outlook

the official journal of the National Emergency Nurses' Affiliation Inc.

Volume 35, Number 1, Spring 2012

In This Issue:

Canadian Triage and Acuity Scale National Working Group (CTAS NWG) update 11

National Course Administration Committee (NCAC) Report Spring 2012 12

NENA National Conference 2012
30 Years of Navigating the Depths of Emergency Nursing 17

Conference registration form 19

Effective trauma teams: Trauma team simulations . . . 21

The New Brunswick Trauma Program: A model of inclusivity 23

Vicarious traumatization and the call for universal precautions 25

Call for nominations: Communication officer and president-elect 31

The NENA Bursary 32

PERMANENT FULL-TIME EMERGENCY NURSING Opportunities Across Niagara Health

Registered Nurses: this is an exciting time to join Niagara Health System and be part of a changing, evolving environment while promoting nursing excellence and quality patient-centred care. If you have experience in Emergency or Critical Care, consider joining our team.

With six hospitals and an ambulatory care centre, new regional cardiac and cancer programs, and a new Health-Care Complex nearing completion, we are the major provider of acute care in Niagara.

To join Niagara Health is to spend more time enjoying life than commuting. Nestled between Lake Ontario and Lake Erie, and best recognized for its tourist attractions, the area also offers great geographical advantages. Our hospital sites are located in thriving communities, where affordable housing, an abundance of recreational and cultural activities, and a variety of settings make both family and single living a rewarding, enriching experience.

Several **permanent full-time Emergency Nursing** positions are available for ER Nurses at our Niagara Falls, Welland and St. Catharines sites. The RNs we seek are skilled in physical assessment, hold current CNO registration, Critical Care and BCLS certification, and have 2 years of related clinical Emergency experience. While Emergency-related certification or training is preferred, we will consider qualified RNs who are willing to become certified.

For more information or to apply for these and other positions, visit **www.niagarahealth.on.ca**. Apply online or send your resume to **hrrecruit@niagarahealth.on.ca**.

NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA
TOGETHER IN EXCELLENCE · LEADERS IN HEALTHCARE

JOIN US ON TWITTER twitter.com/nhscareers

WWW.NIAGARAHEALTH.ON.CA

outlook
Guidelines for submission

Editorial Policy

1. **Outlook** 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 NENA Outlook editor. The author should retain one complete copy.

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

3. Author's name(s) and province of origin must be included.

4. Clinical articles should be limited to six pages.

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

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

Please submit articles to:
Stephanie Carlson, Outlook Editor,
e-mail: communicationofficer@nena.ca

Deadline dates:
January 31 and September 8

outlook
the official journal of the National Emergency Nurses' Affiliation Inc.

Outlook is the official publication of the National Emergency Nurses' Affiliation Inc., published twice annually by Pappin Communications, 84 Isabella Street, Pembroke, ON K8A 5S5. ISSN 1499-3627. Indexed in CINAHL. Copyright NENA, 2012

Editorial staff

Editor: Stephanie Carlson, communicationofficer@nena.ca
Kids' Corner: Sharron Lyons, sharron_lyons@telus.net
Trauma Corner: Margaret Dymond, margaret.dymond@albertahealthservices.ca
4N6RN: Sheila Early, sdeconsulting@telus.net
Geriatrics Matters: Cathy Sendecki communicationofficer@nena.ca

No part of this journal may be reproduced in any manner without written permission from NENA.

The editors, association and the publisher do not guarantee, warrant or endorse any product or service mentioned in this publication.

For information on advertising, contact Heather Coughlin, Advertising Manager, Pappin Communications, The Victoria Centre, 84 Isabella St., Pembroke, Ontario K8A 5S5, telephone 613-735-0952, fax 613-735-7983, e-mail: heather@pappin.com
Rate card available at www.pappin.com

Send manuscript inquiries or submissions to: Stephanie Carlson, Outlook Editor, e-mail: communicationofficer@nena.ca

Cover image: Sunset at Halifax Harbour, photo by Benson Kua http://www.flickr.com/photos/bensonkua/5983118229

NENA elected executive

President
Sharron Lyons
president@nena.ca

Past-President
Landon James
pastpresident@nena.ca

Secretary
Cate McCormick
secretary@nena.ca

Treasurer
Sherry Uribe
treasurer@nena.ca

Communication Officer
Stephanie Carlson
communicationofficer@nena.ca

Provincial directors

British Columbia
Emergency Nurses Association of British Columbia (ENABC)
Sherry Stackhouse
bcdirector@nena.ca

Alberta
Emergency Nursing Interest Group of Alberta (ENIG)
Dawn Paterson
abdirector@nena.ca

Saskatchewan
Saskatchewan Emergency Nursing Group (SENG)
Raegan Gardner
skdirector@nena.ca

Manitoba
Emergency Department Nurses Association of Manitoba (EDNA)
Irene Osinchuk
mbdirector@nena.ca

Ontario
Emergency Nurses Association of Ontario (ENAO)
Janice Spivey
ondirector@nena.ca

New Brunswick
New Brunswick Emergency Nurses Association (NBENA)
Erin Musgrave
nbdirector@nena.ca

Nova Scotia
Nova Scotia Emergency Nurses Association (NSENA)
Michelle Tipert
nsdirector@nena.ca

Prince Edward Island
Prince Edward Island Emergency Nurses Association (PEIENA)
vacant
peidirector@nena.ca

Newfoundland & Labrador
Newfoundland & Labrador Emergency Nurses Association (NLENA)
Todd Warren
nldirector@nena.ca

Committee chairs

Archives Committee
Cate McCormick: **archives@nena.ca**

Awards/Bursaries
Stephanie Carlson: **awards@nena.ca**
Cate McCormick

CEDIS
Chair: Colleen Brayman

Conference Planning Liaison
Jennifer Clarkson:
conference@nena.ca

CTAS/NWG
Representative to the Board:
Colleen Brayman
Committee member: Traci Foss-Jeans

National Trauma Committee
Margaret Dymond: **chairncac@nena.ca**

Nominations
Jan Spivey: **nominations@nena.ca**

Nursing Research
Dawn Paterson: **research@nena.ca**
Raegan Gardner

Political Action
Landon James: **politicalaction@nena.ca**
Sharron Lyons, Stephanie Carlson

Professional Practice and Documents
Sharron Lyons:
professionalpractice@nena.ca
Stephanie Carlson, Todd Warren

Outlook is the official publication of the National Emergency Nurses' Affiliation. Articles, news items and illustrations relating to emergency nursing are welcome. **Outlook** is published two times per year. Opinions expressed are not necessarily those of NENA, or of the editor. NENA reserves the right to edit information submitted for publication. The use by any means of an article, or part thereof, published in **Outlook,** is an infringement of copyright law. Requests for written consent prior to reprinting of any article, or part thereof, should be addressed to the editor.

President's message

2012 has arrived and, along with half the population, I made a few New Year's resolutions, one of which was to catch up on the NENA President's paperwork! The problem is that I am happy to charge ahead with the upcoming work or events, however, the paperwork I keep putting off just keeps growing and growing… anyone want to become a volunteer paper pusher?

The most exciting thing to happen in 2012 is having the Quebec nurses join NENA! Thanks to the hard work of numerous people, in particular, Landon James and Valerie Pelletier, the NENA organization can say we are now truly a national emergency nursing organization. Join us in Halifax to welcome the Quebec nurses.

NENA has been involved in many activities over the past few months. However, of particular importantance to NENA members are the following two matters.

The first is the situation with the Canadian Registered Nurse Exam (CRNE). If you are not aware of the situation, let me put it in a nutshell. The 10 Canadian RN regulatory colleges and associations put forward a request for proposals for the development of a computer-based RN exam to replace the present paper one. This, in itself, is a good idea. However, the decision was made to give the contract to a U.S. company and this is where things get cloudy. A press release by the U.S. company states they will use the NCLEX exam with some "tweaking" of Canadian lab values, etc. The 10 regulatory colleges and associations state the exam will be developed in Canada with Canadian content. I have been involved in numerous teleconferences and meetings, but cannot tell you which is correct or what is really going on. Now is the time for all RNs to be asking questions of their regulatory boards, unions and politicians. Nurses have the right to know what is happening to their profession and to have some input.

The second is the partnership formed with the *International Emergency Nursing Journal (IENJ),* which will allow NENA members to have an annual subscription to the journal (includes four issues delivered directly to you) at a 50% reduced rate. To learn more about this offer, see the article on page 24. To subscribe, go to: **www.internationalemergencynursing.com**

Don't forget the upcoming 2012 conference in Nova Scotia. Information is available on the NENA website and in this issue of *Outlook*. Believe me, it is looking to be one of the liveliest conferences yet!

Sharron Lyons,
President

Message du président

2012 est arrivé et, comme la moitié de la population, j'ai pris quelques résolutions pour la nouvelle année. L'une d'elles est de rattraper mon retard avec toute la paperasse qui tombe sur le bureau du président de la NENA (National Emergency Nurses Affiliation)! Mon problème c'est que j'aime aller de l'avant avec les dossiers et les événements qui arrivent mais ce sont les tâches administratives, cette paperasse, qui restent en plan et qui ne cessent d'accumuler ... Quelqu'un veut-il se porter bénévole en ce domaine ?

La chose la plus passionnante pour nous en 2012 c'est d'accueillir les infirmières et les infirmiers d'urgence du Québec (l'AIIUQ) au sein de la NENA! Grace au grand travail de nombreuses personnes et notamment de Landon James et de Valérie Pelletier, nous pouvons dire que nous sommes vraiment une organisation nationale d'infirmières et d'infirmiers d'urgence. Veuillez vous joindre à nous à Halifax pour souhaiter la bienvenue aux infirmières et aux infirmiers du Québec.

La NENA a été impliquée dans beaucoup de choses ces derniers mois, cependant il y en a deux qui sont d'une plus grande importance pour ses membres à l'heure actuelle :

La première concerne la situation de l'examen d'autorisation infirmière au Canada (EAIC). Si vous n'êtes pas au courant de cette situation permettez-moi de vous l'expliquer dans deux mots. Les 10 collèges et associations canadiens de réglementation des IA ont lancé un appel d'offres pour le développement d'un examen IA informatisé qui remplacera la version papier. Cela est sans doute une bonne idée, sauf la décision a été prise de donner ce contrat à une compagnie américaine et c'est là où les choses se compliquent. Dans un communiqué de presse la compagnie américaine affirme qu'elle se servira de l'examen NCLEX (National Council Licensure EXamination) avec quelques retouches relatives aux unités de mesure canadiennes en laboratoire, etc. Les 10 collèges et associations canadiens de réglementation affirment que l'examen sera développé au Canada avec un contenu canadien. J'ai participé à de nombreuses téléconférences et à des réunions mais je ne peux pas vraiment tirer la chose au clair pour vous. Il est important pour toutes (tous) les IA de poser dès maintenant leurs questions à leurs organismes de réglementation, à leurs syndicats et à leurs politiciens. Les infirmières et les infirmiers ont le droit de savoir ce qui se passe dans leur profession et d'y apporter leur avis.

La deuxième chose est le partenariat établi avec l'International Emergency Nursing Journal (IENJ) qui permettra aux membres de la NENA d'avoir un abonnement annuel à cette revue (qui comprend 4 numéros livrés directement chez vous) à un taux réduit de 50 %. Pour en savoir plus sur cette offre voir l'article à la page 24. Pour vous abonner aller à : **www.internationalemergencynursing.com**

N'oubliez pas la prochaine conférence de 2012 en Nouvelle-Écosse. L'information est disponible sur le site NENA et dans ce numéro d'*Outlook*. Croyez-moi, cette conférence s'annonce être une des plus animées à ce jour!

Sharron Lyons,
président

Communication Officer's report

There has never been a more exciting time to be a nurse. Across Canada the scope of nursing practice is expanding in step with the competence required to provide excellent nursing care. Nurses are increasingly performing tasks once reserved for other health care personnel.

When I came home from my first day on the floor of our emergency department, I told my family, *working there is kamikaze nursing*. Compared to emergency nursing now, I believe the load was more predictable; I think patients were generally less acute; and I know there weren't as many of them. I now describe the emergency experience as nursing in a crucible. It's challenging. It's physically hard work. It's mentally draining. It's emotionally taxing. I believe my assessment is validated in many agencies by their attrition rates and absenteeism.

In spite of the excitement and satisfaction of new practices, there is the weight of added responsibility. The burden is substantial. Employers and nurse managers can make and do make creative attempts to reduce stress and counter the tension of working in the pressure cooker of emergency. These measures are often as effective as painting a tiger grey and calling it *a house cat*.

If there were an easy solution, someone would market it and make a fortune. There isn't. I have observed, however, that dissatisfaction and stress may be mitigated by relationships. Collegiality among nurses is the key. I have had quite a few jobs in my adult life and I have heard people say that they **went** to a new job for more money, but seldom have I heard of anyone say that they **left** a job because of the pay alone. It is not unusual to hear that a nurse left a position because of the coworkers. So…

I know of an opportunity for all emergency nurses to recharge the batteries, to refresh the relationships, to replenish the knowledge store, and to rejuvenate the sense of humour. This opportunity has it all, and in a beautiful setting! The Nova Scotia Emergency Nurses Association is hosting the 2012 NENA Conference in Halifax in May. If you are longing for something to restore that enthusiasm that brought you to emergency nursing, please join the Nova Scotia nurses for this exciting event. See you there.

