Winter | 2021

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A Word from the Editors

Dr Sandra Richardson
Co-Editor | Emergency Nurse NZ

He aha te kai ō te rangatira? He Kōrero, he kōrero, he kōrero.

(What is the food of the leader. It is knowledge. It is communication.)

Welcome

Tēnā koutou katoa. Welcome to the current edition of the CENNZ journal. In line with the whakatauki above, as leaders in health care, emergency nurses need to seek knowledge, to engage in communication and to share our experiences. The Emergency Nurse NZ journal provides us with the opportunity to do this.

The winter 2021 edition of the CENNZ journal has finally emerged. I am taking this opportunity to introduce myself, and together with Polly Grainger we have taken on the role as co-editors of the journal. I work in Christchurch ED as the Nurse Researcher, as well as a Senior Lecturer with the University of Canterbury, and have previously been a committee member and Chair of the College of Emergency Nurses. The role of co-editor is one that offers new challenges and will allow further opportunities to work alongside members of the profession.

We will continue to seek advice from the previous team, and in particular are grateful for the efforts of Matt Comeskey, the previous editor. We welcome submissions and contributions to the journal and are happy to respond to questions regarding potential articles. If you wish to contact the editorial team, please do so via:

editor.cennzjournal@gmail.com

Editorial

There are a number of issues facing emergency nurses in NZ today, and these continue to increase in terms of significance and severity. Nurses in all areas are facing concerns relating to workplace conditions, the pressures of industrial action and the need to address safe staffing and make difficult choices relating to this. For emergency nurses, these issues are even more worrying. As we all know, for EDs, there are no options in terms of closing the doors, halting the flow or refusing to take any more patients. We can seek to deter patients from unnecessary visits (at the risk of also deterring those who need to be here, and facing the consequences this brings) or of trying to 'ramp' ambulances at the risk of failing to provide services in the community. We can ask an already overloaded primary care system to take on additional load (and hope that there is no Covid outbreak / RSV / or 'flu season) or we can try and inform those in positions of power that we are understaffed, overworked and in crisis (but haven't we been doing this for the last ten years plus?).

We have reached a point where the wider health system is finally recognising that the crisis is no longer somewhere 'in the future' – it is here now. The nursing shortage has arrived, and it is not going to be fixed by throwing money at it – even if there was enough to do so. We are struggling to find sufficient, qualified nurses to meet the needs of the public, and to enable safe, structured mentoring and education that will encourage nurses to remain in the profession. Despite this, nursing remains a rewarding career option, but we need to find ways to make it viable into the future. For nurses working in acute care, urgent care and emergency care the issues of education, knowledge gain and the ability to maintain and gain further skills are

A Word from the Editors cont.

imperative. As we continue to develop innovative approaches, incorporating new technologies, simulation, and look to retain the caring and compassion central to our work, the pressures can become overwhelming. Increasingly, nurses are told there is no time, no funding or no opportunity for further education. Staff training is cancelled to maintain staffing levels on the floor, as more staff leave, become unwell, or are placed in situations where they feel unable to cope. Even as we spend additional time introducing wellness programmes and spaces in our EDs, our academics are studying compassion fatigue, burn out, moral distress and rising rates of suicide in health workers.

This edition of the journal touches on the concerns of many ED nurses, with the issue of moral distress raised in Matt Comesky's article *Moral Injury: An Opinion*. The realities of workplace stress and the impact on staff are identified in the series of staff impact statements that Jones, Thompson and Geddes outline in the article *Emergency Departments at capacity: Nurses voice their concerns*. The importance of interprofessional and collaborative teamwork within the ED can be seen in the inclusion of new and innovative allied health roles based in EDs, with brief profiles of two of these presented in the Profiles Section, highlighting the Occupational Therapy and Liaison Nurse for Acute Demand services at Christchurch Hospital ED. The Chair of CENNZ has noted in her report the range of issues and the importance of safe staffing, with the theme of 'grit – passion and persistence' underlying this years Emergency Nurses Day in October. We have much to work on, but also much to work with – strong, passionate and dedicated nurses, but ones who need support and acknowledgment. We need to look after ourselves, if we are to be able to look after others.

Kia Kaha

Na Mihi nui

Sandy

A Word from the Editors cont.

Polly Grainger
Co-Editor | Emergency Nurse NZ

Editorial

Welcome to the winter 2021 edition of the CENNZ journal. I'm Polly Grainger and I'm one of your new co-editors. I work in Christchurch ED as the Nurse Coordinator, Clinical Projects as well as a Clinical Editor for Hospital HealthPathways. I'm looking forward to working alongside you to further develop the art and science of emergency nursing in Aotearoa New Zealand.

Firstly, thank you to Matt Comeskey, our outgoing editor. Matt has provided to us with regular reading material, and we are grateful for his commitment, his work ethic and his passion for emergency nursing. Likewise, thank you to Sean McGarry who helps us make this look attractive, and thank you to those who have offered pieces for publication.

Since there are now two editors we have created a new email address for you to contact us on: editor.cennzjournal@gmail.com.

There won't be dramatic changes to the Emergency Nurse New Zealand journal. Because we're working as a team, theoretically reducing the workload, we plan to introduce some new features. What we are most hoping for, of course, is to hear your voice. And yes, as ever, we will help you through the process of publishing. We are currently updating the online submission guidelines, which are fully detailed on the CENNZ Journal (nzno.org.nz) webpage and the basic details are now printed in the journal itself.

We've introduced profile articles. This edition includes the role of two sets of allied health professionals in ED. We're keen to hear more from individuals or teams around the country, you can enter pieces as interviews or as a day in the life of.... We'll also profile some of the CENNZ committee members in upcoming issues.

One key date for your diary is for the 29th College of Emergency Nurses New Zealand Conference on the 5th & 6th November 2021 at Rydges Latimer, Christchurch. The theme is '*Ready to Respond – Kia Mataara*', something emergency nurses embody every day. The organisers are looking for presenters as well as attendees. Look out for the details in the advert later in the journal.

With the change of season, we again have high numbers of the usual winter ailments, as seen in the news, plus winter sports injuries. We've had (and are facing more) industrial action, and unsafe workplaces abound. You'll see more about Christchurch's activity in the article by Kez Jones, Tania Thompson and Lisa Geddes. All these challenges do create distress, which Matt Comeskey talks about in his article on moral injuries.

On the upside, we have our winter sports to enjoy, its time to snuggle up in our knit ware, sipping warming soups, stews and mulled wine (as you fancy), while we put our gardens to bed and plan for spring. Whatever we choose to do, there is always something we can do that will give our minds and our bodies a rest from our work. This is important to help us maintain our work life balance. I'm hoping that you all find time to care for yourselves each day.

Take care, and welcome to this edition of The Journal of the College of Emergency Nurses New Zealand (NZNO): Emergency Nurse New Zealand.

Polly

News and Events

Update to CENNZ Knowledge and Skills Framework

When the Knowledge and Skills framework was published in October 2016 it was the intention of CENNZ to ensure it was a living document, continually rethought, reworked and updated. We wanted to develop a toolbox of resources including practice exemplars from each aspect to illustrate how the framework could be used in practice. This has taken longer than expected but a small group has reconvened to review and update the framework and work on the exemplars.

While we are reviewing the whole framework already we can see that some areas require greater strengthening and development than others eg Equity, Workforce Wellbeing, Disaster Management, Mental Health Care.

We know that some areas are using the framework to support their education and orientation programmes. If you have examples of how the framework is being used in your area can you please share them with us; Anne.Esson@cdhb.Health.nz

The new (*and part of the old*) working group are:

– Suzanne Rolls

– Angela Joseph

– Sandy Richardson

– Leona Robertson

– Anne Esson.

If anyone else is interested in joining us to develop the framework and exemplars please let me know.

Anne Esson

Chair of the CENNZ K&S Framework Working group.

Case Study

Facial Swelling? Allergic Reaction

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Key words: Diagnostic reasoning, focussed clinical assessment, childhood diseases.

INTRODUCTION: Presents to triage with parental concern over worsening facial swelling and new foot swelling. Symptoms for 3 days now and given a triage 4 on a busy ED afternoon shift and was a while to be seen (waited 3 hrs).

PC: Facial swelling in a 2 year old female child.

