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EMERGENCY NURSE NEW ZEALAND

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EMERGENCY NURSE NZ

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Emergency Nurse N.Z. is the official journal of the College of Emergency Nurses of New Zealand (CENNZ) / New Zealand Nurses Organisation (NZNO). The views expressed in this publication are not necessarily those of either organisation. All clinical practice articles are reviewed by a peer review committee. When necessary further expert advice may be sought external to this group. All articles published in this journal remain the property of Emergency Nurse NZ and may be reprinted in other publications if prior permission is sought and is credited to Emergency Nurse NZ. Emergency Nurse NZ has been published under a variety of names since 1992.

A WORD FROM THE EDITOR:

A (belated) Happy New year to all members and whanau, and a gentle reminder that in order to continue receiving the Journal and all the other benefits of being a CENNZ member you will need to re-new your membership at the end of March (see details inside).

The New Year heralds the recommencement of the MECA negotiations and for those of you who are not on their email list you can get regular updates from them via that dreadfully intrusive social media site FaceBook (**www.facebook.com/NZNursesOrganisation**) or via email from lizr@nzno.org.nz. From the latest email update you can be reassured that the negotiation team will not except a pay rise of anything less than 1% but temper that with the following statement *"the health budget has endured severe cuts over the last 6 years and it looks like 2015 will be no different. We expect 2015 to be a volatile year for negotiations in the public sector"* which loosely translated reads 'we did warn you' when the eventual settlement fails to attract the ambitious (sic) 1% they are fighting for on your behalf. Apparently our (yours, mine) resolve to fight (for a 1 % pay rise) has been strengthened by news of the recent pay rises of the DHB CEO's. The fact that there are only 20 CEO's running the DHB's and managing budgets in the hundreds of millions of dollars and 25,000 plus registered and other nurses under the NZNO collective agreement seems to have been forgotten. I personally have no problem with them being paid a wage that reflects the stress and performance expectations placed on them and see this as a futile distractor from our own negotiations. Given the fact that the CEO pay scales are set by the States Service Commission one can only ask who negotiated for them and why aren't they on our team ho ho!

On a completely different topic I have included a copy of the Maori Health for your interest in this journal. I receive this and many other two page pdf's via email every month as supplied by Research Review New Zealand (**www.researchreview.co.nz**). There are multiple choices from a wide range of medical and surgical specialties to choose from and a quick and easy way of keeping up with NZ specific research.

Feedback, articles, news and events always welcome.

MICHAEL GERAGHTY
EDITOR | EMERGENCY NURSE NZ
CENNZJOURNAL@GMAIL.COM

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

EMERGENCY NURSE NZ

SUBSCRIPTION:

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

Website: www.cennz.co.nz

JOURNAL COORDINATOR/EDITOR:

Michael Geraghty: MN,
Nurse Practitioner, ADHB
Email: cennzjournal@gmail.com

PEER REVIEW COORDINATOR:

Michael Geraghty: MN.
Nurse Practitioner
Auckland City Hospital Adult Emergency Department, ADHB.

PEER REVIEW COMMITTEE:

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Dr. Sandra Richardson: PhD. Senior Lecturer. Centre for Postgraduate Nursing Studies, University of Otago.

Deborah Somerville: MN. Senior Lecturer. Faculty of Medical and Health Sciences, University of Auckland.

SUBMISSION OF ARTICLES FOR PUBLICATION IN EMERGENCY NURSE NEW ZEALAND.

All articles submitted for publication should be presented electronically in Microsoft Word, and e-mailed to cennzjournal@gmail.com. Guidelines for the submission of articles to Emergency Nurse New Zealand were published in the March 2007 issue of the journal, or are available from the Journal Editor Michael Geraghty at: cennzjournal@gmail.com. Articles are peer reviewed, and we aim to advise authors of the outcome of the peer review process within six weeks of our receipt of the article

TRIAGE COORDINATOR:

Sharon Payne
Email: cennztriage@gmail.com

CENNZ NZNO MEMBERSHIP:

Membership is $25.00 and due annually in April. For membership enquiries please contact:
Amanda Biggs-Hume
Email: cennzmembership@gmail.com

DESIGN / PRODUCTION / DISTRIBUTION:

Sean McGarry | Creative Director

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Phone: 04 801 5453
Email: sean@basetwo.co.nz

www.basetwo.co.nz

Chairperson's Report

This is my first report since taking on the role of Chairperson of CENNZ.

I feel honoured and proud to be leading the committee and thankful to have had the time to work alongside our outstanding outgoing Chairperson, Lynette Baines. On behalf of the committee, we would like to thank Lynette for her commitment and passion to the college and look forward to her ongoing involvement and support.

Summer has brought amazing weather. I hope that you have been able to take some time to recharge batteries and spend quality time with family and friends after what was a busy 2014 in emergency departments around the regions. I certainly did and the long hot days camping, swimming, fishing and relaxing reminded me of summers as a child. Long may the fine weather continue for those who worked through the beginning part of the year and now have leave.

The CENNZ committee met a fortnight ago for 2 days in Wellington. We had a very productive time with much achieved. 2015 is going to be a busy year with several key pieces of work to complete, plus continuing with our other activities. We are currently seeking nominations for a Northland and Southland Representative. Tracy Lyons (Northland) stood down at the beginning of this year – thank you to Tracy for her time with the committee. Carly Hawkins (Southland) will be ending her term slightly short of 4 years, as she is heading back to England for a year. Carly has flown the CENNZ banner admirably in her region and has contributed hugely to CENNZ over her tenure period. She has transformed the website and kept the awards and grants in good order. The website has information on what is required to be a committee member or you can contact me or cennzsecretary@gmail.com if you have any questions.

"It is now easier than ever to renew your membership with our online process. There is information in this journal about how to do this."

Members were asked to feedback on the CENNZ draft position statement on "Redirection of patients presenting to an emergency department to primary healthcare facilities". Thanks to those CENNZ members who did feedback; we also had excellent feedback from nurses from the College of Primary Healthcare Nurses and Te Rununga. The final draft is now in your inboxes with the document then being taken to the NZNO Board. Even if your department isn't redirecting or thinking of redirecting, I think it is well worth nurses being aware of this position statement.

With the increased violence seen in emergency departments (there has been a lot of media coverage on this of late), CENNZ has embarked on drafting a position statement "Zero tolerance to violence in emergency departments". Please keep a check on your emails as this will be coming your way for feedback in the near future – we really want your input and ideas as you are the nurses who see and experience this on a day to day basis.

CENNZ has committed to developing an Emergency Nurse Knowedge and Skills framework. This will describe the emergency knowledge and skills that Registered Nurses require to practise. Work began last year and we have a tight timeline for completion in 2015. This is a large project and we have welcomed interested nurses from around the country that will be instrumental in achieving our timeframe. Please read the update from Anne Esson in this journal outlining the potential and intention of developing this Knowledge and Skills framework.

We continue to hear from emergency nurses around the country, how difficult it to get access to and funding for ongoing education and courses. Within the financial constraints of healthcare, this is an issue that is difficult to resolve. CENNZ is committed to assisting its members financially to attend relevant emergency nurse education, conferences and seminars. Please contact our Awards and Grants Portfolio holder by email cennzawards@gmail.com if you would like to discuss your needs or require assistance with applying. Our website details the awards, requirements to apply (you must have been a levied CENNZ member for 2 years) and application process.

Our membership has now hit the 450 mark! This is the highest for a number of years. Thank you for continuing to support the college and please remember to renew your membership which lapses on the 31 March. It is now easier than ever to renew your membership with our online process. There is information in this journal about how to do this. If you have any queries, email cennzmembership@gmail.com.

Finally, Wellington is gearing up to host the CENNZ National Conference on Thursday 14th and Friday 15th October. There will be an Advanced Emergency Nurses Network (AEN) workshop on Saturday 17th October. So start planning: speak with your manager and put in your leave form, apply for CENNZ conference funding (these are discussed and approved at our monthly teleconferences so you will hear if you are successful within a quick timeframe), speak to colleagues about sharing a room to reduce costs and we hope to see you in Wellington for another fantastic conference.

LIBBY HASKELL | CHAIRPERSON
AUCKLAND REGION REP
CENNZCHAIR@GMAIL.COM
LIBBYH@ADHB.GOVT.NZ

ADVANCING CLINICAL EMERGENCY CARE – OFFERING POSTGRADUATE EDUCATIONAL OPPORTUNITIES IN THE SOUTH

By: Johanna Rhodes

Nursing Educator (The Southern Institute of Technology, Invercargill, New Zealand) BN, RN

PGDipRehab, PGCertHealSc(Emergency Nursing) CertAdultTching, DipTchingTertiary MHealSc(Nursing), PGCertHighE(Clinical Education), MTchg

This article details the establishment of an Emergency Nursing specific paper at the Southern Institute of Technology, Invercargill outlining the rationale for and specific contents of the course.

Dr Adam McLeay and Clinical Nurse Specialist Lara Gleeson approached the Southern Institute of Technology, Invercargill after recognising a 'gap' in postgraduate nursing education, namely within the speciality of emergency nursing. Auckland University offers a postgraduate opportunity in this speciality, however, the reality of traveling to Auckland created concurrent educational and economic barriers for many nurses and their employers in the South Island. Therefore, it was proposed to the Southern Institute of Technology that their offering a postgraduate paper would 'fill the void' within emergency nursing. Consequently, 'Advancing Clinical Emergency Care' became an element in the Postgraduate Certificate/Diploma in Health Science at the Southern Institute of Technology. This NZQA level eight 30 credit paper's purpose is to refine advanced nursing/midwifery practice in the emergency setting, by enhancing nursing/midwifery skill and expertise in assessment, diagnostic processes, and interventions using evidence based practice. This is achieved by offering speciality topics such as, but not restricted to, referrals, interpretation of x-rays, application of casts, suturing, and nerve blocks. Underpinning these skills is advanced assessment and interventions for health consumers presenting in emergency situations and settings. The students who enrol in this paper will have previously been introduced to advanced health assessment and diagnostic reasoning in the pre-requisites for this paper which include 'Advanced Clinical Assessment and Diagnostic Reasoning' or 'Advanced Pathophysiology' (or equivalent).

The Southern Institute of Technology offered the Advancing Clinical Emergency Care paper in Semester II, 2015, and feedback from the students indicated that the content met their expectations. Collectively the students who are employed in an emergency department setting stated "We completed the advanced clinical emergency care paper last year through the Southern Institute of Technology. This paper was a competently organized and covered all aspects that were relevant to our employment as Clinical Nurse Specialists (CNS) in the Emergency Department. We were very fortunate that this paper was run as it is the only one of it's kind in the South Island. This paper was strongly clinically based and that enhanced the education and learning of the topics taught, including nerve blocks, suturing, X-ray reviews and many more interesting topics. We thoroughly enjoyed this paper and felt it extended and enhanced our scope of practice as CNSs. The time, work and effort that was put into the paper by both the coordinator, and lecturers was noted by the interest and enjoyment that all the students got from it. We recommend this paper for any one that is interested in extended learning."

Demonstrating advanced skilled health assessments, along with synthesising clinical data systematically to provide prioritised interventions with reflection, evaluation and modification of treatment plans in the emergency setting is delivered using simulation, workshops, experiential learning, and problem solving. The students also promote and contribute to the development of policies, procedures, and standing orders within their own clinical settings embedded by evidence based practice methodology. The assessments are varied and utilise assessment methods such as visual assessment questions (VAQs), Objective Structured Clinical Examinations (OSCEs), and Plans of Care.

The enrolments in this paper were not isolated to nurses working in an emergency department, with enrolments from students employed in primary health settings also.