Stephanie Carlson

Treasurer's report

As I begin my term as NENA Treasurer, I want first of all to say thank you to Lori Quinn, NENA Treasurer until November of 2011. She did a great job in managing NENA's finances and also in assisting me as I was learning. Her support and availability has been the best. Thank you, also, to Landon James, NENA Past-President, for his assistance and support.

For our members who do not know me, my name is Sherry Uribe. I live in the south Okanagan in British Columbia, with my husband Mike, on our three-acre cherry orchard. I retired from full-time employment about one year ago, after working in a variety of positions for almost 38 years. I am now able to work as little or as much as I want, in front-line emergency nursing, as well as in management and project coordination.

I look forward to working with the NENA executive, board of directors and, of course, our members, managing financial affairs for NENA. I do have some ideas, which I will share with you in the coming months, trying to simplify and standardize some of the processes for conferences, education courses, etc.

NENA's finances continue to be very stable, allowing us to continue to invest in activities to support the professional practice of emergency nursing.

Our next big event is our national conference, being held this year in Halifax, Nova Scotia, May 3–5. Please join us as we celebrate NENA's 30th Anniversary at the conference, *30 Years of Navigating the Depths of Emergency Nursing*. Online registration is now available on our website at **www.nena.ca**. Register by March 23 for an Early Bird Discount.

Again, thank you for the opportunity to serve as NENA Treasurer. I look forward to meeting many of you in Halifax and I welcome questions or suggestions at any time. Please email me at **treasurer@nena.ca**.

Sincerely,
Sherry Uribe

Trauma Association of Canada (TAC) Annual Scientific Meeting
April 12 - 13, 2012, The Hilton, Toronto, Toronto, ON

The Trauma Association of Canada (TAC) hosts Canada's premier multi-disciplinary conference on trauma. The 2012 program will feature a wide range of educational activities, including discussion panels oncontroversial topics, special interest group meetings, clinical updates, and special symposia. The non-scientific portion of the meeting includes an Opening Reception at the Hilton Toronto and a Conference Dinner in the historic Distillery District.

Highlights include:

- **Dr. Louis Francescutti (Royal College Lecture) - Creating a Stronger Voice for Reducing Injuries**
- **Dr. Charles Tator (Murray Girotti Lecture) - Prevention of Catastrophic Injuries in Sports and Recreation in Canada.**
- **Dr. Ari Leppaniemi (International Lecture) - Identity Crisis of Trauma Surgeons—The Northern European View**
- **Dr. Rao Ivatury** presenting the **Fraser Gurd Lecture**

The Division of Continuing Professional Development, Faculty of Medicine

Registration now open!
Tel: 1-604-875-5101
www.ubccpd.ca; cpd.info@ubc.ca

TAC

News from the provinces

British Columbia: ENABC

The past few months have been a "get to know the job" for several new members of the B.C. executive, president included. We have added a new treasurer, education coordinator and a member at large, who is leading our ENPC planning. Our membership is currently at 167 and we are always recruiting more. Our spring executive meeting is planned for April 2 in Vancouver where we will set goals for the next year. Our newsletter came out in February after much encouragement for submissions from our keen communications officer Colleen Brayman.

Many hospitals in B.C. are actively engaged in clinical care management, a Ministry of Health focus on nine clinical areas, that has emergency departments actively engaged in sepsis/stroke and medication reconciliation. There is no shortage of projects in all of our EDs with a focus on improving patient care. As well, sites across the province have been undergoing accreditation using the new Qmentum methodology. With this new process there is a real focus on effecting positive change at the unit level.

B.C. is partnering again with Washington State for our fall education conference, and we will head to Seattle October 12–13. Our colleagues in Victoria have planned an exciting RN/MD emergency conference for April 20–21 in sunny Victoria. "Top 5 in 5" has 40 speakers booked for the day and already 67 participants signed up. Those Islanders know how to draw a crowd. BC and Alberta are partnering for the third time on an overcrowding conference, this time in Vancouver April 27–28 (WEDOC) Finally, the annual St. Paul's Emergency Medicine conference will be held in Whistler September 27–30, with a nursing stream that drew 35 keen nurses last year.

TNCC course are happening all over the province. For more information on that and the new CAMAN airway course, visit: **www.emergencynursing.ca**. ENPC courses are posted on the ENABC website. ACLS provider and Update courses are happening all over the province, as well. The newest update to the CTAS course has begun rollout as well.

We are looking forward to connecting with our colleagues across the country in Halifax!

Sherry Stackhouse
ENABC President

Alberta: ENIG

Membership in Alberta remains constant around 180 members. We continue, as an executive, to think of new ways to increase membership, while coming up with incentives for ongoing members. ENIG continues to offer education days across the province and to encourage all members to attend TNCC and ENPC courses.

Our education day and AGM was held on March 2, 2012, in Edmonton. The day had a variety of speakers including a presentation by Edmonton City Police on street drugs. This comes at a time in Alberta when we are seeing a rise in young adult deaths related to the drug ecstasy. This information gave us a better idea of what we are looking at and for in caring for these patients.

Alberta continues to see increasing demands and volume in our emergency departments. Reports state we have had a 20% increase in emergency department visits in the last year. Our AGM and education day allowed our membership an opportunity to reconnect and discuss similar problems we are all experiencing in our areas of the province with increased demands on capacity. During these times of increased demands our members continue to provide optimal care throughout the province.

The ENIG executive continues to encourage our members to send us ideas for education opportunities and ideas on how to increase membership.

Dawn Paterson
ENIG President

Saskatchewan: SENG

As I watch the snow falling outside the window, it is hard to imagine that spring is just around the corner. Spring is always a time to look forward to, and within SENG we look forward to our Annual Spring Conference. This year, we are hosting our conference and AGM on April 20, and are excited to offer many interesting topics for emergency nurses from across the province. SENG also continues to offer and support TNCC and ENPC courses throughout the province. To get more course information, please contact us!

This past winter, our emergency departments in Saskatchewan continued to face the issues that are faced across the country. Overcrowding and boarding in emergency departments continue to be a challenge. In Saskatchewan, we also face rural hospital closures due to physician and nursing shortages. We look towards the future and anticipate progress on these issues.

On a bright note, I continue to see nurses standing up in the face of adversity and challenging work conditions and providing excellent patient care. This makes me proud to continue to say that I am an emergency nurse. The time for certification is also upon us and I wish good luck to all those nurses pursuing their Emergency Nursing Certification.

For any information on our spring conference or SENG activities, please contact us at **directors@seng.ca**. Happy spring to all!

Raegan Gardner
SENG President

Ontario: ENAO

In keeping with the decision by the ENAO BOD to extend our 40th anniversary celebrations over two years, plans are well underway for the ENAO 2012 conference. "Compressions for Compassion" will take place in September in Toronto, bringing Emergency Nurses together for what promises to be an exciting educational event. Watch the ENAO website (**www.enao.me**) for conference updates.

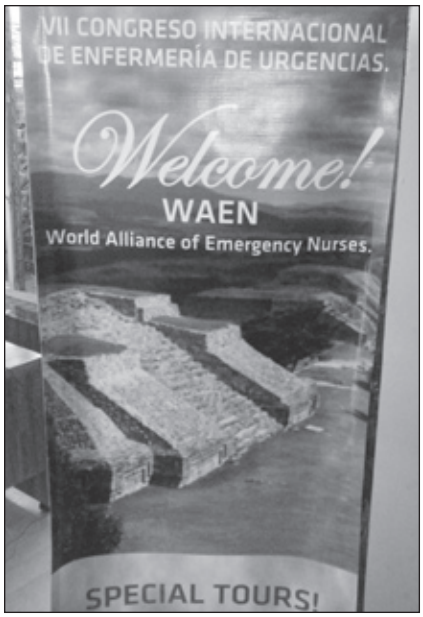
ENAO members are encouraged to watch their mailboxes for the planned 40th anniversary ENAO commemorative journal edition, currently in the creation phase.

ENAO has been invited to be a participant on the Provincial Paediatric Pandemic Influenza Planning (P4) working group. This important group comprising a variety of experts is determined to create a paediatric-specific pandemic planning document. The goal is to improve Ontario's provincial preparedness to better meet the unique variety of needs of our youngest patient population in future pandemic situations.

As ENAO president, I was invited to be a speaker at the national congress of the "Asociacion Mexicana de Enfermeria en Urgencias A.C."—AMEU (Mexican Emergency Nurses Association), which was held in October 2011 in Oaxaca, Mexico. My presentation topics included: "Management of Geriatric Emergencies", "Disaster Triage: A Canadian Trial Run" and "Violence in Emergency Departments". This information sharing was well received by the 350 Mexican nurses and nursing students in attendance. During the congress closing ceremony, I was honoured to be inducted into the AMEU "Socio Honorario" (Honour Society).

During my days in Mexico, I also represented Canada at the second meeting of the World Alliance of Emergency Nurses (WAEN). This new and expanding organization has been created to facilitate international educational opportunities for emergency nurses.

Respectfully submitted,
Janice L. Spivey
ENAO President



Quebec: AIIUQ

In the last two years, the AIIUQ has put a lot of effort into the reorganization of the association. We are happy to say that we are back on track financially and stronger than ever.

As most of you know, we are very proud to have joined NENA. It's very important that all the emergency nurses in Canada are connected.

The membership is now up to 137 active members and we are hoping that this number will double in 2012.

The OIIQ (Quebec nurse order) passed a new law requiring that, starting in 2012, all nurses in Quebec will have to complete 20 hours of continuing education per year.

The AIIUQ received this news with a lot of joy. At the same time, the AIIUQ is aware of the potential challenge that continuing education will pose for all emergency nurses in Quebec. For that reason, AIIUQ is now looking to establish various means of acquiring continuing education hours that will satisfy the requirements of the association.

We are working hard to certify our emergency nurses to CTAS. Last fall, AIIUQ made provision for some of its nurses to become CTAS instructors in Quebec. The certification of CTAS will be ongoing from now on.

To conclude, the next AIIUQ conference will be held on October 3–4, 2012, with the title: *Les soins d'urgence, un milieu propice au développement professionnel*. The conference will be accredited for continuing education.

Valerie Pelletier
AIIUQ Vice President

Nova Scotia: NSENA

As the new president for NSENA, I was very excited to attend the NENA BOD meeting in November and meet all the smart, dedicated and wonderful provincial and executive representatives from across the country. New to the position, I am still getting myself organized and hope to soon be able to meet with the members of NSENA and start moving us forward.

Provincially, we are faced with many of the same challenges as other provinces, but have also seen some exciting initiatives move forward, as well. The province has introduced the Better Care Sooner Plan. This plan was developed based on recommendations from the Dr. John Ross report on emergency care and focuses on accessibility, patient-centred emergency care, care for seniors and people with mental health illness and appropriate use of paramedics and the provincial 811 nurse line. Included in this plan are standards that provincial emergency departments will be held accountable to meet. A number of these standards include education requirements for emergency department staff, which include CTAS, ACLS, TNCC and PALS or equivalent. One of the initiatives from the Better Care Sooner plan that was rolled out in the fall was the RESTORE program whereby emergency departments are working closely with Emergency Health Services (EHS) to deliver the pre-hospital STEMI reperfusion strategy. With this initiative, paramedics are able, in consultation with emergency department physicians, to deliver thrombolytic therapy in the field. So far, the initiative has proven very successful.

We are very excited to be hosting the NENA conference in Halifax this May and look forward to extending a warm Nova Scotia welcome to all NENA members. Hope to see you there!

Michelle Tipert
NSENA President

Newfoundland and Labrador: NLENA

Over the past six months, as the newly-elected director for NLENA, I have been busy becoming familiar with the duties of the director. I have contacted all existing members to introduce myself and ask for member concerns and insight. I will be visiting rural hospitals, as time and travel allow over the winter and spring. I have also contacted managers of emergency departments and colleagues in an effort to increase our numbers, with good results, I might add!

Our numbers have been steadily increasing and will continue to do so, as advocates are working to encourage members to embrace and be proud to be part of a unique emergency nurse association. I appreciate all those who express pride in being an ER nurse and encourage you to speak proudly of your "specialty."

As the director, I have made it my mandate to revive a provincial symposium and have developed a committee to get a symposium off the ground this fall. Thank you Vikki, Rorey and Deanne. We are extremely excited to offer the symposium with a tentative date of October 19–21, in Corner Brook, NL. The theme of the symposium will be "Disaster Preparedness in the Emergency Department—Are we ready?"

Throughout the province, we are experiencing a few main issues of concern: longer wait times, an increase in staff abuse by disgruntled patients and families compounded by a lack of administrative support, and an increased workload with no increase in staff numbers causing overtime, a lack of breaks on 12-hour shifts and burnout. Fewer family physicians also cause strain on an already busy ER, as patients have nowhere else to turn.