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Complaint/Risk Factors:

puffy face since Thursday.
not relieved with
antihistamine from GP. mum
states foot is also now
swollen. concerned nil
improvement. eating and
```

HISTORY OF PRESENTING COMPLAINT: Flu like illness 3 weeks ago, seemed to settle and then for the last 3 days worsening infra orbital swelling according to mother. Attended GP and put on Prednisone and Loratidine. Subjectively the mother had noticed increased snoring at night and desquamation of the fingers with new foot swelling for the last 24 hrs. Has been thirsty and had been coughing some times when being active/ running around.

IPMHX: No surgical or medical hx

SOCIAL HX: Immunised, lives with mum and her brother-in-law and her direct cousin. Up to date with immunisations. Non-smoking house. No familial kidney problems noted.

EXAM:

HEENT: Slight puffiness to the infraorbital region, no conjunctivitis or scleral injection. Unremarkable tongue/throat, normal neck veins and nodes.

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

RESP: Normal Work of breathing, Chest clear to examination.

ABDO: No rashes, Soft non tender with no herniae. No organomegaly with no sacral oedema. Bowel sounds normal, normal tympany.

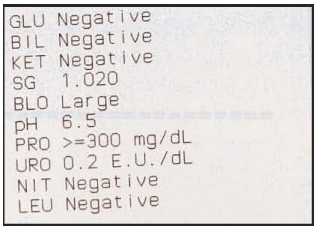
LIMBS: Upper limbs NAD, slight dorsal pedal oedema, good colour and pulses noted.

IMPRESSION: Post streptococcal glomerular nephritis

DIFFERENTIAL DIAGNOSES: Continued allergic reaction, ? SLE ? Kawasaki disease

RESULTS:

MSU:



Visual: microscopic haematuria.

Case Study

Facial Swelling? Allergic Reaction Cont.

Labs:

Sodium	135	mmol/L		135-145
Potassium	5.1	mmol/L		3.5-5.2
Urea	**9.5**	**mmol/L**	**H**	**1.8-5.4**
Creatinine	22	umol/L		<50
Cholesterol	**7.5**	**mmol/L**	**H**	**2.9-5.4**
Triglyceride	**2.7**	**mmol/L**	**H**	**0.5-2.3**
HDL Cholesterol	1.43	mmol/L		0.8-1.9
LDL Chol - calculated	4.8	mmol/L		
Total/HDL Chol Ratio	5.2			
HAEMOGLOBIN	106	g/L		105-140
HCT	0.33	L/L		0.32-0.41
MCV	74	fL		70-86
MCH	24	pg		23-29
RDW	15.1	%		11.5-16.0
WBC	5.1	x10E9/L		5.0-14.5
Neut Seg	2	x10E9/L		1.0-7.0
Lymphocyte	2.7	x10E9/L		2.0-8.0
Monocyte	0.3	x10E9/L		0.3-1.3
Eosinophil	<0.1	x10E9/L		0.0-0.9
Basophil	0.1	x10E9/L		0-0.2
PLATELET COUNT	239	x10E9/L		150-500
Bilirubin total	3	umol/L		0-25
Alk Phosphatase	195	U/L		80-450
GGT	6	U/L		0-50
ALT	13	U/L		0-35
Total Protein	**56**	**g/L**	**L**	**60-80**
Albumin	**23**	**g/L**	**L**	**34-48**
Globulin	33	g/L		25-35
CRP	0.8			0-8

DIAGNOSIS: Nephrotic syndrome

DISPOSITION: Referred to Paediatric registrar for investigation and monitoring.

DISCUSSION: The Emergency Department often sees people with an allergic reaction during the year, this aside something drew me to looking deeper into this case as things did not add up. The GP had done everything right and despite that the carer had noted no change in condition and came forward for assessment.

Nephrotic syndrome is caused by renal diseases that increase the permeability across the glomerular filtration barrier. It is classically characterised by four clinical features, but the first two are used diagnostically because the last two may not be seen in all patients:

- Nephrotic range proteinuria – Urinary protein excretion greater than 50 mg/kg per day
- Hypoalbuminemia – Serum albumin concentration less than 30 g/L
- Oedema
- Hyperlipidemia

The estimated incidence of pediatric nephrotic syndrome is 2 per 100,000 children per year. Primary nephrotic syndrome is more common in younger children, particularly in those less than six years of age. There is a male predominance, with reported ratios of boys to girls of 2 to 1.

Nephrotic syndrome in children is characterized by general edema. Elevated blood pressure and hematuria are less common findings in children with minimal change disease than in children with focal segmental glomerulosclerosis or secondary causes of nephrotic syndrome.

Oedema — Childhood idiopathic nephrotic syndrome generally presents with oedema and often occurs after an inciting event, such as an upper respiratory infection or an insect bite. Oedema increases gradually and becomes detectable when fluid retention exceeds 3 to 5 percent of body weight. Typically, periorbital oedema is noted first and is often misdiagnosed as a manifestation of allergy. The oedema is gravity dependent, and thus, over the day, periorbital oedema decreases while oedema of the lower extremities increases. In the reclining position, oedema localises to the back and sacral area. Other dependent areas that can become edematous include the scrotum, penis, or labia. The affected areas are non-erythematous, soft, and pitting.

Case Study

Facial Swelling? Allergic Reaction Cont.

Elevated blood pressure — The likelihood of elevated blood pressure varies with the underlying cause of nephrotic syndrome. Hypertension is common in patients with glomerulonephritis, but is infrequent in patients with minimal change disease. For patients with glomerulonephritis, hypertensive encephalopathy is an uncommon but serious complication. (UTD)

TREATMENT OPTIONS:

Management (Starship guidelines)

Diet Normal protein intake.
Salt restriction during relapses.

Antibiotics Oral penicillin should be given during both initial illness and relapses. Pneumoccoccus is the most common bacteria causing infection. If peritonitis suspected, cover gram negative organisms as well.

Diuretics Careful use of frusemide, only in the absence of hypovolaemia, if fluid restriction (e.g. 70% maintenance) and salt restriction alone not effective in controlling oedema formation.

IV Albumin Only for clinical evidence of hypovolaemia or severe oedema. Maximum dose 1g/kg of 20% albumin over minimum of 4 hours.

If given for severe oedema, follow with IV frusemide 2-3 mg/kg/dose.

Complications: hypertension, hyponatraemia, hypokalaemia, pulmonary oedema.

If patient has evidence of renal impairment discuss with Nephrology prior to IV albumin use.

Steroids This is the mainstay of treatment and should be commenced once the diagnosis is established. If there are concerns of the possibility of secondary nephrotic syndrome please discuss with nephrology prior to commencing steroid therapy.

Many patients require the addition of gastroprotective medication whilst on high dose daily steroids.

Steroid therapy for first presentation:

The most recent systematic analysis (Cochrane library 2015) recommends 3 months of corticosteroid therapy.

- Prednisone or Prednisolone - start at 60mg/m2/day (max 80mg) in a single daily dose to complete a total of 28 days.

- This is followed by alternate day therapy at 40mg/m2/day (max 60mg) for further 28 days.

-Then wean steroid dose gradually over the next 4-6 weeks and stop.

-Total treatment duration of first presentation should be approximately 3 months.

Steroid therapy for relapses:
Infrequent Relapses

Prednisone or prednisolone - start at 60mg/m2/day (max 80mg) until in remission. Then give alternate day prednisone or prednisolone at 40mg/m2/day (max 60mg) for total of 28 days, then stop.

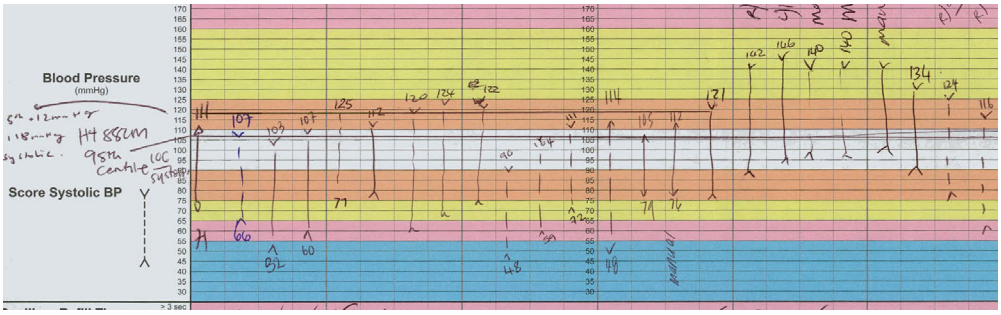
Children having <2-3 relapses per year can be managed with repeated courses of prednisone, providing they have a complete response to treatment each time.

OUTCOME:

Episodic hypertension (Normal systolic is between 85-95 mmHg) was noted during the child's in-hospital stay, and treated with oral frusemide with the proteinuria settling on day 4 by urine testing. Interestingly, she had all of the 4 criteria as listed in the Up-to-date information on diagnostic testing. Much of the nursing documentation mentioned the child being active +++ and running around the ward from the oral steroid administration. The child did well over the 5 day stay in hospital and is continuing to do well within the community with outpatient follow up while still on a tapering dose of prednisone.

Case Study

Facial Swelling? Allergic Reaction Cont.



CONCLUSION:

If you don't use your clinical head for inquiry then these will slip through your hands and once again if you *don't look then you won't find* the problem or potential problem on presentation to the acute and busy emergency department.

REFERENCES:

- **Starship Hospital guidelines.** https://www.starship.org.nz/guidelines/nephrotic-syndrome/
- **Up-to-date.** https://www.uptodate.com/contents/etiology-clinical-manifestations-and-diagnosis-of-nephrotic-syndrome-in-children?search=nephrotic%20syndrome%20children&source=search_result&selectedTitle=1-150&usage_type=default&display_rank=1

Paediatric Pearls

Author:

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Starship Children's Emergency Department

Most foreign bodies are in the most anterior part of the anterior nasal vault and are usually seen with good lighting. Common objects pushed into the nose include cotton, paper, beads, toys such as Lego, food matter, and button batteries.

Assessment

History is often vague. The only clue may be an unexplained discharge coming from one nostril...yuck!

Can be tricky to visualize depending on what the object is.

Consider there may be others....

Red Flags

Button batteries and magnets must be removed immediately because they may burn or perforate the nasal mucosa and/or septum.

Consider your options

Kissing technique (worth trying first):

- Ask the parent to hold the unaffected nostril shut and place their mouth over the child's.
- Instruct them to give a *quick and forceful blow* into the child's mouth.
- The idea is that the pressure generated can often "blow" the object out.

Instruments: Your choice will depend on the type/shape of foreign body you want to remove:

- Jobson Horne probe
- Hook
- Alligator forceps

Katz extractor... if you don't have one of these then may I suggest a 6 Fr Foley catheter. This works just as well and is a much cheaper option. **Tip:** Often need to advance the end a bit further than what you think before inflating the balloon – 2ml of air is about right. https://www.aliem.com/trick-trade-nasal-foreign-body-removal-using-foley-catheter/

Suction: Limited success with this

Tools

- A good light source is a must. If you have access to an ENT headlamp then use this.
- Applying a topical vasoconstrictor such as *Co pheylcaine spray* can help reduce swelling of the nasal mucosa and any subsequent bleeding.
- Consider continuous flow nitrous for younger patients. Apply for 3 mins at 70% which should give you a window of 30 seconds to attempt removal.

Viewpoint

Moral Injury: An Opinion

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In our emergency departments, the day to day operational pressure generated often compromises the delivery of quality care to patients and whānau. At times our professional resilience, as ED nurses is challenged to the point of distress. 'Burnout' is commonly used to describe occupational distress experienced by nurses; this being characterized by malaise, fatigue, frustration, cynicism and inefficacy (Fruedenberger, 1974).