ADVANCING CLINICAL EMERGENCY CARE – OFFERING POSTGRADUATE EDUCATIONAL OPPORTUNITIES IN THE SOUTH

Their feedback also supported the value of this paper, "Thoroughly enjoyed the paper, although I felt so overwhelmed by the knowledge around me, but I learnt heaps, and valued the interaction with my fellow colleagues". Another student said "I work in a primary rural location and learning the skill of plastering and nerve blocks will greatly enhance my scope of practice, and the comfort for health consumers who need to travel into the base hospital. This travel can be over two hours duration, so learning these advanced skills is empowering for my practice, but importantly for the health consumer's comfort and well-being in my care".

The on-site sessions were delivered by health professionals with content based expertise and credentials. The use of the simulation suite at The Southern Institute of Technology provided a clinical environment to learn advanced skills concurrent with the opportunity to replicate and improve competency. Information was presented on Blackboard (virtual learning environment and course management system) for continuing off-site learning. The expectation was that students would spend 15-20 hours each week undertaking on-line activities, and practicing advancing clinical skills in preparation for the formative and summative assessments. Throughout the delivery of Advancing Clinical Emergency Care the students certainly appeared engaged in learning and the statistics from Blackboard supported that each student had regularly completed the learning actives during their off-site time. In addition to the on-site sessions at the Southern Institute of Technology and the off-site learning material the enrolled students were offered (supernumerary voluntary status) clinical time in the emergency department at Southland Hospital, which provided effective opportunities for practicing and developing the advancing clinical skills taught in this paper. The student evaluations indicated that the paper was thought provoking and interesting, and that the work load of this paper was appropriate. Furthermore the assessments were an accurate reflection of learning. The students also noted that they received good support from the Southern Institute of Technology during the paper. Having the opportunity to develop this new postgraduate paper was thought provoking and enlightening. I look forward to this paper continuing in the Postgraduate Diploma of Health Science at the Southern Institute of Technology

Enquiries about this paper are welcomed. ***Please contact: johanna.rhodes@sit.ac.nz***

GRANTS, GRANTS, GRANTS, 2015!

IT'S THAT TIME OF YEAR AGAIN TO START THINKING ABOUT THE YEAR AHEAD, STUDY OPTIONS, CAREER PATHWAYS AND FOR THOSE OF YOU NEW TO EMERGENCY NURSING HOW ABOUT COMPLETING YOUR TRIAGE TRAINING, OR PARTICIPATING IN THE TNCC OR ENPC COURSES.

CENNZ-NZNO has a number of options for funding available to CENNZ members who have been members for 2 concurrent years.

EDUCATION GRANT: suitable for applicants of the TNCC, ENPC, Triage courses

CONFERENCE GRANT: looking at attending the 2015 CENNZ-NZNO Conference in Wellington and require funding

POST GRADUATE STUDY GRANT: for those of you looking at completing Post graduate study which is related to your working practice

PACIFIC NURSE ISLAND GRANT: award for nurses interested in completing volunteer work with our pacific island colleagues

IF YOU ARE INTERESTED BUT UNSURE OF WHICH GRANT SUITS YOUR NEEDS OR YOU HAVE A QUESTION, PLEASE EMAIL CENNZAWARDS@GMAIL.COM

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Health Improvement & Innovation Resource Centre

USE OF AN ACCELERATED DIAGNOSTIC PATHWAY ALLOWS RAPID AND SAFE DISCHARGE OF 70% OF CHEST PAIN PATIENTS FROM THE EMERGENCY DEPARTMENT.

New Zealand Medical Journal, 127(1408) 2015

http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1408/6416

In this New Zealand study, the authors "... show how a pathway of care in the Emergency Department (ED) for people who present with chest pain (and who are not clearly having a heart attack on the first ECG), can allow rapid and safe discharge for the non-high risk group".

PATIENT EXPERIENCE IN THE EMERGENCY DEPARTMENT: INCONSISTENCIES IN THE ETHIC AND DUTY OF CARE.

Journal of Clinical Nursing, 24(1-2), 275-288 2015

http://dx.doi.org/10.1111/jocn.12612

In this qualitative study, undertaken in New Zealand, the authors analyse information from a range of sources, including interview data from 34 people with chronic illness who have presented on multiple occasions to the emergency department.Participants described how they experience their health professionals' moral comportment (ethic of care and duty of care); and the consequences for their ongoing choices in care. The authors identify four moral comportment positions attributed to the health professionals in emergency department: "'sustained and enmeshed ethic and duty of care', 'consistent duty of care', 'interrupted or mixed duty and ethic of care', and 'care in breach of both the ethic and duty of care'". The authors conclude that investigation into what stimulates the different modes of moral comportment is needed.

MULTI-DISCIPLINARY APPROACH FAST TRACKS LUNG CANCER DIAGNOSIS.

http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/cancer-stories/multi-disciplinary-approach-fast-tracks-lung-cancer-diagnosis

Patients suspected of having lung cancer are being diagnosed earlier at Dunedin Hospital thanks to the introduction of Respiratory Fast Track Clinics. This one-stop-shop approach brings together a multi-disciplinary team who can carry out all required lung cancer assessments in one day.

THE WIDER ECONOMIC AND SOCIAL COSTS OF OBESITY: A DISCUSSION OF THE NON-HEALTH IMPACTS OF OBESITY IN NEW ZEALAND.

http://www.superu.govt.nz/publications/wider-economic-and-social-costs-of-obesity-to-new-zealand

Social Policy Evaluation and Research Unit asked NZIER to review the evidence of wider economic and social impacts of obesity. This report identifies the broad range of social and economic costs of obesity for New Zealand, excluding the direct health costs relating to obesity. The discussion is structured in two sections: (1) Obesity has become a major health concern; (2) The wider economic and social costs of obesity.

'BUT I DO BELIEVE YOU'VE GOT TO ACCEPT THAT THAT'S WHAT LIFE'S ABOUT': OLDER ADULTS LIVING IN NEW ZEALAND TALK ABOUT THEIR EXPERIENCES OF LOSS AND BEREAVEMENT SUPPORT

By Bellamy, Gary; Gott, Merryn; Waterworth, Susan; McLean, Christine & Kerse, Ngaire.

Health & Social Care in the Community. Jan 2014, Vol. 22 Issue 1, p96-103. 8p.

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Health Improvement & Innovation Resource Centre

THE HIGH HEALTH BURDEN FROM ALCOHOL IN NEW ZEALAND AND THE NEED FOR AN APPROPRIATE GOVERNMENT RESPONSE

Nick Wilson & Tony Blakely

New Zealand Medical Journal, 20th February 2015, Volume 128 Number 1409.

THE BURDEN OF DISEASE AND INJURY ATTRIBUTABLE TO ALCOHOL IN NEW ZEALANDERS UNDER 80 YEARS OF AGE: MARKED DISPARITIES BY ETHNICITY AND SEX

Jennie Connor, Robyn Kydd, Kevin Shield & Jürgen Rehm

New Zealand Medical Journal, 20th February 2015, Volume 128 Number 1409.

LONG-TERM IMPACT ON ALCOHOL-INVOLVED CRASHES OF LOWERING THE MINIMUM PURCHASE AGE IN NEW ZEALAND

Taisia Huckle; Parker, Karl.

American Journal of Public Health. Jun 2014, Vol. 104 Issue 6, p1087-1091. 5p.

COMPARING BEDSIDE METHODS OF DETERMINING PLACEMENT OF GASTRIC TUBES IN CHILDREN

Ellett, Marsha L. Cirgin; Cohen, Mervyn D.; Croffie, Joseph M. B.; Lane, Kathleen A.; Austin, Joan K.; Perkins, Susan M.

Journal for Specialists in Pediatric Nursing. Jan 2014, Vol. 19 Issue 1, p68-79. 12p.

SURVEY OF ALCOHOL-RELATED PRESENTATIONS TO AUSTRALASIAN EMERGENCY DEPARTMENTS. MEDICAL JOURNAL OF AUSTRALIA, 201(10), 584-587 2015.

https://www.mja.com.au/journal/2014/201/10/survey-alcohol-related-presentations-australasian-emergency-departments

The authors investigated the proportion of alcohol-related presentations to emergency departments (EDs) in 106 hospitals in Australia and New Zealand, at a single time point on a weekend night shift. Based on the results of their analysis, the authors conclude that "one in seven ED presentations in Australian and New Zealand at this 02:00 snapshot were alcohol-related, with some EDs seeing more than one in three alcohol-related presentations. This confirms that alcohol-related presentations to EDs are currently underreported and makes a strong case for public health initiatives".

BALANCING THE DIET AND THE BUDGET: FOOD PURCHASING PRACTICES OF FOOD-INSECURE FAMILIES IN NEW ZEALAND

Smith, Claire; Parnell, Winsome Ruth; Brown, Rachel Clare & Gray, Andrew R.

Nutrition & Dietetics. Dec 2013, Vol. 70 Issue 4, p278-285. 8p.

PREVALENCE PREDICTIONS FOR AGE-RELATED MACULAR DEGENERATION IN NEW ZEALAND HAVE IMPLICATIONS FOR PROVISION OF HEALTHCARE SERVICES

By David Worsley & Andrew Worsley.

New Zealand Medical Journal, 20th February 2015, Volume 128 Number 1409.

ADVANCED EMERGENCY NURSES NETWORK SURVEY 2014

By: Rick Forster, RN, MN

Registered Nurse. Tauranga Emergency Department

Rick.Forster@bopdhb.govt.nz

Key words; Clinical Nurse Specialist, Nurse Practitioner, Emergency Department, New Zealand

INTRODUCTION

Internationally, health services aim to provide high quality healthcare whilst maximising resources. Roles traditionally performed by medicine are now being undertaken and further developed by nurses (MOH, 2014; Pirret, Neville & La grow, 2014). Clinically based advanced nursing practice roles providing emergency healthcare have been gaining momentum within recent years in New Zealand (NZ) (Jennings, Clifford, Fox, O'Connell & Gardner 2014; Colligan et al, 2011).

Two clearly defined advanced clinical practice nursing roles found within NZ Emergency Departments (EDs) are the Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP). The CNS practices under the scope of a Nursing Council of New Zealand (NCNZ) defined Registered Nurse (RN). The College of Emergency Nurses New Zealand (CENNZ) provides a position statement on the role of the CNS (CENNZ, 2013). The NCNZ guideline on expanded practice for RNs describes criteria for defining a role as expanded practice. This document allocates three additional competencies regarding preparation and ongoing evaluation of practice (NCNZ, 2011). NPs practice under an alternative scope of practice defined and administered by the NCNZ (Gagan, Boyd, Wysocki & Williams 2014).

The Advanced Emergency Nurses Network (AENN) aligned with CENNZ provides education and clinical support for these roles (CENNZ, 2014). A post graduate specialty paper is now available from two universities in NZ aiming to provide specific knowledge and skills around musculoskeletal and soft tissues injuries. This paper is usually undertaken as part of a post graduate Master's degree.

STUDY AIM:

The aim of this survey was to gather information regarding the current roles and context of employment for AENN nurses such as, geographical location, contractual employment data, patient population and current case mix. An attempt was made to discern levels of independence in practice as with personal views on future development of ED CNS and NP. Opinions were also sought regarding future educational and professional development.

METHOD:

An online questionnaire was developed using Survey Monkey which was emailed to members of AENN. The AENN email group consists of approximately 70 people of mixed roles including CNS, NP, Medical Officers and RNs interested in the role. Approximately 50 - 60 nurses are thought to be actively involved in an advanced clinical Emergency Nurse role within New Zealand.

DESIGN:

Multiple choice answer options given to each question.

Q1: Current role?

Q2: Who are you primarily employed by?

Q3: What patient age groups do you see?

