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EMERGENCY NURSE NEW ZEALAND

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ON THE WEST
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OF A DESCRIPTIVE
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*Authors: Julie A.M.
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**PERSPECTIVES OF
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A WORD FROM THE EDITOR:

Hello all and as always a belated Happy New Year, trust you were able to have some time off over the festive period.

I drew the short straw and worked over both Xmas and New Year - a period where ED becomes more of a GP service than it normally is. On a positive note my holiday will be taken when most kids, families are back at work / school so the roads and beaches blissfully quiet(er).

*A quiz to open the inaugural journal of 2016**:*

1. The smoking rate in NZ has decreased by what percentage since 2006/2007?

3% 5% 7%

2. The smoking rate in people aged between 15 - 17 years has decreased by what percentage since 2006/2007?

5% 7% 10%

3. What percentage of adults in NZ are considered to be obese?

25% 31% 39%

4. Crime is declining: What is the percentage drop in victims of personal crimes when compared to 2008?

6% 7% 9%

5. The rate of teenage (aged 15-19) pregnancy has dropped by approximately how much since 2008?

25% 50% 75%

***For the answers and some more interesting reading go to: Ministry of Health. 2015. Annual Update of Key Results 2014/15: New Zealand Health Survey. Wellington: Ministry of Health.*

<http://www.salvationarmy.org.nz/sites/default/files/uploads/20160107TSA%20Annual%20Report%202015%20CC.pdf>

As you may be aware Auckland has puts its name forward to host the 2016 conference and whilst we are at the early stages of planning we have a fun packed but stimulating programme to offer you and look forward to seeing you in November - seems a long way away but time soon flies!!

MICHAEL GERAGHTY
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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.

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Chairperson's Report



“In August this year, emergency nursing will be featured in Kaitiaki. This is an exciting opportunity to profile and celebrate our specialty. If you have suggestions for content please email me cennzchair@gmail.com”

January has gone by in a flash. I enjoyed good weather during a camping holiday in Northland with family and friends. I hope you managed to enjoy some relaxation to replenish energy stores after what was another very busy year for emergency nurses. I have just returned from the CENNZ 2-day national committee meeting in Wellington. We had a productive time together and 2016 looks to be another busy year for the college. Our discussions focused on increasing engagement with our members. We will be putting a link via our website to provide a brief update on what was covered at our meetings. We would like to make this a two-way process; so please do contact either your regional committee member or myself at any time.

A fantastic start to the year was hearing that our membership has almost reached 500! Thanks to you all for showing commitment to the college. This is the highest membership for many years. Our online membership process is going well. Please remember to rejoin after 1 April to ensure your membership stays current - we will be adding in some demographic and other questions when you register which

will provide us with useful information on our members. The annual levy remains at \$25 per year for direct debit online payment (or \$30 if paying by credit card).

A clear and recurring theme emerged during our regional round ups. The frequency and intensity of episodes of violence being experienced by ED nurses around the country is very concerning. Our position statement on zero tolerance of violence towards nurses is in it's final stages of being written. This will be sent to you and interested parties for consultation and feedback. The college will be raising our concerns with NZNO and engaging in dialogue with key stakeholders around this issue. I would welcome hearing from you on this - if you have solutions to share or ideas of how we can improve national awareness in addressing this issue, then please send them through to the committee via cennzsecretary@gmail.com.

We had an update on the emergency nurses Knowledge and Skills Framework. This is a large piece of work that the college is committed to completing this year. The national

working party have accomplished an outstanding and comprehensive document so far. We will be consulting with you on this in the middle of the year.

The committee met with the Health Quality and Safety Commission New Zealand. It was great for the college to be involved in the scoping and planning phase of the potential “Deteriorating Patient Quality Improvement Programme”. If this goes ahead, the programme will look at a standardised national early warning system including vital signs chart, goals of treatment escalation plan and patient/whanau escalation.

In August this year, emergency nursing will be featured in Kaitiaki. This is an exciting opportunity to profile and celebrate our specialty. If you have suggestions for content please email me cennzchair@gmail.com

I am looking forward to seeing a great year ahead. A highlight for me will be attending the CENNZ national conference (and celebrating our 25th anniversary). This is being held in Auckland on 3rd and 4th November with an AENN workshop day on the 6th. Do get in early to secure your leave and perhaps think about applying for a CENNZ conference grant.

LIBBY

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CLINICIAN'S PERCEPTIONS OF TELEHEALTH FOR EMERGENCY CARE ON THE WEST COAST OF NEW ZEALAND: FINDINGS OF A DESCRIPTIVE STUDY

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ABSTRACT

Telehealth has been highlighted as having the potential to provide high quality health care for populations living in rural and remote areas throughout New Zealand. There has been media attention around telehealth especially with success stories from the West Coast in paediatrics; this success however, has not followed through to emergency services. The aim of this qualitative descriptive study was to explore what the West Coast clinicians working in emergency services saw as the barriers and opportunities for telehealth in emergency care. Semi-structured interviews were undertaken with 12 staff who work in or with emergency services and the data from these were thematically analysed. Five themes were identified: knowledge, implementation, skills, opportunities and barriers. The findings identify that while staff did not understand telehealth well, they could see potential benefits it's in rural Emergency Departments, but were concerned how it could be integrated into their work. Barriers identified included the reliability of internet connections and technology, and using the technology in the Emergency Department environment. With consideration of clinician's concerns and careful implementation the barriers to telehealth can be overcome, opening up the opportunity for people in rural and remote communities to gain, and sustain, equity of access to healthcare.

KEY WORDS:

Telemedicine, Emergency medical services, Rural health services, Remote consultation

INTRODUCTION

With the centralisation of healthcare services internationally, and in New Zealand (NZ), it has become increasingly difficult to attract health professionals to rural and remote communities. This has meant populations in these areas face challenges accessing comprehensive healthcare. Telehealth is seen as a solution, as it can bring specialist care at a distance to rural areas through the use of technology. Telehealth originated from the Greek 'tele', meaning distant, hence telehealth is the delivery of healthcare at a distance. Telehealth utilises some type of technology to bridge the distance, such as the internet or a video link (Wootton & Bonnardot, 2010). However telehealth has not integrated well into some areas of health, such as emergency care, and the West Coast of NZ is an example of this. This study explores the perception of healthcare professionals working in emergency services for the West Coast District Health Board (WCDHB) related to telehealth, and the potential barriers and opportunities it may provide to a rural or remote Emergency Department (ED).

BACKGROUND

Drivers for telehealth can be broken down into two categories: technological and non-technological (Norris, 2002). Technological drivers include the capabilities afforded by advances in information and communication technology (ICT), network and telecommunications infrastructure. NZ is increasing its networks and broadband (Ministry of Business Innovation and Employment, 2012). However, according to Moffatt and Eley (2011) technological drivers can also be a barrier, with issues like poor internet service in rural areas. Non-technological drivers include lack of access to healthcare and specialist services due to geographical isolation, potential cost-savings, and to improve the range and quality of available health services (Duplantie, Gagnon, Fortin, and Landry, 2007; Smith and Gray, 2009).

Staff in ED work in a "fast paced environment were activity requires flexibility" (Parker, 2005, p. 70), and the perception is telehealth may not lend itself to this diversity and pace. Therefore it is important that telehealth as part of emergency

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care must be based on a system design that is simple, easy to use, with the capabilities for assessment and treatment of emergency patients (Galli, Keith, McKenzie, Hall, and Henderson, 2008). When introducing telehealth Buck (2009) suggests it is important to first consider the needs of the user, as success depends on the interaction between the user and the technology, with Joseph, West, Shickle, Keen, and Clamp (2011) identifying staff scepticism and training as potential issues.

CONTEXT FOR THE STUDY

The WCDHB is rural and unique in NZ due to its sparse geographical area and isolated population (Statistics New Zealand, 2012). Cities, as main urban areas, have bigger hospitals, facilities and better infrastructure, where rural and remote areas have smaller and fewer hospitals due to less requirements. Tertiary healthcare refers to major hospitals that have the ability to provide a level of specialty care, such as trauma care. These hospitals are generally situated in large cities throughout NZ. The lack of specialist services in rural areas makes equity of care difficult.

