July | 2017
The Journal of the College of Emergency Nurses New Zealand (NZNO)
ISSN 1176-2691

EMERGENCY NURSE NEW ZEALAND

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EMERGENCY NURSE NZ

EDITORIAL COMMITTEE

A WORD FROM THE EDITOR:

"DON'T BOO - VOTE!"

For those not familiar with the above catchphrase this was Barack Obama's go to slogan during the run up to the last elections and the inference being if you're not happy with what's going on, don't moan about it, get out and vote. Fat lot of good that did young Hillary (and the rest of the world come to think of it) but the theory was sound.

This year is the alignment of two stars - the MECA negotiations and the General Election and we need to take full advantage of this. I do not believe the Government wants to piss off a bunch of nurses and upset the general public by offering us some token wage rise BUT it is up to us to ensure these negotiations are in the face of nursing staff and the public at large. Historically the turnout and voting by DHB NZNO members has been spectacularly poor which gives the NZNO team very little mandate to push for more pay, better conditions on our behalf. The majority of DHB NZNO members who are eligible to vote don't seem to care if they are paid well, if they work in a safe environment and alongside enough, suitably trained staff; BUT I bet many of them go home after (another) crap shift, stressed, emotional and maybe at times dreading the thought of coming back to work the next shift.

So, if you don't get involved, if you don't make sure your colleagues are involved (in and outside of ED) then don't be surprised if the outcome of the negotiations are another damp squib. The NZNO exists to work on our behalf to achieve the best results for us - keep them honest, keep them aware and do not accept mediocrity.

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

EMERGENCY NURSE NZ

SUBSCRIPTION:

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

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SUBMISSION OF ARTICLES FOR PUBLICATION IN EMERGENCY NURSE NEW ZEALAND.

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

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Chairperson's Report

Greetings Emergency Nurses across Aotearoa

Winter is upon us again and traditionally the most frenetic period of the year. Presentations rise and our waiting rooms swell with those who succumb to the seasons various ailments. Our College has had an active first half of the year managing our routine business whilst undertaking new projects.

In May CENNZ successfully hosted a national ED charge nurse managers day for the first time. Unit managers from 13 departments met in Wellington to discuss contemporary issues faced in our EDs. It provided an ideal opportunity for a group of our speciality leaders to network and share ideas. A National Advisor representing the Ministry of Health acute services team provided an interesting presentation. She acknowledged the hard work being done across the country in our EDs and explained some of the Ministry of Health's current strategic goals. Security and staff safety was also discussed by the participants with some creative innovations being shared.

CENNZ continues to be engaged with the Safe Staffing and Healthy Workforce Unit (SSHW). The unit is supported by District Health Boards and the New Zealand Nurse Organisation, it looks to address the complexities of matching nursing demands with resources. Emergency departments are unique and it will take some creative thinking to find a solution. SSHW and CENNZ are planning to facilitate a project day to aid in developing a submission for the SSHW executive, outlining proposed requirements and goals.

"The Health Quality Safety Commission's deteriorating patient project is well underway.

The Health Quality Safety Commission's deteriorating patient project is well underway. The first work stream entails the implementation of a national early warning score (EWS) chart. Trial sites around the country are using the new system with a national rollout planned to begin later in the year. District Health Boards will develop their own local response systems for patients identified as at risk. Use of EWS in New Zealand's EDs is variable, however they are becoming more embedded as a tool for communicating the physiological condition of patients being admitted and their requirements. Comprehensive information about the project can found on the following website:

https://www.hqsc.govt.nz/our-programmes/patient-deterioration/

Katie Smith has recently joined the CENNZ national committee. Katie is a Nurse Practitioner within the New Zealand Army and contributed in the development of the CENNZ Knowledge and Skills Framework. It will be very interesting to hear her perspective of emergency nursing.

Financial constraints are ever present in healthcare making it difficult for nurses to access professional development. One significant activity of CENNZ is supporting its members through various awards and grants. Each year we support many nurses in accessing education and conferences. *For further information please visit our website.*

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

Our membership for the last financial year peaked at a record of just above 600 levied members. This is a great achievement for our College, thank you for your continued support. If you have any questions about CENNZ please feel free to contact your regional representative.

In June the CENNZ Advanced Emergency Nurses Network (AENN) held a study day at the Taranaki base hospital. The theme for this seminar was aptly titled "Going rural". In recent years we have seen increasing growth in regional ED Clinical Nurse Specialist and Nurse Practitioner roles. It is brilliant to see the AENN days getting out into the provinces.

Rapidly approaching and being hosted in Queenstown this year is the 2017 CENNZ conference. The conference website is linked to the CENNZ homepage providing up to date information from the Southern DHB organising team. It will be another excellent conference and would be great to see you there.

Best Regards

RICK FORSTER

Chairperson

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AN INTERVIEW WITH PAULA (POLLY) GRAINGER AND DR. SANDRA RICHARDSON.

INTERVIEW BY MICHAEL GERAGHTY.

WORLD ASSOCIATION FOR DISASTER AND EMERGENCY MEDICINE (WADEM) WORLD CONGRESS 2017

Paula Grainger is the Nurse Coordinator Clinical Projects, Christchurch Emergency Department. Dr. Sandra Richardson is the Nurse Researcher, Christchurch Emergency Department and a Senior Lecturer, Centre for Postgraduate Nursing Studies, University of Otago, Christchurch.

I hear that you attended an international conference this April – Tell us a little about it:

We have recently returned from Toronto, Canada where the World Congress for WADEM (World Association for Disaster and Emergency Medicine) was held. This is the premiere international disaster conference, it's held every two years, and attracts a wide range of health providers and humanitarian aid workers

How did you get funding to get there?

Like many nurses, accessing funding to attend an international conference is a challenge. However, because we felt that this was a significant conference, that had real relevance to our field of practice and to which we felt we could also contribute, we decided to make the effort. We approached a range of organisations we hoped would support us and applied for a series of grants. We are particularly grateful to CENNZ who provided funding for a large portion of the expenses, likewise the Emergency Care Foundation (ECF). As you will know, the costs of registration, flights, and accommodation are significant, so we also approached other sources too. Sandy received support from the University of Otago and Polly won a CDHB quality initiative poster award that paid for her registration. A Fisher and Pykel NZNO conference grant enabled us to eat!

Funding opportunities are greater if you are presenting at a conference, especially if this is result of university/polytechnic study or a formal research project – this then gives you access to research funding, community grants, travel grants and similar sources. If you have been doing something worthy of sharing, then consider submitting this to your local quality initiative awards and other opportunities that arise – whether you win a prize or not, this looks good on your CV and as part of your PDRP. Remember, if you have been a financial member of CENNZ for a minimum of two years, you can apply for assistance from them, there are also a range of grants available via NZNO. While it can be time consuming, and often you need to approach multiple sources it is possible, and worthwhile.

The next WADEM congress will be held in 2019 and, conveniently it will be in Brisbane. You might want to start planning for your attendance now – and preferably to participate as well.

What does or could WADEM do for NZ emergency nurses?

A great deal. As readers of this journal you will likely be emergency nurses or nurses who work in areas such as afterhours emergency clinics and the like. In a disaster it falls to us to respond. WADEM is the international organisation for hospital and pre-hospital emergency healthcare. They have members from a range of disciplines from more than 55 countries who shape the international guidelines for disaster response. You can learn more about WADEM on their website: https://wadem.org/about/association-overview/. Being a member gives you access to their journal (Prehospital and Disaster Medicine) that's full of peer reviewed research plus workshops and webinars for further education.

The WADEM organisation has several sub-sections including Nursing, Emergency Medical Response, Psychosocial and Mass Gathering. The mission statement for the Nursing Section is to foster collaboration among nurses involved in research, education, management, and practice in prehospital, emergency, public health, and/or disaster health care.

It's clearly a big organisation, was this reflected in the congress?

Yes! This congress gave participants the opportunity to share knowledge and skills in a variety of ways, through oral presentations, poster sessions, workshops, plenary sessions, debates, table top exercises, and pre and post conference courses such as the two-day Advanced HAZMAT Life Support (AHLS) Provider Course and AIIMS Disaster Ultrasound Course. With more than 900 delegates, representing 65 countries, and 563 abstracts the range and depth of information was huge.

As is usual in conferences there were

AN INTERVIEW WITH PAULA (POLLY) GRAINGER AND DR. SANDRA RICHARDSON CONT.

WORLD ASSOCIATION FOR DISASTER AND EMERGENCY MEDICINE (WADEM) WORLD CONGRESS 2017

multiple concurrent sessions that could be followed or switched between these included: CBRNE (Chemical, Biological, Radiological and Nuclear defence), Disaster Medicine Controversies, Disaster Medicine Principles, Ethics, Health Systems, Humanitarian Aid, Improving Emergency Medical Team Capacity, Lessons from the Field, Mass Gatherings, Nursing Track, Paediatrics, Prehospital Care and Transport Medicine to name a few. While there was no dedicated climate change track, this was evident as a recurrent theme with applications to healthcare. There was something of interest for everyone involved in emergency healthcare.

As the conference covered so much and provided such a wealth of information, we will be writing a series of articles based on some of these topics.

Were you able to contribute to the knowledge shared at the Congress?

Our own shared presentation addressed the fact that there are many published "lessons learnt" articles following crisis and disaster events; yet when you look at them together, many are saying the same things, so we're clearly not learning from each other. We are currently researching why this might be, and how we do learn, whether ultimately this is only from what we directly experience. Sandy also presented on ED Overcrowding and risk recognition related to potential responses to this, such as referral away from ED's.

