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Regulars

A Word from the Editor

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Letters to the Editor are welcome. Letters should be no more than 500 words, with no more than 5 references and no tables or figures.

At the time of writing the last editorial we were staring down a crisis. What a difference a few months makes? It is worthwhile reflecting on the achievements in addressing COVID 19 to-date. These include, improved infection control, increased vaccination rates, coordination of tertiary and primary level care and improved facilities and equipment. All of which is well covered in the regional reports in this issue. My hope is that those gains will be embedded in our practice and that community transmission remains eliminated.

In contrast, another issue of concern has sat like the proverbial elephant-in-the-room, going nowhere and occupying an awful lot of space. There is a dis-connect between the NZNO Board, its executive and the NZNO membership. It's sadly ironic that while our nursing profession pulled together to go 'above and beyond' to achieve unprecedented elimination of community transmission of a novel coronavirus, our professional body is struggling to maintain unity. All this is happening when the core public health message aimed at addressing the pandemic is based around altruism and kindness. I don't profess to understand the issues or the history of this disagreement at NZNO board level but the reputational damage caused is self-evident, public and painful.

COVID 19 lockdown has given us an unforeseen opportunity, to reflect on how to do new things, and how to do the same old things - but better. Perhaps it is time to push 'pause' on dissecting our differences and re-group to focus on our common goals. We need to be open to doing things differently within NZNO in the face on an unprecedented health and economic challenges.

I'd like to think that NZNO – and that's all of us - would want to be more inclusive, particularly to those whose voices are getting lost in the racket of press releases, legal action, complicated voting processes and social media posts. Nobody is served well when we retreat into separate camps and shout at each other. A little more kindness might make a big difference.

Matt

Editorial Info

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Chairperson's Report

Welcome to the new normal – New Zealand post lock-down is confronting in many ways, while offering a mix of stimulating and difficult situations. As we come to terms with integrating social distancing, routine handwashing and limited travel options into our everyday routine this alongside a profound gratitude for the relative safety in which we find ourselves.

Despite the uncertain economic future, we have managed to maintain a degree of control over the covid-19 pandemic which is lacking in most other countries. Despite this, emergency departments remain at the forefront of any potential response, while needing to manage the usual challenges of winter surges, staffing difficulties and service overload.

The College remains focussed on supporting individual nurses, practice settings and the wider profession as we all seek to maintain the highest possible standards, and find solutions to the difficulties and demands that have presented during this period.

It is important to recognise the positives as well as the testing elements, and there have been innovations as a result of the Covid-19 response which are likely to be carried forward. One of these has been the establishment of on-line CNM meetings. While we have traditionally hosted a face to face meeting to enable the sharing of information and ideas, this of course was not possible during lock-down. Instead, we commenced regular zoom meetings, to allow CNMs from around the country to share information, techniques, responses, and pose questions or ask for specific information as part of the effort to share resources during the pandemic. While not limited only to issues of Covid-19, this has certainly been a main stream of discussion.

Along similar lines we hope to start a series of online meetings for nurse educators, to address issues and share knowledge around ED topics. The move to zoom has created a greater sense of familiarity and willingness to use this medium, and has opened up the opportunity to develop regular interactive forums.

Cancellation of paediatric symposium; need for on-line AGM

We have all realised that travel is inevitably limited in the post lock-down period. This is in part due to restrictions still in place, and partly due to a reluctance from organisations to allow staff to travel for educational or other purposes. As a result of this, we know you will understand why we have chosen to formally announce the cancellation of the 2020 CENNZ Paediatric Symposium. However, we do need to provide a forum to host the College AGM. While this may not have been the favourite part of the conference or symposium, I ask that you remember that this is essential to enabling us to progress as a working college. This year, the AGM will be held on-line, via a zoom process, and we need your support to ensure that we have a quorum of members. We will be minimising this to essential business only, and including a guest speaker to provide additional interesting material. The details for this (*including date and presentation topic*) will follow.

CENNZ has continued to advocate for responses to violence and aggression in the workplace, with representation on the national NZNO committee working in this area, and we continue to follow the progress of the Protection for First Responders Bill which is going through parliament at present.

Chairperson's Report Cont.

There are on-going questions around how New Zealand and the health system can best manage the influx of returning kiwi's, and the placement of quarantine facilities. This has impact not only for primary healthcare staff, but also for the ED sector. We need to be mindful of the importance of having clear plans and processes for managing the 'what if's' in regard to out breaks, to unforeseen illness and injury, and how to manage should ED staff be called on to assist if current service provision is insufficient.

Are we in a position where this would be possible? Is this part of our role? And if not, then what systems are in place to manage such requests? We need to act as ED nurse's always do – to be prepared, and with a high index of suspicion for the unexpected.

I wish you all well, and thank you once again for the contribution you have always made, and continue to make to the healthcare of New Zealand.

Kia Kaha

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New CENNZ Honorary Member

On International Nurses Day 2020, CENNZ announced a new Honorary Life Member to the college: **Rosie Simpson, from Dunedin.**

Rosie graduated from the Dunedin School of Nursing in 1975 and started working in the Dunedin Emergency Department in 1988. Where at this time she worked four nights a week, while raising a family. In 2000, Rosie became actively involved in emergency nursing, on a national level. Having completed one of the first triage courses offered in New Zealand, she became a triage instructor - a position that she held for ten years. During this time, Rosie travelled around the country on her days off, providing education for her fellow emergency nurses.

As a triage instructor, Rosie contributed to the revision of the triage course and development of the Triage Manual and course materials and continued to ensure the course and materials were kept up-to-date, for over a decade. In 2002, Rosie stepped into the newly-creates Associate Charge Nurse Manager role at Dunedin ED, and held the position until 2009. Rosie then spent two years as the Emergency Planner for Dunedin Public Hospital, but missed emergency nursing so returned to Dunedin ED in 2012, where she has continued to support students, graduate nurses and new nurses. Rosie was involved in the Emergency Department simulation governance group, and the simulation suite development and design. She has been vocal in the need to include, develop and to have access to education for nurses throughout her 30 years in the department.

Rosie has been an active CENNZ member in the southern region for many years, being involved in study days that were run by earlier regional representatives. She encouraged fellow nurses to be involved in change at a local and national level. As a CENNZ member she attended a number of conferences, always willing to share her ideas, knowledge with her peers and be involved in promoting the education of emergency nurses.

Rosie has been a professional role-model and has promoted excellence in emergency nursing within Aotearoa New Zealand and is a worthy recipient for an Honorary Life member of the College of Emergency Nurses New Zealand.

Rosie retired in June 2020, and we wish her well. **Congratulations Rosie!!!**

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What are the success factors for children with obesity having obesity discussions? A cross-sectional multiple methods study in an emergency setting.

Abstract:

Introduction

In New Zealand, almost 22% of children aged 2-14 are overweight and another 11% are obese. The children's Emergency Department (ED) was within the main hospital serving South Auckland, which has even higher rates of obesity. We set out to explore the experience of families and Healthcare Professionals (HCP) when having an obesity diagnosis discussion (ODD) in the childrens' ED.

Methods

Mixed method research design comprising interviews, HCP's survey and an HCP focus group. Convenience sampling was used to recruit eight parents who had had an ODD at childrens' ED in the previous 2-3 weeks. This article relates only to parent interviews.

Results

Most parents were unaware that their child was obese. Once identified, all parents wanted to have the healthy living discussion with the HCP. Several factors affected parental engagement in the ODD and the these aligned with HCP's experiences. All parents were keen to make some of the suggested lifestyle changes, yet they identified similar factors preventing them.

Discussion

Parents have demonstrated an ability to make changes to family lifestyle after a brief ODD. Positivity and non-judgemental conversations were usually well received by parents. HCP should prioritise ODDs with families when parental engagement criteria are met.

Keywords: New Zealand; child; obesity; discussion; HCP; parent; eating; Pacific.

What are the success factors for children with obesity having obesity discussions? A cross-sectional multiple methods study in an emergency setting cont.

Introduction

Childhood obesity has been recognised worldwide as a non-communicable disease of global health concern (Shackleton, Milne et al. 2017). Obesity in childhood and adulthood is associated with chronic illnesses affecting quality of life and early mortality (Kohut, Robbins et al. 2019). Children with obesity are at an increased risk of becoming obese in adulthood, and developing related co-morbidities (Lakshman, Elks et al. 2012, Aarestrup, Bjerregaard et al. 2016, Ministry of Health 2016). There has been no published literature having ODDs in an emergency department. Findings from Primary health have identified that both HCPs and parents find the ODD difficult and this has led to fear and concern from the HCP, preventing ODDs occurring (Turner, Shield et al. 2009, Turner, Salisbury et al. 2012).

