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EMERGENCY NURSE NEW ZEALAND

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EMERGENCY NURSE NZ

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A WORD FROM THE EDITOR:

Day three post the CENNZ national conference and just beginning to unwind; the past year has been spent slowly but surely putting together an event which we (the organizing committee) are quietly proud of. The theme of the conference was 'Balance' and reflecting the balance required both as it relates to patient care but more so the need to balance our needs as healthcare professionals in order to continuing to care, to not burn out. The success of any conference often relates to the less tangible aspects, the venue, the conference dinner and also the networking. Opening the conference is always a nerve racking experience but as I looked out across the delegates I was aware that I knew about 40-50% of the people there, so welcoming delegates as whanau was very apt.

Congratulations to Jane Boyd (WDHB) out latest Emergency Nurse Practitioner, successfully interviewed in the past month and with a job offer to boot!! I've lost count of how many Emergency NP's there are now which is a great thing for nursing, our patients and the profession.

So, a very brief editorial this time and I will finish by wishing you all a wonderful Summer, Xmas and as always trust you get the chance to take a well-deserved break with your loved ones, whanau.

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

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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

This is my final report as CENNZ Chair. My four year term on the national committee comes to an end at the Annual General Meeting in November. Writing the Chair report for the AGM gave me the chance to reflect on the last four years and help realise the work that has been completed over this time.

Key highlights over this time have been:

- CENNZ membership going online and the ongoing increase in our levied membership to over 500 emergency nurses currently
- The national triage course being streamlined from booking, to payment, to getting course material out, with clear timeframes for each step
- CENNZ representation as a voice for emergency nurses on national working groups: Suicide Guidance Group, Shorter Stays Advisory Group, National Patient Deterioration Group
- The development of the Advanced Emergency Nurses Network group with significant growth in numbers attending as we see an increase in Clinical Nurse Specialists and Nurse Practitioners in EDs

"I would encourage you to think about whether the national committee may be something you would be interested in, or being involved in other activities or projects that CENNZ is undertaking."

- Active participation and feedback from CENNZ on many documents which effect emergency nurses and our patients
- The completion of the emergency nurses Knowledge and Skills Framework
- Completion of position statements on:
- Role of the Clinical Nurse Specialist in emergency departments
- Patient handover
- Redirection of patients from emergency departments to primary healthcare facilities
- Zero violence in emergency departments
- Review of triage course, course book, teaching materials and exams
- Ongoing commitment to updating the staffing repository
- Successful and high quality annual conferences
- Giving back to our members through awards and grants
- Showcasing the specialty of emergency nursing in the recent Kai Tiaki journal (August 2016)

Time on the committee has been very productive, but also has provided me with opportunities for personal growth, expansion of professional relationships and broadening of my strategic thinking. I would encourage you to think about whether the national committee may be something you would be interested in, or being involved in other activities or projects that CENNZ is undertaking. Our annual online membership is collecting some data from you on areas you may be interested in, with the plan to approach those who are keen to be involved.

As Anne Esson, Sharon Payne and I stand down at the AGM we are delighted to welcome Sandra Richardson, Paula Draper and Michelle Peperkoorn. Thank you to Anne and Sharon for your excellent work during your time on CENNZ – I have enjoyed worked with and getting to know you both.

Rick Forster will be taking over as Chair. Rick has been CENNZ Secretary during the past year and we have worked closely over this time. I know that he will be excellent in this role and will be supported by the excellent national committee and Suzanne Rolls (our Professional Nursing Advisor) who all bring great strengths and dedication to continue on with the work ahead.

LIBBY

Outgoing Chairperson

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Chairperson's Report Cont.

INCOMING CHAIRPERSON RICK FORSTER

Having served 2 years on the CENNZ national committee in various roles it is exciting to take on the Chairperson role. I would especially like to thank Libby for her hard work, guidance and enthusiasm during her term. Going forward we are fortunate to have a dynamic team of Emergency Nurses from throughout New Zealand to continue the momentum.

One current large project is the CENNZ Knowledge and Skills Framework. Our membership feedback supports the creation of a tool kit to sit alongside this document. It is envisioned this will include professional development resources and examples of how to operationalise the framework.

The update of the CENNZ National Triage Course has been an important and significant undertaking. To perform triage effectively prerequisite Emergency Nursing specialist knowledge as well an in-depth understanding of the Australasian Triage Scale is necessary. Our course supports professional development to achieve this whilst providing a nationally recognised certification for the role.

We acknowledge that Emergency Nursing is not just the domain of those working within hospital Emergency Departments. On review of our membership, a significant number are employed in community situated Urgent Care facilities. Looking to the future, we would like to maintain and strengthen our relationships with this sector.

RICK FORSTER

Secretary
College of Emergency Nurses

ZERO TOLERANCE OF VIOLENCE TOWARDS NURSES

WRITTEN BY: MATT COMESKEY - AUCKLAND ED

The national committee of the College over the past year has become increasingly aware of incidents of violence, 'near misses' and the changing context in which aggression and violence occur within the EDs and A&M clinics in our community. With this in mind, a brief, online survey was circulated to CENNZ members to gauge the experiences of college members and to guide the committee in it's response. There were 63 respondents. The responses – confirmed the initial impression formed by the committee.

Briefly the responses included:

- 41% of respondents stated either their work place did not have mandatory reporting of incidents of violence or were not sure if it did.
- 81% of respondents were aware of an incident that was not formally reported.
- 79% reported not feeling supported in the process of reporting an incident of violence.
- 22% reported that they felt somewhat protected in their workplace, 6% didn't feel protected at all.
- 52% of respondents reported having been nursing for 20 + years.

Clearly there is a problem that requires a response.

Violence and aggression in the emergency department setting has historically – and unfortunately - been seen as part and parcel of the emergency department experience or culture. It is unfortunate that this will likely remain the case as ED staff will always be at the front line - dealing with patients and their family's who may, during their time in our care, be under great stress. However, the context in which this occurs is changing. This contextual change includes;

- The seemingly increasing prevalence of drug and alcohol intoxication and related aggression that occurs – not just in large urban EDs – but perhaps of more concern, in smaller provincial EDs and A&M clinics where there is less staff and less security.
- The prevalence of social media being employed as a means to intimidate staff.
- Verbal aggression and 'acting out' as a means of expediting care is seen by some in the community as a legitimate means of seeking medical attention, possibly as a reflection of a sense of entitlement disproportionate to need.
- The increasing awareness that there are people in our community who routinely carry concealed weapons.
- The incidence of serious violence occurring in other community settings and government agency 'front line' work places.

These factors suggest that the way in which violence occurs in our community and spills over into our nursing workplace is changing. Realistically, with some of these factors, there is little we can do to make effective change. It's likely we will remain conflicted between our professional duty of care in the face of challenging behavior and our right to be respected as health professionals and members of the community. However, there are some things we can remain mindful of and continue to seek to improve. We can lobby local and national bodies on alcohol and drug regulation and local body licensing. We can be more thorough at reporting violence and ensuring that appropriate follow up occurs. We can appropriately advocate a 'zero tolerance' policy to violence in our workplaces. We can model our response to a zero tolerance and our attitudes to new graduates and students and ensure they are aware that being subjected to violence should not be part of their

ZERO TOLERANCE OF VIOLENCE TOWARDS NURSES CONT.

ED experience. We can ensure our managers are aware of the extent of a problem and steps required to address it. We can liaise proactively with local police to improve the response to requests for assistance or follow-up after an incident. We can share ideas between workplaces to find innovative solutions and reporting systems that work.

The recently mandated CENNZ Position Statement on Violence in the Emergency Department is a starting point for our collective response to addressing this issue. The CENNZ National Committee is liaising with NZNO and the National Bi-Partite Action Group that is looking at addressing the issue of violence in the nursing setting generally, in light of recent changes to health and safety legislation. We will follow this with interest and look forward to reporting it's progress.

As a college, it is important that we share ideas and resources to improve the well-being of all our members and that of the wider community. Your input and comments to the CENNZ committee are welcomed. Finally, - perhaps our most important response is what we do as individual's – to continue to support our colleagues who are subject to violence and aggression and to continue to actively reject violence and aggression being part of the 'normal' workplace culture.

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COLLEGE OF EMERGENCY NURSES NEW ZEALAND POSITION STATEMENT: ZERO TOLERANCE OF VIOLENCE TOWARDS NURSES

RATIONALE:

The College of Emergency Nurses New Zealand (CENNZ), believes emergency nurses within New Zealand have the right to be treated with respect and to be able to work in a safe and healthy workplace, - free from violence and aggression.

