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EMERGENCY NURSE NEW ZEALAND

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Features

Regulars

A Word from the Editor

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

Welcome to the first journal edition of 2019.

I trust we have all had some rest and respite over the summer period.

Unfortunately, on a couple of occasions recently I have seen in the news, stories in which nurses had been seriously assaulted in their place of work. It has given me pause for some reflection. The dialogue around violence directed at nurses and how it should be addressed has been going on for some time now within and between NZNO colleges and sections and the NZNO executive. Three years ago CENNZ members voted to adopt a position statement in a bid to kick off a dialogue and action towards addressing this issue. Progress has been made with many initiatives and workplace improvements being reported to the CENNZ National Committee as reflected in the regional reports published in this journal.

As good as these local and regional responses are - there is still a place for NZNO to lead a coordinated, national response to what is a problem in many of our nursing workplaces. NZNO is now catching-up by issuing it's own position statement and research on violence. This is a good place to start - but there is more required of our national body. Please read in this edition Memo Musa's (NZNO Chief Executive) response to issues raised by the CENNZ National Committee last year. I look forward to hearing from the NZNO executive about enacting a coordinated plan to address this critical issue.

Also in this edition, you will find a new feature. Research posters will be presented as pdf files that you can print or enlarge to read online. If you have relevant research you'd like to share, this presents a great opportunity to be published. If you have news or a burning issue you'd like to write about, consider a letter to the editor or email me with any ideas for a contribution you may like to make.

And finally, a big thanks to those who have contributed to this edition of the journal.

Matt

College Logo

The CENNZ National Committee is currently considering changing the College Logo.

The current logo was adopted some time ago with the Māori inscription "Ringa Ringa". The logo and inscription are representative of hands used for healing and has to date served us well.

The committee feels that the current logo does not reproduce well in digital productions and has a level of detail in the design that is often lost in reproduction. Additionally, a number of other NZNO Colleges and sections now have logos that are strikingly similar.

In the near future, new logo designs will be presented for CENNZ members to consider.

Editorial Info

Subscription:

Subscription to this journal is through a membership levy of the College of Emergency Nurses New Zealand - NZNO (CENNZ). The journal is published 3 times per year and circulated to paid Full and Associated members of CENNZ and other interested subscribers, libraries and institutions.

Website: www.cennz.co.nz

Editorial Committee

Emergency Nurse N.Z. is the official journal of the College of Emergency Nurses of New Zealand (CENNZ) / New Zealand Nurses Organisation (NZNO). The views expressed in this publication are not necessarily those of either organisation. All clinical practice articles are reviewed by a peer review committee. When necessary further expert advice may be sought external to this group.

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Submission of articles for publication in Emergency Nurse New Zealand.

All articles submitted for publication should be presented electronically in Microsoft Word, and e-mailed to mcomeskey@adhb.govt.nz. Guidelines for the submission of articles to Emergency Nurse New Zealand were published in the March 2007 issue of the journal, or are available from the Journal Editor Matt Comeskey at: mcomeskey@adhb.govt.nz Articles are peer reviewed, and we aim to advise authors of the outcome of the peer review process within six weeks of our receipt of the article **CENNZ NZNO Membership:**Membership is $25.00 and due annually in April. For membership enquiries please contact: *Kathryn Wadsworth*
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Chairperson's Report

Greetings from CENNZ

On behalf of the College I would like to convey a heartfelt thank you to our Christchurch Colleagues. This is the second time in the last decade you have been called upon to provide care for your community in a time of absolute tragedy and suffering. We share the gratitude of the Nation and enormous pride in our profession. Our thoughts continue to be with you.

We have begun our work for 2019 with great energy, enthusiasm and some major changes to the committee. I would like to acknowledge and thank Chris Thomas (Northland), Matt Comeskey (Auckland) and Erica Mowat (Southland) whose terms as regional representatives have come to an end. Their contributions to the work of the College and emergency nursing nationally has been huge. Replacing them are Sue Stebbeings, Natalie Anderson, Anna-Marie Grace and Anne O'Gorman. It is great to have them on board.

Our Hamilton and Thames colleagues havepicked up the baton and taken on the task of hosting this year's national conference. Work is underway and it will be another great event on the emergency nursing calendar. To any regions around the country, that have a group of talented organisers, expressions of interest for the future are most welcome.

A major area of CENNZ work is supporting national networks of emergency nurses. These include the Triage Instructors, Advanced Emergency Nurses, Charge Nurse Managers and Nurse Practitioner groups. The benefits of these collaborations are immense. These groups comprise our most expert and informed nurses who are leaders in their fields. This has enabled the sharing of initiatives and working strategically across the country.

A goal this year is to establish and support a national 'Emergency Nurse Educators' network. This will be beneficial in understanding how to develop our workforce and 'hot-house' our new nurses in emergency care. I also consider it is time to extend this model and work on shared issues across specialties and with other Nursing Colleges and Sections. This may strengthen our platform and ability to enact change. In the last month, we have begun preliminary dialogue with the Mental Health Nurses Section (NZNO) on violence and aggression. This has included working together on responses to the NZNO position statement on violence and we hope to explore how we may work with solidarity to achieve urgent action on this escalating challenge.

Jo King

Chairperson

College of Emergency Nurses New Zealand

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Case Study: Superficial Venous Thrombosis (SVT)

KEY WORDS: Diagnostic reasoning, differential diagnoses, clinical assessment, bedside ultrasound use in ED setting.

INTRODUCTION: This case study considers the clinical risk of DVT propagation from a Superficial Venous Thrombosis and the treatment options for a patient with a coagulation disorder, in this case Factor V Leiden gene disorder (FVL).

HISTORY OF PRESENTING COMPLAINT: Female patient presents with acute thigh pain (medial and lower), worsening erythema with some heat and concern. No recent long haul flights, trauma or exercise related injuries noted.

PMHX: 2 NVD, Factor V Leiden gene disorder (FVL), stable asthma and hypertension.

SOCIAL HX: European female aged 38, non smoker, married with children.

EXAM: Observations entirely normal. Alert.

HEENT: Unremarkable, normal neck veins and nodes.

CARD: Dual heart sounds with no murmurs, good pulses to the groin and popliteal and equivalent perfusion/refill. Well perfused with no increased work of breathing or cyanosis.

RESP: Chest, clear to examination.

ABDO: Soft, non tender with no herniae.

LIMBS: NAD, except for the left leg. Slight erythema noted, some warmth and tenderness to palpation and equal gastroc girth measurements.

IMPRESSION: Superficial venous thrombosis (SVT)/ thrombophlebitis.

DIFFERENTIAL DIAGNOSES: Infection / cellulitis / DVT

RESULTS: Bloods entirely normal including a CRP and WBC / neut.

On Practitioner bedside ultrasound in ED (POCUS), high definition probe: No adipose cellulitis or oedema noted. Dilated varicose vein with thrombus noted in the vessel with an absence of flow surrounding the thrombus on colour mode. Non-compressible to direct probe pressure and the thrombus can be traced proximally towards the mid-thigh with the thrombus 6 cms in length.

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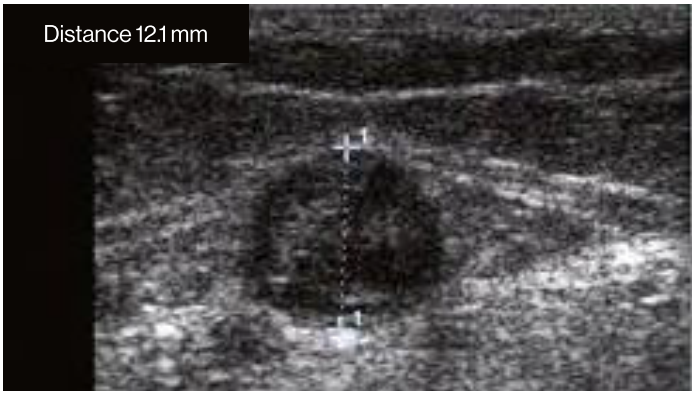


Case Study: Superficial Venous Thrombosis (SVT) cont.

Image: Transverse section of the superficial thigh vein with a diameter of 12 mm.

Groin view: Compressible veins with normal flow and no evidence of thrombus.

Posterior Knee view: Compressible veins with normal flow and no evidence of thrombus. This can be traced distally to the medial gastroc belly with similar results to pressure and flow.

DIAGNOSIS: Superficial Venous Thrombosis (SVT).

DISPOSITION: Home on topical heparnoid cream and a NSAID.

DISCUSSION

I have seen many people with Superficial Venous Thrombosis and dismissed them with the usual care as described by Up-To-Date.com.

The question came up: could someone with no history of a VTE/DVT but having a SVT be at increased risk for propagating into a DVT because of Factor 5 Leiden gene disorder?

After much discussion with the SMO group and considering the data available as research guidance; we gave this patient the options of either aggressive intervention or standard treatment. I sent this patient home with the standard treatment of heparin cream, and advice of, "Keep active and warm compresses may help but your body will break down this thrombus by itself".

Factor V Leiden and Activated Protein C Resistance

Factor V, encoded by the F5 gene, is a pro-coagulant clotting factor that amplifies the production of thrombin, the central enzyme that converts fibrinogen to fibrin, which leads to clot formation. At risk patients with FVL include patients on oral contraceptives, hormone replacement therapy and those pregnant or with a coexisting cancer (UTD).

