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In this issue

Editorial Information

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Dr. Sandra Richardson:
Nurse Researcher, Emergency Department, Christchurch Hospital, Waitaha Canterbury, Te Whatu Ora Health New Zealand.

Email: editor.cennzjournal@gmail.com

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Design / Production:

Sean McGarry
Phone: 029 381 8724 | Email: seanrmcgarry@gmail.com

Editorial

Dr Sandra Richardson
Editor | Emergency Nurse NZ

Highlighting the humanitarian work of nurses.

We have been highlighting the work of nurses' during natural disasters in the last edition of the journal, and the work of nurses' as humanitarian responders in this edition. Nurses are capable and committed to meeting the needs of others, whatever the nature of the crisis they are faced with. As a profession, we have a reputation for stepping up, finding solutions, and 'being there' for others. I think you will be motivated to read the work of ED nurses such as Raechel Keepa and Bronnie McBain, who have combined their passion for emergency nursing with a desire to make a difference on the wider stage of international health care.

As each seeks to address issues of health care inequality by contributing in practical ways, volunteering on humanitarian missions and raising awareness of the needs in the Pacific and disaster zones, we can be proud of the contribution of kiwi nurses. We can also look to the contribution of nurses such as Dr Doug King, working in international research spaces, addressing trauma needs and presenting in this volume of the journal his work together with Dr Alan Pearce as part of a team focussing on traumatic brain injuries and management of concussion. It is apparent that the range of crises experienced by ED nurses is both broad and complex to define. To those outside of the ED world, disaster nursing, mass casualty situations and trauma are often the situations that come to mind when defining ED crises. Yet for those working within the emergency and urgent care fields, many will identify the more 'mundane' and apparently low key situations as the most challenging and disturbing. The recognition of the challenges faced by everyday people in overcoming disabilities and chronic illness, the fear seen in the faces of elderly who realise this visit to ED may signal the end of their independence and loss of their home as they face moving into care.

As we struggle with the growing poverty in Aotearoa New Zealand, we are increasingly confronted with issues of inequality, lack of access to what should be basic health services, and growing concerns over our ability to provide safe and compassionate care. It is not only those in identified war zones, lower income or poorly resourced countries who need our support.

Aotearoa New Zealand is also facing a series of disturbing crises. We see our health system under threat, the standard of care we have upheld being challenged, our infrastructure no longer fit for purpose. The foundation of our society, Te Tiriti o Waitangi and the resurgence of Te Ao Māori which was slowly making inroads in health disparities is increasingly being undermined. For many, the growing loss of a cohesive health system, the inability to provide safe and consistent levels of staffing in our EDs, has led to a crisis in confidence. For ED nurses, this is evident in the fear that patients may die under our watch. For patients and whanau, there is a fear that our system, our EDs are no longer safe, and that they do not want to add to the burden of a broken system. We need to remind ourselves, and the wider public, that we remain humanitarians. We are here to provide the best possible care, and that our EDs are the right place to come when you are in need of urgent assistance. We need to focus on providing compassionate and motivated care and responding with the same sense of urgency.

I orea te tuatara ka patu ki waho.

A problem is solved by continuing to find solutions.

Sandy

Articles, Case Studies and Practice Reflections

It's more than a head knock. Getting seriousness about concussion in emergency departments.

Authors: Doug A King PhD[3], BN, CNS (Emergency)[a,b,c] | Alan J Peace PhD[d*]

[a] Emergency Department, Te Whatu Ora Capital, Coast and Hutt Valley, Lower Hutt, New Zealand

[b] Auckland Bioengineering Institute, The University of Auckland, Auckland, New Zealand

[c] Traumatic Brain injury Network (TBIN), Auckland University of Technology, Auckland, New Zealand d School of Health Science, Swinburne University, Melbourne, Victoria, Australia

***Corresponding Author**

Alan J Pearce PhD Swinburne University Burwood Road, Hawthorn Victoria, AUSTRALIA, 3122 apearce1@swin.edu.au

Doug King: ORCID ID: 0000-0003-0135-0937

Alan Pearce: ORCID ID: 0000-0002-9264-9880

Abstract

Attention and awareness regarding concussion injury in New Zealand has notably increased in the last decade. While most of this increase is due to discussion regarding concussions from sporting endeavours, the majority of concussions are from non-sport environments including motor vehicle crashes, workplace incidents, falls, accidents, assault and intimate partner violence. In most of these cases, hospital Emergency Departments (ED's) are often the first point of contact. As argued in our Opinion here, there are concerns regarding the consistency of concussion care protocols between hospitals, advice given to patients, and lack of follow up education and management after discharge. Our Opinion is to provide a constructive discussion as well as suggestions on long-term improvements. Finally, we provide some recommendations that could be implemented immediately to improve clinical practice for presentations of concussion injuries in ED's.

Keywords:

Brain concussion, clinical decision-making, diagnosis, patient outcome assessment, research priorities.

In February 2024, the Accident Compensation Corporation (ACC) announced national concussion recommendations for community sports providing consistency in the recognition and treating concussion that involved a 21-day rest period followed by medical clearance to return to sport. This decision is positive and has contributed to increased awareness about concussion throughout the wider sporting community. However, these standards are only specific to sports-related concussion played at the community

It's more than a head knock. Getting seriousness about concussion in emergency departments. cont.

levels of participation. Despite ongoing media headlines regarding concussion and repetitive neurotrauma increasing risks of chronic traumatic encephalopathy (CTE), concussions and mild traumatic brain injuries (mTBIs) in sport only account for between 5–20% of all injuries (Finch et al., 2013; Hon et al., 2019; King et al., 2019). The majority of concussions results from motor vehicle accidents, workplace incidents, falls, assaults, and intimate partner violence.

Concussions are an under-identified injury with a recent report suggesting 88% of concussions go unrecognised and/or unreported (Hon et al., 2019). Available data on TBIs, estimated from hospital admissions, suggest that 80-90% of TBI cases presented to emergency departments (ED's) are mild TBI (mTBI)/concussion (Finch et al., 2013). Consequently, nursing staff (along with doctors) in ED's are the initial point of contact, and in many cases if not all, the only clinical management provider for concussed patients throughout their recovery (Koval et al., 2020). However, missed diagnoses are a well described and recognised problem in the ED settings due to a lack of specific education, and no universal standard of clinical practice guidelines (Pearce et al., 2024; Rowe et al., 2018b). In this Opinion we will contend that consistent clinical ED guidelines for nurses and doctors are required across all New Zealand hospitals for concussion diagnosis, management, and follow-up. Further, we opine that concussion education should be included in approved professional development and ongoing education programmes.

With continuing international media attention on concussion, awareness and understanding regarding short- and long-term effects of concussions has increased notably in New Zealand, and this increased awareness around concussion is positively changing attitudes. Certainly with the evidence linking concussion injuries with mental illness (Topolovec-Vranic et al., 2015), and the global concerns of risks of CTE with repetitive neurotrauma (Nowinski et al., 2022), the stigma attached to concussion that was once seen as an individual showing "weakness", being laughed at after stagging around following a concussion, or concern over nothing more than a "head knock", is now much less diminished. Concussion is now no longer joked about or downplayed.

However, this increase in awareness and concern has been attached towards the so-called 'sport- related concussion' and has somehow differentiated the injury, as being 'less-severe' to concussions experienced in non-sport environments (Maddocks & Saling, 1996). The forces involved in sport- related concussion have been considered 'less severe' than those observed in other forms of head trauma where the term 'concussion' is used (Maddocks & Saling, 1996). Despite this, international consensus guidelines (*Centres for Disease Control and Prevention. Heads Up*, 2022; Patricios et al., 2023) outlining the evaluation and management of sport-related concussion have become default for all concussion injuries. With this 'downgrading' of concussion as something of a recreational injury, it is not surprising that there is an increased risk of missed, or misdiagnosis of, concussion. International studies have reported that challenges faced by ED's result in ~56% of patients who met the criteria for a concussion not receive a diagnosis of concussion (Powell et al., 2008; Rowe et al., 2018a). In a recent New Zealand study reporting on intimate partner violence and traumatic brain injuries, it was reported that only 0.8% underwent an assessment for concussion and 0.5% were referred for further treatment (King et al., 2023). In another American study (Koval et al., 2020) it was reported less than 50% of injured patients presenting to an ED were concurrently evaluated for concussion. Of these, only 37% were diagnosed with concussion. Further, discharge concussion education was provided to only 15% of these patients who received the diagnosis of concussion.

Clinical care and management practice disparities have also been observed between hospitals (Stern et al., 2017). Anecdotally, it is not uncommon to hear that a concussed patient in one hospital will receive a completely different protocol of assessment and care to another similarly level hospital. In Australia, the recent *Federal Parliament Senate Inquiry into Sports-Related Concussion and Repeated Brain Trauma* highlighted many of these concerns from patients who experienced multiple concussion injuries. The lived experience of these people at the Inquiry expressed confusion as to inconsistent assessments (if they even were assessed), clinical perspectives from nurses and doctors, and lack of concussion-specific information following discharge (*Parliament of Australia. Concussions and repeated head trauma in contact sports.*, 2023).

Incongruences in clinical protocols between hospitals may reflect the wider concern regarding a lacking in clinical training of medical, nursing, and allied health practitioners. At conferences, seminars, informal presentations and group meetings where we talk about concussion, repetitive neurotrauma, and neurodegenerative disease risk (e.g. CTE), it is consistently brought to our attention that there is a continued lack of formal training, and professional development, towards the recognition and management of concussion.

Consequently, the deficiency of education and clinical training has given rise to growing concerns including an absence of awareness of the nature and risks of concussions experienced. Ignorance and/or downplaying of concussion ('head knock' is usually described which undermines the seriousness of the injury) continues to contribute to inhibit those seeking medical help. Further, lack of clinical knowledge in regards to concussion injury evaluation usually incorporates an over-reliance on imaging which has shown to have little to no diagnostic sensitivity (Patricios et al., 2023). While imaging is used to rule out more serious brain injury (Koval et al., 2020), the interpretation of a negative imaging is that the patient is "not concussed". Anecdotally, we have many tell us of their lived experience being discharged, only to suffer a post-traumatic convulsion whilst driving, or are unable to work the following weeks due to disabling symptoms. If not attended to or treated appropriately, risk of lingering symptoms can occur (Kontos et al., 2020; Stern et al., 2017).

Further concerns involve medical seniority/experience in doctors and interactions with nursing staff. For example, a nurse assessing a patient with suspected concussion could be overruled by a doctor

It's more than a head knock. Getting seriousness about concussion in emergency departments. cont.

who is relying on outdated models of concussion diagnosis (e.g., loss of consciousness and Glasgow Coma Scale <13), focusing on just the specific injury (e.g., fracture mandible, nose, facial fracture) or not have been hit directly in the head (e.g., fall onto hip or back). Similarly, given that concussion awareness and discussion have a western society dominance, nursing and medical doctors from varied non-western cultural backgrounds maybe unfamiliar with the seriousness of concussion, may not recognise the signs and symptoms of concussion, or be aware of the rehabilitation for concussion.

Many patients return to hospital ED's due to a variety of reasons. For example, inaccessibility to their own health practitioner, a need for further review as the patient doesn't have a health professional, have been directed back there for a review, or they cannot afford the associated costs despite being an ACC claimed injury. Further to disparities in clinical care protocols, there are also concerns regarding discharge follow up and how to provide clinical decisions on appropriate recovery to return to work, school/study, and/or sports. Currently there are no nationally agreed upon ED guidelines for the medical clearance of recurring ED patients, who return for follow up checks, in the weeks after.

Despite international studies on concussion care (Koval et al., 2020; Seabury et al., 2018; Stern et al., 2017), no research has been undertaken in New Zealand to quantify concussion care protocols in ED in regards to the evaluation, diagnosis, and discharge education provided. Throughout the course of our research work into concussion over the last two decades, we have received many lived experiences of patients who have provided us with disparate accounts of concussion diagnosis between hospitals and staff within the same hospitals. Studies to date have reported that missed diagnosis increases the risk of persistent post-concussion symptoms, or further complications requiring potentially preventable allied health and psychological care (Stern et al., 2017).

Our Opinion here has raised current concerns facing ED nurses and doctors with regards to concussion. Further to undergraduate training of concussion more comprehensively in nursing and medical courses, we would like to propose the following recommendations:

1. **In patient assessments:** There is a need to take prior concussion history. While alcohol, smoking and recreational drug history are taken in the medical screening, no patient history is taken of concussion, or even if they played or currently play contact sports such as rugby or soccer (other than in those who present following a sports concussion);
2. **Policy development:** Hospital ED's need to develop policies that incorporate a clinical pathway that allows for brain injury assessment in patients with multiple trauma injuries;
3. **National guidelines:** There is an urgent need to formulate consistent New Zealand guidelines for assessment, management and follow up that can be used at all hospitals (at all levels); and
4. **Continuing education:** Nursing Council of New Zealand support a formal postgraduate (PG) education program and professional development pathway for nurses that includes the assessment and management of concussion. This PG program could be run as either an academic qualification or as part of the annual education updates, with the objective to educate both nurses and allied health professionals for a consistent approach to concussion management and follow up.

In conclusion, with increased awareness of concussion continuing nationally and internationally, there is an urgent need to support ED nurses to develop a greater awareness of concussion. This awareness includes an appreciation of the potential long-term consequences that involve risks of persistent symptoms, but also potential life altering effects for those suffering multiple concussions such as risks of cognitive impairments and neurodegenerative disease. Having improved, consistent, and systematic ED guidelines, and professional development courses, for nurses will ensure better patient outcomes and overall health for concussed patients.

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Mental Health & Addictions Peer Support Service in Te Whatu Ora Nelson Emergency Department.

Co-authors: Jennifer Hoolihan, Team Leader, Intentional Peer Support Service, Nelson Health Action Trust.

Hilma Schieving Mental Health and Addiction Nurse Educator (Acute Support), Nelson Emergency Department, Nelson Marlborough Te Whatu Ora.

People with lived experience of mental health and addiction, working within an Intentional Peer Support Model of practice, make a real contribution to people experiencing mental health or addiction crises in many health care settings.

Nelson Emergency Department (ED) was the first ED in Aotearoa to offer this service. Nelson celebrated the first anniversary of Intentional Peer Support Services (IPSS) on October 1st 2023.

The pilot programme has a three-year term to sustain commitment on a contractual level, establish verifiable data related to the those receiving IPSS and to establish meaningful primary health care pathways.

Peer Support programs such as this one, offer a vital pathway toward recovery. IPSS's presence in ED attests to the possibility of recovery; through support, collaboration, and empowerment. As IPSS Team Leader Jennifer Hoolihan says ***"Shared experience gives space to hold the hope that recovery is possible" and "No one gets it like someone who has lived it."*** In this way Intentional Peer Support Workers (IPSWs') create an atmosphere focused on mutuality rather than diagnosis. Nelson Health Action Trust has a 28-year history of developing and designing innovative peer support solutions.

IPSS are utilised across Aotearoa, but until now, primarily in Community Services. The concept of Intentional Peer Support Services, however, is not new and has been utilised internationally in many settings including Emergency Departments.

The He Ara Oranga (translates as Pathways to Wellness) Government Inquiry into Mental Health and Addiction, 2018 Report, provides a clear message that peer support which encompasses lived experience, is the pathway forward.

In November of 2021 Paul Martin, the former Suicide Prevention Co-ordinator, Nelson Marlborough contacted Hilma Schieving the ED Mental Health & Nurse Educator (MH&A NE) and Jenny Fenwick (Consumer Advisor, Adult Mental Health Services, Nelson Marlborough Te Whatu Ora to share a research this article. Peer-Support-Workers-inEDs-Issue-Brief.pdf.(thenationalcouncil.org).

Paul Martin thought the research could be applicable to any person who had presented with an overdose to an Emergency Department. Jenny Fenwick supported the concept and suggested we collaborate with Nelson Health Action Trust.

In late 2021 the ED Mental Health & Nurse Educator (MH&A NE) collaborated with Health Action Trust and Nelson Marlborough Mental Health Service providers to explore the possibility for IPSS in Nelson ED. In January of 2022 the MH&A NE was charged with surveying Nelson ED staff to educate and explore interest in the concept.

The survey provided a definition, a description of how Intentional Peer Support Service (IPSS) might look, explained the model of practice including the training processes, certification and competencies that IPSW's undertake.

The following short, reader friendly, educative links were provided to support ED staff understanding.

PowerPoint: Developing a peer support model for the emergency department.

https://www.otago.ac.nz/wellington/departments/psychologicalmedicine/research/otago739880.pdf

Article: How could Mental Health Peer Support Workers Improve Emergency Departments

https://pursuit.unimelb.edu.au/articles/how-could-mental-health-peer-support-workers-improve-emergency-departments

The following quotes from the article above were used to illustrate key functions of the role.