Q4: As a CNS/NP are you employed to focus on seeing which group? (Minor = not obviously life threatening)

Q5: Do you primarily work in a fast track, streaming or see and treat area

Q6: How long have you been employed in a CNS/NP role?

Q7: What are your current CNS / NP hours as per full time equivalent (FTE)?

Q8: What pay scale are you on as a CNS/NP per Multi-employer collective agreement (MECA)?

Q9: If also employed in another nursing role other than CNS what is it?

Q10: How many patients would you see routinely over an 8 hr shift?

Q11: Medicine and ultrasound

Q12: Trauma, wounds, fractures and orthopaedics

ADVANCED EMERGENCY NURSES NETWORK SURVEY 2014

Q13: Surgery, ophthalmology, ear, nose, throat (ENT) and dental

Q14: Paediatrics, obstetrics and gynaecology (O & G)

Questions 11-14: 3 part questions examining clinical practice with multiple clinical situations related to the general heading.

Part A - In each clinical situation how often are you involved in their management or performance in an AEN role?

Often (weekly); Occasionally (<3/12); Rarely (>3/12); Never Out of personal scope; N/A to workplace.

Part B - If patient management or task is undertaken which statement most frequently reflects practice?

Independent without discussion with SMO (Senior medical Officer) or specialty Dr (+/- pathway); Make initial assessment then immediately handing duty of care to doctor; Manage care in collaboration with ED SMO or other Dr until disposition.

Part C - If currently never seen / performed or out of scope which health professional role should manage care?

With appropriate education could the patient be managed by a CNS (+/- collaboration); NP (+/- collaboration); Only to be managed by Dr., Not sure.

Questions 11-14: Case/Clinical situation list

Q11: Medicine and ultrasound	Q12: Trauma, wounds, fractures and orthopaedics
Anaphylaxis	Blunt abdominal trauma
Cardiac Arrest	Concussion
Non cardiac chest pain	Lowered Glasgow coma score (GCS) post head injury
Cardiac chest pain	Facial fractures
Confusion	Cervical spine injury
Shortness of breath (SOB)	Status 1-2 multiple injury trauma patients
Deep vein thrombosis (DVT)	Status 3-5 multiple injury patients
Urinary tract infection (UTI)	Wounds including simple closure
Asthma	Complex wounds
Constipation	Limb soft tissue injuries, non-severe
Collapse	Limb fracture, satisfactory position, nil complications, no manipulation
Skin problems	Limb fracture manipulation under local anaesthetic (LA)
Minor allergic reaction	Limb fracture manipulation under sedation
Ultrasound - FAST scan	Shoulder dislocation
Ultrasound Pneumothorax	Fracture clavicle
Ultrasound - Soft tissue	Hip dislocation
Ultrasound - IV insertion	Hip fracture
	Soft tissue knee injury
	Calf and Achilles tendon injury
	Back pain
	Acute arthritis
	Gout
	Soft tissue knee injury
	Calf and Achilles tendon injury
	Back pain
	Acute arthritis
	Gout

Q13: Surgery, ophthalmology, ear, nose, throat (ENT)and dental	Q14:Paediatrics, obstetrics and gynaecology (O & G)
Abdominal pain	Immunisation
Appendicitis	Advanced life support (ALS)
Renal colic	Skin problems
Retention of urine	Upper respiratory tract infection (URTI)
Skin and soft tissue abscess	Febrile illness
Corneal trauma	Gastroenteritis
Visual disturbance, non-injury	Asthma
Red eye	Bronchiolitis
Earache	Croup
Epistaxis	Limping child
Nasal fracture	Head injury minor
Sore throat	Upper limb injury
Dental trauma	Lower limb injury
Non trauma dental pain	Bleeding in early pregnancy

ADVANCED EMERGENCY NURSES NETWORK SURVEY 2014

Q15: As a CNS/NP are you allocated non clinical time to participate in quality improvement projects? (Per 1.0 FTE)

Q16: What other roles do you undertake during non-clinical time?

Q17: Are you rostered non clinical time for personal professional development?

Q18: How frequent should we have AENN study days?

Q19: Who do you think initial CNS training is best provided by?

Q20: Should the initial course or post. graduate paper include minor adult medical illness presentations?

Q21: Should a minor medical illness course or post. graduate paper be developed for existing CNS?

Q22: Current CNS; were ED NP roles to become available would you aim to move to a NP role?

Q23: Should an advanced clinical practice course or post grad paper aimed at advanced ED CNS / NP roles be developed?

RESULTS

Overall there were 30 respondents with 21 full completions and 9 partial completions.

Q1-10

On review of the information supplied by respondents advanced clinical practice roles were predominantly CNS at 78.5% with 10.7% NP and 10.7% trainee CNS. These Nurses are widely spread through North Island District Health Boards (DHBs) with only 1 South Island DHB responding and 6.6% from community providers (fig 1.) The vast majority of nurses are seeing minor injury and illness or general presentation groups (fig 2). Approximately 2/3 work within a mixed adult and paediatric workplace, with 2/3 in a see and treat, fast track or streaming area. Over a routine eight hour shift 63.3 % report treating 5-10 patients, 16.7% 10 -15 and 16.6% 15 or more.

Results display a workforce relatively new to advanced clinical practice roles with 90 % in the first 5 years of practice and 43% in the first 2 years (fig 3). Approximately 2/3 are employed in an advanced practice role of 0.7 FTE or greater. When examining the Senior Nurse pay scale as per the national MECA the main groupings were at Level 4 $85,880 (34.4%), Level 5 $90,247 (24.1%) and unsure (17.2%).

Q11: Clinical practice - Medicine and ultrasound

When combining the options of performed often and occasionally the most frequently seen conditions were skin problems (90%), minor allergies (80%), DVT (66.6%), UTI (66.5%), and asthma (52.6%). Approximately 50 % of respondents reported being involved in cardiac arrest or anaphylaxis care occasionally or rarely. 40% are utilising ultrasound for difficult intravenous line insertion.

With the most frequently seen case types the majority of Nurses (65-75%) are most commonly managing care in collaboration with a Senior Medical Officer (SMO) or other Doctor. 15 - 20% are treating independently without discussion however care pathways may be used within this group. Respondents record cardiac arrest (78.5%) and confusion (53.3%) as the leading reasons for an immediate handover of duty of care to a medical officer.

The leading cases identified by respondents currently not undertaking care as requiring medical management were cardiac arrest (78.5%), cardiac chest pain (53.8%), confusion (53.3%) & collapse (36.3%). Generally there was backing that most of the listed presentations could be managed by a CNS or NP in a supportive environment. Cases with the strongest trend towards NP were anaphylaxis (NP 36.3% vs CNS 27.2%), confusion (NP 20% vs CNS 13.3%), collapse (NP 27.2%vs CNS 27.2%) and fast scan (NP 33.3% vs CNS 33.3%).

Q12: Clinical practice - Trauma, wounds, fractures and orthopaedics

A very high level of activity is seen within this group. Almost 100% often treat patients with wounds (including simple closure), soft tissue limb injuries, limb fracture without complications and soft tissue knee injuries. Most frequently never seen or out of scope were status 1 and 2 trauma, blunt abdominal trauma and low GCS (65%), fractured hip and dislocation (approx. 50%)

A high level of medical collaboration was revealed, wounds including simple closure and soft tissue limb injuries were the presentations most performed independently at approximately 50 %. Of the 57.1% of respondents who see back pain 61.5 % work in collaboration, 30.7 % handover duty of care and 7.6% treat independently. Cases most likely to be handed over include blunt abdominal trauma and decreased GCS both at 50%.

Respondents' currently not undertaking care strongly supported CNS as potentially capable of managing most cases. Conditions with a trend towards NP were blunt abdominal trauma (NP 25% vs CNS 8.3 %), C-spine (NP 22.2% vs CNS 0 %). Cases associated solely to medicine included status 1 and 2 trauma (81.8%), c-spine injury (77.7%) and blunt abdominal trauma (66.6%).

Q13: Clinical Practice - Surgery, ophthalmology, ENT and dental

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When combining the managed often and occasionally options the most regularly seen were skin and soft tissue abscess (90.4%), ear ache and non-trauma dental (76.1%), dental trauma (76.2%) nasal fracture (71.4%) and sore throat (66.5%). Patients most commonly not seen after combining never and out of scope were renal colic (70%), non-injury visual disturbance (66.7%), appendicitis (65%) and abdominal pain (60%).

Within the most commonly seen presentation groups respondents indicated a high level of collaborative practice (70-75%) with approximately 25-30% managing independently. Cases most often leading to an immediate handover of duty of care included renal colic (62.5%), appendicitis (55.5%) and abdominal pain (50%).

Respondents currently not undertaking care generally indicated with appropriate training and support most cases could be undertaken by an advanced nursing practice role. Very strong support was demonstrated towards this in the ophthalmology and ENT fields. The presentations with the greatest association to a medical lead were also the highest for NP. Renal colic (Dr 41.6 % vs NP 33.3%), abdominal pain (Dr 40% vs NP 40%) and appendicitis (Dr 36.3 % vs NP 36.3%).

Q14: Clinical Practice - Paediatrics, Obs and Gynae

When combining the managed often and occasionally options the most regularly seen revolved around minor injuries. Limb injuries at 95%, minor head injuries 85% followed by skin problems at 66.7%. Approximately 1/3 of nurses are involved in the cluster of common paediatric medical illnesses. Generally for those who treat the common paediatric illness presentations 25 % will manage independently, 50% will manage in collaboration and 25 % will handover duty of care. 52.3 % of individuals report involvement in immunisation and 36.8% with advanced life support (ALS). Vaginal bleeding in early pregnancy was never seen or out of their scope of practice 85% of all respondents.

Respondents not currently involved in certain presentations generally found that most cases could be undertaken by a suitably prepared and supported advanced nursing role. ALS was the presentation mostly associated to be solely medically led at 37.5%. However there was strong support for CNS 25% and NP 12.5 % to manage care within an AEN role potentially using a collaborative approach.

Questions 15-23

Approximately 50% receive rostered non clinical time to participate in quality improvement projects etc. During non-clinical time 93.7 % of respondents were involved in quality improvement projects, 87.5% in staff development and 31.2% with management. Approximately 2/3 reported never being rostered regular non clinical time for personal professional development activities.

On review of the frequency of AENN study days the majority are happy with days being held every three (52.3%) or four (42.8%) times per year. A strong preference is indicated towards a university based paper as the provider for initial CNS training (78.9%) and with the inclusion of common adult medical conditions (75%). The vast majority of 85.7% also support the development of a minor medical illness post graduate paper to compliment the current musculoskeletal paper.

In respect to the transition from CNS to NP, 95% of all respondents expressed a very strong interest in taking on an NP role if this was available. Extremely strong support (90%) is also given towards the development of an advanced clinical practice course or post grad paper for the advanced CNS or NP.

Figures 1, 2, 3

Q2: Who are you primarily employed by ?

