JULY | 2015
The Journal of the College of Emergency Nurses New Zealand (NZNO)
ISSN 1176-2691

EMERGENCY NURSE NEW ZEALAND

Inside:

IN THIS ISSUE

FEATURES:

REGULARS:

EMERGENCY NURSE NZ

EDITORIAL COMMITTEE

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

Auckland District Health Board A+ Trust began a new initiative this year to recognize long service in its employees; as such I was invited to a ceremony recently to celebrate 20 years of continuous employment with the DHB. Having initially accepted the invitation I was a bit hesitant to attend on the day being the cynic that I am so was very surprised to arrive at the venue to find a lot of effort had gone into setting up the venue (balloons etc), tables with food, drink and a significant number of the Executive Leadership Team in attendance to boot.

Twenty years in one organisation is a bit like a marriage (apart from the bedroom antics I guess), most of the time you enjoy the relationship, sometimes it truly pisses you off, sometimes you really wish you don't have to be there but on the whole you keep coming back because of a loyalty that may not be love but respect for the organisation and for those people within. Over the past 20 years colleagues become friends, share the highs and lows of your professional and private life and it is that camaraderie, (particularly prevalent in the ED setting) that enables you to turn up to work irrespective of how tired, grumpy you may feel that day.

In my time in ADHB I have worked in Paediatrics, cardiovascular surgery, ICU (to name a few) and maintain that that varied experience became the background that enable me to become a now 'seasoned' ED nurse. It was humbling and reflective to see other nurses and medical staff who have also been around for similar lengths of time who have also made successful careers within ADHB. Some of the current Clinical Directors were raw, terrified house surgeons back then and again humbling to see them and particularly have them acknowledge the help, assistance given to them back in their early days by their nursing colleagues.

On a slightly more sensitive note I would like to use this space to mihi atu ki a Carol Dewes, ex- CNS Waitakere ED (WDHB). Carol successfully applied for and became registered as an Emergency Nurse Practitioner in August 2014, since then she has been battling with WDHB to have that position recognised and be employed as a NP. Ironically the senior management and clinicians who supported her with letters of attestations, references for her portfolio are the same ones who have shown great reticence in establishing a role within ECC at Waitakere Hospital and with little hope of a role ever being established Carol has resigned.

Kaua e mate wheke, mate ururoa, e hine.

Michael Geraghty – Editor

ERRATUM

In the last edition of the journal the authorship of the article *Exploring the potential of the Knowledge and Skills Framework* was incorrectly attributed to Anne Esson.

The article was written by *Dr Sandra Richardson, Nurse Researcher Emergency Department, Christchurch Hospital.*

e-mail: sandra.richardson@cdhb.health.nz

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:

Jane Bebbington: MHSc. Senior Lecturer. Faculty of Medical and Health Sciences, University of Auckland.

Margaret Colligan: MHsc. Nurse Practitioner. Auckland City Hospital Emergency Department, ADHB

Lucien Cronin: MN. Clinical Nurse Specialist. Auckland City Hospital Emergency Department, ADHB

Nikki Fair: MN. Clinical Nurse Specialist. Middlemore Hospital Paediatric Emergency Care, CMDHB

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

Libby Haskell: MN. Nurse Practitioner. Children's Emergency Department Starship Children's Health, ADHB

Carmel Hassan: Clinical Nurse Specialist. Paediatric Emergency care, Middlemore Hospital, CMDHB

Dr Doug King: PhD. Clinical Nurse Specialist. Hutt Valley Emergency Department, HVDHB

Sharon Payne: MN. Nurse Practitioner. Hawkes Bay Emergency Department, HBDHB.

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

BASE TWO - One Creative Source

Level 1 | 82 Willis Street | Wellington

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

www.basetwo.co.nz

Chairperson's Report

CENNZ would like to welcome Christine Thomas (Whangarei Emergency Department) as well as Erica Mowat (Dunedin Emergency Department) on to the national committee. They will represent Northland and Southern regions respectively. They both bring a wealth of nursing and emergency experience with them. It is excellent to see nurses' putting themselves forward for these roles, as it is a challenge but also a fantastic learning and networking experience.

We will be seeking nominations in the near future to replace our Wellington and Top of the South committee members, Craig Jenkin and Sharon Scott who will be ending their 4 year term in October. Now is the time to start thinking if you would like the opportunity to represent your region. Feel free to contact myself or any other of the committee members if you would like to discuss the role.

The committee had the opportunity to feedback on the NZNO draft strategic plan. Overall we felt that it was a good plan. We requested specific mention of the challenges that emergency nurses (and no doubt other specialty nursing groups) around the country have in access and funding to

"We will be seeking nominations in the near future to replace our Wellington and Top of the South committee members, Craig Jenkin and Sharon Scott who will be ending their 4 year term in October. Now is the time to start thinking if you would like the opportunity to represent your region. Feel free to contact myself or any other of the committee members if you would like to discuss the role."

relevant and required ongoing professional development. We felt that NZNO should add to the plan that they would, *"Actively lobby employers and the government to allocate consistent, transparent funding to enable and optimise ongoing nursing professional development"*. On that note, CENNZ have funding available which we are very keen to allocate to CENNZ members who meet the criteria. Please see the website for full details.

You may have seen a brief article in the April, Kai Tiaki with a photo of the committee. It was great to be able to profile our college as well as give an update on what we are doing this year.

The committee is very aware that redirection from emergency departments is a process being discussed and implemented in some emergency departments around the country. In fact there was an article in the Taranaki Daily Times early in June, in regards to Hawera Emergency Department implementing a redirection process. This is in response to their department running at capacity and is for patients they feel would be better managed in primary healthcare. CENNZ has finalised our "Redirection of Patients Presenting to an Emergency Department to Primary Health Care Facilities" position statement. Endorsement of position statements is completed at the national AGM. However, we feel strongly that with the increasing occurrence of redirection, this position statement needs to be available for nurses sooner than October.

We are hoping to expedite the release of the position statement by undertaking an online endorsement process with our members. Please keep an eye on your inbox for this. In the meantime, if you are redirecting, we want you to keep yourself and your patients safe by working within your skill and comfort level and within your DHB's policy on redirection. Ensure you are documenting clearly and that you speak to your employer or CENNZ if you are not feeling comfortable with redirection.

Winter is upon us and it appears that ED presentations are increasing around the country. I wish you all the best for the next few months. The CENNZ Conference is in Wellington on the 15th and 16th October. Conference is always an excellent way to boost morale, re-energise, catch up with nurses from around the country and learn!

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

INTRANASAL FENTANYL FOR ANALGESIA IN THE ADULT EMERGENCY SETTING

By: Carmel Rigby

Clinical Nurse Specialist in Paediatric Emergency Care, Kidz First, Middlemore Hospital CMDHB, 2015

Carmel.Hassan@middlemore.co.nz

Key words: Opiate administration, intra nasal devices, pain management, pharmacotherapeutics.

INTRODUCTION

Intranasal analgesia has been widely used in the Paediatric emergency setting for the last decade or so to rapidly and effectively treat moderate to severe pain (1, 2, 7). Previously when a child came into the ED with severe pain, one of the first interventions to happen was another source of pain in the form of an intravenous cannula. When the intranasal (IN) atomiser started to be utilised as an effective and pain-free alternative to delivering intravenous (IV) opiate medications to children, it widely replaced the need for an IV line for many conditions such a minor burns or lacerations and bought time for topical anaesthetics to work for those children who needed IV access during their stay.

The advantages of IN medications include:

- Avoidance of hepatic first pass metabolism
- Direct delivery of drugs to the systemic circulation, rapid onset of pharmacological action
- High bioavailability of lipophilic drugs, very close to those of intravenous injection (Fentanyl has been shown to have an 80% bioavailability for nasal administration)
- Administration of lower drug doses through the nasal route, may lead to less adverse effects ie: respiratory depression
- IN drug administration is fast, painless, and does not require sterile technique.

ANATOMY OF THE NASAL MUCOSA

The adult nasal cavity surface area is 150–180cm2 and lined with a thin, porous and highly vascularized epithelium with total blood flow greater than that of muscle, the brain, or the liver ensuring rapid absorption and onset of therapeutic action.

Within this space, the respiratory region has a surface area of about 130 cm2 and occupies the majority of the nasal cavity consisting of the inferior, middle and superior turbinates.

The olfactory region located in the roof of the nasal cavity and on the upper part of the nasal septum contains the receptors for the sense of smell and has a direct connection to the central nervous system via the olfactory route, which serves as the route for IN absorption (4).