Over five percent of Caucasians suffer FVL gene disorder with a higher prevalence of the FVL mutation (12 to 14%) reported in parts of Greece, Sweden and Lebanon.

The risks associated with a FVL gene disorder are recurrent VTE, arterial thromboembolism (including myocardial infarction or stroke), foetal loss, obstetric complications. Vascular beds can be affected (resulting in thrombosis in the cerebral/mesenteric/portal veins, superficial vein thrombosis and isolated PE).

TREATMENT OPTIONS

Factor: Indications for aspirin include cardiovascular disease (as primary prevention in high risk patients); cardiovascular disease (secondary prevention); ST-segment elevation myocardial infarction (STEMI); non-ST-elevation acute coronary syndromes (NSTEACS); unstable angina; transient ischaemic attack or ischaemic stroke not associated with atrial fibrillation; acute ischaemic stroke; acute transient ischaemic attack; post operative coronary artery by-pass surgery and finally, mild to moderate pain and pyrexia.

In this case aspirin is not likely to be helpful treating a superficial thrombophlebitis. It is more useful as a prophylaxis than a treatment.

Clopidogrel: Indications include prevention of vascular ischaemic events in patients with symptomatic atherosclerosis (recent ischaemic stroke, recent myocardial infarction or symptomatic peripheral arterial disease); prevention of artherothrombotic events in acute coronary syndrome without ST-segment elevation and in acute myocardial infarction with ST-segment elevation (given with aspirin) and finally, prevention of thromboembolism after placement of intracoronary stent (with aspirin).

Clopidegrel is not likely to be an effective treatment of a superficial thrombophlebitis. It is more useful as prevention rather than treatment.

Rivaroxaban: Indications for Rivaroxaban include prophylaxis of venous thromboembolism following joint replacement surgery; treatment of deep-vein thrombosis; prophylaxis of recurrent deep-vein thrombosis and pulmonary embolism; prophylaxis of stroke and systemic embolism in patients with non-valvular atrial fibrillation (with at least one of the following risk factors: congestive heart failure, hypertension, age ⩾ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack).

Rivaroxaban may be helpful, provided a diagnosis of a DVT is made. If this is the case then Rivaroxaban can be prescribed as fully funded medication.

Warfarin: Indications for Warfarin include, prevention and treatment of venous thrombosis and pulmonary embolism; prevention of stroke following myocardial infarction in patients with increased embolic risk; prevention of thromboembolism in atrial fibrillation; prevention of thromboembolism in patients with prosthetic heart valves. Warfarin inhibits the hepatic synthesis of vitamin K-dependent coagulation factors (II, VII, IX and X), and the antithrombotic factors protein C and S. This prevents further extension of formed clots and secondary thromboembolic complications.

Case Study: Superficial Venous Thrombosis (SVT) cont.

Warfarin may be helpful, although it's use can be problematic where undeclared over-the-counter medications and diet can alter the INR. Additionally the patient may require regular INR testing.

Heparinoid: Evidence shows one case where Heparinoid made a clinical improvement versus placebo, and one case where it made no difference (Up to date; 1a). This treatment is expensive and is borne directly by the patient. One of my last patients told me it is around 90 dollars. Topical NSAID could be an alternative given that is cheaper cost to the patient. In this case the patient was prescribed a topical Heparinoid.

OUTCOME

This patient re-presented a number of days later with features suggestive of a DVT- girth swelling to the gastrocnemius, increased warmth and increasing pain with pedal oedema. Consequently a SVT propagation to a DVT from her hereditary gene disorder was diagnosed.

CONCLUSION

Factor V Leiden and Protein C resistance patients need higher medical intervention and cannot be classed as usual disease pathways which are governed by evidence shown in this case study.

This patient after consideration, and with a courtesy call to her GP, was started on Rivaroxaban 15 mg twice daily with food for 21 days, then 20 mg once daily with food. No bridging Clexane was required-if she was on it.

When changing from intermittent subcutaneous **unfractionated heparin** or **low molecular weight heparin** to rivaroxaban treatment, the parenteral anticoagulant is stopped and the first dose of rivaroxaban is to be given at the time the unfractionated or low molecular weight heparin dose would have been due or up to 2 hours beforehand.GP follow up in 48 hrs was recommended with consideration of a formal ultra sound if there was concern about worsening symptoms. The end result for the patient was a full resolution of the DVT.

References

1. Up to date:

a. https://www.uptodate.com/contents/phlebitis-and-thrombosis-of-the-superficial-lower-extremity-veins?search=superficial%20venous%20thrombosis&sectionRank=1&usage_type=-default&anchor=H75310998&source=machineLearning&selectedTitle=1-91&display_rank=1#H75310998

b. https://www.uptodate.com/contents/factor-v-leiden-and-activated-protein-c-resistance

2. New Zealand Formulary:

a. https://nzf.org.nz/nzf_1529

b. https://nzf.org.nz/nzf_1531

c. https://nzf.org.nz/nzf_1508

d. https://nzf.org.nz/nzf_1440

e. https://nzf.org.nz/nzf_1493

Authors: Judy Gilmour – HIV nurse

Conference Report: ConnectED 2018, Napier

The Napier, Hawke's Bay Region, provided a welcoming and engaging line-up of speakers and activities for the 27th annual College of Emergency Nurse's Conference. The theme of the conference was ConnectED: Strong Connections, Giant Gains chosen to represent the multiple dimensions within ED care and the diversity of staff, services and interactions that make up this sector. The conference committee had worked hard to develop this theme and as well as representing this through connections with community, colleagues and tangata whenua. There was an excellent trade display which offered opportunities for delegates to review and update technical and clinical developments in emergency medicine, education and health related issues. Attendance was high with over 150 participants registered for the two day event, and 16 trade stands.

The programme provided a well-balanced outline of emergency nursing topics, with a series of concurrent sessions interspersed between the combined speaker presentations. The speakers

Conference Report: ConnectED 2018, Napier cont.

were from a range of backgrounds, both nursing, medical and lay fields and all offered challenging and insightful perspectives into their areas of expertise. The venue and food (always of interest to conference attendees) was of a high standard, and participants could be seen networking and sharing ideas and perspectives during the breaks. One of the first speakers was Christchurch ED Consultant, Dr Jan Bone, originally from the Hawkes Bay, who offered a 'pot pourri of ED cases' which focussed on the issues of biases, ways of thinking, and the implications associated with fast and slow thought streams. She offered real life cases and engaged with the audience in discussing situations where risk and assumption meet, and the outcomes can be other than those anticipated, The recognition of the role of biases – our own and other, those we are aware of and those that are unconscious, were introduced in relation to clinical diagnoses and action. A highly relevant topic for all present.

Lucy McLaren, NP with Acute Service Wairarapa DHB was able to highlight the implications of rural vs urban locality in regard to access to healthcare, and that not all services are as easily available across all areas. She introduced the 'Connect with the Expert' telestroke service operating in rural New Zealand, and the impact this has had on reducing the disparities and improving access and outcomes for patients experiencing stroke. This service has enabled direct access to the on-call tertiary centre neurologist after hours, providing significant health benefits to patients, and support to staff. Other topics and speakers included Colleen Law, from Nelson ED, with her presentation 'Being and Staying ConnectED in the ED' emphasising the importance of relationships and remaining connected. The significance of valuing our colleagues and ourselves, and recognising the roles and interplay of individuals within the ED, and the team cohesion that is needed for a successful service also remains a number one contributor to staff wellness. Kevin Henshall is the Counties Manakau Nurse Specialist for the Trauma Service, and he presented 'Turning Chest Trauma Patient's Analgesia Strategies on its Head'. This paper focussed on analgesia regimes and the relationship with blunt force chest trauma, and in particular the issues associated with rib fractures and the elderly. This is a highly relevant topic, given the rapidly ageing population, and the recognition of the potential complications for this apparently 'simple' trauma in a vulnerable group.

The importance of being aware of the impact of ED work on staff was evident in Katy Cryer and Catherine Thorley's presentation 'Caring for the Carers'. Stress and the importance of fostering resilience in staff is a topical issue, and the peer support service introduced in the WDHB in 2017 offers an opportunity for a wellness focus and a recognition of the need for timely critical incident debriefing. The service that had developed was initiated by staff with recognition of the unique stressors experienced in the ED – exposure to trauma and resuscitation situations, workload pressures, experiences of verbal and physical abuse and aggression in the workplace, but also personal issues and workplace behaviours that can impact on individuals. The key outcomes sought from this programme were around staff education, in the form of improving staff safety, offering de-escalation training, and increased staff wellness and resilience. In addition, there was also a focus on developing increased social cohesiveness within the staff group, through increased social activities, development of a wellness and roster governance group, and establishment of an employee of the month recognition programme. Practical changes have included the increased mental health presence in the ED, in particular a mental health service Nurse Practitioner working in ED.

