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Editorial

Dr Sandra Richardson
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Infection and ED nurses

I am sitting at my desk in ED, writing this editorial, and feeling guilty every time I cough. I don't have COVID (yes, I tested), I don't even have a 'flu-like illness (no fever, no muscle aches and I did get immunised) but I do have a nasty, persistent bronchial cough. And it won't go away. The temptation to want an easy answer (surely a quick dose of abs will make a difference? – no, it won't) or maybe just taking some time off work? But it is not infectious, just an irritable and annoying symptom. When do we make the decision to stay home, use our precious sick leave? When do we go down the route of 'presenteeism' – turning up sick to work, and spreading our infections, because we are concerned that the ED just can't manage without us, and we are too short staffed to function, and all the other rationale that seem to make sense when you are just not functioning at your best. These are questions we need to keep asking ourselves. We are in the midst of 'flu season, rhinoviruses, RSV, and covid are continuing to circulate. Pertussis cases (whooping cough) are continuing to be reported, although numbers are starting to decrease, with a total of 32 cases present in the first week of July compared to the high of 128 on the 31st January (PHF Science, 4 July 2025).

While respiratory conditions certainly have a major impact on emergency departments, we deal with many other forms of infectious disease and infectious processes, including the risk of measles (a current public health advisory as of 5 June 2025). We need to consider the impact of new and emerging antibiotic resistant infections, the shift to the range of diseases that we might see as a result of climate change (dengue fever is an easy consideration, but what other possibilities are heading our way?) as well as a resurgence of conditions we thought eliminated or well managed with herd immunity as the impact of individual choices, inaccurate information and reduced immunisation levels are seen. Add to this the resurgence of sexually transmitted diseases – is syphilis on the list of differentials for your patient presentations? Syphilis has increased worldwide, and within NZ, a 45% increase in cases between 2022-2023 has been recorded, with 736 cases reported in 2023.

The clear focus for all ED nurses when it comes to infection is likely to remain sepsis, and in particular, the risk of the undifferentiated, unwell patient, and the potential for rapid deterioration. This is the nightmare scenario for all of us – the individual who has presented with generalised, not particularly severe symptoms and who may either end up waiting with a lower triage or be sent home to see their GP if things don't improve. For those of us who have been in the ED system for a long time, we have all seen the patient who is a 'near miss', the one who we just felt wasn't right, and held onto for a bit longer. We have also seen situations that didn't work out as well. A quick search of the Health and Disability Commission cases found 196 cases that matched for sepsis and nurse (HDC, 2023).

Cases you may want to read include:

- 15HDC01504 Patient admission to ED with signs of sepsis;
- 18HDC00793 Recognition and treatment of sepsis;
- 15HDC01053 Care provided to man in hospital;
- 12HDC01172 Triage assessment of a patient with reported exposure to meningitis; delays in treatment.

Whatever the type of infection or the risk we perceive, as part of our clinical toolbox of responses, ED nurses remain critical thinkers, aware of the risk of biases and stereotypes. We need to continue to reflect on the realities of inequitable health outcomes, of sociodemographic factors that result in individuals presenting with a history that precludes a healthy lifestyle, access to preventative strategies, or the capacity to make choices available to others. ED nurses should also continue to reflect on their own practices, to consider whether there are instances of assumption or judgment in their practice and look at the culture of the health system within which they work.

K Me mahi tahi tātou

Mō te oranga o te katoa

(We work together for the well-being of everyone).

Sandy.

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Articles, Case Studies and Practice Reflections

Sepsis – from the other side.

Author: Annalise McKenzie, Clinical Nurse Specialist, Patient at Risk Team, Dunedin Hospital.

Sepsis is something we learn about in the early stages of nursing school and right through our nursing careers. We learn how to identify the early signs of sepsis, and start treatment before it becomes life threatening. As a nurse in my 30s, I never thought I would have to identify it in myself.

I do however have vesicoureteral reflux, a condition that causes urine to flow backwards from the bladder into the kidneys, causing me to get recurrent urinary tract infections. I feel this has led me to become somewhat of an expert on identifying early signs of a UTI in myself and commence timely treatment. I wouldn't call myself the typical 'high-risk patient' that would develop sepsis. I am neither elderly or infant, comorbid, nor immunocompromised. I am health literate and commence antibiotics the moment I have any signs of a UTI.

However, I didn't realise how quickly sepsis can get you.

What Happened?

I woke up late one morning following an afternoon shift in the emergency department. When I woke, I noticed dull R) flank pain, which meant I must have refluxed into my R) kidney in my sleep. I got up to go to the toilet and noticed some dysuria. "Oh great, I get to spend my days off with a UTI" I thought. I went and had my first dose of antibiotics, as I have back-pocket antibiotics at home. After my shower, I started feeling cold and shaky, nauseous and the R) flank pain was getting worse. I said to my husband that I was worried I had developed pyelonephritis and we may have to call the GP. While we were getting ready to head into town to the GP, I suddenly became very nauseous and rushed to the bathroom and started vomiting. As I sat against the bathroom wall, diaphoretic and rigouring, my husband decided he was going to take me into ED instead. This took a lot of convincing, as I did not want to spend my day off at work…. But as he is a paramedic, it was hard to argue against his logic.

As I walked up to the triage desk, my colleague realised who was standing in front of her and ushered me straight through. "I think I have pyelo", I told my colleague. Once I gave her the history and she took my observations, it became clear I was sicker than I thought. I was still rigouring, my temperature was 40 degrees, and my heart rate was 130 bpm. "Triage 2" was called over the loudspeaker while I awkwardly made my way through the department to the bed space. The only thing more awkward than turning up to work as a patient, is having it announced over the loudspeaker that you are sick enough to be a triage 2.

From there I had my medical and nursing colleagues come to my bed space quickly to obtain history, observations and bloods. One of the questions asked was "how long have you sat on this infection for?". The answer of "two hours" was a surprise to my colleagues, given how sick I was. When the doctor returned, he said my blood results showed that I had sepsis. My CRP had risen to the mid-200s, and my white cell count was very high. I was given stat gentamycin and other IVABs and referred to the medics. I was quickly admitted to the medical ward after lunch. By the time the afternoon shift nurse had started and came around to introduce themselves and check my observations, I was beginning to feel more unwell. I couldn't stop rigouring and the R) flank pain was getting worse. My nurse got a shock when my heart rate was up to 150bpm, my temperature was 42 degrees, and my systolic blood pressure was in the 80s. "I think I'm quite sick, you might need to call the doctor…." I said to her. She left very quickly and next thing I know I have a team of doctors, the

Cont. overleaf…

Sepsis - from the other side cont.

patient at risk nurse, and the ICU registrar in my room. After some discussion, the decision was made to transfer me to the HDU. We also realised I hadn't passed urine since I woke. As a nurse, I know how important urine output is, and yet as a patient, I didn't even think about the fact that I hadn't passed urine all day. Unfortunately, that meant I had to get an IDC inserted. The only bonus of this, however, was that I was feeling so lethargic and unwell, I didn't have any energy to get out of bed anyway. As my urine output and blood pressure were so low, I was given more bags of IV fluids.

Unfortunately, I was given too much IV fluids and ended up fluid overloaded. My oxygen saturations began to drop, and I was started on high flow nasal prongs (HFNP). However, I didn't tolerate the HFNPs very well. I would describe them as feeling like someone blowing a hair dryer up your nose. I became one of those patients that could only tolerate the flow at 35L at most. I was unable to lie flat as I felt like I couldn't breathe, and I learned first-hand what third spacing looks like. Unfortunately, I became that oedematous that they were no longer able to get peripheral access, and I had to get a PICC line inserted.

While I have had multiple episodes of pyelonephritis in the past, none of that compared to how sick I felt then. My body felt like it was giving up and I didn't think I would ever get better.

For the first two days, they couldn't get my temperature below 40 degrees. The nausea was horrific, and everything I took in orally, I vomited back up. My right flank pain was so severe, that I was started on a PCA. All I did was sleep. I could barely keep my eyes open, even when my husband would come in with our baby. I remember telling him that I felt like I was going to die.

I spent five days in HDU and another five days on the medical ward. While I do not remember a lot of it, I do however remember the nurses. I had the most amazing team of nurses looking after me, and it reminded me exactly why I became a nurse in the first place.

What this experience has taught me is that sepsis can happen quickly, and anyone can get it. It highlighted to me the importance of early recognition and timely treatment, as I know my outcome could have been a lot worse if it wasn't for that.

Understanding Sepsis.

Author: Annalise McKenzie, Clinical Nurse Specialist, Patient at Risk Team, Dunedin Hospital

Introduction

Sepsis is a life-threatening condition and one of the leading causes of mortality in hospitals (McVeigh, 2020). It is a worldwide health problem, leading to approximately 11 million deaths per year. In New Zealand, the in-hospital mortality rate from sepsis is 19% and the 1-year mortality rate is 38% (Rogan et al., 2022). Sepsis is a syndrome and is described as an inappropriate response to infection by the host's immune system, causing life-threatening organ dysfunction (Wattanapaiboon, 2020). Sepsis is considered an emergency condition and if left untreated, can lead to life-threatening conditions such as septic shock, disseminated intravascular coagulation and multiple organ failure (Rababa et al., 2022). This article presents the pathophysiology of sepsis and the common sites of infection for adults. The clinical features associated with sepsis and septic shock and the predisposing factors for sepsis are also presented. The importance of identification, early intervention, and management of the septic patient in the emergency department is critically analysed, as the emergency department is most often the first point of care for patients presenting with infection, and therefore, where early sepsis can be identified (Tong-Minh et al., 2021). Early identification and timely treatment and management of sepsis is crucial in reducing morbidity and mortality in patients (Saito et al., 2023).