Over the past decade the WCDHB has grappled with sustainability of their healthcare services. However, there is a public expectation that standards of healthcare should be no different on the West Coast from that delivered nationally (Peterkin, 2009). As a result, a telehealth project was started in partnership with the Ministry of Health, WCDHB and CISCO in 2008 (Kerr & Day, 2010). Kevin Hague, CEO of WCDHB at the time, suggested that telehealth would reduce the need for travel by patients and consultants, and reduce the need for transfer to tertiary hospitals within NZ, therefore reducing travel costs (Witts, 2008). The telehealth project was evaluated (Day, 2009; Kerr & Day, 2010). However, to date utilisation of telehealth has not had the uptake expected in ED despite a number of unsuccessful trials due to the arrangement of equipment, privacy and the length of time taken for a telehealth consultation. Understanding clinician's perceptions of telehealth use in ED may identify if it can be successfully used in this clinical setting.

METHODS

The aim of this descriptive study was to identify the barriers and opportunities for telehealth in the emergency departments of rural and remote hospitals in the WCDHB by seeking the views of clinician's working in the front line. There are three emergency services in the WCDHB. One emergency department is at the base hospital in Greymouth (a secondary level care hospital with some specialist services on site); the other is a rural level one hospital (with no specialists on site);

and the final emergency service is provided by the Rural Nurse Specialist (RNS) team in South Westland. Ethical approval for this study was obtained (URB/11/EXP/050) and the support of the WCDHB Acting Chief Executive Officer CEO and the Service Manager. In 2012 an invitation to participate in this study was sent to 22 staff who work in or with the WCDHB emergency services, and 12 (55%) agreed to an interview. Participants comprised six doctors and six nurses. Six of the participants came from the base hospital; the others came from outlying areas (Table 1). Semi-structured interviews were audio-taped and transcribed. Data analysis used a four step process involving familiarisation with the data, identifying key concepts and themes, then data was synthesised from all participants according to themes and finally associations between themes were mapped (Gerrish & Lacey, 2010).

FINDINGS

Five themes were identified from the thematic analysis: knowledge, implementation, skills, opportunities and barriers. Each of these will be described using illustrative quotes.

KNOWLEDGE

A lack of knowledge about telehealth was found among those situated at the base hospital. For example, when asked what she knew about telehealth Participant 1 stated, "Very little, other than an outlying area can dial in using telehealth and the patient can be seen on the screen and the doctor on the other end can see the patient and decide what to do". Those working away from the base hospital displayed greater knowledge. For example, Participant 2 stated, "It provides a better service for integrated health. It saves the patient and the health professional a lot more time and they can have a better service and it's a lot more convenient" and Participant 8: "It's an electronic means of face to face communication with health professionals in remote areas. I see it as an adjunct to the way we communicate now". Overall the doctors seemed to have a better understanding of telehealth than the nurses.

Concerns around legal and ethical aspects of care were indicated, though one participant also stated they felt comfortable using telehealth when they knew there were protocols and procedures in place to cover care at a distance.

Another aspect under this theme concerned staff knowing the telehealth team they were working with. Participant 4 explained this saying: "A major barrier to use is you might not know the person on the other end and they might not know you and your ability. You will never get buy in from clinicians as staff may not feel comfortable putting trust in people they have never met".

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IMPLEMENTATION

Issues related to the implementation of telehealth concerned the placement of equipment. Participants considered it important to have the equipment in close proximity to the work place, or it could be a distraction from caring for other patients. Participant 4 stated: "The less intrusive it is, the better. If it's just there in close proximity and you can quickly flick it on, then that is handy". Staff also expressed concerns about privacy for their patients, although they did admit that privacy is always a challenge in the fast paced ED environment where there are cubicles without solid doors and people coming and going. Participant 4 stated: "There is always an issue with privacy in the ED whether it is with telehealth or face to face, until we get sound proof curtains it will always be an issue... everyone can hear everything that's going on."

One participant described telehealth implementation "as purely a cost saving measure where the DHB saved on transport for patients and travel costs for the specialist". This may be true but cost and sustainability of a service is paramount in any health service. Other participants drew on the WCDHB experience of telehealth in paediatrics where a coordinator ran telehealth, so all clinicians needed to do was turn up at the right time: "The patient was there, the specialist was on the other end and the equipment was on and ready to use". This ease of technology use was also expressed with a participant saying: "Flexibility is important in the ED; [technology needs to be] simple to use and reliable. So if you are turning it on and it takes ages to boot up or there is a 70% chance that it is going to work, then telehealth will not get utilized".

SKILLS

Developing the necessary skills to use telehealth were a concern for all participants. Most thought that training should not only happen at the initial stages but on a continuing basis. It was suggested that as rural areas have a high turnover a new doctor or nurse may not know how to use the equipment. Participants could see opportunities for additional training and education by utilizing the technology to connect to grand rounds in tertiary hospitals and other education sessions.

Participants considered telehealth could either increase or decrease their skills. For example, one participant stated: "A potential risk to doctors will be a loss of skills...It could create a lazy handover culture". Alternatively others saw an opportunity to increase skills and the potential to keep higher acuity patients in their area with the help from specialists in tertiary hospitals.

OPPORTUNITIES

Many participants identified better support for patients and clinical staff, more efficient use of specialist's time, better quality of care, lower travel costs and improvement in sustainability of services as opportunities that telehealth could bring. Examples of participants descriptions of these opportunities include: "If you don't have a specialist on the floor and you are in Greymouth, given our weather, it could help guide the doctor on the floor with the steps he should be taking to ensure patients get good care and the best outcomes" and "Support from specialists you don't have locally is really good. It is like a safety valve, knowing someone is there to support you".

BARRIERS

Telehealth can represent a change, by introducing new technology and processes in the work place. Participant 10 suggested, "Staff need to relax and not be suspicious of the new technology, and they need to use it to their advantage." If change does not go smoothly staff can become sceptical: "Telehealth is this generation's answer to everything"; and another who stated: "Don't bring telehealth into the service until you can provide me with a clear problem that telehealth can solve and a description of how it is going to solve the problem". Another concern was that telehealth might replace people. Participant 6 explains: "It's really important to use it as an adjunct rather than replacing anyone".

Not having telehealth equipment available when needed was identified as a barrier. Participant 12 stated: "The weather and the equipment are definitely barriers... Power is also a problem; we have a lot of power cuts, again due to weather, although one site does have a generator, however the other five clinics do not. Reliable technology that can provide consistent, fast internet access was seen as needed for effective telehealth in ED. Participant 11 stated: "We need to have the proper IT equipment and the bandwidth to go with it. Even now there is a slight delay in Buller and that has to stop as it makes it terrible to work with". Additionally, Participant 11 suggested: "Make sure there are enough units and they are available. Ensure that the IT system is up to grade and that IT support is available 24/7". Participant 7 could not see telehealth working in ED due to reliability issues, stating: "You have to be able to connect ... the person you are connecting to has to have the technology where they are. Most areas, such as South Westland do not have the infrastructure to ensure the technology will work, so really you have to do scheduled things rather than acute emergency situations"

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Time constraints were also seen as potential barriers, as explained by Participant 3 who stated: "Time constraints depending where it is sited is a concern. If it's in the middle of the ED then it could be distracting for those people using it", and "there is only one doctor on per shift and I see it as time consuming".

DISCUSSION

Findings from this study illustrate clinicians consider telehealth can be effective to deliver healthcare in rural and remote EDs. All participants had a good understanding of the benefits of telehealth but lacked awareness on how it could be successfully integrated in their workplace. Participants identified benefits for their patients and themselves in terms of the additional support that could be available. Potential barriers recognised by participants were reliable and speedy internet connections; additional workload; that telehealth might distract from providing care; access to the technology and also concerns around privacy. The need for someone to co-ordinate telehealth was raised, which is supported by others (Smith and Grey, 2009).

Poor implementation of telehealth has been highlighted as a barrier, not only in this study but also in literature (Joseph et al., 2011; Keane, 2009; Stronge et al., 2007; Wootton, Craig and Patterson, 2006). Research shows the success of any telehealth project, relies on clinician's participation in processes and decision making (Stronge et al., 2007; Wootton et al., 2006). This study indicated some participant's concern over being replaced by technology, and others have perceived telehealth as a threat if used as a substitute for specialists in rural areas (Duplantie et al., 2007).