"Peer support specialists can enhance consumer motivation to change, to initiate services, and / or to engage in recovery activities".

"Peer support staff are living models of resilience and hope – that recovery is possible and attainable".

The MH&A NE had anticipated some resistance to the concept having attended international webinars on the topic. In the webinars Peer Support Workers talked freely about both challenges and

Mental Health & Addictions Peer Support Service in Te Whatu Ora Nelson Emergency Department cont.

achievements. The response to the Nelson ED staff survey, however was overwhelmingly positive and insightful. Here are two examples.

"A resounding, vocal, large YES from me"

"Yes. Sounds good and would be beneficial for people presenting in crisis when they have no-one else to turn to".

On each ED MH Study Day, the MH&A NE aims to assist all staff in identifying people presenting to ED, who are a priority for psychosocial support. People who attend ED alone are often the most vulnerable and may also experience lack of resources in their community. The RN's comment "no one else to turn to" is in essence how IPSS's work – through engagement and connection.

In February of 2022 a hui took place which was facilitated by Mary Ellis (CEO, Nelson Health Action Trust - Te Mana Taki Hauora) and attended by Paul Martin (former Suicide Prevention Officer Nelson Marlborough District), Michael Bland (former General Manager Nelson Mental Health Services, Te Whatu Ora), Jenny Fenwick (Mental Health Consumer Advisor, Nelson Marlborough Te Whatu Ora), Rita Van Iddekinge (Nelson Mental Health Service Manager), Nicola McKay (Nelson Community Assessment Team Coordinator), Peter O'Donnell (Service Manager Health Action Trust – Te Mana Taki Hauora), Lorraine Moss Smith Contracts Manager, Mental Health, Addictions and Disability Support Services, Nelson Marlborough Health) and Hilma Schieving (Mental Health and Addictions Nurse Educator, Nelson Emergency Department).

The instigation of the pilot in Nelson Emergency Department was supported by Health Action Trust's established relationship with Nelson Marlborough Mental Health clinical partners through their other long standing reputable peer support projects at both the community and secondary level. This assisted in the building and maintenance of trust between services.

By September 1st 2022 IPSS had begun in Nelson ED.

The Peer Support workers recruited for the ED peer support team came with existing qualifications and their own lived experience of mental health and/or addiction. Men and women alike. Some, completing psychology degrees, others trained counsellors, one in their final year in social work, another qualified in nutrition and tourism. They were also fully trained in the model of Intentional Support embedded in the role.

The IPSS operates Wednesday to Sunday 2.30 pm - 11.00 pm throughout the year including Public Holidays. This schedule was selected as it represents the highest data for people attending Nelson ED for MH&A issues. The IPSS have two staff on each duty. This is important as it allows for mutual support within their own team. IPSS wear mufti and the badge has their first name with Advocate written on it.

The tangata whaiora / patient IPSS see, do not have to have a mental health diagnosis. It can be a person or family member in distress; in triage, in the waiting room or in the department. Initially the IPSS concentrated their efforts on adults, but it soon became apparent that young people required their time as well. Since their commencement the ED team have utilised the service fully.

IPSW's work comfortably with all team members, taking requests from the Shift Clinical Co-ordinator, Registered Nurses and they also identify tangata whaiora / patients in need, themselves. IPSW attend the Afternoon Hand Over meeting (also attended by HCA's and RN's).

IPSW's must not act in place of a Te Whatu Ora employee in the respect of one-to-one observation by an RN or HCA. If the acuity of the patient requires 1:1 (triage 1 or 2 or an escalation to triage 1 or 2, IPSW's (who are not Te Whatu Ora employees) cannot fulfil this task and cannot be clinically accountable for this level of identified risk. They can however, work alongside the assigned Te Whatu Ora ED staff member. IPSW's must follow the Health Action Trust policies and procedures as well as those of Te Whatu Ora.

The IPSW role is a nonclinical role that supports psychosocial needs; providing advocacy, compassion and reassurance in a stressful situation as well as a navigator role for support after discharge from ED.

IPSW's are particularly skilled in the advocacy role. This is an essential skill as the process of advocacy is required to make clear the needs and wants of tangata whaiora. The process of advocacy may brush up against the focus of clinical partners e.g. during a MH service assessment or by a hospital ward receiving tangata whaiora.

IPSS engagement with tangata whaiora early in the pathway of care often significantly reduces agitation and escalation (reducing the need for 1:1, security call outs). There have been several occasions whereby tangata whaiora have voluntarily handed over knifes and ropes.

During the international webinars attended by the MH&A NE, the comments from ED staff went from ***"What are they (IPSW's) doing here?" to "How did they actually calm that patient".*** In Nelson Emergency Department, beginning through to experienced RN's, now ask what process the IPSW used to calm and de-escalate. In this respect, IPSW's also serve as educators in ED. Nelson ED sensory modulation equipment use has also markedly increased however IPPW's primary mode of de-escalation is via engagement. Nelson ED staff also witness how comfortably an IPSW will listen and respond to talk of suicide or non-suicidal self-injury. These conversations occur with empathy, dignity and the conveyance of hope as tangata whaiora are acknowledged in the crisis they present with. This process is a key antidote for shame and guilt often experienced in such a crisis. Gently exploring the next steps in recovery options sits comfortably in these conversations.

A vitally important aspect of the IPSS is their referral processes to local IPSS and other regional primary health services. For E.g. an IPSW will arrange to phone tangata whaiora after they leave ED and can arrange to see them at a community venue such as Hauora Hub in Nelson city (another Health Action Trust community peer support service). Tangata whaiora who may have had limited contact with support services, can be connected to services in

Mental Health & Addictions Peer Support Service in Te Whatu Ora Nelson Emergency Department cont.

their own community. This supports tangata whaiora to seek help appropriately via primary service providers. E.g. it is usual practice for all staff to offer whanau / family a pamphlet on family services such as Yellow Brick Road. Being able to say ***"Would you like support to meet with Yellow Brick Road offers immediate relief and a way forward."***

If tangata whaiora require transfer to another hospital ward or Wahi Oranga, the acute mental health inpatient unit, an IPSW will visit there. IPSW's will also offer or respond to a request and attend appointments such as e.g. during mental health Community Assessment Team (CAT) assessment, GP or Social Welfare agencies.

MH&A & ED services welcome IPSW's to shared training opportunities. This makes for much richer study day participation; shared understandings and it fosters a one team approach.

Bringing this primary health service in to one of the busiest secondary health services in a public hospital is a major endeavour. The outcomes speak for themselves. It's little wonder the Nelson Marlborough Te Whatu Ora Consumer and Family Advisors report a reduction in complaints.

Going forward, the aim is to have IPSS available every day of the week. This availability would create equitable access for people seeking help for mental health issues and result in even greater involvement in community services.

An alliance and mutual respect between the MH&A Nurse Educator and the ED Peer Support Team strengthens the service to manage the normal challenges inherent in the Emergency Department.

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An interview with...

Raechel Keepa, (emergency nurse, ultra-marathon runner, humanitarian aid worker and much more)

Raechel is a senior emergency RN currently working in the Waitaha Christchurch Hospital Emergency Department. She works across all areas including triage, Team Leader and Resus. The following interview took place in August 2024, with Dr Sandy Richardson, editor of Emergency Nurse New Zealand.

Raechel: My name is Raechel Keepa and I've been working in the emergency department for the last 12 ½ years. I did my new grad, half of my new grad in the emergency department and just never left.

Sandy: *What I'd like to ask you about is your work outside of the emergency department but drawing on your emergency skills. I know you've worked in humanitarian roles, can I ask how that came about?*

Raechel: There's been a couple of opportunities that have come across my path, that I've grabbed, that I've run with... first is the NZMAT which is the New Zealand Medical Assistance Team which gives the opportunity to be deployed nationally and within the South Pacific, it needs to be a natural disaster, and also faith based medical ships where I've gone to the South Pacific, predominantly to Papua New Guinea and the various islands within Vanuatu. My role primarily has been with vaccinations, including responding to the polio outbreak in Papua New Guinea.

Sandy: *What qualifications, or what expectations were there for you to be a suitable candidate for these jobs?*

Raechel: Having an emergency background, with a general knowledge of a lot of things, including wounds, primary health, and emergency care, as well as knowing what a deteriorating patient looks like. On the ships we do ophthalmology, so we do cataract surgery, we do dentistry as well. Usually I am on the island itself, I work alongside the doctors who are assessing patients. We see a wide range of tropical diseases, skin diseases, syphilis, TB, spinal TB, a lot of interesting things.

Sandy: *What was the first placement that you did?*

Raechel: Hmm so I was on Pacific Hope which was an old Japanese fishing trawler and we shipped from Port Vila to the coastal island of West Santo. We give them about 3-4 weeks' notice that the ships are coming with medical supplies, dentistry, ophthalmology. So basically we'll tell one village and they pass it on to the next and over the course of 2 or 3 days that we're there, before we move on to the next location. We'll have people coming over mountainous terrain, 50-60ks, with their young pikinini, their children, their elderly, coming to see us and will wait 6-10 hours in the sun for their care and yet there's just joy there, its so amazing.

The first time I was there, 2016... cyclone Pam had come through in 2015 and you could still see the path, and they had nothing to eat 'cos a lot of these islands are very isolated, but when I got there the islands were flourishing, reaping their first harvest and they just give so generously. You know that's their food for the week, but of course its disrespectful if you don't take some of it, even just a little bit. Once you have a little bit, then everyone joins in....

Sandy: *How did you feel, managing people with quite different needs to people in New Zealand EDs?*

Raechel: Well, there's only one hospital in Vanuatu, that's in Port Vila, they only have one ventilator. ... and they have no access to antibiotics, they have no access to simple wound care, they rely heavily on their traditions. There's a high mortality as far as mama and ... and that's disheartening knowing we [New Zealand] are only three hours away. The deformities of TB. It was hard because I saw the need, but I saw also the [opportunities for] education and what we need to bring, but incorporating their culture not bringing our Western views but working alongside and that was really encouraging.

There was a lot of debriefing because you know, I saw malnourished children that I don't think would survive and there was not a lot we could do. 3-4 days in the ship to the mainland, then how would they get back? Everything costs money. You can't go to the emergency department without having to pay, you can't have surgeries without having to pay, so a lot of these things that we take for granted here in New Zealand, there you've got to pay for everything. Even though it might not seem like much to us, this is like 2,3,4, months wages to them.

Sandy: *What's the health system like? do they have trained nurses?*

Raechel: They do. Each village tends to have a health clinic, but the clinic might be run by someone who is nominated but has no medical background. I remember going to one place and they obviously get a lot of donations of medications. ... they get a lot of help from overseas but no education, how do I use this equipment? And whether they've got equipment that attaches, or instructions in their language, or in English, 'cos a lot of the medications are in a foreign language. The best intent, but...

Sandy: *How long would you typically be away for when you do one of these trips?*

Raechel: It's usually about 3 weeks. You can be on the ship for up to 6 months.

Sandy: *I know you use your annual leave for this, do you get much other support for this work to enable you to go away?*

Raechel: Our emergency college has helped me hugely, with the last grant (the Pacific Nursing Award) I was able to pay for my flights,

An interview with.... Raechel Keepa, (emergency nurse, ultra-marathon runner, humanitarian aid worker and much more) cont.

because you pay for all your accommodation, pay for all your food and all the rest of it as well and I was able to pay for the majority of that.

Sandy: *And Papua New Guinea, how often have you been there?*

Raechel: Twice with the same organisation as for Vanuatu, Marine Reach Faith based Hospital Ships.

Sandy: *Papua New Guinea can be quite a dangerous country, have you ever felt unsafe?*

Raechel: We've always had convoys, the locals went with us but I've never felt unsafe. Probably the most unsafe I've felt has been before I've been with the teams, when I fly into Port Moresby, to a hotel with barbed wire and security guards...

Sandy: *You mentioned going up into the Highlands, which is quite remote. What kind of work have you been doing there?*

Raechel: Mainly vaccination. Keeping up with the immunisation schedule. Obviously, there's no computers so everyone carries a little booklet with them with all their details which is very effective, so we know exactly when they had their last schedule and we know when its due and that works really well. Sometimes there's a language barrier. We had these little packets when we have to give medications, with a sun and a moon and a half-moon, so they know exactly when to take how many tablets.

I was also in the physio role; a lot of them do really hard manual work, so I was teaching them how to protect their backs... they crowd around and you're doing all these exercises and you've got the mother saying 'you join in', it's hilarious!

We have cue cards and there's the odd person who can speak English. Some of them are incredible, they can speak 3 or 4 languages because there's French schools as well as English schools and then they speak broken English which is there trade language and then there's their village language and if they marry outside of that village, there's their language...

Sandy: *What would be the most memorable event that has occurred to as part of your humanitarian work?*

Raechel: There's a few actually. I went for a run. And of course you have to wear a dress. Cultural sort of thing. There were several of us, and we felt like the pied piper. There are beautiful trails and tracks and waterfalls, and we must have had about 15 kids running behind!

And then, when I was gifted a dress. Which would have been easily 2-3 months worth of their earnings. And I do ultras (ultra running), run in this dress, and I fundraise for this clinic over in Vanuatu... the woman who gave me this dress didn't speak any English...I've got this bright multi coloured dress on and I'm thinking what am I going to do with this... its very much a traditional mama dress and its very faded now and it's my most worn dress. And I just think she never knew what gift she gave me. At the time I just thought 'what am I going to do with this dress?', beautiful gesture, so appreciate it, but not really appropriate for New Zealand... and then into ultra-running wearing this dress, people asking me about it, donating money to the clinic in Vanuatu... being able to give back its been the most precious thing.

Sandy

If you want to follow Raechel's journey or contribute to her work, you can find more information on her Fuelling Hope Face book page https://www.facebook.com/raechel.keepa/ and Give a little https://givealittle.co.nz/cause/fuelinghope pages.




Photo credit: A selection of photos taken by Raechel on her trip to Vanuatu

Humanitarian Work in Vanuatu.

Author: Raechel Keepa, RN

Waitaha Christchurch Hospital ED Te Whatu Ora

Recipient of the CENNZ NZNO Pacific Nursing Grant

I've not long returned to NZ after spending just shy of three weeks in Teaomu Valley, Efate, Vanuatu. I thought I would just share with you a little of my time over there at the Family Care Centre and clinic.

The Family Care Centre (FCC), is a faith based not for profit organisation that provides affordable dental, opthalmology and medical assistance to the Ni-Van community. The FCC is a Marine Reach Vanuatu missions centre located in Teouma Valley, located approximately 20 minutes from the capital city of Port Vila. The clinic helps to support access to basic medical and dental care, in addition to providing health education, focussing on support for women and children at risk (Family Care centre, 2023).

Vanuatu is a nation of 83 islands, which stretch across 1300 kilometres in the South Pacific Ocean, encompassing a land mass of 12,300 square kilometres (WHO, 2017). Of these, 63 islands are permanently inhabited, with a population estimated to be around 314,000 in 2024 (Pacific Community, 2024). The capital of Port Vila is located on the island of Efate, in the Shefa Province. The population is culturally diverse, with three official languages (English, French and Bislama) but having a total of 138 distinct languages identified (WHO, 2017). As an archipelago within an exposed ocean setting, the islands are at risk of multiple natural hazards including the effects of climate change. Vanuatu has high vulnerability to the impact from flooding, tropical cyclones and storms, with Cyclone Pam causing damage, displacement of over 65,000 people and a death toll of 11 in 2015 (World Bank Group, 2021). Vanuatu has been consistently at the top of the World Risk Index rankings for global disaster risk. Overall disaster risk is calculated based on four components, exposure, susceptibility, coping capacities and adaptive capacities. It is not only first in terms of overall disaster risk, but also first for the category of 'exposure' which covers exposure to earthquakes, cyclones, floods, drought, and sea-level rise (Bündnis Entwicklung Hilft / IFHV, 2021).

Health services in Vanuatu are mainly provided by the Government, in addition assistance is received from non-governmental organisations, and faith based organisations. There are six regional health centres, one hospital and the services provided by the FCC offer much needed additional support. The key health issues facing Vanuatu are the increasing burden of noncommunicable diseases, the impacts associated with climate change and natural disasters, illness resulting from communicable disease, and conditions affecting mothers and children. Limited access to neonatal, obstetric and maternal care has seen continuing problems in healthcare for women and infants. Vaccine preventable diseases such as dengue fever and measles as well as the need for access to childhood immunisations remains an issue (WHO, 2017). The geographical isolation, widely distributed populations, poor infrastructure, costly transportation and logistics present significant challenges in delivering essential services, even when these are available.