Pathophysiology of Sepsis

An infection is caused by a pathogen breaching the body's physical barriers of the respiratory, gastrointestinal and genitourinary tracts or skin (Lehman, 2022). This triggers a set of pathways that recognise the infection, control the spread, and repair the damage, leading to a localised inflammatory response. However, a virulent pathogen can cause a systemic reaction, which can lead to dysfunction of organs and shock (Lehman, 2022). This virulent pathogen releases toxins, triggering the release of proinflammatory cytokines. These cytokines cascade the activation of the body's complement, coagulation and kinin system and release of neutrophils (McCance et al., 2014). The neutrophils migrate to the site of injury and once the pathogen is identified, phagocytosis occurs. The process of phagocytosis causes superoxide anion production of reactive oxygen species (ROS) (Jacobi, 2022). However, the production of ROS in sepsis may be uncontrolled and cause release of toxic substances, consequently leading to increased vascular permeability and widespread inflammation (Jacobi, 2022). Widespread degranulation and release of proteases is the result of excessive inflammation, leading to endothelial damage (Jacobi, 2022). These toxins or anti-inflammatory cytokines cause endothelial cell dysfunction and lead to capillary leak, impaired vascular tone, tissue hypoxia and microvascular thrombus (McCance et al., 2014). Therefore, consequently leading to multiple organ dysfunction.

Sites of Infection

Clinical features and rates of mortality differ in adult patients depending on site of infection (Toshikazu et al., 2019). Chou et al., (2020) highlighted the importance of early identification of the site of infection, as it dictates the specific treatment and management required for the septic patient. In Toshikazu et al., (2019) study, the most common sites of infection were the lungs at 31%, intra-abdominal 26.3% and urinary tract at 18%. Intra-abdominal infections can be broken down into sites of the peritoneum, the gall bladder, the pancreas, the bowel and the appendix (Toshikazu et al., 2019). Other sites of infection included wound/soft tissue, catheter related sites, central nervous system, and bloodstream. Interestingly, 15% of infections were from an unknown site (Wang et al., 2020). Although extensive diagnostic interventions are carried out, the source of infection isn't always able to be identified in patients presenting with sepsis (Wolfertz et al., 2022). It is important for clinicians to be aware that certain sites of infection have significantly higher mortality rates, and these sites include lower respiratory tract, intra-abdominal and biliary tract infections (Chou et al., 2020).

Clinical Features of Sepsis and Septic Shock

Sepsis is defined as a systemic inflammatory reaction syndrome (SIRS), that is a consequence of infection. The diagnosis of sepsis is based on clinical features, such as patient's symptoms, objective signs and laboratory tests (Edman-Wallér, 2016). Symptoms of sepsis vary between each person, causing a problematic issue for clinicians (Wattanapaiboon et al., 2020). Symptoms can be related to the site of infection, for example dysuria in urinary tract infections and productive cough in respiratory tract infections, or they can be systemic (Edman-Wallér, 2016). Fever and chills, dysuria or productive cough are some symptoms of infection that are easy to identify; in patients that are immunocompromised or elderly, symptoms can be atypical or vague (Wattanapaiboon et al., 2020). Other common symptoms of infection include confusion, dyspnoea, rigors and severe breathlessness. Vague symptoms of infection include fatigue, nausea and vomiting, diarrhoea, and headache (Wattanapaiboon et al., 2020). In Wattanapaiboon et al., (2020) study, 15% of patients that presented with only vague symptoms of infection, were immunocompromised. It can be difficult for clinicians diagnosing patients with sepsis that are immunocompromised, as the key signs of infection are altered in an immunocompromised state (Wattanapaiboon et al., 2020). Concerningly, there was also

Understanding Sepsis cont.

a clear link between patient's presenting with vague symptoms of infection and higher mortality rates (Wattanapaiboon et al., 2020). A possible reason for this could be those patients presenting with typical symptoms of infection, are diagnosed and receive treatment earlier than patients who present with vague and atypical symptoms (Edman-Wallér, 2016).

Laboratory tests are useful in the diagnosis of sepsis. Because the immune response is excessive and dysregulated in sepsis, biomarkers in the blood such as elevated cytokines, peptides and signalling molecules can be detected (Tong-Minh et al., 2021). The specific blood tests used in the diagnosis of sepsis include elevated C-reactive protein (CRP), white blood cell counts, and serum lactate, and bacterial growth in blood cultures (Edman-Wallér, 2016).

Abnormal vital signs are a clinical feature seen in the septic patient. Clinical scoring systems are used for monitoring vital signs and useful in the early identification of sepsis when outside of normal parameters (Tong-Minh et al., 2021). The clinical scoring systems utilised are the Early Warning Score (EWS) and Quick Sequential Organ Failure Assessment (qSOFA). These scoring systems highlight abnormal vital signs, and therefore, the severity of infection (Tong-Minh et al., 2021). Abnormal vital signs in patients with sepsis included elevated temperature, tachycardia, hypotension, tachypnoea and low oxygen saturations (Edman-Wallér, 2016). The shock index of increasing tachycardia and hypotension is seen to increase with the severity of disease (Wolfertz et al., 2022). However, when a patient becomes hypotensive and hypo perfused and/or shows signs of organ dysfunction, this condition was highlighted as severe sepsis. Dyspnoea, altered mental status, gastrointestinal symptoms and muscle weakness were evidenced in patients with severe sepsis (Edman-Wallér, 2016).

Septic shock is defined as sepsis associated with hypotension, that isn't responding to adequate fluid resuscitation (Edman-Wallér, 2016). Patients with septic shock require vasopressors to keep their mean arterial pressure >65mmhg and had a serum lactate of >2mmol/L (Wang et al., 2020). Septic shock is one of the most common reasons for admission to the intensive care unit and is a leading cause of death, with around a 20-45% mortality rate (Reaven et al., 2022).

Risk and predisposing factors for sepsis

There are a number of risk and predisposing factors for developing sepsis, including increased risk of mortality in sepsis. Patients who are elderly are more at risk of developing sepsis and have higher mortality rates (Reaven et al., 2022). This is due to the increased number of comorbidities they have and reduced physiologic reserve, which decreases their ability to recover from sepsis (Reaven et al., 2022). Another reason the elderly are more susceptible to sepsis could be due to the vague symptoms of infection they experience; therefore, they don't believe they need to urgently seek health care. Consequently, leading elderly to develop sepsis and seek health care a number of days after onset of symptoms, when they become more unwell (Olander et al., 2023).

Immunocompromised patients are at a higher risk of developing sepsis. Patients were considered immunocompromised if they had a history of transplantation, malignancy or had an autoimmune disease (Thomas-Rüddel et al., 2023). The immunocompromised patient isn't able to produce a typical innate immune response, and therefore is susceptible to opportunistic pathogens (Kalil & Opal, 2015). The clinical features of infection and sepsis may be vague or absent in a patient who is immunocompromised, due to the bodies reduced ability to produce an immune response (McCreery et al., 2020). As immunocompromised patients do not present with the classic clinical features of infection and sepsis, they have the potential to deteriorate quicker, due to their ineffective immune response and potential delay in diagnosis and treatment (McCreery et al., 2020). Vascular access devices such as central lines are common in immunocompromised patients. However, these devices are also a source of infection due to being a direct portal of entry into the bloodstream, particularly from skin flora, or accommodating as a foreign body for biofilm formation from other sites of infection (McCreery et al., 2020).

Patients with comorbidities have a higher risk of developing sepsis. These comorbidities include diabetes, lung disease and cardiovascular disease (Stenberg et al., 2023). Other comorbidities identified in studies of patients having a higher risk of developing sepsis were kidney disease, cancer, liver disease, and haematological diseases (Wolfertz et al., 2022). Thomas-Rüddel et al., (2023) concluded in their study that comorbidities contributed substantially in mortality rates of patients with sepsis. However, the authors found it difficult to differentiate if the cause of death in a septic patient was related to sepsis alone, the underlying comorbidity, or both. Their study did highlight that it was relatively rare for a patient to die from sepsis, without having relevant comorbidities (Thomas-Rüddel et al., 2023).

Another risk factor for developing sepsis is a patient's low socio-economic status. There are multiple factors attributing to low socio-economic status being a risk, including unhealthy lifestyles, limited access to health care, and low adherence to treatment for comorbidity conditions (Stenberg et al., 2023). Low socio-economic status can contribute to a higher risk of infections through poor living conditions, inadequate nutrition, and access to preventative treatment (Minejima & Wong-Beringer, 2021). Low-socioeconomic status also aligns with poor education, therefore poor health literacy. Poor health literacy may limit a person's ability to recognise symptoms of infection and access timely health care, consequently putting them at higher risk of developing sepsis (Minejima & Wong-Beringer, 2021).