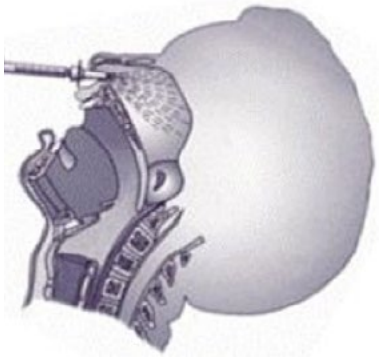
Due to the lipid solubility and the relatively low volume needed for efficacious analgesia, Fentanyl has been the opiate of choice for IN analgesia in our emergency department. It is a potent synthetic lipid soluble opioid analgesia with a rapid onset and short duration of action. It causes less nausea, and less histamine mediated itching, in relation to morphine and at a dose of 1mcg/kg has proven to be as effective as 0.2mg/kg of IM Morphine which makes it useful in moderate to severe pain and when IV access is difficult (2).

When compared to IV Morphine the total equipment cost is similar, both less than $10 at current prices.

Contraindications to delivery include: head trauma (basal skull fracture), fractured nose, chest trauma, abdominal trauma, hypovolaemia, hypersensitivity to opioids.

INTRANASAL FENTANYL FOR ANALGESIA IN THE ADULT EMERGENCY SETTING

ADMINISTRATION USING A MUCOSAL ATOMISER DEVICE (MAD)



Retrieved from Starship Clinical Guidelines: Intranasal Fentanyl (https://www.starship.org.nz/for-health-professionals/starship-clinical-guidelines/f/fentanyl-intranasal/)

The patient should be reclining at 45 degrees and the syringe should be held horizontal and the contents expelled as a mist in one rapid dose

Rhinorrhoea or other cause of blocked nose may cause unreliable delivery of the medication. Secretions should be expelled prior to administration.

Doses of 1 mL (50 micrograms) or more should be divided between nares to avoid run-off into the pharynx.

INTRANASAL FENTANYL IN THE ADULT POPULATION.

Finn et al, (2004) published a randomised double-blind placebo controlled two-treatment crossover trial comparing IN Fentanyl to oral Morphine for procedural pain. This trial included 26 patients aged 18-69 years with burns TBSA 1-25%. During dressing changes the patients received either:

- Day 1 – patient controlled IN Fentanyl (9 mcg/dose with 2 min lockout, range 0.34-2.47mcg/kg) and an oral placebo.
- Day 2 they received - IN Placebo and oral morphine (Range 15-40mg). Loading doses of either 36mcg IN Fentanyl (8 minutes prior) or 25-40mg oral morphine (30 minutes prior) were given before the procedure.

They concluded that there was no difference in safety, efficacy or patient satisfaction when comparing the medications. Adverse effects reported during the trial included reports of hypotension, nausea and sedation, all more likely to be found in the oral Morphine group and all resolved without significant incident.

Rickard et al (2007) compared IN Fentanyl to IV Morphine, with a randomised controlled trial of 258 patients, 18-65 years (mean 43) with severe cardiac type pain > 5/10 or non-cardiac pain >2/10 in the pre-hospital setting.

Patients received either IN Fentanyl 180 mcg (0.6ml of 300mcg/ml, a more potent strength than is currently available in NZ, or IV Morphine 2.5-5mg with 2 further doses of 60mcg IN Fentanyl or 2.5-5mg IV Morphine given a 5 min intervals if required. They also received other medications such as Penthrane™ (methoxyflurane) and GTN if clinically indicated. Results concluded that there was no significant difference in pain reduction between groups and no difference in verbal rating score from baseline to arrival at ED; 4.2 (INF) vs 3.5 (IVM) ~ 27-30 minutes. There were slightly more adverse effects reported in the IN Fentanyl group, including low respiratory rate/SpO2 - 7 vs 3, Hypotension - 8 vs 5 and Sleepiness/dizzy - 5 vs 0 though this was thought to also be potentially related to underlying diagnosis. Interestingly 12% of patients in IV Morphine group were unable (7%) or were very difficult to establish IV access which lead to delayed or no analgesia.

Comparing IN Fentanyl to IV Fentanyl. Christrup et al (2008) included 24 patients (18-40 yrs) in a balanced, randomised, double-blind, double-dummy, 2-way cross-over design who needed dental extractions. The patients received the same Fentanyl dose (75-200 mcg) twice (min 1 week between) by IN or IV route. They all also had Ibuprofen. Results found that the median time to pain relief was IN 7 minutes vs IV 2 minutes. Duration of effect was IN 56 minutes vs IV 59 minutes.

When comparing the doses of Fentanyl, patient's satisfaction for both routes rated equally for doses 100mcg and over. Adverse effects included vertigo and respiratory depression in doses exceeding 150 mcg, more likely to be in the IV groups and none of which required intervention.

Blood levels of Fentanyl were taken for both groups and serum levels were found to be comparable IN vs IV at 8 minutes or more, *see figure 1*.

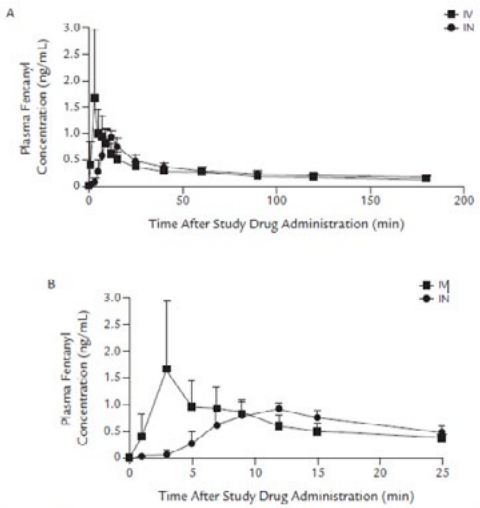


Figure 1. (A) Mean (SD) plasma concentration–time profiles after IN and IV dosing of 100 μg of fentanyl (n = 7). (B) Expanded plot of the first 25 minutes.

INTRANASAL FENTANYL FOR ANALGESIA IN THE ADULT EMERGENCY SETTING

CONCLUSION

In consideration of the research discussed in this article, intranasal Fentanyl should be considered for adults with moderate to severe pain when an opiate is required in consultation with local guidelines. It is rapid, efficacious, cost effective and painless with a safety profile similar to IV Morphine. The safe and effective dose seems to be 1.5mcg/kg (not exceeding a total dose of 150mcg) so should provide efficacious analgesia for adults up to 100kg. To provide maximal absorption, doses over 1ml should be given in divided doses delivered using a mucosal atomiser device, 0.5ml/nostril with a few minutes between doses.

References;

1. Borland. M., Jacobs. I., King. B., O'Brian. 2007. A Randomized Controlled Trial Comparing Intranasal Fentanyl to Intravenous Morphine for Managing Acute Pain in Children in the Emergency Department. *Annals of Emergency Medicine, 49*(3), 335-340

2. Cole J, Shepherd M, Young P. 2009. Intranasal fentanyl in 1-3-year-olds: a prospective study of the effectiveness of intranasal fentanyl as acute analgesia. *Emerg Med Australas, 21*(5):395-400.

3. Christrup LL, Foster D, Popper LD, Troen T, Upton R. 2008. Pharmacokinetics, efficacy, and tolerability of fentanyl following intranasal versus intravenous administration in adults undergoing third-molar extraction: A randomized, double-blind, double-dummy, two-way, crossover study. *Clinical Therapeutics, 30*, 469–81

4. Dale. O, Hjortkjaer. R., Kharasch. E. D. 2002. Nasal Administration of Opioids for Pain Management in Adults. *Acta Anaesthesiol Scand (46)*, 759–770

5. Finn. J., Wright. J., Fong. J., Mackenzie. E., Wood. F., Leslie. G., Gelavis. 2004. A randomised crossover trial of patient controlled intranasal fentanyl and oral morphine for procedural wound care in adult patients with burns. *Burns, 30*(3), 262–268.

6. Rickard. C., O'Meara. P., McGrail. M., Garner. D., McLean. A., Le Lievre. P. 2007. A randomized controlled trial of intranasal fentanyl vs intravenous morphine for analgesia in the prehospital setting. *The American Journal of Emergency Medicine, 25*(8), 911–917

7. Younge PA, Nicol MF, Kendall JM, et al. 1999. A prospective randomised pilot comparison of intranasal fentanyl and intramuscular morphine for analgesia in children presenting to the emergency department with clinical fractures. *Emergency Medicine 11*(2), 90-94.

PLEASE SEE THE CENNZ CONFERENCE AD ON PAGE 23

REGIONAL REPRESENTATIVES WANTED WELLINGTON + TOP OF THE SOUTH

Having completed their terms of office, two delegate positions will become vacant in the latter part of this year (October 2015).

If you are a CENNZ / NZNO member and interested in representing your region, have a chat with your current delegate (*Sharon Scott, Craig Jenkin*) to find out more.

Further information, dates for nominations etc. will be emailed to members in the not too distant future...

AENN REPRESENTATIVE WANTED

The Advanced Emergency Nurses Network (AEEN) is a sub section of CENNZ and specifically for those working as NP / CNS's in emergency care. The role of the representative is to act as the liaison between AENN and CENNZ committee, to oversee AENN study days and be the primary communication avenue between the two groups.

