Volume 22 | Issue 01

EMERGENCY NURSE NEW ZEALAND

The Journal of the College of Emergency Nurses New Zealand (NZNO)
ISSN 1176-2691

In this issue

Editorial Info

Subscription:

The journal is available on the CENNZ NZNO College website: www.cennz.co.nz/journal

Editor:

Dr. Sandra Richardson:
PhD Senior Lecturer, School of Health Sciences, University of Canterbury.

Email: editor.cennzjournal@gmail.com

Submission of articles for publication in Emergency Nurse New Zealand.

All articles should be submitted electronically in Microsoft Word, and emailed to: editor.cennzjournal@gmail.com. *Articles are peer reviewed and we aim to advise authors of the outcome of their submission within six weeks of our receipt of the article. Brief guidelines for manuscript submission are included on the last page of the journal, and more detailed guidelines are available from the editors:* editor.cennzjournal@gmail.com.

CENNZ Contacts:

Chairperson: *Sue Stebbeings* contact via: cennzchair@gmail.com

Treasurer: *Keziah Jones* contact via: cennztreasurer@gmail.com

Secretary: *Amy Butto*n contact via: cennzsecretary@gmail.com

Membership, Grants & Awards:
Lyn Logan contact via either; **Membership:** cennzmembership@gmail.com or **Awards:** cennzawards@gmail.com

NZ Triage courses: *Tanya Meldrum* contact via: cennztriage@gmail.com

Professional Nursing Advisor (NZNO): *Suzanne Rolls* contact via: suzanne.rolls@nzno.org.nz

CENNZ NZNO Membership:

Membership is $25.00 and due annually in April. For membership enquiries please contact: *Lyn Logan*
Email: cennzmembership@gmail.com

Design / Production:

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

Editorial

Dr Sandra Richardson
Editor | Emergency Nurse NZ

Editorial

Emergency Nursing: a positive choice in challenging times.

Nursing in general, not just Emergency Nursing, continues to be under strain within New Zealand. The challenge is how to find a positive message, while remaining realistic and continuing to advocate for both patients and nurses, and indeed for the wider health system.

Like many of you, I am increasingly finding it hard to focus on that positive aspect. We know that the health system has been chronically underfunded, that our staffing levels are woefully inadequate in many sectors, and that the emergency care area are fast running out of suitable metaphors to describe our situation (the safety net is too full of holes and the canary in the coal mine has long since fallen off its perch). Yet despite this, emergency nurses continue to turn up to work every day.

They may not always manage to smile or present a relentlessly cheerful manner, but they are there. They sometimes lose their temper (unfortunately even nurses are human, and working overtime, being sworn at, and knowing you cannot make things right can take their toll). But they carry on (regardful, not regardless – cultural safety to the fore as they battle to care for patients in a setting where nurses and other HCW are left culturally unsafe). And somehow, these nurses (men, women and those who are bravely gender diverse in a workplace that remains female orientated and gender biased) continue to turn up to work. Why? Because despite everything, we know that nursing can still be the best possible job. For some it is a fulfilling career, for some it is a vocation (although it has become almost unacceptable to describe it as such – since when did a passion and fire for our work become linked to some notion of subservience and sacrifice?). For some it is a passport to travel and the opportunity to remain in guaranteed employment. All of these are acceptable reasons for being and staying a nurse.

Given the significant shortages we are facing in retaining and strengthening the emergency nursing workforce, we need to question how we can send a positive message, alongside our rightful outrage and calls for change. Emergency Nursing retains a positive commitment from its members, but this needs to be valued and built on.

This edition of the journal focuses on mental health, by highlighting the roles of those nurses working to provide support and build on the knowledge and confidence of ED nurses in caring for patients and their family/whanau who present with mental health needs.

This is one of the positive moves we have seen in the ED setting. Recognition that there is a need to continue developing our workforce, and having a funded and experienced nursing response to this need offers support and acknowledgment of emergency nurses. Mental health, wellness focus and the importance of supportive environments is increasingly recognised by staff, employers and service providers; recognised as necessary to maintaining a workplace culture that allows best possible response in challenging times.

So, our focus needs to be on the care and management of patients with mental health needs (which effectively means all of our patients), while also recognising the need for mental well being amongst the work force. Specialty knowledge of mental health conditions, including those we find most challenging to understand and respond to, such as patients who present with self-harm, diagnoses of personality disorders or behave in ways we find difficult to manage, is essential.

The great thing about emergency nursing is that there is always more to learn, and the challenge is for us to find the opportunities and energy to continue to do so. Drawing on the skills of our colleagues is a clear opportunity to address areas where we may lack confidence or knowledge. The introduction of the varied Mental Health education and support roles provides an excellent point of contact, and connection into this area.

Whāia te hauora hinengaro kia puāwai ai te hauora tangata.

There is no health without mental health.

Sandy

Guest Editorial

Author: Tony Farrow, RN, PhD

Mental Health in Emergency Departments

Welcome to this issue! I am very pleased to see the roles of mental health emergency department educators highlighted throughout, as these positions have been developed to support the work of Emergency Department (ED) staff and to get better outcomes for people with mental health or addictions issues who present at emergency departments.

It is almost redundant to state that ED nurses are multi-skilled professionals who work in a fast-paced and changeable environment. Although I have never worked in this clinical area, I have had the privilege of observing ED nurses in action. Like most of us I have myself been a patient at ED and have been a support person to family and friends. I have also worked both as a mental health clinician interfacing with emergency departments as part of mental health crisis teams, and as an educator supporting ED nurses to work with people who present to the emergency department with mental health and/or addiction issues. More recently I have been the manager of a mental health nurse educator who works with ED nurses and other staff. I am therefore pleased to be able to offer a reflection on the work of these educators and the value thy can bring in supporting ED nurses.

I have always been acutely aware of the knowledge, multiple-skills and compassion that ED nurses bring to their work in often difficult circumstances. When facilitating workshops with ED nurses I have always been very impressed by the desire of participants to reflect on and improve their practice with those who present with mental health or addictions issues. I have always left these sessions invigorated by the participants and in awe of the skilled work that they do.

ED nurses' skills and compassion are needed, for the evidence is clear that people with significant mental health issues have a shorter life expectancy than other people, often have co-morbidities, and have worse physical health than people without mental health or addiction issues. As a mental health clinician and educator, I am passionate about reducing these disparities, and I know that nurses play a vital part in this goal. On many occasions mental health consumers present at emergency departments (for physical or mental health reasons, or a combination of both). ED nurses are the frontline clinicians who communicate, assess and sometimes treat consumers, and their knowledge and skill, (including communication skills) play a vital role in achieving good health outcomes.

People presenting at ED with mental health or alcohol and drug issues can present unique practice challenges for nurses. It may be, for instance, that people present with suicidal thoughts, have self-harmed, are very anxious, or have any other array of complex symptoms and issues. ED nurses have to rapidly communicate and assess in an environment that doesn't well lend itself to the kinds of communication needed, and where the presenting symptoms or behaviours may seem unusual or challenging. Taken together, otherwise skilled ED nurses sometimes may not feel well prepared for such work.

There are, however, four pieces of good news. First, research shows us a lot about the commonalities that many mental health/drug and alcohol consumers have, which in turn gives clues to how ED nurses can respond. Second, we have evidence about what consumers want from clinicians. Third, ED nurses already have many of the skills that are needed, and with some support can utilise these in their practice. And fourth, the Ministry of Health has recognised the need to support E.D. nurses (and other front-line ED professional and non-professional staff) to meet the needs of consumers and have funded the role of mental health ED educators. These roles solely exist to support ED staff with their confidence and capability in working with consumers.

I was delighted when the Ministry of Health requested expressions of interest from DHBs about the establishment of mental health ED Educator roles. I believe it was no accident that the funding for the roles is premised on supporting ED staff to improve their "capability and confidence". Experience has shown that educators are particularly helpful in assisting ED nurses refine existing interpersonal skills, and to help develop their confidence to use them. In addition, educators can help ED nurses increase their knowledge for

Guest Editorial Cont.

practice. There is a huge research base for understanding mental health and addiction issues, and importantly, how clinicians should work with people in distress. Much of this evidence is, however, aimed at the mental health practice setting. Mental health ED educators can help ED nurses sift through this information to translate it into useful practice guidance in the emergency department setting.

One very relevant component of the vast mental health and addictions research is the evidence that most people with mental health or addiction issues have experienced trauma in their lives. This is significant in two ways. First, trauma can cause changes to brain structures. At the risk of vastly over-simplifying a complex area, this means that some individuals with a trauma background are pre-disposed to responding to stress in ways that are different to other people. Knowing this helps us understand that people's responses to stress (such as self-harming or rapid escalation) are not "behavioural' but are instead products of the trauma background. Second, people who have experienced trauma can find it very difficult to form trust relationships. Although ED nurses are often expert at gaining rapport with people, a slightly different approach may need to be taken with people with trauma backgrounds. Mental health ED educators are well placed to support ED nurses to understand the place of trauma in peoples' symptoms and what this might mean in terms of the way they might present or react.

Knowing "why" people behave the way they do can be helpful, but it is equally important to know "how to respond". There is a small but growing literature evidence about what mental health consumers want from clinicians, including ED nurses. These wants are primarily about interpersonal processes, with a desire from consumers to be understood, to be empathised with, to have experiences and feelings validated, and to be offered hope. ED nurses already have interpersonal skills refined from, for example, working with people in pain, families who are frightened, or patients who don't know what is happening to them. Mental health ED educators can assist ED nurses to further refine these skills when working with people with mental health or addiction issues. Experience and the research evidence show that when this happens better outcomes occur.

It's not possible in an editorial piece to completely summarise the needs of consumers who present at emergency departments; similarly, it is difficult to begin to do justice to describing the complexities of practice of ED nurses. However, I sincerely believe that skilled and compassionate ED nurses make a significant, positive difference to outcomes for those with mental health or addiction needs. I also know that the support of mental health educators in emergency departments can and do assist ED nurses to add to their confidence and capability. I therefore hope you enjoy this issue and take the opportunity to reflect on the roles of the mental health ED educators. More importantly, I encourage you to talk to the mental health ED educators in your area and make full use of this resource.

Tony Farrow RN, PhD

Nurse Consultant: Workforce Development, Specialist Mental Health Services, Canterbury District Health Board

Email: Tony.farrow@cdhb.health.nz

Staff Profile:

Mental Health and Addictions Clinical Educators in Emergency Departments

Author:

Jane Foley

Mental Health and Addictions (MH&A) Clinical Educators are now working in many Emergency Departments throughout Aotearoa. These pilot positions, funded by the MOH for three years, have been established to help strengthen and improve the responses and supports offered by ED's to people and whānau who present with MH and Addiction health needs or in acute crisis. A diverse group of experienced MH&A staff have been employed into these roles.

These roles are intended to support the professional development and build the capacity and confidence of clinical, non-clinical and administration staff who are called on to interact with individuals presenting with mental health needs or distress to the ED. Each area and each of the individuals in these roles will develop a responsive, individual approach to meeting these needs; while the role is not identified as a clinical position, the individuals will offer support, supervision and coaching alongside traditional and innovative education initiatives.

As these new roles are developing, and impacting a key area of emergency nursing practice, a series of profiles will follow the individuals who are acting as pioneers in this field, highlighting the opportunities and initiatives that they are introducing. The first of these will focus on Hilma Schieving, who is working in the ED at Nelson -Marlborough District Health Board. We wish to thank her for sharing this story, which was originally published in the Winter 2021 edition of the NMDHB publication 'Connections'.