Equipment that is not fit for purpose, suitable for the area, and with the required functions, is another potential barrier to telehealth. To ensure the correct equipment is installed the decision is best made in conjunction with the user and must meet their requirements (Buck, 2009; Stronge et al., 2007). Reliability of equipment is also seen as a key to telehealth success (Wootton & Bonnardot, 2010). With any equipment comes the infrastructure to enable its use. New Zealand is still in the process of rolling out the Ultra-Fast Broadband Initiative but is not expected to be finished until 2020 (Ministry of Health, 2012).

Literature supports the findings of this study that telehealth can be clinically supportive and educative by facilitating contact with peers (Bashshur & Shannon, 2009; Norris, 2002; Wootton et al., 2006). Furthermore, education can improve quality of care for patients (Mahadevan, Muralidhar, & Shetty, 2011; Söderholm & Sonnenwald, 2010).

Cost and decreased travel for staff were emphasised as opportunities from participants and this is supported by Mahadevan, Muralidhar and Shetty (2011), although another study suggested telehealth in ED was not cost effective because of the need to increase staff and technical resources (Söderholm & Sonnenwald, 2010). From the patients' perspective it has been found that patient travel requirements plus travel related costs were reduced (Peterkin, 2009). The findings from this study indicates that telehealth in ED can present a number of challenges due to the unpredictability of the work, and the perceptions of clinical staff need to be taken seriously in order to address these.

Limitations of this study include the small sample size and that only one setting was used. Although the findings cannot be generalized they may help inform other rural ED incorporate telehealth.

Areas for further research include investigation into establishing telehealth in rural EDs as this is an area that is likely to grow as smaller community hospitals look at alternate ways to provide equitable health services. Additionally, as the true costs for telehealth have not yet been established, research into the costs and benefits for patients, staff and health service delivery is warranted.

CONCLUSION

Employing the latest technology to provide telehealth in rural and remote hospitals has the potential to respond to the needs of communities who at present have difficulty accessing specialist services. Telehealth can support more equitable care, and there are savings through reduced travel costs and time. The use of telehealth in ED is always going to be precarious due to the unpredictability of emergency services. However, listening to health professionals that work in the area is a priority for telehealth developments to be successful.

PRACTICAL IMPLICATIONS:

- Involve ED health professionals to ensure they are well informed and involved in telehealth developments.
- Ensure protocols and guidelines for telehealth are available to support safe practice.
- Determine where to place telehealth equipment to promote easy access and usage, minimise disruption to ED staff, and privacy for patients and whanau.
- Technological infrastructure must be reliable in terms of internet access and speed.
- Empower staff with knowledge and training, not just initially but continuously.

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TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Participant	Gender	Age Group	Ethnicity	Profession	Years of Practice	Years in Emergency Medicine
1	Female	40-60	NZ European	ED Nurse	36	12
2	Female	40-50	NZ European	ED Nurse	16	4
3	Female	60-70	NZ European	ED Nurse	39	24
4	Male	30-40	English	Doctor	11	9
4	Female	40-50	American	Doctor	20	4
6	Male	30-40	NZ European	Doctor	14	8
7	Female	60-70	American	Doctor	34	31
8	Female	60-70	NZ European	Rural Nurse	41	16
9	Male	60-70	English	Doctor	30	4
10	Female	40-40	NZ European	Doctor	14	7
11	Female	40-60	NZ European	Clinical Nurse Specialist	26	11
12	Female	30-40	NZ European	Clinical Nurse Specialist	14	2

HEALTH INNOVATION AND IMPROVEMENT DIGEST

NEW ZEALAND

ANNUAL UPDATE OF KEY RESULTS 2014/15: NEW ZEALAND HEALTH SURVEY

<http://www.health.govt.nz/publication/annual-update-key-results-2014-15-new-zealand-health-survey>

WHO GETS ADMITTED TO THE CHEST PAIN UNIT (CPU) AND HOW DO WE MANAGE THEM? IMPROVING THE USE OF THE CPU IN WAIKATO DHB, NEW ZEALAND

Judith Jade, Paul Huggan, and Douglas Stephenson

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4645697/>

LATE-LIFE SELF-HARM IN THE WAIKATO REGION

WA de Beer, J Murtagh, G Cheung

<https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1426-4-december-2015/6749>

IS A NATIONAL TIME TARGET FOR EMERGENCY DEPARTMENT STAY ASSOCIATED WITH CHANGES IN THE QUALITY OF CARE FOR ACUTE ASTHMA? A MULTICENTRE PRE-INTERVENTION POST-INTERVENTION STUDY.

Jones P¹, Wells S², Harper A¹, LeFevre J³, Stewart J³, Curtis E⁴, Reid P⁴, Ameratunga S².

<http://www.ncbi.nlm.nih.gov/pubmed/26762650?dopt=Abstract>

INTERNATIONAL

IMPROVING EMERGENCY DEPARTMENT FLOW THROUGH RAPID MEDICAL EVALUATION UNIT

BMJ Qual Improv Rep. 2015; 4(1): u206156.w2663.

Lucas Chartier, Timothy Josephson, Kathy Bates, and Meredith Kuipers

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693106/>

IMPLEMENTATION OF HOSPITAL-WIDE REFORM AT IMPROVING ACCESS AND FLOW: IMPACT ON TIME TO ANTIBIOTICS IN THE EMERGENCY DEPARTMENT.

Roman CP¹, Poole SG^{1,2}, Dooley MJ^{1,2}, Smit V³, Mitra B^{3,4}.

<http://www.ncbi.nlm.nih.gov/pubmed/26679042?dopt=Abstract>

PERSPECTIVES OF A NEW GRADUATE

AN INTERVIEW WITH COURTNEY EATON AND RAEGAN LUPI – TWO NEW GRADUATES TO EMERGENCY CARE AND WORKING IN ACH ED, ADHB | Interviews by Michael Geraghty.



PERSPECTIVES OF A NEW GRADUATE CONT.

OK, lets start with some basic stuff, how old are you, when did you graduate and is this your first job?

COURTNEY: “I’m 21 years of age, graduated in 2014 and yes this is my first job since graduating and started here in February 2015”

RAEGAN: “I’m 24 years old, and pretty much the same as Courtney, graduated in 2014, started here in February 2015 and my first job!”

Why did you choose to work in emergency nursing?

COURTNEY: “Ever since a young age I have been extremely interested in emergency nursing, in particular the life-saving skills that I learnt when I first became a qualified lifeguard over 7 years ago. I was lucky enough to get a placement at ACH ED in my final year of nursing school and also did a voluntary placement at Taranaki Base Hospital Emergency Department in 2014. It was my time spent in both these areas that exposed my passion for emergency nursing. I love being one of the first people that patients’ and their families encounter during a vulnerable/stressful time and being able to make a positive difference. Being able to work alongside doctors, consultants and nurse specialists to assess patients and determine the treatment path that they are going to take is extremely rewarding. I love the fast paced environment and the exciting life-saving procedures you get to be involved in.”

RAEGAN: “I chose to work in ED because of the variety I thought it would provide. After graduating, I wished to discover the knowledge and skills needed to interact with a wide range of different individuals I would meet during my nursing career, and learn how to assess and treat an even wider range of health complaints these people could suffer from. I believed ED could provide me with this knowledge and skills.”

And is it turning out to be the sort of work you thought it would be?

COURTNEY: “Since I had ten weeks as a pre-registration student in ACH AED, I knew what I was coming into. One thing I have noticed though, is how busy the winter months get and how high the patient turnover can get – at times it can be pretty overwhelming.”

RAEGAN: “Yes and no. Since I did my pre-reg placement at AED I already had an idea of how the department worked and what an ED nurse did when I started working there as an RN. Also ED does have the variety I was expecting and hoping for.

However, I never expected it to be as busy as it can be at times. I remember throughout one 12-hour shift, I helped take care of a total of 22 patients in my 6-bedded acute room. I never knew how important prioritization was in an area like emergency.”

What were your first impressions starting here?

COURTNEY: “Organized chaos. There can be so much going on in the department at one time. You are only assigned to a small portion and can get so caught up and busy with what you are doing that you don’t realize what else is going on in other areas of the department. When you are a newbie starting out and look around at what’s going on, it just looks like organized chaos.”

RAEGAN: “Since AED had never taken new-grads before Courtney and I, I was really nervous before I started. However, after learning about the orientation programme our Nurse Educators Nancy and Mary designed for Courtney and I, and how welcoming the entire AED team was, my fears dissipated and I felt that I would learn a lot and be well supported by my new colleagues.”

