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# EMERGENCY NURSE NEW ZEALAND

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# EMERGENCY NURSE NZ

## EDITORIAL COMMITTEE

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## A WORD FROM THE EDITOR:

Hello and welcome to the second journal of 2016 full of fun packed interviews, clinical articles to keep your warm on these dreadful chilly nights!

Hopefully by now you are tapping your nurse manager on the shoulder and begging to be allowed to spend an instructive and educational few days in the unofficial capital of NZ for the annual conference. An almost guaranteed way of getting time off to attend is to register as a speaker or develop a poster for the conference. For those who have been CENNZ members for greater than two years you can also apply for one of ten free registrations on offer – email your expression of interest to the national committee (cennzsecretary@gmail.com), it's on a first come, first served basis so hurry, hurry, hurry!!!

Congratulations to the four ED nurses who have recently become registered as NP's (see CENNZ News and interviews) – it was a long time ago since I did my panel assessment and know the process has been streamlined but it is still a reflection of each individual's tenacity, their collegial support and professionalism that has taken them to this level. As an NP myself I admit to being a little biased towards NP development. The successful implementation of CNS and NP roles within our ED' s has opened up a new career pathway for nurses, providing timely and quality care alongside their nursing and medical colleagues, - and the more the better!!!

**MICHAEL GERAGHTY**
**EDITOR | EMERGENCY NURSE NZ**
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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.*

# EMERGENCY NURSE NZ

**SUBSCRIPTION:**

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*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*

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# *Chairperson's Report*

It is hard to believe that we are almost half way through 2016. It has been lovely to have such a great summer, but this has made it difficult seeing the leaves falling off the trees and the colder days here. I hope you and your departments are all ready for winter!

The CENNZ national committee had a busy and productive two-day meeting in Wellington last month. It is fantastic to see our current levied membership being around 300 (*since 1 April*) – this is an amazing start to the New Year. If you haven't rejoined, please do so online through our webpage. We have added in some demographic as well as other questions which we will feedback to you later in the year. One of the questions is whether you are interested in being actively involved with CENNZ, and it is great to see that many are!

As mentioned in my last Chair report, the ongoing issue of violence in EDs continues to be heard from many regions. Our position statement on this is coming out to you and key stakeholders imminently. Please take the time to review this individually or in your teams and give feedback. CENNZ wrote to NZNO earlier in the year in regards to our concerns for emergency nurses and the escalating issue of violence in EDs. We had a very positive response received from Hilary Graham-Smith (*NZNO Associate Professional Service Manager*) saying she agreed that this issue required highlighting at a national level and it is the view of NZNO that a whole of sector workforce approach is needed. We will continue to liaise with NZNO and engage key stakeholders on this issue. Additionally, CENNZ will be sending out a survey monkey to our members' to gauge your opinion on violence in EDs. This is really just a beginning, as we are hoping to continue with a bigger piece of work on this in the future.

*"The emergency nurses Knowledge and Skills Framework is out for consultation. Please feedback on this also. Thanks to the great team who have worked with great commitment to get this completed in such a productive way."*

The emergency nurses Knowledge and Skills Framework is out for consultation. Please feedback on this also. Thanks to the great team who have worked with great commitment to get this completed in such a productive way.

Check out the August issue of Kaitiaki as emergency nursing is being featured! We hope to have a comprehensive range of articles on our specialist field. *Please email me if you would like to contribute cennzchair@gmail.com*.

A real highlight of the first half of 2016 is the announcement of four new emergency Nurse Practitioners!

I wish you well in the next phase of your careers. There are several other emergency nurses who are awaiting NP panel interview. It is fantastic to see a positive move nationally in the progression of advanced practice roles over the last couple of years.

Please take care of yourselves over the winter months. Plan some "me" time to rejuvenate and revitalize. Remember to book your leave for the conference in November in Auckland!

**LIBBY**

**LIBBY HASKELL | CHAIRPERSON**
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# CLINICAL CASE PRESENTATION – A SORE THROAT

**Author: Brett Turnwald (ENP, Tauranga ED) presents an interesting case highlighting the importance of thorough assessment and appropriate investigations on what initially seemed like a straight forward case.**

**Email for correspondence: Anton.Turnwald@bopdhb.govt.nz**

**KEY WORDS:**

**Diagnostic reasoning, travel history, differential diagnoses, clinical assessment, immunisation.**

## HISTORY OF PRESENTING COMPLAINT

Mrs S, a 35 year old woman presents to the ED with a four day history of a sore throat and rash. She had seen her GP twice during this period and had been prescribed a course of Amoxicillin plus analgesia for a presumed group A streptococcal infection (GAS). She describes an intermittent fever and her main concern on presenting to the ED was the persisting rash. She states the rash has not been itchy, and that it started centrally and moved to her limbs- also alludes to joint pain.

Mrs S is an Indian born NZ resident and stay at home mother of two. She has been holidaying in India for the past two months at her local town in the Gujarat region- Western India near the Pakistan border. She returned to NZ about one week prior to becoming ill and reports neither her husband nor her children being similarly affected.

## PMHX:

**Nil of note.** NKDA No regular prescribed medications.

Immunization: Hepatitis A and Typhoid prior to commencing holida

## EXAM:

Well looking lady in no obvious distress, articulate and with good English.

Vital signs – Afebrile. Normal domains

**Rash:** Fine non vesicular erythematous rash on face/trunk and limbs including her palms.

**Chest:** clear to auscultation with equal AE and no wheeze. Coughing periodically before assessment and admits to nocturnal coughing.

**Abdomen:** SNT with no masses or reactive nodes noted.

**HEENT:** Slight conjunctival erythema with no exudate and no oedema. Lips dry with some epithelial sloughing. Tongue and throat NAD. Reactive anterior cervical chain nodes with no submandibular nodes.

**Limbs:** hand swelling with joint pain to the fingers and MCP region. Knee and ankle pain with slight effusion noted to the ankle joint- bilateral.

## IMPRESSION:

35 year old woman with normal vital signs, well looking with generalised erythematous rash and polyarthralgia.

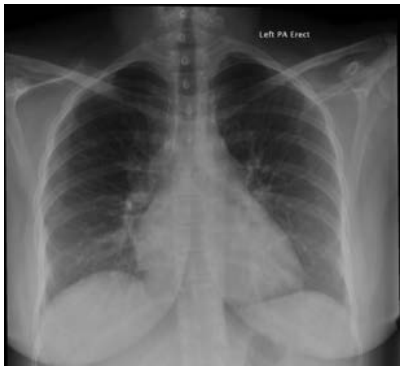
## DIFFERENTIAL DIAGNOSES:

1. Viral illness / exanthema
2. Rheumatic fever
3. Rubella
4. Chikungunya virus
5. Zika virus
6. TB
7. Reactive arthritis

# CLINICAL CASE PRESENTATION – A SORE THROAT

## INVESTIGATIONS:

| TYPE | RATIONALE |
|---|---|
| ECG | Rheumatic fever exclusion for 2nd degree HB |
| MSU | Looking for proteinuria (post strep' glomerular nephritis) |
| Bloods | FBC, U and E's, CRP. TB Quantiferon, rubella, streptococcal, syphilis serology and Igm antibody testing |
| CXR | Had a persistent cough during the initial exam and given recent overseas travel a useful way to exclude other systemic disease i.e TB. |
| Throat swab | Not indicated |




## RESULTS:

**Bloods:** Lymphocytosis/leucopoenia and slight thrombocytopenia, CRP 23.

Strep/TB serology negative, Syphilis serology negative (after 72 hrs)

**CXR:** Bilateral central hilar nodes noted suggestive of possible infection (TB, mycoplasma), malignancy (lymphoma, carcinoma) or inorganic dust disease (silicosis).

**ECG:** NSR – normal pr interval and qrs interval, normal axis.

**MSU:** NAD (Protein free)

## DIAGNOSIS:

Positive serology for Rubella (German Measles)

## DISPOSITION:

Discharged home with an outpatient General Medical review at 72 hours.

Family members and other potential contacts where screened for currency of vaccination and educated appropriately about the need to be immunised.

## DISCUSSION:

**Rubella** (aka German measles) is generally a benign viral illness although it can cause significant complications to the developing foetus in the unvaccinated pregnant woman. Similar to measles it is an airborne contagion with an incubation period from two to three weeks. Common symptoms of Rubella include a brief widespread rash, swollen lymph glands and painful joints, the latter mainly occurring in adults. The rash looks similar to other rashes and it is best diagnosed by rubella immunology serology. Infection during pregnancy (particularly the 1st trimester) frequently results in the new born having features of the congenital rubella syndrome (CRS):

- Ophthalmologic abnormalities (cataracts and retinopathy)
- Cardiac abnormalities (patent ductus arteriosus, pulmonary artery stenosis)
- Auditory abnormalities (sensorineural deafness)
- Neurologic abnormalities (behavioural disorders, meningoencephalitis, mental retardation).

Infants with CRS are frequently growth retarded, have radiolucent bone disease, hepatosplenomegaly, thrombocytopenia and purpuric skin lesions. The severity of disease burden lessens with increasing gestational age at time of infection. Thirty percent of people contracting rubella may develop some complication (thrombocytopenia, ear infection with hearing loss, pneumonia, encephalitis and even death) and usually children under five or adults 20 years of age and above

The MMR (measles, mumps and rubella vaccine) is free to all ages in NZ

**Measles** is a highly infectious (but preventable) viral illness affecting all ages. It is an air borne contagion spread through coughing, sneezing and breathing on others. Measles can be a life threatening illness and one in ten people with measles require hospitalization. Measles during pregnancy is linked to miscarriage, premature labour and low birth weight neonates.