We continue to hold TNCC courses twice yearly, training new instructors as others move on. Thanks to those who helped keep this program going over the years. As the new course director in my region, I am finding out how much work is done by volunteers! Thank you, Anne Casey, for your mentoring over the years. Staff love doing this course and it is proving to be used more and more in our daily jobs. I also would like to send a shout out to all the paramedics in this province—you have become more valuable every day, as you further educate your staff. I have seen this role change immensely over my 17 years.

Todd Warren
NLENA President

outlook Bouquets

- Thank you to Cathy Fewer for her years of service to NENA as Provincial Director from Newfoundland and Labrador. Welcome to Todd Warren from Corner Brook, who has joined the NENA Board.
- Congratulations from the ENAO BOD to the following ENAO/NENA members for winning education scholarships, which were awarded for earning their ENC(C) certification or for successfully recertifying their ENC(C): Kimberly Deline, Deb Moore, Nancy Evers and Janice Spivey. ENAO is grateful to the law firm of Singer Kwinter LLB for its generous financial support of the ongoing education and national certification of these emergency nurses.
- The Inukshuk pictured on the cover of the last Outlook was erected near Minton, SK, as a memorial to our brave young men, the soldiers who have lost their lives in Afghanistan.
- From Todd Warren: I have a colleague who is semi-retired and works in our emergency department. Her name is Bernadette Flynn, RN, and she has worked for approximately 25 years as an emergency/triage nurse. Bernadette is a very positive influence on everyone with whom she works. She has tireless energy and an infectious laugh that is heavenly. She continues to relieve a short-staffed department, thereby allowing others to get a much-needed break from time to time. I would like to thank her for all that she brings to a stressful place to work. She is our divine intervention! Bernadette works at the Western Memorial Regional Hospital, Emergency Department, Corner Brook, Newfoundland.

ANA Recognizes Emergency Nursing as Specialty Practice

The American Nurses Association (ANA) has formally recognized emergency nursing as a specialty practice.

SILVER SPRING, MD – The American Nurses Association (ANA) has formally recognized emergency nursing as a specialty practice.

Emergency nursing is the care of individuals across the lifespan with perceived or actual physical or emotional alterations of health that are undiagnosed or require further interventions. Emergency nursing care is episodic, primary, typically short-term, and occurs in a variety of settings.

ANA also approved the Emergency Nursing Association's (ENA) scope of practice statement and acknowledged the standards of practice for emergency nursing. These documents, written by the ENA, form the foundation of emergency nursing and outline the expectations of the professional role within which emergency nurses must practice.

"The criteria for attaining specialty status are rigorous, so the recognition of emergency nursing as a specialty is a significant achievement," said ANA President Karen Daley, PhD, MPH, RN, FAAN. "ANA's role in this process is to protect patients by ensuring high quality in nursing practice and performance. This recognition tells the public that emergency nurses are dedicated to meeting high standards of care and patient safety."

ENA President AnnMarie Papa, DNP, RN, CEN, NE-BC, FAEN, said the recognition acknowledges the unique aspects of emergency nursing, and gives emergency nurses a stronger voice in health care policy debates.

"It allows other health professionals and health care consumers to have a clear understanding of the range of emergency nursing practice and gives a better understanding of the roles emergency nurses fill," Papa said.

Papa added that the designation establishes a common language and understanding within the emergency care field, strengthens the case for ongoing research to apply best practices at stretcher-side, and reinforces "the need of the emergency nurse to embrace career advancement in leadership, education and advanced practice nursing."

By consensus of specialty nursing groups, ANA became the neutral reviewing body of scope of practice statements and standards of practice for nursing specialties in the late 1990s. Specialty nursing practices must meet certain criteria to gain recognition, a review process intended to ensure consistency in nursing practice.

Adam Sachs, ANA
301-628-5034/adam.sachs@ana.org

Anthony Phipps, ENA
847-460-4054/ aphipps@ena.org

NENA Board meeting Fall 2011

The fall Board Meeting and NCAC meeting were held in Whistler, B.C. Back row: Sherry Stackhouse, Erin Musgrave, Colleen Brayman, Sherry Uribe, Michelle Tipert, Janice Spivey, Todd Warren and Lori Quinn; Front row: Dawn Paterson, Cate McCormick, Sharron Lyons, Stephanie Carlson and Landon James.

NLENA President Todd Warren

NSENA President Michelle Tipert

ENAO President Jan Spivey

CTAS Representative to the Board Colleen Brayman and ENABC President Sherry Stackhouse

ENIG President Dawn Paterson

NBENA President Erin Musgrave

Acting PEI Director Esther Currie

NENA Secretary Cate McCormick

Canadian Triage and Acuity Scale National Working Group (CTAS NWG) update

Dear CTAS Instructors,

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

The new materials have been saved with an expiry date of July 1, 2012. This coincides with the renewal of CTAS Instructor and NENA memberships, and is to ensure all CTAS Instructors are using the most up-to-date materials vetted by the CTAS NWG, NENA and CAEP. What this means is that as of July 1, 2012, the materials will become corrupt and you will not be able to use them until you have renewed both of your memberships, and have taught at least one course per year.

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

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

A few highlights of the provider course revisions are:

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

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

The following are a highlight of some of changes:

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

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

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

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

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

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

Visit our new website **http://caep.ca**

Follow us on Twitter: @Caep_Docs
http://twitter.com/#!/CAEP_Docs

Like us on Facebook:
http://www.facebook.com/pages/CAEP/275451855826447

National Course Administration Committee (NCAC) Report Spring 2012

By Margaret Dymond

Traci Foss-Jeans, Debra Bastone, Margaret Dymond and Monique McLaughlin.

ENPC 4th edition updates

2012 will be a busy year for ENPC instructors. NCAC is waiting for final approval to commence the dissemination of 4th edition ENPC course, which is anticipated to be fall 2012. The ENPC 4th edition manual is close to completion. A selected group of ENPC instructors are assisting with the exam review process. ENPC instructors can find a bridging document online at **ena.org** that updates the BCLS/PALS content in the 3rd edition manual to current standards.

TNCC

A call for working group members for the next TNCC revision process is underway. ENA expects to start working on the next TNCC revisions in fall 2012.

NEW: Online course application process for TNCC and ENPC

ENA launched **e-Course Ops in** November 2011. All Canadian course directors for TNCC or ENPC can go online to **ena.org** to register your courses. NCAC suggests that all Canadian TNCC/ENPC course directors visit the website and view the demo video on the application process. Canadian course directors do not need to be ENA members.

The other benefits for course directors include tracking your courses, fee payments, and viewing outstanding invoices. Phase two roll out will occur in Spring 2012, and will permit course directors to enter student marks from courses. No more paper!

All course directors are responsible to ensure their instructors are current in teaching and are NENA members.

NENA Conference, May 3–5, 2012—Halifax

NCAC will be hosting a booth at the National Emergency Nurses conference. Activities include a demo of the new online course application process and a "gift bag" for all TNCC/ENPC/CTAS instructors. Don't forget to indicate on the registration form that you are a TNCC, ENPC, or CTAS instructor!

Canadian Triage and Acuity Scale (CTAS) courses

NCAC is taking over the administrative work for CTAS courses. A new course administrative manual is available. Requests for the new manual can be made to **CTAS@nena.ca**. All Canadian CTAS instructors must have current instructor status and be NENA members. The provider and instructor manuals plus the course slides were updated in 2011. CTAS instructors who are not current will not have access to the new material. The CTAS materials and slides are located on the CAEP website.

NCAC communication with TNCC/ENPC/CTAS instructors

The NCAC newsletter latest edition is located on the NENA website at **nena.ca**. Some TNCC/ENPC instructors may also receive information from ENA's Course Bytes.

NCAC Course Administrative Manual for ENPC/TNCC

The Canadian Course administrative manual has been revised. TNCC/ENPC course directors can obtain a copy from **ncac@nena.ca**. NCAC is anticipating the manual will be posted on the **nena.ca** website.

NCAC contact information

Need to contact NCAC for course issues? The generic email address is **ncac@nena.ca**.

NCAC Membership:
Chair:
Margaret Dymond
margaret.dymond@albertahealthservices.ca

Western Rep: BC, AB, SK, MB, NWT, YK
Monique McLaughlin
monique.mclaughlin@vch.ca

Central Reps: Ontario
Debra Bastone
dddbastone@bell.net

Brenda Lambert
lambertbrenda17@gmail.com

Eastern Rep; QC, NB, NS, PE, NL, NU
Ann Hogan
ann.hogan@horizonnb.ca

CTAS Rep:
Traci Foss-Jeans
traci.fossjeans@centralhealth.nl.ca

Team Broken Earth

By Jackie Williams-Connolly, RN, Janeway Emergency, Team Broken Earth

When the opportunity to travel to Haiti in July came my way, I was so excited because it was a dream of mine to be involved in humanitarian work… No time like the present—I read everything about Haiti and the devastation the people had endured and continued to endure. I was ready!

My family and friends wondered how I would get along in Haiti, but armed with my bottle of Spray 9 (it kills everything—don't laugh, I had the cleanest bed, bathroom and ICU equipment in Haiti) off I went.

YouTube, pictures and graphic descriptions did not prepare me for the surreal feeling I had when we landed in Haiti.

Arriving at the Bernard Mevs/Medishare Hospital in Port au Prince, a quick orientation and we hit the ground running and quickly immersed ourselves in our areas of work.

The amazing interpreters who worked with Project Medishare made quick introductions and we started work alongside our new colleagues, the Haitian nurses in their various departments, pediatrics (NICU and PICU), operating and recovery room, medical and surgical wards, emergency, triage and ICU.

Haitian nurses quickly warmed up and came to us with questions, looking for better ways to organize their workspaces that were very cramped and needed to be made more efficient. We tested intubation equipment, developed crash carts, fixed EKG machines (with my lip gloss for oil), taught rhythm strip/EKG interpretations, tracheostomy care and cleaning, wound care, IV therapy and the importance of fluid administration, medication administration and effective charting, chest tube care and even dialysis because it was something they were interested in, but had no experience.

During our time off, we were helping out in all departments, feeding the children or just rocking them for comfort, talking and going to x-ray with the patients, helping out in the emergency room, triage or the pediatric clinics doing whatever needed to be done. We had a high number of critical patients including gunshot wounds to various traumatic accidents giving us an abundance of experience.

It was an adventure that I will never forget. We went to help the people of Haiti and came home with amazing stories and friendships.

Would I go again? In a heartbeat!

Would I encourage people to volunteer? Most definitely, because, as with all volunteering, you always get so much more than you give!

I'm very fortunate to have made a return trip to Haiti February 17–27, 2012.

You can check out our webpage: **www.brokenearth.ca**

30 Years of Navigating the Depths of Emergency Nursing

The Nova Scotia Emergency Nurses' Association (NSENA) is thrilled to host the National Emergency Nurses' Affiliation (NENA) National Conference in beautiful downtown Halifax, Nova Scotia (Westin Conference Centre/ Hotel) in May 2012. NENA is a professional association for emergency nurses. This three-day conference is open to all nurses across Canada. This year is the 30th anniversary of NENA. The conference information starts on page 17 of this issue.

Board of Certification for Emergency Nurses

Dear Emergency Nurses,

The **Board of Certification for Emergency Nursing (BCEN®)** has begun an exciting new chapter. On December 1, 2011, BCEN realized an important goal by establishing its own independent office, moving out of our space at the Emergency Nurses Association (ENA) and independently outsourcing administrative support services.

BCEN continues to provide certification services that promote excellence and critical thinking in emergency nursing through testing and knowledge assessment. BCEN continues to develop, refine and administer exams, and promote emergency nursing certifications across the emergency care continuum. BCEN also continues to strengthen its important relationships with affiliate organizations such as the Emergency Nurses Association (ENA), the Air & Surface Transport Nurses Association (ASTNA) and the Pediatric Nursing Certification Board (PNCB).

You may have experienced some challenges with contacting BCEN during the month of December 2011. Our temporary technology and phone system issues have been resolved. We sincerely apologize for any inconvenience this may have caused. Please know the BCEN team greatly appreciates your patience and understanding as we worked through the transition period.

BCEN's new physical and mailing address is:
Board of Certification for Emergency Nursing
55 Shuman Boulevard, Suite 300
Naperville, IL 60563-8467

NEW PHONE: +1-630-848-9259
NEW FAX: +1-630-596-8250
NEW EMAIL: **bcen@bcencertifications.org**
UPDATED WEBSITE: **www.BCENcertifications.org**

Our toll-free number +1-877-302-BCEN (2236) remains the same.

An important goal for BCEN is to keep you all informed as we move forward. Take a moment to review your BCEN Credential Manager Account and update your contact information and email address. Access your account at **www.BCENcertifications.org** and click on "Credential Manager" located at the top of the left-hand navigation bar. From here you can log in to your BCEN record to complete and submit your exam application, submit applications for your certification renewal, log and submit your CE requirements, safely and securely publish your BCEN credentials to a third party, purchase BCEN merchandise, and leverage a host of other self-service tools.