Recognition, early intervention and management of the septic patient in the emergency department

The early identification of sepsis and the commencement of appropriate treatment is crucial in reducing the mortality of patients presenting with sepsis (Saito et al., 2023). The emergency department is most often the first health care setting patients access

Understanding Sepsis cont.

when presenting with symptoms of infection, therefore, where early identification of sepsis can be detected (Tong-Minh et al., 2021). Early stages of sepsis can be difficult to diagnose, consequently leading to a delay in treatment and increasing the risk of mortality. Identifying the patients with sepsis and at high risk of mortality early is important in regards to deciding if they need admission, a higher level of care, and ongoing monitoring, to improve the patient's long-term health outcomes (Tong-Minh et al., 2021). Early decisions of disposition of the patient, for example if they need intensive care unit admission, has resulted in lower in-hospital mortality rates (Sabir et al., 2022). It is important to begin treatment for sepsis as close to presentation to the emergency department as possible, as it leads to better outcomes for the patient. Every hour that treatment is delayed, the mortality rate increases by 4% (McVeigh, 2020). The International Surviving Sepsis Campaign 2021 was initiated globally to reduce morbidity and mortality rates of patients with sepsis, by producing best practice guidelines for the identification, management and treatment of sepsis, thereby improving clinical outcomes of these patients (You et al., 2022). The Surviving Sepsis Campaign 2021 highlights the need to start treatment within one hour of presentation with sepsis, however, interventions need to be put in place in the emergency department to meet this goal (McVeigh, 2020). Interventions to identify the septic patient early included a triage assessment by the nurse at arrival to the emergency department and the use of a sepsis screening tool (McVeigh, 2020). The role of the triage nurse is crucial as they are usually the first person to assess the patient on arrival to the emergency department. The triage nurse can identify the patient with sepsis based on a sepsis screening tool, vital signs and suspected infection, and prioritise the patient at risk, thereby reducing the time to appropriate treatment (McVeigh, 2020). Another intervention is the use of sepsis bundles or pathways that are utilised in the emergency department when a patient presents with sepsis. These sepsis pathways are based on the best practice guidelines of the Surviving Sepsis Campaign 2021 and facilitate early recognition and treatment of the sepsis patient (Sabir et al., 2022). These pathways are standardised and provide a checklist for nurses and doctors about how best to manage and treat the sepsis patient, including taking bloods as soon as possible, starting timely antibiotics and intravenous fluids if necessary (McVeigh, 2020). Timely antibiotic administration to the septic patient is important in early treatment, as delays in administration of antibiotics has been related to poorer health outcomes in patients with sepsis (McVeigh, 2020). Utilising and completing the requirements of the sepsis pathway on septic patients has seen a 25% reduction in mortality rates for patients presenting with sepsis (McVeigh, 2020).

Conclusion

Sepsis contributes to approximately 5.3 million in-hospital patient deaths globally (Litell et al., 2021). In Australia, there are 500,000 patients that present to the emergency department each year with sepsis (Rogan et al., 2020). Sepsis is considered an emergency medical condition due to the risk of leading to septic shock and multiple organ failure, if left untreated (Rababa et al., 2022). There are 18,000 patients admitted to the intensive care unit in Australia and New Zealand due to sepsis. Mortality rates of sepsis remain high, particularly in patients with medical comorbidities, the elderly, and patients who are immunocompromised (Rogan et al., 2020). Early recognition, treatment and management of the patient with sepsis is crucial in reducing mortality rates (Saito et al., 2023). Predominantly, patients will present to the emergency department first with symptoms of sepsis, therefore, the early recognition and management of the patient in the emergency department is an important determinant of patient's outcomes (Rogan et al., 2022). Utilisation of sepsis pathways in the emergency department that support best practice guidelines from the Surviving Sepsis Campaign 2021, lead to a significant reduction of mortality rates in patients presenting with sepsis (McVeigh, 2020). Following the sepsis pathway supports early recognition of the sepsis patient, thereby timely treatment and management, leading to better health outcomes for the patient with sepsis (McVeigh, 2020).

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Regular Features:

Article of Interest, Reports & Policy Releases

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

Articles of Interest: Infection and Infectious Disease in ED

Author/s	Title	Journal	DOI
Sepsis			
Carter, K., Jennings, N., Lowe, G., & Tori, K. (2025).	Nurse Practitioner Management of Sepsis In Rural Hospitals: A Case Review.	*The Journal for Nurse Practitioners, 21*(7), 105419.	https://doi.org/10.1016/j.nurpra.2025.105419
Guarino M, Perna B, Cesaro AE, Maritati M, Spampinato MD, Contini C, De Giorgio R. (2023)	Update on Sepsis and Septic Shock in Adult Patients: Management in the Emergency Department.	*J Clin Med. 12*(9):3188.	doi: 10.3390/jcm12093188.
Huggan, P.J., Walland, K., Lao, C., et al (2024)	Raise the Flag II: sepsis mortality before and after the introduction of a whole-of-system quality improvement programme at a tertiary hospital in New Zealand	*NZMJ* 2024 Feb 23; 137(1590).	ISSN 1175-8716 https://www.nzmj.org.nz/
Rogan, A, Lockett, J, Peckler, B, Robinson, B, & Raymond, N. (2022)	Exploring nursing and medical perceptions of sepsis management in a New Zealand emergency department: A qualitative study	*Emerg Med Australas; 34*(3):417-427. Epub 2021 Dec 9.	doi: 10.1111/1742-6723.13911
Sasse, R., Borland, M. L., George, S., Jani, S., Tan, E., Neutze, J., ... & Paediatric Research in Emergency Departments International Collaborative (PREDICT) Network. (2024).	Appraisal of Australian and New Zealand paediatric sepsis guidelines.	*Emergency Medicine Australasia, 36*(3), 436-442.	https://doi.org/10.1111/1742-6723.14381

Article of Interest, Reports & Policy Releases cont.

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

Respiratory conditions			
Aune, K. T., Davis, M. F., & Smith, G. S. (2021).	Extreme precipitation events and infectious disease risk: a scoping review and framework for infectious respiratory viruses	*International journal of environmental research and public health, 19*(1), 165.	https://doi.org/10.3390/ijerph19010165
Prasad N, Trenholme AA, Huang QS, Duque J, Grant CC, & Newbern EC. (2020)	Respiratory Virus-related Emergency Department Visits and Hospitalizations Among Infants in New Zealand.	*Pediatr Infect Dis J.39*(8):e 176-e182.	doi: 10.1097/INF.0000000000002681.
Measles			
Durrheim, D.N;, Murray, P.;Turner, N. (2024)	Resurgent global measles: A threat to Australia, New Zealand and Pacific Island Countries.	*Journal of Paediatrics & Child Health, 60,* 2/3, 73-75,	DOI 10.1111/jpc.16530
Hernández-Aceituno, A., Falcón García, I.,	Measles outbreak transmission in the ER waiting room: the role of vaccination	*Revista Clínica Española (English Edition) 222*(10) 646-649.	https://doi.org/10.1016/j.rceng.2024.10.002
Marichal, M., et al. (2024)			
Huang, W., Vogt, T., Park, J., Yang, Z., Ritchie, E. A., Xu, R., ... & Guo, Y. (2024).	Risks of infectious disease hospitalisations in the aftermath of tropical cyclones: a multi-country time-series study.	*The Lancet Planetary Health, 8*(9), e629-e639.	
MacMahon, D., Brabyn, C., Dalziel, S. R., McKinlay, C. J., & Tan, E. (2021).	Fever phobia in caregivers presenting to New Zealand emergency departments.	*Emergency Medicine Australasia, 33*(6), 1074-1081.	https://doi.org/10.1111/1742-6723.13804

Policies & Websites

Infection and Infectious Diseases in ED

Policy Documents

Organisation	Title	Web Address
ACEM (2023)	Reducing the Spread of	https://acem.org.au/getmedia/8c142867-8286-4294-b096-b463e771a669/G26-Guidelines-for-Infectious-Disease-and-Biohazard-Exposure-in-the-ED-v03.aspx
MoH (interim update 2024)	Communicable Infectious	https://www.health.govt.nz/system/files/2024-07/interim_nz_pandemic_plan_v2.pdf

Websites, Guidelines and Pathways

Infection / infectious disease

Organisation	Title	Web Address
ACC (2020)	Guiding Principles for Healthcare Associated Infections in New Zealand	https://www.acc.co.nz/assets/provider/guiding-principles-healthcare-associated-infections.pdf
Te Niwha	Te Niwha (Infectious Diseases Research Platform)	https://www.teniwha.com/
WHO	Infection prevention and control	https://www.who.int/teams/integrated-health-services/infection-prevention-control

Respiratory infections

Organisation	Title	Web Address
NICE guideline (2023)	Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management (NG237)	https://www.nice.org.uk/guidance/ng237
Health New Zealand (2019)	Guidelines for Tuberculosis Control in New Zealand, 2019	https://www.tewhatuora.govt.nz/publications/guidelines-for-tuberculosis-control-in-new-zealand-2019

Sepsis

Organisation	Title	Web Address
NICE guidelines (2024)	Suspected sepsis: recognition, diagnosis and early management (NG51)	https://www.nice.org.uk/guidance/ng51
Sepsis Trust NZ (2025)	Sepsis Trust NZ	https://www.sepsis.org.nz/
Sepsis Trust NZ (2025)	Screening tools	https://www.sepsis.org.nz/clinical-tools/
UK Sepsis Trust (2024)	The Sepsis Manual	https://sepsistrust.org/wp-content/uploads/2024/07/Sepsis-Manual-7th-Edition-2024-V1.0.pdf

NP Tips, Tricks and Trips

Author:

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Wounds and Antibiotics in Emergency Department.

Antibiotics or not?

Just a bit of a discussion about this, as you will all know, it sometimes seems like a lottery as to who gets and doesn't get antibiotics. I thought I had this sorted but then someone comes along and.....

I purposely haven't talked about specific antibiotics in detail as you really need to consider local guidelines, type of wounds and circumstances. And I would love to do an update on topical coverage, but another day.

So, I was thinking about a situation that happened recently. A gentleman had bought his young lad in, who had stood on something, had a puncture wound, two days ago, but they were travelling so this was the first opportunity to be seen.

Case: Two-day-old injury, no sign of infection, no swelling or discharge, up to date with immunisations. Had bought in to get checked and x-rayed and get AB's. Nil FB seen, no co-morbidities well healthy child. No fever/chills, no swelling, nil erythema, no discharge, able to weight bear. Wound required no intervention, only a dressing on the sole of the foot.