Aotearoa/New Zealand has one of the highest levels of both childhood and adult obesity in the world (Organisation for Economic Cooperation and Development 2017). Inequities exist in obesity prevalence rates, with rates highest among lower income groups. Ethnic differences also exist, with the highest rates in the indigenous Māori population and children of Pacific Islands ethnicity (Ministry of Health 2016). Prevalence rates also differ by geography, with some Auckland (the country's largest city) areas having almost double that of the national average (Ministry of Health 2018). For the purpose of this paper, the term 'Pasifika' will be used, to describe people of Pacific descent, who are currently living in New Zealand. The term "recognises the diversity of Pacific nations and their inherent cultural practices, languages and history that underscore each ethnic group" (Firestone, Funaki et al. 2018).

The burden of childhood obesity is not contained to the New Zealand health system as societal and governmental organisations are working towards healthier children, yet progress is slow (Swinburn & Wood, 2013). In a review conducted six years after the 55 recommendations from the Parliamentary Inquiry report of 2006-2007 (Kedgley 2007) was released, it was found that only a handful were enacted and maintained (Swinburn & Wood, 2013). Healthy nutrition is fundamental to children maintaining a healthy weight (Ministry of Health 2016). Parents are ultimately the gatekeepers to their child's nutrition, and play an essential role in their child's nutrition behaviours (Bradbury, Chisholm et al. 2018). Yet, nutrition behaviours do not occur in isolation and are not limited to the family environment. Social norms, environmental prompts and barriers to eating well, and economic and pragmatic issues likely converge to act as system barriers or enablers to healthy nutrition (Swinburn & Wood, 2013).

Children who are already classified as obese require prompt support to mitigate current and future health burden and risk associated with obesity. This research aims to understand perspectives on barriers and enablers to their child's healthy eating with parents of children who have received an obesity diagnosis.

Methods

Study context and protocol

This research was conducted in an Auckland area with higher than average childhood obesity rates. Parent/caregiver (hereafter parents) interviews were conducted between November 2018 and January 2019.

Ethical approval was provided by the University of Auckland Human Participants Ethics Committee (UAHPEC; ref 021795), the tertiary care provider's Research Office, and the local hospital research group. Consultation with both Māori and Pasifika cultural safety research advisors occurred. Their advice was incorporated into the research design and when developing interview and focus groups questions.

Participants

Convenience sampling was used to invite parents who had recently participated in an obesity diagnosis discussion (ODD) with a Healthcare Professional (HCP) at the tertiary care hospital emergency department. HCPs gave parents a 'consent to contact' form after their ODD. Parents who consented to be contacted were telephoned by JT to explain the study and arrange an interview time and location of the parent's choosing. Written informed consent was gained in person, prior to conducting the interview. Recruitment continued until data saturation was achieved (McKenna and Copnell 2019). To be eligible, parents needed to have conversational English.

Measures

Semi-structured interviews were conducted using an interview guide. JT led the interviews and a research assistant experienced in conducting research with Pasifika parents (LS), attended as many interviews as possible to ensure cultural safety. Before the interview began, a karakia was said over the food and time together. Upon completion of the interview, the research participants were given a $20 petrol voucher and $50 Countdown

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voucher (local supermarket) as an acknowledgement of their time and travel costs. Brief notes were taken by JT and LS during the interviews. A reflective diary was also written by JT describing the researcher's emotions during the parental interview data collection and thematic analysis.

Analysis

Interview data were analysed thematically following Braun and Clarke (2008) six steps of thematic analysis. Firstly interviews were transcribed verbatim by JT, read and reread in order to gain understanding of participants' views and experiences at the group level (Graneheim and Lundman 2004, Elo and Kyngäs 2008). Notes taken were utilised to provide additional context or detail where required. The data were then organised through open coding, creating categories and abstraction (Graneheim and Lundman 2004, Elo and Kyngäs 2008). Next, data were examined for themes which had an underlying meaning, linking different categories together. JT and MS then discussed the analysis and sought agreement. Co-researchers may come up with different interpretations, due to subjective perspectives, in which case discussion occurred to reach a mutual agreement (Graneheim and Lundman 2004). For this research, decisions regarding this step was documented in the writing up, as part of reflexivity, increasing strength in credibility of the qualitative research (Baxter and Eyles 1997). Once themes had been reviewed, they were named and coding was completed. Finally, excerpts from the participants were identified to support the themes being discussed.

Results

All parents who were invited agreed to participate and attended an interview (Figure 1). Data saturation was reached after eight interviews, as no further data or insights were revealed by the parents (McKenna and Copnell 2019). Children were all between eight and twelve years old, with majority males. Family 8 included the mother (P8) and the older sister (S8), around 20 years old, who was present during the ODD, and helps the mother care for the child on a day-to-day basis. Interviews occurred between 4-71 days (median 16.5 days) post the ODD, and lasted between 26-185 minutes (median 50 minutes). Parents self reported ethnicity, with all but one family identifying as Pacific, with one identifying as Māori. There is recognition that not all families who identify as Pacific are a homogeneous group, yet strength comes from similar findings from these families.

Understanding the complex and multi-faceted barriers to making healthy changes

Themes generated from the inductive analysis centred on identifying current unhealthy behaviours and then barriers to supporting healthy behaviour changes. These barriers were complex, multifaceted, often inter-linked and present across a range of social and environmental layers. Fundamentally, the key themes centred on the fact that behaviour change strategies were often occurring in isolation (e.g., focusing on the child or immediate family only, with little external support). These often combined with the normalisation of consumption of unhealthy foods. The downstream impacts made sustained behaviour change and improvements to child health almost impossible.

Social support and the essential role of the extended family

Most of the families interviewed reported that grandparents and extended family members had an active role in their child's daily life and child care. During these times, the grandparents' normal food of choice for the grandchildren mainly consisted of unhealthy foods including fast foods, takeaways and those with high sugar content for afternoon tea or dinner. Parents brought up the difficulty in changing this normal pattern in terms of food given by grandparents. Parents emphasised that they had tried to change the food habits of the grandparents or extended family. They had tried teaching grandparents about healthy afternoon tea snacks and meals and suggested either healthier options for takeaways or advising the grandparents to eat at home rather than take the children out for dinner. Parents had reported difficulty in getting grandparents to grasp or understand the magnitude of the obesity diagnosis for the child, thus the need for changes to food intake. This issue was highlighted in the majority of the families, and caused the parents stress and worry. The parents reported that they needed and wanted a relationship between the grandparent and the grandchild/children, but recognised that the issue of unhealthy food consumed during the time together needed to be addressed and changed to promote a healthier lifestyle for the children.

> P3. So, what my Dad does, is some mornings, he buys them pies to eat, and then some evenings when he drops them off [to school], he buys them hot chips or butter chicken, sauce and stuff, [giggle]. I don't know, I keep telling him, please will you try... [healthy options]. Or else he will bring them boxes and boxes of pies or doughnuts, creamy doughnuts and muffins and... yeah, my boys enjoy those.

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P2. Like, my brothers and sisters and my in-laws, and when they see my kids, they think, 'Aahhh lets go and buy a chocolate, or you want chicken and chips? Or what you want to eat?' kind of thing.

Parents discussed a mixture of feelings such as exasperation, failure and concern when having these discussions with extended family members, particularly their parents'. Parents reported the difficulties arose as it was not culturally acceptable to question elders, particularly their parents

P7. I cannot say no to kids or Grandma. Yeah, because sometimes, I feel like I will upset my Mum, because I don't like her to do that to my kids, it is too much, like, you know feed them... that's why their weight goes high.

P7. Very hard, yeah, coz they are my parents, and I can't tell them 'stop that'. Na, I can't do that.

Conversely, some parents discussed the changes towards a healthier lifestyle with their parents and reported that she felt able to trust the grandparent to mirror what the changes she had made at home.

P5. Yeah, she [*Grandma*] does it, [what Mum does at home], and then she makes sure that everyone else has it as well. So, he is not singled out, so whatever he can have, everyone else has, so she is into everything. She is really good, and it makes it a whole lot easier.

Some parents highlighted that once they had heard the information at the ODD there were differences between the parents of the child as to the importance of making changes to the child's lifestyle.

P2. So, my partner [*C2's father*] ... this is his first son, so he was thinking... he was thinking along the lines of, it is ok, it is our his first born, you know, my first baby, my first son. He can eat whatever he wants, treat him like a king.

P3. [*We, the parents are*] Not on same page. That was my struggle this week, because yeah... I tried to serve my kids the right amount of food, and then he [*Dad*] says to them, have some more, don't worry about it, or he'll say, erm... is that all that the kids are eating? And I say yup.

