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EMERGENCY NURSE NEW ZEALAND

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EMERGENCY NURSE NZ

EDITORIAL COMMITTEE

Emergency Nurse N.Z. is the official journal of the College of Emergency Nurses of New Zealand (CENNZ) / New Zealand Nurses Organisation (NZNO). The views expressed in this publication are not necessarily those of either organisation. All clinical practice articles are reviewed by a peer review committee. When necessary further expert advice may be sought external to this group. All articles published in this journal remain the property of Emergency Nurse NZ and may be reprinted in other publications if prior permission is sought and is credited to Emergency Nurse NZ. Emergency Nurse NZ has been published under a variety of names since 1992.

A WORD FROM THE EDITOR:

Kia ora,

I am sitting in the editors chair for this edition, filling in for Mike Geraghty whilst he is on leave.

In this journal, you'll find Sandy Richardson's comprehensive report on the college conference in Queenstown - there's plenty there to absorb. The conference and CENNZ supported Nurse Unit Managers meetings - are a great opportunity for ED nurses to exchange ideas, network and pool resources. Both events are supported with your CENNZ subscription.

In discussing the conference and the NUM a number of people commented on the paucity of our newer, younger ED nurses. We know you are out there - we work alongside you, preceptor you and sit next to you in the tea room - but we don't see you at conference. This may be a reflection of the restricted nursing education budgets that many DHB are subject to. If that's you - please remember the College does offer grants for conference registration each year. But the disproportionate amount of grey hair in the room might also reflect the fact that some of our younger colleagues are not college members. So next year - I'm hopeful we'll be able to look around the conference crowd and see a whole lot of colleagues who will one day be our charge nurses, managers and NPs. This is more likely to happen if every CENNZ member encouraged one younger nursing colleague to join the college. We would soon become - a 'younger' organisation and more accurately reflect the wider ED nursing family.

Earlier this year you may recall that CENNZ members were surveyed on their preference of a printed or digital copy of the journal. The survey results indicate that members prefer a digital copy of the journal in the form of a high definition pdf file emailed to each member. This was discussed at College AGM. Next year we will work towards making this happen.

In the meantime, I hope we all have a great summer and - hopefully - a well earned rest.

MATT COMESKEY
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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.

EMERGENCY NURSE NZ

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SUBMISSION OF ARTICLES FOR PUBLICATION IN EMERGENCY NURSE NEW ZEALAND.

All articles submitted for publication should be presented electronically in Microsoft Word, and e-mailed to cennzjournal@gmail.com. Guidelines for the submission of articles to Emergency Nurse New Zealand were published in the March 2007 issue of the journal, or are available from the Journal Editor Michael Geraghty at: cennzjournal@gmail.com. Articles are peer reviewed, and we aim to advise authors of the outcome of the peer review process within six weeks of our receipt of the article

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Chairperson's Report

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

I would like to thank the Southern DHB team for hosting a very successful conference in Queenstown this year. 110 emergency nurses from around New Zealand travelled to hear about contemporary topics within our speciality. There was a great feeling at the event with nurses not just enjoying the speakers but meeting and sharing stories with fellow emergency nurses.

At last year's AGM and several prior it has been raised whether a move from a print to digital journal could be made. This year a survey was undertaken of the membership to gauge the views of the college. 88 people responded with 76% supporting the move to a high resolution electronic format. This reflects a continued move away from paper based formats. Individuals would still be able to print out a copy if required. There would still be a cost producing the journal however it is estimated that approximately $10,000 to $15,000 p/a may be saved. At this year's AGM the committee was supported to continue with this project.

The CENNZ committee also recognises that social media is an important and effective way to communicate with the membership. We are pleased to announce that CENNZ is currently developing social media platforms. These will be more widely advertised as they are finalised.

"I would like to thank the Southern DHB team for hosting a very successful conference in Queenstown this year."

We can report that the revised national triage course is underway. This includes an updated workbook and course resources. A huge thank you to the dedicated team who undertook this significant enterprise. The triage course remains well subscribed and supported, it provides great preparation for those about to begin this challenging role. The course dates for 2018 are available on the website. If you have questions please contact the triage course coordinator Erica Mowat.

I am pleased to announce that CENNZ will be supporting another ED charge nurse managers meeting day next year. This will provide an excellent opportunity for our services leaders to strengthen their networks and share ideas. A hot topic will be the ongoing work with the Safe Staffing Healthy Workforce Unit. We see this work as very important and may be part of puzzle of addressing the building pressures within our EDs.

This year the committee updated our strategic plan. It was endorsed at the AGM with a vision to promote leadership and excellence in emergency care. The document describes the key aspects the college undertakes to achieve its mission statement, further information can be found on the CENNZ website.

Our Mission: *The College of Emergency Nurses NZ believes that emergency nursing is a specialty within the profession of nursing. Our mission is to promote excellence in Emergency Nursing in NZ / Aotearoa, through the development of clinical practice frameworks, policy, education, research and leadership. The College provides a forum for supporting, advocating and highlighting the role of emergency nursing in NZ / Aotearoa.*

The current membership is steady at just over 500 out of approximately 1000 NZNO members that identify as emergency nurses. We believe that continuing to grow our membership strengthens our voice. Much of the work that is undertaken by CENNZ is for the benefit of our patients, whanau and all emergency nurses rather than just our membership. Over the next year we will consider how we can increase our membership. Support from existing members promoting our activities is very important.

Next year's conference will be held in another regional hot spot, the Hawkes Bay. Thank-you to the Hawkes Bay ED team for undertaking this. The conference is named ConnectED, with a theme of exploring how EDs and emergency nursing interact with the wider community. This is very topical, as we all strive to find new ways to ease the burden of increasing acute demand.

The national committee is looking forward to 2018 with a number of new and exciting projects planned. I wish you and your families a fantastic and safe holiday period.

Ngā mihi o te Kirihimete me te Tau Hou.

RICK FORSTER

Chairperson

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SHARING KNOWLEDGE, VALUING INNOVATION AND EVIDENCE: THE CENNZ 2017 CONFERENCE

By: Dr. Sandra Richardson, RN, PhD Nurse Researcher Christchurch Emergency Department

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ROLE OF THE COLLEGE

A key element of the College of Emergency Nurses has always been the recognition that networking between colleagues, and the sharing of information, innovations and opportunities is an essential element of practice. In order to support and facilitate this, CENNZ regularly holds a professional conference for Emergency Nurses; more than just providing the seeding funding and professional support to enable this to occur, the College offers a number of funded places for CENNZ members to attend. These funded attendances, together with other educational and professional scholarships, are made possible through the membership levy, as is the provision of the CENNZ Journal of Emergency Nursing – an opportunity for sharing knowledge, skills and experiences within the wider emergency community.

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CENNZ CONFERENCE 2017

This year's emergency nurse's conference was held in the beautiful scenic location of Queenstown –a definite drawcard on its own, even without the excellent presentation line-up and offering of knowledge and skills sessions.

The conference was opened with Mihi whakatau including wero, hongi and haka powhiri performed, and explained by tangata whenua Joe Waide. This was well received by the audience, and followed by a further welcome and introductory speeches from Jane Wilson, Chief Nursing and Midwifery Officer and Rick Forster, Chair of the College of Emergency Nurses, New Zealand.

Feedback from the 2017 conference participants identified perceptions of a focus on responsible interventions, critical thinking, and good sharing of innovations. There was an overall sense of presenters talking 'with' not 'at', the audience, the generation of dialogue, a sense of camaraderie, shared experiences and understanding, of catching up, and meeting new people.

ALCOHOL IN EMERGENCY DEPARTMENTS – A CONTINUING ISSUE

Following the formal openings, the conference presentations began with a thought-provoking summary by Dr John Bonning, Clinical Director of Waikato ED, on the ongoing impact of Alcohol and Drugs on NZ emergency departments and staff. He cited a recent snapshot study of Australasian EDs, which showed that the NZ EDs during the time period (0200 on Dec 17th, 2016) had a 1:4 ratio of patient presentations affected by alcohol or drugs, of interest the Australian comparison was 1:8. While this was no surprise to many, it is a timely reminder of the significant impact that this sector of our patient population has on work setting, staff and overall workload. Take home messages from this presentation included the importance of continuing to work to publicise the problem, undertake brief interventions when possible, collect data to allow for meaningful comparisons, to encourage peer group responsibility, and to review policies in line with presentations and population findings. The impact of alcohol related patient presentations at Middlemore Hospital ED was outlined by Clinical Associate Nurse Manager, Sharon Cox. This study involved a survey of staff, looking at barriers and enablers towards establishing brief interventions following identification of alcohol related presentations. An NZMJ publication detailing the findings from the study is forthcoming.