Initiatives to address burnout trialed in other industries have been applied to healthcare. Solutions in my own workplace include subsidized gym memberships, mindfulness training, 'open door' counseling with a dedicated occupational psychologist, mentorships, social club events and sports – all of which are undoubtedly helpful and needed. But these are personal responses; there remains an environment in which undue levels of stress occurs despite our own efforts to best manage ourselves and support our colleagues. Despite increased staffing, additional spending and ongoing systems improvements – the collective unease, frustration and fatigue persist. There is a disconnect between our personal efforts to address our mood and energy and our work place environment, which remains unchanged – if not more stressful.

The common understanding of 'burnout' and how the term is applied suggests a failure of personal resourcefulness and resilience. These are traits that ED nurses have in abundance. To suggest to an ED nurse they are burnt out is to critique their suitability to the role they have chosen and are likely to be highly committed to. This might also explain why initiatives to address burnout are not always universally embraced despite acceptance that there is a significant problem that needs to be addressed. The conversation about how we respond to overbearing stress needs to shift beyond one of personal response to consider a wider cause.

In 2018 Dean, Talbot and Dean wrote an article in which they attempted to articulate the experience of working in a health care environment under resource constraint and stress. They borrowed from the concept of moral injury. This term was first applied to US military personnel returning from Vietnam with symptoms similar to, but not entirely fitting post-traumatic stress syndrome (PTSD). Psychologists noted some returned veterans were not responding to the recognized treatments for PTSD at the time. On closer analysis, it was determined that some service members presenting with PTSD were in fact traumatized not by any predominant, imminent threat to their physical well-being or mortality – but in a greater degree by an assault to their morality. This typically occurred when they were ordered to do something that offended their moral beliefs. By following orders they subsequently questioned their core beliefs and humanity. Their injury was further exacerbated when they were repeatedly placed in such a position (Shay, 1995).

It's a long stretch to equate the trauma of war to the day to day work in an ED. But lessons can be drawn in the experience of operating in daily, moral conflict. We currently work in busy, pressured departments. We are placed in positions of moral conflict where our core nursing beliefs are compromised. Beliefs such as 'do no harm', 'advocate for the patient' and 'place the patient at the center of decision-making' get lost in the push towards operational efficiency. In practice, conflict occurs when juggling bed shortages, balancing rosters, triaging out, pushing for referrals and discharging against better judgment. I would suggest the moral injury from these daily conflicts is further exacerbated when the corporate values of our employing organization are additionally compromised by the under resourced environment we practice in. We face choices between doing the best for our patient and meeting

Viewpoint

Moral Injury: An Opinion Cont.

our organizational objectives and values. I have no doubt, with the best intentions, we strive to meet the objectives and expectations of both – and in a perfect world they would be perfectly aligned with the resources need to fulfill the needs of both. But I know from experience that this is not always possible, – and is becoming increasingly challenging. Conflict and stress accumulate – and moral injury is sustained. Quantifying the degree of moral injury remains problematic. There is no accepted clinical threshold. But there are tools to quantify burnout, it can be measured, and by extrapolation moral injury can be identified as occurring.

Why is any of this important? Isn't it enough, day to day, to do our best, to protect ourselves from the bigger, wider, systemic assaults that we can't challenge or change? To address a problem we need to be able to articulate what it is. If we can effectively articulate our situation, we have more chance of successfully advocating for our patients and ourselves. However, being able to articulate our personal response to workplace stress is not a solution in itself. We need to effectively advocate for solutions beyond our personal resources to address. In this case it is perhaps a starting point of a wider conversation based on a better understanding of why despite everything, we remain working in a stressful environment, and who is responsible for alleviating that stress?

Burnout continues because the moral injury at the root of the problem remains unaddressed. Moral injury locates the source of distress, not with the broken individual but with a broken system and allows us to redirect our efforts to consider the systemic causes of occupational distress.

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Viewpoint / Current Issues

Emergency Departments at capacity: Nurses voice their concerns

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In March, Dr John Bonning and Dr Sandra Richardson raised issues relating to the current pressures on emergency departments (EDs) across the country. Nationally all EDs are experiencing the same issues, with significantly increased patient presentations, overcrowding and access block, and nurses are feeling the pressure of these demands. ED is the canary in the mineshaft, manifesting the problems of the broader health system. We want our concerns acknowledged and for district health boards (DHB) to take immediate action to prevent events that lead to serious harm or death of a patient and ensure adequate support for nursing staff. Christchurch nurses have responded by providing the CEO and executive team with personal experiences of the impacts of the issues.

Sir Mason Durie illustrates health and wellbeing as a whare (meeting house) with four walls representing the aspects that balance and impact a person's wellbeing (Ministry of Health, 2017),

- taha tinana / physical health,
- taha wairua / spiritual health,
- taha whānau / family health, and
- taha hinengaro / mental health.

This wellness model, Te Whare Tapa Whā, represents the holistic model of care that nurses strive to provide and incorporate into their everyday patient interactions and nursing practice.

While emergency nurses are highly competent, well-trained professionals prepared to respond and deal with crises and emergencies, nurses cannot provide the holistic care and support that patients and their whānau deserve when waiting rooms are full, triage times breaching, and patients are in corridors and other inappropriate clinical spaces. With departments constantly at capacity and nurses pushed to their limits, this sustained high workload it is taking its toll. Nurses want to practice with integrity, knowing they have given the best possible professional care to their patients, including addressing and supporting patients' holistic healthcare needs. Instead, nursing care is compromised, reduced to task-focused care and limited to providing only the basics. The balance of the four supporting walls of the whare is left vulnerable and unchecked as nurses cannot provide a high standard of care under the stressors of the current situation.

Three Christchurch ED nurses took the opportunity to highlight some of the concerns and pressures their fellow nursing colleagues felt during a Breakfast TV interview with John Campbell. Following this, nurses throughout the ED began to

Viewpoint / Current Issues

Emergency Departments at capacity: Nurses voice their concerns

share their stories and frustrations working in unsatisfactory and stressful conditions. Nurses chose to speak their truth by writing personal impact statements, empowering them to share these important stories. These impact statements were anonymised and presented to the Canterbury DHB executive team. Nursing staff provided 55 impact statements that reflected the daily stressors they were experiencing. Nurses felt that they were running on empty physically, mentally, and emotionally, which is now spilling over and impacting all aspects of their wellbeing, their personal lives and their whānau.

The impact statements had strong recurring themes:

- Feeling of exhaustion, overwhelmed, sad, angry, frustrated, discouraged, despairing, hopelessness
- High volumes of patients and unmanageable workloads with nurse to patient ratio up to 1:5 or 1:6
- Staff feel unsupported and vulnerable, they are scared of making clinical errors or failing to identify a deteriorating patient
- Unacceptable wait times in dangerously full waiting rooms of undifferentiated patients including young children and the elderly
- Patients unable to be assessed within recommended triage times
- Triage nurses feel the burden of risk with patients in the waiting room who require monitoring
- Fear for patient safety, concerned about near misses and unacceptable patient outcomes
- Concern that this is the perfect climate for a sentinel event and that nursing staff will be held accountable, fear that our professional nursing registration is at risk due to circumstances outside of our control.

This united nursing voice had a powerful impact and the CDHB responded to the call for action, they provided an additional 8.3 nursing FTE and 2.1 hospital aide FTE. They promise a staged response to fully addressing the concerns which were raised.

In sharing this, we hoped that the messages would resonate with other ED nurses nationally as they did with our CEO and executive team. We hope that we can find ways to ensure nursing voices are acknowledged as we navigate these current challenges. Nurses are exhausted, worried and approaching burnout. The message is loud and clear; we cannot safely manage these high patient loads, we are existing in survival mode. We desperately need more nurses to ensure the provision of quality nursing care and best practice standards.

References

Ministry of Health. (2017). *Māori health models – Te Whare Tapa Whā*. www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

Allied Health Profile **01**

Occupational Therapy role within the Christchurch Emergency Department

Authors:

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Conflict of Interest: none