Hilma Schieving: Clinical Educator, Mental Health and Addictions (Acute Support).

Hilma started her career in the early 1980s. She has worked in mental health as a registered nurse for many years, primarily in acute mental health services (Home Based Treatment Team, CAT team). Her career path has also included roles as a charge nurse, and academic staff member and Head of School at NMIT, plus locums as a Mental Health Care Manager in Nelson and Blenheim, Court Liaison and Forensic, and a few years at Tipahi Mental Health (Subacute Inpatient Unit).

The aim of the position is to help ED staff meet the needs of people presenting to ED with mental health or addiction issues. The Ministry of Health has funded this role throughout Aotearoa to build the capability and confidence of ED staff to improve the patient journey towards health and to improve outcomes.

This role supports and acknowledges the premise that Mental Health is everyone's business. Emergency Departments' in Aotearoa have historically provided skilled life preserving interventions for physical emergencies such as trauma, sickness or bodily disease. This initiative acknowledges that mental health crises also require skilled emergency assessment and intervention.

ED has seen a significant increase in people seeking help for mental health and addiction needs. When someone experiencing mental health and addiction needs, accesses our

Staff Profile:

Mental Health and Addictions Clinical Educators in Emergency Departments Cont.

services, the goal is to use the opportunity to assist the person toward wellbeing. In our ED we support the use of Haoura Hinengaro, a pathway that invites holistic assessment and intervention. It is based on Te Whare Tapa Wha.

The clinical educator role is not just for nurses, it is to support all ED staff – clinical and non-clinical; nurses, allied health, medical and administrative staff. The first person someone sees in ED is an administrator, then the triage nurse, so it's important that the Mental Health and Addiction Educators influence all points in the person's journey.

Applying Whare Tapa Whā in ED

Anyone arriving at an Emergency Department (ED) is at their most vulnerable. They may be experiencing considerable distress, and for whānau with mental health and addiction needs, it's highly likely that have already experienced considerable trauma.

To help meet the mental health needs of tāngata whaiora (people seeking wellness) ED has implemented the Hauora Hinengaro ED care pathway. Te Taha Hinengaro (psychological health) represents one of the four dimensions of wellbeing in the Māori holistic model of health, Te Whare Tapa Whā developed by Professor Sir Mason Durie in 1984.

As health providers, we need to respect all four dimensions and provide a holistic approach to anyone accessing our services. If a mental health need is identified during the triage process in ED, the Hauora Hinengaro ED pathway is applied. This helps in identifying the risk to self and others and determines the urgency and level of observation and support the patient requires. It also requires staff to provide clear communication and information to their colleagues, to the patient and other people involved in their care and follow up.

To help build the capability and confidence of staff in ED who interact with individuals presenting with mental health needs a new role has been created: Nurse Educator, Mental Health and Addictions. Hilma Schieving holds the role in Nelson three days a week while Greg Davies is in Wairau Hospital one day a week.

Hilma's aim is to help staff with the Hauora Hinengaro ED pathway, and to support their understanding of mental health and addiction issues. Hilma says ED staff have welcomed her to their team and have shown a great willingness to develop their confidence and skills in caring for the psychological and emotional needs of patients. "There are some difficult situations, especially when a patient has co-existing conditions, for example someone may have two conditions such as diabetes and psychosis — dual needs of equal importance". Hilma also helps staff understand what is going on for someone with a mental health problem, and how to form a rapport quickly so they can more readily meet their needs and determine what intervention or is needed.

When someone experiencing mental health and addiction needs accesses our services the goal is to use the opportunity to assist the person toward wellbeing. It is early days in this initiative but Hilma hopes the educator role will influence the patient's journey towards health, help improve care and positively influence outcomes.

Whangarei Emergency Department: CATT Team and Emergency Department Mental Health Specialist

Author:

Katrina Tonks, RN/DAO

I am a registered nurse and duly authorised officer working as part of the mental health community assessment team (CATT), based in the Whangarei Emergency department. This is part of the wider CATT team based in the community.

CATT is a Specialist Team that provides a service for people who are experiencing a Mental Health crisis and who may be considered a risk to themselves or others, and who present for care to the ED. The Emergency Department Mental Health Specialist role is a relatively new one, commencing in October 2021. I have enjoyed pioneering this new role, each day it has challenges, but being wholeheartedly welcomed by the ED team has made it worthwhile.

The goal of the role was "To initiate a transformational change process that will establish and implement Mental Health and Addiction related treatment and interventions based in the Whangarei Hospital Emergency Department". The majority of the role is involved with providing assessment of those attending ED with unmet or existing Mental Health needs. Secondly it is focussed on providing support for ED staff working with whaiora requiring mental health and addiction support, and while working alongside ED staff it has an educative responsibility to build their capability and competency in working together with whaiora and whanau.

The role aims to provide training, coaching, mentoring and active demonstration of best practice approaches. The intention of this is to facilitate ED staff to further improve their skills and knowledge in identification of a range of mental health and addiction needs. The education component is met by providing informal and formal education for ED staff and providing expert support for ED staff working with whaiora requiring mental health and addiction support. This has been challenging in times of covid where face to face training and education sessions were placed on hold. The majority of education has been 'on the spot' with mentoring and best practice examples occurring when able.

My working hours are 1100hrs - 2130hrs, 7 days a week, which has been based around most frequent presentation times of clients with MH issues. The role is shared with a colleague, we work 4 10 hour shifts each week, with both of us sharing Wednesday to facilitate education of ED staff. Outside of these hours the community CATT team cover any presentations to ED. Referral to us is through a partnership approach with the emergency department. People can self refer, be brought in by police or ambulance or referred by GP.

Earlier in my career as an RN I have previously worked in ED so had a good understanding of the operation of an emergency department. I am enjoying the diversity of the role and seeing the positive outcomes being based here to support tutoro as they present.

Alcohol and Drug Screening, Brief Intervention and Referral to Treatment (SBIRT) role within Whangarei Emergency Department.

Author:

Michelle Petricevich, Alcohol and Other Drug Practitioner DAPAANZ

Email for correspondence: michelle.petricevich@northlanddhb.org.nz

Brief Background

Four years ago, a project started in Whangarei Emergency Department.

Alcohol and Drug Screening, Brief Intervention and Referral to Treatment (SBIRT).

We began with an idea, evidence base, purpose-built software, a great team, support from management, and funding from Te Ara Oranga (the Methamphetamine Harm Reduction initiative in Northland).

The premise was simple: have an alcohol and drug registered health clinician on site to screen, refer, motivate and support patients and their whānau with alcohol and other substance issues.

The team started with a Project Lead, a team Psychologist and a full-time screener in ED. We wanted to support the community, staff and individuals to move towards better outcomes.

The team currently consists of one full-time alcohol and drug practitioner, plus support from an alcohol and drug on-call supervisor on weekends. The contracted weekend screening team consists of 5th-year medical doctors or student nurses. In addition, a lived experience addictions peer has recently joined the weekend screening team.

Weekend screeners are funded with thanks from ACC and Te Hiringa Hauora (Health Promotion Agency).

A day in the role of an Alcohol and Other Drug Screener

A walk through the department and a look at the whiteboard will reveal if anyone is waiting for alcohol or other drugs (AOD) input.

Next, we check the whiteboard reporting to see if anyone has been referred for follow up since the last shift. These are consented by patient follow up calls for a quick kōrero about options for support. Brief interventions, the menu of options, referrals to other services and information provided.

We then spend our shift working through the emergency department whiteboard list of current patients. Unfortunately, we currently only screen those 18 years and over. We want to screen youth, but we don't have the resources to do so.

Alcohol and Drug Screening, Brief Intervention and Referral to Treatment (SBIRT) role within Whangarei Emergency Department.

Patients are approached after coming into the main department and having their initial consult with the attending doctor/clinician. Verbal consent is sought, and once obtained, the screener asks a series of screening questions. We currently use the Alcohol Use Disorders Identification Test (AUDIT) and the Alcohol, Smoking, Substance Involvement Screening Test (ASSIT-Lite). The Rataora IPAD based software can hold any screening tool and can be used in primary care, police, Plunket and can be easily used as an encrypted referral system across multiple organisations.

This service fits well with the mandated national alcohol question asked at triage as it provides follow up and an offer of support. If the patient consents, after a series of questions and feedback, they are provided with a menu of options for support. Questions are asked specifically about tobacco, alcohol, cannabis, synthetic substances and methamphetamine. We offer a range of follow-up, including local clinical services, non-government organisations, peer support, helplines, and online forums. We refer directly and explain the process. For those undecided, a follow-up call is offered at a later date.

Doctors and nurses will ask for input with their patients. The screener has knowledge of local support, can access community mental health and addiction notes and stays up to date with local addiction trends/topics. The screener is also trained in urine drug screening. Close working relationships exist with community mental health and addictions, crisis team, community peer support groups and any community resource providing recovery support.

Case example

21-year-old male with multiple presentations for abdominal pain and vomiting. AUDIT score of 35.*

Self-reported drinking 10 cans of RTD's (ready to drink premixed spirits) per day or 1 ½ bottles of whiskey. He recently started drinking in the morning and felt that he was losing control of his drinking.

Follow up call by Psychologist and referred to local NDHB service. At assessment, disclosed methamphetamine use and met criteria for depression. He has engaged with the service.

He has stopped drinking and is back working fulltime. Nil admissions to the department in last 12 months.

This client was not comfortable seeing his GP because it was a family friend.

***Patient had presented multiple times in the previous 18 months and had never disclosed his alcohol use.**

What we have discovered

Four years on, we have made many referrals, built connections and helped inform service quality improvement.

The role has impacted how the emergency department manages alcohol and other substance involved patients.

- This role fits seamlessly with a busy department and can flex to fit changing situations. We have strengthened working relationships with partners
- Quick referral process to agencies with some next day follow up
- People do not understand recommended amounts of alcohol
- Many are not aware of local support and how to access
- Many are not aware of the effects of alcohol and other substances on health
- Many have no general practice doctor (GP) or are embarrassed to talk about alcohol and other substance issues with them
- Those who have relapsed feel shy to go back to services and need support and encouragement to do so
- Hard to engage clients can be motivated to attend appointments or re-engage with services
- Whānau members don't realise they can get help too

This role became business as usual and has earned its place in the department. Feedback has been positive from patients, nurses and doctors.

Special thanks and gratitude to the fantastic clinicians, takawaenga, allied health staff, and others who welcomed and encouraged this mahi. Thanks also to the patients for sharing their inspirational journeys. Ngā mihi nui.

Based in the Emergency Department at Whangarei Hospital

Hours:

Monday: 10 to 6.30 pm

Tuesday: 9 to 5.30 pm

Wednesday: to Friday 12 to 8.30 pm

Weekends: 12 to 8 pm

Discussion Paper: **Behaving Badly?** *A mental health nurse discusses the complexities of borderline personality disorder (BPD)*

Author:

Stacey Smart, RN, PG Dip Health Science

Email for correspondence:
stacey.smart@cdhb.health.nz

One of the things I get asked from time to time is WHY do certain people act in certain ways, why can / can't mental health services just fix people, and what makes someone do the destructive or self-harming actions we see here in ED at times?. Why are people ok with behaving so badly sometimes?? So I thought I would take this opportunity to talk about some of the things that drive behaviour, and give you some of my views on it. I am basing this on 19 years clinical work in mental health and collating all other opinions of various specialties, professionals, tangata whaiora and what I have felt to be true in my experience.