What do you like the most?

COURTNEY: “I love being able to perform succinct comprehensive assessments in regards to a patients’ presenting complaint and then being able to initiate care for them in a timely manner. Being able to be a person that people can trust and look up to during some of their most vulnerable times is extremely rewarding. I also thoroughly enjoy working as part of a great team, alongside a range of different health care professionals in the emergency department.”

RAEGAN: “The different areas of the AED, from triage to resus. While I have only worked in the acutes area of the department, I will be moving into monitoring shortly, and look forward to building on my knowledge and learning the different skills that are needed to work in this area of the AED monitoring and others. I also like the AED staff, and the strong sense of teamwork that is essential in emergency.”

What do you dislike the most?

COURTNEY: “The emergency department always has it’s challenges, especially when it gets extremely busy. Trying to meet government/department targets, and keep up on top of your workload whilst still providing quality care with the large increase in patient presentations at any time, definitely adds a bit of unwanted stress.”

PERSPECTIVES OF A NEW GRADUATE CONT.

RAEGAN: “How busy the department can get, especially in acutes, because when everyone else is also busy it is difficult to get the help you need to manage your ever increasing workload.”

If you had a magic wand what would you change?

COURTNEY: “This is a tricky question because ED is such a great place to work - partly because it is so different to other areas of Nursing. However, one thing would be to somehow reduce our current six patients to one nurse ratio in the acute’s area to allow more time to be spent with each patient to improve their overall outcome. I believe this would allow us to perform more thorough assessments, provide treatment without the extra added time pressure, and allow us to have the time to educate patients sufficiently to help stop re-presentations to the department. Basically if I had a wand that could control the number of people who present to ED at one time and could increase the staffing level accordingly - that would be the perfect magic wand.”

RAEGAN: “A better nurse to patient ratio in the acutes area of ED, and perhaps a GP service in ACH or a private accident and medical clinic near ACH that we could refer patients to who do not need to be at our AED. I believe these interventions will help decrease our currently high numbers in AED.”

If you look to the future what are your plans?

COURTNEY: “To continue to progress through the department at ACH AED and gain more skills in resuscitation and triage to allow myself to work confidently in all areas of the ED. I am also currently completing my post-graduate certificate in Advanced Nursing through the University of Auckland. I would love to get quite a few years under my belt working in such a busy and well known Emergency Department in this country.”

RAEGAN: “I would like to become a Level 3, and stay at the AED for perhaps another 2-3 years to gain experience in all the different areas of the department before maybe travelling overseas to use the skills I gained at AED to work with the New Zealand Medical Assistance Team or some similar organization to help those most in need.”

Thank you to you both!!

Whilst the introduction of new grads into emergency nursing in NZ is not a new strategy it is not without its critics or its challenges and I think all in ACH ED would agree that you both do yourself and the department proud!!!

**IF YOU WOULD LIKE TO SUBMIT AN
ADVERTISEMENT OR ARTICLE FOR
THE NEXT ISSUE OF THE JOURNAL
PLEASE CONTACT THE EDITOR MICHAEL
GERAGHTY FOR MORE INFORMATION!**

Work



Life



CALL FOR ABSTRACTS – 25TH NATIONAL CONFERENCE 2016

**CENNZ will be celebrating its 25th Annual
Conference in Auckland**

DATES:

- Thursday 3rd and Friday 4th November
- Saturday 5th November AENN seminar – all welcome

VENUE:

- Heritage Hotel, Auckland CBD
(<http://www.heritagehotels.co.nz/hotels/heritage-auckland>)

The theme of the conference is 'balance' - balancing work and play, balancing budgets, balancing limited resources, balancing needs of patients or any other interpretation you care to choose!

We are currently calling for abstracts for oral and poster presentations and cordially invite you to forward your abstract for consideration.

Prospective topic areas: Pre - hospital, paediatric, management, research, clinical initiative, new graduate / novice presenter, mental health, quality improvement, older people's health, pharmacology.

www.cennz2016.co.nz

Abstracts can be submitted via the website - this will be live on Tuesday 29th March.

ORAL PRESENTATION	POSTER PRESENTATION
1. Name (s)	1. Name (s)
2. Contact email address (one only)	2. Contact email address
3. Topic area (optional)	3. Title
4. Title	4. Abstract (100 words)
5. Abstract (250-300 words)	



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Geoff Annals
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ACC6704 11/12 *Offer ends 31 December 2016. Terms and conditions apply.



The Advanced Emergency Nurses Network – Regional Training Days 2016.

The Advanced Emergency Nurses Network is a sub section within CENNZ that supports ED nurses working in advance roles such as CNS and NP. Three regional study days are held every year giving these nurses the opportunity to network with their colleagues across the motu, to share clinical information and support the development of the role throughout NZ. Given the fact that over 80% of nurses working in these roles are in the Auckland region the study days are mainly based there. It is hoped, however that other regions will take up this challenge and run their own days in their regions - Wellington certainly did a great job of hosting such a day after the national conference in October.

Kathryn Johnson (NP, CED Starship) has now taken over the role of coordinator of these days and the groups link with the national committee.

The dates for 2016:

- Tuesday 8th March - Middlemore Hospital
- Tuesday 7th June - North Shore Hospital
- Saturday 5th November - This will be organised by ADHB and as part of the CENNZ 25th National Conference and is open to all CENNZ members irrespective if they are CNS and NP's. Places are limited and there will be a small charge for this day.

FOR MORE INFORMATION ABOUT THESE DAYS, AENN GENERALLY OR IF YOU WOULD LIKE TO BE ADDED TO THE GROUP EMAIL PLEASE EMAIL CENNZAE@GMAIL.COM.



COLLEGE MEMBERSHIP RENEWAL DUE 1ST APRIL 2016

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.

MEDIC SIMON AINSWORTH HONOURED FOR EXCEPTIONAL WORK

By: Kirsty Lawrence – Manawatu Standard. December 16th 2015.



Working long hours and tending to mass casualties was something Major Simon Ainsworth didn't have to do, but going above and beyond is just in his nature. Amputation, gunshot wounds and trauma were all injuries he treated in Afghanistan.

"It's never good to see anyone who's injured ... [but] to help people with their injuries is a very rewarding experience and I'm very humbled to have that opportunity."

Ainsworth, from Linton, was awarded a Defence Meritorious Service Medal for his contribution to the final deployment of the New Zealand Provincial Reconstruction Team and Theatre Extraction Team in Afghanistan.

He was deployed to Afghanistan in October 2012 as the New Zealand medical liaison officer to the United States Air Force Craig Hospital at Bagram Airfield.

His role was working as a liaison with the hospital and did not require him to work in the hospital, but Ainsworth said he wanted to help out where he could.

"I guess I technically didn't have to do it, but who wouldn't want to do it as a nurse?"

While in Afghanistan for seven months, Ainsworth treated 331 medical patients and 862 surgical patients, as well as helping train other nurses who were working around him.

"[At] times we had mass casualties...so that's quite challenging ... but very rewarding to be able to care for patients and help them recover."

In his liaison role, he helped co-ordinate the requirements of ill patients for those medically evacuated out of theatre, as well as providing information and support to an NZDF medical fact-finding mission.

The original article plus a 1 minute 40 second video interview is available via the following link:

<http://www.stuff.co.nz/manawatu-standard/news/75107374/Medic-Simon-Ainsworth-honoured-for-exceptional-work>

Article printed with permission of Fairfax Media NZ / Manawatu Standard.

TRIAGE REPORT | *March 2016*

There are 9 triage courses planned for 2016 and applications are currently being taken via the CENNZ website.

Christchurch and Tauranga course registrations have closed. Invercargill (April 16 + 17) is fully booked. Other courses are planned for Northland (12 + 13 May), Lower Hutt (28 + 29 May), Waikato (26 + 26 June and 4 + 5 Sept), Christchurch (15 + 16 October) and Wellington (26 + 27 Nov).

The course is currently under review and the triage instructors met to plan this at the end of 2015.

The pre reading workbook review is almost complete and a revamp of the power points, scenarios, and exam is underway. This will be launched in the middle of 2016.

If you are planning to do this course, we recommend you apply soon to secure a place.