Child preferences for unhealthy food

Children, themselves, also played a role in determining the food they ate. Parents expressed concern due to an inability to get the children to eat vegetables, in a range from any to advised quantities.

While parents found it difficult to encourage children to eat healthy food at home, their control over what children ate at school was even lower. Parents reported the importance of their child eating food during the school day. This led to some parents providing children with unhealthy food options in their lunchbox, knowing that this would be eaten, rather than letting the child go hungry

P5. He will have like 3 different kinds of fruit [in his lunchbox] and I guarantee you that he's never eaten them, but they are always there. And then not so good stuff, but just so he has something.

P5. So, I'm like, as long as you eat... I'm OK, you know... so that's where we are at... yeah...

P3. It was like a happy thing to see him eat.

Time scarcity and accessibility and availability of unhealthy food options

Parents acknowledged that when they were time poor, they fed children easy-to-grab fast food. In these instances, quantity of energy, rather nutritional quality of food, was prioritised. There was discussion about the differences between living in the [*Pacific*] Islands and in New Zealand with respect to the food available. Parents highlighted that there was easy access to takeaways in New Zealand, which served parents well when they were rushed, due to the day-to-day business of life.

P2. 'It was just me, [going to] university and then doing the kids trainings and trying to work at events and stuff, and it all got too much, so I would always pack, you know, the cheapest, the fast food, whatever I could get that would feed them, until I had finished my meetings or finished whatever I was doing to cover them... and they are not going to interrupt me, you know, they are going to be hungry and then people are going to look at me and say "why aren't you feeding your kids?"

P8. [*In NZ*] The veggies are expensive, the fish is expensive, so we are going to resort to cheaper meals and takeaways and all.

Obesity (and the downstream consequences) as a rite of passage

Normalisation and acceptance, even a parental desire to want a larger child was discussed frequently. There was recognition from the parents that part of this was cultural. Yet there was

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no discussion as to what it meant for the child's health and longevity, prior to the ODD. The normality and desire for a larger child was reinforced by grandparents and sometimes at church or within their social group.

> P3. That is what really got me [*that he was heavier than me, when he stood on the scales*] ... but normally people are like... 'O my God, he is sooo chubby', it was like... I loved it. I loved it. That my kids were chubby, like... you know... like... and I didn't want my baby to lose like... I didn't want them to [reduce their] weight...

> P5. You know so from when he was born, he was born, he was born big. He is big for his age... like in my culture, in comparison with my family, that is like our normal. He is actually small in our family, like weight wise'. [*Dad's family*] they are like ... 'Ahh we need to feed you'. They think he is too small. Like in my family, he is... he is just like all the other kids. He is bigger and he is taller than all the other kids, than my sister's kids, but they are all European, but erm... but he does not look overly big, just tall, you know, nothing out of the norm, like with my brothers and sisters and their kids.

Pacific relationships with food culture as both barriers and opportunities

Many parents attributed lifestyle around food choices being intrinsically related to cultural practices and their wider community. This cultural aspect came from both the parents who were of Pacific Island descent born in New Zealand, and some who had been born and lived in the Islands, then immigrated to New Zealand. Most of the parents interviewed had their parents, who had been born and brought up in the Pacific Islands, living in New Zealand. Parents reported that there was direct cultural conflict between the lifestyle that the parents or grandparents had been brought up with overseas and the New Zealand lifestyle. This is intermingled with the value placed on children and spoiling them with food, while they are young.

Parent 2 reported that healthy food was not the normal in her extended family, and she has used the ODD as an opportunity to educate the extended family around healthier food options.

> P2. Yeah, being in the Pacific family, we always turn around and screw our nose up at stuff that is healthy... So, my in laws [*do*]. I live around people who are like 'why is there olives in here, why is there lettuce? And I just say, it is just for when I want to snack, yeah. So, it will be good for him, in the family with his cousins and stuff, let them explore something different instead of having a big meal and just being so lazy. And it affects them in the long run.

Food was identified as a very important cultural component of being in a Pasifika family. Food's importance came from its link with bonding time with family members and rewards or methods of expressing love; it was not seen exclusively as a nutritional component of a healthy lifestyle. This meant that, for some families, on a daily basis, much emphasis was put on the children eating with the extended family. Parents reported that the children would receive large portion sizes, with not much attention put into providing healthy meals or snacks for the children.

> P7. My Mum and my sister, they don't have any kids. Only me have kids. They give them like coke, chips, chocolate all the time. Takeaway, McDonald's, KFC. Yeah, they always go outside [*to*] eat, every day.

Relationships with extended Pasifika family and food

Some parents were aware Pasifika people living in New Zealand are represented negatively in health statistics. Knowing this, Parent 8 had a desire for this not to be the case for her family.

> S8. Mum said that we are not going to be like that [poor Pacific Island statistic]. She said "we should not just do the whole 'leave it, she will just grow out of it...' lose the baby fat type of mentality. And if we start doing that, then when she becomes older, it will be harder for her, where you said you should not be like... Food isn't everything. You should eat to live, not live to eat".

Parent 4 identified with her Māori culture. She discussed her journey of learning the Māori culture, as an adult, and what this meant for her. She referred to the values of respect and dignity. When applied to food she said:

> P4. It is about respect, respect, about others respecting self. But how do we do that, with food? With kai? It is love. Yeah, you know respecting the things, we karakia [prayer] over the food that we have.

> P4. 'Because life matters, quality of life. And all its aspects is a gift, and it is about respecting this life we have, the food we have, our body. My body.

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The conflict that these parents have expressed seems to indicate that maybe there are conflicting values as a parent particularly with respect to food. Conflict identified here is around the nourishment that the food provides and also the role of the mother who wants to demonstrate her love to her child through food.

> P4. My love language is quality time. In that quality time, food is how I love my kids, so being respectful of what we are eating, erm, the times we are eating, eating together

> P4. Food... not matter what the event. Love them with the food.

Easy access to, and normalisation of, unhealthy foods

There was discussion on some of the differences between 'living in the Pacific Islands' and in New Zealand with respect to the food available. The focus of the discussion was on the easy access to takeaways in New Zealand and the more rushed day-to-day life which required quick meals.

Parents also pointed out the cost of fresh fruit and vegetables and the accessibility in South Auckland. For Parent 2, the cost of fresh fruit and vegetables was not a hindrance, but was new concept for her to start buying vegetables every few days. Parent 8 reported that the high cost of fresh fruit and vegetables was prohibitive to her providing enough for her family on a daily basis.

> P2. I don't think so, I think it's... because if I can afford fast food, I can afford fresh veggies. I know it goes off, but I like to pick different varieties, so that I know... So I'll pick say, a lettuce, and it will last us say 2-3 days max, and when that lettuce has gone, I'll quickly grab something else to replace it, so I just buy as it goes.

> P8. Yeah, like here fish is expensive, veggies, the type of veggies we eat here is not the same... Financially you cannot afford the healthy... You know, OK we had healthy meals, but it is much healthier here [*in New Zealand*]. The veggies are expensive, the fish is expensive, so we are going to resort to cheaper meals and takeaways and all.

The environment where they lived or the area the children went to school was not supportive of healthy food options. This was demonstrated by parents reporting hot chip shops and unhealthy cheap foods so close to the schools. This was encapsulated by Parent 8's frustration when she took her children to Movies in the Park, a free event at a Māori university, where there were only unhealthy food stalls.

> P8. But it does not help when you go to Movies in the Park, and everything is around there for the children. Then the children walk past and saw her and were 'Wow, I want one of that Mummy!' [*candy floss*]. Even me, I felt bad, I said 'Damn it, buying it for her, just because she wants it, and what am I advertising to the other families, and to the other children. You know, educational and awareness out there. The Wānanga put up that Movie in the Park, why don't they put up a healthy fruit stalls for free?

Discussion

The aim of this research was to understand perspectives on barriers and enablers to their child's healthy eating with parents of children who have received an obesity diagnosis. Key findings were that a range of barriers existed across the socio-ecological spectrum, including social norms and relationships, environmental factors, and time and financial barriers. Parents discussed many problems that they faced with their children particularly with the child's desire for treats and being spoilt by extended family members. Parents reported that the extended family continued to give treats to the children, either with fast foods during contact time or lollies, even after being explicitly requested not to do so by the parents. Further examination on the nature or reasons for grandparents spoiling the children was not discussed within this research.

It could be concluded that a level of parental resilience is required to overcome child demands and negotiating with family members. This aligns with the notion of 'pester power' (Mikhailovich and Morrison 2007). In working with families, HCPs might need to acknowledge that this could happen. This might support parents by making them aware of the need to build resilience and strategies to bring the child on board with the journey deal with children pushing for unhealthy treats or being resistant to an activity.