Just to get some idea of the health provision in Vanuatu, their only hospital has one ventilator, two ICU beds, one steriliser, two theatres with mostly contracted surgeons from Fiji, Australia and NZ, and an Emergency department that recently opened in 2014. I had the great fortune of meeting the hospital Coordinator who shared much of the hospitals struggles, including those associated with the recent cyclones and covid-19 pandemic.

There is an estimated one doctor for every 30,000 people in Vanuatu. Every health service costs in Vanuatu, 6,000vt ($60) for maternity, 750vt ($7.50) per night including emergency, medical or surgical stays, which is a huge outlay for the average Nivan.

The clinic at FCC, founded in 2015, has expanded over the years with a second dental clinic in progress, a pharmacy, a room available for a laboratory. When patients attend the FCC, it's a first come first serve basics (unless a patient is obviously unwell).

Patients are triaged in, which was generally my role and charged accordingly,

- 1500 VT or about $1.25 NZ for adults (or the same price as a bus ticket!)
- 1000 VT for pikininis (children)
- 500 VT for maternity consultation
- 800VT for dental for adults, 500 VT for pikininis

This gives all Ni-Van's within the valley and beyond, exceptionally affordable and accessable health care. Prior, all medical services were free, but it was noted that the Ni-Van's were rarely attending follow up wound or medical clinics.

However, it was found that by placing a price on a service, (this also includes any medications prescribed), places value upon the medical treatment they receive, therefore patients become invested, appreciating their health, returning for follow up appointments more frequently. (Although all medical, dental, anti-natal and optometry outreaches inland or in the high lands continue to be free).

Humanitarian Work in Vanuatu cont.

As a non-profit organisation, with no government support, the clinic depends heavily upon outside support and donations. Utility bills like power, are similar to what you would expect to pay in NZ, even in an impoverished country like Vanuatu. The clinic also relies upon the generosity of volunteers, with all doctors, nurses, midwifes and dentists needing to be partially but mostly fully self-funded.

The most common presenting complaints we see at the clinic is Yaws (painless bacterial ulcers belonging to the same family of bacteria as syphilis, cured with a stat dose Azithromycin), skin wound and cuts, (bleach baths are generally recommended , 1 lid of bleach to 1L of water, to prevent wounds becoming infected), musculo-skeletal ailments, diabetes and HTN etc.

Severe cases of skin diseases like ichthyosis and the odd presentation of leprosy have been treated at the clinic also. The clinic may see any number of patients between 10 and 30 a day, but just as the physical is treated, Nivan culture valves the social, spiritual, mental and emotional aspect of their well-being therefore appointment times are never rushed.

Now I have been to the clinic I hope to return again, maybe in a couple years. Time also to brush up on my broken Bislama 😊 (national language).

I hope this gives a little insight of my time in Vanuatu.

And many thanks again for the CENNZ Pacific Nursing grant, which helped enable me to contribute to this work.

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An interview with....

Bronni McBain, emergency nurse, paramedic, humanitarian aid worker, wife, mother and grandmother.

Sandy: *Tell me a little bit about who you are, where you work, what your role is...*

Bronni: Okay. So my name's Bronni McBain, short for Bronwyn. I am a wife, mother, grandmother. And a nurse of 20 years. I came to nursing later, in my early thirties, when my children were about intermediate age.

... my mother died and left me some money to go to medical school, and I hadn't studied for 14 odd years, so I thought maybe I could do some papers through Massey university... so I did health science papers. And then I thought, well, medicine might be a step too far, so I did nursing.

I loved the nursing... my aunties on my father's side, and great aunties had all been nurses, and they had in the fifties, which was more uncommon then, worked in Africa and Asia, and done a lot of traveling and worked as matrons in Scotland and through Africa. So I guess it was something that was just in the blood.

I graduated at the end of 2005, and in my second year of nursing, 6 of us from our second year decided that we wanted to go and work in Vanuatu and the outer islands of Vanuatu, and provide health care more as a as caregivers at that stage ... from the moment I got there I thought this, this is what I'd like to do.

I think maybe if I took it a step back my parents were great travellers, and we were very lucky as a family to do quite a lot of travelling when we were young. I remember our family when I was probably about nine going to Fiji. And I was terribly distressed. My parents didn't know what was wrong with me, but I couldn't understand why people lived underneath cardboard and tin on the side of the road when we were going across the causeway to a huge hotel and had everything we wanted in it. So, I think probably from early on I had that I I had a real sense of the haves and the have nots...I think that's probably where it came from.

So, my husband said, go away to Vanuatu and get that out of your system. But we came back on the 23rd of December. I think that was 2004, and we'd only been home about 3 or 4 days, and the tsunami hit in Indonesia.

And...anyway, I went and I worked over there for 6 weeks, and I put together an Australian medical team and gathered $10,000 worth of medical equipment and just got on the phone and cold called, so we got Rolls Royce gave us 3 or 4 boats with motors... and we hired a ship... and we did 6 weeks work down the eastern coast from Banda Acheh. So I did that and came home, and I guess from then on, my husband never said, 'Don't go' again.

I usually went for 8 to 10 weeks every year and grouped all my holidays together ... would spend my holidays away doing volunteer work in Africa, Burkina Faso, Mali, Bolivia, Indonesia. The Singapore Government sent a group of us to Pakistan with the Pakistan earthquake, in 2005.

So it's just been something that I've integrated into my practice the whole way along.

Sandy: *Did this have any impact on completing your studies? did you find your program was supportive of you?*

Bronni: The support was there, I guess. I think on two occasions I actually did resign to be able to do it. But that was not until I've been nursing for 10 or 12 years...and I understood it, that I couldn't have leave without pay, and they were very good, really, and they would put me straight back on a contract afterwards.

I had started on postgraduate study from the first year out. In the first two years I'd done the diploma and then I carried ... I think I've got 9 or 10 postgraduate papers. And then everyone said you must do Nurse Practitioner. I sought of shied away from that a wee bit it wasn't really what I wanted to do. About 4 or 5 years ago, I decided to do a degree in paramedicine. It was just something that gave me another avenue, and I could use internationally and nationally, and help that my community...

...everybody, whoever hears me talking, and I hate speaking at things. But the new grads, they say, 'How can we do this?' And the big thing is, you need the education behind you to do it.

You're not taken seriously in any arena, nationally or internationally, if you haven't got the backup of study.

Sandy: *You've gone back to Vanuatu multiple times. Have you worked in other pacific countries?*

Bronni: I've got friends that ran the hospital, and in Rarotonga. So I would go over and do shifts and and things... I've done 11 trips to Nauru...through 2016 and 2017, because a lot of the refugees there were starting to hurt themselves. You might remember it being in the paper, and they were drinking bleach and...because if they became really unwell, they would send them to Australia for treatment.

So [under] the Geneva Convention, if you hold refugees, you have to provide them with the same health care as the country who's governing them. So they sent in a group of experts, HDU and ED. To upskill all of the staff at the Nauru Hospital. We did all of the training, did ACLS [Advanced Cardiac Life Support], and while they had an HDU, the doctors didn't know how to treat patients, how to ventilate patients...we spent a full year with the Australian Government upskilling them. So that that was an amazing job. That was an eye opener.

Sandy: *When you're working in New Zealand, do you find you mostly work in emergency care.*

An interview with…. Bronni McBain, emergency nurse, paramedic, humanitarian aid worker, wife, mother and grandmother cont.

Bronni: I always did as it's where my passion was, but when I was doing my 7th and 8th [papers], to finish my masters, I did the acute ICU Care papers…I felt like I needed to commence this into my practice, and … [I] did ICU nursing in Dunedin just to put it into practice… Well when I got there, I didn't like it. It's too formal. I felt like all I was doing was making up infusions, changing propofol… and I know people love it, I didn't. I like chaos or something. And it made me realise emergency nursing was where I wanted to be and where I was comfortable. Since 2019 I've worked as a CTC [Clinical Team Co-ordinator] at Invercargill Hospital, and this year that's changed over to the PAR Team, so currently I'm casual on the Patient at Risk Team.

Sandy: *And when you do any of your work overseas, do you work through a formal type of agency?*

Bronni: …so first 10 odd years, it was all volunteer. I guess It seems like there's a lot of volunteers in humanitarian work … you run into the same people all the time, and if you do a good job… I'm a member of the ICRC [International Committee of the Red Cross] and the IFRC [International Federation of Red Cross and Red Crescent Societies] so the Red Cross.

So I did the training - I think there was an eight day impact course which was quite involved, to be a team leader. They sent me to Bangladesh - I went as an ED nurse, by the end of the week they asked me to look after the emergency department and by the end of the fourth week I think I was the hospital manager!

A lot of the work I do is through Aspen Medical in Australia, it's Canberra based.

So when I went to Sierra Leone for Ebola, the initial team was Australian and New Zealanders, there were four of us that went as a group. The team was put together and trained by Aspen Medical… they now work for the WHO [World Health Organisation] and for the UN [United Nations]. So nowadays a lot of the work I do is through the UN and the WHO putting together teams.

Sandy: *I was wondering whether you were seen now seen as a consultant for the UN, WHO and for organizations like that?*

Bronni: They really like New Zealanders, because New Zealanders work. We work really hard, we're pragmatic. We don't moan as much, you know, like, if it's cultural things we do as we're told. Like, if we have to be covered, we don't turn up in our bikinis. We follow direction generally. Well, they just like Kiwis and Kiwis just quietly get the jobs done. So they do tend to come back to the kiwis more often than not to lead teams.

Once your name's out there, then groups will say, Who's done this work? Where have they worked?

Can they work in difficult conditions? Can they live in a tent for 6 or 8 weeks and 40 degrees, with no power and no water can they work at the front line and be able to cope?

There's a huge difference between what people think working in the third world or in a war zone…[is like]… There's kind of a romanticism around it… and even when you get home … I liken it to childbirth. It's awful at the time. But when you get home it's like, you forget all the nasty bits, and remember the nice bits. And there's nothing very romantic about it. Really, when you've got vomiting and diarrhoea and you've still got to run your ICU and your ED, and you've got no power and no water, and it's 50 degrees outside in Iraq or minus 10 degrees somewhere else. Yeah. It's interesting. And it's getting harder. Because I started doing this when I was about 34 or 35, and I definitely am not that now. So I actually don't know if I'd be good for eight weeks in a tent anymore, with no power and no fan and no water…

Sandy: *Is this something you think you'll continue to do for a while longer?*

Bronni: Absolutely! Absolutely! All my family, my mother died at 60, I'm almost there, so I figure If I'm well enough to do it, and my husband's happy for me to do it, and my children are happy for me to do it, then why not? It's giving something back

Someone actually said to me the other day… 'Are you the lady that was in the paper for Ebola?' he says 'why did you do it? You caused real ructions in New Zealand', which I did, I guess. But people said, 'Why did you go and do it?' And I said, 'Has anyone thought from the other side, that if some people didn't go and do it and keep it there, the whole world would have had it just like Covid?'

And you do have to be very careful. And it was scary, because we knew we wouldn't be coming home if we needle-stuck ourselves at a hundred percent mortality rate.

…I think you know what you have to know, what you're getting yourself into like…there is a romanticism about it, and then people get there. We had to send a lot of people back from Iraq that didn't deal with the trauma. They didn't deal with 70 to 100 status one and two trauma patients every day. That's quite confronting. We even broke psychologists.

It was pretty traumatic. When you have 10 children under 10 arrive and in the back of a truck, and not one of them have got all their arms and legs, you know, and that was happening every day, and at the end of the day you'd have eight children that had no mothers or fathers and all injured. And what are you going to do with those children? How are you going to feed them, where they're going to sleep?

Sandy: *Do you think that being a nurse is something that has made it easier for you to do this work?*

Bronni: 100%. There's no way I would have ever had the opportunities or done the work I have with without nursing. I actually find in a lot of places, a lot of the organizations I work with and the places I end up… they have plenty of medical staff, I suppose, because doctors are given more time off. They've got sabbatical time, a lot of them work casually…

…when I was trying to put medical teams together, [I could] have 20 surgeons who all wanted to go chop gangrenous legs and arms off after the tsunami, or in Pakistan after the earthquake. It was it? But I said, no, you can't, because we couldn't get nurses because nurses are at home with their families and their husbands and their partners and their children, and their mortgages, and they can't just go and do this sort of work as often … We could have done a lot more should we have had more nurses.

An interview with…. Bronni McBain, emergency nurse, paramedic, humanitarian aid worker, wife, mother and grandmother cont.

I think it's really important to realize that doctors can't do the work without the nurses. Someone said to me 'why don't we go here and deal with this?' And I said, ' So once you've done that, who's going to look after them? Who's going to feed them? give them the medications? Do you know how to do iv antibiotics? Can you put in a line? And when was the last time you did that, you know? who is going to care for them? For the next 10 days, two weeks, six weeks, once you've fixed their bones?

…we really struggled in Iraq because we were at the front line. And it was obviously a very Muslim country, and we could only have male nurses…obviously Muslim families aren't going to send their nursing daughters to the front line. But then we had men, women, and children, which all had to be separated… And if they're all male nurses who's going to look after the females in a Muslim hospital? and then, if they need an indwelling catheter, or if they need the amputations and the stump dressed, they're not going to let him… And when the woman died, which they do, men aren't allowed to deal with the bodies of women, they're not allowed to touch them or see when they're dead. So I think I probably lived on about 2 or 3 hours sleep each 30 days …

Sandy: *Thinking back over this huge diversity of experiences …what would you say is the most challenging thing you've experienced?*

Bronni: Every country and every continent and every job that I've done has unique challenges. The challenges aren't any different there than they are at home on a busy day in ED. Probably the most challenging thing for me on a personal level is being able to marry up my passion for humanitarian work and maintain a good and fulfilling job at the local hospital, and manage being a grandmother, being a friend, being a mother, being a wife, because we've been married 40 years next year, and actually being able to make them all work is probably the most challenging.

… because my family will always come before everything else. So probably the challenge I've had for the last 20 plus years is making sure that there's enough of me to be that special person to all the people that need it.

Sandy: *is there anything that stands out as being the most satisfying?*

Bronni: … people say, you know, you can't save the earth. But It's just helping one person at a time, on that day… you can't fix everything at once, but just one patient at a time…

Sandy: *And is there any advice you would give to someone who is going to be reading this? is going to be reading about what you have experienced, and thinks they'd like to become part of this type of journey. What would you recommend that they do?*

Bronni: a lot of the young ones, new grads, stop me and say 'Can you take me with you?'… But the thing is that you really need emergency nursing and/or a little bit of CCU or ICU. You need those skills. And you need to do study. I know that Aspen Medical, and any of the companies I work with, will only look at someone that has a diploma at the very, very least.

So, if it's something you want to do, you really need to put the work in.

[for me] It was all voluntary. So it's… you're not going to get rich doing it. You have to love it… and it's only through that hard work and the study that that you'll end up with the amazing jobs.


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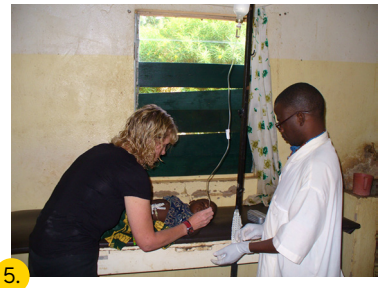
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1. Bangladesh 2018 Team Leader and Head Nurse
2. Bolivia
3. Burkina Faso 2010 Primary Health Care
4. Sierra Leone Ebola Hospital Team Leader
5. Burkina Faso 2010
6. Outback Australia
7. Post Pakistan Earthquake

Reflection: Humanitarian Work in a War Zone.

Author: Bronni McBain

BN, RN, PG.Dip.Health Sciences, PG Cert Acute Care, B.Health Science (Paramedicine)

Iraq 2017:

In late 2016, I was contacted to consider joining as a registered nurse an international team being assembled by Aspen Medical, an Australian owned global provider of healthcare solutions. This team would work under the umbrella of the World Health Organisation (WHO) and United Nations Population Fund (UNFPA) to set up and open modular trauma field hospitals and maternity units as close as possible to the front lines of the city of Mosul, Iraq1.

I was one of the first medics to travel to Erbil Iraq early in 2017, and joined the team involved in the initial set up of the field hospital travelling for three to four hours by ISIS (Islamic State of Iraq and Syria) affected roads at the outskirts of the besieged city of Mosul.

The Battle of Mosul lasted 9 months (Oct 2016 to July 2017). It is reported that the armed conflict to free the city of Mosul is considered the largest urban battle since World War 2 (Doctors without Borders, 2018). The battle occurred between fighters from the Islamic State of Iraq and al-Sham (Isis), and Iraqi Army.