The presentations continued with a further variety of topics, including Natalie Anderson's findings from her research into New Zealand ambulance personnel and their experiences around decision making and resuscitation – 'When to start and when to stop?'. Natalie is undertaking her PhD research exploring the experience of deciding when to start, continue, withhold or terminate resuscitation attempts. She notes that despite the information offered via popular media, when an individual arrests in the community there is often limited contextual information. Despite best efforts, many individuals will not survive, and the decision at times must be made whether to cease (or even whether to commence) resuscitative interventions. The background to her research has identified that only in around 45% of cases of community cardiac arrest is CPR initiated. Natalie's study is undertaken through the University of Auckland, and involved interviews with 16 NZ paramedics. A number of themes emerged, including the recognition of grey areas, where key information is often lacking; the presence of exceptional cases – unusual or unfamiliar situations and the uncertainty associated with these; the impact of first encounters; the significance of managing situations involving children and where a secondary arrest occurs.

Many more presentations were offered over the day, including exploration of the Clinical Nurse Specialist Role (Toni Hill,

Conference Report: ConnectED 2018, Napier cont.

Tina Whibley, Sandra King from Thames ED, WDHB), with a focus on the introduction of a pilot role and following the development of this advanced practice pathway from 2011 to current status. After Critical Events Review (Renee England and Tracey Murray, Starship Hospital), is the standardised approach to debriefing that has recently been introduced following recognition of a critical event. 'Routes to Diagnosis of Cancer' (Aimee Meldrum, Dunedin ED, SDHB) acknowledged that many initial cancer diagnoses that occur, do so as a result of ED presentations. Her research was part of a Ministry of Health funded project, which explored the route to diagnosis for cancer patients, involving ED, oncology and surgical services. Findings to date suggest that there are poorer outcomes for patients who had their initial diagnosis via ED than by any other route, with a one year survival rate of 55%. The implications of patients who can be categorised as 'Mixed Presenters: People who present to the ED for self harm and other reasons', the topic of Silke Kuehl's PhD thesis, was also presented. This study identified significant self-harm risks for this group of patients, and the need for recognition and targeted ED care.

There was also a strong sense of interconnectedness, with acknowledgment of the role of colleagues, and integration of care within the health sector. Presentations from medical and allied health colleagues added to the flavour of the conference, and raised valuable perspectives that contribute to our practice. The HBDHB's Allied Health (Orbit Team) outlined the impact of providing a 7 day, 7am-7pm inter-professional health service to the ED and AAU, offering one point of referral. The aims of this service included to reduce unnecessary admissions, promote timely discharges, and provide links between hospital, community and home. The intention is to reduce repetition within the wider system, whether the repeated asking of the same questions, or seeking the best source of referral and to improve access to key team members and overall enhancing the continuity of care. There is a focus on assessing safety for discharge, and facilitating this process;

Rachel Harvey, Senior Social Worker with Te Puaruruhau, the child protection team at Starship Hospital presented on 'The risk with risk factors' and the difficulties in identifying where problems can occur. This tied in well with the earlier presentation on biases in thought processes, and the need to become consciously aware, and to account for these in our assessments. Rachel outlined the known areas for risk in regard to child abuse and also presented several case studies, where the risks were less obvious or even contrary to what might be expected. In her summary, she emphasised that risk assessment check lists while helpful, can also be unreliable; babies with serious injuries can look ok, that normal babies don't bruise, having social support in place is not a panacea that cures everything and overall that vigilance and rigour of approach is needed – working together is crucial.

The concept of 'presenteeism' was not a new one for most people in the audience, although the term was! Clare Buckley shared the findings from her research which had explored this concept, and explained that it related to the idea of someone attending work despite being unwell. The significance of course being, that we all focus on rates of absenteeism, and often see this in terms of cost to our organisation and even as a self-imposed need to be present in order to support our colleagues, but that we have not really recognised the implications of doing so when unwell. Clare's research is exploring nurse's sickness behaviour, and particularly the impact that presenteesim has on the overall quality of nursing work, with this measured in terms of nursing work left undone. It is this 'missed nursing care' that was the core of the talk, and recognition that although many reasons for required nursing care not being delivered are outside of nurses control, health behaviour – going to work when sick – is one aspect that can be managed.

Rather than celebrating the fact we have not taken our allocation of sick leave, or being frustrated when a nurse rings in sick, perhaps we should be more annoyed if they do turn up to work, and be making it easier for nurses to feel it is ok to be off work. Many in the audience clearly recognised the symptoms – a reluctance to call in when sick, and a sense of frustration with others when they did so – even the acknowledgment that we may have at times suggested that the person was playing the system or in some way not suitably tough enough for nursing. This presentation triggered some thoughtful discussion about what it meant to recognise the implications of presenteeism, and the very clear case studies and the costings presented of turning up to work when unwell provided further factors to ponder.

The additional speakers over day one of the conference included Neil Campbell talking about the ongoing and serious issue of multi-resistant organisms, and a look at what the future for infectious diseases might hold for health care. Rochelle Robertson presented on the importance of communication and relationship building, and Brendan Hutchinson (St John Ambulance) and Glen Varcoe (Fire and Emergency New Zealand) on 'Working Side by Side' – the introduction of a joint service, the benefits, risks and day to day issues.

Conference Report: ConnectED 2018, Napier cont.

Heather Te Au-Skipworth, outlined her personal journey as a Maori woman, her engagement with health promotion and ultimately her development of the Iron Maori programme. Her talk was entertaining, engaging and at times emotional. It highlighted the reality of indigenous health needs in a very real way, but also the passion and delight that comes with making a difference in people's lives.

Liz Cloughessy, Director of the Australasian College of Emergency Nurses, presented a keynote address on Mistakes and Miracles – acknowledging the split second decision making that emergency care providers are faced with, and re-visiting examples and case studies. The approaches we take to managing these situations have long ranging impacts, on individuals as well as services, and the importance of being able to review cases with a quality mindset, learn from them rather than focusing on apportioning blame is essential. She identified that each clinical shift involves at least 5,000 decisions, and if there is between a 1:100 and 1:1000 error rate, then this implies between 5-50 errors per shift. This emphasises the reality that an error free practice setting is unrealistic. What is important, is how we respond and manage the expected element through education, situational awareness and structured decision making processes.

The conference continued on Day Two following an excellent dinner at Brooklands winery (including entertainment from the Fawlty Towers crew) and for those early birds, a pre-conference Art Deco walk through the streets of Napier. The wide ranging presentations carried on, with Judy Leader, NP in pain management from mid-central health presenting on the contemporary understandings of pain and the ability of nurses to positively influence the health of individuals presenting in pain. The significance of different types of pain and pain processes, in particular the three main pain pathways and the underlying pathophysiology associated with these (Nociceptive pain, neuropathic pain and sensory hypersensitivity) were presented. This has considerable relevance to our everyday ED practice, and recognition of the significance of these, and that they may react differently to different treatment interventions, is useful. Similarly, identifying that a patient have more than one pain type present, and therefore more than one process which needs addressing, has direct impact on our practice. The role of pain interpretation and sensitisation was presented, and the analogy of the sheep track offered – the idea that over time, the repeated activation of a pain pathway make the simple flattening of the grass track in the metaphor into a well-worn and bare ground track – much easier to travel and transmit the sensation. The www.retrainpain.org website was recommended as a useful resource., along with www.iasp-pain.org and www.emergingsolutionsinpain.com.

A commonly asked question in healthcare, when the patient has a serious condition, is 'do you want everything done?', and more explicitly, 'do you want to be resuscitated?'. Dr Mike Park highlighted the way questions are often (if unintentionally) presented, where the patient or their family is essentially unclear about what they are agreeing to, and only knowing that they don't want to be left with 'no care'. There is a sense that these questions are only asked of patients for whom we think that the options should be limited, the resuscitation choices reduced. This suggests we may be asking the wrong question – is it appropriate to offer a therapy (in this case, CPR), that does not make sense, or offer a viable outcome? Why are we asking a closed, rather than an open question? We ask, with the assumption that by doing so we are offering autonomy to the patient – but what we are really asking is for the patient (and family) to consider what their goals of care are, and this a broader question. The importance of acknowledging uncertainty, and recognising that interventions will not necessarily return an individual to their pre-injury or illness state needs to be identified. As health professionals, we also need to recognise that patients and their families may not know what questions they need to ask, and that their perceptions of resuscitation, and for them this is usually interpreted as CPR, is informed by media portrayals. The significance of questions asked about end of life care must include how they are asked, what is actually being asked, and what the intent is behind these questions. Again, a thought-provoking discussion that was easy to relate to.

An excellent overview of the Hawke's Bay experience with managing the campylobacter outbreak and the contamination of the Havelock North water supply was shared by Dr Nick Jones, HBDHB and Dr Peter Culham Te Mata Peak Practice. They were able to provide useful, challenging and entertaining information on 'How to survive a Poonami'. The role of the community in managing patients, and of district nurses and GP services in keeping the number of patients that needed to attend ED to a minimum was significant, and emphasises the importance of existing systems and connections across services.