Occupational therapists have a client centred and holistic approach to their practise. Within the Emergency Department (ED) setting we see a wide range of cliental. Our primary referrals are those who have fractured a bone and have a change in functional status i.e. non-weight bearing in a limb and therefore require potential ACC supports and short term loan equipment whilst they recover. We also get referred frail and older patients who are high falls risks, those who were admitted with mild traumatic brain injury and those with change in cognitive status who may need to be referred for follow up assessment and to determine safety within the home.

Our ED occupational therapist is also responsible for referrals from orthopaedic outpatients. Staff refer via Vocera (a hands-free voice communication device), phone call or paper. This includes any afterhours patients who presented after Occupational Therapy working hours and a need is identified for occupational therapy input.

A day in the role of an ED Occupational therapist:

On arrival in the morning, we identify any after-hours referrals that have either been faxed to the department or have been placed in the ED Allied Health Office. Our ED occupational therapist screens these referrals to identify those who are a more urgent priority, i.e. severity of injury, age and presence or absence of social supports. Our ED occupational therapist also screens the ED's online queue screen (ED at a Glance or EDaaG) for any possible referrals to our service and then we attend the 8:00am MDT handover. Our first priority is to see any patients who are physically present within the ED, then we complete the phone referrals.

When interacting with patients, either face-to-face or via phone call, we assess their functional ability to manage basic day-to-day tasks at home such as showering, dressing/undressing, toileting, mobility, transfers and productivity/household tasks. Through our assessment, we identify how functional strategies and adaptive equipment can facilitate independence and safety when completing activities of daily living and can prescribe required adaptive equipment.

If a client has an ACC claim, we provide them with information and frequently advocate around ACC processes including loss of earnings, childcare, transport assistance, equipment unavailable through hospital system and can refer for short term support services (if need identified during assessment).

When reviewing head injury patients, we complete the most appropriate assessment (e.g. Westmead post-traumatic amnesia

Allied Health Profile **01_Cont.**

Occupational Therapy role within the Christchurch Emergency Department Cont.

scale or the abbreviated Westmead post-traumatic amnesia scale) pending the mechanism of injury and severity of head injury and we review concussion symptoms via Rivermead post-concussion symptoms questionnaire. We provide education around recovering from a concussion and around ACC information and we can refer to a specialist concussion clinic if need identified.

Some clients who we contact via phone or see face to face require further occupational therapy intervention once in community; for this group we can either refer to our Acute Home Visit Occupational Therapist or refer to community occupational therapy teams.

We work closely alongside other members of Allied Health such as physiotherapists and social workers to help determine safety for home versus the need for admission.

The role is covered Monday – Friday 07:30 until 16:00 and Saturday – Sunday: for phone referrals between 09:00- 15:00. There is a weekend and public holiday service which is able to be referred to for any discharges or head injuries. At the moment, there is one occupational therapist based within the Christchurch ED working 4 days per week. On Wednesdays, the role is covered by another occupational therapist who will see those who are verbally referred via cell phone/Vocera to our service and complete after-hour phone referrals.

Allied Health Profile **02**

Liaison nurses for the Acute Demand Service

Authors:

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Conflict of Interest: none

Acute Demand is a short-term community based care 7 day service, it is an alternative urgent care pathway and GP support to keep people out of Canterbury DHB hospitals. The service aims to prevent inpatient admission from ED, reduce length of stay in wards and prevent readmission.

The service is funded by the CDHB and is completely free for the patient. We do have a specific geographical treatment area, which includes outer city suburbs and satellite towns. Our service provides rapid response community nursing with highly experienced RNs delivering:

- Comprehensive nursing assessment
- IV therapy
- Medication administration
- Blood taking
- USS and X-ray in the community
- Transport for appointments for Acute Demand patients
- Free GP follow-up / review

We consider referrals from any hospital department. We frequently see patients with heart failure, COPD, DVT/PE requiring anticoagulation, pneumonia, pyelonephritis, skin and soft tissue infection and arrange outpatient USS. A senior medical officer is available within the Acute Demand service to provide clinical oversight and make medication adjustments.

The Acute Demand Liaison Nurses are a team of three liaison nurses, working within Christchurch Hospital, between 0745 and 1700hrs Monday to Saturday, including most stat holidays except Christmas or New Year's Day. The liaison nurse provides a vital link between hospital and community. Our role is to screen patients from a daily inpatient data list and identify patients who could be relevant for medical treatment in the community, including rest home and hospital level of care residents. Patients are referred to the service from

- ED handovers
- ward board rounds from MDT and medical teams,
- direct referral from medical teams, and
- proactively by liaison nurses screening patient notes and writing a note to highlight to teams that patient may be appropriate and suitable for timely discharge.

We liaise closely with emergency department and the medical and surgical assessment units, generating the referral process to the Acute Demand Coordination team. We ensure the

Allied Health Profile **02_Cont.**

Liaison nurses for the Acute Demand Service

correct paperwork is completed and the patients have received first doses, if appropriate, prior to discharge. The liaison nurse provides Acute Demand coordination with contact numbers and ensures that they have any appropriate paperwork and drugs if required for the team to use.

We discuss the service with the patient and what they can expect, and feedback anything else relevant to our team on the referral. The patient is supplied with a card with a contact phone number.

Snippets 01: Winter 2021

Snippets: Emergency cuttings, reviews, resources and contemplations.

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

These are sources that can keep you updated, which offer regular messaging or input. Some of them can be tailored to your interests or needs. The CENNZ journal offers these as suggestions, but does not take responsibility for the content or endorse specific items.

In this edition we introduce a New Zealand and two UK sites that you may find useful in expanding your general information base.

Health Improvement and Innovation Digest:

This is a newsletter which is published fortnightly, offering summaries of articles and publications, put together by the NZ Ministry of Health Library. The Digest provides links to key evidence of interest related to health topics, with content arranged by topic.

You can read recent issues and subscribe to the Digest via the following link:

https://www.health.govt.nz/about-ministry/ministry-health-library/health-improvement-and-innovation-digest

CHAIN - Contact, Help, Advice and Information Network –

is an online network for people working in health and social care. For more information on CHAIN and joining the network please visit website: www.chain-network.org.uk The network is multi-professional and cross organisational and has over 30 sub-groups.

National Institute for Health Research (NIHR): Patient Experience Collection -

Published on 4 March 2021 (doi: 10.3310/collection_44878). This Collection brings together NIHR research relating to patient experience. The Alerts explore personalised rehabilitation, mental health, decision aids and health inequalities and cover a range of health conditions such as stroke, anorexia, multiple sclerosis and type 2 diabetes. A useful resource for understanding the patient perspective, reminding us of the realities for our patients. Accessible at:

https://evidence.nihr.ac.uk/collection/patient experience/?source=chainmail

Snippets 02: Winter 2021

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 have the opportunity to impact health care, to raise awareness around issues of equity and access, and to challenge aspects of power and its misuse. This section aims to highlight resources and information that may inform your understanding of Cultural Safety.

The Health System also 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.

The editors of Emergency Nurse New Zealand want to offer the opportunity to share resources and information that may assist nurses in their journey towards cultural safety and increasing their understanding Te Ao Māori.

Many Emergency Departments and urgent care centres have made considerable efforts in these areas. Share your resources and stories here.

If you know of any items suitable for inclusion in 'Cultural Safety and Te Ao Māori Snippets', please e-mail these through to: editor.cennzjournal@gmail.com.

Te Reo Māori

The use of language – Te Reo Māori – continues to grow in New Zealand. However, it remains an area where we can all develop and expand our abilities.

Maori language week for 2021 is coming up in September: 13th-19th. If you want to practice or learn how to create a mihi, try looking at: Kia Kaha Te Reo Māori.

https://www.reomaori.co.nz/learn_your_mihi

Also check out the general website with ideas for Te Reo: https://www.reomaori.co.nz/

Learn Kaikōhau

A kaikōhau (expression of hope) is commonly used as part of Matariki (Māori New Year) celebrations, but is not limited to this time – it can be used in many other circumstances.

The following is re-printed with permission, but visit the https://www.reomaori.co.nz/learn_kaikohau site for more information.

Kaikōhau means to express your hopes and desires. When you say it, you are welcoming all things that are good and wishing for them to be plentiful in times to come. 'Hua' (fruits) references all things that are good. This can be the food laid out in front of you, it can be your mahi (work), health, whānau and friends, and many other things in your life that you hope to be fruitful and abundant.

Nau mai ngā hua

Nau mai ngā pai

Nau mai kia nui

Kia hāwere ai

Welcome all things that have grown

Welcome all things that are good

May they be plentiful and abundant

Guidelines for working with Asian patients and their families (2012; Last updated 25/06/2021)

