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- NENA-AB Triage Statement

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- The Importance of Syphilis Screening in the Emergency Department **Click here!**
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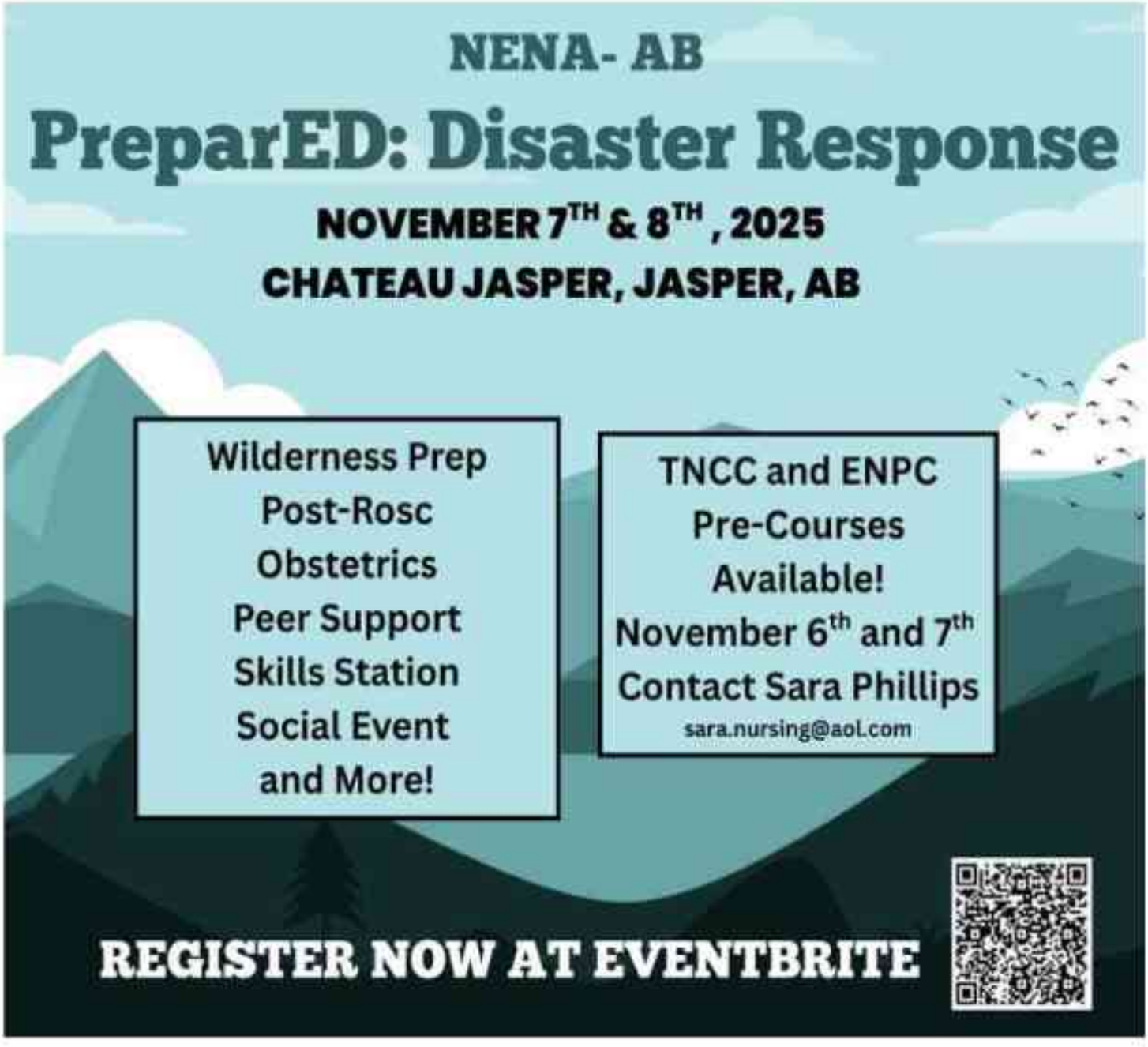

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University of Alberta, Edmonton, Canada

Ronnie Bilitsky
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BScN RN SANE-A
Clinical Nurse Educator
Central Alberta Sexual Assault Response Team & Domestic Violence Program Coordinator
Counter Exploitation Educator & SANE Clinic Specialist

Dr. Alexander Perreault
Pelvic Fractures
MD, FRCS(C)
Central Alberta Orthopedics /Brent Sutter Sports Medicine Clinic

Natalie Anderson
BN RN ENC (C)
Supporting Our Staff (SOS) Peer Support Coordinator
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Joshua Anderson
"When your patient kinda glows, recognizing Haz-Mat in Trauma"
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Red Deer Emergency Services

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0830 - 1630

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Annual General Meeting- November 8th, 2025

Jasper, Alberta

- **Elections for President Elect**
  - The election of officers shall be by secret ballot unless by acclimation. Members not attending the Annual General Meeting may vote by signed proxy through another member who will be attending the meeting or with a proxy signed by one witness and sent to the NENA-AB Secretary prior to the election. Proof of signed proxy must be given at the Annual meeting.
  - The nomination of Officers shall be received at the Annual General Meeting.
  - The official election results shall be documented at the Annual General Meeting, and circulated to the membership by the Secretary, within four weeks of the election.
- **NENA-AB Triage Position Statement**
  - Members will vote to accept or regret the position statement
  - Statement follows on next page

National Emergency Nurses Association-Alberta Chapter

NENA-AB Position Statement	Role of the Triage Nurse
Number of Pages	5
Approval Date:	August 2025
Past Revision Dates:	

Issue: Triage is a dynamic and complex aspect of emergency nursing that requires rapid, focused patient assessment to accurately prioritize care (Canadian Triage and Acuity Scale, n.d.). The National Emergency Nurses Association (NENA) asserts that triage is a critical sorting process comprising the use of clinical assessment, critical thinking, clinical experience and standardized guidelines to assess patients' needs upon arrival at the Emergency Department (ED) and Urgent Care Clinic (UCC) settings. The national position statement excludes the recommendation for the Licensed Practical Nurse (LPN) to triage patients. In many Alberta hospitals, the triage nurse is a Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN) who works within the ED or UCC. To support patient safety and effective triage outcomes, all triage nurses should complete formal Canadian Triage and Acuity Scale (CTAS) education from a NENA instructor, to perform triage assessment.