We all have personality. We all have behaviour. Our personalities and temperaments may be fairly set but are also influenced by our environment (nature and nurture at play). You probably have heard of the Big Five Personality traits (extraversion, agreeableness, openness, conscientiousness, neuroticism), and are aware we all basically rate along the spectrum of these five traits as such. At times aspects of our personality may get amplified, but we return to a baseline of being just who we are. Most of us have good attachment, a sense of who we are in the world, and a sense of safety and competence in our lives.

But as you know, under duress, extreme stress (good or bad), under the influence of substances, sleep deprivation, winning awards, planning for wedding, heartbreak... aspects of our personality can get a bit... exaggerated in certain aspects at times. You might fly off the handle or burst into tears over something seemingly insignificant after a particularly stressful week. You might take a comment too personally, that you would normally not think twice about. You might feel despondent, lose motivation or desire to see people or do things, questioning what is the point of everything?! Or you might get a bit bridezilla or diva-ish over an event. You could act like a "drama queen" or "narcissist" or "borderline" or any others other cliché (temporarily) because our personality is made up of all of those parts. And it is your behaviour that reflects the dominant part of your personality at that time. In fact, your behaviour is often the main external clue about what is going on! Your behaviour is the messenger of how your internal world is going.

Now, hopefully, you have managed to not alienate yourself or others too badly during this wee "phase", and everyone tolerates your temporary annoyingness with love and understanding. Because they know it is an exaggeration of you, not WHO you are. So, what distinguishes a personality DISORDER from a personality glitch? Essentially an individual would present with serious and significant, sustained disorder that exhibits particular traits to a more extreme level, where other more functional parts of their personality will be eclipsed. Personality disorders can be a contentious issue, but this is not the time or space to get into debate about the diagnosis and relevance. My goal here is for you to consider personality, but

Discussion Paper: **Behaving Badly?** *A mental health nurse discusses the complexities of borderline personality disorder (BPD)*

more broadly to contemplate what is the purpose of the more maladaptive behaviour we see and what is behind it.

Right, so let's start peeling this onion! What is behaviour? Well, it is something we all have. We are all behavioural. Behaviour is communication, behaviour is an external reflection of our internal world, balanced against our conscientiousness, to follow societal norms for what is and is not appropriate behaviour. Something that helps us "behave right", is our ability to accurately interpret our own feelings and those of others around us and regulate our emotions (that is, control the volume of our emotions). It is also very helpful that we identify each other as complete separate entities from ourselves, who have different thoughts and feeling to ourselves. As you will recall from your undergraduate human development studies, this ability to mentalise is a major developmental step in early childhood. Trickily, it is also one of the things that can take a significant hit when there is early childhood trauma, or significant mental illness or developmental or neurological disabilities.

The ability to mentalise is an invisible but critical part of how we get on in the world and how we interpret the world, and informs our emotional intelligence. It is a skill that many of us begin to learn at a young age (I understand the object still exists even if I cant see it, I can interpret the message your facial expressions tell me, I can think abstractly). Like all skills, there can be those who have under-developed or not developed the ability to mentalise. This can occur due to intellectual disability, neurodiversity (Autism Spectrum Disorder for example), and trauma/attachment issues. At this point, I cannot emphasise enough how healthy attachment is essential for not just survival, but also our happiness and wellness in the world.

What is very common (but not true for everyone), is that tangata whaiora with "borderline" presentations, have often come from situations where healthy attachment was seriously disrupted or harmed in some manner along the way. We all know that children are 100% egocentric little unicorns who place themselves at the centre of all things (its normal development to do so). They are also hardwired to just love and love no matter how horrible their lives can be or what gets done to them. Survival is dependent on it! Sadly, this combination of being egocentric, having child brains, limited world experience and complete dependence on adults to keep them alive means children are especially vulnerable. And they are especially vulnerable to perceiving any mistreatment and abuse as THEIR fault/responsibility or burden, and they will still feel love towards the perpetrators of the mistreatment. If the person/people they trust and love, repeatedly hurts/neglects/abuses an infant/child, the child therefore lives with a very confusing reality. Without a healthy attachment to a warm, responsive and good enough attachment figure for a good enough amount of time, a child will learn their own way to process it all and cope in a world that is inconsistent and unsafe (for further reading on *good enough, have a google of Circle of Security).

Trauma can occur in the home, with violence, neglect, serious accidents, exposure to inappropriate things. it can also occur as a result of war, natural disasters, exposure to horror, fear, or displacement all of which can disrupt and traumatize the sense of trust and safety. While not every traumatic thing causes Post traumatic stress, or is deeply damaging, it is still true that one experience is enough to cause Post Traumatic Stress Disorder (PTSD). The severity of this is linked to how significantly the person felt their life was in danger and how wildly the threat varies from their perceived safety in the world (eg: a belief that nothing like that could EVER happen, and that life was very much in jeopardy, is likely to make the event that much more impactful and traumatizing). Some people have deeply held beliefs that help them be more resilient and less vulnerable to long term damage from trauma, while other people are just more vulnerable to the effects. Building resilience is now recognised as a really important skill to teach young people, and many of you will be aware of resilience programmes in schools such as mindfulness and pets in schools. "Never had it back in my day and we are just fine?" Mental health professionals would disagree! PTSD, Complex-PTSD, Anxiety and depression, attachment disorders, emotional dysregulation, addiction/alcohol and drug misuse, maladaptive coping, eating disorders have always been there. So, out with stoicism, in with resilience, I reckon!

Repeated traumas (including high ACES [adverse childhood experiences], ongoing domestic violence, physical/sexual abuse, prisoner of war experiences, being a refugee) can lead to Complex-PTSD. C-PTSD has all the hallmarks of PTSD but has additional symptoms including: changes to self-perception, feeling dissociated from oneself, losing memories, difficulty regulating emotions and impulses, difficulty with relationships (inability to trust, recreating or seeking cycles of rescuer/abuser), loss of meaning and loss of core beliefs. This can include a deep sense of being out of control and powerless for so long that it causes severe psychological harm. But it is not so simple as that may imply. Because trauma lives in our sensory responses and creates a sympathetic nervous system response that runs deeper than just knowing the cause.

Discussion Paper: **Behaving Badly?** *A mental health nurse discusses the complexities of borderline personality disorder (BPD)*

As you already know, stimuli creates emotions (your brain's split-second response to input) and your body follows the cues, which you attach thoughts and feelings to. Your feelings and thoughts are based on your previous experiences. A fair and very simple example of this is the way trucks used to sound pre-earthquake (just trucks, no particular emotional response) compared to post earthquake, where the rumble of trucks triggered an emotional reaction and thoughts (another shake) and feelings (anxiety). However, sometimes the triggers are not as accessible or obvious (could be a certain angle of light, a sound, smell or a person's walk) that can lead to the emotional knee jerk reaction, and subsequent cascade of responses and thoughts. Why? Because our memories are made with our senses before we add narrative. Over the next couple of days, listen to other people describe things. Listen for people describing distressing past events: you notice as much as they talk about the feelings, they will be talking about the sensory input: the colour of things, the sounds, the smell of something, the lighting... Also, pay attention to how many times you are taken on an unplanned trip down memory lane because of a smell, song or someone reminded you of someone else. We are all the same! We do not get to pick it. We cannot control it. We can choose how to respond to it because we have the skills. But not everyone has those skills. We can support a return to baseline by interrupting with alternate and competing sensory input. I will go further into sensory modulation another day.

So what has this got to do with behaving badly? Remember, behaviour is communication. We all have behaviour. "Behavioural" isn't a thing. We have adaptive behaviour and maladaptive behaviour. Behaviour that is causing difficulty now, once served a very protective and essential role. Maybe it elicited caring in a world where there was neglect, maybe it prevented people getting too close and grooming you for more abuse, maybe it stopped the overwhelming feelings ever being felt so the person could survive without complete psychological collapse, maybe the substances made all of the feelings and triggers somewhat bearable, or gave a sense of confidence that isn't really there, maybe the DSH [deliberate self-harm] helped with grounding and managing strong emotions, maybe because chaos is the only feeling that is familiar, and everything else feels unsafe. Either way, the behaviour that was once helpful, is now being harmful. And now the person is ricocheting around ED. So what do we do??

Now you would think that your gut reaction to this insight might be to pour sympathy on the person who's getting triggered left and right. But a lot of what is useful for someone who is in this highly emotive, highly reactive head space is to remember they are likely operating from a highly reactive and damaged developmental space. In the most non patronizing way, you need to be the calm adult while this person is off being a mistrustful infant (metaphorically) (please have google of transactional analysis if you want more detail on this).

Use all of those skills that you would use to support a dysregulated child: validate their feelings and experience, be trustworthy: say what you mean, mean what you say, identify when things will or won't likely happen: be consistent, be kind and non-judgmental, don't take it personally because it's really not. Follow through with consequences, identify (as appropriate) your feelings and help them identify their own (gently). Our role is to be trustworthy, adult, kind and to role model. We are teaching adaptive engagement by keeping calm and holding our boundaries with kindness. Easy.

Now this next bit is (in my experience), the most challenging (and most interesting) part for clinicians: that you can often tell the level of dysfunction and psychological damage by how many groups of professionals become entangled and embroiled in the chaos. Perhaps this rings a bell as a phenomenon known as Splitting. It's famously thrown around as one of the hallmarks of working with someone with a personality dysfunction, but is also common in a variety of places, particularly those with high stress. Splitting is the view of people as all good or all bad and involves a good amount of transference/counter transference: displacement of your feelings onto a person, or the displacement of their feeling onto you. It's where you start to represent someone you are not, or they may represent someone they are not (the rejecting, the person you couldn't save, the bully from school, your friend's child). It can occur within teams, services and organizations. It's something that happens, and usually an extension of the person's hero/perp dynamic where we start to also be good cop/bad cop between ourselves and agencies. It is helpful to be aware of this, and notice when it is happening, so you can acknowledge your reactions and then operate from a more objective base.

I am going to repeat that. Because it is THAT important. We do not want to hold power that is not ours, positive or negative. Because you are very nice, you may want to offer sympathy and kindness and feel protective of this person. But if you find yourself getting drawn in, wanting to go out of your way to do more than you are required to do, accept the person sees you in the role of Hero... please DON'T. Likewise, if you are reacting with anger or being/feeling rejecting or dismissive or hostile then, you may be part of the cycle as rejecting parent, or perpetrator or other reinforcer of shamed emotion.

Discussion Paper: **Behaving Badly?** *A mental health nurse discusses the complexities of borderline personality disorder (BPD)*

Please DON'T. Be kind, be consistent, be clear, we are passing figures in this person's life. While it is tempting to think our view of the person is the most accurate, it is important to have some self-awareness that we are also players in larger psychodynamic chaotic role-play of people in power being goodies or baddies, and we are in control whether we play that role or not. Let's not add to their chaos by being inconsistent.

Clinical Supervision is a really useful tool to access to process some of the feelings and transference that arises from working with people who elicit such strong emotions in ourselves, as well as helping process some of that vicarious trauma we accumulate from our jobs. Mental health clinicians all get access to clinical supervision, it is baffling to me that clinicians in ED and ICU do not have same access to this, but I say, if you can get it, you won't regret it. It is useful to know that the person may have a lot of difficulty with identifying 'what' or 'why' they feel the way they do, and they may not interpret or read your emotion and tone accurately (worthwhile looking up negative attribution bias for the low down on that). The world feels unsafe, and people are untrustworthy, yet despite this, the person may feel a desperate need to test and seek trustworthiness. It is useful to be honest and direct in a kind manner in our communication, and be clear about what will happen and when, and what the boundaries are.