DEFINITION:

Workplace violence is defined as "...any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, wellbeing or health. The violent episode can be instigated by a patient, another staff member or a member of the public" (New Zealand Government, 2009).

Violence can be overt, such as in physical, verbal (i.e., threats that result in personal injury or harm and intimidation), financial and sexual behaviours; or they can be covert, such as in neglect, rudeness, humiliation in front of others and withholding information (Canadian Nurses Association, 2014).

BACKGROUND:

There is clear and consistent evidence that New Zealand hospital emergency departments (EDs) are environments in which is a high risk for aggression and violence (Gale, Greenwood, Swain; 2014). It is estimated that up to 90% of ED staff have experienced violence in their workplace (Australasian College of Emergency Medicine, 2011).

CENNZ acknowledges that:

- Emergency Nurses can be at significant risk of workplace violence.
- The persistence of a culture of acceptance around workplace violence in the ED is a barrier to reducing and preventing incidents of violence in ED.
- All patients, visitors and staff in the emergency department have the right to a safe environment.
- The mitigation of violence in the ED requires "zero tolerance" instituted and supported by all nurses and hospital management.
- Employers are required to provide a safe working environment as described by the Health and Safety in Employment Act (Work Safe NZ, 2013).
- Emergency nurses have the right to education and training related to the prevention, recognition, management and mitigation of violence.
- Each ED must have policies and procedures regarding the management and reporting of acts of violence.
- Emergency nurses have the right and a responsibility to report incidents of violence to their employer and law enforcement without fear.
- Means of reporting acts of violence should be readily accessible to all staff and be easy to use.
- Emergency nurses have the right to expectations of privacy, appropriate injury care and the option for debriefing and professional counselling.
- Reports of violence should be audited regularly to identify areas of concern so timely and appropriate action can be undertaken to address risk and enhance safety.
- There should be on-going national monitoring of violence in ED and research in how it can be addressed and mitigated.

CENNZ advocates for an increase of public education around violence in the emergency department setting; specifically:

- A nationally consistent approach of "zero tolerance to violence" in the ED.
- Clear signage in waiting rooms and departments advocating "zero tolerance" to violence and acts of aggression.
- An on-going, public commitment to alcohol reduction.

COLLEGE OF EMERGENCY NURSES NEW ZEALAND POSITION STATEMENT: ZERO TOLERANCE OF VIOLENCE TOWARDS NURSES CONT.

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- Ethnic differences in clinical outcome of patients presenting to the emergency department with chest pain Authors: de Hoog VC et al. Reference: Eur Heart J Acute Cardiovasc Care. 2015;Dec 29
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- Gout in Aotearoa New Zealand: are we going to ignore this for another 3 years? Authors: Dalbeth N et al. Reference: N Z Med J. 2016;129(1429):10-3
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FRACTURE CLINIC REDESIGN IN THE ED: BREAKING THE MOULD. PART TWO: WEBER A, 5TH METACARPAL AND 5TH METATARSAL FRACTURES

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Olivia Murray (Clinical Nurse Specialist, Southland Emergency Department)

ABSTRACT

Southland Hospital Emergency Department (ED) Clinical Nurse Specialists (CNS) Lara Gleeson and Olivia Murray have developed management guidelines for minor orthopaedic injuries. This article will discuss 5th metacarpal neck fractures, base 5th metatarsal fractures and Weber A (ankle) fractures.

KEY WORDS:

Clinical nurse specialist, emergency department, fracture clinic redesign, metatarsal fractures, metacarpal fractures, Weber A fractures.

INTRODUCTION

The introduction and implementation of management guidelines for minor stable fractures in the ED has been based on the fracture clinic redesign process developed at the Glasgow Royal Infirmary in Scotland (Glasgow Royal Infirmary, 2016). The Glasgow Fracture Pathway team found that by redesigning their fracture clinic processes, they reduced unnecessary attendances at the fracture clinic. Therefore, increasing the time available for improving standards of care, teaching and training with no extra resources needed (Jenkins et al., 2014).

The key element to these management guidelines is that these patients are not referred to fracture clinic or to their General Practitioner (GP) for follow up, rather if they identify any concerns, then the patient makes contact with the fracture clinic as advised in the patient handout (Jenkins et al., 2014). Follow up can be difficult for patients who have to travel long distances and availability of clinics can also be an issue (Giddins, 2015). Long wait times at clinics, having to take time off work, and in some instances arrange child care can reduce patient's satisfaction with services (Abdelmalek, Harrison & Scott, 2015). The use of management guidelines for patients to be directly discharged from the ED can reduce visits to the fracture clinic and provide a service that is cost efficient (Abdelmalek et al., 2015; Midgley & Toeman, 2011).

5TH METACARPAL NECK FRACTURES MANAGEMENT GUIDELINE:

Metacarpal (5th) neck fractures, also known as Boxers fractures are the most common type of hand injury and account for up to 68% of all metacarpal fractures (Tintinalli, 2016; Kollitz, Hammert, Vedder & Huang, 2014; Keenan, 2013; Toeman & Midgley, 2010). These types of fractures usually occur when an object is punched with a closed fist, with direct impact to the knuckles. This type of injury can also occur when a person falls on to their closed fist (Tintinalli, 2016; Keenan, 2013).

There is a paucity of literature and variation on the management of 5th metacarpal neck fractures (Giddins, 2015; Kollitz et al., 2014; Keenan, 2013; Toeman & Midgley, 2010; Poolman et al., 2005). Historically, these injuries have commonly been managed in the ED with closed reduction of the fracture and simultaneous casting for immobilisation. A post reduction x-ray and referral to fracture clinic for post fracture management would then have been routinely initiated (Abdelmalek et al., 2015; Keenan, 2013). Therefore a review of the literature was undertaken prior to developing the author's management guideline for the 5th metacarpal neck fracture. Specific areas of interest were degree of angulation, malrotation and immobilisation compared to early mobility of the hand.

Angulation, rotational deformity and open or closed fracture

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are the key indicators for management of 5th metacarpal neck fractures (Abdelmalek et al., 2015; Kollitz et al., 2014). Acceptable palmar angulation guidelines range from up to 50 to 70 degrees with no significant risk of hand disability (Giddins, 2015; Kollitz et al., 2014; Toeman & Midgley, 2010). The literature discusses that correct measurement of the palmar angle of the fracture can vary among clinicians, often with clinicians measuring the oblique instead of the lateral view on x-ray (Keenan, 2013). When to reduce these fractures often presents clinicians with concern. Reduction is often not successful, with the fracture displacing post reduction due to the muscles of the hand applying force to the fracture (Keenan, 2013; Poolman et al., 2005). Therefore reduction is not indicated in the majority of cases. Significant deformities can result in a loss of function; therefore these fractures require follow up in case surgical intervention is required (Giddins, 2015).

Functional disability of the hand is rare, when there is no rotational deformity of the little finger (Keenan, 2013). Malrotation can cause complications of scissoring, which in turn can result in loss of grip and affects functionality of the hand (Kollitz et al., 2014; Toeman & Midgley, 2010). This should be assessed with the finger in flexion with normal alignment towards the scaphoid tubercule (Kollitz et al., 2014).

Studies have found either improvement or no difference in range of motion (ROM) and grip strength between fractures that were not immobilised and were encouraged to do early ROM exercises, compared to fracture's that were immobilised (Giddins, 2015; Keenan, 2013). Toeman and Midgley (2010) suggest that short periods of immobilisation can cause restriction in ROM. Studies have shown that 5th metacarpal neck fractures that are treated with buddy strapping, return to work earlier than if immobilised in Plaster of Paris (POP) (Toeman & Midgley, 2010). Therefore, early ROM with no immobilisation is recommended where possible (Diaz-Garcia & Waljee, 2013, Kollitz et al., 2014).

Conservative management of fractures of the 5th metacarpal neck have a satisfactory outcome due to tolerance for angulation and shortening (Kollitz et al., 2014). Patients can experience persistent deformity or loss of the knuckle, however will maintain full function of the hand (Giddins, 2015). Common complications include stiffness and malunion. Malunion can be surgically corrected; however the outcome is not as favourable to correct stiffness surgically (Kollitz et al., 2014). Open fractures are to be referred to the orthopaedic team on call (Abdelmalek et al., 2015).

Metacarpal (5th) neck fractures can be safely managed and discharged from the ED using an agreed management guideline (Abdelmalek et al., 2015). Evidence based pathways can prevent unnecessary immobilisation of joints and allow for early return of function in fractures that are deemed appropriate (Abdelmalek et al., 2015; Toeman & Midgley, 2010). When developing the 5th metacarpal neck fracture management guideline, consideration was given to the review of the literature with final consultation from Mr Paul Rae (Head of Orthopaedics for Southland Hospital). Specifics around degree of angulation and manipulation were discussed with both FACEM s and the orthopaedic team. Fractures that are greater than sixty degrees or have rotational deformity are placed in an ulna gutter slab in functional position and referred to the fracture clinic. These fractures do not require reduction prior to casting.