The parental need for support in this journey has been found in a study which documented of the struggle of the 'lead parent' when having to battle the extended family who undermine their actions (Stewart, Chapple et al. 2008). Usually, parents reported that still the grandparents were found to have undermined the lead parent both verbally and physically, in changes towards a healthier lifestyle. In future, parents may need further support,

What are the success factors for children with obesity having obesity discussions? A cross-sectional multiple methods study in an emergency setting cont.

after an ODD to keep their resolve strong. The parents might also need strategies to help communicate with grandparents and bring them on board with the healthy lifestyle, as well. Stewart, Chapple et al. (2008) also recorded it was difficult for the parents to have the discussion with grandparents, with respect to asking them not to feed children certain foods, as demonstrated here. Although this was discussed in the current study's interviews, a solution was not apparent. A solution to developing support for parents and families must include allowances for those who have time pressures or children who pester them.

Parents spoke about the difficulty of holding conversations with grandparents about making changes as this could seem disrespectful and, in any event, appeared to have little effect. These findings align with previous evidence showing that parents need family support to maintain changes. Stewart, Chapple et al. (2008) undertook 17 interviews with parents who had completed a six-month intervention programme, in Glasgow; they found that the lead parent, usually the mother, needs support from someone outside the family to continue to motivate the child. They also found that the lead parent needs help as other family members continue to offer treats and undermine the parent's action and lifestyle changes. These findings also support the current study, which found that many of the parents said that they had difficulties with their partners or grandparents understanding the need for both the changes and ongoing support for the mother on this journey.

Eli, Howell et al. (2014) interviewed parents and grandparents regarding body weights and found they reported on the difficulty of having intergenerational discussions on a child's weight. This equates with the findings of the current research. Whereas Eli, Howell et al. (2014) reported on difficulty in words used in discussing weight with their child/grandchild, the findings from this research are around a parent engaging the grandparent in understanding the health risks associated with continuing current lifestyle choices, mainly in relation to food. Further research in this area might yield better advice for parents to enable these discussions.

Parents' reported their rationales were cultural and generational, with grandparents specifically wanting larger grandchildren. Parents reported that traditional Pacific culture demanded that larger children were wanted without awareness of determinants of health. Discussions in Firestone, Funaki et al. (2018) and within the HCP focus group were around the awareness over differences between Pacific culture and westernised beliefs surrounding body size and health

The quotes from the parents showed the pull between Pasifika people's cultural desire for bigger children and healthy children, as thinness was often equated with ill health (Firestone, Funaki et al. 2018). It could be determined that prior to the ODDs, the parents interviewed for this research were unaware of the detrimental effect that higher BMIs could have on the child's health. This was an uncomfortable discovery for most parents and caused distress. The latter was due to the conflict between previous thoughts on increased food intake for their child and new realisations of potential long-term health complications.

Firestone, Funaki et al. (2018) conducted focus groups discussing health and well-being with Pasifika people. It was found that they identify with a unique and strong sense of well-being. Pasifika well-being is associated with the well-being of the "family unit", as opposed to the "individual being sick". "Health" was found to be a state of "doing", that is, having a work-life balance which leads to a healthier lifestyle. It also includes "feeling motivated and a healthier life" embracing the physical and mental well-being of the family unit (Firestone, Funaki et al. 2018). This could be applied to these findings, with recognition that Pasifika do not view health and well-being in the traditional western views. HCPs might be better able to understand the Pasifika's holistic view of the child within the family as demonstrated by the use of 'weight' per se was not a specific health determinant for Pasifika people, whereas increased childhood weight indicated poorer health outcomes for westernised families. Health for Pasifika families, is measured by a desire to live longer so as to look after the next generation. The desire for parents to make a change to the child's current lifestyle, could be related to the desire for the child to live longer.

Conclusion

Parents care passionately about their children. Universally, these parents were able to associate obesity with being unhealthy and they did not want this for their child. Parents valued the ODD which enabled them to reflect on current lifestyle practices that they employed, that they now realise to be unhealthy, and were making changes. Changing children's nutritional behaviours was commonly discussed by parents.

What are the success factors for children with obesity having obesity discussions? A cross-sectional multiple methods study in an emergency setting cont.

Several families discussed difficulties and challenges such as the cost of food, time, extended family, and cultural and social norms. These difficulties are similar to those previously identified and published yet this study showed parents were able to start making changes after a very short ODD. Comprehensive approaches that support families in their journey to healthy nutrition are urgently needed.

References

Australasian College of Emergency Medicine (2001). Guidelines for Implementation of the

Aarestrup, J., Bjerregaard, L. G., Gamborg, M., Ängquist, L., Tjønneland, A., Overvad, K., . . . Baker, J. L. (2016). Tracking of body mass index from 7 to 69 years of age. *International Journal of Obesity, 40,* 1376. doi:10.1038/ijo.2016.88 https://www.nature.com/articles/ijo201688#supplementary-information

Baxter, J., & Eyles, J. (1997). Evaluating qualitative Research in Social Geography: establishing 'rigour' in interview analysis. *Transactions of the Institute of British Geographers, 22,* 505-525.

Bradbury, D., Chisholm, A., Watson, P. M., Bundy, C., Bradbury, N., & Birtwistle, S. (2018). Barriers and facilitators to health care professionals discussing child weight with parents: A meta-synthesis of qualitative studies. *British Journal of Health Psychology, 23*(3), 701-722. doi:10.1111/bjhp.12312

Braun, V., & Clarke, V. (2008). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3*(2), 77-101. Retrieved from https://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa

Eli, K., Howell, K., Fisher, P. A., & Nowicka, P. (2014). "A little on the heavy side": a qualitative analysis of parents' and grandparents' perceptions of preschoolers' body weights. *BMJ Open, 4*(12), e006609. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med8&AN=25500371

http://openurl.auckland.ac.nz/resolve?sid=OVID:medline&id=pmid:25500371&id=-doi:10.1136%2Fbmjopen-2014-006609&issn=2044-6055&isbn=&volume=4&issue=12&spage=e006609&pages=e006609&date=2014&title=BMJ+Open&atitle=%22A+little+on+the+heavy+side%22%3A+a+qualitative+analysis+of+parents%27+and+grandparents%27+perceptions+of+preschoolers%27+body+weights.&aulast=Eli&pid=%3Cauthor%3EEli+K%3BHowell+K%3BFisher+PA%3BNowicka+P%3C%2Fauthor%3E%3CAN%3E25500371%3C%2FAN%3E%3CDT%3EJournal+Article%3C%2FDT%3E

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. doi:10.1111/j.1365-2648.2007.04569.x

Firestone, R., Funaki, T., Dalhousie, S., Henry, A., Vano, M., Grey, J., . . . Ni Mhurchu, C. (2018). Identifying and overcoming barriers to healthier lives *The Journal of Pacific Research, 21*(2), 54 - 66. doi:10.26635/phd.2018.913

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105-112. doi:10.1016/j.nedt.2003.10.001

Kedgley, S. (2007). *Inquiry into Obesity and Type 2 Diabetes in New Zealand.* Retrieved from https://www.parliament.nz/resource/en-NZ/48DBSCH_SCR3868_1/0dc21f5e18be663253b-73066c4e12a418a62944f

Kohut, T., Robbins, J., & Panganiban, J. (2019). Update on childhood/adolescent obesity and its sequela. *Current Opinion in Pediatrics, 31*(5), 645-653. doi:10.1097/MOP.0000000000000786

Lakshman, R., Elks, C. E., & Ong, K. K. (2012). Childhood Obesity. *Circulation, 126,* 1770-1779. doi:10.1161/CIRCULATIONAHA.111.047738

McKenna, L., & Copnell, B. (2019). Understanding how research is done. In *Fundamentals of Nursing and Midwifery Research. A practical guide for evidence-based practice* (pp. 37 - 56). Australia: Allen & Unwin.