For our own health and warding of compassion fatigue, I highly recommend supervision or support to work through more challenging feelings when working with this group of people.

In ED we often see very emotionally dysregulated people repeat the same maladaptive behaviours, DSH and impulsively making choices that land them in ED. I wonder if in an ED setting, the details (like whether it is BPD, C-PTSD, or the impulsive reactions in young adults learning to regulate emotions), are less important than how we ourselves, as health professionals, present to them in this space. I think the most important thing is to understand is that these issues are complex, multi layered and there is no quick fix or magic pill. However, we can help, by treating the person presenting with kindness, calmness and clear and direct communication that provides information and respect. I am personally not convinced people can only be helped if they want help. While this is true of therapy, I personally believe by treating people with respect and kindness, and by maintaining our own clear boundaries, we show the person that they are worthy of respect and kindness. It is a small thing, that can have a huge impact in the story that someone tells themselves about themselves and world they inhabit.

Peer support workers and management of patients with Mental Health needs in the Emergency Department

Author:

Sandy Richardson, PhD

Nurse Researcher, Emergency Department, Christchurch Hospital

Mental Health and Addiction (MHA) service trends have continued to show increasing growth over the past decade, with service users increasing by approximately 40% in the years 2010/11 to 2019/20. The number of Māori presenting comprise 34% of service users, despite only representing around 11% of the total population, and while the total number of nurses working in the MH nursing workforce increased by 16% between 2016 and 2019, this is less than half the growth rate in client numbers over the same time period (ASMS, 2021). The potential for introducing trained peer support workers into emergency departments (EDs) is one that has been raised in the past, and the opportunity to introduce this model for patient's presenting with mental health needs has being trialled internationally. The ED environment is a potentially intimidating space, often noisy, chaotic and increasingly one where individuals are facing long periods of waiting and forced delay to care (Chavulak et al., 2018; Minshall et al., 2020a; Shattell et al., 2014). Despite our best intentions, it is difficult to provide a calm, ordered and quiet space, one which facilitates defusing of heightened emotions and agitated thoughts. The waiting room is an area that is typically inhabited by a diverse group of people, young and old, from varied backgrounds, with little in common other that their anxiety, distress and often pain and fear at what might be occurring. While nurses may attempt to reassure, to manage the immediate needs, many of those who present are safe to wait, in a general sense, and this physical capacity to wait means that they may have to remain in this environment for an extended period of time. The impact of hospital crowding and associated waiting times conflicts with efforts to work within a recovery-oriented framework such as that advocated for mental health patients, for example CHIME (connectedness; hope and optimism; identity; meaning; empowerment) (Ballesteros-Urpi et al., 2019). The capacity to introduce such frameworks effectively into the ED remains challenging, due to the nature of the service, constrained resources and the environmental and staffing limitations.

The absence of food, entertainment, distractions and the active presence of noise, movement and at times aggressive, impaired (by alcohol, drugs, pain or other factors) individuals can create a challenging situation. One response to helping to de-escalate the stress this creates for vulnerable individuals, is the role of the mental health peer support worker (Minshall et al., 2020a). Australian research has focussed on ways to develop innovative service provision that supports Mental Health consumers, and increasingly acknowledges that the role of EDs, as the gateway into the wider health system, needs additional support. The limited ongoing support and opportunity available to ED staff to formally build on their existing mental health knowledge and skills was acknowledged in the Australian research (Minshall et al., 2020b), as it has been in NZ. While in NZ the Ministry of Health has responded in part to this recognition with the introduction of the funded mental health nursing education and support roles, the Australian response has included the development and support for the peer worker concept. The current draft systems and services framework for Mental Health and Addiction, currently out for consultation by the NZ Ministry of Health, includes the suggestion that there needs to be several critical shifts to ensure a transformed approach to mental wellbeing. Critical shift 3 in this document is to build peer-led transformation. While this is currently a consultation documentation, and does not represent government policy at this time, it does signal an awareness and willingness to look at this model. The discussion relating to peer support workers does not refer specifically to ED, but rather identifies the intention is to be inclusive, noting a goal that there "will be peer support specialists in all specialist mental health and addiction services" (Ministry of Health, 2022, p.7).

Peer support workers and management of patients with Mental Health needs in the Emergency Department cont.

The term peer support worker is defined by Australian researchers (Minshall et al. 200b) as referring to practice support work undertaken by individuals "who identify as having lived experience of mental health issues, trauma, psychiatric illness or severe and persistent distress" (p8) and that such peer support work is:

> *Professional work that is undertaken by individuals who utilize their own lived experience, in addition to professional competencies, for the purpose of supporting other people. It includes a range of roles such as peer support work, education and training, advocacy, consulting and advisory roles. (Minshall et al., 2020b, p.8)*

The peer worker role was introduced into the ED of St Vincent's hospital in Melbourne, where a follow up survey with 14 mental health consumers sought to determine the response to this initiative. The peer worker role was part of a wider program intended to reduce restrictive interventions and was designated as Pre-Admission Liaison (PAL) and intended to support individuals who had been assessed in ED as requiring an in-patient admission (Chavulak et al., 2018). Eleven of the 14 identified the PAL worker as helpful, with three noting this as being 'unhelpful' – two respondents offered no further explanation, while the remaining one indicated that they would have preferred to see a mental health advocate. A further qualitative Australian study (Brasier et al. 2021) also explored the benefits and limitations of employing peer support workers in the ED. This study used focus groups, including consumers, support workers and ED staff to identify perceptions; they identified beneficial skills associated with the inclusion of peer support workers in the ED team such as listening, empathy, relationship-building and de-escalation. However, barriers and limitations were also identified, including the need to ensure that peer support workers are identified as full and expert members of the ED team, and that there is workforce and organisational support (Brasier et al. 2021).

Internationally, the MH peer support role in EDs has been used in the United States, more commonly to support individuals with opioid use disorder, as part of the response to the opioid crisis (Crisanti et al., 2022; McGuire et al. 2020). While there is still relatively limited research around this initiative, studies have demonstrated increased social connection, improved interaction and engagement with high-risk populations, and higher levels of harm reduction education (McGuire et al. 2020; Samuels et al., 2018). A broader scope of practice is suggested by Heyland et al., (2021) in their discussion of Peer Support Specialists (PSSs) as a model of emergency psychiatric care suitable for use in EDs. They define PSSs as individuals who are in recovery from their own mental illness, and who draw on lived experience and formal training to provide MH care to individuals in psychiatric crisis. The PSS is seen as being able to provide on-on one support, offer empathetic and non-judgmental support, relationship building and communication. The benefit of lived experience is believed to enhance communication skills, increase the effectiveness of de-escalation and thus decrease the need for psychiatric medications and restraint. There are also potential links identified to faster discharge times, and reduced return visits associated with consistent and effective health need providers, with suggestions that the PSS is able to effectively act as a bridge between social support and formal clinical support (Heyland et al., 2021).

The potential for the peer support role in NZ seems positive, with the opportunity to develop this as a non-clinical advocacy role to support the patient's psychosocial needs. This could include on arrival, at triage, as a navigator within the system, in the waiting room or with the Crisis team. Core benefits have been seen as providing an emotional/compassionate/reassuring support in a stressful situation, and as a facilitator/navigator role in terms of linking into other support options after discharge, such as phone/text follow-up and safety planning assistance.

References

ASMS (2021). What proce mental health? The crisis and the cure. https://www.asms.org.nz/wp-content/uploads/2021/06/What-price-mental-health-Research-Brief.pdf

Ballesteros-Urpi A, Slade M, Manley D, et al Conceptual framework for personal recovery in mental health among children and adolescents: a systematic review and narrative synthesis protocolBMJ Open 2019;9:e029300. doi: 10.1136/bmjopen-2019-029300

Brasier, C., Roennfeldt, H., Hamilton, B., Martel, A., Hill, N., Stratford, A., Buchanan-Hagen, S., Byrne, L., Castle, D., Cocks, N., Davidson, L. and Brophy, L. (2022), Peer support work for people experiencing mental distress attending the emergency department: Exploring the potential. Emergency Medicine Australasia, 34: 78-84. https://doi.org/10.1111/1742-6723.13848

Carey, C., Jones, R., Yarborough, H., Kahler, Z., Moschella, P., & Lommel, K. (2018) 366 Peer-to-Peer Addiction Counseling Initiated in the Emergency Department Leads to High Initial Opioid Recovery Rates. *Ann. Emerg. Med.,* 72 (4) S143–S144

Chavulak, J., L. Buckley, and M. Petrakis, Recovery co-design and peer workforce development in the acute inpatient setting. New Paradigm, 2018. Summer 2017/18: p. 34-39.

Crisanti, A.S., Earheart, J., Deissinger, M., Lowerre, K., & Salvador, J.G. (2022). Implementation Challenges and Recommendations for Employing Peer Support Workers in Emergency Departments to Support Patients Presenting after an Opioid-Related Overdose. *Int. J. Environ. Res. Public Health, 19,* 5276. https://doi.org/10.3390/ijerph19095276

Heyland, M., Limp, M., & Johnstone, P. (2021). Utilization of peer support specialists as a model of emergency psychiatric care. Journal of Psychosocial Nursing & Mental Health Services, 59(5), 33-37. doi:https://doi.org/10.3928/02793695-20210107-02

McGuire, A.B., Powell, K.G., Treitler, P.C., Wagner, K.D., Smith, K.P., Cooperman, N., Robinson, L., Carter, J., Ray, B., Watson, D.P. (2020). Emergency department-based peer support for opioid use disorder: *Emergent functions and forms. Journal of Substance Abuse Treatment, 108,* 82-87, https://doi.org/10.1016/j.jsat.2019.06.013.

Ministry of Health (Draft document 2022). The Mental Health and Addiction System and Service Framework 2022–2032 Core Concepts. https://consult.health.govt.nz/mental-health/d8389151/supporting_documents/SSF%20for%20Sector%20Conversations.pdf

Minshall, C., Roennfeldt, H., Hamilton, B., Martel, A., Hill, N., Stratford, A., Buchanan-Hagen, S., Byrne, L., Castle, D.J., Cocks, N., Davidson, L. and Brophy, L. (2020a). *Examining the role of mental health peer support in emergency departments.* Melbourne: Melbourne Social Equity Institute, University of Melbourne.

Minshall, C., Roennfeldt, H., Brophy, L., Hill, N., Hamilton, B. (2020b). How could mental health peer support workers improve emergency departments? *Health & Wellbeing* https://pursuit.unimelb.edu.au/articles/how-could-mental-health-peer-support-workers-improve-emergency-departments

Samuels, E.A., Baird, J., Yang, E.S., & Mello, M.J. (2018). Adoption and Utilization of an Emergency Department Naloxone Distribution and Peer Recovery Coach Consultation Program. *Acad. Emerg. Med., 26,* 160–173. DOI: 10.1111/acem.13545

Shattell, M.M., et al., A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: 'The Living Room'. Issues in Mental Health Nursing, 2014. 35(1): p. 4-12

Paediatric Pearls - Capillary blood collection

Author:

Bridget Venning
Clinical Nurse Specialist, KidzFirst ED at Middlemore Hospital. Email: bridget.venning@gmail.com

Capillary blood sampling can provide a faster, less invasive, cheaper way of blood collection in paediatric patients presenting to the emergency department (Ponampalam et al., 2012).

Indications:

(Clinical and laboratory standards institute, 2018; Krleza et al., 2015; WHO, 2010).