Remember to add BCEN's email address, **bcen@bcencertifications.org**, to your safe sender's list. Taking these steps will help to ensure you receive important communications from BCEN.

Note Regarding ENA Membership: In accordance with ENA's direction to BCEN, please be advised that BCEN can no longer accept ENA membership payments. BCEN and ENA remain affiliate organizations. At this time, BCEN continues to offer ENA members discounted pricing on BCEN exams and renewals for the Certified Emergency Nurse (CEN®), Certified Flight Registered Nurse (CFRN®), and Certified Transport Registered Nurse (CTRN®). Please contact ENA direct for membership information.

Regarding ASTNA Membership: BCEN continues to accept membership payments for the Air & Surface Transport Nurses Association (ASTNA) and continues to offer ASTNA members discounted pricing on BCEN exams and renewals for Certified Flight Registered Nurse (CFRN®) and Certified Transport Registered Nurse (CTRN®). Visit BCEN's website for more information: **www.BCENcertifications.org**.

Please share our news with your colleagues and be sure to check our website at **www.BCENcertifications.org** often for more updates.

Best wishes to you and your continued success with your career in emergency nursing.

The BCEN Team

"We must be prepared to collaborate and respond"

By Janice L. Spivey, RN, ENC(C), CEN

In January, I had the honour of being one of 100 invitees to attend the 2012 Emergency Preparedness and Response (EPR) Forum in Edmonton, Alberta. The goal was for the EPR Forum to be "the main Pan-Canadian event to address key strategic policy issues in public health and emergency management in Canada." It was to also be "the primary interface for PHAC (Public Health Agency of Canada) between federal, provincial/territorial governments and non-government organizations involved in the delivery of public health, health care and emergency management services." The 2012 Forum's theme was "Strengthening Collaboration Between Public Health, Health Care and Emergency Management".

My invitation to represent emergency nurses, as a member of NENA nationally and ENAO provincially, originated from Dr. Theresa Tam, Director General, Centre for Emergency Preparedness and Response, Public Health Agency of Canada. The expectations of me were clear. "As a participant of a non-government organization, we hope that you will bring the expertise and insight of your organizations to the EPR Forum discussions. We also hope that communications at the Forum of best practices and gaps experienced by you and members of your organizations on the front line will allow PHAC's Centre for Emergency Preparedness and Response to make informed policy and programming decisions."

In this article, I will attempt to share my experiences and my learning from some quite amazing national and international speakers.

Dr. Tam served as the Master of Ceremonies throughout the entire Forum. During the opening ceremonies, Kathryn Howard, Assistant Deputy Minister, Emergency Management and Corporate Affairs Branch, PHAC, discussed the vital interdependence between members of the Public Health, Health Care and Emergency Management teams in Canada and beyond.

The first plenary session was a panel discussion including Dr. Andre Corriveau, Chief Medical Officer of Health for Alberta, Andre Picard, Public Health Reporter for the *Globe and Mail* newspaper and Dr. Daniel Kollek, Executive Director for the Centre for Excellence in Emergency Preparedness (CEEP) and CAEP Disaster Committee. Dr. Corriveau reviewed the key activities and achievements in strengthening collaboration and coordinating the actions between emergency preparedness key stakeholders. Andre Picard stressed the importance of public health and health care officials presenting a united front and providing non-conflicting messages to the public in times of a disaster. Dr. Kollek called for better communication between Canada's EDs and the various public health agencies, identifying the importance of front-line staff involvement in planning, preparation, goal setting and public messaging. After all, we are the professionals who must adapt to make the plans work, while dealing with the realities on the front line of any disaster.

Dr. Theresa Tam, Janice Spivey, Dr. Bonnie Henry, Dr. Carl Jarvis, Dr. Brian Schwartz and Dr. Daniel Kollek.

The second plenary session explored how the emergency management, health care and public health sectors can better support each other during emergencies. Dr. Wadieh Yacoub, Medical Officer of Health, Director of Health Protection, Health Assessment and Surveillance, First Nations and Inuit Health Branch of Health Canada, talked about the "travel nursing teams" where nurses were shared between First Nations communities to ensure timely and equitable H1N1 vaccine distribution to all Canadians. Chris Smith, Executive Director, Emergency Management Unit, British Columbia Ministry of Health, shared information about the valuable and timely use of videoconferencing to facilitate information distribution during a pandemic or other disaster situation.

Dr. Kevin Yeskey, Deputy Assistant Secretary for Preparedness and Response, Department of Health and Human Services, United States, was the speaker of the third plenary session. He discussed

recent U.S. disasters, such as the oil spill in the Gulf of Mexico. I was surprised to learn of the magnitude of the increasingly apparent long-term health issues in fish and shellfish, the physical health effects of the oil and the oil dispersants in many emergency responders, as well as the growing evidence of long-term stress, as seen through increasing rates of depression, domestic violence and substance abuse in the areas most affected by this disaster.

The following concurrent sessions presented difficulty for me in choosing which one to attend. Journalist Andre Picard examined the challenges faced by public health officials and the media in trying to keep the public informed throughout an evolving emergency situation. Dr. Barbara Raymond, Director, Pandemic Preparedness Division, Centre for Immunization and Respiratory Infectious Diseases of PHAC, discussed the collaborative research initiated following SARS in 2003 and H1N1 in 2009, jointly involving the disciplines of public health, infectious disease and critical care. Dr. John Marshall, Professor of Surgery, University of Toronto, Attending Surgeon and Intensivist, St. Michael's Hospital, Chair of Canadian Critical Care Trials Group, talked about ongoing development of new models of response for future disease outbreaks, earthquakes, floods, terrorism and nuclear disasters. Dr. Robin Cox, Associate Professor and Program Head, Master's Program in Disaster and Emergency Management, Royal Roads University, helped us to better understand the complex and unique challenges in responding to emergencies in rural, remote and isolated Canadian communities.

Thus, ended the very intense morning of day one of the EPR Forum.

Gerilynne Carroll, Director, Emergency Management Branch, Ontario Ministry of Health and Long-Term Care, and Allison Stuart, Assistant Deputy Minister and Chief, Emergency Management Ontario, shared the podium for next plenary session. They spoke about the emergency situation in 18 communities of Northern Ontario during last summer's forest fires. Fire and smoke resulted in the required evacuation and subsequent repatriation of 10,000 people. We learned how Ontario's Emergency Medical Assistance Team (EMAT) deployed with a 56-bed hospital, which was used for 10 days, assisting with the surges of evacuated people into receiving communities.

The international guest speaker for the next plenary session was Dr. Tomoya Saito, International Health Crisis Management Coordinator, Office of Public Health Emergency Preparedness and Response, Health Science Division, Ministry of Health Labour and Welfare, Japan. Dr. Saito took us on an amazing journey through the events of the March 11, 2011, major earthquake (fourth largest in world history) off the northeast coast of Japan, the many aftershocks, followed by the powerful tsunami (the largest in 450 years with waves 30 to 40 metres), resulting in the loss of electricity to operate the nuclear reactor cooling systems, ultimately leading to the subsequent nuclear accident. We learned that 380 Japanese hospitals were affected by this incomprehensible disaster, 10 were completely destroyed, 290 were partially destroyed, and the remainder suffered significant damage. Dr. Saito's final words remain with me, as he quietly said, "Reality far exceeded any expected scenario."

The final plenary session of the day included a panel of experts who reviewed the state of Canada's nuclear preparedness and our ability to respond to health issues that could arise following a nuclear disaster. Dr. Bonnie Henry, Director, Public Health Emergency Services, British Columbia Centre for Disease Control, discussed the many concerns on Canada's west coast about potential consequences here following Japan's recent serial disasters (i.e., radioactive debris washing ashore in B.C., contamination of fish and seafood, much misunderstanding about possible radiation risk across the Pacific Ocean). Dr. Carl Jarvis, Medical Director of the Emergency Department Disaster Planning, and Assistant Professor, Department of Emergency Medicine at Dalhousie University, questioned whether our EDs are ready to effectively respond to a nuclear "event"? He recommended the Medical Emergency Treatment for Exposures to Radiation (METER) course for front-line emergency personnel in areas of Canada having the highest risk of a nuclear accident. David Duschene, Chief, Nuclear Emergency Preparedness and Response Division, Health Canada, talked about Canada's response to the earthquake and its sequellae in Japan. Efforts were made to assist Japan, while also protecting Canadians in Japan. Canada quickly deployed radiation detectors to the Canadian embassy in Japan, while simultaneously adding additional radiation detectors along the western coast of B.C. Following concerns for potential radiation in the air or rain water, this Canadian environmental monitoring remains ongoing.

Dr. Tam closed day one of the EPR Forum with the thought that significant and ongoing financial and human support are both essential in order to achieve and maintain an appropriate standard of emergency preparedness, as would be required to mount an effective response to a future disaster. While we were all overloaded with information from all that we had heard and with feelings from the incredible pictures that we had seen, we could hardly wait to see what day two of the EPR Forum would bring. Unfortunately, NENA members will have to wait for the next edition of *OUTLOOK* to find out.

Calling all instructors

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

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

National Emergency Nurses Affiliation
National Conference 2012

30 Years of Navigating the Depths of Emergency Nursing

May 3–5, 2012
Halifax, Nova Scotia

Register by March 23 to save!
For more information, visit www.nena.ca

Who should attend:
Any emergency department nurses and allied health care professionals who are seeking to learn more about various topics from around the country.

What is it:
National Conference 2012—Celebrating 30 years as NENA.

When:
May 3–5, 2012

Where:
The Westin Nova Scotian, 1181 Hollis Street, Halifax, NS

Registration:
Early bird rates close March 23, 2012. Regular registration for NENA Members $400.00, non-NENA members $475.00, and students $175.00. Visit **www.nena.ca** for a full schedule of education sessions and events and register today!

Program

Thursday, May 3

0730 Registration/Breakfast
0830 Opening Ceremonies
0930 Better Care Soon — *Dr. John Ross*

Nutrition Break

1045 Breakout Sessions
1. Period of Purple Crying — *Sharron Lyons*
2. ACLS Guidelines — *Sherry Stackhouse*
3. Becoming "Social" in 2012 — *Landon James*

1145 Exhibit Hall Open/Lunch

1230 Trauma in Afghanistan —
Lt.(N) Henneberry and Cpl. Brad Casey

1400 Breakout Sessions
1. Good, Bad and Ugly (Burns) — *Carole Rush, Joy Boyd*
2. Delirium Strategy for ED — *Laura Wilding*
3. Implementing MediTech 6.0 — *Joanne Bayes*

Nutrition Break

1500 Breakout Sessions
1. Developing a Disaster Plan — *Cathy Dobson*
2. Improving ACS Care/Nova Scotia —
Meala Gill, Kathy Harrigan
3. P.A.R.T.Y. — *Jan Calnan*

1730 NENA 30-year Celebration

Friday, May 4

0730 Breakfast
0830 Good Morning/Questions from opening day
0845 Survive and Thrive with Humour — *Tim Westhead*

1000 Breakout Sessions
1. Thoracotomy—Nursing Role — *Lindsay Richards*
2. Emergency Disaster Management — *Landon James*
3. Manitoba Nurse Retention Project — *Jo-Ann Sawatzky*

1045 Nutrition Break

1100 Breakout Sessions
1. Concussion — *Carole Rush*
2. Follow-up Patient LWBS — *Nikki Kelly*

1145 Exhibit Hall Open

1200 Lunch and NENA Annual General Meeting

1330 Legal Aspects — *Dawn McKevitt*

1415 Breakout Sessions
1. Mental Illness in the ED — *Debbie Phillips*
2. Improving Access to ED Care — *Susan Kriening, Lisa Sullivan, Andrew Sharpe*

Nutrition Break

1515 Breakout Sessions
1. Inside Triage — *Karen Melon*
2. Flight Nurse in the Arctic — *Caroline Ross, Denise Devison*
3. Overcoming Challenges of Overcrowding — *Landon James, Claude Stang*

1730 Social Event at Murphy's on the Water

Saturday, May 5

0730 Breakfast
0830 Good Morning/Introduction of Conference Committee Members
0845 Trauma for the Non-Trauma Nurse — *AnnMarie Papa*

0945 Breakout Sessions
1. ED Delivery—Not in My ED — *AnnMarie Papa*
2. Minutes Count—ECG Delay in STEMI — *Karen Melon*
3. Improving Discharge of Seniors — *Jo-Anne O'Brien*

Break

1045 Breakout Sessions
1. "What's Bugging You"—Common Infestations — *Nancy Connor*
2. Give PEACE a Chance — *Mohamed Toufic El Hussein*

1145 Closing Ceremonies

Murphy's

The Cable Wharf

Murphy's Cable Wharf is situated at the foot of George Street on the **Halifax waterfront**. Halifax's largest Tour Boat & Restaurant Operator is a can't miss destination combining **nightlife, nature tours, sightseeing, fine dining, tours of historic properties** and much more, all in the company of the friendliest people you'll meet! Join us at Murphy's Cable Wharf for a **tour of Halifax** from the water, plan an unforgettable event, visit our newly renovated **Gift Shop,** or dine while enjoying an unparallelled **harbour view in the new Murphy's Restaurant**. Named one of Canada's Top Ten Attractions by Where Magazine, visitors and locals alike truly experience the best that Halifax has to offer at our destination.

http://www.mtcw.ca/

The Westin Nova Scotian

In the heart of downtown Halifax, The Westin Nova Scotian's prime location offers a peaceful respite in this beautiful city. With easy access to nearby shopping and dining, you can experience all that downtown has to offer, or simply enjoy a stroll by the boardwalk and wharves of Halifax Harbour. Refresh and renew at our state-of-the-art fitness centre, which includes an indoor heated pool. Let our food and beverage specialists help you host the perfect event in one of our 23 versatile meeting spaces. Enjoy stunning views of either Halifax Harbour or Cornwallis Park from one of our 310 guest rooms and suites. Each room has contemporary amenities and an oversized bathroom. Relax in one of our cozy Heavenly Beds®.

http://www.starwoodhotels.com/westin/property/overview/index.html?language=en_US&propertyID=1081

2012 NENA Conference Registration
Westin Nova Scotian Hotel and Resort
Halifax, N.S., May 3–5, 2012

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

❑ Non-member ❑ NENA member ❑ NENA board/conference committee ❑ Student ❑ Speaker

Online Registration and Payment: Online registration and payments, including credit card, are only available through PayPal. Please visit the NENA website at **http://nena.ca** and click on the NENA Conference 2012 link under the "Conference" tab for more details.