NENA-AB Position:

Many nurses in Alberta possess the training, knowledge, skills, and abilities to perform triage competently. NENA believes that the triage process is best performed by nurses with specialized training, demonstrated competence in emergency nursing practice, and ideally two years recent emergency nursing practice (National Emergency Nurses Association, 2019). The nurse is responsible for performing a triage assessment, rapidly evaluating the patient's presenting complaints, assigning an acuity level, providing immediate care, and

directing the patient to the appropriate care location based on organizational requirements. The triage nurse ensures patient reassessments occur based on acuity and understands that patients' condition may evolve over time. NENA suggests that employers have a responsibility to ensure competency training and appropriate site-specific clinical training and experience prior to nurses being placed at triage. Specifically, each site should ensure that competency training is regularly obtained and managed to establish proper transition to the role of triage and that there is ongoing quality assurance and improvement while in the triage role.

Rationale

NENA believes that the triage process is best performed by nurses with specialized training (National Emergency Nurses Association, 2019). As patient volume and acuity rise in emergency settings, an accurate and efficient triage decision-making process supports safe, appropriate care (Ouellet et al, 2022). Formal triage education and ongoing validation of triage competencies are essential for maintaining high standards of care and decreasing errors in this high-risk skill (Ouellet et al, 2022). Regular education, self- reflection, triage feedback, along with quality assurance measures, support the triage nurse to deliver safe and competent patient care (College of Licensed Practical Nurses of Alberta, 2023; College of Registered Nurses of Alberta, 2023; Nova Scotia College of Nursing, 2025). All nurses are accountable for their own practice and engage in interprofessional collaboration with team members for support as needed (College of Licensed Practical Nurses of Alberta, 2023; College of Registered Nurses of Alberta, 2023; Nova Scotia College of Nursing, 2025).

The triage nurse possesses the following competencies (National Emergency Nurses Association, 2018):

- Proficiency in accurately assessing patients' conditions and assigning appropriate triage categories based on established CTAS guidelines.
- Strong analytical and critical thinking skills, as well as sound clinical judgement, to identify emergent situations, anticipate patient needs, and make timely decisions.

- Effective verbal and written communication to interact with patients, families, and the healthcare team to gather information, provide instructions, and ensure proper documentation.
- A solid foundation in emergency nursing, specific to the unit where performing the triage role, anatomy and physiology, pharmacology knowledge, along with proficiency in performing necessary medical procedures and interventions. Understanding the pertinent patient assessment will help determine the acuity based on stated complaint.
- The ability to offer emotional support, demonstrate empathy, and maintain a calm and reassuring demeanor in high-stress, urgent situations.

It is important to note that while the qualifications, requirements, and responsibilities for triage nursing may vary slightly across provinces and healthcare facilities in Canada, the core principles and competencies outlined here are vital to the success and safety of the triage process.

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The importance of screening for Alcohol withdrawal syndrome in the Emergency Department and conveying empathy during CIWA-Ar patient screening

Submitted by: Heather Murray BSN, RN, CEN, TCRN

In emergency nursing, each time an addictions and mental health patient touches our healthcare system, it is an opportunity to provide compassion, support, education and resources to help cope with their addiction challenges. A 2021 Canadian community health survey indicated that 18% of people aged 15 and older meet the clinical criteria for alcohol use disorder (AUD) (Paradis et al., 2023). Approximately 50% of patients with AUD experience alcohol withdrawal (Schmidt et al., 2016). Screening and quantifying alcohol withdrawal syndrome in the emergency department is key to preventing morbidity and mortality of withdrawals and early recognition of withdrawal symptoms is essential to preventing seizure and life-threatening delirium tremens (Newman et al., 2024). The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) is a validated screening tool that can determine a patient's risk of developing complicated (moderate-to-severe) alcohol withdrawal syndrome in the ED (Wood et al., 2023). The clinical institute withdrawal assessment -alcohol revised (CIWA- Ar) is an extensively studied scale that quantifies alcohol withdrawal syndrome and guides pharmacotherapy to prevent severe complications.

Symptoms of Alcohol withdrawal syndrome can occur at eight hours or as late as 72 hours due to the metabolism and duration of action of alcohol (Schmidt et al., 2016). Benzodiazepines are first line treatment for withdrawals due to the CNS depressant effects that are similar to that of ETOH. Diazepam is commonly used as the pharmacological treatment in CIWA protocols based on the CIWA score and dosing protocol. However, lorazepam may be preferrable in patients with liver failure due to decreased metabolism (Gottlieb et al., 2024). Health professionals proficient in using assessment-based measures provide patients with a safe and humane approach to withdrawals (Scullard, 2016).

Conveying empathy is essential during a CIWA-Ar assessment. It is also important to commit to Antiracist practices and confront and recognize racist structures in health care. It is essential to build self-awareness of your own position within oppressive systems (Wood et al., 2023). Trauma and violence informed practice including indigenous cultural safety and humility can help improve care and health outcomes for racialized populations (Wood et al., 2023). It is important to remember you are assessing someone who may be experiencing intense physical and emotional distress, so your tone, body language, and words should all communicate safety, respect, and compassion.

Case Study

The patient is a 55 y/o Male admitted to a step down unit from the emergency department (ED) 12 hours ago. The patient arrived to the ED complaining of abdominal pain and was diagnosed with an abdominal aortic aneurysm (AAA). Pt is currently admitted on a labetalol drip for blood pressure control and heparin drip protocol for AAA. The nurse receives report on the patient in the morning. The patient has a controlled blood pressure and vital signs are as follows:

HR:88, BP: 108/66, RR: 22; SpO2: 98% on room air; Temp: 37 oral; GCS 15

The patient is a caucasian military veteran who is fit and stoic. Upon assessment pt is a GCS of 15, cooperative, respectful but seems unable to sit still. Patient is repetitively calling his spouse during assessment. The spouse calls the nurse with concern of the erratic nature of the phone calls. The patient also had a bed alarm on overnight, because he required frequent redirection to stay in bed. The nurse is in a busy assignment, the patient is a fall risk, but a sitter was unavailable to sit with the patient.