The MMR (measles, mumps and rubella vaccine) is free to all ages in NZ

**Chikungunya Virus** is a febrile viral illness transmitted by mosquitoes. Chikungunya shares some clinical signs with dengue and can be misdiagnosed in areas where dengue is common. Chikungunya has been identified in nearly 40 countries in Asia, Africa, Europe and the Americas. Since 2011 Chikungunya has been identified in the Pacific Region. The mosquitoes that are able to spread Chikungunya virus are not normally found in New Zealand. Chikungunya infection is notifiable in New Zealand as an arboviral disease.

# CLINICAL CASE PRESENTATION – A SORE THROAT

**Symptoms of Chikungunya infection**

The majority of people infected with Chikungunya virus become symptomatic. The incubation period is typically 3–7 days (range, 1–12 days). There is no specific therapy for Chikungunya virus infection and acute symptoms typically resolve within 7–10 days

- acute onset of fever (typically >39°C)
- acute onset of polyarthralgia, usually bilateral and symmetric, and can be severe and debilitating
- headache, myalgia, arthritis, conjunctivitis, nausea/vomiting and a maculopapular rash.

Chikungunya virus infection should be considered in patients with acute onset of fever and polyarthralgia, especially travellers who have recently returned from areas with known virus transmission.

As Chikungunya infection may cause a rash that could be confused with other diseases such as dengue and measles, these diseases need to be ruled out. Diagnosis of Chikungunya will first and foremost be by exclusion of other diseases such as dengue and measles, based on symptoms and travel history. *From http://www.health.govt.nz/our-work/diseases-and-conditions/chikungunya-virus.*

**Rheumatic fever** is a serious but preventable illness. It mainly affects Māori and Pacific children and young people (aged 4 and above), especially if they have other family members who have had rheumatic fever.

Rheumatic fever starts with a sore throat that is known as 'strep throat' – a throat infection caused by Group A Streptococcus. Most sore throats get better on their own, but if left untreated can cause rheumatic fever in at-risk children. Because rheumatic fever is such a serious illness, all sore throats in Māori and Pacific children and young people (aged 4 and above) are at risk.

## EFFECTS OF RHEUMATIC FEVER:

Rheumatic fever makes the heart, joints (elbows and knees), brain and skin swollen and painful. Rheumatic fever is an 'autoimmune disease', which means there is a problem with the immune system (the cells and organs that protect the body against illnesses and infections).

While the symptoms of rheumatic fever may disappear on their own, the inflammation can cause rheumatic heart disease, and consequent scarring of the heart valves. Rheumatic heart disease can be life threatening

*http://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/rheumatic-fever*

## CONCLUSION:

This case study demonstrates the importance of establishing immunisation status, particularly of people who have emigrated to NZ. Whilst NZ's immunisation rates have significantly increased over the years low immunisations rates prior to 2009 means that breakthrough of preventable disease like measles will still occur. One of the Ministry of Health's health targets is that 95 percent of infants aged eight-months will have completed their primary course of immunisation (six weeks, three months and five months immunisation events) on time. As previously noted immunisation of adults for specific diseases is free and should be encouraged.

*References;*


- http://www.health.govt.nz/our-work/diseases-and-conditions/chikungunya-virus
- http://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/rheumatic-fever
- http://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/measles
- http://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/new-zealand-immunisation-schedule
- http://www.immune.org.nz/diseases/rubella

# CENNZ NEWS

## FOUR NEW EMERGENCY NURSE PRACTITIONERS!!

**Congratulations to the following nurses who have successfully registered as Emergency Nurse Practitioners in the past few months:**

1. Chrisy Austin – Waitemata DHB
2. Julie Scott – Starship CED
3. Katie Smith – NZ Defence Force
4. Sue Stebbeings – Northland DHB

## CENNZ 26TH ANNUAL CONFERENCE 2017

Expressions of interest are invited for any region keen to host next year's conference. *Please send your expression of interest to: cennzsecretary@gmail.com by 31st August 2016.* Expressions of interest should include a main contact person. In the event of more than one interested region, the final decision will be at the discretion of the national committee.

## GREATER WELLINGTON REGIONAL REPRESENTATIVE – NEW SECONDMENT

Ben Storey has been seconded to the National Committee as the Wellington regional representative. Ben will hold this position until the AGM in Auckland on the 4th November 2016.

## CENNZ 25TH ANNUAL CONFERENCE 2016 – AUCKLAND

The Auckland Regional Conference Committee report that the conference organisation is going to plan with the programme slowly taking shape.

Interested individuals can now register via the link: http://www.conference.co.nz/cennz16/registration/registration

*If you would like further information regarding any of the above or other CENNZ matters please contact Libby Haskell, Chairperson: cennzchair@gmail.com*

## ARTICLES OF INTEREST:

- Narayana S et al. Bedside Diagnosis of the 'Red Eye': A Systematic Review. Am J Med. 2015 Nov;128(11):1220-1224.e1. doi: 10.1016/j.amjmed.2015.06.026.
- Oral prednisolone in the treatment of acute gout: a pragmatic, multicenter, double-blind, randomized trial Authors: Rainer TH et al. Ann Intern Med. 2016;164(7):464-71
- Risk of suicide after a concussion. Authors: Fralick M et al. CMAJ. 2016;188(7):497-504
- Ear acupuncture for acute sore throat: a randomized controlled trial. Authors: Moss DA et al. J Am Board Fam Med. 2015;28(6):697-705
- A preliminary examination of over the counter medication misuse rates in older adults. Authors: Stone JA et al. Res Social Adm Pharm. 2016 Jan 18.
- A comparative exploration of community pharmacists' views on the nature and management of over-the-counter (OTC) and prescription codeine misuse in three regulatory regimes: Ireland, South Africa and the United Kingdom. Authors: Carney T et al. Int J Ment Health Addiction. 2016 Feb 10.
- How much information about antibiotics do people recall after consulting in primary care? Authors: McNulty CA et al. Fam Pract. 2016 Apr 12.

# INTERVIEWS WITH FOUR OF OUR NEW NURSE PRACTITIONERS:

**AN INTERVIEW WITH SUE STEBBEINGS – NORTHLAND DHB, CHRISY AUSTIN – WAITEMATA DHB, KATIE SMITH – NZ DEFENSE FORCE AND JULIE SCOTT – CED STARSHIP FOUR NEW NURSE PRACTITIONERS.**
**Interviews by Michael Geraghty.**

## SUE STEBBEINGS – NORTHLAND DHB

*1. What inspired you to become an NP?*

**SUE:** Initially, the motivation to develop advanced practice skills was a growing belief that emergency nurses could do more to decrease peoples waiting times and length of stay when supported to work in a different way. Over the last 10 years I was supported in my practice development and more recently employed in a clinical nurse specialist role. Practice experience highlighted that there would be greater benefit for our population with the NP scope of practice. Hearing about the practice of NP's working in Emergency Departments encouraged me to persevere with the challenge of registering as a NP. I find it rewarding to provide care for people through assessment and individualising their management plans, and have always been interested in figuring out the reasons for peoples' presentations.

*2. What advice would you give to a fellow ED nurse wanting to become an NP?*

**SUE:** It is great to have an advanced clinical care pathway in nursing. Spend time exploring advanced nursing and NP practice. Talk to people practicing in those positions and discuss the roles with people in your team. Get advice about the best ways to develop your own practice and as you progress in the journey clarify the population and area of practice you will be working with. Good clinical mentoring is essential. As a recent survivor of the juggle of work, study and family life, it was invaluable to have great support from everyone. The journey to NP is part of developing your practice and is worth it.

*3. Where do you see the role developing in the next 3- 5 years?*

**SUE:** Transition to NP practice and consolidation of skills will be the initial focus before continuing to broaden the range of presentations that I routinely manage. Building stronger links with services relevant to lower acuity presentations will continue to be a focus over the next 1 -3 years. I am positive that there will be many opportunities to develop the NP role in our ED and support the establishment of the role in this DHB. Sustainable progress, strong connections with relevant networks, and mentoring others in their NP journey will be important considerations.

**N.B.** I am still working as a CNS while the anticipated funding for the NP role is finalised.

*4. Is there any one thing you are particularly proud of when thinking back on your journey to becoming an NP?*

**SUE:** The support of colleagues to complete the journey has affirmed the value of establishing the NP role into our model of care.

*5. Anything else you want to say?*

**SUE:** The CENNZ Knowledge & Skills Framework that is under development is a good resource to support progression in emergency nursing practice.

# INTERVIEWS WITH FOUR OF OUR NEW NURSE PRACTITIONERS:

## CHRISY AUSTIN – WAITEMATA DHB

*1. What inspired you to become an NP?*

**CHRISY:** That's quite funny because you and Marg Collighan inspired me. At first when I looked at the requirements: 4-5 years of study while working, plus the NP portfolio and passing nursing council I found this overwhelmingly daunting. Then I thought, I can do nothing and in 5 years nothing will have changed or I can crack on with it and in 5 years I could be an NP. The 5 years are going to pass anyway.

Being a CNS/NP can be a lot of fun, especially the practical stuff; reducing fractures/dislocations, casting, putting in regional blocks, suturing wounds. Having extra skills is just awesome, I enjoy the feeling of being able to do more. When that amputated finger comes in I can effectively eradicate the patient's pain instantly with a simple ring block or get the disclocated shoulder reduced. It's often pretty simple stuff and it makes me feel more useful to the service and the population.

