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# EMERGENCY NURSE NEW ZEALAND

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## A Word from the Editor

**Matt Comeskey**

**Editor | Emergency Nurse NZ**

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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.

This edition of the journal reflects a healthy level of activity in CENNZ. It is exciting to see the formation of the ED Nurse Educators Group and the ongoing activity of the Clinical Nurse Managers Group. Their efforts to share resources and ideas will no doubt benefit our colleagues and patients. Together we are stronger.

One of the problems we face is the growing burden of acute mental health presentations in our EDs. In the previous Journal, Jo King likened EDs as the canary-in-the-coal-mine. An explanation may be required. In the bad old days, canaries were taken underground in cages by coal miners as an improvised early warning system. The canary would fall off its perch and die if lethal levels

of explosive, odourless, methane gas were to build up. EDs are a bit like those canaries - whatever is going on in our local community is played out in our workplace. We are amongst the first to see the direct result of social and economic change - for better or for worse.

The change we are seeing is evident and ongoing. The rate of mental health presentations to our EDs is growing at a rate greater than the corresponding increase in community and inpatient mental health services. Consequently, our resource stressed EDs are placed in the position of providing acute mental health care to meet the shortfall. On 7 June ACEM (Australasian College of Emergency Medicine) convened a one-day symposium to discuss this issue. Our College Chair, Jo King, represented CENNZ.

One week before the symposium being convened, the Government announced the allocation of \$1.9 billion in the most recent budget to address wellness. This allocation is in part a response to the findings of He Ara Oranga Report into

Mental Health and Addiction Inquiry. It remains to be seen if any of this funding will be allocated to EDs. The allocation will be followed closely by ACEM, the CENNZ National Committee and the NZNO Mental Health Nurses Section. A report on the symposium is featured in this edition.

Finally - speaking of wellness... please don't fall off your perch this winter. Be kind to yourself and others. Don't be a canary in a coal mine - escape your cage for a bit and spread your wings somewhere warm and sunny.

### Correction

*In the last edition the featured Conference Report: ConnectED 2018, was incorrectly attributed. The report was written by Sandra Richardson, Senior Lecturer, School of Health Sciences, University of Canterbury, Canterbury Westland CENNZ rep. My apologies.*

**Matt**



## Editorial Info

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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 [mcomeskey@adhb.govt.nz](mailto:mcomeskey@adhb.govt.nz). 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 Matt Comeskey at: [mcomeskey@adhb.govt.nz](mailto:mcomeskey@adhb.govt.nz) 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.

**CENNZ NZNO Membership:** Membership is \$25.00 and due annually in April. For membership enquiries please contact: *Kathryn Wadsworth* *Email:* [cennzmembership@gmail.com](mailto:cennzmembership@gmail.com)

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# Chairperson's Report



On behalf of the National CENNZ committee, greetings to all our nursing colleagues.

Reports from around the country identify similar themes in the world of emergency nursing. They are increased demand, high acuity and complexity of presentations, bed block, overcrowding, pressure on ICU beds, inadequate staffing and limited variance response. And of course high rates of influenza continue to add to the mix.

There are two urgent needs. One is to identify a robust and validated model to calculate what is accurate base staffing for New Zealand emergency departments. The second is to ensure variance response scoring has nationally standardised indicators that reflect clinical risk that is specific to emergency nursing.

Finding a tool to accurately calculate base staffing, that has research validation and is nationally acceptable to employers has been a challenge for some time. There is even a lack of evidence in the international setting to help solve this problem. The College has done work on this for many years without much traction. I believe we must prioritise this and be able to work with Safe Staffing Healthy Workplaces (SSHW) and the CCDM programme to move this forward.

The Variance Indicator Scoring (VIS) is aimed at providing an early warning of the mismatch between capacity and demand. The work to standardise the scoring nationally is an excellent

initiative to ensure we all talk the same language. In the emergency department we have some key objective indicators that represent significant clinical risk. Furthermore they highlight immediately that there is a capacity versus demand mismatch. These are breaches, patients who are placed in un-resourced or virtual beds, patients outside triage times and large numbers in our waiting rooms adding to the workload of triage nurses. These factors are unique to emergency departments and are often not acknowledged as representing variance. It is important they are understood in discussion around capacity / demand mismatch.

While I talk of challenges and gaps in practice to calculating staffing and variance, it also creates a unique opportunity to get this right. If we can work collaboratively across NZ to identify standardised staffing models and ED specific variance indicators we may be in a much stronger position to achieve safe staffing and mitigate clinical risk.

Jo.

**Jo King**

Chairperson

College of Emergency Nurses New Zealand

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# Moving beyond Pillows and Pills - How do we respond to the increasing number of people presenting to Emergency Departments in a state of mental crisis?

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**Everyone has the right to timely access to appropriate mental health care. Data collected in emergency departments across Australia and New Zealand, confirms that people in crisis are routinely experiencing unacceptable delays in access to mental health care in our emergency departments (1).**

This finding is confirmed through the lived experiences of those treated and the professionals delivering treatment. The associated outcomes are negative and well known. Our ability to minimise harm has been compromised by the demand on our services, from not only the increasing burden of mental un-wellness in the community but the resource constraint that emergency departments, mental health services and first responders are currently operating under.

In June this year, ACEM (Australasian College of Emergency Medicine) convened a one-day symposium to address this issue. Invited parties were drawn from psychiatry, mental health nursing, ED nursing, ED physicians and consumer advocate groups. The symposium met the week after the Government announced a significant budget allocation to 'Wellbeing'. This allocation came in the wake of the recently released findings of the Government Inquiry into Mental Health and Addiction, He Ara Oranga (2).

The inquiry was wide-ranging in its breadth and number of respondents. The report identified significant gaps and inequities in the provision of mental health services - including the management of crisis in the Emergency Department.

During the course of the day, a common and recurring theme of presentations was 'lived experience' - that being the sharp end of mental health service delivery as spoken by those with real-world experience of what it is to be in a state of crisis.



**“Change can’t happen without the perspective of others”**

**Clare Skinner. Director of  
Emergency Medicine. Hornsby  
Ku-ring-gai Hospital. Australia.**

*Three key issues were addressed in the programme.*

## **What is the Size of the problem?**

Speakers presented data from their DHBs that suggested several themes in presentations. Broadly described these include:

1. An increasing number of mental health presentations over and above population growth. The number of people presenting to New Zealand EDs for mental health related reasons, increased significantly between the 2017 and 2018, 3.7% of all presentations in 2017 to 7.4% in 2018 (1.).
2. There has been a significant increase in overnight and prolonged stays in EDs. People experiencing mental health crises experienced a significant increase in ED waiting times between December 2017 and October 2018. The proportion of mental health presentations who had an ED length of stay of eight or more hours while waiting for an inpatient bed increased between the 2017 and 2018 study periods, from 4.5% to 27.5% (1.).

# Moving beyond Pillows and Pills - How do we respond to the increasing number of people presenting to Emergency Departments in a state of mental crisis? cont.

3. A disproportionate number of Maori present in a state of mental health crisis. Māori are over represented in the population of those accessing mental health and addiction services at 27.7%, compared with their proportion in the general population, at 15.4% (1.).
4. There is continuing inequity of service and barriers to the provision of community mental health services experienced by Maori and the wider population particularly in rural areas.
5. There is an increasing predominance of drug and alcohol-related presentations associated with crisis. There has been a steady annual increase in the number of people accessing mental health and addiction specialist services across New Zealand.
6. There is difficulty in distinguishing between behavioural disturbance and psychological distress and consequently neither treatment path may be well managed.
7. There is a predominance of young adults and children presenting in crisis.

The information presented suggested we need better data to guide practice. It is worth considering that ED presentations are the tip of the iceberg that is the burden of mental unwellness in our communities. Without comprehensive data, we do not have the information required to ensure changes signalled in the Wellbeing Budget are targeted to the right people or if they have been useful. Additionally, without robust data we cannot hold ourselves and the Government to account for progress.

## **Mental Health and the Emergency Department Experience: Using and Working in the System.**

Mental crisis has always been a core ED presentation, and this will not change. The challenge, however, is in maintaining quality of care in the face of an increasing number of presentations and already stretched resources. Additionally, we need to ensure the 'carers' - nurses, doctors, watches and security staff, amongst others, are not over-burdened and face their own professional or personal crisis.

**"With current resourcing we have run out of 'white rabbits to pull out of hats. We are failing in our duty of care to maintain patient safety and provide best practice that is culturally appropriate."**

**Jo King. Chair, College of Emergency Nurse New Zealand (CENNZ). NP Intern. Nelson Emergency Department.**

Several speakers gave examples of sentinel events in EDs related to delays to psych assessment and delays to transfer to inpatient treatment. Additionally, barriers to timely care and assessment are additionally problematic in provincial and rural ED settings. Regardless of location, in any ED, the clinical environment is a significant contributor to further distress. Noise, 24-hour lighting, a lack of peer support and the alienation experienced with seclusion and security watches - are all significant contributing factors exacerbating distress.

**"Often what we need is what you don't have - time."**

**Caro Swanson. Principal Advisor, Mental Health and service user lead. Te Pou o te Whakaaro Nui (Te Pou). Mental Health Consumer.**

# Moving beyond Pillows and Pills - How do we respond to the increasing number of people presenting to Emergency Departments in a state of mental crisis? cont.

A police representative described the current experience from his point of view. He described people in crisis in the police cells - as the “bad old days when bad things happened”. He acknowledged that while the ED environment is safer than that of a police cell, it is better that acute assessment is done in the community. Police involvement often escalates crisis (6). Police involvement in effect risks criminalizing a health issue. He described the frustration police experience in being used as a default responder in crisis because of limited community mental health services. Police often find themselves as sole responders or at best, co-responding with a paramedic and usually without community mental health support. This impression was backed-up by the assistant medical director from St John.

We heard about significant delays to psych assessment and transfer to inpatient beds for those medically cleared from ED. Delay to assessment and treatment is a problem across the District Health Boards. Delay increases the likelihood of a cycle of agitation - sedation - observation - agitation and re-sedation. Consequently, there is an additional delay to transfer or discharge, adding significant distress and placing extra demand on limited ED resources. In short, delays to assessment and treatment are contributing significant further harm. In any other medical or surgical service, these delays would be deemed to be utterly unacceptable.

**“We cannot allow systems failure to become business as usual.”**

**Scott Orman. Emergency Medicine Specialist. ADHB.**

We heard from consumer advocates and users of mental health services in the ED. One of whom related their experience of the care received in addressing the pain associated with a cardiac arrest as opposed to the pain of a mental crisis - the difference between the two separate experiences was stark and disturbing.