Expressions of interest to Michael Geraghty please:
mgeraghty@adhb.govt.nz

Treatment injury case study

Sharing information to enhance patient safety — *August 2012 – Issue 47*

EVENT: Wrong Site of Ventrogluteal Injection

INJURY: Infection

Case Study

32-year old Losefina presented to her General Practitioner (GP) with hip pain on movement and walking following her monthly benzathine penicillin intramuscular injection (IMI).

Losefina had a history of rheumatic fever and so was given the monthly prophylaxis injection. On this occasion the practice nurse gave 500mg of benzathine penicillin intramuscularly. The medical notes documented that the injection was given into the right ventrogluteal (VG) site.

Losefina went back to the medical centre the next day with painful movement in the right hip while walking, and inability to fully extend her hip. On examination her GP diagnosed an infection of the right anterior trochanter because of the IMI. Her GP was of the opinion that the benzathine penicillin injection had not been given into the VG site. Losefina was further reviewed and the treatment for infection injury was prescribed.

A treatment injury claim for the infection was lodged and accepted as it is not a necessary part or ordinary consequence of the treatment. ACC was able to assist with some of the costs of the additional treatment.

Key points

- Best practice supports the ventrogluteal (VG) site as the preferred site for administering intramuscular (IM) medication
- Advantages for the VG site include
  - thickness of gluteal muscle
  - freedom from penetrating nerves and blood vessels
  - narrow layer of adipose tissue overlying the site
- Only staff who have received training with practical oversight should administer a VG intramuscular injection (IMI)

Expert commentary

Gillian Sim, RN, BHSc, Master of Nursing

Implicated in the presenting case study, and common in the literature, is the failure to use proper procedures in locating injection sites conceivably related to inadequate knowledge of IMIs.

IMIs have known risks that include nerve injury, infection, abscess formation, tissue necrosis, neuropathy, paralysis, haematomas, bleeding, granulomas, muscle contractures, bony injury, local irritation, pain and muscle fibrosis (3). Despite these risks, the IM route is a valuable mode of medication administration, utilised when requiring a relatively quick uptake of medication by the body with a reasonably prolonged action (4) as in the circumstances outlined in this case study where benzathine pencillin was clinically indicated. Although nurses may be well aware of IMI risks, preventable complications still occur and some of these are attributed to lack of knowledge.

Competence in the administration of IMIs is an expectation of undergraduate, enrolled and registered nurses. Given the emphasis within nursing in recent years of keeping abreast of evidence-based practice (EBP), it is not surprising that nurses are implementing the best-practice advice on IMIs (1,2) and choosing the VG site as the preferred site for administering IM medication. However, as this case study highlights, empirical knowledge and technical knowledge need to inform practice alongside EBP to ensure safe patient care.

Literature on IMIs can be contradictory and there are discrepancies among a number of texts with regard to

IMI technique (7). Similarly, videos readily available via the internet are not reliably accurate. Although there is some best-practice guidance in the literature, written by individual health practitioners, there are currently no IMI best-practice guidelines emanating from a formal systematic review providing authoritive direction on the topic.

Clinical decision-making is central to a nurse who holds a practising certificate. Clinical decision-making regarding IMIs should be influenced by the age of the client, the medication to be injected, the volume of medication required, the general condition of the client and the manufacturer's instructions (5).

There has been considerable discussion in nursing literature over recent years on the site of choice for IMIs (1, 2, 4). Of the five suitable sites for IMIs (deltoid, dorsogluteal, ventrogluteal, rectus femoris and vastus laterals muscles), the VG is proposed as the preferred site for routine IMIs in adults (6). Nurses, like the one in the case study, choose this site as it provides the greatest thickness of gluteal muscle, is free from penetrating nerves and blood vessels and has a narrow layer of adipose tissue overlying the site (7). These factors mean that there is less likelihood of complications and more likelihood of injecting the medication into the muscle and not elsewhere. Using anatomical landmarks to correctly identify each IM site is imperative for safe IMI practice. These should be palpated as just using visual calculations can result in a misplaced injection.

Despite the VG site being taught in undergraduate nursing programmes for many years, and additional workshops being held for experienced nurses to learn the correct techniques, the common use and confident practice of administering a VG IMI is atypical. The VG site has been historically notoriously under-utilised by nurses both internationally and in New Zealand (NZ) – with one study determining that only 9% of NZ nurses used the site (8). It is reported that many nurses do not feel confident using the VG for IMIs in particular in relation to anatomical land marking of the site.

Education, combined with clinical support at the coal face of practice, is vital to the successful adoption of EBP for IMIs and an associated reduction in actual or potential patient harm. To avoid complications, nurses must continuously update their knowledge and skills as part of their professional obligation to competent practice. Like any other technical skill, only staff who have received training with practical oversight should administer a VG IMI. Nurse educators and nurse leaders in both primary and secondary settings can support nurses by providing clinical education on IMIs, with practical mentorship from VG champions confident in their practice. Clinical guidelines based on a systematic review of the literature would support safe, consistent and competent IMI practice.

References

1. Nicoll, L.H. & Hesby, A. (2002). Intramuscular injection: an integrative research review and guidelines for evidence-based practice. *Applied Nursing Research*, 16(2), 149-162.
2. Wynaden, D., Landsborough, I., McGowan, S., Baigmohamad, Z., Finn, M. & Pennebaker, D. (2006). Best practice guidelines for the administration of intramuscular injections in the mental health setting. *International Journal of Mental Health Nursing*, 15,195-200.
3. Barron, C. & Cocoman, A. (2008). Administering intramuscular injections to children: what does the evidence say? *Journal of Children's and Young People's Nursing*, 2(3), 138-144.
4. Cocoman, A. & Murray, J. (2008). Intramuscular injections: a review of best practice for mental health nurses. Journal of Psychiatric and Mental Health Nursing, 15(5), 424-434.
5. Rodger, M.A. & King, L. (2000). Drawing up and administering intramuscular injections a review of the literature. *Journal of Advanced Nursing*, 31(3), 574-82.
6. Cocoman, A. & Murray, J. (2010). Recognising the evidence and changing practice on injection sites. *British Journal of Nursing*, 19(18), 1170-1174.
7. Walsh, L. & Brophy, K. (2011). Staff nurses' sites of choice for administering intramuscular injections to adult patients in the acute care setting. *Journal of Advanced Nursing*, 67(5), 1034-1040.
8. Floyd, S. & Myer, A. (2007). Intramuscular injections – what's best practice? *Kia Tiaki Nursing New Zealand*, 13(6), 20- 22.

Claims information

Between 1 July 2005 and 30 June 2012 ACC received 451 claims related to IMI treatment injuries, of them 287 were accepted and 152 were declined.

The most common reason for declining was no physical injury caused by treatment was able to be established.

Out of total IMI claims, less than 4 claims are related to the VG site injection treatment injuries.

How ACC can help your patients following treatment injury

Many patients may not require assistance following their treatment injury.

However, for those who need help and have an accepted ACC claim, a range of assistance is available, depending on the specific nature of the injury and the person's circumstances. Help may include things like:

- contributions towards treatment costs
- weekly compensation for lost income (if there's an inability to work because of the injury)
- help at home, with things like housekeeping and childcare.

No help can be given until a claim is accepted, so it's important to lodge a claim for a treatment injury as soon as possible after the incident, with relevant clinical information attached. This will ensure ACC is able to investigate, make a decision and, if covered, help your patient with their recovery.

ACC6527 Aug 2012 ©ACC 2012

Printed in New Zealand on paper sourced from well-managed sustainable forests using oil free, soy-based vegetable inks.

About this case study

This case study is based on information amalgamated from a number of claims. The name given to the patient is therefore not a real one.

The case studies are produced by ACC's Treatment Injury Centre, to provide health professionals with:

- an overview of the factors leading to treatment injury
- expert commentary on how similar injuries might be avoided in the future.

The case studies are not intended as a guide to treatment injury cover.