What did you learn that might be important for NZ emergency nurses to consider?

Bringing the findings back to emergency nurses – we need to ask ourselves, what is the value in thinking about disaster preparedness? Here are some questions to consider. If a disaster occurred, what happens if you're the nurse in charge? Who informs you if it's an external incident, or who makes 'the call' to bring in colleagues? Who will come if you do make the call? What's your chain of command – especially afterhours? Do you think pulling out the plan at that stage is enough? Do you know if your organisation has a plan, and when did you last look at it? Do you know if there are task cards? Task cards have bullet point activity reminders – have you read them a couple of times yet? We live in a disaster prone country, and work in a disaster and crisis orientated area of nursing – we need to be alert, able and aware!

Let food be thy medicine and medicine be thy food."
Hippocrates

SNIPPETS

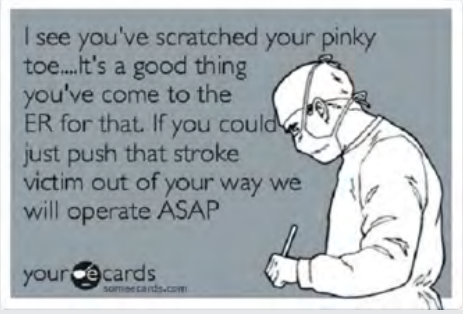
- Suicide in Asian communities: An exploratory study in NZ - 201
  Ho E et al. *Asian Health Review Issue 19. 2017.*
- Asthma and Respiratory Foundation NZ adult asthma guidelines: a quick reference guide
  Beasley R et al. *N Z Med J 2016;129(1445):83-102*
- Acetaminophen versus ibuprofen in young children with mild persistent asthma
  Sheehan WJ et al. *N Engl J Med 2016;375(7):619-30*
- Acute Achilles tendon ruptures: an update on treatment
  Kadakia AR et al. *J Am Acad Orthop Surg 2017; 25(1):23-31*
- How mentors can influence the values, behaviours and attitudes of nursing staff through positive professional socialisation
  Norman, Kay. Nursing Management (2014+); London 22.8 (Nov 2015): 33
- The effect of cigarette smoking on lung function in young adults with asthma
  Hancox RJ et al. *Am J Respir Crit Care Med 2016;194(3):276-84*
- Enhanced hip fracture management: use of statistical methods and dataset to evaluate a fractured neck of femur fast track pathway-pilot study.
  Gilchrist et al. *N Z Med J. 2017 May 12;130(1455):91-101.*
- A systematic review of the impact of nurse-initiated medications in the emergency department.
  Cabilan and Boyd Australas Emerg Nurs J. *2017 Apr 24*

NZ TRIAGE COURSES 2017

THE PUBLIC HEALTH BURDEN OF ALCOHOL AND THE EFFECTIVENESS AND COST-EFFECTIVENESS OF ALCOHOL CONTROL POLICIES: AN EVIDENCE REVIEW.

There are three courses available in the latter part of 2017. For more information go to:

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



REGION	DATES	VENUE	CLOSING DATE FOR APPLICATIONS	CLOSING DATE FOR PAYMENT	REGISTRATION
CHRISTCHURCH	30 SEPTEMBER / 1 OCTOBER 2017	PROFESSIONAL DEVELOPMENT UNIT, 5TH FLOOR, CHRISTCHURCH HOSPITAL, RICCARTON AVENUE, CHRISTCHURCH	5 AUGUST 2017	19 AUGUST 2017	BOOK NOW 19 PLACES LEFT AS AT 11/05/17
WAIKATO	7/8 OCTOBER 2017	CLINICAL SKILLS CENTRE (UNDER THE LIBRARY) WAIKATO HOSPITAL CAMPUS, CORNER SELWYN AND PEMBROKE STREET, HAMILTON WEST	12 AUGUST 2017	26 AUGUST 2017	BOOK NOW 24 PLACES AVAILABLE
LOWER HUTT	3/4 NOVEMBER 2017	THE LEARNING CENTRE, 2ND FLOOR, CLOCK TOWER, HUTT HOSPITAL, HIGH STREET, LOWER HUTT	8 SEPTEMBER 2017	22 SEPTEMBER 2017	BOOK NOW 23 PLACES LEFT AS AT 11/05/17

WITNESSED RESUSCITATION IN THE EMERGENCY DEPARTMENT: THE FAMILY'S EXPERIENCE

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ABSTRACT

The literature review aims to investigate the effects and experiences of family when witnessing resuscitation and how they cope with this experience. It aims to look at whether family find this experience helpful to their grieving process and how they would like health professionals to assist them during this time. A narrative review was undertaken, reviewing a total of eighteen articles from online databases and journal articles using keywords specific to the purpose of the review. The articles needed to include the experience of family witnessing the resuscitation of an adult in an Emergency Department. Two main themes and five subthemes were found in relation to the roles family felt they played in the resuscitation. Overall, family experiences during resuscitation were positive; families felt they helped the health care team in their efforts to save the patient and they found being present provided them closure and decreased anxiety, ultimately assisting in their grieving process.

To help family cope with the resuscitation of their loved one, hospitals need to have a policy in place outlining options available to them when in this circumstance. Families should have a staff member with them to help them throughout the process. This enables the family's best interests to be protected as well as ensuring safety for the patient and staff involved.

KEY WORDS:

Cardio Pulmonary Resuscitation, Emergency Nursing, Grief, Friends, Family, witnessed resuscitation.

METHODS

To assess the effect on families of witnessing the resuscitation of a loved one, a review of original literature was undertaken. In this review the term "family" was used as a broad term to include friends and significant others. The keywords and search terms used were "family", "family stress", "loved ones", "spouse", "friend", "family experiences", "resuscitation", "witnessed resuscitation", "emergency" and "arrest". The search was conducted using the Cumulative Index of Nursing and Allied Health Literature, PubMed, ProQuest and Cochrane Library databases. The reference lists of the initial articles found were then searched to ensure a wide enough scope was achieved.

Articles were included only if the research focused on the family's experience during an emergency department based resuscitation and not that of the patients or health professionals. Research did not have to consider the outcome of the resuscitation; instead, the outcome of interest was the effect of the experience on the families. There was no date restriction for this review, ensuring there was not any seminal research excluded. The review did exclude research focussing on paediatric or obstetric resuscitations; as with children guardianship needs to be considered in medical decisions. In the case of obstetric resuscitations you are dealing with two patients, the baby and the mother, which further complicates the resuscitation.

RESULTS

Following a comprehensive search 18 articles were found that satisfied the above criteria. Two main themes and five subthemes emerged from the extant literature base (Figure 1). The families felt they played two roles in witnessing resuscitation, *the helping role* and *the receiving role*, with the subthemes being *provider of information, support and comfort, acceptance and closure, insight and spiritual experience*.

THE HELPING ROLE

Prior to witnessing the resuscitation some family members were concerned that their presence may interfere with medical professionals' ability to fulfil their roles (Hung & Pang, 2011), this is also a documented concern of health care professionals themselves (Dwyer & Friel, 2016; Parial, Torres & Macindo,

WITNESSED RESUSCITATION IN THE EMERGENCY DEPARTMENT: THE FAMILY'S EXPERIENCE

2016). However it was found across several research articles this was not the case and that following the experience family felt that they were helpful rather than a distraction. Families discussed the various ways in which they provided assistance during resuscitation of their significant other and this made them feel they were a pivotal part of the experience (Hung & Pang, 2011; Leske, McAndrew & Brasel, 2013; Meyers, Eichhorn, Guzzetta, Clark & Taliaferro, 2004; Weslein, Nilston, Lundqvist and Fridlund, 2006). After reviewing the literature it became clear this role included both helping the health care team by being the *provider of information* and the patient by providing *support and comfort*.

Provider of Information

Family felt included by the fact that they could provide the health care team with vital information regarding the patients' medical history including any current medications, health conditions and any past history that could be of relevance (Leske et al. , 2013). Relaying important health information led to the family feeling they had played a positive role in the whole resuscitation process (Hung & Pang, 2011; Weslein et al., 2006).

Being present also enabled the family member to relay information to friends and other family of the patient without any of the medical jargon that health care members may use. It meant information regarding the resuscitation could be discussed with more of a personal focus rather than a medical focus. (Leske et al., 2013).

Support and Comfort

Several articles found that family felt they provided a supportive role to the patient during resuscitation through physical and emotional comfort (Hung & Pang, 2011; Leske et al., 2013; Meyers et al., 2004). Being able to touch the patient, hold their hand or verbally reassure them empowered the family to feel they were able to ease some of their loved ones fears. They were more likely to focus on their comforting role rather than the trauma of the resuscitation, thus reducing the stress and anxiety that can often be associated with such an event (Meyers et al., 2004).

THE RECEIVING ROLE

Family members and health care professionals also expressed concerns that being present during resuscitation would be traumatic and that they would gain little from the experience (Parial et al., 2016). After witnessing the resuscitation, family reported that this was not the case. Research found several ways in which they personally benefited from witnessing the resuscitation (Doyle et al., 1987; Holzhouser, Finucane & De Vries, 2006; Hung & Pang, 2011; Leske et al., 2013; Meyers et al., 2004; Mottillo & Delaney, 2014). Several themes emerged from the literature which have been categorised into subthemes acceptance and closure, insight and spiritual experience.