Literature supported the development of a pathway that encouraged early mobility of the hand with closed fractures that were below sixty degrees of angulation with no rotational deformity. Finger (buddy) strapping to the neighbouring finger is encouraged for the first week then removal of strapping and early mobility of the hand is encouraged. Specific discharge information to the patient is once again important to ensure that the patient has identified expectations / outcomes of recovery from the injury. Return to fracture clinic, if any deviation from the discharge advice sheet is also advised.

5TH METATARSAL BASE FRACTURE MANAGEMENT GUIDELINE

Acute 5th metatarsal fractures are the most common fractures in the foot, accounting for approximately 35% in adults and 65% in children, with up to 70% of these located proximally. These fractures are usually sustained from an inversion injury, whilst the foot is plantar flexed (Boutefnouchet, Budiar, Backshayesh & Ali, 2014). The base of the 5th metatarsal can be divided into three fracture zones; a stress fracture, Jones fracture and avulsion fracture. Care needs to be taken when diagnosing a base of 5th metatarsal fracture, as the Jones and stress fractures require more specialised care (Hatch, Alsobrook & Clugston, 2007).

Historically, avulsion fractures have been treated in a below knee back slab plaster cast with non-weight bearing for two to four weeks, requiring follow up with either a fracture clinic or GP. However several studies over the past fifteen years have shown that avulsion fractures at the base of the 5th metatarsal, treated in either a walking moon boot or double tubi grip, have an improved outcome in level of pain, function and mobilisation (Shaid, Punwar, Boulind & Bannister, 2013).

Within the diagnosis of the base of the 5th metatarsal avulsion fracture, there are specific criteria required to be met, including that it is an isolated injury, closed fracture and displacement/

FRACTURE CLINIC REDESIGN IN THE ED: BREAKING THE MOULD. PART TWO: WEBER A, 5TH METACARPAL AND 5TH METATARSAL FRACTURES

angulation is of no more than 2mm or 10% (Ferguson, McGlynn, Jenkins, Madeley, Kumar & Rymaszewski, 2015). All of these aspects, including degree of angulation were reviewed with both ED and orthopaedic teams, and consideration of current literature, to develop a safe and functional pathway. Early mobilisation, with no aids and simple tubi grip for comfort is now the new line of treatment for this injury in the Southland ED. The tubi grip can be removed in four to six weeks and no running or physical activity for the same amount of time is advised. Plasters and non-weight bearing are now not required for these injuries. Patients can be safely discharged and allowed to weight bear at the time of initial ED presentation, if they are provided with appropriate information and have ready access to experienced fracture clinic staff (Ferguson et al., 2015). Therefore, as per the previous minor orthopaedic management guidelines, we have again developed specific patient hand outs and thorough education is given at the time of discharge.

Jones and stress fractures are treated in below knee back slabs, non-weight bearing for six to eight weeks and in some cases may require theatre.

WEBER A (ANKLE FRACTURE) MANAGEMENT GUIDELINE

Ankle fractures are the third most common fracture seen in New Zealand (NZ) public hospitals however, once again there is a scarcity of literature surrounding ankle fracture follow up (Lash, Horne, Fielden & Devane, 2002). The Weber (also known as Danis-Weber) classification system is a classification tool often used in defining ankle fractures. The Weber classification is defined as: a lateral malleolus fracture below the syndesmosis is called type A; a fracture at the level of the syndesmosis, type B; and fractures above the syndesmosis, type C (Goost et al, 2014).

Weber A fractures usually have good to excellent functional outcome (Lash et al., 2002). Commonly, Weber A ankle fractures have been treated with immobilisation in below knee POP cast or walking casts / moon boots. Literature now indicates that early mobility is preferred over immobilisation of the fracture (Thackray & Taylor, 2013). Early mobility of Weber A fractures has shown a significant improvement in ROM in the first two months, a shorter rehabilitation period and no difference in pain experienced (Port, McVie, Naylor & Kreibich, 1996). Weber A fractures can be treated like external ligament ruptures and placed in a stabilising ankle orthosis that encourages early function and weight bearing as pain tolerates (Goost et al., 2014).

Previously in the authors area of practice, Weber A fractures would have been placed in a POP non-weight bearing cast for up to two weeks and then would have been reviewed in the fracture clinic and placed in a moon boot for up to four weeks. With the introduction of the management guideline; an isolated Weber A fracture with no displacement, nil joint involvement, less than 4 mm of fracture displacement and a fragment size of less than 5mm would enable the patient to be discharged direct from the ED with no fracture clinic follow up. The criteria to meet direct discharge from the ED are strict and review of the fracture fragment size will be reviewed at a later timeframe. If the patient can mobilise then early mobility is encouraged. If the patient requires crutches to mobilise, then the patient is placed to a moon boot for four weeks with weight bearing as tolerated. After four weeks the patient removes the moon boot and can self-initiate physio if required. Similar to the other management guidelines, the patient is discharged with a specific information sheet that advises on expected outcomes and gives written advice if the patient has any concerns. Historically, staff would have referred a patient to the orthotics department for a moon boot; however with the implementation of these management guidelines, a supply is available directly in the ED.

The management guideline has specific information on expected management and the referral process for Weber B and C fractures. A definition of the Weber Fracture classification system and diagrams accompany the management guideline.

AUDITING:

Monthly auditing is undertaken by members of the ED CNS team to ensure that each management guideline is followed correctly, and that written and verbal discharge advice is given. Quality is an important aspect of the implementation of the management guidelines and changes and further education has been implemented due to this process.

Financial savings have been quantified by the business analyst as a saving of $379.88 each visit to fracture clinic. Audits have been completed from January to September (inclusive) 2016 with numbers and costs saved for each management guideline as follows:

Fourteen patients were placed on the 5th metacarpal neck fracture management guideline with a total cost saving of $5318.32. Fifteen patients were placed on the base 5th

FRACTURE CLINIC REDESIGN IN THE ED: BREAKING THE MOULD. PART TWO: WEBER A, 5TH METACARPAL AND 5TH METATARSAL FRACTURES

metatarsal fracture management guideline with a total cost saving of $5698.20. Four patients were placed on the Weber A management guideline (audit from June to September 2016 inclusive) with total saving of $1519.52. Auditing of patients discharged under the Weber A fracture management guidelines will identify any patients who returned with possible complications and evaluate if increasing the size of the fracture fragment is a consideration.

The current management guidelines have been recently introduced to Gore Health, a locally operated facility in Gore that provides health services to its community. The authors presented the management guidelines to the medical, radiology and nursing staff.

CONCLUSION:

The implementation of the management guidelines has had a positive impact on the Southland Hospital ED and Fracture Clinic. In today's fiscal environment, it is essential to be able to assess processes and adapt practice where able with support of evidence based practice and the literature. In the future, the authors are working towards implementing management guidelines for the Mallet finger tendon injury / Mallet finger avulsion fracture and Radial Head fracture. While some management guidelines such as the Mallet finger may not alter clinical practice considerably, the ability to have clear, consistent guidelines and structured referral process is important.

Networking, collaboration and the ability to implement change successfully are positive outcomes of the work undertaken by the authors. However, the ability to implement management guidelines that have the patient at the centre of care has been the most important aspect of this project. Patient focused care, evidenced based practice and nurse led initiatives are key components to have emerged through the development of the fracture management guidelines.

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NZ TRIAGE COURSES 2017

NZ TRIAGE COURSES 2017

Each course has a good 4-6 weeks of pre-course work before attendance. You need to make the commitment to be available to do this work when applying to attend any particular course. Course material is not sent out to attendees until payment is received.

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Cost: $550 for CENNZ levied members, $650 for non-members. (You must be a member of NZNO to join CENNZ)

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.

BOOK EARLY TO AVOID DISAPPOINTMENT.

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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'.

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PLEASE DO NOT SEND IN ANY APPLICATIONS ON THE OLD FORM AS THEY WILL NOT BE ACCEPTED.