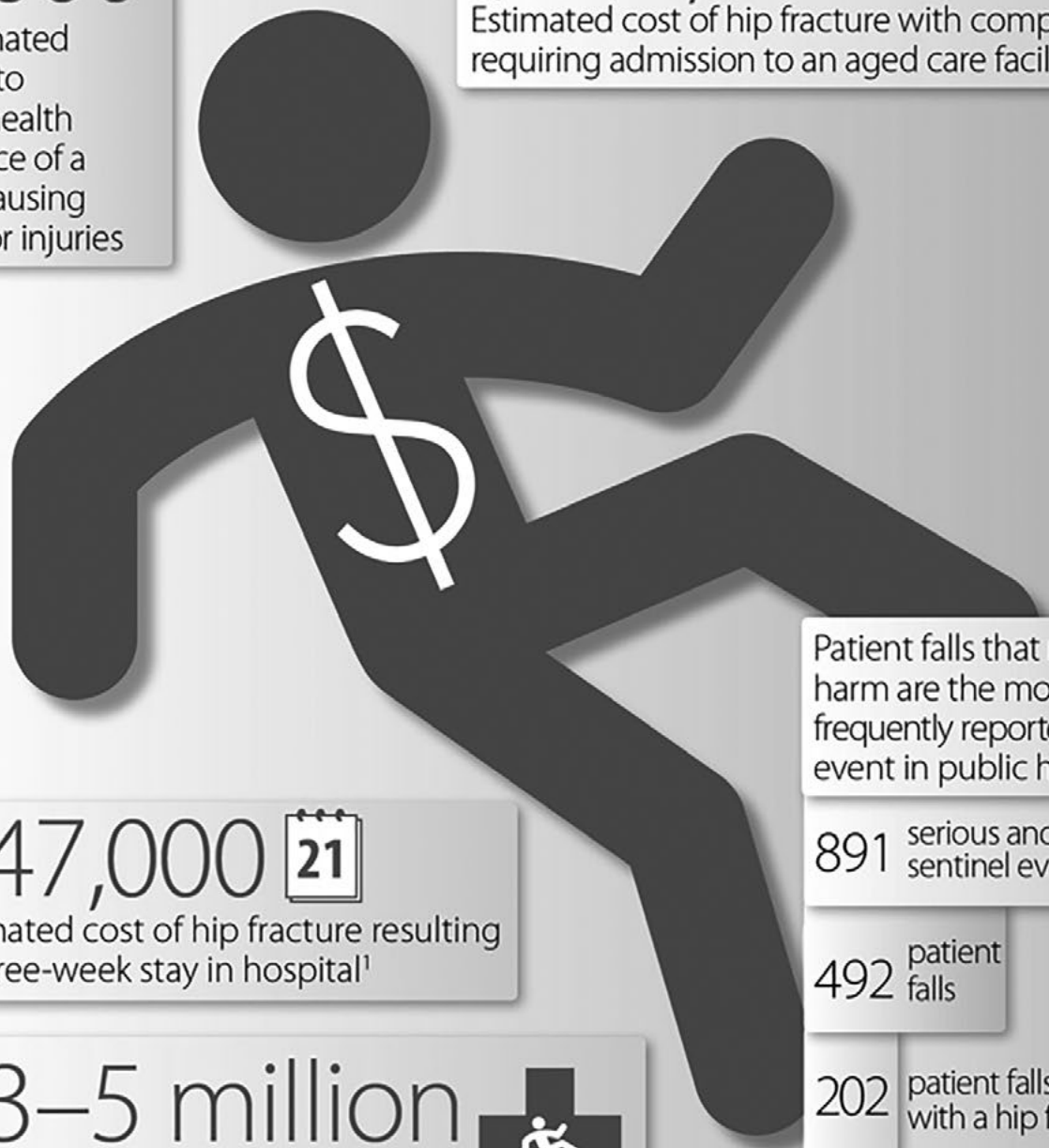
Send your feedback to: TI.info@acc.co.nz

open
FOR BETTER CARE
Hāpai ake te taiora

Harm from falls

$600
Estimated cost to the health service of a fall causing minor injuries

$135,000
Estimated cost of hip fracture with complications requiring admission to an aged care facility[1]



$47,000
Estimated cost of hip fracture resulting in three-week stay in hospital[1]

$3–5 million
Direct costs of patient falls in hospitals for 2010–11[1]

Patient falls that result in harm are the most frequently reported adverse event in public hospitals.

891 serious and sentinel events

492 patient falls

202 patient falls associated with a hip fracture*

* It is estimated that 22 more people died than we would otherwise expect[2]

Source: 2013–14 serious and sentinel events reported by district health boards to the Health Quality & Safety Commission.

www.hqsc.govt.nz/atlas/falls

Stand up to FALLS

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

newzealand.govt.nz

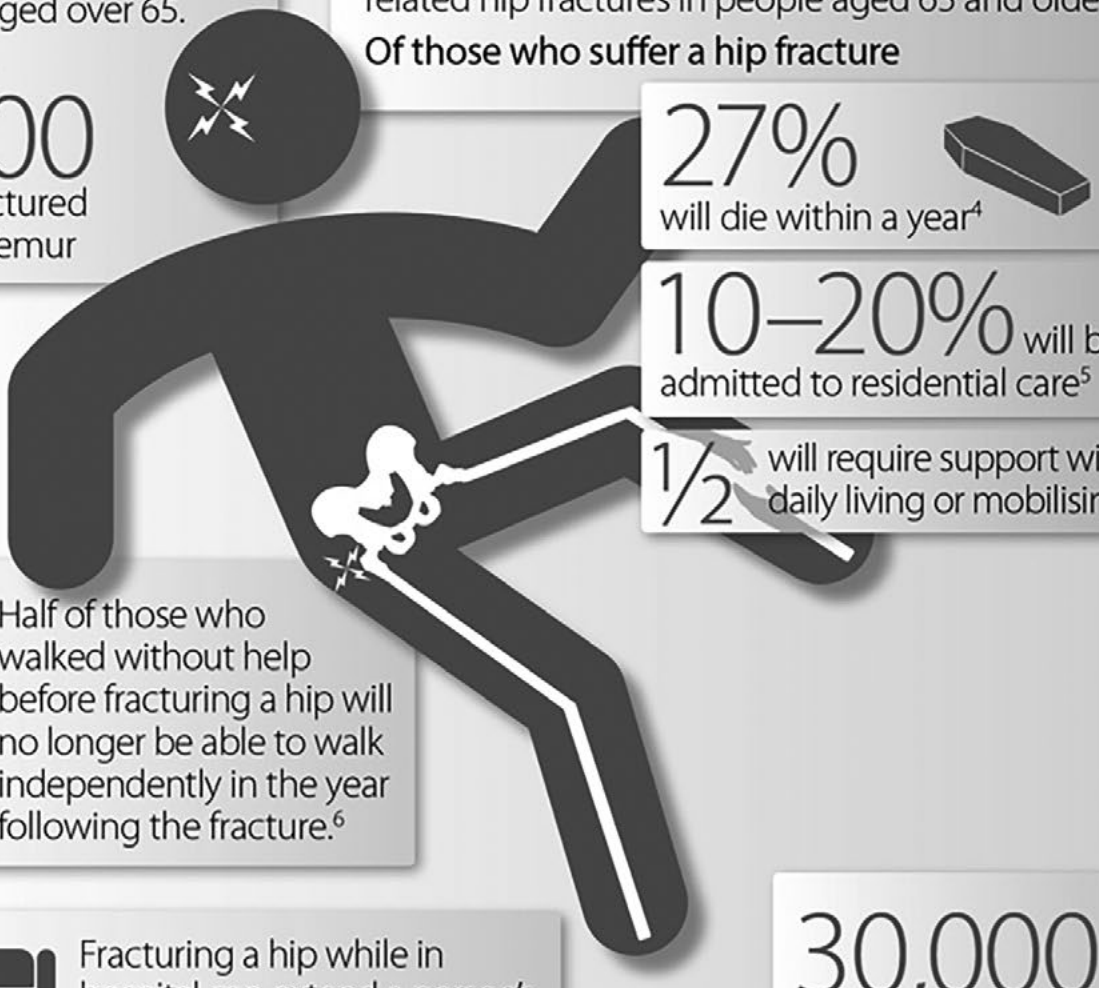
126,000
New accepted ACC claims in 2013–14 for falls in people aged over 65.

Of these
4500
were fractured neck of femur

The most serious injuries resulting from falls are fractures and head injuries, with hip fractures being the most common fracture after age 75.[2]

In 2013 there were 3239 hospital admissions for fall-related hip fractures in people aged 65 and older.[3]

Of those who suffer a hip fracture



27% will die within a year[4]

10–20% will be admitted to residential care[5]

1/2 will require support with daily living or mobilising.[6]

Half of those who walked without help before fracturing a hip will no longer be able to walk independently in the year following the fracture.[6]

Fracturing a hip while in hospital can extend a person's length of stay by over a month.

$26,000 conservative estimated cost[1]

30,000
Fall-related discharges in 2013–14
Over half represented those aged over 65

1. De Raad JP. 2012. *Towards a value proposition… scoping the cost of falls.* Wellington: New Zealand Institute of Economic Research.
2. Rubenstein LZ. 2006. Falls in older people: epidemiology, risk factors and strategies for prevention. Age and Ageing 35-S2: ii37–ii41.
3. Health Quality & Safety Commission. 2015. Atlas of Healthcare Variation (falls domain). Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/atlas/falls (retrieved 18 March 2015).
4. New Zealand Health Information Service. 2002. Fractured Neck of Femur Services in New Zealand Hospitals 1999–2000. Wellington: Ministry of Health.
5. Autier P, Haentjens P, Bentin J et al. 2000. Costs induced by hip fractures: a prospective controlled study in Belgium. Belgian Hip Fracture Study Group. Osteoporosis International 11(5): 373–80.
6. Osteoporosis New Zealand. 2012. *Bone Care 2020.* Wellington: Osteoporosis New Zealand.