I also love the extra knowledge, I have had thousands of Ahh haa moments. I was frustrated by the basic level of knowledge I had and the lack of opportunity to continue to build up knowledge. I used to eaves drop on the house officers discussing their patients with the consultants and found that process of learning fascinating, like a mini review which makes the clinician reflect. A learning process that would be awesome to bring into nursing if we could find a way to incorporate it into our hectic day.

Mostly though I want to eventually do some field work with the Red Cross and I thought I would be more useful if I had more skills and knowledge.

*2. What advice would you give to a fellow ED nurse wanting to become an NP?*

**CHRISY:** Make sure it is the path you want (it's not easy) and develop a thick skin. Become comfortable with fear and do it anyway. Someone said to me if you are not seeing patients that make you feel scared you are not pushing yourself to learn and I have found this to be true. Know that sometimes you will feel so small and so down and so low that you have to hide in the loo to cry but it becomes worth it when you conquer a skill or have the elation of doing something well, improving the journey for a patient and then you walk down the corridor on a complete high. Make sure you have a supportive team, this is critical, not everyone will be supportive, attach yourself to the ones who are and avoid the others. Plan your university pathway carefully. University of Auckland had a clear pathway that prepared me well and I am very grateful to the lecturer's invaluable guidance.

*3. Where do you see the role developing in the next 3- 5 years?*

**CHRISY:** For me the NP role is the clinical peak of nursing (a peak that keeps growing). There is really no limit to where this role can go and as we win the confidence of fellow clinicians and patients what we do today will expand to incorporate more clinically challenging situations. I see a need for an "on the floor" clinical mentor available for nursing staff especially in areas heavy with new/junior staff, this could be another branch to the NP role.

*4. Is there any one thing you are particularly proud of when thinking back on your journey to becoming an NP?*

**CHRISY:** I'm really proud that I got first class honours for my Masters. I've never been an A student so that was pretty special for me and I worked hard for it. Inspiring other nurses makes me proud too and giving patients excellent care. I have done over 300 distal radius/ulna facture (Colles/Smiths type) reductions now and I know that when a patient with this injury sees me they are getting the best treatment our department can offer and that makes me proud.

*5. Anything else you want to say?*

**CHRISY:** Well that's my one page done!!!

# INTERVIEWS WITH FOUR OF OUR NEW NURSE PRACTITIONERS:

## KATIE SMITH – NZ DEFENCE FORCE

*1. What inspired you to become an NP?*

**KATIE:** After beginning my new graduate nursing career at Waikato Hospital, I have spent my entire nursing career in trauma and emergency nursing, both in NZ and around the world. The skills and knowledge I gained from working within busy urban depts to rural and remote and now in the New Zealand Defence Force (NZDF) have allowed me to have a varied career and hopefully add value back into the nursing work I am doing currently. I have met a lot of inspirational health professionals along my journey, mostly nurses, who are challenging best practice, advancing nursing practice, and providing world class health care. I felt that I could offer more in terms of mentoring and coaching for colleagues, providing advanced clinical care and improving patient outcomes, and the best way for me to do that myself, was as an Acute Care Nurse Practitioner. I began the pathway several years ago, and it has been a long, challenging but very rewarding journey.

*2. What advice would you give to a fellow ED nurse wanting to become an NP?*

**KATIE:** Challenge yourself. You are surrounded by many nurses who you will learn from and teach on a daily basis. They will be your sounding board, and your reality check. They will challenge your concepts of what care should be delivered, and you should accept the challenge of providing the best care you can with the constraints you have in your workplace. You will have doubts. You can do this. At the end of the day, if there is a small part of you that thinks you want to do this, you should. The process has become more streamlined, so I believe this will encourage more nurses to undertake the pathway to become an NP. Oh and find a good mentor. These people are invaluable!

*3. Where do you see the role developing in the next 3- 5 years?*

**KATIE:** There is always room for development and advancement in knowledge, skills and clinical practice. With changes at a governmental level and funding released to support the development of NPs, I see an increase in numbers, which will hopefully translate into an increase in the positions available for Acute Care NPs in DHBs and acute care settings outside of DHBs. My current role is very resuscitation and trauma centric, which is a shift from the current expected Acute Care/ Emergency NPs outputs that are currently being provided in most emergency depts. I would like to see this concept transition into DHBs to include NPs onto trauma services which will directly effect patient outcomes. I think Acute Care NPs are limited in what patient presentations they are currently able to care for, however this scope is increasing all the time with the realisation that NPs are adding value to patient care, increasing positive patient outcomes, reducing waiting times and increasing patient satisfaction, and that can only be a good thing.

*4. Is there any one thing you are particularly proud of when thinking back on your journey to becoming an NP?*

**KATIE:** This has been a long road for me, studying part time to complete my MN, then having to complete extra papers to meet the education requirement. I had a baby and took some time off in the middle of finishing my Masters and completing my portfolio, and there were times when it all seemed like too much work. But I decided that I really did want this, and that what I could provide for clinical care was important. I submitted my portfolio finally last year and then in March became the first NP in the New Zealand Defence Force, something that I am particularly proud of. I am proud to represent the Royal New Zealand Nursing Corps (RNZNC), and the NZDF, and reflect on the challenges that have been and the future challenges that await. I am excited to see where this journey leads.

*5. Anything else you want to say?*

**KATIE:** I am very proud to be an emergency nurse in New Zealand. I am constantly reminded of the high calibre of our nurses when I work with my colleagues around New Zealand.

# INTERVIEWS WITH FOUR OF OUR NEW NURSE PRACTITIONERS:

## JULIE SCOTT – CED STARSHIP

*1. What inspired you to become an NP?*

**JULIE:** I have worked in the Childrens Emergency Department at Starship since I graduated as a new grad in 2003. It was the speciality I wanted to work in from the beginning and I was lucky to get an RN position there and then be supported to work, develop my career and complete my family in the early years. Once working at the most senior level clinically for a period of time it became obvious to me that I needed to either advance my career within the department or consider finding new challenges elsewhere. I absolutely love paediatric emergency nursing but I was becoming frustrated with the restriction in the RN scope clinically, comparative to knowledge and experience gained over the years. I liked using my skills to assess, diagnose and commence management within my practice as an RN but I got frustrated that I generally wasn't able to formalise that outside a very narrow scope and had very limited autonomy in providing complete care for the patient and family. When the nurse specialist and nurse practitioner role became established in CED I knew that the clinical nature of this role was the direction I wanted my career to take and would provide the challenge I was wanting.

*2. What advice would you give to a fellow ED nurse wanting to become an NP?*

**JULIE:** I think if you are keen to become a nurse practitioner and have gained/are gaining the necessary clinical experience as an RN then get started on masters pathway early and put yourself forward for leadership roles and senior nurse roles within your department. The nurse practitioner role is so much more than just providing clinical care to patients and the more experience you can gain in areas such as leadership, education and quality for example, the more you can bring to the role. Having a global understanding of how departments and hospitals function and the factors that impact on the patient journey which ultimately affect patient outcomes is also really important and will assist in your development in to the role. Lastly, soak up every little bit of learning you can. The knowledge required in the NP role is so different to what we learn as undergrad students and RN's so take every opportunity you can to expand your clinical knowledge.

*3. Where do you see the role developing in the next 3- 5 years?*

**JULIE:** I think role development is probably department dependant still but I think on a national scale it would be great to see support for an increase in numbers in the NP role and a focus on widening of the scope of the NP outside of minor injury and illness/pathway pts. As far as the role within our department, we are lucky enough to work in an environment where we are fully supported to manage any triage 2-5 patient that presents regardless of their presenting complaint or background complexities. Role development for us involves expansion into team management of the triage 1 patient and we are being supported in this by our department through involvement in CRM and APLS courses and increasing exposure in resus in the medical role.

*4. Is there any one thing you are particularly proud of when thinking back on your journey to becoming an NP?*

**JULIE:** I think for me personally it was a. making the decision to advance my career when it was so comfortable being a long standing senior nurse within the team and b. completing the educational aspect of the training. Completing a masters while working fulltime and trying to adapt to a new role (CNS) was never going to be particularly fun, throw in 5 kids you are trying hard not to ruin through neglect and it was often a total nightmare (and then some). We all survived though and having the kids attend graduation and see the outcomes of hard work and commitment, and the pride that they felt for me, was definitely up there in the awesome life achievement list.