The price Mosul's residents paid in blood to see their beloved city freed left between 9,000 to 11,000 dead, and a civilian casualty rate nearly 10 times higher than the death rate. Over 500 precision-guided munitions and bombs per week landed in Mosul city and at its height up to 650 bombs per week (Al Jazeera, 2017; Amnesty International, 2017). Obviously, this is not touching on the combat at the street level, and the atrocities that the ISIS fighters inflicted on the local Mosul inhabitants.

On arrival at the first field hospital (Athba Field Hospital), we were given 72 hours to open the door to causalities. Our small team were handed the mammoth task of interviewing local staff to work in the field hospital, including Iraqi trauma surgeons, anesthetists, theatre staff, ICU trained staff, ED consultants, ED doctor's, Theatre, ICU and ED nurses, pharmacists, security staff, advanced care paramedics, cleaners, cooks and sterilizing staff.

This was made more difficult for staff, as they had to live in cramped modular staffing quarters and work under constant threat of attack or rogue or planned ISIS bombings. They also experienced 24 hour a day noise and buildings shaking with the nearby bombings, shelling and coalition military aircraft overhead. As a final point, they had to be willing to work 7 days on and 7 days off.

Understandably, we had a team of all male RNs due to Muslim Iraqi woman not having family support to work in these circumstances.

Adding to the workload, we had to set up pharmacies, find local pharmacists, organize medications, in conjunction with setting up the 56-bed field hospital and two theatres, including the full receiving ED and a four bed ICU. The field hospital was the only trauma unit with operating theatres and a functioning ICU, including four ventilators. These ventilators were only for short term support, usually post major trauma surgery.

We were to provide advanced clinical care, undertake life-preserving procedures and trauma surgeries on a minute-to-minute basis, and stabilize all patients within a 72-hour window. We would stabilise these multiple patients then coordinate transfers, moving them all by road to Iraqi cities further south (Erbil and Baghdad predominantly), up to eight hours away. These roads were riddled with ISIS laid explosive devices, pockmarked with exploded bombs, and the roads were scarred intentionally with bulldozer damaged gouges and trenches. ISIS would bring in bulldozers during the nights and scour out the main roads to make them impassable to road traffic. All vehicles had to have the capability to skirt the damaged roads (but only after careful daily clearing of the landmines and explosives set by ISIS to catch these vehicles out). We travelled in fully armored vehicles, with armed soldiers; we were always in full body armor and hard hats. All members of the international team were military, ex-military or well trained in strategies to deal with the dangers of warzones.

Our front-line field hospitals moved with the active front providing care to the inhabitants of Mosul who had been unable to leave the city before the start of the 9month war. We ended up setting up three Field Hospitals over the Jan- July 2017 time frame. We also treated members of the allied military forces. From the first day we opened, we would receive and treat around 50-70 status 1 and 2 patients daily. Triage 3, 4 and 5 (our walking wounded) were roaded to Erbil (3-4 + hours away depending on road condition and passibility). Injuries included, IED injuries (often in children who would inadvertently run into fields with ISIS planted explosives losing multiple limbs), blast injuries, gunshot injuries, burns, crush injuries from buildings being bombed and disintegrating, and sadly, chemical burns and injuries from contact and inhalation. Many of the patients were in appalling physical condition from sustained months of starvation due to ISIS occupation, and ISIS holding them in their under-home bunkers limiting their ability to get supplies of food or water.

On top of the clinical trauma work, we each managed a portfolio, mine included some of the policy and procedure work for this new

Reflection: Humanitarian Work in a War Zone cont.

environment, and ordering and stock taking of our ever-dwindling medical supplies and medications (no mean feat in a war zone). It was always gratifying that medical personnel could stoically cope with not having the medical equipment and supplies that we all have become accustomed to in our normal first world hospital lives. Using urinary catheters for chest drains, to treat blast lung and chest injuries from bullets, missiles, mortar blast injuries, and crush injuries from building collapses. Using 20 ml syringes with oxygen tubing on male children in lieu of indwelling catheters, and many other improvisations for the care we strived hourly to provide.

Chemical warfare was sadly a tool used by ISIS. Mustard gas poisoning became more prevalent, and setting up decontamination areas and training medical personal became a necessity. Several of our team had worked in Sierra Leone and Liberia with Aspen Medical during the Ebola outbreak in 2014-15, and we had sound practice in the use of respirators and Personal Protective Equipment (PPE) suitable to eliminate the transfer of the mustard gas between patients and staff.

Triaging in a war zone had its challenges. The sheer number of high acuity patients, arriving often with no prior notice or ability to prepare, arriving in cars, buses, 4 wheel-drives and ambulances, made this vital tool in urban warfare extremely challenging. Consideration of the culture and faith of our Iraqi staff had to be understood and adapted to fit the situation at times.

A maternity hospital was started alongside the trauma hospital. This went on to deliver 2,997 babies on the outskirts of Mosul, being the only maternity hospital that could provide Caesarian births, Neonatal Intensive Care Unit (NICU) facilities and multiple birth assistance. We also had the only blood bank facilities within a 4-hour circumference by road (for both the trauma hospital and the maternity hospital).

We all lived in portable cabins, 6-8 to a room which comprised of 3 or 4 bunk beds. We had to manage all of our roommates being on different shifts (day and night shift staff), doctors, nurses, pharmacists and midwives, mixed nationalities and languages, and all in a 15 square metre area, with temperature over my tours ranging from -5 to 49 Celsius degrees over the six months. This made for a massive amount of patience and understanding. In 40 + degree temperatures, you couldn't go outside, and with no common rooms, our bedspaces were the only areas outside the actual hospital that had heat pumps for air-conditioning (when the power worked!). We slept a little, we read a little, we listened to music (this drowned out the constant sound of Chinook helicopters overhead and the bombings often in near range which shook the buildings regularly). Some watched downloaded shows and others just quietly reflected on being where we were. Often the new incoming rotation staff would sleep in their body armor and hard hats, not take off their boots and would physically 'startle' with the bombs and gunshots. Most started to feel more comfortable within a week or so, but some never settled, and if they made it through the 30-day rotation, didn't return.

The Goals of Disaster Management include Mitigation, Preparedness, Response and Recovery. These are important concepts for any disaster response and one that the UN and WHO are adept at orchestrating in these events. Our management team had the team's safety and wellbeing as its paramount goal. We were all very aware that we were in an unsafe and volatile environment but had complete belief in this team to ensure our collective safety. We had robust exit strategies and plans and had daily meetings with full transparency of the situation within the city and surrounding our field hospitals

I can honestly say that being in a war zone is not for everyone and I was often surprised how and why some people coped with the challenges and others struggled.

I guess this environment starts to make one ask questions. What makes an individual want to go to a war zone?

I guess many of us join this work for similar reasons: Wanting to help those not as lucky as we are? Having the training to make a difference in this area of work? The excitement of working and travelling in foreign lands? Running away from reality? Having read of courageous people who have done this work and wanting to experience it also, or perhaps the perceived glamor and challenges of working in formidable situations?

But, although some individuals survive and thrive, the simple truth is that "it is never easy, and it is always challenging"! At times we all question our sanity, but we work together and support each other, forming lifelong relationships that are incredibly strong and enduring. I have found time and time again after working in 13 countries with civil unrest, war, famine, chronic and acute outbreaks of endemic and epidemic disease, that it ALWAYS seems easier looking back at it once you are home safely than it was at the cliff face.

During March 2017, upwards of 255,000 internally displaced Iraqi civilians were living in 26 camps surrounding Mosul. The health and welfare of these internally displaced persons (IDP's) then became important. As with all uprisings, wars and hostilities, medical problems do not discriminate. As we evolved, our trauma hospital had to evolve, adapting our services to treat status 1 and 2 medically unwell patients also. It became necessary to provide treatment to a full myriad of acute patients; cardiac patients, pneumonias and acute respiratory failure, snake and scorpion envenomation, stroke, , acute abdomens, septic patients, ketoacidosis patients, and paediatric emergencies, to name a few. This meant broadening our scopes of practice and bought with it a whole new set of processes to work through.

Another question that is often discussed around the hypothetical 'campfire' in our small amounts of downtime is:

'What helps a warzone nurse/medic build "Resilience" and the ability to persevere under such difficult circumstances?

This always brings out the philosophical ideas within the eclectic group of individuals this genre of work attracts! In developing world medical teams and disaster response groups it has been suggested that the individuals who do this work fall into four groups: that we are either missionaries, mercenaries, madmen or misfits. This always causes healthy debate, and many of us fit one or more of the classifications at different times during our working lives in this area of work!

Reflection: Humanitarian Work in a War Zone cont.

It is important that we understand that stress is inherent in humanitarian work. In the war situation, exposure to a whole series of daily aggressions against the individual have a cumulative effect. Cumulative stressors in the warzone included the daily conditions; lack of privacy, confinement, extremes of heat and cold, the constant sound of aircraft, helicopters, regular bombings which shock our living quarters and the hospital, wearing helmets and vests, the stress of always having grab bags and all-important documents on your person (in case of immediate evacuations). Above all, you must 'know' yourself, know your limits, and listen to what your body is telling you.

On we as a team of 140 staff from 25 countries worked together to provide care for 47,890 patients over our tenure and delivered 2997 babies. We had a mortality rate of just 0.39% despite the dangerous conditions and the traumatic nature of injuries (aspenmedical.com 2017).

An outstanding achievement and one that the entire team can feel incredibly proud of.

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All photos including faces with full consent. Bronni McBain

[1] Since March 2017 Aspen Medical provided services at several field hospitals in Iraq including three around Mosul during the Iraqi Army offensive against ISIS.

Regular Features:

Paediatric Pearl: Disaster Planning

It is estimated that around 25-30% of patients involved in a disaster are children, and emergency nurses should be well equipped and prepared to respond (Chiu et al., 2022). A useful tool to help emergency department teams in preparation for the potential of a large volume of injured or unwell children is the **4 S's of Disaster Management** framework. This framework has demonstrated success during periods of large paediatric surges globally (Baker et al., 2024). The table below outlines the 4 key components of the framework and a few interventions to consider within each aspect are suggested.

SPACE	
This involves managing treatment areas, triage spaces, and temporary facilities to expand the capacity for patient care.	· If decontamination is required, try to keep children and parents together. The privacy of children must be protected if removal of clothes for decontamination is required
	· Nurse Practitioners and medical staff with paediatric experience should aim to prevent admissions for conditions that could be evaluated safely with close outpatient follow-up via home care nursing teams or a GP
	· Involve home care nursing teams to consider expanding the range of services that can be provided at home (eg, home oxygen or IVAB)
	· Identify alternative care sites (eg, meeting rooms/ play rooms) for inpatients and consider feasibility in advance. Consider the creation of portacoms or tents to provide care for low acuity patients
STAFF	
Ensuring that there are enough skilled, trained and prepared staff members ready to handle a sudden increase in paediatric patient numbers.	· Ensure staff who do not regularly work with children receive education on the key anatomical and physiological differences in children. In the context of traumatic injuries such as those in some disasters, these differences are well articulated on the RCH Trauma website: https://www.rch.org.au/trauma-service/manual/how-are-children-different/
	· Ensure clinicians who will potentially care for children during a disaster or surge are certified in paediatric life support and sufficient staff are educated in paediatric critical care nursing
	· Increase confidence in caring for unwell children through departmental simulation. Regular paediatric trauma simulation and paediatric inclusion in disaster management drills are associated with better paediatric patient outcomes (Allen et al., 2007; Graef et al., 2024)
STUFF	
Making sure that all the essential equipment and supplies required for providing care to paediatric patients during a disaster are available and accessible.	· Ensure sufficient stock of equipment such as high flow stock and paediatric appropriate sized equipment is maintained and checked regularly
	· Ensure training in using paediatric equipment including resus trolleys, airway equipment, paediatric-sized blood tubes, and common medications is provided
	· Consider creating flip charts attached to equipment with guidelines/ instructions for use. These act as a useful guide for nurses and other who find themselves working with equipment that they do not usually use on a regular basis
	· Consider the use of colour-coded supply trolleys to assist clinicians with less experience caring for paediatric patients
STRUCTURE	
This pertains to the organisational structure and established policies that facilitate effective clinical care during the management of a disaster.	· Improving paediatric surge capacity is associated with mitigating effects of disasters on paediatric patients (Allen et al., 2007)
	· Consider optimising use of urgent cares through voucher systems or posting of waiting times in main triage. Suitability for redirection and exclusion criteria will differ from adult patients.
	· Nurses can play a pivitol role in providing feedback to management teams regarding changes implemented during surge so improvements can be made in the future
	· Utilise disaster algorithm at triage as required. Paediatric triage disaster algorithms may be beneficial to facilitate rapid decision making - there is no consensus in the literature as to the best triage system in a paediatric mass incident, although a large scoping review found the Pediatric Physiological and Anatomical Triage Score (PPATS) to be the best tool to predict mortality during secondary triage (El Talwil et al., 2023; Toida et al., 2018).

(Table adapted from Baker et al., 2024; Bongiorno et al., 2024)

Paediatric Pearl: Disaster Planning cont.

The presentation of multiple injured or ill paediatric patients can be overwhelming for staff working in dual or non-paediatric emergency departments, however, the implementation of interventions through a preparedness framework can reduce stress and improve patient outcomes.

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Article of Interest, Reports & Policy Releases

The following are a selection of recent articles and reports of interest to those working in the emergency health sector, nursing and with relevance to New Zealand / Aotearoa health services.

Samadbeik, M., Staib, A., Boyle, J. et al. (2024). **Patient flow in emergency departments: a comprehensive umbrella review of solutions and challenges across the health system**. *BMC Health Serv Res 24*, 274. https://doi.org/10.1186/s12913-024-10725-6

Globally, emergency departments (EDs) are overcrowded and unable to meet an ever-increasing demand for care. The aim of this study, published in BMC Health Services Research, is to comprehensively review and synthesise literature on potential solutions and challenges throughout the entire health system, focusing on ED patient flow.

The authors found the majority of interventions were focussed on the 'within-ED' phase of the patient journey, with fewer looking at the pre or post-ED stages, and that most interventions had mixed or nonsignificant outcomes.

Antunovich, D., Romana, J., Lewis, G.N., Morunga, E., & Bean, D.J. (2024). **The lived experience of chronic pain for Māori: how can this inform service delivery and clinical practice? A systematic review and qualitative synthesis.** *NZMJ 137*(1591). DOI: 10.26635/6965.6271

This article, published in The New Zealand Medical Journal, synthesised the literature describing experiences of chronic pain and pain management for Māori, to understand how this could inform service delivery and clinical practice.

Three themes were identified: 1) a multidimensional view of pain and pain management: Māori expressed a holistic and integrated understanding of the multiple factors that influence pain and its management, 2) a responsibility: respectful tikanga-informed care: the experiences of Māori participants with healthcare highlight a need for antiracist approaches, and a clinical responsibility to practice manaakitanga and tikanga, and 3) tino rangatiratanga: a desire for knowledge, choice and autonomy in pain management: Māori valued the empowering nature of knowledge about pain, and information and support to make decisions about treatment, including considerations regarding Western and traditional Māori medicine.

These authors concluded that Health services need to understand and respect the multidimensional aspects of pain, minimise racism and discrimination, use whakawhanaungatanga, manaakitanga, and tikanga-informed practices, and provide appropriate information to support tino rangatiratanga for pain management

Sweeny, A.L., Alsaba, N., Grealish, L., Denny, K., Lukin, B., Broadbent, A., Huang, Y.L., Ranse, J., Ranse, K., May, K., & Crilly, J. (2024). **The epidemiology of dying within 48 hours of presentation to emergency departments: a retrospective cohort study of older people across Australia and New Zealand.** *Age Ageing. 53*(4):afae067. doi: 10.1093/ageing/afae067.

Emergency department (ED) clinicians are more frequently providing care, including end-of-life care, to older people. The objective of this study, published in Age and Ageing, was to estimate the need for ED end-of-life care for people aged ≥65 years, describe characteristics of those dying within 48 hours of ED presentation and compare those dying in ED with those dying elsewhere.

Key points identified included that for Australia and New Zealand, the 48-hour mortality rate for older persons was 6.43 per 1,000 emergency presentations. About half of the older people admitted to hospital had a prior palliative-type presentation or admission in the last 6 months. Factors associated with an increased risk of dying in the emergency department included arrival by ambulance and a triage category of 1, 2 or 5.