SHARON PAYNE

TRIAGE COURSE CO-ORDINATOR

CONTACT: CENNZ.TRIAGE@GMAIL.COM

NZ TRIAGE COURSE INFORMATION

REGISTER ON LINE AND VIA THE FOLLOWING LINK:

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

- Each course has a good 4-6 weeks of pre-course work before attendance
- **Maximum of 24 places per course - Book early to avoid disappointment**
- Registrations are on a first come first served basis, we will not hold places for anyone on these courses.

TRIAGE COURSE OUTLINE

APPLICATION PROCESS:

Applications are accepted online only and must be received before the close off dates. We now have a credit card payment option along with an invoice option where you can pay by direct credit or cheque. Invoices and receipts are sent directly by email when booking is complete. Please ensure you have the correct email address and invoicing details for whom this is to go to. We cannot change the invoice once it has been sent. We also cannot resend the invoice if you have put in the incorrect email. This is all done via the website on application.

Cost: : \$550 for CENNZ levied members, \$650 for non-members.

You must be a levied member for the financial year of which the course is being held. (You must be a member of NZNO to join CENNZ).

JOIN NOW!!!

If you are not a member of CENNZ and your DHB only pays the member cost of \$550.00, you will be expected to cover the extra cost of \$100.00.



NZ TRIAGE COURSE DATES

2016 COURSE DATES:

The “Book Now” links will take you to the online booking for that course. There you will see if the bookings are still available. It will either have a ‘book now’ link or it will say ‘booked out’.

There is an option to book more than one attendee at a time and an option to invoice to one place i.e. your manager or finance department.

REGION	DATES	CLOSING DATE FOR APPLICATIONS	CLOSING DATE FOR PAYMENT
Christchurch	19/20 March 2016	23 January 2016	6 February 2016
Tauranga	2/3 April 2016	5 February 2016	19 February 2016
Invercargill	16/17 April 2016	19 February 2016	4 March 2016
Northland	12/13 May 2016	17 March 2016	31 March 2016
Lower Hutt	28/29 May 2016	2 April 2016	16 April 2016
Waikato	25/26 June 2016	30 April 2016	14 May 2016
Waikato	3/4 September 2016	9 July 2016	23 July 2016
Christchurch	15/16 October 2016	20 August 2016	3 September 2016
Wellington	26/27 November 2016	1 October 2016	15 October 2016

REGIONAL REPORTS



NORTHLAND/TE TOKERAU REGION

CHRIS THOMAS

Registered Nurse

Emergency Department
Whangarei Hospital

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Happy New Year and best wishes for a happy and healthy 2016!!

Northland has as usual been inundated with visitors over the summer holiday period which brings a degree of change to the types of ED presentations throughout the region. Trauma (major and minor), viral illnesses, Ds and Vs, sunburn and assorted problems caused by people being away from their normal GPs and medical services become the flavour of the season.

Sadly, over the Christmas/New Year period, much of the road trauma we saw was alcohol related leaving staff feeling utterly despondent that the message about drinking and driving continues to fall on deaf ears. The far north particularly saw a large number of preventable tragedies reflected not only in fatalities but in the life changing consequences of serious injury.

On December 23rd 2015 the new reception and triage area at Whangarei Hospital ED was opened. This area is adjoined by an additional four bay room which is set up with a gurney and three lazy boy chairs and another medical office/workspace with extra computers. The new additions have been well utilised since opening and do appear to have taken some of the pressure off the rest of the department and have definitely helped with patient flow. The four bay room is used predominantly for minor presentations, taking blood samples or for low risk chest pain patients who are waiting for a second troponin and don't need cardiac

monitoring.

We have also changed the way we admit patients to the department with most triage 3, 4 & 5 patients being returned to the waiting room following triage and then pulled through by the coordinator rather than pushed by the triage nurse. This system appears to be working well with much less pressure on the available beds and less waiting for patients arriving by ambulance. Good communication between the coordinator and triage nurse is still key to the smooth running of this system. We are interested to see if these improvements cause a shift in our EDLOS stats although with the closure of some ward beds over the holiday period we were again adversely affected on several occasions by hospital bed block.

Nurse staffing at Whangarei ED has had some challenges in recent months to maintain an adequate skill mix with the departure of a few of the more senior staff for a variety of reasons. As always, other staff pull together and plug gaps but this has led to an increase in staff illness over the summer period.

With the availability of a triage course being held in Northland, mid-year, it is hoped to progress a larger number of staff into the triage role than would otherwise be possible.

It also provides a great opportunity for the staff at peripheral hospitals throughout Northland to upskill.

CHRIS

REGIONAL REPORTS



AUCKLAND REGION

MATT COMESKEY

Clinical Nurse Specialist

Auckland District Health Board

Adult Emergency Department,
Auckland City Hospital

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Greetings from Tamaki Makarau

The Christmas - New Year period was one of unprecedented numbers through the department. Historically, the maximum number seen in Auckland Adult ED in a 24 hour period was set in winter 2015. This number was comprehensively beaten post New Year's day. The period saw consecutive shifts where the number of patients seen in ED was consistently over 200. This was not entirely unexpected as it followed a trend that has been seen in previous years. There may be a number of reasons for this, which primarily includes a lack of GP and dental services in the city on public holidays. In addition, anecdotally, patients report the cost of seeing a GP or accessing a service provided by an A&M clinic is a significant barrier, particularly post-Christmas when those who are reliant on wages from casual work may not be employed or are under financial stress. Also of note has

been a significant increase in the number of mental health related presentations.

Changes to the process of assessing patients under section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, has seen some significant changes in the Auckland adult ED. Under section 109 of the act, any person found wandering at large in a public place in a manner that gives rise to a reasonable belief that they may be mentally unwell can be taken by a police officer to a police station, hospital, surgery or another appropriate place to be assessed by a medical practitioner.

Formally, in Auckland this was often done at a police station. The change in process under section 109 means police officers are more likely to present people for assessment by the ADHB psych liaison service in the ED. Under this new process police officers must remain with the person they present with until that person has been assessed and deemed by ED staff not to pose an undue security risk. Under section 109 a person may be detained for six hours, or the time it takes to conduct an assessment, or whatever is shorter. The problem is that there is often a delay in the person being seen, particularly when the psych liaison team are seeing other patients. This has the effect of tying up police officers in the department when they would rather be on patrol. The police officers have at times shifted that pressure onto the charge nurses to release them to leave people in the department who may pose a yet to be identified security risk.

When the new process was first implemented prior to Christmas, there was significant elevated stress within the department. The additional demand for secure bed spaces and security watches since has increased markedly. However it should be noted that since implementation, the overall numbers of presentations under section 109 has

been relatively small - in relation to the previously mentioned sharp increase in mental health related presentations generally.

Since the initial stage of implementation and the problems that have been mentioned, security has been improved in the department. Communication and lines of responsibility between police, ED and psych services are being addressed and have also improved. It has to be acknowledged that the move to take unwell people out of police cells and away from the risk of harm, into an environment where they can be safely assessed is a long overdue step in the best interests of everyone - especially the unwell.

However, while the ED environment is an improvement from the police cells, it is debatable whether an ED is the best place in which some people should be assessed under the act. People presenting under section 109 who have no precipitating medical disorder, intoxication, known overdose or trauma - perhaps should be presented directly to a dedicated mental health facility. This would perhaps ensure more timely assessment and eliminate the need for a transfer from ED to a mental health facility if an ED doctor found there are reasonable grounds for further assessment under the act.

On a lighter note, each year we celebrate the achievements of one of our Auckland based ED medical trainees with the presentation of the Robin Mitchell Medal. Robin was an SMO with a passion for teaching who some of us had the pleasure of working with until he sadly passed away at a young age. This year's recipient of the award is Heather Park - notable because some of us will remember Heather as a registered nurse at North Shore Hospital ED and as a clinical nursing tutor at Auckland University not too long ago.

MATTHEW

REGIONAL REPORTS



AUCKLAND REGION

LIBBY HASKELL (Chairperson)

Nurse Practitioner

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Starship Children's Health

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AUCKLAND REGION UPDATE

CHILDREN'S EMERGENCY DEPARTMENT, STARSHIP CHILDREN'S HEALTH

Warmer weather has been a welcome change from the last time I wrote this report.

Presentations to CED continue to increase year on year, but we have enjoyed some slightly quieter moments over the holiday period.

Our 8 new nurses orientated well to the department at the end of 2015 with the support of a temporary clinical coach and a tailored orientation package. We welcome 2 new graduates and 2 experienced paediatric nurses to our department shortly. This puts us in a good position heading in to winter.