NZ TRIAGE COURSES 2017

REGION	DATES	VENUE	CLOSING DATE FOR APPLICATIONS	CLOSING DATE FOR PAYMENT	REGISTRATION
Christchurch	4/5 March 2017	Professional Development Unit, 5th Floor, Christchurch Hospital,	7 January 2017	21 January 2017	Booking available via website
Dunedin	18/19 March 2017	Conference Room A, First Floor, Fraser Building, 464 Cumberland Street, Dunedin	21 January 2017	4 February 2017	Booking available via website
Tauranga	1/2 April 2017	Tauranga Hospital Education Centre, 889 Cameron Road, Tauranga.	4 Feb 2017	18 Feb 2017	Available soon
Taranaki	8/9 April 2017 TBC	TBC			
Wellington	6/7 May 2017 TBC	TBC			
Waikato	17/18 June 2017	Clinical Skills Centre (under the library) Waikato Hospital Campus, Corner Selwyn and Pembroke Street, Hamilton West	22 April 2017	6 May 2017	Available soon
Christchurch	30 September / 1 October 2017	Professional Development Unit, 5th Floor, Christchurch Hospital, Riccarton Avenue, Christchurch	5 August 2017	19 August 2017	Available soon
Waikato	14/15 October 2017	Clinical Skills Centre (under the library) Waikato Hospital Campus, Hamilton West	19 August 2017	2 September 2017	Available soon
Lower Hutt	3/4 November 2017	Clinical Training Unit, Hutt Hospital,			
Lower Hutt	8 September 2017	22 September 2017	Available soon		

25TH CENNZ CONFERENCE REPORT | 2016

WRITTEN BY: MATT COMESKEY - AUCKLAND ED

Auckland turned on some great spring weather for the out-of-town visitors for the 25th CENNZ conference held at the Heritage Hotel. Those of us blessed to live in Tamaki Makarau know it's a great place to live and work – and this pride was reflected in the warm welcome extended to the conference particiapnts by Ngati Whatua representatives and the out-going college chair, Libby Haskell. Libby quite rightly acknowledeged CENNZ members not present because they were covering the shifts of their colleagues.

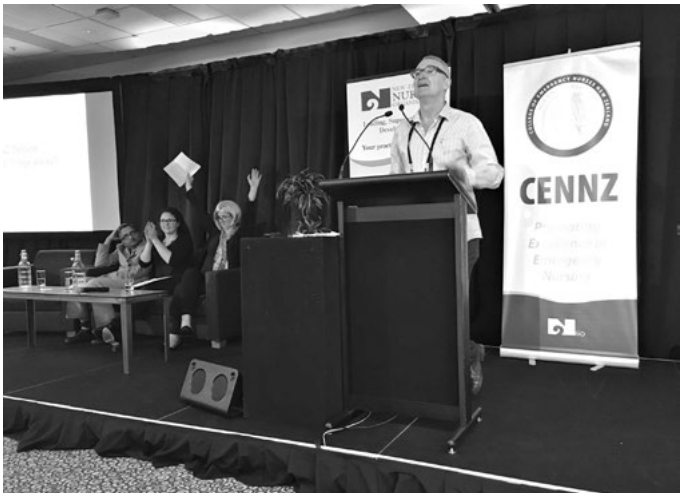
The conference speakers were led off by the key note speaker, Jason Shon Bennett, health advocate and author. He spoke to the conference theme of 'Balance - caring for others, caring for ourselves'. He described his own journey from chronic ill health to wellness by addressing the root cause of illness. He achieved wellness after he had embarked on a research and reflective journey with the aim to change his diet and responses to the health challenges he faced. Along the way he presented some frightening statistics on trending ill-health and it's consequences – both on a macro scale and the personal toll it takes. His condensed message was simply that which our parents and grand parents have extolled – eat your greens, sleep more and avoid alcohol. I guess it's not rocket science. The challenge for ED nursers is to achieve that while working shifts, juggling kids, home life, study and somewhere along the way getting some time out for ourselves.

The first concurrent session split into either a sepsis or paediatrics theme. I could see benefit in both but elected sepsis. Jo King from Nelson ED gave a concise account of a sentinel event out of which a neutropenic sepsis pathway was developed, starting at triage, to quickly identify the rapidly deteriorating patient and expedite antibiotic treatment. There were learnings addressed that could be applied in any ED or A&M setting.

Lunch followed – the salads got hammered, the delicious desserts were sadly ignored – and then Chelsea Willmott addressed the question 'Why do nurses like to eat their young?' I couldn't help but try to reconcile the title with the morning's session on diet – but we quickly moved on from the literal to a consideration of how nursing power and caring are polar opposites. When anger experienced by nurses is suppressed and cannot be directed upwards – it is directed against each other. The value of kindness and honesty were discussed and how they can make a positive change in the workplace.

The afternoon split into two sessions again, both addressing emerging research. Peter Jones addressed the latest about the six hour MOH target for EDs. The stats show patient outcomes continue to significantly improve. Sandra Neva followed with a presentation on hand hygene in the ED – and I'll be honest – the thought of another session on why I should wash my hands would normally make my eyes glaze over – but this was very entertaining and informative. I particularly liked the trial of different posters in patient rooms to remind staff to wash their hands. The one that was most effective was a picture of a smiling Sandra holding a bottle of hand gel - no text just a picture – which evidently motivates staff to comply. Which made me wonder if Sandra is very scary and known for eating her young or is she just really, really good at getting the message across - simply by being 'present' in the room. Sandra deservedly won the award for best novice conference presenter. Nice work. Cecelia Rademeyer followed with Best Care Bundles employed by CNSs and NPs which dovetailed nicely with Jo King's work on pathways presented earlier.

The day finished with a debate - "Fair Play to Triage Away". The affirmative featuring 'Donna Trump' AKA Jan Boyd who wanted to build a wall and make someone else – anyone else - pay for it. The tactics employed by this team included producing dubious leaked emails from members of the opposing team supporting their argument. It has to be said they played hard – I was going to say dirty – but after a compelling hand hygene presentation and with Sandra sitting



Above; Michael Geraghty addresses the debate

Above; Anne Esson discussing the Knowledge and Skills Framework

in the audience that couldn't possibly be the case. In the end a draw was called by the adjudicator Mike Geraghty – a lame call really after Peter Jones of the opposing team had pulled out the trump card – the CENNZ position statement on redirection from triage – that alone should have dealt a crushing defeat to the scurrilous email hackers and wall builders who would send vulnerable ED attenders into the dark, cold night.

With that injustice weighing me down, I was looking forward to lightening the load at the evening dinner. This was held at the tea rooms of the Heritage Hotel a wonderful art deco room where we were well fed and later entertained by Kerre McIvor as the after dinner speaker. Kerre gave a personal account of her marathon training and the challenges of the large breasted woman – sparing no detail – please don't ask – and a gripping account of her experience of ketamine sedation in the Auckland ED that featured rainbows, unicorns and a guest appearance by George Clooney. You had to be there. Just fantastic.

Day two kicked off with an early yoga class – yes really. Jo Egan spoke on accentuating the positive, which featured an elaborate game of pass-the-parcel in the audience which resulted in a lot of gifts being given, each of which had meaning corresponding to a positive quality that can be employed in EDs to improve our wellbeing and relationships with colleagues and patients. The CENNZ AGM passed smoothly with the high lights including the out going national committee members being thanked and ratification of the emergency nurses Knowledge and Skills Framework and a college position statement addressing violence in the ED.

The morning concurrent session featured three themes- Paediatrics, Outside Hospitals and Balance and Safety. Tough choice, but I elected to sit in on Outside Hospitals. The first speaker Michelle Peperkoorn, who talked us through retro sterno clavicular dislocations. Jackie Clapperton followed with an account of her varied work as an NP in a paramedic role as well as a rural GP practice locum. Graham Zinsli gave a quietly understated account of his work with Red Cross in conflict zones that left me in awe of the commitment and risks taken – both physical and emotional, that is involved with nursing in the world's hard places.

After lunch Paul Leslie gave a deeply moving account of his journey through the death of his sister closely followed by that of his wife – a timely reminder that the smallest of gestures offered to families in crisis in the ED can have meaning above and beyond that which the person offering help can ever know. Chris Denny followed up with a consideration of what resilience is and how it can be fostered in ED and emergency services settings to ensure we maintain balance and well being in our care for others and avoid burn out.

By the end of day two and with the conference closing, I felt well satisfied that my mind and body had been healthily fed and well nurtured. And yet there was more to come. The following day the AENN training day was hosted by Auckland ED for nurses in advance practice roles in ED or A&M clinics and was well attended.

Credit should be given to the conference organising committee, Conference Innovators and the conference speakers for delivering on the conference theme and providing a fun and enjoyable experience. There is a lot of personal time and energy that goes into making it all happen and I'm grateful to those doing the hard yards. A special thanks should be also be offered to the conference sponsors who are valued supporters of the conference and the work of the college generally.