FOCUSSING ON THE EVIDENTIAL BASE FOR CARE

There was a strong theme throughout the conference on the role of evidence based healthcare, and looking at ways of providing and supporting 'best practice'. Dr Bonning's talk also focussed on a secondary aspect, that of resource utilisation, and the recently introduced "Choosing Wisely" campaign. This has been introduced and championed in NZ following similar developments internationally, and is focussed not on rationing of resources, but on rationalising of them. In this way, the importance is placed not on the cost alone of interventions and tests, but primarily on what they can add to the patient journey. Recognition is given to the issue of the potential (and actual) harm that is done to patients through over testing and inappropriate and unnecessary interventions, with a focus on asking if the test is necessary, evidenced, and in the patients best interest. There are 10 DHBs in NZ currently signed up to the program, and for those interested in finding out more the website: choosingwisely.org.nz is a good starting point.

An effective example of the direct application of the principles of the 'Choosing Wisely' campaign were evident in the findings from Lynne Gledstone-Brown's Master's research. Lynne's study focussed on the routine insertion of peripheral intravenous cannula (PIVC) in ED patients, often a task that is undertaken with little consideration for its clinical need or the potential consequences. This is a task typically carried out by nurses in many EDs, and one which has become an expected and habitual practice, not based on individualised consideration

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of need. Recognition that many of the IV cannula routinely placed were not necessary was initially generated from a review of literature, with one study showing that 50% of such lines are never used. An audit of actual practice in Wellington ED showed that 84% of patients had a peripheral line placed, but only 33% resulted in therapeutic use. In response to the study findings, Wellington ED has embarked upon a patient-centred quality initiative to improve cannulation best practice and to encourage critical thinking and assessment. Practice Responsible Intravenous Cannulation Today (PRICT) has now been implemented with guidelines for insertion of PIVC. This has allowed a greater focus on critical thinking and critical analysis; of interest to managers in particular, while cost was not a driving factor behind the study approximately $6,000 per month in savings has resulted from the change in practice. Further details regarding the study and its findings are due to be published in Emergency Medicine Australasia.

Further examples of the importance of recognising and utilising evidence as a framework in practice were evident in Dr Celia Rademeyer's sharing of the Waitemata 'Best Care Bundles'. This is a development which has enabled a package of care delivery with streamlined, standardised evidence based processes, initiated by nurses, resulting in improved patient service. All have the same language, layout, and use of symbols. The bundles include a clear nursing assessment guide, 'red flag section', and the back page always includes the formulary, based on best practice, evidenced guidelines. There are a number of paper elements which make up each bundle, including the checklist, patient information sheet, and discharge information sheets compiled with help from the patient information literacy group. Additional options such as pre-formatted clinical notes providing for easier documentation of relevant clinical negatives are also available. There are also unseen elements, which are equally critical to the effectiveness of each bundle. These include the need to establish standing orders, interdepartmental agreements, and effective education. Further information regarding this initiative can be gained from e-mailing: bestcarebundles@waitematadhb.govt.nz.

Furthering the discussion and the recognition of the usefulness of the bundle approach to health care, Jane Key, NP at Waitakere Hospital, Waitemata, introduced the findings from her recent Master's dissertation. Her study was a systematic style literature review examining the evidence base in support of paediatric rehydration, and was used to provide the evidential underpinning for the Best Care Bundle Paediatric Rehydration. She found a number of relevant studies which met the criteria for inclusion in her review, and the findings were formulated into six overarching themes, these were

assessment of dehydration, route of dehydration, volume of rehydration fluid, type of fluid, adjunct therapies, and patient advice.

Further information can be gained from the full copy of the dissertation posted on research gate, available at: http://aut.researchgateway.ac.nz/bitstream/handle/10292/9813/KeyJ.pdf?sequence=3

'HE TĀNGATA, HE TĀNGATA, HE TĀNGATA'

A number of presentation at the conference centred on people, on the stories, experiences and value of individuals, of teams and of communities of practitioners. Perhaps most evocative of these was the presentation by Dr Jan Bone, Christchurch ED Consultant, who commenced with a brief video of the experiences of the Christchurch community during the Canterbury earthquakes. A visual reminder with the haunting music of the Crusaders theme song Conquest of Paradise, as an introduction to the development of an innovative 100 day team programme – EDGE – ED Getting Exercise. This was introduced in the period post-earthquake, following a recognition of the drop in staff morale and sense of team spirit. This programme saw the introduction of a multidisciplinary exercise focussed series of activities which garnered 'points' for the teams – more points for activities with multiple attendees, more again for those involving multiple representatives for example, nursing, allied health, reception, medical staff. Additional activities were developed to add

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interest – not all highly strenuous – from swimming, lunchtime walks, box fit, tramping to more adventurous challenges including handstands, team jumps and dog related activities! Improvements in morale and recognition of each other as individuals was noted amongst the large ED workforce, and the program was extended in the following year at the request of radiology to include RAGE – Radiologists Getting Exercise.

Recognition of the challenges of staff working in rural areas highlighted, and the issues for Queenstown with a highly fluctuating itinerant tourist population were outlined by Keith Raymond, St John Station Manager. The importance of providing a well-trained, flexible and responsive service was outlined, with recognition of the unique challenges associated with the regions geography and associated access and communications issues.

Kirsty Lewis, newly appointed Acute Care NP in Southland ED, was able to outline the challenges not only of the role itself, but of the personal journey she had experienced. She described the developed of the role, working part time in ED and also in primary care and PRIME. The journey and development within an advancing practice role was outlined - as expertise develops, so too does scope of practice in regards to the type of patient who can be seen within the ED. Kirsty described the importance of the NP role in terms of health promotion and education, with decision making, role modelling and policy development as important elements. She also identified that NPs are likely to form a stable element in staffing within EDS, being more likely to remain in employment than similarly positioned medical staff.

AN OVERVIEW OF THE EXPERIENCES OF MEMBERS OF THE NEW ZEALAND MEDICAL

Assistance Team (NZMAT) responding to Cyclone Winstone in Fiji was provided by Dr Adam McLeay. NZMAT is a civilian-based disaster medical assistance team comprising of clinical and allied staff that include doctors, nurses, paramedics, allied health, and non-medical members such as logisticians. Further information about the role and work of NZMAT, as well as the process for registering interest to volunteer with this group can be found on the Ministry of Health website, at: http://www.health.govt.nz/our-work/emergency-management/new-zealand-medical-assistance-team

The importance of providing supportive, effective education within a team environment is an ongoing challenge for all areas in healthcare, and Ben Ross, Nurse Educator in Hutt Hospital ED has been working on establishing interdisciplinary, in-situ simulation training. This has now become a well-established and integral element within the educational programme. The benefits associated with this include improved teamwork, more realistic training opportunities, improved staff morale, with individuals feeling more comfortable in their roles. There has been a movement away from 'guerrilla sim', the surprise, unexpected simulation, to 'teaching sim' with an associated reduction in anxiety. This type of simulation builds on initial in-depth briefing, identification of desired learning points, the enactment of the simulation, then debrief. The same scenario will be repeated to consolidate knowledge.

SKILLS, KNOWLEDGE AND FOCUSSED LEARNING

The Conference was held alongside the AENN study day, which provided the opportunity for focussed learning in

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relation to advanced nursing practice. In addition to this, there were a series of targeted workshop provided on the first day of the conference offering smaller group sessions to work through specific skill based topics. These included a range of relevant areas, with conference delegates being invited to choose two of the four options to attend. The workshop included a focused review of the role and management of arterial lines, ABGs and effects of inotropes; x-ray interpretation and fractures; USS guided IV lines; Mass Transfusion Protocol, blood loss and weight, and estimation of blood loss. A number of practical tips and useful clinical guidelines were provided during these sessions, and links made to clinical scenarios.

Emergency care and emergency nursing represents a broad scope – and the need for a continuing commitment to review our knowledge base. Like all areas within nursing, we are faced with the necessity to constantly update our core understanding; the difficulty is that our core business is spread more widely that any other area. Our scope of practice extends across the lifespan, over all specialty areas and within all settings. Inevitably, the difficulty is to find ways of accessing the information necessary to maintain competence and confidence across this landscape. Access to specialty knowledge and the specialist viewpoint is one of the benefits of attending professional conferences. The CENNZ conferences was able to offer several further opportunities to look in greater depth and to update clinical understanding of relevant issues and clinical concerns.