Acceptance and Closure

It was discussed in many studies how family felt that watching the resuscitation assisted in their acceptance of the situation and provided them with closure. It allowed them to see how hard the health care team were working to save their loved one and that all options were being exhausted (Barrat & Wallis, 1998; Leske et al., 2013; Meyers et al., 2004). Being able to see that every attempt was made to help the patient led to a decrease in any anger, frustration and blame that family may have felt towards the medical team (Doyle et al., 1987; Holzhouser et al., 2006; Mangurten et al., 2005; Parial et al., 2016; Post, 1989). By being there and knowing their loved one was with somebody who loved them at the time of death provided family with some closure and comfort (Meyers, Eichhorn & Guzetta, 1998; Meyers et al., 2004; Mottillo & Delaney, 2014).

By being able to both accept a situation and find closure from it assists the family in moving through the grieving process (Meyers et al., 2004; Post, 1989). Several studies focussed on the involvement of witnessing resuscitation, how this affected the family members' acceptance and grieving process. These studies further discussed the different types of grief that can occur following the death of a loved one such as complicated grief, including Post Traumatic Stress Disorder. (Compton et al., 2011; Jabre et al., 2014). There are differing opinions on whether family will experience complicated grief following a witnessed resuscitation but the overall consensus is that they are no more likely to, than someone who was not present in the resuscitation room (Christiakis & Allison, 2006; Compton et al., 2011; Jabre et al., 2014; Mottillo & Delaney, 2014).

Insight

Witnessing resuscitation first hand helped the family to better understand the patient's condition and comprehend the severity of it (Duran et al., 2007; Meyers et al., 2004). The family were able to observe and receive information as it was happening which assisted them in their understanding of the process (Hung & Pang, 2011). Knowledge of the event removed the mystery that can often surround resuscitation, giving the family realistic expectations of the outcome for

WITNESSED RESUSCITATION IN THE EMERGENCY DEPARTMENT: THE FAMILY'S EXPERIENCE

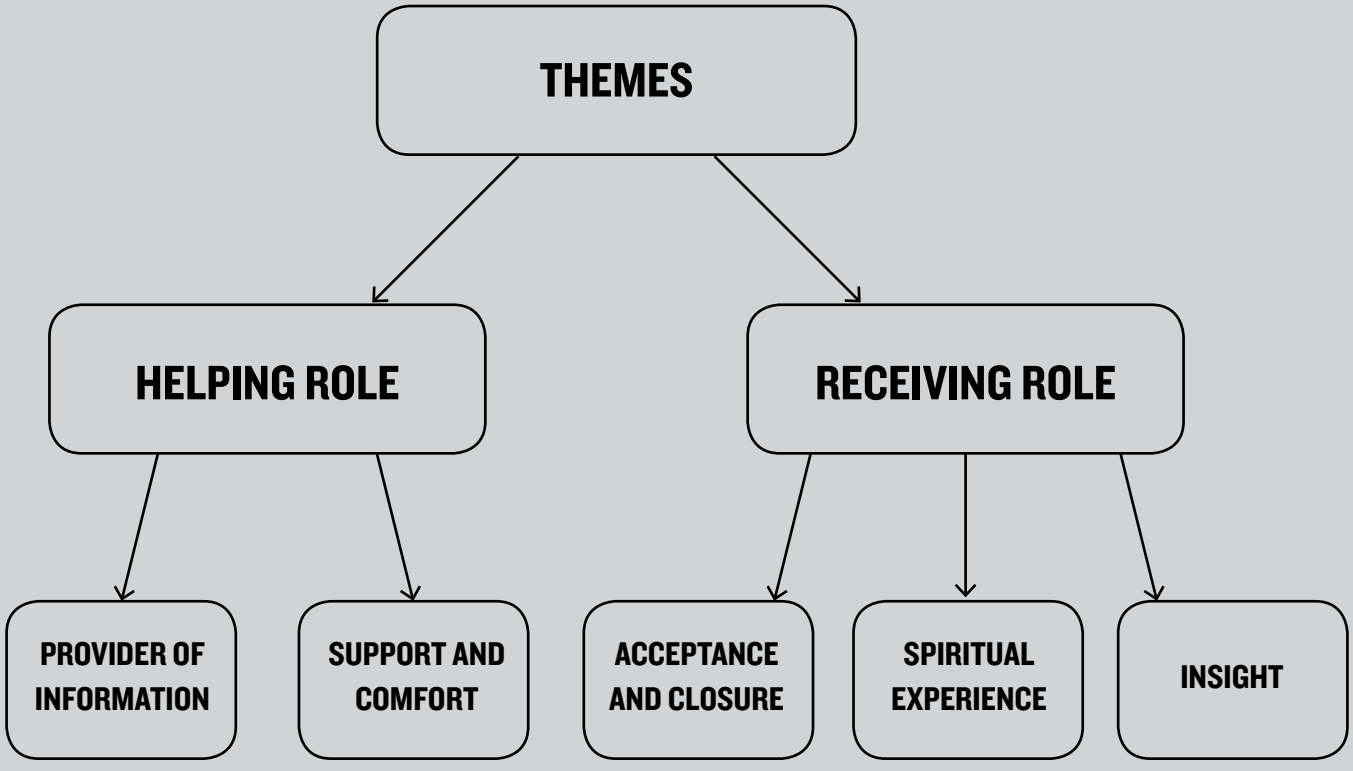
the patient (Doyle et al., 1987; Robinson, Mackenzie-Ross, Hewson, Egleston & Prevost, 1998). It also decreased anxiety for the family around what was happening in the resuscitation room. Family felt that had they been in another room they would have spent considerable time and energy worrying about what was happening. This impacted on their insight as to the reality of the situation (Barrat & Wallis, 1998; Hung & Mangurten et al., 2005; Pang, 2011; Robinson et al., 1998; Weslien et al. 2006). It was also found that lower incidences of anxiety for family when witnessing resuscitation also lowered the incidences of post-traumatic stress syndrome and intrusive imagery following the event (Jabre et al., 2013; Robinson et al., 1998).

Spiritual Experience

Many family members explained the experience of witnessing resuscitation as a spiritual one (Leske et al., 2013; Meyers et al., 2004; Parial et al., 2016). Some family felt this was more so when the resuscitation was unsuccessful and death occurred. They described intuitively knowing their loved one had passed even before it was announced by the health care team. This was described as being a change in the air, a feeling of peace and of a deep knowing their loved one had passed. They also reported intuitively knowing that the patient was comforted by their presence (Meyers et al., 2004; Parial et al., 2016).

Family report that when the patient was awake they felt they could provide spiritual support through prayer, by talking to the patient about their life and helping them to see the purpose of life. Being able to do this created stronger and deeper bonds between patient and family (Leske et al. 2013; Parial et al. 2016). This made them feel closer to their spiritual belief and guider enabling them to put more trust in afterlife and feeling their loved one will be looked after (Parial et al., 2016).

Figure 1. Identified themes and subthemes of family roles when witnessing resuscitation.



WITNESSED RESUSCITATION IN THE EMERGENCY DEPARTMENT: THE FAMILY'S EXPERIENCE

DISCUSSION

The review of literature concerning family witnessed resuscitation shows that being present during resuscitation is mostly a beneficial experience for family members. It has been identified that it provides the family with closure, less anxiety and assistance in their grieving process. By achieving this, family may feel more at peace with the overall care their family member received and satisfied with the health care teams' efforts (Leske et al., 2013). If this is not achieved, family members have the potential to become stressed with increasing anxiety. This anxiety could disrupt the surrounding environment and possibly have an overall negative effect on the patients' health outcome and affect the family members' memory of the experience and overall grieving process (Duran et al., 2007; Meyers et al., 2004).

Although the majority of the literature identified positive experiences of family when witnessing resuscitation, two articles explored some negative findings. Post (1989) briefly mentions that two of the respondents to his survey felt witnessing resuscitation had left an unpleasant memory but this was not expanded on further. Van Der Woning (1999) completed a small study of five family members who witnessed resuscitation and found that three people had a negative experience. These three individuals regretted their decision to be present, describing the experience as frightening, and reporting they felt disconnected from their loved one. Reasons for their negative experience could that the hospital in which the study took place did not have any previous experience with family witnessed resuscitation, perhaps staff were not prepared to deal with family members, or possibly there was no policy in place to guide staff-relative interaction in this scenario.

It has been widely recognised that there is a need for hospital policies regarding family witnessed resuscitation (Basol, Ohman, Simones & Skillings, 2009; Doyle et al., 1987; Hung & Pang, 2011; Leske et al., 2013). Policies ensure staff are informed of the processes, communication amongst staff and also between staff and patients is improved and consistency is provided. It removes the uncertainty for staff around dealing with family, further instilling confidence in the family that the health care team is experienced and capable (Basol et al., 2009). When there is effective communication between staff and family it is proven that family feel acknowledged and involved and complaints towards the health care team are less likely to be made (Jabre et al., 2014). The policy needs to provide the option for family to be present during resuscitation when appropriate and that the decision to be involved or excluded should lie with the family themselves, not the health professionals (Basol et al., 2009). It is expected that a policy will fit with the model of care that the health sector aim to provide in which family are acknowledged as being an essential part of the patients care and decisions are made in conjunction with family when the patient is unable to make these decisions themselves (Bourdreaux, Francis & Loyacano, 2002).