Finally, it's not hard to imagine that in another 25 years time the college's 50th conference will be discussing the same key themes that lie at the heart of ED nursing, along with new ways of doing what we do – delivering research driven, improved care for patients. It's a bit of a stretch to think I will I be at the 50th conference, but this year, on looking around it was really pleasing to see younger colleagues amongst us who might be. In the mean time I am looking forward to the next conference in Queenstown, October 2017. See you there.

AN INTERVIEW WITH OUR LATEST NURSE PRACTITIONER:

AN INTERVIEW WITH JANE BOYD – Interview by Michael Geraghty.

JANE BOYD

1. What inspired you to become an NP?

JANE: I wanted a role where I could practice at an advanced level but still retain patient contact. I have worked in the academic field, as an educator, a nurse specialist and a charge nurse and whilst I will always enjoy teaching and learning, I missed the patient contact and felt decidedly unenthusiastic about pursuing higher management roles. I had worked with NPs in the acute setting and saw that they were working clinically but also making a significant impact on the practices and care given to children in the service. They offered leadership and lead practice innovation and had an enviable level of knowledge and expertise. I quickly realised that this was a role that would allow me to maintain patient contact but to also allow me to develop and use clinician reasoning skills every day. The challenge of taking information from a history and marrying that with examination findings in order to create a list of potential differentials and then using critical reasoning to unravel a definitive diagnosis appealed to my analytical personality. However, I love that as a nurse I can approach the patient from the perspective of identifying holistic needs which will influence how I may choose to manage their care. During my studies I have read a lot about Evidence Based Practice and I wonder if nurses have an advantage because we are already focussed on understanding the patients' perspective whereas our medical colleagues seem to be much more focussed on efficacy of interventions. I may be wrong but I think the most effective drug is useless if the patients can't or won't be compliant.

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

JANE: The ED CNS role is a bit of an anomaly in my opinion, it is not diagnosis or condition specific and if you map out the features of a CNS role against the NP role you will see far more commonalties with the NP role than the CNS one. This is not way to detracts from what CNSs do, it is just a different emphasis. The ED CNS deals with populations (NP role), and takes a history, examines patients and orders tests and then tries to work out what is wrong with them (diagnosing which is NP rather than CNS). If I ruled the world an ED CNS would be called an NP intern or something else and once they had finished their NP pathway that they would become an NP. The problem is that ED CNSs do such a similar role to an NP (just without prescribing and with less autonomy) that it can be hard for service managers to see much value added to taking that final step towards an NP. Of course there is a plethora of evidence that shows that the more autonomy a role has the more value it brings, that NPs offer more workforce flexibility, and that their outcomes are similar or better in some instances to Drs. However, the water is so muddied by different roles, definitions, expectations and the ensuing difficulties in coming up with ways of measuring their impact that this continues to be a barrier to NP roles. I would like to see NPs or the chance of progressing to NP something that is available more widely and I would like the route to be less tortuous for those who embark upon it.

AN INTERVIEW WITH OUR LATEST NURSE PRACTITIONER:

3. What advice would you give to other nursing staff wishing to become an NP

JANE: ED nurses are a pretty resilient bunch and you certainly need to be both resilient (stubborn) and tenacious (very stubborn) to both become an NP and then secure a role as an NP. Juggling study, work and family is a challenge, as is keeping your both energy and motivation levels maintained during this long and often arduous journey. My advice would be look after yourself, try to enjoy the process and learn as much as you can, try not to get disheartened if there are obstacles, get a good support network in place both personally but also professionally (your problems seem less massive when you hear that your experiences are similar to everyone else's) and above all trust that you are ultimately more obstinate than any of the things that may hinder your progress.

4. Looking back on your journey to become an NP is there anything you are particularly proud of?

JANE: Looking back, I can see the that I have developed both professionally and personally, during this journey. I have learned a lot but have also matured as a person. It has been hard, I won't lie but I 'm proud of what I have achieved and that I didn't give up, I'm proud of the work I have produced and that I am a better person having completed both my MHSc and my NP application process. I'm proud that I have maintained my (dark/dry/twisted) sense of humour and (mostly) my sanity. There have been sacrifices but like any big life changing event, it filters out those people who fall by the wayside because the journey is too hard for them, leaving just those who encourage and bolster you, who are there with you at the end and without whom you wouldn't have made it. I'm proud to say that I have great friends and colleagues who have loved and supported me throughout this journey.

5. Anything else you would like to say?

JANE: I would like to acknowledge the support I have enjoyed from my friends and my family, who have seen less of me and have dealt with any mercurial behaviour on my part with humour and equanimity; my colleagues and my manager who have had to endure my endless questions, impatience and sometimes frustrations and also have frankly had to hear more about paediatric gastroenteritis than anyone should have to (MHSc dissertation topic). Finally I would like to thank my NP colleagues who are endlessly patient with my questions and are always ready to offer whatever was needed to help me be successful.

REGIONAL REPORTS

NORTHLAND/TE TOKERAU REGION

CHRIS THOMAS

Registered Nurse / CNS

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Greetings form Northland

Winter is drawing to a close and the days are warming and lengthening, however, the presentations at ED are reflecting a similar pattern to last year where our traditional winter presentations are continuing longer into spring. It has been gratifying to see a lower rate of bronchiolitis presentations this year which we are hoping is the result of both a Healthy Homes program, which has been running in Northland and increased education around smoke free child environments. I'm sure a mild winter in Northland has also helped.

Patient acuity levels have continued to increase, particularly among the elderly patients, with sepsis being a very common problem over winter and early spring. This has created a problem with our ICU/HDU department with increased demand for bed space and has sometimes resulted in a delay in getting those patients out of ED. Ward bed block has also been a problem at times although there is now much improved communication between disciplines and a greater hospital wide effort to address the problem when it arises. New initiatives within ED around patient flow include some electronic whiteboard modifications and a more streamlined bed request form which the medical team has had input into and reflects more precisely the information they need for placement of patients on the ward. The efforts that have been made to improve communication have shown real benefits in breaking down barriers and improving attitudes and understanding of interdepartmental issues.

At Whangarei ED we are proud to maintain good nursing staff practice development opportunities with a monthly education session. These sessions utilise both external speakers and ED staff who present on a range of topical subjects. We also have several staff doing post grad papers at present. Our NP position has still not been formally signed off but the DHB are supportive and we eagerly await the completion of that signoff process. This will no doubt encourage more staff to consider that particular pathway as an option for career advancement.

Christmas is the next big event on the calendar and hasn't that crept up suddenly.

We look forward to a busy summer season and wish all our members a safe and happy festive season.

CHRIS

REGIONAL REPORTS

AUCKLAND REGION

MATT COMESKEY

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ADULT EMERGENCY DEPARTMENT, AUCKLAND CITY HOSPITAL

Greetings from Tamaki Makarau.

Winter kicked off with an expectedly busy start to the season. The 'new' winter normal was an expected 220 ED presentations daily. This is an increase on presentations in recent winters. Despite this increase and the resultant pressure on resources, new innovations are being trialled in the department.

Projects include:

- A bariatric bundle. This includes a bariatric bed positioned in the department and associated equipment that then follows the patient in their stay in the hospital.
- The 'releasing-time-to-care' project has commenced.
- The completed 'Knowing-how-we-are-doing' project that has the practical outcomes of clearer corridors and rationalised storage within the department. No doubt further practical improvements will come out of this on-going work.
- The on-going building projects continue: the latest being improvements to the security and visibility to our secure observation room which are now completed.
- Improved pathway for 'frail' older person's short-stay and review by the older peoples health service.
- Resilience study commenced, conducted by ED SMOs and AUT to trial interventions designed to reduce stress experienced by ED nurses and doctors.
- Improved recording of alcohol related medical and trauma presentations.

There have been 1200 presentations through the ambulatory care area, opened earlier this year. This is approximately 24% of total ED admissions over the same period. This represents good value, with significant improvement in patient care, for a very small out-lay of funding, to establish an area that is servicing a significant proportion of the department's patients. Nursing and medical staff report the calmer, more comfortable waiting area is working for them as well as the patients. The amount of use the area is getting and the projected growth in workload, indicate that it will need to be expanded to meet demand in the near future. Already there are plans to tweek the design and layout to meet demand and improve flow.

Two of our senior nurses have been gifted a CENNZ conference registration by the department's SMO group – in acknowledgment of their 'above and beyond' efforts on the day to day work they do.

Despite workload and winter illness, there have been ongoing, informal celebrations - sometimes for no particular reason – sports events, skiing and gatherings.

It's reassuring to know that despite the busyness and demands of work and study we can occasionally come together to celebrate success, share stories and generally look after each other.