Dr Craig Ellis (HBDHB) identified (and de-bunked) a number of myths associated with anaphylaxis. These included that symptoms are due to histamine release – arguing that the response is actually far more complex than this; that anaphylaxis

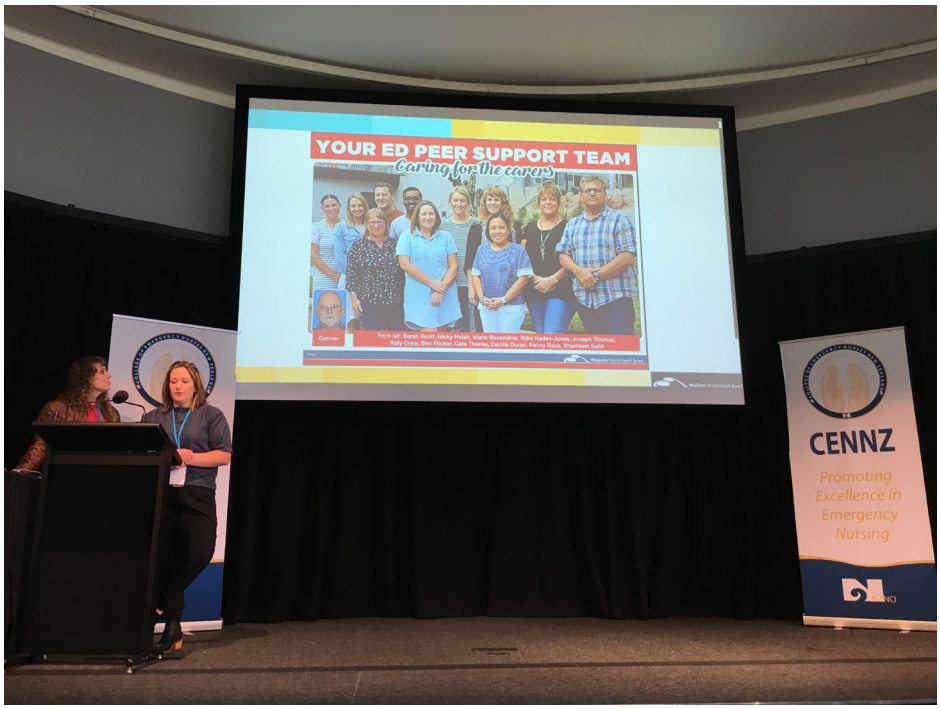
Conference Report: ConnectED 2018, Napier cont.

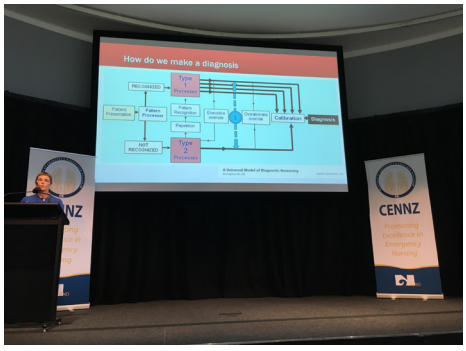
is a form of distributive shock – whereas it can in fact be representative of all types of shock; that we encourage patients to position themselves as comfort dictates, on the presumption that they will do so in a way that maximises respiratory function - yet sitting in an upright, tripod position has been linked as a precipitant to cardiac arrest in anaphylaxis. In regards to treatment, the standard use of antihistamine has not been shown as beneficial, and in fact can be dangerous within the resuscitation process. It is likely that the standard algorithms for adrenaline are effectively under-dosing the patient – that a patient is more likely to require higher doses, and that these need to be IV rather than IM. Once again – the presentation gave rise to much discussion, and the intention to look into the topic in further detail for many attendees.

Additional sessions included Susie St Louis' interesting presentation on teaching skills and the challenges that many clinicians are expected to teach – both colleagues and patients, but without any formal training around this skill. She was able to share a number of useful tips and pearls, one in particular that resonated being the concept of aiming for a 'take home' rather than a 'give home' message. A great quote was cited at the start of her talk from Bismark, this being: "A fool learns from his own mistakes, yet a wise man learns from the mistakes of others", a good goal to hold to! Dr Chris Porter (HBDHB) provided an entertaining update on head injury management, and reminded us of the importance of gaining GCS rather than AVPU when taking baselines, as well as avoidance of c-spine collars and over tight ET tubes. Dr Rebekah Bennett (HBDHB) outlined the key factors to consider in toxicology management, including screening and recording ECG, BSL and paracetamol levels. The importance of a systematic approach was emphasised.

Dr Paul Quigley gave two presentations, on alcohol and synthetic cannibinoids – both well received and having significant impact on the ED environment. He was able to outline the history and underlining pathophysiology associated with the toxicity of synthetic cannabis and its presence in NZ. There have been approximately 50 reported deaths from synthetic cannabis, largely in relation to disenfranchised groups – typically homeless, 40's+ poly substance users, often where the substances are used not for the hallucinogenic effects but for the memory loss or 'absence' they provide. Where deaths have occurred, these have typically been linked to lengthened QTc.

Overall, this was a well-conceived and executed conference – the presentations were of a high standard and of interest to the broad group of ED and urgent care practitioners in attendance. We are now looking forward with enthusiasm to the 2019 conference to be held in Hamilton.





Foreign Bodies - Button Battery Ingestion

The most serious injuries are usually associated with 20 mm diameter batteries, about the size of a 10c coin, because they are most likely to get lodged in the oesophagus.

Button Battery Ingestion - The Science

Tissue damage is due to **alkaline caustic exposure.**

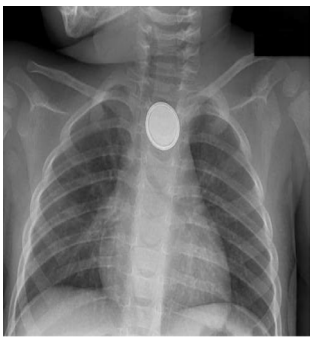
When the battery is placed in a moist environment an electrical charge is generated.

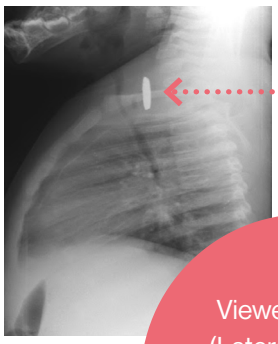
The Lithium Button Batteries have twice the capacitance of other button batteries.

- The Oesophagus (and nostril) are highly susceptible to this injury.
- **Serious damage can occur within 2 hours!**

Imaging

Fortunately, we are looking for a radio-opaque coin-like object! Plain films should be sufficient – it is important to request both AP and Lateral views





Viewed on edge (Lateral), a button battery may have **a central bulge or "step-off"**

Kathryn Johnson NP
Starship Children's Emergency Department

Management

- **Button Batteries that are in the Oesophagus need to be removed promptly – within 2 hours!**
- Once in the stomach they pose less of a risk.....that's because a button battery moving freely does not generate enough hydroxide ions in one location to produce focal damage.

  The caveat to this is batteries larger than 20mm in the stomach of children (<5yrs) are less likely to traverse the pylorus and should be referred to the surgical team for consideration of removal.
- All other button batteries that are in the stomach or beyond, in an **asymptomatic patient,** can be monitored on an out patient basis and allowed to pass.

Regional Reports

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

Northland/Te Taitokerau Region

Sue Stebbings
Nurse Practitioner

Emergency Department
Whangarei Hospital

Contact: Chrisl_t@Yahoo.com

Kia Ora and greetings.

This is my first report as I begin representing emergency nursing in our region on the CENNZ committee. Just a brief update as I gain a better understanding of the current issues.

I have been working as a Nurse Practitioner in the Low Acuity / Fast Track area of Whangarei ED for the last couple of years, but I have worked in the department for many years prior to this.

A huge thanks to Chris Thomas for all her hard work and energy.

Hot dry summer weather encouraged visitors to enjoy our region with the usual expected increase in ED presentations. Unfortunately, we have also noticed increased trauma presentations over the summer months. There were a few GP clinics run in the medical outpatient department at Whangarei on some weekends and public holidays to increase capacity to manage ED presentations. Evaluation of the cost- effectiveness of this strategy is currently underway.

There has been lots of staff changes in the last few months. Amanda Harrison has returned north to take on the Nurse Educator role. Chris Thomas and June Hilton-Jones have started in the new ACNM role that will improve senior nursing resource and support, particularly over weekends. It's always sad to wave off colleagues who are moving away for many reasons, however we are glad to welcome our new staff.

An important focus at the start of this year is consolidation of new processes from triage. There are several in-house workshops running to support the new processes in streaming to low acuity or main department. These workshops will highlight tools to strengthen focussed assessments for both streams.

In response to aggression and violence incidents in ED, there was a security staff member located in the department from 2100 – 0500 during the festive season. This presence proved effective and hopefully will be reviewed as the security contract is due for renewal.

The new Phillips monitors have arrived. The capability to collect 12 lead ECGs from the monitor and increased capnography capacity have been a couple of the advantages.

The Meningococcal W community outbreak and consequent immunisation programme remains topical. The campaign finishes at the end of March with high school and pharmacy involvement. Prior to Christmas almost 11,000 doses were given in 16 days. Anecdotally, there were several presentations related to concerns about meningococcal disease and vaccine effects.

The escalation plan for overcrowding in ED that Chris mentioned in the previous report has been used a few times. It is one of the last options in endeavouring to restore safety in ED, recognising that the overwhelming demand is a hospital wide issue.