Joyce, L.R., Cleland, L., Forman, E., Hlavac, A., Foulds, J., Crossin, R. (2024). **Changes in alcohol-related emergency department presentations—a comparison of three waves in 2013, 2017 and 2022**. *NZMJ. 137*(1593). DOI: 10.26635/6965.6375

Emergency departments (EDs) around the world are increasingly overcrowded, which is associated with significant patient harm. Alcohol use is a known contributor to ED overcrowding. This study, undertaken in the Christchurch Hospital ED, aimed to assess trends in the characteristics of alcohol-related ED presentations over time. Over the time this study was run, a change in the age profile was identified, with a shift towards older patients attending with alcohol related issues. The median age increased to 39 years and presentations in the 65+ age group had doubled.

Article of Interest, Reports & Policy Releases cont.

Pledger, M., Irurzun-Lopez, M., Mohan, N., & Cumming, J. (2024). **How is enrolment with a general practice associated with subsequent use of the emergency department in Aotearoa New Zealand? A cohort study**. *Journal of Primary Health Care 16*, 135-142. https://doi.org/10.1071/HC24023

This was a NZ study looking at the use of general practice health care, and subsequent use of ED. Around 5% of people in Aotearoa New Zealand (NZ) are not enrolled with a general practice. The researchers compared responders from New Zealand Health Surveys (2013/14-2018/19) looking at self-reported general practice use according to their enrolment status (enrolled and not enrolled). They were then followed up to examine their subsequent use of an emergency department.

Those not enrolled were more likely to be young, male, Asian, more socioeconomically deprived and with better health status than those enrolled. Generally, those not enrolled utilised general practice services less. Those not enrolled who had used an emergency department were more likely to have used it as a substitute for general practice (40% vs 26%).

Penney, S., Dicker, B., & Harwood, M. (2024). **Cultural safety in paramedic practice: experiences of Māori and their whānau who have received acute pre-hospital care for cardiac symptoms from paramedics**. *Journal of Primary Health Care 16*, 180-189. https://doi.org/10.1071/HC24010

This research explored experiences of cultural (un)safety for Māori and their whānau who received acute pre-hospital cardiovascular care from paramedics. Cardiovascular disease remains a major health concern for Māori, with culturally unsafe experiences in health care reported, resulting in poor health outcomes. In-depth semi-structured interviews were undertaken with 10 Māori patients and/or whānau. Systemic and structural barriers were identified. Paramedics' clinical knowledge and interpersonal skills, including appropriate communication and ability to connect were identified.

Government Policy Statement on Health 2024-2027

https://www.health.govt.nz/publication/government-policy-statement-health-2024-2027

The Government Policy Statement on Health 2024-27 is the public statement of what Government expects the health system to deliver and achieve, and how success will be measured, monitored, and reported. The GPS sets the direction for the health system as a whole and incorporates the Government's priorities. It sets the expectations for health entities to make sure they are working towards common goals that matter for New Zealanders.

The GPS 2024-27 sets out five priority areas for the health system.

Access – ensuring all New Zealanders have equitable access to the health care services they need, no matter where they live.

Timeliness – making sure all New Zealanders can access these services in a prompt and efficient way.

Quality – ensuring New Zealand's health care and services are safe, easy to navigate, understandable and welcoming to users, and are continuously improving.

Workforce – having a skilled and culturally capable workforce who are accessible, responsive, and supported to deliver safe and effective health care.

Infrastructure – ensuring that the health system is resilient and has the digital and physical infrastructure it needs to meet people's needs now and the future.

Komene, E., Davis, J., Davis, R., O'Dwyer, R., Te Pou, K., Dick, C., Sami, L., Wiapo, C., & Adams, S. (2024). **Māori nurse practitioners: The intersection of patient safety and culturally safe care from an Indigenous lens**. *Journal of Advanced Nursing, 00*, 1–13. https://doi.org/10.1111/jan.16334

A group of five Māori NPs worked alongside a Māori nurse researcher to explore their perceptions of patient safety. Together, they held an online hui (focus group) in early 2024. Data were analysed collectively, informed by kaupapa Māori principles, using reflexive thematic analysis. Three themes were identified: (1) Te hanga a te mahi: the intersection of cultural and clinical expertise; (2) Mātauranga tuku iho: the knowledge from within, where safe practice was strongly informed by traditional knowledge and cultural practice; (3) Te Ao hurihuri: walking in two worlds, where Māori NPs navigated the westernized health system's policies and practices while acting autonomously to advocate for and deliver culturally safe care.

NP Tips, Tricks and Trips

Author:

Paddy Holbrook Nurse Practitioner, Acute Care. Email: paddy.holbrook@otago.ac.nz

Well, it is winter and pretty cold down here in the south, and like most of you we have seen lots of Influenza A, RSV, COVID and reasonably often a mixture of two. There have been lots of other non-specific URTI and sore throats to throw into the mix. I thought I would briefly talk about an interesting case that is not that common, but one it is good to be reminded about. Otitis Media in an adult patient.

I picked up this gentleman as he was in significant pain, triage nurses had given him the standard paracetamol and NSAID but he required more. Please note the following is only a brief case study, not including full details.

Case outline:

39 M, NZ European ethnicity, referred by GP with ?mastoiditis, initially disucssed with ENT but they suggested ED see first 😊

PC: Left ear pain, sore throat, feeling hot and cold.

HPC: Five days URTI symptoms, COVID negative, last night developed left ear pain. Mild fevers, but pain in ear 'the worst ever'. Taken codeine with minimal effect, presented to GP and referred to ED.

Nil past hx of note, nil meds, NKDA, nil illicit drugs, non-smoker, no recent travel.

Currently employed, lives with partner, no diving but does swim regularly, fit and well.

Exam; T 37.5, HR 102, SPO2 98%, RA, Pain 9/10 despite 10mg severedol given. A=Patent, B=speaking full sentences, nil incr. WOB, C= tachy, mildly febrile, D=GCS 15

Face/Neck; No trismus or drooling. Throat; erythematous, nil swelling or exudate.

Right ear: NAD.

Left ear: Swollen anterior cervical glands, no swelling or erythema over mastoid, non-tender. Pain on movement of tragus, and auricle. Ear canal moist, TM intact but bulging, some exostosis.

Other body systems examined with no abnormal findings.

Relevant bloods: CRP 78, WBC 13.1, neut 10.8

Impression: Acute otitis media, +/- otitis externa.

Plan: referral to ENT, analgesia, bloods, swab, IV amoxicillin.

Discussion: this gentleman required opioids to manage his pain. He presented with a relatively mild neutrophilia, mild tachycardia, not particularly febrile. I gave him sevredol and IV fentanyl with minimal effect. He was distraught and when referred to ENT they carried out an urgent myringotomy and suction of pus in the ED.

He went on to be admitted, two days later his AB's were changed to Augmentin. He has an increasing CRP and WBC, noted CSF leak, and his CT showed opacification of the mastoid bone with concern for erosion. He was referred to neurosurgery for advice.

Further MRI imaging was undertaken, which showed no abscess formation, likely mastoid effusion and no dural venous sinus thrombosis.

Eight days later, he underwent surgery for mastoidectomy on left.

This gentleman had an extended stay, he deteriorated over 48 hours, he developed temporal bone involvement and a CSF leak. He continued on AB's post his discharge and was still undergoing follow up 8 weeks post initial presentation.

Otitis media is uncommon in adults, occurring in less than 1% of presentations. It is most often identified after a viral illness. Discussion in the literature describes this as a normally self-limiting condition without requirement for antibiotic therapy. Of note, differing sources suggest different management plans. Mastoiditis is even more uncommon and despite early intervention, this gentleman still went on to require surgery. Mastoiditis is a life threatening complication of Otitis media, which can lead to brain abscess and meningitis.

Common pathogens as per UptoDAte (2020) are Haemphilius influenza, Strep pneumonia, and Moraxella catarrhali, staph aureus and Group A strep. Although, as the literature states, often there is no growth on swabs as with the case with this gentleman.

I found this case really interesting, partly because it was uncommon but also because had he not been in so much pain, I wouldn't have been overly concerned. His blood results were not majorally deranged, he did not have the classic appearance of mastoiditis, with no swelling or tenderness over the bone. It is something to consider not just in children but in our older population. Interesting we are seeing a decrease in otitis media in children, most likely related to immunisations that cover the most common causes, (Rijk et al 2021).

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Cultural Safety and Te Ao Māori

Cultural Safety and Te Ao Māori Snippets

Incorporating aspects of culture and operationalising Cultural Safety are key elements with New Zealand nursing, that have the potential to make our practice unique. Within Emergency Nursing, we can impact health care, raise awareness around issues of equity and access, and challenge aspects of power and its misuse.

The Health System has specific responsibility and accountability towards Māori, and as representatives of the wider health system, emergency service providers need to understand the implications of their actions (and inactions). One way of developing our responsiveness to Māori is by increasing the wider understanding of Te Ao Māori – the Māori world view – and use of Te Reo – Māori language.

Māori Models of Health: The Meihana Model

Sandra Richardson, RN, PhD
Christchurch Emergency Department, Waitaha

Rārangi Kupu (vocabulary list)

- Āhua: Personalised indicators
- Aku: crossbeams (of the Waka Hourua)
- Hauora: health
- Hinengaro: Mental and emotional well-being.
- Hiwi: hulls (of the Waka Hourua)
- Iwi Katoa: Wider societal influences (now ratonga hauora, access to quality health services)
- Karakia: prayer
- Kaupapa: Attending to the main purpose of the encounter.
- Mihimihi: Initial greeting engagement.
- Nga Hau e Wha: The Four Winds
- Nga Roma Moana: The ocean currents
- Poroporaki/Whakamutunga: Closing the session.
- Ratonga hauora (previously iwi katoa): access to quality health services
- Taiao: Physical Environment.
- Tikanga: Māori cultural principles
- Tinana: Physical well-being.
- Wairua: Spiritual well-being, connectedness
- Waka Hourua: double hulled canoe
- Whakawhanaungatanga: Making a connection.
- Whakatere: navigation
- Whānau: Family and support networks, relationships, role and responsibilities
- Whenua: specific genealogical or spiritual connection between client and/or whānau and land
- Whakatere: navigation

Introduction

As we continue to look at the range of health models developed within and relating to Te Ao Māori, this edition of the journal will focus on the Meihana Model. This model was built on the concepts identified in Te Whare Tapa Wha, together with the other approaches which seek to introduce the key cultural beliefs integral to Te Ao Māori. It was designed to enable and support health practitioners to more fully understand the context and presenting complaints of Māori patients and whānau. It provides a framework within which non-Māori practitioners can structure their approach and understanding when assessing Māori patients and whānau.

The Meihana model has continued to develop and undergo refinement since its initial development in 2007, associated with Suzanne Pitama and colleagues working within the Department of Maori/Indigenous Health Innovation at the University of Otago (Pitama et al., 2007). In combination with the Hui Process (Lacey et al, 2011), these two approaches form the Indigenous Health Framework, used as a scaffold for health practitioner interviews as part of the clinical assessment process (Pitama, Huria & Lacey, 2014), and more recently being specifically adapted and trialled in the field of applied psychology (Pitama et al., 2017). The underlying intention is to enable health professionals to incorporate cultural safety effectively into their practice, to improve health service delivery and challenge existing health disparities between Māori and non- Māori.

The Hui Process is now widely recognised and used in health care and other interactions. It was initially piloted within medical education training as part of the clinical interviewing process, with the intention of developing a culturally congruent practice with Māori patients and whānau. It includes four stages, mihimihi (initial greeting engagement), whakawhānaungatanga (making a connection),

Cultural Safety and Te Ao Māori cont.

kaupapa (attending to the main purpose of the encounter), and poroporoaki/whakamutunga (closing the session) (Lacey et al, 2011).

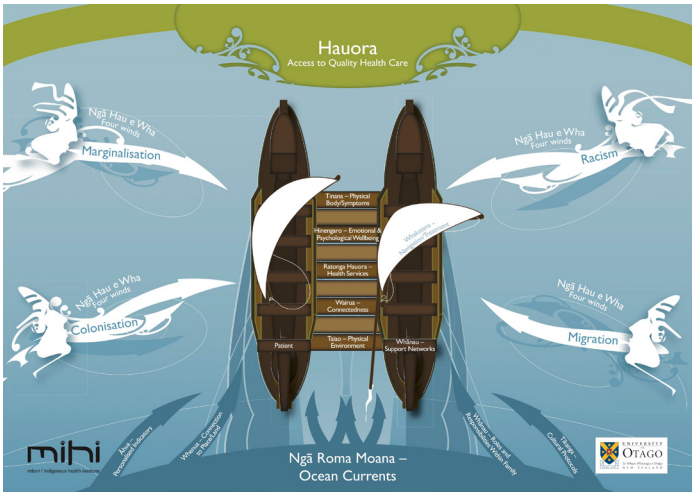
Components of the model

The Meihana model builds on the earlier work of Te Whare Tapa Whā (Durie, 1998), adding to the initial concepts introduced here, and utilising a different analogy. Within the Meihana model, the Waka Hourua (double-hulled canoe) consists of the two hiwi/hulls (representing patient and whānau) connected by five aku/crossbeams (tinana/physical health; hinengaro/psychological and emotional wellbeing; wairua/beliefs about connectedness; taiao/physical environment; and ratonga hauora/access to quality health services).

Patient and whānau form the two hulls of the waka, demonstrating the need for considering both within the assessment and as necessary for the journey towards hauora (health). The health practitioner is able to come aboard the waka hourua for a negotiated period, becoming a part of the patient's support network (kaupapa whānau). Part of the clinical assessment includes confirmation of the patient's ethnicity as Māori, addressing the recognised inaccuracies of existing data collection around ethnicity in healthcare and moving towards normalisation of this question. Ethnicity is a recognised determinant of health, and the more culturally safe the healthcare environment, the more comfortable an individual may feel to identify as Māori. Whānau includes both biological family (whakapapa whānau) and/or other significant supports (kaupapa whānau) who are important to the patient's health and well-being (Pitama, Huria & Lacey, 2014).

The Waka Hourua is subject to the forces of Nga Hau e Wha – The four winds. These represent the historical and societal influences on Māori as the indigenous peoples of Aotearoa/New Zealand. These forces are described as Colonisation, Racism, Migration and Marginalisation. In addition to the influences of Nga Hau e Wha, the Waka Hourua is subject to the impact of Nga Roma Moana – Ocean Currents. These include Āhua, which is defined as those personal indicators of Te Ao Māori which have importance for the patient and whānau, such as the use of te reo, or wearing of specific taonga. Other currents are represented by Tikanga, Māori customary principles (for example whether a patient might have expectations around karakia/prayer) and Whānau – which involves identifying the relationships, roles and responsibilities of the patient within Te Ao Māori, including whānau, hapu, iwi and other organisations. The final component here is Whenua, which refers to the genealogical or spiritual connection between patient and/or whānau and land (Pitama, Huria & Lacey, 2014).

In order for the Waka Hourua to reach its destination, in this case Hauora (health), requires Whakatere or Navigation. This is analogous to the health practitioner and patient/whānau working to identify and implement proposed treatment interventions, healthcare plans and recommendations.



The rationale for use of an approach such as the Indigenous Health framework, and the embedding of Māori models of assessment such as the Meihana model can be seen in the evidence linking inappropriate and inaccurate assessments to misunderstandings, misdiagnosis and mistreatment, and the continuation of health inequities within New Zealand/Aotearoa health services. By acknowledging and staying informed about the impacts of Nga Hau e Wha, by recognising the presence of systemic and institutional racism, the impact of unconscious bias and the pervasive presence of social and environmental inequalities, a clearer understanding of the health status and issues facing Māori patients and whānau is possible.

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Pae Ora Report October 2024

Author: Natasha Kemp (Te Arawa), Whakatane Emergency Department

Vision: To provide a Culturally supportive environment for Māori accessing care and working within the Emergency Departments of Aotearoa.

Mission: CENNZ continues to work towards improving and supporting Māori whanau and the Māori workforce within the Emergency Departments of Aotearoa.

This Government is failing on Kawa Whakaruruhau-Cultural

Safety standards.

The last couple of months have been busy. In May, myself and two other members from CENNZ, Lauren (chair) and Lyn (membership) were invited to meet with Dr Shane Reti, Minister of Health. This was a prime opportunity and one that we were grateful for. So, we structured our questions and rehearsed with each other; we had previously met with the Labour Minister of Health, Dr Ayesha Verrall in 2023 so we were aware of the process and the time restrictions placed on our team as we went in to highlight the struggles of nursing and specifically give a state of the nation-no filtered discussion from the front line of Emergency nurses.