- Small volume of blood required such as FBC, U+E, blood gas
- Child who will not require a PIVC
- Anxiety about blood sampling
- Fragile/ inaccessible veins

Contraindications:

(Clinical and laboratory standards institute, 2018; Krleza et al., 2015; WHO, 2010).

- Child is likely to need a PIVC
- Large volume of blood required (more than 2 micro-containers)
- Capillary sample is not appropriate if coagulation, ESR or blood cultures are required.
- Dehydration
- Oedema/swelling at the site
- **Non credentialed or untrained staff. If carried incorrectly capillary blood sampling can cause inaccurate test results, pain and tissue damage**

Sampling

(Clinical and laboratory standards institute, 2018; Malonowski, 2020; Starship Clinical Guidelines, 2019; WHO, 2010).

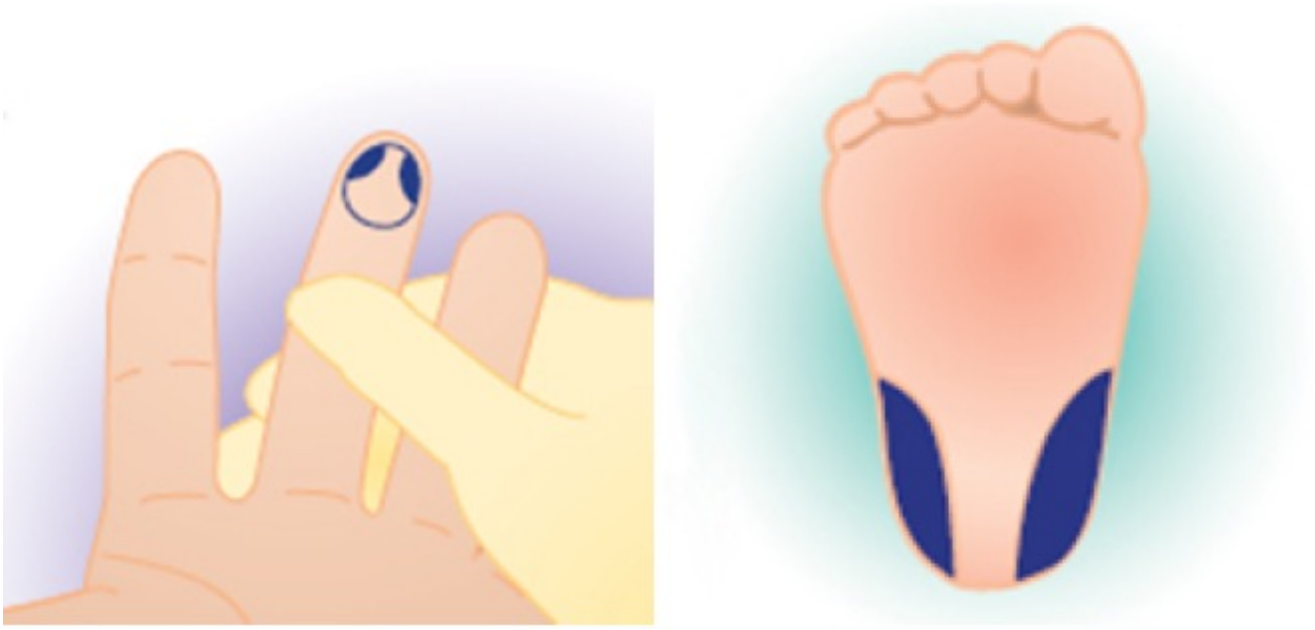
1. Assemble equipment:

Micro collect tubes, alcohol swab, gauze swab, correct lancet size* for age and site, pressure pad or plaster.

* Lancet size can be determined by age and size of child. Generally, the recommended depth of puncture is 1.0mm for term infants, 1.5mm for children 6 months-8 years, and 2.4 mm for children >8 years of age. **Staff should be familiar with locally used lancets and their sizing.** Smaller sizes are available for neonates and preterm neonates.

2. Choose puncture site:

- Under one year of age, only use the heel of the foot. Use the posterior lateral or medial plantar surface of the heel. Punctures to the central area of the foot may result in injury to nerves, tendons, and cartilage. Be aware of callus build up if then infant is walking – it may be better to do a peripheral collection if no suitable sites, instead of attempting multiple heel pricks that fail.
- Over one year, use the finger tip of the non-dominant ring or middle finger.
- Do not use previously punctured sites (accumulated tissue will affect results) OR sites that are inflamed, infected, oedematous or cyanotic.



Shaded blue: Site for heel and finger puncture

3. Collection:

(Clinical and laboratory standards institute, 2018; Krleza et al., 2015; WHO, 2010).

- Gain consent for the procedure and position the child in a comfortable safe position. Breast feeding infants at the time of puncture can improve collection
- Ensure the site is warm. A caregiver can put booties on the foot or hold the foot of the infant. Washing the older child's finger under warm water may be a good option. The puncture site must feel warm and have brisk capillary refill.
- Clean the site in a circular motion using 70% alcohol wipe and wait to air dry (~20 seconds). Moisture residue may disrupt results.
- Hold the limb:
  - HEEL: Partly encircle the infant's heel at the arch and ankle with non-dominant hand and gently squeeze foot to bulge flesh away from bone. Puncture the heel with the lancet flush to skin at 90 degrees.
  - FINGER: Puncture the immobilised finger with the lancet flush to skin at 90 degrees. Wipe first blood away with dry gauze pad
- Collect drops into microtainers. Hold the finger/ foot in a downward direction and direct the drop of blood using the scoop on the container. The correct order of draw to reduce platelet clumping is: Capillary gas, FBC then U+E to prevent platelet clumping.
- Use gentle pressure to massage the finger or heel (pressure then release to refill capillaries) above the incision. Gentle pressure is all that is required, avoid excessive milking as this will be uncomfortable for the patient and risk haemolysing of specimens which may cause inaccurate results.
- If blood gets smeared, use dry gauze to clean before gently massaging finger to promote blood flow again

Some differences in venous and capillary blood can exist and it is recommended that you note the sample is capillary. When accuracy is critical, results should always be confirmed by venous blood sampling. *(Clinical Laboratory Standards Institute 2018; Ponampalam et al., 2012).*

References

Clinical and Laboratory Standards Institute. (2008). Procedures and Devices for the Collection of Diagnostic Capillary Blood Specimens. Approved Standard – Sixth Edition. Clinical Laboratory Standards Institute; Pennsylvania, USA.

Krleza, J. L., Dorotic, A., Grzunov, A., Maradin, M., & Croatian Society of Medical Biochemistry and Laboratory Medicine (2015). Capillary blood sampling: national recommendations on behalf of the Croatian Society of Medical Biochemistry and Laboratory Medicine. Biochemia medica, 25(3), 335–358. https://doi.org/10.11613/BM.2015.034

Ponampalam, R., Fook Chong, S. M. C., & Tan, S. C. (2012). Comparison of full blood count parameters using capillary and venous samples in patients presenting to the emergency department. ISRN Emergency Medicine, 2012. https://doi.org/10.5402/2012/508649

Starship Clinical Guidelines (2019). Blood sampling in NICU Retrieved from: https://starship.org.nz/guidelines/blood-sampling-in-nicu/

World Health Organization. (2010). WHO guidelines on drawing blood: best practices in phlebotomy. Retrieved from: https://www.who.int/infection-prevention/publications/drawing_blood_best/en/

NP tips, tricks and trips

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

Topical anaesthetics and paediatric wounds – simple non complicated

Building on the last NP Tips, Tricks and Trips I talked about cleaning dirty wounds and working as a team. So, I thought I would add to this after coming across a couple of interesting paediatric wounds the other day, so love to share my thoughts.

Let's set the scene, kid comes in, has a good laceration to top of the head, blood, and really sad. Triage is heaving, a queue of people, the waiting room is eyeballing the triage nurse, and kid gets appropriate triage and sits wide eyed and tearful in the back of the waiting room. (This, of course, is for those unfortunate people who don't have a kid's area / department).

What I would like to talk about is considering prepping the wound for a quick closure or cleaning. Fixing it is another story ☺

Just a note

I use the term ALA but in overseas reports it is LET or ALT. This is to do with the mixture of the two anaesthetics tetracaine and lignocaine with adrenaline / epinephrine.

Consider

- Will this need a procedural sedation?
- Will the child tolerate this?
- Will the parent tolerate this?
- Can you fix it ? Yes, you can!

Preparation

Not taking anything away from the paediatric nurses but in many ED's the nurses are not specialist paediatric nurses, and some are even terrified of those small people (I was at the beginning). So, for those simple wounds that will be fixed in ED:

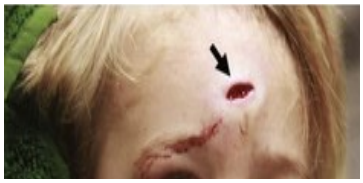
- ✓ Start planning early.
- ✓ Try and minimise the changing staff members, helps the child to trust the environment.
- ✓ If you can get them out of the main waiting room – do it! And do it quickly, the longer a child is waiting the harder you will find it to get near to them.
- ✓ Think of bedtimes, routines etc.

I love to use a topical agent right at the beginning. This will do most of the work for you – if you get it right. So, what are your options of topical anaesthetics?

- I use ALA, my personal favourite, (Topicaine adrenaline 0.1% (1 mg/mL) + tetracaine 0.5% (5 mg/mL) + lidocaine hydrochloride anhydrous 4% (40 mg/mL), 5 mL syringe solution) NZF.
- Ametop® (tetracaine), EMLA® are both not recommended for broken skin. But in the real world they are so check your local area.

Just to show that it is not my own crazy idea there is research including a Cochrane review meta-analysis (Tayeb, Eidelman, Eidelman, McNicol & Carr, 2017). All consider the use of topical anaesthesia an effective, non-invasive method for superficial laceration repair.

In the first picture, you can see they have put the anaesthetic on a large dressing, this will absorb a large amount of the anaesthetic, leaving little available for wound absorption. It's better to use a small piece of gauze big enough to cover the wound and the edges.



I soak it in the anaesthetic and then place on the wound gently, and very carefully push in to the wound if possible. The gauze just stops it running out. Next, cover with the best adhesive you have, that doesn't hurt when taken off, and let them loose to play for 20-30 mins. You will see in the second picture that it has blanched around the edges.

You may then successfully suture with no further anaesthetic infiltration – and if you do it is often quite painless compared to without.

This use of topical anaesthetic has helped me complete wound repair without sedation, it has stopped admissions for operating theatre time, and referral to busy inpatient teams.

Stepping in and managing these children early in their presentation often saves a lot of time and angst.

Topical

Child 1–18 years usual dose approximately 0.1 mL/kg; soak sterile gauze with solution, pack wound with gauze, add further solution, then cover with an occlusive dressing; wait 30 minutes before procedure – skin should become blanched at the edges (NZ Formulary [NZF] for Children (2022a)

It's also important to point out that we shouldn't necessarily reserve topical anaesthetics for children alone. There are reports of excellent success at obtaining effective anaesthesia in children > 8 years old and adults using Lidocaine-Adrenaline-Tetracaine (LAT), with only 23.6% needing additional analgesia (Tayeb, Eidelman, Eidelman, McNicol & Carr, 2017).

Anyway, that's what I like to do, and I love it when the nurses at the first point of call come and ask me, do you think? And can I? Yes, you can!

Tips for the non-NP or beginning ED nurse

Did you know the first topical anaesthetic was cocaine, and it is still available for use – it's just less appealing due to stigma?

The red flags for wounds are the same.