The nurse hears the bed alarm go off but needed to doff PPE from another room to respond. The patient is found on the floor, both drips are still running. The patient is assessed, VS are still stable, pedal pulses are present, and no signs of cyanosis or abdominal aneurysm rupture are found. The nurse notifies the physician; requests help from her team and continues the post fall assessment. After being assisted back to bed he continues to try to get up. When the patient is questioned regarding why he is getting out of bed he states that he hasn't taken any of his anxiety meds since admission. The nurse notes no anxiety medications ordered and does a medication history review with the patient. The patient is becoming increasingly anxious and at risk for injury. Further assessment reveals he takes some psychiatric medications for PTSD and benzodiazepines for acute anxiety scheduled and PRN daily at home. The patient also reports to the nurse that he drinks a significant amount of hard alcohol (ETOH) daily. The patient is becoming increasingly unstable with his sensorium. A MET is called on the patient. The patient is found to be in acute alcohol withdrawal syndrome (AWS) in conjunction to withdrawal from abruptly discontinuing psychiatric medications and ETOH consumption upon admission. The patient is transferred to the ICU to be put on dexmedetomidine (precedex) and treated for alcohol withdrawal syndrome and stabilized until his AAA repair.

Case Study Discussion points:

- As the ETOH and benzodiazepine levels dropped in this patient his withdrawal symptoms were partially masked by the betablocker (tachycardia and elevated systolic and diastolic blood pressure) but evident in the agitation and inability to stay in bed/sit still.
- Patient may not have disclosed his addictions or psychiatric history in the emergency department, and the ED was concerned with treating his abdominal pain and AAA emergently.
- Patient was a fit, well groomed, Caucasian male and may not have been screened for these risk factors.
- The patient should have been screened for alcohol use disorder and put on a revised Clinical institute of Withdrawal Assessment for alcohol and benzodiazepines scale (CIWA-Ar) upon admission.
- Upon reflection this patient would have scored severe on the CIWA-Ar scale had it been performed. Early intervention and screening prior to admission could have prevented harm and ICU admission.

Language to assist with asking the CIWA questions with empathy

"Hi [Patient's Name], I'm [Your Name], one of the nurses here in the ER. I know this might be a tough moment for you, and I want you to know we're here to help. I'm going to ask you some questions because we are concerned you are in alcohol withdrawal. It's okay to be honest—there's no judgment here." Remind them they're being monitored and cared for. "You're in a safe place."

CIWA-Ar Category	Empathetic Approach
Nausea and Vomiting	"Have you been feeling nauseated or throwing up? Even a little discomfort matters—we want to treat it."
Tremors	"Can you hold out your hands for me? I'm checking for any shaking. It's common, and we're keeping track so we can help you feel better."
Sweating (Paroxysmal Sweats)	If a patient is withdrawing and feels clammy -Diaphoresis can't be 'faked.'
Anxiety	"Are you feeling nervous or anxious right now? Withdrawal can stir up a lot of emotions, it's okay to talk about it. Everything we talk about is confidential."
Agitation	"You seem to be feeling restless, that is part of the withdrawals and important for us to know."
Tactile Disturbances	"Have you felt anything unusual on your skin like itching, burning, pins and needles, or crawling sensations?" (patients reports "bugs crawling on them")
Auditory Disturbances	"Are you hearing anything that others don't seem to hear—like buzzing, clicking, or voices?"
Visual Disturbances	"Have you seen anything that felt strange or wasn't really there—like shadows or flashes?"
Headache or Fullness in Head	"Do you have a headache or a feeling of pressure in your head? Even mild discomfort is worth noting."
Orientation and Sensorium	"Can you tell me your full name, where you are right now, and what day it is? This helps us understand how clearly you're thinking."

Closing: "Thanks for answering all of those questions. I know it's not easy, especially when you're not feeling well…

If giving medication: "We'd like to give you some medication to help with the withdrawals and prevent seizures. If anything changes or you feel worse, please let us know right away. You're not alone in this."

CIWA-Ar is a structured tool, the way you deliver it can make all the difference. Patients in withdrawal may feel vulnerable, ashamed, or scared, your empathy when performing a CIWA screening can help them feel seen and supported. Use a calm, reassuring tone, avoid sounding clinical or rushed, validate their experience and acknowledge discomfort without judgment.

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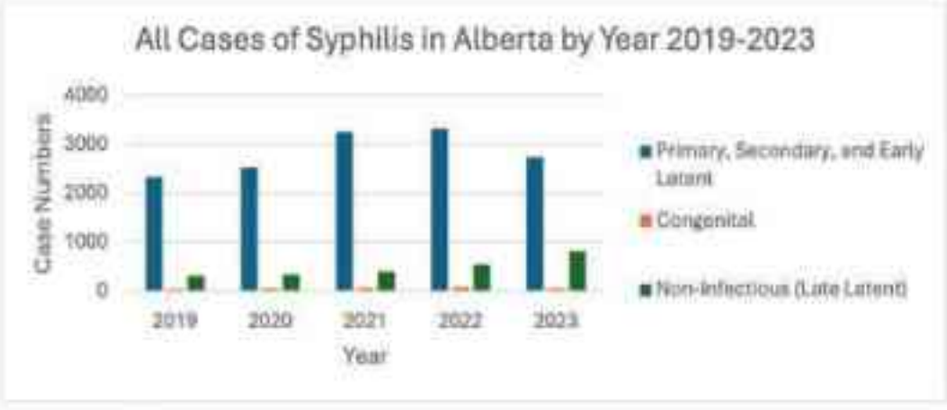
The Importance of Syphilis Screening in the ED

Syphilis cases in Alberta have climbed rapidly from 160 in 2014, to over 17,000 total cases between 2019 and 2023. In 2019, Alberta Health declared a syphilis outbreak. While rates remain high, the last published number of syphilis cases in 2023 show a slight decline for the first time in several years. While this downward trend is encouraging, surveillance is key to identifying and treating syphilis. Reporting syphilis to provincial public health authorities is mandatory by provincial legislation.



Source:

What is Syphilis?

Syphilis is a bacterial infection (*Treponema pallidum)*, transmitted through sexual contact either orally, rectally or genitally. The primary mode of transmission is via direct contact with an infectious lesion. Syphilis can also be transmitted transplacental during pregnancy or with contact with an infectious lesion at birth. This is referred to as congenital syphilis.