All EDs face the challenge of managing acute respiratory

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patients, and the presentation by Dr Kyle Perrin, General and Respiratory Physician Wellington Hospital, on the assessment and treatment of respiratory disease in the ED provided a clear overview. Particular focus was given to asthma, PE and spontaneous pneumothorax. Discussion around the management of asthma and severity assessment raised the emphasis on use of the asthma foundation algorithm, and a reminder that in moderate or severe asthma, the use of a peak flow reading remains the most objective measure. (**For those readers who may not have recently reviewed the guidelines, I would recommend the NZMJ article Asthma and Respiratory Foundation NZ adult asthma guidelines:** a quick reference guide, Beasley et al., 2016 as a good starting point https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1445-18-november-2016/7068).

When considering the potential for PE, the emphasis was placed on responding to the symptoms – to the level of presumed severity. Thus, the process was suspect, make the diagnosis, assess the level of severity, treat according to severity. The take home message here being that the patient is going to die from cardiovascular not respiratory collapse, the major concern is risk of systemic hypo-perfusion. This again led to discussion about recognising the appropriate use of tests, and the concern with over testing in the absence of need. An even more dramatic example was introduced with the findings from a series of studies which indicate that despite current practice, there has for many years been evidence which suggests that not only is intervention for primary pneumothorax unnecessary, it can in fact result in long term increased risk of recurrent pneumothoraxes.

Another group the represents a core and growing section of the ED population are the elderly, although the definition of elderly is one that seems subject to interpretation. One thing remains clear – that the number of elderly within NZ society is continuing to rise, and inevitably the number who come to hospitals in the last years of their lives will also increase. Dr John Chambers, Dunedin Hospital, spoke about the importance of assessment of the vulnerable elderly in ED with a particular focus on the recognition and differentiation of delirium. Of particular note, was that while many will consider delirium in its more active and visible state, far fewer are aware that 70% of delirium presents initially as hypo activity, disorganised thinking, and change or altered level in awareness. In this way, the importance of acknowledging the family member who notes that the patient is unlike their usual self, is quieter, withdrawn, and unresponsive and confused takes on greater significance. Similarly, the importance of noting that this is a symptom, not condition and discerning the differences between delirium and dementia are important. Delirium is an acute, fluctuating condition compared to dementia, which is insidious in onset and constant. Attention and consciousness is disordered in delirium, while generally preserved in dementia. In order to effectively assess the elderly patient, it is important to utilise appropriate tools and measures, such as CAM, Confusion Assessment Method.

Confusion Assessment Method (CAM) Diagnostic Algorithm	Date of assessment	
	Time of assessment	
		Yes or No
1. Acute onset and fluctuating course? (Acute change in mental status from baseline, fluctuating behaviour through the day)		
2. Innatention? (Difficulty focussing attention, easily distracted, difficulty keeping track of what is being said)		
3. Disorganised thinking? (disorganised or incoherent thinking, rambling or irrelevant conversation, unclear or illogical flow of ideas)		
4. Altered level of consciousness? (This feature is shown by any answer other than "alert", including: hyper-alert, lethargic, stupor, or coma)		
The diagnosis of Delerium by CAM requires the presence of features 1 and 2 AND EITHER 3 or 4		
Delerium detected?		**YES NO (circle)**

Reference: Inouye SK, Van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI (1990) Clarifying confusion Assessment Method, *Annals of Internal Medicine* 113: 941-8

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A useful mnemonic for considering the range of possible causes of delirium was suggested, that of: DIMES

- Drugs and alcohol – largest category in older patients
- Infection –Pus, pneumonia, UTI, skin
- Metabolic – check bloods
- Environmental – too hot/cold
- Structural: CNS events

Don't forget urinary retention, constipation and faecal impaction as a cause of delirium.

A number of DHBs are identified as using useful processes and educational toolkits relating to delirium recognition; one such identified was that of the CDHB THINKdelerium project, with further information available at: https://www.cdhb.health.nz/Hospitals-Services/Health-Professionals/think-delirium/Documents/Think-Delirium-236949.pdf

Falls in the elderly population were also identified as a significant issue for EDs, and in particular the difficulty in clearly determining the underlying cause. It has been found that it is not always possible to give an accurate history of, or to recall an incident of syncope; the older person may well not identify this has occurred. A more helpful factor is to seek clarification from a witness, or to maintain an index of suspicion. Following on from this, is consideration of safe discharge – and the need to identify potential risk factors. The significance of the 'Get up and go test' was discussed, and the example of the Nottingham Hospitals NHS trust and the reduction in falls that was achieved following the introduction of a falls reduction toolkit. When considering potential falls risks and frailty, the possibility of cognitive bias, in particular of anchoring (tendency to focus on one trait or piece of information, eg I tripped), needs to be considered and avoided. In this case, it is important to also check for potential metabolic causes

Other aspects specific to the elderly that need to be considered when assessing the ED patient include alteration to those typical presentations associated with certain conditions. For example, Acute Coronary Syndrome is more likely to be associated with breathlessness than with chest pain; appendicitis presents atypically, no localised signs, but high mortality; cholecystitis should be considered when working up sepsis in an elderly patient, but may present without localised tenderness, nausea, fever, vomiting, or elevated white blood cell count; femoral hernia can be a commonly missed cause of bowel obstruction.

THINKING, REFLECTING AND QUESTIONING.

Throughout the conference, the concept of questioning and critical thinking was apparent. It was clear that just accepting the status quo is no longer enough – as health care practitioners we need to challenge ourselves, and our colleague, to ensure that we are providing the best possible, evidence based care. That we have a clear rationale for what we do, that we have thought about what it is the we are offering patients, and what information is necessary to enable them to fully understand what is involved. Whether this apparent in the choosing wisely philosophy of the underpinning to best care bundles, nurses are challenged to think about their practice. Whether it is in regard to their ability to work effectively in a team, to maintain their own health and wellbeing, or to be fully responsible and accountable for their actions, emergency nurses are continuing to question and to validate their actions.

The movement towards pathways, and other evidence based processes provides a sound base from which to ground our practice. It should not be seen as limiting, but rather as an opportunity to move forward and to expand the role where necessary, while providing for safe boundaries around those still developing the confidence of clinical expertise. One national innovation being developed currently is that of the National Early Warning Score, or NEWS. This is part of the Health Quality and Safety Commission's work on the

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deteriorating patient. Rick Forster, the CENNZ representative on the expert advisory group, presented an update on the process so far. There is considerable variation in the recognition and response systems used currently, with movement towards standardisation.

The different work streams under development include:

1. National Early Warning chart

2. Korero Mai – patient, family and whanau escalation

3. Shared goals of care: recognising that unwanted / unwarranted end of life care can occur, and the importance of goal of therapy conversations

Additional information, fact sheets, and links have been developed, but the role and fit with emergency departments is still being clarified. Further information is available from the HQSC website at: https://www.hqsc.govt.nz/our-programmes/patient-deterioration/recognition-and-response-systems/

When considering the difficulties in introducing new knowledge, and in updating current practices, the recognition of 'urban myths' within our professional pool of knowledge is certainly worth considering. While most nurses have long been aware that much of what we do is linked to rote behaviour, routine or simply repeated because 'we've always done it that way' (regularly putting patients into hospital gowns, regardless of their presenting complaint springs to mind), there are other more serious factors to consider. Dr Amy Leuthauser, Dunedin Hospital ED Consultant, identified a number of practice elements which could be considered to have an element of the 'urban myth' about them. Perhaps more accurately, they are based on a large degree of assumption or failure to think through an issue. The tendency for members of the public to be influenced by the surprisingly effective success rate of CPR (as portrayed on endless tv shows) – unfortunately we have all seen the consequence of this, the devastated family members who are shocked that their loved has actually succumbed, and is not sitting up in bed, smiling at them. As nurses, we see this more widely, I would suggest – how many of us have to deal on a daily basis with the failure to recognise what an ED nurse actually does, as compared to what the tv or romance novel or porn movie suggests? Other suggestions were equally valid however, the belief in the imminent increase in patient numbers (and disruption) expected at certain phases of the moon – despite studies which have shown this to be untrue; the increase in agitation when someone leaves the shift, wishing us a 'quiet' night!. Other aspects of our routine behaviours can also be challenged – the belief we cannot use local anaesthetic with adrenaline in suturing finger injuries, or that there is value in estimating blood loss (given the proven level of inaccuracy). These are only a few of the examples – a good starting point to begin challenging ourselves – why do we do what we do? Do we actually have a rationale, and if so, is it still valid?