MATT

REGIONAL REPORTS

EMERGENCY DEPARTMENT, WAITAKERE HOSPITAL

Well it's official!

We have officially opened the new Waitakere ED and from the 17th of August our patients and staff have been working and being cared for in new facilities with much more space! In the first week of August our staff had orientation to the new area and we mixed it up by running scenarios including a treasure hunt to enable us to get used to the new geography. This was a fun way of getting us familiar with the lay out finding equipment and new ways of working.

Moving house is stressful and so is renovating but we are finally here with completion of stage 1! Over the next 7 months there will be a staged refurbishment of the current department. We know there will be a few teething issues as we open the new extension, but the facility is spacious and fit for purpose for our growing population.

Growth in west Auckland saw our patient numbers soar from 28,000 in 2009 to 52,000 in 2015, a third of these being paediatric presentations. This is the biggest increase of any ED in New Zealand. Along with patient numbers, our staff numbers have also increased to meet this demand. Previously we were often constrained by space issues with patients being cared for in the corridors and having to wait to do procedures impeding our flow through the department. The new area will help streamline our care and provide improved lower acuity patient flow.

We have a new front of house, including a new reception and triage area, dedicated child waiting area and 4 ambulance bays instead of 2. There is an area dedicated to families and whanau to meet as their loved ones are being cared for, 3 new resuscitation bays and dedicated procedural sedation room. But we haven't stopped there; by March 2017 we will also have a more private paediatric area to better suit our young children needing emergency care away from some of the adult action! This project has required a multitude of staff and contractors coming together to make this plan a reality and we are looking forward to the benefits it will bring both to our patients and our working lives.

We will continue to maintain our close working fun culture amongst the staff we will however be getting more exercise as we walk the new halls.

JAN BOYD

PAEDIATRIC CLINICAL NURSE SPECIALIST

WAITEMATA DISTRICT HEALTH BOARD

EMERGENCY DEPARTMENT, WAITAKERE HOSPITAL

From left to right; Toni Scott Admin Manager, Kate Allan Assoc CD, Collette Parr-Owens OPS Manager, Marja Peters CNM, Willem Landman CD, Lester Levy Chairman Waitemata DHB, Dale Bramley CEO, Naida Glavish Tikanga advisor, Andrew Brant CMO

Above; Photo of new Waitakere ED

REGIONAL REPORTS

AUCKLAND REGION

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AUCKLAND REGIONAL UPDATE

CHILDREN'S EMERGENCY DEPARTMENT, STARSHIP CHILDREN'S HEALTH

The dreary winter weather looks finally to be easing.

It has been unbelievably wet north of the Bombay Hills. This has brought the usual increase in respiratory illnesses that bring our younger folk to the ED. Interesting, January to April saw significant growth in our presentations, but winter has been fairly mild. The CED team has once again worked well together and have come through winter in good shape.

The positive side of this was that after 2 years, 1 month and 1 day (you can tell that no one was counting!), our Wheeze and Steroids in Pre-schoolers study (WASP) completed recruitment of 400 patients who were randomised to either prednisolone or placebo. Starship, KidzFirst and Waikato Hospitals all worked hard to recruit this number of children. Additionally, Starship and KidzFirst contributed admirably to the Paediatric Acute Respiratory Intervention Study (PARIS High Flow study) which has also now completed recruitment across Australasia. We will look forward to the results of both studies and how they may change our practice of infants with bronchiolitis and children with preschool wheeze.

CED is very excited to have a new Nurse Practitioner. Lucien Cronin successfully went through Nursing Council panel in September and has the scope of Acute Care: Lifespan. We are fortunate to share Lucien with Auckland Emergency Department – he works 0.5FTE in both EDs. Well done Lucien – a fantastic achievement. This brings our number of Nurse Practitioners in CED to four with another waiting in the wings to go to panel next year.

We have welcomed another new graduate to CED in September. Our two other new graduates have recently successfully completed their NETP programme and are a huge asset to our team.

Emergency nurses day on the 12th October, saw CED present their first CED Emergency Nurses Award. There were numerous high quality nominations with Frances Sai-Louie being the inaugural and well deserved recipient for her positive spirit, commitment to health and safety in the department and great role model for others. Frances started in CED as a new graduate nurse several years ago.

By the time this journal goes to print, the 25th CENNZ national conference in Auckland will have been and gone. CED has a number of nurses attending and presenting on paediatric topics.

After four years on the CENNZ national committee representing Auckland region, my time has come to step down. It is with sadness that I write my final report. Michelle Peperkoorn (CNS, NP intern from Middlemore ED) will now be representing the Auckland region along with Matt Comeskey (Auckland ED). Michelle brings a wealth of experience and knowledge to the role and I wish her all the best.

I look forward to ongoing involvement with CENNZ going forward.

LIBBY

REGIONAL REPORTS

MIDLAND REGION

RICK FORSTER

Registered Nurse

Tauranga Emergency Department

Bay of Plenty District Health Board

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Greetings from the Midland Region

We have come through another busy winter with the expected increase in workload pressure. High presentation numbers coupled with bed block from elevated inpatient occupancy has reared its head again. I do suspect that we have been let off a little this year by seasonal influenza not making its usual impact. However, the population of our area is rapidly expanding with many people chasing the Bay of Plenty lifestyle placing strain on our infrastructure. Unlike winter though this growth does not last just for a few months.

On a happier note, Auckland's loss is our gain with the arrival of our new Nurse Manager Stephanie Watson. She brings a long career in emergency care nursing and leadership roles. Stephanie has quickly settled into the role and is passionate about keeping our patients in the centre of our endeavours.

Within our department we are undertaking a quality improvement project to reduce unnecessary IV cannula insertion during blood sampling and unnecessary blood test requests. Our data shows there is scope to save a great deal of resources by moving away from a routine 'just in case' cannulation.

We are also refocusing on how we manage patients presenting with mental health issues. The recently updated MOH Management of those at risk of suicide in EDs is providing useful guidance.

The Tauranga Hospital has engaged the services of an external consultation group to develop a 12-month improvement portfolio focused on acute flow improvement. Key points include, optimising the ED, enhancing the acute surgery pathway, initiating ambulatory emergency care and supporting our frail elderly. It is most likely our department will undergo some large and significant process changes next year.

Staffing resources over both the Tauranga and Whakatane EDs are currently tight. The Whakatane Emergency Department is currently trialling a Clinical Nurse Specialist role.

Due to the workforce needs of a smaller centre their Clinical Nurse Specialists are starting with a case mix much wider than the more traditional single system injury and minor illness brief.

RICK

REGIONAL REPORTS

HAWKES BAY / TARAWHITI REGION

SHARON PAYNE
(Triage Instructor)

Nurse Practitioner

Hawkes Bay District Health Board

Hawkes Bay Emergency Department

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Greetings from Hawkes Bay.

This will be my last report, my term with the committee comes to an end. I welcome Paula Draper, clinical nurse coordinator who will be my replacement. Paula comes with a wealth of experience both in NZ and the UK.

Hawkes Bay ED has continued to be busy, with high acuity and high numbers of presentations. Increased staffing numbers have helped to manage this workload; however, we are still working to make these permanent positions.

The "front of house" refurbishment is finished with just a few small issues to be completed. The increased capacity is great, but with any refurbishment within existing walls - and in our case 'pillars', - it comes with some teething problems. But ED nurses are good at making things work and these issues will sort themselves out over time

The urgent care alliance project looking at how urgent care is provided in Hawkes Bay is ongoing with some behind-the-scenes work going on at present and we await an announcement of what this will look like in the near future. It is hoped it will have a positive impact on our increasing presentations that find themselves unable to gain timely appointments with general practitioners.

An organisational restructure has just been announced that doesn't directly affect the Emergency department but will have some impact on our support structures. We have offered our support to those who are now without jobs.

Wairoa acute ward continue to see a steady stream of patients.

SHARON

GISBORNE HOSPITAL EMERGENCY DEPARTMENT

The Emergency Department has been very busy over the last few months with the annual increase in attendances of ills and chills.

Our presenting numbers mixed with staff illness have put the department under some pressure particularly in August and September so it is great to see some sunshine. Despite our increasing numbers of presentations we have managed to continue to achieve some good results in managing our 6 hour target which is a credit to all our ED staff who have worked hard to balance good patient care with the government benchmarks.

Planning for the New Year's exodus to Rhythm and Vines is well underway; many of those attending R&V will be warming up for this annual event at the Road to Rhythm event at Te Awa Winery in Hastings. With high ticket sales currently being experienced it looks as though this will be another busy time for the ED.