Answer Choices	Responses	
Auckland District Health Board (Auckland)	13.33%	4
Bay of Plenty District Health Board (BOP)	13.33%	4
Canterbury District Health Board (Canterbury)	0.00%	0
Capital and Coast Disctrict Health Board (Capital & Coast)	3.33%	1
Counties Manukau District Health Board (Counties & Manukau)	10.00%	3
Hawke's Bay District Health Board (Hawke's Bay)	0.00%	0
Hutt Valley District Health Board (Hutt Valley)	0.00%	0
Lakes District Health Board (Lakes)	0.00%	0
MidCentral District Health Board (MidCentral)		2
Nelson Marlborough District Health Board (Nelson Marlborough)	0.00%	0
Northland District Health Board (Northland)	3.33%	1
South Canterbury District Health Board (South Canterbury)	0.00%	0
Southern District Health Board (Southern)	16.67%	5
Tairawhiti District Health Board (Tairawhiti)	0.00%	0
Taranaki District Health Board (Taranaki)	3.33%	1
Waikato District Health Board (Taranaki)	6.67%	2
Wairarapa District Health Board (Wairarapa)	0.00%	0
Waitemata District Health Board (Waitemata)	20.00%	6
West Coast District Health Board (West Coast)	0.00%	0
Whanganui District Health Board (Whanganui)	0.00%	0
Community Healthcare Provider	6.67%	2
Total Respondents: 30		

ADVANCED EMERGENCY NURSES NETWORK SURVEY 2014

Q4: As a CNS or NP are you employed to focus on seeing which group ? (Minor = not obviously life threatening)

Answer Choices	Responses	
Minor injury	16.67%	5
Minor illness	3.33%	1
Minor injury and major illness	70.00%	21
General E.D. Presentations	33.33%	10
Total Respondents: 30		

Q6: How long have you been employed in a CNS or NP role ?

Answer Choices	Responses	
Minor injury	16.67%	5
Minor illness	3.33%	1
Minor injury and major illness	70.00%	21
General E.D. Presentations	33.33%	10
Total Respondents: 30		

LIMITATIONS

There is no accessible data on the actual number of ED Nurses engaged in advanced clinical practice roles within NZ. There were only 21 full survey and 9 partial reply's out of a possible 50-60 potential respondents. Trainee CNS, CNS and NP responses are not divided so data reflects members in differing roles. Large groups from one District Health Board (DHB) working within the same systems will sway results towards their working environment. No descriptive or interferential statistical analysis is performed.

It should be noted CNS are not authorised prescribers. Therefore unless administering medications from standing orders they would need to collaborate with an authorised prescriber to facilitate drug therapy. Response rates for Questions 11-14 are lower than the more simply formatted question regarding current employment situations and professional development.

DISCUSSION

Within this survey a wide variance in question response is seen, however often clear trends are also identifiable. Variance in practice may be influenced as roles develop. The advanced nurse evolves to meet the needs of their specific environment. Each workplace will have varying resources available with roles shaped by the individual clinician and departmental leadership. Factors that cause inter-departmental practice variation may include care pathway use, differing departmental supervision requirements and member's stage of professional development.

Variation between roles has the potential for causing confusion in stakeholders. Confusion may negatively influence further role progression and opportunities. Development of national and international skill and knowledge frameworks for advanced Emergency Care Speciality roles may alleviate this. Creation of clearly defined roles would aide workforce development projects and transferability between employers.

With the rather rapid growth of positions within the last two -five years another layer of senior nurse roles have begun to populate NZ Emergency Departments. It is likely these nurses have the ability to positively influence practice and outcomes. However it would appear a significant number of respondents currently have limited dedicated non clinical time. Also of note a significant number of nurses report a paucity of formally allocated professional development time.

A strong personal interest in ongoing professional development was demonstrated. With appropriate preparation and clinical support AENN members believe that CNS can manage wide variety Emergency Care presentations. There also appears to be some support for NP to manage more complex presentations traditionally not cared for by CNS. The majority of CNS also demonstrated an interest towards NP registration should positions become available.

CONCLUSION

It is an interesting time to be practicing Emergency Care Nursing within New Zealand, a period of growth in advanced clinical roles is well underway. The AENN provides a platform for education, professional development and collegial support. Advanced clinical practice roles are underpinned by legislation and professional standards, however regional variance is apparent. This survey provides an opportunity to reflect on the AENN member's current environments and roles. Information shared within this survey may be used to influence future professional and role development.

ADVANCED EMERGENCY NURSES NETWORK SURVEY 2014

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COLLEGE OF EMERGENCY NURSES NEW ZEALAND CONFERENCE

Welcome.

On behalf of the Emergency teams across our 3DHBs we Invite you to join us in Wellington for the 24th Annual Conference of the College of Emergency Nurses New Zealand, held at the Rydges Hotel, Wellington.

Themed Craft Care, we will explore what quality care is and how we deliver that in our unique ways, whilst keeping patient safety at the heart of all we do. From our diverse rural, secondary and tertiary level department settings, we will provide an amazing opportunity to brew up some great ideas, collectively share successful quality innovations and current clinical thinking around what constitutes best practice.

The conference will excite, challenge and engage Emergency nurses at all levels with a structure to allow exploration of these concepts through clinical case studies, formal brief lectures, simulation training, patient stories and a challenging complaint and compliment review workshop. We will analyze our roles, how we can effectively carry them out to meet the publics expectation, and discuss the real issues behind what lies ahead in the world of quality care for emergency departments. We invite you to explore how we as nurses can ensure we continue to deliver excellent practice standards and quality patient centred care.

Purposely hosted over a Thursday and Friday we hope you will plan early and stay for the weekend to soak up some awesome Wellington culture and explore the regions that make up our 3DHB structure through the Hutt Valley and the wonderful sun drenched, grape filled, Wairarapa.

We look forward to seeing you on the 15 & 16 October 2015.

CENNZ 2015 Conference Committee

PLEASE SEE THE CENNZ CONFERENCE AD ON PAGE 26

ISSN 1178-6191

In this issue:

Abbreviations used in this issue
CPAP = continuous positive airway pressure
CVD = cardiovascular disease
OSA = obstructive sleep apnoea

Tēnā koutou katoa

Nau mai ki tenei Tirohanga hou Hauora Māori. He rangahau tuhi hou e paa ana ki nga hau ora a ki te oratanga o te Māori. No reira noho ora mai raa i o koutou waahi noho a waahi mahi hoki. Ngā mihi o te wā me te Tau Hou ki a koutou katoa. Noho ora mai.

Meri Kirihimete me nga mihi mo te tau hou.

Greetings

Welcome to this issue of the Māori Health Review. Each issue attempts to bring you research relevant to the health and wellbeing of Māori. I welcome feedback and suggestions for papers/research to include in future issues and I'm pleased to hear and read about the excellent work being undertaken in Hauora Māori.

Best wishes for the Christmas season.

Nga mihi
Matire
Dr Matire Harwood
matire@maorihealthreview.co.nz

Variation in gout care in Aotearoa New Zealand: a national analysis of quality markers

Authors: Jackson G et al.

Summary: The Health Quality and Safety Commission's Atlas of Healthcare variation (www.hqsc.govt.nz/atlas) shows that on average 41% of people with gout across New Zealand are regularly prescribed allopurinol. However, there is marked nationwide variation, with regular use of allopurinol ranging from 33% among people residing in the Auckland District Health Board (DHB) area to 47% in Nelson-Marlborough. These researchers sought to determine whether the quality of gout care varies in Aotearoa New Zealand primary care, using data from the New Zealand Atlas of Healthcare Variation to examine regularity of allopurinol dispensing, laboratory testing for serum urate, and acute hospitalisation for gout. For New Zealanders aged 20–79 years with gout, 57% were dispensed allopurinol in 2010/11. Of these, 69% were receiving allopurinol regularly, and only 34% of people dispensed allopurinol had serum urate testing in a 6-month period. The annual hospitalisation rate was 1% of people with gout. Māori and Pacific people with gout were less likely to be on regular allopurinol treatment, despite having more than twice the chance of being hospitalised with acute gout.

Comment: A great paper outlining the ways in which routinely collected data can be used to monitor quality of care.

Reference: N Z Med J. 2014;127(1404):37-47
Abstract

CLICK HERE **to read previous issues of Māori Health Review**

Māori health literacy research: Gestational diabetes mellitus

The research report *Māori health literacy research: Gestational diabetes mellitus* was released on 2 July 2014. The report focuses on young, pregnant Māori women (less than 25 years of age) in relation to gestational diabetes mellitus (GDM), which is diabetes that presents only during pregnancy. The report identifies health literacy barriers in understanding and managing GDM. The report also highlights interventions that may be effective in strengthening health literacy to allow better understanding of GDM and greater uptake of screening for GDM. The report was developed by Workbase Education Trust with funding from the Ministry of Health.

The report is available to download from the Ministry of Health website **www.health.govt.nz** or directly at the Workbase Health Literacy website **http://www.healthliteracy.org.nz/research-and-projects/#4087**

For more information, please go to http://www.maorihealth.govt.nz

Barriers to early initiation of antenatal care in a multi-ethnic sample in South Auckland, New Zealand

Authors: Corbett S et al.

Summary: The Counties Manukau DHB (CMDHB) in South Auckland serves the most economically deprived areas of New Zealand, with a high proportion of young mothers, and women of Māori and Pacific ethnicity. CMDHB has high rates of late booking for antenatal care and also the highest perinatal mortality rate in New Zealand, with a 3-year perinatal-related mortality rate of 13.70 per 1000 births compared with the national rate of 10.75 per 1000 births. This study aimed to identify barriers to early initiation of antenatal care (before 19 weeks of pregnancy) among women using CMDHB maternity services. The study recruited 826 pregnant women who were either in late pregnancy (>37 weeks gestation) or who had recently delivered (<6 weeks postnatal). They completed a questionnaire about their antenatal care at CMDHB. 137 women (17%) booked for antenatal care at >18 weeks (late bookers). Ethnic groupings were 43% Pacific Peoples, 20% Māori, 14% Asian, and 21% European or other ethnicities. According to multivariate analysis, women were significantly more likely to book late for antenatal care if they had limited resources (e.g. no transport) (OR 1.86), no tertiary education (OR 1.96), or were not living with a husband/partner (OR 2.34). Notably, the odds of late booking for antenatal care was almost 6 times higher among Māori (OR 5.70) and Pacific (OR 5.90) women compared to those of European and other ethnicities.

Comment: Given the fact that good antenatal care is associated with positive long-term outcomes, more must be done to address these issues for Māori and Pacifica mums and their babies.

Reference: N Z Med J. 2014;127(1404):53-61
Abstract

Continuous positive airway pressure treatment for obstructive sleep apnoea: Maori, Pacific and New Zealand European experiences

Authors: Bakker JP et al.

Summary: This paper describes Māori, Pacific and New Zealand European experiences of continuous positive airway pressure (CPAP) treatment for obstructive sleep apnoea (OSA). Patients identifying as Māori (n=5), Pacific (n=5), or NZ European (n=8) ethnicity referred for CPAP treatment for OSA attended separate, 1.5-hour group discussions facilitated by a health care worker of the same ethnic group. Patients in all three groups reported that they had little knowledge of OSA or CPAP prior to treatment initiation. All participants identified barriers to treatment (both at the CPAP initiation phase and long-term), reported feelings of being 'overwhelmed' with information during the initial CPAP education session, and discussed the importance of successful role models.

Comment: A nice project about a relatively little-known subject. I've seen first-hand the difference CPAP can make to people's lives including better management of diabetes, hypertension and mood disorders. Strategies to improve its uptake must therefore be identified and supported.

Reference: J Prim Health Care. 2014;6(3):221-8
Abstract

A patient-centred clinical approach to diabetes care assists long-term reduction in HbA1c

Author: Titchener J

Summary: Outcomes are reported from an audit comprising a before-and-after assessment of 185 patients referred to the GPSI Diabetes service – a patient-centred intervention for diabetes management – between 2008 and 2010. The aim of this audit was to determine if this patient-centred intervention improves diabetes care, as measured by changes in glycosylated haemoglobin (Hb_{A1c}). The GPSI Diabetes service is a community-based service, run by a general practitioner with a specific interest (GPSI) in diabetes, and a practice nurse. Adults with diabetes are referred to the service by their GP and care is provided using a set of loosely structured diabetes-specific patient-centred approaches. Following a series of visits, patients are discharged back to their GP. At intake, baseline Hb_{A1c} was higher among Māori than among New Zealand Europeans. This difference was reduced by the patient-centred intervention. Immediate and sustained (two-year) improvements in Hb_{A1c} were observed in both New Zealand Europeans and Māori with type 2 diabetes and type 1 diabetes. Completed patient and GP satisfaction questionnaires did not contain any negative feedback, but the response rate was low among patients.