It has been suggested that policies surrounding family witnessed resuscitation may need to include the option for a support person or facilitator for the family when possible (Eichhorn, Meyers, Mitchell & Guzzetta, 1996; Holzhauser et al., 2006; Hung & Pang, 2011; Jabre et al., 2014; Meyers, et al., 2004; Weslein et al., 2005). The role of the facilitator would be to provide family with essential information regarding interventions, patient responses to treatment and providing overall support to the family (Jabre et al., 2014). They would be able to interpret medical jargon for the family and also give information regarding expected outcomes, leading to the family being able to make informed decisions (Holzhouser & Finucane, 2007). Family found the role of providing support and comfort to the patient helpful and a facilitator would be able to aid this by encouraging the family to speak to and touch the patient when appropriate (Meyers, et al., 2004). Agard (2008) discusses how it is important the facilitator is not actively participating in the resuscitation and that the family is their main concern and focus. This enables them to gauge the family's response to the resuscitation, their level of understanding and level of distress which will enable them to decide whether the family were coping ok or needed to leave the resuscitation room (Hung & Pang, 2011). All of this would be done with the aim to lessen family stress and the anxiety that is often associated with resuscitation in an emergency department.

CONCLUSION:

Family members' presence during resuscitation is a beneficial experience. Research has shown that initial concerns connected to families and health care professionals are often ill-founded. These findings could be used to develop policies for hospitals for family witnessed resuscitation, and potentially lead to an improvement in communication and positive experiences between staff and family. This is important in assisting with families grieving process, in their trust in the health care sector and in the reduction of health and disability complaints.

WITNESSED RESUSCITATION IN THE EMERGENCY DEPARTMENT: THE FAMILY'S EXPERIENCE

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VIOLENCE AND AGGRESSION IN NZ EMERGENCY DEPARTMENTS

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ABSTRACT

There continues to be a rising incidence of violence and aggression within healthcare settings; this is neither new nor surprising. What is (or should be) surprising, is the level of acceptance with which we approach the elements that contribute to this. A significant number of events are reported but there seems little doubt that an even greater number go unreported. The reasons for this are complex, and the responses equally so. What needs to be considered, however, is the impact of a continuing workplace culture where certain aspects of violence have become normalised; where, as a profession, emergency nurses have accepted and, by default condoned the actions that contribute to this. A review of the conceptual and practical aspects associated with this topic are briefly presented, to raise awareness and stimulate further discussion. Why are nurses willing to accept so much, and how bad do things need to get before we are prepared to make changes?

INTRODUCTION:

The circumstances facing emergency nurses in New Zealand are no different to those affecting many other nurses, in many other settings nationally and internationally, at least in the broadest sense. Violence and aggression as a feature of modern societies has also become evident within healthcare settings, and has been shown to have particular impact within nursing and for care workers. Certain elements of this are not unique to emergency nursing, including the impact of growing expectations and associated frustrations by members of the public, whether patients or family/friends leading to at times unrealistic expectations can boil over into anger and acting out. The effect of unanticipated delays, misunderstandings and poor communication are cumulative and often lead to escalating frustration and poorly conceived or executed efforts at advocacy. Conditions of high staff turnover, junior workforce, low staff to patient ratios and high patient acuity create an atmosphere of tension and concern regarding staff and patient safety. The need to prioritise patient care can be misinterpreted by patients, family and significant others as neglect or failure to care and exhaustion and burn out seen as disinterest or avoidance. Issues such as these can be further exacerbated by internal conflict within the workforce, including bullying, lack of respect and absence of effective teamwork. These are aspects which can and are present across a range of settings. Added to these, in the ED setting, is the impact of a highly volatile and unstructured workflow – the effect of a constantly changing patient cohort characterised by undifferentiated conditions and variable patient flow. There is no effective capacity to close the doors, to halt the stream of patients or to limit service access. Where mechanisms have been introduced to try and minimise the use of ED services this can have a flow on effect for nurses including increased stress regarding patient and public misunderstanding, anger and aggression around changed services, and patient expectations and concern over whether correct judgments have been made. Where such systems as redirection and ambulance diversion are not possible, the increased patient numbers simply add to the sense of an overwhelming workload; from a patient perspective, this often leads to unanswered questions and further waiting times and delays. The combination of such circumstances creates an atmosphere where tensions become heightened and aggravation is more easily experienced. Added into this mix is the increased level of distress and fear and associated disinhibition which accompanies this in conjunction with acute concerns. These, together with the incidence of drug and alcohol intoxication and impairment in the ED setting makes it an environment of particular risk. It is clear that there are identifiable risks and triggers for violence within the specific ED setting over and above those present in healthcare generally, relating to the patient population, the environment, and the healthcare culture itself.

THE NZ SETTING:

Issues of safety in relation to violence in the workplace can be traced through a number of sources. Media reports have highlighted the presence of increasing violence across the healthcare continuum. A 2014 research report in the New Zealand Medical Journal (NZMJ) identified high rates of

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exposure to violence, aggression and abuse, with 93% of hospital workers reporting that they had been exposed to verbal abuse and 65% to physical aggression within the past year (Swain, Gale & Greenwood, 2014). Of particular concern, when commenting on the research the lead researcher, Nicola Swain noted that: ...nurses and support staff, such as nurse aides, chaplains and receptionists, experienced the greatest number of aggressive incidents. "Nurses have come to accept a level of aggression in their work. It's quite sad," she said. (Mathewson, 2014, The Press).

A media article published in 2015 showed increasing incidents of abuse, and provided examples which highlighted the reality for workers, while noting the majority of examples were occurring in the ED and mental health settings: ... a nurse from Tairawhiti DHB who was punched in the face and bitten on the arm while helping a patient go to the toilet; a Counties Manukau DHB doctor who was kicked in the groin; an aggressive patient who tried to kiss a Capital and Coast DHB staff member; and a Waikato DHB worker who was assaulted and abused for telling a patient not to smoke inside. (Theunissen, 2015, NZ Herald)

Violence and the culture of violence is evident in terms of the type of patient conditions seen in EDs – these are our 'bread and butter' presentations. Violence in the form of interpersonal aggression resulting in injuries, with or without the use of weapons; associated with alcohol, drugs, and impaired driving leading to motor vehicle and other transport related injuries; domestic violence abuse against children, elderly, women and in the form of targeted hate crimes; deliberate, pre-mediated violence and unintentional violence resulting from foolish actions with consequences that exceed those that were anticipated. These are reflections of rising levels of violence within the wider society, of changing behavioural expectations, and shifting moral perspectives.

Within our own workplace settings, we need to consider the culture which ED nurses help to create, and within which we practice. Do we replicate this external violence, in accepting that exposure to aggression on a frequent basis is normal? What are the implication if we become desensitized, essentially develop an immunity, to such exposure in terms of our ability to care and interact meaningfully? We also need to consider what contribution nurses make to the situation, and while it is important to be honest we also need to avoid stigmatisation and victim blaming. Acknowledging that nurses and the culture of nursing may also need to change is not the same as indicating or allocating blame. Recognition that for many nurses it is easier to simply maintain the status quo, without recognising the slippage that can occur over time, is important. It becomes a part of the ED culture to be tough, to get on with the job, and to ignore or dismiss such aspects. These are increasingly seen merely 'background noise'. Unfortunately, this can include verbal abuse, low level sexual innuendo, threatening comments and harassment. The risk in developing the 'thick skin' that is often advocated, is that we do end up taking this for granted – we start to see these actions as no more than background noise and as such, they become accepted and by default acceptable. The underlying problem is that this allows a slow creep towards acceptance of more significant and aggressive behaviour; it is easier to act out in an environment where yelling, swearing and abuse is present than one where it is not.

Similarly, if as professionals we fail to follow through and report such incidents, and if we tolerate a workplace culture which minimises and dismisses these as unimportant, we place ourselves at risk of greater harm. Verbal abuse is a good example, with many practitioners prepared to ignore this, dismissing the time needed to report such actions as wasteful and unproductive. Yet exposure to a constant environment of targeted or general abuse can be likened to a continuous drip of water wearing away at stone. While it seems minimal in its impact, over time it has devastating effect. Indeed, Martin et al., (2007) reviewed a range of literature looking at the impact of verbal aggression, and noted that stress from repeated experiences was associated with "...complaints such as depression, panic disorder, and posttraumatic stress disorder, but also could be related to physical ailments such as hypertension..." and that "... verbal abuse is one of the strongest factors that contributes to dissatisfaction and high rates of attrition in nurses" (p.41).

Many nurses suggest there is no point reporting minor incidents, on the basis that nothing changes as a result, this raises the question of what we, as a workforce, are doing to ensure that it is taken seriously? While there are many actions that can be taken, how often do we let things pass because we are too busy, too exhausted or too 'over it' to follow through? We need to recognise that the very thing we are ignoring is contributing to this exact state. And while some nurses will genuinely be comfortable ignoring even quite explicit behaviours and responses, some will not; or after a 20 year

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exposure, maybe that 'sudden' burnout is not so sudden after all.

It is important to share experiences and to acknowledge what we want the culture within our workplaces to be. If it is not there at present, how do we move towards achieving this? How do we signal to others that this is a problem, and one that needs to be taken seriously?

INFLUENCING FACTORS

Alcohol and drug use

To suggest that the presence of alcohol and drugs exacerbates and triggers violence and aggression, whether in the general setting or in ED, will come as no surprise to any ED nurse (Ahmad et al., 2015; Matthewson, 2014; Preston, 2016; Speroni et al., 2015). While it is only one of many contributing factors, it's prevalence within NZ society is such that it is worthy of specific focus. The opportunity to comment on local and national policies related to alcohol use, to make submissions as individuals or part of professional groups is one further way in which ED nurses can act to help change the culture of violence we face (NZNO, 2016; CENNZ, 2011; CENNZ, 2011a).