Mikhailovich, K., & Morrison, P. (2007). Discussing childhood overweight and obesity with parents: a health communication dilemma. *J Child Health Care, 11*(4), 311-322. doi:10.1177/1367493507082757

Ministry of Health. (2016). *Clinical Guidelines for Weight Management in New Zealand Children and Young People.* (ISBN: 978-0-947515-95-9). Wellington: Ministry of Health Retrieved from https://www.health.govt.nz/system/files/documents/publications/clinical-guidelines-weight-management-nz-children-young-people-dec16.pdf

Ministry of Health. (2018). New Zealand National Health Survey Regional Data Explorer. Retrieved from https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update/_w_b4bbda38/_w_796994bd/#!/compare-regions. https://minhealthnz.shinyapps.io/nz-health-survey-2014-17-regional-update/_w_b4bbda38/_w_796994bd/#!/compare-regions

Organisation for Economic Cooperation and Development. (2017). *Obesity update 2017.* Retrieved from https://www.oecd.org/els/health-systems/Obesity-Update-2017.pdf

Shackleton, N., Milne, B. J., Audas, R., Derraik, J. G. B., Zhu, T., Taylor, R. W., . . . Taylor, B. (2017). Improving rates of overweight, obesity and extreme obesity in New Zealand 4-year-old children in 2010-2016. *Pediatric Obesity, 22,* 22. doi: https://dx.doi.org/10.1111/ijpo.12260

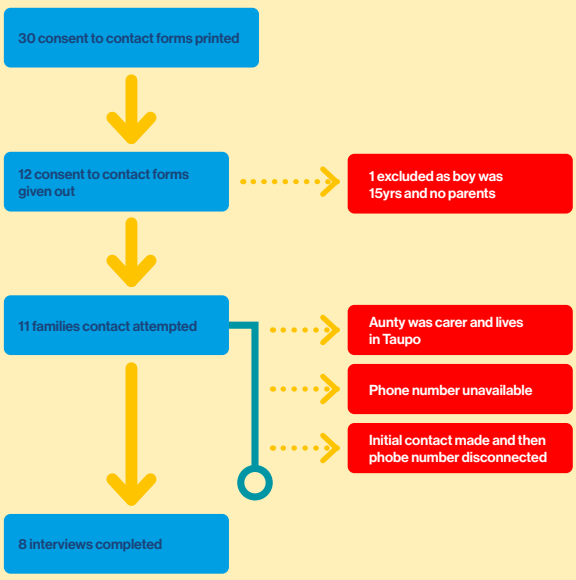
Stewart, L., Chapple, J., Hughes, A. R., Poustie, V., & Reilly, J. J. (2008). Parents' journey through treatment for their child's obesity: a qualitative study. *Archives of Disease in Childhood, 93*(1), 35 - 39. doi:10.1136/adc.2007.125146

Swinburn, B., & Wood, A. (2013). Progress on obesity prevention over 20 years in Australia and New Zealand. *Obesity Reviews, 14*(2), 60 - 68. doi:10.1111/obr.12103

Turner, K. M., Salisbury, C., & Shield, J. P. H. (2012). Parents' views and experiences of childhood obesity management in primary care: a qualitative study. *Family Practice, 29*(4), 476-481. Retrieved from https://cmdhb.idm.oclc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c-cm&AN=104363714&site=ehost-live&scope=site

Turner, K. M., Shield, J. P. H., & Salisbury, C. (2009). Practitioners' views on managing childhood obesity in primary care: a qualitative study. British *Journal of General Practice, 59*(568), 856-862. doi:10.3399/bjgp09X472269

Figure 1. **Consent to contact forms leading to interview flow chart**:



Embedded Earrings in Kids

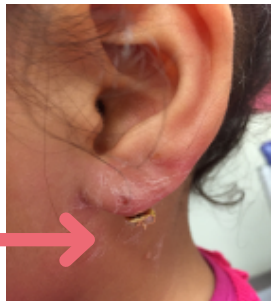
On occasion you will encounter a child with an earring stuck in their ear lobe.
This most commonly occurs in girls younger than 12 years of age.

Assessment

Typically, at least part of the earring is visible or palpable. It is common to see the back of the earring +/- with butterfly attached

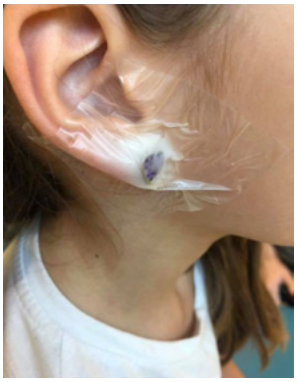
The stud is usually buried in the ear lobe itself

The area may be tender to the touch with localised redness and swelling



Analgesia

- Apply Ametop to the back of the earlobe (*by default often covers the front too*)
- Consider continuous flow nitrous for younger patients
- Local infiltration can be used for older kids, or you could consider just using cold spray



Removal

- A quick clean with chlorhexidine
- Make a small incision in the posterior portion of the ear lobe. Never make an incision to the front for aesthetic reasons
- Use small alligator/artery forcepts to remove the embedded earring

Outcome:

Once the earring is removed, the area can be dressed with a simple dressing i.e. small Primapore (island dressing) cut to size

Leave the incision to heal by secondary intention

Oral antibiotics are not needed after removal of an embedded earring from the ear lobe. NB: earrings removed from the helix should have a 5 day course of ABx i.e Ciprofloxacin, which will cover Pseudomonas Aeruginosa

Usually takes 6-8 weeks for the site to heal

Re-piercing may be possible after this

Kathryn Johnson NP
Starship Children's Emergency Department

Regional Reports

Northland/Te Taitokerau | Auckland
Midland | Hawkes Bay/Tarawhiti
Mid Central | Wellington | Top of the South
Canterbury/Westland | Southern

Vacancy

The position representing **Hawkes Bay/Tarawhiti** on the CENNZ National Committee is currently vacant.

Please see application information on page 23

Northland/Te Taitokerau Region

Sue Stebbeings
Nurse Practitioner

Emergency Department
Whangarei Hospital

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My last report seems a lifetime rather than a few months ago. Our people did an amazing job, rising to meet the recent challenges with energy and all the resources that we could recruit or develop. May this teamwork continue to flourish not only in ED but across the hospitals and communities.

Self-awareness of our well-being can help us to access the supports to manage issues and to be aware of our colleague's situations. ED piloted the Mayo Well-being Index in February this year, which has now been rolled out across our DHB. Staff can monitor their well-being through regular quick surveys, and resources are available to explore. Another well-being initiative promoted in our department just before COVID19 was the Workplace Well-being at Emergency Departments (https://www.woweated.com/) which aims to measure and facilitate improvement in staff well-being. Data analysis from the staff surveys is underway.

I attended one of the COVID debrief sessions arranged across Whangarei Hospital. The session focused on personal factors, not operational processes. It was a valuable opportunity to listen to the facilitator offering an outside perspective and uncovering impacts that I had not considered amongst the small ED group present. We are so-often focused on getting on with 'what's in front of us' and working with 'what it is', especially when we have been working in emergency nursing for some time. The thought I took away from the session was to be mindful of the changes, choices and challenges we experienced so that we can be kind to ourselves as well as others.

Operationally, in ED the green and red zones are merging. Potentially infectious presentations are placed in single cubicles as much as possible, and aerosol-generating procedures continue to require negative pressure cubicles. Slowly, processes are returning to business as usual - or the new business as usual. Emergency Q continues to be an option offered for appropriate presentations.

Community COVID testing clinics are likely to stop by the end of July. Medical centres and iwi providers will continue swabbing as necessary. It remains to be seen if this will increase ED presentations.

Recently there has been increased acuity in ED presentations amongst the 30 - 65 year age group. Usual respiratory illnesses are more visible now that social distancing is less of a thing. Sadly, we have also seen the evidence of increased aggression and stress in the community with more family violence presentations, and an escalation in aggressive behaviours from patients and families. We have CCTV cameras covering many areas of the department and more to be installed to improve visibility of the area, particularly at night. Our security alert has been updated so that a silent alarm can be sent directly to security staff from 4 points - 3 at front of house / triage. Plans are pending to increase security staff presence in ED.

We are delighted to welcome many new staff - many who have had the additional challenge of joining the team during COVID restrictions. We appreciate their input and fresh perspectives.

Sue

Auckland Region

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Children's Emergency Department

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Starship Children's ED

From the first announcement about lockdown CED saw a dramatic reduction in presenting numbers. This was a gift in that it gave us time to really get prepared. The initial weeks were so full-on with process change - never had we seen so much change so quickly.

We set up a CED COVID group - we were able to manage the amount of change and communication of change between us, which was great. Clear communication both ways from us to all the staff and the staff to us was the priority for group to try and reduce the anxiety of the situation.

We did this by setting up:

- Whiteboards for our team to have their questions answered and suggestions listened to
- The COVID group met (zoomed) daily to answer the questions and suggestions and sent the answers out each day
- Whole team zoom meetings- which were really successful, our team were able to get up to date information from Sarah our SCD and me

Our department as it did in Measles was divided into yellow and red zones (in measles we were less classy and called them dirty and clean zones). We needed to take over our play area to make a Donning station as we have only two negative pressure rooms with no anterooms.

We are still in a time of reduced presentation numbers for what we would usually be seeing- we are thinking perhaps better hand hygiene, cough etiquette and kids staying home when they are sick might be helping this!