The low acuity /fast track area is often utilised to facilitate assessment of patients awaiting cubicles during times of ED overload.

Kaitaia – Rachel Thompson, the Clinical Nurse Manager of the Emergency Department and General Ward, highlighted the challenges in supporting professional development and course attendance for her staff due to distance and travel time from the Far North.

Sue

Auckland Region

Natalie Anderson
Registered Nurse
Doctoral Candidate
& Professional Teaching Fellow

Auckland Hospital Adult Emergency Department

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Anna-Marie Grace
Nurse Unit Manager

Children's Emergency Department

Starship Children's Health

Auckland City Hospital

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Like the rest of the regions, Auckland's Emergency Departments remain busy - be assured if this ever changes it will be reported! This report covers just Auckland ED there is no news incoming from the other departments this quarter.

Auckland Adult ED is consistently seeing 200 + patients a day. Nursing FTE is a struggle to maintain. Full nursing coverage has been difficult particularly in the evenings. Recruitment is ongoing and we have welcomed some new graduates to the department again this year.

Pressure on bed spaces is being felt particularly in our resus area. One contributing factor to this is the prevalence of clot retrieval patients being seen in our department, often referred from other centers. Neurology nurses will assist with these patients in resus but there have been delays getting them admitted to a neurology ward after treatment is initiated. The clot retrieval pathway is a valuable service to our region but there are some resourcing issues that remain to be fully ironed-out.

The Ambulatory Care area is seeing a regular, high turn-over of patients as GP services - particularly after hours, weekends and public holidays are inaccessible or unaffordable for many people. To respond to this demand and keep our length of stay in control, there has been a marked increasing in medical cover across the ambulatory area. A newly initiated fast track room for non-ambulatory patients who will likely require admission has been successfully up and running after a trail at the end of last year. The increase in medical staffing hasn't yet been met by a corresponding increasing in nursing cover, resulting in patients being quickly worked up but facing delays in nursing initiated tasks and treatments.

An additional and significant obstacle to an expedited and smooth pathway of patients through the department remains for patients medically cleared but waiting on mental health review. The cost of security and patient watches is currently being borne out of the ED budget.

On the social front - babies are born, much treasured colleagues retire, new faces are introduced, departmental sports teams get amongst it and life goes on. It has been particularly fun and enlightening to recently welcome nursing colleagues from Canada, Chile and Australia and Tongan ED RMOs.

Natalie

Children's Ed: Starship

Children's ED at Starship is probably the same as around the country with a busy department compounded by poor patient flow. Flow has been challenging with the overall occupancy at Starship higher than expected for January and February. We had two new nurse specialists start in February- Sally Hollis and Kristina Gill. Julie Smith was appointed permanently into the Nurse Educator position that Sally vacated. We have 4 new nurse's start-two New Graduates and two nurses from other areas of Starship.

Anna-Marie

Midland Region

Kaidee Hesford
Nurse Manager

Lakes District Health Board Emergency Department, Rotorua Hospital

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I hope everyone has been able to get out from under the fluorescent ED lights and enjoy the great weather we have had.

It has been an eventful start to the year for the Midland region. With the significant increase in traumas across the area, this has added pressure to the already "bursting at the seams" ED's. With the warm temperatures, there has also been an increase in water related presentations from those enjoying the picturesque lakes and beaches.

Waikato is in full swing planning the CENNZ conference for later this year. Keep your diaries free for September 13 and 14th, and the AENN day on the 15th September.

Waikato ED are also focusing on staff safety and liaising with the police and security - At present they are in the early stages and have just started looking at the model of care and changes which they would like to make in regards to an increasing FTE around the department to keep up with trends in the increasing presenting population.

Tauranga ED have gone live with electronic triaging in early February and are now working towards implementing the ED trend care package April/May. Tauranga has recently increased the CNS FTE by 1.8 and have appointed 3x RN's to this. Numbers have been significantly higher due to the summer events across the region.

Lakes: With the recent lost of our onsite helicopter in Rotorua, it has at times been challenging in escalating transport of patient's promptly to Waikato and beyond. With this regularly getting reviewed we a hoping to resolve a few teething issues. Of late, we have up skilled a group of senior nurses to be able to fly on the dual engine helicopter and broadened the scope of the standing orders for transfers.

Kaidee

Article submissions for the mid year issue of the journal are now open. Please contact the editor matt comeskey for more information!

email Matt at: mcomeskey@adhb.govt.nz

Mid Central Region

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

NZDF

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Palmerston North Emergency Department

Happy New Year, although it feels like that was an age ago. There has been a lot of change in PNED. First was the appointment of a new NP. I began in the new role at the end of Jan, and I am currently working full time, full scope across all of ED. The high patient numbers haven't stopped, so it has been a busy start to another busy year. The support received from my nursing, medical and allied health colleagues and admin staff has been overwhelming, and made the transition back into full time ED roster much easier. Thanks everyone.

The Junior Doctors strikes have been intermittent over the last few weeks, however patient presentations continue. Well done to all staff working through these strike days, and big thank you to the Senior ED Drs for working extra duties to cover.

Jan 2019 saw 3961 people attend ED, the second highest month of presentation number in the last 6 years. The reduction in numbers that has traditionally occurred over the summer appears to be no longer, and staff are consistently attending to increased presentation numbers throughout the year. Thanks to all the staff who are constantly dealing with the high presentation numbers and acuity on a daily basis.

High staff turnover has seen new RNs recruited, and further FTE filled. There are a few more vacancies on the horizon, with recruiting continuing. We have also welcomed Alana to the team as our new NETP nurse, and she is settling in well. Welcome Alana!

The ongoing ED renovations have been completed! With 3 new triage rooms, and a sub-acute area where the old minor works station used to be, the patient flow from the waiting room is improved. A flow nurse is currently on trial here to manage the streaming from triage. The model of care remains in development for ED, and this is an exciting opportunity for our dept to improve pt. care and outcomes.

Angela Joseph – Charge Nurse ED, Palmerston North.

NZDF

Clinical placements in ED continue, and this sees both RNs and NZDF Medics undertaking placements. Watch out for them in the black scrubs, they will be conducting these placements throughout the year, and are a valued part of our ED team. The NZDF Nursing Officers and medics will also be conducting clinical placements in other EDs around the country. Thank you for your ongoing support with this.

Taranaki

Jonele Woodhead started as our ED nurse educator in September after no ED nurse educator for five years - welcome to the team Jonele!

Our staffing levels have been challenging over summer due to resignations, and a high amount of sickness. We are currently about 3.5 Fte down until March, with new staff starting, which does put a lot of pressure on our roster and our regular staff to pick up extra shifts.

We are also struggling with skill mix to cover Resus and Triage at the moment, but are upskilling as fast as we safely can.

We've had really busy shifts over summer, and continue to have a lot of busy shifts, our volumes have been pretty consistent since winter, seeing about 2800 patients a month.

Therese Manning – Charge Nurse Manager, ED / TDHB

Whanganui

NIL report available.

Katie

Wellington Region

Kathryn Wadsworth
Clinical Nurse Manager

Acute Services
Wairarapa District Health Board

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Another very busy start to the year for the three DHB's in the Wellington region. The summer weather certainly hasn't slowed up the presentations to ED nor the admissions into the hospital. CCDHB reports some issues around bed closures within the hospital over the Christmas period impacting further on flow and causing further issues with bed block and the inevitable increased pressure on ED staff. The GP shortage is definitely being felt in the Wairarapa with significant growth in the region resulting in the ED being the only option for many people in the community.

On a very positive note CCDHB are about to start the interview process for two Nurse Practitioner positions in the ED with Hutt ED also hopeful to achieve this role within their department in the next few months. Wairarapa continue to have two Nurse Practitioners working out of the ED and are now investigating the potential for a Clinical Nurse Specialist pathway to support other nurses choosing this direction.

Hutt ED are working with the schools of nursing identifying and facilitating more Maori and Pacific Island nursing students into the ED in the hope that with this exposure there may be an increase in those interested in joining their teams when qualified.

Security issues continue to plague our departments with Hutt Emergency Department experiencing a very nasty event with multiple staff assaulted and four of those staff now on a return to work program spanning over a three month period. Hutt are in the process of an external review of this event with recommendations due by the end of February. Further work is being done at Wairarapa DHB around restraint and de-escalation training but this is ongoing with appropriate training still being identified.

Some very much needed security presence has now been implemented into the Wairarapa hospital although this remains limited. Wairarapa ED has commenced the project of a DHB drafted letter of warning being delivered by Police to those patients whose behavior was deemed unacceptable in the department. This appears to be having a relatively positive result with less unruly behavior noted by some repeat offenders.

Communication issues and resulting complaints arising from front of house particularly at the reception area of both Hutt and Wairarapa ED have been rising. Both ED's have had external providers delivering communication training to this essential part of our service with some positive results seen.

Predictive demand and capacity management is being rolled out in all three Emergency Departments within the Wellington region but the time frames around this are varied with the multitude of challenges that need addressing to facilitate this program ongoing. We hope that this will give an accurate picture of the Emergency Departments unique needs.

Many pieces of quality work and initiatives are present within our departments with a strong focus on Emergency nurses advancing practice and how this can support not only the patients being cared for but the staff delivering that care. This is another year with many of the same struggles, with summer numbers remaining high and acuity reflecting the complexity of patients presenting. ED nurses thrive on pressure and diversity with the safety of our patients at the forefront of any care delivered.