In 2014, over 2000 ED clinicians (medical and nursing) working in EDs in Australia and NZ responded to an online survey asking about alcohol related violence and aggression. 98% of respondents had experienced verbal and 92% physical alcohol related aggression over the previous year, with 87% of respondents having felt unsafe in the presence of an alcohol affected patient. When respondents were broken down by profession, nurses were found to have experienced the highest level of concern with safety, at 92% (n=863). Alcohol related aggression was identified as occurring on a daily basis, and alcohol-related presentations were perceived as negatively affecting waiting times, patient flow, work satisfaction and resource allocation (Egerton-Warburton et al., 2016).

A 2016 snapshot survey of alcohol related ED presentations in Australasia showed a quarter of NZ ED patients were there as a result of the harmful use of alcohol. The Clinical Director of Waikato Hospital ED, Dr John Bonning, commented that these patients, in addition to the harm they inflict on themselves:

"...put an undue strain on our emergency departments and can be rude, aggressive, or – in the worst circumstances – even violent towards doctors and nurses" (ACEM, 2016)

The clinical setting

In addition to the presence of intoxicated or impaired individuals, a number of other factors have been linked to the high rates of violence associated with ED settings and the ED patient group. These include the loss of control and increased impulsivity associated with experiences of pain, distress, delirium, altered cognition and pre-existing mental health concerns (Angland, Dowling & Casey, 2014; Speroni et al., 2015). All of these are associated with varying degrees of disinhibition, and emotional lability.

Unique features of the emergency setting further contribute to an environment that enables violence and aggression to occur – the physical setting, frequent crowding, delays in care processes and associated waiting times being examples of these (Gillespie et al., 2013; Morphet, 2014). The acute nature of ED care, the undifferentiated patient in association with sudden changes in priorities and often unrealistic patient expectations further contribute to an atmosphere within which communication can become strained and misunderstandings abound. An inability to offer definitive answers, to provide timely response and meet the range of possible needs can result in staff frustration and avoidant behaviours as well as patient irritation, escalation of anger and acting out.

FAILURE TO ACCURATELY RECORD INSTANCES OF WORKPLACE VIOLENCE

The circumstances surrounding the emergence of violence and aggression, whether considered in terms of physical setting, individual characteristics or external triggers all combine to create what has become increasingly seen as a 'normal' working environment. The expectation that a degree of aggression is just part of the working life of a nurse is not new, nor is the expectation that nurses (and other healthcare workers) will be willing (and able) to ignore the presence of occasional violent outbursts. Yet the acceptance of violence and aggression as part of the work environment has not lessened over time, and is associated with continued minimisation of some forms of violence and a reluctance to report all examples of aggression. The reluctance to report all incidents of violence and aggression is widely recognised (Knowles, Mason & Moriarty, 2012; Morphet et al., 2014; Ray, 2007; Senzuan, Ergun & Karadakovan, 2005), although the reasons underpinning this vary. These include perceptions relating to the relative utility of doing so, and the sense that nothing will be achieved; that the process is cumbersome and time consuming with little benefit; staff desensitisation

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and acceptance or normalisation of violence; recognition of underlying reasons for violence (such as delirium) and reluctance to 'blame' the perpetrator if the situation is seen as outside their control (Arnetz et al., 2015; Gacki-Smith, Juarez & Boyett, 2009; Kennedy, 2005; Morphet et al., 2014).

Dissatisfaction and disillusionment with organisational responses and a sense that reported offenders are not held to account is often suggested as a barrier to staff compliance. Associated with this is the belief that only certain types of incident are worth reporting, and that there is no benefit to reporting in the absence of a physical injury. The use to which such reporting is put can also influence the desire and consistency associated with reporting. If hospitals are only required to formally report on physical injuries, less importance is given to other forms of aggression. When incidents of physical aggression or threats of the same are not followed by some form of response, whether in terms of police involvement or subsequent legal follow up, staff often express a sense of frustration, anger or abandonment feeling that they are less valued and supported than other community members.

RENEWED INTEREST AT A NATIONAL LEVEL

There are increasing opportunities for nurses to make changes and to raise awareness within the political and legislative healthcare framework. Discussion at conferences, and sharing of ideas at forums such as the recent CENNZ ED Nurse Manager's group have offered opportunity to identify the regional issues relating to violence within NZ EDs. The focus is one that fits well with the recent changes to the NZ legislation, with the introduction of the Health and Safety at Work Act 2015, and the associated responsibilities of employers to manage work-related risks that are within their control. While this doesn't mean the need to remove all risks, regardless of cost, it does require that risks are identified and managed in proportion to the relative seriousness of consequences or outcomes. WorkSafe NZ is the official work health and safety regulator for the country, and amongst other functions identifies the role of risk management in relation to psychological risk and threat of violence in the workplace (WorkSafe NZ, 2017). It is emphasised that any threat of violence should be taken seriously, whether physical or verbal. In terms of practical advice and recommendations, direction is still given to the Good Practice Guide Managing the Risk of Workplace Violence to Healthcare and Community Service Providers (Department of Labour, 2009).

There is a continued output in terms of academic literature, focussing on research, expert opinion and discussion of the sociological and professional impact from violence in health care. Within nursing, a number of dissertations and thesis have been written which explore aspects of this phenomenon, its impact on the health workforce, the ability to provide health care, and the experience of the patient. There is also a growing focus and willingness to respond on a national level, with the development of policies, guidelines and standards aimed at developing a cohesive response. Equally important, is the willingness of individual EDs to showcase and share their responses and innovations in dealing with the ongoing problem of violence. We are constantly reminded that nurses are the largest component of the health workforce – certainly largest in terms of number, but not necessarily in terms of influence. We need to recognise that we have the potential to influence change through the sharing of stories, highlighting not only the challenges and problems we face, but also the examples of best practice.

The CENNZ knowledge and skills framework identifies key aspects of emergency nursing practice. Under the Management of Care aspect, specific reference is made to Violence and Aggression in the emergency setting, and a graduated pathway of expertise is mapped showing the progression of involvement and response that emergency nurses can undertake. As nurses move into senior roles, there is an expectation for leadership and participation in policy development and culture change (CENNZ, 2016).

While looking at the possibilities offered by the nursing voice and the nursing network, it is necessary to acknowledge the need to act on a national level. What remains lacking, despite an increased awareness, is the presence of a consensus, uniform approach underpinned by a national framework. This needs to allow recognition, measurement and response to issues of violence and aggression, and to enhance the safety of staff, patients and all others who are affected by this experience.

CONCLUSION:

There is nothing new or surprising in the knowledge that violence and aggression remains problematic in EDs in NZ. This does not mean we can afford to dismiss or assume that all that can be done, is being done. We need to remind ourselves that the smaller instances of violence also have implications, that if we don't have time to report those constant episodes of verbal abuse, or if we feel nothing happens as a result, then it is time to look at the wider system. This can be uncomfortable, challenging, and exhausting; but failure to act means that "we will always get what we've always got".

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MAJOR TRAUMA NATIONAL CLINICAL NETWORK

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Significant changes are underway to transition New Zealand's trauma system in to line with contemporary trauma systems overseas. These changes are led by the Major Trauma National Clinical Network whose goal is to establish a formal, contemporary trauma system in New Zealand. There is good evidence to suggest good trauma care can reduce in-hospital mortality rates, improve recovery from injuries, and improve efficiency of the health system. A few of the priority areas of the network are explained below:

OUT-OF-HOSPITAL DESTINATION POLICY

This new policy was implemented in March 2017 with the intent to take patients to the most appropriate hospital for definitive care direct from the scene, where feasible. In some instances this may mean overflying the nearest hospital. On occasion, the patient may be staged at a medical facility to wait for helicopter transport.

Developed in conjunction with the ambulance sector, we envisage it will impact around 200 patients per annum nationally. The policy and supporting documents are located at: www.majortrauma.nz/resources and encompass:

- NZ major trauma triage policy
- Regional major trauma destination policies for the four regions
- Staging guidelines

A review of the policy will be undertaken at 6, 12 and 18 months.

REGIONAL NETWORKS TO DRIVE CHANGE

Four regional trauma networks are established (Northern, Midland, Central and South Island) and comprise clinical,nursing and other representation. The networks and the overarching Major Trauma National Clinical Network are instrumental in changing how the pre-hospital and hospital system manage trauma patients.

NEW ZEALAND MAJOR TRAUMA REGISTRY

The NZ-MTR was implemented in July 2015 and there are trauma data collectors in all acute hospitals. The inaugural report of the 2015-16 data included all North Island District Health Boards but excluded South Island due to gaps in collection. The key findings showed an overall incidence of 40.8 / 100,000 with variation between the regions ranging from 36 – 48/100,000. Incidence for Maori was nearly double the rate than for non-Maori. Case Fatality Rate was a consistent 9% for each region. Three age peaks were observed at 20 – 24 years, 50 – 60 years and above 75 years. Road traffic crashes account for 50% of all caseload.

WHERE TO FROM HERE?

With the initial foundation work largely in place, the current focus of work is to develop a strategic direction for the next five – 10 years. This will help inform us of the funding and resource requirements and enable a common vision across New Zealand. The key foundations for the trauma system will be the capacity and capability of the workforce and using data from the NZ-MTR to drive quality improvement initiatives.

The nursing workforce across pre-hospital, emergency medicine, surgery and other specialties are key to quality improvement and we look forward to engaging with interest groups and Colleges to work collaboratively to achieve world class trauma care in New Zealand.

The national network is sponsored by ACC and the Ministry of Health, in collaboration with other agencies such as the NZ Transport Agency.