Comment: Useful information here about how to apply the concept of 'patient-centred care' in clinical practice.

Reference: J Prim Health Care. 2014;6(3):195-202
Abstract

A short report on the oral health of elderly people is available

Oral Health in Advanced Age: Findings from LiLACS NZ presents key findings about the oral health of Māori (aged 80 to 90 years) and non-Māori (aged 85 years). The findings are from a population-based sample of people in advanced age living in the Bay of Plenty, who are taking part in a longitudinal study of advanced ageing, called *Life and Living in Advanced Age: a cohort study in New Zealand - Te Puāwaitanga o Ngā Tapuwae Kia Ora Tonu* (**LiLACS NZ**). The report was funded by the Ministry of Health and produced by the LiLACS NZ research programme which is led by Professor Ngaire Kerse. Additional short reports will be released in the coming months including: Alcohol use, Falls, Primary care, Medication use and Income. These reports will be useful to those working in the health sector to improve the health of the elderly population.

The report is available to download at: **https://www.fmhs.auckland.ac.nz/en/faculty/lilacs/research/publications.html**

For more information, please go to http://www.maorihealth.govt.nz

Working with racism: a qualitative study of the perspectives of Māori (indigenous peoples of Aotearoa New Zealand) registered nurses on a global phenomenon

Authors: Huria T et al.

Summary: The experience and impact of racism on Māori registered nurses within the New Zealand health system was explored in this analysis of narratives contributed by 15 Māori registered nurses. The transcribed interview material was coded using Jones's levels of racism. The structural analysis identified that experiences of racism were a commonality. The nurses experienced racism on institutional, interpersonal, and internalised levels, leading to marginalisation and being overworked yet undervalued.

Comment: A really good examination of the experiences of an Indigenous health workforce; the Jones coding framework is well described here and would be a good resource for researchers wishing to examine the levels of racism in other areas.

Reference: J Transcult Nurs. 2014;25(4):364-72
Abstract

Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please CLICK HERE

Time spent reading this publication has been approved for CME for Royal New Zealand College of General Practitioners (RNZCGP) General Practice Educational Programme Stage 2 (GPEP2) and the Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please CLICK HERE to download your CPD MOPS Learning Reflection Form. One form per review read would be required.

Independent commentary by Dr Matire Harwood

Dr Matire Harwood (Ngapuhi) has worked in Hauora Māori, primary health and rehabilitation settings as clinician and researcher since graduating from Auckland Medical School in 1994. She also holds positions on a number of boards, committees and advisory groups including the Health Research Council. Matire lives in Auckland with her whānau including partner Haunui and two young children Te Rangiura and Waimarie.

Racial disparities in pediatric kidney transplantation in New Zealand

Authors: Grace BS et al.

Summary: This retrospective analysis of data obtained from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) identified 215 patients aged <18 years who started renal replacement therapy in New Zealand between 1990 and 2012. The analysis revealed disparities in live donor transplantation: Europeans and Asians were most likely to receive a transplant (92% and 91% transplanted within 5 years, respectively), while Pacific and Māori patients were less likely to receive a transplant than Europeans (51% and 46%, respectively). Pacific patients were more likely to have glomerulonephritis and focal segmental glomerulosclerosis. Rates of 5-year death-censored graft survival were lowest among Pacific patients (31%), higher among Māori (61%) and highest among Europeans (88%). Retransplantation after loss of primary graft did not occur in any Pacific patients within 72 patient-years of follow-up, whereas 14% of Māori patients and 36% of European and Asian patients were retransplanted within 5 years.

Comment: An excellent overview of the management of ESRF in children, highlighting differences in the cause of renal failure and disparities in transplant rates.

Reference: Pediatr Transplant. 2014;18(7):689-97
Abstract

Clinical and demographic associations with optic nerve hypoplasia in New Zealand

Authors: Goh YW et al.

Summary: These researchers retrospectively reviewed the medical records of 1500 children with severe visual impairment registered with Blind and Low Vision Educational Network New Zealand. The study aimed to determine the clinical features of optic nerve hypoplasia (ONH) and prevalence within this population. The review identified 94 children (6.3%) with ONH; 91 cases (97%) were bilateral. Of all 94 cases, 52 children (55%) were male and ethnicities were European Caucasian (52%), Māori (40%), Pasifika (6%) and other (2%). Most children with ONH had poor vision; 60% demonstrated ≤6/60 Snellen visual acuity equivalent. The median maternal age was 20.0 years, with 52% aged ≤20 years. The ONH cohort had significantly higher rates of Māori ethnicity (40%) and young maternal age (44% were aged <20 years) compared with the general population (14.6% and 7.4%, respectively; p<0.0001). Half had hypopituitarism and 60% of cases demonstrated neuroimaging abnormalities. Cerebral neuroradiographic abnormalities were associated with a higher rate of developmental delay (OR 9.764; 95% CI, 3.246 to 29.373).

Comment: The incidence of ONH is increasing internationally, it is associated with other important outcomes (including developmental delay), and although some studies have described possible risk factors (such as young maternal age), the cause is yet to be identified. Importantly, there is clear evidence here that it occurs more frequently for Māori, requiring appropriate screening (and hopefully treatment) interventions.

Reference: Br J Ophthalmol. 2014;98(10):1364-7
Abstract

Prevalence of abnormal sleep duration and excessive daytime sleepiness in pregnancy and the role of socio-demographic factors: comparing pregnant women with women in the general population

Authors: Signal TL et al.

Summary: Outcomes are reported from an investigation into abnormal sleep duration and daytime sleepiness during pregnancy among Māori and non-Māori women versus the general population, and the influence of sociodemographic factors. Self-reported total sleep time (TST) over a 24-hour period, Epworth Sleepiness Scale scores and sociodemographic information were obtained from nullipara and multipara women aged 20–46 years at 35–37 weeks of pregnancy (358 Māori and 717 non-Māori), and from women in the general population (381 Māori and 577 non-Māori). In analyses accounting for ethnicity, age, socioeconomic status, and employment status, pregnant women were found to have on average 30 minutes less TST than women in the general population. The distribution of TST was also greater in pregnant women, who were 3 times more likely to sleep for ≤6 hours and 1.9 times more likely to sleep >9 h. Pregnant women >30 years of age experienced greater age-related declines in TST. Pregnant women were 1.8 times more likely to report excessive daytime sleepiness (EDS). Abnormal sleep duration was more likely among women identifying as Māori, those who were unemployed, and those doing night work. EDS was also more likely among Māori women and women who worked at night.

Comment: An interesting study. Although hormonal changes are often given as the main reason for increased sleepiness during the day, this project suggests social factors are also at play.

Reference: Sleep Med. 2014 Sep 3. [Epub ahead of print]
Abstract

Decolonising the Academy: the process of re-presenting indigenous health in tertiary teaching and learning

Authors: Curtis E et al.

Summary: This book chapter addresses disparities in Indigenous health workforce development in New Zealand. It discusses the recent development of the Hauora Māori curriculum within the Faculty of Medical and Health Sciences at the University of Auckland, which aims to improve Māori student recruitment and help to retain Māori and Pacific students, to ensure tertiary success within the Academy.

Comment: Yes, unashamedly plugging the work of my colleagues. However, I truly believe this paper will be useful to people supporting excellent health workforce development programmes.

Reference: Māori and Pasifika Higher Education Horizons. Eds.: HT Frierson, et al. Diversity in higher education, vol. 15, pp147-65. Emerald Group Publishing Ltd. 2014.
Abstract

Cost-effectiveness of interventions to prevent cardiovascular disease in Australia's Indigenous population

Authors: Ong KS et al.

Summary: This research was designed to help address the evidence gap regarding economic evaluations that could assist decision-makers to allocate additional resources in the primary prevention of cardiovascular disease (CVD) in Australia's Indigenous population. The study authors explain that CVD is the leading cause of disease burden in Australia's Indigenous population and the greatest contributor to the Indigenous 'health gap'. Five interventions (1 community-based and 4 pharmacological) to prevent CVD in Indigenous Australians were selected for economic evaluation. Pharmacological interventions were evaluated as delivered either via Aboriginal Community Controlled Health Services or mainstream general practitioner services. All pharmacological interventions produced more Indigenous health benefit when delivered via Indigenous health services, but cost-effectiveness ratios were higher due to greater health service costs. Cost-effectiveness ratios were also higher in remote than in non-remote regions. The polypill proved to be the most cost-effective intervention, while the community-based intervention produced the most health gain. The study authors advise that policy makers seeking to address health inequities and bridge the health gap must consider both the extent of health gain and cost-effectiveness ratios. As they conclude, "*failure to do so may result in redirection of resources away from where they are needed most to address health inequities*".

Comment: Really interesting research looking at the benefits and costs across a range of CVD interventions delivered to Indigenous peoples.

Reference: Heart Lung Circ. 2014;23(5):414-21
Abstract

EXPLORING THE POTENTIAL OF THE KNOWLEDGE AND SKILLS FRAMEWORK

By: Anne Esson

CENNZ Committee Member

Nurse Manager, Emergecny Department, Christchurch Hopsital

Introduction: *During the CENNZ conference held in Tauranga, it was announced that the College is in the process of developing a formal Knowledge and Skills Framework to help clarify the expectations and to stimulate discussion relating to competency in emergency nursing. As part of this process, it was announced that regular updates and information relating to this process would be shared with College members, via the journal. The first of these is in the form of an article outlining the purpose of Knowledge and Skills Frameworks and what they involve. Further updates and information generated from the process will continue to be developed and presented in the journal.*

Anne Esson

INTRODUCTION

The College of Emergency Nurses New Zealand has commenced the process to developing a formal Knowledge and Skills Framework (KSF) to help define and structure the expectations relating to education, competency and standards of practice for Emergency Nursing. The introduction of KSFs has been seen as way of identifying and embedding specialty nursing knowledge while recognizing the unique aspects and levels of practice that are evolving. This formalized process is intended to provide, as the name implies, a framework within which specialty nursing can continue to evolve, allowing for internally driven expectations and goals, measured against evidence based standards.

The movement towards establishing formal Knowledge and Skills Frameworks within nursing specialties in New Zealand (NZ) has drawn on work undertaken in the United Kingdom's (UK) National Health Service (NHS). An underlying intention, both internationally and in NZ, is to support recognition of those elements unique to specialty practice. This is achieved by providing an ongoing framework that allows for the development of continuing education and the establishment of specialty standards of practice.

There are differences, however, between the UK and NZ in regard to the primary use to which these frameworks are put. Within the UK, the frameworks emerged as part of the national Agenda for Change Reforms, and provide explicit links between competencies, pay and career progression (Gould, Berridge & Kelly, 2007). The NHS, like many health services, is facing concerns with staff recruitment and retention, as well as issues relating to skill mix and optimizing clinical roles to ensure best possible outcomes. As part of the overall response to such issues, health care staff roles (excluding those of doctors) were reviewed to identify the core clinical skills and expertise associated with job profiles. The knowledge and skills related to specific posts were assessed, rather than those of individual practitioners. The expectation is that this, in conjunction with annual review of the individual staff member, will allow for development of tailored continuing education programmes to support attainment of required knowledge and skills. Advantages are seen in relation to improved consistency resulting from national standards; with the overall process linking to the provision of quality care and support for lifelong learning (Agenda for Change Project Team, 2004).