## **System Reform: What are the Government’s Next Steps?**

At this time, it is unclear how the Government plans to allocate spending under the Wellbeing Budget. The Government has identified mental health and community wellbeing as a priority. Exactly what this entails remains to be seen.

Collectively, presenters identified significant gaps and challenges in mental health services.

**“We forget the chronically, mentally unwell, are often chronically physically unwell too.”**

**Taimi Allan. CEO, Changing Minds.**

*Broadly, these include:*

1. The need for an appropriately trained workforce.
2. Timely assessment.
3. 24/7 community services of crisis care.
4. Safe spaces in ED.
5. Mental Health staff placed in EDs.

In response to these challenges, presenters shared experiences of effective models of care, innovations in service delivery and structures that addressed the core elements needed to improve emergency care for people in a state of mental health crisis. There was a discussion about the appropriateness and safety of ED clinicians undertaking mental health assessments in some cases to expedite discharge from ED - thereby freeing up psych services to focus on more complex cases. There was a discussion about risk management in this context.



# Moving beyond Pillows and Pills - How do we respond to the increasing number of people presenting to Emergency Departments in a state of mental crisis? cont.

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**“Whose risk are we managing? Our own or our patient’s?”**

**Alain Marcuse. Consultant Psychiatrist. Crisis Resolution Services. CCDHB.**

Discussion followed on what is an acceptable time for a person medically cleared, to wait in an ED for psych assessment and transfer to an inpatient service. Also, what does appropriate follow up by community mental health services look like? Innovations discussed included remote telemedicine psych assessments of people in remote or rural locations. These may diminish travel time and reduce delay to assessment. More extensive use of peer group supporters and mental health advocates in ED may go some way towards de-escalating agitation and bridging understanding between people in crisis and the professionals caring for them. Dedicated areas in EDs for mental health assessments may go some way to addressing the immediate shortfall in community services - but are unlikely to be a long term solution. The ED will remain a less than favourable environment, even if there are physical modifications to meet specific needs, for managing crisis.

## **What now?**

This symposium is the first step in the process of engagement and advocacy. The day concluded with a communique that included immediate priorities for policy, funding and workforce

reforms (3.) In the next six months, ACEM undertakes to develop a Consensus Statement that captures commitments and provide a mandate for systemic actions by the Government. CENNZ will continue to be engaged in this discussion and will continue to advocate for service improvement. Engagement will be an ongoing work that cuts across other projects the College is involved in - such as safe staffing, shorter stays in ED, and addressing violence and aggression in our workplaces.

The systemic challenges identified in the symposium may lie beyond us to address, - out there on the floor, day after day, doing our best in an often messy, chaotic and demanding environment. This symposium is a starting point. Broader conversations need to be had that address the systemic failure to deliver consistent, quality care to people in crisis in EDs and the wider community. However, there are a few simple things that each of us can do to improve the care we give to people presenting in crisis.

Let's change our vernacular. We need to stop referring to people as “Frequent Fliers”, “Attention Seekers”, “Cutters” or any of those other terms we use to minimize the suffering people are experiencing in any moment. Our conversation travels in our departments. We know curtains are not soundproof, but we treat them like they should be. People are hurt overhearing unprofessional talk. Ruth Large, an ED SMO from Thames, gave a moving presentation that you can watch here.

<https://vimeo.com/340605232/20d607547e>

**“It should be Okay to NOT be Okay”.**

**Ruth Large. Emergency Physician, Rural Hospitalist, Clinical Director, Information Services and Virtual Health Care.**

# Moving beyond Pillows and Pills - How do we respond to the increasing number of people presenting to Emergency Departments in a state of mental crisis? cont.

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Let's stop judging suicidality, or the seriousness of an attempt, by the degree of toxicity in an overdose or the mechanism of self-harm. Let's accept that someone presenting in crisis is just that - a person in crisis, regardless of the potential lethality or our preconceived notion of the 'seriousness' of their suicide attempt. Let's resolve not to distinguish between the depth of emotional and physical pain and the urgency in which we should address either - pain is pain. Let's recognize that we are failing Maori and resolve to be open to being guided by Maori in how to do better - even if it challenges us professionally and challenges our world view. Let's re-engage with the compassion that is at the core of nursing by recognising that people in crisis are simply that - people in a crisis. Any one of us or our colleagues could be that person experiencing similar distress.

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Author: Dr Mike Nicholls , Auckland Adult Emergency Department, FACEM

# Workplace Wellbeing in Emergency Departments

## Results of a Wellbeing Survey Undertaken at Auckland City Hospital Emergency Department

*"He who has a why (to live for) can bear almost any how."* Friedrich Nietzsche.

The importance of the wellbeing of emergency department staff is obvious to all who have worked in emergency departments. Experiential understanding is supported by a recent meta-analysis which demonstrates that as well as being important for ourselves, our patients probably receive improved care from those who are not burnt out. (Pangioti, JAMA, 2018) We clearly have a "why".

But what can be done to address workforce wellbeing? What factors are most important, what interventions may make a difference, what is actually doable and can these be measured? "How" can we improve our wellbeing for ourselves, our patients and the health system overall?

Researchers, with support from the multidisciplinary Healthy Workplace Group (HWG) at Auckland City Hospital Adult Emergency Department, sought to identify baseline measures of wellbeing (the extent of the "why") as well as identify what measures may improve wellbeing in their department (the potential "how") for all workgroups. (read the EMA article online) Wellbeing was conceptualised as being influenced by personal resilience, culture of wellness, and workplace efficiency domains. (see figure, adapted from Bohman, NEJM catalyst, August 7 2017)

Despite personal burnout (measured using the Copenhagen Burnout Inventory) reaching 51% among nurses (30% for doctors, and 0% for cleaners), most staff found their work meaningful (81%), felt they had a good work-life balance (74%), and agreed their department was "an excellent place to work" (72%).

What matters most to staff is providing safe, high-quality care for their patients, and team work. Barriers to these included high workload, being understaffed and lack of support within teams and from management.

The HWG has adopted a quality improvement approach to address some of the survey findings. Initiatives include a nurse mentoring program, an information technology improvement program, a mindfulness meditation program, and a "hot" debrief project.

While we can't do everything, there are things we can attempt to improve that may make a small but important difference.

Rather than trying to improve everything, a key principle of quality improvement is identifying what is potentially controllable and focus on what is potentially doable. Another important principle is measuring the effects of interventions, something the research group is attempting.

I would encourage all nurses and ED staff to get involved in their workplace wellbeing and staff support programs. Thinking and acting locally with a multidisciplinary team makes sense.

Figure 1. Reciprocal Domains of Staff Wellbeing



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**Author: Jo King | Chairperson | National Committee of the College Of Emergency Nurses, NZ (CENNZ)**

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# Worksafe NZ: Consultation, Draft Good Practice Guidelines on Violence in Healthcare

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I am submitting this feedback on behalf of the national committee of the College of Emergency Nurses New Zealand (CENNZ).

We acknowledge that the draft guidelines outline many recommendations which constitute best practice in reducing violence and aggression in the workplace; however, as the voice of emergency nursing in New Zealand, we would like to register our disappointment and concerns regarding this draft document.

We do not consider the guidelines are an adequate response to the escalating violence and aggression that is experienced by emergency nurses in their daily practice.

Furthermore, we do not see these guidelines making any immediate impact on the safety of nurses in their current workplaces.

The draft document 'Violence in the Healthcare Industry: guidance for PCBUS' is a guideline with recommendations. What is urgently required is not guidance and recommendations but mandated regulations. The document states that "Work safe New Zealand is the work health and safety regulator" (2.1). As such, we see a critical responsibility to ensure regulation, mandated safety standards, mandated reporting, accountability of employers and robust investigation processes with enforceable outcomes.

- The document discusses - the likelihood of hazards and risks (2.5), identifying potential for violence (3.1) and assessing risks (3.2). The risks in emergency departments have been identified and well documented for a long time. They are multifactorial and relate to overcrowding, patients and families under stress, mental health presentations, alcohol and drug intoxication, concealed weapons and organic illness. There has been no adequate response.
- The document discusses looking at previous violent incidents in an organization and asking about workers' experiences (3.1) to identify risk. These are daily occurrences in our emergency departments, some with

significant consequences that have been reported using official processes. This is supported by evidence and data. There is current research in the New Zealand setting (Richardson et al, 2018). There are escalating numbers of reportable and sentinel events submitted through DHB reporting processes. There is ACC data relating to workplace injuries sustained through violence and aggression and significant media coverage of this issue. There has been no adequate response.

- The document discusses valuing a violence-free workplace (4.2) and the provision of adequately trained staffing. Many emergency departments in NZ do not have dedicated security personnel or only a paucity of security that is not 24 hours a day. Emergency department Charge Nurse Managers are spending large amounts of time advocating for security and writing business cases to DHB executive for adequate security. All emergency departments in NZ report using significant police resources to maintain safety. This situation is untenable.
- The document recommends significant changes to workplace environments (4.3) such as dual exit points in interview rooms, appropriate consult rooms for high risk patients, reduction of noise, staff car parks close to work exits, comfortable waiting areas, appropriate staff rest areas, metal detectors, treatment rooms away from public areas, closed circuit TV (4.3). These are all very ideal recommendations which would require significant rebuilding and restructuring of NZ emergency departments and considerable financial investment. They therefore do not represent the reality of the world of emergency nursing at the coal face of acute care in NZ. These recommendations, while ideal are unlikely to contribute to making the workplace of emergency nurses safer in the immediate future.
- The document discusses client assessment (4.6). Emergency nurses have robust and validated frameworks, such as the New Zealand Mental Health Triage Tool' (CENNZ, 2018), to identify patients who may pose risks



# Worksafe NZ: Consultation, Draft Good Practice Guidelines on Violence in Healthcare cont.

of violence and aggression. Furthermore, we understand the level of security and observation required. However, emergency nurses do not have adequate access to resources to meet best practice guidelines. This has been highlighted for some time, such as on DHB risk registers and reportable/sentinel event reporting. Service gaps include inadequate staffing, inadequate security and the inability to provide dedicated mental health observation in appropriate emergency department spaces. There has been no adequate response.

The College of Emergency Nurses Zealand considers an urgent response to the escalating issues of violence and aggression is critical.

We consider that Work Safe NZ, as the regulator of work health and safety, has a responsibility to ensure safety in emergency departments is immediately actioned as a priority.