For further information go to the MTNCN website: www.majortrauma.nz/resources

REGIONAL REPORTS

NORTHLAND/TE TAITOKERAU REGION

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Greetings from Northland.

Winter is upon us again and the gloss of living in the "winterless north" tends to fade a little as the slogan gets put to the test with predominantly wet weather over this period. However, from an ED perspective there are some positive changes afoot in the region.

Work is commencing at the Bay of Islands Hospital for a major rebuild of facilities including a new accident and medical department, radiology, after-hours GP and medical ward. The project is designed to help deliver a more patient- centered and integrated model of care that sees collaboration across providers on after-hours primary health care. There will be improved utilization of clinical spaces and access to service delivery in a community setting. This model should serve the people of the mid north and Bay of Islands area extremely well.

Whangarei Hospital has also got some developments pending with a proposal to create a 12-bed medical assessment unit (MAU) with allowance for some higher acuity beds also. The proposal would see the number of medical teams in the hospital increase from 5 to 6 and the unit would be run by a Medical SMO, 2 Registrars and nursing staff. It is hoped this will help to alleviate bed block in ED which for some time has been a serious out-flow problem, with ED being forced to hold patients for prolonged periods when the hospital is running at capacity. Although the proposal includes some bed closures and only sees the permanent net gain of four beds it should at least provide some further flex-up capability.

Within the ED we are constantly streamlining systems and processes to improve service delivery and minimize wait times against a background of steadily rising presentation numbers. There is currently a small and dynamic team working on improvement ideas and projects including collaboration with other specialty services to streamline admission processes and constantly tweaking patient flow in ED.

Webpas is now up and running successfully through-out the hospital replacing our old alpha system and we are acquiring an EDAAG system, in the near future.

There has been quite a large turnover of nursing staff at Whangarei ED recently and although it is always sad to see colleagues leave and remaining staff go through a slight period of upheaval it is equally exciting to have some new people join the team. An influx of fresh perspective and ideas has the effect of being stimulating for the entire team. We will also be taking on two new graduates shortly. This has worked very well for us in the past and some of the students who have done placements in ED demonstrate great potential. It will be a bonus to have them join us permanently.

We look forward to a happy and healthy winter season.

CHRIS

REGIONAL REPORTS

AUCKLAND REGION

MATT COMESKEY

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Auckland District Health Board

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ADULT EMERGENCY DEPARTMENT, AUCKLAND CITY HOSPITAL

When I see the flu vaccinators doing the rounds of the emergency department - I am reminded that winter upon us.

Winter work load planning has been underway for some time in anticipation of the annual busy season. But already the department is seeing early signs of stretched resources and staffing. Episodic bed blockage has occurred, particularly in the weekend and early week when the hangover of weekend admissions coincides with the demand for elective surgical bed spaces results in delays transferring patients to inpatient services. Meanwhile, the numbers through the door continue to grow.

Despite this, the department educators have Analgesia April, Medication May - a push to get as many nurses signed off on medications standing orders to expedite analgesia and broncodilators and steroids to treat asthma, and opioids and nitrates that are incorporated in an undifferentiated chest pain pathway.

Work started in June on the long-awaited Clinical Decision Unit (CDU). It is anticipated that after patients have been assessed in ED and referred to an inpatient specialty – they will be transferred to the adjacent CDU to undergo specialty assessment and admission to a ward. The guidelines for exactly how this will be staffed and how flow to the wards will be applied are still being drawn-up. The unit will have 24 single bedded rooms or cubicles and a procedure room.

A new online DHB wide reporting system for recording incidents, near misses and risk management is now live and operational. It replaces four seperate programmes and will, hopefully, remove some of the uncertainty about which platform to on which to report on, resulting in improved accessibility and data collection. The seperate incident categories are aligned using the World Health Organisation's (WHO) standards - presumably in an effort to gather some nationally and internationally comparable data.

Auckland ED new nursing model of care was rolled out on 14 June after review by NZNO representatives at the request of some NZNO members. We have been using a 'Named Nursing' model for the past 10 years. To meet increasing demand on nursing time and resources the new nursing model is a hybrid of named and team nursing after a trial of team nursing was found to not meet the needs of the department's nurses satisfactorily. At the time of the trial nurses asked for named nursing to remain but additional support added.

A series of winter walks, dinners and sport arranged amongst staff will hopefully take some of the edge off the stresses of working the next few months. No doubt some skiing action will help too - all of which somehow manages to be announced magically via social media or by a notice stuck on the staff room fridge door.

The Auckland region now has three newly registered NPs. Michelle Peperkoorn , based at Middlemore, Danielle Naylor at Starship and myself. Danielle and I completed the NPTP (Nurse Practitioner Training Programme) funded by Health Workforce NZ and administered by either Auckland or Massey University. This brings the number of NPs nationally working in ED to 19, 7 of whom work in Starship or Auckland ED and 3 in Middlemore or North Shore Hospitals. It's worth noting the value in having a core of NP colleagues in easy proximity with whom ideas, support and resources can be shared in both informal and formal settings. Hopefully, over time, this synergy can be replicated in other regions too.

On reflection, the NP journey is not something you undertake on your own. To paraphrase the saying - if it takes a village to raise a child - it certainly takes a whole ED to raise an NP. I'm very grateful for the support of my nursing and medical colleagues and Auckland University in helping me get across the line.

Thank you.

MATT

REGIONAL REPORTS

WAITAKERE EMERGENCY DEPARTMENT

JAN BOYD PAEDIATRIC

Clinical Nurse Specialist

Waitakere Nurse Specialist

Hello from Waitakere ED

We are finally at the end of a massive renovation of our ED which has had its final blessing and opening with the Minister of Health Jonathan Coleman in attendance. This has been a project going on for 2 years and as with any build has had its ups and down and frustrations. Kudos goes to the staff and patients of the ED who have worked and been cared for whilst building goes on around us.

Our new paediatric area is working well and is a spacious and pleasant area in which our younger patients can be cared for. It will be interesting to see how flow works during the winter months as we still have only 9 beds and will need to utilise the front waiting room and consults area to prevent overflow. There is a separate treatment procedure room for children now which allows us to provide best care for children by carrying out "ouchy" and distressing procedures away from their rooms; something which we tried to do in the old department but with shared facilities was not always possible.

We congratulate Cheska Santos on her new position as paediatric clinical nurse specialist intern and wish her well as she commences the CNS paper.

Our new graduate nurses are rotating through the different areas of Waitakere ED and are coming to grips with a busy and now large department. Their coaches are doing a great job in teaching these nurses the specialist skills required of emergency nursing.

We are as I am sure other departments can attest getting more and more patients through our doors. Marja Peters CNM tells me that we have had an increase of another 7.5% on this time last year. The government is concerned with Auckland housing and how we can meet the housing needs of new arrivals but it's not just housing that we need to focus on. We will be challenged to care for a marked increased demand for health care with this growing population in Auckland and we are already feeling it.

Some of us are looking forward to a road trip to Taranaki in June for the next AENN regional study day. Of course we will be leaving super early the day before to get down the Southern Motorway before it is at a standstill.

This is just a snippet of what has been going on out West, we have a great team culture and as we are now a big spread out department. Our next challenge is to keep it the "Waitakere way".

JAN

POEMS BY AOTEAROA NEW ZEALAND NURSES

NZNO celebrated International Nurses Day in Wellington with the launch of Listening with my heart: Poems by Aotearoa New Zealand nurses. Edited by Professional Nurse Advisor Lorraine Ritchie, this fabulous new book features the work of 35 nurses. Production of this poetry book is part of NZNO's Visibility of Nursing Project.

"By their involvement in the arts, whether poetry, painting, or writing novels, nurses and other health professionals have the opportunity to express a side of themselves which is not always possible in their day-to-day work. It is a creative way of reflecting and thinking about what they see and do and feel in their daily contact with patients.

"There has never been a book of poetry written by nurses about nursing in NZ, so this will be a first and tremendously exciting for all involved and a boost for nurses too." ~ Lorraine Ritchie, Editor

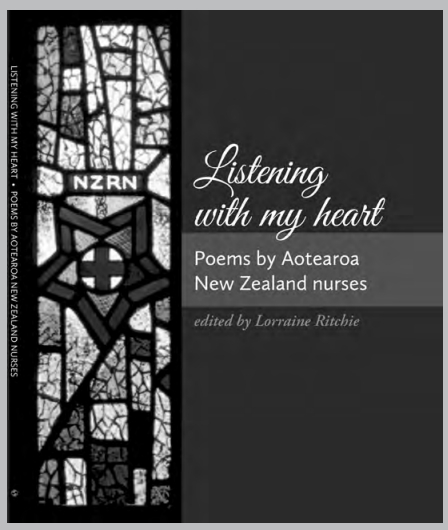
'Listening with my heart' : Poems by Aotearoa New Zealand nurses

A beautiful book to delight your soul

NZNO members: $25.00

Non NZNO Members: $30.00

To order copies: http://www.nzno.org.nz/resources/nzno_publications/listening_with_my_heart



REGIONAL REPORTS

AUCKLAND REGION

MICHELLE PEPERKOORN

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Middlemore Hospital Emergency Department

Counties Manukau District Health Board

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Nga mihi o te wa ki a koutou ara ki a tatou katoa

Ka mihi ki tenei wa ara te wa o Matariki

Well it's now into winter and fast approaching Matariki which is traditionally toward the end of June. (Maori New Year).

Numbers through the emergency department have continued to surprise us with a few of the busiest days to date. We have been averaging 300+ most days with 369 on one particular Monday. Our adult waiting and assessment area are the focus of intensive multi-disciplinary evaluation to look at patient seen-by times and flow through the department. Paediatrics is already noticing an increase in the numbers of usual winter presentations.