*5. Anything else you want to say?*

**JULIE:** Yep...a very big thank you to the awesome CED team. For the clinical director and nurse manager for believing in the NP role and supporting its introduction and development in our department, the senior medical team for 100% backing us clinically to be successful practitioners and to the SNT and entire CED team for personally supporting me on what was a long and sometimes not very fun, but incredibly worthwhile journey :)

*Thank you all!!*

# FRACTURE CLINIC REDESIGN IN THE ED: BREAKING THE MOULD

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## ABSTRACT

*The author's present part one of a two part series discussing the management of specific and common orthopaedic injuries. Part one discusses the management of paediatric clavicle and torus fractures. The next article will focus on the management guidelines of the 5th Metacarpal Neck Fractures, Base 5th Metatarsal Fractures and Weber A fractures.*

*Emergency Departments (ED) are continually looking at how they can improve services and the patient journey. Minor orthopaedic injuries are often unnecessarily referred to the fracture clinic causing an increased workload for staff and unnecessary attendances for the patient (Huntley, 2012). This article describes the development of a series of guidelines for the management of minor orthopaedic injuries and specifically reviewing current practice and the out-patient follow up of certain orthopaedic injuries with the aim to free up clinic time and improve care for the patient. A series of articles will discuss the implementation of these guidelines along with audit and patient questionnaire data. This article will cover two guidelines developed; the paediatric clavicle fracture and the paediatric torus fracture of the distal radius and ulna (both 14 years and under).*

## KEY WORDS:

**Clinical Nurse Specialist, Emergency Department, Fracture Clinic Redesign, Clavicle Fracture, Torus (Buckle) Fracture.**

### INTRODUCTION

Historically there has been minimal discernible change to how fracture clinics are organised, with many stable fractures continuing to return for review, as this is how they have been managed in the past (Vardy et al., 2014). Internationally, fracture clinic redesign has occurred due to large referral numbers, high return and low discharge rates (Huntley, 2014). Protocols have thus been developed which has enabled fracture clinics to provide a service that is efficient and financially sound in today's fiscal environment (Mathews, Boyd, Bott & Metcalf, 2014; Murray, Christen, Marsh & Bayer, 2012; O'Neill, Molloy & Curtin, 2011).

The Glasgow Royal Infirmary in the United Kingdom implemented a redesign of their fracture clinic using a modern and innovative approach to patient care. Certain minor orthopaedic injuries were discharged direct from the ED with standardised advice, access to telephone advice and required no further follow up (Glasgow Royal Infirmary, 2016). Benefits that have been identified for the ED are a simplified referral pathway, standardised information leaflets for patients / caregivers and a reduction in time taken to manage patients (Glasgow Royal Infirmary, 2016).

The writers are currently employed as Clinical Nurse Specialists (CNSs) in the ED at Southland Hospital and through post graduate study and the support of the Head of Orthopaedics, Mr Paul Rae, management guidelines have been developed for a number of minor fractures. The work completed by the team at the Glasgow Royal Infirmary provided the vison for change within the Southland emergency and orthopaedic teams. These management guidelines are utilised on a daily basis within the ED by doctors, CNSs and Registered Nurses (RNs).

### PAEDIATRIC CLAVICLE FRACTURE MANAGEMENT GUIDELINE

Clavicle fractures in children are the most common of paediatric fractures and this is usually associated with trauma from a direct blow to the shoulder (Caird, 2012; Paladini, Pellegrini, Merola, Campi & Porcellini, 2012). Children's fractures have excellent remodelling characteristics therefore fractures that are displaced at the lateral aspect of the clavicle usually join with no complication (Caird, 2012; Calder, Solan, Gidwani, Allen & Ricketts, 2002). The mid third of the clavicle is the most common site to fracture with 80%

# FRACTURE CLINIC REDESIGN IN THE ED: BREAKING THE MOULD

occurring here. Less common sites are the lateral (15%) and medial (5%) (Daolagupu, Gogpi & Mudiganty, 2013; Accident Compensation Corporation (ACC), 2008).

Complications rarely develop in simple, isolated paediatric clavicle fractures and surgical intervention is seldom required (Mathews et al., 2014; O'Neill et al., 2011; Calder et al., 2002). No radiographic follow up is required in these situations (ACC, 2008). Risk of complication (non-union, mal-union or re-fracture) does increase with age and displacement, however the risk is still low (Strauss, Carey, Seabrook & Lim, 2011). Non-union is associated with significant displacement and shortening (Tintinalli, 2016). This type of fracture will require follow up, to ensure adequate healing is occurring. Displaced distal clavicle fractures which can be associated with rupture of the coraco-clavicular ligament may require surgical intervention to prevent non-union (Tintinalli, 2016).

The management guideline for the paediatric clavicle fracture has incorporated variances as discussed above in treatment options and provides the practitioner with clear instructions of when referral or consultation is required. Any open fracture, tenting, neurovascular compromise or involvement of the sternoclavicular joint will be referred directly to the orthopaedic registrar. Uncomplicated, isolated clavicle fractures with any bone contact will be discharged with a sling, analgesia and a patient information sheet. No General Practitioner (GP) follow up is required and there are clear instructions on the patient information discharge sheet should any concerns arise.

## PAEDIATRIC TORUS (BUCKLE) FRACTURE MANAGEMENT GUIDELINE

Torus fractures also known as buckle fractures of the distal radius and ulna are common fractures in children under the age of fourteen (Randsborg & Sivertsen, 2009; Khosla et al., 2003). Historically these fractures have been treated in a Plaster of Paris (POP) cast for two to four weeks thus requiring follow up care through fracture clinic (Handoll, 2008; Bhatia & Housden, 2006). These fractures heal without complications as there is no break to the cortex of the radius or ulna (Williams et al., 2013; Oakley, Keat & Barnett, 2008). Torus fractures are classed as stable fractures, therefore no follow up x-ray is required (Ransburg & Sivertsen, 2009; Oakley, Keat & Barnett, 2008). Evidence now supports that the use of splints as opposed to POP casting is more likely to result in the wrist returning to normal function, heal in a similar timeframe and is cost effective (Neal, 2014; Firmin & Crouch, 2009).

Torus fractures of the distal radius and ulna are now treated in the Southland Hospital ED with a velcro wrist splint or a soft cast back slab (for children under the age of two or if deemed appropriate) instead of POP casts. The family member / caregiver removes the splint in three weeks and as with the paediatric clavicle fracture, no GP follow up is required. However, there is an exception on the management guideline for children under the age of 12 months and any fracture that has more than 15 degrees of angulation as this would indicate it is a greenstick fracture (Randsborg & Sivertsen, 2009). Consideration for Non Accidental Injury (NAI) has also been given within this arm of the management guideline. These patients are referred to the fracture clinic.

## IMPLEMENTATION

Education was provided at the time to nursing and medical staff members and the writers are continually providing training to staff members as they start in the department and after auditing. Consultation with the Primary Health Organisation (PHO) occurred and they conveyed the changes to their associated General Practitioner (GP) practices in the community.

A patient /caregiver discharge information sheet has been developed for all related management guidelines. An essential aspect of the sheet is that it includes advice and contact numbers for parents / caregivers if they have any concerns about the recovery of the injury (Glasgow Royal Infirmary, 2016). The provision of verbal and written information is essential for patients and caregivers to understand information given and to ensure compliance (Mathews et al., 2014). All management guideline discharge information sheets have been devised with a similar format to ensure ease of use with nurses and lay language has been utilised so that patients and caregivers can assimilate information provided easily.

Being the recipients of a monetary grant from the Southern Innovation Challenge team in 2016 has also enabled the implementation of these management guidelines in Lakes District Hospital (Queenstown) and in developing further guidelines and auditing.

## QUALITY: AUDITS / PATIENT QUESTIONNAIRE

Audits are carried out every three months and each patient that was placed on the management guideline is audited. The audits specifically look at adherence to the management guideline, documentation and appropriate discharge information both written and verbal instructions being given.

# FRACTURE CLINIC REDESIGN IN THE ED: BREAKING THE MOULD

Financial saving has been quantified by the business analyst as a saving of $379.88 per clavicle visit and $223.88 per buckle fracture visit placed on the guideline. In the past 12 months, 34 patients were placed on the paediatric clavicle fracture management guideline and 27 patients were placed on the torus fracture management guideline. This has led to a combined saving of $18,960.68 over 12 months.

A patient / caregiver questionnaire was developed, to follow up with patients and families to ascertain whether the process surrounding the management guidelines was safe and efficient. Usefulness of the patient discharge information sheet and if any follow up visits to other health professionals (GP / fracture clinic) were required was also ascertained. Over a period of 11 months, 28 patient's families were contacted by phone at a period of 3-6 weeks after their initial presentation. No patients required any follow up at fracture clinic or their GPs and all parents / caregivers stated they were satisfied with the process. Positive feedback was received in regards to the torus fractures with the wrist splints being more suitable for children (being able to take on / off for swimming / showering). The patient discharge information sheets were found to be informative and the pictures were helpful to parents / caregivers in understanding the nature of the injury.

## SUMMARY

The development of management guidelines for paediatric clavicle and torus fractures has provided a pathway for appropriate care for the patient that has reduced unnecessary referrals and has had considerable financial savings for the Southern District Health Board (SDHB). Perhaps however, the biggest benefit which is not quantifiable is the saving to the patient and their family of not having to take time off work / school or to travel to attend appointments at the fracture clinic.

The ability for doctors and CNSs to be able to utilise a tool that combines evidence based practice and is supported by orthopaedic and emergency medicine teams, is essential to the success of the management guidelines within the clinical environment. Change in ED and fracture clinic systems, improved patient care and decreased patient waiting times has made a significant impact within the ED and fracture clinic setting.