Syphilis is known as the "great imitator" due to the variety of signs and symptoms that present like many other conditions and can affect almost any organ in the body. Untreated syphilis may progress to four stages of infection: primary, secondary, latent (early and late) and tertiary. Primary infection signs and symptoms include swollen glands and ulcers noted where the bacteria have entered the body (mouth, genitals, etc.). Ulcers may be small and are not usually painful and so may go unnoticed. Secondary syphilis may develop between 2-12 weeks after exposure. Symptoms include fever, headache, rash to the hands and soles of feet, weight loss and alopecia. Pink or white lesions may develop in moist areas. Latent syphilis is noted for its absence of signs and symptoms except for a possible development of the pink or white lesions of the secondary stage. During this stage, patients with asymptomatic syphilis may be infectious in the first 12 months (early latent) but not usually after 12 months (late latent).

Risk Factors

Behavioural risk factors include multiple sexual partners; barrierless sexual activity involving oral, genital, or anal contact; sexual contact with a partner known to have syphilis or another sexually transmitted infection; and substance use. Other associated risk factors are history of syphilis or another sexually transmitted infection; HIV; belonging to a population or community experiencing high levels of syphilis; and homelessness.

Why should we be concerned?

Untreated syphilis may ultimately progress to the tertiary stage. This stage is defined as progressing to the brain, heart, blood vessels, and the nervous system. Symptoms depend on which organ is involved. infection of the nervous system symptoms may include headache, vertigo, seizures, hallucinations, paranoia, hemiplegia, tremors, ataxia, and change to vision. Lesions may form in skin, bones, and the liver and may become fibrotic. Infections of the cardiovascular system are often found many years after initial infection and can include aneurysms, aortic valve insufficiency, and decreased cardiac output. Progression to this stage may end in death.

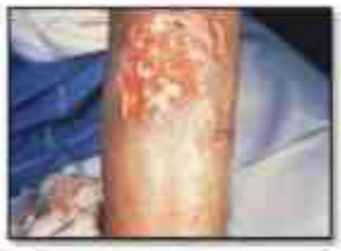


Image: Lesion on the arm. Late stage tertiary syphilis. CDC Public Health Image Library, ID# 17837. Public domain. Retrieved from Public Health Image Library(PHIL)

Congenital syphilis can cause loss of pregnancy and morbidity in newborns. Newborns may exhibit a variety of serious disease manifestations such as low birth weight, fever, jaundice, myocarditis, CHF, hepatomegaly, renal issues, meningitis, seizures and more. About half will be asymptomatic. The Canadian Pediatric Society has recommendations for assessment, testing, and treatment of newborns at risk. Risk factors would include positive syphilis diagnosis during pregnancy or the postpartum period, clinical findings suggestive of syphilis in the infant, and unknown antenatal care.

Why do I need to know this?

The emergency department is an opportunity to interact with patients at high-risk that may not have access or present to primary care. History, physical exam, lifestyle factors are all a part of our assessment in the ED and may flag a potential risk of syphilis. This includes our pregnant patients. Screening in the emergency department has had a positive impact on the decline of infection rates in the US. Emergency departments in South Carolina were able to show that a screening program for testing opportunities in the ED identified many previously missed testing opportunities. A study in Chicago in 2024 demonstrated that providing testing in the emergency department led to an increase in diagnosis. To note, most of the patients diagnosed had no symptoms. Research in Ohio suggests that co-testing for syphilis with other tests for sexually transmitted infection can increase the number of diagnosed cases.

Emergency nurses are in a unique position to identify syphilis risk factors and symptoms via assessment and history with the potential for a positive impact on disease diagnosis and treatment.

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Pulmonary Embolism and Severity Recognition

Each day someone will be diagnosed with a pulmonary embolism (PE) in an Alberta hospital. The question is how do we know a PE diagnosis is serious? There is a wide range of PE diagnosis from the low risk patient to cardiac arrest. Despite the wide range of PE's, it is important to understand the severity, so treatment is not delayed resulting in poor outcomes.

The European Society of Cardiology offers four different categories of PE severity as follows:

· Low-risk patients in this category do not require oxygen; show no signs of RV dysfunction along with no abnormal biomarkers.

· Intermediate-low risk patient has elevated biomarkers or RV dysfunction.

· Intermediate-high risk patient has both elevated biomarkers and RV dysfunction.

· High-risk patients will have prolonged hypotension (systolic blood pressure <90 mmHg for at least 15 minutes) and require pressor support or cardiac arrest.

High-risk clinical feature not to be taken lightly.

Let's focus on the high-risk pulmonary embolism (PE) patient, as this category represents a critical subset with significant potential for rapid deterioration and high mortality. High-risk PE is never to be taken lightly, given the strong association with poor outcomes and death if not recognized and managed promptly. However, what makes high-risk PE particularly challenging is the wide spectrum of clinical presentations. On one end, it may manifest as overt hemodynamic collapse, such as cardiac arrest or profound hypotension requiring immediate resuscitation. On the other, a patient may appear relatively stable on initial assessment awake, alert, and without obvious distress yet demonstrate subtle but concerning markers of impending decompensation, such as a mildly elevated lactate, tachycardia, or a "soft" blood pressure (e.g., systolic blood pressure in the low 90s). These patients may not immediately raise alarms but are, in fact, at significant risk for sudden deterioration. This variability in presentation underscores the need for vigilance, a high index of suspicion, and a nuanced approach to risk stratification and early intervention in suspected or confirmed cases of PE Some of the other things to be aware of is a rapid onset of symptoms, syncope, comorbidities, and obvious deterioration on physical exam. On physical exam the patients skin maybe clammy with cool extremities along with altered mental status. The pulmonary embolism severity index (PESI) has been validated clinical prognostic model for patients with acute pulmonary embolisms. There are a variety of other tools that you may see other practitioners use including the Wells score and PE rule- out criteria PERC.

Pulmonary Embolism Workup

Now the question is what laboratory result and additional testing will give us a clear picture of the outcome of this patient diagnosed with a PE?

Let's start with the electrocardiogram (ECG) because despite it not telling us if the patient has a PE, it will suggest right ventricular (RV) dysfunction. We should look for the following findings S1Q3T3, right axis deviation/right bundle branch block (RBBB), and atrial fibrillation.

What would you consider if the patient had an elevated BNP and high sensitivity troponin? If you would question the correlation of the elevation to the PE you would be correct. An elevated troponin can be related to a variety of non-PE reasons such as acute kidney injury (AKI), chronic kidney disease (CKD), and heart failure (HF). It is important to take into consideration that a negative troponin does not rule out a significant RV strain/significant PE that may be at risk for acute decompensation. The same consideration should be taken when reviewing an elevated brain natriuretic peptide (BNP) although we must consider that an elevated BNP should trigger the practitioner to look for previous echocardiograms to rule out past cardiac history. When I think of PE the first thing that comes to mind is an elevated d-dimer. Although this may be used to support further testing like a CT scan it does not clearly relate to acute decompensation but has been associated with increased in-hospital mortality.