Lauren asked questions focused on education and the increasing demands placed on Emergency departments. Lyn was wearing her CCDM and staffing hats, so Lyn asked questions on these topics and more. I asked the Minister what actions the Ministry offers to improve outcomes for Māori, especially in the Emergency setting. This is where the very articulate (but always a politician) answered with: by looking at Respiratory illness rates, vaccinations rates and Hospital admission rates, this would show improvements in these areas. I thought these were slightly ambitious considering we don't administer vaccinations, except ADT and admission rates will continue to climb when primary care services are broken, and Emergency departments become the default service between Primary and Secondary care.

We also talked about the role of the Iwi Māori Partnership Boards (IMPB) post the dis-establishment of Te Aka Whai Ora. I couldn't help myself I had to raise the question, like so many other Māori and health professionals nationally who were gutted at the disestablishment of Te Aka Whai Ora. I also asked what actions will be provided to support the growth of Māori nurses, for me I always say if you want to improve Māori Health Outcomes-start with the Māori nursing workforce! I was advised that the rate of Māori nurses is growing. Kei hea?-where? I have not seen any increase-especially in the environment of Emergency, again his answer didn't quite hit the mark for me. This sentiment is reinforced in July, when Te Whatu Ora were making statements about reducing recruitment of our newly graduated nurses - disappointing.

So, whilst I was grateful for the hui, the buzz of going to the Beehive soon fizzled out and continues with the actions of this coalition government that continues to disestablish and disable anything that potentially supports Maori, not only in health, but in all determinants of health-education, justice, social development, taiao and challenging Te Tiriti o Waitangi. The racism and ignorance of this present government coming to the forefront and reflected in this governments actions. In response to this, I held two webinars. The first one in May was titled Improving the Environment for Māori accessing Emergency care: I wanted to share the history of Māori health to provide some context for the inequities that Māori are challenged with every day. The second webinar in July was titled Pae Ora-Healthy futures within Emergency care. The purpose of this webinar was to improve our nursing response when caring for Māori and bring attention to the Pae Ora Hauora Model as a tool for all nurses, as part of this webinar highlighting that health is a holistic approach incorporating the Mauri ora-individual health, Wai ora, - environment awareness and Whanau Ora, inclusion of family in patient care. So again, I was disappointed to hear that on July 24th this government and Act leader David Seymour have stated that Te Whatu Ora staff are to no longer incorporate karakia into their work.

Kāore-No! Spiritual health, karakia, actions that supports the Wairua is essential to supporting the tinana-physical, whanau -family and hinengaro-mental health. All elements are interconnected and essential to health. Sometimes, often lately staff-myself included need karakia to deal with all the challenges we face. In the above two webinars I also reaffirmed attention to 'Kawa Whakaruruhau'-Cultural Safety a Kaupapa developed by Dr Irihapeti Ramsden over 20 years ago and even more relevant and needed today. So, for me, this government is failing on Cultural awareness and Cultural Safety. I was asked recently who can go and teach them? I replied, I will go!

Naku na, Natasha Hemopo

Whakatane Emergency CNC

Snippets: Humanitarian Responses

Snippets

A snippet is a "small part, piece, or thing, especially a brief quotable passage." If you know of any items suitable for inclusion in 'Snippets', please e-mail these through to:

Editor.cennzjournal@gmail.com

Useful Links and Resources

Check out the following resources, if you haven't already:

New Zealand Resources

NZ Red Cross: International delegate programme. https://www.redcross.org.nz/about-us/what-we-do/what-we-do-overseas/international-delegate-programme/

Guidelines, Standards and Policies:

ICRC Nursing Guidelines. https://www.icrc.org/en/publication/4020-icrc-nursing-guidelines

RCN (2022). Humanitarian Crises Framework. file:///C:/Users/sandrar/Downloads/RCN-Humanitarian-Crises-Framework.pdf

WHO (2020) Quality of Care in Humanitarian Settings. https://www.who.int/publications/m/item/quality-of-care-in-humanitarian-settings#:~:text=Overview.%20Improving%20the%20quality%20of

Websites:

These websites and apps have links to information relevant to emergency nursing and offer resources or further ideas you may find of interest. Please note that while these are offered for consideration, Emergency Nurse NZ and NZNO does not endorse any specific products that may be mentioned.

Websites	Links
Mercy Ships NZ	https://mercyships.org.nz/who-we-are/
https://mercyships.org.nz/volunteer-job/nurse/	
UNjobs: jobs for nursing	https://unjobs.org/themes/nursing
MSF Australia (medecins sans frontiers)	https://msf.org.au/join-our-team/work-overseas/who-we-need/medical/nurses
ICRC International Committee of the Red Cross	https://careers.icrc.org/content/Healthcare/?locale=en_GB
Aspen Medical	https://careers.aspenmedical.com/#en/sites/AUS/job/993
IFRC The International Federation of Red Cross and Red Crescent Societies	https://www.ifrc.org/our-work/health-and-care/emergency-health

College Activites:

CENNZ Reports

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

Committee Roles

CENNZ Mission Statement

We believe that emergency nursing is a speciality within a profession. We aim to promote excellence in Emergency Nursing within New Zealand / Aotearoa, through the development of frameworks for clinical practice, education and research.

CENNZ Committee Roles		
Role / portfolio	Portfolio holder	Location and Link
Chairperson	Lauren Miller	cennzchair@gmail.com
Secretary	Vicki Bijl	cennzsecretary@gmail.com
Treasurer	Brendon Tampus	cennztreasurer@gmail.com
Membership	Lyn Logan	cennzmembership@gmail.com
Grants and Awards	Lyn Logan	cennzawards@gmail.com
Staffing Repository	Vicki Bijl	cennzrepository@gmail.com
NZ Triage courses		cennztriage@gmail.com
Professional Nursing Advisor (NZNO)	Suzanne Rolls	suzanne.rolls@nzno.org.nz
Te Rūnanga Representative	Natasha Kemp	
Knowledge and Skills Framework	Lauren Miller	cennzchair@gmail.com
Website and Social Media	Wendy Sundgren	
Webinars	Laura Cottrell	
Pae Ora	Natasha Kemp	
Networks	**Name**	
Clinical Nurse Educator Network	Lauren Miller	
Charge Nurse Managers Network	Vicki Bijl	
Advanced Emergency Nurses Network	Lydia Moore	
Emergency Nurse Practitioner Network	Craig Jenkin	

Committee Regional Representatives

Committee Regional Representatives

Region	Name	Daily Role
Te Rūnanga	Natasha Kemp	Clinical Nurse Coordinator, Emergency Department, Whakatāne Hospital
Northland / Te Tai Tokerau	Brendon Tampus	Associate Clinical Nurse Manager, Te Tai Tokerau Emergency Department
Auckland	Wendy Sundgren	Associate Clinical Nurse Manager, Emergency Department, Middlemore Hospital | Professional Teaching Fellow, The University of Auckland
Auckland	Lydia Moore	Clinical Nurse Specialist, Emergency Department, Waitakere Hospital
Midlands / Bay of Plenty	Lyn Logan	Associate Clinical Nurse Manager, Emergency Department, Rotorua Hospital
Hawkes Bay / Tairāwhiti	Laura Cottrell	Clinical Nurse Educator, Emergency Department, Hawkes Bay Fallen Soldiers' Memorial Hospital
Mid Central Region	Lauren Miller	Clinical Nurse Educator - Taranaki Emergency Department
Wellington	Craig Jenkin	Nurse Practitioner, Emergency Department, Wellington Regional Hospital
Top of South	Vicki Bijl	Clinical Nurse Manager - Nelson Hospital
Canterbury / Westland	Jo Aston	Nurse Unit Manager, Emergency Department, Christchurch Hospital
Otago / Southland	Michelle Scully	Clinical Nurse Educator | Staff Nurse, Emergency Department, Southland Hospital

Chairperson's Report

Lauren Miller
CENNZ Chairperson
Contact:
cennzchair@gmail.com

Healthcare and nursing have never felt more pressured and that is certainly impacting on us as emergency nurses around the country. Given the current climate, the CENNZ committee has been all the more driven to continue to fly the emergency nursing flag and to develop resources and campaign for emergency RN's across the country.

The College of Emergency Nurses New Zealand- New Zealand Nursing Organisation (CENNZ- NZNO) met with the Honorable Dr Shane Reti, Minister of Health NZ, on Thurs 23rd May. The

meeting came about after CENNZ penned a letter to the Minister that highlighted topics that we hoped to discuss.

The meeting focused on the current state of Emergency Departments (ED) and its implications on emergency nursing, shorter stays in ED's and health equity in the specialty. We highlighted the reality of ED nursing in NZ, particularly around staffing and workforce, and violence and aggression. When considering the shorter stays in emergency department health target, we queried the consistency of the data being collected and reported. We highlighted that we strongly felt that for this target to be achieved, acute patient flow must be addressed and a wider hospital approach to the target as essential. We also felt it important to ask the Minister what assurances of actual measures to support Māori will be offered and if there were any specific strategies to address disparities in access to emergency care services, particularly in rural or remote areas of New Zealand. Overall, we felt that the Minister understood and respected our role and shared our concerns as emergency RN's. The opportunity to share the unfiltered reality of our experiences directly with Honorable Dr Shane Reti was a worthwhile and important opportunity for us as a college.

A major focus for CENNZ over the last year has been the redevelopment of the CENNZ Triage Course. This has been a significant undertaking and has involved refreshing the course content and its

delivery. I would like to thank all those who have given significant time and effort to bring this course in line with current practice and to update the course content, workbook, scenarios and evaluation process. I would particularly like to thank Suzanne Rolls and Katie Smith, who have worked tirelessly on this project. We have been delivering the new triage course content since June with positive feedback to date.

CENNZ has had a number of key achievements in the last year, of which for me the highlight was the 2023 CENNZ Conference. The Ready to Respond Conference was held in Christchurch, drawing together 190 emergency department professionals to deliberate on emergency response

Chairperson's Report Cont.

strategies in light of recent New Zealand incidents, including the Christchurch Mosque shooting, the Whakaari White Island eruption and Cyclone Gabrielle. The event also provided a platform to commemorate accomplishments in emergency nursing nationwide.

CENNZ has been having ongoing discussion and awareness of improving equity within EDs. Led by and in collaboration with Natsha Kemp, our CENNZ Te Runanga representative, CENNZ has been developing a Pae Ora strategy. Throughout this process we have already been able to commence several impactful workstreams with a Pae Ora focus or influence. These include, but are not limited to Pae Ora education and awareness, which has been delivered to the Nurse Educators and Triage Instructors, and made accessible to our members through webinars with a Pae Ora focus. We have commenced work to update the CENNZ Knowledge and Skills framework to acknowledge Te Tiriti O Waitangi principles "Aspects of Responsive to Māori". This includes Māori knowledge frameworks to reflect matauranga values. We have also increased support for Māori nurses by promoting the grants we have available and providing easier access to these grants.

This year has not been without its challenges and there are a number of issues that CENNZ has been aware of, these include:

- There has been a large Increase in IQNs as part of the nursing workforce. We feel we haven't been able to support these nurses as well as we should have due to inequities in the workforce around the country, including different levels of FTE for education roles across the motu. We would like to improve the onboarding of this workforce and provide robust support so that IQNs are welcomed. CCDM needs to include robust education hours for differing levels of orientation.
- Growing our own workforce has become increasingly difficult due to budget cuts, hiring freezes, and having available FTE for new graduates.
- Unmet needs in the community, hospitals at capacity, and long waits to be seen by specialty services has meant access block and overcrowding within EDs across NZ.
- TrendCare usage has increased, however not in all ED's due to IT infrastructure and support from management. Therefore, there are continued delays to safe staffing.
- An increase in aggression and violence in our communities has resulted in an increase in aggression and violence towards staff and patients, and an increase in trauma-related injuries. CENNZ would like to see trained security as a requirement in all ED's throughout Aotearoa.

CENNZ has sustained our commitment and continues to voice and campaign in these spaces.

We do this through fostering networking groups tailored for Nurse Educators, Nurse Managers, and Advanced Nurses, and facilitating collaborative endeavors and ongoing professional advancement nationwide. CENNZ currently has representation on the NZNO bargaining team, Te Rūnanga and Manaki Mana, ACEM, ED NAG and CCDM groups, which provide us with seats at many tables where we can fly the emergency nursing flag, to make sure that we are continuing to be heard.

I look forward to continuing to lead this committee in 2025 and to celebrate our profession again at the CENNZ 2025 Conference.

Lauren Miller

CENNZ Chair.

Te Tai Tokerau | Northland

Regional Representative

Brendon Tampus

Associate Clinical Nurse Manager

Whangārei Base Hospital Emergency Department

Te Whatu Ora Te Tai Tokerau

Kia ora Aotearoa New Zealand

We started 2024 in Whangārei ED with successful recruitment of FTE requirement for Registered Nurses. However, the midyears statistical findings suggest an increase of acuity and patient presentations in Whangārei ED. Bed reallocation and workloads for nurses have constantly changed to meet patient care demands. Among the hurdles facing the team includes fast track chairs in Whangārei ED having no nursing resource every morning, therefore SMOs and nurse practitioners have been managing their workloads on their own.

Rising above the challenges are silver linings in the works...

First, Whangārei ED is on track in full implementation of TrendCare after a long delay due to data and digital outage issues. The initial plan will be "training the trainers" before September. We are anticipating that the TrendCare system will improve the mahi and facilitate support for Whangārei ED nurses. Alternatively, our application for an ED Nurse Practitioner role was approved by Health New Zealand and recruitment is in progress.

Second, Whangārei Hospital was recognised as one of the best hospitals in New Zealand, meeting the national target for 6 hours waiting time in the ED. The collaborative effort by ED nurses, doctors and the multidisciplinary team are the highlight to this achievement. Moreover, our medical registrars have implemented an initiative called Same Day Emergency Care (SDEC) to manage patients with predominantly chronic conditions in the Short Stay Medical Assessment Unit, bypassing the ED.

Lastly, a special acknowledgement to our partner, Woolworths, and quality improvement project "food insecurity" founders, ED consultant Steph Richling and Social Worker, Andy Blain. A distinguished part of the A-D assessment tool will help many vulnerable kiwis and whānau access healthy food. Whangārei ED was delighted by the abundance of kai being donated and distributed to our patients in need.

Living up to the excellence, Whangārei ED is well known nationwide to produce competitive and highly skilled nurse leaders. We would like to congratulate Leigh Guddat and Amanda Harrison for completing and passing the TNCC instructor course, and Rachel Thorn for being an outstanding role as national delegate for the NZNO bargaining team.

Kia kaha te mahi!

Brendon

Associate Clinical Nurse Manager

Kaitaia Hospital Accident and Medical Department

The gateway to beach paradise at the top of the north was not exempt from the increasing demand for emergency care for its people. The lack of on-site doctors in Kaitaia Hospital prompted the implementation of the first Emergency Consult in the country. This service provides immediate expert advice through video conference and is continuously being utilised to relieve a pressured health system across the motu.

Te Tai Tokerau | Northland cont.

An incredible change that has happened at Kaitaia A&M is the funding and employment of RNs to work in triage. Also, a new A&M was rebuilt in Kaitaia offering a more spacious treatment area and resuscitation rooms.

Awesome recognition to our nursing leadership team and colleagues of Kaitaia A&M for their selfless dedication to render a high standard of nursing service to our rural communities.

Written on behalf of:

Narelle Stayte & Robbie Williams

Bay of Islands Hospital (Kawakawa) Accident and Medical Department

The colourful steam train town of the Bay of Islands has recently completed a redevelopment of the hospital to provide better services to patients and whānau up north. Albeit the A & M department has been confronted with a shortage of senior medical officers. The domino effect made patients and ambulances divert to the main regional hospital in Whangārei, which delays patient treatment and puts capacity pressure on respective EDs.

Our current staff vacancy has a Nurse Educator position left unfilled. Kawakawa A&M have successfully progressed to employing three nurses on morning and afternoon shifts, with two nurses for the night shift; daunting times when one of the RNs at night gets pulled out for ambulance transfers. In relation to equipment and facilities, Kawakawa A&M have a brand new ultrasound scan machine and computer-on-wheels (COW) to deliver high standard emergency services.

Acknowledgement to all the hard-working Kawakawa A&M team for providing continuous top-notch care to our Ngāpuhi and visitors.

Written on behalf of:

Yasameen Singh

Tāmaki Makaurau | Greater Auckland Region

Regional Representative

Lydia Moore

Clinical Nurse Specialist

Waitakere Hospital Emergency Department

Te Whatu Ora Waitematā

Regional Representative

Wendy Sundgren

Associate Clinical Nurse Manager

Te Tari Rongoaa Ohorere | Middlemore Hospital Emergency Department

Te Whatu Ora Counties Manukau

Professional Teaching Fellow

School of Nursing

Waipapa Taumata Rau | The University of Auckland

Waitākere and North Shore Hospital Emergency Departments.