In 2015 /16, ED staff including a receptionist and nursing staff worked alongside St John to deliver care at R&V. Daily clinics were held at R&V by St John's resident Emergency Nurse Practitioner / Intensive Care Paramedic (Jackie Clapperton). In a new initiative, Jackie with the assistance of an ED receptionist with 3G access to the hospital patient management system was able to register and order diagnostic tests for patients who required x-rays and lab tests and in-hospital follow-up. This reduced the waiting times and pressure in ED significantly and demonstrated how well St John, the ED and Haoura Tairawhiti worked together to make this happen.

Over 78 patients who would normally have been admitted to the ED were managed at R&V with the assistance of St John, the ENP clinic and senior ED nurses who looked after these patients in the field hospital at R&V.

REGIONAL REPORTS

MID CENTRAL REGION

AMANDA BIGGS-HUME
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Spring arrived about the same time as the opening of Kauri Health, Palmerston North's new integrated family health centre.

This has seen the merging of three existing primary health practices and one individual practitioner into a brand new, purpose built premises. Each previous practice is now run from a pod with colour-coded carpet. This allows patients to maintain a sense of place within a big building and maintain a connection with the staff and clinicians that know them, - both general and nurse practitioners. The centre also houses several other services such as a sleep specialist, private dermatologist, MidCentral's new Health of the Older Persons team and a pharmacy. Even though the new centre is not an Accident and Medical centre, it is expected to help relieve the pressure on Palmerston North's emergency department by accepting patients who previously could not register with a primary health practice due to lack of capacity. Since Kauri Health's opening they have enrolled 2,000 new patients.

Good work has been undertaken with primary health practitioners and a local accident and medical clinic to streamline the pathway for patients with cellulitis who require the administration of intravenous antibiotics. This has resulted in simplification of the pathway paperwork, and streaming some patients away from the district nursing service to the accident and medical clinic where they receive free treatment. This is the way of the future and just one small example of how integration of primary and secondary care is being used to streamline resources and improve the service delivery for patients.

The normal winter work load seen each year is finally dropping off and we have even experienced some eerily quiet days which has allowed staff to recharge their batteries and catch up with a bit of paper work.

In the past few weeks we have said good-bye to one consultant who has moved to another DHB, and said hello to another consultant from the USA.

AMANDA

REGIONAL REPORTS

TOP OF THE SOUTH REGION

JO KING

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As spring arrives to the Top of the South it is a welcome reminder that summer and the holiday season is just around the corner.

The last 3 months have been a time of relative stability in work and flow. Patient presentations remain constant and the 6 hour target has been at 96% for August. Over the last month, we have seen an increase in category 2 and 3 patients, however at the same time there has been a concurrent decrease in total patient minutes in the department. This may reflect a slow but gradual paradigm shift whereby the 6 hour target is seen as more of a hos-pital wide KPI. While there is still work to do this is a positive step. The national reduction in reported flu cases over the winter period has also been noted in our department.

We have had a disturbing escalation of violence, abuse, threatening behavior and concealed weapons in our emergency department over the last months. For this reason I would like to devote the majority of my regional report to this issue. I consider it is a major challenge facing nurses at the coal face of emergency practice. I was fortunate to attend the recent NZNO conference as the CENNZ representative and hear Linda Silas, President Canadian Federation of Nurses speak. Her presentation was titled "If you are not at the table, you are on the menu", a phrase attributed to an unknown Washington politician. She said nurses need to take every opportunity to be at every table and speak on every issue that affects nurses, nursing and patient care. I suggest this is one of those issues. She also spoke of how nurses constantly advocate for patient safety, it is often the common theme in our conversations, however we must also advocate for nurse safety.

There is also a wider departmental cost to security incidents and disruptive behavior that should be considered. These events tend to consume large amounts of staff time and this can compro-mise the care of others. The disruption often means patients wait longer to be seen, pain relief may be delayed, the deteriorating patient may not be noticed and flow is generally hindered. At the CENNZ AGM in November a college position statement on violence will be presented. This has largely been the work of Matt Comeskey (ADHB). If adopted I think this could provide a platform to raise the profile of violence in emergency departments and an opportunity to campaign for zero tolerance. In our area, I consider one of the most urgent needs is dedicated security which would allow us to go about our core business of patient care in a safe and secure environment.

These recent security and violent incidents have also triggered a review of electronic alert systems which give triage nurses immediate information about patients and potential risks. This has highlighted many gaps in many systems. There is certainly a need for a singular and robust process that is NHI linked and this will be an ongoing project.

On a more positive note, we have welcomed a great crew of new faces to our department. Many staff are seeing the light at the end of a year of post graduate study and many more are completing applications to begin study next year.

We are looking forward to a great CENNZ conference hosted by our Auckland colleagues.

JO

REGIONAL REPORTS

WELLINGTON REGION

BEN STOREY

Charge Nurse

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Capital Coast District Health Board

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CCDHB: WELLINGTON – SUMMARY

- Presentation rates remain high, with numbers exceeding those seen same month on 2015.
- Acuity continues to be high with 61% of presentations Triage 1-3.
- Admission rate 35%.
- Like everyone – we are looking forward to summer and hopeful easing of workload and demand and of course the ED Christmas shin-dig!
- Interagency (Police , MH and ED discussions continue across our 3DHB). Following the success of our Police to ED staff handover form (used on all patients brought to the ED by police), the group is now working towards a better way to escalate urgency of response from police from a colour coded escalation pathway.
- PRICT (Practise responsible intra venous cannulation today) analysis continues with a 35% reduction in cannulation rate! This is much better than expected and a testament to the entire Emergency team to deliver better, safer and more responsible cannulation practise.
- Nurse led ultrasound guided IV access workshop planned for November 2016 – CNS team will attend and become the departmental champions.
- Continued progress on Quality Framework reporting.
- Plans to build an exciting new children's / parents space in the waiting room progressing to architect drawings.
- In final stages of a Mental Health team being on site between 0730-2300 7 days a week enabling delivery of more timely MH service to Emergency patients.
- Late October CCDHB hosted the St Johns EMERGO training exercise to simulate a mass casualty event. Approximately 55 patients from a ferry accident brought in lots of near drowning, burns and trauma. An excellent multi-departmental turnout from Labs, ICU, Theatres, ED, Radiology and more.

CCDHB

- Over the last few months Occupancy routinely at 100% meaning 'overflow' areas required to manage demand. Our SSiED has suffered as a result, however despite increase utilization of service and higher acuity, our SSiED is comparable to 2015.
- ED staffing recruitment means we are now up to new FTE levels following approval for a FTE increase in April / June 2016. Recruitment has been difficult, along with the usual winter turnover of transient staff so it is pleasing to now have a Nov / Dec roster that encompasses our new model of care with the aim to lessen our nurse-patient ratios.
- We are excited to host our first CAP student and grow new staff to potentially enter the NZ workforce.
- We continue to encourage Ambulance, nursing and nurses and students from NZDF to our department – our structured student orientation and training programme has been met with positive feedback.

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AGGRESSION IN ED

Reported aggression in ED is lower through October / November (16 and 9 reported cases).

We continue to use an aggressive incident reporting system that is an easy paper report that takes an RN 2-3 minutes to complete. An ACNM will then retrospectively submit an RE (it is the RE that was seen as the limiting factor for better reporting).

We continue to be acutely aware of Health and Safety of patients and staff and have our Security Orderly on site from 2300-0700 7 days a week patrolling the ED / SSU area.

We are working with our new H&S officer for up-skilling our Security / orderly team and looking at levels of responsibilities / ability to manage difficult and challenging situations.

This work is also in conjunction with Wellington Police as a sub group of our Inter agency Working Group that meets every 6 weeks.

HUTT ED – MIKE JOHNSON (CNM HVDHB)

Unlike last winter that seemed to be relentlessly tough going, we have had some good days mixed into the craziness of this season. Triage 1 and 2 have increased adding to the acuity and pressure.

From a recruitment view we have welcomed a new 0.6FTE ACNM as well as a new SMO with another starting December 2016. We are still actively recruiting for our CHOD.

Our SSiED has been better than 2014 and 2015 same periods with a 2% improvement which is encouraging given the additional acuity and workload.

As of January 2017 we will welcome a new grad at 0.8FTE. We are currently orientating two additional new staff who should be flying solo by December 2016.

Bring on the Summer!

BEN

REGIONAL REPORTS

CANTERBURY / WESTLAND REGION

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CANTERBURY/WESTLAND

Hi from the West Coast.