Mail Registration and Payment: Payment by cheque or money order. Cheques/money orders should be made out to "NENA 2012 Conference Committee" and must accompany this completed registration form. All memberships must be paid online.

I am registering as:	Early Bird (Before March 23)	Regular Fee (After March 23)
❑ NENA Member	$375.00	$425.00
❑ Non-Member	$425.00	$475.00
❑ Student	N/A	$175.00
❑ Individual Day (Thur/Fri)	N/A	$175.00/day
❑ Individual Day (Sat)	N/A	$75.00/day

Social admission on Friday night is included in full conference fee for both members and non-members. Those attending as students or on individual days must buy their social ticket separately at a cost of $55.00 per ticket. Extra social tickets may be bought for accompanying guests to a max of four (this is subject to change based on availability).

Admission to Social $55.00 x _____ = $ _____

I am paying by cheque or money order for a total of $ _____, made payable to: NENA 2012 Conference Committee. Please send completed form and payment to:

Sherry Uribe
RR 5 @10 C7
Oliver, BC V0H 1T0

Please select your entrée for the Social on Friday May 4, if applicable:
❑ Chicken ❑ Haddock ❑ Vegetarian

Please identify if you have any allergies: _____

*** Please identify if you are a TNCC/ENPC or CTAS instructor ***
Please include your email address if you have indicated that you are an instructor: _____

Session Registration

Please select one breakout session in each of the following time slots:

Thursday, May 3

1045–1145

- ❑ Period of Purple Crying — *Sharron Lyons*
- ❑ ACLS Guidelines — *Sherry Stackhouse*
- ❑ Becoming "Social" in 2012 — *Landon James*

1400–1500

- ❑ Good, Bad and Ugly (Burns) — *Carole Rush/Joy Boyd*
- ❑ Delirium Strategy for ED — *Laura Wilding*
- ❑ Implementing MediTech 6.0 — *Joanne Bayes*

1500–1600

- ❑ Developing a Disaster Plan — *Cathy Dobson*
- ❑ Improving ACS Care/Nova Scotia — *Meala Gill/Kathy Harrigan*
- ❑ P.A.R.T.Y. — *Jan Calnan*

Friday, May 4

1000–1045

- ❑ Thoracotomy—Nursing Role — *Lindsay Richards*
- ❑ Emergency Disaster Management — *Landon James*
- ❑ Manitoba Nurse Retention Project — *Jo-Ann Sawatzky*

1100–1145

- ❑ Concussion — *Carole Rush*
- ❑ Follow-up Patient LWBS — *Nikki Kelly*

1415–1500

- ❑ Mental Illness in the ED — *Debbie Phillips*
- ❑ Improving Access to ED Care — *Susan Kriening, Lisa Sullivan, Andrew Sharpe*

1515–1600

- ❑ Inside Triage – *Karen Melon*
- ❑ Flight Nurse in the Arctic — *Caroline Ross, Denise Devison*
- ❑ Overcoming Challenges of Overcrowding — *Landon James, Claude Stang*

Saturday, May 5

0945–1030

- ❑ ED Delivery—Not in My ED — *AnnMarie Papa*
- ❑ Minutes Count—ECG Delay in STEMI — *Karen Melon*
- ❑ Improving Discharge of Seniors — *Jo-Anne O'Brien*

1045–1130

- ❑ "What's Bugging You"—Common Infestations — *Nancy Connor*
- ❑ Give PEACE a Chance — *Mohamed Toufic El Hussein*

Effective trauma teams: Trauma team simulations

By Margaret Dymond, RN, BSN, ENC(C), Rachelle Saybel, RN, and Cathy Falconer, RN, BScN

Introduction

Resuscitation and management of patients with major traumatic injuries can be challenging and stressful for trauma teams. Shapiro et al. (2004) have reported that effective team training can affect performance improvement in clinical situations. Education and training often focus on skill attainment, but not on team building and dynamics. Effective teams that communicate well can improve the outcomes for patients and play a role in avoiding errors (Shapiro et al., 2004). A planned approach with all trauma team staff members understanding their respective roles is considered a patient safety-orientated approach to care. Harkins (2009) describes trauma as a "team sport". This team sport concept was the underlying focus for our trauma simulation day with an emphasis on communication.

Background

Trauma simulations are a monthly routine at our trauma facility. Simulation exercises (both adult and pediatric) permit teams to practise trauma scenarios in the environment in which they work and become familiar with trauma resuscitation routines. Simulations allow trauma teams to participate and interact together and practise their roles in a safe learning environment in real time simulation. Table 1 describes the members of our trauma team.

Table 1. Trauma Team Members

Trauma Team Leader — physician (Debrief Lead)
Trauma Team Leader — ED resident
Senior and Junior Surgery Residents
Neurosurgery Resident
Orthopedic Resident
Anesthesia Resident
RN Recorder
RN Procedure
RN Assessment
Respiratory Therapist
LPN-orthopedic Technician
Radiology Technicians
Pastoral Care (family support)
Social Work (family support)
Other services as required

The trauma simulations are designed in two phases: the simulation and the debriefing. Critical to the process of team simulation exercises is the debriefing following the event. This is an opportunity for team members to discuss how they feel the simulation progressed, their role in the simulation, and points for improvement.

Taking simulation to a new level: From simulation scenario to simulation day

The trauma program routinely organizes an orientation for all new surgery residents in July of each year. An opportunity existed to combine the concepts of simulations and orientation together for a mass of new surgery residents in one day. Planning began to host a simulation trauma day with the new surgery residents, trauma team leaders, emergency department staff, and simulation staff. Since simulation exercises are ideal in the environment that teams are expected to perform in, the emergency department hosted the real time event. A separate room was set up for viewing the real time streaming video and for debriefing the teams.

Organization/agenda

A multidisciplinary team of physicians, nurses, radiology, respiratory services, and simulation personnel met together to plan the event several months in advance.

The simulation education day was organized into six different simulations that were divided into three morning and three afternoon sessions. The day ended with a Grand Trauma Rounds by an engaging a dynamic presenter on Crisis Management and its Role in Trauma. This presentation discussed the importance of crisis management principles in the safe and efficient care of unstable patients, the basics of patient safety as they apply to trauma and practical strategies in teamwork, communication, and leadership.

The simulation day was advertised to trauma team leaders, surgeons, intensivists, nursing staff of the emergency department, the surgical trauma unit, the neurosurgical trauma unit, and the general systems and neurological intensive care units. Volunteers were enlisted from all of these areas. The volunteers were able to watch the streaming live video and observe how the trauma team functioned in action or participated in real time simulation as an active trauma team member. More than 100 personnel participated throughout the one-day event. See Table 2 for learning objectives.

Table 2. Objectives for the Trauma Simulation

- To educate and promote characteristics that will enhance the acute management of trauma patients.
- Teaching members of the multidisciplinary trauma team skills to not only effectively manage the patient, but also the acute crisis at hand (crew/crisis resource management).
- Emphasizing: communication to improve teamwork and crisis management, how to effectively communicate, how to improve understanding, and how to enhance completion of tasks.

A goal of the trauma day was to allow as many new residents as possible to participate in the event. Teams of eight residents were divided into two groups per session. While one group enacted the trauma case, the other group watched from another

room via video. The simulation centre staff were key to setting up the simulation area and equipment for streaming the video. Once the acting group completed the trauma case, they joined the watching group for a debriefing on what worked well, what did not, and on the importance of team communication. The debriefing was led by experienced and dedicated trauma team leaders and provided an opportunity for resident and participant questions and learning. The group that watched the video first went to act out the same trauma simulation while the first group watched the live video. The second group had the advantage of viewing the video and participating in the debriefing prior to their simulation. Lessons learned during the initial debriefing were put into practice in the repeat scenario.

For the six simulations, four trauma cases were utilized for learning. The cases were a mix of adult and pediatric scenarios.

Scenario one

A flail chest/respiratory distress case. The teaching points were focused on the primary survey, tension pneumothorax as a clinical diagnosis, and the early need for airway management especially for major thoracic injuries.

Scenario two

A traumatic brain injury case. The teaching points were the recognition and management of traumatic brain injury and the avoidance of secondary brain insults. Other emphasis for teaching and learning included the importance of assessing and managing concomitant spinal injuries and the potential for missed injuries.

Scenario three

A penetrating trauma/massive transfusion case. The teaching points were establishing early and adequate IV access, the triad of death—acidosis, hypothermia, coagulopathy, and the need for resuscitation, rewarming and early transfusion.

Scenario four

A severe injury to the extremity case. The teaching points were control of hemorrhage using direct pressure with or without a tourniquet, the establishment of early and adequate IV access, assessing for all injuries, consider the mechanism of injury, and avoid being distracted from the obvious visible injury.

Teaching material, including posters in the simulation area outlining trauma team members, their duties, and responsibilities as a member of a team, were handed out. Signage was visible in the emergency department that alerted all staff and visitors that a simulation was in progress.

Crisis resource management

Following the simulation exercises, all staff were invited to trauma grand rounds. The topic was presented by an intensive care physician on crisis resource management. The focus of grand rounds was to reflect on communication during crisis management and day-to-day practice. The presenter focused on the importance of communication for improving teamwork and outcomes for patients (Brindley et al., 2011).

Evaluation

All participants had an opportunity to complete an evaluation that had a rating scale, as well as a chance to add other comments.

Overall, participants rated the experience as positive and a fun way to learn. They felt the day was well organized and met their learning objectives. Highlights included that the debriefing techniques and video feedback enhanced learning, and simulation days should be planned more often. The participants felt all staff and facilitators were non judgmental, which made the experience a safe learning environment. Most participants felt that this learning opportunity had made them feel that they would be more comfortable dealing with a true trauma situation. Areas for improvement and consideration for the next planned simulation day include a demonstration of the equipment and mannequin at the beginning of the day, more time for each scenario, a larger room for the debriefing, and for surgery residents to act out roles they normally would be expected to play (a plastic surgery resident acting in this capacity). The surgery residents stated they would have been better prepared if they had taken Advanced Trauma Life Support (ATLS) prior to participating. All participants stated they would participate in future simulation exercises.

Conclusion

The trauma simulation day committee felt the goals for the event were achieved. The staff who took part highly valued the experience and felt the simulation exercises should continue.

About the authors

Margaret Dymond is a Clinical Nurse Educator, Emergency Department, University of Alberta Hospital/Stollery Children's Hospital, Edmonton, Alberta.

Rachelle Saybel is the Trauma Coordinator, University of Alberta Hospital, Edmonton, Alberta.

Cathy Falconer is the Pediatric Trauma Coordinator for the Stollery Children's Hospital in Edmonton, Alberta.

References

Brindley, P.G., & Reynolds, S.F. (2011). Improving verbal communication in critical care medicine. *Journal of Critical Care, 26*(2), 155–159.

Harkins, D. (2009). Trauma is a team sport. *Journal of Trauma Nursing, 16*(2), 61–63.

Shapiro, M.J., et el. (2004). Simulation based teamwork training for emergency department staff: Does it improve clinical team performance when added to an existing didactic teamwork curriculum? *Qual Saf Health Care, 13*, 417–421.

The New Brunswick Trauma Program: A model of inclusivity

New Brunswick, Canada's only officially bilingual province, has a population of approximately 730,000 people and covers a geographical area of 71,355 square kilometres (Statistics Canada, 2007). The provision of quality trauma care for all citizens of such a diverse province is a daunting task.