We held semi-post-COVID (because we can't say post-COVID yet) team drinks a few weeks ago with a good attendance.

Anna Marie Grace

Auckland Adult ED

Change is never easy, and those leading change often face barriers including resistant team members and resourcing constraints. As it turns out, shared adversity in the form of the COVID19 pandemic is the ultimate catalyst for widespread, rapid change. Over the past few months the people have adapted to a series of changes to our physical environment, daily staffing, communications, triage processes and – of course – infection control and cleaning procedures. Although it has been a stressful time for all, many important quality improvements have been fast-tracked. Regular email communications to all Level 2 staff have helped to keep us informed, and were vital when important processes were sometimes altering several times, within a week. After the initial rush and a host of uncertainties, we are grateful to be moving into a more settled period whilst maintaining vigilance, including caring safely for those presenting from Managed Isolation Facilities. Of course, the threat of community outbreaks is likely to continue for some time.

After experiencing the lockdown lull in presentations reported by many EDs, patient numbers are rapidly

Auckland Region cont.

approaching 'usual' winter levels (around 200 presentations to ED, per day). We are fortunate to have increased our nursing FTE over the past few months, and this has led to trialing of different daily staffing models and improved nurse-patient ratios, in some areas. The doctors are also trialing team-based care, with weekly KPI reporting and plenty of opportunities for staff feedback.

I'd love for the Greater Auckland Regional Report to be Greater and cover more than the ADHB, so if you're a CENNZ member working at Middlemore ED or Waitakere ED, and could contribute a brief update 3-4 times per year, please contact Natalie Anderson.

Natalie

Contributions for Publication

We are always open to receiving submissions for publication. Submissions in the form of case studies, research posters and practice guidelines are welcome. There is a modest contribution for featured articles.

You can find guidelines for publication here: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal

Alternatively, email and enquire: mcomeskey@adhb.govt.nz

Midland Region

Kaidee Hesford
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Lakes District Health Board

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Rotorua ED:

Tourism in the Midland region seems to be on the increase following lockdown. As we are in the midst of school holidays, luge and mountain biking injuries are again a common presentation seen in our department.

The Rotorua community has been in full support of us essential workers and put on a night of luging and dinner for staff – a few minor injury's were suffered, but was a great team building night out!

New Graduates; We have two NETP's in Rotorua ED who have really raised to the challenge of being in ED for their first year out, and have done amazingly with the perpetual changes during COVID. With the reduction of nursing students through the local campus, we endeavour to have at least 1-2 NETP's in ED yearly. We have recently had a NETP educator appointed for additional support to all new graduates throughout the DHB which is great for a DHB of this size.

Resus;

We now have 90% of ED staff trained to work in resus. This has been a huge project lead by Natasha Kemp (ED CNC) and Janet Atkinson (ED CNE). There is now a very thorough orientation process and assessment in place for those who are at the 12-18 month stage of being in ED and have attended the resus in house study day. There is ongoing resus training for all staff by the way of simulations run by both ED and Paediatrics in resus regularly and this is has really been advantageous for the Rotorua ED.

Paeds liaison; For 5 months over the winter period, we have implemented a paediatric liaison role within Rotorua ED. This role is a 1.0FTE, which is split between 2 senior RN's. They facilitate early assessments, intervention and treatment of children in ED, and results have shown a reduction in paediatric

Midland Region Cont.

presentations by having this role readily available in ED.

Taupo ED

After 15 years as Taupo ED Clinical Nurse Manager, Wendy Ayre has stepped down from the role. Wendy has taken the opportunity to move into a more clinical role within the Taupo ED as a clinical nurse coordinator. At time of writing, the

Taupo ED CNM role is yet to be filled – so watch this space.

Kaidee

Hawkes Bay/Tarawhiti Represenative

The position representing Hawkes Bay/ Tarawhiti on the CENNZ National Committee is currently vacant.

If you have an interest in representing the CENNZ membership of this region and a passion for the professional development of emergency nurses nationally – **please contact the board chair Sandy Richardson.**

cennzchair@gmail.com

Mid Central Region

Katie Smith

Nurse Practitioner, ED
(Knowledge & Skills Framework
& Website/Social Media)

NZDF
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Midcentral DHB

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MidCentral DHB ED

Obviously COVID-19 has taken up much of the headlines in the last few months, with much change and churn within DHB's across New Zealand. The MidCentral response was a DHB wide response which enabled the ED to set up a pod for pre-screening outside of the ED, then stream patients to direct them to community swabbing centres, or into the dept to our green or red zone as appropriate. With limitations such as one negative pressure room meant some changes to creating a red zone area for respiratory patients, green zone for low risk, and saw our sub-acute area move from within the ED space to our transitory care unit for several weeks.

The ED saw some re-shuffling and what seemed like constant change as the direction from the Ministry and DHB changed according to what the latest recommendations were. The dept is used to change, and was able to adapt and overcome the challenges given to them on the almost daily basis. There was innovation, ideas sharing, small wins like some new, much needed equipment for the dept, so all was not doom and gloom. COVID-19 also saw a reduction in our usual presentation numbers, which actually was quite a relief for staff, who are used to working with large numbers and a regularly full to overloaded dept. As predicted, with people staying at home, we did get some interesting and usual DIY injuries through the dept!

Although we did not see large numbers of COVID-19 patients within our dept, it saw us move to a state of preparedness for such an event. The at-risk patients presenting with flu-like illness or respiratory complaints were identified early and placed appropriately within the dept. We were provided extra health staff to the dept, which enabled an increased spread across the dept. The whole ED team worked like troopers throughout this unusual time, and there were lots of lessons learned.

The dept has returned to business as usual, and now seeing our regular winter numbers increasing. Ongoing challenges with increased hospital capacity, bed block and challenges with flow are not unusual and our staff continue to work incredibly hard as a team to ensure the patients are looked after, and provided exceptional care while in the ED.

Advancing Nursing practice is an exciting ongoing project in the ED. We will see our first NP Candidate work towards her Nursing Council submission later this year, with another CNS becoming qualified this year. Our advancing nursing team now consists of 1 x NP, 1 x NPC, and 4 x CNS's. There are plans afoot to continue to grow this service within the ED.

Staff recruiting is ongoing – for both nursing and medical, and we are back up to almost a full FTE. New staff bringing with them new ideas, skills and experience and we look forward to the new additions to our team.

Now that we are back to business as usual, we are able to now continue with RN education and training, which is being welcomed by staff across the DHB. ED had planned to host a TNCC course locally, but with COVID-19 causing some hiccups, this has been temporarily paused with a look to reschedule as soon as we can.

This has been an interesting year, and I'm not sure how we got to July so fast. We know winter numbers will continue to put pressure on our departments, and as such, rely on our teamwork and professionalism to get us all through. Look after each other.

Katie Smith

Mid Central Region

Taranaki DHB ED

A few wins in the last quarter:

We have two new Clinical Nurse Specialist's - Victoria Hill and Daniel Hurley, who have passed their CNS paper last semester. They have accepted casual CNS positions in ED and covering leave at present and also trialling extended CNS hours to see if this has an impact on our patient flow in the ED.

We have a new clinical coach role in ED with 0.2 dedicated FTE.

We are piloting a new dedicated education unit (DEU) in ED for 10 weeks in August. The aim is that the students are supported in practice by a dedicated Clinical Liaison Nurse (CLN) and a dedicated Academic Liaison Nurse (ALN) from WITT. It's an alternative to the standard preceptor role, in that the CLN will provide orientation for nursing students on their first day, arrange student rosters and liaise with the ALN and work with students on a one-to-one basis as required and review their clinical practice diaries/assessments. Initially our clinical coach will be the CLN for the pilot.

Challenges: Constant changes over the Covid time, and having consistency in our screening and placement of patients with respiratory symptoms. The new Higher Index of Suspicion criteria has helped with the screening and appropriate placement of patients.

Also challenging is our lack of capacity in the ED, more of a challenge when we had a dedicated isolation 6 bed negative pressure area, but we have now opened this up to our regular patients, and using side rooms and our single negative pressure room for patients who need isolation if meet criteria or need isolation for other reasons.

Therese Manning

Whanganui DHB – Carla O'Keeffe

Nil report available.