EMLA® is not for use on non-intact skin surfaces and mucosal surfaces. It doesn't work as well on the palms and soles, where the stratum corneum is thicker and it may not penetrate. Unlike LET, which has never shown any adverse outcomes in studies, EMLA® has a few reported: localised skin blanching, localised erythema, and more seriously methemoglobinemia after prolonged exposure in infants.

Lots of extra reading and references;

NZ Formulary [NZF] for Children. (2022a). Lidocaine + tetracaine + adrenaline. https://www.nzfchildren.org.nz/nzf_7067. Accessed 25 March 2022.

NZ Formulary [NZF] for Children. (2022b). Search results for "adrenaline" lignocaine "tetracaine". https://www.nzfchildren.org.nz/Search/Results?term=%22adrenaline%22%20lignocaine%20%22tetracaine%22&Page=Tetracaine&Type Accessed 25 March 2022.

Tayeb BO, Eidelman A, Eidelman CL, McNicol ED, Carr DB. (2017). Topical anaesthetics for pain control during repair of dermal laceration. *Cochrane Database of Systematic Reviews*, Issue 2. DOI: 10.1002/14651858.CD005364.pub3. Accessed 25 March 2022.

Wound Preparation Series: Topical Anesthetics *Closing The Gap* https://lacerationrepair.com/wound-blog/wound-prep-series-topical-anesthetics/ Accessed 25 March 2022.

Snippets 01: Winter 2022

Snippets: Focus on Mental Health.

Cuttings, reviews, resources and contemplations.

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

We all need help, especially in our pressured workplaces, and all of us have challenges at home to some degree or another. As such, the following are a range of resources, in addition to those from our workplaces.

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

Assistance for immediate help

- 1737 brief intervention counselling: https://1737.org.nz/
- Alcohol and drug helpline: https://alcoholdrughelp.org.nz/helpline/
- Mental Health Foundation: https://mentalhealth.org.nz/help
- The Depression Helpline – 0800 111 757 or free text 4202 (to talk to a trained counsellor about how you are feeling or to ask any questions).

Services

- **EAP** (Employee Assistance Programme) Services – confidential counselling and other support for DHB staff and their close family - in the first instance, up to three sessions are provided, although an extension may be sought in some circumstances: https://www.eapservices.co.nz/contact/
- **Wellbeing service** – Ministry of Health and Healthcare NZ: https://www.healthcarenz.co.nz/wellbeing-service/
- **Workplace Support** – Onsite access to independent support staff who can help employees navigate personal or work difficulties and link them to up to three confidential counselling sessions per year for DHB staff and their close family: https://www.workplacesupport.co.nz/

Apps, blogs, and newsletters

- **All Right?** Getting through together – free help if you're not alright: **https://www.allright.org.nz/articles/not-all-right**
- **Calm** – tools to meditate, sleep and relax: https://www.calm.com/
- **Five Ways to Wellbeing at Work Toolkit** – resources to support you to introduce mental health and wellbeing into your workplace and focus on promoting positive mental health, from the Mental Health Foundation: https://www.mentalhealth.org.nz/home/our-work/category/42/five-ways-to-wellbeing-at-work-toolkit
- **Groov by Mentemia** – tools to meditate, sleep and relax: https://www.groovnow.com/covid-19
- **Headspace** – tools to meditate, sleep and relax: https://www.headspace.com/headspace-meditation-app
- **Just a thought** – free online therapy courses for skills to manage your thoughts and feelings: https://www.justathought.co.nz/
- **Small Steps** – Brief tools to help with feelings of anxiety, stress, or low mood: https://www.smallsteps.org.nz/
- **Thrive Global** – Blog: https://thriveglobal.com/stories/
- **Umbrella** - Thinking – newsletters to lead the wellbeing conversation in New Zealand: https://umbrella.org.nz/thinking/
- **Woebot** – AI-powered chatbot that uses cognitive-behavioural therapy (CBT) principles to help people manage their mental health: https://woebothealth.com/
- **Workplace Wellbeing** – resources such as posters, videos, infographics, presentations, news and events on workplace health and wellbeing: https://wellplace.nz/

Useful websites:

- **Mind** – https://www.mind.org.uk/information-support/tips-for-everyday-living/wellbeing/wellbeing/
- **Te Pou** – https://www.tepou.co.nz/

Snippets 01: Winter 2022 Cont.

Helplines:

- He Waka Tapu 0800 439 276 (0800 HEYBRO) – for men who feel they are going to harm a loved one or whanau member
- Vaka Tautua 0800 652 535 (0800 OLA LELEI) – free national Pacific helpline. Mon-Fri 8.30am - 5pm
- Anxiety Helpline 0800 269 4389 (0800 ANXIETY)
- Aoake te Rā 0800 000 053 – free counselling for people bereaved by suicide. See www.aoaketera.org.nz
- Rural Support 0800 787 254 – for people in rural communities dealing with financial or personal challenges
- Shakti Crisis Line 0800 742 584 (0800 SHAKTI) – for migrant or refugee women living with family violence
- Rape Crisis 0800 883 300 – for support after rape or sexual assault
- 24/7 HELPline 0800 623 1700 www.helpauckland.org.nz – support for sexual abuse survivors
- Asian Family Services 0800 862 342 help@asianfamilyservices.nz – provides professional, confidential support in multiple languages to Asians living in New Zealand, Monday to Friday 9am – 8pm

Snippets 02: Winter 2022

Cultural Safety and Te Ao Māori Snippets

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

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

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, we can all develop and expand our abilities.

Check out the Te Reo Hāpai Māori language glossary for use in the mental health, addiction and disability sectors, a great resource.

https://www.tereohapai.nz/

In line with the mental health focus in this edition of the journal, below are some phrases and proverbs *Kīanga, Kīwaha, Whakataukī* of relevance to mental health and well-being, from Te Reo Hāpai.

Ahakoa he aha te rākau he hua kei roto

No matter the species of tree each bears its own unique fruit - Celebrate diversity.

Whāia te hauora hinengaro kia puāwai ai te hauora tangata

There is no health without mental health.

Tirohia te tangata, kaua ko te waranga.

See the person, not the addiction.

E pēhea ana tō ngākau i tēnei wā?

(Dialect variation for 'seat of emotions')

How are you feeling at this time?

Iti nei, iti nei.

Take small steps to achieve your goals

CALD (Cultural and Linguistic Diversity) Courses

The New Zealand publicly funded health and disability workforce are eligible for the Ministry of Health funded face-to-face and online Courses for Working with CALD Patients; face-to-face Courses for Culturally Diverse Workplaces and face-to-face and online Courses for Interpreters.

From July 2021 a new four paper program was added for those working in mental health areas, "CALD Cultural Competency in a Psychiatric Context". This is described as developing awareness, sensitivity and knowledge of cultural and linguistic diversity (CALD) factors when working with culturally and linguistically diverse (CALD) clients in a psychiatric context. It uses case examples and vignettes, as well as opportunities to apply awareness, sensitivity and knowledge to develop skills in engagement, assessment, cultural formulation, treatment, and collaboration in practice.

https://www.ecald.com/

Learning and education modules on understanding bias in health care

These modules have a strong focus on Te Tiriti o Waitangi, colonisation and racism. The link below takes you to a series of three videos, developed for Wiki Haumaru Tūroro | Patient Safety Week 2019. If you want to gain a certificate for evidence of completion, you will need to access these resources via LearnOnline (the Ministry of Health's education and learning platform).

https://www.hqsc.govt.nz/resources/resource-library/learning-and-education-modules-on-understanding-bias-in-health-care/

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

Committee Roles

CENNZ Mission Statement

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

CENNZ Committee Roles

Role / Portfolio	Conference Name	Location and Link
Chairperson	Sue Stebbeings	cennzchair@gmail.com
Secretary	Amy Button	cennzsecretary@gmail.com
Treasurer	Keziah Jones	cennztreasurer@gmail.com
Membership	Lyn Logan	cennzmembership@gmail.com
Grants and Awards	Lyn Logan	cennzawards@gmail.com
Staffing Repository	Anna-Marie Grace	cennzrepository@gmail.com
NZ Triage courses	Tanya Meldrum	cennztriage@gmail.com
Professional Nursing Advisor (NZNO)	Suzanne Rolls	suzanne.rolls@nzno.org.nz
Te Rūnanga Representative	Tina Konia	
Journal Editor	Dr Sandra Richardson	editor.cennzjournal@gmail.com
Website and Social Media	Dr Natalie Anderson	
Networks		
Clinical Nurse Educator Network	Anna-Marie Grace	
Charge Nurse Managers Network	**Anna-Marie Grace**	
Advanced Emergency Nurses Network	Beccy Fenn	
Emergency Nurse Practitioner Network	Sue Stebbeings	

Committee Regional Representatives

Committee Regional Representatives

Region	Name	Daily Role
Te Rūnanga	Tina Konia	Registered Nurse – Hawkes Bay Fallen Soldiers' Memorial Hospital
Northland / Te Tai Tokerau	Sue Stebbeings	Nurse Practitioner – Whangarei Hospital
Auckland	Anna-Marie Grace	Nurse Unit Manager – Starship Children's Health
Auckland	Natalie Anderson	Registered Nurse, Professional Teaching Fellow – Auckland City Hospital
Midlands / Bay of Plenty	Lyn Logan	Nurse Manager – Rotorua Hospital
Hawkes Bay / Tairawhiti	Amy Button	Registered Nurse – Hawkes Bay Fallen Soldiers' Memorial Hospital
Mid Central Region	Lauren Miller	Clinical Nurse Educator - Taranaki Emergency Department
Wellington	Shannon Gibbs	Nurse Practitioner - Wairarapa Emergency Department
Top of South	VACANT	
Canterbury / Westland	Keziah Jones	Registered Nurse – Christchurch Hospital
Otago / Southland	Michelle Scully	Associate Charge Nurse Manager – Southland Hospital Emergency Department

Chairperson's Report

Sue Stebbeings
CENNZ Chairperson

Contact: cennzchair@gmail.com

E hara tāku toa i te toa takitahi, engari he toa takitini

My strength is not as an individual, but as a collective

Kia ora koutou katoa
Hello everyone

Team work has always been an important aspect of emergency nursing, and it seems even more essential in the current challenges. The last four months have continued to magnify the existing issues we face, yet I am aware of so many positive examples of nurses working together. Hopefully you have been able to take a break in whatever way possible to relax and refresh your energies.

Around the country, Emergency Departments continue to experience high staff turnover, difficulty recruiting, and staff sickness which leads to increased stress on nurses. The CENNZ committee remains committed to improving the staffing situation and has sent correspondence to the Minister of Health following the release of the Nursing Safe Staffing Report in February.

Members will have received the remit on the updated position statement on Registered Nurse Staffing Requirements in Emergency Departments. Voting is now underway as discussed during our AGM last year.

NZNO has recently established a network for NZNO Health and Safety Reps to provide a discussion forum and support for this important role, particularly in relation to escalation of safety concerns such as the Provisional Improvement Notices submitted under Health and Safety at Work Act. Sharing experiences and information is a valuable resource, and I encourage Health and Safety Reps in EDs to join the group. ***Contact information from Kai Tiaki is below;***

NZNO health and safety representatives can apply to join the WhatsApp group by emailing John.Howell@nzno.org.nz.

Enter the email subject as: Application – NZNO HSR WhatsApp

Please provide your NZNO membership number and your mobile phone number.

The CENNZ representative on NZNO project Address Violence and Aggression Against Nurses (AVAN) is Midlands Bay of Plenty regional representative Lyn Logan. Anecdotally there has been an increase in the incidence of violence and aggression that appears to be triggered by Covid related aspects of care such as RAT testing, mask use, and visitor restrictions.