We consider best practice initiatives must be actionable, mandated by the regulatory body, they must be enforceable, and there must be organizational accountability with processes that ensure investigation and remedial actions must be taken. Guidelines and recommendations are an inadequate response unless they are underpinned by accountability and authority.

## Recommendations

- Mandatory reporting by emergency staff of all incidents of violence and aggression.
- Mandatory reporting by DHBs of all incidents where staff sustain injuries through violence and aggression in the workplace.

- Mandatory reporting by ACC to Work safe NZ of all injuries sustained by emergency staff.
- Mandated requirements for security staff in emergency departments.
- Mandatory, fully funded training for all emergency nurses such as the 'Management of Actual or Potential Aggression' course (MAPA).
- Mandatory personnel duress alarms for emergency nurses.
- Organizational support and assistance for emergency nurses to pursue criminal charges for incidents of assault.
- Government funded national advertising campaign on violence and aggression in emergency departments. The intent to stimulate both individual and community reflection on this issue to change behaviours.
- Funded research to understand social and community behaviours which suggest a societal normalization of behaving badly in emergency departments.

The College of Emergency Nurses New Zealand is a key stakeholder and a leading authority on violence and aggression in emergency departments. We are very willing to collaborate on initiatives to mitigate the risks to the health and safety of emergency nurses in their workplaces.

## E References

CENNZ (2018). New Zealand Mental Health Triage Tool.

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# Minor Scald Burns in kids

Burn injuries are a common paediatric emergency department (ED) presentation. In the paediatric population most are small (<10%) and scalds are the most common injury mechanism.



## Initial Management

**Cooling:** Cold running water for 20 mins can cool for up to 3hrs post injury.

**Analgesia:** IN Fentanyl (1.5mcg/kg)

- Give Paracetamol & Ibuprofen
- Cover with cling film once cooled.



## Assessment

Burn wound assessment comprises two main areas.

Calculating the depth of the burn + working out your total burn surface area (TBSA).

### Depth

Depth assessment can be difficult. There are helpful tables for this. Fortunately most scald burns in kids are limited to partial thickness.

Suspicion of deep dermal or full thickness burns warrants referral.



### Burn Surface Area

For small or patchy burns use the palmar surface of the patient's hand (from fingertips to wrist) = Approx. 1% of burn surface area  
Do NOT include areas of erythema in your calculation.

## Management (isolated, <10% TBSA)

- Analgesia (see initial management). +/- Continuous Flow Nitrous.
- Check Immunisations. Tetanus status.
- Evidence regarding the management of blisters is limited, but de-roof/ debride if blister/s are large or overlying a joint. Do not debride burns on the palms of hands or soles of feet.
- Dressings that can remain in situ for 3-7 days are recommended for partial thickness burns. Silver based dressings are a good choice, either Acticoat or Aquacel Ag. Tip: Acticoat is great for dressing finger tips
- In Starship ED Aquacel Ag is our primary dressing of choice for burns as it can be left in place until the burn wound has fully healed. See: <https://www.starship.org.nz/guidelines/burns>

Kathryn Johnson NP  
Starship Children's Emergency Department



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# Regional Reports

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

# Northland/Te Taitokerau Region



## Sue Stebbings

Nurse Practitioner

**Emergency Department  
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Kia Ora.

I am writing this on a cold wintry day with thunder, lightning and power cuts - winter weather has arrived to match the calendar. Winter illnesses arrived quite a few weeks ago.

In Whangarei, our lack of appropriate isolation space to assess possible measles presentations has been challenging. The process has changed frequently over the last couple of weeks as numbers

increased while planned renovations to create a small isolation cubicle were brought forward. Most recently there is a portable cabin in the car park nearby for stable presentations.

We are awaiting feedback from the ACEM symposium on mental health in ED. Safety for staff and all patients remains the priority.

Methamphetamine use in the region is reflected in the number of meth-related ED presentations. A more positive aspects are the outcomes coming out of the ED Alcohol and other Drugs screening and brief intervention programme in Whangarei - both with patient and whanau engagement in community support programmes.

Staffing resources are low in both the nursing and medical rosters, exacerbated by winter illnesses. We are grateful for bureau staff and locum cover. Several staff are on leave growing their families or travelling. Submissions to increase staffing levels are underway. If approved, recruitment will be the next step to return to adequately covered shifts.

The Trendcare ED module is on the horizon, with discussions continuing as the HL7 interface is introduced. The aim is to retrieve as much data as possible from EDaAG whiteboard rather than unnecessary duplication and data entry.

There is a review of the triggers and factors leading to ED overload and the actions/processes that are

initiated hospital-wide. The aim is that data feeding from EDaAG can be communicated to flag ED reaching the threshold for levels of overload automatically.

The newly refreshed hospital integrated op centre is working on ward- to-ward transfers so that stable transfers do not come to ED.

The Friends of ED volunteer service has started in April - 2 shifts from noon till 8 pm. This has been much appreciated by patients and staff.

## Rawene

Staff recruitment continues due to people leaving to work overseas. There are plans to send new staff to triage course when rosters and funding can be arranged.

## Kaitaia

They are exploring options for overnight care/admission for people with mental health presentations as the general ward or ED is not appropriate. Subacute services are often full. Overnight there are 3 nurses on shift - 1 in ED and 2 on the ward. Security staff are available 24 hrs a day with improved police access to the hospital after a critical incident overnight.

Access to tele-education via mobile health services has been a helpful strategy for staff professional development that avoids travel out of the area.

## Sue



# Auckland Region



## Natalie Anderson

Registered Nurse

Doctoral Candidate

& Professional Teaching Fellow

**Adult Emergency Department,  
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## Anna-Marie Grace

Nurse Unit Manager

**Children's Emergency  
Department**

**Starship Children's Health**

**Auckland City Hospital**

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As anticipated, patient presentation volumes at Auckland Emergency Department continue to rise. Within a setting of high patient-care workload, our hard-working teams continue to support staff professional development, undertake research and implement numerous initiatives, quality improvements and risk reductions.

Winter seasonal presentations have already proven plentiful, and systems are in place to quickly identify and safely care for patients presenting with symptoms of influenza or measles.

SNOMED, with its uniform triage categorisation, has been implemented and staff have worked to overcome the cognitive and administrative challenges, associated with a new system.

An important programme of facilities refreshment continues across Level 2 at Auckland City Hospital, with careful planning, hoardings and signage ensuring minimal interruption to clinical work, even as sections of our department become construction sites.

Auckland District Health Board is developing a team of specialised health security staff. Readily identified by their distinctive bright green uniforms, they will have training and support for the unique demands of working with clinicians, patients and families in an emergency department.

Our charge nurse group have been working hard to raise awareness of staffing challenges and ensure clear

reporting where these arise. This process is helping to formally identify the impact of key staffing factors - such as sick calls and skill mix, and key workload factors - including patient acuity, public holidays and major events. Emergency departments must deal with a certain amount of unpredictability, and there is no easy-fix for system-wide issues. However, nurses have a critical role advocating for patient safety and need to raise awareness where unsafe staffing occurs.

## Natalie

### AED, CED and Middlemore ED

High winter volumes are impacting overall Hospital and ED capacity. Patients are being seen in the corridors and other spaces.

Auckland Adult ED and Middlemore are continuing to see high volumes in mental health presentations that is putting a huge impact on resources

Both areas have initiated pastoral care programmes with EAP to support the staff with an increase in aggression that is being seen.

Auckland AED and CED, along with Middlemore ED, have been doing some work on nursing staffing models and looking to make this more regional.

Anna-Marie is working on using the staffing discussion outcomes for a national statement on nursing staff for the College of Emergency Nurses New Zealand (CENNZ).

## Anna-Marie

# Midland Region



## Kaidee Hesford

Nurse Manager

**Lakes District Health Board  
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It has been a steady few months throughout the Midland region with numbers on the increase as we head into the cooler months. Recently the ACEM (Australasian College of Emergency Medicine) Winter Symposium was held in Rotorua, this was a very successful conference with large attendances and the content was enlightening, ranging from pre hospital care, pediatrics and a presentation from Christchurch ED on the management of mass casualties.

### Taupo

The new helicopter service in Taupo has already been used several times with great success since now having an Intensive care paramedic permanently rostered to the helicopter. This has helped with transfers out of the department and will be developed further as more training is given.

Security remains an issue due to having no security on site. Staff continue to complete datix forms and this is added to the database regarding unsafe work conditions.

### Waikato

Over the past 5 months the Waikato Emergency Department has been reviewing their Model of Care, this includes looking at processes and models in ED and how they can make changes to promote positive ways of working such as a triage pull model and looking at increased FTE staffing numbers for both nursing and medical (they are awaiting the outcome of this at present).

There has also been a large number of new staff come and join our team which has lead to the increased need of support from our professional development unit in regards to education support particularly in the pediatric area.

Waikato ED have welcomed Kirsty Greaves into a 6 month secondment in ED as our pediatric nurse educator at 0.7 FTE working alongside our existing nurse educator Helen Gavin and they have just announced a 0.3 FTE clinical mentor in the pediatric unit along with 7 day a week cover of clinical mentors throughout the department who will cross cover the pediatric unit outside of the 0.3 FTE pediatric mentor to support the staff on the floor.

Waikato are continuing to work with mental health around patients who present with mental health crisis in ED to ensure they have a streamlined journey through the department, they are also working closely with security and the New Zealand Police around staff safety and continue to ensure our staff are well supported with the fantastic peer support group which was developed in house and has representatives from the MDT in ED.

Waikato are prepping to host the 2019 CENNZ conference in September, which their staff have been working tirelessly on and hope to see you all there.

Fingers crossed winter is nice to us this year and all the winter planning pays off.

**Kaidee**

# Hawkes Bay / Tarawhiti Region



## Paula Draper

Registered Nurse

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Hawkes Bay Regional Hospital**

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Hi everyone from a cold but sunny Hawkes Bay.

Winter is certainly hitting us hard here this year. As usual each winter, the hospital is at capacity, with high acuity patients, and staffing and resources are struggling to meet the demand.

This is especially true for the Emergency Department, which has yet again become the holding area for patients needing admission and complex care. As always, the staff of ED work hard and selflessly to meet the needs of patients. However, this is not without a cost to staff. Staff are physically and emotionally impacted by the ongoing stress of trying to meet the demands of caring in an environment that is under-resourced for the volume and acuity of patients.

Many staff are leaving for a variety of reasons. Many of those leaving have stated they can no longer work in a department that is having a negative impact on their health, well being, and their families.

Although recruitment is actively pursued to fill vacant positions, there is inevitably a delay, which again adds further pressure on staff to cover roster gaps.