Within NZ, some of the elements associated with the Agenda for Change are already evident, in the existing process that provides for competency based practice. Concern has been raised, however, over increasing sub specialization within nursing and the resulting need to develop relevant standards, policies and procedures. As a result, multiple documents have emerged across a range of settings, with little co-ordination, consensus or centralized access. The benefits of developing national standards are reflected in the movement towards establishing KSFs, with these providing opportunities for clarifying specialty practice and having an identified central repository for information. An additional strength is in facilitating and supporting nursing direction of core components, rather than waiting for this to be imposed in response to other agendas and from other sectors/professions.

THE ESTABLISHMENT OF THE NATIONAL NURSING CONSORTIUM

The establishment in 2011 of the NZ National Nursing Consortium (NNC) has provided an endorsement process for practice standards and KSFs in nursing. The consortium was formed with representation from the major nursing

EXPLORING THE POTENTIAL OF THE KNOWLEDGE AND SKILLS FRAMEWORK

organisations, the New Zealand Nurses Organisation (NZNO), the College of Nurses Aotearoa, the NZ College of Mental Health Nurses and the National Council of Maori Nurses.

The objectives of the NNC are given as:

1. Provide professional nursing endorsement of standards and specialty knowledge and skills frameworks.
2. Establish criteria for the endorsement of nursing standards and specialty knowledge and skills frameworks.
3. Establish a central repository of consortium approved standards and knowledge and skills frameworks, with public access.
4. Facilitate support and advice to groups expressing interest in the development of practice standards or knowledge and skills frameworks. *(NNC 2013a)*

The NNC information and database of KSF are housed on the Health Improvement and Innovation Resource Centre (HIIRC). This site was established in 2010 and is sponsored by the Ministry of Health, with the intention of sharing examples of innovation and quality improvement and *"making New Zealand research more available to people working in health"* (HIIRC, 2015).

As of February 2015, there are seven KSF which have been developed and endorsed for NZ nursing specialties. These are in the areas of cancer nursing, child health nursing, youth health nursing, pain management, nephrology, addiction specialty and respiratory nursing. The full documents related to these are available at http://www.hiirc.org.nz/section/15221/national-nursing-standards/?tab=6850.

DEVELOPING A KSF

Information, including the development of the KSF Toolkit, has been made available to provide clear guidelines and assist in the recognition of essential information to develop a specialty KSF (NNC, 2013b). The process involves three stages – the initial need is to establish legitimacy, that is, to demonstrate the evidence that identifies the chosen area as one that is a discrete and recognized specialty. This includes providing evidence that there is a specialty body of literature, as well as demonstrating that there is *"maturity and growing inter-disciplinarity, where nurses are acknowledged as experts within the specialty and collaboration is accepted"* (Hamric et al., 2009 cited in NNC 2014). In the case of emergency nursing, this involves recognition of the development over time of emergency nursing within NZ, together with the establishment of a research base and recognition from peers and colleagues.

The second stage is the identification of the particular elements of care for the specialty area. This provides an opportunity for practitioners and consumers of the specialty health service provided to define and clarify those aspects that make it unique. Identifying what is distinct about the population for whom care is provided together with the identification of health care needs forms part of this process. *The NNC (2014) suggest that aspects of care to be considered may include the following:*

- Assessment
- Pathophysiology
- Interventions
- Medications
- Health promotion
- Context of care

This process involves continuing Maori engagement, actively seeking the perspectives of consumers, specialty nurses and members of the wider interdisciplinary team in which the specialty functions (Holloway, 2012; NNC, 2014).

The final stage is the development of the KSF which *"addresses what the nurses providing care within the specialty area must know and be able to do in relation to the identified aspects of care"* (NNC, 2014, p.4). This stage provides information relating to the essential knowledge and skills required across three levels of practice, described in relation to what needs to be known by **all** nurses; what is needed by **many** (specialty), and what is needed by **some** (specialist). The concept of 'all' nurses is based on recognition that all registered nurses may at times be involved in the care of specialty patients, and so relates to the more general level of knowledge and skills required for safe nursing care. This aspect of the framework is described as providing guidance regarding orientation for nurses new to an area of practice, rather than necessitating extensive checklists (NNC 2013b). The reference to 'many' nurses is directed to those who are considered 'specialty' nurses; these nurses work within the specialty to provide *"routine, non-complex care for patients with specialized care needs"* (NNC, 2013b, p.3). A smaller group are those referred to as 'some' or 'few' in the documents, and these nurses are described as specialist nurses, caring for patients with *"increasingly complex, unpredictable specialized care needs"* (NNC, 2013b, p.3) and who are seen as leaders and experts within the area. Terminology used to describe these levels is not always consistent, but the nature of levels is.

EXPLORING THE POTENTIAL OF THE KNOWLEDGE AND SKILLS FRAMEWORK

DEVELOPING A NZ EMERGENCY NURSING FRAMEWORK

The first stage for the CENNZ working group is the clarification of emergency nursing within the NZ setting, identifying its perceived role within nursing and the associated scope of practice. Categorising emergency nursing as a specialty area of practice may seem straight forward, but it is important to recognise that it has not always been seen as such, and to trace the development and evidential base underpinning this. Those who consider themselves 'emergency nurses' often do so on the basis of their place of employment, for example, working in an Emergency Department, Accident and Emergency Clinic, After Hours Acute Care centre, or similar. However, emergency nursing is not defined simply by physical location, but more importantly, by the nature of the nursing undertaken. In this way, recognition of certain skills, attributes, attitudes and beliefs are brought together to enable the provision of a specialised range of cares. The emergency nurse may therefore be providing care in line with such an approach, while working in an area not designated as 'emergency' but incorporated within a broader service provision. Examples of this are nurses working under PRIME directives in rural settings, those acting in triage roles in smaller hospitals without an emergency centre and those working in primary and community care settings with additional skills to manage an undifferentiated patient population.

There are many thoughtful and thought provoking definitions of emergency nursing, with the following quote taken from the Emergency Nursing World website, which encapsulates many of the aspects associated with the specialty:

> *Emergency Nursing is a specialty in which nurses care for patients in the emergency or critical phase of their illness or injury and are adept at discerning life-threatening problems, prioritizing the urgency of care, rapidly and effectively carrying out resuscitative measures and other treatment, acting with a high degree of autonomy and ability to initiate needed measures without outside direction, educating the patient and his family with the information and emotional support needed to preserve themselves as they cope with a new reality. These activities may be carried out in a variety of settings and not necessarily in an "Emergency Room." Trimble*

The recognition of characteristics of the professional role, such as caring for patients in the acute phase of their illness or injury, together with acknowledgement of the individual characteristics required, including an ability to prioritise and to act autonomously contribute to an understanding of the features of emergency nursing. It is important, however, to ensure that we can justify and provide a rationale for why this combination of factors makes emergency nursing a unique and cohesive specialty, and to differentiate it from other areas that also draw on similar resources.

The development in NZ of a formalised national body representing the professional interests of emergency nurses can be seen as having progressed over time. An early initiative was the establishment of an NZNO Special Interest Group, which was followed in 1991 by the formation of a National Section within NZNO, with a membership of 91 nurses. Establishment of an Annual Emergency Nursing Conference dated from 1991 and has continued since.

The initial aims of the Emergency Nurses Section were:

- To encourage education and professional competence in accident and emergency personnel
- To promote improved standards of accident and emergency care
- To encourage and assist in the establishment of career training programmes in A&E nursing
- To promote interest and research in the A&E field
- To provide professional communications, through publications and meetings, to allow members to present and discuss the practice, research and study of A&E and allied subjects
- To provide official recognition for A&E personnel at local and national levels (Bickley, 1992)

In 2001 the national section was further developed and accepted as a Specialty College. The mission statement of the College of Emergency Nurses New Zealand (CENNZ) states:

> *We believe that Emergency Nursing is a specialty 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.*

A logo was developed, showing two cupped hands; the hands represent the womb of mankind, representing the concept that spiritual and physical healing go hand in hand. The hands are shown cupped together, indicating balance, Nga Ringa Ringa Aroha, the hands of love.

CONTRIBUTING TO THE KSF

The first stage is that of determining the legitimacy of a claim to 'specialty' practice, which is currently under way in NZ. As part of this, information is being collated on the educational opportunities, the research presence and peer recognition

EXPLORING THE POTENTIAL OF THE KNOWLEDGE AND SKILLS FRAMEWORK

of emergency nursing. This will be followed by widespread consultation within the healthcare community, and as part of these processes, the contributions of emergency nurses will be sought. Regular updates from the sub-committee looking into this process will be posted in the Emergency Nurse New Zealand journal, as will requests for particular information, perspectives or other assistance.

One way in which you can contribute to the current section of the KSF is to consider the following question:

> *Do you hold a Master's level or higher postgraduate qualification with relevance to emergency nursing?*

Efforts are underway to collate a comprehensive list of nurses who have completed a dissertation, thesis or research project as part of completion of such qualifications, with the intention to demonstrate a clear NZ generated research base for emergency nursing, and also with the intention of raising awareness within the specialty of the range of existing research knowledge. For those nurses who have studied to this level, and who have developed a core of expertise in their area of interest, this is also a good time to consider how this information could be effectively disseminated – an article for the specialty journal being an effective avenue to consider.

Further articles and updates relating to the KSF will be forthcoming, but if you answered 'yes' to the above question, please contact:

Dr Sandra Richardson

Sandra.richardson@otago.ac.nz

With the following details:

- The qualification you received
- Year this was awarded
- Type of research (eg thesis, dissertation, project)
- Title and abstract of the project
- The university or institution from which you graduated

References;

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A VACANCY CURRENTLY EXISTS ON THE COMMITTEE FOR REPRESENTATIVE FROM THE NORTHLAND/TE TOKERAU REGION

PLEASE EMAIL THE CENNZ CHAIRPERSON LIBBY HASKILL FOR MORE INFORMATION!

AUCKLAND REGION

MATT COMESKEY

Clinical Nurse Specialist

Emergency Department
Auckland City Hospital

Contact: mcomeskey@adhb.govt.nz

Greetings

It has been a busy summer in the Auckland, with net migration into the city continuing to place further demand on the emergency services in the region. Auckland Hospital Adult Emergency Department had its busiest day ever on 2nd January with 222 patients seen over a 24 hr period. Work load has been added to with a number of regional and national level events occurring in the city. These included the Nines Rugby League tournament, World Cup Cricket and an increased number of visiting cruise ships - all of which have brought visitors into the city.

The redesign / redevelopment of Auckland city Hospital ED is ongoing. It is anticipated that no physical work will be undertaken until winter has passed. There is still considerable planning to be done around re-thinking models of care before the practical layout and design of the department can be finalised.

Auckland ED has employed three new graduate nurses. This is a first for Auckland, and has generated some discussion and planning on how a new graduate can be safely oriented and supported in a busy department.

Another very successful AEEN day was hosted by Middlemore Hospital in March. It was great to meet ED nurses from across the North Island. Presentations included eye assessment, ENT presentations, child protection and administration of intra nasal fentanyl. An interesting presentation and discussion was led by Carol Dewes (Waitakere ED) covering her journey to Nurse Practitioner and the challenges she successfully faced in achieving a hard fought-for goal. From the degree of discussion generated around Carole's presentation the issue of transition to NP roles will probably be a discussion regularly revisited by AEEN members, in particular how NP registration results in employment in an NP role. This is particularly relevant given the increasing number of ED nurses in specialist roles who are also on the NP pathway or who want to be; (*see Rick Foster's paper 'Advanced Emergency Nurses Network Survey 2014' included in this edition*).

With the days getting cooler and Autumn just around the corner, I trust everyone is rested up and ready for the winter ahead.