NB Trauma Program
Programme de traumatologie du NB

Horizon Health Network | Réseau de santé Horizon
Vitalité Health Network | Réseau de santé Vitalité
Ambulance NB
New Brunswick Department of Health | Ministère de la santé du Nouveau-Brunswick

The New Brunswick (NB) Trauma Program was created in 2010 as a formalized partnership between the NB Department of Health, Horizon Health Network, Vitalité Health Network, and Ambulance New Brunswick with a mandate to develop and implement a comprehensive system of trauma care, injury prevention, education, and research to serve the needs of trauma patients from across the province. A total of 19 trauma centres in New Brunswick are included in the system's design, ranging from 11 smaller, rural hospitals (Level V) to the province's two major trauma centres. The inclusion of all acute care hospitals, the shared ownership of the program, and the program's extensive scope are what set apart the NB Trauma Program from other systems in Canada.

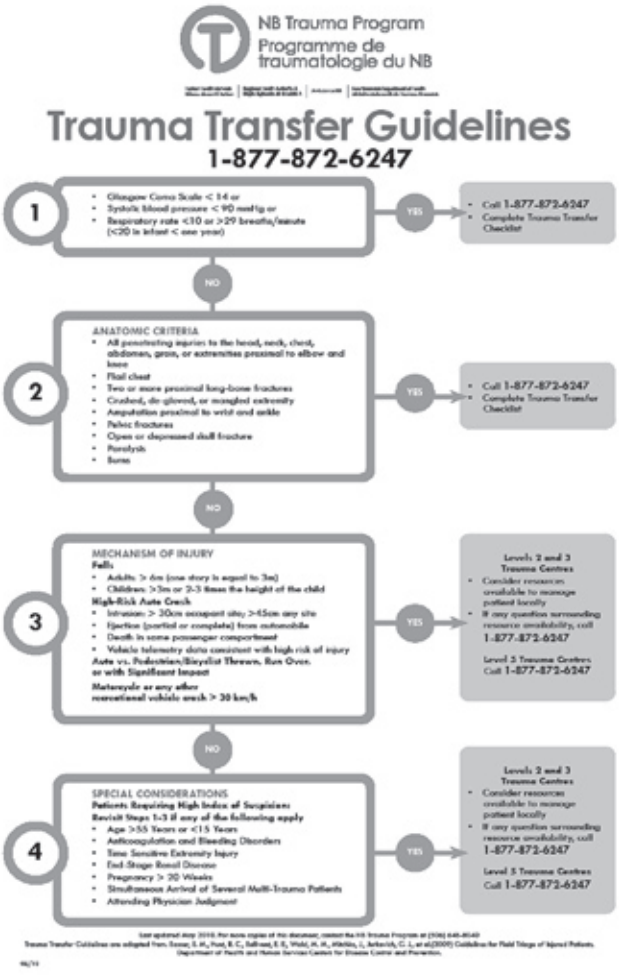
Achievements to date

The majority of New Brunswick's population lives in rural areas, which introduces the need for prolonged trauma transfers before reaching definitive care. To help expedite both the decision-making process and the logistics associated with trauma transfers, one early objective of the NB Trauma Program was to implement provincially standardized Trauma Transfer Guidelines and a supporting Toll Free Trauma Referral System. Coupled with a provincially binding Guaranteed Access policy of major trauma patients, this system provides smaller trauma centres with immediate, 24/7 access to a provincial trauma control physician to offer clinical support and a destination decision. Fully integrated with the provincial EMS communications centre, staff at Ambulance NB is able to immediately (and automatically) dispatch a paramedic crew to transfer the patient.

The system has resulted in tangible and sustained improvements in access to trauma care across the province. Every call is recorded, and a rigorous quality improvement program reviews the timing, participants and processes applied during each trauma transfer call. Since April 2011, the average interval from arrival at a small trauma centre to arrival at a large centre has been reduced to four hours and 47 minutes.

Recognizing that trauma patients are best served by being transported directly to the trauma centre that is most appropriately staffed and equipped to manage their needs, the NB Trauma Program has also developed a provincially standardized tool called Field Trauma Triage (FTT) for use by all Ambulance NB paramedics. The FTT guidelines apply the best available evidence to ensure those with a significant risk of major injury are transported directly to a Level III, II or I Trauma Centre.

The program has also led multiple interdisciplinary, inter-hospital case reviews in which the trauma care and transfer processes for major trauma patients who are transferred to other hospitals for definitive care is reviewed in detail by all those involved, including physicians, nurses, and paramedics regardless of where the patient first presented. These case



reviews are summarized to create three key recommendations, which are then given to people best suited to implement the recommendations. Case review findings are logged by the NB Trauma Program to allow early identification of trends that require more global resolution.

Next steps

Data collection, analysis and resulting changes in practice are integral to the continued success of the NB Trauma Program. An enhanced dataset is currently being collected from the province's Level I and II-designated trauma centre, with nationally defined data elements being used to also help populate the National Trauma Registry. This year, data collection is also starting from Level III trauma centres for both admitted and non-admitted trauma patients, which will help paint an accurate picture of the true burden of injury in New Brunswick. More importantly, these data are being used to help identify areas for improvement in the processes of care, as well as help direct continuing education and public primary prevention activities across New Brunswick.

Trauma Notes, which had previously been used in one New Brunswick facility, are being piloted at other provincial institutions. Once the pilot is complete and feedback is considered, the next step is provincial implementation, in both English and French.

The program is mindful of the requirements of the Trauma Association of Canada, the accrediting body for all trauma systems in the country. With revised accreditation guidelines released in June 2011, the program is well positioned to invite a province-wide system accreditation visit within the next two years.

Summary

The NB Trauma Program has made sizable strides in decreasing the burden of injury for residents of New Brunswick. The benefits of initiatives such as field trauma triage, a guaranteed access policy for major trauma patients, and the implementation of trauma transfer guidelines are already apparent. Ongoing data collection, analysis and resulting continuous improvements ensure the provision of quality trauma care for all New Brunswickers.

About the author

Erin Musgrave, BScN, RN, ENC(C), is the Triage Coordinator at The Moncton Hospital, a part of the Horizon Health Network, current NBENA President, and Chair of the NB Trauma Program's Education Subcommittee.

Reference

Statistics Canada. (2007). *Population and Dwelling Count Highlight Tables, 2006 Census*. Catalogue no.97-550-XWE. Ottawa. Version updated February 2009. Ottawa. Retrieved from http://www.statcan.gc.ca/cgi-bin/IPS/display?cat_num=97-550-XWE2006002

outlook

NENA at work

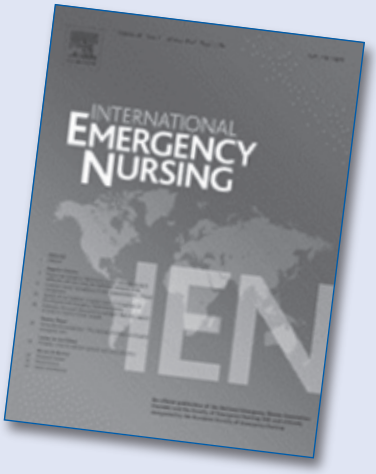
NENA offers new membership benefit!

NENA is now able to offer our members an additional benefit of membership including a discounted subscription to International Emergency Nursing Journal: **www.internationalemergencynursing.com**.

International Emergency Nursing is a peer-reviewed journal devoted to nurses and other professionals involved in emergency care. It aims to promote excellence through dissemination of high-quality research findings, specialist knowledge and discussion of professional issues that reflect the diversity of this field. With an international readership and authorship, it provides a platform for practitioners worldwide to communicate and enhance the evidence-base of emergency care. The journal publishes a broad range of papers, from personal reflection to primary research findings, created by first-time through to reputable authors from a number of disciplines. It brings together research from practice, education, theory, and operational management, relevant to all levels of staff working in emergency care settings worldwide.

An annual subscription to the journal includes four issues delivered directly to you and is available to NENA members at an introductory rate of USD $51.00 for 2012.

If you are interested in subscribing, please contact Elsevier directly at **JournalCustomerService-usa@elsevier.com**. Please note you will need your NENA ID number found on the NENA website under membership. If you have any questions, require further information or experience any problems with your subscription contact the Publisher directly at **s.davies@elsevier.com**.



Vicarious traumatization and the call for universal precautions

By Susan M. Short

FSCT 8103
Sheila D. Early
July 29, 2005

"Vicarious Trauma"—these are two words that you may or may not be familiar with as a registered nurse. I can assure you that once you read the following article, you may well find you know what it is, just not what it was called.

The student nurses in my forensic nursing courses have often undergone changes in their personal and professional lives because of their work with patients they have cared for in traumatic and/or violent incidents. Yet, information on vicarious trauma is often lacking in their curriculum.

Emergency nurses are hourly confronted with the traumatic histories of their patients, as they obtain the information needed to assess their patients and provide nursing care. It is not a question of "if" a nurse will be affected by vicarious trauma, but "when." Susan offers an overview of vicarious trauma and suggestions for reducing its impact on your life.

—Sheila Early

> *"I love my work, but lately I find it contaminating my personal life. I have nightmares about the horrible things I hear from clients, my sex life has deteriorated, I'm irritable and distractible, I'm afraid for my kids and tend to overprotect them and I don't trust anyone any more. I don't know what is happening to me." —A therapist (Evenson, 2004)*

In order to the halt the spread of infection, hand washing along with glove, mask and gown used as part of universal precautions, have been a part of training in any medical scenario. As health care providers, we have become quite accustomed to taking care of the physical. A neglected arena is the emotional one, especially for the caregiver. Spahn Nelson (1996) states:

> *"Many of us, especially those of us in a helping profession, are secondary witnesses to trauma almost everyday. As we listen to our clients tell about their trauma of incest, rape, domestic violence… we bear witness to their victimization. We listen, we support… we can't help but take in some of the emotional pain they have left with us."*

We have overlooked protecting ourselves from becoming "victims by extension" (Lynch, 1997).

In order to do this, we need to identify what the potential problem is, who it affects, why it happens, how to identify and treat it, and what we can do to prevent it, both personally and within our organizations.

Vicarious traumatization is known by many names—compassion fatigue, empathetic strain, secondary trauma and burnout. Commonly seen as a potential problem for those whose job it is to interact in an empathetic way with trauma survivors, such as health care providers, police officers, firefighters and counsellors, it can also affect the clergy, journalists, co-workers, and family members.

Many people can describe what vicarious traumatization is, but defining it is more problematic. Giardino, Datner, Asher, et al. (2003, p. 459) use Sandra L. Bloom's definition—"the cumulative transformative effect on the helper of working with survivors of traumatic life events." Richardson (2001, p. 7) cites Figley's observation—"the natural consequent behaviours and emotions resulting from knowing about a traumatizing event… (and) from helping or wanting to help a traumatized or suffering person." Essentially it is the result of being involved with victims of trauma and, in the process, there is a residual effect on the caregiver that leaves a lasting impression. Whether these effects are positive or negative will depend on what the caregiver's reaction is to this stimulus. A healthy response would be to connect with peers and an unhealthy one would be a change in thinking such as "all men are potential child molesters".

It is interesting to note that if the traumatic event is "perceived as natural and without malicious intent or manmade negligence" (Ater, 2003), there is less likely to be any stress reaction. Also, if a caregiver has a "history of trauma in their own background and if they extend themselves beyond the boundaries of good self-care or professional conduct" (Giardino et al., 2003, p. 459) there is increased risk of more severe vicarious traumatization.

While a few authors have indicated that there is no exact cause empirically defined, there is much discussion on the contributing factors. Work conditions play a significant role on the effect of vicarious traumatization on a person. This can include shift work, false alarms and unpredictability, especially for ambulance and firefighter staff. Another work condition that is an issue is the lack of closure for the caregiver, or the opportunity to know if they had made a difference in what they had done for the victim. Taking on too large a workload and overextending themselves is also a risk factor. Experience, both lack of and too much, will also increase the rate of vicarious traumatization, as will dealing with large numbers of traumatized children or people with dissociative disorders. And if a person neglects themselves physically—such as lack of sleep, proper nutrition, or exercise, or emotionally—lack of adequate socialization and relaxation, or spiritually—getting out of touch with themselves, their god and their view of themselves in the world, they are at greater risk for vicarious traumatization.

Warning signs are as varied as the people who experience them. Giardino et al. (2003, p. 336) list symptoms specific to vicarious traumatization as being:

> *"Disturbed frame of reference; Disrupted beliefs about other people and the world… (1) world is seen as a much more dangerous place, (2) caregiver may see other*

people as malevolent, evil, untrustworthy, exploitative or alienating, (3) maintaining a sense of hope and belief in the goodness of humanity is increasingly difficult; Psychologic areas affected are safety, trust, esteem, intimacy and control—(1) loss of secure sense of safety leads to increased fearfulness, heightened sense of personal vulnerability, excessive security concerns, behaviour directed at increasing security, and increased fear for the lives and safety of loved ones, (2) capacity to trust may be so impaired so that a belief develops that no one can be trusted. Trust in one's own judgment and perceptions can be negatively altered, (3) it becomes difficult to maintain a sense of self-esteem, particularly around areas of competence. It may also become difficult to maintain a sense of esteem about others, leading to a pervasive suspiciousness of other people's motivations and behavior, (4) problems with intimacy may develop, leading to difficulties in spending time alone; self-medication with food, alcohol, or drugs; engaging in compulsive behaviours (shopping, exercise, sex). These problems can also lead to isolation from others and withdrawal from relationships (family, friends, and professional colleagues), (5) the more control the caregiver feels has been lost, the more control he or she tries to exert over self and others. Efforts may also be made to narrow or restrict the scope of one's world in the hope of avoiding anything that may be experienced outside of one's control; Positive, as well as negative impacts are noted. Choices must be made to support positive, rather than negative transformational changes."