We have had 25 brand new RN's start since Feb bringing our total RNs to 270. We now have a full Educator team with 2 currently working in adults and another 2 due to start over the next 2 months; 1 in paediatrics and the other joining the adult team.

BE ON THE LOOKOUT: *We have had some interesting presentations, including a case of secondary syphilis. This disease is on the rise in New Zealand as it is around the rest of the world. So look out for non-itchy/ non-painful rashes on the hands and feet which are patho-pneumonic. It has been called, "The Great Pretender" as it can mimic many other conditions.*

PROJECTS AND QUALITY INITIATIVES:

- Recognition of the Unwell Child study day, – designed by our paediatric CNS Nikki Fair and Tash Steel. The day is aimed at increasing the knowledge base of our dual nurses in preparation for triage. It consists of didactic and interactive teaching sessions covering paediatric differences and how this impacts on nursing care of common paediatric presentations. Paediatric trauma and non-accidental injury is also covered. While this is a sobering topic, New Zealand has horrific statistics when it comes to child abuse. Recognition and appropriate intervention is an important responsibility as paediatric healthcare professionals.
- We have also implemented obesity screening of all our paediatric patients over 2 years of age. As part of the program we provide healthy lifestyle education to the family. This pilot project is being led by RN Jo Thompson and so far the feedback from the families has been very positive.
- We have 2 new clinical coaches in paediatrics. Their brief is to provide senior nurse support and bed side teaching opportunities for our more junior staff. Stacey Barron and Tracey Young have won the 'Clinical Coach of the Year award' at the recent Counties Manukau Nursing and Midwifery awards. Rosanna Cullen was awarded New Graduate of the Year.
- ED Foundations Programme – designed by Kellie Brown (Nurse Educator-adults) and Annie Fogarty (CND) which is designed to incorporate a comprehensive programme over 7 mornings to assist new RNs with their transition and orientation in to Middlemore ED. This programme is aimed at focussed assessments, critical thinking, bundles of care, building resilience – getting a good grounding and consistent base prior to being preceptored on the floor. Also a chance for cannulation and phlebotomy sign off, medication sign off, skills stations etc. Will also get a small introduction to career pathways, professional development opportunities, and quality improvement projects within the department and what they mean to us.
- Thursday Simulations – link to the ongoing simulation opportunities for all ED staff that are held every Thursday at 0900 http://www.mmheme.org/simulation-2/

We look forward to sharing our winter adventures with you in 3 months' time.

Meanwhile stay safe and warm. Don't forget your flu vaccine :)

MICHELLE & NICKY

REGIONAL REPORTS

MIDLAND REGION

RICK FORSTER

Registered Nurse

Chairperson

Tauranga Emergency Department

Bay of Plenty District Health Board

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Greetings from the Midland Region

It was fantastic to attend the recent CENNZ National Charge Nurse Forum held in Wellington. This gave me the opportunity to catch up with two new unit mangers within the Midland region. Sandra King has taken up the role in Thames. It was interesting to hear about the challenges associated with smaller hospitals such as inter-hospital transfers and dealing with massive surges in presentations during the holiday period.

Kaidee Hesford has made a welcome return to the Bay of Plenty. She has recently commenced the role of unit manager for the Rotorua Emergency Department. It was great to hear about the establishment of their new Senior Nurse Clinical Coordinator positions. I am sure this will greatly support leadership and quality care within their unit.

In the Tauranga Emergency Department our two wonderful new grads have completed their first year of practice successfully. They have both secured on-going positions with us and it is exciting to have this year's graduates now working on the floor. The enthusiasm of new graduates brings a nice element to our department and challenges us to reflect on our own practice when guiding them.

A period of significant change continues in our department. Three long serving Senior Nurse Clinical Coordinators have recently moved on. Over many years I have seen these nurses put their hearts and souls into the role, using their broad knowledge and skills to navigate our department through many tough situations. They all valued the importance of emergency nurses as patient advocates and were also willing to speak up for their respective teams. Their huge contributions will not be forgotten any time soon and I wish them well for the future endeavours.

Our focus on the early identification and referral of the frail elderly continues to pay dividends. The care of the elderly outreach multidisciplinary team perform regular rounds with the Emergency Department. They review the situation for all patients identified using a brief risk assessment tool completed by the RNs. This has been found to also improve care for those being admitted to the wards supporting safe and timely discharge.

The "front of house" model of care is becoming embedded. One nurse triages over the counter with another waiting room based nurse performing reassessments, interventions and starting investigations or pathways. For example the asthma care pathway is being readily used and definitely helps get treatment underway sooner; a great tool to have as we navigate this winter.

A front-of-house team leader, supports triage and the waiting room nurse. Whilst liaising with the Shift Coordinator they facilitate inwards flow into the department. These activities may not have improved the time to see a Doctor KPI, but it is likely helping the time to discharge from the Emergency Department.

Our recent shorter stays in ED target has improved by approximately two percent taking us to around 95-96%.

RICK

REGIONAL REPORTS

HAWKES BAY / TARAWHITI REGION

Paula Draper

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Emergency Department

Hawkes Bay Regional Hospital

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Greetings from a sunny but chilly Hawkes Bay, where winter is starting to put in an appearance with some very frosty mornings!

The coughs colds and sniffles are currently affecting both staff and patients. There has been a great response to the staff flu vaccine immunisation programme this year, and the department has also been offering vaccination to patients who are at risk.

Just like the rest of the country, Hawkes Bay's ED and walk in medical centres continue to be busy with ever increasing presentations. The hospital has been at capacity on numerus occasions which of course impacts on ED flow. Despite this, the Shorter Stays in ED target is at 95%.

New initiatives that are almost up and running include the introduction of care bundles. The first ones to be introduced will include croup, hyperemesis, and fractured neck of femur. Alcohol screening of patients will also be introduced soon.

We have said goodbyes to a number of staff, as well as hello to new ones. We welcome to our department Annatjie Pretorius, our latest Nurse Practitioner and we have also celebrated the 25 years of service to ED by Dr John Trewick.

In an effort to stay healthy, get fit and have some fun, Team ED has developed a Team Challenges group and are currently working their way through the many activities that are on offer each weekend in Hawkes Bay.

Participants have included staff from St John's Ambulance as well as medical staff from outside of ED, so some good competitive 'fun' being had, as well as some very interesting Team names!

PAULA

MID CENTRAL REGION

Katie Smith

(Currently Overseas)

REGIONAL REPORTS

TOP OF THE SOUTH REGION

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Greetings from the Top of the South. Autumn has suddenly given way to winter in the South Island and the first dustings of snow on the hills have excited the skiers amongst us.

It is business as usual in the emergency department and in the past months that has increasingly come to mean a daily battle to achieve flow, match resources with demand and navigate bed block. There have been many consecutive days of hospital occupancy over 100%. This has been matched with a 10% increase in ED presentations and high admission rates. These factors have all combined to impact negatively on key performance indicators (KPI). The last two months has seen Nelson fall below the 95% six hour target, patient minutes in the department have increased by 6% and people choosing not to wait has risen. It is of note that during May a 17% increase in triage 3 patients was recorded and no doubt this has contributed to the higher than normal admission rates.

There is strategic work going on in the organisation around the development of Acute Admitting Unit (AAU) facilities but this will not be an immediate fix. Some short term strategies have been to open day stay beds overnight and for suitable patients to be redirected to a GP service at the DHB's cost. Working to longer term solutions is vital. The constant mitigation of clinical risk that ED overcrowding and bed block creates is challenging for all staff.

Despite the busy days at the coal face there are also many positive developments to acknowledge. We are currently trialling the first ever dedicated HCA in the ED. Sophie has become an integral member of the team. Nursing has regained valuable minutes previously spent doing non-nursing tasks and I'm sure this role has contributed to falls prevention and the improved observation of mental health and confused patients.

We also are about to commence an 8 month pilot of 2 Clinical Nurse Specialist (CNS) positions. This is a great opportunity to see how advanced practice roles may add to our model of care and positively influence KPIs. It is also a landmark for nursing in our department. We have many nurses who have made major commitments to post graduate study so hopefully a successful pilot may present career pathways for others and extend over the hill to Wairau ED.

Many of the ED team are involved in quality initiatives. We are conducting a prospective wound audit and also overhauling our sepsis pathway to ensure it is 'triage initiated' and standardised across the department. We are also beginning to look at how other health care agencies may be better placed to provide care for patients with long term indwelling catheter complications. These patients are often elderly and immobile and spending many hours in the ED is not ideal.

We have recently held a Resus study day for both Nelson and Wairau staff. This is an annual initiative and designed to prepare staff to work in this area. We are also fortunate to be hosting the ENPC in Nelson shortly. On many occasions planned nursing education and training is cancelled to meet the demands of a busy department. Understandably priorities to patient care do dictate this. However this has initiated discussion about how we can find a sustainable way to protect these activities and foster nurse - led education and journal club in our department. I would be very interested to hear of any successful strategies others may have adopted.

Finally, we have welcomed a cohort of enthusiastic new staff and sadly said goodbye to Mel D who has headed to Invercargill ED. We have also waved Renee off to Mosul in Iraq on a short term assignment.

As we receive some of her first communication about the harrowing experiences for people living in a conflict zone we are very appreciative of our own patch.

JO

REGIONAL REPORTS

GREATER WELLINGTON REGION

BEN STOREY

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Capital Coast District Health Board

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WELLINGTON ED

As we all continue on with ever increasing workloads across our EDs the focus remains on providing excellence in nursing and medical care.