Despite the warmer weather, we continue to recruit steady numbers of patients in to the PARIS (heated high flow humidification versus standard oxygen therapy in children with bronchiolitis) and WASP (Wheeze and Steroids in Pre School children) studies. Starship is co-ordinating ConSEPT (Convulsive Status EPilepticus Trial), comparing phenytoin versus levatiracetam in status epilepticus. Understandably, this international randomised controlled trial has a slower recruitment

rate, and continues to bring new sites on board regularly.

We have just launched a MOS (Management Operating Systems) board in our clinical workroom. A daily meeting is run by the NUM/CCN team at the board at 12MD. The aim of this is to reduce email traffic around departmental issues and come up with solutions in real time. It also keeps staff up to date with upcoming projects and how we are doing as a team in our assigned targets. There are 3 columns on the board: concern, cause and countermeasure. Anyone can write up a concern but must also come up with a cause and countermeasure. These are then tracked through to resolution. We have also added a "how many days since a medication error" counter to the board, to raise awareness of medication safety.

We are thrilled that Danielle Naylor, one of our Clinical Nurse Specialists, was successful in being chosen for the pilot Nurse Practitioner training project commencing this year.

We wish her well on her journey of finishing her Masters and progressing to Nurse Practitioner.

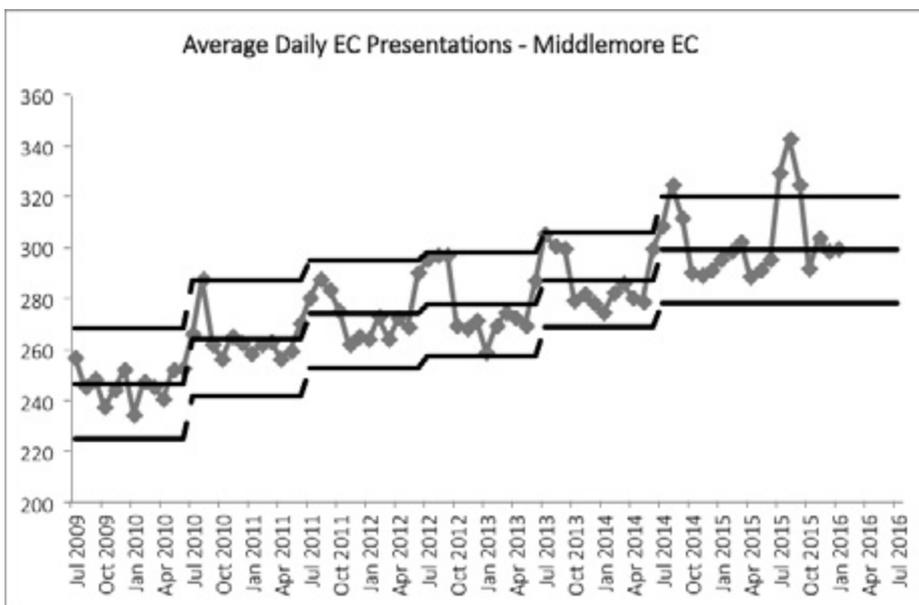
LIBBY

REGIONAL REPORTS

MIDDLEMORE HOSPITAL

A very happy 2016 to everybody, hope you all had some time off with family and friends over summer. Although summer has seen a down turn in presentations, the lull is at previous

year's winter presentations, making the summer time as challenging as some of our busier seasons but with better weather. Daily volumes in December and January were 299 per day, with significant peaks and troughs.



Projects and Quality Initiatives

Our Emergency care projects: Documentation, Airway, Analgesia, Sepsis, Heart and Hand hygiene are moving along well and have not only increased awareness and education but are having a dramatic effect on patient safety and satisfaction.

New CT

CT has been reconfigured to fit in the Emergency Care Radiology suite to improve accessibility thereby improving patient safety, flow and satisfaction. With the Liaison Radiologist in the department Monday to Friday we have quicker and easier access to expert radiology opinion for those tricky films.

Paediatric Emergency Care

KFEC is soon to start a revamp with planning in the early stages; staff are busy putting forward their suggestions to future proof and meet the needs of our rapidly expanding population. We are currently in the process of appointing a fourth Paediatric Clinical Nurse Specialist to join the team, bringing the total numbers of CNS to 8 across the department. The adult CNS team welcomed Vernon Chungson to the team in November, he is enjoying the challenges the advanced nursing role brings and is looking forward to starting the Auckland University Specialty paper in second semester.

Surgical Assessment Unit

Since the opening of the Surgical Assessment Unit in July 2015 a number of patients have enjoyed the expedited journey through the acute care hub whilst the on-call surgical team have settled into their new surroundings in acute care.

Heads up!

We are looking forward to hosting another successful AENN education day on 8th March. The focus of the day is ENT and neurology with some passionate speakers lined up.

See you all then.

MICHELLE AND NIKKI

REGIONAL REPORTS



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 scorching summer is back and as we come through another busy holiday period we look to settle back into our routines. On reflection the Tauranga E.D continues with a pattern of growth in presentations. This is resulting in greater than predicted numbers of people arriving for acute care over summer. The E.D team has been working hard and pulling together to meet this high demand. The nursing roster has been very tight of late and we are looking forward to a handful of new eager staff just about to settle into life in the Bay.

Currently a project is underway within the department to improve and streamline our admission processes this includes moving towards full digital capture of key patient journey event times. As with ED Nurses completing the first page of the ward admission nursing care planning document. This area includes admission related information in a SBARR like format as with safety related information such as falls risk.

On the education front, Tauranga is hosting the National Triage Course in April with a number of local nurses participating. Tauranga is quite central so is a good option for those in the wider Midland Region. The 2016 CENNZ conference will be held in Auckland this year. It would be great to see more delegates from our region attending.

Looking ahead for the year within the region, I see increasing focus in quality as defined by the Ministry of Health ED quality framework. Services will remain constrained within an environment of fiscal restraint. Health service planners and funders will look to strengthen community based services, aiming to improve care and reduce pressure on hospitals as they struggle with increasing demand. Advanced clinical practice nursing roles in Emergency Care will continue to grow.

Momentum is increasing as the benefits become more evident nationally.

RICK

WAIKATO EMERGENCY DEPARTMENT

Some staff had a well-earned break, but those that didn't have worked a very busy summer. Every year we hear about slowing down after our busy winters, but without quoting figures, there seems to be no let up. Boxing day was one of our worst shifts due to trauma and there is a definite increase in high acuity patients.

We are very proud of the success of our redirection policy. For people who do not understand, when a patient presents and needs to be seen by a Doctor, the patient is redirected to a medical centre and the hospital will meet the cost of that visit. We are still getting a lower than expected return rate. We are running the risk of developing a culture where people are presenting expecting to get redirected, once again, we are victims of our own success. Not sure if 2016 will bring some critique to our practise around redirection.

The department has had a big drive on IV Cannulation. We no longer put the "just in case" luer in. We had good evidence that a lot of cannulation was occurring just to get blood samples and then was never getting used again before being removed. We have seen a significant reduction in unnecessary cannulation which is great.

We have welcomed Jo Shea-Kelly as our new Nurse Manager and look forward to the skills she brings. We welcome all our new nurses too, and those nurses who are returning from maternity leave, great to have you back.

As a profession of carers, remember to look after each other.

L. BAINES

REGIONAL REPORTS



HAWKES BAY / TARAWHITI REGION

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Hawkes Bay like most other departments has had a busy holiday period, with little let up in patient presentations or acuity.

Many were holiday makers with multiple ailments and injuries needing care, many of whom seemed unsure of where they could access that care.

A couple of multiple patient vehicle crashes resulted in calling back staff to manage the surge of patients. It's ironic that at these times there is usually one of two other patients that seem to arrive at exactly the same time needing urgent attention.

The front-of-house project is proceeding. We are hoping to improve the flow of patients, as we seem to have done our best with the actual flow within the department. This is going to mean some very interesting building work for both us and the construction company. It might be a good time to take leave.

Our compliance to the national 6 hour target is woefully poor, despite multiple attempts and strategies to try and improve it. We have however managed to gain an extra nurse in the afternoon shifts, who is a dedicated resource or flow nurse. It is their role to try and negotiate flow to improve target compliance. This comes as a welcome relief for the afternoon / evening coordinator as this shift in particular struggled with numbers and acuity.