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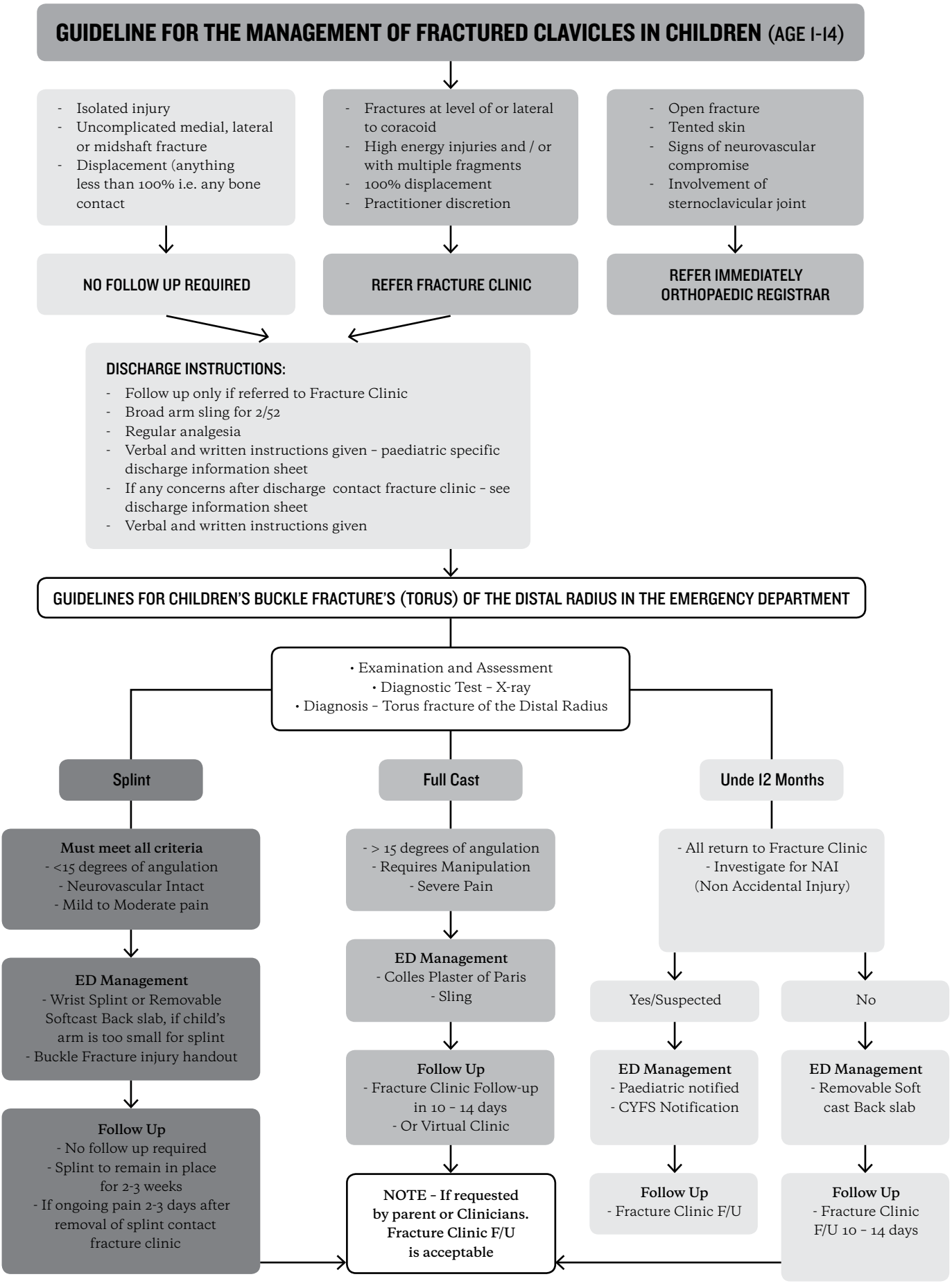
GUIDELINE FOR THE MANAGEMENT OF FRACTURED CLAVICLES IN CHILDREN (AGE 1-14)
- Isolated injury
- Uncomplicated medial, lateral or midshaft fracture
- Displacement (anything less than 100% i.e. any bone contact
- Fractures at level of or lateral to coracoid
- High energy injuries and / or with multiple fragments
- 100% displacement
- Practitioner discretion
- Open fracture
- Tented skin
- Signs of neurovascular compromise
- Involvement of sternoclavicular joint
NO FOLLOW UP REQUIRED
REFER FRACTURE CLINIC
REFER IMMEDIATELY ORTHOPAEDIC REGISTRAR
DISCHARGE INSTRUCTIONS:
- Follow up only if referred to Fracture Clinic
- Broad arm sling for 2/52
- Regular analgesia
- Verbal and written instructions given - paediatric specific discharge information sheet
- If any concerns after discharge contact fracture clinic - see discharge information sheet
- Verbal and written instructions given
GUIDELINES FOR CHILDREN'S BUCKLE FRACTURE'S (TORUS) OF THE DISTAL RADIUS IN THE EMERGENCY DEPARTMENT
• Examination and Assessment
• Diagnostic Test - X-ray
• Diagnosis - Torus fracture of the Distal Radius
Splint
Full Cast
Unde 12 Months
Must meet all criteria
- <15 degrees of angulation
- Neurovascular Intact
- Mild to Moderate pain
ED Management
- Wrist Splint or Removable Softcast Back slab, if child's arm is too small for splint
- Buckle Fracture injury handout
Follow Up
- No follow up required
- Splint to remain in place for 2-3 weeks
- If ongoing pain 2-3 days after removal of splint contact fracture clinic
- > 15 degrees of angulation
- Requires Manipulation
- Severe Pain
ED Management
- Colles Plaster of Paris
- Sling
Follow Up
- Fracture Clinic Follow-up in 10 - 14 days
- Or Virtual Clinic
NOTE - If requested by parent or Clinicians. Fracture Clinic F/U is acceptable
- All return to Fracture Clinic
- Investigate for NAI (Non Accidental Injury)
Yes/Suspected
No
ED Management
- Paediatric notified
- CYFS Notification
Follow Up
- Fracture Clinic F/U
ED Management
- Removable Soft cast Back slab
Follow Up
- Fracture Clinic F/U 10 - 14 days

# REGIONAL REPORTS

## NORTHLAND/TE TOKERAU REGION

CHRIS THOMAS

Registered Nurse

Emergency Department
Whangarei Hospital

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*Greetings from Northland.* After a long warm summer that has just kept on going, we were starting to believe the winterless north myth until very recently!

While presentation numbers and acuity continue to track upwards at Whangarei ED, we seem better placed to deal with the flow since opening a four space room - equipped with 3 lazy-boy chairs and one bed. This takes some strain off the rest of the department. This area is used for low acuity patients who are seen by a swing shift doctor between midday and 8.30 pm. Theoretically there is no nurse assigned to this area so there is often no nursing input. In practice, nursing staff help out as required or when able to do so.

We have had an unsettled period in terms of our head of department at Whangarei with the resignation of the incumbent, temporary appointment of another and finally one of our senior consultants, Dr Scott Cameron, being appointed permanently into the role. It is good to have some stability back in the team and we look forward to hopefully getting some traction on issues that continue to plague the department. ED length of stay being one of the issues we have made little improvement in over the years as outflow (hospital bed block) at times continues to be a major problem. We are currently working closely, particularly with the medical team, to fine tune processes around this as hospital capacity is not a problem to fix quickly.

With fiscal restraint a priority at the moment, we have had a battle over the loss of a nursing shift that was extremely beneficial to the department. The shift was an 11-1930 senior nursing role that allowed for both coordinator support and the ability to flex up when we needed extra hands in Resus. This shift was cancelled by management without due process or consultation. The decision was challenged and after much debate from a variety of quarters, common sense prevailed and the shift was reinstated.

Whangarei hosted a CENNZ triage course in May which was attended by ED staff from throughout Northland and was a great opportunity for upskilling of staff into the triage role. Feedback from participants was extremely positive in terms of learning and enjoyment of the course, not to mention the catering. So well done triage instructors!!

On another positive note, Sue Stebbeings, a CNS at Whangarei ED successfully completed her Nurse Practitioner training in April (as featured in this journal) and was presented with an excellence award at the Northland Nursing Awards in May. She is the first ED based Nurse Practitioner in Northland and a business plan is currently in the wings for her position in ED. She has inspired others in the team and there is lots of ongoing nurse education in progress.

*Congratulations Sue!!*

CHRIS

## AUCKLAND REGION

MATT COMESKEY

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Auckland District Health Board

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*Greetings from Tamaki Makarau*

You know it's winter when there are more leaves on the ground than are on the trees. Winter has arrived late – and will hopefully be mercifully short. However, I don't expect it will be any less busy than last year. With that in mind, the Auckland EDs have initiated a number of projects since last winter that will place us in a better position to meet demand.

### ADULT EMERGENCY DEPARTMENT, AUCKLAND CITY HOSPITAL

From June 1 the nursing model of care in AED changed from Named Nursing to Team Nursing. Named Nursing is the model of care we have been using in AED for more than 10 years. In that time the patient numbers and the workload have increased exponentially.

# REGIONAL REPORTS

During the same period we have had increments of staffing increases and have initiated numerous efficiency projects to help everyone meet the growing demand on nursing services. However, over the last few years the workload has outstripped our resources – even the best and most diligent of staff have, at times felt unsupported. The most recent research shows the best model for us is Team Nursing.

Further winter planning changes include a new ambulatory care area. This has opened for both AED / APU. It is anticipated that it will serve patients presenting for assessment, treatment and discharge in under six hours. Other recent additions are an additional four bed room, short stay area and adding cardiac monitoring to acute area bed spaces.

A new neck of femur fracture pathway has been commenced. The objective is to expedite care by placing the patient in a resus bay, giving pain relief with femoral nerve blocks, x-ray, orthopaedic referral and transfer to an orthopaedic ward from ED.

The department has appointed four CNS's to newly created positions. These staff start in July. It is anticipated that once fully trained they will be able to provide greater CNS / NP coverage across the roster.

