inférieur.

Cas nº 3

Ce dernier cas décrit une pénétration ano-rectale de l'avant-bras ayant entraîné une perforation rectale. En 2011, Delacroix et collègues ont décrit le cas qui suit. Une femme de 16 ans s'est présentée aux urgences en se plaignant de saignements vaginaux, d'incontinence rectale et de douleurs thoraciques. Elle affirmait aussi souffrir de léthargie, de douleurs épigastriques, de nausées, de vomissements et de douleurs anales. Elle disait avoir consommé une grande quantité d'alcool et avoir eu des relations sexuelles vaginales et anales avec un homme. Elle ne se rappelait pas tous les événements de cette journée, mais elle a insisté sur le fait qu'il y avait eu seulement pénétration pénienne. À noter aussi que la patiente était ivre lorsqu'elle s'est présentée aux urgences. Elle avait déjà reçu un diagnostic de trouble dépressif majeur avec tendances psychotiques et prenait les médicaments appropriés. L'inspection anale, réalisée aux urgences, a révélé une lacération superficielle sur la surface antérieure, aucun saignement actif et un tonus sphinctérien intact. L'examen vaginal à l'aide d'un spéculum n'a révélé aucune lésion vaginale et une petite quantité de sang de type menstruel dans la cavité. Un examen médico-légal a été effectué, à l'exception de l'examen avec spéculum, puisqu'il avait déjà été fait. Conclusions de l'examen : saignements vaginaux et rectaux; rougeur et lacération à la cuisse gauche; œdème bilatéral aux petites lèvres; lacération dans la fourchette postérieure (région située juste à l'extérieur de l'ouverture du vagin). La patiente a été gardée en observation aux urgences pour la nuit. Le matin suivant, son état s'était détérioré et un tomodensitogramme de l'abdomen a révélé la présence d'air libre et de liquide dans la cavité abdominale. On a procédé à une laparotomie exploratoire. On a aussi constaté une érosion de l'anus, ainsi qu'une lacération; l'abdomen contenait de grandes quantités de matières fécales et de liquides ayant entraîné une péritonite diffuse; le rectum présentait aussi une déchirure linéaire. La déchirure a été suturée et une colostomie a été pratiquée pour finalement être retirée neuf mois plus tard afin de permettre la guérison de la déchirure.

Considérations cliniques

La pénétration du poing doit faire l'objet d'une forte vigilance, vu les graves conséquences possibles des blessures qui ne seraient pas diagnostiquées.

N'oublions pas qu'il pourrait être difficile pour le patient de verbaliser ce qui s'est passé, que l'activité sexuelle ait été consensuelle ou non, et qu'il pourrait ne pas se rappeler les détails, même s'il n'est pas en état d'ébriété. En cas de pénétration par le poing, il faut tenir compte du risque accru de perforation. Ajoutez à cette information les plaintes du patient concernant les saignements anaux ou vaginaux, la douleur abdominale et les blessures génitales, et agissez en conséquence.

À propos de l'auteur

Susan Short est infirmière autorisée depuis plus de 25 ans et elle a passé la majeure partie de sa carrière aux urgences. Spécialisée en soins infirmiers médico-légaux, elle est actuellement coordonnatrice du programme de santé Fraser (Fraser Health program) de l'Abbotsford Regional Hospital, en Colombie-Britannique. Susan a été la première étudiante à obtenir, avec distinction, le certificat spécialisé avancé en technologie médico-légale – option sciences de la santé médico-légales du British Columbia Institute of Technology (BCIT). Poursuivant dans la veine de ce certificat, elle a obtenu un baccalauréat en technologie des sciences médico-légales du BCIT. Susan enseigne au BCIT depuis 2006. Par le passé, elle a été présidente de la Canadian Forensic Nurses Association et elle est membre à vie de l'International Association of Forensic Nurses.

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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 (included with this issue of (CJEN). 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:
4. Review all applications submitted by provincial directors and make recommendations to award bursaries based on the NENA selection criteria.
5. Forward names of approved candidates to the NENA Board of Directors for presentation by the President.

NENA Bursary application form "A" (Member)

Name: _____ Date of Application: _____

Address: _____

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

E-mail: _____

Place of employment: _____

Name of course/workshop: _____

Date: _____ Time: _____ Length of course: _____

Course sponsor: _____ Cost of course: _____

Purpose of course: _____

Credits/CEUs: _____ ENC(C) Certification: ❑ Yes ❑ No

Previous NENA Bursary: ❑ Yes ❑ No Date: _____
Bursary applied for: NENA: ❑ Margaret Smith Memorial: ❑ Debbie Cotton Memorial: ❑
Please submit a proposal of approximately 200 words stating how this educational session will assist you and your colleagues to provide an improved outcome for the emergency care user. In submitting your proposal, bursary recipients are agreeing to permit NENA to publish the essay in CJEN/NENA website. Attached?: ❑ Yes ❑ No

Ensure photocopies of provincial RN registration and provincial emergency nurses association membership are included with your application. Attached?: ❑ Yes ❑ No

NENA Bursary application form "B" (Employer)

I acknowledge that _____ (name of applicant) is currently employed in an emergency care setting. This applicant should receive monies for _____ (name of course).

Reason: _____

Other comments: _____

_____

Signed: _____

Position: _____

Address: _____

NENA Bursary application recommendation form "C" (Provincial director)

Name of bursary applicant: _____ Province: _____

Length of membership with provincial emergency nurses group: _____

Association activities: _____

_____

Do you recommend that this applicant receive a bursary? ❑ Yes ❑ No

Reason: _____

Provincial director signature: _____ Date: _____

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