A large contingent of nurses met with NZNO just prior to Christmas to express their concern re workload and expectations. Many felt unsafe and unsupported in their work and wanted to identify this and attempt to resolve a growing problem. Discussions are ongoing and we hope this will have a positive outcome for all involved.

Our Head of Department has recently stood down from this role. We are seeking a replacement, plus we have the opportunity to employ more consultants.

I have been privileged to have just completed a teaching cruise on board the Voyager of the Seas. I was one of the instructors and it was run by ACEN. What a great way to deliver education. Morning teaching sessions, leaving the afternoons and evenings to play and

enjoy and mingle. We managed to visit a hospital in Lautoka. When you look at the conditions they work under, we are very lucky. I loved a phrase on their wall, conditioning, cramped fairly primitive conditions, triage code 4, expected waiting time 6 hours. Also got to visit the ships medical facility, they have all the equipment, ventilator, can do thrombolysis, no CT however but can do bloods and x-rays. Very interesting.

For Australian nurses, they are able to claim the entire cruise against their tax. Maybe we need to lobby our board and government. There were 50 nurses and feedback was very positive.

A date for your calendar, September 2017 there is to be a multi discipline, international emergency care, 7 day cruise around the Caribbean.

Tarawhiti (Gisborne) ED survived another year of Rhythm and Vines over the New Year period, with some good pre planning and organisation.

Keep up the great work, keep smiling.

SHARON

REGIONAL REPORTS



MID CENTRAL REGION

AMANDA BIGGS-HUME
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Summer is traditionally the time for ED staff to gain a bit of R&R from the extreme workload that bears down on us each winter.

However, this summer both Palmerston North and Whanganui hospitals have reported unseasonably high presentation numbers, which has not allowed staff to catch their breath.

At Palmerston North, Management have theorized that this increase in presentation numbers is due to the implementation of under 13's free GP visits displacing patients from GP surgeries to ED. This theory doesn't explain an increase in numbers, as those who couldn't afford to take their children to the GP used to present to ED. Therefore, the implementation of the free visits is likely to only change the demographics of patients presenting to ED, rather than absolute numbers.

Palmerston North is not normally a drawcard as a summer holiday destination. This usually produces a bit of drop in ED presentation numbers. Yet again the populace made up for it by over-enthusiastic use of DIY tools and the use of children's toys. The trampoline park has featured regularly, along with mountain biking injuries, and falls from motorbikes used in the sand dunes and long stretches of beaches in our region. Palmerston North has also experienced a heat wave with temperature reaching the low 30s day after day. These high temperatures resulted in an increase of "collapse query cause" presentations.

St John's launch the electronic report format in February and staff are looking forward to the incoming patients screen that will be set up in the next few months. I for one will be looking forward to see how this works. It will certainly help with my auditing of patients for the Trauma Network.

MidCentral has a new CEO and there have been some changes in the higher echelons, and in order to better align the implemented changes in organisational structure our previous service manager has returned. In a bid to save money some beds in the hospital have been closed over summer with the redeployment of some staff including into ED.

A fierce round of interviewing has seen the appointment of one of the ED staff nurses into a CNS role for 12 months to cover maternity leave. This is seen as a positive for the service as the role was left vacant during the last episode of maternity leave.

In Whanganui the ED Medical HOD position is currently vacant and they are looking forward to an appointment into this role.

Whanganui ED has also implemented data collection via Trendcare for the last year. This data will be assessed by the Care Capacity Demand Management (CCDM) team. A process of roster engineering will be used to analyse the data to establish whether roster requirements are met when linked to patient volume, acuity and timeframes of peak presentations.

MANDY

REGIONAL REPORTS



GREATER WELLINGTON REGION

KIRSTY HAYNES

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Hello there from the South of the North Island.

As the weather steadily improved throughout spring the attendance numbers and acuity have decreased. This has resulted in much needed time for recovery and reflection as well as time to plan for next winter.

Working over the Christmas period is never much fun but here in Hutt ED it was made all the easier by the hard work of one of our ACNM's- Stephanie Beddis who did a fantastic job decorating the department with a spectacular Christmas tree in the waiting room and magical decorations in the children's waiting area including the special Christmas train. Due to the generosity of a number of outside sponsors, including St Johns, we also had Christmas presents and soft toys to give out to all children who attended on Christmas day which

put a smile on faces and helped to reduce distress. We had a number of Christmas related presentations with children and adults falling off new toys and injuring themselves and sadly the usual number of presentations related to mental health issues over the Christmas period.

Here in the Hutt Valley we have finally received the long awaited external report which has highlighted staff shortages in ED both medical and nursing. At the moment the nursing complement remains under establishment and we are actively recruiting to reach establishment before considering increasing our FTE in line with the report. We look forward to working with the board to implement the changes suggested in the report in line with reviewing our current models of care and systems within the department.

Unfortunately it has been a challenging quarter for the region with respect to the shorter Stays target and all three DHB's have slipped in their performance. In the light of this Hutt Valley DHB has been visited recently by Mike Ardagh who has reviewed the systems and flows in place and in conjunction with the external review has helped the staff to focus on the task ahead changing the flow within the department to hopefully have a future positive effect on the target.

The change in the weather has resulted in several related attendances with a number of patients attending with heat stroke and dehydration. The recent Sevens resulted in a few alcohol related attendances but with the event much watered down not as many as seen in previous years.

Reconfiguration of the Police service throughout the region has resulted in an increase of mental health patients in

both ED's requiring CATT assessment and a corresponding upsurge in security incidents. In response to this Wellington ED has been trialling a new innovation for 3 months that started on the 24th of December. Overnight Security are now present from 2300-0700. Their role is purely as a security presence and it has been vital to make sure they were not utilised for orderly tasks such as patient transfers. This trial has been based on Christchurch's 'May Not Ok' model. Normally each month there are on average 8 violence complaints reported but in September a focused effort highlighted a total of over 20. Hutt ED is considering running a project of their own utilising the excellent simplified paperwork developed in Wellington to capture the true picture of security incidents.

Wellington ED are hoping to maintain their vigilance so that when the trial completes in another couple of months there is ample proof of the benefit of the continuous Security presence.

Wellington currently have a Full FTE. One new grad has been taken on in each department and we wish them both a warm welcome.

At Wairarapa DHB Stephen Downie-Fribbens has been appointed as Charge Nurse Manager for acute services and is due soon to commence this role. He comes down to the region from Auckland and has an idea of the region having worked for a couple of months in Hutt ED before his successful application for CNM.

He was here for only a short time but made many friends and we wish him all the best in his new role.

KIRSTY

REGIONAL REPORTS



TOP OF THE SOUTH REGION

JO KING

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Greeting from the Top of the South.

We have enjoyed a wonderful summer with record numbers of holiday makers swelling our population and enjoying all the region has to offer. New Year saw the highest number of presentations in the history of the Nelson emergency department and it feels like the increased workload has persisted. Total patient minutes in the department for the month of January were 436634. This is the highest since monitoring of this indicator commenced and reflects acuity, workload and hospital flow issues over the summer period. Our challenge has been providing care with fixed staffing and fixed bed spaces. The Summit Rescue Helicopter also reports a very busy time flying an increased number of missions across our very large catchment area.

NMDHB received less than expected in the fiscal envelope and the message of cost saving prevails. We have welcomed several new staff but are still waiting to fill 2.2 FTE positions. It remains disappointing that we lag behind many NZ departments with no advanced nursing roles in the emergency department. We continue to advocate strongly for these positions as we recognize the contribution they would make to patient outcomes and workforce development. There has been a change in the Head of Department in Nelson ED with Dr

Tom Morton standing down after many years and Dr Andrew Monroe taking over. We thank Tom for leading our team and welcome Andy to the role.

This month sees the roll-out of Phase 2 of the 'Nelson Marlborough Code STEMI Project.' This has been a collaboration between ED, Cardiology and St Johns and involves Paramedics communicating directly, while in the field, with the on-call cardiologist. This enables expedient decisions to be made about transport, the best destination and pre-hospital thrombolysis if indicated. Very successful multidisciplinary study days were held in both Nelson and Blenheim this month as part of the roll-out. In April the TNNC will be held in Nelson which will be a great opportunity for emergency nurses across our region.