A nice summary of this and many of the other thoughts about how we do (or do not) think rationally was provided by Professor Mike Ardagh, in his presentation 'Thinking about thinking'. He touched on the concepts associated with rationing and rationalising, as identified by john Bonning, on the errors associated with bias and the risk of over testing and not thinking clearly about implications and consequences. He reminded us of the implications associated with sensitivity and specificity – if we are doing are job correctly, there will be some 'failure' in the system – 100% is not possible. If we are not seeing this, we are, by default, over testing, over treating, and therefore putting patients at risk from the associated harms that this brings. He talked about the imprecise science that is medicine – acknowledging that there is risk, and the potential outcomes, with the associated importance of conceding and sharing that imprecision. This led on to considering the dual processes of fat (intuitive) thinking, and slow (analytical) thinking, and the role each plays in our decision making.

In the fast paced ED, much of our processing and decision making inevitably takes place in the intuitive mode, and that brings with it a number of inevitable risks and biases, and therefore the need to be conscious of these, and to acknowledge the context within which we are working and take steps to counter these cognitive biases.

SLEEP...THE FINAL FRONTIER

A final presentation was, appropriately enough, on the topic of sleep. It was a thoughtful and challenging reminder of the implications of shift work for nurses, as well as the implications of sleep and sleep disorders for patients. Dr Alex Bartle was able to provide a timely outline of the processes associated with normal sleep, as well as the consequences of disruptions to sleep and the effects of cumulative sleep deficit. It was interesting to be reminded that spinal paralysis occurs during REM sleep, that it is actually normal to wake

SHARING KNOWLEDGE, VALUING INNOVATION AND EVIDENCE: THE CENNZ 2017 CONFERENCE

during sleep, and that we all experience a brief period of amnesia immediately prior to falling asleep. For an average adult, regular sleep equates to 7-8 hours while for the elderly it is not that much less, only 7-7½; however, less than six hours sleep on a regular basis is insufficient. Of concern was the growing evidence of a strong correlation between poor sleep (quality and quantity) and Alzheimer's disease. Consequences of fatigue were equally an issue, including impaired cognitive function; poor concentration, learning and memory difficulties, impaired decision making and reasoning, lapses in attention, slowed responses/reaction. Poor sleep is also often accompanied by micro sleeps – momentary losses of concentration. Psychosocial, physical and workplace consequences were outlined.

ALL WORK AND NO PLAY...

No conference would be complete without a little fun and games, and while what happens at conference stays at conference, there is no point pretending that an excellent evening out on the Spirit of Queenstown for the dinner cruise was not enjoyed by all, with an excellent meal, some high quality dancing, and adventurous driving by a string of captains. The scenery was pretty good too!

LETTER TO THE EDITOR

THE EDITOR,

THE JOURNAL OF THE COLLEGE OF EMERGENCY NURSES NEW ZEALAND.

COLLEEN LAW R. N. B. N.

EMERGENCY DEPARTMENT,

NMDHB,

NELSON.

24/08/2017

Dear Sir/Madam,

The article, 'Violence and Aggression in NZ Emergency Departments', was a telling read of the growing problem in NZ's Emergency Departments. I agree wholeheartedly that as nurses we need to be vigilant about reporting all incidents of violence and aggression, so we don't, 'tolerate a workplace culture which minimises and dismisses these as unimportant,' or 'we will put ourselves at risk of greater harm.'

I would also like to use this platform to suggest that E.D.'s have a solid structure supporting training for all ED staff, in interpersonal skills and de-escaltion. I believe having these skills has the potential to reduce the risk of abusive behaviour. A de-escalation training program has been running for around seven years in the Nelson E.D. and it has been noted, this, supported by good interpersonal skills (mainly by acknowledging people early in their distress), has been effective in managing some incidences of pre-escalation and de-escalation.

This is not an easy fix and as noted by Dr. Richardson, there are many issues facing nurses that can lead to an escalating situation.

Nurses need to feel safe and supported in their work environment, I believe good interpersonal skills and de-escalation training has a part to play in this.

Yours sincerely,

Colleen Law, R.N. B.N.

MINOR ISSUES

- ROAD RASH IS A FRICTION BURN
- IT IS THE MOST COMMON NON-THERMAL BURN
- A HIGH NUMBER OF PATIENTS PRESENTING WITH THIS ARE BETWEEN 5-20 YEARS OF AGE

CAN BE COMPLICATED BY TRAUMATIC TATTOOING

WHAT IS IT:

- Forceful impregnation of dirt, asphalt, gravel, glass into dermis.
- After re-epithelisation, becomes a permanently discoloured area (black or blue).

WHAT TO DO:

Best strategy to prevent tattooing is to remove all of the foreign bodies before the region re-epithelializes.

Sounds painful right…….so before you grab that chlorhexidine scrubbing brush

1) Apply a thin layer of topical 2% lignocaine to the area (3-5 mg / kg).
   Leave on for five minutes before wiping off.
2) Paracetamol (15mg/kg/dose) and ibuprofen (10mg/kg/dose)
3) Entonox >5yrs or continuous flow nitrous if <5yrs

The mechanical action of rubbing the wound removes slough, exudate, and debris.

If there is remaining grit in the wound then you can use Intrasite™ Gel which works by autolytic debridement over 24-48hrs. Cover the gel with a non-adherent dressing, i.e. Mepitel™ and then cover with gauze followed by Hypafix ™

Get the wound reviewed by the GP in a couple of days, with advice on looking out for the signs / symptoms of infection.

KATHRYN JOHNSON NP STARSHIP CED - AUGUST 2017.

Let food be thy medicine and medicine be thy food."
Hippocrates

SNIPPETS

ADULT

- Intracranial hemorrhage in patients with atrial fibrillation receiving anticoagulation therapy Lopes RD et al. Blood 2017;129(22):2980–7
- Cultural and religious beliefs and values, and their impact on preferences for end-of-life care among four ethnic groups of community-dwelling older persons Ohr S et al. J Clin Nurs. 2017;26(11-12):1681-89
- New persistent opioid use after minor and major surgical procedures in US adults Brummett CM et al. JAMA Surg. 2017;152(6):e170504
- Use of antibiotics during pregnancy and risk of spontaneous abortion Muanda FT et al. CMAJ. 2017;189(17):E625-E63.

  Bottom line: *Penicillins or Cephalosporins should always be first choice.*
- Violence and self-harm in severe mental illness: inpatient study of associations with ethnicity, cannabis and alcohol Dharmawardene V, Menkes DB Australas Psychiatry. 2017;25(1):28-31
- Clinical management and patient persistence with antibiotic course in suspected group A streptococcal pharyngitis for primary prevention of rheumatic fever: the perspective from a New Zealand emergency department Mathan JJ et al. N Z Med J. 2017;130(1457):58-68

PAEDIATRICS

- Oral and topical antibiotics for clinically infected eczema in children: a pragmatic randomized controlled trial in ambulatory care Francis NA et al. Ann Fam Med. 2017;15(2):124-30
- Parents' expectations and experiences of antibiotics for acute respiratory infections in primary care Coxeter PD et al. Ann Fam Med. 2017;15(2):149-54
- Silk garments plus standard care compared with standard care for treating eczema in children: A randomised, controlled, observer-blind, pragmatic trial (CLOTHES Trial) Thomas KS et al. PLoS Med. 2017;14(4):e1002280
- The combination of bed sharing and maternal smoking leads to a greatly increased risk of sudden unexpected death in infancy: the New Zealand SUDI Nationwide Case Control Study Mitchell EA et al. N Z Med J. 2017;130(1456):52-64

SHORTER STAYS IN THE EMERGENCY DEPARTMENT

- N.Z. Med J. 2017 May 12;130(1455):15-34.

  Impact of a national time target for ED length of stay on patient outcomes. Jones et al

  Aim: The impact of national targets for emergency department (ED) length of stay(LOS) on patient care is unclear. This study aimed to determine the effect of New Zealand's six-hour time target (95% of ED patients discharged or admitted to hospital within six hours) on a range of quality indicators.

  Conclusions: Most outcomes we investigated either improved or were unchanged after the introduction of the time target policy in New Zealand. However, attention is required to ensure that reductions in hospital length of stay are not at the expense of subsequent re-admissions
- N.Z. Med J. 2017 May 12;130(1455):35-44.