He was being seen by an inpatient registrar (junior), and they wanted to give Cephalexin, but were concerned the son may have had a reaction to it in the past. Dad was unsure about the reaction, but quite keen to have a trial, not my patient, but I was interested as you can imagine. So I asked why? Then I found out Dad, the new SMO just starting at this hospital, sighhhhh, it was too late, I had asked. I am not sure I would have given antibiotic prophylaxis after two days with no signs of infection. So now you all get to read about considering which wounds should, or might or don't need prophylactic antibiotics.

Remember, there are always absolutes and maybes. You need to treat every wound as a new being 😀 We can consider the wound, the high-risk types of wounds and the high-risk patient.

Wound classification;

Clean minor wound; superficial lacerations, punctures, minimal tissue damage, no risk factors – you can mostly clean/irrigate, debride, and no antibiotics.

Contaminated wounds, farm injuries, human/animal bites, outdoor wounds – always consider antibiotic prophylaxis.

Open fractures; always cover with appropriate antibiotics.

High-risk considerations;

The animal or human bites need to be considered different microbes, and thus, amoxicillin/clavulanate is a good option.

Open fractures; Broad spectrum and quickly, particularly if large skin loss or damage and then consider adding gentamicin and possibly penicillin.

Deep wounds with major tissue damage, orthopedic deep tissue wounds - consider looking at Gustilo criteria, in the references.

Wounds over or near joints, over or near joint replacements.

High Risk Population

Immunocompromised patients, consider medications, co-morbidities.

Diabetics, Peripheral vascular compromise,

Older age, frailty

Wounds more susceptible and why;

Abrasions often have a large surface area, e.g. road rash, that can leave debris.

Bites, including punch/fight wounds from teeth, need consideration of polymicrobial contamination.

Deep, **crush wounds** or with foreign body. Crush injuries can cause tissue devitalization and poor perfusion, also risk of compartment syndrome.

Puncture wounds can cause deep inoculation of microbes into the tissue, also have anaerobic conditions, so you need to consider this with your antibiotic choice.

Degloving or avulsion injuries often have difficulty closing, impaired blood supply, extensive tissue damage.

Traumatic **burns** cause loss of skin barrier, risk of necrosis and colonisation

Location on body

Feet and digits; decreased circulation, often contaminated with soil, particular concern in diabetics.

Hands have high exposure, also at risk of tendon and joint infection; careful consideration of treatment and return advice.

So, what common ED presentation wounds need AB's or would you consider AB's or not? There are absolutes, there are recommendations and then there are those maybe's.

MOIST areas (I know you love that word): axilla, perineal, groin, genitals, great place to allow natural flora to colonise.

The face and scalp are less prone to infections despite bleeding heavily. Unless contaminated at the time.

NP Tips, Tricks and Trips cont.

Lower limbs (unless elderly) are not high risk unless, of course, contaminated at the time.

New Zealand

We're outdoor types, so we are at greater risk of certain injuries and infections. We have a greater number of rural populations, so risk of soil or animal contaminants. We live on an Island, so we also have risks of waterborne infections. We like a bit of space and a pet, so we have a high percentage of dog ownership and agriculture. We also have a large percentage of elderly in our population, one in four ED presentations are over the age of 75y, this group is at risk of skin tears, lower limb injuries and reduced perfusion.

Māori and Pacific people have a greater number of presentations with skin infection, including a greater number of admissions. They are disproportionality represented in those with group A streptococcal disease. This makes us question the impact of socio-economic disparities, and their role as being risk factors for infections and repeated infections, and the system's inequities depriving our indigenous peoples of access to health care. Māori and Pacific children appear to have a higher prevalence of eczema, diabetes, which can be a factor in these presentations

Considerations that increase susceptibility to infection

Delayed presentation or treatment greater than 6-12 hours. Poor irrigation, cleaning or retained debris or foreign body in wound. The host itself, immunocompromised, diabetic, steroid use, reduced circulation, etc. Presence of necrotic tissue or ischemia at edges, hematoma in the wound size of wound.

Take-home messages;

- Thorough cleaning, irrigation is integral to avoiding infections.
- If obvious contaminants will need antibiotic cover, even after a thorough clean and debridement.
- Use your local guidelines, get familiar with them.
- Speak up if you are concerned; remember nurses rock.
- Don't forget your tetanus prophylaxis.
- Of note, I still don't think that I would have given that lad POAB's 😀

References;

Antibiotic guide EOLAS, HTTPS://www.eolasmedical.com/

Bpac, (2012). Managing skin infections in Maori and Pacific families. https://bpac.org.nz/BPJ/2012/August/skin.aspx

Clinical Pharmacology Prescribing Guidelines, Te Whatu Ora. https://cp-pg.carepathways.tewhatuora.govt.nz/cdhb-antimicrobial-guidelines/bone-and-joint

Gustilo criteria for wound antibiotic management. https://www.orthobullets.com/trauma/1003/gustilo-classification

Wound integrity, treatment of Bone, Skin, & Wound infections.

https://www.woundintegrity.com/wound-care-info-center/treatment-of-bone-skin-wound-infections-including-antibiotic-therapy/#!

Cultural Safety and Te Ao Māori

Cultural Safety and Te Ao Māori Snippets

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

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

Reviewing Māori Models of Health: Ngaruroro model for understanding Māori wellbeing.

Sandra Richardson, RN, PhD
Christchurch Emergency Department, Waitaha

Rārangi Kupu (vocabulary list)

- here tāngata – social and family ties
- te taiao - the environment
- taonga tuku iho - cultural treasures
- tinana – physical body
- wairua - spirit
- ngākau - inner-system
- matea - core needs
- mana - authority

Introduction

This model was published in 2024 and the authors describe it as representing a new model for Māori wellbeing. They go on to outline the process through which this model emerged, through Kaupapa Māori methodology, grounding the model in the lived experiences of Māori people. This involved a thoughtful, critical review of existing Māori models and frameworks of health that have developed over the past 40 years. This was followed with an analysis of how lived experiences of wellbeing could be identified and incorporated within a wellness approach. A series of interviews, the use of reflexive thematic analysis, and a culturally responsive approach was used to achieve this.

As a result of the processes described, a Māori wellbeing model was formulated, with the resulting outline consisting of eight themes (*refer to table 1*). The concept of Māori wellbeing is presented as "dynamic, interconnected and holistic" (Johnson et al 2024, p.1).

The eight themes are supported by a further series of items within each of the themes, which identify significant aspects. The first theme is *Here Tāngata,* described as connections. These are the social and family relationships that link people together. The additional items associated with this are indicative of the different levels of possible interaction, including references to *whānau* (family), *iwi* (tribal) links, and *tipuna* (ancestors) amongst others. Connections to others are seen as essential to wellbeing and included the relationships with *hoa* (friends) as well as family, and those links that are made to community (*hapori*) groups and organisations. The second theme is *Tinana* and refers to physical health and making healthy choices about wellbeing. The items in relation to this theme relate to factors that influence physical wellbeing, and include aspects such as *kai* (food), *kori tinana* (physical activity, *moe* (sleep) and being physically present with others (*kanohi kitea*). Risk mitigation factors and the role of culturally connected activities are also considered. The third theme is *Ngākau* which relates to emotional and psychological wellbeing, includes items such as *kare-ā-roto* (emotions), *waiaro* (attitudes) and trauma. The fourth theme is *Wairua*, and relates to spirituality, the fifth theme *Taiao* relates to the natural environment and wellbeing derived from interaction with aspects of this. *Matea* is the sixth theme, and incorporates the concept of core needs, of social and economic aspects and the impact of these on wellbeing. *Mana*, the seventh theme, identifies how authority and the ability to express this is important to establishing and maintaining wellbeing, and includes items such as *whakatere* (the ability to be able to navigate change). The final theme is *Taonga Tuku Iho* the connection to generational cultural treasures, and the relation this holds with wellbeing.

Cultural Safety and Te Ao Māori cont.

Overall, the Ngaruroro model builds on previous Māori models and frameworks, with key aspects reflecting concepts of interconnectedness, the importance of a holistic approach, recognition of the dynamic nature of wellbeing, and the immersion within a cultural context. Unique to this model, however, are the inclusion of *mana, matea* and *taonga tuku iho*. The authors describe the inclusion of these concepts as introducing additional wellbeing resources. They identify the significance of mana in that "it describes relational capacities that are key to understanding one's sense of agency and efficacy" (Johnson et al 2024, p.18), with the sub-theme (item) of *tu tanagata* emphasising the importance of being able to stand in the fullness of who one is – recognising the significance of intersectionality and the often complex interplay of cultural identities (such as gender, religion, sexuality and others in addition to ethnicity). *Matea* is the recognition of the material reality facing many individuals – the impact of economic and social factors that affect the choices and ability to reach goals for wellbeing. *Taonga tuku iho* recognises that cultural treasures have the potential to be significant resources and mediators for wellbeing, citing the value of "connection to ancestral language, knowledge, practices, and ways of being" (Johnson et al 2024, p.18).