Chairperson's Report Cont.

This unfortunately reflects the increased community stressors and for many a deterioration in our mental health. Please continue to keep this issue visible in your workplaces.

We were extremely disappointed that the omicron covid surge led to the deferral of CENNZ conference until 2023, however we are making progress on our project to support professional development with the start of a partnership with My Health Hub to provide webinars on emergency nursing related topics. Invitations to the webinars will come through usual CENNZ mail out process, and access to the recorded sessions will be available if you are unable to attend. Please contact us regarding topics or speakers that you would be interested in. As travel around the country is supported and release time from work becomes available, we can look at planning for CENNZ networks to connect.

The national committee hopes to finally meet face to face in May to continue work on a number of initiatives. We hope to welcome new regional representatives that have arisen due to completion of committee terms, change of workplace and existing regional vacancies. Full representation enables us to achieve maximal impact and progress.

Ngā mihi nui tatou katoa,

Sue

Sue Stebbeings
Nurse Practitioner – Whangarei Hospital

Northland/Te Taitokerau Region

Sue Stebbeings
Nurse Practitioner

Whangarei Emergency Department

Reflecting on the last few months, there are many examples that Aretha Franklin would call 'accentuating the positive' and 'holding on to the affirmative' – something we all need to remind us of what we have achieved.

Huge shout out to all the team members across the north who continue to get together, create, innovate, show up, hang in there, and put their hand up to be involved. Together, we are providing the best emergency care that we can in challenging circumstances. There have been many people from outside ED seconded from their usual roles, particularly in the screening team.

A warm welcome to new staff – some returning familiar faces and overseas recruits who will finally be able to get into the country. We also have two new clinical nurse specialists here in Whangarei with the aim of progression along the nurse practitioner pathway. The nurse practitioner team has grown to three since David and Kylie's registration.

There is a proposal underway for another nurse on night shift. In the meantime an additional late PM shift is being rostered when possible.

We were glad to be able to hold a CENNZ triage course last month in Whangarei was to provide training and credentialling in this essential specialised role.

Our staff room is undergoing a refresh to enhance relaxation during break time. We also have the option of outdoor picnic tables; however these may be less attractive as the season changes – gazebos proved to be a hazard due to the roof helipad nearby 😀

There are several projects in different stages to improve the use of the limited space available while we wait for a new department and hospital. These include enlarging our very small waiting area to avoid people sitting in the front hospital corridor, adding sliding glass stacker doors to 4 more single rooms, and the staff hub/computer write up / medication room area. We will need to develop new processes and ways of working with the new shape of waiting room as the visibility from the existing area is limited.

The increase in mental health-related presentations emphasises the value of the CATT in ED role mentioned in the last journal report. Earlier specialist assessment reduces waiting times and supports people in their ED journey.

Incidents of violence and aggression continue to be challenging, particularly in relation to Covid related requirements. Dates for a full day De-escalation training course are being planned which will include techniques for protecting your own physical safety and restraint. A duress alarm has been arranged in the front tent. Keeping the issue visible and ensuring we log incidents of unacceptable behaviour is essential. There is a new NDHB Workplace Violence campaign beginning shortly.

Sue

Greater Auckland Region

Anna-Marie Grace
Nurse Unit Manager

Children's Emergency Department

Starship Children's Health

Auckland City Hospital

Starship Children's ED

The beginning of 2022 brought the third instalment of COVID to EDs around the country. And with it came new challenges and again increased the pace of change which was challenging.

With previous outbreaks CED didn't have to move outside to triage as the numbers presenting remained pretty low due to lockdowns and our Waiting room area was big enough to manoeuvre in. But Omicron and its more infectious nature meant that we moved out into a tent to triage. This worked really well except for one weekend when the rain finally hit Auckland and the tent flooded!

One of the biggest challenges we expected (learnings from NSW) was that we would likely see a lot of children who were COVID positive but wouldn't require admission. This would mean discharging a large number of Covid positive tamariki - the complexity much higher than other discharges.

We developed a COVID discharge coordinator role that supported the clinical teams ensuring tamariki were being discharged with the right supports in place to isolate at home with their whanau. This role was well supported by redeployed Starship senior nurses and Allied Health professionals. It brought a really collegial feel to have the support from across the hospital.

The teamwork required to pull off the planning and execution of this amount the change and process development is massive – in CED we are really lucky to have a great MDT!

We are already seeing bronchiolitis and the challenge of 2022 winter ahead is still unknown, but have quite a few new recruits coming from within Starship and from overseas.

Anna Marie Grace

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.

Auckland Region cont.

Natalie Anderson
Registered Nurse & Senior Lecturer

Auckland Emergency Department & The University of Auckland

Auckland Adult ED

It has been a time of change and adaptation at Auckland ED as our physical environment and processes continue to evolve to meet the demands of widespread COVID in the community. Initial screening processes and some care of COVID+ patients has taken place outside the department in our tent or undercroft area. With cooler weather coming, we've further adapted our environment to improve safe access to the department for COVID+ patients.

As COVID peaked in Auckland, our DHB briefly added financial incentives to encourage existing staff to pick-up extra night shifts. We are also grateful to all those who were redeployed to ED to lend a hand when demand was highest.

Safe staffing is an ongoing concern and our NZNO reps have worked with senior nursing staff to encourage documentation and follow-up of unsafe staffing incidents.

A further 19.3FTE has been funded across our level (ED & CDU) but recruitment remains challenging. High staff turnover continues, and although open borders will likely draw further staff away, we're also welcoming numerous enthusiastic new members to our team. Our educators are and preceptors are doing such important work, supporting our new and new-to-ED nurses.

We're gradually increasing use of electronic notes. Infrastructural limitations (notably, insufficient computers) remain a major barrier to elimination of paper notes. However, as our DHB is still using faxes and pagers, this is at least a move towards 21st century technology. When I think of all the time nurses spend trying to locate patient notes and struggling to decipher handwriting, a successful move to digital notes would truly be 'releasing time to care'.

Natalie

Midland Region

Linda (Lyn) Logan
ACNM
Rotorua ED at Lakes DHB

Rotorua ED

Rotorua ED has seen a lot of changes recently, including former CENNZ Committee member Kaidee Hesford moving to a senior position at BOP DHB. We will miss Kaidee for her vision to empower people to promote changes for the better within our department. I would like to welcome Nigel Naylor as our new CMN who has worked in varying senior roles within Waikato and Counties Manakau DHBs. Our new initiatives also include an introduction of a Mental Health CNE within our dept and the mental health unit.

We have also been trialling our CNS team working in partnership with our local police station to improve health outcomes. More information on these initiatives will be in the next report.

Tauranga ED has had some huge gains with trendcare recently. Their CMN John Wylie will discuss this further below.

Lyn

Tauranga ED

After six months of planning, including meeting with other ED users and other key stakeholders, drafting plans for the TrendCare coordinators, submission of plans to the Director of Nursing, training TrendCare champions and the purchasing of multiple computers for the department, we finally went live with TrendCare ED in November 2019.

Myself and one of my ACNM colleagues put our hands up to lead the project in June 2019. There had been a lot of talk around the country about the system – good, bad and indifferent - however it had only ever been used in the smaller Emergency department setting. TrendCare fits as one of the five standards in the Care Capacity Demand Management program - patient acuity, core data set, staffing methodology such as FTE and skill mix, variance response (forecasting and responding to demand), and governance and programme monitoring).

We visited and spent some time with our ED colleagues in Whanganui, who showed us TrendCare ED in use and answered our many questions. Its use here provided the necessary evidence that more staff were required - this boosted our enthusiasm to get things moving.

It took a huge amount of time and effort on our part to get to 'go live day' and keep the ED team engaged with optimism. Like every other Emergency department in the country, our team was tired and ran short/inadequately staffed every day.

From 'go live' day in November 2019, it was very evident that the acuity of our patients coming through the door required significant increases in nurses /nursing time to care for them; however, valid data requires time, annual Inter Relator Reliability Testing (IRR) and patient types to be within the benchmark. Yes – data input is just something else that the nursing team must do but honestly, it is just a couple of clicks of a mouse!

We have had two rounds of calculations to date, which have seen an increase in our nursing team of greater than 11.0 FTE. The hard part now is replacing those staff who have left and recruiting to the additional FTE; however, more applications appear every day, and we can feel the pressure lifting. We have an outstanding team of nurses here in Tauranga ED who have gone above and beyond - particularly over the past 18 months – deserve recognition and better conditions. My senior nursing team and I are doing everything to deliver that.

We had encouragement and support from our Director of Nursing, Associate Director of Nursing and TrendCare coordinators to implement TrendCare, and the ongoing support is appreciated.

John Wylie

ED CMN Tauranga Hospital

Hawkes Bay/Tarawhiti

Amy Button
ACNM

Emergency Department, Hawke's Bay Fallen Soldiers' Memorial Hospital

Hawkes Bay ED

2022 has brought many changes to the Emergency Department in Hawkes Bay. We have had to make some sad farewells, with both our CNM and ACNM moving on to new career opportunities within the DHB. The ED staff are staying positive and looking toward a bright future. We are excited about the constructive changes the new leadership team will bring. The hospital management has had a restructure too, and as a result, ED has a new Operations Manager, Susan Hawken. Susan brings a wealth of experience, including working in senior nursing roles within ED at Hawkes Bay.

Covid continues to be a daily presence in our workplace and the ED staff have worked tirelessly to ensure that their patient care isn't compromised. The department has been revamped to make more single isolation rooms with closed doors. This allows us to isolate patients when necessary to ensure the best care for all oour patients in the most appropriate environment.

The PIN issued last year by our work safe representatives has produced some positive changes so far, especially in regards to nursing FTE. We have been approved to decrease our nurse to patient ratio in the acute area from 1:4 to 1:3 and have been approved an extra Resus nurse on night shift. Other positives changes are in the process of being approved.

It is the positive team culture here in Hawkes Bay ED that keeps keep our department going. As always the staff are hard-working and uncomplaining. Every day, we are turning up to ensure that our patients receive the best care possible. The future is full of opportunities for our department, and we are looking forward to the positive changes the rest of 2022 will have for us.

Amy

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.

Mid Central Region

Lauren Miller
Clinical Nurse Educator

Taranaki Emergency Department

Kia Ora All,

I am beginning to find my feet as a new CENNZ member, and this is my first opportunity to complete the regional report, reach out and get a feel for what has been going on for the mid-central region for the challenging start of 2022. I'm looking forward to meeting the rest of the CENNZ committee in person in May and establishing myself further as the regional CENNZ Rep.

Whanganui Emergency Department

Has been experiencing the challenges of managing patient volumes with the national Omicron surge. As a DHB various measures were taken to assist through this, including reducing some surgical services to lessen the load on the wider DHB and ED.

Whanganui ED has been a national front runner in the implementation of TrendCare, having had it in place in their ED for over five years. Recent CCDM calculations have positively resulted in an increased budget for a further increase in RN FTE. They are currently recruiting for these positions.

Excitingly Whanganui is running a local TNCC course, coming up at the end of May. This is a great opportunity to increase local nurse confidence and competence in the assessment and management of trauma patients.

Carla O'Keeffe (CMN Whanganui)

Taranaki DHB ED

Much like elsewhere, we have faced the challenge of managing patient loads and staff absences throughout the Omicron surge, but our staff across the board have shown exceptional resilience and adaptability through this trying time. We have also had a successful recent recruiting period and would like to welcome all the newcomers to our department.