  Effect of the Shorter Stays in Emergency Departments time target policy on key indicators of quality of care. Jones et al

  Aim: To determine whether implementation of a national health target called Shorter Stays in Emergency Departments impacted on clinical markers of quality of care.

  Conclusion: Introduction of the Shorter Stays in Emergency Departments target was not associated with any clinically important or statistically significant changes in the time to treatment and adequacy of care for five different clinical indicators of quality of care in Aotearoa New Zealand. For those indicators measured at one site only, it is unknown whether these results can be generalised to other sites.
- Australas Emerg Nurs J. 2017 May;20(2):53-62. doi: 10.1016/j.aenj.2017.04.001. Epub 2017 Apr 25.

  A systematic review of the impact of nurse-initiated medications in the emergency department. Cabilan CJ & Boyde M

  Background: Nurse-initiated medications are one of the most important strategies used to facilitate timely care for people who present to Emergency Departments (EDs). The purpose of this paper was to systematically review the evidence of nurse-initiated medications to guide future practice and research.

  Conclusion: Nurse-initiated medications are safe and beneficial for ED patients. However, randomised controlled studies are required to strengthen the validity of results.

REGIONAL REPORTS

NORTHLAND/TE TAITOKERAU REGION

CHRIS THOMAS (CENNZ TREASURER)

Registered Nurse / CNS

Emergency Department
Whangarei Hospital

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Greetings form Northland.

We are very pleased to be putting a miserable winter season behind us in Northland although at the time of writing this report we are only just beginning to see a change in presentation numbers and complaints. Patients with flu-like symptoms were more prevalent this winter, than last, and respiratory illnesses in both adults and children were again high on the list of presenting issues.

While the opening of four extra medical beds finally happened in August, it did little to solve the issue of bed block in the Whangarei ED and regrettably this has become the "norm". All hospitals in the region were repeatedly operating at capacity over the winter months and there were constant flow problems with patients spending many hours in ED awaiting admission to wards. As always, nursing staff coped with the extra pressure by working harder and often longer shifts but this took its toll on people's health and subsequently a risk in sick calls.

At the Bay of Islands building is underway for their new hospital, with some of the two-storey slabs now in place so progress is now highly visible. Staff are continuing to work in the old building which is just adjacent to the new structure so there have had to be some changes made to ambulance access but it appears that disruption is minor.

Further in-house trauma workshops were run at Whangarei for nursing staff to provide opportunity for up-skilling and the monthly education sessions continue. ED staff are also preparing for the annual Quiz Night competition with police, St John and fire fighters which we won last year – so the pressure is on!

Two new grads joined the Whangarei ED team in August and have settled in well. Both nurses did placements in ED during the last year so a lot of the ground work by them and their preceptors had been done, making their transition to post graduate work easier.

As this is the last journal report for the year I'd like to wish all our members a happy and safe festive period and wish them well for 2018.

CHRIS

REGIONAL REPORTS

AUCKLAND REGION

MATT COMESKEY

Nurse Practitioner

Auckland District Health Board

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Adult Emergency Department

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ADULT EMERGENCY DEPARTMENT, AUCKLAND CITY HOSPITAL

As I'm writing this spring is on the horizon. I like the cool clear days and snow to play on - but I'm really looking forward to summer.

Over the winter period Auckland ED has again, experienced growth in patient presentations which has led to prolonged periods of bed blockage. The ability to deliver quality care has been challenging - particularly with the high rate of sickness amongst nurses. Despite this, our team has done well to cover sick leave and school holidays as well as take patient loads that in ideal circumstances would not be asked for. However, as winter ground on, there was an increasing sense that as a team we were getting worn down, and that our resilience was being challenged. There have a been a couple of unpredicted factors that have played a part in the increased winter demand this year. The less than optimal efficacy of the flu vaccination has led to more presentations of influenza like illnesses - amongst whom there has been some self presenting, very sick young people, as well as the expected at-risk co-morbid population. The other on-going challenge was presented by a spike in synthetic 'cannabis' related presentations. This toxin was sold predominately to the homeless and street dwelling population living nearby. The agitation, seizures, toxidrome and mental health issues involved in each presentation stretched resources. And sadly, to date, a cluster of deaths occurred within a month in the Auckland area, pointing to an on-going, deadly problem on our door step.

These two unforeseen factors aside, the increased winter demand on emergency services is not unprecedented - nor is it unforeseen. It is a predictable event. As one of our SMOs wrote to senior colleagues a year ago in frustration after a series of particularly gruelling shifts, - winter happened last year, it will happen again next year and will likely happen every year there-after. Historically, demand on the Auckland ED has grown year upon year for more than a decade now. And each year hospital winter work load planning is done, - to an increasing level of detail. But we are still not getting ahead of the curve. We have to ask "Why?" and continue to seek improvement.

Soon enough summer will arrive and with it the obligatory - "Haven't we all done well to get through that mess" email from a managerial leader in our organisation, whom few of us have met, who is unlikely to be seen in our department on a night shift, a weekend or a public holiday. Please forgive my cynicism, I truly want to be positive, but without sustainable change I can confidently predict we will be facing the same mess of "unprecedented winter demand" this time next year.

On a more positive note, our department continues to celebrate the good in what we do and the pretty amazing people who make it happen. Please read Auckland SMO Peter Jones et al's study of the effectiveness of the six hour shorter ED stay in the NZ Medical Journal. The paper is the culmination of a lot of work that serves to validate the MOH national six hour target, whether we like it or not - to improve outcomes for the patients we care for.

MATT

REGIONAL REPORTS

AUCKLAND REGION

MICHELLE PEPERKOORN

Nurse Practitioner

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Counties Manukau District Health Board

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He mihi nui, he mihi mahana, ki a koutou katoa

Ki a ratou ma kua wheturangitia heare, haere, haere atu ra.

Ki a tatou te kanohi ora, tena hoki tatou katoa

Naku te rourou nau te rourou ka ora ai te tangata

With your contribution and my contribution the people will prosper

Well done to the Southland DHB's for putting together an informative and exciting conference in Queenstown, a beautiful setting with some excellent education and networking opportunities. We are all looking forward to the 2018 conference in Hawkes Bay.

The past three months have been a surprising mix of losses and gains. We have lost a number of our senior nursing team and gained more patients presenting to the ED. The latter seems to be par for the course for ED's throughout New Zealand. There has been increasing numbers presenting to the ED across all age groups. They tell us that this has not been a "bad flu" season which is a little unsettling as we consider the likelyhood of an increasing number of similar presentations next year. We have however seen a rise in mumps in adults and a small cluster of meningococcal presentations in the paediatric department.

Our unit Nurse manager-Mary McManaway has left us after 12 years at Middlemore Emergency Department. Mary has been an inspiration for nurses within the ED. She has been instrumental in the development of numerous nursing pathways enabling progression to senior nursing roles within research, education, management and clinically focussed areas of emergency medicine within Counties. Mary will be sorely missed. Debbie North has left the Clinical Nurse Specialist team and is moving to Brisbane to take up a senior nursing role at the Royal Prince Alfred hospital.

With a changing of the guard not only in government but also within the Counties Manukau hierarchy there are changes on the horizon across the board. However, despite what has been reported in the media lately, we are pleased to say that there are no planned redundancies for frontline clinical staff in the immediate future! The executive team have acknowledged the impact on staff morale struggling to match limited resources to increasing demands from within the community. However, as always, excellent team work and some great social activities, helps us get through our shifts with a smile on our faces.

In Kids ED we have obtained funding for an 0.4FTE position to increase the work we are doing with overweight children. The role is being led by a senior Staff Nurse who is teaching staff how to have the difficult conversation with patients and their families about their weight. This is done in conjunction with the BE SMARTER tool (designed by Waikato DHB) which is receiving very positive feedback from families. Families are then encouraged to refer to one of the community groups that help with improving family lifestyles including diet and exercise. On discharge the patients GP is notified where they fit in the healthy to obese range, to encourage the GP's to assist with community support. One of the key messages coming out about weight is the impact poor sleep has on our health – probably something we all need to consider as shift workers!

We are now heading into Summer and the Xmas season and looking forward to longer days and warm summer evenings.

No reira

Meri Kirihimete, a, he mihi nui o te tau hou hoki ki a koutou me o koutou whanau

Na nga manu tioriori no Middlemore.