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Johnson, F. N., Wehi, P., Neha, T., Ross, M., Thompson, V., Tibble, S., Tassell-Matamua, N., Shedlock, K., Fox, R., Penman, Z., Ritchie, T., Winter, T., Arahanga-Doyle, H., & Jose, P. E. (2024). Introducing 'Ngaruroro', a New Model for Understanding Māori Wellbeing. International Journal of Environmental Research and Public Health, 21(4), 445. https://doi.org/10.3390/ijerph21040445

Themes	Description	Items	
Here Tāngata	Connection to social and familial ties	*Whānau*	Family
		Hapü	Sub-tribe
		Iwi	Tribe
		Tipuna	Ancestors
		Hoa	Friends
		Hapori	Community
Tinana	Lifestyle choices related to the tinana and physical health	*Kai*	Diet
		Kori tinana	Physical activity
		Moe	Sleep
		Kanohi kitea	Having your face physically seen
		Kai Whakapiri	Substances that people use to feel a sense of connection or self-medicate
Ngākau	Capacities related to the 'inner-world'	*Kare-ā-roto*	Emotions
		Whakaaro	Thoughts
		Waiaro	Attitudes
		Aroha	Love
		Pāmamae	Trauma, grief, deep pain
Wairua	Lifestyle choices related to spirit	*Atua*	Māori deities, ancestors of continued influence, god(s)
		Wana	Exhilarating and breath-taking experiences
		Wāhi wairua	Spaces that nurture your sense of wairua
		Mahi aroha	Activities or work you do for passion, love, or service
		Poipoi i te mauri	Nurturing the lifeforce of the beings, spaces, and things around you
Taiao	Connection to the environment	*Ngahere*	Bush and forests
		Whenua	Land features
		Wai tai	Bodies of salt water
		Wai māori	Bodies of fresh water
		Ngā rangi	Celestial bodies

Cultural Safety and Te Ao Māori cont.

Themes	Description	Items	
Matea	Capacities to meet core needs	*Whai mātauranga*	Acquiring knowledge
		Tuku mātauranga	Passing on knowledge
		Kainga	Housing
		Putea	Money
		Wā whakatā	Relaxation
Matea	Capacities related to exercising mana	*Tü tangata :*	Stand in the fullness of who you are
		Whiriwhiri:	Power to decide how your life unfolds
		Manaaki:	Uplifting, caring for, and being hospitable to others
		Whakatere:	Navigate challenges in life
		Tü toa:	Stand confident, accomplished, or capable in a skill or area
Mana	Connection to cultural treasures	*Te Reo Māori*	Māori language
		Tikanga Māori	Māori customary protocols and practice
		Mātauranga Māori	Traditional and contemporary Māori knowledge
		Uaratanga Māori	Māori values
		Turangawaewae	Traditional and contemporary places of belonging

Pae Ora Report March 2025

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

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

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

A perspective of infectious disease and infection – the impact for Māori.

The impact of infectious disease for Māori can be seen in our history as a nation pre and post colonisation and are still evident today. Pre colonisation period the population of Māori in 1769 was approximately around 100,000 (Chapple, 2018). During the immigration of European settlers to Aotearoa the Māori population plummeted to approximately 40,000 largely due to exposure to diseases such as tuberculosis, measles, typhoid, influenza and smallpox. The arrival of Captain James Cook and his crew on the Endeavour, are also associated with the introduction of venereal disease, syphilis and gonorrhoea were also to have an impact on Māori wahine as these outbreaks triggered a fertility decline, compounding a rapid decline in Māori population due to disease, death from war and land conflicts, all contributing to comments made by Pakeha such as "Māori are a dying race" in that period. The period from 1840 to 1890's is referred to as 'Dislocation and Disease" (Lange, 1999). A large portion of Māori were physically dislocated from their tribal lands due to land confiscation and land wars, which led to an inability to access kai and resources on their tribal and whanau lands. Simultaneously, Māori were exposed to diseases they had no immunity to. During this period, a large number of tamariki did not survive their first year of life. The impact of colonisation was devastating to Māori and continues to have ongoing negative effects today.

In response to infectious disease outbreaks, such as smallpox, teachers from the Native Schools would distribute medications, missionaries would establish small camps to contain and treat patients with the outbreaks. Colonial government support and funding for these camps was poor. The 1913 Smallpox epidemic in Waikato reflects the neglect and mistreatment of Māori during this period for a disease they were not responsible for and received cruel mistreatment fueled by racism and poor knowledge of containment of the diseases, common in this period (nzhistory.govt.nz/smallpox-epidemic). The devastation caused by these infectious diseases was often described as a "spear from heaven" or "tokotoko rangi" in Māori oral traditions reflecting the devastating impacts of these epidemics on whanau and Iwi.

Infectious diseases in this early period had devastating effects on Māori, due to a lack of immunity to these diseases reflected in high mortality rates. The evidence is clear when you visit urupa (cemeteries) to see whanau burial plots that identify death due to influenza and smallpox. The land and whenua dislocation still has ongoing impact today evident in high rates of mental illness, although not the only cause, dislocation and poverty are contributors to health disparities.

High incidence of infectious diseases affecting Māori currently include:

Tuberculosis: Māori continue to have higher rates when compared to non-Māori.

Meningococcal disease: Māori and Pacifica whanau have higher rates when compared to other population groups in Aotearoa.

Covid: Māori were affected at higher rates than non-Māori, as identified by Dr Rawiri Taonui (2021) who also highlighted that the rollout of the vaccinations and funding to Hauora services to administer the vaccinations was also markedly under-funded. This led to Iwi services stepping up vaccination drives to deliver covid vaccines to whole whanau and communities rather than the delayed group specific approach by the government.

Other infections: Māori also experience high rates of other infectious diseases such as influenza, RSV and sexually transmitted diseases. Māori also experience higher rates of chronic diseases such as cardiac, diabetes, cancer and kidney disease, therefore when infected with an infectious disease as above, the morbidity and mortality rate is much higher.

(Ministry of Health, 2019)

Ongoing Health Disparities are still evident today and continue to have a heavy impact on Māori and whanau:

Social determinants of health: such as poverty, poor housing conditions have a significant role in health outcomes. Education and poor health literacy is also a challenge.

Access to healthcare: Poor access to primary services in this current social and political environment, especially in rural areas where

Pae Ora Report March 2025 cont.

Māori whanau live in larger populations are some of the barriers for whanau. Local hauora providers continue to bridge the gaps present in primary care such as immunisations, whanau ora, wellness checks and screening. Emergency departments continue to be a default service for whanau who cannot access primary care services.

Cultural awareness: Inclusion of cultural beliefs and practices related to Hauora is crucial for improving Māori health outcomes. Enabling cultural support to allow these practices to be included is essential. This is crucial in view of the history of multiple epidemics and pandemics that Māori have endured and exacerbated by poor, delayed responses from the government services, past and present. Building trust between hauora services and whanau is key moving forward.

To address these issues and reduce the incident of infectious diseases for Māori includes support at several layers. Addressing the social determinants and providing social and financial support. Whanau and hapu based solutions, engaging with communities to work from 'grass roots' rather than working from a government design of 'one size fits all' as this has not worked in the past, for a problem that continues to affect Māori currently and in the future. These collaborations are vital for addressing the ongoing impact of infectious diseases.

The COVID pandemic is at the forefront of most kiwis' experience of infectious diseases and the devastation that follows an outbreak. However for a lot of Māori whanau and Iwi, epidemics feature too often in our history. What is needed is learnings and tangible actions taken from the COVID experience, nationally and internationally to help prepare our whole nation's response to infectious diseases and the health, and human impacts they have on all people living in Aotearoa New Zealand.

Mauri ora Natasha Hemopo.

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College Activites:

CENNZ Reports

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

Committee Roles

CENNZ Mission Statement

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

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

Committee Regional Representatives

Committee Regional Representatives

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

Chairperson's Report

Lauren Miller
CENNZ Chairperson
Contact:
cennzchair@gmail.com

The first quarter of 2025 has been both productive and challenging for the CENNZ.

As the voice of emergency nurses across Aotearoa, we have actively contributed to several significant national discussions, advocating for safe, sustainable, and patient-centred emergency care. These past few months have been marked by ongoing policy reform, a heightened media focus on emergency department safety, and complex changes to interagency practice, all of which have required thoughtful, responsive engagement from the College.

A key focus for the College has been progressing the review and republication of the Knowledge and Skills Framework (KSF) for emergency nurses. The KSF is a foundational document that outlines the expectations, competencies, and developmental pathways for our workforce. First published in 2016, the current review process has involved careful consideration of our evolving clinical environment, Te Tiriti o Waitangi obligations, and alignment with the recently updated national nursing competencies. This updated framework aims to provide clear, practical guidance for emergency nurses at all stages of their careers, while also embedding principles of equity, cultural safety, and professional excellence. We are pleased to report that the editing phase is well underway, with a targeted publication date later in 2025.

CENNZ has also made a formal submission on the Ministry of Health's consultation document, Putting Patients First: Modernising Health Workforce Regulation. This document, released by the Minister of Health, proposes significant changes to how health professions are regulated in Aotearoa. CENNZ felt it was essential to respond with urgency and clarity. Our submission strongly opposed any moves that would erode the independence of regulatory bodies, including the Nursing Council of New Zealand. We stressed that regulators must be free from political influence to ensure their primary role—protecting public safety—is upheld. Regulatory bodies must retain governance over registration, scopes of practice, and disciplinary processes. To compromise this independence risks undermining public trust and the professional integrity of nursing regulation. We continue to monitor this process closely and are working with other stakeholders to ensure emergency nursing voices are included in any future dialogue.

In response to a recent study by the Australasian College for Emergency Medicine (ACEM) on violence and aggression in Emergency Departments, CENNZ provided public comment through Radio New Zealand. The findings of the report—highlighting the frequency and severity of violent incidents in EDs across the motu—resonated strongly with our members. CENNZ unequivocally supported the study's

Chairperson's Report Cont.

recommendations, particularly the need for 24/7 embedded security personnel in all emergency departments. We stressed that these security staff must not only be physically present, but also specifically trained to understand the ED context, including trauma-informed care and de-escalation strategies. Security personnel should be integrated as valued members of the multidisciplinary team, contributing to a safer and more supportive environment for both staff and patients.