This document from the Health Quality & Safety Commission contain information and guidance for clinicians to increase cultural awareness, sensitivity, knowledge and skills when working with Asian patients and their families. Developed by WDHB.

https://www.hqsc.govt.nz/assets/ACP/PR/Asian-health-support-services-guidelines-for-advance-care-planning.pdf

CENNZ Reports

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

Vacancy

There is a position representing Top of the South on the CENNZ National Committee currently vacant.

Please see application information on page 43

Chairperson's Report

Sue Stebbeings
CENNZ Chairperson

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Kia ora koutou katoa
Hello everyone

This is my first report as chairperson on behalf of your CENNZ national committee.

We welcome new regional representatives Amy Button from Hawkes Bay/Tairāwhiti and Keziah Jones from Canterbury / Westland. Thank you to Louise Holland for her work as CENNZ secretary. There is now a regional vacancy for Top of South, and there will be a vacancy for Mid Central rep when Katie Smith completes her committee term at the end of this year.

We especially want to acknowledge the commitment of Sandy Richardson during her term as chairperson, particularly with the challenges of Covid turning so many things upside down, including the cancellation of our face-to-face meetings. We appreciated your patience and attendance at our virtual AGM in November 2020. As Sandy mentioned in her February report, there are opportunities for positive change among the many challenges.

From looking at old CENNZ journals, I realise that emergency nurses have been working together since 1991 to improve the care we provide here in Aotearoa/New Zealand and address the critical issues. The themes remain similar over the years and reflect international concerns, although there are new risks to business as usual such as cyber-attacks. Our thoughts are with our Waikato colleagues as they persevere with the limited computer resources during ever-increasing presentations and acuity.

So here we are in 2021, working on the foundations of previous committees' work. The CENNZ aim to promote excellence in emergency nursing means that we need to continue to advocate for safe staffing, access to education and support networking across the country.

We are very much aware of the escalating crisis across our EDs, reflecting the lack of acute care capacity in our health system. Safe staffing is crucial for patient safety and the delivery of quality emergency care. Staff wellbeing is also an essential consideration and inevitably impacts the recruitment and retention of nurses. There has been evidence of an alarming deficit in nursing care hours wherever data has been available. A recent letter to members highlighted the option of presenting anonymised staff impact statements along with the quantitative data. We also need to continue to file safety, incident and Datix reports.

As a committee, we have made safe staffing the priority for this year and plan to do what we can to keep your

Chairperson's Report Cont.

and our concerns visible through writing to the Minister of Health and responding to media interest. Core CENNZ activities such as triage courses continue. There are several other projects underway however, many are works in progress as they take longer than anticipated.

This month we have the privilege of allocating conference grants for the upcoming CENNZ Conference in Christchurch. A new feature is that the network days are occurring the day before the conference.

The organising committee is developing a great programme and keynote speakers. We are looking forward to getting together after last year's cancellation due to the uncertainty of Covid.

Finally, Grit – passion and persistence – is the ENA theme for Emergency Nurses Day in October. Emergency Nurses in Aotearoa exemplify passion and persistence every day in their care to those coming to the front and back doors of ED. Grit helps us to care for each other and hang in there during stressful times. Teamwork, respect, and innovation is part of the glue that holds us together as each new challenge arrives – be it RSV, resurgence of Covid, electronic systems failure, or running out of essential supplies…again.

Kia kaha, continue to be strong.

Look after yourselves, and keep warm over winter.

Ngā mihi nui,

Sue.

Northland/Te Taitokerau Region

Sue Stebbeings
Nurse Practitioner

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Whangarei Hospital

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Even though we may be the warmest part to the country, the usual winter illnesses are also making their presence known with increasing numbers of respiratory presentations. We face the same issues as other EDs including increasing presentations, increasing acuity and delays to inpatient admissions.

In Whangarei, the Adult Assessment Unit opened recently for stable medical referrals and admissions during morning and afternoon shifts. The unit closes overnight due to staffing constraints, however we are hopeful that this will change so that it can have a greater impact on reducing access block and overcrowding.

It was a relief that the renovation to make the temporary Covid related alterations permanent was completed without major obstacles or complications and quicker than anticipated. This involved putting glass doors onto the 6 cubicles and between the 2 resus rooms so that the negative pressure capacity is available long term. Permanent bilingual cubicle numbers have been ordered to replace our temporary laminated signs.

The Workplace Violence Prevention team are piloting a CALM Plus 8 hour study day. This is a more advanced de-escalation training course that includes physical break away and self-protection skills.

Actilyse is now in use for STEMI thrombolysis. Great efforts have been made to support safe transition to the more complex infusion calculation while Tenecteplase is unavailable.

The ongoing issues with supplies creates opportunity for ingenuity and innovation - I for one didn't realise that our patient ID wristbands came from Singapore.

On a brighter note, we welcome all our new staff moving to the region, the grass is very green at the moment and summer is coming :).

Sue

Greater Auckland Region

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Starship Children's ED

Well we are truly into a proper winter this year. The department is in the midst of something we didn't see last year .....bronchiolitis season and the bronchiolitis cry that echoes through the department. We are seeing numbers we have never seen before. A busy day was 145 and now with RSV taking off we are seeing in the 180's.

CED has had a lot of new staff start in the last 12 months- we have seen quite a few of our staff leave to take up senior positions in Starship, a couple move to Australia and the COVID baby boom has 5 of our staff on parental leave (10% of our staffing fte!). We have been lucky to secure RN's who have come to us with ED experience- thanks Whangarei, Counties and Adult ED Auckland! Although recruiting to vacancy is still challenging and covering the winter nursing model has been hard along with high sick leave of nursing and medical.

We have just had our 2nd annual wellbeing week. It is unfortunately coincided with our presentation surge of RSV so some of the activities planned didn't pan out but some of the highlights was daily breakfasts, care packs for all staff , the Matariki photo competition and those on days off or pre-shift enjoyed the harbor bridge climb and a dog walk on Takapuna beach.

One of our Nurse Practitioners Libby Haskell had some of her PhD published in the highest rated pediatric journal - The Journal of American Medical Association - Paediatrics. Her article title is "Effectiveness of Targeted Interventions on Treatment of Infants with Bronchiolitis - A randomized Clinical Trial".

Anna Marie Grace

Auckland Adult ED

As the media have been reporting, we have recently had a number of nurses leave their ED roles. Some are taking-up opportunities in Australia or to assist with the COVID19 vaccination efforts. Patients are presenting in record numbers, with greater complexity. Fatigue, stress and the RSV outbreak have likely all contributed to an increase in ACC and sick leave. This has meant we are experiencing critical staffing gaps. Whilst other health services may be able to 'close' beds or delay elective surgeries or procedures, we have no way to reduce demand in this context of decreased resource. We are looking forward to onboarding enthusiastic new staff.

In more positive news, we have appointed some fantastic new senior staff including two new Nurse Consultants a new Nurse Educator and a dedicated Mental Health Educator. Nurses are now involved in regular departmental M & M meetings and we have a clinical psychologist onsite two mornings a week for staff.

Importantly, efforts are being made to address the increasing violence and aggression in the department. These include the presence of dedicated Health Security Officers in the department, Management of Actual or Potential Aggression (MAPA) training and the establishment of a Behaviours of Concern emergency response process.

Natalie

Auckland Region cont.

Middlemore Hospital ED

Kia ora koutou,

Over recent months we have certainly seen a peak in patient presentations, with well over 2,500 patient attendances to the department in one week. While the adult side of the ED has been witnessing high patient volumes, the increased total number of ED patient presentations has been significantly influenced by a large number of paediatric patient attendances and RSV. This challenge has been compounded by substantial access block within the organisation as a whole.

Overall, senior lead triaging is running well in Middlemore ED, with an SMO and TAR nurse based at the ED front door between 1100 and 2300hrs most days. This has been an evolving process, and thanks must go out to the hard mahi of the staff nurses, doctors, clerks, orderlies and emergency department quality improvement team who have led this change.

In May, we welcomed Tracey Mitchell to the role of Service Manager for the ED, and Bev McLelland was appointed to the Clinical Nurse Director for Acute Critical and Clinical Services role. We are soon to welcome back Christopher Chu, who will be joining us in the role of Nurse Unit Manager for the ED. Christopher has previously worked in our department as an Associate Clinical Nurse Manager but has spent the last 18-months working with Capital and Coast District Health Board. We are looking forward to working with you all; continuing to make positive changes for the population of South Auckland and our staff.

In regards to staffing, we are in the process of recruiting new RNs and are welcoming on board some new members to the SMO team (some of these are familiar faces). Over recent months, five new Associate Charge Nurse Managers have been appointed in the ED, two of these specialising in paediatrics.