MICHELLE & CAROL DEWES

REGIONAL REPORTS

CHILDREN'S EMERGENCY DEPARTMENT, STARSHIP CHILDREN'S HEALTH

We are hopeful that the commencement of daylight saving and improvements in the weather will see a resultant decrease in presentations to Children's Emergency Department. It has been a busy winter for us with an 8% increase in presentations compared to 2016. This increase has proved challenging in itself, but has been exacerbated by challenges with hospital staffing and availability of beds. Once again, the hospital works well together to ensure children and families have the best experience possible. It has been heartening to see the number of positive comments and written feedback we have continued to receive from families over a somewhat challenging time.

A restructure of the 24/7 hospital functioning has recently occurred. The launch of this new model began in mid-July.

There have been two new teams created:

- The Clinical Nurse Manager team provides a 24 hour senior clinical support to nurses and junior medical staff. They assist staff to provide complex clinical care, provide frontline response to code orange calls (security code), provide response to other security issues and site-related events, assist with staffing and patient flow as well as being the first point of escalation in the after-hours period. There is increased coverage of this role in the after-hours period compared to during the week day.
- A Patient at Risk (PaR) team has been established to support ward staff in managing unwell and deteriorating patients. The aim is to ensure the level of care is appropriately escalated when necessary. The Nurse Specialists in the team provide 24 hour cover and are a frontline response to clinical codes, respond to Paediatric Early Warning Score escalation, and act on an escalation due to nurses' concerns about a deteriorating patient. They are supported by a Senior Medical Officer and a Charge Nurse.

The feedback on these new roles is very positive and that there is overall improved after-hours safety within the hospital. These roles came about following the disestablishment of the Duty Manager and Clinical Nurse Advisor roles.

CED continues to support New Graduates to practice and currently have three pre-registration nursing students with us. We have also had a steady flow of Paramedic Students spending time with us. Our aim is to welcome another two New Graduate nurses to our team in February 2018. It is always refreshing and invigorating to have new entry to practice nurses join us and support them to grow in to competent emergency nurses.

By the time this journal comes out, the 26th CENNZ national conference will have been held in Queenstown. Our department is supporting a large contingent of both junior and senior nurses to attend.

The CED team are planning on enjoying several social functions in the lead up to Christmas – we are always good at having some fun things on our social calendar post winter! Our annual CED tennis tournament is booked (no real need to have any tennis skill for this event but dress up is mandatory!), the Emergency Services Ball is a hot social calendar event in November and then our annual Christmas party will finish off the year in December. Nurses are being proactively encouraged to take some leave over the summer so they can refresh and revitalise after a rather hectic winter.

LIBBY HASKILL

REGIONAL REPORTS

MIDLAND REGION

RICK FORSTER

Registered Nurse

Chairperson

Tauranga Emergency Department

Bay of Plenty District Health Board

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Greetings from the Midland Region.

It was fantastic to attend the recent CENNZ National Charge Nurse Forum held in Wellington. This gave me the opportunity to catch up with two new unit mangers within the Midland region. Sandra King has taken up the role in Thames. It was interesting to hear about the challenges associated with smaller hospitals such as inter-hospital transfers and dealing with massive surges in presentations during the holiday period.

Kaidee Hesford has made a welcome return to the Bay of Plenty. She has recently commenced the role of unit manager for the Rotorua Emergency Department. It was great to hear about the establishment of their new Senior Nurse Clinical Coordinator positions. I am sure this will greatly support leadership and quality care within their unit.

In the Tauranga Emergency Department our two wonderful new grads have completed their first year of practice successfully. They have both secured on-going positions with us and it is exciting to have this year's graduates now working on the floor. The enthusiasm of new graduates brings a nice element to our department and challenges us to reflect on our own practice when guiding them.

A period of significant change continues in our department. Three long serving Senior Nurse Clinical Coordinators have recently moved on. Over many years I have seen these nurses put their hearts and souls into the role, using their broad knowledge and skills to navigate our department through many tough situations. They all valued the importance of emergency nurses as patient advocates and were also willing to speak up for their respective teams. Their huge contributions will not be forgotten any time soon and I wish them well for the future endeavours.

Our focus on the early identification and referral of the frail elderly continues to pay dividends. The care of the elderly outreach multidisciplinary team perform regular rounds with the Emergency Department. They review the situation for all patients identified using a brief risk assessment tool completed by the RNs. This has been found to also improve care for those being admitted to the wards supporting safe and timely discharge.

The "front of house" model of care is becoming embedded. One nurse triages over the counter with another waiting room based nurse performing reassessments, interventions and starting investigations or pathways. For example the asthma care pathway is being readily used and definitely helps get treatment underway sooner; a great tool to have as we navigate this winter.

A front-of-house team leader, supports triage and the waiting room nurse. Whilst liaising with the Shift Coordinator they facilitate inwards flow into the department. These activities may not have improved the time to see a Doctor KPI, but it is likely helping the time to discharge from the Emergency Department.

Our recent shorter stays in ED target has improved by approximately two percent taking us to around 95-96%.

RICK

REGIONAL REPORTS

HAWKES BAY / TARAWHITI REGION

Paula Draper

Registered Nurse

Emergency Department

Hawkes Bay Regional Hospital

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Hello from sunny Hawkes Bay.

Winter pressures continue to impact on ED with a high number of presentations, high acuity and bed blockage. I'm sure that every DHB is facing the same pressures. Needless to say, we are not meeting the 6 hour LOS target.

Staff have been working extra hours in order to maintain safe staffing and to help with departmental overload. Shift Coordinators are regularly scoring the Department as part of the CCDM and highlighting when it is in crisis.

Our ED team activities continue to help deal with the stresses of working in the ED. Staff have recently competed in the Hatuma Lime half marathon, and are currently preparing for a mud run, and a white water rafting day.

We have recently changed the screening for sepsis criteria from using SIRS to Q-SOFA and also now have a dedicated PAR team working hospital wide. This team consists of mainly experienced ED nurses.

Other good news is that Sue Revell has just been appointed as our 3rd Nurse Practitioner! Well done Sue! Sue has over 27 years of experience in ED both in New Zealand and the UK.

Hawkes Bay is also very pleased to be hosting the 27th CENNZ conference in 2018. We look forward to seeing you there!

PAULA

REGIONAL REPORTS

MID CENTRAL REGION

KATIE SMITH

Nurse Practitioner

Knowledge and Skills Framework and Website/Social Media (Taking over from Ben Storey)

NZDF

Bay of Plenty District Health Board

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FROM PALMERSTON NORTH ED:

Tena koutou katoa,

PNED experienced the usual heavy winter workload. Everyone did very well managing those difficult shifts, and the trial of a winter roster with fewer swing shifts and another nurse on the pm and night shift was a success. Now that the attendance numbers are starting to drop off and the hospital crowding is easing, there are fewer patients parked in corridors. This is a great relief for patients and staff alike. The nursing team kept their morale up well through the trying winter months, and are now all focused on the upcoming renovation project and the changeover to a new patient administration computer system (Webpas). Janine Kereama is leading the renovations project from the clinical side and she started work in September on a new model of care for the enlarged sub-acute area. Team nursing will be trialled in readiness for the renovations which are likely to take more than 6 months. Unfortunately the budget didn't stretch to a full rebuild but the waiting room, consultant's offices, reception area, and subacute areas will be completely changed and improved.

And just because it is good to have many major changes simultaneously, the patient administration system is planned to switch from the appropriately named Homer to WebPas in early December. We have already enjoyed the dubious pleasure of the clinical portal rebuild and its effects on the radiology system, so Webpas is being eyed suspiciously. In a completely unrelated move, the admin assistant and charge nurse are both leaving in November; one to retire after 31 years, the other to move to a warmer climate.

The CNS team are gradually expanding their range of patients and the usual turnover of nursing staff has brought new people into the team (and some old ones back again). ED's nurses continue to work as a notoriously supportive team, with plenty of social activity on the side.

The educators are working hard on family violence screening and mental health/suicide screening. Some excellent work with the mental health clinical liaison nurse has led to all ED nurses completing a mental health risk assessment education programme, which is helping nurses' confidence in working with this patient group.

The St John FEDs had their 10-year anniversary in September, with much cake and celebrating. There are now 2 FEDs in the department every day from 10am until 10 pm, which is much appreciated by patients and staff.

The summer months are going to be chaotic as staff manage the renovations, change the care model and work processes, learn the new Webpas, and carry on doing what they do best- enthusiastically caring for the amazing variety of patients that use our services

Nga mihi nui

IONA BICHAN

REGIONAL REPORTS

FROM THE NZDF:

This time of year sees a busy period for the emergency nurses within the NZDF.

We have been lucky enough to have several people attend the Annual CENNZ conference which was well received with a variety of interesting and clinically relevant topics, as well as best practice updates. Another successful conference in a very beautiful part of our country.