Going into winter our APU nursing FTE is fully staffed but the ED nursing FTE is currently short some appointments and recruiting is on-going. A significant issue for getting appointees into work is the delay in completed Police vetting – which is currently averaging three months - this is for New Zealand residents.

The alcohol harm study that has been collecting data from patient's presenting to ED over the summer period has finished data collection. We look forward to the outcomes of the study.

*I'm looking forward to the up-coming conference in Auckland. It will be great to meet as many members there as possible and debrief after winter – and most importantly reflect on how far emergency nursing has come in the 25 years that CENNZ has been operating.*

**MATT**

## EMERGENCY DEPARTMENT, WAITAKERE HOSPITAL

*The Waitakere ED continues to be transformed with the new build forging ahead and a first stage move in date scheduled for July-August 2016.*

This will give the department much needed space, hopefully getting patients out of the corridor and hallways which has now become the norm as we see increasing numbers attending the department. We have already seen a 5% increase in presentations since same time last year.

The paediatric patients attending Waitakere now have access to portable continuous nitrous oxide for conscious sedation, another tool for decreasing anxiety and pain for children requiring minor procedures. We are grateful to Paediatric Emergency Specialist Dr Stefan Van Der Walt and Clinical Engineer Bill MacDougall for making this possible. Nurses are being trained in its safe use and this will be a real quality improvement for the care of children out West.

WiTH ED Mental health nurses are kept busy most shifts assessing patients in our department which expedites Mental Health triage and treatment. Their work is challenging because of the current geography and increased demand for their skills. The new department will allow for better quality of care for the mentally ill client.

E-prescribing is now part of the adult landscape at Waitakere and now we have E radiology orders just launched in the last 2 weeks. There have been plenty of "early adopters" who are finding the new platform for ordering radiological interventions easier and more intuitive with the advantage of being able to track where your patient is placed on the list of requests. E-vitals are also on track to be adopted by WDHB in the near future. Whilst WDHB already use NEWS scoring, our ED in conjunction with Child Health has recently developed a PEWS scoring tool.

Two new Adult Clinical Nurse Specialist Interns have been employed at Waitakere ED to meet growing demand and replace staff that have left. They start their course in the second semester and we wish them well in their studies in what we know is a very challenging time of learning and new skill acquisition. Our new graduate nurses are embracing the challenges of working in a busy and challenging environment. They are being well supported by their mentors and coaches and are all doing a great job.

We wish all our colleagues around the country the very best as we all head into our busiest time of year. I think always with some trepidation as we are seeing ever-increasing demand for our service with limited resources.

*However, our great team culture in ED gets us through as I am sure it does for you all.*

**JAN BOYD**

**CLINICAL NURSE SPECIALIST**

**WAITEMATA DISTRICT HEALTH BOARD**

**EMERGENCY DEPARTMENT, WAITAKERE HOSPITAL**

# REGIONAL REPORTS

## AUCKLAND REGION

**LIBBY HASKELL** (Chairperson)

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### AUCKLAND REGION UPDATE

### CHILDREN'S EMERGENCY DEPARTMENT, STARSHIP CHILDREN'S HEALTH

*The start of 2016 saw a busy few months in CED with presentations increasing at around 5% from last year. April and May saw some calmer days and time to prepare ourselves for the arrival of winter.*

One of Starship's winter initiatives is an after-hours Flow Co-ordinator over the busier months. This provides a 7 day per week, from 2.30pm – 11pm. A review of this role occurred after last winter, with a change in focus occurring. The role is now the Flow and Safety Co-ordinator. This is a dual focus role: coordinating acute patient flow from CED into the hospital, while also providing clinical support and guidance to nurses in all areas of the hospital. This busy role will assist and support nursing teams throughout Starship Hospital over the challenging winter months and ensure children get the right care, at the right time, in the right place.

We are very excited to have a new Nurse Practitioner in CED. Julie Scott successfully went through Nursing Council panel in April. She was in the first cohort of nurses that went through the fast track programme through the University of Auckland. Our department is thrilled to have a third Nurse Practitioner in the team. Julie came to us in 2003 as a new graduate and has worked her way to now achieving NP status. She is a real inspiration as she managed to achieve this while juggling a busy family of 5 children! She is featured in this journal.

The CENNZ national conference is coming up quickly. We are hoping for a good turn out from CED staff – it does make a difference with no transport and accommodation costs! Several of our staff are putting in abstracts to present, so you can be sure to see some paediatric content!

After four years on the CENNZ national committee, I will be stepping down in November. It has been a great experience working alongside a dedicated and focused committee.

*I have learnt so much over my term and will really miss being part of the committee. Nominations for my replacement will be being called for shortly – if you would like to discuss any aspects of this role, please feel free to contact me.*

**LIBBY**

### MIDDLEMORE HOSPITAL

### SURGICAL ASSESSMENT – ONE YEAR ON

*Middlemore continues to expand; it will be one year since we opened the Surgical Assessment (SA) adjacent to Emergency Department.*

This area was opened July 2015 for General Surgical patients presenting acutely to the hospital (triage Cat 3 -5) to be seen in one geographical area. We recruited nurses primarily with a surgical background, and they have been fantastic. The SA was a four month pilot, however it has continued to operate for a further 8 months, our team of nurses have been instrumental in this success.

The aim of the area is to reduce the number of surgical patients admitted into inpatient beds and keep surgical patients at the front of the hospital who need a stay of less than 28 hours. Although only funded for 10 beds, the model has worked well. We are advocating that the unit be funded for 15 beds to get the full benefit of the model.

### MENTAL HEALTH SERVICES IN THE EMERGENCY DEPARTMENT.

There has been significant changes to mental health services which has resulted in having Mental Health RN's based in emergency department 24 hours per day, 7 days per week to support care. The additional support assists our RNs and HCAs working in our Short Stay unit to provide extra specialised nursing care and education for our patients under the care of mental health services. A Psychiatrist is also based in ED Monday to Friday.

# REGIONAL REPORTS

We continue to work closely with our local Police and security to ensure we have a safe environment for our patients and staff. Our Community Constables walk through the unit daily, which has been well received by staff and great to see.

### NEW GRADUATE PROGRAMME.

We have taken our first graduate from the May intake this year and we continue to support the NETP programme. Middlemore ED celebrated their 100th New Graduate in the 2016 February intake which has been a great achievement for all our staff involved in the training and development of our unit. It will be our 10 year anniversary next year for the New Graduate Programme in Emergency Nursing. Many of our graduates have remained in emergency nursing - some are now in senior nursing positions such as Clinical Coaches, ACNMs and CNSs. It has been a great way to grow our workforce and embed the culture of learning. Well done everyone, past and present who has been involved in the preceptoring, nurturing and growing our future.

*We should all take time to celebrate this success.*

**MARY MCMANAWAY**

**NURSE MANAGER – EMERGENCY CARE**

# REGIONAL REPORTS

## MIDLAND REGION

RICK FORSTER

Registered Nurse

Tauranga Emergency Department

Bay of Plenty District Health Board

Contact: rick.forster@bopdhb.govt.nz

*Greetings from the Midland Region.*

The Bay of Plenty feels like a region on the fast track to growth with high numbers choosing the great lifestyles available.

Local health infrastructure is straining to meet this increased demand. One local infrastructure success story is the new Eastern Motorway saving significant time with the journey to Whakatane, this promotes greater sharing of resources between our two hospitals.

Whakatane ED reports rising presentation numbers with big increases over the weekends. Some contributing factors may include population growth, an increasing frequency of major weekend sporting events and presence on the weekend of a free ED to GP stream. Staffing has settled recently as a large group starting last year has gained in professional development. The team is enjoying the new department with great improvement in removal of some environmental constraints. New FACEMs are starting and a multi-disciplinary clinical governance program is underway.

Te Whare Wānanga o Awanuiārangi provides a kaupapa based Bachelor of Nursing degree from its Whakatane campus. It has a 30 student intake, currently year 2 students are on the wards, some of these will have ED placements next year.

Here in Tauranga our presentation numbers also continue to grow with more frequent top-of-the-range days into the 180s. At the time of writing, our Shorter Stays in ED target has been drifting down. Causes are multifactorial relating to increasing presentations and ongoing hospital wide system deficiencies. Certainly with the cooler temperatures and increasing community viral load we can expect some challenging days ahead. Moving practice forward, our department has just received an Airvo humidified high flow nasal prong oxygen, this device will be used for both paediatric and adult patients. Great timing with winter upon us.

Supporting our departments resilience has been a relatively slow staff turnover. Six significantly experienced RN's have recently joined us from throughout New Zealand, they are all transitioning very nicely to our department. We have also poached a couple of FACEMs from Auckland who are not too shabby either.

The College of Emergency Nurses NZ 25th Anniversary Conference is being held just up the road in Auckland this year. It would be fantastic to see a few more Midland Region ED nurses this year.

*The College does look to support delegate attendance through conference grants, more information is available on the website..*

RICK

# REGIONAL REPORTS

## HAWKES BAY / TARAWHITI REGION

**SHARON PAYNE**
(Triage Instructor)

Nurse Practitioner

Emergency Department, Hawkes Bay Hospital

Hawkes Bay District Health Board

Contact: sharon.payne@hawkesbaydhb.govt.nz

*Hello from Hawkes Bay.*

With winter here, we are looking at how we might manage our expected increasing patient presentations. We have seen a steady increase of patients for a number of months now, much more than projected and that doesn't bode well for the upcoming winter months.