NZNO LIBRARY - LATEST EDITIONS TO THE LIBRARY

Health Improvement & Innovation Resource Centre

SUDDEN UNEXPECTED DEATH OF INFANTS (SUDI) IN PRIMARY CARE: DEVELOPING A CONSISTENT SYSTEMATIC PROCESS FOR RISK ASSESSMENT.

(http://www.hiirc.org.nz/page/55142/)

Mitchell, SUDI Researcher, has developed a risk assessment tool and has agreed that this can be integrated into existing software for the public good – access the link provided for more information of this proposed initiative.

PRESENTATIONS FROM A FORUM ON THE IMPLEMENTATION OF 'A QUALITY FRAMEWORK AND SUITE OF QUALITY MEASURES FOR THE EMERGENCY DEPARTMENT PHASE OF ACUTE PATIENT CARE IN NEW ZEALAND'.

(http://www.hiirc.org.nz/page/54813/)

This page provides links to the presentations from the national emergency department forum, held on 23 March 2015 in Wellington.

THE EMERGING ROLE OF TELEHEALTH IN A NEW ZEALAND AMBULANCE SERVICE

(http://hdl.handle.net/10063/4171).

Research was undertaken to better understand how telehealth could improve patient outcomes, improve effectiveness, or create efficiencies for the St John ambulance service. Key recommendations are described.

THE NEW ZEALAND LONGITUDINAL STUDY OF AGEING: SUMMARY REPORT – HEALTH.

(http://www.massey.ac.nz/massey/learning/departments/school-of-psychology/research/hart/publications/project-reports_nzlsa.cfm)

Summary report based on the New Zealand Longitudinal Study of Ageing (3311 participants, aged between 50 and 85 years), a descriptive overview of the health status, health behaviours and health care utilisation reported by this sample. Includes data on smoking behaviour, alcohol consumption, physical activity, and health care utilisation.

DIAGNOSING, ASSESSING AND MANAGING CELLULITIS IN THE COMMUNITY

Journal of Community Nursing 28.5 (Oct/Nov 2014): 92,94-96.

COPD AND ADULT ASTHMA - UPDATES ON ASSESSMENT & TREATMENT

This session led by Dr Jeff Garrett, Respiratory physician,supported by an interdisciplinary team including a clinical nurse specialist, physiotherapist and GP will focus on updates on assessment and treatment for both COPD and adult asthma.

Date: 20 August 2015

More information: https://www.pharmac.health.nz/seminars/copd-and-adult-asthma/

INTERVIEW WITH FLEUR COLLINS, RN VOLUNTEER NURSING IN SIERRA LEONE

Fleur Collins is a staff nurse at Auckland City Hospital, Emergency Department and an aid worker with New Zealand Red Cross. She spent 5 weeks at the Red Cross Ebola Treatment Centre in Kono, Sierra Leone Cross between 22nd February to 29th March 2015 (Photos and content published with the consent of the NZRC.)

WHAT INSPIRED YOU TO TAKE ON SUCH A CHALLENGING ADVENTURE?

> To work for Red Cross has been something I wanted to do before I even left school. It just so happened that I had finally qualified as a New Zealand Red Cross (NZRC) aid worker as the Ebola virus in West Africa intensified. On my last day of training with the NZRC I met the first two Kiwi Red Cross aid workers who had been working as part of the Ebola response in Sierra Leone and listening to their experience further encouraged me to go.

1. Inside the high risk area - nurses always enter in pairs, have their names written on their headgear (*with full PPE on it is hard to recognise who is who*) and spend a maximum of one hour treating patients before leaving.

HOW WELL PREPARED DID YOU FEEL YOU WERE BY THE TIME YOU GOT TO SIERRA LEONE? (THE TRAINING PROVIDED, SUPPORT ETC)

> I had really comprehensive support and training from the New Zealand Red Cross, before I went to Sierra Leone. I had a briefing in New Zealand and was given plenty of opportunities to speak with other aid workers who had similar overseas roles with Red Cross. I then attended the EVD (Ebola Virus Disease) training at the Red Cross headquarters in Geneva covering the history of Ebola, the current epidemic, Red Cross response, how the Ebola Treatment Centre worked. This also included dressing and undressing of PPE personal protective equipment - which is a big and crucial job for anyone working with Ebola patients.

INTERVIEW WITH FLEUR COLLINS, RN VOLUNTEER NURSING IN SIERRA LEONE

HOW DID YOUR EXPERIENCE AS AN EMERGENCY NURSE HELP YOU?

> I think what's really handy about being an emergency nurse is being able to look cool, calm and collected even when you're feeling quite the opposite. Also never knowing what might be coming through the doors next gives you the ability to adapt to situations a lot easier. These both definitely came in handy whilst being in Sierra Leone.

2. Nursing rounds in the ETC.

WHAT WERE YOUR LASTING MEMORIES OF YOUR TIME THERE, THE HIGHS AND THE LOWS?

> The highs were really high; for me I'd have to say the best whilst I was there was discharging our last confirmed Ebola patient home. It was always a big celebration sending someone home, but for this young man it was very exciting... lots of singing and dancing! On the flip side of this, the lows could be pretty low. Unfortunately Ebola affects all people of any age. I never expected to see quite as many children as we did.

HOW WELL WERE YOU RECEIVED BY THE LOCAL POPULATION PARTICULARLY GIVEN THE FACT THAT MANY BELIEVED IT WAS OUTSIDERS THAT BROUGHT THIS DISEASE TO THEIR COMMUNITIES?

> By the time I arrived in Kono the Red Cross was pretty well known and local people knew who we were and what we were there for. I was only ever shown big smiles and friendly waves by the local community.

INTERVIEW WITH FLEUR COLLINS, RN VOLUNTEER NURSING IN SIERRA LEONE

WOULD YOU GO BACK AGAIN?

> To Sierra Leone? Yeah in a heartbeat, it's an amazing country. But if you mean the Ebola Treatment Centre? I would love to go back there and work but it would be a very different role now as the Kono district has been counting their Ebola free days since I left.

WHAT ADVICE WOULD YOU GIVE TO ANYONE THINKING OF EMBARKING ON A SIMILAR EXPERIENCE?

> Make sure you go with an organization, like the Red Cross that you know will support you and have the necessary knowledge and experience in the field.

3. Removing PPE - a structured and rigorous process involving lots of chlorine!

MORE INFORMATION ON THE WORK OF THE RED CROSS CAN BE FOUND HERE: HTTPS://WWW.REDCROSS.ORG.NZ/

Open Book

Learning from close calls and adverse events

Triage of patient with post-procedure ophthalmic symptoms in the emergency department

This report aims to alert providers to the key findings of a recent review, with emphasis on the changes implemented to prevent recurrence. Providers are advised to consider this report, and whether the changes made are relevant to their own systems.

This report is relevant to:

- emergency department staff
- ophthalmology specialists.

Incident

A patient presented in the emergency department (ED) with eye discomfort and reduced vision three days after an ophthalmology procedure, but the complications were not immediately recognised as potentially serious.

Chronology

- The patient had received an intraocular injection of Avastin® (monoclonal antibody) three days prior to attendance at ED.
- No visual acuity was performed at ED, and the patient was given a non-urgent triage category.
- ED became extremely busy, and the patient self-discharged after four hours of waiting without having been seen.
- The following day, the patient returned to ED, and was seen after two hours.
- The patient was referred to an ophthalmologist, and subsequently transferred to a tertiary hospital.

Actions subsequently taken

- A protocol was developed covering (i) patients who present in ED within a week of an ophthalmology procedure and (ii) specific education of ED staff on ophthalmology.
- Nursing staff are permitted to contact ophthalmology specialist staff directly if ED medical staff are unable to assess the patient within 30 minutes of presentation.
- All patients presenting with eye injury or eye pain are to have a visual acuity test within 30 minutes of presentation in ED.

Health Quality & Safety Commission comment

- Since 2013, three incidents relating to assessment in ED of symptoms post-ophthalmic surgery have been reported to the Commission as serious adverse events.
- Auckland Eye recently released the Auckland Eye Manual as a free download (Apple or Android) – www.aucklandeye.co.nz/About-Us/The-Auckland-Eye-Manual). The manual covers ophthalmic history and examination, and includes flowcharts of common ophthalmic signs and symptoms.

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

open for better care
Hāpai ake te kōiora

newzealand.govt.nz

TO ADVERTISE IN THE JOURNAL PLEASE CONTACT THE EDITOR MICHAEL GERAGHTY.

MICHAEL HAS ALL THE INFO ABOUT COSTS, AD SIZES, FREQUENCY OF THE JOURNAL AND EVERYTHING THAT YOU NEED TO KNOW!

email Michael at: cennzjournal@gmail.com

REGIONAL REPORTS

NORTHLAND/TE TOKERAU REGION

CHRIS THOMAS

Registered Nurse

Emergency Department
Whangarei Hospital

Contact: chrisl_t@yahoo.com

Greetings from a wet and wintery Northland which is currently displaying our usual four seasons in one day – roll on summer!!