Kia ora from Waitematā,

Since our last regional update, we have experienced significant developments. In terms of patient flow, similar to other departments nationwide, we have observed exponential increases in presentations, with viruses being a frequent presentation during the winter season. Regrettably, this has led to a rise in instances where corridor beds are utilised or, in some cases, where beds cannot be provided at all. Our amazing staff continue to work hard despite these challenges. North Shore Hospital has stood up a Medical 'Flex Ward' for 3 months, 4 days/week, which will support patient flow out of ED. Waitemata also has a very successful 'Hospital in the Home' (HiTH) programme which supports patients discharged to the community with a Doctor and RNs by phone (like a virtual ward) and the ability for remote patient monitoring.

Regarding staffing, there continues to be inflow and outflow of staff. At present, Waitakere ED is fully recruited, whereas Northshore ED has ongoing vacancies. Like many EDs, we have lost experienced ED RNs. The introduction of Flow, Coach and Acute Care Practitioner Speciality roles has ensured new or junior staff receive adequate orientation and support in managing departmental flow. In addition, we have doubled the number of Health Care Assistants (HCAs) throughout the Waitakere department, which has notably alleviated RN tasks and ensured our patients are safe and well cared for. These include MSU dipsticks, vitals, ECG's (all under direction of the delegated nurse) to ensuring our patients have food and water.

An initiative by one staff member on simplifying the RL6 reporting of violence and abuse within the department has enabled us to have an increase in security measures, resulting in a notable decrease in both physical altercations and verbal confrontations.

The implementation of ED TrendCare earlier this year has been met with enthusiastic adoption among our staff, but continues to be a challenge with the time pressures within the department. We are looking forward to seeing what FTE the departments will get following this.

Furthermore, our adult and paediatric Educators continue to deliver informative monthly newsletters and creatively designed educational resources, such as the "Paeds While You Pee" toilet signs, to effectively disseminate learning topics across all staff

Excitingly, Northshore ED is looking at upgrading triage and the waiting room to expand their very small seating area and to improve flow and the patient journey. We look forward to this development!

We wish all EDs a safe winter!

Lydia Moore,

Clinical Nurse Specialist.

Auckland Region cont.

Starship Children's Emergency Department.

The under 12's group presenting to Emergency Departments is the biggest growth across the country. Children's ED Starship has seen this increase and its mostly lower acuity Triage 4 patients. This does demonstrate the poor access to primary health.

Whilst volumes are higher than we have had before from a nursing point of view its one of the best winters we have had. In May, after about 9 months, we were fully recruited to our new CCDM model (thanks TrendCare) and FTE. This was a 40% increase. It took 9 months as a lot of our candidates came from across the globe- US, UK, Phillipines and a couple from India. It has meant that when we have a couple resus patients, that there are still nurses caring for all the other tamariki in the department. One sick call does not paralyse us.

We are doing a Nurse Assessment audit, already we antecdotally know that the Nurse Assessment post triage time has improved, as well as the intitation of care. We have junior doctor vacancies and associated longer wait times – so the nursing intiation of care piece is so important.

Anna-Marie Grace,

Nurse Unit Manager.

Middlemore Hospital Emergency Department.

It has been a winter where we've broken all the records we didn't want to. From having the highest daily presentation number in June of 441 patients over 24 hours, to having a record-breaking month of 11,800 presentations for July, with 6 days of over 400 presentations, to having the greatest number of patients in the department at one time - 254 patients.

In April we moved to a "registration first" process which allowed us to better capture the time patients were waiting to be triaged. This also gives those running the department a sense of how many patients are waiting in order to better redirect resource. The change will enable us to better identify and quantify what some of our areas of need are, so that we can work on possible solutions to meet the demand.

In June we flipped our Adult Short Stay and Surgical Assessment Units (SAU), and in the process changed the SAU from a unit that just accepted General Surgical patients to one that accepted all Surgical specialties and Women's Health patients. We rebranded the Adult Short Stay as the ED Short Stay (EDSS) to emphasise that the unit was ring fenced for ED patients. The combination of these changes has allowed us to decant the Adult Waiting Room by allowing for these areas (particularly the EDSS) to be unimpeded by patients waiting for beds on the ward.

On a recruitment front, this remains slow due to the Regional approvement process. We will be looking for a Charge Nurse Manager (CNM) for our Adult Acute Department and are currently recruiting to the CNM Kidz First Department, with this role having recently been made vacant. We have a small amount of RN and HCA vacancy which we will also recruit to in time once Regional approval has been granted.

Chris Chu,

Nurse Unit Manager.

Auckland Region cont.

Middlemore Hospital Emergency Department.

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Chris Chu,

Nurse Unit Manager.

CENNZ Members

If you would like to highlight a colleague, we invite you to write to the editor at: editor.cennzjournal@gmail.com.

We can provide you with a set of interview questions or you can create your own.

Waikato | Bay of Plenty Region

Regional Representative

Linda (Lyn) Logan

Associate Clinical Nurse Manager (ACNM)

Rotorua Emergency Department

Te Whatu Ora Lakes

Rotorua Emergency Department.

Like many EDs this winter, Rotorua has had increased presentations, complex patients, along with long wait times due to delays with specialities seeing patients, and bed block. Along with the financial issues we are all facing, this winter has been particularly difficult, with no end in the high workloads and requests to help support the team without being paid overtime. There has also been the return of dreaded covid, amongst influenza and RSV for both patients and staff. The impact of the Covid leave being removed from July has not quite hit yet, but I am sure many will have to use discretionary leave to get through this winter period.

Rotorua and Taupō EDs have also been in the news lately due to the lack of FACEMs to cover both areas, with the accredition of training ED doctors also being put in jeopardy. I for one fully support the work that Sarah Dalton from ASMS is undertaking with our HOD and FACEMS to ensure their voices are being heard in this battle, and that our staff and patient safety is, as always, at the top of our agenda.

TrendCare has been in our department for 6 months now, and we can see, on the daily, the care deficit hours increasing as the department is overcrowded. We start to undertake IRR testing in the coming month and hope to look at FTE calcs at end of Nov/ Dec. I will be interested to see how our figures compare, and if we do get a huge uplift of staff, as to how long it will take for funding and then to recruit in this financial world of Health New Zealand - trying to save every penny.

On a positive note, we had our troponin point of care implemented into our dept and it has clearly helped support our cardiac pathways for patients. It would be good to look at other quality iniatives that we can use to support improved patient care in our EDs.

Please feel free to reach out to any of the CENNZ representatives for networking and support in your areas. Take care of each other in these challenging times and remember we are stronger together.

Lyn Logan,

Associate Clinical Nurse Manager.

Waikato | Bay of Plenty Region cont.

Hauora a Toi Bay of Plenty.

Matariki has arrived and allowed us time to reflect and think of those who are no longer with us and a time to share the company of whānau, work collegues and community. A time to reaffirm our connections to others and our Tāiao. Also, a time to look ahead, plan for the future and consider all that is important to us.

Within the current work environment, times have been challenging to say the least. The recent recruiting 'freeze' was felt by our team, combined with high sick leave and general fatigue, has meant a challenging couple of months. The extra layers of management sign off has caused delays in recruiting to existing positions. External problems such as patients unable to access their own GP's or even register with primary services in Whakatāne has meant the volume of patients accessing care has exceeded resources within our department. Unfortunately, this is becoming a new normal. Whakatāne Emergency is now also providing Primary Care services, as there is no capacity in the Community. This, compounded with frequent access block, means that like many departments, our admitted patients often have to await ward beds in the ED.

Adding to these concerns is reduced funding for education, which impacts on the progression of our staff. Like other Emergency teams, we are dealing with pressures from multiple directions. However, to uplift team spirit, Michelle one of our talented RN's organised our cool 'Hoodies' so that we look and feel like a team. Also, our HCA team spent a lot of time and aroha decorating our department and providing activities for our tamariki to celebrate Matariki. For those of us who worked the public holiday, we also paused-briefly and shared kai to acknowledge our work whānau and consider the future of our department, hospital and wider health system. It was also a timely reminder that it is the people who will see us through.

He aha te mea nui o tēnei ao?

What is the most important thing in the world?

He tangata, He tangata, He Tāngata

it is the people, it is the people, it is the people.

He mihi aroha ki a koutou ōtira ki ō koutou whānau.

Nā, Natasha Hemopo.

Clinical Nurse Coordinator

Te Āhuru ō Rehua-ariki/Whakatane Emergency Department

Te Whatu Ora Hauora a Toi

Waikato | Bay of Plenty Region cont.

Waikato Emergency Department.

Winter is well and truly hitting us. Influenza A, another round of Covid and the latest kid on the block, VRE, are really stretching our capacity to safely house patients 'in isolation'. Having not reverted our 'Covid isolation zone' back to a children's short stay unit is having its benefits.

Ramping, or the preferred title, 'delayed entry to ED' is the new norm as the entire system is unable to cope with the volume - be it beds in the wards, enough doctors to see patients, or enough nurse management to move our patients to the wards in a timely manner. The current Waikato target is to have everyone out of ED before the 24 hour mark – a long way from the 6 hour target set by the Government .... In the wider picture this is giving St John a headache, trying to manage its workload and respond to jobs in a timely fashion.

HNZ Chief's assurances that the ELT groups 'changes' to help tighten management and budget control would not affect frontline staffing is not what we are experiencing. In fact, some front-line vacancies are waiting up to 3 months to be signed off - vacancies - NOT new positions! This is making future planning very difficult and staffing just a little bit short some days. As for the delay in getting our TrendCare signed off for the staff we know we need.... that's another story that started early in June and remains without an annoucement at the time of writing (18 July).

Waikato hosted the most recent AENN study day. It was well attended, with a range of topics covered, including discussion surrounding current issues with education and the changing landscape of the care we provide in the ED. It was really good to network with other advanced emergency nurses from around the motu and get their perspectives. We look forward to attending the next one!

Take care of each other in these challenging times. Never be afraid to ask for help.

Tracy Chisholm,

Staff Nurse.

Te Matau a Māui – Hawkes Bay Region

Regional Representative

Laura Cottrell

Clinical Nurse Educator

Hawkes Bay Emergency Department

Te Whatu Ora Te Matau a Māui

Like many hospitals across the country, Hawke's Bay has continued to experience an increase in patient presentations, higher acuity levels, and extended inpatient stays. In response, we are currently trialing a new escalation plan to help alleviate the strain on our Emergency Department (ED). Although there are still some adjustments to be made, we are optimistic that this initiative will reduce the pressures we are facing.

A major development has been the implementation of Point of Care troponin testing units, thanks to our colleagues in Christchurch. This has been a game-changer for our department, enabling quicker disposition planning and timely treatment for patients presenting with potential cardiac issues. The national rollout was well-executed, and the comprehensive training provided ensured a smooth transition, highlighting the importance of making new systems easy to adopt.

We are also in a "rebuilding phase" regarding our staffing. At the start of 2023, we were operating with a deficit of 24 Full-Time Equivalents (FTE), a gap we've since filled. However, with many senior staff having left over the last few years, the department has required extensive training and education, with newer staff stepping into leadership roles earlier than usual in their careers. While the team has adapted admirably, we are closely monitoring staff well-being to prevent early burnout due to increased responsibilities.

A particularly exciting addition to our department has been the introduction of the Geriatric Emergency Department Intervention (GEDI) Clinical Nurse Specialist role. Lani Preston, who took on the role in March, has already made a significant impact, both within the department and in the wider community. This role focuses on improving care for patients over 75, facilitating quicker transfers to wards, and ensuring that this high-risk group receives immediate, specialized care. Although the position is currently temporary and extended on a 3 monthly basis, its success has sparked discussions about hopefully making it a permanent fixture in our ED..

Laura Cottrell,

Clinical Nurse Educator.

Mid Central Region

Regional Representative

Lauren Miller

Clinical Nurse Educator

Taranaki Base Emergency Department

Te Whatu Ora Taranaki

Taranaki Base Emergency Department.

We're in the heart of winter here at Taranaki Base ED, with high volumes and acuity. We are feeling the limited capacity of our current ED, and looking forward to our new ED, which is being built, and should be ready in the second half of 2025.

New initiatives in our ED include a new 777 form that we are trialling at triage, and changes to how we take our blood cultures to reduce contamination – no longer off the IV line, but only from a fresh 'stab'. This has improved the contamination rate from 9.9% in April to 0.8% in July! We also have a new nurse initiated blood sample form, which hopes to streamline and standardize nurse initiated blood work, for better selection of testing, which aims for better patient outcomes.

We are celebrating having 97% or our staff IRR tested for TrendCare, and also a great improvement in appropriate trauma calls for major traumas – which has increased from 30% of trauma calls put out for major traumas (ISS score >12) at the start of this year, to 100% appropriate trauma calls for major traumas in April and May..

Therese Manning,

Clinical Nurse Manager.

Hāwera Emergency Department.

In Hawera ED we are currently working on head injury assessment quality improvement. The lead occupational therapist is currently providing education sessions to the team on how to correctly identify these patients at triage and the pathway to follow.

The new point of care blood gas analyser went live in the last 2 weeks – so lots of work on educating the ED nurses with this.

Working on IRR testing – completed and awaiting FTE calculations in August.

Orientating 4 nurses from the inpatient ward to the emergency department, difficult to recruit in rural ED's so the focus is on training and developing our own nurses.

Ongoing education on documentation and achieving triage targets being worked on to ensure we are meeting these targets as well as doctor seen times.

The department is extremely busy with winter presentations, The department is overcrowded and patients face long waits. We are trying to manage this as safely as possible, particularly on the busy shifts.

Shannon Drought,

Clinical Nurse Manager.

Te Upoko o te Ika a Maui | Greater Wellington Region

Regional Representative

Craig Jenkin

Mātanga Tapuhi | Nurse Practitioiner

Te Pae Tiaki | Emergency Department, Wellington Regional Hospital

Te Whatu Ora Capital Coast

Te Pae Tiaki | Emergency Department.

Welcome from the Greater Wellington Region,

This is my first report as the Greater Wellington rep. I am however no stranger to the College as a prior representative about ten years ago. I clearly remember how busy this committee can be so am expecting a busy time ahead.

In Wellington we have had an increase of registered nurse FTE thanks to TrendCare. The increase in FTE has led to the need for support these new staff. We have been able to establish a full Clinical Nurse Educator team of 3.8 FTE and implemented Clinical Coaches to support the new RN's development.

Presentations in Wellington have been averaging around 180 per day. With the extraordinary access block this number of presentations have compounded the issues of seeing and treating Emergency presentations. Senior nurses are feeling the pressure of juggling acute presentations / traumas / new RN's and the inherited medical surgical ward due to bed block. The bed block can be quantified in looking at the increased length of stay for waiting for beds from approximately 20hrs in the previous report, to up to 50-60hrs currently. This can be a normal winter variant however Te Pae Tiaki | ED has a considerable smaller footprint than other urban ED's and we have been using corridor spaces between ED and the hospital to manage these long waits. This has led to discussions with senior organisation management as there is a need to mitigate the risk of across the organisation as opposed to being "just an ED" problem. Hopefully there will be action happening in the near future.

With the RN FTE increase the new initiative focus has been on Triage. The CNE staff have been focusing on a well-functioning triage team to support the new presentations and patients waiting in our Waiting Room. These patients who can mainly be un-differentiated have the highest clinical risk. More support in "front of house" will be best for our patients and nurses.

One of the big challenges that the department is seeing, and can be echoed across the motu will be the employment freeze on any further employment. As half the Clinical Nurse Specialist workforce have resigned / left on maternity leave and are not being able to be recruited into, our Rohe Kakariki, or "fast track" area may need to be repurposed to allow best use while staff numbers are limited.

Looking forward to the warmer weather and changes on the horizon

Craig Jenkin,

Mātanga Tapuhi | Nurse Practitioner.

Te Upoko o te Ika a Maui | Greater Wellington Cont.

Masterton Emergency Department.

Wairarapa are struggling alongside other ED's with the usual winter issues such as high presentation numbers, high acuity patients and staff sickness. I'm not sure of our actual presentation numbers recently, there is no time to check data with all hands being needed on deck, but it feels worse than it has ever been and staff morale is low.

Wairarapa has a real lack of GP's in the area which results in people with no option but to present to ED. We are trailing the virtual GP service Practice Plus with vouchers given at triage for those deemed suitable for a virtual consult. There has been a slow uptake with the community showing reluctance to engage with virtual services and additional staff are needed to promote and support this concept.