To the staff of Middlemore ED, once again, thank you for the hard mahi, your commitment and the great work that you do. You are all absolute superstars.

Wendy Sundgren

Northshore ED

Reflecting the challenges across the country , we've seen increased presentations and poorer staffing ratios and increased incidents of violence and aggression. Staff feel undervalued and overworked! For us in Auckland the ability to recruit due to staff leaving for less expensive parts of New Zealand or leaving for Australia is having a huge impact on staffing. We do not have the ability to recruit from overseas, and any overseas staff wanting to visit families are prevented from doing so as they can't return if not residents. Burnout 'post' COVID is real and staff are more tired and less resilient than previous years. Lots of sickness and use of EAP.

Locally we have be nominated for the Health excellence awards for our work around equity and anti-racism. We have also worked very hard with our Nurse Educator and the Mental health teams to develop better practice for patients. We designed a programme of education and practical learning for therapeutic observers for patients in ED presenting with Mental health issues or the elderly dementia / delirium patients . We no longer use any outside security guards, instead , training HCAS to interact, de-escalate and support the patients during their stay in ED . This along with our early intervention 'Best care bundle' for those with agitation and self-harm , improved communication with the MH teams and early plans for levels therapeutic observation , has led to a calmer ED less restraint and less seclusion on admission to the inpatient units.

Our Nurse Practitioner internship is set up and fully running with our newest graduates starting in ED in March with more on the way! A great asset for our department.

Sue Lamb

Midland Region

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Rotorua ED

Winter has certainly been felt in the Midland region with Emergency departments and wards constantly full. With staffing vacancies critical and the increasing number of staff sickness it is a worrying time across the health sector.

On a positive note here in Rotorua we have some exciting new roles within our department……..

Rotorua ED now has a physio based in ED, Monday – Friday who is proving to be invaluable in assisting with early discharges and is also easing the workload of our minor stream patients. The physio role is liaising with our ED SMO team to assist with early discharges and complete a wrap around allied service for our short stay patients. This role has only been in place for 1 month and already it is proving to be a huge asset to the department. Our ED physio is able to see and treat and discharge many of our minor isolated limb injury's, provide support and detailed assessment for elderly – to reduce readmission and also works in partnership with our ED SMOs to expedite and safety discharge patients who require additional mobility assessment and community referrals.

Over winter we have 1.0FTE paediatric CNS in the department. This role is predominantly rostered for when paeds present in ED, which seems to be in the evenings. With the recent spike in RSV presentations this role is able to support early intervention i.e rehydration, assessment and early referral to paeds consultant as required. The Paeds CNS helps facilitate admissions from ED to ICU and the paeds ward. We have 2 very senior ED /paeds RN's who fill this role. They also support education and growth of our ED staff to develop their paeds knowledge.

We also now have 3x ED CNS's in Rotorua ED. With the additional FTE we are working closely in developing a model in which this role can flex and support the Rotorua remand centre / police hub. We are in the early stages of discussions around this and how it would look, but it is an exciting project which, in turn should reduce the ED attendances of patients who are best kept with our colleagues in corrections.

(Photo below from L to R: Anna - ED physio, Sandy and Lisa - ED CNS and missing from picture Khristian - ED CNS).

Midland Region cont.

The new palliative care room (above) in Rotorua Hospital's Emergency Department was created to enable palliative care patients some comfort when they need treatment. For the past year, the room has been used for the staff to don and doff PPE. However, the transformation means it now has comfortable chairs, a beautiful wall mural, soft lighting and warm knitted blankets. The idea was to make it a quiet restful place to provide privacy and peace for patients and their whanau who are at the end of their life or have recently passed.

We recognised that palliative patients will have no alternative but to attend ED sometimes and they wanted to provide a space where they could wait if they were not desperately unwell or needing treatment. We also understand that, for many patients and whanau, the ED can be a place that triggers very painful memories. To be able to offer them a room that looks very different from our usual clinical areas is really special. The idea for the room came about thanks to the efforts of an ED nurse Lee-Ann Church. Lee-Ann is passionate about palliative care in the ED and decided to fundraise so that ED could create something special for palliative patients. Lee-Ann's ideas coincided with other work being done to improve the experience for patients in ED, and for staff is just the start of a series of improvement projects being undertaken in conjunction with the palliative care service. The new room highlights the amazing goodwill of our staff who go above and beyond to show compassion and respect for our patients. The room has already benefited some patients and the feedback from whanau has been very positive

Tauranga has a new CNM at the helm - John Wylie, who was an ED ACNM within the department previously. John took over the role from Stephanie Watson at the end of 2020. Of recent, Tauranga ED has had Trendcare in situ and the data is showing marked deficits. There has been a noticeable increase in winter illnesses with paeds RSV presentations proving challenging.

Whakatane have utilised their Whakaari / White Island CENNZ conference grants and are looking forward to 5 of their team attending the conference in Christchurch in November. With the embedded Trendcare this is proving valuable for Whakatane gaining additional nursing FTE and senior roles.

Kaidee

Hawkes Bay/Tarawhiti Representative

Amy Button
Emergency Nurse

Acute Services
Wairarapa District Health Board

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We welcomed a new Clinical Nurse Manager to our Department in February - Lorelei Hennessy.

As the year goes on we are experiencing higher and higher numbers of patient presentations. In May we recorded our highest number of presentations in a 24hr period - 188 patients.

Over the last month, like all of New Zealander Emergency Departments we have had a surge in the number of patients presenting with RSV, majority are you g children 2 years and under. However, we have also seen a significant number of adults presenting with RSV.

Our hospital is at capacity almost daily, making it difficult to have adequate flow of patients from ED to the wards. This in turn creates a backlog of admitted patients sitting in ED waiting for a bed on the ward, and subsequently leads to patients being nursed in the corridors in ED.

This year we have established the Patient Flow role within ED. Working to try and facilitate the flow of patients from ED to the ward. This role is already well established in lots of our ED's nationally, and we are working on building the relationship between ED and the wards to enable a smoother oat with transition through the hospital.

As with many other ED's nationally, we are struggling with a growing population and a hospital that is not large enough to support that population. The nurses are working hard every single day, doing their very best to provide the best care that they can for their patients. However, with increasing numbers of patients presenting to ED, and increased admitted patients staying in ED long periods of time before they get to a ward, the nurses are stretched thin to care for their patients.

We are grateful to have been allocated some further FTE to employee. So ED management have been very proactive and busy with advertising of vacancies and recruitment.

We are a very strong team here in Hawkes Bay ED and we work hard to keep our patients and each other safe. We couldn't do this job on the daily without the support of our colleagues.

Amy

Mid Central Region

Katie Smith

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

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Midcentral DHB

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I looked back to the July report for 2020, and much discussion was around the DHB and ED response to the COVID-19 screening, management and changes to the whole department and system. Twelve months on from that report, COVID-19 is still a daily discussion, but maybe some things have changed. There is no longer a screening pod out the front of ED, and we are back to Level 1, with some travel bubbles open with our neighbours. Amongst the doom and gloom of COVID-19, there were some wins over the last few months – strengthened teamwork, discussions around patient management, teaching, training and lastly some new equipment.

I find the last 12 months have changed our dept – and currently we are dealing with different challenges that the previous year maybe did not have. Like most of our colleagues around New Zealand, we are dealing with large patient volume and high acuity presentations – challenges with bed block, flow, access to care, and high admission rates, perpetuating a vicious cycle of large numbers of patients presenting and remaining in ED.

This has been putting care burden onto staff – who continue to dress up, show up and work hard for their patients and colleagues. Because that's what nurses do. Our dept is seeing staff leave nursing, or leave the dept to other nursing roles, or reducing their FTE hours to enable self care and a better work-life balance to be able to manage the work. A recent day saw 77 patients in the dept – this is a huge number considering the size of our department. The workload and presentations do not seem to be diminishing and with predicted increases over the new few months with influenza and RSV, this will create some challenges for all staff to balance wellness and workload.

On the positive side, there has been an increase in SMOs within the department, Registrars returning to training positions, and the many babies, engagements and weddings. Staff training continues within the dept for both nursing and medical staff, as well as those nurses who have the opportunity to study for Postgraduate qualifications. This is so welcome when work can feel like groundhog day, and well done to those who are managing to study right now!