Evensen (2004, p. 5) notes that these symptoms "can emerge suddenly and without warning, are often disconnected from the real causes and can persist for years after working with clients." She also cites Figley (1995) that symptoms "include a sense of helplessness, confusion and isolation."

The International Critical Incident Stress Foundation, Inc. (2001) states, "Occasionally, the traumatic event is so painful that professional assistance may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by himself."

"Emotional distress is a natural and understandable outcome of working with those who have survived horrifying events. Accepting these responses as 'normal' allows for opportunity to explore these reactions without blame, shame or pathologizing" (Ruzek, 1993).

As with any good medical theme, Evensen (2004, p. 16) lists the mnemonic "Awareness, Balance and Connection" as the "ABCs of addressing trauma and transforming the helplessness."

Schenk (2004), a "psychotherapist who works extensively with therapists and health care providers and with survivors of trauma including torture, domestic violence and adult survivors of physical and sexual abuse", has some helpful strategies for dealing with vicarious traumatization:

- Remember to feel gratitude for the ability to work with clients on a deep and profound level, and to appreciate that this has resulted in a positive transformation in your life.
- Recognize that being impacted by your clients is an expected part of the work of a therapist.
- Maintain a solid commitment to managing the impact of exposure to your client's trauma material in your own life. It is your professional right and responsibility.
- Work from a strengths perspective, not a disease perspective.
- Pursue your own psychotherapy and consultation throughout your professional career.
- Find a healing practice that helps to bring meaning into your life (meditation, yoga, writing, art).
- Bring laughter into your life every opportunity you have.
- Evaluate what is truly meaningful in your life and pursue those activities that are the most meaningful and bring the most joy.
- Re-evaluate the role of spirituality in your life, however you define it.
- Recognize and acknowledge the gift you have in working with others, and allow yourself to feel what it means to your clients to have made such an impact.
- Periodically evaluate the work that you are doing, and your satisfaction with your work. Don't be afraid to make a change when needed.
- If a particular graphic accounting is upsetting to you, visualize the traumatic material moving through you, without impacting you. Replace a negative visual image with a positive image.
- Bring balance into every area of your life; strive for balance in all aspects of your personal and professional life.
- Assume as much control over your own work schedule as possible. Schedule breaks and lunches with colleagues.
- Take time for renewal with workshops, retreats, vacations.
- Avoid volunteer work that brings you too close to the work you do every day.
- When you take a walk, touch every leaf along the way.

Prevention should, ultimately, be our goal though, and it should include individual and organizational plans. Prevention strategies for caregivers (Giardino et al., 2003, p. 344–5) suggested are:

- Personal-Physical: engage in self-care behaviours, including proper diet and sleep; undertake physical activity, such as exercise and yoga.
- Personal-Psychologic: identify triggers that may cause you to experience vicarious traumatization; obtain therapy if personal issues and past traumas get in the way; know your limitations; keep the boundaries set for yourself and others; know your own level of tolerance; engage in recreational activities, e.g., listening to music, reading, spending time in nature; modify your work schedule to fit your personal life.
- Personal-Social: engage in social activities outside of work; garner emotional support from colleagues; garner emotional support from family and friends.
- Personal-Moral: adopt a philosophical or religious outlook and be reminded that you cannot take responsibility for the client's healing, but rather you must act as a midwife, guide, coach or mentor; clarify your own sense of meaning and purpose in life; connect with the larger sociopolitical framework and develop social activism skills.

- Professional: become knowledgeable about the effects of trauma on self and others; attempt to modify or diversify caseload; seek consultation on difficult cases; get supervision from someone who understands the dynamics and treatment of Post Traumatic Stress Disorder (PTSD); take breaks during workday; recognize that you are not alone in facing the stress of working traumatized clients—normalize your reactions; use team for support; maintain collegial on-the-job support, thus limiting the sense of isolation; understand the dynamics of traumatic re-enactment.
- Organizational/Work Setting: accept stressors as real and legitimate, impacting individuals and the group as a whole; work as a team; create a culture to counteract the effects of trauma; establish a clear value system within your organization; develop clarity about job tasks and personnel guidelines; obtain management/supervisory support; maximize collegiality; encourage democratic processes in decision making and conflict resolution; emphasize a leveled hierarchy; view problems as affecting the entire group, not just the individual; remember the general approach to the problem is to seek solutions, not to assign blame; expect a high level of tolerance for individual disturbance; communicate openly and effectively; expect a high degree of cohesion; expect considerable flexibility of roles; join with others to deal with organizational bullies; eliminate any subculture of violence and abuse.
- Societal: general public and professional education; community involvement; coalition building; legislative reform; social action.

Another important role of the leadership is debriefing the caregiver after contact with trauma. According to Potter, there are three phases. The first is the "Review Phase", which uses questions to have the caregiver think about and give feedback on their work, in an attempt to validate any reactions and provide guidance on handling those reactions. Examples of questions include "How did it go? How do you think you did? What 'ditzy' thing did you do? Is there anything you are worried about?" The second phase is the "Response Phase" and it is trying to draw out any reactions from the caregiver about "blaming themselves for something or worried they did something wrong". Using questions like "What did you say that you wished you hadn't? What didn't you say that you wished you had? How has this experience affected you? What is the hardest part of this experience for you?" Ultimately, the goal in this phase is to reassure the caregiver and give alternate solutions to any problem. The last phase is the "Remind Phase" with questions such as "Is there any follow up (that you need to do)? What are you going to do to take care of yourself in the next 24–48 hours? What will it take for you to ultimately 'let go' of this experience?" This is all in an effort to help with self-care. Some other activities suggested by Potter (2004) include:

> *"Follow-up phone calls to provide private processing time for each team member; journaling or reporting about lessons learned; other opportunities to talk with one another about their experiences in a structured way; an opportunity for the … team to report to others about their experience and what they learned…"*

It is by educating caregivers about what vicarious traumatization is that we can recognize and prevent it from occurring.

> *"It is clear that secondary traumatic stress is a predictable outcome of significant exposure to traumatized people. Therefore, any caregiving environment should anticipate the occurrence of vicarious traumatization and establish built-in 'hygienic' practices that can serve as antidotes to the spread of 'infection' within the organization" (Giardino et al., 2003, p. 467).*

So, much like a good hand washing technique, the caregiver needs to cleanse themselves through their self-care activities, such as talking to peers, doing something special for themselves or even avoiding the repeated assault of violence on their senses through different forms of media. And just like donning protective gear such as gloves, gowns and masks, the caregiver needs to become educated about vicarious traumatization in order to have the appropriate armour on. This could include identifying triggers, improving their ability to express themselves emotionally or evaluating and maintaining a healthy attitude about themselves, their purpose in the world and a realistic view of what they can realistically achieve.

> *"Every episode of violence—physical, emotional, sexual or social—must be viewed as a potentially lethal pathogen whose impact must be minimized if the environment is to become healthy" (Giardino et al., 2003, p. 467).*

To review, vicarious traumatization is the indirect reaction to a traumatic event experienced by those whose job it is to empathize with the survivor. The risk of this reaction is amplified if the caregiver has had previous trauma in their life, does not engage in self-care or is overextending themselves. The type of clinical environment will also play a role in this effect, particularly if the caseload involves children or those with dissociative disorders. Symptoms can be seen in every part of a person's life, in the physical realms, as well as the emotional, psychological, social and spiritual areas. To help the caregiver, good support from peers and management is essential. Psychotherapy may also be necessary. And, as always, prevention is the key. Knowledge of vicarious traumatization, its causes, effects and prevention techniques will be paramount in protecting the caregiver. There needs to be a personal and an organizational commitment to this effort. By employing modified universal precautions to vicarious traumatization, the effects can be dealt with effectively.

About the author

Susan Short is Co-coordinator of the Forensic Nursing Services program at Abbotsford Regional Hospital and Cancer Centre in Abbotsford, B.C. She has been a sexual assault nurse examiner since 2000, as well as working in emergency for several years.

She is enrolled in the Advanced Specialty Certificate in Forensic Health Sciences Option at British Columbia Institute of Technology. She is President-Elect for the Forensic Nurses Society of Canada, as well as being a long-standing member of the International Association of Forensic Nurses.

References

Ater, R.W. (2003). Post-traumatic stress disorder. *On the Edge*, 9(3), 4–7.

American Counseling Association. (2000). *Crisis fact sheet: 10 ways to recognize post-traumatic stress disorder from BC Women's Health Centre SANE Training Manual, 2001*. Retrieved from http://www.counseling.org/consumers_media/facts_ptsd10ways.htm

Conner, M.G. (2004). *Dealing with the impact of secondary trauma on adolescents in residential schools and programs*. Retrieved from http://www.crisiscounseling.com/TraumaLoss/TraumaResidential.htm

Evensen, K. (2004). *Surviving ourselves—Understanding and treating vicarious trauma*. Retrieved from http://www.tribal-institute.org/ovc/handouts/E7,%20F8-Kimber%20Evensen%20-%20Vicarious%20Traumatization%20short%20version.pdf

Giardino, A.P. (2003). *Quick reference sexual assault: For healthcare professionals, social services and law enforcement*. St. Louis, MO: G.W. Medical Publishing Inc.

Giardino, A., Datner, E., Asher, J., et al. (2003). *Sexual assault victimization across the life span—A Clinical Guide*. St. Louis, MO: G.W. Medical Publishing Inc.

International Critical Incident Stress Foundation, Inc. (2001). *Critical Incident Stress Information Sheets*. Retrieved from http://www.icisf.us/images/pdfs/rar/Critical%20Incident%20Stress%20Information%20Sheet.pdf

Johnson, C.N.E., & Hunter, M. (1997). Vicarious traumatization in counselors working in the New South Wales Assault Service: An exploratory study from BC Women's Health Centre. *SANE Training Manual 2001*.

LaRowe, K. (2004). *The personal cost of care*. Retrieved from http://www.breathofrelief.com/article_5.html

Lynch, V. (2006). *Forensic Nursing*. St. Louis, MO: Elsevier Mosby.

Lynch, V. (1997). *Clinical Forensic Nursing*. Fort Collins, CO: Bearhawk Consulting Group.

Palm, K.M., Polusny, M.A., & Follette, V.M. (2004). Vicarious traumatization: Potential hazards and interventions for disaster and trauma workers. *Prehospital and Disaster Medicine on the Web*. Retrieved from http://pdm.medicine.wisc.edu/19-1%20pdfs/Palm.pdf

Potter, D. (2004). Bringing your debriefers home after a disaster: Debriefing the debriefers. Retrieved from http://www.icisf.org/articles/Acrobat Documents/TerrorismIncident/DebriefingDebriefersDisaster.html

Richardson, J.I. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers*. Retrieved from http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/trauma_e.pdf

Ruzek, J. (1993). Professionals coping with vicarious trauma. *NCP Clinical Newsletter 3(2)*. Retrieved from http://www.ncptsd.va.gov/publications/cq/v3/n2/ruzek.html

Schenk, B. (2004, Sept/Oct.). You cannot touch a trauma without being touched by it: Managing vicarious trauma. *East Bay Therapist*. Retrieved from http://www.eastbaytherapist.org/2004/0408_managing_vicarious_trauma.html

Spahn Nelson, T. (1996). *Vicarious trauma: Bearing witness to another's trauma*. The 20th Annual Convening of Crisis Intervention held in Chicago, April 12-14, 1996. Retrieved from http://www.uic.edu/orgs/convening/vicariou.htm

Zlodre, N. (2004). *Facing the pain: Enhancing resiliency in workers*. Presented April 2, 2004, at the Sexual Assault and Domestic Violence Treatment Centres Convention, Hamilton, Ontario.

Appendix 1

Recommended resources on vicarious trauma

(from Health Canada's *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* by Jan I. Richardson)

Figley, C.R. (Ed.). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner/Mazel, 1995.

Summary: This book was written to introduce the notion of secondary traumatic (or compassion) fatigue. Each chapter is organized with respect to three themes: describing the concept of compassion fatigue and its assessment, outlining methods of treatment, and identifying ways to prevent traumatic stress reactions. Information presented forms the basis for current views of compassion fatigue and illustrates the need for trauma professionals to be aware of compassion fatigue and develop effective ways of coping.

Pearlman, L. et al. *Vicarious Traumatization I: The Cost of Empathy; Vicarious Traumatization II: Transforming the Pain*. Ukiah, Calif.: Calvalcade Productions Inc., 1995.

Summary: Produced by the Traumatic Stress Institute, these videotapes summarize the institute's findings and observations concerning vicarious trauma. The vicarious trauma and the negative impact of trauma work on helpers." Transforming the pain" focuses on recognizing the symptoms of vicarious traumatization and provides strategies useful in reducing the negative effects of vicarious traumatization. In addition to providing factual information, the videotapes feature interviews with trauma therapists describing the impact of trauma work on their lives.