Wellington Region

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Wairarapa District Health Board

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It's difficult to believe that we are in July with plenty of snow on the ranges and half the year gone already. All three of the Wellington region's Emergency Departments are back into their winter numbers with flow and capacity a never-ending battle. The far more vigorous management of potentially infectious patients is one piece of improved practice that COVID has brought to the forefront in our departments. The screening of acute respiratory illness, the need for the right and appropriate PPE at the right time and the general acknowledgement from the team that their protection is paramount has without doubt improved practice. Wellington ED continues to have a separate screening area for all patients presenting and at this stage has decided to embed this into their department. Hutt hospital have developed a screening process on their map view which allows them to identify and manage the patient group requiring masking/isolation. A similar but more manual process is also being utilised in the Wairarapa. Hutt ED are initialising a new visitor policy in the hope they can reduce the number of unnecessary people within their ED.

All three ED's currently have a fairly stable work force helped with the closing of our boarders. Many Wellington based staff are looking to purchase property as an alternative to travel right now. Hutt ED have had significant changes in their leadership team but all positions are now full and stable. There is a strong focus on succession planning in Hutt ED with opportunities for interested staff to step up into an ACNM role for a fixed term. This has been achieved through short term secondments and some rolling FTE available for those looking at this pathway in the future. Hutt have also recently re-recruited three experienced ex Hutt ED nurses back into their department.

The impact of cancelled leave can be felt amongst the team with the winter pressure evident in the departments. Conscious management of this is necessary to maintain a strong resilient team with staff wellness identified as vital in many COVID-related surveys and reviews. Juggling high leave balances whilst being conscious of the particular skill set required to safely manage a pressured ED is the challenge faced by us all. Education is slowly commencing again with staff taking advantage of these opportunities. Nurse Practitioners, Clinical Nurse Specialists and now nurse prescribers are all part of the diverse makeup of our teams. We are also very lucky to have our Emergency Department volunteers well embedded into our departments and the contribution they make substantial to staff and patients alike.

The research being undertaken in Wellington ED with a focus on asthma treatment and optimal management for the acute presentation continues. Equity is a focus of all our departments with some interesting work streams developing. CCDHB are about to direct their programme towards signage in their department. The Wairarapa are focusing on identifying and supporting the patient group who present to ED repeatedly due to not having a relationship with primary care. This initiative is in conjunction with the Maori Health Directorate empowering the user to connect with the right provider for them as individuals and supporting the transfer of care from the ED back into the community services most appropriate.

There are various work streams happening throughout the Wellington region to address flow and expedite patient movement within the six hour target period. Hutt are trialling the use of MAPU for not only medical patients but surgical and gynaecological patient assessments. This has already had a beneficial effect on patient waiting times in the ED. Wairarapa is looking at the whole of hospital and identifying areas that are contributing to patient flow issues with some positive results and opportunities for change being identified.

My thoughts remain with our colleagues overseas and the battle they continue to fight. I am grateful for a lot of things and living in this country is definitely one of them.

Kathryn

Top of the South Region

Louise Holland
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Hello from the Top of the South. COVID-19 has been challenging. While Level Four saw a decrease in presentations, there was a spike in high acuity patients and since moving into Level One, these presentations have steadily increased. Respiratory isolation has also been putting pressure on staff due to the associated workload, lack of isolation beds and toilets. There has also been an increase in sick leave due to fatigue and illness. A positive outcome of COVID, however, was the introduction of the SWOOP teams which meant that people could be assessed and treated at home. In addition, Nelson ED has been trialling an HCA overnight, which has been going well.

Other positive news is that the region now has three Nurse Practitioners, three new Expert Level nurses and a number of staff working towards their Masters in Nursing. We are also able to accommodate a New Graduate nurse this year and even though the addition of 15 new nurses to the Nelson ED has been challenging, they have brought with them new ideas, enthusiasm and knowledge, which has been great. Another positive is that this has allowed the progression of our mid-range nurses into leadership roles.

Finally, I wanted to congratulate Wairau ED for being named the best performer in New Zealand for space and layout, it has been well deserved.

Louise

Canterbury/Westland Region

Dr Sandra Richardson
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Christchurch ED

The Christchurch hospital ED staff continue to face the expectation that we will move into the 'new hospital' despite some additional concerns and delays. This has meant ongoing development and commitment to establishing new models of care that will accommodate the very different layout and capacity of the new ED. While it will certainly involve a lot more walking, every patient room will have a view, and we will have CT in the department – there are many positives to look forward to! Moving date is currently set for September, all going well.

Staffing wise, all is looking well. Surprisingly, we are currently at full FTE, and this together with reduced numbers of presentations has seen a reduction in sick leave. It would seem to suggest that if there are sufficient staff, and a reasonable workload, staff can manage well – has anyone else noticed this? Overall, our patient numbers have increased since lockdown, but are still not back to the levels pre-covid and pre the mass shooting event of March this year.

The ED is also moving to pilot the Cortex clinical documentation system, using i-pads and will be introducing the ED module for Trendcare. In terms of education initiatives, the Ed is running a vaccinator course for 15 ED nursing staff to increase the number of immunisations that can be offered rapidly across the ED team and to offer assistance across the DHB.

Christchurch ED is starting to pull together a conference committee and looking to plan the 2021 CENNZ conference, there is talk of having some joint workshops with colleagues attending the ACEM symposium, so keep in mind an awesome conference is in the planning stages!

Sandy

If you would like to submit an advertisement or article for the next issue of the journal please contact the editor matt comeskey for more information!

email Matt at: mcomeskey@adhb.govt.nz

Southern Region

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It is hard to believe that it has been four months since I wrote the last regional report. Like the rest of the country, a global pandemic – COVID, has caused lots of changes within our department/ region. It is a testament to the staff who work within it, that they could adapt to change and meet the demands that this pandemic brought with it.

The departments have had to adjust to pre-triage screening all patients and visitors. These screening tools changed frequently as information became available, and the definition criteria changed. During this time our departments separated into two streams/pods, green pod and red pod. Since June we have been able to dis-establish the red pod, however plans are in place if they need to be re-activated. The department's physical footprints had to expand and adapt, to accommodate moving triage entries for the different streams/pods. This has had a significant impact on staffing, patients and their families. It makes you realise how emergency nurses can cope with a variety of situations with such professionalism.

The flow-on effect of the pandemic for our departments has included the cancellation of triage courses and access to needed education has been limited. Southern is grateful that a triage course within our region has been able to be facilitated. The building work for Dunedin's much needed ambulatory Care area has not started, having been delayed by our pandemic response, meaning the delay in much needed extra space as we head into the winter months. Currently, Southern does not have managed isolation in our community, however this may come shortly.

We are now moving back to business as usual, however, screening continues with an adjusted screening tool for patients and visitors. The presentation numbers that had decreased over this period, are now back to our normal.

Tanya

College Activities

Triage Courses 2020

Please continue to check the CENNZ web page for ongoing updates / details:

https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/courses

Region	Dates	Venue	Closing date for booking	Closing date for payment	Registration
Christchurch	25/26 September 2020	Manawa Building [Registration 3rd Floor] Health Education & Research Facility 276 Antigua Street, Christchurch	31st July 2020	14th August 2020	**COURSE FULL**
Lower Hutt	16/17 October 2020	The Learning Centre, 2nd Floor, Clock Tower Block, Hutt Hospital, High Street, Lower Hutt	21st August 2020	4th September 2020	BOOK NOW **13 places left as at 10/06/2020**
Waikato	14/15 November 2020	Clinical Skills Centre (under the library) Waikato Hospital Campus, Corner Selwyn and Pembroke Street, Hamilton West	19th September 2020	3rd October 2020	**COURSE FULL**

Post Graduate Advanced Emergency Nursing, University of Auckland.

Post Graduate Advanced Emergency Nursing, University of Auckland.

Nursing 784 (Advanced Emergency Nursing Practicum) has concluded for 2020, with 18 students having completed the course – congratulations to those students. They are now applying their skills in emergency care settings throughout Aotearoa, in Christchurch, Wellington, Palmerston North, New Plymouth, Taumaranui, Thames, Tauranga, Hamilton and Auckland. It is really encouraging to see these opportunities for emergency and urgent care nurses to expand their practice, with the value of these roles being recognised with funding for new emergency nurse specialist positions.

This course is always challenging, but this year the disruption caused by COVID created more than the usual degree of stress. Some of the students were re-deployed to other roles, and all students found that with reduced emergency presentations there were correspondingly less opportunities to practice the core skills of wound care and musculo-skeletal injury management and to complete the required minimum of 100 supervised clinical hours. In addition, we had to change the way we assessed students, with on-line written examinations and locally provided OSCES rather than the usual format of the students coming to Auckland University for Exam Day.

We plan to provide the course again in semester 1, 2021 commencing February 15th 2021, and concluding in June. The course consists of ten study days (five blocks of two days), and a final day of examinations at the end of the course. Students need to complete a minimum of 100 hours of supervised clinical practice. Pre-requisites for the course are completion of Auckland University 773 or an equivalent post graduate clinical assessment and reasoning paper; employment as a clinical nurse specialist in an urgent or emergency care setting; and funding and leave to attend the ten study days and one exam day in Auckland.