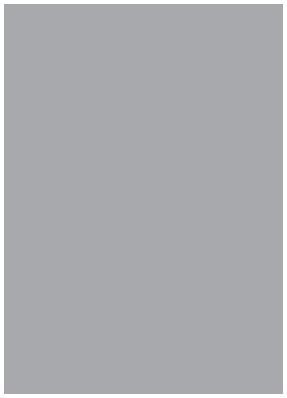
Our emergency nurses continue to conduct clinical placements in several DHBs including CCDHB, HVDHB, and HBDHB, with the largest presence of our emergency nurses in MidCentral DHB. The ongoing clinical placements within DHBs enables our clinicians to conduct clinical training, and at the same time, network with other emergency nurses and provide clinical care to the local community, and continue to foster positive relationships between the NZDF and the DHBs.

Over the next two months, many of the NZDF nurses will take part in a large multi-national exercise called Exercise Southern Katipo in the South Island where they will be employed in a variety of roles. From point of injury care through to resuscitation and damage control surgery in an exercise capacity and throughout the evacuation chain to ensure patient movements are conducted in a safe and timely manner. Keep an eye out for it on the news and in your local papers and social media pages – you might see some familiar faces.

Even though it feels like winter has only just left us, with the arrival of spring and pending silly season, busy emergency departments and large patient presentation numbers continue to be a challenge.

Look after each other, keep safe and enjoy the festive holiday season.

KATIE



GREATER WELLINGTON REGION

POSITION VACANT

REGIONAL REPORTS

TOP OF THE SOUTH REGION

JO KING

Registered Nurse

Emergency Department,
Nelson Hospital

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Greetings from the Top of the South. Autumn has suddenly given way to winter in the South Island and the first dustings of snow on the hills have excited the skiers amongst us.

It is business as usual in the emergency department and in the past months that has increasingly come to mean a daily battle to achieve flow, match resources with demand and navigate bed block. There have been many consecutive days of hospital occupancy over 100%. This has been matched with a 10% increase in ED presentations and high admission rates. These factors have all combined to impact negatively on key performance indicators (KPI).

The last two months have seen Nelson fall below the 95% six hour target, patient minutes in the department have increased by 6% and people choosing not to wait has risen. It is of note that during May a 17% increase in triage 3 patients was recorded and no doubt this has contributed to the higher than normal admission rates.

There is strategic work going on in the organisation around the development of Acute Admitting Unit (AAU) facilities but this will not be an immediate fix. Some short term strategies have been to open day stay beds overnight and for suitable patients to be redirected to a GP service at the DHB's cost. Working to longer term solutions is vital. The constant mitigation of clinical risk that ED overcrowding and bed block creates is challenging for all staff.

Despite the busy days at the coal face there are also many positive developments to acknowledge. We are currently trialling the first ever dedicated HCA in the ED. Sophie has become an integral member of the team. Nursing has regained valuable minutes previously spent doing non-nursing tasks and I'm sure this role has contributed to falls prevention and the improved observation of mental health and confused patients.

We are also are about to commence an 8 month pilot of 2 Clinical Nurse Specialist (CNS) positions. This is a great opportunity to see how advanced practice roles may add to our model of care and positively influence KPIs. It is also a landmark for nursing in our department. We have many nurses who have made major commitments to post graduate study so hopefully a successful pilot may present career pathways for others and extend over the hill to Wairau ED.

Many of the ED team are involved in quality initiatives. We are conducting a prospective wound audit and also overhauling our sepsis pathway to ensure it is 'triage initiated' and standardised across the department. We are also beginning to look at how other health care agencies may be better placed to provide care for patients with long term indwelling catheter complications. These patients are often elderly and immobile and spending many hours in the ED is not ideal.

We have recently held a resus study day for both Nelson and Wairau staff. This is an annual initiative and designed to prepare staff to work in this area. We are also fortunate to be hosting the ENPC in Nelson shortly. On many occasions planned nursing education and training is cancelled to meet the demands of a busy department. Understandably patient care priorities dictate this. However, this has initiated discussion about how we can find a sustainable way to protect these activities and foster nurse - led education and journal club in our department. I would be very interested to hear of any successful strategies others may have adopted.

Finally, we have welcomed a cohort of enthusiastic new staff and sadly said goodbye to Mel D who has headed to Invercargill ED. We have also waved Renee off to Mosul in Iraq on a short term assignment.

As we receive some of her first communication about the harrowing experiences for people living in a conflict zone we *are very appreciative of our own patch*.

JO

REGIONAL REPORTS

CANTERBURY / WESTLAND REGION

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CANTERBURY/WESTLAND

Educational opportunities have continued across the region with participants undertaking the first of the new triage courses.

A number of staff were able to attend the recent CENNZ conference held in Queenstown, which was much enjoyed, and proved both relevant and entertaining. One topic that was discussed by several presenters has also been part of the local focus – the introduction and implications of the 'choosing wisely' campaign. Further to educational opportunities, Christchurch ED NP Paddy Holbrook has indicated that she is willing to coordinate one of the AENN study days in Christchurch next year, so this will worth looking forward to!

We have continued to see an increase in workload through August, with a high number of days where there have been more than 300 presentations, an increase of around 7% when compared to August 2016. Overall growth in patient numbers has not been sustained however, or reached the forecasted levels only achieving around a 2.1% average increase compared to last year. Ministry of Health ED targets were not met for the first quarter of the year, reaching 94%, although this is an improvement of the first quarter of the previous year. We have been fortunate in that the anticipated number of influenza cases did not prove problematic for ED, although within the ICU this has been more of an issue.

The continued hospital wide focus on patient flow has enabled an improvement in patient movement from ED onto the wards, despite the increase in patient numbers. An improvement of almost 19 minutes compared to last winter in regard to patient movement has resulted. The appointment earlier in the year (in May) of a further two ACNMs to the department is also felt to have had a positive impact on the ability to focus on and improve the flow of patients and to assist with overall coordination and planning within the ED.

Staffing across all areas has remained tight at times, with a number of unfilled shifts, and the commitment and willingness of staff to provide additional cover has been a valuable and appreciated resource. The introduction of roster changes and the development of a suite of online tools to facilitate and empower staff to better manage their work/life balance, meet staffing needs and improve communication has resulted in the submission of a poster about the process to the Health & Safety Quality Awards. This is titled 'Roster in Your Pocket'.

Much energy and effort remains focussed on the new Acute Services Build (ASB) and the development of the geographical layout of the proposed ED, with over twice the clinical footprint of the existing facility, alongside the need to incorporate a dedicated Paediatric ED, and integrate the acute orthopaedic unit. Development of the cubicle layout, spacing and placement of work sections as well as the changes that will be necessary in terms of managing altered workload and best models of care continues.

The ED recently help its Open Day, when other staff from within the CDHB are invited to visit and tour the department. A total of 25 visitors came through, and three staff chose to come and work alongside a nurse or hospital aid. Hosted on the same day is the annual emergency nursing award ceremony. Two awards are presented, the Paul O'Donovan Memorial Award for Excellence in Emergency Nursing, and this year a second award was introduced, 'Making a Difference in Emergency Nursing'. Registered Nurse Kiri Thomson received the Paul O'Donovan Memorial Cup. Her first day of work in ED was February 22nd, 2011 – the day of the 6.3 Christchurch earthquake. Kiri's nomination and award summary referred to her excellent assessment skills, thorough documentation, ability to work autonomously and to her cheerful, kind and caring nature. The 'Making a Difference' award is intended to recognise and celebrate innovation, and was awarded to Nurse Coordinator, Clinical Projects, Polly Grainger. Polly was described as diligent and tenacious, with her contributions impacting all ED staff, and being recognised for her generosity in sharing her knowledge and time.