Extra nursing staff are now rostered onto the Nightshift, and a further nurse will be rostered to the front of house which continues to be a high-risk area.

However, the department has lost an RN off the afternoon shift to cover the night shift, the dedicated orderly which it had in the afternoon and evening time, as well as the Dedicated Care Associate that was employed for Fast Track and Front of House.

Sadly, staff are also reporting that there has been an increase in violent incidents. Staff no longer have faith in the powers that be who have promised improvements. These promises have been made before but not fulfilled. Recent media reports also highlight similar concerns of the senior medical staff at the DHB of under-resourcing to meet the health demands of Hawkes Bay.

I am sure these issues are not unique to Hawkes Bay, and many of you are facing the same issues.

Balancing the books is, unfortunately, a necessity, but at what price?

Stay safe and well everyone.

**Paula**

# Mid Central Region



## Katie Smith

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

### NZDF

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Emergency Department**

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### Palmerston North Emergency Department

So as winter has only just begun, we have hit our capacity on more than one occasion, and the trend begun long before we hit the winter season. The high acuity presentations, large volumes and an often full hospital continue to place pressure on the ED. We are seeing very high numbers of patients, and have recently set new record high numbers for the dept. A greater VRM response to ED overload has been asked for and initiatives to assist with surge capacity are being considered. Hopefully this will provide some relief with the ongoing pressures of winter, and we will be able to review the data as we continue over the next couple of months.

There are several changes in the Associate Charge Nurse space, as we say goodbye to Margot, who is off to join the Duty Nurse Manager team. We wish you all the best, and can't wait to see the great value you add to the DNM team. We are sure to see you around ED in your new role. Several new ACNs have been appointed into permanent and temporary roles, and we wish the new ACNs all the very best in their new roles.

As always, staffing numbers continue to alter, with staff leaving and new staff being appointed, or returning. Welcome to all the new members of staff, you're all valuable team members, and we are very lucky to have you all.

A warm welcome back to our new SMO Oni Alias - who comes back to us in her new capacity as a FACEM SMO - Oni spent some of

her Registrar years with us, and it is great to welcome her back to the team.

We have continued presence within the dept of our NZDF Nursing colleagues, and welcome them conducting regular clinical shifts.

After the recent renovations to ED, and the redevelopment of our sub-acute area and waiting room, we have seen large numbers streamed through this area, and processes being streamlined for maximum patient care and safety. The RN/CNS/SMO team is working well, and the colour coded system at triage to identify appropriate patients for care in this area is proving successful.

This winter has already proved to provide high acuity patient load and large volumes of presentation numbers into the dept. Staff continue to work extremely hard, and have often worked over time and extra duties to cover roster gaps and a busy dept. This was recently acknowledged in the local newspaper, with one of PN EDs busiest weekends. This is a timely reminder for everyone to look after themselves and each other, and take some time out if you need it.

### Katie

#### Taranaki DHB Emergency Dept

We have been utilising clinical coaches recently to support our new staff, especially with our skill mix being a challenge. This has been well received, and although is only short term while we had vacant Fte, it is a concept we are hoping to continue to better support our new staff in ED.



## Mid Central Region

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We will be trialling a medical assessment unit from 20th May for about 8 weeks, and hoping if this is successful it may be ongoing, and will help with our ED bed block and capacity issues. For the trial the medical assessment unit will be on the medical ward and stable GP medical referrals will be triaged, have lines, bloods and x-rays if needed and go directly to the medical assessment area on the ward.

We are planning the new build for our ED, which is still in the design

stages, but very exciting to be able to start planning our model of care for the new build and getting an idea of what the new ED might look like.

We have a working group including ED admin, clinical co-ordinator, and senior staff nurses, as well as ED doctors who are working with the architects and planners for the new build.

We are seeing record numbers coming through the door, and high acuity patient presentations.

We are also having some staff turnover and delays in recruitment that are making some roster challenges. Winter has definitely arrived!

**Therese Manning – Charge Nurse Manager, ED / TDHB**

**Whanganui DHB**

NIL report available.

**Carla O’Keeffe**

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## 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.**

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You can find guidelines for publication here: [https://www.nzno.org.nz/groups/colleges\\_sections/colleges/college\\_of\\_emergency\\_nurses/journal](https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal)

Alternatively, email and enquire: [mcomeskey@adhb.govt.nz](mailto:mcomeskey@adhb.govt.nz)

# Wellington Region



**Kathryn Wadsworth**

Clinical Nurse Manager

## Acute Services

## Wairarapa District Health Board

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A busy start to the year with some reprieve felt during the RMO strike week here in the Wairarapa although the all or nothing feel was very apparent. The ED was either frantic or empty with very little in between. The messaging from Hutt Emergency Department is that their winter has arrived early with significantly unwell patients and associated challenges filling their department. The same theme comes out of Wellington Emergency Department with them recording their highest presentations over a 24 hour period on the 5th March 2019.

Hutt are very excited to have 1.0 FTE approved for the first Nurse

Practitioner in their Emergency Department. Wellington has also secured 2.0 FTE for the Nurse Practitioner role. Both of these departments have battled tirelessly to achieve these advanced nursing roles and they are excited about showing the value and proving the benefit this will add to departments under pressure coupled with improved patient management.

Staff shortages, sickness, injury and turnover are something that all three Emergency Departments in this region are battling. It is fair to say this goes beyond the Emergency Department and into the wider hospital. Volunteers are now pivotal to the smooth running of our departments and in Hutt their roles are being expanded to move into MAPU, this can only support how valuable this resource is to our services. This group work tirelessly to support our departments for very little recognition but very quickly have become part of the wider team in our ED's.

Following the December event in Hutt's Emergency Department where multiple staff were assaulted and many off work for a significant time period a review was undertaken. This review is yet to be released but when published it will have short and long term recommendations that will undoubtedly have wider hospital ramifications. It is hoped that the learning from this terrible event is spread beyond the isolation of one hospital and shared amongst all Emergency Departments who are equally at risk of this scenario and battle the same issues. Wellington

reports significant security issues with ongoing discussions on how to best address these.

The Wairarapa ED continues to struggle with the effects of inadequate GP coverage and the results of this impinging on the Emergency Departments wait time's which now far exceed reasonable limits. Unfortunately it is the lower triage group who is fairing the worst with this. Like many other departments in the country this exacerbates frustrations resulting in aggression, complaints and poor patient flow but this seems the reality of our environments currently. Increasing population is now being felt and will only worsen over time with huge housing developments happening throughout the Wellington region.

The annual mass casualty exercise in the Wairarapa happened in May with good interest from our wider support networks like Police, Fire and Regional Emergency Management. Due to our isolation it is vital we have a collaborative approach and this has been a challenge to achieve, however some ground is being made both externally and internally of the Wairarapa DHB. A previously identified weak point in the mass casualty plan was the front door triage area and this was made a focus for this exercise with promising improvements made. Another significant project that has had huge success is the training programme developed by our educator aimed at the care of the ventilated patient within the department. This has captured the nursing group that often are nervous and unsure of this

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## Wellington Region Cont.

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task and has provided them with the skills to manage this patient group with some confidence.

Wellington Emergency Department has secured a fixed term position for a research nurse funded through MRINZ that is great news for that department. Many nurses continue on their pathway of post graduate education and with this the benefits are very clear within the department with initiatives being undertaken to improve patient safety, management and flow. It is wonderful to see this advancing nursing workforce and the

benefits they offer to a challenging environment.

The pressures of winter are nearly upon us and many are suggesting that what used to be easily identified as changing pressures as colder weather came our way is not as clearly defined now. This leaves our departments with minimal down time. The need to nurture our new nurses and support our more experienced ones is an ongoing challenge for us all. Our teams turn over quickly which results in additional pressure to continuously

train and mentor those coming in but is a crucial aspect of emergency nursing again supporting advancing nursing roles within our teams.

Fingers crossed for the next round of flu season that is upon us. Knowing that every department essentially faces the same battles there is some solace in the sharing of the challenges, frustrations and concerns.

**Kathryn**

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**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](mailto:mcomeskey@adhb.govt.nz)

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# Top of the South Region



## Jo King

Nurse Practitioner Intern  
(CENNZ Chairperson)

Emergency Department,  
Nelson Hospital

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Greetings from the Top of the South. Winter has arrived and so has influenza which is placing considerable strain on a service already under pressure.

### Nelson Emergency Department

There are many challenges currently facing emergency nursing in this part of the country. The themes are - relentless demand, high complexity and acuity, overcrowding, bed block and inadequate staffing resources to respond to variance. At times it feels like the only tool navigating us through this are the attributes of a very cohesive and resilient team.

Data continues to support the increasing workload of the department. Presentations are up per year, patient minutes in the department continue to rise, deterioration in the 6hr LOS and increasing admission rates. VRM data also demonstrates increasing periods spent in red. In June this year Nelson recorded a 262% increase in Triage 1 patients compared to June 2018. This equated to ED nurses providing 80 hours of 1:1 nursing care while waiting for ICCU beds. The impact of this on ED staffing resources is significant. If there is an upside, it has been all the opportunities for revising, coaching and development of ventilator and critical care skills.

A 10-bed Medical Assessment and Planning Unit (MAPU) officially opened in early July. This should provide some assistance to ED flow. However, at the same time, we have lost our 1745- 0215 nursing shift, 7 days a week. This shift was added to our roster as a result of the Meca / CCDM staffing initiatives. While it was introduced for a temporary

6 month period, it has had a major impact on evening workloads and a reduction in the need for afternoon staff to do overtime. Loosing these 8 hours of nursing per day is certainly a cause for concern. Over the last 2 winters, the department also had a CNS service working Friday - Monday. This has also ceased as it was funded from additional money resulting from the Kaikoura earthquake. Loosing these resources at a time of high winter demand adds to the challenges at the coal face. However, the establishment of a 7 day a week, 1-9.30pm, HCA position has been welcomed.

Improving the care of mental health patients in the emergency department is high on the 'To do' list. It is recognised the clinical risk that is created when we are unable to meet the National MOH standards for observation. Work is ongoing across the region on a triage initiated mental health pathway. The aim is to ensure the correct observation is implemented and documented for triage code and the risk identified. Barriers to implementing this pathway remain the lack of adequate staffing resource, such as health care assistants, to provide observation. The recent Australasian College of Emergency Medicine (ACEM) summit which was held in Wellington was a great first step in moving this discussion forward.

I would like to congratulate Diane Varey, one of our senior staff nurses, who has been appointed as a National Triage Instructor. As well as this Di is our Health & Safety representative and her work in this area should be acknowledged. She has been tireless in advocating for staffing resource and for strategies to



# Top of the South Region Cont.

address violence and aggression and maintain staff and patient safety.