Another key area of engagement this quarter has been the ongoing work around the national review of police involvement in mental health responses. With Phase Two of this process now underway and increasing pressure on emergency departments to accommodate changes in how mental health crises are managed, CENNZ members have been participating in union-led meetings to assess the potential impact. We have significant concerns about the pace and scope of these changes, particularly given the lack of dedicated resourcing, workforce planning, and policy guidance provided to ED teams. Emergency nurses are being expected to fill critical gaps without the necessary support or frameworks to do so safely. In response, CENNZ is preparing a dedicated webinar to support our members through these changes, offering guidance, professional support, and a platform for shared concerns and collective solutions.

Overall, the first quarter of 2025 has underscored the importance of a strong, unified emergency nursing voice in national policy and practice conversations. After penning a letter in February to the Minister of Health, we have been invited to meet with him in late July. This is the third year in a row that we have met with the respective Ministers of Health- giving CENNZ the opportunity to advocate for safe environments—for patients and staff alike—and to ensuring that emergency nurses are supported, recognised, and empowered in the critical work they do every day, at the highest level.

At our last face-to-face meeting, we took the time to farewell Lydia. Over her time on the committee, Lydia has shown great motivation and commitment, whilst managing a number of personal and professional challenges. We truly appreciate all the time and energy you showed and wish you the best for your ongoing adventures.

Ngā mihi

Lauren Miller

CENNZ Chair.

Te Tai Tokerau | Northland Region

Regional Representative

Amanda Harrison

Clinical Nurse Educator

Whangārei Hospital Emergency Department

Te Whatu Ora Te Tai Tokerau

Whangārei Hospital Emergency Department

As Whangārei Emergency Department (ED) transitions into the winter months, the usual seasonal pressures are being felt. Like most departments Whangārei continues to experience high volumes, increased acuity, and elevated staff sick leave. These challenges are further compounded by a significant number of staff heading off on maternity leave.

Despite ongoing constraints in budget and staffing, the department has made good progress since the last regional update.

To manage the winter surge, a "Front of House" team, consisting of a Registered Nurse (RN) and a Senior Medical Officer (SMO), now operates Mondays and Tuesdays from 1100 to 1930 hours. Their focus includes early identification and escalation of deteriorating patients, front-loading investigations (e.g., imaging and blood work), reducing unnecessary testing, implementing a see-treat-discharge model directly from the waiting room and identification of patients deemed safe to wait.

In tech and operations, the department has recently phased out the hospital-wide tannoy system previously used for emergency codes and MET (Medical Emergency Team) calls, replacing it with MedTasker, a mobile communication and task management platform. The transition from aging LifePak defibrillators to ZOLL defibrillators is also underway. Building on these advancements, TrendCare has been successfully embedded within the department. Thanks to the hard work of the team, data may be ready for analysis within just six months of its implementation.

The department is continuing to put energy into staff education and development, facilitating essential courses such as the CENNZ Triage and TNCC (Trauma Nurse Core Course). In May, Networkz delivered a successful four-hour training session, made possible by funding from Waka Kotahi. Additionally, the Northern Regional Trauma Network sponsored a Paediatric Trauma Life Support course facilitated by instructors from the Australian College of Emergency Nursing. Staff have also attended specialised courses, including Emergency Management of Severe Burns and participated as nurse observers in Emergency Management of Severe Trauma.

Despite the pressures of the season, Whangārei ED continues to adapt and innovate in its delivery of emergency care.

Amanda Harrison

Clinical Nurse Educator.

Dargaville Hospital

Our presentations have stayed similar, however the acuity of our patients on presentation has increased again with patients not always being able to see their GP due to a lack of appointments.

We have had no physical overnight doctors since February and have been utilising Emergency Consult to assist with acute presentations from 5pm to 8am. An escalation pathway is in place with the assistance of St John and DSN for critical presentations. Stat 1 and 2 ambulances are being bypassed over this time, or staged only.

We have seen an increase in the number of transfers out due to the need to reduce the acuity of our patients being kept in the ward with no overnight doctor. Emergency Consult is also supporting us with our ward-based patients after hours.

We are seeing some movement in the recruitment of medical staff who will be able to potentially provide some night cover moving forward.

We continue to provide ongoing education to our nursing staff on physical nursing assessment and emergency skills training.

Karen Katipa

Clinical Nurse Manager.

Tāmaki Makaurau | Greater Auckland Region

Regional Representative

Rachel Wilson

Associate Clinical Charge Nurse

Waitakere Hospital Emergency Department

Te Whatu Ora Waitematā

Regional Representative

Wendy Sundgren

Associate Clinical Nurse Manager

Te Tari Rongoaa Ohorere | Middlemore Hospital Emergency Department

Te Whatu Ora Counties Manukau

Professional Teaching Fellow

School of Nursing

Waipapa Taumata Rau | The University of Auckland

Te Whatu Ora Waitematā - North Shore / Waitākere Hospital Emergency Departments.

Kia ora from Waitematā,

As winter begins, our department has been making the most of the colder season by hosting soup and bread days. I believe I speak for everyone when I say that nurses truly enjoy sharing food, and this winter warmer initiative has been warmly embraced by all staff.

In addition to this, a 'Social Squad' has been formed and is actively organising a variety of fun events throughout the year, including during shift times.

Other recent highlights include celebrating a staff member becoming a Nurse Practitioner, welcoming new graduates who have completed their orientation across both departments, and the arrival of department babies. We've also had a number of successful study days for RNs, covering topics such as ACLS, APLS, resuscitation, plastering, consultations, triage training, and more. We continue to recognise outstanding staff with our Employee of the Month programme.

Senior nurses, Charge Nurses, and CNS/NPs from both North Shore Hospital and Waitakere Hospital Emergency Departments recently came together for a study day. They day was very well received and served as a valuable opportunity to connect and collaborate.

Additionally, we continue to run themed monthly teaching sessions following handover, offering brief but meaningful learning opportunities for all staff, and fostering a culture of both teaching and continuous learning.

We have remained diligent with TrendCare and look forward to reviewing the final results.

With the ongoing development of the High Dependency Unit (HDU) at Waitakere Hospital, our department has faced some challenges in adjusting room layouts to accommodate the construction. While this has been somewhat disruptive, both staff and patients have managed well, and we eagerly anticipate the unit's opening next year.

Despite the challenges, we continue to receive positive patient feedback highlighting the professionalism and compassion of our team—an encouraging reminder of the dedication and excellence of our staff.

We wish all Emergency Departments across the motu a safe and well-staffed winter.

Ngā mihi nui,

Waitemata ED.

Lydia Moore,

Nurse Practitioner.

Auckland Region cont.

Starship Emergency Department.

Starship ED is having a busy winter as I am sure everyone else around the country is too. Our biggest growth is the lower acuity tamariki who are presenting to CED instead of primary health care. We know there are lots of barriers for primary healthcare access. We have secured a winter project to have a GP work in CED 1700-2200 to support trying to see some of this volume. Delayed recruitment has impacted CED both on nursing and clerical along with RMO vacancy- this has made the higher presentation rates more challenging. But we have had really good whānau feedback, even with the wait times. My favourite is below recognising a long wait but staff working with purpose out in the WR.

- "We had a decent wait but I observed every member of staff working with purpose, nurses checking in with all children and families, offering ice blocks or lolly pops for those with sore throats."

CED had a really successful wellbeing week at the end of May- with breakfast, nacho Friday night, massages and lots of cool prizes.

Anna-Marie Grace

Nurse Unit Manager.

Te Tari Rongoaa Ohorere | Middlemore Hospital Emergency Department.

Middlemore ED continues to experience higher patient volumes with an average of 11,179 patients per month over the Months from March to May 2025 which is a 6.1% increase on the equivalent period last year. Interestingly, we continue to have good flow through our medical division and access block in the surgical division continues to be an issue for the department.

April brought about Phase Two of the Police Mental Health Response changes, in which our department introduced a "Code Silver" call that is to be made from triage. The aim of Code Silver is to bring together ED, mental health and security staff so that the patient can either be redirected from ED to a more appropriate location, or a safety plan can be made in a timely fashion.

Violence and aggression continue to be an issue facing our staff. We have recently had a win with the recognition of our QR code method of reporting verbal aggression now being included in the national database along with the incidents logged on Safety First.

On a positive note, we have completed our first round of IRR testing for TrendCare as we seek to work towards embedding this into our practice.

Chris Chu,

Nurse Unit Manager.

Waikato | Bay of Plenty Region

Regional Representative

Linda (Lyn) Logan

Associate Clinical Nurse Manager (ACNM)

Rotorua Emergency Department

Te Whatu Ora Lakes

Rotorua Emergency Department.

With winter here, our emergency department is experiencing a surge in high-acuity patients daily. Many have waited weeks for GP appointments or found urgent same-day slots to be unavailable.

We are still awaiting on our first FTE calculation endorsement, so we are still working in a chronically understaffed department with little hope of getting FTE on the floor until after the winter season. The team is working hard and has introduced fun activities like scrub Fridays and crazy sock days to boost morale.

The CNS team has been diligently working in the department and studying throughout this year. There are plans to expand the team later this year, and into next year, with Nurse Practitioners added to the team.

Violence and aggression are ongoing issues at our hospital, and we seek additional security funding from Health NZ. We currently have only two security personnel on duty at any time, which is insufficient. With the new mental health building opening later this year and being farther from the main hospital, increasing security levels is essential.

The team will participate in ACEM wellness week with various activities listed on the wellness board, including mountain biking (MTB), walks, and pamper sessions. Additionally, soup Wednesdays are scheduled, with Senior Medical Officers (SMOs) preparing soup for the team.