SANDY

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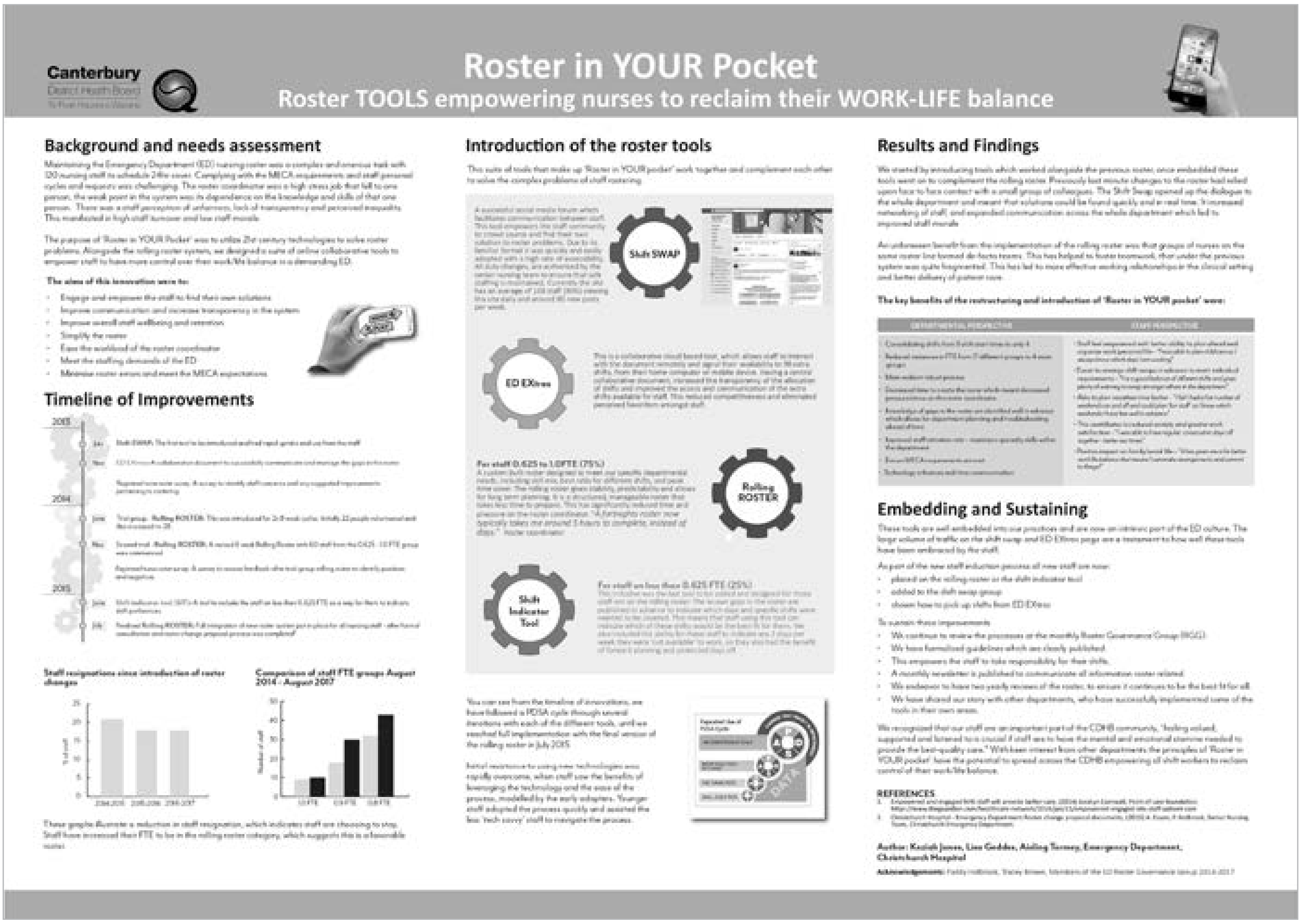

Left: Nurse Coordinator, Clinical Projects, Polly Grainger with The ‘Making a Difference’ award.

Right: Registered Nurse Kiri Thomson with her Paul O’Donovan Memorial Cup award.

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SOUTHERN REGION

ERICA MOWAT
Registered Nurse

Triage Portfolio

Southland District Health Board

Emergency Department Dunedin Hospital

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The last few months the SDHB conference committee have been preparing for the annual College of Emergency Nurses New Zealand annual conference. We would like to knowledge and thank the conference committee Leanne Shallish, Oliva Murray, Laura Gleeson Jenny Burt, Shona Willers and Erica Mowat for their efforts in producing a very successful conference in Queenstown.

Information regarding the presentations will be accessible through the CENNZ website in the near future and a survey monkey will be sent to all attendees to gather information for our next conference in 2018 in Hawkes Bay.

DUNEDIN

ATTENDANCES

We welcome the opening of the Medical Assessment Unit on September 4th. It has 8 beds and will be used for direct referral from GPs and other SDHB hospitals as well as ED. While patient flow and admission criteria is currently being developed we hope that the opening of this unit will have a positive impact on patient presentations in ED and facilitate the patient's journey

Attendances over the last few months have increased minimally with the range of 3800 to 4200 monthly presentations over the winter. However there has been a noticeable increase in the acuity and complexity of the presentations. This has stretched the skill mix and demands on available staff especially on night duty with many night duties resulting in a full department with less medical and nursing staff availability to deal with the increased demand over that time both within the emergency and speciality teams.

EDUCATION

Seven staff attended the conference from Dunedin emergency department returning with positive feedback on the variety of speakers and implications for practice. Interest in attendance was great and while more staff wish to attend, funding and daily staffing requirements limited the amount of staff able to. Other educational opportunities have been available with several staff requesting funding and enrolling for post graduate education opportunities in 2018.

STAFFING

Over the winter we have had many gaps in the staffing requirements due to illness, new staff and skill mixes - although we are currently fully staffed.

We have had 5 third year's on placement and 2 second year's about to start placement with an overlap of 3 weeks and a further 2 enrolled students. This is the most students we have had in the department at any one time. While we naturally think that ED is a challenging and exciting place to work, it has placed further demands on the nursing staff with some relatively new staff to the area orientation students and other new staff.

INVERCARGILL

The winter has been very busy not only with preparation for the Queenstown conference but with the impact of staffing challenges over this busy time.

Staffing was down 1.8 FTE due to difficulty recruiting suitable ED nurses. This lead to roster gaps over the winter which hospital resources were unable to alleviate. The winter flex position was therefore extended by two months to assist with staffing but will be unable to be extended further and a 0.8 FTE R/N position has recently been advertised. ED attendance has increased over the winter period by 10 % on last year due to the increased pressures on staffing projects such as 'Releasing Time to Care', that have been difficult to progress.

QUEENSTOWN

It has been a busy winter in Queenstown with presentation up 20% on last year. This was a challenge to provide adequate staffing even with the winter flex and overtime. The peaks of winter and summer presentations are no longer as pronounced with a constant continual increase leading to up to 50 presentations a day. This provides challenges for a 7 bedded ED with only 5 staff to cover over a 24 hr period. However, the good news is that the ED is about to be redeveloped and extended

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to a 9 bedded unit with a CT scanner on site. This will require a review of the current model of care and service delivery

OAMARU

Welcome to Olivia Shearer, the new hospital duty manager who started work in Oamaru 3 months ago. She had previously worked recently in an Accident and Emergency clinic in Christchurch and the Emergency Department in Timaru hospital. Unfortunately, none of the staff were able to attend the CENNZ conference in Queenstown. The SDHB CENNZ representative hopes to visit Oamaru in the near future to update them on points of interest from the conference.

STAFFING

The recently instituted swing shift has been utilised to relieve the nurses in ED for meal breaks. However, some are unfamiliar with trauma or have triage experience. This has led to a steep learning curve as there is only one nurse on duty at any time.

The welcomed recent addition of a receptionist to the ED team is currently 8 am to 8 pm seven days a week which has allowed the ED nurses to concentrate on patient care. It is unclear at present whether this position will continue in its current format. The recent health review of Waitaki District Health Services the has left staff and the community feeling unsettled and awaiting an indication of how the strategic plan may be operationalised, its effects on the Oamaru services and its potential impact on Dunedin Hospital and ED. The emphasis is a one health system approach stemming from a team of clinicians, management who had held workshops in the community in 2016.

It proposes ways to reduce the load on Oamaru hospital.

ERICA

ADVANCED EMERGENCY NURSES NETWORK (AENN) STUDY DATES 2018

DATES FOR NEXT YEAR'S AENN DAYS, FOR AENN MEMBERS ARE AS FOLLOWS:

DATE	HOST DHB	THEME
Friday 9th March 2018	Canterbury DHB Christchurch Hospital	TBA
Thursday 7th June 2018	Waitemata DHB North Shore Hospital	TBA
October 2018 - Date TBC	Held in conjunction with the CENNZ conference Hawkes Bay DHB	TBA

All dates avoid the school holidays and make allowances for busier winter months in respective clinical areas.

FOR FURTHER INFORMATION ABOUT THE TRAINING DAYS PLEASE CONTACT KATHRYN JOHNSON THROUGH THE CENNZ EMAIL:
cennzaenn@gmail.com

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