MATTHEW

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AUCKLAND REGION

LIBBY HASKELL (Chairperson)

Nurse Practitioner

Children's Emergency Department
Starship Children's Health

Contact: libbyh@adhb.govt.nz or cennzmembership@gmail.com

The Children's Emergency Department finished a very busy 2014 on a fabulous high. After several years of amazing effort but disappointment at not winning first prize and not being able to ***Let It Go***, we finally won the Starship Christmas decoration competition! The commitment shown by all of our multi-disciplinary team who spent hours on the ***Frozen*** themed project, as well as seeing the excitement from involving the children and families visiting our department, finally paid off. Judging day was very stressful: staff were dressed in ***Frozen*** theme, many of our staff brought their ***Frozen*** themed children to be part of the fun and we had 2 amazing ***Frozen*** ice sculptures gleaming (and melting!) in the department (kindly donated by a grateful family). In true CED style, we had a fabulous ***Frozen*** themed morning tea – food is a large part of our CED culture! Hope you enjoy the photos. On a serious note, this event really brought our team together as it had been the busiest winter on record. It also brought lots of visitors from the rest of the hospital to CED to enjoy the ambience and share the festive spirit.

Summer has seen some reduction in overall patient numbers but we are still having some busy days with high acuity

Anna, Georgia, Nate and Kittie Essex (CED Nurse and competition coordinator)

Nate looks in wonder at the amazing decorations!

and volumes. We are performing many procedural sedations on each day using continuous nitrous oxide sedation as well as ketamine. This reduces the need for theatre time, admissions as well as reducing the time for families spent in hospital.

Our staffing is good and we have several nurses knocking on our door wanting to join our team. We have welcomed another new graduate nurse this year – it is always so inspiring to have these new keen and excited nurses join us.

Our department has had a real lift with a paint job over the summer. Our colours have slightly changed and it really has brightened up our environment.

The hospital is undergoing change with a new Single Point of Accountability (SPOA) structure being introduced. This has resulted in a new role of Service Clinical Director (was Clinical Director) and our department's Charge Nurse Manager now taking additional responsibility in a Nurse Unit Manager role. It is exciting times ahead.

We are currently undergoing a Well Organised Ward (WOW) process and introducing Releasing Time to Care. This process involves "knowing how we are doing" with performance tracked against core objectives of improving

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patient safety and experience, reliability and efficiency of care and staff wellbeing. As part of this process, we will be looking at patient observations, shift handover, medications and meals for families.

We have just commenced recruiting for the ConSEPT study (a RCT of children presenting with convulsive status epilepticus comparing levetiracitam (kepra) vs phenytoin). CED is the lead site with one of our SMO's being the principal investigator and our research nurse being the study coordinator. This is a multi-centre study involving 13 hospitals across Australasia. We continue recruiting to the WASP study (Wheeze And Steroid in Preschool children) study which aims to tell us whether the use of steroids in preschool wheeze is of benefit. The chocolate you get for enrolling patients is always well received and the results will be very interesting!

Hoping to have an update in our next journal from our colleagues at Counties Manukau.

LIBBY

COLLEGE OF EMERGENCY NURSES NEW ZEALAND CONFERENCE

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MIDLAND REGION

RICK FORSTER

Registered Nurse

Tauranga Hospital Emergency Department. Bay of Plenty District Health Board

Contact: Rick.Forster@bopdhb.govt.nz

Greetings to you all from Tauranga.

The pesky winds of the equinox have given way to a glorious summer in the Bay. With this thousands of happy holiday makers make their pilgrimages to our golden beaches and warm waters. Such an influx influences our departments workload. Our daily presentation numbers when viewed over a year appears like a two humped camel with the summer and winter spikes.

The summer case mix invariably brings an upswing in minor injuries and illness as well as major trauma. Sadly the roads of the Midland Region have claimed many victims this summer as widely reported in the media. Our emergency departments regularly have had to flex -up and manage multiply multi-trauma patients.

Greater hospital wide engagement in owning the shorter stays target has been seen. This should be celebrated as is necessary if departments are to meet this goal. Combining the two Bay of Plenty DHB EDs we are currently tracking close to the 95 % target for this quarter. Our ED has also been accredited by the Australian College of Emergency Medicine as a registrar training site. This will support a knowledgeable ED medical workforce.

Within Tauranga ED we have had a trickle of nursing staff leaving us with new fresh faces on the horizon. Two new graduate RNs have just joined us for an exciting and challenging first year of practice. Notably departing is Louis Cubis who has had a long career within our DHB. She has performed many roles within this time but has held a core value of patient advocacy throughout.

Tauranga ED has recently introduced a "Bundles of Care" trial, thank you Waitemata DHB for sharing these with us. These multidisciplinary pathways engage RN, CNS, NP and doctors to deliver care for common presentations in an evidence based manor. We are also commencing a process to improve our management of patients with sepsis. A recent audit found we could do a lot better. The new process is based on the surviving sepsis campaign and its 6 interventions. RN are being encouraged to facilitate implementation of these within 1 hour of sepsis identification. A simple template of care sticker outlining these is attached to the notes to work off. As nurses we are in a great position to really make a huge improvement in the care of the patient with sepsis.

Whakatane hospital staff have been extremely busy with the move to a new campus including a brand new 17 bed ED. Feedback from patients to me is the new environment is a massive improvement. Since June 2014 the ED team has also implemented a joint after hours service with the local Primary Healthcare Alliance. This involves the ED managing additional primary health patients during the week, whilst on weekends patients may be referred to a GP's clinic. This has resulted in an improved service to the community particularly during the busy weekends. A large reduction in "did not waits" has been seen. This collaboration with primary health is continually evolving and now includes teleconference between the ED medical staff to nurses in a satellite service in Opotiki Health Centre.

The Whakatane ED is looking for RN's to join their dynamic workplace. Working in a rural department lends itself to development of a broad knowledge base and flexibility in practice. If you are interested in joining their team and enjoying the natural beauty of the Eastern Bay of Plenty this could provide an attractive lifestyle option for you. Contact the Whakatane ED Nurse Manger Colleen MacGregor for further information. I will be looking to make contact with the Waikato DHB team for the next report.

Looking into my crystal ball for the year I see a continuation of last year's trend towards higher than forecast presentations, placing our department into a high variance response. Again resources will be tight as with all government departments, an underlying direction of fiscal restraint will be employed. The EDs will engage more with the new ED quality care measures whilst the Shorter Stays in ED (aka 6 hour target) will remain a focus of joy and sorrow for some. Though as nurses we can sometimes feel like the meat caught in the sandwich the new quality measures are aiming to improve care, encouraging and quantifying positive patient outcomes and experiences.

RICK

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HAWKES BAY / TARAWHITI REGION

SHARON PAYNE
(Triage Instructor)

Nurse Practitioner

Emergency Department
Hawkes Bay Regional Hospital

Contact: sharon.payne@hawkesbaydhb.govt.nz

The end of 2014 went out in a flurry of sick and injured patients, our December /January numbers were our highest on record.

We opened our new 4 bed ED Observation unit just prior to Christmas, and while we had a few staffing issues due to recruitment not being finalised, these beds were well used during this period. Along with these beds a lot of work has gone into improving the journey for our patients and decreasing the time spent waiting in ED. Our compliance to meeting the 6 hour target was deteriorating so a whole hospital approach was again used to address this issue. There are currently a number of projects being undertaken at present within the DHB to look at some of these issues. This includes the AIM 24/7 project looking at care over the complete 24 hours and not just office hours, and an after hours project, looking at what care is provided during this time. In Hawkes Bay currently, there is very limited after hours options for people within our community if they need to seek healthcare.

In the last 2 months we have recruited 11 new staff, to cover maternity leave, natural attrition and to cover the new ED obs beds. Two of these staff are new graduates, and having had positive experiences of new grads for many years we welcome them with open arms. The numbers of new staff is putting a bit of a burden on our senior nurses, but in the end we plan to have a great team of nurses on board.

Our pregnancy virus appears to be contained. There are no new announcements as yet. The first of our babies have arrived; 2 girls and one boy. Mums, Dads and the babies are all doing well.

Our Wairoa nurses have come to spend a few days with us. This is a great initiative, allowing these nurses exposure to a number of experiences and challenges.

We have held an ENPC course in HB last month with some very positive feedback and we look forward to TNCC later in the year.

The DHB leadership awards were held in the later part of last year with ED. AAU along with the respiratory team winning an award for the COPD project. The leadership award went to one of our staff. A great achievement for our department.

We have lost one of our FACEMS this month, so we are looking for a new one. Any spares with good references, please send our way, need to come with good references however. It leaves our senior medical team a bit light, so our nurses are there to support them as much as they can.

We are gearing up to start our Flu vaccinations soon, scary really. Winter is coming. We have 5 qualified vaccinators, so anyone that dares to walk through our department may find themselves offered a flu jab. This group are also in there doing opportunistic vaccinations for our children.

Keep up the good work, enjoy the rest of summer

SHARON

REGIONAL REPORTS

MID CENTRAL REGION

AMANDA BIGGS-HUME
(Membership Secretary)

Clinical Nurse Specialist

Emergency Department Palmerston North Hospitalh

Contact: mandyhume@hotmail.com

MidCentral DHB has agreed to increase the ED nursing staff by 3.0 FTE, which will be used to increase the nursing resources at triage. After a particularly strenuous winter in 2014, ED nurses met with management to air their concerns and this, along with input from the senior medical team in ED has led to this agreed increase in nursing FTE. Having two nurses at triage for 16 hours of the day will significantly improve the care of patients in the waiting room. It will also enable patients to be moved in and out of the waiting room to facilitate flow within the department. It is now fully understood that the waiting room is an active treatment area. In addition to increasing the FTE, recruitment is underway for nurses to replace staff resignations.

The overall presentation numbers at Palmerston North ED have been slightly down over the summer months. There was however an increase in muscular skeletal injuries related to recreational activities and new Christmas presents that meant our CNS service saw close to record numbers of patients over the past couple of months.

Summer also brought some interesting and unusual trauma cases, and there has been a lot of attention from the local press. A reporter spent New Year's Eve in ED, and fortunately there were no dramatic events while she was there.

ED has finally achieved success in the smoking cessation target due to a change to the documentation. Electronic records are the way to go, and we can't log a patient off the computer system without completing the smoking fields. The organization has also made progress against the shorter stays target so we are no longer languishing at the bottom of the table. The co-ordination and senior nursing team state that this has "been refreshing to be able to move patients quickly to ward beds". The only downside being that it is now highlighting some of the delays caused by ED practices.

With a lot of new nurses about to come on board, there will be plenty of mentoring and support available from the experienced nurses. The Nurse Educator role has also been increased from 0.6 FT to 1.0 FTE with the appointment of one of our current senior nursing team, who will increase her hours of work to assist the current Educator. She will have a dual role of both Associate Charge Nurse and Nurse Educator.

It is good to see the organisational acknowledgment of our increasing workload and the resulting increase in staff numbers to help meet this. There has also been a strategic acknowledgement about the importance of, and development of Advanced Nursing roles across the whole health care sector, which can only be good news for nursing in general and the delivery of care to the community we serve.

Yet again, I would like to make a plea to our colleagues in the rest of the Mid Central region. I would like to hear from any CENNZ member who would like to be the contact person from the Whanganui and Taranaki regions.

Please email me at the above address.

MANDY

REGIONAL REPORTS

GREATER WELLINGTON REGION

CRAIG JENKIN (Treasurer)

Clinical Nurse Specialist / Associate Charge Nurse Manager

Wellington Regional Emergency Department. Capital & Coast DHB

Contact: craig.jenkin@ccdhb.org.nz or cennztreasurer@gmail.com

Hello all. As the warmer weather of summer sinks in, the normal decrease in patient presentations has passed by the lower north island. Wellington and the Hutt Valley have either become a haven for holiday makers (http://www.stuff.co.nz/business/better-business/66183974/capitals-canny-bbc-crusade-running-hot) as the BBC highlights or the usual exodus from the region has not occurred. 2014, the busiest winter on record for the country, doesn't seemed to have eased up just yet.