From an infrastructure point of view, we had our ED ventilation system completely rehauled to establish a separate system from the rest of the hospital. This has been an essential change to ensure that the department meets the needs of the staff and patients.

TDHB has some exciting developments, including the recent successful certification of Nateshea Holley as a Nurse Practitioner- Congratulations Tesh, we are very happy for you!

We also recently appointed an ACNM. Emma Holmes is due to start this role in early May. This is a new role for TDHB ED and as a department, we are really excited to have Emma as part of the leadership team, to provide support to the Coordinators and for the assistance she will give to the CNM.

The department implemented TrendCare in Dec 2021 and has been slowly assimilating to this new system. We are currently working hard to get all our staff IRR tested so that we can begin to accurately produce the data that we need to justify how hard we are working.

Much like Whanganui we have the opportunity to run a local Triage and TNCC courses in the coming months. Running the courses locally provides a good chance to get a cohort of local nurses through the training and grow and develop the staff within the ED.

Therese Manning (CNM TDHB ED)

MidCentral DHB – Emergency Department

After a very busy summer and Christmas period, April has arrived already. We have seen a lot general trauma and road trauma over this quarter, which has kept our dept, hospital and regional retrieval service quite busy. Our Trauma CNS has been working hard both up front on the initial presentation and then the ward follow-up, discharge planning, and all important clinical coding.

In June, we are looking forward to NetworkZ trauma training as part of the national simulation-based

Mid Central Region cont.

training within the National Trauma Network. More opportunities for training and upskilling, and this is always a really productive, fun day to be involved in.

COVID-19 is still here! We have seen regular numbers through the dept. We have tested and adjusted local policy and guidelines and developed paediatric and adult pathways with clinical treatment guidelines working well.

As part of this, in collaboration with the Paediatric service, the take-home education packages for parents have been a great help in explaining trajectory of illness, and sound advice for managing our paediatric population safely at home.

Changes within the dept have seen guidelines around resuscitation and intubation streamlined, more protection for patients and staff with the modification of our resuscitation bays, and changes to flow within the dept have all assisted with how we manage these patients. Lots of innovations and improvements going on in this space.

We have to celebrate successes where we can- and we need to congratulate our ED Registrars, who all successfully passed the written exam for their Part Ones. Well done team, we are super proud of you all. All the best for the VIVAs.

This year has seen staff turnover and staff taking the opportunities to seek out professional development opportunities in other places. We wish those well who have moved on to other roles and welcome those new to our team. We have also added another CNS to our Advanced Nursing Practice team and wish Jaime all the best with the start of her training this year.

The dept has also had approval to appoint an ED Maori Specialty Nurse to support Manaaki Mana, and we look forward to welcoming this role within our dept.

Things are tough in nursing around the country right now, and I would like to take the opportunity to thank our dedicated team in our ED for continuing to work in very challenging conditions. Many times, there are roster gaps that have required extra duties, over time, working through breaks, being re-tasked outside of usual roles, and many times this seems thankless. The team is the reason ED nurses are so awesome, and your dedication to your profession is seen every day.

Until the next time... go well.

Katie Smith NP

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
Charge Nurse Manager
Acute Services
Wairarapa DHB

This is my last Regional report for the CENNZ Journal as I have completed my term and am stepping out, ready for another CENNZ member from the Wellington region to take up the reins. From when I started in this role, the challenge of incorporating Nurse Practitioners into our Emergency Department, defining their place within multidisciplinary teams and proving their worth was an uphill battle. Now they are not only valued team members but a discipline that's growing in numbers and necessity in all three departments in the region. Trainee programmes for upcoming Nurse Practitioners, Clinical Nurse Specialists, and Registered Nurses with prescribing show the progress of the advancing nursing roles within our teams.

Our strong desire to grow our nursing workforce has pushed our departments to support additional Nursing Entry to Practice (Netp) nurses. This comes with huge positivity for the teams, but also additional demand for those working in extremely busy (sometimes chaotic) environments. Acknowledging firstly the determination of these new nurses that have stepped into Emergency Departments that are pushed beyond breaking point at times and the experienced nurses that have guided, protected and educated these inexperienced Clinicians on safe patient and self-care. This relentless task needs to be applauded, for it is the future nurses we are now supporting to grow.

The introduction of TrendCare is another exponential task that all three Emergency Departments have implemented and are now looking at IRR testing, data validation and impending FTE calculations. It will be no surprise that negative care variance is the prominent feature within our teams, thus providing empirical evidence using validated data to support increasing staffing requirements. Successfully implementing TrendCare in the midst of the pandemic response is something all teams involved should feel very proud of.

The need for additional space and improved isolation capacity is another challenge that has been identified with varying degrees of progress. Planning, workarounds and considerable building has made our departments ever-changing workplaces. Again working through this the additional disruption of these changes has added another layer of complexity to providing care to our vulnerable patient group. Still, again our teams have pushed on and worked around it.

The strength of character, the personal and professional control, the humour and loyalty to providing care to those most in need makes up our teams and enables a continuation of care. The physical and mental toll of the pandemic has pushed Emergency Department nurses very hard and the impact of that is clearly evident amongst our colleagues, regardless of what role you hold.

This is no small job and acknowledging the Emergency Department nurses contribution is difficult to articulate but is something I feel immense pride in especially over the last couple of years.

Kathryn

Top of the South Region

Vacancy

Regional Representative

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

See page 43 for details of the role and how to nominate for the position.

Canterbury/Westland Region

Keziah Jones
Registered Nurse

Christchurch Emergency Department

Christchurch Waipapa ED

Times have been challenging as we constantly adjust and adapt to considerable changes with our COVID response. We continue to wear N95 and PPE in ED and have been able to discharge around 60% of the COVID positive patients safely. Cases in Canterbury have now reached their peak and seem to be stabilising, although we anticipate ongoing peaks and troughs.

Patient presentations average around 318 patients per day in January, 306 patients per day in February and 300 in March. Since January, we have seen a slight reduction in ED attendance which is in line with data predictions.

Christchurch ED has welcomed many new nurses and hospital aides into our team over the last few months.

We are looking forward to fully opening the Children's Emergency Care (CEC) area in June, where ED nurses and Child Health nurses will work together in a purpose-designed space.

We also welcome an increase to the Kaimaha Hauora Maori Team, which provides ED with extra cover over the weekend and some after hours.

We have a trial for three months of our dedicated security guard to support ED staff in managing distressed patients, monitor developing situations and provide an immediate response to any incidents within the ED.

We continue with Trendcare aiming for consistent 95% actualisation of patient data as we approach our FTE calculation due in August, with a full year's worth of data. We are hoping this will provide an increase in FTE, watch this space.

Kez

Southern Region

Tanya Meldrum
Professional Development Unit
Southland District Health Board
Dunedin Hospital Emergency Department

Southern Report –April 2022.

Invercargill emergency department has been busy with education to start the year. They have successfully held a CENNZ triage course and a Trauma Nurse Core Course (TNCC). It has been great to have these provided and for the DHB to have supported nurses to attend. These are such vital education opportunities to help progress staff in the departments. In February, Invercargill welcomed a new permanent Charge Nurse Manager.

The Dunedin emergency department has introduced a new voice-operated, hands-free communication system by Voicera. It has had a positive impact, making it easier to talk to people in isolation rooms and throughout the department. It also has a duress option, if required by staff. It even has options of talking to Santa Claus "Ho Ho Ho," and sound effects for Star Trek fans.

Dunedin ED have also been trialling a well-being app - Chnnl - where staff spend approximately 30 seconds to a minute per day to give feedback into how they are feeling. The app then gives direction for improving the staff overall well-being. It channels feeling into what is going well and what staff find challenging.

Dunedin has seen some changes in the senior nursing team due to four associate charge nurse managers moving on. This has created opportunities for staff to progress through the department, but their experience will be missed.

Sadly, this is my last report as the CENNZ Southern Regional representative. I am moving on to work in the Professional Development Unit but will continue to have contact with new graduate nurses in the emergency department. I will also will be staying on as the CENNZ Triage coordinator for 2022.

I would like to take this opportunity to both acknowledge and thank the CENNZ national committee. They work tirelessly to support and contribute to emergency nursing and the nursing profession. Often, their work is behind the scenes, but they are working hard to have emergency department nurses' voices heard.

Take care and look after each other.

Tanya

College Activities

College Vacancies

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

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 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).

The nomination form is available at on the CENNZ website and should be 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

Publications

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

College Activities: Courses

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

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

For the details see the CENNZ websites at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/courses and https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/advanced_emergency_nurses_network_aenn

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

Education: Conferences and Seminars

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

The NZNO offers members a range of scholarships and grants. These grants are funded from various trusts. NZNO also administers a range of other NZNO local and national grants. See the NZNO Scholarships and Grants page at https://www.nzno.org.nz/support/scholarships_and_grants for the details and application processes.

Some upcoming conferences in the coming year are as follows:

Conferences and Seminars

Dates	Conference Name	Location and link
25-26 July 2022	Disaster and Emergency Management Conference	Gold Coast https://anzdmc.com.au
TBC in 2022	Frontline ED Conference – Australia and NZ College of Emergency Nursing	TBC https://www.anzcen.edu.au/frontline-ed-conference/
August 05-06, 2022	International Conference on Emergency Nursing Practice and Emergency Interventions ICENPEI	Montreal, Canada International Conference on Emergency Nursing Practice and Emergency Interventions ICENPEI Montreal, Canada https://waset.org/emergency-nursing-practice-and-emergency-interventions-conference-in-august-2022-in-montreal
September 30-Oct 3rd 2022	ENA Conference (Emergency Nurses Association)	Denver, Colorado, USA https://www.ena.org/events/emergency-nursing-2022
27-29 October 2022	Emergency and Ambulatory Care Nursing – Nursing World Conference	Hybrid event: online and Florida https://nursingworldconference.com/program/scientific-sessions/emergency-and-ambulatory-care-nursing
10-12 November 2022	Global Conference on Emergency Nursing and Trauma Care	Gothenburg, Sweden https://www.elsevier.com/events/conferences/global-conference-on-emergency-nursing-and-trauma-care/location

Education: Conferences and Seminars Cont.

Conferences and Seminars Cont.

Dates	Conference Name	Location and link
6-9 December 2022	The London Trauma Conference 2022	London https://www.londontraumaconference.co.uk/Programme
6-7th March 2023	Frontline Mental Health Conference	Gold Coast, Australia https://anzmh.asn.au/fmhc-2023

Submissions Guidelines - (Brief)

Journal Submissions

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

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

Category of manuscripts

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

Format:
Title page: title, authors, abstract and keywords
Body: introduction, methods, results, discussion
References: limited to 30

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

Format:
Integrative, scoping or systematic literature reviews are preferred
Use of JBI for integrative or scoping reviews recommended
Use of PRISMA for systematic reviews recommended

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

Format:
Introduction: brief overview context / problem
Case: patient description, case history, examination, investigations, treatment plan, outcome
Discussion: summarises existing literature, identifies sources of confusion or challenges in present case.
Conclusion: summary of key points or recommendations
Acknowledgement that consent has been obtained from the patient plus any ethical issues identified
References: limited to 20

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

Approximately **2000-3000** words
Format: free-text
References: limited to 20

Profiles – These should be on a role within emergency or acute care that makes a difference to patients and staff activities:
Approximately **600-1000** words

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

Reference style

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

EMERGENCY NURSE NEW ZEALAND

The Journal of the College of Emergency Nurses New Zealand (NZNO)
ISSN 1176-2691