Advancing Nursing practice within the dept continues to be an exciting area of development. We will see our second NP Candidate work towārds her Nursing Council submission later this year, with another CNS added to our team earlier this year. Our advancing nursing team now consists of 2 x NP, 1 x NPC, and 4 x CNSs. There are plans afoot to continue to grow this service within the ED.

Staff recruiting is ongoing. New staff bringing with them new ideas, skills and experience and we look forward to the new additions to our team.

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

A reminder that the triage courses continue to be well-attended, and the dates for next year will be up on the website soon.

Lastly – this is my last year as the MidCentral regional representative – so get your thinking caps on for anyone you think might be keen to work in this role. It's a great opportunity! Call for nominations will be out later in the year.

Kathryn

Mid Central Region cont.

Taranaki DHB ED

With the general theme of the nation being high presentations, low bed availability, and staff turnover – there have been some small wins for the dept.

The FTE has increased for the night triage nurse and the clinical initiatives nurse – 7 days a week.

The dept is planning on starting TrendCare in November – we will see what the results of this look like.

The dept is running a Networkz Trauma Sim day in July – what a great opportunity for staff and the department. We are also running weekly MDT resus sims, which are going well, and the staff are really enjoying them.

There is still 2.6 FTE vacant owing to sick leave and maternity leave, and this will be looking better in about 6 weeks when some of this staff vacancy can be filled to ease up some pressure on the floor.

We are still covering CBACs and vaccination clinics, so staffing gaps and high acuity is putting pressure on daily workload and shift cover.

Therese Manning – Clinical Nurse Manager

Whanganui DHB – Carla O'Keeffe

Nil report available

Clinical articles – case-studies and reflections

We are always looking for clinical articles. These could be written entirely for the journal or as a part of a post-graduate course.

If you are willing to share a piece of work: write to the editors at editor.cennzjournal@gmail.com. Articles will be peer reviewed and the editors will provide editorial support.

Wellington Region

Kathryn Wadsworth
Clinical Nurse Manager

Acute Services
Wairarapa District Health Board

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As 2020 rolls to an end looking back seems a little unproductive although the lessons learnt by us all will without doubt follow us into the future. The Wellington region is no different to all the other ED's around the country with the need to rapidly respond to the changing care needs within our community this year. The toll of that is now being felt amongst those team members that were directly faced with the uncertainty, risk and management of constant change. Some staff have moved out of the Emergency Department setting because of this prompting a focus on wellbeing, leave management and team resilience. This, coupled with multiple pregnancies within the departments, has opened up FTE availability and a huge recruitment drive. The result of this has been an influx of new staff members excited to be part of our teams with a broad range of experience from novice to expert. The challenge of maintaining a safe skill mix is ongoing for us all.

Advancing roles within nursing are slowly becoming a norm within our areas with interest in postgraduate education now very high. Many staff have been successful in securing health workforce development funding and with this comes wide-reaching opportunity to not only develop advancing skills but open the scope for multiple staff driven quality initiatives and service development driven by those within it. The Wairarapa has been successful in supporting another Nurse Practitioner in training for next year taking the total to three by 2022. Hutt and Wellington ED is focusing on implementing pathways for senior roles and are also committed to developing the advancing nursing workforce.

Trendcare within the Wellington region is either being discussed, implemented or underway. This piece of work alone is considerable for those departments involved and with the significant increase in presentations being felt particularly in the last two months, the results will be of interest to many. As we all know, ED is not always a numbers game with high acuity a factor impacting on flow and workload. Wellington Emergency Department have nearly doubled their ATS1 and ICU admissions from this time last year. Hutt ED have increased their average volume of presentations by approximately 30 to 40 patients per day. All three hospitals have experienced bed block with areas designed for lower acuity patient management being utilised for inpatient units. It's fair to say that despite the considerable effort put into achieving the shorter stays in ED health target, it is not being achieved by any of us.

On a positive note, there is some great work happening out there. Hutt ED is working closely and teaching collaboratively with all front line officers in the Police and from next year working with staff from Rimutuka Prison. They have also celebrated receiving the HVDHB Quality award in Clinical Excellence - The Chief Executives' Award for the Whakaari/White Island collaboration and care Hutt ED contributed to this disaster.

The current focus in the Wairarapa is to identify and facilitate those patients not enrolled in a GP practice and assist them in doing so at the point they present to the ED. This has been a far larger cohort than expected with wider concerning community issues identified and addressed. Running alongside this piece of work is the redirection project which required significant collaboration with our Primary Care colleagues and has saved many patients hours of wasted waiting time in our department. Audited results suggest that care is being achieved effectively and efficiently in this group.

It feels like it's nearly safe to breathe out as the year draws to a close but in the back of all our minds is the increasing demand we are all experiencing. Summer holidays with closed borders brings another unanticipated wave of challenge to our doors but gratitude that this is what we are managing and not the alternative like many countries and colleagues in the world.

Kathryn

Top of the South Region

Louise Holland
Emergency Nurse

Emergency Department, Nelson Hospital

Contact: louise.holland@nmdhb.govt.nz

Hello from NMDHB. We continue to have increased presentations, high acuity and staffing issues. In addition, some of our patients are experiencing double breaching due to a lack of isolation beds on the wards and overworked medical teams. Most days we are in VRM (Variance Response Management) red or orange. We also expect an influx of visitors into the region over the Christmas period which will put additional pressure on our ED's. There are plans, however, in Nelson, to create a negative pressure room and more monitored bed spaces to help mitigate these issues. A proposal has also been made for additional staffing and a flow nurse for our PM shifts. Despite this, we have a great team of ED nurses and I want to take this opportunity to thank them all for their hard work in these challenging times.

Louise

Vacancies within New Zealand

If you would like to advertise for staff to join your ED team, we invite you to write to the editors at; editor.cennzjournal@gmail.com.

Canterbury/Westland Region

Keziah Jones

Emergency Nurse

Emergency Department, Christchurch Hospital

Canterbury District Health Board

Contact: Keziah.Jones@cdhb.health.nz

Kia ora from the Canterbury Region.

Christchurch is settling into the new department and the new facilities in our new hospital Waipapa. The name Waipapa was gifted by Runanga Ngāi Tūāhuriri Ūpoko and means "surface water" denoting the many springs in the area. There are multiple challenges associated with moving house and changing models of care to fit the new environment, and we are adapting well. As with the rest of the country, our biggest challenge is keeping up with increased patient volume. Patient numbers are averaging around 318 patients per day in April, 314 patients per day in May, and 320 patients per day in June, with a consistent 30% admission rate through April, May and June.

We are trialling working as pod pairs to support less experienced nurses as they grapple with the workload and presentations. In addition, we are developing a trial to try and reduce the number of blood components wasted during MTPs. We're interested to hear what interventions other EDs have done to protect this precious and expensive resource.

After a recent trial using Cortex for digital documentation, we decided not to use this hospital documentation tool. While it works well in inpatient settings, our trial demonstrated too many shortcomings for ED use. We are working with Orion to develop a desktop tool that will be more effective for us. It's already being developed in the North Island, and we are excited to try it out.

Trendcare is now fully embedded in ED. We aim to achieve the 95% target of actualised patients for the data to be accepted undisputed. Already, it highlights what we already know - the need for an increase in our baseline nursing FTE.

Our nurses spoke on TV1 Breakfast about the current challenges facing emergency departments, particularly nurses. These nurses provided faces to our nation of the impact of what we experience. They were clear to say that this is not an isolated experience and we acknowledge all other EDs across the country with the same struggles. One outcome for us is that Christchurch nurses collectively wrote personal impact statements about the challenges of providing care and maintaining our standards of care; we delivered these to the CDHB executive team. Nurses described the current situation through their own experiences, highlighting the concerns from their daily work perspective. We demonstrated the stresses and demands of constantly working to maximum capacity and at times beyond capacity and that nurses are worried about patient outcomes, safe staffing and the impact on their nursing practice - they are struggling to provide the high standard of care they would expect with the demand of increasing workloads. This powerful united nursing voice, supported by our senior nursing team, has seen some immediate additional nursing FTE approval. We are now busy recruiting and welcoming nurses, hospital aides, and admin staff with orientations in progress.