It feels as though our winter increase in ED presentations has begun already with the first few days of June being particularly busy at Whangarei Hospital. Medical wards are, at times, full to above capacity despite winter planning contingencies of more medical and stroke beds opening.

Bed space in the ED also continues to be an issue with our bed utilization rate being very high compared to other DHBs. As a new or revamped department is still in the planning stages staff continue to do the best they can within the physical constraints of the department. We do however reflect badly in the ED LOS stats, languishing around 91% compliance which prompted a recent assessment by MOH Target Champion for the Shorter Stays in ED, Angela Pitchford. Angela made some constructive recommendations' including the urgent need for an acute assessment unit and a new model of care to improve the patient's journey from primary to secondary care with a shared responsibility for meeting targets across the various specialties. We look forward to progress on these issues. In the near future, within ED, there is to be some physical reconfiguration of the reception and triage areas so hopefully this will help with patient flow in that area.

In May eight of our nursing staff from Whangarei ED and some from our peripheral hospitals were able to attend a triage course held in Whangarei. This has increased the proportion of staff with the necessary skills to take on more senior roles in the department and has improved the skill mix greatly. Staff turnover has been moderate with replacements coming on board in a timely fashion. On the whole the nursing team remains a resilient and enthusiastic bunch. In May morale was given an extra boost by a team building event organized by some of the nurses which included an Amazing Race followed by a pot luck "meal of your culture" dinner which was a fantastic success. We are now bracing for the winter onslaught!!

CHRIS

REGIONAL REPORTS

AUCKLAND REGION

MATT COMESKEY

Clinical Nurse Specialist

Emergency Department
Auckland City Hospital

Contact: mcomeskey@adhb.govt.net.nz

Greetings from Auckland.

It looks like an early start to the winter season. Numbers continue to increase with some very busy weekend shifts that have coincided with the start of winter sports and colder weather. I'm looking longingly at my skis and willing it to snow... It's a good news, bad news scenario. The fall in temperature will no doubt mean an increase in patient workload , that's the bad news. This will occur in some kind of proportional relationship to the volume of the snow falling on the ski fields, this being the good news. I feel both excited and exhausted already.

In Auckland ED planning for the winter work load is on-going. An over-flow ward primarily for short stay patients has been used periodically. A streamlined ED-Gen Med referral process has been trialed where patients who are to be admitted for less than 36 hours can be referred directly to an admissions planning unit by ED doctors to be admitted under general medicine, rather than held in ED until Gen Med assess and admit.

Auckland ED is one of four EDs nationally to be centers for the assessment and treatment of Ebola and any other emergent viral diseases (EVDs). There is an on-going training programme in place along MOH guidelines covering personal protective equipment (PPE) and the procedures associated with the assessment and treatment of infectious disease and the management of presenting patients. Two procedure rooms in the department are undergoing redesign to provide an additional negative pressure isolation room with corridor isolation and to provide an adjacent designated safe donning and doffing area for PPE. The reality of managing new emergent viral diseases has been brought home to the Auckland ED team. One of our colleagues attended our training having recently returned from working at an Ebola treatment center run by Red Cross in Sierra Leone. She gave both a sobering and hopeful view of her work there.

Over the next few months new Draeger cardiac monitors are being introduced to the ED to replace the aging and much thrashed GE monitors. The department is the first in ADHB to have it's monitors upgraded. Initial impressions are favorable.

The department is currently adequately staffed. Our new graduates continue to settle in to the role with on-going preceptorship from the nurse educator and two newly appointed staff nurse mentors.

MATTHEW

REGIONAL REPORTS

AUCKLAND REGION

LIBBY HASKELL (Chairperson)

Nurse Practitioner

Children's Emergency Department
Starship Children's Health

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

CHILDREN'S EMERGENCY DEPARTMENT, STARSHIP CHILDREN'S HEALTH

Presentations this year continue to rise with an average 4% increase in January, February and March of this year. Sixty more children required care in the resuscitation room in March compared to the same time period in 2014. Acute oncology presentations account for a portion of the triage 1 and triage 2 presentations, and for about 2/3rds of the increase in patients requiring resus care. In May we saw an increase of 282 children through our doors compared to last year. This is an impressive 10% increase. We are still managing to meet the 6 hour target and are pleased that for the first time in April, the admitted patients 6 hour percentage was over 90%. The ongoing commitment in making the target a hospital wide initiative is really helping our children and families to get the right care, in the right place and at the right time.

We have been looking at strategies to improve our layout through a WOW of the department. Work has completed on a revamped storage area which is helping to make it easier and more expeditious to find those elusive items that you seem to spend ages looking for.

We have rolled out a new process for nurse assessment following initial triage. Our more junior nurses, who had not completed our triage course, had a study day to teach them skills for this role. This was followed up with practical teaching sessions. A Clinical Coach was used to assist with teaching and to help embed this new process. We have reconfigured our allocation of rooms to nurses – this allows rooms nurses to be responsible for the nurse assessment on their own patients. As with any new process, we will need some time for everyone to get comfortable with this, with our aim being that our families receive continuity of nursing care, and a quicker timeframe to nurse assessment and nurse initiated cares.

We are very proud of Leigh Elton (one of our fabulous nurses and a CENNZ member) who was awarded the ADHB Local Hero monthly award. This is a fantastic achievement and well deserved, as Leigh has motivated and worked unrelentingly to raise awareness and support our multi-disciplinary team to complete Family Violence Screening within CED.

We will shortly be starting to recruit to an Australasian randomised controlled study comparing standard oxygen therapy with high flow nasal cannula therapy for our under 1 year olds who present with bronchiolitis. This has resulted in a hospital wide teaching package for the use of high flow. We should be able to recruit voraciously by the number of wheezy babies we are already seeing now winter weather has arrived.

Hoping that our emergency nursing colleagues around the country are ready for winter, and have some time planned for rest and recuperation. If you are ever in Auckland, we are always happy to show folk around our department, and welcome those interested in paediatric emergency nursing. Just flick me an email to arrange a time to pop by.

LIBBY

REGIONAL REPORTS

MIDDLEMORE EMERGENCY CARE

We are excited to be running a pilot scheme to improve patient flow over the winter months. It encompasses a 10 bed Surgical Assessment Unit with dual assessment and short stay function for up to 28 hours for General Surgical patients. It has the added advantage of creating 20 beds for General Medicine.

Annual nursing awards have been held; EC was proud of our staff who received awards for Best Support Person (Tanya Hooper HCA), Research (Lima Amani RN) and Graduate Nurse Emma Whitehouse. We also celebrated our 100th New Graduate from our New Graduate programme which commenced in 2007 with the Emergency Care Services Award. It's been a great success in growing our own and retaining graduates to Emergency Nursing.

We have a successful internship programme for our ACNMs pathway and currently have four ACNM interns covering maternity leave and vacancy. Recruitment is underway for permanent positions and the internship programme will continue, providing opportunities to grow staff into leadership roles.

We are excited to have permanent Nurse Educator positions after an 18 month transition process. This has given stability going forward, particularly for our paediatric area.

Our newest Clinical Nurse Specialist Intern has hit the ground running; Tash Steele is currently focusing on paediatrics but with her dual skills will be a valuable resource across the department.

As with other emergency departments around the country we are heading into our busiest time of the year. With our culture of innovative thinking we are confident we will continue to improve patient experiences.

REGIONAL REPORTS

MIDLAND REGION

RICK FORSTER

Registered Nurse

Tauranga Hospital Emergency Department. Bay of Plenty District Health Board

Contact: Rick.Forster@bopdhb.govt.nz

THAMES

Thames is the home of a rural level 3 ED with approximately 15,500 presentations a year. They have come through their busy summer period were the population spikes from 26,000 to around 130,000. Being part of the Waikato DHB patients are regularly transferred to the Hamilton Hospital for speciality care. The ongoing roster is tight covering daily staffing with fluctuating transfer needs. At last report a small amount of vacancy was unfilled if anyone is keen to move to renowned Coromandel.

The Thames ED team have been busy working towards implementing the new national ED quality framework and measures; including presenting at a recent national forum. Further information regarding this can be found on the HIIRC website.

TAURANGA

With the first chills of winter comes the inevitable spike in winter illnesses and the regular hiss of priming inhaler spacers. The familiar scenario of back to back days of big presentations surges onto a full department are upon us. Dreaded high hospital occupancy is already starting to negatively affect our ED flow.

Tauranga as a retirement destination, with an aging population. This leads to significant numbers of complex elderly patients requiring care, either presenting from home or rest homes. There is a great need for strong community based healthcare. The DHB is aware that the current local models of primary and secondary care delivery will not meet the community's needs. Planning and funding are involved in an integration of a healthcare project.