Despite the controversy around many of the labs there is clear evidence to support an increase in short-term mortality with a lactate of >2mmol/L.

There is no doubt that this patient should qualify for a CTPA although the clot burden is noted to have different implications based on the patient. The practitioner should take into account that in a high-risk patient, if the clot burden is minimal there should be some concern about an alternative explanation for the patient's clinical picture.

We cannot forget about the benefits of point-of-care ultrasound (PoCUS), a qualified practitioner could use bedside ultrasound to provide rapid assessment of RV function and rule out other causes of shortness of breath.

What medications might we anticipate for the PE patient?

The medication needed will depend on the patients presentation. When we consider the following medications alteplase (TPA) and Tenecteplase (TNK) the first indications that come to mind are stroke and myocardial infraction. However they should be the medication that you are reaching for when you have a patient with a PE that progress into cardiac arrest or for the peri-arrest and high-risk PE.

Studies indicate that for the intermediate-risk patients, low-molecular-weight heparin is preferred over unfractionated heparin as it has been shown to improve outcomes and result in fewer bleeds.

We must always consider the volume of intravenous (IV) fluids that we administer to a PE patient as excess fluids could worsen the RV dysfunction so should be avoided or closely monitored.

What about the use of oxygen for the PE patient? Studies have highlighted the importance of avoiding hypoxia in the PE patient as it can precipitate the RV death spiral. Oxygen should be administered in the least invasive manner to start such as nasal cannula however if this is not

sufficient a nonrebreather should be used especially if the patient is a mouth breather. Intubation should be done by an experienced practitioner to avoid periods of hypoxia and optimization of the ventilator settings should minimize hemodynamic effects on the RV, targeting low tidal volumes and minimizing PEEP.

Key take home points for management of the pulmonary embolism.

· It is vital to encourage early consultation for further care of the PE patient but first ask yourself and team these questions. Is the PE causing the clinical picture, or is there another underlying cause, what is the patients bleeding risk, and has the patient deteriorated?

· Avoid excessive fluid administration.

· What are the protocols and physicians' thoughts on the use of TNK and TPA for high-risk PE, peri-arrest or arrest patient at your site?

· Do you have someone that is qualified to preform PoCUS at your site?

· Determine patient risk for anticoagulant therapy including: recent bleeding (e.g. gastrointestinal (GI) tract, epistaxis, recent surgery), previous dangerous bleeds (e.g. intracranial hemorrhage [ICH], GI bleed), or past history of adverse events on anticoagulants (e.g. difficulty maintaining stable international normalized ratio [INR], heparin induced thrombocytopenia [HIT]), medications that will interact with anticoagulants, and renal function.

· Review the local protocols at your site to ensure that you are well versed in the treatment options and care plan.

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10 things to Know About Rabies

1. Rabies is a zoonotic disease caused by a virus that affects the brain and spinal cord.
2. Rabies is spread through saliva or brain tissue. People get rabies by being bitten, scratched, or licked on open skin by an infected animal
3. While it is rare in North America, people are still potentially exposed to rabies when they come in contact with wild animals and unvaccinated pets. Animals such as bats, raccoons, skunks, foxes, and coyotes are considered high risk.
4. Once the virus enters the body, it travels from the wound along nerve pathways to the brain, where it causes progressive inflammation, resulting in symptoms of the disease (headache, fever, confusion, agitation, paralysis) and eventually death.
5. Timely and appropriate postexposure prophylaxis will prevent human rabies. Administration of rabies postexposure prophylaxis is a medical urgency, not a medical emergency, but decisions must not be delayed.
6. Postexposure prophylaxis will be released by the Medical Officer of Health. It is comprised of Rabies Immune Globulin (RIG) and the Rabies Vaccine series.
7. RIG is a blood product (need consent) that provides fast protection against rabies, but it is not long-lasting.
8. The rabies vaccine series should be initiated on the same day the patient receives RIG to stimulate antibodies and provide long-lasting protection.
9. Ideally, RIG should be infiltrated into the wound (out of nursing scope- should be performed by an MD).
10. Any remaining RIG should be administered intramuscularly in an anatomical site distant (Vastus Lateralus) from the vaccine (Deltoid).

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President- Dawn Peta

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A Message from the NENA-AB President to Emergency Nurses

Dear Emergency Nurses I hope this message finds you well. It has been some time since we last connected, and I want to take this opportunity to acknowledge the incredible work you continue to do, often behind the scenes, to provide critical care in times of need.

Emergency nursing is a profession built on resilience, compassion, and an unwavering commitment to patient care. Your ability to face unprecedented challenges head-on, whether it's during natural disasters, surges in patient numbers, or the ongoing unpredictability of the healthcare landscape, is nothing short of inspiring.

I deeply regret the distance that time has placed between us, but I want you to know that our commitment as the NENA-AB team is to support you. Exciting news is that our team roster is full, which means we have representation from across the province. Please review the team sheet that shows who is in your area that you can connect with.

We are working tirelessly to address the challenges that you face every day and to ensure that you have the tools, resources, and recognition that you deserve. Your dedication to saving lives, providing comfort in moments of fear, and giving your all— day in and day out—is something that deserves to be celebrated. I am humbled by your strength and honored to stand with you as we continue working together in uncertainty in healthcare.

Thank you for your exceptional service and for being the heart of emergency care. We have missed you, and we are grateful for the tireless work you do to keep our communities safe.

Can't wait to see you all at our future events. Do not hesitate to reach out to any of our team.

With deepest gratitude and respect,

Dawn Peta, BN, RN, ENC(C)

Administration Officer- Heather Murray

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Hello Fellow NENA colleagues My name is Heather Murray BSN, RN, CEN, TCRN, and I am the current administration officer (Secretary) for NENA Alberta. I joined the NENA board in July 2024 and I currently work as a Nurse Educator. I grew up in Northern Alberta and moved back to central Alberta in 2019 after living in Texas for 15 years. I attended Tarleton State University in Stephenville, Texas for my BSN and as a baby nurse I completed a 1-year nurse residency at JPS hospital the level 1 trauma center in Fort Worth, Texas. I am currently completing my MN through USASK.