Di is currently involved, with NZNO, in working to achieve a review of department nursing FTE. From all of us, thank you.

## Wairau /Blenheim

The winter respiratory illnesses continue to provide high rates of admissions to the medical and ATR units. Some of the Aged Care residential homes have done a wonderful job with alerts that their facility is in lock down and great infection control measures. Influenza is on-going in the community and public health and the infection control teams are doing a great job, including the flu vaccination clinic for staff. Having the urgent care closely co-located to ED has been a helpful model; however the emergency department continues to see influenza like illnesses and high acuity pts.

Many have required high level care and increased staff resources.

The work of our Nurse practitioners and St John Ambulance, with initiatives such as falls referrals and the clinical desk assistance, has also made a positive contribution to the department.

Daily capacity meetings are held. These provide a regional view and there has been a focus on early discharges and innovated practices just as PJ paralysis day. The CNM/CNCs dressed in their PJs to promote this.

Mental health observation can be challenging and it should be noted that the acute mental health unit is a 2-hour journey to Nelson. A close working relationship with our local mental health team is very helpful.

We have had a spike in natural attrition with several staff leaving but also new staff joining the team.

It is great to see skills brought to the department and skills learnt. We are fortunate that some of our departing team members will continue on in a casual capacity.

Wairau ED is currently fully recruited with no active vacancy. We are looking forward to the clot retrieval capability and our CNE are currently developing a learning package. We have just had Dr James McKay visit Nelson and Wairau and able to join on video link - an amazing and moving account of the day of the Mosque shooting and the trauma preparation.

*Thanks to -*

*Sharon North*

*Charge Nurse Manager*

*ED/HDU/AAU*

*Wairau Hospital department.*

**Jo**

# Canterbury/Westland Region



## Dr Sandra Richardson

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Health Board**

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### Christchurch ED

has been very busy over the past weeks, peaking with a particularly busy day with 327 patients attending. The ongoing high numbers (late 200's to early 300's) together with the increasing acuity and high number of traumas has resulted in a stressful and challenging workload for staff. This has occurred at the same time as we are seeing the impact of the seasonal flu and viruses, impacting staff as well as patients. Looking at the figures for the last quarter, we met the 6 hour target 90% of the time. Of interest, however, over that same period ED occupancy rates - in terms of the number of patients, measured in hours, over the bed/treatment space availability was 898 hours compared to 660 hours in the same quarter of last year. Our numbers and acuity are continuing to increase. Within the region, there are currently 13 rest home positive for influenza like illnesses.

We have continued to run our 'May its not ok' campaign, focussing on incidents of violence and aggression in the ED. We do this to help identify the rates of violence, in a more realistic manner, knowing that we under report, despite staff efforts, because of the stress and time constraints and sat times the sense that it makes no difference. What we do find, is that the targeted months show significantly higher rates of violence, (this year's May - 101 reports) but we know that even these are under reported. We need to demonstrate the reality of what our work environment is like, and acknowledge that this is not acceptable.

Some positive reports - our Kaimahi Hauora Maori / Maori Health worker, Kara Tuhua, has been working with staff at handover and in education sessions to teach Te Reo, with some positive results! We have had a number of staff successfully complete the TNCC course, and also hosted the CAPEN course (Course in Applied Physiology in Emergency Nursing) which will be run in Christchurch again next year. Congratulations to successful students who completed this challenging 2 day course which covers physiologic concepts, aiming to strengthen the critical decision making skills of nurses caring for injured patients. The Christchurch ED students who completed the course were Emily Fielder, Sarah Gallagher, George York, Rachel Fraser, HeeJin Lin, Sarah Keenan, Jill Esser - well done! The ED education team are also developing a team leadership course, and working hard on the orientation modules needed for transition into the new ED build, set for October. We have also seen 4 new CNS appointments, as part of the NP pathway.

### Sandy Richardson, Christchurch ED

### Ashburton ED

Ashburton has been a busy Rural ED, with Influenza increasing our workload and Terminal Clean skills. Snow is on hills and Mt Hutt ski field is open for business, the mountains looking very cold from down here.

We have been reviewing our current patient flow and looking at ways to improve this for both patients, family/whanau and staff. Presently

# Canterbury/Westland Region

we are looking at having 1 or 2 NP's (training in Rural NP roles) to take over care of Triage 4 and 5 after hours, as that is where our problems arise. This has been presented to staff by DON and we are awaiting feedback from staff interested in taking on this role and its associated professional development pathway.

Staff have been attending TNCC and Triage courses, and all have provided positive feedback on this learning. Thank you to the tutors. Ashburton has again employed a NetP nurse in our area and she is enjoying her exposure to many different clinical presentations, and enjoying her learning development. Staffing has been difficult at times due to my staff being seconded to other areas for 6 months, and having to recruit for short term contracts is not always easy. But I have a terrific team of nursing staff and acknowledge the hard work they all do to ensure the smooth running of the department and providing excellent care to our patients.

**Marg Anderson, CNM AAU**

## West Coast ED

We are starting to get busier as winter approaches and flu season hits. There are more complex medical patients requiring more resources due to acuity.

We have had a number of our nurses upskilling with RN Felix Rosaroso recently attending the CAPEN (Course on applied physiology for emergency nursing) which he highly recommends. Two more nurses Emma Walthart and Gian Maturan both successfully passed the Australasian Triage course.

Recruiting for staff continues as we have a number of new mothers and pregnant nurses at present adding to the positions already available.

We are working alongside the Critical Care Unit nurses here developing an education plan which will enable CCU and ED nurses to provide support in each area. This is driven by the nurses on the floor who are keen to learn. They are identifying learning needs towards developing an orientation book. There is a group working together identifying infusions we use for complex patients and ensuring we have protocols which span both areas. This is to prevent confusion as patients are transferred between areas. Complex infusions have traditionally started in CCU due to staffing availability, however as the model of care changes and patient needs changes the process of infusion administration is changing. The hope is to also align infusion protocols with Canterbury as this

is the hospital many of the sick patients are transferred to.

We are working with the Greymouth general medical consultants, Stroke CNS and Neurology services in Christchurch to develop a Telestroke service.

This includes an acute stroke pathway which ensures patients presenting within 4.5 hours with stroke symptoms get a CT immediately. The neurologist is then contacted and using a COW (Computer on Wheels) at the bedside a video link is set up to enable the neurologist to see the neurological assessment as it is completed. The aim is to develop good outcomes for thrombolysis and clot retrieval as appropriate. We are hoping to reduce CT to needle time by utilising the specialist advice of the neurologist.

The hospital rebuild continues and workgroups are now restarting considering the patient flow through the ED. The new model includes an Integrated Family Health Center. This means a patient presenting to ED will be triaged to ED or to the Integrated Family Health Center as appropriate.

Hopefully everyone is keeping warm and avoiding the winter bugs.

Ngā Mihi,

**Jennie Bell, Nurse Practitioner, Acute**

# Southern Region



**Anne O'Gorman**

ACNM

**Southland District Health Board**

**Dunedin Hospital Emergency  
Department**

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## Dunedin

Hello from the deep South (SDHB).

Winter is not coming it has already arrived. Here in Dunedin we have seen an increase of approximate 10 patients per day up on last year. Acuity and length of stay appear to have increased, hence occupancy has been running high. The Variance Response Management system (VRM) we utilise here has certainly reflected that. The duty managers do respond to this and provide extra resource usually nursing staff when appropriate, and staffing allows. Access block has already been

pretty evident and patients have been waiting excessive amounts of time in ED for inpatient beds. This unfortunately has had an increase in the utilisation of inappropriate bed spaces within the department. The triage area has experienced high volumes of patients waiting outside of their triage times adding to clinical risk in this area. The Early Treatment Zone does however help elevate this risk which has seen an increase in its through put.

There has also been an increase in trauma calls and alerts this quarter. Definite increase in helicopter retrievals especially since the introduction of Queenstown's new rescue helicopter service.

Recruitment has been going well with many appropriate applicants to advertised vacancies. Dunedin ED has welcomed 4 new graduate nurses, transitional Registered Nurses as well as experienced Registered Nurses. We have also said farewell to a number of experienced nurses. We wish them well in their new adventures. The increased staff turnover therefore has caused the skill mix in the department to be somewhat of a challenge at times, however a new detailed education framework/template has been put in place as well as a new updated orientation package.

There has also been some movement in the Dunedin Senior Nursing Team. Due to a local baby boom both CNS and ACNM roles have become available. We welcome 2 new ACNM's and 1 CNS to the team. A well-deserved, Janet Andrews (CNM) was also nominated by the ED team for a leadership award for the Otago Nursing Excellence Awards.

The Francis Health consultancy group have been recruited by the SDHB to assist and facilitate new project work. The 'Valuing Patients' Time Programme is certainly gaining momentum with lots of trials that are proving successful.

In ED the focus has been on acute flow and increased efficiency through the department. The project 'Fit 2 Sit' (ambulatory care) continues and is working well. Showing potential for further development.

The trail of Patient Flow coordinator (PFC) is in its early stages but is having a positive impact on flow through the department, expediting discharges both to the ward and home. The PFC is a dedicated Registered Nurse who works closely with the charge nurse managers on the wards and the duty manager to try to unlock any delays. These may include anything from chasing laboratory results and X-rays to coordinating transport for discharge.

A trial of the addition of a Senior Medical Officer to the early treatment area has been commenced. The aim is to increase efficiency and decrease patient's length of stay by earlier decision making at the front door.

We are currently reviewing our Variance Response Management tool indicators that we utilise for volume and acuity in the department prior to oncoming seasonal influx. This will hopefully initiate new actions to assist in times of overload. A capacity and occupancy measurement tool is also being revisited and continues to be a work in progress, giving a more detailed overview of occupancy and capacity at any time within the 24hrs of the day.

# Southern Region Cont.

The ED simulation group have also been busy. They have recently had half of the resource/meeting room turned into a small simulation lab, providing a base for practical teaching sessions. An 'insitu sim' has also been running once a week over the past 6 weeks. It has assisted in providing valuable education and promoting great teamwork with both nursing and medical personnel. The Abbreviated Westmead PTA Scale (A-WPTAS) concussion package and Rivermead Post Concussions assessment have been introduced for mild head injuries and appears to be working well providing better discharge planning for patients.

We have also seen the introduction of the National Early Warning Score system (EWS) after 18 months of preparation it has been launched throughout the hospital as well as ED.