Thanks to a communal effort and support within our nursing staff we have managed to secure funding for 2 more FTE permanently plus 2 FTE on a temporary basis, pending the result of a business case in the next funding round. We have recruited a number of staff and now begins the orientation and support process. We have done some work on our orientation process to hopefully, make this a much more supported welcome to ED. This will bring our nurse-patient ratios down to a manageable level, 3-4 patients per nurse rather than 6-7 per nurse which was almost impossible.

Work has begun on the redevelopment of our front-of-house providing more space to manage the waiting room. The triage nurse is also going to be the first person spotted by incoming patients, while those not actually coming to ED will be redirected through another corridor, thus decreasing traffic. Interesting times, working with builders and contractors but so far this hasn't been too bad. Patients with ear plugs however are having difficulty hearing their name called.

A CNS trauma nurse (0.5 FTE) has been appointed and has commenced her role with the DHB. Currently her role includes collecting data on HBDHB's major trauma patients and following up admitted trauma patients. The aim of this is to ensure that all of these patients get a tertiary survey done at about 24 hours post injury to identify any missed injuries.

In the future we will better understand trends in our region and be able to benchmark ourselves against other hospitals. The ultimate goal is the formation of quality initiatives to guide the formation of trauma policies within the Central region and develop staff education with the DHB itself.

We ran a fun trauma evening, recently with an elderly trauma patient, and a paediatric patient. We also had brief presentations on the CNS trauma role, managing primary haemorrhage, and breaking bad news. Pizza's were supplied and it was a great opportunity to meet the teams we will work with caring for our trauma patients.

We are still advertising for a Head of Department and FACEMs so our current medical staff is a little thin on the ground but as nurses we support and assist them where we can.

*We wish all our colleagues a healthy, reasonable winter, look after yourselves.*

**SHARON**

# REGIONAL REPORTS

## MID CENTRAL REGION

**AMANDA BIGGS-HUME**
(Membership Secretary)

Clinical Nurse Specialist

Mid-Central District Health Board

Emergency Department Palmerston North Hospitalh

Contact: mandyhume@hotmail.com

*Palmerston North Hospital has experienced high attendance numbers through February and March, which then slowed down in April.*

Yet at the same time, we experienced a lot of road-related, and other trauma incidents passing through the department.

The Clinical Nurse Specialist team's newest member has settled into her role well. We said farewell to a long-standing member of the Emergency Department nursing team to start her new permanent role as an Associate Charge Nurse in our Medical Assessment and Planning Unit.

The hospital's seasonal plan saw very low recruitment through summer and there have been a couple of resignations of nursing staff from our Emergency Department, so we are in catch-up mode, with many new nurses starting, including NETPs. This will keep our two nurse educators very busy over the upcoming months.

Our Emergency Department has conducted a review of our triage system following the "Observations within 20 minutes" system that was set up last winter. This has demonstrated that patient presentation numbers have put too much pressure on triage nurses making this goal too difficult to achieve. The nursing team is now working on a "Fast First" triage system and has made other changes to relieve the pressure on the Triage nurses and the waiting room in general. Part of the changes involves a nurse educator spending time with each Triage nurse to ensure everyone understands the requirements fully. These changes are working well, with improved patient and staff satisfaction reported. We have also made changes to the way young children are managed at triage in order to improved patient safety.

This year International Nurses' Day was celebrated with each nurse pulling a random name out of a box, writing a compliment for that nurse about their professional practice, and then passing the compliment on to that nurse. There was also the obligatory cake making, and subsequent eating by staff.

*Wishing everyone around the country the best with finding personal and organisational strategies to survive the upcoming winter onslaught.*

**AMANDA**

# REGIONAL REPORTS

## TOP OF THE SOUTH REGION

JO KING

Registered Nurse

Nelson Hospital Emergency Department

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*Winter has finally arrived in the 'Top of the South' and we are enjoying frosty mornings, sunny days and snow on the mountains.*

Presentation numbers have settled after the summer highs but remain well above the same period last year. As we outgrow our department the challenge of finding enough beds to meet high demand is becoming more frequent. This certainly adds a level of stress on busy shifts.

It is timely that the issue of violence in New Zealand emergency departments has gained some attention.

There have been several significant incidents in our area and there is certainly a rising level of concern about risk in the workplace. In response to this we are actively campaigning for dedicated ED security staff. This year CENNZ is working towards the adoption of a position statement on violence and I consider this may be the platform for increased scrutiny of this issue in the future.

The ED / mental health interface has been to the forefront in recent months. The department has collaborated extensively with both mental health and police to accommodate the changes in the assessment of patients under section 109 of the Mental Health Act (1992). This has led to some physical changes to the department. The MOH 'Preventing Suicide: guidelines for emergency departments' (2016) have also challenged us to look at our processes around observation of suicidal patients. We consider this may be an area of risk in our department and work needs to be ongoing in this area.

In May we held one of our combined Nelson/ Wairau ED meetings. This is a day both medical and nursing staff meet in Havelock, which is half way between our departments, and the gateway to the beautiful Pelorous Sounds. Sessions included an update on the latest intensive care practices for the emergency department, a review of the evidence in stroke thrombolysis and a great session on managing patients with acute pain who are also on opiate diversion therapies.

Sharon North (CNL) briefed us on the latest from Wairau ED. Major earthquake strengthening of their building is ongoing and despite this they continue to maintain a fully functioning department. This means working alongside contractors in their clinical areas.

A considerable flood through the ceiling necessitated putting evacuation procedures to the test and as the deluge came down they were faced with quickly troubleshooting to protect IT and monitoring equipment from water damage. Just another day in the life of an ED nurse.

Wairau is also implementing a board project called 'Reduce 5000'. The intent of this is to promote the appropriate use of primary care services for suitable people.

The safe redirection of patients is supported by the CENNZ redirection policy. The workload this places on triage nurses is acknowledged.

Both Nelson and Wairau are to be part of the national 'Tele stroke' initiative. This will see an on- call specialist in a tertiary centre oversee decisions around thrombolysis in stroke for suitable patients. This use of telemedicine will be new to our departments and we look forward to experiencing its possibilities.

Winter planning is probably a familiar word for all of us and no doubt it will be business as usual at the coal face. Nelson ED has submitted a case for the trial of a health care assistant over this busy period. We have also experienced some measles presentations in recent weeks prompting a brush-up on processes for these patients.

*Regards to all our ED colleagues and may it be a short winter.*

JO

# REGIONAL REPORTS

## CANTERBURY / WESTLAND REGION

**ANNE ESSON**
Nurse Manager

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Christchurch Hospital

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### CHRISTCHURCH HOSPITAL

*After a busy start to the year, the latter weeks of April and through May have been quieter with daily averages around the 250/day mark.*

Interestingly we are seeing the return of large day to day variances having experienced a more consistent (if not high) daily volume earlier in the year. Our growth is in the non-admitted group and in the 35-39 age group. We are now also seeing a return to seasonal variation in attendances which was not present in the first few years post-earthquake. Predictions are that we will reach 300/day in August (winter variation) which we need to plan for. This is on the backdrop of one of the lowest attendance rates in the country at 186 per 1000. The CDHB is planning on launching another media campaign to inform the population of the acute care options in the city and importantly the need for people to stay connected to their GP. The previous large media campaign was prior to the Canterbury earthquakes and since then the population has changed and shifted.

A full hospital is placing a strain on the IP areas, however bed flow from ED continues to be good since the spotlight was placed on it 18 months ago.

Good bed flow into the IP (in-patient) areas is vital as we would not manage if we still had the delays we encountered 2 years ago.

Activities to assist us with the increase in demand and ensure our processes are efficient and effective include the approval of additional nursing and medical staff, consolidation of the CNS (NP candidates) roles, improved utilisation of the Emergency Observation Unit, a revised ED Overload Escalation Plan and the Releasing Time to Care (RT2C) programme. Medchart will be introduced in August and while we are supportive of this project it will present changes and challenges to our current work flow practices and slow down prescribing and dispensing in the initial stages.

Our rolling roster is working out well with a survey to go out to all staff this month (the 9 month mark). It certainly makes compiling the roster much easier and the staff enjoy being able to plan well in advance.

The new format of our in-service nursing education is building nicely with increasing numbers of our nurses taking the opportunity to attend some or all of the 4 hour sessions.

**ANNE**

### TIMARU

*ED continues to be busy in South Canterbury.*

The department continues to work on sustaining changes made with the ED review started in 2015. The focus being improving triaging and improving the times patients are 'seen by a doctor' in the department. We have made steady progress and continue to maintain this target and also with accuracy of triage codes. A new paper clinical record is being developed and job sizing is underway for SMOs.

The latest news has been a proposed restructure of middle management in South Canterbury DHB with the principle being to flatten the management structure. Proposals have included a decrease in the number of charge nurse managers by combining areas of responsibility (eg ED-ICU).

*Submissions have been sent in by a variety of staff and these have been supported by NZNO.*

**RACHEL MILLS**

**CNM ED TIMARU HOSPITAL**

### WESTCOAST

*Hi from the West Coast.*

Winter has arrived with a vengeance. We have had a really good uptake with staff having the flu vaccination this year. This aside, we have had a spike in Doctors and nurses being off sick particularly during the month of May. This has stretched our already minimal resources to the maximum. Our rebuild is about to get under way at the end of May beginning of June 2016. We have been busy with meetings looking at the detailed design and signing these off.