Our staffing shortages remain critical in the nursing arena within the ED setting. We have been very fortunate that Christchurch ED have put their hand up in our time of need. Anne Esson (Nurse Manager ED Christchurch) has very kindly released a number of her Registered Nurses to come over to the Coast. This has worked really well. Our team and the nurses that have travelled over have really enjoyed the experience. A huge thank you to Leah, Erin, Jane and Stacey. Also, thank you to Natalie who will join our team on a short term contract for a month. There is some light at the end of the tunnel with 3.5 nurses joining the team over the next month.

We now have the St. John tablet up and running for the ePRF. This has certainly streamed lined the system and made it more efficient for all concerned. Our transport ambulance that transfers patients daily across the alps is working really well. Two of the transfer nurses are now fully PRIME trained. The position for a trauma nurse has now closed and an announcement for the successful applicant will be announced in the next few weeks. It has been noted that the traffic seems to be intensifying with tourists on our roads. And lastly, not long until Christmas.

A very happy Christmas and safe New Year to all from the West Coast.

LYNLEY MCINROE

CNM ED/OPD

GREY BASE HOSPITAL

CHRISTCHURCH HOSPITAL

I would like to start my final report by thanking the Canterbury/Westland members and the national CENNZ committee for their support during my 4 year tenure as the Canterbury/Westland regional representative.

In particular I'd like to thank CENNZ members for their feedback on the Knowledge and Skills Framework which will be presented at the AGM for ratification and if successful will be presented to NZNO and then the National Nursing Consortium for endorsement.

Sandy Richardson from Christchurch ED will take over as the Canterbury/Westland region representative on the national committee. Sandy has been an ED nurse for most of her nursing career and currently works in a joint appointment role between the University of Otago where she is a senior lecturer and Christchurch ED where she is a nurse researcher. Sandy's research includes ED overcrowding, cultural safety, disaster response and violence and aggression.

Christchurch ED celebrated International Emergency Nurses Day on October 12th by holding its annual open day in conjunction with the presentation of the 'Excellence in Emergency Nursing' award. For the second time in the 7 year history of this award we had a joint winner. Congratulations to Vera Fortune and Rachel Burt who were presented with the 2016 'Excellence in Emergency Nursing' award (albeit Vera 'attended' from Germany via Skype).

REGIONAL REPORTS

The common theme that was apparent through their nominations was their willingness to share their knowledge and help their colleagues. The Open Day saw around 30 people taking up the offer of seeing ED 'behind the scenes' with tours being held throughout the day.

The winter has been challenging at times, not so much in relation to volume but associated with acuity and complexity. Our practice of using triage codes as a surrogate acuity/complexity measure doesn't enable us to see the real picture, - for although volumes are not rising greatly, patients are staying in ED for longer. We failed to meet the Shorter Stays in ED target for the first time in two years, the reasons being in-patient bed block, complexity and admission avoidance activity. Fortunately, the predictions of an average of 300 admissions per day over August did not become a reality.

A round-up of projects in 2016 have included (but not limited to)

- The appointment of two CNSs on the Nurse Practitioner Pathway - a first for Christchurch ED.
- Preparation for e-meds which has stalled a few times but is set to go live late November.
- Engagement in the 'Releasing Time to Care' programme with 2 modules undertaken and more planned for 2017.
- An increase in nursing staffing for our 10 bedded observation area which will enable better utilisation of the area during the day and provide more support for the staff working in the area.
- The re-work and re-launch of our overload /capacity plan and development of new dashboards which provide us with real time ED and Hospital activity and capacity.
- A new model for delivering our nursing education which is being well supported by the staff and providing a platform for staff to share their knowledge and experiences.
- Discussions with Child Health, Orthopaedic and Mental Health services are well underway as we prepare for new co-locations and models of care in our new facility which is due to open in 2 years.

Being on the national committee has provided me a great deal of insight into Emergency Nursing within the New Zealand context and it has been a privilege to have had this opportunity.

Emergency nursing is in good hands - all the best for the future and thank you.

ANNE

From left to right; Excellence in Emergency Nursing Award Winners Rachel Burt and Vera Fortune

SOUTHERN REGION

ERICA MOWAT
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Southland District Health Board

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2016 - A YEAR OF CHANGE FOR THE SOUTHERN DHB

This year has seen the resignation of Carol Heatley the SDHB CEO, the dismissal of the elected hospital board and the appointment of a commissioner Kathy Grant until 2019.

Nelson Marlborough Health chief executive Chris Fleming has been appointed as the interim Southern District Health Board chief executive and started mid September. He has previously worked for the SDHB returns for a 6 month secondment, while a permanent appointment to the CEO role is sought.

It has also been a year of challenges and changes for our SDHB Emergency Departments. The Dunedin Charge Nurse Manager (CNM), Justin Moore, has been on a project secondment and returns in late December to his permanent role. The Assistant CNM has had the opportunity to fulfil this role with Tanya Meldrum being the current acting CNM. Two of our senior nurses, Amy Rata & Greer Keogh Snyder have in turn filled the assistant CNM role. The Southland CNM, Sue Bamford, has recently resigned and her position has been advertised. Sue will be missed but we wish her well in her retirement.

I'm Looking forward to catching up with a few of the SDHB members at the Auckland Conference in November. Planning for next year included the possibility of the 2017 Emergency Nurses Conference being held within the Southern DHB.

Just wait and see what we have in store should CENNZ confirm the southern venue…

DUNEDIN HOSPITAL EMERGENCY DEPARTMENT

A winter peak in presentations of 4,086 was seen in August with presentations on most days being between 132 to 159 in the Dunedin ED, with corridor spaces being utilised.

There was an occasional daily variance of up to 30 presentations over the winter with the average dropping to 134 per day over a 10 week period. The challenges for this winter were staff sickness, limited inpatient bed availability and specialty referrals, which inhibited the patient flow through the department. While the addition of a winter flex nurse assisted with covering staff sickness and patient care, however the department lost this extra staff member at the end of September.

The 'Releasing Time to Care' projects continue within the ED with Fast Track trialling of a procedure chair rather than utilising a stretcher. The plans for alterations to one of the cubicles for Biers Blocks and minor injuries being on hold due to ongoing asbestos issues inhibiting alterations to the area. Plans also continue for the development of our main medication room and the dirty utility area.

The August Kai Tiaki had an Emergency Nursing focus and saw Elizabeth Walsh, from Dunedin interviewed and reflecting on a lifetime of nursing and changes within ED. We have also seen another experienced nurse Sharon Mc Garry retire in August from emergency nursing and her position as Charge Nurse of the resource team.

However, her plans for so called retirement include assisting with setting up a skills lab and teaching Advanced Cardiac Life Support and cannulation in Samoa!

ERICA

INVERCARGILL

Southland ED experienced the usual busy winter period with high acuity and numbers with corridor beds in use once again.

We have finished a month long trial of utilising a designated flow nurse. We have found has improved flow within the department and provided senior coverage in our triage and MTR areas, along with providing support to the coordinators. The Winter Flex helped staffing over the three months winter period, but this additional FTE has now stopped. We have a high number of staff completing post graduate study and there are some exciting projects being completed by staff, having a positive impact clinically on the running of the department. Staff are also getting involved with "Releasing Time to Care" so we look forward to seeing some innovative ideas translated to the clinical area that can allow us to concentrate on our patients more.

On a positive note, spring is in the air - calving and lambing is well under way, the bulbs are up and we can feel summer coming!

OAMARU

Winter in Oamaru brought the usual illnesses both in town but also among staff, so the hospital was very busy, placing an extra load on staff, who are already stretched because of shortages.

This made it particularly challenging at Duty Nurse level. During the winter the inpatient ward has been in lockdown with very restricted visiting because of a gastro-intestinal bug which affected both staff and patients.

In-patient bed numbers were recently decreased. This has meant the hospital capacity is reached more frequently, and patients have required to be escorted between Oamaru and Dunedin ED. The Emergency Department has continued to be extremely busy. We have recently begun using a swing shift which is working really well. It has meant that usually each day ED staff now get a meal break both at midday and in the evening! It has begun at only 5 days a week but it is hoped it can be extended to 7 days.

Currently Senior Nursing staff are looking at a model of care which it is hoped will address the stretched staffing levels.

QUEENSTOWN

This was a very busy winter season for Queenstown, with a significant increase in the number of presentations each month.

Staff sickness levels were high, including some staff off on long term ACC . This has put a strain on nursing resources. Thanks to nurses picking up extra shifts and some overtime, we have managed to maintain safe staffing levels and ensure patients are cared for appropriately. However, these issues highlight our vulnerability with only a small staffing pool to call upon.

We are all looking forward to spring and the end of the ski season, and the challenge of "mountain biking" ahead!!

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EMERGENCY NURSE NEW ZEALAND