Two papers recently submitted for publications: The Lime Scooter Injury Audit and sports concussion-Pilot study of early return to play following concussion.

Emergency Medicine Curriculum Pilot: the aim of this study is to better understand how emergency medicine knowledge is taught to and learned by registrars at Dunedin Public Hospital. The overarching research question is: What is the impact of an emergency medicine

curriculum for registrars on the knowledge and attitudes learners and teachers? Additional studies include Periosteal Block Study: Randomized Controlled trial comparing Biers Block to Periosteal Block for reduction of distal radius fractures (currently enrolling) And Dunedin ED is participating in a multi-centre observational study of headache - we are currently collecting data.

## Regional

### Queenstown

Exciting and very busy past few months with move into our new ed, still a work in progress with 2nd stage of triage room, waiting room, clinic room and offices due for completion by September. Still getting used to our new environment and it has raised some staffing issues which are being looked at presently. Extra fte given to enable more staffing on weekends which is working well but further additions necessary. One nurse recently attended triage course, one ldh nurse invited to attend EMST in August as an observer which is a great opportunity.

CT scanner now operational on site - fantastic and long awaited - so will likely impact on our transfer

numbers. Number of presentations show consistent growth on last year with another expected busy ski season underway.

Appointment of Jess Dixon as educator has been very well received and we look forward to having Jess here from 17 July to assist with onsite education, orientation of new staff through the E.D. and lots more!

### Oamaru

Currently Oamaru is going through a recent restructure. We are focusing on broadening nursing skills and encouraging Nurses to work in both ED and Ward. Our focus as a rural hospital is to have all staff working at the absolute top of their skill base and able to work autonomously when required. We have just currently recruited 5 RNs with excellent acute experience and 2 fulltime Enrolled Nurses. We are a rural hospital and our future goal is to have all staff work at the top of their skill base delivering excellent patient care. The future for Oamaru Hospital is looking very optimistic and the changes have been difficult for some staff but our ultimate goal is to have an amazing Rural hospital delivering the highest quality of patient care.

### Anne





# College Activities

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# Triage Courses 2019

Please see CENNZ Web page for details:

[https://www.nzno.org.nz/groups/colleges\\_sections/colleges/college\\_of\\_emergency\\_nurses/courses](https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/courses)

Region	Dates	Venue	Closing date for Applications
Christchurch	23/24 August 2019	Manawa Building [Registration 2nd Floor] Health Education & Research Facility 276 Antigua Street, Christchurch	28th June 2019
Waikato	14/15 September 2019	Clinical Skills Centre (under the library) Waikato Hospital Campus, Corner Selwyn and Pembroke Street, Hamilton West	20th July 2019
Wellington	8/9 November 2019	Education Centre, Level 11, Ward Support Block, Wellington Hospital, Riddiford Street, Newtown	12th September 2019

# AENN Study Days 2019

## AENN Study Days 2019 information available here:

[https://www.nzno.org.nz/groups/colleges\\_sections/colleges/college\\_of\\_emergency\\_nurses/resources/advanced\\_emergency\\_nurses\\_network\\_aenn](https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/advanced_emergency_nurses_network_aenn)

Date	Host DHB
Sunday 15 th September	Waikato DHB, Held in conjunction with the CENNZ Conference

## 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](https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal)

Alternatively, email and enquire: [mcomeskey@adhb.govt.nz](mailto:mcomeskey@adhb.govt.nz)

# University of Auckland : NURSING 784 - Advanced Emergency Nursing Practicum

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This course is intended to support emergency nurse specialists as they develop their practice in an advanced nursing role in an emergency department or urgent care setting. It was developed by emergency care medical and nursing clinicians working in the various Auckland emergency departments and a significant number of emergency nurse specialists and nurse practitioners in the Auckland region, and many from further afield have completed this course. Lectures are provided by emergency care clinicians, with learning content focusing on musculo –skeletal injuries and wound care as well as an introduction to management of common emergency paediatric presentations.

The course has previously been offered annually in semester two, running from July to November. In part to shift the paper away from the busy winter months, this paper will next be

offered in Semester One, 2020, with a provisional start date of February 10th 2020. There are five blocks of two days (Mondays and Tuesdays) over the course of four months, with a final exam in early June; that is, ten days in the class room and a final day of examinations.

Students find this a challenging but rewarding course, and an excellent foundation for practice. To enrol in the course you need to have completed NURSING 773 - Advanced Assessment and Clinical Reasoning (or an equivalent course), and you need to be practising in an advanced nursing role.

**If you are interested in this course and would like to know more about it, my e-mail address is:** [lucien.cronin@adhb.govt.nz](mailto:lucien.cronin@adhb.govt.nz)

I'm looking forward to welcoming a new group of students next Summer.

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## Lucien Cronin

Course Coordinator Nursing 784, University of Auckland

Nurse Practitioner, Emergency Departments, Auckland  
and Starship Hospitals.

## 28th College of Emergency Nurses NZ Conference 2019



The 28th annual College of Emergency Nurses Conference 2019 is being held on the 13th and 14th of September in Hamilton at FMG Stadium. Convened this year under the name Kotahitanga with the theme of Compassion and Inclusion we are excited to bring you a full programme that will inform practice and engage all facets of emergency nursing.

Waikato is also host to the AENN Day on the 15th September, to be held at the Clinical Skills Centre, Waikato Hospital. The programme will soon be confirmed and posted on the conference website.

Registrations are now open at: <https://www.regonline.com/builder/site/Default.aspx?EventID=2559974> Looking through this page you will also discover an awards section.

The conference dinner 'Night at the Oscars' will be an event not to miss with a chance for delegates to recognise individuals and departments for their outstanding achievements in Emergency Nursing with an awards evening. We look forward to receiving your nominations.

You can also find us on Facebook where we have regular updates and speaker information. Find us at @CENNZConf2019 and have a look for the post that gets you in the draw to win a registration on us.

We look forward to welcoming you to the College of Emergency Nurses Conference 2019 in Hamilton.





## (CNM) Forum

# National Charge Nurse Manager (CNM) Forum

On March 15 2019, twenty four CNMs from Auckland to Dunedin gathered in Wellington, with the aim of being updated on national perspectives, discussing issues common to us all, learning from each other and networking.

We began by each naming our top 2 issues, which showed very similar concerns: overall the top 4 were flow, staff fatigue, inadequate FTE and security.

The College of Emergency Nurses (CENNZ) updated us on the work they are doing, then Bridget Smith, Director of Care Capacity Demand Management (CCDM), gave us an update on CCDM as it related to ED. It was highlighted that the absence of a valid Trendcare (TC) module for emergency nursing is a constraining factor on our ability to make ED nursing work visible to the wider organization for FTE recalculations. The CNM meeting recommended to CENNZ that they liaise with CCDM to establish business rules for TC in EDs, and look at piloting TC in a range of different EDs with FTE support.

Sophia Faure, senior advisor for acute demand at the Ministry of Health (MOH), updated us on the government's priorities and showed us performance data from the different DHBs.

We then collectively looked at the actions required for the 2019 MOH annual plan. We considered strategies to improve Maori patient experience, management of patients with long-term conditions, and patient flow.

We devoted an entire session to management of patients requiring mental health and addiction services. A panel of Anne-Marie Pickering from Auckland, myself from Nelson and Margaret Anderson from Ashburton presented metropolitan, regional and rural ED perspectives, followed by discussion.



Group Photo: Anna-Marie Grace

Jane Bodkin and Nicky Mulholland from the Office of the Chief Nurse came to answer questions around workforce and funding. The inequity in post-graduate funding between medicine and nursing was highlighted.

Finally we broke into metropolitan, regional and rural groupings to discuss initiatives and solutions relative to our different contexts.

Anne Esson was a co-facilitator however returned early due to the terrorist attacks in Christchurch. The last sessions of the meeting were fairly subdued.

Thanks to CENNZ for sponsoring this very valuable day.

Sharon Scott | CNM Nelson ED, co-facilitator

# Snippets Winter 2019

## **Emergency department care for patients with mental health problems, a longitudinal registry study and a before and after intervention study.**

**International Emergency Nursing. 2019 Feb 25.**

This study describes the numbers and length of stay (LOS) of patients with mental health problems at a Dutch emergency department and the effect of a psychiatric intervention team on patient flow.

<https://www.ncbi.nlm.nih.gov/pubmed/30819584>

## **Common emergency department presenting complaints of prisoners: A systematic review.**

**EMA: Emergency Medicine Australasia. April 2019.**

Prisoners are a particularly vulnerable minority group whose healthcare needs and management differ substantially from the general population. The overall burden of disease of prisoners is well documented; however, little is known regarding the aetiology and frequency of prisoners' acute medical complaints requiring an ED visit. Objectives of the review were to identify, review and appraise existing literature regarding prisoners' presentations to EDs.

<https://onlinelibrary.wiley.com/doi/10.1111/1742-6723.13161>

## **Safe to send home? Discharge risk assessment in the emergency department.**

**EMA: Emergency Medicine Australasia. April 2019.**

If risk is the probability of suffering harm, safety is reduced exposure to risk. In general, physicians are more risk averse than patients, and equate risk reduction with hospital admission. This is especially powerful for emergency physicians – we transfer risk to inpatient teams by admitting the patient, whereas we accept risk ourselves in discharging. Discharging a patient to outpatient care has risks of inadequate social,

medical and physical support at home. This risk is not minimal – inadequate supervision for the cognitively impaired or an unsafe environment can cause falls, worsening of illness, or death. Almost one-third of older adults will experience an adverse outcome (ED revisit, subsequent hospital admission, admission to a long-term care facility or death) within 3 months of the ED visit.

<https://onlinelibrary.wiley.com/doi/10.1111/1742-6723.13250>

## **The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand – a decomposition analysis.**

**New Zealand Medical Journal. 2019.**

Using New Zealand death registration and population data from 2013 through 2015, these researchers assessed life expectancy differentials associated with potentially avoidable causes of death within Māori and Pacific populations when compared to the non-Māori/non-Pacific population. As the study researchers explain, avoidable mortality can be used as a measure of how effectively healthcare, health and social policy are contributing to population health and health equity, by how many premature deaths occur from certain conditions and in the presence of timely, effective and equitable healthcare or other appropriate interventions. In each of the three target study populations, much higher proportions of all deaths were attributed to potentially avoidable causes of death among Māori (53.0%) and Pacific peoples (47.3%) than among non-Māori/non-Pacific populations (23.2%). Conditions considered to be both preventable and amenable made the greatest contribution to the life expectancy differentials within both Māori and Pacific groups, compared with non-Māori/non-Pacific. Within Māori males and females, trachea, bronchus and lung cancers accounted for 0.8 and 0.9 years of the life expectancy differential, respectively. Avoidable injuries including suicide contributed as much as 1.0 year to the differential in Māori males. Coronary disease, diabetes and cerebrovascular disease were large contributors to the differential in both Pacific males and females.