My emergency nursing career began in 2016. I transitioned to JPS ER, one of the busiest Level 1 trauma hospitals in North America. I gained a passion for ER nursing and the dynamics of high functioning resuscitation and trauma teams. The mentorship, accountability, and encouragement I received from the ER nurses, physicians, Paramedic Techs and leaders that raised me, has influenced how I approach emergency nursing, teamwork, and challenges in this crazy environment. I also was privileged enough to be a part of a SANE program as a support team leader and was active in forensic evidence preservation and collection through our trauma services program.

I achieved my specialty certification in emergency nursing (CEN) in 2016, and my specialty certification in Trauma Nursing in 2018 (TCRN) through the Board of Certification for Emergency Nurses (BCEN). My favorite roles in the ER are Trauma and Triage. In Canada I have worked in both urban and rural ER in BC and Alberta. I have also worked in home care and as a patient care coordinator. Throughout my career I have learned the value of being involved in my profession and pursuing professional development and lifelong learning.

I now live in Rural Central Alberta and my hobbies include showing my Horse Ruby in reining and cowhorse and we are also learning to breakaway rope (I'm hoping no ER visits)! I also have a small farm where my husband Ron and I do farm to table meats.

I feel privileged to be a part of the NENA AB team to collaborate, network and advocate with my fellow nurses and leaders across the province, nationally and internationally.

Treasurer- Sandra Walsh

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Hello everyone!

I'm your current NENA AB Treasurer. I work as an Acute Care/Emergency CNE covering the far east corner of Central Zone. My background is mainly in rural and remote emergency nursing, having worked over 10 years in the Northwest Territories. Recognizing the lack of organized education in rural/remote areas has always driven me to find ways for furthering education for my colleagues and myself. I feel strongly about investing in ways to improve practice and maintain excellence in our field. I've recently attained my PALS instructor status, and I also teach CTAS. I will be completing my ACLS instructor training in the coming months. I look forward to connecting with many of you at our upcoming conference. As with work, my door (or email) is always open for any questions, concerns, or even just a friendly chat!

Education Coordinator- Sara Phillips

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I am the clinical nurse educator at Strathmore Hospital. I have worked in the Emergency Department here since 2008. Before that I was a travel nurse in the USA, specializing in pediatrics. I am the Education Co Ordinator for NENA Alberta. I am also on the ICAC (International Course Administration Committee) for NENA, and the GAC (Global Advisory Committee) for ENA. I am a member of both ENA and NENA. I am an Instructor Trainer and instructor for both TNCC and ENPC. I also teach CTAS, ACLS, PALS, BLS, and NRP. I stay busy with 4 kids who are old enough to need rides everywhere, but not old enough to drive themselves.

If you are looking for help to co ordinate TNCC or ENPC courses at your site, please be in touch as I would be happy to try to help you with that. You can email me at sara.nursing@aol.com

Communications Officer- Mandy Blacklock

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I have been a registered nurse for 14 years, practicing in rural and urban emergency departments and urgent care centers across Alberta. I have a passion for emergency nursing and my heart will always remain in rural.

My current role as is at Airdrie Urgent Care as the Clinical Nurse Educator. Continuing education is important to me and within this new NENA role, I would like to encourage others to share their passion for emergency nursing and professional development. I look forward to working together to continue striving for excellence in emergency nursing.

I am also an ACLS, PALS, and CTAS instructor. I look forward to the CTAS updates and educating frontline staff about all the changes throughout the coming year.

Southeast- Terri Egger

~Bassano~Brooks~Medicine Hat~Vauxhall~Bow Island~Taber~Oyen~Milk River
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I work in rural Alberta, in Taber Emergency.
I love all things rural emergency nursing, especially with the amazing team we have.

I've been an RN for thirteen years, primarily in emergency. I am also the simulation team lead for Taber and an NRP instructor.

I enjoy continuing to learn and teach through SIM and the diverse elements that this brings to front line staff.

I look forward to this new role with NENA as the southeast representative, and the opportunity to network and meet some of the amazing nurses that Alberta has.

Southwest- Annamaria Mundell

~Lethbridge~Fort Macleod~Pincher Creek~Crowsnest Pass~Cardston~Raymond~Claresholm
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Annamaria Mundell brings a wealth of expertise to her role as the southwest zone NENA representative, coupled with over twenty years of clinical experience as a Registered Nurse. Her career spans pivotal roles in esteemed emergency departments at Calgary's Foothills Medical Centre (FMC), Alberta Children's Hospital (ACH), and Pincher Creek Hospital.

Currently, Annamaria assumes the position of Clinical Nurse Educator (CNE) within the southwest zone, alongside her integral role as a simulation consultant for the eSIM Provincial Simulation Team, catering to Chinook Regional Hospital.

In her capacity as a simulation consultant, Annamaria oversees a comprehensive outreach simulation program, extending its reach to six rural hospitals across southern Alberta. Central to her responsibilities is the provision of support, mentorship, and guidance to nurses, fostering their professional growth and facilitating continued education, particularly in the realms of leadership and excellence, both locally and provincially.

Annamaria is deeply committed to the advancement of equitable healthcare access, with a particular focus on the engagement of Indigenous populations through simulation-based education initiatives tailored to rural settings. Beyond her professional endeavours, she is actively engaged in her community. Outside of her professional commitments, Annamaria finds solace and rejuvenation in outdoor pursuits, sharing these moments with her family.

Calgary Urban- Janine van Beurden

~FMC~ACH~PLC~RGH~SHC~Sheldon Chumir Urgent Care~South Calgary Urgent Care
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I have worked as a staff nurse at the Peter Lougheed Emergency since 2005. Prior to working in the PLC ED, I worked on a medical teaching and hematology unit and worked as an events nurse for the Calgary Stampede.

In 2022, I began as one of the clinical nurse educators at the PLC Emergency department- it has been an amazing learning experience, and I have completed my certifications to be able to help provide ACLS, PALS, TNCC, ENPC, and CTAS courses to our staff.

My goal in my CNE role and what I hope to accomplish as the Calgary Urban NENA representative is to help provide great educational opportunities and have emergency nurses feel confident and proud of their integral role in providing excellent patient care.

Calgary Rural- Natalie Palmer

~Airdrie~Cochrane~Okotoks~Banff~Canmore~Black Diamond~High River~Didsbury~Strathmore~Vulcan
natalie.palmer@ahs.ca

Hello! My name is Natalie Palmer, your Calgary Rural representative for NENA AB. I grew up in Banff and still call this beautiful place my home with my husband, teenage daughter, and our dog Doug.