We were lucky to get some new staff employed before the hiring restrictions were put in place and are better staffed than we have been in the recent years. However the challenges of an influx of junior staff either new to the area of nursing or new to the country, requires extensive orientation beyond the traditional..

Corrina Rooderkirk,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Hutt Valley Emergency Department.

Hutt is in a better place than last year. I feel fortunate we are only 3.72 FTE vacancy rather than the 30+ FTE that we were short last winter. The team are happier, feeling more supported and patients have a nurse to care for them even if it remains in the corridor.

Hutt Valley ED is seeing on average 180-200 presentations per day. There has been two 2 GP surgeries closed in the Hutt Valley with 9000 patients each, so we are seeing a lot of GP presentations from these practices. The DNWs (did not wait) are rolling over to represent the following day.

With more staff, we've been trialling new intiatives such as a waiting room nurse, additional support in our resus and triage areas and having two Associate Charge Nurse Managers on per shift with separate roles. For example, flow, coordinating, staffing support.

The challenges we are facing are the recruitment freeze, skill mix, no FTE calculations approved with unfulfilled roles/FTE, the resilience of ED staff with some big cases coming through, staff are still getting sick, and changes to sick leave. Other challenges include meeting the 6 hour target, long stays in ED, changes with Police MOU /109.

Lots of new IQNS, although great to have nurses it creates a lot of hard work for the Educators and Clinical Coaches with longer orientation processes.

We look forward to Hutt hosting the CNS CENNZ study/conference next year.

We are fully recruited to our CNS team with 3 new members joining the team. The NP role still has a 1.6FTE vacancy

Charley Gibson,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Te Tauihu | Top of the South Region

Regional Representative

Vicki Bijl

Charge Nurse Manager Nelson Emergency Department and Medical Admission Planning Unit

Nelson Emergency Department

Te Whatu Ora Te Tauihu Nelson Marlborough Health

Nelson Emergency Department.

Tēnā koutou,

Like many other ED's around the motu, Nelson ED is facing the same challenges of managing winter illnesses and long stays in ED. It has been made more difficult with the days and shifts with no patient flow into the hospital and more frequently needing to activate delayed entry and ramping procedures with Hato Hone, St John. The number of patients staying in ED Nelson over 24 hours has gone up 3000% in the past year.

The Tasman region was the fastest growing region in the latest census however, infrastructure has not kept up. ED has been working to complete a refurbishment to ensure it is a suitable size for the region, to have isolation rooms that are of international standard, mental health treatment areas that are suitable and enough areas for all the staff that are required to work in ED. However, this has been delayed due to being over budget. The project has been relooked to try and save a few pennies, however, the risk of shaving too much off to save money could jeopardise the integrity of the project.

In 2022 TrendCare arrived, and with a lot of hard mahi from the team, we completed accurate data after 6 months to complete a calculation. This led to a whopping 17 FTE increase (RN, HCA, and Senior Nursing). It has taken until August 2024 to fill this vacancy and to get our roster aligned with the CCDM recommendations. However, recruitment has come with its challenges. We attempted to stagger some of the new team members so the team could manage onboarding, and so the team wasn't bottom heavy with new starters and/or those new to Aotearoa's Health system - this strategy worked until April. After this point all new starters from May had a delayed start until the 1 July.

Intentional peer support for Mental Health has now been embedded in our world and like many other ED's they will experience this as a decision from the Ministry of Health. Please see the article written by our Mental Health Nurse Educator Hilma about how successful this new ED workforce has been.

I am lucky to lead and be a part of such an amazing team that continues to deliver specialty emergency care of an excellent standard to our Nelson community.

Vicki Bijl,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Canterbury | Westcoast Region- Te Tai o Poutini | Waitaha Region

Regional Representative

Jo Aston

Nurse Manager

Christchurch Emergency Department

Te Whatu Ora Waitaha Canterbury

Christchurch Waipapa ED.

Christchurch ED has seen a new record in patient presentations this winter. On 16 June, 467 patients presented here.

Despite the challenges of increasing volume, access block and overnight stays, initiatives have been implemented. A team leader role in the acute care space has improved clincial oversight and flow of patients from the waiting room. A fast track area within the children's emergency care has been created to stream lower acuity children. The front of house rapid assessement team remain focused on assessing waiting room patients and commencing diagnostics, using standing orders and pathways. In addition, we have telehealth for patients who are appropriate and wish to use it.

The trial of a casual pool, recruitment of experienced nursing staff and stability of the workforce has provided more robust rostering and the ability to give some spot leave.

May gave the staff a wellbeing boost with food treats, creative experiences and outdoors opporuntities to engage in. Winter arrived and The Minisitry of Fun (social club) organaised a well attended dinner with an exceptional demonstration of musical abilities with the theme of karaoke.

On 31 July we celebrated the opening of ED Observation. This will provide an additional 12 beds to care for this cohort of patients and adhere to ACEM requirements.

Fortunately we have retained security in ED and continue to drive the reporting of workplace violence utilising our digital readers and stressing the improtance of safety first reporting.

The ED education team is seeking new and innovative ways to deliver education. They developed a pictorial progression plan to enable staff to review the steps and requirements to progress. Activ8 was launched during July – providing 8 minute face-to-face active education sessions 3 times per week including a 1 minute quiz to validate learning. The information is available to those that have missed the sessions to support knowledge further through a QR code.

The Manaaki Manaki Waitaha group have begun equity teaching sessions to weave cultural safety/equity into RMO and nursing education long term. They are introducing some resources/ Tikanga, focussed on delivering culturally safe care for patients/whānau when a loved one dies in the ED. There is also mahi to ensure we are correctly identifying and capturing ethnicity and gender, looking into inequities in the triage process, and raising awareness around the correct use of pronouns for our patients.

We look forward to spring when we welcome six NETP's and hopefully better weather and all that gives us.

Jo Aston,

Nurse Manager.

Canterbury | Westcoast Region- Te Tai o Poutini | Waitaha Region cont.

Acute Admitting Unit, Ashburton hospital.

Acute Admitting Unit (AAU) is an 8-bed unit, 1 Resuscitation area providing services to a population of approximately 36,300 people in a mainly rural and farming district. Attendances to AAU are gradually increasing with time, especially during these winter months like most other areas. Patient presentations are predominately primary care admissions, mostly triage 4 & 5's due to greatly reduced GPs in the Mid Canterbury region and difficulty in recruiting into rural settings. Healthline is supporting the medical practices out of hours by triaging and referral processes. Ashburton Hospital AAU is the the afterhours service from 4pm-8am for the area.

CCDM has resulted in increased FTE for nursing which has been well received, but the rise in patients presenting has a significant impact on the medical team, with one RMO on shift after 4.30pm for AAU and the inpatient areas (39 inpatient beds). The SMO's are not always on-site but are called in when required for seriously unwell patients providing support for the medical officers.

The Ka Ora telehealth service was implemented prior to Christmas last year to support rural communities across NZ/Aotearoa from 5pm to 8am (evening and overnight) on weekdays, and 24-hours on weekends and public holidays. Other telehealth providers are available during work hours Monday-Friday. Nursing provide this intel to all presenting patients as an option and for future access to health providers, telehealth is not accessible at Ashburton hospital. We understand there has been a good uptake of telehealth services, but we are not experiencing any reduction in the volume of patient's presenting to AAU. We would not be unique in this situation and consider a contributing factor to be the cost of living.

Chemist Warehouse has opened in Ashburton providing 7 days a week services with extended hours which we have not had prior. This has been a welcomed support servicing the community well.

Jane Harnett,

Nurse Manager Acute & Inpatient services Ashburton Hospital.

Southern Region | Te Whatu Ora

Regional Representative

Michelle Scully

Registered Nurse/
Clinical Nurse Educator

Southland Hospital (Invercargill)
Emergency Department

Te Whatu Ora Southern

Invercargill Emergency Department.

Leadership update:

Over the last quarter our presentations and acuity have increased significantly which has brought added challenges to the department. Presently our triage and fast track nurses are facing increased pressure when the department experiences a surge in demand. Our department has commenced implementing TrendCare, and staff have embraced this tool which reflects the amount of work required to care for patients. We have had a recent computer system upgrade, and this has caused issues logging into TrendCare.

Successes in our department have been the introduction of the ACNM role as this has strengthened the leadership in the department. The staff in these roles have taken on projects to further consolidate and improve knowledge and processes. The Clinical Coach role has proved to be invaluable, and they are working in coordination with our Educator to support and grow our staff. Our Educator has commenced weekly simulations in the department which has been an excellent initiative in consolidating and improving staff knowledge and growth.

Despite pressures over the last quarter the team has worked hard and have done a fabulous job.

Education update:

TrendCare has been the common theme in the Southern Region this past quarter.

Southland Emergency Department was fortunate to have had NetworkZ come from Auckland and Queenstown and do 3 large trauma simulations. These simulations tested many processes in the department and we are working to make changes and improvements as a result of these findings.

The Southern region has also been running Leading an Empowered Organisation (LEO) leadership training courses for Educators, Charge Nurses and Senior Nurses and we are looking forward to seeing the fruits of the hard work of all the projects being undertaken.

In Southland ED our acting Charge Nurse Manager has been appointed to Charge Nurse Manager. We are fortunate to see Leigh-Anne put her stamp on the Department and along with her 6 x ACNMs there is a large amount of work being produced. It feels like everyone is rowing the waka in the same direction, that of wanting to provide better patient care.

Invercargill was recently visited by The Minister of Health, Dr. Shane Reti. Typically, the department was calm while he was visiting, unlike later in the afternoon with large queues of patients, ambulances being ramped and the department being in access block. However, Dr Reti did acknowledge with the evidence of our statistics that an extension is needed in Invercargill due to our lack of space.

Invercargill ED continues to be a great place to work, come join us!!

Leigh-Anne Fearn

Michelle Scully,

Charge Nurse Manager Southland

Clinical Nurse Educator Southland

Southern Region | Te Whatu Ora cont.

Lakes District Hospital (Queenstown).

Over the last 3 months we have seen increasing numbers of patients presenting to ED as well as an overall increase in acuity. July 2024 has been our busiest month on record. Our peak day was 90 patient presentations (17 from a bus crash, luckily all minor injuries, but all needing to be seen). We are averaging 65 patients per day. Our average overall from 2023 was 45 patients per day.

TrendCare is still in trial stages, but staff have been really dedicated to getting it completed. We are already showing huge deficits in the numbers of hours required and the numbers of nurses we actually have. There has been many afternoon shifts where TrendCare is showing we are needing 3-4 more nurses.

A lack of senior nursing staff continues to be an issue. We submitted a business case for increased ACNM FTE during the day and a daily afternoon CNC. Currently there is no afternoon or night senior nursing role at Lakes and the lack of this cover is becoming more apparent as we work with an increasingly junior and medical workforce.

We are working at rolling out a few pathways that are new to us such as the #NOF pathway and the sepsis pathway.

Lisa Friesen,

Charge Nurse Manager.

Dunedin Emergency Department.

Dunedin has had high numbers of presentations and high acuity including significant respiratory illnesses and traumas.

The soft launch of TrendCare was at the end of May and there has been high rates of actualisation on mane shifts but this drops off slightly on nights and weekends. Inter Rater Reliability (IRR) training is in August and IRR will commence post this. So far TrendCare is showing a daily deficit of 68 clinical hours (July). The average daily bed usage is 193%.

We are attempting to work within the current limit set by Health New Zealand in regards to recruitment. There are currently 2 x RN maternity leave positions awaiting approval and 2.2 clerical FTE replacements awaiting approval.

The Educator and Staff Nurse attended Emergency Nursing Course "Beyond the Algorithm- Clinical Reasoning in Adult Emergency Medicine" virtually at the end of July. This was run by the same team that runs the PEMs courses. This was a great 3 day course with access to the lectures for 6 months. The learning was diverse with combined Dr/ RN classes for the first 2 days, and the last day was a RN day. The virtual course was quite cost effective.

Simulation is going well. Insitu sims continue weekly. Planned Networkz sims were affected by the loss of funding to the Neyworkz organisation. In Dunedin the day will go ahead with education in the morning and a comprehensive simulation in the afternoon, run by Dunedin hospital's simulation team.

Five staff have been orientated to triage along with a revamp of the triage orientation booklet. Currently we are trialling ways to decongest the triage space. Resus orientation is planned for the rest of the year due to significant retention of staff ready to take the next steps through the department. There is also a drive to get staff signed off for casting, nurse Initiated x-rays, VIP and CORE.

Jenn Wilson,

Clinical Nurse Educator Dunedin.

College Publications

- A list of all the current college position statements are on the CENNZ website at https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/publications.
- Previous copies (where digitised) of Emergency Nurse NZ are available on the CENNZ website at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal.

College Activities: Courses

The CENNZ webpage keeps ongoing updates and details of courses that are administered by CENNZ and others that are run externally. **These include:**

- Triage Course
- Trauma Nursing Core Course (TNCC)
- Emergency Nurse Paediatric Course (ENPC)
- International Trauma Life Support Course (ITLS)
- Paediatric Trauma Life Support Course (PTLS)
- Course in Applied Physiology in Emergency Nursing (CAPEN)
- AENN training days

For the details see the CENNZ websites at:

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

and;

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

- Any questions on triage course, content or holding a course in your area, contact your nurse educator where available then the Triage Course Director – email: cennztriage@gmail.com
- For any enquiries or bookings for TNCC, contact: Hayley Kinchant, email: hayleykinchant@gmail.com, Phone: 027 245 7031
- For enquiries of bookings for ITLS, PTLS, ENPC or CAPEN contact: the Programme Coordinator – Sharon Payne, email: sharon.acen2014@gmail.com, Phone: 027 245 7031

Submissions Guidelines - (Brief)

Journal Submissions

Emergency Nurse New Zealand welcomes submission of projects and research, case studies, literature review papers, viewpoint / opinion pieces, reflections, short reports, reviews and letters.

Manuscripts submitted to Emergency Nurse New Zealand are expected to conform to the journal style and not to have been previously published or currently submitted elsewhere. See the CENNZ Journal website for full details including the submission checklist at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal

Category of manuscripts

Research papers – These should describe improvement projects and research undertaken: up to 4000 words (including references but excluding title page, abstract and tables, figures and graphs).

Format:

Title page: title, authors, abstract and keywords

Body: introduction, methods, results, discussion

References: limited to 30

Review articles – These should describe the current literature on a given topic: up to 5000 words (excluding title page, abstract, references and tables, figures and graphs)

Format:

Integrative, scoping or systematic literature reviews are preferred

Use of JBI for integrative or scoping reviews recommended

Use of PRISMA for systematic reviews recommended

Case studies – These should describe a detailed examination of a patient case or cases, within a real-world context: approximately 2000 words

Format:

Introduction: brief overview context / problem

Case: patient description, case history, examination, investigations, treatment plan, outcome

Discussion: summarises existing literature, identifies sources of confusion or challenges in present case.

Conclusion: summary of key points or recommendations

Submissions Guidelines - (Brief)

Journal Submissions cont.

Acknowledgement that consent has been obtained from the patient plus any ethical issues identified

References: limited to 20

Opinion/Viewpoint – These should be on a topic of interest to emergency and acute care nurses

Approximately 2000-3000 words

Format: free-text

References: limited to 20

Profiles – These should be on a role within emergency or acute care that makes a difference to patients and staff activities:

Approximately 600-1000 words

Format: free-text, may include describing a typical day or arrange as a question/answer interview.

Reference style

Emergency Nurse New Zealand uses APA 7th edition. It is the authors responsibility to ensure that references are accurate.

Education: Conferences

Upcoming Conferences

Organisation	Title	Date	Location	Link
ANZICS	Australia and New Zealand Intensive Care Society	11-13 Nov 2024	Auckland, NZ	https://www.ivvy.com.au/event/ANZICS23/index/travel
WADEM	23 Congress on Disaster and Emergency Medicine	2-6 May, 2025	Tokyo, Japan	https://wadem.org/congress/tokyo-2025/
ICN	Nursing Power to change the world	9-13 June 2025	Helsinki, Finland	https://www.icn.ch/events/icn-congress-2025-helsinki
IFNA	International Family Nursing Association	17-20 June 2025	Perth, Australia	https://internationalfamilynursing.org/
ENA	Emergency Nursing 2025	17-20 Sept 2025	New Orleans, USA	https://www.ena.org/events/2025/09/17/ena-annual-conferences/emergency-nursing-2025
AAENP	American Academy of Emergency Nurse Practitioners National Conference	14-16 March 2025	Dallas, Texas, USA	https://aaenp.memberclicks.net/2025-emergnp-homepage

College of Emergency Nurses NZ

Ngā Ringa Ringa Aroha NZNO

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