# Snippets Winter 2019 Cont.

## **HEART Score Risk Stratification of Low-Risk Chest Pain Patients in the Emergency Department: A Systematic Review and Meta-Analysis.**

**Annals of Emergency Medicine . 2019**

The objectives of this systematic review and meta-analysis are to appraise the evidence in regard to the diagnostic accuracy of a low-risk History, ECG, Age, Risk Factors, and Troponin (HEART) score for prediction of major adverse cardiac events in emergency department (ED) patients. These included 4 subgroup analyses: by geographic region, the use of a modified low-risk HEART score (traditional HEART score [0 to 3] in addition to negative troponin results), using conventional versus high-sensitivity troponin assays in the HEART score, and a comparison of different post-ED-discharge patient follow-up intervals.

The study employed 25 studies published from 2010 to 2017, with a total of 25,266 patients included in the final meta-analysis.

<https://www.ncbi.nlm.nih.gov/pubmed/30718010>

## **Treatment of Superficial Vein Thrombosis: A Systematic Review and Meta-Analysis.**

**Thrombosis Haemostasis. 2019**

The optimal first line treatment for patients with isolated superficial venous thrombosis (SVT) of the lower extremity is unknown. This article reports estimates of the rate of venous thromboembolic complications among patients with SVT according to treatment. A systematic review and meta-analysis was performed. Seventeen articles, including 6,862 patients, were included in the meta-analysis. The primary outcome was the occurrence of deep vein thrombosis (DVT) or pulmonary embolism (PE) during the study follow-up period.

An interested reader may wish to review the SVT case study in the previous edition of Emergency Nurse NZ.

<https://www.ncbi.nlm.nih.gov/pubmed/30716777>

## **Prehospital Analgesia with Intranasal Ketamine (PAIN-K): A Randomized Double-Blind Trial in Adults.**

**Annals of Emergency Medicine. 2019**

This study compares intranasal ketamine with intranasal placebo in providing pain reduction at 30 minutes when added to usual paramedic care with nitrous oxide.

The study method employed was a randomized double-blind study of out-of-hospital patients with acute pain who reported a verbal numeric rating scale (VNRS) pain score greater than or equal to 5. One hundred twenty subjects were enrolled. The authors conclude, added to nitrous oxide, intranasal ketamine provides clinically significant pain reduction and improved comfort compared with intranasal placebo, with more minor adverse events

<https://www.ncbi.nlm.nih.gov/pubmed/30926189>

## **Point-of-care ultrasound for the diagnosis of shoulder dislocation: A systematic review and meta-analysis.**

**American Journal of Emergency Medicine. 2019**

Shoulder dislocations are a common injury causing patients to present to the emergency department. Point-of-care ultrasound (POCUS) has the potential to reduce time, radiation exposure, and healthcare costs among patients presenting with shoulder dislocations. We performed this systematic review and meta-analysis to determine the diagnostic accuracy of ultrasound compared with plain radiography in the assessment of shoulder dislocations. The study concludes that POCUS is highly sensitive and specific for the identification of shoulder dislocations and reductions, as well as associated fractures.

<https://www.ncbi.nlm.nih.gov/pubmed/30797607>

# Snippets Winter 2019 Cont.

## **The incidence and risk factors of dog bite injuries requiring hospitalisation in New Zealand.**

**NZ Medical Journal. 2019**

Figures from the Accident Compensation Corporation (ACC) show that there were 99,003 claims for dog-related injuries in New Zealand during the period 1 July 2005 to 30 June 2014.<sup>13</sup> However, rates of dog bite injuries requiring hospitalisation in New Zealand have not been monitored since a study by Marsh et al in 2004.<sup>14</sup> This study aims to describe the incidence of dog bite injuries requiring hospitalisation in New Zealand between July 2004 and June 2014. The authors have found that the rate of people being admitted to hospital in New Zealand with a dog bite injury is high. Children under the age of 10 years are most at risk as are Māori, males and those from areas with a higher deprivation score. We are highlighting an on-going and growing public health issue to prompt meaningful conversation and action to reduce this preventable and devastating injury.

<https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2019/vol-132-no-1494-3-may-2019/7865>

## **A systematic review examining the impact of redirecting low-acuity patients seeking emergency department care: is the juice worth the squeeze?**

**Emergency Medical Journal. 2018**

Diverting patients away from the emergency department (ED) has been proposed as a solution for mitigating overcrowding. This systematic review examined the impact of interventions designed to either bypass the ED or direct patients to other alternative care after ED presentation.

The study concludes there was no conclusive evidence regarding the impact of diversion strategies on ED utilisation and subsequent healthcare utilisation.

<https://www.ncbi.nlm.nih.gov/pubmed/30510034>

## **Nurse-Initiated Acute Stroke Care in Emergency Departments.**

**Stroke. 2019**

The study aimed to evaluate the effectiveness of an intervention to improve triage, treatment, and transfer for patients with acute stroke admitted to the emergency department (ED). Methods- A pragmatic, blinded, multi center, parallel group, cluster randomized controlled trial was conducted between July 2013 and September 2016 in 26 Australian EDs with stroke units and tPA (tissue-type plasminogen activator) protocols.

<https://www.ahajournals.org/doi/10.1161/STROKEAHA.118.020701>



# Treatment of moderate to severe cellulitis in the home with once daily IV ceftriaxone after discharge from the Children's Emergency Department

Danielle Naylor

Children's Emergency Department, Starship Children's Hospital, Auckland, New Zealand

## Background

Cellulitis is a common presentation to Paediatric Emergency Departments and children with moderate to severe cellulitis frequently get admitted to hospital for intravenous (IV) antibiotics. Adults in contrast can often be treated under a Primary Options for Acute Care (POAC) scheme in the community. A well-documented barrier for the same practice to occur in the community with paediatrics has been level of skill with obtaining IV access (Ibrahim, Hopper, Babi & Bryant, 2016).

In 2017, the Children's Emergency Department (CED) at Starship introduced a new pathway to treat these children with IV antibiotics in an outpatient-based program. Utilizing the benefits of once daily dosing of IV Ceftriaxone, patients were given the first dose in the Emergency Department and the next 2 doses in the community by the home care nurses. This would be followed by a 4 day course of oral Cephalexin to complete a 7 day course of antibiotics in total. Any deterioration identified by the families or home care nurses would result in a return to the Emergency Department for review.

## Included Patients

- Patients aged 3 months to 14 years 11 months
- Moderate to severe cellulitis requiring IV antibiotics
- Systemically well

## Excluded Patients

- Orbital cellulitis
- Age <3months
- Abscess needing I+D (Unless I+D is completed in CED)
- Complex wound requiring further management
- Co-morbidities or immunosuppression
- Associated FB
- Associated fracture
- Underlying soft tissue malformation
- Lymphoedema
- Allergy to Ceftriaxone
- Families address/geographical location, not suitable for Homecare nurse review
- Overlying a joint

## Benefits/outcomes

### Benefits to the DHB

- Reduced admission rates
- Reduced costs
- Decreased risk of hospital acquired infections
- Decreased use of hospital resources

### Benefits to the families

- Reduced costs for families (time off work/hospital car park fees etc)
- Patient satisfaction and comfort
- Decreased risk of hospital acquired infections
- Better psychologically and physically for the patients
- Better psychologically for the families
- Less disruption to family life and activities of daily living

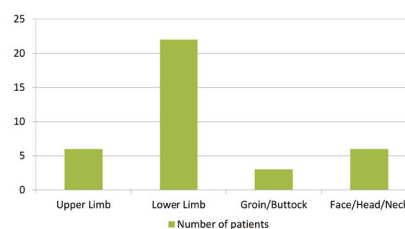
## Patient Feedback

"Our daughter came in with cellulitis ...and was able to come home that day through the new cellulitis pathway. It was such an amazing service for our family of 5! We have a 20 month old who is still breast feeding, a 4 year old (the patient) and a 6 year old. The opportunity for the 4 year old to come home and see a nurse in the home for 2 days of IV antibiotics was really a god send for her and the whole family. Thank you so much for creating such a fantastic service and for allowing us to be one of the first to use it. What amazing care!" Parent (February 2017)

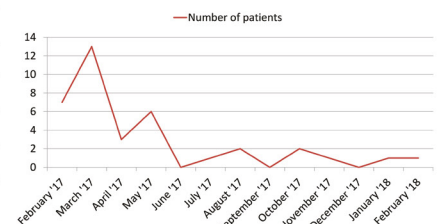
## Results/outcomes

In a 12 month period 37 patients were discharged on the Cellulitis Pathway, with seasonal variances in numbers (higher numbers in summer). Of the 37, 9 patients returned to ED for review with only 3 of those requiring admission to hospital for treatment with a different IV antibiotic. One developed an abscess and the other 2 had worsening cellulitis. There were no issues in this 12 month period with the IV leurs coming out or developing phlebitis. There were a variety of age groups on the pathway but the majority was aged between 1-10 years (28/37). The most common area of the body affected was the lower limb (22/37), and more than half (18/37) of the patients treated with this pathway were NZ European, European and Other European.

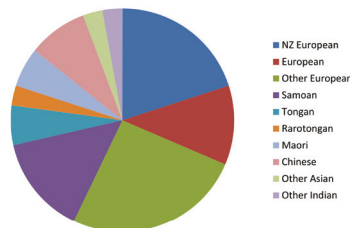
### Area of cellulitis



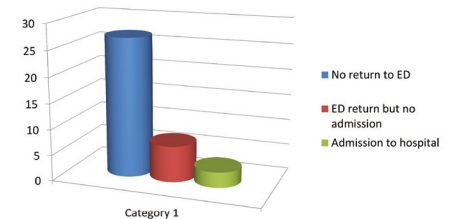
### Monthly Numbers Treated



### Ethnicity



### Return Rates



## Conclusion

In the last 12 months, following the introduction of this pathway, we had a significant reduction in admissions for patients presenting with moderate to severe cellulitis who were systemically well. The implications for this in the current fiscally driven environment include the savings of a 2 day hospital stay and all the related costs. In our experience, the treatment with once daily Ceftriaxone was effective and safe with none of the 37 patients going on to develop sepsis. Families had less disruption to their daily routine, which in turn improved patient and family satisfaction. Due to the positive feedback received from both families and the multi-disciplinary team this pathway has become an on-going change in practice within the Children's Emergency Department with plans to continue auditing and identifying ways the pathway can be improved and updated over time.