I started my 20+ year RN career at the Banff Mineral Springs Hospital as an OR nurse, progressed to med-surg and Labour and delivery, and finally to the ED. I was the Clinical Nurse Educator for the hospital for eight years before taking on the role of Provincial Education Coordination for Emergency Nursing with AHS. In this current role I have met and worked with many extremely talented and engaged nurses across this province.

My academic career includes an Advanced Critical Care Nursing - Emergency Stream certificate and a Master of Nursing with a focus in Clinical Teaching. I have been an instructor for many of the standardized courses over the years. When not at work, I enjoy all things outside – hiking, biking, running, swimming, and just generally being in the mountain environment.

Central West- Natalie Anderson

~Red Deer~Camrose~Drayton Valley~Lacombe~Ponoka~Rimbey~Sylvan Lake~Wetaskiwin
natalie.anderson@ahs.ca

I'm the Central Zone NW representative, covering Red Deer, Camrose, Drayton Valley, Lacombe, Ponoka, Rimbey, Sylvan Lake and Wetaskiwin. I have been a Registered Nurse at the Red Deer Emergency Department since 2017 with previous experience nursing in Calgary and Boyle. I am a CTAS and TNCC instructor and the Team Lead for the Supporting Our Staff (SOS) Peer Support Team for Red Deer Regional and Sylvan Lake Advanced Ambulatory Care. I've recently started working on a 6-month pilot project improving access to peer support for anyone working at Red Deer Regional Hospital, and look forward to sharing more about it at the NENA-AB November Conference & AGM in Jasper.

An upcoming learning opportunity of note: Central Zone Trauma Education Day 2025 at Westerner Park in Red Deer is on October 24, 2025. Contact Brenda.Wiggins@albertahealthservices.ca or rdhctraumaconference@gmail.com for more information.

Please feel free to reach out to me via email if you have any questions or want to discuss what's going on in your department.

Central East-Kristine Osetsky

~Castor~Coronation~Daysland~Hanna~Hardisty~Killam~Provost
kristine.osetsky@ahs.ca

I live and work in the small rural community of Coronation and I am your central zone rural east rep! I have been a nurse for thirty years in a diversity of roles, but my passion is the rural emergency department (ED) and all the things ED. I feel so fortunate to still love my work! Currently I work full time as the Rural Emergency Clinical Nurse Specialist for central zone, and I continue to work casual in a frontline nursing position.

Continuing education and excellence in practice are important to me. I learn in my work every day and strive to improve practice. I completed my MN through the University of Calgary last year. This endeavour challenged me in many ways, but I also learned so much.

I have three amazing grown daughters (two are nurses!) who thankfully all live relatively close. When I am not working, I am bit of a homebody. I like to hang out with my husband, and my fur babies. I enjoy music, arts & culture, puttering in the flowerbeds, delicious food, and travelling.

I am committed to supporting the unique needs of rural nurses and patients. Being more involved in the National Emergency Nurses Association, Alberta chapter is an opportunity for information sharing and advocacy work with and on behalf of my nursing colleagues. I look forward to getting out there and meeting you!

Central South- Erin Acorn

-Drumheller-Innisfail-Olds-Rocky Mountain House-Stettler-Sundre-Three Hills-
erin.acorn@albertahealthservices.ca

My name is Erin, and I am the representative for south central zone. My sites include: Drumheller, Innisfail, Olds, Rocky Mountain House, Stettler, Sundre, and Three Hills.

A little about me: I am a Registered Nurse who has worked in the Red Deer ER for twenty three years. I have recently completed my Masters of Education Post Secondary Studies. I am currently a CTAS and ENPC instructor.

I am passionate about emergency nursing, professional development, and supporting new nurses.

I am looking forward to this new role within NENA and am excited to connect with ER nurses across the province.

If you are within my zone, please feel free to reach out with any questions or comments or to share the news and challenges of your departments.

Edmonton Urban- Domhnall O'Dochartaigh

-Grey Nun's-Misercordia-University of Alberta-Stollery-Sturgeon-Royal Alexandria Hospital
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Hello, I'm Domhnall, an RN and new NENA Edmonton urban representative. I came to Canada to learn to ski last century, and one thing led to another. I retrained as a registered nurse in Westlock via Grant MacEwan rural program. I started at the RAH in ICU and added the ED in 2008. I currently support the Edmonton zone EDs in a clinical nurse specialist role. I also work as a flight nurse and research coordinator for STARS. Over the years my flight role has taken me to many EDs in Alberta. I'm passionate about supporting our frontline providers in these interesting times. Outside of work I stay busy chasing my twins around.

Edmonton Rural-Lindsay Bouffard

~Fort Saskatchewan~NECHC~Redwater~Sherwood Park~Stony Plain~UCC-East Edmonton~Leduc~Devon~
Lindsay.bouffard@albertahealthservices.ca

I am Lindsey, an RN and the Edmonton Rural Representative and stand in Edmonton Urban Rep for NENA-AB. When I am not working at the Westview Health Centre ER and the Northeast Community Health Center ER, I am a wife, fitness enthusiast, mother, chauffeur, loudest hockey fan, personal chef, math tutor, counsellor and all the other roles that come with having young and active children. I am passionate about all things emergency medicine and my goal is to provide education, motivation, and inspiration to all new and seasoned ER nurses. I would love to hear what excites you about emergency nursing, what challenges you or your workplace are facing, any questions you may have or if you are looking to become a part of this amazing group of likeminded nurses, please do not hesitate to reach out. Email me at Lindsey.Bouffard@ahs.ca.

Currently in the Edmonton & surrounding area ERs there is a lot of exciting projects and improvements happening. Across the zone we have standardized the screening, assessment and management of Frostbite with a new Frostbite Pathway. Many of our sites have used this new pathway and seen great outcomes for our patients. Patients presenting with concerns for frostbite should been triaged as a CTAS 2 and rewarming should be initiated within 10 minutes of arrival. It is a labour intensive and 1:1 nursing presentation, however severe frostbite can be described as "a tourniquet on an affected digit/limb that is reduced when rewarmed".