Reflective of this was the Ministry of Health first quarter results showing CCDHB at 89% and HVDHB at 88%. This will create some discussion as to why this occurred. Processes are continuously adapting and improving but within the region, and I believe nationally, quarterly presentations continue to creep up, moving the goal posts and making achieving the target a little harder. Only Wairarapa DHB managed to meet the shorter stays target with 96%.

In Wellington with continuing workload there has been notably an increase in summer sick leave and winter is coming again. There are conversations occurring at management level to help with the winter surges planning. The challenges to staff will be to come up with achievable solutions and ideas that have not been considered to help meet the winter demand.

One of Hutt DHBs current issues is developing a major incident plan for visitor surge during high profile cases. This is based on a recent problem with visitors arriving after social media was used as the trigger during a high profile case in the community with patients in ED.

Patients and their immediate family were not the issue – it was the volume of others wanting to come in to see their 'bro'. Hutt is currently working with security to see what we can do in future to better manage this sort of surge when it became impossible to contain the visitors. The committee is developing a position statement around safety in ED on the background of increasing safety concerns in Departments around New Zealand.

Wairarapa has managed to increase staffing significantly in the past year but there still needs to be a continued focus on getting more leadership positions into EDs in rural hospitals and some flexibility in how care and expertise is obtained such as concepts like telehealth.

With all the ongoing work that the region has for the up and coming year there could be concern that there is not enough time to do anything else. That is not the case at all. On October 15th and 16th the 3 DHB's will be hosting the annual College of Emergency Nurses conference at the Rydges Hotel in Wellington. Planning is well underway and we hope you all will be able to attend. We have some great speakers and concepts that will hopefully show the uniqueness of Emergency Nursing in 2015. See you all there.

Lastly this is my final term as the Greater Wellington Regional representative on the College committee and I will be stepping down following the October Conference. If there is a member thinking of a new challenge you should consider this role.

CRAIG

REGIONAL REPORTS

TOP OF THE SOUTH REGION

SHARON SCOTT (Secretary)

Acting Charge Nurse

Emergency Department
Nelson Hospital

Contact: sharon.scott@nmhs.govt.nz

Nelson and Wairau EDs are consistently meeting the 6 hour target, currently we are back in second place. However we have ongoing challenges with achieving family violence and smoking cessation screening requirements.

Nelson ED had a busy January, with some days up to 100 presentations. The Medical Injury Centre next door also saw large numbers. We are noticing acuity and dependency increasing significantly. We are also having increasing pressure on our facility, with patients in corridors occurring more frequently.

We have had a lot of focus on staffing recently. Four new nurses have been employed to cover leave. This was previously covered by staff working up and casual nurses. Once these nurses are in place it will make a big difference to day-to-day management of the roster and leave balances. A number of our new staff are more junior, resulting in challenges for rostering skill mix. We are trying to utilize our nurse educator more strategically in order to support new staff. One of our senior nurses has formed a group to develop a more clinical orientation programme (including introducing a 'casting card' – thank you Waitemata).

Nelson ED has had a site visit from the CEO in response to ongoing concerns raised at Health and Safety meetings. The draft NICE document *Safe Staffing for nursing in A&E departments* has been a useful tool in highlighting staffing needs, along with staffing repository benchmarking, reportable events and patient complaints. We are awaiting the outcome of the budget prioritization process, hoping that our requests for an advanced nursing role in ED, more nurses on the floor, and a health care assistant are signed off.

We have started having senior staffing meetings of expert nurses and SMOs. Previously the direction of the department has been predominantly SMO driven. We have developed themes for 2015: adequate analgesia, choose wisely, stop the clock. An off-premises regional ED planning day is scheduled, when these themes will be developed more.

One of our nurses has done the MOH Ebola training and will soon be going to West Africa. We have a new DON, Pamela Kiesanowski, and are soon to have a new ADON. Research undertaken by some of our FACEMs has been recently been published in the NZMJ. Have a look at *Use of an accelerated diagnostic pathway allows rapid and safe discharge of 70% of chest pain patients from the Emergency Department*.

No update received from Wairau ED.

SHARON

ARTICLE SUBMISSIONS FOR THE (MID YEAR) ISSUE OF THE JOURNAL ARE NOW OPEN PLEASE CONTACT THE EDITOR MICHAEL GERAGHTY FOR MORE INFORMATION!

email Michael at: cennzjournal@gmail.com

REGIONAL REPORTS

CANTERBURY / WESTLAND REGION

ANNE ESSON
Nurse Manager

Emergency Department
Christchurch Hospital

Contact: anne.esson@cdhb.health.nz

CHRISTCHURCH ED

Presentation numbers have steadily fallen over the past 4 months from a record high of an average of 270 per day in September to 230 in January. This drop has provided us with an opportunity to re-energise and enjoy a less hectic pace of work.

The report resulting from the review which was undertaken last year has been released. An implementation plan of the recommendations will be developed once feedback has been obtained.

We have no registered nurses vacancies although we are still working on backfilling a large parental leave vacancy.

Christchurch Hospital has appointed a Nursing Director of Hospital Operations. The focus of this role is on daily hospital operations and patient flow across the whole hospital. The CDHB has met the 'Shorter stays in Emergency Departments 'for the second quarter and is trending to meet the target for the 3rd quarter.

Facility planning for the new acute services building has recommenced with drilling down on the detail about future models of care being the next major piece of work.

The Advancing Emergency Care Course (AECC) pilot course finished in mid February. Five experienced emergency nurses completed this 8 month course. The goal of this course is to build on the participants knowledge and skills through critical thinking and reflective practice with a strong clinical component. A special thanks to the nursing education team who designed and conducted the course and the ED medical team, especially Drs David Richards and Scott Pearson for their support. The second course begins in March 2015.

The Nursing Education Team from Left to right: Claire Corbishley, Emily Fielder, Julie Bruerton, Nikki Corner and Trish Martin

GREY HOSPITAL

The fabulous weather on the coast brought with it quite a large influx of visitors. So there were a number of busy days. A NetP nurse has joined the ED team at Grey hospital. The plans for the new hospital are at the sign off stage. Two nurses are attending the triage course at the end of February. One of our team is in the final stages of her Master's study.

MARGARET ANDERSON

The Ashburton Acute Assessment Unit continues to see increasing numbers. With the increase in the local population some GP practices are full and unable to take new patients. There has been an increase in the number of alcohol related presentations mainly during the night shift.

ANNE

REGIONAL REPORTS

SOUTHERN REGION

CARLY HAWKINS
(Awards / Grants & Website)

Clinical Nurse Specialist

Emergency Department
Dunedin Hospital

Contact: carly.hawkins@southerndhb.govt.nz

Hi everyone

Hope you all had a great summer may it continue....

Here in the Southern region we have had a busy summer with the great heat and long dry summer days. Lots of visitors to the region but then this bring lots of road traffic accidents.

DUNEDIN ED

The Students are back in town, Orientation week which is held by the University of Otago went well, too note a lot to patient presentations of students and young folk who are not attending University but visit from around NZ to join in the fun, and yes fun has been had by all. Oh, forgot not just Orientation week, but international cricket and rugby matches in town, so lots of visitors, great weather, more fun.

We had large numbers of presentations over the week but we managed to meet the 6hr target 7 days in a row, well done everyone. Then unfortunately then came the 3 days of 160, 141 and 160 patient numbers in a row, big numbers for Dunedin ED. Hopefully things might else up.

We have 1 NETP student at present, and are thinking of taking on a 2nd mid-year. The ED is continuing to support Enrolled nurse students from SIT who are on placement at the end of their studies, great to have them as part of the team, hopefully we can move forward to employing Enrolled nurses to join us in the team especially to work within the EDOB's area and fast track.

New ETZ (Early treatment Zone) trial: Mon – Fri for 2 hours per day has been running. It works with an SMO and senior RN streaming pts, commencing pt. plans, x rays, bloods, ECG. The role of the project is to stream pts. too acute, SAU, Fast Track, referral to inpatient speciality or discharge home.

The CNS role was reviewed end of 2014 within input of ED staff and SMO's. At the end of Jan the revised role commenced with all 3 CNS sharing shifts equally in fast track (minors) with extended CNS hours on a Fri, Sat, Sun and Mon evening until 23.30hrs.

With the 6 hour period of overlap on these 4 days, the CNS time will being spent working on staff development. Exciting times ahead for all.

Ongoing is a project for the review of the trauma team. This includes the review of ownership of the call i.e. ED running the trauma, historically it has been the Surgical department, the project is also who attends a trauma call, nursing roles etc. As a teaching hospital there can be large numbers of staff and students attending.

There has been an increase in number of nurses within the ED completing Post graduate study, with 3 nurses completing their Masters and hope to graduate in May. On another positive note Dunedin ED seems to have a similar problem to other ED's around the country with a tsunami of pregnancies, lots of baby toys being bought.

We held another Southern Regional CENNZ-NZNO Study day at the end of January. 74 nurses were able to attend from around the region. A great variety of speakers: from Stroke Thrombolysis, Massive blood transfusion to Preceptorship within the ED.

REGIONAL REPORTS

QUEENSTOWN ED

It has been a busy holiday season in Queenstown with high visitor numbers and subsequently high daily presentations.

Many medically unwell patients have required transfer to Southland or Dunedin Hospitals.

As with Dunedin and across the region there have been several very nasty traumas.

The CNM is meeting with nursing management to discuss staffing levels for winter season and next Christmas holiday period, as staffing is no longer adequate to maintain safe staffing.

We have 2 staff undertaking postgraduate study this year.

There is the ongoing pressure from doctors to redirect patients to primary care. There is debate being had about the potential risks to nursing practice with redirection. Additionally, what role if any the ED nurse should have in relation to informing patients of charges or obtaining payments.

This is my last regional report for the Southern Region as my time is over.

So I would like to say thank you to all the CENNZ members as well as the National committee members who I have had the pleasure and opportunity to work alongside over the past 4 years. I wish you all the best in your career, your work places and keep up the excellent work. Southern Regional members please take the opportunity to consider applying to join the committee. It is a great opportunity to network, broaden your knowledge and lead change in emergency nursing in NZ.

CARLY

CENNZ NATIONAL COMMITTEE

SOUTHERN REGION REPRESENTATIVE

Carly Hawkins is returning to the UK leaving a vacancy on the National Committee In becoming a committee member for CENNZ you will be involved in strategic planning, governmental dialogue, collaboration with national agencies, development of education for emergency nurses and networking with other emergency nurses nationally and internationally. The term of office is for 2 years (maximum of 4 years) and requires a moderate time commitment and computer skills. There are four face-to-face meetings per year (which are for 2 days each) and a monthly half hour teleconference. The role also involves other committee responsibilities between meetings as well as disseminating information back to your region.

If you are interested or wish to get further information, please contact the CENNZ Secretary at cennzsecretary@gmail.com

Nominations close Friday 24th April 2015

COLLEGE MEMBERSHIP RENEWAL DUE 1ST APRIL 2015.

Full members may hold office, have full voting rights and are eligible to apply for financial assistance as offered in the form of scholarships and grants by CENNZ-NZNO.

The annual membership fee entitles members to the college journal (published three times a year) and significantly reduced fee for the college's annual conference. Annual membership is presently $25 per annum, (paying by credit card will incur a $5.00 charge for processing).

Membership can be renewed on-line on the CENNZ home page (http://www.nzno.org.nz/groups/colleges/college_of_emergency_nurses) under the 'Join Us' tag.

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