The recent cluster of serious MVAs and associated deaths within the region continues. These have been reported widely, becoming a topic of interest for both media and politicians. Tauranga ED has developed a 1 day trauma training day for ED RN. Whilst our hospital's Trauma CNS is working with Midland Regional Trauma System to develop regional guidelines for trauma care and patient management.

We are fully recruited with good retention. Currently 2 enthusiastic new grads are settling into the department and cutting their teeth. Tauranga recently hosted the national Triage Course preparing a new batch of triage nurses just in time for winter. Of note is the departure form ED of our CNM Marama Tauranga, after 8 years.

Marama has been a huge driving force in moving ED Nursing forward with many quality improvement projects locally and nationally. She has taken up a role as the Nurse Leader for Maori Regional Health within the Bay of Plenty DHB. Our new CNM will be joining us shortly and we look forward to welcoming her to the Bay.

HAMILTON

Over the Kaimai's a very heavy workload is being reported with Monday presentations in autumn predicted at 215 reaching 260. The familiar foe of significant ward bed access block is also rearing its head early.

More work is going into primary options pathways to re direct patients to community healthcare providers. Pathways are also being used by St John where patients will be taken to a community provider rather than ED. Currently approximately 6-700 patients per month or up to 25 per day are being redirected. Further pathways are being developed for common medical conditions. Extension of existing CNS scope of practice is also being considered.

ACNM coverage has just become 24 hours a day. Previously overnight cover was by experienced RNs rather than a contracted Senior Nurse Role. Current RN staffing levels are good with a large recruitment last year of approx. 34 staff. Retention is reported as good currently with the ongoing development of a solid skilled ED RN workforce. Changes have been made to staffing allocations whereby RN hours have been moved from AM to PM where need is greater.

The rattle of the flu vaccination trolley prowling for friendly deltoids has departed our corridors for another year. Winter is here and for many EDs the most consistently frenetic period of the year. The only way to thrive or often just survive will be for our respective teams to pull together effectively whilst maintaining a balanced life out of work.

RICK

REGIONAL REPORTS

HAWKES BAY / TARAWHITI REGION

SHARON PAYNE
(Triage Instructor)

Nurse Practitioner

Emergency Department
Hawkes Bay Regional Hospital

Contact: sharon.payne@hawkesbaydhb.govt.nz

Hello from Hawkes Bay and East Coast region.

Hawkes Bay ED has seen the last of the current wave of babies being born, a few more boys in this wave, Congratulations to you all and enjoy you time as mothers and fathers.

We have employed 11 new staff in the last few months and they are all now up and running after some orientation. Welcome to you all and thanks for all you hard work over the last few busy months.

Thanks also to the senior nurses who have held us together, covering triage and resuscitation while our new nurses grow and develop.

The ED observation beds are up and running reasonably well with high occupancy and has resulted in significant improvement in our ED length of stay. Added to this have been changes to the medical staff, providing longer double cover to cope with the large numbers of medical patients and the changes in processes in the acute assessment ward.

As part of the AIM 27 project, a lot of work has been done looking at the "Front of House" and the process through reception, triage and fast-track (previously known as MEC). Currently plans are being looked at as to how we may get some more patient scare areas in the front of house, primarily as there is no space to go to in the main department. A brand new department would be nice but this is not in the short term or even long term plans.

Another project the Urgent Care Alliance is looking at acute care across the community including dental services. ED staff are an integral part of this group reviewing acute care and developing business plans and suggestions for the long term care of the acute needs of our community that is affordable, accessible and appropriate.

SHARON

ARTICLE SUBMISSIONS FOR THE (END OF 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

MID CENTRAL REGION

AMANDA BIGGS-HUME
(Membership Secretary)

Clinical Nurse Specialist

Emergency Department Palmerston North Hospitalh

Contact: mandyhume@hotmail.com

For this quarter we hear from another hospital in the Central District. Thank you very much to Michelle and Joanna for preparing this report.

CENNZ REGIONAL REPORT FROM WHANGANUI EMERGENCY DEPARTMENT

Greetings from the Whanganui Emergency Department. It gives us great pleasure to outline for you, information about our service.

The Whanganui District Health Board's (WDHB) Emergency Department is a 15-bed, Level 5 facility with an attached five-bed Acute Assessment Unit (AAU). The collective 20 beds are staffed by ED. We see around 20,000 presentations annually, with this number consistently increasing each year.

We provide a unique model with an Accident & Medical Clinic (A&M) run separately but situated adjacent to our Emergency Department – with a shared waiting area. Presentations are streamed at one triage point to either ED or A&M care. Variations on this model have been trialled, and are currently under review. Our facility is seven years old and overall, we believe it responds well to demand, patient flow and supporting the functional needs of emergency patients.

Our regional demographic includes higher than average numbers of elderly, Maori and lower socio economic consumers who place high demand on Whanganui Hospital's secondary services. Anecdotally, ED staff report increasingly higher acuity and more complex presentations, with TrendCare data supporting this observation. In 2014 ED saw more Triage Category 1 & 2 presentations than any previous years.

The nursing structure in ED consists of one clinical nurse manager who manages ED/AAU and the six-bed Critical Care Unit. We currently have a clinical nurse coordinator (CNC) role Monday to Friday for parts of the day shifts. The CNC role is evolving in response to demand and fiscal ability. Up until this month the CNC role has included a patient load or coordinating role across two clinical areas (CCU). From now on, this role is supernumery to allow for increased demand over the winter months. This allows for smooth transition for the patient journey through ED to discharge or admission. We have a 0.2 FTE dedicated nurse education role in the form of a clinical coach, who provides clinical support and education for ED. Current nurse lead projects in relation to individual post graduate study include nurse initiated analgesia, advanced care planning and utilising smartphone technology to reach a wider audience with discharge planning advice.

Our DHB continues to sit favourably in the DHB ranking with 6 hour targets for ED and smoking cessation screening targets. With 93 percent and 97 percent respectively, these are improvements on our previous performance. Improving our Violence Intervention Programme (VIP) screening rates through focused education has yielded results with increased rates of screening over the last six months. The energy and support from the VIP Coordinator and ED area representatives deserves acknowledgement.

With winter almost upon us, like other EDs, we will be bracing ourselves for the influx of winter related presentations. Corridor patients at Whanganui ED have not previously been the norm, unfortunately they have become more prevalent in the last year. The Emergency Department is preparing for this by working collaboratively with bed managers and CNM's of inpatient units to manage this challenge as a hospital wide issue.

Best wishes to you all for winter. We look forward to the Emergency Nurses Conference, which will also signal the beginning of summer.

(MICHELLE BATTARBEE & JOANNA KNIGHT)

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

As the colder weather approaches Capital and Coast, Hutt Valley and Wairarapa DHB's continue to see a steady increase in presentations. Hutt Valley and Wairarapa met the Shorter Stays target for quarter three. Despite the increase in people through our doors Wellington has improved its performance from the quarter 2 results. For Wellington nearly 500 extra people were admitted, discharged or transferred within six hours of presenting to Wellington Emergency Department between January and March this year. We continue to improve our performance, meeting the six-hour target for 96.1% of patients in April, 96.2% in May and June to-date 92.5%.

With the increase in presentations workplace safety continues to be a concern within the region. Over the past months there have been several incidences of violence, verbal and physical, towards staff and others in all our ED's. We all know the dangers of the environment that we work in and the potential for violence. The region is taking this seriously and have invested in perspex barrier's triage and clerical desks at Kenepuru and Wairarapa with Wellington ED following suit soon. Hutt is currently developing security protocols also. It is a sad but realistic aspect of ED work and this is reflected in the work the committee is doing around a College position statement on the subject.

The build up to winter continues with CCDHB focusing on making sure staff are rested, i.e. taking some annual leave and that there is as much uptake of the influenza immunisation as possible. ED has been fully engaged in the DHB's winter planning this year and currently Wellington ED is sitting above 80% of the staff being immunised.

There has been a recent loss to Wellington ED. Marion Picken, one of the CNE's has left ED but remains within CCDHB in Resuscitation training. Marion has been at Wellington ED in various roles for the last 20 years. However she says she will be back at some time in some form. Good news for the Wairarpa with Sara Denniston being appointed as on the their ACNM. This means the ACNM post (1.6 FTE) has gone seven days a week between 0800-1630 which is a huge step from 2 years ago. Also developed is an educator position (0.7 fte) and as well as securing an additional RN FTE. This in conjunction changing work patterns / shifts to match demand has improved nursing cover and support at Masterton ED.