This has been through the development of new pathways and protocols (Hutt Hospital), ED guidelines (3DHB) and combining our nurse and medical education (3DHB). We are all committed to standardising our approach to emergency health care and growing resilience in our teams.

It is always a challenge thinking of new ways to ensure our departments remain decongested and we have free flow through the pipelines that are the infrastructure of the hospital. We are pleased to report an increase in our SSiED over this last quarter. Acute flow remains a constant focus for all at Wellington. We have been working with the Francis Health group to better manage flow and communication within our own department. A process of using Rapid Cycle Tests of Change (RCTCs) have resulted in some key changes for us here in Wellington, including how we run our shifts, focusing on the senior leadership team, introducing regular 'rounding' and improving communication across all members of the team. Results to date are really positive and it certainly is creating a sense of improved support (clinical, communication and resilience) for all.

One great quality project we would like to share is the PRICT project (Practise Responsible Intra Venous Cannulation Today). Championed by one of Wellington's ACNMs Lynne Stephens, the project has looked into unnecessary IV cannulations and blood tests. The buy-in across ED and speciality services has been extraordinary resulting in a huge decrease in unnecessary tests and invasive procedures. To hear more about this you'll need to wait for Lynne's presentation in Queenstown! Hutt ED has now taken on the project. They are hoping for similar results. Again, it's all about safe and responsible practice!

We hope you all enjoyed your International Nurses Day celebrations. Here in Wellington we celebrated with a waffle breakfast starting at 06.00 for the night staff and on-coming AM shift. Our CNM and senior staff treated the team to this delicious breakfast that also included spot prizes to the movies and wine. Our separate DHBs also hosted a celebratory awards evening which was well attended.

As we all head in to winter we hope you are all looking after yourselves and had your flu jabs! Uptake this year in Wellington has been over 90% of all ED staff so here's hoping the viruses stay away!

That's it from us. Stay safe and well this winter and see you all in Queenstown for what is promising to be an awesome conference.

BEN

REGIONAL REPORTS

CANTERBURY / WESTLAND REGION

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Canterbury District Health Board

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CANTERBURY/WESTLAND

Challenges continue to present for nurses working across the region, as the ongoing effects from the Kaikoura earthquake continue to impact resources (both human and other), the winter illness levels start to become apparent for staff and patients, and attention is focussed on the effects of health constraints in terms of service provision (particularly mental health).

Despite this, there are many positives also evident, with a number of emergency nurses having recently completed the Emergency Nurses Paediatric Course (ENPC) and the Emergency Management of Severe Burns (EMSB) programmes.

We have been very fortunate to receive support from the regional ECCT (Emergency Care Coordination Team) to support staff attendance at the ENPC course, with funding provided for five Westland, two Ashburton and seven Christchurch ED nurses.

Christchurch Hospital Emergency Department has seen further development of its movement towards introducing advanced practice opportunities for nurses. Following on from the successful appointment of Paddy Holbrook as the South Island's first ED based NP, the Christchurch Hospital ED has a second CNS working towards NP accreditation (Morag Lawson). In addition, two further CNS roles have been approved offering development opportunities leading towards NP application, with Carla Turnbull and Frances MacDonald the successful applicants for these positions. Paddy and Morag are providing a wide ranging nursing care service, moving beyond the more traditional minor injury and illness management, incorporating more complex patient care and negotiating new parameters of practice.

The ED has continued to meet its overall MoH targets, with 95% of patients being seen within the six hour target, as of April of this year. Recent opportunities to share knowledge and experience with other EDs and services has included a visit from the Waitemata DHB staff and the opportunity to exchange information on clinical pathways and bundles of care. Of particular interest was the focus on nursing within the care bundles presented, the opportunity and expectation that nurses would undertake meaningful interventions early on in the process, and in line with this the importance of developing any such initiative with support from a wider, multidisciplinary team.

Clinical focus within the department has included awareness of the guidelines relating to sepsis management and early detection/intervention, the roll out of the stroke awareness public education campaign, and development within the department of additional pathways to help maintain safe and effective management of mental health patients, in collaboration with the Psychiatric Consult Liaison Team. The stroke pathway has been updated to include clot retrieval as well as thrombolysis, offering more clinical choices in terms of intervention. The Mental Health pathways have focussed on developing guidelines and tools to support assessment of mental health patients, including the Ministry of Health/adapted Australasian Triage Score recommendation. Additional education and support has been provided for both nursing and security staff with regard to requirements for 'patient watches' and education around recognition and assessment of competency and safety integrated into nursing team training days.

SANDY

REGIONAL REPORTS

SOUTHERN REGION

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SDHB ORGANISATIONAL CHANGES

Chris Fleming SDHB CEO is currently reviewing the organisational structure of the DHB. The current proposed changes may result in the loss of thirteen 13 senior nursing positions in Dunedin Hospital and the loss of a DON in Invercargill Hospital. The highest nursing representative will no longer be at member of the executive level. There is a petition from staff in progress to represent the nurses' viewpoint on the proposed changes.

A campaign is also currently in progress from Dunedin City Council and the public on the planning and redevelopment of Dunedin Hospital. The emphasis is on the development of a new hospital remaining in the central city.

CENNZ CONFERENCE UPDATE

The conference website is constantly getting updated and looks great. Registrations are open and are coming in while the work continues on sponsorship. Abstracts are open until 14 June. These will be confirmed the following week and updated on the website.

DUNEDIN

STAFFING

We welcome Janet Andrews as Dunedin ED's new Charge Nurse Manager. Janet has been active in the role since February and promotes a cooperative collegial approach to working in ED. Janet and Leanne Shallish, the CNM at Invercargill hospital, recently attended the inaugural meeting of CNM in Wellington arranged by CENNZ. They found it positive and beneficial with great opportunities for networking and sharing ideas with other CNMs.

Congratulations to Nic Holborow who was successful in gaining the temporary ACM role, and Cheryl Jellone who his currently assisting in the ACM role while other staff members continue with project work.

EDUCATION

ED's educator Shona Willers has also been affected by the current restructuring with direct responsibility to the Knowledge Centre together with all other educators throughout the hospital. Thankfully we will not lose Shona who will remain based within ED.

There has been an emphasis on education during the early part of this year with many of the staff taking the opportunity to learn and enhance skills during simulation teaching, suturing, plastering and minor injury study day. Congratulations also to all the staff that passed the triage course in March.

PATIENT PRESENTATIONS

Daily presentations in the first few months did not decline but increased with an average of 130-140 presentations a day. Day to day variations have meant that on some days presentations have reached 150 - 170. The last few weeks have also seen a rise in patient acuity with up to 25 percent of presentations needing referral to specialist disciplines within the hospital. This has impacted on the patient journey, compounded by ward bed availability, delaying transfer of patients to the ward. Specialty consultants have reviewed patients in the ED environment.

REGIONAL REPORTS

INVERCARGILL

STAFFING

In March our first ED Nurse practitioner Kirsty Lewis commenced and is in this new position, working really well. She is seeing Triage 2 and 3. Recruitment for the winter flex position had been delayed and has only recently been advertised together with another RN permanent position.

PRESENTATIONS

There has been an average presentation of 2520 patients monthly in the first quarter, with increasingly high acuity. Multiple large traumas with significant injuries, multiple transfers and long hospital stays have impacted on the ED and hospital.

PROJECTS & EDUCATION

We are currently looking into patient flow and a project around this is in the early stages. We are holding a paediatric education day in June.

OAMARU

VISITS

An open forum was held in March regarding the hospital's re-development. SDHB managers Richard Thompson, Chris Fleming and Dick Bunton visited. We eagerly await the outcomes of this forum.

We were also visited by our SDHB CENNZ representative who met the new Nursing Director Janice Clayton. Janice has a background in mental health nursing.

PRESENTATIONS

Presentations for April 2017 were slightly down although acuity levels remain the same. Night duty nurses and doctors report these times being busier. This has affected the inpatient ward with transfers to Dunedin when beds spaces are full. A roster for overnight on call registered nurses in ED is being arranged.

STAFFING.

We are excited to welcome a new role, emergency department receptionist. The plan is to have reception cover from 0800hrs - 2000hrs 7 days per week.

This will be reviewed in 6 months time.

Staffing and funding remain an issue with upcoming (June 2017) DHB negotiations. Duty nurses continue to take over the ED at 4 pm rather than a specific ED nurse and issues relating to the nurses answering all the phone calls as well as triaging and providing patient care persists. There are also more frequent requests for RN escorts for ambulance transfers. This is proving difficult to provide at short notice.

QUEENSTOWN

No report was available at time of going to print.

ERICA

NEW ZEALAND NURSES ORGANISATION

Southern District Health Board
Piki Te Ora

CENNZ 2017
Conference

"Remotely Rural in the City"

The 26th Annual College of Emergency Nurses New Zealand Conference is being held at Rydges Hotel, Queenstown on the 13th and 14th October 2017.

Early bird registrations close 30th June 2017 so be in quick to register.

For more information on registration , abstracts, speakers and much more visit
www.cennz2017qtown.co.nz

AENN 1/2 Day - 12th October 2017
This will be held at Queenstown hospital - Seminar room from 1330 - 1730 hours. (This is a 10 minute walk from the airport)

For further information please contact sandra.buzzard@southerndhb.govt.nz

July | 2017
The Journal of the College of Emergency Nurses New Zealand (NZNO)
ISSN 1176-2691

EMERGENCY NURSE NEW ZEALAND