Another initiative that has been launched at the UAH ER, and hopefully to the entire Edmonton Zone, is the INFO Clinical Event Debriefing. This is a for of "hot" debriefing that is voluntary, fast, occurs within minutes to hours of the event, limited to participants present for the event and 'focuses on immediate reactions to identify processes, procedures, and safety measures that ca be improved upon quickly and in real time'. One Edmonton Urban site is getting a new product called Purewick The BD PureWick™ System - Official Site which looks like a really great product to decrease skin breakdown from other incontinence products as well as avoid unnecessary catheterization of patients, especially in our busy EDs.

Some challenges being faced in our area that I am sure are similar to many areas is the lack of space and time to provided education and training. Many CNEs want to provide education (eSim, in-services, on the spot training, courses) however are lacking the space to appropriately and safely provide this education. I know the goal at my site (one day) would be to have a designated space, essentially a sim lab.

North West- Jennifer Willox

~High Level~Fort Vermillion~Manning~Peace River~Grimshaw~Mclennan~High Prairie~Valleyview~Beaverlodge~Fairview~Spirit River~
~Grande Prairie~Grande Cache~Fox Creek~
jennifer.willox@albertahealthservices.ca

I was born and raised in Peace River, Alberta, and am proud to serve as the Clinical Nurse Educator for Area 2, which includes Peace River, Grimshaw, Manning, and Fairview. In my role as an educator, I find great fulfillment in supporting frontline staff by sharing evidence-based practices and the latest in best practices. I have a strong passion for continuing education and am deeply aware of the unique challenges that rural nurses face. Teaching in a hybrid format, combining virtual and inperson methods, allows me to reach a wider audience and better serve staff across a large region. My heart lies in the fast-paced environment of the Emergency Department, and I truly enjoy connecting with fellow emergency nurses. I strongly encourage all ER nurses in Alberta to join the NENA team—it's an excellent opportunity to network, share knowledge, and learn from each other.

North Central- Kristen Mackenzie

~Athabasca~Barrhead~Boyle~Edson~Hinton~Jasper~Mayerthorpe~Slave Lake~Swan Hills~Wabasca~Westlock~Whitecourt~
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Hey everyone! Here's a little bit of news from the north! Despite our winter woes and unpleasant weather, education continues to be offered both in person and online. There has been some recent changes to the Emergency Practice, Intervention, and Care in Canada (EPICC); a new company has taken over the program and will be bolstering the current content. Talk to your local educators about getting this course at your facility to elevate your everyday emergency skills. TNCC and ENPC can be accessed online and occasionally in person, available to both AHS and Covanent employees. If you're ready to heighten your trauma skills a bit more and do some interdisciplinary play, consider auditing an Advanced Trauma Life Support (ATLS) course; the next one is available in Athabasca in April. If you really want a challenge, sign up for an Emergency Department Echo (EDE) course and learn some bedside/point of care ultrasound (POCUS). AND YES, this is in the RN scope of practice! RhPAP has really become a great resource for rural nurses and provided funding for courses, conferences and various other things, so take a look at their website and see what you can take advantage of! I just recently saw an offer to sponsor nurses to go to the Alberta Association of Nurses (AAN) conference, which will definitely have some fantastic content - so be sure to check it out. Speaking of conferences, be sure to attend the NENA AB conference in April and ensure that the North represents! Feel free to reach out with questions about emergency processes, education, or just general thoughts of things that are happening in our communities up here past our capital city.

North East- Sarah Kasper

~Cold Lake~Bonnyville~Elk Point~St. Paul~Lamont~Tofield~Two Hills~Vegreville~Viking~Wainwright~Vermillion~Fort McMurray~
~Smoky Lake~Lac La Biche~
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I am honoured to join the NENA as the north-eastern Alberta representative. Over the past 23 years I have worked in emergency medicine as a Emergency Medical Responder (EMR), Primary Care Paramedic (PCP), Licenced Practical Nurse (LPN), and Registered Nurse. Each role has reiterated the importance of education ensuring I provide my patients current evidenced based care.I currently work in the Cold Lake Emergency department. Over the past several years the noth-eastern region has faced nursing and physician shortages which has further highlighted the need for staff to have the knowledge to care for the high acuity patient that present to the ER departments in the region. Over the years I have been forunate to be mentored by coworkers that value continuing education and understand the importance of supporting me through difficult shifts and EMS calls. I have been thankful for courses like TNCC,ENCP,and CTAS which have been available locally thus allowing staff to engage in learning without the barriers of traveling and additional time away from home. I look forward to encouraging and supporting staff as they navigate the changes and challenges facing them as they practice emergency medicine in Alberta.

Novice ED Rep- Jehanna Joyes

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My name is Jehanna. I work at the Westview Health Centre Emergency Department in Stony Plain, Alberta. I am proud to say that I will be filling the Novice Nurse position at NENA-AB. Here is a bit about myself and my experience in emergency so far. My nursing career started in 2020 as a Healthcare Aide at the Royal Alexandra Hospital, floating on the medicine and surgical floors. I graduated in June 2023 and began my RN position in women's health, which had a range of patients from postpartum to palliative oncology. I decided to make a career switch in April 2024 to the emergency department. I was drawn to Westview because Stony Plain is my hometown and I wanted to support my community's health.

Outside of nursing, my life is just as busy and chaotic as the emergency department can be. I love my little family which includes my partner, dog and two cats. We love all things outdoors. In the winter, that means lots of bundled walks, and in the summer (our preferred season), we go camping, biking, hiking, and swimming. I love creating and in the last few years, I have gotten really into pottery. Making home-cooked meals and baked goods is also essential to my day to day. I've recently taken a liking to using sourdough, which has commandeered my baking style. If someone had told me in my first year of nursing school that I would be an emergency nurse, I would have looked like a deer in headlights. Throughout school and as a new grad, I did not have a grand plan to work my way into a specialty. I was content in medicine and surgery. Until one day, I got an itch to try something new. Although I had less than a year of RN nursing experience, I decided to test my luck and apply for emergency positions. When I started my new role, I felt overwhelmed, intimidated and out of my league. I had that familiar little voice at the back of my mind trying to tear down my confidence. I worked hard in my first few shifts to fight the imposter syndrome and keep it from taking the forefront of my thoughts. Now, a year into my ED career, I feel confident and capable. I still have so much to learn about emergency medicine but I have a solid foundation to now build upon. I am excited to join NENA to expand my knowledge of emergency medicine and to share my perspective as a Novice Nurse. Please contact me, via the email below. I look forward to hearing from all nurses, long-serving and new, about their experiences as a novice nurse in the ED.