Lyn Logan,

Associate Clinical Nurse Manager.

Te Āhuru o Rehua-ariki | Whakatāne Emergency Department.

Tena koutou katoa,

The annual winter surges have definitely rolled into Eastern BOP with high numbers of presentations in the ED and also in our urgent GP clinic 'Te Awe Tieke'. This has been compounded by nil to little inpatient bed availability. "This week has been one of our worst overload weeks we have ever had" (Colleen, CNM). Ongoing slow recruitment in nursing and medical services has an ongoing impact now. Staff over all specialties are stretched, with all staff picking up extras and extending shifts to backfill gaps. This is to be commended and reflects the whanaungatanga of our ED and the wider hospital. With high attention on the 6 hr target by the MOH, facilitating acute flow on the ED floor and through the wards is near impossible.

Like other departments our leadership team has created wellness activities to tautoko our staff. These include beach walks, sauna sessions, meditation and fishing charter trips where I am sure there will be some tall fishing stories shared.

Ongoing staff development has enabled some of our staff to attend triage courses and over the next 3-4 months another eight nurses will attend the TNCC. We welcome our new graduate nurses and students as we continue to grow our own and manaaki our future workforce.

Nā, Natasha Hemopo.

Clinical Nurse Coordinator.

Waikato | Bay of Plenty Region cont.

Tauranga Emergency Department.

Winter illness is already prevalent here in the Bay and we are seeing a significant increase in our paediatric presentations. Our days of experiencing over 200 people through the doors are becoming more frequent. Team morale is good and simple events such as 'Fun scrub Friday' or participating in National Health Awareness days boosts this. Even on the busiest of days it is nice to hear laughter on the floor.

Some really good work is being progressed with Mental Health services and the police in relation to the national changes, the collaborative meetings to date have been extremely positive.

We (the department) were delighted to be presented with the Al Spillman award at the recent ACEM conference in Gisborne. This was in recognition for the work that was primarily initiated by Jo Cole (ED SMO) in the Manaaki Mana space. It was a pleasure being present at the conference to see Jo, alongside Moana Nepia (HCA) and Jean Hiini (RN), accept the award.

I would like to thank the organisers of our online hui last week, as always it was extremely useful to get together and discuss what is happening in our departments.

John Wylie.

Clinical Nurse Manager.

Tairāwhiti/Hawke's Bay - Te Matau-a-Māui Region

Regional Representative

Position Vacant

Taranaki/Manawatū/Whanganui Region

Regional Representative

Lauren Miller

Clinical Nurse Educator

Taranaki Emergency Department

Te Whatu Ora Taranaki

Taranaki Base Hospital Emergency Department.

We have a new ACNM in ED after nearly a year without one!

It's feeling like winter already with high numbers of presentations over the last couple of weeks, with high acuity and a full hospital.

We've been trialling a new fast-track model utilising a portacom outside our ambulance bay. There is a dedicated nurse in this area focusing on pulling through lower acuity patients to be seen by our Clinical Nurse Specialists, Nurse Practitioners and Registrars. We've seen an improvement in our short stay target, a decrease in patients who leave without being seen; this has helped with the capacity in our ED.

We've recently been FTE calc'd, and are hoping that this is approved and we receive an increase in budgeted Registered Nurse FTE for ED. We will need this before we move into our new ED next year!

Therese Manning,

Clinical Nurse Manager.

Te Upoko o te Ika a Maui | Greater Wellington Region

Regional Representative

Craig Jenkin

Mātanga Tapuhi | Nurse Practitioner

Te Pae Tiaki | Emergency Department, Wellington Regional Hospital

Te Whatu Ora Capital, Coast and Hutt Valley

Te Pae Tiaki | Wellington Emergency Department.

One of the biggest developments that has hit the headlines on national news is the approved funding to facilitate a refurbished ED. Te Pae Tiaki was opened in 2001 as a temporary building while the, at the time, new regional hospital was being developed. The refurbished ED will be located in the area originally designated for ED within the regional hospital, completing the design set out in the late 1990s. Due to open by 2029, this development will increase Wellington capacity to manage an ever-increasing workload.

With a bigger space new models of care will be needed. There has already been an increase in SMO FTE. CNS numbers have also increased FTE and employment into these roles. New Staff will be starting over the June-July period. We wish them best of luck with their new career direction and the likely steep learning curve. NP FTE has also increased. We realize that trying to employ NP's can be difficult, however we hope to be able to grow our own using FTE to support NP internships and NP development within the department. Lastly new ACNM FTE has also been recruited to.

Overcrowding remains one of the biggest issues. Patients unable to flow through to acute inpatient beds thus blocking ED work. This in hand causes long lengths of stay and directly affects our SSiED targets. Our treat and discharge stream, which will be the mainstay of the CNS, and to a degree, the NP workforce role, is doing well. This stream alone has been achieving a daily average of 80%.

Lastly, we are instigating a new Safety Improvement Training which involves both ED and security staff. This training focusses on safe restraint processes.

Craig Jenkin,

Mātanga Tapuhi - Nurse Practitioner.

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

Wairarapa Emergency Department.

At Wairarapa Emergency Department staffing remains fairly constant. We managed to secure a third NETP, which is fantastic news for us.

Last year we signed up to take part in the NZED workplace wellbeing research. The post intervention questionnaire has now finished. While the data is still being analysed, we are hopeful that our interventions have resulted in less staff burnout.

Our trauma CNS managed to secure an extra Networkz sim. On the 28th May we ran one adult and one paediatric sim. Networkz seemed impressed with our trauma bay set up and our trauma bundles. This also gave us a great opportunity to test our new initiatives recently implemented.

Corrina Rooderkirk,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Hutt Valley Emergency Department.

Hutt Valley ED has finally had approval to recruit to vacant nursing FTE. With over 100 applicants from places as far reaching as the UK and the US, all with ED experience, we will be able to replace skill mix. These roles have been vacant for some time, but the biggest gap is in my Admin Team Front of Whare, with over 25% vacancy. Across the department, we are 15 FTE short of RNs, NPs, HCAs and administrative staff.

With the increase in predicted FTE required (approximately 32 FTE) the biggest difficulty will be where all the new staff will fit. We literally have no space for staff probably the same as Wellington.

On the whole though we have a great team, who are working their hardest, enjoying ED and making it a great environment. My ACNM's are rocking flow and supporting the staff daily, despite being under the spotlight, for SSiED targets.

There are lots of new initiatives following the national flow Project... but no projected funding.

Charley Gibson,

Clinical Nurse Manager.

Te Tauihu | Top of the South Region

Regional Representative

Vicki Bijl

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager

Nelson Emergency Department

Te Whatu Or Te Tau Ihu,
Te Waipounamu

Nelson Emergency Department and Medical Admission Planning Unit.

The Nelson ED refurbishment is in full swing, which has been challenging while remaining operational. It has meant that for 7 months, we have temporarily lost three acute beds. We are eagerly awaiting the new wing to be open in November. This wing includes eight new rooms, isolation rooms, another triage room, increased staff write-up areas, and a larger utility and mediation room.

While we navigate working in our ever-changing department, we also continue to face, as in many other EDs, an increase in presentations, challenges in hospital flow, and an increase in patients who have left without being seen. While we haven't seen a change in the short-stay target, there has been a shift, and the hospital is actively working to get patients out of the ED rather than being pushed by the ED team.

We were fortunate to have NetworkZ do some training with our team in April. It was well timed to include the updated massive blood transfusion protocol to align with the national standard.

Our workforce has been reasonably stable over the past 12 months. We implemented geographically/team nursing in October 2024, which has been successful, especially for newer team members. An uplift from our TrendCare calculations will further support our team nursing.

For June, our ED is celebrating staff wellness to align with the ACEM wellness week. Over the month, we have promoted the well-being index tool and looked to review 1% change ideas that are in our influence of change to improve our workplace or processes. We have also planned activities outside of work to get everyone a chance to connect and promote team building. Activities included basketball, a hand building pottery class, mountain biking, a mid-winter sea swim (more like a dip), an Indian cooking class, Yoga, and an Aerial hoop class. So, a very diverse range of activities!

Vicki Bijl,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Westland/Canterbury – Te Tai o Poutini/Waitaha Region

Regional Representative

Jo Aston

Nurse Unit Manager

Christchurch Emergency Department

Te Whatu Ora Waitaha Canterbury

Christchurch Emergency Department.

This is a collaboratively written report, and we are placing a lens on innovation, research, education and wellbeing in Christchurch ED.

Christchurch ED is currently leading two significant research initiatives. The first study involves recruiting 2,000 chest pain patients to validate an alternative device in the Abbott i-STAT high-sensitivity troponin point-of-care assay. This will build on our successful ICare-FASTER program that integrated advanced Point Of Care troponin measurements across six New Zealand hospitals and has remained as a standard of care for our patients presenting with chest pain.

Concurrently, we are conducting a 500-patient study evaluating point-of-care biomarkers for mild and moderate traumatic brain injury assessment. The intention is to address gaps in current diagnostic pathways and potentially transform how we manage TBI patients in the ED setting. These studies demonstrate our commitment to translating emerging diagnostic technology into improved patient outcomes.

Christchurch ED continues to have excellent examples of research with several RNs engaging in postgraduate study, taking on projects with the potential to inform and improve ED practice. Areas of interest currently being explored include pain management and the nurse-initiated treatment and response to hand injuries. This work is being supported Zoe Baker and Tracy Barr both in CNS roles. Other research and quality work continues, with the ED Nurse Researcher (Sandy Richardson) currently summarising findings from the Cemplicity database of patient feedback, focussing on family/whānau experiences in ED, to present at the 17th International Family Nursing Conference in Perth, Australia. The significance of patient experience, and its links to wider family nursing as part of ED engagement, will be explored in an upcoming qualitative research study within the ED.