Kathryn

Top of the South Region

Jo King
CNS / Registered Nurse (Chairperson)

Emergency Department, Nelson Hospital

Contact: jo.king@nmhs.govt.nz

Greetings from the Top of the South and a very happy 2019 to all our emergency nursing colleagues around the country.

Nelson

It has been a hot, dry summer in the Top of the South culminating in the recent Tasman fires. This has been a challenging time for the community and also for some of our staff who found themselves refugees or on evacuation alert. The coordinated response from those involved in firefighting and civil defence has been outstanding. The Nelson emergency department (ED) has seen a small number of fire related presentations but there have been no critical injuries or loss of life. As a consequence of the high fire risk all of the regions outdoor recreational areas have been closed and the reduction in mountain biking injuries is very noticeable.

Summer has been characterised by high demand and high acuity. In January, the department experienced a 55% increase in Triage 1 presentations compared to previous months. This of course impacts heavily on nursing resources, ICCU demand and capacity.

Data demonstrates that the mean waiting time for an ICCU bed is 2.3 hours and that 93 hours of ED nursing time has been required to provide 1:1 care for these patients in the last month. It is understood that this is a challenge facing many emergency departments around the country. On the positive, January saw a decrease in 'patient minutes in the department', slight improvement in the 6hr LOS and a significant reduction in Safety- First notifications related to staffing. This may be partially attributed to additional staffing that has resulted from CCDM initiatives. A new daily shift 1745 – 0215 has been trialled using resource staff. The benefits of this have been positively, particularly in the reduction of overtime required at the end of afternoon shifts. A consultation process is currently in process around introducing this shift pattern permanently to the roster.

In January, Nelson hosted its first 'Bay Dreams' event which was held in the CBD. There were 20,000 tickets sold and 17,500 of these were to outside the region. This certainly signalled the influx of partying festival goers the community could expect. Significant planning was undertaken by local bodies, police, emergency department, St Johns and NMDHB and this resulted in a very successful event. In order to provide a blueprint for future planning one of the staff collated and analysed all presentation data around this event. The front line medical tent operated by St Johns, with medical and RN support, triaged 570 people and the majority of these were managed on-site. The emergency department registered 28 presentations that were 'Bay Dreams 'related and only 2 people required admission. It was a great outcome and a good example of collaborative planning and being prepared.

The 2 Clinical Nurse Specialists (CNS) in the department will take up Nurse Practitioner intern roles this year. This is a very positive step in workforce development. Additionally, there is a significant increase in nurses engaged in post graduate study. The next challenge will be to establish permanency of Nurse Practitioner and CNS positions as we move forward.

Top of the South Region

An urgent focus for the coming year will be the safe and appropriate management of patients who present with mental health needs. This continues to be an area of concern and risk. Current work is taking place on best-practice guidelines and triage-initiated pathways however this will not provide all the solutions. Challenges will continue to exist around staffing resource, security and appropriate clinical spaces. We have recently had a staff member attend MAPA training in Auckland and it will be great when this is more widely available.

Wairau /Blenheim

Wairau emergency department has also experienced the usual summer surge that comes with the influx of holiday makers to the area. Late afternoon and night shifts have been times with increased demand and high admission rates. Presentations have been across the spectrum including flu. There has also been a noticeable increase in procedural sedations performed in the department as a result of high trauma and injury. The proximity of the Marlborough Sounds results in the presentation of people from cruise ships. This brings it's unique set of challenges when patient's boats are about to set sail. The annual Wine and Food Festival is a key event each summer and was held in early February. This went well with little impact on the department.

The first Nurse Practitioner intern has commenced in the emergency department. This role is going well and has been embraced across both the medical and nursing teams. CCDM staffing initiatives have impacted favourably. A hospital-wide resource nurse with a focus on flow and a dedicated ED nurse position have been established. Both valuable additions to staffing resource.

We are reviewing the National Stroke Clot Retrieval Pathway and how this will work in our regional department.

Jo

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

email Matt at: mcomeskey@adhb.govt.nz

Canterbury/Westland Region

Dr Sandra Richardson
Nurse Researcher

Emergency Department, Christchurch Hospital

Canterbury District Health Board

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Christchurch

The Christchurch ED is seeing similar attendance and admission patterns, although with some increases apparent in January. There are no longer the usual clear seasonal variations that have traditionally been evident across the year, with the winter volumes replicated in summer and hospital occupancies remaining high. The average length of stay within the hospital has increased, which together with these trends has seen pressure over the wider system, largely a result of increased acuity and complexity rather than numbers alone. A drop in staffing numbers within the ED has followed on from recent resignations, and recruiting continues to address this. The business case for the new model of care and transition to the new facility is underway - an expected date for moving has now been set: November the 18th!! The department has seen an increase in trauma recently, and is still adjusting to the two new computer management systems. As a result, the data quality is less than ideal with the 6hr targets affected.

We have two new NETP nurse's starting, Brooke Tarres and Sarah Wilkinson and current vacancies for NPs and CNSs on the pathway to become NPs. The interdepartmental simulations are ongoing, established from the ED education team and involving various combinations of ambulance, anaesthetic, paediatric, surgical, obstetric and neonatal staff. The department is involved in several clinical projects, including the Pressure Injury Prevention roll out, with staff taking on educational and advocacy roles and working on the introduction of air pal mattresses for use with neck of femur patients.

The department is hosting the CAPEN (Course in Applied Physiology in Emergency Nursing) on the 24th and 25th June, offered by the Australasian College of Emergency Nursing. This course teaches physiologic concepts and critical decision making skills in relation to advanced trauma management. For further information, contact the ED education team - Leona or Tamsin Leona.Robertson@cdhb.health.nz; Tamsin.Attenburrow@cdhb.health.nz

Also welcome to Jennie Bell, WestCoast correspondent who is able to provide us with an update on what is happening across the mountains - many thanks for this input!

Sandy

West Coast

Salutations from the West Coast.

The West Coast has been very busy this summer with both increased volume and acuity of patients through the department. This has included many holiday makers who have met with misfortune on vacation. There is a wide range of presentations from complex medical to some trauma from motorcross bikes and holiday makers alike.

In April 2018 our first Nurse Practitioner was introduced to the Emergency Department. The NP does a swing shift from 1130 until 2000 to help cover high patient volume times. This has been found very useful and there is now a swing shift for medical staff to help cover the volume when the NP is not working. Staff turnover in general has been very high with a number of our experienced registered nurses moving on to new places. We wish them all the best and are happy to see them extend themselves. This has started another round of ongoing recruitment for positions.

The department is busily getting ready for accreditation which has seen many staff participating in quality development projects. This includes process improvement for nursing handovers, orientation information for visiting staff and centralisation of resources for patient education.

Bye from the sunny West Coast.

Jennie Bell, Nurse Practitioner

Southern Region

Erica Mowat
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Southland District Health Board

Emergency Department
Dunedin Hospital

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Dunedin

The 2018-2019 summer period saw a wide daily variability in the number of presentations with seasonal dip of 200 per month between November and January from the previous summer season. This phenomenon continued until late January and February 2019 when the trend reversed dramatically with up to an extra 30 presentations per day. An increase in the number of

trauma presentations, especially motor vehicle accidents, has meant that the department's resus areas have been under constant pressure with staff both from ED and other specialities needing to prioritize their time to deal with the trauma calls and Triage 1 patients. This has led to some delays especially with the specialties dealing with referrals to their disciplines from the community and within the department. The cruise ship season has also added to the congestion within the department although the outbreaks of D & V has not been as prevalent in this area leading to some delay in dealing with other patients in the department.

There has been a lot of changes to the staffing of the Dunedin ED. Firstly we welcome Signe Stanbridge as our first Nurse Practitioner and wish Anna Doughty well as she embarks upon her nurse practitioner course during 2019.

There had been a loss of some senior staff leading prior to Christmas with three new staff joining the team at the end of December. The safe staffing level promoted in the recent Mecca has also meant a total of a further 4.9 FTE. Being added to the nursing team. A further seven staff joined us between early January and in February another two staff with join us, bringing the total to twelve. This has put increased demands on the current team, both for management during the recruitment process and for staff orientating the new team members. Skill mix has been an issue at times, with many senior staff offering to do extra shifts to provide a stronger skill mix.

We have managed to progress some of our current projects within Dunedin ED include 'Fit to Sit'. This is a project where 2 'lazy boy' chairs have replaced one bed space, extending the ED obs capacity to 11 spaces. This hopefully will assist in managing patient expectations regarding the need to remain in hospital, especially over night for minor injuries. Educational opportunities are now accessed through the Professional Development unit's sharepoint to improve access to educational opportunities throughout the hospital. One of the main changes in the last month has been the

The roll out of a change of defibrillator from Medexus to Life pack-as used by St John.

Summer School classes ending Friday 15th February. Orientation week started this week as the students back to university. Introduction of Lime scooter; it took till late evening on the first day to receive of first victim in January although with the return of the university student there has been an increase in injuries attributed to their use.