Wairau ED is facing some operational challenges as they work while major strengthening of their building is carried out. A trial was also conducted over summer aimed at encouraging the use of primary care for appropriate presentations. This initiative involved consultations with a Primary Care Nurse Practitioner being available for some patients.

We look forward to feed-back on this change to the emergency department's model of care.

JO

REGIONAL REPORTS



CANTERBURY / WESTLAND REGION

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CHRISTCHURCH HOSPITAL

The year has started in a celebratory manner with the appointment of two Clinical Nurse Specialists who are on the Nurse Practitioner Pathway.

This is a significant step for these nurses and for nursing practice in our department. We are designing a workforce model which involves developing and expanding advanced nursing roles.

We have developed a programme for new graduates and two nurses on the NetP programme joined us in January. We welcome them into our team and emergency nursing and look forward to seeing them grow and develop in their practice.

Christchurch Emergency Department has seen lower volumes over the summer months but acuity and complexity feels higher. However this is hard to quantify as we do not have a tool to measure this. The variation in volume from day to day (100 patient variation) is a challenge as we do not have a responsive workforce plan. The inpatient admission rate has dropped to around 40% with a subsequent rise in the volume (up to 700 per month) and percentage (now between 9-10%) of those patients being admitted into our Observation unit and managed by ED.

Projects for the upcoming year include the introduction of e-meds into ED (using mini iPads for medication administration), undertaking the Releasing Time to Care programme (RT2c) and working with our colleagues in acute orthopaedics and child health to work on the finer details of our models of care in the new facility.

Winter planning needs to start now and we have some ideas to assist us to manage the increase in demand and other challenges which we face during the winter months.

ANNE

WESTCOAST

We have had an extremely busy summer in ED with multiple RTCS involving overseas tourists. There have also been some large events taking place such as the "Coast to Coast", "Buller Gorge Marathon" and the Waipuna Motor-X. This also ensures some brisk activity within the ED environment. As usual we have had staff coming and going both medical and nursing.

On the 03 February 2016 there was a meeting called for all staff at Grey Base Hospital. We were informed that the new rebuild was on hold as we were 1.3 million over budget. This has been a complete blow to everyone concerned.

Anyway, on a lighter note the weather has been absolutely stunning for weeks now. So we should enjoy this beautiful weather while it last.

Until next time farewell from the Coast.

LYNLEY MCINROE

CNM ED/OPD

GREY BASE HOSPITAL

REGIONAL REPORTS



SOUTHERN REGION

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OAMARU

In December I had the opportunity to visit Oamaru Hospital; one of the rural emergency departments within the SDHB.

It was good to meet the nursing, medical and management team, who provide secondary level emergency care for a population of 22,000 within the Waitati District. The unit is funded for 4,000 patients a year, but on average sees 7,000 patients a year.

Oamaru's main area for acute emergency admissions is a four bedded unit. Two of the beds are also equipped as resus bays. Plans have been discussed for the development of a separate resus but this development

has positives and negatives, especially in relation to staffing. This rural ED relies on its close knit team to cope with the increasing presentations and managing the patients in their care. Frequently only one nurse and one doctor are on duty at any time and are relieved for meal breaks by nurses from other areas of the hospital. An 'on call' roster for both nursing and medical staff is part of expected duties to provide cover for the department and hospital. There is no separate triage nurse and patients are transferred directly from the ambulance bay, being triaged on arrival in the acute area. Ambulatory patients present to the office and are directed to an assessment room for investigation and treatment. One other room is utilised for minor surgical procedures and plastering.

This visit gave me insight into the different stresses and demands on our rural hospitals. The video 'a year at Oamaru Hospital' highlights the difficulties that rural emergency nursing and medicine face today and is well worth viewing. It makes us appreciate our colleagues and the work they do with limited financial & staffing resources.

My thanks to my nursing colleagues Robyn Keno, Linda James, the emergency physician Dr Peter Rodwell and the hospital's CEO Mr Robert Gonzales (CEO) for their time and insights into working in a rural emergency department.

DUNEDIN ED

Over the last few months our CNS and senior nursing team have been involved in the project 'Releasing Time to Care'. The focus of this project is to provide more time for staff to provide clinical care. Improving specific areas has been facilitated by groups working

within areas to make them user friendly. The concept of "lean thinking" has been reintroduced into the department. The development of a 'care centred' departmental vision is nearing completion with staff and patient survey results informing the progress on other modules. This has resulted in the main acute area, resus and medication rooms getting a long overdue reorganisation, enabling staff to improve function and patients to receive timely care within the department. Although many areas still have a lot of work to be undertaken, we look forward to the many positive changes that will occur. Close liaison with other ward areas also participating in the project has enabled the sharing of ideas, with the enthusiasm being generated by other participants infectious to all. We are looking forward to the next module which is about reviewing handover processes within the ward.

The daily business of ED has continued while the Releasing time to care progresses. The holiday averages have been between 110 & 116 presentations a day over December January period. There has been vast diversity in the number of daily presentations ranging from 89- 130. The last yearly quarter has seen Dunedin meet the 6 hour target with a consistent average of 96.39 % for the first 19 days of January. This is partially due to the nurse led 'Early Treatment Zone' where patients are seen initially with investigations and diagnostics instigated to limit delays in patient care and treatment. Staffing over this period has been difficult due to increased sickness and staff turnover and skill mix.

Finally, the team at Dunedin would like to wish Carly Hawkins well for her future career. She has chosen to continue her work in England, resigning her position as a one of three CNS in Dunedin ED.

REGIONAL REPORTS

SOUTHLAND HOSPITAL

Over the holiday period it has been quieter than usual; however this has not reflected the unusual numbers of high acuity patients. We have struggled with staffing due to unexpected resignations and secondments. One

coordinator has been seconded for a year to the maternity unit and we are currently advertising this position. We have a CNS participating in the Nurse Practitioner training scheme this year. On the education front the emphasis has been updating the ACLS, IV training and Rapid Sequence

Induction. The CNS team continue to progress the minor fracture clinic guidelines and hope to implement these in Lakes District and Dunedin ED's in the coming months.

ERICA

VACANCY: NURSE SPECIALIST – ADULT EMERGENCY DEPARTMENT, ADHB-092719

Are you looking to work in a modern, world renowned tertiary Hospital that provides a comprehensive orientation and on-going education in a supportive team based environment?

We are seeking a senior registered nurse with strong leadership and advanced nursing skills to work with our dynamic Nurse Practitioner/ Nurse Specialist and Medical team in our Adult Emergency Department!

You will be an experienced Registered Nurse with current acute emergency nursing skills and have experience working with complex patients.

In this role you will provide professional and clinical leadership, patient care co-ordination, education and clinical teaching to patients and staff. It is important that you can work autonomously, prioritise workload and work as part of a supportive senior nursing team committed to effective/evidenced based nursing practice. As part of this role you will be expected to have on-going educational commitments internally and externally to maintain your professional portfolio.

The successful applicant will have extensive nursing experience and be practicing at a senior level.

We are looking for a proactive person who is ready for a new challenge and a chance to take a step up in their career path. *Post graduate qualifications and Research skills would be an advantage.*

It is essential that you meet the following criteria:

- Have **at least** 5 years acute nursing experience
- Interact effectively with a multi-disciplinary Team and Service members
- Maintain safe cultural practice and develop your cultural knowledge
- Have excellent supervisory, communication and problem-solving skills are essential in order to relate to and work with staff and patients at all levels

- Align with the Auckland DHBs values

- Have NZ Nursing registration with a current Annual Practicing Certificate.

Ideally, you will hold or would be working towards a Post-Graduate Certificate or Diploma in specialty nursing practice.

To apply, click on this link: <http://www.careers.adhb.govt.nz/> and make an online application attaching your latest CV and cover letter, quoting reference number 092719. *Note that only applications submitted online via the ADHB website will be accepted.*

For a position description please see email address below:

For assistance with the online application process contact Pieter Erasmus, Recruitment Consultant, on perasmus@adhb.govt.nz

Applications close: 21 March 2016.

Auckland DHB is committed to the application of the Vulnerable Children Act 2014 and its intent to improve the safety of all children. This position is a Children's Worker role as defined by the Act.

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Organisation: Adult Medical Services

HealthBoard: Auckland DHB

Job: Senior Nursing

Full-time Rostered / Rotating.

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EMERGENCY NURSE NEW ZEALAND