To enhance our trauma education, we are working in collaboration with Anaesthetics, Surgery and ICU to pilot 2 new Trauma Team Training Simulation Days. The intentions is to specifically provide training for medical, nursing and anaesthetic tech staff who are new to working as part of a Trauma Team in Christchurch Hospital. The training day is being delivered by an interprofessional and interdepartmental faculty team.

On the wellbeing front, the peer support specialists are embedding their role into the department. As part of the recent CNM CENNZ Hui we listened to a presentation from Dr Annie Southern on Peer Support Specialists in ED and how they can advocate and support the patient journey.

June has brought a cold snap as we celebrate wellbeing month, aligning this with ACEM wellbeing week and a variety of activities. These activities range from: planking competition, Sankalpa meditation, style yourself up, international food day, funky sock Friday and highlighted in the photo - dog walk day in Halswell Quarry. There are a lot more too.

On a final note, as expected and like all other EDs nationally, we continue to navigate the increase presentations with the usual increase in winter-type presentations of influenza like illnesses and sports injuries.

Jo Aston,

Nurse Manager.

Westland/Canterbury – Te Tai o Poutini/Waitaha Region cont.

Te Nikau Grey Emergency Department TeWhatu Ora – Te Tai o Poutini.

Kia ora from the wild West Coast and Te Nīkau Hospital Emergency Department (ED).

It's been a year of growth, resilience, and adaptation at Te Nīkau Hospital's ED. While we remain a small rural service, our dedicated team continues to provide high-quality emergency care to our community, often under uniquely challenging conditions.

What's New

Over the past year, we've introduced several key developments:

- TrendCare and CCDM (Care Capacity Demand Management) have been implemented to support safe staffing and care delivery. Our FTE (full-time equivalent) calculations are due in the near future.
- Ka Ora Telehealth is now in use to provide afterhours rural primary care, helping bridge access gaps for remote patients.

Our ED continues to see a steady number of presentations, averaging 30-40 per day. However, we've observed an increase in patient acuity, with more complex cases requiring higher levels of care.

Workforce and Development

We're close to being fully staffed with just a few fixed term positions remaining unfilled. Our workforce strategy is focused on sustaining a generalist nursing model to suit our rural context.

- Over 75% of our Registered Nursing (RN) team is triage-trained, with many beginning to move into roles such as shift coordination and triaging.
- A significant number of our nurses have joined from overseas in the past two years. Their adaptability, professionalism, and resilience have added immense strength to our small but mighty team.

Our Associate Clinical Nurse Managers (ACNMs) play a vital role in facilitating and enabling point of care teaching and skill acquisition, coordinating shifts, and supporting clinical practice. We are fortunate to have 2.0 FTE ACNMs, and their contribution is deeply valued across the department.

Challenges in Rural Emergency Nursing

Like many rural EDs, we face several persistent challenges:

- Long travel distances for patients accessing emergency or primary care.
- Weather-dependent transport for patients to tertiary centres.
- Geographic isolation, which complicates access to professional development, with most education requiring 3.5 hours of travel each way.

Celebrations

Despite the challenges, there is much to celebrate:

- Our department consistently meets or exceeds the Shorter Stays in Emergency Department Health Target.
- The team is skilled, flexible, and highly collegial, contributing to a supportive and positive work environment.
- Clinical simulation training is held regularly and remains well-attended and valued.

Staff Wellbeing Initiatives

In line with the Australasian College of Emergency Medicine's Manaaki Mana values and our own Acute Zone Team Charter, we launched the "Appreciation Station" last June:

- Staff write and share notes of appreciation, thanks, and aroha, which are displayed in the handover room.
- Beside this sits our "Staff Resus Trolley", stocked weekly with healthy snacks and fruit – an initiative funded by staff to help keep each other fuelled and supported.

We are proud of our progress and the strong spirit of collaboration that defines Te Nīkau ED. We look forward to continuing to serve our community with heart, resilience, and a commitment to excellence in rural emergency care.

Sharon Gamble,

Clinical Nurse Manager.

Westland/Canterbury – Te Tai o Poutini/Waitaha Region cont.

Southern Region – Te Tai Tonga

Regional Representative

Michelle Scully

Clinical Nurse Educator/
Registered Nurse

Southland Hospital Invercargill
Emergency Department

Te Whatu Ora Southern

Te Whatu Ora Southern ED's.

Winter has reached the deep south with a hiss and a roar. First, we had storms with heavy rain and strong winds and now we are having strong frosts accompanied by black ice. This of course causes all sorts of road traffic accidents, falls and fractures.

Southland Hospital has been extremely busy with increasing presentations along with high acuity access block and flow challenges. Patients are facing the challenge of GP availability. Ambulances are ramping and St. Johns are commencing rapid handover to staff if they have been onsite for longer than 45 minutes. We are also noticing increased aggression in the department. Local data Council and TrendCare Calculations are in progress. CNSs now cover 16 hours of the day, and this has reduced waiting times for our triage 4s and 5s. Despite the challenges, Triage and TNCC courses have been convened in Invercargill and Dunedin, with four new TNCC instructors being blooded in.

Wellness week was super busy and fun. Invercargill had several walks out in the crisp air, a delicious breakfast of pancakes maple syrup and streaky bacon provided and cooked by our CNM for the night and morning staff. The staff room smelled divine. We were gifted chair massages by our local School of Massage, and this reminded us of all that we need to pay attention to self-care. Dog day was fun, but the real hit was Filipino Independence Day on the 12th of June. We had a presentation on the history, a lesson on greetings, dancing, and the most fantastic meal. This coincided with our first ever Associate Charge Nurse Managers meeting and so it was a real day of celebration. We also did random acts of kindness for each other, which was a lovely way of getting to know each other and added to the team building. Queenstown Staff were supported by many businesses and many staff went to iFLY and enjoyed flying.

Queenstown and Invercargill both had NetworkZ running trauma simulations. Queenstown focussed on transporting patients to Dunedin ICU. These sims highlight the challenges of working in a rural setting. Queenstown is also facing challenges of getting nurses trained in presentations seen less often.

The Queenstown Educator, Erin, is hoping to implement a trial of nurse rotation between Queenstown Hospital to tertiary hospitals within the referral pathway to increase exposure, consolidate training and enhance collaboration between rural and urban centres. Erin role models nursing excellence, embraces simulation and displays all of the attributes expected of Southern nurses. Erin Hills, the Educator, received a Nursing Excellence award for working tirelessly to meet the education requirements of the whole team.

The Southern Region has had large volumes of staff undertake the Leading Empowered Organisation Training and there are numerous fantastic projects in progress. As a follow up the staff are being invited to a Fundamentals of Nursing Course. Patients who have passed through ED have been interviewed to find out about the aspects of nursing which detracts from or enhances their experience. Many patients have told their story, and these have truly resonated with staff. The next projects are going to focus on attempting to enhance the ED patients experience and many of these are simple fixes such as being offered a freshen up, being offered food and fluids or receiving adequate analgesia. More patients are staying in ED for longer, so their basic needs need to be met.

Dunedin ED continues trying to catch up on projects from last year. Three New Graduates started in March. A flurry of staff are going on maternity leave and fortunately there has been some RFRs approved so staff can be replaced. TrendCare continues to show that there is a significant gap between nursing hours required versus nursing hours available.

Southern Region | Te Whatu Ora cont.

During ACEM wellness week I had the privilege of moderating a webinar on wellness presented by Dr. Jo Cole. Being that she is an Emergency SMO she clearly understands the pressures of ED and wants clinicians to be able to care for themselves, the team and, in turn, the organisation. This was an amazing webinar and well worth watching as she has some practical advice and is promoting a tool for gathering data on levels of wellness. It was important to be able to see the data as well as hear the stories.

I also had the pleasure of participating in the Clinical Nurse Educator network where Standing Orders, wellness initiatives and a central area to store resources was discussed. It feels to me that despite tough political times and economic constraints Emergency Nurses keep finding ways of forging a way forward and trying to remain positive. They continue to work on projects trying to create positive change.

Michelle Scully,

Clinical Nurse Educator Southland.

College Publications

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

College Activities: Courses

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

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

For the details see the CENNZ websites at:

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

and;

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

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

Submissions Guidelines - (Brief)

Journal Submissions

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

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

Category of manuscripts

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

Format:

Title page: title, authors, abstract and keywords

Body: introduction, methods, results, discussion

References: limited to 30

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

Format:

Integrative, scoping or systematic literature reviews are preferred

Use of JBI for integrative or scoping reviews recommended

Use of PRISMA for systematic reviews recommended

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

Format:

Introduction: brief overview context / problem

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

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

Conclusion: summary of key points or recommendations

Submissions Guidelines - (Brief)

Journal Submissions cont.

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

References: limited to 20

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

Approximately 2000-3000 words

Format: free-text

References: limited to 20

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

Approximately 600-1000 words

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

Reference style

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

Education: Conferences

Upcoming Conferences

Organisation	Title	Date	Location	Link
ENA Emergency Nurses Association	Emergency Nursing 2025	September 17 - 20, 2025		https://www.ena.org/events/2025/09/17/ena-annual-conferences/emergency-nursing-2025
ACNP Australian College of Nurse Practitioners	National Conference	29-31 Oct	Canberra, ACT	https://www.acnp.org.au/nationalconference2025

College of Emergency Nurses NZ

Ngā Ringa Ringa Aroha NZNO

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