Queenstown

Lakes District Hospital ED has had an extremely busy last 3 months with higher numbers and acuity putting strain on resources and staff. This has resulted in the forming of a local data council to look at our resources and models of care. We can then take ownership of finding solutions to these issues, also formulating a local recognition and response strategy to surge situations.

Our new ED is currently under construction with stage 1 being completed at the end of April, several weeks ahead of schedule. We will move into the new ED while the existing space is remodelled

Regional Reports

into triage and waiting rooms, office space and a teaching room.

While this is such an exciting time ahead the building work has, and will continue to, test our positivity over the coming months – but what a wonderful facility we will have at the end of it. Having CT on site will hugely improve the care we can offer to locals and visitors alike and should reduce the number of transfers needed to other facilities. We will need to review our nursing transfer model in the future, possibly providing back up to the onsite staff.

Last year 3 nurses attended the triage course and are developing their practice in ED with support from senior nurses. Two nurses also attended TNCC which has given increased confidence, knowledge and skills to their practice.

There must be something in the water as currently there are 4 nurses off on parental leave, and with recent resignations there is a need to expedite the succession of junior staff through the ED. It is recognised that this puts an extra load on the senior nurses who are mentoring junior staff while still managing a heavy nursing load.

There has been a trial of a co-ordinator shift on the weekends 1230-2100 which has given valuable support over these busy times. We are fortunate to have been given extra 0. 4 FTE to facilitate these demands. Ongoing recruitment into vacancies will continue and hopefully have both ward and ed staff fully orientated before our busy winter months.

Oamaru

On February 11th a proposal of change document was given to all employees at Oamaru Hospital, during a brief consultation meeting with each individual department. This has prompted the development of the Waitaki Community Hospital Action Group, a public voice to provide commentary on the proposals. Information that has been made public includes the proposal to disestablish all registered and enrolled nurses' roles. The hospital kitchen has been closed and meals are now outsourced. NZNO have been notified regarding complex as The Waitaki District Health Services Trust are not a partner in the recent MECCA.

All applications to reapply for positions are currently on hold whilst external advertising takes place for experienced ED nurses. The consultation time line has been extended by 2 weeks to March 25th with a decision expected on April 8th. New roles, confirmation of appointments should take place by May 27th. The intended aim of the management team is to improve services; however, the process has been extremely stressful to staff who are working under increasing pressure. Financial pressure for the trust has also come from the difficulty in employing permanent medical staff as locums have filled many of the positions over the last 2 years, much of the budget has been spent on employing locum doctors although the management team state they are in the process of employing permanent doctors.

Erica

Triage Courses 2019

Course details, terms and conditions available:

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

Region	Dates	Venue	Closing date for Applications	Closing date for payment	Registration
Rotorua	8/9 June 2019	Conference Room, 3rd Floor, Clinical Services Block, Rotorua Hospital, Corner Arawa Street and Pukeroa Road, Rotorua	13th April 2019	27th April 2019	Book Now
Lower Hutt	21/22 June 2019	The Learning Centre, 2nd Floor, Clock Tower Block, Hutt Hospital, High Street, Lower Hutt	26th April 2019	10th May 2019	Available soon
Waikato	14/15 September 2019	Clinical Skills Centre (under the library) Waikato Hospital Campus, Corner Selwyn and Pembroke Street, Hamilton West	20th July 2019	3rd August 2019	Available soon
Wellington	7/8 November 2019	Education Centre, Level 11, Ward Support Block, Wellington Hospital, Riddiford Street, Newtown	12th September 2019	26th September 2019	Available soon
Christchurch	22/23 November 2019	Manawa Building [Registration 2nd Floor] Health Education & Research Facility. 276 Antigua Street, Christchurch	27th September 2019	11th October 2019	Available soon

AENN Study Days 2019

AENN Study Days 2019 information available here:

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

Date	Host DHB
Tuesday 26th March	Auckland DHB, Starship Childrens Hospital
Tuesday 25th June	Counties Manukau DHB, Middlemore Hospital
Sunday 15 th September	Waikato DHB, Held in conjunction with the CENNZ Conference

Article submissions for the mid year issue of the journal are now open. Please contact the editor matt comeskey for more information!

email Matt at: mcomeskey@adhb.govt.nz

28th College of Emergency Nurses NZ Conference 2019

28th CENNZ Conference 2019

Hamilton
September 2019

Conference:
13 & 14 September 2019

AENN training day:
15 September

Please check the CENNZ web page for details:

https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/conferences_events#Current

Snippets Autumn 2019

Grey areas: New Zealand ambulance personnel's experiences of challenging resuscitation decision-making.

International Emergency Nursing, 39, 62-67.

When faced with a patient in cardiac arrest, ambulance personnel must rapidly make complex decisions with limited information. Much of the research examining decisions to commence, continue, withhold or terminate resuscitation has used retrospective audits of registry data and clinical documentation. This study offers a provider-perspective which characterises uncertainty and highlights clinical, cognitive, emotional and physical demands associated with decision-making in the cardiac arrest context.

https://doi.org/10.1016/j.ienj.2017.08.002

Beyond prognostication: Ambulance personnel's lived experiences of cardiac arrest decision-making.

Emergency Medicine Journal, 35 (4), 208-213.

The purpose of this study was to explore ambulance personnel's decisions to commence, continue, withhold or terminate resuscitation efforts for patients with out-of-hospital cardiac arrest. The study employed semi-structured interviews with a purposive sample of 16 demographically diverse ambulance personnel, currently employed in a variety of emergency ambulance response roles, around New Zealand.

https://doi.org/10.1136/emermed-2017-206743

Commence, continue, withhold or terminate? A systematic review of decision-making in out-of-hospital cardiac arrest.

European Journal of Emergency Medicine, 24 (2), 80-86.

This systematic integrative review identifies all research papers examining resuscitation providers' perspectives on resuscitation decision-making for out-of-hospital cardiac arrest patients. A total of 14 studies fulfilled the inclusion criteria: nine quantitative, four qualitative and one mixed-methods design. Five themes were identified, describing factors informing resuscitation provider decision-making: the arrest event; patient characteristics; the resuscitation scene; resuscitation provider perspectives; and medicolegal concerns. Established prognostic factors are generally considered important, but there is a lack of resuscitation provider consensus on other factors, indicating that decision-making is influenced by the perspective of resuscitation providers themselves.

https://doi.org/10.1097/MEJ.0000000000000407

Alcohol-related emergency department attendances after the introduction of the Sale and Supply of Alcohol Act 2012

Cross-sectional observational study of hospital ED attendances during three-week waves of data collection in 2013 and 2017, at Christchurch Hospital.

https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1483-5-october-2018/7710

Snippets Autumn 2019 Cont.

Livestock-related injuries in the Midland region of NZ

New Zealand Medical Journal October 2018

This study aims to evaluate the incidence and nature of injuries related to large livestock in this region, when they occur, and which demographic groups are at higher risk to support focused interventions to reduce the impact of large animal-related injury on the community.

https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1483-5-october-2018/7707

Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: US Preventive Services Task Force Final Recommendation Statement

JAMA. 2018 Oct

Intimate partner violence (IPV) and abuse of older or vulnerable adults are common in the United States but often remain undetected. In addition to the immediate effects of IPV, such as injury and death, there are other health consequences, many with long-term effects, including development of mental health conditions such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, and suicidal behavior; sexually transmitted infections; unintended pregnancy; and chronic pain and other disabilities. Long-term negative health effects from elder abuse include death, higher risk of nursing home placement, and adverse psychological consequences.

https://plus.mcmaster.ca/EvidenceAlerts/NewArticles.aspx?Page=3&ArticleID=82913#Data

Assessing Risk of Future Suicidality in Emergency Department Patients.

Academic Emergency Medicine . 2018

Emergency departments (ED) are the first line of evaluation for patients at risk and in crisis, with or without overt suicidality (ideation, attempts). Currently employed triage and assessments methods miss some of the individuals who subsequently become suicidal. The Convergent Functional Information for Suicidality (CFI-S) 22-item checklist of risk factors, which does not ask directly about suicidal ideation, has demonstrated good predictive ability for suicidality in previous studies in psychiatric patients but has not been tested in the real-world setting of EDs.

https://plus.mcmaster.ca/EvidenceAlerts/NewArticles.aspx?Page=1&ArticleID=83382#Data

Frailty in older people: a discussion

BPAC November 2018

The recognition and management of acute conditions in older people is becoming a bigger issue in our emergency departments and community primary care settings. The paper discusses factors contributing to frailty that are not necessarily related to chronological age and the disparities that Maori in particular are subject to.

https://bpac.org.nz/2018/frailty.aspx

Snippets Autumn 2019 Cont.