I often have enquiries from nurses who would like to undertake the course, some of whom I have to decline because they are not working as emergency nurse specialists. Nursing 784 is designed and intended to support emergency nurse specialists as they develop their practice and requires that students have consistent, supervised, mentored clinical experience. For emergency nurses, Nursing 708 (Emergency Specialty Nursing) is an excellent option, which I highly recommend to all emergency nurses.

If you are interested in Nursing 784, you can contact me at: lucienc@adhb.govt.nz

I look forward to hearing from you.

Snippets Winter 2020

Non-steroidal anti-inflammatory drugs for acute low back pain.

Cochrane Database Systemic Review. 2020 Apr 16;4

Lower back pain (LBP) is a common health problem. Non-steroidal anti-inflammatory drugs (NSAIDs) are often used in the treatment of LBP, particularly in people with acute LBP. In 2008, a Cochrane Review was published about the efficacy of NSAIDs for LBP (acute, chronic, and sciatica), identifying a small but significant effect in favour of NSAIDs compared to placebo for short-term pain reduction and global improvement in participants with acute LBP. This is an update of the previous review, focusing on acute LBP.

The study concludes people with acute low back pain (LBP), non-steroidal anti-inflammatory drugs (NSAIDs) were found to be slightly better in reducing pain (moderate quality evidence) and disability (high quality evidence) than placebo in the short-term. However, the magnitude of the effect is small and probably not clinically relevant. There is low quality evidence that there is no clear difference between selective COX-2 inhibitor NSAIDs and non-selective NSAIDs in reducing pain in the short-term. In all cases, potential (gastrointestinal) adverse events should be taken into account.

https://www.cochranelibrary.com/cdsr doi/10.1002/14651858.CD013581/full

Beyond awareness: Towards a critically conscious health promotion for rheumatic fever in Aotearoa, New Zealand.

Social Science and Medicine. Jan. 2020

The Rheumatic Fever Prevention Programme has targeted Māori and Pacific communities with messages to get sore throats checked. Although the Health Promotion Agency consulted with Māori and Pacific health leaders to develop a culturally-appropriate intervention, the structural roots of rheumatic fever and the potentially harmful effects of the message presentation were not considered. By targeting health promotion to Māori and Pacific communities with the highest rates of rheumatic fever, the intervention inequitably distributed responsibility and created collateral damage in the form of stigma, internalised blame, emotional suffering and hypervigilance. Conceptually this can be regarded as structural violence. The authors suggested that consideration of how families experience public health messaging in the context of their daily lives may extend health promotion beyond awareness and behaviour towards equity.

This paper highlights that any intervention that is introduced must be monitored. With the best intentions, we may in fact further marginalise people and therefore contribute to inequities.

https://pubmed.ncbi.nlm.nih.gov/32007766/

Predictive value of D-dimer testing for the diagnosis of venous thrombosis in unusual locations: A systematic review.

Thrombosis Research. 2020 May 189:5-12.

The value of D-dimer testing for the diagnosis of thrombosis in unusual sites is not properly established and evidence is scarce. We performed a systematic review of the literature.

D-dimer testing should not be currently recommended for the diagnosis of thrombosis in unusual sites as a first line diagnostic tool. The development of algorithms combining biomarkers such as D-dimer and clinical decision tools could improve the diagnosis.

https://pubmed.ncbi.nlm.nih.gov/32126379/

Corticosteroids as standalone or add-on treatment for sore throat.

Cochrane Database Systemic Review. 2020 May 1: 5

Sore throat is a common condition associated with a high rate of antibiotic prescriptions, despite limited evidence for the effectiveness of antibiotics. Corticosteroids may improve symptoms of sore throat by reducing inflammation of the upper

Snippets Autumn 2020 Cont.

respiratory tract. This review is an update of a review published in 2012.

Oral or intramuscular corticosteroids, in addition to antibiotics, moderately increased the likelihood of both resolution and improvement of pain in participants with sore throat.

https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD008268.pub2/abstract

Vaccines for measles, mumps, rubella, and varicella in children.

Cochrane Database Systematic Review. 2020 Apr 20:4:

Measles, mumps, rubella, and varicella (chickenpox) are serious diseases that can lead to serious complications, disability, and death. However, public debate over the safety of the MMR vaccine and the resultant drop in vaccination coverage in several countries persists, despite its almost universal use and accepted effectiveness. This is an update of a review published in 2005 and updated in 2012.

Existing evidence on the safety and effectiveness of MMR/MMRV vaccines support their use for mass immunisation. Campaigns aimed at global eradication should assess epidemiological and socioeconomic situations of the countries as well as the capacity to achieve high vaccination coverage. More evidence is needed to assess whether the protective effect of MMR/MMRV could wane with time since immunisation.

Effect on Opioids Requirement of Early Administration of Intranasal Ketamine for Acute Traumatic Pain.

Clinical Journal of Pain. June 2020 36(6):458-462.

This is a double-blind, randomized, prospective, controlled study conducted in the ED. Patients were randomly assigned to intranasal ketamine or placebo. Protocol treatment was given at the triage. The primary outcome is the need for opioids during ED stay.

The study concluded intranasal ketamine administered early in the triage was associated with a decrease in opioids and non-opioid analgesics needed in patients with acute limb trauma-related pain.

https://pubmed.ncbi.nlm.nih.gov/32080000/

Ethnic inequality in non-steroidal anti-inflammatory drug-associated harm in New Zealand: A national population based cohort study.

Non-steroidal anti-inflammatory drugs (NSAIDs) are associated with many serious complications and they are widely used in New Zealand. However, differences in NSAID-associated risk for these complications between ethnic groups are largely unknown. This paper assessed ethnic disparities in risk of hospital admission for upper gastrointestinal bleeding (UGIB), heart failure, and acute kidney failure (AKF) in NZ's primary care population prescribed and dispensed NSAIDs. Over the counter NSAIDs were not included.

The paper concludes Māori and Pacific patients were more likely to be hospitalised for UGIB and heart failure and Māori more likely to be hospitalised for acute kidney failure during NSAID treatment than Europeans. The relative risk of UGIB and heart failure compared with Europeans was greatest in Māori and Pacific patients under 60 years of age. Further research is required to investigate the cause of this disparity.

https://onlinelibrary.wiley.com/doi/full/10.1002/pds.5028

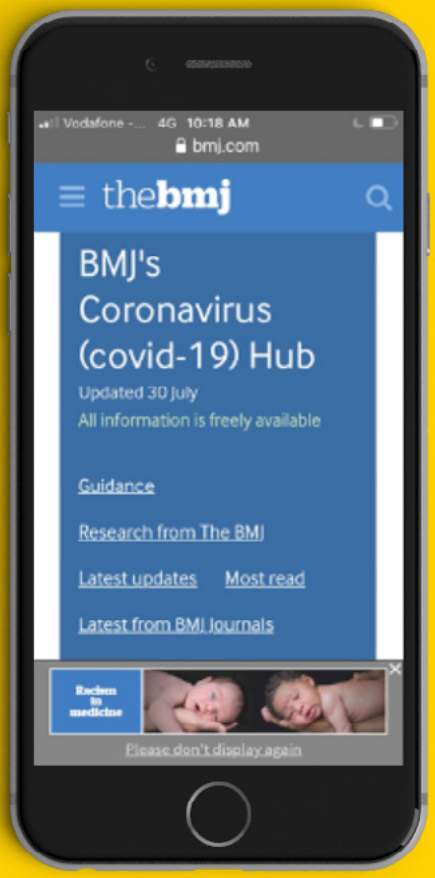
What are you looking at?

COVID 19 Research

I have to confess that I quite enjoyed living in my pandemic bubble for a few weeks. It was wonderfully quiet in my neighborhood, I wore-out a pair of track pants, I did loads of gardening, spent plenty of on-line time with friends and family, read a few books and enjoyed plenty of sleep. Despite that I'm mindful of those making critical decisions and those who anxiously waited-out the lockdown fearful of the economic aftermath.

There is a flood of research coming out of this pandemic. The question being how do we keep up with new information and how do ensure the research is based on sound methodology? And on a personal note, - how do we respond to questions from family and friends as well as patients and perhaps help dispel some of the mis-information out there?

The British Medical Journal (BMJ) has a free online publication with links to relevant findings and has brief easy to read summaries of current research and guidelines. It's a sound, one-stop, reliable site with information added continuously without the politics that drives the media news cycle.



BMJ's Coronavirus (covid-19) Hub:
https://www.bmj.com/coronavirus

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