Saakvitne, K.W. & Pearlman, L.A. *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: W.W. Norton & Company, 1996.

Summary: In response to workshop participants' requests, the authors have developed a workbook featuring worksheets and exercises to assist in reducing the negative effects of vicarious trauma. The book presents simple and easy-to-read charts, questionnaires to identify the symptoms of vicarious trauma, activities designed to assist in developing techniques, and strategies to prevent and cope with vicarious trauma. The activities are useful for anyone working with individuals who have been traumatized.

Stamm, B.H. (Ed.). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, & Educators*. Lutherville, MD: Sidran Press, 1995.

Summary: The chapters written in this edited book were written by leading professionals in the field of secondary traumatic stress. The purpose of the book is to summarize current perspectives of secondary stress and present new directions for study. Because the authors were encouraged to choose their own topic, a wide array of information is presented, including ways to protect trauma workers, effects of stress on communication, and ethical issues associated with secondary traumatic stress.

Warren, E. & Toll, C. *The Stress Workbook.* London: Nicholas Breaky Publishing, 1997.
Summary: Based on their experience running stress workshops and training courses in many different organizations, the authors have developed a comprehensive and easy-to-use workbook to assist individuals, managers and organizations as a whole in reducing work-related stress. The signs of stress, as well as the impact of stress on both individuals and the workplace, are discussed. Various practical ways of achieving balance and reducing the negative effect of stress by turning it to your advantage are discussed. Ways in which management can help its employees to cope with job-related stress more effectively and thereby reduce stress in the organization are discussed.

Louden, J. *The Women's Comfort Book: A Self-Nurturing Guide for Restoring Balance in Your Life.* New York: Harper-Collins Publishers, 1992.
Summary: A comprehensive workbook with hundreds of suggestions for self-care, *The Women's Comfort Book* is intended to help the reader build a lifetime commitment to caring and nurturing the self. Self-care is essential, yet individuals rarely acknowledge its importance. However, as Louden notes, in order to nurture others, people need to build the necessary resources by comforting and caring for themselves. The book outlines how to identify one's self-needs, how to develop a self-care schedule, and how to begin to develop a positive view of one's self. A variety of suggestions for self-care are presented, ranging from establishing personal sanctuaries to becoming a "guru of play."

David Baldwin's Trauma Information Pages
http://www.trauma-pages.com/index.phtml
Summary: This is an informative and award-winning site on PTSD and related topics. According to the Canadian Traumatic Stress Network, "It is a huge resource, a labour of love, which we very much appreciate for its invaluable contents and fine organization. If you are ever looking for information on trauma or disaster, this should be your first step." The site is by David V. Baldwin, PhD, a psychologist based in Eugene, Oregon.
Email: dvb@trauma-pages.com

http://www.fsu.edu/~trauma/
Summary: Edited by Charles Figley, this site is an online journal. It contains the International Electronic Journal of Innovators in the Study of the Traumatization Process and Methods for Reducing or Eliminating Related Human Suffering.
Email: cfigley@garnet.acns.fsu.edu

Psychotherapy http://tsicaap.com/
Summary: This is the website of the Traumatic Stress Institute and describes the activities of the institute.

Policy guidelines for OUTLOOK article submission

Approval date November 2009

Past revision date November 2007

Next revision date November 2011

Editorial policy

NENA *OUTLOOK* welcomes the submission of clinical and research articles relating to the field of emergency nursing care and articles of human interest related to emergency nursing and emergency nurses.

Statements or opinions expressed in the articles and communications are those of the author(s) and not necessarily those of the editor, publisher and/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.

Authors are encouraged to have their articles read by others for style and content prior to submission.

Preparation of manuscripts

1. The original copy of manuscripts and supporting material should be submitted to the NENA *OUTLOOK* editor. The author should retain one complete copy.
2. Manuscripts must be typed, double-spaced (including references), and formatted to fit on 8 ½" × 11" paper with 2.5 cm margins. Manuscripts may be submitted in electronic form.
3. Author's name, credentials, a brief biography, and province of origin must be included. A digital image is desirable.
4. Clinical articles should be limited to six typed pages.
5. Direct quotations, tables and illustrations that have appeared in copyrighted material must be accompanied by written permission for their use from the copyright owner and original author and complete source information cited.
6. Photographs of identifiable persons, whether patients or staff, must be accompanied by signed releases, such as the following: "I hereby give (author's name) permission to use the photograph of (subject's name) in the NENA *OUTLOOK*.

Letters to the editor

Letters raising a point of current interest or commenting on an article should be no longer than one typewritten page. The editor reserves the right to accept, reject, or excerpt letters without changing the views of the writer. The author of an article will have an opportunity to respond to unfavourable comments.

Board meeting highlights

Highlights of NENA Board of Directors meetings will be submitted by the NENA secretary to keep the membership informed. The president's report will be submitted annually.

Research studies/abstracts

Readers are encouraged to submit abstracts of research studies that would be of interest to emergency nurses. A research abstract is a brief description of the problem, the design and method, and the important findings of a study. If taken from the research literature, the abstract must include the title, author(s), publication, volume, page numbers, and year of publication. Abstracts must be submitted on computer disc, and/or in an electronic format, in Word Perfect or Word, IBM compatible.

Case study/ clinical articles

Readers are encouraged to submit actual emergency situations with valuable educational potential, descriptions of procedures in emergency care, samples of patient care guidelines, and/or triage decisions.

Future events

Information regarding meetings of interest to emergency nurses may be submitted. NENA-sponsored events will be identified.

Book reviews

Emergency nursing books, specifically books on the CNA's bibliography for certification, will be reviewed. Solicitation from book publishers or donated books for review will be accepted.

Nena *OUTLOOK* submissions

Submission dates for article publication in the NENA *OUTLOOK* are to be set by the Communications Officer and dictated to publishing deadlines.

Please note: Nursing special interest groups may advertise upcoming conferences and seminars free of charge.

© November 2009

Call for nominations: "president-elect" and "communication officer"

Are you interested in serving on the board of directors? Then read on—this year there are two available positions. The president-elect position is a one-year term preceding the presidential role, and the communication officer position is a two-year term. Both positions would begin following the annual general meeting in Halifax, N.S. The board of directors meets twice yearly. Both meetings are three days in length. Typically, the spring meeting, though, is held in conjunction with a regional or national conference, so time away from home is usually longer.

As president-elect you are a vital member of the board. You would be expected to assume the role of president if the current president were to resign. Other duties include: reviewing and revising (as needed) the policy manual, position statements, bylaws and preparing achievements and actions in the strategic plan. There may be other duties that would be assigned to you by the president.

As communication officer, you are expected to ensure the production and dissemination of the Outlook journal every six months. You will liaise with provincial communication officers to encourage members to submit articles, pictures, tips, etc., to the journal. You will establish and maintain a credit rating with a printing firm for the production of Outlook. You will ensure that all invoices for the production of the journal are correct and are submitted to the NENA treasurer for payment. You will also maintain a liaison with NENA webpage designers to ensure updated information is displayed, and you will act as a contact resource for affiliation members who wish to use the website services. You will also assist with national and regional conferences by acting as a liaison between the conference committee and the board of directors.

Two NENA members must nominate candidates and the nominee must be a NENA member in good standing. A nomination form has been included for your use. Please forward a completed nomination and curriculum vitae to Jan Spivey. Her address is listed on the nomination form. Announcement of successful candidates will be made following the election at the AGM in Halifax, N.S.

outlook
Nomination form

NENA executive position

Positions:

- Communication Officer
- President-elect

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

_____
for the position of

_____
on the NENA executive.

_____
(nominee) is in good standing with NENA.

1. Name: _____

Date: _____

Signature of nominator: _____

2. Name: _____

Date: _____

Signature of nominator: _____

I, _____,
do hereby accept this nomination for the position of

_____
on the NENA executive.

Signature: _____

Date: _____

Please return this letter of intent and CV, by April 15, 2012, to:
Jan Spivey, 112 Old River Road, RR2, Mallorytown, ON K0E 1R0
e-mail: nominations@nena.ca

The NENA Bursary

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

Applications must be submitted prior to the spring Board of Directors meeting of NENA for review by the standing committee for bursary disbursements. On April 1 of each year, the number of bursaries awarded will be determined by the number of registered members per province for that NENA fiscal year i.e.:

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

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

Successful candidates can receive a bursary only once every three years.

NENA Bursary application process

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

1. Number of years as a NENA member in good standing
   - 2 years ..... 1 point
   - 3–5 years ..... 2 points
   - 6–9 years ..... 3 points
   - 10 + years ..... 5 points

2. Involvement in emergency nursing associations/groups/committees:
   - Provincial member ..... 1 point
   - Provincial chairperson ..... 2 points
   - Special projects/committee—provincial executive ..... 3 points
   - National executive/chairperson ..... 5 points

3. Candidates with certification in emergency nursing and/or involved in nursing research will receive an additional five points.

If two candidates receive an equal number of points, the committee will choose the successful candidate. All decisions of the bursary committee are final.

Each application will be reviewed once per spring board meeting.

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

Candidates must have completed Forms A, B and C (included with this issue of **Outlook**). The provincial director may forward applications at the spring board meetings.

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

Eligibility

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

Application process

Candidates must complete and submit the following:

a. NENA Bursary application form "A"
b. Bursary reference form "B"
c. 200-word essay
d. Photocopies of provincial registered nurse status and NENA registration

Provincial representative responsibilities:

a. Completes bursary candidate's recommendation form "C"
b. Ensures application forms are complete before submission
c. Brings to Board of Directors meeting all completed applications

Selection process

The standing committee for bursary disbursements will:

1. Review all applications submitted by provincial representatives and award bursaries based on selection criteria.
2. Forward names of successful candidates to the Board of Directors for presentation.

See the nomination form on page 33.

NENA Bursary application form "A"

Name: _____ Date of Application: _____

Address: _____

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

E-mail: _____

Place of employment: _____

Name of course/workshop: _____

Date: _____ Time:_____ Length of course: _____

Course sponsor: _____ Cost of course: _____

Purpose of course: _____

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

Previous NENA Bursary: ❑ Yes ❑ No Date: _____

Please submit a proposal of approximately 200 words stating how this educational session will assist you and your colleagues to provide an improved outcome for the emergency care user: Attached?: ❑ Yes ❑ No

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

NENA Bursary application form "B"

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

Reason: _____

Other comments: _____

_____

Signed: _____ Position:_____

Address: _____

NENA Bursary application provincial director's recommendation form "C"

Name of bursary applicant: _____ Province: _____

Length of membership with provincial emergency nurses group: _____

Association activities: _____

_____

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

Reason: _____

Provincial director signature: _____ Date: _____

NENA Award of Excellence application form

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

Award of Excellence in: _____

Nominee: _____ Address: _____

_____ Postal Code: _____

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

E-mail: _____

Employer: _____ Current position: _____

Nominator: _____ Address: _____

_____ Postal code: _____

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

Letter of support (1) from: _____

Letter of support (2) from: _____

Signature of nominee: _____

Signature of nominator: _____ Date: _____

We are looking for the best
TO JOIN OUR TEAM...

Come to work in one of the newest and most modern hospitals in Ontario.

William Osler Health System has:

- One of the largest and busiest Emergency departments in Ontario,
- Operates a 75 bed, fully equipped state-of-the-art Emergency Department in Brampton,
- Redesigned ED patient flow into specialty zones such as the 'See N' Treat' area and Cardiac Assessment Zone.

Why work for Osler's Emergency Department?

We offer:

- Dynamic, exciting and challenging full-scope nursing roles,
- Clinical Nurse Educators and Resource Nurses 24/7 to provide support and,
- Educational and financial support for emergency related courses.

Now hiring RNs and RPNs for our Emergency department.

To learn more, please contact:
Melanie Pacheco, RPR
Recruitment Specialist
William Osler Health System
melanie.pacheco@williamoslerhs.ca

WILLIAM
OSLER
HEALTH
SYSTEM

SAFE AND COMPASSIONATE CARE
www.williamoslerhs.ca

Come for the **job.** Stay for the **team.**

Vancouver Coastal Health is world renowned for innovation and a focus on quality care and outcomes. The remarkable range of specialties places VCH at the forefront of career destinations. Launch an exciting career with us where you can apply your skills and develop new ones alongside some of Canada's finest practitioners.

- ✔ **Incredible Lifestyle**
- ✔ **Outstanding Career Move**
- ✔ **Attractive Relocation Assistance**

We are hiring Registered Nurses who have completed an advanced certificate program in Emergency Nursing, or have a minimum of two (2) years' recent emergency nursing experience. Positions available at:

- **Richmond General Hospital**
- **Vancouver General Hospital**
- **Lions Gate Hospital, North Vancouver**
- **St. Mary's Hospital, Sechelt**
- **Powell River General Hospital**

To find out more and to apply, visit:

careers.vch.ca

Phone: 604.675.2500
Toll-Free in North America: 1.800.565.1727

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

2012 BC's Top Employers