Addressing methamphetamine use in primary care

BPAC November 2018

Usage of methamphetamine is likely to remain prevalent in our community for some time to come. Increasingly, meth or P use is disclosed by patients seen in primary care – and not always as a component of their primary presenting complaint. This paper offers useful, practical, guidance in recognising and addressing methamphetamine use.

https://bpac.org.nz/2018/docs/meth.pdf

Use of a Rapid Diagnostic for Chlamydia trachomatis and Neisseria gonorrhoeae for Women in the Emergency Department Can Improve Clinical Management: Report of a Randomized Clinical Trial

Annals of Emergency Medicine. 2018

Rapid C trachomatis and N gonorrhoeae testing in the ED led to a significant reduction in overtreatment for women without infections compared with the standard-of-care control group. Additionally, in the rapid test group there was significant improvement in appropriate treatment for patients with infections.

https://plus.mcmaster.ca/EvidenceAlerts/NewArticles.aspx?Page=4&ArticleID=83434#Data

Triage Performance in Emergency Medicine: A Systematic Review

Annals of Emergency Medicine. 2018

The authors synthesize existing ED triage literature by using a framework that enables performance comparisons and benchmarking across triage scales, with respect to clinical outcomes and reliability.

The authors conclude that a substantial proportion of ED patients who die post-encounter or are critically ill are not designated as high acuity at triage.

https://plus.mcmaster.ca/EvidenceAlerts/NewArticles.aspx?Page=2&ArticleID=83751#Data

Clinical validation of a risk scale for serious outcomes among patients with chronic obstructive pulmonary disease managed in the emergency department

Canadian Medical Association Journal. 2018 Dec.

The Ottawa chronic obstructive pulmonary disease (COPD) Risk Scale (OCRS), which consists of 10 criteria, has been used to identify patients in the emergency department with COPD who were at high risk for short-term serious outcomes. This study (consisting of 1145 enrolled participants), showed the OCRS is useful for predicting short-term serious outcomes for COPD patients post treatment in ED.

https://www.ncbi.nlm.nih.gov/pubmed/30510045?dopt=Abstract

New Research

Examining Emergency Department Inequities: Do they exist? (EEDI)

EEDI aims to investigate whether clinically important ethnic inequities between Māori and non-Māori exist within emergency departments across New Zealand. This study builds upon and extends the work undertaken by the Shorter Stays in Emergency Department (SSED) national research project investigating the effect of the six hour time target policy introduced into New Zealand emergency departments in 2009 (Jones et al., 2012). The SSED project consists of a nationally representative quantitative dataset of emergency departmentclinical outcomes and process measures of performance between 2006-2012.

The EEDI research is funded by the Health Research Council.

CENNZ and NZNO Responses

CENNZ and NZNO Responses to Violence and Aggression in Emergency Departments

The CENNZ National Committee continues to voice, at any opportunity, the issue of violence and aggression directed towards our emergency department colleagues. The following letter to the NZNO Chief Executive and their response to the CENNZ Chair have been published here for members to review and to consider the progress to date on addressing this critical issue affecting our membership.

NZNO is currently drafting a position statement addressing violence in the nursing workplace. CENNZ has been invited to comment on the draft position statement.

CENNZ members may wish to view CENNZ own position statement endorsed by members at the 2016 AGM.

View pdf here

22nd August, 2018

The College of Emergency Nurses New Zealand

Chairpersons

Board of Directors

New Zealand Nurses Organisation

To the Chairpersons,

I am writing on behalf of the College of Emergency Nurses New Zealand (CENNZ). The committee would like to table its concern regarding the escalating exposure of emergency nurses in this country to violence and aggression. While we speak on behalf of emergency nurses, we are aware this risk is not confined to the emergency setting.

Emergency nurses have stated they consider this is one of the key challenges facing them in their practice environment. Furthermore, objective data supports that incidents of violence and aggression, both actual and threatened, are increasing nationally. Research also demonstrates that this issue is significantly under-reported.

Dedicated ED security, de-escalation training, duress alarms and hospital response systems to violence are varied, both in regard to access and efficacy. In many EDs, such interventions are non-existent. This is placing nurses in situations of considerable and unacceptable risk. We consider it a matter of urgency that all nurses in NZ have the right to work places that are safe.

The CENNZ committee would like to request that NZNO prioritise this issue and works towards national strategies which mandate the provision of safe working environments for New Zealand nurses.

Yours sincerely

Jo King

CENNZ Chair

NEW ZEALAND NURSES ORGANISATION
TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

8 October 2018

Jo King
Chairperson
College of Emergency Nurses New Zealand

By email: cennzchair@gmail.com

Dear Jo

Re: Correspondence to the Annual General Meeting

I confirm that your letter received by e-mail on Thursday 18 August 2018 was presented to the Annual General Meeting (AGM) on Wednesday 19 September 2018. The letter was considered and discussed under 'General Business' towards the end of the AGM. It was also deemed to be an incidental matter which could be discussed but no decision could be made on the issues raised in the letter.

The contents of the letter, specifically drawing attention to the increasing violence and aggression against nurses was discussed. There was general consensus that the increasing violence and aggression is happening across all settings in health whilst acknowledging that this might be more prevalent within Emergency Departments.

There was general agreement that the New Zealand Nurses Organisation (we) should continue to highlight the increasing violence and aggression against nurses, and the impact this has including work on national strategies for provision of safe working environments.

We recently raised our concerns to WorkSafe NZ about nurses experiencing and suffering serious injuries in some cases having been assaulted by patients. WorkSafe has invited us to participate and support the work they are doing in developing guidance. I am shortly about to contact the Accident Compensation Corporation as I understand that they have a programme of work with a focus on addressing violence and aggression in the health sector.

We will establish internally a co-ordinated approach to make sure we are joined up in our effort to gather data/information to highlight and address this very important issue. We will seek input from and involve the College of Emergency Nurses New Zealand in the work we are doing.

Yours sincerely

Memo Musa
Chief Executive

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What are you looking at?

Auckland Eye Manual App: A review

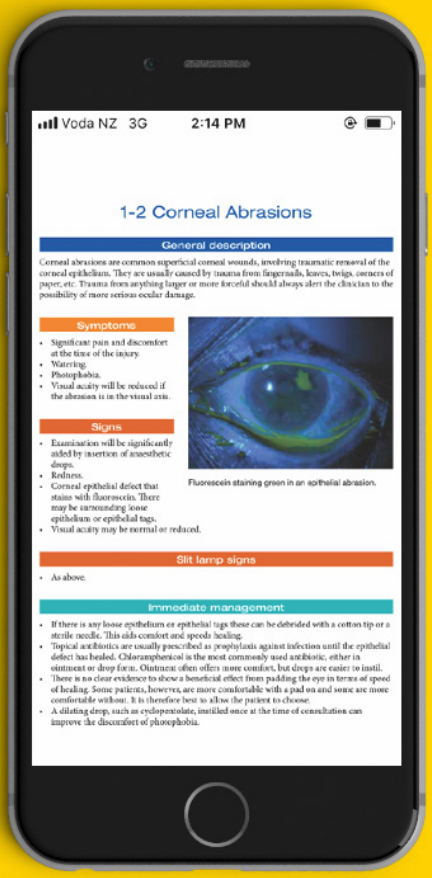
This app provides a comprehensive overview of just about any eye presentation you are likely to see in a primary or emergency care setting. It has been compiled by fourteen New Zealand eye surgeons to help GPs, optometrists and nursing professionals with the aim that a reader should be able to confidently diagnose eye disorders. In short - it meets this objective. The Auckland Eye Manual app took out the top non-clinical prize at the Leaders in Quality Awards run by the New Zealand Private Surgical Hospitals Association (NZPSHA).

Content is listed in easily read chapter headings. The underlying text under each subject heading is generally broken up into bullet point descriptions and accompanied by useful colour photos to aid in identifying signs for of over 100 common eye conditions.

Perhaps the most useful chapters are the first ones that go into methods for taking an ophthalmic history and how to perform a basic eye exam. The description of examination techniques employs both use of a slit lamp – or without. This is useful, given that a lot of primary care settings do not have access to a slit lamp.

There are easy to follow flow charts for working through the differentials for a number of common presenting complaints. The app explains immediate and longer-term management of eye conditions and includes referral guidelines.

And the price is right – it is generously provided for free on both the android and apple app stores.



Research Showcase

Neck of Femur fracture : ED Pathway

This is a new feature to provide a platform for ED related nursing research presented as posters. If you have a research poster you'd like to share please contact the editor.

Click on this link to view in full size.

Optimising the care for patients presenting with fractured Neck of Femur with a Fast-track pathway In Adult Emergency Department

Neck of femur fractures are a common presenting injury seen in the emergency department - and are often sustained by co-morbid, elderly patients. Treatment priorities include effective analgesia and timely referral. The authors consider barriers and opportunities to streamlining the patient pathway through the emergency department with the aim of optimising patient care.

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

email Matt at: mcomeskey@adhb.govt.nz

Frequently Asked Questions

What is the CENNZ Repository?

The repository is a regularly updated database of ED staffing, in each DHB. The CENNZ National Committee is tasked with ensuring the data base is relevant. The information collected is broken down into different roles – for example numbers of educators, RNs, CNSs and so forth that make-up a department's staffing and what their respective FTE is. This information can be used to enable workforce planning and easy benchmarking against other DHBs when preparing business cases.

Any CENNZ member can access the repository data base via the CENNZ webpage. You will need your NZNO membership number and a CENNZ password. If you don't have a password there are directions attached to the web page that will tell you how to get one.

More information can be found on the NZNO website:

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

CENNZ Membership Renewals

Memberships are due for renewal on 31 March 2019 for the following year.

Please see the web page below for details:

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

EMERGENCY NURSE NEW ZEALAND

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