We currently have one of our Registered nurses (Jennie Bell) completing her

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nurse practitioner qualification. Jennie has two ED Doctors as her mentors. We also have our fifth year Medical Students from Dunedin. They are with us for the whole year and are very much part of the team. The Medical Students always enjoy their clinical experience in the rural setting as they are exposed to such a vast variety of situations. That is about it from the Coast.

*I look forward to updating the progress of the rebuild later in the year. Good bye for now.*

**LYNLEY MCINROE**

**CNM ED/OPD**

**GREY BASE HOSPITAL**

## SOUTHERN REGION

**ERICA MOWAT**
(Repository)

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Southland District Health Board

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### DUNEDIN HOSPITAL

#### PATIENT PRESENTATIONS

The period between January and April has been extremely busy with a mixture of quiet days to ones with high presentation numbers. The highest total being 179 patients during a twenty four hour period. Over the last quarter Dunedin saw an extra 641 patients in comparison to last year. For February the daily presentations was 138 and over March, 131. While we are pleased to say that we have made the target for the first part of the year, the 6 hour target has been more difficult to meet over the last 2 months.

The Early Treatment Zone has been instrumental in meeting the target. It has been identified as being pivotal in decreasing the patients' length of stay in the department. The nursing staff in this area initiate diagnostics and care reducing the time the patient is reviewed and plan of care confirmed by the emergency team doctor.

Patients referred to specialities are also affecting the flow in the department with a high number of referred patients occupying the ED cubicles at any time. It is hoped that the Internal Medicine Winter flex Unit (IMWFU), will open over the winter months, improve the movement of patients within the hospital and ED.

#### STAFFING

Dunedin has had a high nursing turnover but has been fortunate enough to have gained experienced nurses from other areas. The staff are all working hard and embracing 'Releasing Time to Care' and 'Skills For Change' projects, including value stream mapping to develop an improved working and patient environment.

We have Associate Charge Nurse Managers (ACNM) rotating through the Charge Nurse Manager position and we welcome Greer Keogh and Amy Rata who are covering the ACNM role. Signe Stanbridge has been appointed to the role of CNS in a 0.5FTE position, giving us a total of 2.5 CNS FTEs. The other 0.5 FTE funding release by a current reduction in the CNS team will remain in the senior nursing budget for the next year. However these finances are currently being utilised to employ another RN to assist in the fast track minor injuries area. This area currently cares for up to 40% of the total presentations in a 24 hour period.

We welcome the addition of a winter flex nurse to assist with the anticipated increased patient presentations during the winter months.

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### AWARDS

Six nurses have completed the triage course held in Invercargill in April with Lyndsay Johnston being nominated for the Kirsty Morton Award.

The Dunedin Emergency Department has also been acknowledged for its care of SDHB Staff following a blood and body fluid exposure . It has been recognized at the Health & Safety Awards in which the ED were acknowledged for "for on-going commitment to staff wellbeing".

## SOULTHLAND HOSPITAL

### WORK LOAD & STAFFING

The department has experienced several periods of bed blockage recently, compounding on-going high volumes and acuity. Staffing has been an issue recently with staff moving on. The department has been actively recruiting and an increase of 1.4FTE has been agreed for winter flex – May to September. The department is trialling a Flow Nurse position at present which is having some success in improving triage times and flow into the department. The role is providing increased adaptability in responding to department workload.

### PROTOCOLS DEVELOPMENT

Southland are continuing to implement clinical pathways – the latest being a NOF pathway that reduces delays in these patients being transferred to the ward.

Minor orthopaedic fracture guidelines developed by two of our CNS's in conjunction with the Orthopaedic Service continue to be developed, these are:

- Neck of 5th metacarpal
- Base of 5th metatarsal
- Mallet finger
- Non displaced Webber A #
- Radial head fractures

These fractures are not referred for follow up in fracture clinic, which has seen a decrease in numbers, allowing orthopaedic staff more opportunity to work with their more complicated patients.

These guidelines have been also been implemented in Lakes and Gore Hospitals (both within the catchment area for referrals to Southland fracture clinic) as audits have confirmed positive outcomes for the patients involved.

## OAMARU ED

There were 693 presentations for March 2016. Oamaru hospital is funded for 4,000 attendances per annum, but actual attendances as at 30 June 2015 was 7,742. The number of patient presentations this year also appears to be steadily increasing although a further winter increase in numbers is not anticipated.

This allowed a business case to be put forward for extra staff. The current DHB funding level in our ED allows for base staff of one Nurse, one Doctor. A swing shift – 1300-2130 has recently commenced for five days a week. The rationale for this was due to increased ED patient loading from 16.00 hours; a peak in presentation numbers at 11 am and the Duty Nurse who covers ED from 1600 hours being unavailable to cover or support the ward staff.

Statistical analysis of the ED presentations suggested that Tuesday & Wednesday were not as busy as the rest of the week. Therefore these days were not covered by the new swing shift. The swing shift nurse will allow lunch cover for the ED and if necessary for HDU during the rest of the week as well as further assistance in either ED or the ward. Staff are still experiencing difficulty getting meal breaks on these days as there is only one RN on duty at any time so this situation may require further review as this would allow the Duty Nurse (who covers ED and the ward from 1600 hours) flexibility. This additional position is funded for 1 year and then will be reviewed. Implementation of this role has been difficult with shifts not fully covered with current staff working up to the role to provide cover for the department.

## QUEENSTOWN ED VISIT MAY 2016

At the beginning of May I travelled to Queenstown to visit their ED. Queenstown, for those unaware of its charms, is a capital of tourism in the south island. The impact on the ED is in noticeable in their high percentage of trauma and minor injury work. They have experienced a 15-20% growth over the last 10-15 years in numbers which is partially due to residential growth and the on-going popularity of Queenstown as an international adventure destination.

### PATIENT PRESENTATIONS

The average monthly patient Presentations are 700. There is an 8% increase in the yearly patient presentations in January 2016 the highest presentation in a 24 hr period of 60 patients was recorded. The Queenstown hospital has a catchment area of Queenstown to Lumsden and the Crown Range , a large mountainous area with difficult access. Queenstown is situated 4hrs by road from Dunedin & 2 hrs 15mins from Invercargill. Patients are regularly transported from Queenstown to both Dunedin and Southland Hospitals with most of the transport work occuring from July to August with 70-80 transfers per month. Transfer of patients is usually

# REGIONAL REPORTS

via ambulance, although a helipad is present in the hospital grounds. The Dunedin ICU retrieval team are frequent visitors with the flight time between Dunedin and Queenstown being 50 minutes.

### STAFFING

There is one RN on duty at all times with another RN providing extra staffing between the hours of 12.30 and 21.00. Nurses from Southland Institute of Technology have the opportunity for placements in ED during their second year. The Nursing Coordinator, Jenny Burt has held an 0.6 FTE senior nursing position, for the last 3 years. This position covers not only ED, but also the adjacent 10 bedded ward. The ED nurse educator from Southland Hospital assists with educational updates. Jenny loves the work and states that there is a heavy emphasis on team work within this rural hospital. The main problem experienced in this rural location is the terrain and distance make it and difficult to extract patients from this mountainous area. It is not always well understood by others unfamiliar with the area calculating extraction times or transferring patients, especially in poor weather. An extra staff member for a fixed term winter contract is planned – 2 morning and 2 afternoons in ED. This will make a big difference as Queenstown is now receiving night flights allowing for a greater influx of tourists during the winter season.

### FACILITIES AND INNOVATIONS

The ED has five cubicles which includes a main resus area. There is limited laboratory and x-ray access. X-ray facility are available between 8am and 8pm weekdays and 12pm - 5pm at weekends, although a doctor may call the radiographer into the hospital outside these hours. Patients with minor injuries may have their initial nurse treatment at presentation, especially clavicle and shoulder injuries with follow up x-rays the following day.

The hospital reception staff at the main entrance notify the triage nurse when a patient presents. The patient is then collected from reception & taken to the triage area for assessment.

All the emergency nurses are part time and spend an extra 24 hours on call within each two week period. They may complete up to 3 transports to Dunedin or Southland Hospitals within this 'on call' period or be called into ED. The helipad is an invaluable link in the event of urgent transfer to Invercargill or Dunedin. Queenstown flight access is affected by adverse weather conditions. Importantly a video link has been established with Dunedin ICU which allows interaction between the Queenstown ED staff and ICU staff in an emergency. The video link was installed this year, due to a strong business plan being put forward. It is helpful when the Dunedin retrieval team cannot fly due to weather or other demands.

### ERICA


# COLLEGE MEMBERSHIP RENEWALS FOR 2016 ARE STILL OPEN!!!!

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.***

# ARTICLE SUBMISSIONS FOR THE NOVEMBER ISSUE OF THE JOURNAL ARE NOW OPEN! PLEASE EMAIL THE EDITOR MICHAEL GERAGHTY FOR MORE INFORMATION!

*email:* cennzjournal@gmail.com


WORK | LIFE

# College of Emergency Nurses New Zealand Conference

## 3 - 4 November 2016

## Heritage Hotel, Auckland

## Balance – Caring for others, Caring for ourselves

NEW ZEALAND NURSES ORGANISATION

**AENN day details**

Advanced Emergency Nurses Network (AENN)

Auckland City Hospital, Lab Plus

Big Rangitoto Room

**Saturday 5 November 8.30am – 4.00pm**

**www.conference.co.nz/cennz16**

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# EMERGENCY NURSE NEW ZEALAND