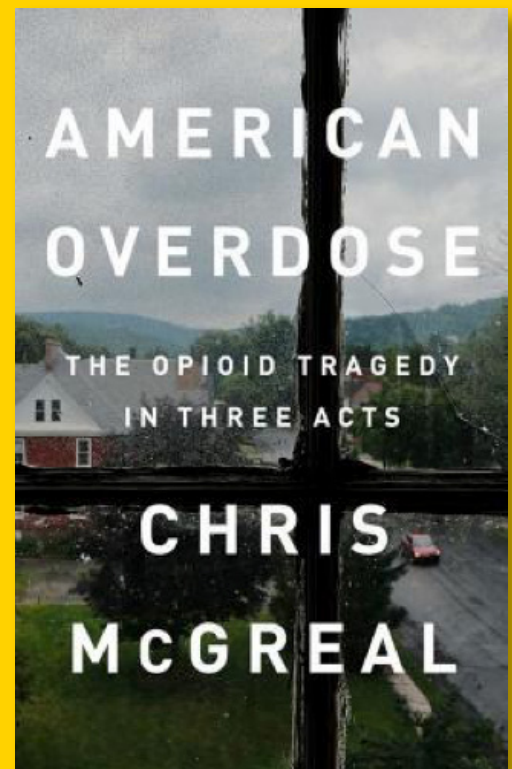
### References

Ibrahim, L. F., Hopper, S. M., Babi, F. E. and Bryant, P. A. (2016). Who Can Have Parenteral Antibiotics at Home?: A Prospective Observational Study in Children with Moderate/Severe Cellulitis, *Pediatr Infect Dis J*, (35), 269-274



# What are you looking at?

## Book Review. American Overdose: The Opioid Tragedy in Three Acts. Chris McGreal. Publisher: Public Affairs. 2018.



The author Chris McGreal takes a dispassionate look at how over ten years some 350,000 Americans died of opioid overdoses. Let that number sink in for a moment and consider many of those who died were prescribed the drugs that killed them. In the same time, Americans consumed 80% of the world's pharmaceutical opioid supply. Politicians and the media describe this ongoing situation as an epidemic or crisis. The book's author, Chris McGreal, perhaps more accurately calls it a tragedy. In examining the causes of this ongoing event, the narrative of the book could be characterized as an exploration of unintended consequences.

Up until the early 1990s opioid prescribing in the US had been restricted by federal legislation administered by several US federal agencies. Some palliative care physicians expressed concern that their patients and those suffering chronic pain were being under-medicated because of overly restrictive regulation governing prescribing. In response to this, Purdue Pharma, a drug manufacturer, saw an opportunity to extend opioid sales. On the back of some highly dubious research, they manufactured and aggressively marketed to GPs and specialists, a slow release oxycodone formulation: Oxycontin as a safe drug, not addictive, fit for regular, long term use to address chronic pain. At the same time, the US Government took an increasingly hands-off approach to drug regulation. Consequently, the FDA (Federal Drug Administration) became increasingly reliant on Purdue's own seriously flawed drug trials in regulating opioid distribution. Oxycontin proved to be very effective at removing pain – the problem was it was also highly addictive and was being prescribed not just for palliative patients, but for just about any pain condition.

Very early in the process of marketing Oxycontin, Purdue targeted low-income economic areas where there was a higher likelihood of people living with chronic pain associated with manual occupations, coupled with poor access to rehab services like physio. McGreal's research focuses on the town of Williamson, West Virginia, (pop. 3191), in the heart of the Appalachian foothills as one such community. Typical of many surrounding towns, Williamson is described as a poor, rural, coal mining town with high unemployment. Despite having a small resident population, in just ten years, a staggering 20 million prescriptions for opioids were dispensed from Williamson's numerous pharmacies and 'Pain Clinics'. Opioid dispensing quickly became the biggest money earner in town. One such high turn-over GP practice, or pill-mill, was set-up by a former male escort, convict and con man who recruited doctors he had met in jail to write prescriptions for patients they barely had time to examine but for who they were comfortable writing scripts for large quantities of Oxycontin. Meanwhile, the local police turned a blind eye to car park drug dealing and overdoses in nearby streets. The events in Williamson could be a plot for a novel – but tragically this is all true.

The tragedy that occurred in Williamson was repeated in poor communities right across Middle and Southern America. Very soon, there were reports of misuse and addiction associated with Oxycontin across the US. The high dose, slow release opioid tablets could be crushed, snorted or injected with devastating effect. The FDA and Purdue initially ignored warning signs from primary care and ED settings that Oxycontin was abused on a large scale in their pursuit of profit.

# What are you looking at?

## Book Review Continued.

McGreal describes numerous communities and individuals, corrupted by addiction and the easy money made. This corruption extended from the corporate level to individual users, to physicians, lawmakers, federal and state regulatory bodies. By the late 2010s, kids were dying in wealthier communities across the US. The issue became too big to ignore. The pill-mills were shut down. Again, the unintended consequences of this action caused havoc. Supply of prescription opioids was restricted without any significant, corresponding increase in rehab services. The result was an addicted community of prescription drug users having to maintain their addiction illegally. This ready-made market was now supplied with high potency fentanyl and heroin manufactured off-shore and imported into the US illegally. Mortality from drug overdoses skyrocketed. Street sourced, highly concentrated fentanyl varies in potency, leading users to overdose easily. First responders and EDs were initially overwhelmed. Internationally, naloxone supplies came close to being exhausted. In a cynical response, the same opioid manufacturers saw a business opportunity in this misery and ramped up naloxone production while continuing to produce new versions of potent slow release opioids under new names and branding.

Donald Trump stepped into this mess of federal inaction during his presidential campaign in 2016, promising to address the issue if he was installed in office. Subsequently, he captured the vote of the white, working, poor in Middle America and delivered formerly solid Democrat voting Pennsylvania and Virginia, - 'ground zero' of this tragedy - to his Republican

Party. Arguably, this gave him an edge which won him the White House in a very narrow margin over Hilary Clinton. President Trump subsequently appointed his son-in-law Jared Kushner to address the 'opioid crisis' that has rumbled on, mostly unaddressed in any meaningful way ever since.

The book ends at mid-2018 without much hope for resolution beyond individual communities and primary health providers resourcing efforts at rehab on their own. Purdue and other manufacturers have been fined millions and are faced with numerous court cases - but they remain sitting comfortably on turn-over totalling billions and are still manufacturing and marketing oxycodone and other versions of high potency, slow release opioids.

In all, this book is a thoughtful and thorough examination of the history of this tragedy to date and the greed that powers it. I do not think we can feel too smug thinking the same sort of thing could never happen here in Aotearoa. The lesson in this book is not so much about the cynical practice of some drug manufacturers, but the unintended consequences of up-ending established norms of medical practice based on inadequate evidence. New Zealand's Parliament is currently considering some potentially significant changes in legislation related to end-of-life care and marijuana reform. This book is a sobering example of what can happen when the Government decides - with the best intentions - to de-regulate areas of established medical practice and drug use without considering the broader consequences.

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# Social Media Update

The CENNZ website has had a small re-vamp recently, with the addition of buttons to the landing page, and easy to find pictures with appropriate links to the most useful pages on the site.

We have removed some content that was old or out of date, so hopefully making the website more user friendly and easier to navigate. Feedback is always welcome, so drop by and have a look.

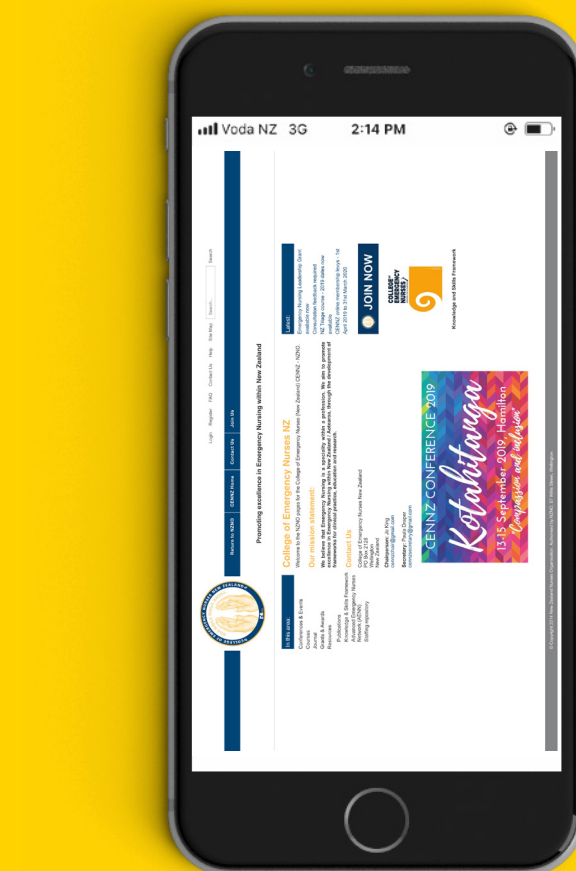
Also on the landing page you will find opportunities for training/grant applications etc and these have easy to see thumbnails.

The social media accounts have seen an influx in followers over the last few months, and hopefully you have noticed some useful information, posts and evidence-based medicine popping up on both the Facebook group and twitter page.

The closed Facebook group is available for CENNZ members to join, and the intent is to post regular practice updates/information and educational posts here. Currently the group is at 240 members. We also have a generic Facebook page, where basic information is shared, and people can link onto the website, the Facebook group or the twitter page. The current Facebook user name is @NursingCENNZ. Updates and reminders around membership and conferences and educational opportunities such as the leadership grant are also linked through here.

Twitter is an interesting beast, and as a non-tweeter generally, this is something that I am getting used to using, so this has been a little sporadic! However, thanks to people much cleverer than I, there is always a volume of education and information to be re-tweeted.

Feel free to follow @NursingCENNZ for Twitter too. Currently we have 105 followers to the account, and I aim to try and tweet things of interest to emergency nursing, emergency medicine, or any practice updates and discussions that are relevant to our practice and current environments.



As always, feedback is encouraged on how to make these platforms user friendly, and anything specifically you would like to see covered or included, let me know. These are your opportunities to network, and reach information and education in a way that works for you, so we are here to support your social media addiction. It's great to see how many people are currently interacting with these platforms, thanks for your support with this!

**Katie Smith**

# EMERGENCY NURSE NEW ZEALAND

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