Lastly I can not forget to that The College of Emergency Nurses conference is to be held in Wellington at the Rydges Hotel on the 15th and 16th of October. The focus of the conference is "Quality Care and Patient Safety, Brewing good ideas". Registration and call for abstracts are open now! The conference topics will look at

- Quality Care
- Patient safety
- Clinical focus
- ED Nursing – What's ahead

If you feel the urge to present at a national conference or want to come to Wellington, the coolest little capital in the world and explore what the region can offer go to the website and register now!

www.cennz2015.co.nz

CRAIG

REGIONAL REPORTS

TOP OF THE SOUTH REGION

SHARON SCOTT (Secretary)

Acting Charge Nurse

Emergency Department
Nelson Hospital

Contact: sharon.scott@nmhs.govt.nz

SHARON NORTH CNM REPORTS FROM WAIRAU ED:

- The on-floor registered nurse flu vaccinations have worked well for staff having ready access to vaccine.
- The winter flu's have begun to make their appearance with respiratory illnesses now presenting.
- Wairau now has access to a new MRI unit which is co-located to radiology.
- There is a multi agency group looking at safe alcohol communities.
- The ambulance transit vehicle is now functioning on a scheduled timetable. This vehicle is taking pts from Wairau to Nelson and return every day. This has helped immensely and also having the nursing transit nurses dedicated to this model and the vehicle leaving at regular time and connecting regionally.

Both Wairau and Nelson are ironing out processes in the regional LifeNet STEMI project. The patient is commenced on the STEMI pathway prehospital. If PCI is not available they are lysed in ED and then quickly transferred by helicopter to a centre where more definitive intervention can occur.

In Nelson we are continuing to have skill mix challenges with a number of new staff. Following the budget prioritization process, it seems that our requests for an advanced nursing role in ED, and a health care assistant have not been successful. However we have some more 'on the floor' nursing resource, with a new shift starting at 1300 each day that will make a significant difference.

We have a new ADON, Linda Ryan, who comes from CCDHB and previously Australia and Saudi. Linda has a critical care background and we are looking forward to revisiting the advanced nursing role in ED with her support.

We have had some very well attended inservices on Pregnancy in ED and HEADSS youth assessment. We have also started having brief clinical teachings at handover, which is involving a wide range of nurses. We want to cultivate a culture of teaching and learning in the department. We have some coordinator workshops planned, in preparation for these we have had good feedback on the attributes of an effective coordinator, from a range of perspectives.

We are coming to grips with a new electronic South Island wide Reportable Event programme. There have also been recent serious and sentinel events involving ED staff which has been stressful for those involved. ED is a high risk environment, reinforcing the need for robust systems. We are currently working on improving our processes around mental health observation, thank you to Christchurch ED for your resources.

My four year term as CENNZ regional representative for the Top of the South concludes in October. If you are interested in this role, nomination forms can be downloaded from the CENNZ website. Contact me if you would like more details.

SHARON

REGIONAL REPORTS

CANTERBURY / WESTLAND REGION

ANNE ESSON
Nurse Manager

Emergency Department
Christchurch Hospital

Contact: anne.esson@cdhb.health.nz

CHRISTCHURCH ED

Christchurch ED - presentation numbers have been lower across the autumn months compared to the corresponding months in 2014 (averaging 10 fewer patients per day). Although overall numbers are lower and triage figures remain consistent there is a sense that there is more complexity but we do not have an acuity tool to measure this. We are seeing high numbers out of hours with high daily variances (up to 100).We are working to improve the utilisation of our observation area. This 10 bedded unit is the highest admitting area in the hospital with April having 700+ admissions.

ED is driving the recommendations from the2014/2015 review. We are embarking on a 4 month trial over the winter months to improve patient flow both within and external to ED. An additional ACNM will be rostered each day with the department divided in two so we can have a dynamic approach to patient flow. Other major pieces of work include the implementation of a rolling roster for all staff whose FTE is above 0.625 ,the roll out of a hospital wide nursing electronic handover process and the introduction of the Observation (including specialling) Policy for Special Mental Health Service patients in ED.

We are starting to see staff movement again which follows last year's pattern. We struggled to recruit into the vacancy last winter and therefore we are concerned the same may occur this year.

The CDHB has met the 'Shorter stays in Emergency Departments' for the 3rd quarter and is trending to meet the target for the 4th quarter.

ANNE ESSON

GREY HOSPITAL ED

As we head into winter the big push is on for flu vaccinations. Our Health & Safety nurse is hoping for a target of over 90% this is a work in progress. As we move into the new model of care within the WCDHB there are changes afoot. Some of these changes are starting to occur. We have merged AT&R with the medical ward, so this created surplus staff. Nurses depending on competency level, are going to where the need is greatest. This is giving nurses the opportunity to broaden and enhance their knowledge.

In the new rebuild, ED and Primary health are going to be integrated. This has highlighted the need for practice nurses to attend triage and be qualified in triage. St John is now running a door to door transfer service seven days a week, fifty two weeks of the year plus they supply a driver. We supply the transfer nurse and are currently looking at employing four nurses within the DHB, so demands are met. The Ambulance can transport three patients at a time. There is often a back-load of patients being transferred back from CDHB to WCDHB. Part of our new model of care is to be more community focused. This requires increasing the type and amount of services required, and how much we will need to increase resources. So as you see it is exciting times ahead. That's about it from the West Coast.

LYNLEY MCINROE

ASHBURTON HOSPITAL – ACUTE ADMISSIONS UNIT

Ashburton Acute Admitting Unit continues to have increasing number of presentations, more so with the winter sports season in full swing. Demolition of the old earthquake condemned theatre building is almost complete and work will soon commence on the new AAU and operating theatre building. There are also changes to our model of care and medical staffing in progress. This will be a complete change in work for us so change management is in progress.

MARGARET ANDERSON

SOUTHERN REGION

ERICA MOWAT
Registered Nurse

Southland District Health Board

Emergency Department
Dunedin Hospital

Contact:
Erica.Mowat@southerndhb.govt.nz

Hi, as you can see I am the new CENNZ representative for the Southern District Health board and this is my first report. I have taken over from Carly Hawkins and hope that you will bear with me while I find my feet as Carly leaves a large gap in knowledge and abilities affecting all her contacts throughout the SDHB. We wish her well in her new education position in Cumbria England. I have been busy since my appointment in May. I have briefly been in contact with most areas providing emergency care within the SDHB to find out the scope and size of each facility and whether they have assessment units or emergency departments.

So here is the news from the region.

Dunedin and Kew Hospital, Southland recently had a visit from Angela Pitchford, Clinical Director of Emergency Department Services, who leads the team to improve the effectiveness, efficiency and quality of acute services. Her recent visit in May to Dunedin and Southland emergency departments produced positive comments on recent initiatives to promote shorter patients' stays within the departments. Local initiatives that were working well and received special praise included the ED observation unit, Fast track minor injuries area and the Early Treatment Zone in Dunedin and the ED Huddle Initiative in Kew Hospital. She also commented on the development of the Short Stay Medical Unit as having a potentially positive impact on patient flow through the Dunedin ED.

In Dunedin the impact of the recent floods has been a major focus for the hospital. Roads were closed and power disconnected from homes in south Dunedin and on the Taieri for safety reasons. One resthome, Radius Fulton was evacuated and residents sent to Dunedin Hospital. This put pressure on bed availability, impacting on patient flow from ED to the wards over the following days. Surprisingly not many patients were brought into ED as a direct result of the floods but it did have an impact on staffing. Staff were given assistance from the Emergency Operations Centre, who have an operation policy in place for adverse weather conditions. The SDHB re organised staffing to cover clinical areas, including ED, and transport for staff to and from home.

In Kew Hospital two Clinical Specialists, Olivia Murray and Laura Gleeson are currently completing a service improvement project in conjunction with Mr Paul Rae, head of Orthopaedics in Southland. This project is on paediatric clavicle & torus fractures and aims to standardise patient leaflets and simplify referral pathways leading to a reduction in patient time management. They are also attending an international forum on Quality & Safety in Healthcare in Hong Kong where they will present their work and talk about their project.

In conclusion I would to congratulate all those who have completed their post graduate studies over the last few months including Anna Askerud and Jo Baxter who now have their Masters in Health Science Degree through Otago University.

ERICA

NEW ZEALAND EMERGENCY DEPARTMENTS CONFERENCE

TAUPO | 28th-30th OCTOBER 2015

PARTNERSHIP

Promoting Partnership in Practice

Last year we talked Quality, this year we are expanding into Partnerships. Save the date for this National ED conference now in its 8th year. This is YOUR conference, an opportunity to get together with like-minded individuals and bring things back to your departments that truly make a difference. A conference solely based on administrative and logistical issues which affect NZ Emergency Departments, suitable for all Emergency doctors, nurses and managers.

FEATURING:

- Breakout groups: CNM, CNS and CD
- Anthony Hill from the Health and Disability Commision
- Damian Tomic from Primary Care Liason
- Tony Smith from St John's ambulance
- The Minister of Health has once again been invited
- Key note speaker yet to be confirmed
- Sessions on partnering with technology, patients and colleagues
- Metropolitan session – Christchurch's turn this year

Registrations commence in September

For more information please see www.midlandreds.org.nz

JULY | 2015
The Journal of the College of Emergency Nurses New Zealand (NZNO)
ISSN 1176-2691

EMERGENCY NURSE NEW ZEALAND