The Ministry of Fun has been busy lifting our spirits by providing some great activities to keep the team connected. We have regular weekly drinks and nibbles in our local pub, The Peg. This is our ED social

Canterbury/Westland Region Cont.

network made up of doctors, nurses, hospital aids and admin team. We recognise that ED can be a stressful and demanding place to work at times; we work hard together, and we play hard together. Some activities we have to look forward to are the mid-winter Christmas dinner and karaoke night, a paint and sip evening to bring some creative flair and unique artwork for the department and the much-anticipated roller disco for us to get out our 70 and 80s wardrobes and let the good times roll.

We are looking forward to hosting the CENNZ conference Ready to Respond - Kia Mataara in 5-6 November. Registrations have reached 40% of our maximum numbers. We have a great line up of keynote speakers, and we are beginning to receive abstracts for speakers and poster presentations. More are welcome. The super early bird special prices are running until 24 August. We have four good sponsors with more enquiring, and we are optimistic about an excellent conference. The Advanced Emergency Nursing Network is hosting a study day on the Thursday before the conference that offers additional Professional Development opportunities for ED nurses. The National Nurse Managers Network Meeting and the National Nurse Educators Network Meeting will also be held on the Thursday before the conference. We have arranged tours of our new ED on the Thursday and Sunday although numbers are limited. *More information is available online here:* https://au.eventscloud.com/website/1024/home/

Numbers of patients in Christchurch have broken records this July, our CEO reported in his weekly letter to staff, "On Saturday [10 July] the 24-Hour Surgery assessed and treated 373 people with 403 people seen on Sunday which are record numbers for this time of year. Christchurch Hospital's Emergency Department provided care to 390 people on Saturday - this was a record for the Emergency Department in Waipapa. Records were also being broken at Riccarton Clinic on Sunday where they saw 177 patients in 12 hours - 78 of them were children under six years old - this is more than double the number of children they would expect to see on a Saturday. Moorhouse Medical was also busy with significant numbers of children with respiratory illnesses

My apologies for not having coordinated messages from our colleagues in West Coast, Ashburton and Timaru in time for this report. I look forward to representing your ED stories and reports in the future.

Keziah Jones

CENNZ Members

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

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

Southern Region

Tanya Meldrum
Associate Charge Nurse Manager

Southland District Health Board

Dunedin Hospital Emergency Department

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Recently the Regional Emergency Department (RED) meeting was held, where the common themes of recruitment difficulties, nursing gaps, high acuity and high workloads were discussed. There has been an increase recently in paediatric presentations with respiratory concerns. These are common not just in the Southern region but across the rest of New Zealand emergency departments.

Dunedin emergency department will be 1.9FTE permanent vacant from July 2021, this is compounded by two issues; maternity leave cover has been challenging to fill and at times has remained vacant and a significant amount of non-work related ACC.

There has been some changes in the senior nursing team recently, which has created some fixed term opportunities for nursing progression. This is the result of maternity leave, ACC and reduction in hours worked.

However, there are some new opportunities for support and increased nursing staff within the Dunedin emergency department. Firstly the development of a clinical coach role (0.2FTE) until the end of the year, this is an acknowledgement of the need to support nurses working on the floor. There are also business cases in for 24 hour Associate Charge nurse manager cover and a triage/waiting room nursing support. We are still waiting to hear the outcome of these.

The Southern Triage course is due to take place in Dunedin in August 2021. This is the first large course held in the region for a few years. The region is looking forward to newly trained triage nurses and the development of the nursing workforce.

The preliminary design for the new Dunedin Hospital are now completed. The new emergency department will be bigger than the current department and there are now meetings being arranged to look at models of care and how they will look in the new department and workforce planning.

Tanya

College Activities

Conferences and Seminars

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

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

Conferences and Seminars

Dates	Conference Name	Location
15th – 16th September 2021	NZNO Conference and AGM	Museum of New Zealand Te Papa, Wellington, NZ https://na.eventscloud.com/website/22306/
22nd-25th September 2021	Emergency Nursing 2021	Orlando, Florida, USA (In-person and virtual registration) https://www.ena.org/events/emergency-nursing-2021
13th-15th October 2021	18th International Conference for Emergency Nurses (ICEN2021)	SMC Conference and Function Centre, Sydney, Australia https://www.cena.org.au/icen/
2nd-4th November 2021	ICN Congress Nursing Around the World (Virtual)	Virtual Meeting https://icncongress2021.org/
5th-6th November 2021	**29th CENNZ Conference Ready to Respond**	**Rydges Latimer Hotel, Christchurch, NZ https://au.eventscloud.com/website/1024/home/**
10th-12th November 2022	4th Global Conference on Emergency Nursing and Trauma Care	Gothenburg, Sweden https://www.elsevier.com/events/conferences/global-conference-on emergency-nursing-and-trauma-care

Super Early Bird Special Ends 25 August

Click here to Register

The 29th College of Emergency Nurses New Zealand (CENNZ) conference is being held in Christchurch 5 to 6 November 2021. While we are still accepting abstracts, we have been busy confirming some great oral and poster presentations. View the CENNZ conference website for the more information on our presenters.

Keynote speakers

Dr Ashley Bloomfield – Director-General of Health and Chief Executive, Ministry of Health NZ

Dr Sandra Richardson – Emergency Department Nurse Researcher, Canterbury DHB

Prof Michael Baker – Epidemiologist, Professor of Public Health, University of Otago

Prof Dame Juliet Gerrard – Prime Minister's Chief Science, Advisor and Professor of Biological Sciences, University of Auckland

Super Earlybird Special Ends 25 August

CENNZ Member $490 +GST ($563.50)

Non-Member $540 +GST ($621)

Fee includes the conference dinner.

Register online via the CENNZ conference website now to avoid disappointment.

Call for Abstracts

We're still accepting abstracts for oral presentations and posters.

Full details are on the website about how to submit an abstract.

Sponsorship

We would like to thank our sponsors for their support.

For further information on sponsorship opportunities, please contact the Conference Organisers.

Follow CENNZ on Facebook and Twitter (@NursingCENNZ)

College of Emergency Nursing New Zealand
– NZNO/ Ngā Ringa Ringa Aroha

CENNZ Triage Instructors:

Expressions of interest invited.

Expressions of interest are invited for the position of Triage Instructor for the New Zealand Triage Course. This role offers an opportunity to diversify within the teaching arena and be involved in the delivery and shaping of the New Zealand Triage course. The instructor term is for an initial period of three years, with potential to extend this period.

Candidates must hold Registered Nurse credentials with a current NZ practicing certificate, have been a financial member of NZNO, and CENNZ for the two years prior to application and be currently working in a NZ emergency department. They will have successfully completed the NZ Triage course themselves, have evidence of post graduate study and have verified experience teaching adults.

The successful applicant(s) will be expected to teach a minimum of three NZ Triage courses a year, maintain regular communication with the National Triage Director and adhere to the Instructor Code of Conduct. Remuneration is on a course by course basis.

We would particularly like expressions of interest from Northland/Auckland, Wellington Region and South Island.

Should you wish to be considered for this role, please provide 2 referees with an endorsement regarding teaching experience, and indicate your ability to take part in a phone or skype interview.

Please forward your covering letter, CV and references to Katie Smith at;
cennztriage@gmail.com

Deadline for applications is 31st OCT at 5pm.

College of Emergency Nursing New Zealand
– NZNO/ Ngā Ringa Ringa Aroha

Top of South Region Vacancy

Vacancy for Top of South Region Representative on CENNZ National Committee

The committee invites nominations for a regional representative from the Top of South CENNZ members to join the national committee.

This is a rewarding, challenging role representing your region, promoting emergency nursing nationally, and meeting like-minded emergency nurses. A strong commitment and interest in the development of emergency nursing is essential.

By becoming a committee member for CENNZ you will be involved in strategic planning, governmental dialogue, collaboration with national agencies, development of education for emergency nurses, and networking with other emergency nurses nationally and internationally.

The term of office is for 2 years (**maximum of 4 years**) and requires a moderate time commitment. There are four face-to-face meetings per year (**2 day meetings**) and a monthly zoom (**or teleconference**). Each committee member writes a short journal report four times per year. The role also involves other committee and portfolio responsibilities between meetings as well as disseminating information back to your region.

The nomination form should be completed and sent to: emergency@nzno.org.nz

Both nominees and nominators must be current CENNZ members according to college rules.

Any questions or enquiries welcome to: cennzchair@gmail.com

Ngā mihi nui

Sue Stebbeings

Chairperson.

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

Category of manuscripts

Research papers – 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 – 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 – 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
Acknowledgement that consent has been obtained from the patient plus any ethical issues identified
References: limited to 20

Opinion/Viewpoint – 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 – 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.

EMERGENCY NURSE NEW ZEALAND

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